DentaQuest, LLC

Office Reference Manual

Please Refer to Your Participation Agreement for Plans You are Contracted For

Healthy Blue

11100 W Liberty Drive
Milwaukee, WI 53224-3626
888.307.6547
www.dentaquest.com

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* DentaQuest is an independent company providing dental benefit management services on behalf of Healthy Blue.

Healthy Blue is a Medicaid product offered by Missouri Care, Inc., a MO HealthNet Managed Care health plan contracting with the Missouri Department of Social Services. Healthy Blue is administered statewide by Missouri Care, Inc. and administered in the Kansas City service region by Missouri Care, Inc. in cooperation with Blue Cross and Blue Shield of Kansas City. Missouri Care, Inc. and Blue Cross and Blue Shield of Kansas City are both independent licensees of the Blue Cross and Blue Shield Association.
BMOPEC-0463-21 February 2021

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DentaQuest, LLC
Address and Telephone Numbers

Provider Services
11100 W Liberty Drive
Milwaukee, WI 53224-3626
888.307.6547
Fax numbers:
Claims/payment issues: 262-241-7379
Claims to be processed: 262-834-3589
All other: 262-834-3450
Claims questions:
denclaims@dentaquest.com
Eligibility or Benefit Questions:
denelig.benefits@dentaquest.com

Customer Service/Member Services
Healthy Blue: 800-214-9881
DentaQuest: 888-696-9533

Provider Services - 888-307-6547

Fraud Hotline
800.237.9139

TDD
Healthy Blue Health Plan: 711

Multilingual
Healthy Blue: 833-388-1407

DentaQuest* Provider Web Portal
www.dentaquestgov.com
24/7 assistance with member eligibility, clinical history, claim and authorization submission, claims and authorization status, copies of frequently used documents and many other features.

Credentialing
11100 W Liberty Drive
Milwaukee, WI 53224-3626
Credentialing Hotline: 800.233.1468
Fax: 262.241.4077

Authorizations
PO Box 2906
Milwaukee, WI 53201-2906
Fax: 262.241.7150

Authorizations should be sent to:
DentaQuest of MO-Authorizations
PO Box 2906
Milwaukee, WI 53201-2906

Claims should be sent to:
DentaQuest of MO-Claims
PO Box 2906
Milwaukee, WI 53201-2906

Electronic Claims should be sent:
Direct entry on the web – www.dentaquest.com
Or,
Via Clearinghouse – Payer ID CX014
Include address on electronic claims –
DentaQuest, LLC
PO Box 2906
Milwaukee, WI 53201-2906

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DentaQuest, LLC

Statement of Members Rights and Responsibilities

The mission of DentaQuest is to expand access to high-quality, compassionate healthcare services within the allocated resources. DentaQuest is committed to ensuring that all Members are treated in a manner that respects their rights and acknowledges its expectations of Member's responsibilities. The following is a statement of Member's rights and responsibilities.

Member Rights:

1) Dignity and privacy. Each member is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.

2) Receive information on available treatment options. Each member is guaranteed the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.

3) Participate in decisions. Each member is guaranteed the right to participate in decisions regarding his or her health care, including the right to refuse treatment.

4) Be free from restraint or seclusion. Each member is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

5) Obtain a copy of medical records. Each member is guaranteed the right to request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR part 164.

6) Freely exercise these rights. Each member is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the health plan and its providers or the state agency treat the member.

Member Responsibilities:

1) Providing, to the extent possible, information needed by providers in caring for the member.

2) Contacting their primary care provider as their first point of contact when needing medical care.

3) Following appointment scheduling processes.

4) Following instructions and guidelines given by providers.

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DentaQuest, LLC

Statement of Provider Rights and Responsibilities

Providers shall have the right to:

1. Communicate with patients, including Members regarding dental treatment options.

2. Recommend a course of treatment to a Member, even if the course of treatment is not a covered benefit, or approved by Plan/DentaQuest.

3. File an appeal or complaint pursuant to the procedures of Plan/DentaQuest.

4. Supply accurate, relevant, factual information to a Member in connection with an appeal or complaint filed by the Member.

5. Object to policies, procedures, or decisions made by Plan/DentaQuest.

6. If a recommended course of treatment is not covered, e.g., not approved by Plan/DentaQuest, the participating Provider must notify the Member in writing and obtain a signature of waiver if the Provider intends to charge the Member for such a non-compensable service.

7. To be informed of the status of their credentialing or recredentialing application, upon request.

8. To cooperate and provide the MO HealthNet Division, MO HealthNet managed care plans, DentaQuest, government agencies and any external review organizations with access to each Member's dental records for the purposes of quality assessment, service utilization and quality improvement, investigation of Member grievances or appeals or as otherwise is necessary or appropriate. Please note that providers need not obtain the Member's consent in order to release this information. All MO HealthNet Members provided this release when they signed their MO HealthNet application.

* * *

DentaQuest makes every effort to maintain accurate information in this manual; however will not be held liable for any damages directly or indirectly due to typographical errors. Please contact us should you discover an error.

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1.00 Patient Eligibility Verification Procedures

1.01 State Eligibility System

Please use State Eligibility System as primary source of eligibility verification.

573.751.2896 or www.emomed.com

1.02 Plan Eligibility

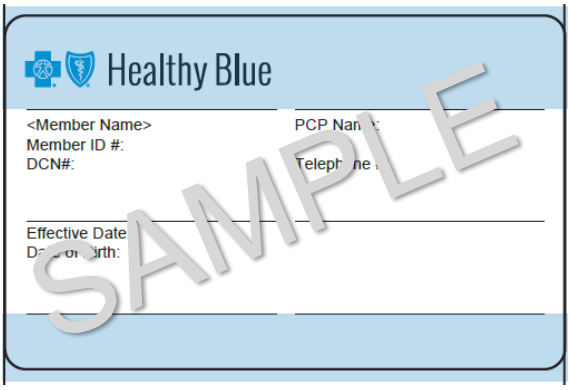
Any person who is enrolled in a Plan's program is eligible for benefits under the Plan certificate.

1.03 Member Identification Card

Members receive identification cards from their Plan. Participating Providers are responsible for verifying that Members are eligible at the time services are rendered and to determine if recipients have other health insurance.

Please note that due to possible eligibility status changes, this information does not guarantee payment and is subject to change without notice.

DentaQuest recommends that each dental office make a photocopy of the Member's identification card each time treatment is provided. It is important to note that the Health Plan identification card is not dated and it does not need to be returned to the Health Plan should a Member lose eligibility. **Therefore, an identification card in itself does not guarantee that a person is currently enrolled in the Health Plan.**



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1.04 DentaQuest Eligibility Systems

Participating Providers may access Member eligibility information through DentaQuest's Interactive Voice Response (IVR) system or through the Dentist Portal which can be accessed via www.dentaquestgov.com. The eligibility information received from either system will be the same information you would receive by calling DentaQuest's Customer Service department; however, by utilizing either system you can get information 24 hours a day, 7 days a week without having to wait for an available Customer Service Representative.

Access to eligibility information via the Internet

DentaQuest's Internet currently allows Providers to verify a Member's eligibility as well as submit claims directly to DentaQuest. You can verify the Member's eligibility on-line by entering the Member's date of birth, the expected date of service and the Member's identification number or the Member's full last name and first initial. To access the eligibility information via DentaQuest's website, simply go to our website at www.dentaquestgov.com. Once you have entered the website, click on the "Dentist" icon. From there choose your 'State" and press go. You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business's NPI or TIN, State and Zip Code. DentaQuest should have contacted your office in regards on how to perform Provider Self Registration or contact DentaQuest's Customer Service Department at 888.307.6547. Once logged in, select "Patient" and then "Member Eligibility Search" and from there enter the applicable information for each Member you are inquiring about. You are able to check on an unlimited number of patients and can print off the summary of eligibility given by the system for your records.

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Access to eligibility information via the IVR line

To access the IVR, simply call DentaQuest's Customer Service Department at 888.307.6547. The IVR system will be able to answer all of your eligibility questions for as many Members as you wish to check. Once you have completed your eligibility checks, you will have the option to transfer to a Customer Service Representative to answer any additional questions, i.e. Member history, which you may have. Using your telephone keypad, you can request eligibility information on a Medicaid or Medicare Member by entering your 6-digit DentaQuest location number, the Member's recipient identification number and an expected date of service. Specific directions for utilizing the IVR to check eligibility are listed below. After our system analyzes the information, the patient's eligibility for coverage of dental services will be verified. If the system is unable to verify the Member information you entered, you will be transferred to a Customer Service Representative.

Directions for using DentaQuest's IVR to verify eligibility:
Entering system with Tax and Location ID's

1. Call DentaQuest Customer Service at 888.307.6547.
2. After the greeting, stay on the line for English or press 1 for Spanish.
3. When prompted, press or say 2 for Eligibility.
4. When prompted, press or say 1 if you know your NPI (National Provider Identification number) and Tax ID number.
5. If you do not have this information, press or say 2. When prompted, enter your User ID (previously referred to as Location ID) and the last 4 digits of your Tax ID number.
6. Does the member's ID have **numbers and letters** in it? If so, press or say 1. When prompted, enter the member ID.
7. Does the member's ID have **only numbers** in it? If so, press or say 2. When prompted, enter the member ID.
8. Upon system verification of the Member's eligibility, you will be prompted to repeat the information given, verify the eligibility of another member, get benefit information, get limited claim history on this member, or get fax confirmation of this call.
9. If you choose to verify the eligibility of an additional Member(s), you will be asked to repeat step 5 above for each Member.

Please note that due to possible eligibility status changes, the information provided by either system does not guarantee payment.

If you are having difficulty accessing either the IVR or website, please contact the Customer Service Department at 888.307.6547. They will be able to assist you in utilizing either system.

1.05 Health Plan Eligibility Phone Number

Healthy Blue Health Plan: 800.322.6027

1.06 Health Plan Facility Authorization Phone Number

Provider should submit services to DentaQuest for authorization. Upon receipt of approval from DentaQuest, Providers should contact the Plan for facility authorization at the number below.

Healthy Blue: 833-405-9086

1.07 Specialist Referral Process

A patient requiring a referral to a dental specialist can be referred directly to any specialist contracted with DentaQuest without authorization from DentaQuest. The dental specialist is responsible for obtaining prior authorization for services according to Appendix B of this manual. If you are unfamiliar with the DentaQuest contracted specialty network or need assistance locating a certain specialty, please contact Provider Services at 888-307-6547.

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2.00 Authorization for Treatment

2.01 Dental Treatment Requiring Authorization

Authorization is a utilization tool that requires Participating Providers to submit "documentation" associated with certain dental services for a Member. Participating Providers will not be paid if this "documentation" is not provided to DentaQuest. Participating Providers must hold the Member, DentaQuest, Plan and Agency harmless as set forth in the Provider Participation Agreement if coverage is denied for failure to obtain authorization (either before or after service is rendered).

DentaQuest utilizes specific dental utilization criteria as well as an authorization process to manage utilization of services. DentaQuest's operational focus is to assure compliance with its utilization criteria. The criteria are included in this manual (see Clinical Criteria section). Please review these criteria as well as the Benefits covered to understand the decision making process used to determine payment for services rendered.

A. Authorization and documentation submitted before treatment begins (Non-emergency) treatment.

Services that require authorization (non-emergency) should not be started prior to the determination of coverage (approval or denial of the authorization). Non-emergency treatment started prior to the determination of coverage will be performed at the financial risk of the dental office. If coverage is denied, the treating dentist will be financially responsible and may not balance bill the Member, the Plan and/or DentaQuest.

Your submission of "documentation" should include:

1. Radiographs, narrative, or other information where requested (See Exhibits A – C for specifics by code)
2. CDT codes on the claim form

Your submission should be sent on an ADA approved claim form. The tables of Covered Services (Exhibits A – C) contain a column marked Authorization Required. A "Yes" in this column indicates that the service listed requires authorization (documentation) to be considered for reimbursement.

After the DentaQuest dental director reviews the documentation, the submitting office shall be provided an authorization number. The authorization number will be provided within two business days from the date the documentation is received. The authorization number will be issued to the submitting office by mail and must be submitted with the other required claim information after the treatment is rendered.

B. Authorization and documentation submitted with claim (Emergency treatment)

DentaQuest recognizes that emergency treatment may not permit authorization to be obtained prior to treatment. In these situations services that require authorization, but are rendered under emergency conditions, will require the same "documentation" be provided with the claim when the claim is sent for payment. It is essential that the Participating Provider understand that claims sent without this "documentation" will be denied

2.02 EPSDT/HCY Screening Services

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MO HealthNet Managed Care health plans are responsible for ensuring that Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screens are performed on MO HealthNet Managed Care members under the age of 21. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity.

This program is referred to nationally as the EPSDT Program. In Missouri, this program is referred to as the Healthy Children and Youth (HCY) Program. Missouri follows the American Academy of Pediatrics' (AAP), July 1991, schedule for preventive pediatric health care as a minimum standard for frequency of providing full HCY screens.

The Omnibus Budget Reconciliation Act of 1989 (OBRA-89) mandated that MO HealthNet provide medically necessary services to children from birth through age 20 years which are necessary to treat or ameliorate defects, physical or behavioral health, or conditions identified by an EPSDT screen regardless of whether or not the services are covered under the Medicaid State Plan. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity. The MO HealthNet Managed Care health plan is responsible for providing all EPSDT/HCY services for their eligible members.

A full EPSDT/HCY screening must include the following components:

- A comprehensive unclothed physical examination;
- A comprehensive health and developmental history including assessment of both physical and behavioral health development;
- Health education (including anticipatory guidance);
- Appropriate immunizations according to age;
- Laboratory tests as indicated (appropriate according to age and health history unless medically contraindicated);
- Lead screening according to established guidelines;
- Hearing screen;
- Vision screen;
- Dental screen.

Appropriate providers may provide partial screens, which are segments of the full screen. The purpose of this is to increase access to care to all children. Providers of partial screens are required to have a referral source for the full screen. For MO HealthNet Managed Care health plan members, this should be the primary care provider who may be a physician, nurse practitioner or midwife. A partial screen does not replace the need for a full medical screen that includes all of the above components. See Section 9 of the MO HealthNet provider manual for specific information on partial screens.

MO HealthNet Managed Care health plans are responsible for required immunizations and recommended laboratory tests. Lab services performed during the screen are reported separately. MO HealthNet Managed Care health plans must provide immunizations in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines and acceptable medical practice. MO HealthNet Managed Care health plans are to report vaccines according to the guidelines outlined in the Vaccine for Children Program policy statement.

If a problem is detected during a screening examination, the child must be evaluated as necessary for further diagnosis and treatment services. The MO HealthNet Managed Care health plan is responsible for the further diagnosis and treatment services.

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The medical record must document that all required components of the screening were performed. If for some reason a small portion of a component of the screen was not performed, the medical record must document why it was not provided and that follow-up is required. Use of the Lead Screening Guide is mandatory for all children age 6-72 months and must be retained in the medical record in paper or electronic format. The Healthy Children and Youth Screening and Lead Risk Assessment Guides are available in an electronic format through MO HealthNet's Web tool, CyberAccesssm.

Miscellaneous

Reference Section 9 of the Missouri MO HealthNet Provider Manual for Healthy Children and Youth Program; Healthy Children and Youth Screening Guides; and AAP 1991 periodicity schedule that are available online at the MO HealthNet Division website www.dss.mo.gov/mhd for additional information. Special bulletins may also be referred online for additional information.

Payment for EPSDT Services

Services for managed care members under the age of 21 which are recommended as the result of an EPSDT screening must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity. When submitting an authorization for an EPSDT related service please check the EPSDT/Title XIX box in the upper left-hand corner of the American Dental Association (ADA) 2006 claim form.

2.03 Payment for Non-Covered Services

Participating Providers shall hold Members, DentaQuest, Plan and Agency harmless for the payment of non-Covered Services except as provided in this paragraph. Provider may bill a Member for non-Covered Services if the Provider obtains a written waiver from the Member prior to rendering such service that indicates:

- the services to be provided;
- DentaQuest, Plan and Agency will not pay for or be liable for said services; and
- Member will be financially liable for such services.

2.04 Electronic Attachments

A. **FastAttach™** - DentaQuest accepts dental radiographs electronically via **FastAttach™** for authorization requests. DentaQuest, in conjunction with National Electronic Attachment, LLC (NEA), allows Participating Providers the opportunity to submit all claims electronically, even those that require attachments. This program allows transmissions via secure Internet lines for radiographs, periodontic charts, intraoral pictures, narratives and EOBs.

FastAttach™ is inexpensive and easy to use, reduces administrative costs, eliminates lost or damaged attachments and accelerates claims and prior authorization processing. It is compatible with most claims clearinghouse or practice management systems.

For more information or to sign up for FastAttach go to www.nea-fast.com or call NEA at:

800.782.5150

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B. **OrthoCAD™ -** DentaQuest accepts orthodontic models electronically via **OrthoCAD™** for authorization requests. DentaQuest allows Participating Providers the opportunity to submit all orthodontic models electronically. This program allows transmissions via secure Internet lines for orthodontic models. **OrthoCAD™** is inexpensive and easy to use, reduces administrative costs, eliminates lost or damaged models and accelerates claims and prior authorization processing. It is compatible with most claims clearinghouse or practice management systems.

For more information or to sign up for **OrthoCAD™** go to www.orthocad.com or call **OrthoCAD™** at:

800.577.8767

2.05 Provider Complaints and Appeals Procedure

A provider may choose to file an Appeal without first filing a Complaint. In addition, a provider may file a Complaint and if the provider is unhappy with the outcome, the provider can then request an Appeal of the matter.

Written notices of appeal must be submitted to:

DentaQuest, LLC
Attention: Utilization Management / Provider Appeals
11100 W Liberty Drive
Milwaukee, WI 53224-3626

Providers have the right to submit documentation with their Complaint or Appeal. It is advantageous for the provider to clearly outline his/her Complaint or Appeal and to provide supporting information. The provider should indicate why a decision should be made in the provider's favor. Complaints and Appeals will be responded to in writing within thirty (30) calendar days of receipt.

Providers also have the right to request and receive a written copy of DentaQuest's utilization management criteria, in cases where the Complaint or Appeal is related to a clinical decision/denial, or other applicable health plan policies or procedures relevant to the decision or action that is the subject of the Complaint or Appeal. These can be requested by contacting Customer Service at 888.307.6547. (Policies 200.010, 200.011, 200.013, 200.017C, 200.019) or via e-mail at denclaims@dentaquest.com.

A. **Complaint:** A verbal or written expression that indicates dissatisfaction or dispute with DentaQuest or the Plan's policies, procedure, claims, denials, or any aspect of DentaQuest or the health plan functions. A provider has six months from the date of the incident, such as the original remit date or date of an adverse determination to file a Complaint.

B. **Appeal:** The formal mechanism which allows the provider the right to have actions taken by DentaQuest or the health plan reviewed when the provider:

- **a)** has a claim for reimbursement or request for authorization of service delivery denied or not acted upon with reasonable promptness.
- **b)** is aggrieved by any rule or policy or procedure or decision by DentaQuest

or the health plan.
Appeals must be filed within six months of the action taken by DentaQuest or the health plan that gave rise to the Appeal. Appeals must be filed in writing.

C. **Complaints and Appeals may be Clinical or Administrative in nature.**

a) Clinical Complaints and Appeals result from DentaQuest or health plan

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actions that were based, in whole or in part, on medical judgment (i.e. medical necessity determination; experimental or investigational determinations; cosmetic determinations).

b) Administrative Complaints and Appeals result from DentaQuest or health plan actions that are not clinical. Issues for review as Administrative Complaint or Appeals can include, but are not limited to, health plan policy, procedure, claims payment, or any non-clinical aspect of DentaQuest or health plan functions.

D. **Expedited Appeal:** Expedited requests are available for circumstances when waiting the usual timeframes for a decision would seriously jeopardize (a) the life or health of a member or in the case of a pregnant member, the member's unborn child; or (b) a member's ability to attain, maintain, or regain maximum function. A verbal request indicating the need for an expedited review should be made directly to Provider Services at 888-307-6547. Those requests for an expedited review that meet the above criteria will have determinations made within seventy-two (72) hours.

E. **Peer-to-Peer Process to Discuss Denial Determination:** Participating Providers must request a peer-to-peer call for any clinical denial within five (5) calendar days from a denial decision. The peer-to-peer call will be a verbal discussion with a DentaQuest Dental Director (who was not involved in the original determination) to discuss denial determination. Any additional clinical information to be discussed in the peer-to-peer call should be submitted within the first five (5) calendar days from a denial decision. The peer-to-peer process does not have to be utilized prior to requesting reconsideration. When submitting a formal appeal, there is an opportunity for Providers or their representatives to present their cases in person to the Peer Review Committee.

Important notes:

•The participating provider must give times available, however it is important to note they are not scheduling an appointment.

•The participating provider must request the peer to peer to be completed within 72 hours of when they submit the follow-up.

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3.00 Participating Hospitals

Upon approval, Participating Providers are required to administer services at Plan's participating hospitals when services are not able to be rendered in the office. Participating Hospitals may change. Please contact plan for current listing.

Healthy Blue Health Plan: 833-405-9086

4.00 Claim Submission Procedures (claim and authorization filing options)

DentaQuest receives dental claims in four possible formats. These formats include:

- Electronic claims via DentaQuest's website (www.dentaquestgov.com).
- Electronic submission via clearinghouses.
- HIPAA Compliant 837D File.
- Paper claims.

4.01 Electronic Claim Submission Utilizing DentaQuest's Internet Website

Participating Providers may submit claims directly to DentaQuest by utilizing the "Dentist" section of our website. Submitting claims via the website is very quick and easy. It is especially easy if you have already accessed the site to check a Member's eligibility prior to providing the service.

To submit claims via the website, simply log on to www.dentaquestgov.com. Once you have entered the website, click on the "Dentist" icon. From there choose your 'State" and press go. You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business's NPI or TIN, State and Zip Code. DentaQuest should have contacted your office in regards on how to perform Provider Self Registration or contact DentaQuest's Customer Service Department at 888.307.6547. Once logged in, select "Claims/Pre-Authorizations" and then "Dental Claim Entry". The Dentist Portal allows you to attach electronic files (such as x-rays in jpeg format, reports and charts) to the claim.

If you have questions on submitting claims or accessing the website, please contact our Systems Operations at 800.417.7140 or via e-mail at:

EDITeam@greatdentalplans.com

4.02 Electronic Authorization Submission Utilizing DentaQuest's Internet Website

Participating Providers may submit Pre-Authorizations directly to DentaQuest by utilizing the "Dentist" section of our website. Submitting Pre-Authorizations via the website is very quick and easy. It is especially easy if you have already accessed the site to check a Member's eligibility prior to providing the service.

To submit pre-authorizations via the website, simply log on to www.dentaquestgov.com. Once you have entered the website, click on the "Dentist" icon. From there choose your 'State" and press go. You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business's NPI or TIN, State and Zip Code. If you have not received instruction on how to complete Provider Self Registration contact DentaQuest's Customer Service Department at 888.307.6547. Once logged in, select "Claims/Pre-Authorizations" and then "Dental Pre-Auth Entry".

The Dentist Portal also allows you to attach electronic files (such as x-rays in jpeg format, reports and charts) to the pre-authorization.

4.03 Electronic Claim Submission via ClearingHouse

DentaQuest works directly with Emdeon (1-888-255-7293), Tesia 1-800-724-7240, EDI

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Health Group 1-800-576-6412, Secure EDI 1-877-466-9656 and Mercury Data Exchange 1-866-633-1090, for claim submissions to DentaQuest.

You can contact your software vendor and make certain that they have DentaQuest listed as the payer and claim mailing address on your electronic claim. Your software vendor will be able to provide you with any information you may need to ensure that submitted claims are forwarded to DentaQuest. DentaQuest's Payor ID is CX014.

4.04 HIPAA Compliant 837D File

For Providers who are unable to submit electronically via the Internet or a clearinghouse, DentaQuest will work directly with the Provider to receive their claims electronically via a HIPAA compliant 837D or 837P file from the Provider's practice management system. Please email EDITeam@greatdentalplans.com to inquire about this option for electronic claim submission.

4.05 NPI Requirements for Submission of Electronic Claims

In accordance with the HIPAA guidelines, DentaQuest has adopted the following NPI standards in order to simplify the submission of claims from all of our providers, conform to industry required standards and increase the accuracy and efficiency of claims administered by DentaQuest.

- Providers must register for the appropriate NPI classification at the following website https://nppes.cms.hhs.gov/NPPES/Welcome.do and provide this information to DentaQuest Dental in its entirety.
- All providers must register for an Individual NPI. You may also be required to register for a group NPI (or as part of a group) dependent upon your designation.
- When submitting claims to DentaQuest you must submit all forms of NPI properly and in their entirety for claims to be accepted and processed accurately. If you registered as part of a group, your claims must be submitted with both the Group and Individual NPI's. These numbers are not interchangeable and could cause your claims to be returned to you as non-compliant.
- If you are presently submitting claims to DentaQuest through a clearinghouse or through a direct integration you need to review your integration to assure that it is in compliance with the revised HIPAA compliant 837D format. This information can be found on the 837D Companion Guide located on the Dentist Portal.

4.06 Paper Claim Submission

- Claims must be submitted on ADA approved claim forms or other forms approved in advance by DentaQuest.
- Member name, identification number, and date of birth must be listed on all claims submitted. If the Member identification number is missing or miscoded on the claim form, the patient cannot be identified. This could result in the claim being returned to the submitting Provider office, causing a delay in payment.
- The paper claim must contain an acceptable provider signature.
- The Provider and office location information must be clearly identified on the claim. Frequently, if only the dentist signature is used for identification, the dentist's name cannot be clearly identified. Please include either a typed dentist (practice) name or the DentaQuest Provider identification number.
- The paper claim form must contain a valid provider NPI (National Provider Identification) number. In the event of not having this box on the claim form, the NPI must still be included on the form. The ADA claim form only supplies 2 fields to enter NPI. On paper claims, the Type 2 NPI identifies the payee, and may be submitted in conjunction with a Type 1 NPI to identify the dentist who provided the treatment. For example, on a standard ADA Dental Claim Form, the treating dentist's NPI is entered in field 54 and the billing entity's NPI is entered in field 49.
- The date of service must be provided on the claim form for each service line submitted.

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- Approved ADA dental codes as published in the current CDT book or as defined in this manual must be used to define all services.
- List all quadrants, tooth numbers and surfaces for dental codes that necessitate identification (extractions, root canals, amalgams and resin fillings). Missing tooth and surface identification codes can result in the delay or denial of claim payment.
- Affix the proper postage when mailing bulk documentation. DentaQuest does not accept postage due mail. This mail will be returned to the sender and will result in delay of payment.

Claims should be mailed to the following address:

DENTAQUEST of MO, LLC-Claims
PO Box 2906
Milwaukee, WI 53224-3626

4.07 Coordination of Benefits (COB)

When DentaQuest is the secondary insurance carrier, a copy of the primary carrier's Explanation of Benefits (EOB) must be submitted with the claim. For electronic claim submissions, the payment made by the primary carrier must be indicated in the appropriate COB field. When a primary carrier's payment meets or exceeds a provider's contracted rate or fee schedule, DentaQuest will consider the claim paid in full and no further payment will be made on the claim.

4.08 Filing Limits

Each provider contract specifies a specific timeframe after the date of service for when a claim must be submitted to DentaQuest. Any claim submitted beyond the timely filing limit specified in the contract will be denied for "untimely filing." If a claim is denied for "untimely filing", the provider cannot bill the member. If DentaQuest is the secondary carrier, the timely filing limit begins with the date of payment or denial from the primary carrier.

4.09 Receipt and Audit of Claims

In order to ensure timely, accurate remittances to each participating Provider, DentaQuest performs an audit of all claims upon receipt. This audit validates Member eligibility, procedure codes and dentist identifying information. A DentaQuest Benefit Analyst analyzes any claim conditions that would result in non-payment. When potential problems are identified, your office may be contacted and asked to assist in resolving this problem. Please contact our Customer Service Department with any questions you may have regarding claim submission or your remittance.

Each DentaQuest Provider office receives an “explanation of benefit” report with their remittance. This report includes patient information and an allowable fee by date of service for each service rendered.

4.10 Direct Deposit

As a benefit to participating Providers, DentaQuest offers Direct Deposit for claims payments. This process improves payment turnaround times as funds are directly deposited into the Provider’s banking account.

To receive claims payments through the Direct Deposit Program, Providers must:

- Complete and sign the Direct Deposit Authorization Form found on the website.
- Attach a voided check to the form. The authorization cannot be processed without a voided check.
- Return the Direct Deposit Authorization Form and voided check to DentaQuest.
  - Via Fax - 262.241.4077 **or**

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- Via Mail -

DentaQuest, LLC.
11100 W Liberty Drive
Milwaukee, WI 53224-3626
ATTN: PDA Department

The Direct Deposit Authorization Form must be legible to prevent delays in processing. Providers should allow up to six weeks for the Direct Deposit Program to be implemented after the receipt of completed paperwork. Providers will receive a bank note one check cycle prior to the first Direct Deposit payment.

Providers enrolled in the Direct Deposit process must notify DentaQuest of any changes to bank accounts such as: changes in routing or account numbers, or a switch to a different bank. All changes must be submitted via the Direct Deposit Authorization Form. Changes to bank accounts or banking information typically take 2 -3 weeks. DentaQuest is not responsible for delays in funding if Providers do not properly notify DentaQuest in writing of any banking changes.

Providers enrolled in the Direct Deposit Program are required to access their remittance statements online and will no longer receive paper remittance statements. Electronic remittance statements are located on DentaQuest's Dentist Portal. Providers may access their remittance statements by following these steps:

1. Go to www.dentaquestgov.com
2. Once you have entered the website, click on the "Dentist" icon. From there choose your 'State" and press go.
3. Log in using your password and ID
4. Once logged in, select "Claims/Pre-Authorizations" and then "Remittance Advice Search".
5. The remittance will display on the screen.

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5.00 Health Insurance Portability and Accountability Act (HIPAA)

As a healthcare provider, your office is required to comply with all aspects of the HIPAA regulations in effect as indicated in the final publications of the various rules covered by HIPAA.

DentaQuest has implemented various operational policies and procedures to ensure that it is compliant with the Privacy, Administrative Simplification and Security Standards of HIIPAA. One aspect of our compliance plan is working cooperatively with our providers to comply with the HIPAA regulations. In relation to the Privacy Standards, DentaQuest has previously modified its provider contracts to reflect the appropriate HIPAA compliance language. These contractual updates include the following in regard to record handling and HIPAA requirements:

- Maintenance of adequate dental/medical, financial and administrative records related to covered dental services rendered by Provider in accordance with federal and state law.

- Safeguarding of all information about Members according to applicable state and federal laws and regulations. All material and information, in particular information relating to Members or potential Members, which is provided to or obtained by or through a Provider, whether verbal, written, tape, or otherwise, shall be reported as confidential information to the extent confidential treatment is provided under state and feral laws.

- Neither DentaQuest nor Provider shall share confidential information with a Member's employer absent the Member's consent for such disclosure.

- Provider agrees to comply with the requirements of the Health Insurance Portability and Accountability Act ("HIPAA") relating to the exchange of information and shall cooperate with DentaQuest in its efforts to ensure compliance with the privacy regulations promulgated under HIPAA and other related privacy laws.

Provider and DentaQuest agree to conduct their respective activities in accordance with the applicable provisions of HIPAA and such implementing regulations.

In relation to the Administrative Simplification Standards, you will note that the benefit tables included in this ORM reflect the most current coding standards (CDT-4) recognized by the ADA. Effective the date of this manual, DentaQuest will require providers to submit all claims with the proper CDT-4 codes listed in this manual. In addition, all paper claims must be submitted on the current approved ADA claim form.

Note: Copies of DentaQuest's HIPAA policies are available upon request by contacting DentaQuest's Customer Service department at 888.307.6547 or via e-mail at denelig.benefits@dentaquest.com

6.00 Member Grievance and Appeal Process

The member is encouraged to discuss his/her concerns with those directly involved such as the provider, medical assistant, receptionist, office or administrative manager. If the question or concern is unresolved, the member is instructed to call or write to DentaQuest or the health plan.

DentaQuest in conjunction with the health plan has established a member grievance process that shall guarantee any member the right for a review when they are dissatisfied with a service/benefit. The member is informed that they may request a State Fair Hearing for appeals, which may be filed simultaneously as the DentaQuest or health plan appeal. Members will receive assistance, if required, to file either a grievance or an appeal.

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Members have two distinct processes to indicate dissatisfaction. These processes are a member appeal or a member grievance. Within the appeal process there is an opportunity for a member to request an expedited appeal as noted below. The grievance process does not have an expedited timeframe period. For both levels, the members have the right to submit written comments.

Members also have the right to request and receive a written copy of DentaQuest's utilization management criteria in cases where the appeal is related to a clinical decision/denial or other applicable health plan policies or procedures relevant to the decision or action that is the subject of the appeal. These can be requested by contacting Customer Service at 888.307.6547. (Policies 200.010, 200.011, 200.013, 200.017C, 200.019) or via e-mail at denclaims@dentaquest.com.

A. **Grievance:** An expression of dissatisfaction about but not limited to issues related to quality of care or services provided and aspects of inter-personal relationships such as rudeness of a provider or employee or failure to respect the Member's rights. Member grievances will be resolved within 30 calendar days.

B. **Appeal:** A request for a review of any matter about an action which is defined as a denial of a requested service or the failure of DentaQuest or the health plan to act within timeframes for the health plan's prior authorization review process. Member appeals will be resolved within thirty (30) calendar days. A provider, acting on behalf of the member and with the member's written consent, may file an appeal. A member or provider may file an appeal either orally or in writing. Unless he or she requests expedited resolution, the member or provider must follow an oral filing with a written, signed appeal.

C. **Expedited Appeal:** Expedited requests are available for circumstances when waiting would seriously jeopardize the well being of the member. A verbal request indicating the need for an expedited review should be made directly to DentaQuest. Those requests for an expedited review that meet the above criteria will have the determinations made within seventy-two (72) hours.

D. **State Fair Hearing:** Members have ninety (90) days from the date of DentaQuest or the health plan's notice of action or appeal decision letter to initiate a State Fair Hearing. To arrange for a State Fair Hearing, members may call (800) 392-2161 or write to the MO HealthNet Division, Recipient Services Unit, PO Box 6500, Jefferson City, MO 65102.

The State of Missouri will normally determine a resolution within ninety (90) days of the date the member filed the appeal initially with DentaQuest or the health plan (excluding the days the member took to subsequently file for a State Fair Hearing) or the date the member filed for direct access to a State Fair Hearing.

E. **Member Inquiry:** An inquiry is a request from a member for information to clarify health plan policy, benefits, procedures or any aspect of the health plan's function where there is no expression of dissatisfaction

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7.00 Utilization Management Program (Policies 500 Series)

7.01 Introduction

Reimbursement to dentists for dental treatment rendered can come from any number of sources such as individuals, employers, insurance companies and local, state or federal government. The source of dollars varies depending on the particular program. For example, in traditional insurance, the dentist reimbursement is composed of an insurance payment and a patient coinsurance payment. In State Medical Assistance Dental Programs (Medicaid), the State Legislature annually appropriates or "budgets" the amount of dollars available for reimbursement to the dentists as well as the fees for each procedure. Since there is usually no patient co-payment, these dollars represent all the reimbursement available to the dentist. These "budgeted" dollars, being limited in nature, make the fair and appropriate distribution to the dentists of crucial importance.

7.02 Community Practice Patterns

To do this, DentaQuest has developed a philosophy of Utilization Management that recognizes the fact that there exists, as in all healthcare services, a relationship between the dentist's treatment planning, treatment costs and treatment outcomes. The dynamics of these relationships, in any region, are reflected by the "community practice patterns" of local dentists and their peers. With this in mind, DentaQuest's Utilization Management Programs are designed to ensure the fair and appropriate distribution of healthcare dollars as defined by the regionally based community practice patterns of local dentists and their peers.

All utilization management analysis, evaluations and outcomes are related to these patterns. DentaQuest's Utilization Management Programs recognize that there exists a normal individual dentist variance within these patterns among a community of dentists and accounts for such variance. Also, specialty dentists are evaluated as a separate group and not with general dentists since the types and nature of treatment may differ.

7.03 Evaluation

DentaQuest's Utilization Management Programs evaluate claims submissions in such areas as:

- Diagnostic and preventive treatment;
- Patient treatment planning and sequencing;
- Types of treatment;
- Treatment outcomes; and
- Treatment cost effectiveness.

7.04 Results

Therefore, with the objective of ensuring the fair and appropriate distribution of these "budgeted" Medicaid Assistance Dental Program dollars to dentists, DentaQuest's Utilization Management Programs will help identify those dentists whose patterns show significant deviation from the normal practice patterns of the community of their peer dentists (typically less than 5% of all dentists). When presented with such information, dentists will implement slight modification of their diagnosis and treatment processes that bring their practices back within the normal range. However, in some isolated instances, it may be necessary to recover reimbursement.

7.05 Fraud and Abuse (Policies 700 Series)

DentaQuest is committed to detecting, reporting and preventing potential fraud and abuse. Fraud and abuse are defined as:

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Fraud: Intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under federal or state law.

Member Abuse: Intentional infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, sexual abuse or sexual assault.

Provider Fraud: Provider practices that are inconsistent with sound fiscal, business or medical practices, and result in unnecessary cost to the program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care may be referred to the appropriate state regulatory agency.

Member Fraud: If a Provider suspects a member of ID fraud, drug-seeking behavior, or any other fraudulent behavior should be reported to DentaQuest.

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8.00 Quality Improvement Program (Policies 200 Series)

DentaQuest currently administers a Quality Improvement Program modeled after National Committee for Quality Assurance (NCQA) standards. The NCQA standards are adhered to as the standards apply to dental managed care. The Quality Improvement Program includes, but is not limited to:

- Provider credentialing and recredentialing.
- Member satisfaction surveys.
- Provider satisfaction surveys.
- Random Chart Audits.
- Complaint Monitoring and Trending.
- Peer Review Process.
- Utilization Management and practice patterns.
- Initial Site Reviews and Dental Record Reviews.
- Quarterly Quality Indicator tracking (i.e. complaint rate, appointment waiting time, access to care, etc.)

A copy of DentaQuest's Quality Improvement Program is available upon request by contacting DentaQuest's Customer Service Department at 888.307.6547 or via e-mail at:

denelig.benefits@dentaquest.com.

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9.00 Credentialing (Policies 300 Series)

DentaQuest, in conjunction with the Plan, has the sole right to determine which dentists (DDS or DMD); it shall accept and continue as Participating Providers. The purpose of the credentialing plan is to provide a general guide for the acceptance, discipline and termination of Participating Providers. DentaQuest considers each Provider's potential contribution to the objective of providing effective and efficient dental services to Members of the Plan.

DentaQuest's credentialing process adheres to National Committee for Quality Assurance (NCQA) guidelines as the guidelines apply to dentistry.

Nothing in this Credentialing Plan limits DentaQuest's sole discretion to accept and discipline Participating Providers. No portion of this Credentialing Plan limits DentaQuest's right to permit restricted participation by a dental office or DentaQuest's ability to terminate a Provider's participation in accordance with the Participating Provider's written agreement, instead of this Credentialing Plan.

The Plan has the final decision-making power regarding network participation. DentaQuest will notify the Plan of all disciplinary actions enacted upon Participating Providers.

Appeal of Credentialing Committee Recommendations. (Policy 300.017)
If the Credentialing Committee recommends acceptance with restrictions or the denial of an application, the Committee will offer the applicant an opportunity to appeal the recommendation.

The applicant must request a reconsideration/appeal in writing and the request must be received by DentaQuest within 30 days of the date the Committee gave notice of its decision to the applicant.

Discipline of Providers (Policy 300.019)

Procedures for Discipline and Termination (Policies 300.017-300.021)

Recredentialing (Policy 300.016)
Network Providers are recredentialed at least every 24 months.

Note: The aforementioned policies are available upon request by contacting DentaQuest's Customer Service Department at 888.307.6547 or via e-mail at:

denelig.benefits@dentaquest.com.

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10.0 The Patient Record

A. Organization

1. The record must have areas for documentation of the following information:

    a. Registration data including a complete health history.
    b. Medical alert predominantly displayed inside the chart.
    c. Initial examination data.
    d. Radiographs.
    e. Periodontal and Occlusal status.
    f. Treatment plan/Alternative treatment plan.
    g. Progress notes to include diagnosis, preventive services, treatment rendered, and medical/dental consultations.
    h. Miscellaneous items (correspondence, referrals, and clinical laboratory reports).

2. The design of the record must provide the capability or periodic update, without the loss of documentation of the previous status, of the following information:

    a. Health history.
    b. Medical alert.
    c. Examination/Recall data.
    d. Periodontal status.
    e. Treatment plan.

3. The design of the record must ensure that all permanent components of the record are attached or secured within the record.

4. The design of the record must ensure that all components must be readily identified to the patient (i.e., patient name, and identification number on each page).

5. The organization of the record system must require that individual records be assigned to each patient.

B. Content-The patient record must contain the following

1. Adequate documentation of registration information which requires entry of these items:

    a. Patient's first and last name.
    b. Date of birth.
    c. Sex.
    d. Address.
    e. Telephone number.
    f. Name and telephone number of the person to contact in case of emergency.

2. An adequate health history that requires documentation of these items:

    a. Current medical treatment.
    b. Significant past illnesses.
    c. Current medications.
    d. Drug allergies.
    e. Hematologic disorders
    f. Cardiovascular disorders.

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g. Respiratory disorders.
h. Endocrine disorders.
i. Communicable diseases.
j. Neurologic disorders.
k. Signature and date by patient.
l. Signature and date by reviewing dentist.
m. History of alcohol and/or tobacco usage including smokeless tobacco.

3. An adequate update of health history at subsequent recall examinations which requires documentation of these items:

   a. Significant changes in health status.
   b. Current medical treatment.
   c. Current medications.
   d. Dental problems/concerns.
   e. Signature and date by reviewing dentist.

4. A conspicuously placed medical alert inside the chart that documents highly significant terms from health history. These items are:

   a. Health problems which contraindicate certain types of dental treatment.
   b. Health problems that require precautions or pre-medication prior to dental treatment.
   c. Current medications that may contraindicate the use of certain types of drugs or dental treatment.
   d. Drug sensitivities.
   e. Infectious diseases that may endanger personnel or other patients.

5. Adequate documentation of the initial clinical examination which is dated and requires descriptions of findings in these items:

   a. Blood pressure. (Recommended)
   b. Head/neck examination.
   c. Soft tissue examination.
   d. Periodontal assessment.
   e. Occlusal classification.
   f. Dentition charting.

6. Adequate documentation of the patient's status at subsequent Periodic/Recall examinations which is dated and requires descriptions of changes/new findings in these items:

   a. Blood pressure. (Recommended)
   b. Head/neck examination.
   c. Soft tissue examination.
   d. Periodontal assessment.
   e. Dentition charting.

7. Radiographs which are:

   a. Identified by patient name.
   b. Dated.
   c. Designated by patient's left and right side.
   d. Mounted (if intraoral films).

8. An indication of the patient's clinical problems/diagnosis.

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9. Adequate documentation of the treatment plan (including any alternate treatment options) that specifically describes all the services planned for the patient by entry of these items:

    a. Procedure.
    b. Localization (area of mouth, tooth number, surface).

10. An Adequate documentation of the periodontal status, if necessary, which is dated and requires charting of the location and severity of these items:

    a. Periodontal pocket depth.
    b. Furcation involvement.
    c. Mobility.
    d. Recession.
    e. Adequacy of attached gingiva.
    f. Missing teeth.

11. An adequate documentation of the patient's oral hygiene status and preventive efforts which requires entry of these items:

    a. Gingival status.
    b. Amount of plaque.
    c. Amount of calculus.
    d. Education provided to the patient.
    e. Patient receptiveness/compliance.
    f. Recall interval.
    g. Date.

12. An adequate documentation of medical and dental consultations within and outside the practice which requires entry of these items:

    a. Provider to whom consultation is directed.
    b. Information/services requested.
    c. Consultant's response.

13. Adequate documentation of treatment rendered which requires entry of these items:

    a. Date of service/procedure.
    b. Description of service, procedure and observation. Documentation in treatment record must contain documentation to support the level of American Dental Association Current Dental Terminology code billed as detailed in the nomenclature and descriptors. Documentation must be written on a tooth by tooth basis for a per tooth code, on a quadrant basis for a quadrant code and on a per arch basis for an arch code.
    c. Type and dosage of anesthetics and medications given or prescribed.
    d. Localization of procedure/observation. (tooth #, quadrant etc.)
    e. Signature of the Provider who rendered the service.

14. Adequate documentation of the specialty care performed by another dentist that includes:

    a. Patient examination.
    b. Treatment plan.
    c. Treatment status.

C. Compliance

1. The patient record has one explicitly defined format that is currently in use.

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2. There is consistent use of each component of the patient record by all staff.
3. The components of the record that are required for complete documentation of each patient's status and care are present.
4. Entries in the records are legible.
5. Entries of symbols and abbreviations in the records are uniform, easily interpreted and are commonly understood in the practice.

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11.00 Patient Recall System Requirements

A. Recall System Requirement

Each participating DentaQuest office is required to maintain and document a formal system for patient recall. The system can utilize either written or phone contact. Any system should encompass routine patient check-ups, cleaning appointments, follow-up treatment appointments, and missed appointments for any Health Plan enrollee that has sought dental treatment.

If a written process is utilized, the following language is suggested for missed appointments:

- "We missed you when you did not come for your dental appointment on month/date. Regular check-ups are needed to keep your teeth healthy."
- "Please call to reschedule another appointment. Call us ahead of time if you cannot keep the appointment. Missed appointments are very costly to us. Thank you for your help."

Dental offices indicate that Medicaid patients sometimes fail to show up for appointments. DentaQuest offers the following suggestions to decrease the "no show" rate.

- Contact the Member by phone or postcard prior to the appointment to remind the individual of the time and place of the appointment.
- If the appointment is made through a government supported screening program, contact staff from these programs to ensure that scheduled appointments are kept.

B. Office Compliance Verification Procedures

In conjunction with its office claim audits described in section 4, DentaQuest will measure compliance with the requirement to maintain a patient recall system.

DentaQuest Dentists are expected to meet minimum standards with regards to appointment availability.

- **Urgent care appointments for illness injuries which require care immediately but do not constitute emergencies (e.g. high temperature, persistent vomiting or diarrhea, symptoms which are of sudden or severe onset but which do not require emergency room services): appointments within twenty-four (24) hours.**
- **Routine care with symptoms (e.g. persistent rash, recurring high grade temperature, nonspecific pain, fever): appointments within one (1) week or five (5) business days whichever is earlier.**
- **Routine care without symptoms (e.g. well child exams, routine physical exams): appointments within thirty (30) calendar days.**
- Waiting times (defined as time spent both in the lobby and in the examination room prior to being seen by a provider) for appointments shall not exceed one hour from scheduled appointment time.

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12.00 Radiology Requirements

Note: Please refer to benefit tables for radiograph benefit limitations.

DentaQuest utilizes the guidelines published by the Department of Health and Human Services, Center for Devices and Radiological Health. These guidelines were developed in conjunction with the Food and Drug Administration.

A. Radiographic Examination of the New Patient

1. Child – primary dentition

   The Panel recommends posterior bitewing radiographs for a new patient, with a primary dentition and closed proximal contacts.

2. Child – transitional dentition

   The Panel recommends an individualized periapical/occlusal examination with posterior bitewings OR a panoramic radiograph and posterior bitewings, for a new patient with a transitional dentition.

3. Adolescent – permanent dentition prior to the eruption of the third molars

   The Panel recommends an individualized radiographic examination consisting of selected periapicals with posterior bitewings for a new adolescent patient.

4. Adult – dentulous

   The Panel recommends an individualized radiographic examination consisting of selected periapicals with posterior bitewings for a new dentulous adult patient.

5. Adult – edentulous

   The Panel recommends a full-mouth intraoral radiographic survey OR a panoramic radiograph for the new edentulous adult patient.

B. Radiographic Examination of the Recall Patient

1. Patients with clinical caries or other high – risk factors for caries

   a. Child – primary and transitional dentition

      The Panel recommends that posterior bitewings be performed at a 6-12 month interval for those children with clinical caries or who are at increased risk for the development of caries in either the primary or transitional dentition.

   b. Adolescent

      The Panel recommends that posterior bitewings be performed at a 6-12 month interval for adolescents with clinical caries or who are at increased risk for the development of caries.

   c. Adult – dentulous

      The Panel recommends that posterior bitewings be performed at a 6-12 month interval for adults with clinical caries or who are at increased risk for the development of caries.

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d. Adult – edentulous

The Panel found that an examination for occult disease in this group cannot be justified on the basis of prevalence, morbidity, mortality, radiation dose and cost. Therefore, the Panel recommends that no radiographs be performed for edentulous recall patients without clinical signs or symptoms.

2. Patients with no clinical caries and no other high risk factors for caries

a. Child – primary dentition

The Panel recommends that posterior bitewings be performed at an interval of 12-24 months for children with a primary dentition with closed posterior contacts that show no clinical caries and are not at increased risk for the development of caries.

b. Adolescent

The Panel recommends that posterior bitewings be performed at intervals of 12-24 months for patients with a transitional dentition who show no clinical caries and are not at an increased risk for the development of caries.

c. Adult – dentulous

The Panel recommends that posterior bitewings be performed at intervals of 24-36 months for dentulous adult patients who show no clinical caries and are not at an increased risk for the development of caries.

3. Patients with periodontal disease, or a history of periodontal treatment for child – primary and transitional dentition, adolescent and dentulous adult

The Panel recommends an individualized radiographic survey consisting of selected periapicals and/or bitewing radiographs of areas with clinical evidence or a history of periodontal disease, (except nonspecific gingivitis).

4. Growth and Development Assessment

a. Child – Primary Dentition

The panel recommends that prior to the eruption of the first permanent tooth, no radiographs be performed to assess growth and development at recall visits in the absence of clinical signs or symptoms.

b. Child – Transitional Dentition

The Panel recommends an individualized Periapical/Occlusal series OR a Panoramic Radiograph to assess growth and development at the first recall visit for a child after the eruption of the first permanent tooth.

c. Adolescent

The Panel recommends that for the adolescent (age 16-19 years of age) recall patient, a single set of Periapicals of the wisdom teeth OR a panoramic radiograph.

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d. Adult

The Panel recommends that no radiographs be performed on adults to assess growth and development in the absence of clinical signs or symptoms.

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13.00 Health Guidelines – Ages 0-18 Years

NOTE: Please refer to benefit tables for benefits and limitations.

Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling, *AAPD Reference Manual, revised 2009*

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PERIODICITY RECOMMENDATIONS					
Age	**Infancy 6 – 12 Months**	**Late Infancy 12 – 24 Months**	**Preschool 2 – 6 Years**	**School Aged 6 – 12 Years**	**Adolescence 12 – 18 Years**
Clinical oral exam (1)	X	X	X	X	X
Assess oral growth and development (2)	X	X	X	X	X
Caries-risk assessment (3)	X	X	X	X	X
Radiographic assessment (4)	X	X	X	X	X
Prophylaxis and topical fluoride treatment (3,4)	X	X	X	X	X
Fluoride Supplementation (5)	X	X	X	X	X
Anticipatory guidance/counseling (6)	X	X	X	X	X
Oral Hygiene Counseling (7)	Parents/ guardians/ caregivers	Parents/ guardians/ caregivers	Patient/parents/ guardians/ caregivers	Patient/parents/ guardians/ caregivers	Patient
Dietary Counseling (8)	X	X	X	X	X
Injury, Prevention Counseling (9)	X	X	X	X	X
Counseling for non-nutritive habits (10)	X	X	X	X	X
Counseling for speech/language development	X	X	X		
Substance abuse counseling					X
Counseling for intraoral/perioral piercing				X	X
Assessment and treatment of developing malocclusion			X	X	X
Assessment for pit and fissure sealants (11)			X	X	X
Assessment and/or removal of third molars					X
Transition to adult dental care					X

1. First examination at the eruption of the first tooth and no later than 12 months. Repeat every 6 months or as indicated by child's risk status/susceptibility to disease. Includes assessment of pathology and injuries.
2. By clinical examination.
3. Must be repeated regularly and frequently to maximize effectiveness.
4. Timing, selection, and frequency determined by child's history, clinical findings, and susceptibility to oral disease.
5. Consider when systemic fluoride exposure is suboptimal. Up to at least 16 years.
6. Appropriate discussion and counseling should be an integral part of each visit for care.
7. Initially, responsibility of parent; as child matures, jointly with parent; then, when indicated, only child.
8. At every appointment; initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity.
9. Initially play objects, pacifiers, car seats; when learning to walk; then with sports and routine playing, including the importance of mouthguards.
10. At first, discuss the need for additional sucking: digits vs pacifiers; then the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.
11. For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; placed as soon as possible after eruption.

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14.00 Clinical Criteria

The criteria outlined in DentaQuest's Provider Office Reference Manual are based around procedure codes as defined in the American Dental Association's Code Manuals. Documentation requests for information regarding treatment using these codes are determined by generally accepted dental standards for authorization, such as radiographs, periodontal charting, treatment plans, or descriptive narratives. In some instances, the State legislature will define the requirements for dental procedures.

These criteria were formulated from information gathered from practicing dentists, dental schools, ADA clinical articles and guidelines, insurance companies, as well as other dental related organizations. These criteria and policies must meet and satisfy specific State and Health Plan requirements as well. They are designed as *guidelines* for authorization and payment decisions and *are not intended to be all-inclusive or absolute*. Additional narrative information is appreciated when there may be a special situation.

We hope that the enclosed criteria will provide a better understanding of the decision-making process for reviews. We also recognize that "local community standards of care" may vary from region to region and will continue our goal of incorporating generally accepted criteria that will be consistent with both the concept of local community standards and the current ADA concept of national community standards. Your feedback and input regarding the constant evolution of these criteria is both essential and welcome. DentaQuest shares your commitment and belief to provide quality care to Members and we appreciate your participation in the program.

Please remember these are generalized criteria. Services described may not be covered in your particular program. In addition, there may be additional program specific criteria regarding treatment. Therefore it is essential you review the Benefits Covered Section before providing any treatment.

These clinical criteria will be used for making medical necessity determinations for prior authorizations, post payment review and retrospective review. Failure to submit the required documentation may result in a disallowed request and/or a denied payment of a claim related to that request. Some services require prior authorization and some services require pre-payment review, this is detailed in the Benefits Covered Section(s) in the "Review Required" column.

For all procedures, every Provider in the DentaQuest program is subject to random chart audits. Providers are required to comply with any request for records.
These audits may occur in the Provider's office as well as in the office of DentaQuest. The Provider will be notified in writing of the results and findings of the audit.

DentaQuest providers are required to maintain comprehensive treatment records that meet professional standards for risk management. Please refer to the "Patient Record" section for additional detail.

Documentation in the treatment record must justify the need for the procedure performed due to medical necessity, for all procedures rendered. Appropriate diagnostic pre-operative radiographs clearly showing the adjacent and opposing teeth and substantiating any pathology or caries present are required. Post-operative radiographs are required for endodontic procedures and permanent crown placement to confirm quality of care. In the event that radiographs are not available or cannot be obtained, diagnostic quality intraoral photographs must substantiate the need for procedures rendered.

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Multistage procedures are reported and may be reimbursed upon completion. The completion date is the date of insertion for removable prosthetic appliances. The completion date for immediate dentures is the date that the remaining teeth are removed and the denture is inserted. The completion date for fixed partial dentures and crowns, onlays, and inlays is the cementation date regardless of the type of cement utilized. The completion date for endodontic treatment is the date the canals are permanently filled.

Failure to provide the required documentation, adverse audit findings, or the failure to maintain acceptable practice standards may result in sanctions including, but not limited to, recoupment of benefits on paid claims, follow-up audits, or removal of the Provider from the DentaQuest Provider Panel.

14.01 Criteria for Dental Extractions

Dental adheres to the following policy for evaluating removal of teeth in order to maintain consistency throughout its dental networks.

Documentation needed for authorization procedure:

- Panorex, bitewing radiographs or periapical radiographs showing the entire tooth (teeth) to be extracted as well as opposing teeth
- Tooth specific narrative demonstrating medical necessity
- A decision regarding benefits is made on the basis of the documentation provided.
- Treatment rendered without necessary pre-authorization is subject to retrospective review.
- Codes:
    - DentaQuest adheres to the code definitions as described in the American Dental Association Current Dental Terminology Users Manual.

Criteria

- The prophylactic removal of asymptomatic teeth or teeth exhibiting no overt clinical pathology is not a covered benefit.
- The removal of primary teeth whose exfoliation is imminent is not a covered benefit.
- In most cases, extractions that render a patient edentulous must be deferred until authorization to construct a denture has been given.
- Alveoloplasty (code D7310) in conjunction with a surgical extraction in the same quadrant is not a covered benefit.
- Extractions performed as a part of a course of orthodontics are covered only if the orthodontic case is a covered benefit.
- The extraction of primary or permanent teeth does not require authorization

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unless:

- Teeth are impacted wisdom teeth
- Residual roots requiring surgical removal
- Surgical extraction of erupted teeth.

- Removal of primary teeth whose exfoliation is imminent does not meet criteria for extraction.

Documentation needed for authorization procedure:

- Diagnostic quality periapical and/or panoramic radiographs,
- Radiographs must be mounted, contain the patient name and the date the radiographs were taken, not the date of submission
- Duplicate radiographs must be labeled Right (R) and Left (L), include the patient name and the date the radiograph(s) were taken, not the date of submission.
- Extraction of impacted wisdom teeth or surgical removal of residual tooth roots will require a written narrative of medical necessity that is tooth specific.

Authorization for extraction of impacted third molars:

Surgical extraction of impacted and erupted third molar teeth is a covered service. Indications of removal and criteria or conditions allowable for reimbursement are to include erupted, partially erupted, and unerupted/impacted third molars. One or more of the following conditions must be present and documented in the participant dental record:

1. Pain
2. Pericoronitis
3. Carious lesion
4. Facilitation of the management of or limitation of progression of periodontal disease
5. Nontreatable pulpal or periapical lesion
6. Acute and/or chronic infection
7. Ectopic position
8. Elective therapeutic removal
9. Abnormalities of tooth size or shape precluding normal function
10. Facilitation of orthodontic tooth movement and promotion of dental stability
11. Tooth impeding the normal eruption of an adjacent tooth
12. Tooth in line of fracture
13. Impacted tooth
14. Pathology associated with tooth
15. Pathology associated with impacted tooth(odontogenic cysts, neoplasms)
16. Tooth involved in tumor resection
17. Preventive or prophylactic removal, when indicated, for patients with medical or surgical conditions or treatments
18. Clinical findings of fractured tooth or teeth
19. Internal or external resorption of tooth or adjacent teeth
20. Anatomical position causing potential damage to adjacent teeth
21. Patient's informed refusal of nonsurgical treatment options

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14.02 Criteria for Cast Crowns

Documentation needed for authorization of procedure

- Appropriate radiographs clearly showing the adjacent and opposing teeth should be submitted for authorization review: bitewings, periapicals or panorex.
- Treatment rendered without necessary authorization will still require that sufficient and appropriate radiographs clearly showing the adjacent and opposing teeth be submitted with the claim for review for payment.

Criteria

- In general, criteria for crowns will be met only for permanent teeth needing multi-surface restorations where other restorative materials have a poor prognosis.
- Permanent molar teeth must have pathologic destruction to the tooth by caries or trauma, and should involve four or more surfaces and two or more cusps.
- Permanent bicuspid teeth must have pathologic destruction to the tooth by caries or trauma, and should involve three or more surfaces and at least one cusp.
- Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma, and must involve four or more surfaces and at least 50% of the incisal edge.

A request for a crown following root canal therapy must meet the following criteria:

- Request should include a dated post-endodontic radiograph.
- Tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the ability to fill the canal to the apex.
- The filling must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.

To meet criteria, a crown must be opposed by a tooth or denture in the opposite arch or be an abutment for a partial denture.

- The patient must be free from active and advanced periodontal disease.
- The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent teeth.
- Cast Crowns on permanent teeth are expected to last, at a minimum, five years.

Authorizations for Crowns will not meet criteria if:

- A lesser means of restoration is possible.

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- Tooth has subosseous and/or furcation caries.
- Tooth is a primary tooth.
- Tooth has advanced periodontal disease.
- Crowns are being planned to alter vertical dimension.

14.03 Criteria for Endodontics

Not all procedures require authorization.

Documentation needed for authorization of procedure

- Sufficient and appropriate radiographs clearly showing the adjacent and opposing teeth and a pre-operative radiograph of the tooth to be treated; bitewings, periapicals or panorex. A dated post-operative radiograph must be submitted for review for payment.
- Treatment rendered under emergency conditions, when authorization is not possible, will still require that appropriate radiographs clearly showing the adjacent and opposing teeth, pre-operative radiograph and dated post-operative radiograph of the tooth treated with the claim for retrospective review for payment. In cases where pathology is not apparent, a written narrative justifying treatment is required.

Criteria

Root canal therapy is performed in order to maintain teeth that have been damaged through trauma or carious exposure.

Root canal therapy must meet the following criteria:

- Fill should be sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal thatlimits the dentist's ability to fill the canal to the apex.
- Fill must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.

Authorizations for Root Canal therapy will not meet criteria if:

- Gross periapical or periodontal pathosis is demonstrated radiographically (caries subcrestal or to the furcation, deeming the tooth non-restorable).
- The general oral condition does not justify root canal therapy due to loss of arch integrity.
- Root canal therapy is for third molars, unless they are an abutment for a partial denture.
- Tooth does not demonstrate 50% bone support.
- Root canal therapy is in anticipation of placement of an overdenture.

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- A filling material not accepted by the Federal Food and Drug Administration (e.g. Sargenti filling material) is used.

Other Considerations

- Root canal therapy for permanent teeth includes diagnosis, extirpation of the pulp, shaping and enlarging the canals, temporary fillings, filling and obliteration of root canal(s), and progress radiographs, including a root canal fill radiograph.
- In cases where the root canal filling does not meet DentaQuest's treatment standards, DentaQuest can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after DentaQuest reviews the circumstances.

14.04 Criteria for Stainless Steel Crowns

Although authorization for Stainless Steel Crowns is not required, documentation justifying the need for treatment using Stainless Steel Crowns must be made available upon request for review by DentaQuest pre-operatively or post-operatively and include the following:

- Appropriate diagnostic radiographs clearly showing the adjacent and opposing teeth and pathology or caries-detecting intra-oral photographs if radiographs could not be made.
- Copy of patient's dental record with complete caries charting and dental anomalies
- Copy of detailed treatment plan.

Note: Failure to submit the required documentation if requested may result in the recoupment of benefits on a paid claim.

Criteria

- In general, criteria for stainless steel crowns will be met only for teeth needing multi-surface restorations or where amalgams, composites, and other restorative materials have a poor prognosis.
- Permanent molar teeth should have pathologic destruction to the tooth by caries or trauma, and should involve four or more surfaces and/or two or more cusps.
- Permanent bicuspid teeth should have pathologic destruction to the tooth by caries or trauma, and should involve three or more surfaces and at least one cusp.
- Permanent anterior teeth should have pathologic destruction to the tooth by caries or trauma, and should involve four or more surfaces and at least 50% of the incisal edge.
- Primary anterior teeth should have pathologic destruction to the tooth by caries or trauma and should involve two or more surfaces or incisal decay resulting in an enamel shell.
- Primary molars should have pathologic destruction to the tooth by caries or trauma, and should involve two or more surfaces or substantial occlusal decay resulting in an enamel shell.

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- Primary teeth that have had a pulpotomy or pulpectomy performed.

Note: DentaQuest may require a second opinion for requests of more than 4 stainless steel crowns per patient.

An authorization for a crown on a permanent tooth following root canal therapy must meet the following criteria:

- Claim should include a dated post-endodontic radiograph.
- Tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the dentist's ability to fill the canal to the apex.
- The filling must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.

To meet criteria, a crown must be opposed by a tooth or denture in the opposite arch or be an abutment for a partial denture.

- The patient must be free from active and advanced periodontal disease.
- The permanent tooth must be at least 50% supported in bone.
- Stainless steel crowns on permanent teeth are expected to last five years.

Criteria for treatment using stainless steel crowns will not be met if:

- A lesser means of restoration is possible.
- Tooth has subosseous and/or furcation caries.
- Tooth has advanced periodontal disease.
- Member is age 6 or older and tooth is a primary tooth with exfoliation imminent.
- Crowns are being planned to alter vertical dimension.
- Tooth has no apparent pathologic destruction due to caries or trauma.

14.05 Criteria for Authorization of Operating Room (OR) Cases or Special Procedure Units (SPU)

DentaQuest may deny coverage for the services for patients over age 21*.

All Operating Room (OR) Cases or (SPU) Must Have Prior Authorization (Except In Emergencies).

Providers must submit the following documents for review by DentaQuest for authorization of OR cases:

- Copy of the patient's dental record including health history, charting of theteeth and existing oral conditions.

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- Diagnostic radiographs or caries-detecting intra-oral photographs†.
- Copy of treatment plan. A completed ADA claim form submitted for an authorization may serve as a treatment plan.
- Narrative describing medical necessity for OR.
- Hospital or Ambulatory Surgical Center will need to be listed as place of service on Prior Authorization to be considered as SPU.
- The word "HOSPITAL" written in box 35 Remarks on the current ADA claim form, and include the name and address of the participating hospital, ASC or facility and anticipated date of service.

When a prior authorization is reviewed for medical necessity for rendering services in a hospital setting or outpatient facility, DentaQuest will automatically add the CDT code D9500 to your claim. D9500 is not a covered code and no fee is attached to this code. Offices should refer to the determination status of the D9500 for indication of approval or denial of a hospital setting or outpatient facility. DentaQuest will review the necessity to perform the services in an outpatient setting and will approve or deny the request. Services must be rendered after the PAR is approved, during the authorization period. This is usually 180 days. Please reference the Provider Determination Letter for specific dates.

Providers must submit the following documents for review to Healthy Blue for authorization of OR cases.

Fax to MO Outpatient PA: 844-886-2750

- Copy of Approved DentaQuest determination letter
- Healthy Blue Medical Precertification Request form MO_CAID_PreCertForm.pdf (healthybluemo.com)

Note: Failure to submit the required documentation may result in a denied request and denied payment of a claim related to that request.

† On occasion, due to the lack of physical or emotional maturity, or a disability, a patient may not cooperate enough for radiographs or intra-oral photographs to be made. If this occurs, it must be noted in the patient record and narrative describing medical necessity. Dentists who "routinely" fail to submit radiographs or intra-oral photographs may be denied authorization for treatment.

Extensive treatment plans including endodontics, implants, prosthodontics, or multiple crowns may require a second opinion as determined by DentaQuest.

The provider is responsible for choosing facilities/providers from Member's MCO panel, obtaining all necessary authorizations, and obtaining a medical history and physical examination by the patient's primary care provider. DentaQuest would not recommend that providers submit this documentation with the authorization request but would assume that this information would be documented in the patient record.

Criteria

In most situations, OR cases will be authorized for covered procedures if the following is (are) involved:

- Young children requiring extensive operative procedures such as multiple restorations, treatment of multiple abscesses, and/or oral surgical procedures if authorization documentation indicates that in-office treatment (nitrous oxide, oral, IM, or IV sedation) is not appropriate and hospitalization is not solely based

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upon reducing, avoiding or controlling apprehension, or upon Provider or Member convenience.

- Patients requiring extensive dental procedures and classified as American Society of Anesthesiologists (ASA) class III and ASA class IV (Class III – patients with uncontrolled disease or significant systemic disease; for recent MI, recent stroke, new chest pain, etc. Class IV – patient with severe systemic disease that is a constant threat to life).*

- Medically compromised patients whose medical history indicates that the monitoring of vital signs, or the availability of resuscitative equipment is necessary during extensive dental procedures.*

- Patients requiring extensive dental procedures with a medical history of uncontrolled bleeding, severe cerebral palsy, or other medical condition that renders in-office treatment medically appropriate.*

- Patients requiring extensive dental procedures who have documentation of psychosomatic disorders that require special treatment.*

- Cognitively disabled individuals requiring extensive dental procedures whose prior history indicates hospitalization is appropriate.

*** The medical condition should be verified by a PCP narrative, which is submitted with the authorization request.**

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14.06 Criteria for Removable Prosthodontics (Full and Partial Dentures)

Documentation needed for authorization of procedure

- Treatment plan.
- Appropriate radiographs clearly showing the adjacent and opposing teeth must be submitted for authorization review: bitewings, periapical or panorex.
- Treatment rendered without necessary authorization will still require appropriate radiographs clearly showing the adjacent and opposing teeth be submitted with the claim for review for payment.

Criteria

Prosthetic services are intended to restore oral form and function due to premature loss of permanent teeth that would result in significant occlusal dysfunction.

- A denture is determined to be an initial placement if the patient has never worn prosthesis. This does not refer to just the time a patient has been receiving treatment from a certain Provider.
- Partial dentures are covered only for recipients with good oral health and hygiene, good periodontal health (AAP Type I or II), and a favorable prognosis where continuous deterioration is not expected.
- Radiographs must show no untreated cavities or active periodontal disease in the abutment teeth, and abutments must be at least 50% supported in bone.
- As part of any removable prosthetic service, dentists are expected to instruct the patient in the proper care of the prosthesis.
- In general, if there is a pre-existing removable prosthesis (includes partial and full dentures), it must be at least 5 years old and unserviceable to qualify for replacement.
- The replacement teeth should be anatomically full sized teeth.
- Fabrication of a removable prosthetic includes multiple steps(appointments) these multiple steps (impressions, try-in appointments, delivery etc.) are inclusive in the fee for the removable prosthetic and as such not eligible for additional compensation.

Authorizations for Removable prosthesis will not meet criteria:

- If there is a pre-existing prosthesis which is not at least 5 years old and unserviceable.
- If good oral health and hygiene, good periodontal health, and a favorable prognosis

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are not present.

- If there are untreated cavities or active periodontal disease in the abutment teeth.
- If abutment teeth are less than 50% supported in bone.
- If the recipient cannot accommodate and properly maintain the prosthesis (i.e.. Gag reflex, potential for swallowing the prosthesis, severely handicapped).
- If the recipient has a history or an inability to wear a prosthesis due to psychological or physiological reasons.
- If a partial denture, less than five years old, is converted to a temporary or permanent complete denture.
- If extensive repairs are performed on marginally functional partial dentures, or when a new partial denture would be better for the health of the recipient. However, adding teeth and/or a clasp to a partial denture is a covered benefit if the addition makes the denture functional.

Criteria

- If there is a pre-existing prosthesis, it must be at least 5 years old and unserviceable to qualify for replacement.
- Adjustments, repairs and relines are included with the denture fee within the first 6 months after insertion. After that time has elapsed:
  - Adjustments will be reimbursed at one per calendar year per denture.
  - Repairs will be reimbursed at two repairs per denture per year, with five total denture repairs per 5 years.
  - Relines will be reimbursed once per denture every 36 months.
  - A new prosthesis will not be reimbursed for within 24 months of reline or repair of the existing prosthesis unless adequate documentation has been presented that all procedures to render the denture serviceable have been exhausted.
  - Replacement of lost, stolen, or broken dentures less than 5 years of age usually will not meet criteria for pre-authorization of a new denture.
- The use of Preformed Dentures with teeth already mounted (that is, teeth set in acrylic before the initial impression) cannot be used for the fabrication of a new denture.
- All prosthetic appliances shall be inserted in the mouth and adjusted before a claim is submitted for payment.
- When billing for partial and complete dentures, dentists must list the date that the dentures or partials were inserted as the date of service. Recipients must be eligible on that date in order for the denture service to be covered.

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14.07 Criteria for the Excision of Bone Tissue

To ensure the proper seating of a removable prosthetic (partial or full denture) some treatment plans may require the removal of excess bone tissue prior to the fabrication of the prosthesis. Clinical guidelines have been formulated for the dental consultant to ensure that the removal of tori (mandibular and palatal) is an appropriate course of treatment prior to prosthetic treatment.

Code D7471 (CDT–4) is related to the removal of the lateral exostosis. This code is subject to authorization and may be reimbursed for when submitted in conjunction with a treatment plan that includes removable prosthetics. These determinations will be made by the appropriate dental specialist/consultant.

Documentation needed for authorization of procedure

- Appropriate radiographs and/or intraoral photographs/bone scans which clearly identify the lateral exostosis must be submitted for authorization review; bitewings, periapicals or panorex.
- Treatment plan – includes prosthetic plan.
- Narrative of medical necessity, if appropriate.
- Study model or photo clearly identifying the lateral exostosis (es) to be removed.

14.08 Criteria for the Determination of a Non-Restorable Tooth

In the application of clinical criteria for benefit determination, dental consultants must consider the overall dental health. A tooth that is determined to be non-restorable may be subject to an alternative treatment plan.

A tooth may be deemed non-restorable if one or more of the following criteria are present:

- The tooth presents with greater than a 75% loss of the clinical crown.
- The tooth has less than 50% bone support.
- The tooth has subosseous and/or furcation caries.
- The tooth is a primary tooth with exfoliation imminent.
- The tooth apex is surrounded by severe pathologic destruction of the bone.
- The overall dental condition (i.e. periodontal) of the patient is such that an alternative treatment plan would be better suited to meet the patient's needs.

14.09 Criteria for in office General Anesthesia and Intravenous (IV)

Sedation

Documentation needed for authorization of procedure:

- Treatment plan (authorized if necessary).
- Narrative describing medical necessity for General Anesthesia or IV Sedation.
- Treatment rendered under emergency conditions, when authorization is not

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possible, will still require submission of treatment plan and narrative of medical necessity with the claim for review for payment.

Criteria

Requests for general anesthesia or IV sedation will be authorized (for procedures covered by Health Plan) if any of the following criteria are met:

Extensive (6 teeth requiring treatment) or complex oral surgical procedures such as:

- Impacted wisdom teeth.
- Surgical root recovery from maxillary antrum.
- Surgical exposure of impacted or unerupted cuspids.
- Radical excision of lesions in excess of 1.25 cm.
- Multiple restorations, treatment of multiple abscessed, and/or oral surgical procedures.

And/or one of the following medical conditions:

- Medical condition(s) which require monitoring (e.g. cardiac problems, severe hypertension).
- Behavior Management issues (e.g combative behavior, etc. that does not make it safe for the member or provider.
- Underlying hazardous medical condition (cerebral palsy, epilepsy, mental retardation, including Down's syndrome) which would render patient non-compliant.
- Documented failed sedation or a condition where severe periapical infection would render local anesthesia ineffective.
- Patients 3 years old and younger with extensive (6 teeth requirement treatment) procedures to be accomplished, such as multiple restorations, treatment of multiple abscessed, and/or oral surgical procedures.

14.10 Criteria for Periodontal Treatment

Not all procedures require authorization.
Documentation needed for authorization of procedure:

- Radiographs – periapicals or bitewings preferred.
- Complete periodontal charting with AAP Case Type.
- Treatment plan.

Periodontal scaling and root planning, per quadrant involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. It is indicated for patients with periodontal disease and is therapeutic, not prophylactic in nature. Root planning is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and as a part of pre-surgical procedures in others. It is anticipated that this procedure would be requested in cases of severe periodontal conditions (i.e. late Type II, III, IV periodontitis) where definitive comprehensive root

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planning requiring local/regional block anesthesia and several appointments would be indicated.

From the American Academy of Periodontology (AAP) Policy on Scaling and Root Planning:

"Periodontal scaling is a treatment procedure involving instrumentation of the crown and root surfaces of the teeth to remove plaque, calculus, and stains from these surfaces. It is performed on patients with periodontal disease and is therapeutic, not prophylactic, in nature. Periodontal scaling may precede root planning, which is the definitive, meticulous treatment procedure to remove cementum and/or dentin that is rough and may be permeated by calculus, or contaminated with toxins or microorganisms. Periodontal scaling and root planning are arduous and time consuming. They may need to be repeated and may require local anesthetic."

Criteria

- A minimum of four (4) teeth affected in the quadrant.
- Periodontal charting indicating abnormal pocket depths in multiple sites.
- Additionally at least one of the following must be present:

    1) Radiographic evidence of root surface calculus.
    2) Radiographic evidence of significant loss of bone support.

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14.11 Criteria for Medical Immobilization* Including Papoose Boards

Written informed consent from a legal guardian must be obtained and documented in the patient record prior to medical immobilization.

The patient's record should include:

- informed consent;
- type of immobilization used;
- indication for immobilization;
- the duration of application.

Indications*

- patient who requires immediate diagnosis and/ or limited treatment and cannot cooperate due to lack of maturity;
- patient who requires immediate diagnosis and/ or limited treatment and cannot cooperate due to a mental or physical disability;
- when the safety of the patient and/ or practitioner would be at risk without the protective use of immobilization.

Contraindications*

- cooperative patient;
- patient who cannot be immobilized safely due to associated medical conditions.

Goals of Behavior Management*

- establish communication;
- alleviate fear and anxiety;
- deliver quality dental care;
- build a trusting relationship between dentist and child;
- and, promote the child's positive attitude towards oral/ dental health.

1. **Routine use of restraining devices to immobilize young children in order to complete their dental care is not acceptable practice, violates the standard of care, and will result in termination of the provider from the network.**

2. **Dentists should not restrain children without formal training at a dental school or approved residency program.**

3. **Dentists should consider referring to specialists those patients who they consider to be candidates for immobilization.**

4. **Dental auxiliaries should not use restraining devices to immobilize children.**

*American Academy of Pediatric Dentistry. Guideline on behavior management. Reference Manual 2002-2003.

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14.12 Criteria for Orthodontic Services

DentaQuest utilizes the orthodontic criteria established by MO HealthNet in making medical necessity determinations. These criteria are excerpted below for your reference.

13 CSR 70-35.010 Dental Benefits and Limitations, Missouri Code of State Regulations

Orthodontia Services. When an eligible participant is believed to have a condition that may require orthodontic treatment, the attending dentist should refer the participants to a qualified dentist or orthodontist for preliminary examination to determine if the treatment will be approved. The fact that the participants has moderate or even severe orthodontic problems, or has been advised by a dentist or orthodontist to have treatment is not, by itself, a guarantee that the patient will qualify for orthodontia services through MO HealthNet. Coverage is determined solely by meeting the criteria listed below in subsections (5)(A) and (5)(B) or (5)(C).

(A) To be eligible for orthodontia services, the participant must meet all of the following general requirements:

1. Be under twenty-one (21) years of age; and
2. Have all dental work completed; and
3. Have good oral hygiene documented in the child's treatment plan; and
4. Have permanent dentition. Exceptions to having permanent dentition are as follows:
    - A. Participant has a primary tooth retained due to ectopic or missing permanent tooth; or
    - B. Participant may have primary teeth present if they have cleft palate, severe traumatic deviations, or an impacted maxillary central incisor; or
    - C. Participant may have primary teeth if they are thirteen (13) years of age or older.
    - D. The orthodontia provider has provided to the Division written documentation which proves that orthodontic treatment is medically necessary under one of the criteria in subsection 5(C).

(B) The determination whether or not a participant will be approved for orthodontic services shall be initially screened using the Handicapping Labio-Lingual Deviation (HLD) Index. The HLD Index must be fully completed in accordance with the instructions in Section 14.3 of the MO HealthNet Dental Provider Manual and **must be submitted** with the ADA Claim Form.

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MO HealthNet will approve orthodontic services when the participant meets all the criteria in section (A) above and one (1) of the criteria listed in paragraphs 1. to 7. below-

1. Has a cleft palate;
2. Has a deep impinging overbite when the lower incisors are damaging the soft tissue of the palate (lower incisor contact only on the palate is not sufficient);
3. Has a cross-bite of individual anterior teeth when damage of soft tissue is present;
4. Has severe traumatic deviations;
5. Has an over-jet greater than nine millimeter (9mm) or reverse over-jet of greater than three and one-half millimeters (3.5mm);
6. Has an impacted maxillary central incisor; or
7. Scores twenty-eight (28) points or greater on the HLD Index.

(C) If the participant does not meet any of the criteria in subsection (B), MO HealthNet will consider whether orthodontic services should be provided based upon other evidence that orthodontic services are medically necessary as indicated in Section 13.42.C. of the MO HealthNet Dental Provider Manual and in 13 CSR 70-35.010 (5)(C). The treating orthodontist/dentist must submit a written, detailed explanation of the medical necessity of the orthodontia services along with the completed HLD Index, the ADA Claim form and treatment plan. All documentation must be completed, signed and dated by the treating orthodontist/dentist. If medical necessity is based on a medical condition (as stated in 13 CSR 70-35.010 (5)(C)2.), additional documentation from a licensed medical doctor, board certified to diagnose the medical condition, justifying the need for the orthodontia services must be submitted along with documentation from the treating orthodontist/dentist. Likewise, if medical necessity is based on the presence of mental, emotional, and/or behavioral problems, disturbances or dysfunctions (as stated in 13 CSR 70-35.010 (5)(C)3.), additional documentation from a licensed psychiatrist or a licensed psychologist who has limited his or her practice to child psychiatry or child psychology justifying the need for orthodontia services must be submitted along with the required documentation from the treating orthodontist/dentist.

(D) (Orthodontic treatment shall not be considered to be medically necessary when –

1. The orthodontic treatment is for aesthetic or cosmetic reasons only; or
2. The orthodontic treatment is to correct crowded teeth only, if the child can adequately protect the periodontium with reasonable oral hygiene measures; or
3. The child has demonstrated a lack of motivation to maintain reasonable standards of oral hygiene and oral hygiene is deficient

Section 13.42E, Comprehensive Orthodontic Treatment, MO HealthNet Dental Billing Book

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Comprehensive orthodontic treatment includes, but is *not* limited to:

- Complete diagnostic records and a written treatment plan;
- Placement of all necessary appliances to properly treat the participant (both removable and fixed appliances);
- All necessary adjustments;
- Removal of appliances at the completion of the active phase of treatment;
- Placement of retainers or necessary retention techniques;
- Adjustment of the retainers and observation of the participant for a proper period of time.

Section 14.3, The Handicapping Labio-Lingual Deviation (HLD) Index, MOHealthNet Dental Manual

The Omnibus Budget Reconciliation Act of 1989 (OBRA '89) mandates that Medicaid-covered services be provided for individuals under the age of 21 when service is medically necessary, regardless of whether the service is covered by the State Medicaid Plan.

Section 14.3A, Guidelines and Rules for Applying the HLD Index, MO HealthNet Dental Manual

1.) Orthodontic benefits are available to eligible beneficiaries under the age of 21 with severe malocclusions and in cases of medical necessity as determined by the orthodontic consultant when the treating orthodontist/dentist submits documentation supporting medical necessity. Benefits are for participants with permanent dentition except in cleft palate cases, severe traumatic deviations, or an impacted maxillary central incisor or with mixed dentition when the beneficiary has reached the age of 13.

2.) Study models *must* be of diagnostic quality. To meet diagnostic requirements, study models *must* be properly poured and adequately trimmed with no large voids or positive bubbles present. Dental study models should simulate centric occlusion of the patient when the models are placed on their heels. Study models that do *not* meet the diagnostic requirements described above are *not* accepted.

3.) Only teeth that have erupted and are visible on the study models should be considered, measured, counted and recorded.

4.) In cases submitted for deep impinging bite with tissue damage, the lower teeth *must* be clearly touching the palate and tissue indentations or other evidence of soft tissue damage ***must*** be visible on the study models.

5.) Either of the upper central incisors *must* be used to measure overjet, overbite (including reverse overbite), mandibular protrusion, and open bite. Do *not* use the upper lateral incisors or cuspids for these measurements.

6.) The following definitions and instructions apply when using the HLD Index to identify ectopic eruptions. Examples of ectopic eruption (and ectopic development) of teeth include:

- When a portion of the distal root of the primary second molar is resorbed during the eruption of the first molar;
- Transposed teeth;
- Teeth in the maxillary sinus;
- Teeth in the ascending ramus of the mandible; and
- Situations where teeth have developed in locations other than the dental

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arches.

- In all other situations, teeth deemed to be ectopic *must* be more than 50% blocked out and clearly out of the dental arch.
- In cases of mutually blocked-out teeth only one is counted.

INSTRUCTIONS FOR THE HLD INDEX MEASUREMENTS
Section 14.4 B MO HealthNet Dental Manual

Procedure:

□ Position the patient's teeth in centric occlusion.

□ Record all measurements in the order given and round off to the nearest millimeter.

□ Enter the score "0" if condition is absent

□ The use of a recorder (assistant or hygienist) is recommended

Conditions 1 through 6 are considered automatic qualifiers under the MO HealthNet Division orthodontic program. If one of the automatic qualifiers is met, the remaining sections of the form do not need to be completed.

1. Cleft palate deformities – automatic qualification; however, if the deformitycannot be demonstrated on the study model, the condition must be diagnosed by properly credentialed experts and the diagnosis must be supported by documentation. If present, enter an "X" and score no further.

2. Deep impinging overbite – tissue damage of the palate must be clearly visible in the mouth. On study models, the lower teeth must be clearly touching the palate and the tissue indentations or evidence of soft tissue damage must be clearly visible. If present, enter an "X" and score no further.

3. Crossbite of individual anterior teeth – damage of soft tissue must be clearly visible in the mouth and reproducible and visible on the study models. Gingival recession must be at least 1 1/2 mm deeper than the adjacent teeth. If present, enter an "X" and score no further. In the case of a canine, the amount of gingival recession should be compared to the opposite canine.

4. Severe traumatic deviations – these might include, for example, loss of a premaxillary segment by burns or accident, the result of osteomyelitis, or other gross pathology. If present, enter an "X" and score no further.

5. Overjet – this is recorded with the patient's teeth in centric occlusion and is measured from the labial surface of a lower incisor to the labial surface of an upper central incisor. Measure parallel to the occlusal plan. Do not use the upper lateral incisors or cuspids. The measurement may apply to only one tooth if it is severely protrusive. Reverse overjet may be measured in the same manner. Do not record overjet and mandibular protrusion (reverse overjet) on the same patient. (Note: If the overjet is greater than 9 mm or reverse overjet is greater than 3.5 mm enter an "X" and score no further.)

6. Impacted Maxillary Central Incisor , automatic qualification. If present, enter an “X” and score no further.

7. Overjet – this is recorded with the patient's teeth in centric occlusion and is measured from the labial surface of a lower incisor to the labial surface of an upper central incisor. Measure parallel to the occlusal plan. Do not use the upper lateral incisors or cuspids. The measurement may apply to only one tooth if it is severely protrusive. Do not record overjet and mandibular protrusion (reverse overjet) on the same patient.

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8. Overbite – a pencil mark on the tooth indicating the extent of the overlap assists in making this measurement. Hold the pencil parallel to the occlusal plane when marking and use the incisal edge of one of the upper central incisors. Do not use the upper lateral incisors or cuspids. The measurement is done on the lower incisor from the incisal edge to the pencil mark. "Reverse" overbite may exist and should be measured on an upper central incisor - from the incisal edge to the pencil mark. Do not record overbite and open bite on the same patient. Enter the measurement in millimeters.

9. Mandibular (dental) protrusion or reverse overjet – measured from the labial surface of a lower incisor to the labial surface of an upper center incisor. Do not use the upper lateral incisors or cuspids for this measurement. Do not record mandibular protrusion (reverse overjet) and overjet on the same patient. The measurement in millimeters is entered on the score sheet and multiplied by five (5).

10. Open bite – measured from the incisal edge of an upper central incisor to the incisal edge of a lower incisor. Do not use the upper lateral incisors or cuspids for this measurement. Do not record overbite and open bite on the same patient. The measurement in millimeters is entered on the score sheet and multiplied by four (4).

11. Ectopic eruption – count each tooth excluding third molars. Enter the number of teeth on the score sheet and multiply by three (3). If condition No. 11, anterior crowding, is also present with an ectopic eruption in the anterior portion of the mouth, score only the most severe condition (the condition represented by the most points). DO NOT SCORE BOTH CONDITIONS.

12. Anterior crowding – anterior arch length insufficiency must exceed 3.5 mm. Mild rotations that may react favorably to stripping or mild expansion procedures are not to be scored as crowded. Enter one (1) points for a maxillary arch with anterior crowding and one (1) points for a mandibular arch with anterior crowding (two points maximum for anterior crowding) and multiply by five (5). If condition No. 10, ectopic eruption, is also present in the anterior portion of the mouth, score only the most severe condition (the condition represented by the most points). DO NOT SCORE BOTH CONDITIONS.

13. Labio-lingual spread – use a Boley gauge (or disposable ruler) to determine the extent of deviation from a normal arch. Where there is only a protruded or lingually displaced anterior tooth, the measurement should be made from the incisal edge of that tooth to a line representing the normal arch. Otherwise, the total distance between the most protruded tooth and the most lingually displaced adjacent anterior tooth is measured. In the event that multiple anterior crowding of teeth is observed, all deviations should be measured for labio-lingual spread but only the most severe individual measurement should be entered on the on the score sheet. Enter the measurement in mm.

14. Posterior crossbite – this condition involves one or more posterior teeth, one of which must be a molar. The crossbite must be one in which the maxillary posterior teeth involved may be palatal to normal relationships or completely buccal to the mandibular posterior teeth. The presence of posterior crossbite is indicated by a score of four (4) on the score sheet.

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HANDICAPPING LABIO-LINGUAL DEVIATION INDEX (HLD) SCORE SHEET

Name (Last, First):_____MO HealthNet Number:_____DOB: _____

All necessary dental work completed? Yes __ No __ Patient oral hygiene: Excellent__ Good__ Poor
(all dental work must be completed and oral hygiene must be good BEFORE orthodontic treatment is approved)

PROCEDURE (use this score sheet and a Boley Gauge or disposable ruler):

- **Indicate by checkmark next to A, B and/or C which criteria you are submitting for review**
- Position the patient's teeth in centric occlusion;
- Record all measurements in the order given and round off to the nearest millimeter (mm);
- ENTER SCORE "0" IF CONDITION IS ABSENT

A.____CONDITIONS 1-6 ARE AUTOMATIC QUALIFIERS (indicate with an "X" if condition is present)

1. **Cleft palate** _____
2. Deep impinging bite **with** signs of tissue damage, not just touching palate _____
3. Anterior crossbite **with** gingival recession _____
4. **Severe traumatic deviation** (i.e., accidents, tumors, etc. attach description) _____
5. Overjet **9 mm** or greater or reverse overjet **3.5 mm** or greater _____
6. **Impacted maxillary central incisor** (can be TX in early mixed dentition) _____

B.____CONDITIONS 7-14 MUST SCORE 28 POINTS OR MORE TO QUALIFY

7. **Overjet** (one upper central incisor to labial of the most labial lower incisor) mm x 1 = _____
8. **Overbite** (maxillary central incisor relative to lower anteriors) mm ____x 1 = _____
9. Mandibular protrusion (reverse overjet, **"underbite"**) mm __ x 5 = _____
10. **Openbite** (measure from a maxillary central incisor to mandibular incisors) mm __ x 4 = ___
11. **Ectopic teeth** (excluding third molars, see note below) # teeth__x 3 = _____

Note: *If anterior crowding and ectopic eruption are present in the anterior* portion of the mouth, score only the most severe condition; ***do not score both***

12a **Anterior crowding of maxilla** (greater than 3.5 mm) if present score _1__x 5 = _____
12b **Anterior crowding of mandible (greater** than 3.5 mm) if present score 1__x 5 = _____
13. **Labio-lingual** spread (either measure a displaced tooth from the normal arch form or labial-lingual distance between adjacent anterior teeth) mm____x 1 = _____
14. Posterior **crossbite** (1 must be a molar), score only 1 time – if present score __ 1_ x 4 = __

TOTAL SCORE (must score 28 points or more to qualify) ___

C.____MEDICAL NECESSITY

MO HealthNet will consider whether orthodontic services should be provided based upon other evidence that orthodontic services are medically necessary as indicated in Section 13.42.C of the Dental Provider Manual and in 13 CSR 70-35.010(5)(C). **The treating dentist/orthodontist must submit a written detailed explanation of the medical necessity of the orthodontia services along with the completed HLD Index, PA request form and treatment plan.**

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Provider Signature_____Date_____

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MO HEALTHNET ORTHODONTIA COVERAGE CRITERIA

(A) To be eligible for orthodontia services, the participant must meet all of the following general requirements:

1. Be under twenty-one (21) years of age; and
2. Have all dental work completed; and
3. Have good oral hygiene documented in the child's treatment plan; and
4. Have permanent dentition. Exceptions to having permanent dentition are as follows:

    A. Participant has a primary tooth retained due to ectopic or missing permanent tooth; or
    B. Participant may have primary teeth present if they have cleft palate, severe traumatic deviations, or an impacted maxillary central incisor; or
    C. Participant may have primary teeth if they are thirteen (13) years of age or older.
    D. The orthodontia provider has provided to the Division written documentation which proves that orthodontic treatment is medically necessary under one of the criteriain (C) below.

(B) The determination whether or not a participant will be approved for orthodontic services shall be initially screened using the Handicapping Labio-Lingual Deviation (HLD) Index. The HLD Index must be fully completed in accordance with the instructions in Section 14.3 of the MO HealthNet Dental Provider Manual and must be submitted with the Prior Authorization (PA) form. MO HealthNet will approve orthodontic services when the participant meets all the criteria in section (A) above and one (1) of the criteria listed in paragraphs 1. to 7. below-

1. Has a cleft palate;
2. Has a deep impinging overbite when the lower incisors are damaging the soft tissue of the palate (lower incisor contact only on the palate is not sufficient);
3. Has a cross-bite of individual anterior teeth when damage of soft tissue is present;
4. Has severe traumatic deviations;
5. Has an over-jet greater than nine millimeter (9mm) or reverse over-jet of greater thanthree and one-half millimeters (3.5mm);
6. Has an impacted maxillary central incisor; or
7. Scores twenty-eight (28) points or greater on the HLD Index.

(C) If the participant does not meet any of the criteria in subsection (B), MO HealthNet will consider whether orthodontic services should be provided based upon other evidence that orthodontic services are medically necessary as indicated in Section 13.42.C. of the MO HealthNet Dental Provider Manual and in 13 CSR 70-35.010 (5)(C). The treating orthodontist/dentist must submit a written, detailed explanation of the medical necessity of the orthodontia services along with the completed HLD Index, the prior authorization request form and treatment plan. All documentation must be completed, signed and dated by the treating orthodontist/dentist. If medical necessity is based on a medical condition (as stated in 13 CSR 70-35.010 (5)(C)2.), additional documentation from a licensed medical doctor, board certified to diagnose the medical condition, justifying the need for the orthodontia services must be submitted along with documentation from the treating orthodontist/dentist. Likewise, if medical necessity is based on the presence of mental, emotional, and/or behavioral problems, disturbances or dysfunctions (as stated in 13 CSR 70-35.010 (5)(C)3.), additional documentation from a licensed psychiatrist or a licensed psychologist who has limited his or her practice to child psychiatry or child psychology justifying the need for orthodontia services must be submitted along with the required documentation from the treating orthodontist/dentist.

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Prior Authorization for Orthodontics

Orthodontia treatment is an example of a procedure that always requires prior authorization. Claims will not be reimbursed unless prior authorization was obtained before the date of service.

Requests for prior authorization should be sent with the appropriate documentation:

- Standard ADA approved claim form, marking the box in the top left corner noting it as a prior authorization request and listing requested services
- Completed Handicapping Labio-Lingual Deviation Index (HLD)
- X-rays, photographs, plaster or digital models
- A written narrative of medical necessity

OrthoCAD Submission Form

Date:_____

Patient Information		
Name (First & Last)	**Date of Birth:**	**SS or ID#**
Address:	**City, State, Zip**	**Area code & Phone number:**
Group Name:	**Plan Type:**	
Provider Information		
Dentist Name:	**Provider NPI #**	**Location ID #**
Address:	**City, State, Zip**	**Area code & Phone number:**

Treatment Requested

Code:	**Description of request:**

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MO Orthodontic Continuation of Care Submission Form

Date: _____

MEMBER Name (First & Last):	Date of Birth:
Address:	City, State, Zip:
SSN of ID#:	Current Member Insurance Plan/Group#:
Initial Banding Date:	Member Insurance at time of Initial Banding:
Months of Active Treatment Completed:	Months of Active Treatment Remaining:

CHANGE IN PROVIDER AND/OR CHANGE IN MEMBER INSURANCE BETWEEN MEDICAID PLANS

- Member initiated treatment with a different Provider (non-affiliated) while covered by the same OR different **Medicaid** program/vendor.

  Required for submission:
  - Completed ADA form for preauthorization of CDT Code **D8999**.
  - Copy of original Medicaid Prior Authorization for Comprehensive Orthodontic Treatment (Prior Authorization from Medicaid program/vendor for Comprehensive Orthodontic Treatment approved prior to initiation of orthodontic treatment).

  ****If required information above is cannot be provided, the case will be reviewed as outlined below.***

CHANGE IN PROVIDER AND/OR CHANGE IN MEMBER INSURANCE FROM NON-MEDICAID TO MEDICAID

- Member initiated treatment while covered by a **NON-Medicaid** program/vendor (FFS or Commercial Insurance plan) OR Self-Pay and Member is now covered by a **Medicaid** program/vendor with the same OR different Provider.

  Required for submission:
  - Completed ADA form for preauthorization of CDT Code **D8999**.
  - Diagnostic records (a copy of the original study models/OrthoCad equivalent and/or a complete set of diagnostic photographs and/or a panorex film). Progress records will be accepted if original records are not available. Documentation should demonstrate qualifying criteria for severe handicapping malocclusion.

CHANGES THAT DO NOT HAVE TO BE SUBMITTED FOR CONTINUATION OF CARE PREAUTHORIZATION

- ☐ Changes between treating providers that are affiliated with the same group practice and changes between different affiliated practice locations. To ensure timely payment, please make sure that any claim is submittedwith the correct Group(Billing) and Provider NPI information.
- ☐ Initiation of Comprehensive Orthodontic Treatment after completion of Interceptive or Limited Orthodontic Treatment (Phased treatment). Please submit a prior-authorization (with any required documentation per plan) with the correct ADA Code for Comprehensive Ortho (D8070-D8090)

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APPENDIX A

Attachments

General Definitions

The following definitions apply to this Office Reference Manual:

A. "DSS" means Missouri Department of Social Services

B. "Contract" means the document specifying the services provided by DentaQuest to:

- an employer, directly or on behalf of the State of Missouri, as agreed upon between an employer or Plan and DentaQuest (a "Commercial Contract");
- a Medicaid beneficiary, directly or on behalf of a Plan, as agreed upon between the State of MISSOURI or its regulatory agencies or Plan and DentaQuest (a "Medicaid Contract");
- a Medicare beneficiary, directly or on behalf of a Plan, as agreed upon between the Center for Medicare and Medicaid Services ("CMS") or Plan and DentaQuest (a "Medicare Contract").

C. "Covered Services" is a dental service or supply that satisfies all of the following criteria:

- provided or arranged by a Participating Provider to a Member;
- authorized by DentaQuest in accordance with the Plan Certificate; and
- submitted to DentaQuest according to DentaQuest's filing requirements.

D. "DentaQuest" shall refer to DentaQuest, LLC

E. "DentaQuest Service Area" shall be defined as the State of Missouri.

F. "Medically Necessary:" A service shall be considered medically necessary if it (1) prevents, diagnoses, or treats a physical or behavioral health or injury; (2) is necessary for the member to achieve age appropriate growth and development; (3) minimizes the progression of disability; or (4) is necessary for the member to attain, maintain, or regain functional capacity. A service shall not be considered reasonable and medically necessary if it can be omitted without adversely affecting the member's condition or the quality of medical care rendered.

G. "Member" means any individual who is eligible to receive Covered Services pursuant to a Contract and the eligible dependents of such individuals. A Member enrolled pursuant to a Commercial Contract is referred to as a "Commercial Member." A Member enrolled pursuant to a Medicaid Contract is referred to as a "Medicaid Member." A Member enrolled pursuant to a Medicare Contract is referred to as a "Medicare Member."

H. "Participating Provider" is a dental professional or facility or other entity, including a Provider that has entered into a written agreement with DentaQuest, directly or through another entity, to provide dental services to selected groups of Members.

I. "Plan" is an insurer, health maintenance organization or any other entity that is an organized system which combines the delivery and financing of health care and which provides basic health services to enrolled Members for a fixed prepaid fee.

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J. "Plan Certificate" means the document that outlines the benefits available to Members.

K. "Provider" means the undersigned health professional or any other entity that has entered into a written agreement with DentaQuest to provide certain health services to Members. Each Provider shall have its own distinct tax identification number.

L. "Provider Dentist" is a Doctor of dentistry, duly licensed and qualified under the applicable laws, who practices as a shareholder, partner, or employee of Provider, and who has executed a Provider Dentist Participation Addendum.

Additional Resources

Welcome to the DentaQuest provider forms and attachment resource page. The links below provide methods to access and acquire both electronic and printable forms addressed within this document. To view copies please visit our website @ www.DentaQuestgov.com. Once you have entered the website, click on the "Dentist" icon. From there choose your 'State" and press go. You will then be able to log in using your password and User ID. Once logged in, select the link "Related Documents" to access the following resources:

- Dental Claim Form
- Instructions for Dental Claim Form
- Initial Clinical Exam Form
- Recall Examination Form
- Authorization for Dental Treatment
- Direct Deposit Form
- Medical and Dental History
- Provider Change Form
- Request for Transfer of Records
- Handicapping Labio-Lingual Deviations Form
- Orthodontic Continuation of Care Form
- OrthoCAD Submission Form

If you do not have internet access, to have a copy mailed, you may also contact DentaQuest Customer Service @ 888.307.6547.

You may also find these forms within this manual.

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ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐ M ☐ F | 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐ M ☐ F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B; ICD-10 = AB)
34a. Diagnosis Code(s) A _____ C _____
(Primary diagnosis in "A") B _____ D _____

31a. Other Fee(s)
32. Total Fee $0.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber Signature Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI | 50. License Number | 51. SSN or TIN

52. Phone Number | 52a. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment | 43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) | 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

54. NPI | 55. License Number

56. Address, City, State, Zip Code | 56a. Provider Specialty Code

57. Phone Number | 58. Additional Provider ID

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The following information highlights certain form completion instructions. Comprehensive ADA Dental Claim Form completion instructions are printed in the CDT manual. Any updates to these instructions will be posted on the ADA's web site (ADA.org).

GENERAL INSTRUCTIONS

A. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard #9 window envelope (window to the left). Please fold the form using the 'tick-marks' printed in the margin.

B. Complete all items unless noted otherwise on the form or in the CDT manual's instructions.

C. Enter the full name of an individual or a full business name, address and zip code when a name and address field is required.

D. All dates must include the four-digit year.

E. If the number of procedures reported exceeds the number of lines available on one claim form, list the remaining procedures on a separate, fully completed claim form.

COORDINATION OF BENEFITS (COB)

When a claim is being submitted to the secondary payer, complete the entire form and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may also note the primary carrier paid amount in the "Remarks" field (Item 35). There are additional detailed completion instructions in the CDT manual.

DIAGNOSIS CODING

The form supports reporting up to four diagnosis codes per dental procedure. This information is required when the diagnosis may affect claim adjudication when specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions. Diagnosis codes are linked to procedures using the following fields:

Item 29a – Diagnosis Code Pointer ("A" through "D" as applicable from Item 34a)

Item 34 – Diagnosis Code List Qualifier (B for ICD-9-CM; AB for ICD-10-CM)

Item 34a – Diagnosis Code(s) / A, B, C, D (up to four, with the primary adjacent to the letter "A")

PLACE OF TREATMENT

Enter the 2-digit Place of Service Code for Professional Claims, a HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are:

11 = Office; 12 = Home; 21 = Inpatient Hospital; 22 = Outpatient Hospital; 31 = Skilled Nursing Facility; 32 = Nursing Facility

The full list is available online at "www.cms.gov/PhysicianFeeSched/Downloads/Website_POS_database.pdf"

PROVIDER SPECIALTY

This code is entered in Item 56a and indicates the type of dental professional who delivered the treatment. The general code listed as "Dentist" may be used instead of any of the other codes.

Category / Description Code	Code
Dentist A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license.	122300000X
General Practice	1223G0001X
Dental Specialty (see following list)	Various
Dental Public Health	1223D0001X
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223D0008X
Oral & Maxillofacial Surgery	1223S0112X

Provider taxonomy codes listed above are a subset of the full code set that is posted at "www.wpc-edi.com/codes/taxonomy"

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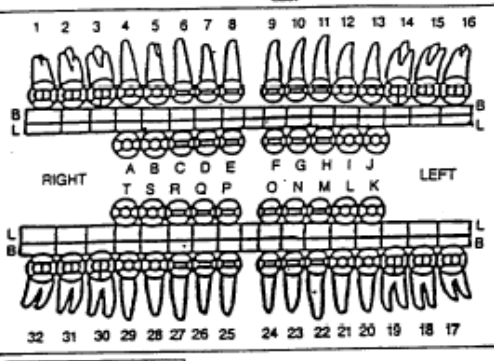
ALLERGY	PRE MED	MEDICAL ALERT

INITIAL CLINICAL EXAM

PATIENT'S NAME _____ Last First Middle



GINGIVA

MOBILITY

PROTHESIS EVALUATION

OCCLUSION 1 11 111

PATIENT'S CHIEF COMPLAINT

	OK
LYMPH NODES	
PHARYNX	
TONSILS	
SOFT PALATE	
HARD PALATE	
FLOOR OF MOUTH	
TONGUE	
VESTIBULES	
BUCCAL MUCOSA	
LIPS	
SKIN	
TMJ	
ORAL HYGIENE	
PERIO EXAM	

CLINICAL FINDINGS/COMMENTS

RADIOGRAPHS	B/P	RDH/DDS

RECOMMENDED TREATMENT PLAN

TOOTH OR AREA	DIAGNOSIS	PLAN A	PLAN B

SIGNATURE OF DENTIST DATE

Note: The above form is intended to be a sample. DentaQuest is not mandating the use of this form. Please refer to State statutes for specific State requirements and guidelines.

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RECALL EXAMINATION

PATIENT'S NAME _____

CHANGES IN HEALTH STATUS/MEDICAL HISTORY _____

	OK			CLINICAL FINDINGS/COMMENTS
LYMPH NODES		TMJ		
PHARYNX		TONGUE		
TONSILS		VESTIBULES		
SOFT PALATE		BUCCAL MUCOSA		
HARD PALATE		GINGIVA		
FLOOR OF MOUTH		PROSTHESIS		
LIPS		PERIO EXAM		
SKIN		ORAL HYGIENE		

RADIOGRAPHS		B/P	RDH/DDS

R **WORK NECESSARY** **L**

TOOTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
SERVICE																
TOOTH	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
SERVICE																

COMMENTS: _____

RECALL EXAMINATION

PATIENT'S NAME _____
CHANGES IN HEALTH STATUS/MEDICAL HISTORY _____

	OK		OK	CLINICAL FINDINGS/COMMENTS
LYMPH NODES		TMJ		
PHARYNX		TONGUE		
TONSILS		VESTIBULES		
SOFT PALATE		BUCCAL MUCOSA		
HARD PALATE		GINGIVA		
FLOOR OF MOUTH		PROSTHESIS		
LIPS		PERIO EXAM		
SKIN		ORAL HYGIENE		

RADIOGRAPHS	B/P	RDH/DDS

R **WORK NECESSARY** **L**

TOOTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
SERVICE																
TOOTH	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
SERVICE																

COMMENTS: _____

NOTE: The above form is intended to be a sample. DentaQuest is not mandating the use of this form. Please refer to State statutes for specific State requirements and guidelines.

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Authorization for Dental Treatment

I hereby authorize Dr._____and his/her associates to provide dental services, prescribe, dispense and/or administer any drugs, medicaments, antibiotics, and local anesthetics that he/she or his/her associates deem, in their professional judgement, necessary or appropriate in my care.

I am informed and fully understand that there are inherent risks involved in the administration of any drug, medicament, antibiotic, or local anesthetic. I am informed and fully understand that there are inherent risks involved in any dental treatment and extractions (tooth removal). The most common risks can include, but are not limited to:

> Bleeding, swelling, bruising, discomfort, stiff jaws, infection, aspiration, paresthesia, nerve disturbance or damage either temporary or permanent, adverse drug response, allergic reaction, cardiac arrest.

I realize that it is mandatory that I follow any instructions given by the dentist and/or his/her associates and take any medication as directed.

Alternative treatment options, including no treatment, have been discussed and understood. No guarantees have been made as to the results of treatment. A full explanation of all complications is available to me upon request from the dentist.

Procedure(s): _____

Tooth Number(s): _____

Date: _____

Dentist: _____

Patient Name: _____

Legal Guardian/
Patient Signature: _____

Witness: _____

Note: The above form is intended to be a sample. DentaQuest is not mandating the use of this form. Please refer to State statutes for specific State requirements and guidelines.

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AUTHORIZATION TO HONOR DIRECT AUTOMATED CLEARING HOUSE (ACH) CREDITS DISBURSED BY DENTAQUEST, LLC

INSTRUCTIONS

1. Complete all parts of this form.
2. Execute all signatures where indicated. If account requires counter signatures, both signatures must appear on this form.
3. **IMPORTANT**: Attach voided check from checking account.

MAINTENANCE TYPE:

_____ Add
_____ Change (Existing Set Up)
_____ Delete (Existing Set Up)

ACCOUNT HOLDER INFORMATION:

Account Number: _____

Account Type:` _____Checking

_____ Personal _____Business (choose one)

Bank Routing Number: ___ ___ ___ ___ ___ ___ ___ ___ ___

Bank Name: _____

Account Holder Name: _____

Effective Start Date: _____

As a convenience to me, for payment of services or goods due me, I hereby request and authorize **DentaQuest, LLC** to credit my bank account via Direct Deposit for the (agreed upon dollar amounts and dates.) I also agree to accept my remittance statements online and understand paper remittance statements will no longer be processed.

This authorization will remain in effect until revoked by me in writing. I agree you shall be fully protected in honoring any such credit entry.

I understand in endorsing or depositing this check that payment will be from Federal and State funds and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws.

I agree that your treatment of each such credit entry, and your rights in respect to it, shall be the same as if it were signed by me. I fully agree that if any such credit entry be dishonored, whether with or without cause, you shall be under no liability whatsoever.

_____ _____
Date Print Name

_____ _____
Phone Number Signature of Depositor (s) (As shown on Bank records for the account, which this authorization applicable.)

_____

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Legal Business/Entity Name (As appears on W-9 submitted to DentaQuest)

Tax Id (As appears on W-9 submitted to DentaQuest)

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MEDICAL AND DENTAL HISTORY

Patient Name:_____Date of Birth: _____

Address: _____

Why are you here today? _____

Are you having pain or discomfort at this time? ____Yes ____No

If yes, what type and where? _____

Have you been under the care of a medical doctor during the past two years? Yes ____No

Medical Doctor's Name: _____

Address: _____

Telephone: _____

Have you taken any medication or drugs during the past two years? ____Yes ____No

Are you now taking any medication, drugs, or pills? ____Yes ____No

If yes, please list medications: _____

Are you aware of being allergic to or have you ever reacted badly to any medication or substance? ____Yes ____No

If yes, please list: _____

When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness or breath, or because you are very tired? ____Yes . No

Do your ankles swell during the day? ____Yes . No

Do you use more than two pillows to sleep? ____Yes . No

Have you lost or gained more than 10 pounds in the past year? ____Yes . No

Do you ever wake up from sleep and feel short of breath? ____Yes . No

Are you on a special diet? ____Yes . No

Has your medical doctor ever said you have cancer or a tumor? ____Yes . No

If yes, where? _____

Do you use tobacco products (smoke or chew tobacco)? ____Yes ____No

If yes, how often and how much? _____

Do you drink alcoholic beverages (beer, wine, whiskey, etc.)? ____Yes ____No

Do you have or have you had any disease, or condition not listed? ____Yes ____No

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If yes, please list: _____

Indicate which of the following your have had, or have at present. Circle "Yes" or "No" for each item.

Heart Disease or Attack	__Yes	__No	Stroke	__Yes	__No	Hepatitis C	__Yes	__No
Heart Failure	__Yes	__No	Kidney Trouble	__Yes	__No	Arteriosclerosis (hardening of arteries)	__Yes	__No
Angina Pectoris	__Yes	__No	High Blood Pressure	__Yes	__No	Ulcers	__Yes	__No
Congenital Heart Disease	__Yes	__No	Venereal Disease	__Yes	__No	AIDS	__Yes	__No
Diabetes	Yes	No	Heart Murmur	Yes	No	Blood Transfusion	Yes	No
HIV Positive	__Yes	__No	Glaucoma	__Yes	__No	Cold sores/Fever blisters/ Herpes	__Yes	__No
High Blood Pressure	__Yes	__No	Cortisone Medication	__Yes	__No	Artificial Heart Valve	__Yes	__No
Mitral Valve Prolapse	__Yes	__No	Cosmetic Surgery	__Yes	__No	Heart Pacemaker	__Yes	__No
Emphysema	Yes	No	Anemia	Yes	No	Sickle Cell Disease	Yes	No
Chronic Cough	Yes	No	Heart Surgery	Yes	No	Asthma	Yes	No
Tuberculosis	Yes	No	Bruise Easily	Yes	No	Yellow Jaundice	Yes	No
Liver Disease	Yes	No	Rheumatic fever	Yes	No	Rheumatism	Yes	No
Arthritis	__Yes	__No	Epilepsy or Seizures	__Yes	__No	Fainting or Dizzy Spells	__Yes	__No
Allergies or Hives	__Yes	__No	Nervousness	__Yes	__No	Chemotherapy	__Yes	__No
Sinus Trouble	__Yes	__No	Radiation Therapy	__Yes	__No	Drug Addiction	__Yes	__No
Pain in Jaw Joints	__Yes	__No	Thyroid Problems	__Yes	__No	Psychiatric Treatment	__Yes	__No
Hay Fever	__Yes	__No	Hepatitis A (infectious)	__Yes	__No			
Artificial Joints (Hip, Knee, etc.)	__Yes	__No	Hepatitis B (serum)	__Yes	__No			

For Women Only:

Are you pregnant? ____Yes ____No

If yes, what month?_____

Are you nursing? ____Yes ____No

Are you taking birth control pills? ____Yes ____No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully.

Patient Signature:_____Date: _____

Dentist's Signature:_____Date: _____

Review Date	Changes in Health Status	Patient's signature	Dentist's signature

Note: The above form is intended to be a sample. DentaQuest is not mandating the use of this form. Please refer to State statutes for specific State requirements and guidelines.

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DentaQuest

Provider Update Form - Provider Operations

Section 1: Current Information - *Complete for all requests*

Provider Last Name | Provider First Name

Individual National Provider Identifier (NPI) #

Telephone Number: | Credentialing E-mail:

Section 2: Name Change/Demographic Change

New Name (Last, First, MI)

New Telephone Number: | New Credentialing E-mail:

Date of Birth: | Social Security #: | Gender: | New Fax Number:

Section 3: Add a Location (*Updated W9 and contract are required for location updates.)

Location Name:

Service Location Address:

City: | State: | Zipcode:

Telephone: | Credentialing E-mail:

Fax: | Tax ID Number:

New Location Office Hours: | Ages: | Languages: | Handicapped accesible | Primary Location

Effective Date: | Medicaid id number (if applicable):

Section 4: Credentialing Correspondence Address Change

Credentialing Contact Name:

Credentialing Address:

City: | State: | Zipcode:

Telephone: | Credentialing E-mail:

Fax:

Section 5: Tax ID Change (*Updated W9 and contract are required for Tax ID number changes)

Old Tax ID Number: | *New Tax ID Number:

Business Name:

Payment Address:

Section 6: Provider Status Change

◯ Term provider at location listed below (Please attach document with any additional locations to be termed)

◯ Term provider at all locations - all networks (Please attach term letter, note or document from provider as applicable)

Term Reason/Comments:

Location Name:

Service Location Address:

City: | State: | Zipcode:

Section 7: Requestor Information

Requestor Name | Date:

Requestor Title

Requestor Phone # | Email address:

Section 8: Notes

You may send this form by fax to 262-241-4077 or by email to StandardUpdates@dentaquest.com

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Request for Transfer of Records

I,_____, hereby request and give my permission to

Dr._____to provide Dr._____any and all information regarding past dental care for_____.

Such records may include medical care and treatment, illness or injury, dental history, medical history, consultation, prescriptions, radiographs, models and copies of all dental records and medical records.

Please have these records sent to:

_____

_____

_____

Signed:_____Date: _____
(Patient)

Signed:_____Date:_____
(Parent, Legal Guardian or Custodian of the Patient, if Patient is a Minor)

Address: _____

Address: _____

Phone: _____

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APPENDIX B

Covered Benefits (See Exhibits A - D)

This section identifies covered benefits, provides specific criteria for coverage and defines individual age and benefit limitations for Members under age 21. **Providers with benefit questions should contact DentaQuest's Customer Service department directly at:**

888.307.6547, press option 2

Dental offices are not allowed to charge Members for missed appointments. Plan Members are to be allowed the same access to dental treatment, as any other patient in the dental practice. Private reimbursement arrangements may be made only for non-covered services.

DentaQuest recognizes tooth letters "A" through "T" for primary teeth and tooth numbers "1" to "32" for permanent teeth. Supernumerary teeth should be designated by "AS through TS" for primary teeth and tooth numbers "51" to "82" for permanent teeth. These codes must be referenced in the patient's file for record retention and review. **All dental services performed must be recorded in the patient record, which must be available as required by your Participating Provider Agreement.**

For reimbursement, DentaQuest Providers should bill only per unique surface regardless of location. For example, when a dentist places separate fillings in both occlusal pits on an upper permanent first molar, the billing should state a **one** surface occlusal amalgam ADA code D2140. Furthermore, DentaQuest will reimburse for the total number of surfaces restored per tooth, per day; (i.e. a separate occlusal and buccal restoration on tooth 30 will be reimbursed as 1 (OB) two surface restoration).

The DentaQuest claim system can only recognize dental services described using the current American Dental Association CDT code list or those as defined as a Covered Benefit. All other service codes not contained in the following tables will be rejected when submitted for payment. A complete, copy of the CDT book can be purchased from the American Dental Association at the following address:

American Dental Association
211 East Chicago Avenue
Chicago, IL 60611
800.947.4746

Furthermore, DentaQuest subscribes to the definition of services performed as described in the CDT manual.

The benefit tables (Exhibits A - D) are all inclusive for covered services. Each category of service is contained in a separate table and lists:

1. the ADA approved service code to submit when billing,
2. brief description of the covered service,
3. any age limits imposed on coverage,
4. a description of documentation, in addition to a completed ADA claim form, that must be submitted when a claim or request for prior authorization is submitted,
5. an indicator of whether or not the service is subject to prior authorization, any other applicable benefit limitations.

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DentaQuest Authorization Process

IMPORTANT

For procedures where "Authorization Required" fields indicate "**yes**".

Please review the information below on when to submit documentation to DentaQuest. The information refers to the "Documentation Required" field in the Benefits Covered section (Exhibits A - D). In this section, documentation may be requested to be sent prior to beginning treatment or "with claim" after completion of treatment.

When documentation is requested:

"Authorization Required" Field	"Documentation Required" Field	Treatment Condition	When to Submit Documentation
Yes	Documentation Requested	Non-emergency (routine)	Send documentation prior to beginning treatment
Yes	Documentation Requested	Emergency	Send documentation with claim after treatment

When documentation is requested "with claim:"

"Authorization Required" Field	"Documentation Required" Field	Treatment Condition	When to Submit Documentation
Yes	Documentation Requested with claim	Non-emergency (routine) or emergency	Send documentation with claim after treatment

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Exhibit A Benefits Covered for
MO Healthy Blue Medicaid Children

Diagnostic services include the oral examinations, and selected radiographs, needed to assess the oral health, diagnose oral pathology, and develop an adequate treatment plan for the Member's oral health.
Reimbursement for some or multiple radiographs of the same tooth or area may be denied if DentaQuest determines the number to be redundant, excessive or not in keeping with the federal guidelines relating to radiation exposure. The maximum amount paid for individual radiographs taken on the same day will be limited to the allowance for a full mouth series.
Reimbursement for radiographs is limited to when required for proper treatment and/or diagnosis.
DentaQuest utilizes the guidelines published by the Department of Health and Human Services Center for Devices and Radiological Health. However, please consult the following benefit tables for benefit limitations.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0120	periodic oral evaluation - established patient	0-20		No	One of (D0120, D0145, D0150) per 6 Month(s) Per patient.	
D0140	limited oral evaluation-problem focused	0-20		No	Not reimburseable on the same day as D0120 and D0150. Not allowed on same day as Non-Emergency definitive treatment.	
D0145	oral evaluation for a patient under three years of age and counseling with primary caregiver	0-2		No	One of (D0120, D0145, D0150) per 6 Month(s) Per patient.	
D0150	comprehensive oral evaluation - new or established patient	0-20		No	One of (D0150) per 36 Month(s) Per patient. One of (D0120, D0145, D0150) per 6 Month(s) Per patient.	
D0160	detailed and extensive oral eval-problem focused, by report	0-20		No		
D0170	re-evaluation, limited problem focused	0-20		No		
D0171	Re-evaluation post-operative office visit	0-20		No		
D0210	intraoral - comprehensive series of radiographic images	0-20		No	One of (D0210, D0330) per 24 Month(s) Per patient.	
D0220	intraoral - periapical first radiographic image	0-20		No	One of (D0220) per 1 Day(s) Per patient.	
D0230	intraoral - periapical each additional radiographic image	0-20		No		
D0240	intraoral - occlusal radiographic image	0-20		No	Two of (D0240) per 24 Month(s) Per patient.	

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Exhibit A Benefits Covered for MO Healthy Blue Medicaid Children

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0250	extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	0-20		No	One of (D0250) per 1 Day(s) Per patient. Narrative of medical necessity shall be maintained in patient records.	
D0251	extra-oral posterior dental radiographic image	0-20	Teeth 1 - 32	No	One of (D0251) per 1 Day(s) Per patient.	
D0270	bitewing - single radiographic image	0-20		No	Two of (D0270, D0272, D0273, D0274, D0277) per 1 Calendar year(s) Per patient.	
D0272	bitewings - two radiographic images	0-20		No	Two of (D0270, D0272, D0273, D0274, D0277) per 1 Calendar year(s) Per patient.	
D0273	bitewings - three radiographic images	0-20		No	Two of (D0270, D0272, D0273, D0274, D0277) per 1 Calendar year(s) Per patient.	
D0274	bitewings - four radiographic images	0-20		No	Two of (D0270, D0272, D0273, D0274, D0277) per 1 Calendar year(s) Per patient.	
D0277	vertical bitewings - 7 to 8 films	0-20		No	Two of (D0270, D0272, D0273, D0274, D0277) per 1 Calendar year(s) Per patient.	
D0310	sialography	0-20		Yes		narrative of medical necessity
D0330	panoramic radiographic image	6-20		No	One of (D0210, D0330) per 24 Month(s) Per patient.	
D0340	cephalometric radiographic image	0-20		Yes		
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	0-20		No	One of (D0350) per 12 Month(s) Per patient. Narrative of medical necessity shall be maintained in patient records.	
D0364	Cone beam CT capture and interpretation with limited field of view, less than one whole jaw	0-20		Yes	One of (D0364) per 36 Month(s) Per patient.	narrative of medical necessity
D0365	Cone beam CT capture and interpretation with field of view of one full dental arch – mandible	0-20		Yes	One of (D0365) per 36 Month(s) Per patient.	narrative of medical necessity
D0366	Cone beam CT capture and interpretation with field of view of one full dental arch – maxilla, with or without cranium	0-20		Yes	One of (D0366) per 36 Month(s) Per patient.	narrative of medical necessity
D0367	Cone beam CT capture and interpretation with field of view of both jaws, with or without cranium	0-20		Yes	One of (D0367) per 36 Month(s) Per patient.	narrative of medical necessity

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Exhibit A Benefits Covered for
MO Healthy Blue Medicaid Children

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0368	Cone beam CT capture and interpretation for TMJ series including two or more exposures	0-20		Yes	One of (D0368) per 36 Month(s) Per patient.	narrative of medical necessity
D0415	bacteriologic studies	0-20		No	Narrative of medical necessity shall be maintained in patient records.	
D0460	pulp vitality tests	0-20		No	Two of (D0460) per 12 Month(s) Per patient. Includes multiple teeth and contralateral comparison(s). Narrative of medical necessity shall be maintained in patient records.	
D0470	diagnostic casts	0-20		No		
D0999	unspecified diagnostic procedure, by report	0-20		Yes		

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Sealants may be placed on the occlusal or occlusal-buccal surfaces of lower molars or occlusal or occlusal-lingual surfaces of upper molars.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1110	prophylaxis - adult	13 - 20		No	Two of (D1110, D1120) per 1 Calendar year(s) Per patient.	
D1120	prophylaxis - child	0-12		No	Two of (D1110, D1120) per 1 Calendar year(s) Per patient.	
D1206	topical application of fluoride varnish	0-20		No	Two of (D1206, D1208) per 1 Calendar year(s) Per patient.	
D1208	topical application of fluoride - excluding varnish	0-20		No	Two of (D1206, D1208) per 1 Calendar year(s) Per patient.	
D1351	sealant - per tooth	5 - 20	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	One of (D1351, D1353) per 3 Year(s) Per patient per tooth. Sealants may be placed on the occlusal or occlusal-buccal surfaces of lower molars or occlusal or occlusal-lingual surfaces of upper molars. Teeth must be caries free. Sealant will not be covered when placed over restorations.	
D1353	Sealant repair - per tooth	0-20	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	Sealants will not be covered when placed over restorations. Teeth must be caries free. Includes buccal surfaces of mandibular molars and lingual surfaces of maxillary molars.	
D1354	application of caries arresting medicament- per tooth	0-20	Teeth 1 - 32, A - T	No	One of (D1354) per 6 Month(s) Per patient per tooth. Four of (D1354) per 1 Lifetime Per patient per tooth. Not allowed with history of any prior or same day D2000, D3000 code on same tooth. D1354 cannot be billed in conjunction with D1355 (caries preventive medicament application – per tooth) on the same tooth within the same six (6)-month period.	
D1355	caries preventive medicament application – per tooth	0-14	Teeth A - T	No	One of (D1355) per 6 Month(s) Per patient per tooth. Four of (D1355) per 1 Lifetime Per patient per tooth. Not allowed with history of any prior or same day D2000, D3000 code on same tooth.	
D1510	space maintainer-fixed, unilateral-per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D1510, D1520) per 24 Month(s) Per patient per quadrant. Indicate missing tooth number and arch/quadrant on claim.	

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Exhibit A Benefits Covered for MO Healthy Blue Medicaid Children

Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1516	space maintainer --fixed--bilateral, maxillary	0-20		No	One of (D1516) per 24 Month(s) Per patient per arch.	
D1517	space maintainer --fixed--bilateral, mandibular	0-20		No	One of (D1517) per 24 Month(s) Per patient per arch.	
D1520	space maintainer-removable-unilateral	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D1510, D1520) per 24 Month(s) Per patient per quadrant. Indicate missing tooth number and arch/quadrant on claim.	narrative of medical necessity
D1526	space maintainer --removable--bilateral, maxillary	0-20		No	One of (D1526) per 24 Month(s) Per patient per arch. Narrative of medical necessity shall be maintained in patient records.	
D1527	space maintainer --removable--bilateral, mandibular	0-20		No	One of (D1527) per 24 Month(s) Per patient per arch.	
D1551	re-cement or re-bond bilateral space maintainer- Maxillary	0-20		No	One of (D1551) per 6 Month(s) Per patient. Not allowed by same provider/location within 6 months of initial placement.	
D1552	re-cement or re-bond bilateral space maintainer- Mandibular	0-20		No	One of (D1552) per 6 Month(s) Per patient. Not allowed by same provider/location within 6 months of initial placement.	
D1553	re-cement or re-bond unilateral space maintainer- Per Quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D1553) per 6 Month(s) Per patient per quadrant. Not allowed by same provider/location within 6 months of initial placement.	
D1556	Removal of fixed unilateral space maintainer- Per Quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D1556) per 24 Month(s) Per patient per quadrant. Not reimbursable by same dentist or group that placed appliance	
D1557	Removal of fixed bilateral space maintainer- Maxillary	0-20		No	One of (D1557) per 24 Month(s) Per patient per arch. Not reimbursable by same dentist or group that placed appliance	
D1558	Removal of fixed bilateral space maintainer- Mandibular	0-20		No	One of (D1558) per 24 Month(s) Per patient per arch. Not reimbursable by same dentist or group that placed appliance	
D1575	distal shoe space maintainer - fixed - unilateral- Per Quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D1575) per 24 Month(s) Per patient per quadrant. Not reimbursable by same dentist or group that placed appliance	

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Exhibit A Benefits Covered for MO Healthy Blue Medicaid Children

Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1999	Unspecified preventive procedure, by report	0-20		No		

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Reimbursement includes local anesthesia and routine post-operative care.
Generally, once a particular restoration is placed in a tooth, a similar restoration will not be covered for at least six months, unless there is recurrent decay or material failure.
Payment is made for restorative services based onthe number of services restored, not the number of restorations per surface, or per tooth, per day. A restoration is considered a two or more surface restoration only when two or more actual tooth surfaces are involved, whether they are connected or not.
Tooth preparation, all adhesives (including amalgam and resin bonding agents),acid etching, copalite, liners, bases and curing are included as part of the restoration.
When restorations involving multiple surfaces are requested or performed, that are outside the usual anatomical expectation, the allowance is limited to that of a one-surface restoration. Any fee charged in excess of the allowance for the one-surface restoration is DISALLOWED.
Billing and reimbursement for cast crowns, cast post and cores and laminate veneers or any other fixed prosthetics shall be based on the cementation date.
The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent teeth.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2140	Amalgam - one surface, primary or permanent	0-4	Teeth A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2140	Amalgam - one surface, primary or permanent	5-9	Teeth A - C, H - M, R - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2140	Amalgam - one surface, primary or permanent	0-20	Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2140	Amalgam - one surface, primary or permanent	5 - 20	Teeth D - G, N - Q	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2140	Amalgam - one surface, primary or permanent	10 - 20	Teeth A - C, H - M, R - T	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2150	Amalgam - two surfaces, primary or permanent	0-4	Teeth A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	

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Exhibit A Benefits Covered for MO Healthy Blue Medicaid Children

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2150	Amalgam - two surfaces, primary or permanent	5-9	Teeth A - C, H - M, R - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2150	Amalgam - two surfaces, primary or permanent	0-20	Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2150	Amalgam - two surfaces, primary or permanent	5 - 20	Teeth D - G, N - Q	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2150	Amalgam - two surfaces, primary or permanent	10 - 20	Teeth A - C, H - M, R - T	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2160	amalgam - three surfaces, primary or permanent	0-4	Teeth A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2160	amalgam - three surfaces, primary or permanent	5-9	Teeth A - C, H - M, R - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2160	amalgam - three surfaces, primary or permanent	0-20	Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2160	amalgam - three surfaces, primary or permanent	5 - 20	Teeth D - G, N - Q	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2160	amalgam - three surfaces, primary or permanent	10 - 20	Teeth A - C, H - M, R - T	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2161	amalgam - four or more surfaces, primary or permanent	0-4	Teeth A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	

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Exhibit A Benefits Covered for MO Healthy Blue Medicaid Children

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2161	amalgam - four or more surfaces, primary or permanent	5-9	Teeth A - C, H - M, R - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2161	amalgam - four or more surfaces, primary or permanent	0-20	Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2161	amalgam - four or more surfaces, primary or permanent	5 - 20	Teeth D - G, N - Q	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2161	amalgam - four or more surfaces, primary or permanent	10 - 20	Teeth A - C, H - M, R - T	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2330	resin-based composite - one surface, anterior	0-4	Teeth C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2330	resin-based composite - one surface, anterior	5-9	Teeth C, H, M, R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2330	resin-based composite - one surface, anterior	0-20	Teeth 6 - 11, 22 - 27	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2330	resin-based composite - one surface, anterior	5 - 20	Teeth D - G, N - Q	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2330	resin-based composite - one surface, anterior	10 - 20	Teeth C, H, M, R	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2331	resin-based composite - two surfaces, anterior	0-4	Teeth C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	

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Exhibit A Benefits Covered for MO Healthy Blue Medicaid Children

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2331	resin-based composite - two surfaces, anterior	5-9	Teeth C, H, M, R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2331	resin-based composite - two surfaces, anterior	0-20	Teeth 6 - 11, 22 - 27	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2331	resin-based composite - two surfaces, anterior	5 - 20	Teeth D - G, N - Q	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2331	resin-based composite - two surfaces, anterior	10 - 20	Teeth C, H, M, R	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2332	resin-based composite - three surfaces, anterior	0-4	Teeth C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2332	resin-based composite - three surfaces, anterior	5-9	Teeth C, H, M, R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2332	resin-based composite - three surfaces, anterior	0-20	Teeth 6 - 11, 22 - 27	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2332	resin-based composite - three surfaces, anterior	5 - 20	Teeth D - G, N - Q	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2332	resin-based composite - three surfaces, anterior	10 - 20	Teeth C, H, M, R	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2335	resin-based composite - four or more surfaces (anterior)	0-4	Teeth C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	

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Exhibit A Benefits Covered for MO Healthy Blue Medicaid Children

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2335	resin-based composite - four or more surfaces (anterior)	5-9	Teeth C, H, M, R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2335	resin-based composite - four or more surfaces (anterior)	0-20	Teeth 6 - 11, 22 - 27	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2335	resin-based composite - four or more surfaces (anterior)	5 - 20	Teeth D - G, N - Q	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2335	resin-based composite - four or more surfaces (anterior)	10 - 20	Teeth C, H, M, R	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2390	resin-based composite crown, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No		
D2391	resin-based composite - one surface, posterior	0-9	Teeth A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2391	resin-based composite - one surface, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2391	resin-based composite - one surface, posterior	10 - 20	Teeth A, B, I - L, S, T	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2392	resin-based composite - two surfaces, posterior	0-9	Teeth A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2392	resin-based composite - two surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	

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Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2392	resin-based composite - two surfaces, posterior	10 - 20	Teeth A, B, I - L, S, T	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2393	resin-based composite - three surfaces, posterior	0-9	Teeth A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2393	resin-based composite - three surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2393	resin-based composite - three surfaces, posterior	10 - 20	Teeth A, B, I - L, S, T	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2394	resin-based composite - four or more surfaces, posterior	0-9	Teeth A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2394	resin-based composite - four or more surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2394	resin-based composite - four or more surfaces, posterior	10 - 20	Teeth A, B, I - L, S, T	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2710	crown - resin-based composite (indirect)	16 - 20	Teeth 1 - 32	Yes	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth.	
D2720	crown-resin with high noble metal	16 - 20	Teeth 1 - 32	Yes	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth.	

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Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2721	crown - resin with predominantly base metal	16 - 20	Teeth 1 - 32	Yes	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth.	
D2722	crown - resin with noble metal	16 - 20	Teeth 1 - 32	Yes	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth.	
D2740	crown - porcelain/ceramic	16 - 20	Teeth 1 - 32	Yes	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2750	crown - porcelain fused to high noble metal	16 - 20	Teeth 1 - 32	Yes	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2751	crown - porcelain fused to predominantly base metal	16 - 20	Teeth 1 - 32	Yes	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2752	crown - porcelain fused to noble metal	16 - 20	Teeth 1 - 32	Yes	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2780	crown - ¾ cast high noble metal	16 - 20	Teeth 1 - 32	Yes	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth.	

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Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2781	crown - ¾ cast predominantly base metal	16 - 20	Teeth 1 - 32	Yes	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth.	
D2782	crown - ¾ cast noble metal	16 - 20	Teeth 1 - 32	Yes	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth.	
D2783	crown - ¾ porcelain/ceramic	16 - 20	Teeth 1 - 32	Yes	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth.	
D2790	crown - full cast high noble metal	16 - 20	Teeth 1 - 32	Yes	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2791	crown - full cast predominantly base metal	16 - 20	Teeth 1 - 32	Yes	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2792	crown - full cast noble metal	16 - 20	Teeth 1 - 32	Yes	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2799	interim crown	16 - 20	Teeth 1 - 32	Yes		
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	0-20	Teeth 1 - 32	No	Not covered within 6 months of placement.	

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Exhibit A Benefits Covered for MO Healthy Blue Medicaid Children

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core	0-20	Teeth 1 - 32	No		
D2920	re-cement or re-bond crown	0-20	Teeth 1 - 32, A - T	Yes	Not covered within 6 months of placement.	narr. of med. necessity, pre-op x-ray(s)
D2921	Reattachment of tooth fragment, incisal edge or cusp	0-20	Teeth 1 - 32	No	One of (D2921) per 1 Year(s) Per patient per tooth.	
D2929	Prefabricated porcelain/ceramic crown – primary tooth	21 and older	Teeth A - T	No	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth.	
D2930	prefabricated stainless steel crown - primary tooth	0-4	Teeth A - T	No	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth.	
D2930	prefabricated stainless steel crown - primary tooth	5-9	Teeth A - C, H - M, R - T	No	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth.	
D2930	prefabricated stainless steel crown - primary tooth	5 - 20	Teeth D - G, N - Q	Yes	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2930	prefabricated stainless steel crown - primary tooth	10 - 20	Teeth A - C, H - M, R - T	Yes	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth.	pre-operative x-ray(s)

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Exhibit A Benefits Covered for MO Healthy Blue Medicaid Children

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2931	prefabricated stainless steel crown-permanent tooth	0-20	Teeth 1 - 32	No	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2932	prefabricated resin crown	0-4	Teeth A - T	No	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth.	
D2932	prefabricated resin crown	5-9	Teeth A - C, H - M, R - T	No	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth.	
D2932	prefabricated resin crown	0-20	Teeth 1 - 32	No	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth.	
D2932	prefabricated resin crown	5 - 20	Teeth D - G, N - Q	Yes	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2932	prefabricated resin crown	10 - 20	Teeth A - C, H - M, R - T	Yes	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2933	prefabricated stainless steel crown with resin window	0-4	Teeth C - H, M - R	No	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth.	

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Exhibit A Benefits Covered for MO Healthy Blue Medicaid Children

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2933	prefabricated stainless steel crown with resin window	5-9	Teeth C, H, M, R	No	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth.	
D2933	prefabricated stainless steel crown with resin window	0-20	Teeth 6 - 11, 22 - 27	No	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth.	
D2933	prefabricated stainless steel crown with resin window	5 - 20	Teeth D - G, N - Q	Yes	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2933	prefabricated stainless steel crown with resin window	10 - 20	Teeth C, H, M, R	Yes	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	0-4	Teeth A - T	No	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth.	
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	5-9	Teeth A - C, H - M, R - T	No	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth.	
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	5 - 20	Teeth D - G, N - Q	Yes	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth.	pre-operative x-ray(s)

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Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	10 - 20	Teeth A - C, H - M, R - T	Yes	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2940	protective restoration	0-20	Teeth 1 - 32, A - T	Yes	Temporary restoration intended to relieve pain. Not to be used as a base liner or under a restoration.	narr. of med. necessity, pre-op x-ray(s)
D2941	Interim therapeutic restoration - primary dentition	0-20	Teeth 1 - 32	Yes	One of (D2940, D2941) per 36 Month(s) Per patient.	pre-operative x-ray(s)
D2949	Restorative foundation for an indirect restoration	0-20	Teeth 1 - 32	Yes	One of (D2940, D2941) per 36 Month(s) Per patient. Narrative of medical necessity.	pre-operative x-ray(s)
D2950	core buildup, including any pins when required	0-20	Teeth 1 - 32	Yes	One of (D2950, D2952, D2954) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2951	pin retention - per tooth, in addition to restoration	0-20	Teeth 1 - 32	No	One of (D2951) per 1 Lifetime Per patient per tooth.	
D2952	cast post and core in addition to crown	0-20	Teeth 1 - 32	No	One of (D2950, D2952, D2954) per 60 Month(s) Per patient per tooth.	
D2953	each additional cast post - same tooth	0-20	Teeth 1 - 32	Yes		
D2954	prefabricated post and core in addition to crown	0-20	Teeth 1 - 32	Yes	One of (D2950, D2952, D2954) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2955	post removal (not in conjunction with endodontic therapy)	0-20	Teeth 1 - 32	Yes		
D2957	each additional prefabricated post - same tooth	0-20	Teeth 1 - 32	Yes		
D2960	labial veneer (laminate)-chair	0-20	Teeth 1 - 32	Yes	One of (D2960, D2961, D2962) per 60 Month(s) Per patient per tooth.	
D2961	labial veneer (resin laminate) - laboratory	0-20	Teeth 1 - 32	Yes	One of (D2960, D2961, D2962) per 60 Month(s) Per patient per tooth.	
D2962	labial veneer (porc laminate) - laboratory	0-20	Teeth 1 - 32	Yes	One of (D2960, D2961, D2962) per 60 Month(s) Per patient per tooth.	
D2980	crown repair, by report	0-20	Teeth 1 - 32	No	One of (D2980) per 1 Lifetime Per patient per tooth. Narrative of medical necessity shall be maintained in patient records.	

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Exhibit A Benefits Covered for MO Healthy Blue Medicaid Children

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2999	unspecified restorative procedure, by report	0-20	Teeth 1 - 32, A - T	Yes		

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Reimbursement includes local anesthesia and routine post-operative care.
In cases where a root canal filling does not meet DentaQuest's general criteria treatment standards, DentaQuest can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.
A pulpotomy or palliative treatment is not to be billed in conjunction with a root canal treatment on the same date.
Filling material not accepted by the Federal Food and Drug Administration (FDA) (e.g., Sargenti filling material) is not covered.
Complete root canal therapy includes pulpectomy, all appointments necessary to complete treatment, temporary fillings, filling and obturation of canals, intra-operative and fill radiographs.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3110	pulp cap - direct (exluding final restoration)	0-20	Teeth 1 - 32, A - T	No	One of (D3110) per 1 Lifetime Per patient per tooth.	
D3120	pulp cap - indirect (excluding final restoration)	0-20	Teeth 1 - 32, A - T	No	One of (D3120) per 1 Lifetime Per patient per tooth.	
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	0-20	Teeth 1 - 32, A - T	No	Not to be used by provider completing endodontic treatment. D3220, D3221 or D3222.	pre-operative x-ray(s)
D3221	pulpal debridement, primary and permanent teeth	0-20	Teeth 1 - 32, A - T	No	Not to be used by provider completing endodontic treatment. D3220, D3221 or D3222.	
D3222	partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	0-20	Teeth 1 - 32, A - T	No	Not to be used by provider completing endodontic treatment. D3220, D3221 or D3222.	
D3230	pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	0-20	Teeth C - H, M - R	Yes	One of (D3230) per 1 Lifetime Per patient per tooth.	
D3240	pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	0-20	Teeth A, B, I - L, S, T	Yes	One of (D3240) per 1 Lifetime Per patient per tooth.	
D3310	endodontic therapy, anterior tooth (excluding final restoration)	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D3310) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3320	endodontic therapy, premolar tooth (excluding final restoration)	0-20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	One of (D3320) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3330	endodontic therapy, molar tooth (excluding final restoration)	0-20	Teeth 1 - 3, 14 - 19, 30 - 32	Yes	One of (D3330) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)

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Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3331	treatment of root canal obstruction; non-surgical access	0-20	Teeth 1 - 32	No	One of (D3331) per 1 Lifetime Per patient per tooth.	
D3332	incomplete endodontic therapy; inoperable or fractured tooth	0-20	Teeth 1 - 32	No	One of (D3332) per 1 Lifetime Per patient per tooth.	
D3333	internal root repair of perforation defects	0-20	Teeth 1 - 32	No	One of (D3333) per 1 Lifetime Per patient per tooth.	
D3346	retreatment of previous root canal therapy-anterior	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D3346) per 1 Lifetime Per patient per tooth. Same provider may not submit within two years of root canal therapy.	Pre and post-operative x-ray(s)
D3347	retreatment of previous root canal therapy - premolar	0-20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	One of (D3347) per 1 Lifetime Per patient per tooth. Same provider may not submit within two years of root canal therapy.	Pre and post-operative x-ray(s)
D3348	retreatment of previous root canal therapy-molar	0-20	Teeth 1 - 3, 14 - 19, 30 - 32	Yes	One of (D3348) per 1 Lifetime Per patient per tooth. Same provider may not submit within two years of root canal therapy.	Pre and post-operative x-ray(s)
D3351	apexification/recalcification - initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	0-20	Teeth 1 - 32	Yes		pre-operative x-ray(s)
D3352	apexification/recalcification - interim medication replacement	0-20	Teeth 1 - 32	Yes		pre-operative x-ray(s)
D3353	apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	0-20	Teeth 1 - 32	Yes		pre-operative x-ray(s)
D3410	apicoectomy - anterior	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D3410) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3421	apicoectomy - premolar (first root)	0-20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	One of (D3421) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3425	apicoectomy - molar (first root)	0-20	Teeth 1 - 3, 14 - 19, 30 - 32	Yes	One of (D3425) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3426	apicoectomy (each additional root)	0-20	Teeth 1 - 5, 12 - 21, 28 - 32	Yes	One of (D3426) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3428	Bone graft in conjunction with periradicular surgery - per tooth, single site	0-20	Teeth 1 - 32	Yes	One of (D3428) per 1 Year(s) Per patient per tooth.	pre-operative x-ray(s)

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Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3429	Bone graft in conjunction with periradicular surgery - each additional contiguous tooth in the same surgical site	0-20	Teeth 1 - 32	Yes	One of (D3429) per 1 Year(s) Per patient per tooth.	
D3430	retrograde filling - per root	0-20	Teeth 1 - 32	Yes	One of (D3430) per 1 Lifetime Per patient per tooth.	
D3432	Guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D3432) per 1 Year(s) Per patient per tooth. Narrative of medical necessity.	
D3432	Guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery	0-20	Teeth 1 - 32	Yes	One of (D3432) per 1 Year(s) Per patient per tooth.	
D3450	root amputation - per root	0-20	Teeth 1 - 32	Yes	One of (D3450) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3471	surgical repair of root resorption - anterior	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D3471) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3472	surgical repair of root resorption – premolar	0-20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	One of (D3472) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3473	surgical repair of root resorption – molar	0-20	Teeth 1 - 3, 14 - 19, 30 - 32	Yes	One of (D3473) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3501	surgical exposure of root surface without apicoectomy or repair of root resorption – anterior	0-20	Teeth 6 - 11, 22 - 27	Yes	One of (D3501) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3502	surgical exposure of root surface without apicoectomy or repair of root resorption – premolar	0-20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	One of (D3502) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3503	surgical exposure of root surface without apicoectomy or repair of root resorption – molar	0-20	Teeth 1 - 3, 14 - 19, 30 - 32	Yes	One of (D3503) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3910	surgical procedure for isolation of tooth with rubber dam	0-20	Teeth 1 - 32	Yes	One of (D3910) per 1 Lifetime Per patient per tooth.	
D3999	unspecified endodontic procedure, by report	0-20	Teeth 1 - 32, A - T	Yes		

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Exhibit A Benefits Covered for MO Healthy Blue Medicaid Children

Reimbursement includes local anesthesia and routine post-operative care.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Periodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211) per 36 Month(s) Per patient per quadrant. A minimum of four (4) affected teeth in the quadrant.	pre-op x-ray(s), perio charting
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211) per 36 Month(s) Per patient per quadrant. One (1) to three (3) teeth in the affected quadrant.	pre-op x-ray(s), perio charting
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	0-20	Teeth 1 - 32, 51 - 82	Yes	One of (D4212) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4230	anatomical crown exposure – four or more contiguous teeth or tooth bounded spaces per quadrant	0-20		Yes	One of (D4230) per 1 Lifetime Per patient.	
D4231	anatomical crown exposure – one to three teeth or tooth bounded spaces per quadrant	0-20		Yes	One of (D4231) per 1 Lifetime Per patient.	
D4240	gingival flap procedure, including root planing – four or more contiguous teeth or tooth bound spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4240, D4241) per 36 Month(s) Per patient per quadrant. A minimum of four (4) affected teeth in the quadrant.	pre-op x-ray(s), perio charting
D4241	gingival flap procedure, including root planing – one to three contiguous teeth or tooth bound spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4240, D4241) per 36 Month(s) Per patient per quadrant. One (1) to three (3) teeth in the affected quadrant.	pre-op x-ray(s), perio charting
D4245	apically positioned flap	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4245) per 1 Lifetime Per patient per quadrant.	pre-op x-ray(s), perio charting
D4249	clinical crown lengthening - hard tissue	0-20	Teeth 1 - 32	Yes	One of (D4249) per 1 Lifetime Per patient per tooth.	pre-op x-ray(s), perio charting
D4260	osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4260, D4261) per 36 Month(s) Per patient per quadrant. A minimum of four (4) affected teeth in the quadrant.	pre-op x-ray(s), perio charting

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Periodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D4261	osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4260, D4261) per 36 Month(s) Per patient per quadrant. One (1) to three (3) teeth in the affected quadrant.	pre-op x-ray(s), perio charting
D4263	bone replacement graft - first site in quadrant	0-20	Teeth 1 - 32	Yes	One of (D4263) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4264	bone replacement graft - each additional site in quadrant	0-20	Teeth 1 - 32	Yes	Two of (D4264) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4265	biological materials to aid in soft and osseous tissue regeneration per site	0-20	Teeth 1 - 32	Yes		narrative of medical necessity
D4266	guided tissue regeneration, natural teeth – resorbable barrier, per site	0-20	Teeth 1 - 32	Yes	One of (D4266) per 36 Month(s) Per patient per tooth.	narrative of medical necessity
D4267	guided tissue regeneration, natural teeth – non-resorbable barrier, per site	0-20	Teeth 1 - 32	Yes	One of (D4267) per 36 Month(s) Per patient per tooth.	narrative of medical necessity
D4268	surgical revision procedure	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4268) per 1 Lifetime Per patient per quadrant.	pre-operative x-ray(s)
D4270	pedicle soft tissue graft procedure	0-20	Teeth 1 - 32	Yes	One of (D4270) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4273	subepithelial connective tissue graft procedure	0-20	Teeth 1 - 32	Yes	One of (D4273) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4274	distal or proximal wedge procedure	0-20	Teeth 1 - 32	Yes	One of (D4274) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4275	soft tissue allograft	0-20	Teeth 1 - 32	Yes	One of (D4275) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4276	combined connective tissue and double pedicle graft	0-20	Teeth 1 - 32	Yes	One of (D4276) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	0-20	Teeth 1 - 32, 51 - 82	Yes	One of (D4277) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	0-20	Teeth 1 - 32, 51 - 82	Yes	One of (D4278) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting

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Exhibit A Benefits Covered for MO Healthy Blue Medicaid Children

Periodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D4283	autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	0-20	Teeth 1 - 32	Yes	One of (D4283) per 1 Year(s) Per patient per tooth.	pre-operative x-ray(s)
D4285	non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	0-20	Teeth 1 - 32	Yes	One of (D4285) per 1 Year(s) Per patient per tooth.	pre-operative x-ray(s)
D4286	removal of non-resorbable barrier	0-20	Teeth 1 - 32	Yes	One of (D4286) per 1 Lifetime Per patient.	pre-operative radiographs
D4322	splint – intra-coronal; natural teeth or prosthetic crowns	0-20	Per Arch (01, 02, LA, UA)	Yes		pre-op x-ray(s), perio charting
D4323	splint – extra-coronal; natural teeth or prosthetic crowns	0-20	Per Arch (01, 02, LA, UA)	Yes		pre-op x-ray(s), perio charting
D4341	periodontal scaling and root planing - four or more teeth per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4342	periodontal scaling and root planing - one to three teeth per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant.	pre-operative x-ray(s)
D4346	scaling in presence of generalized moderate or severe gingival inflammation, full mouth, after oral evaluation	0-20		Yes	One of (D4346) per 24 Month(s) Per patient per tooth. Perio charting, radiographs, and intra-oral photos must be submitted with the operative report. D4346 is indicated for participants who have swollen, inflamed gingiva, generalized suprabony pockets, and moderate to severe bleeding on probing.	Radiographs, perio charting and photographs
D4355	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	0-20		Yes	One of (D4355) per 1 Lifetime Per patient. Not allowed within 6 months after D1110.	pre-operative x-ray(s) or digital photograph
D4381	localized delivery of antimicrobial agents	0-20	Teeth 1 - 32	Yes	Eight of (D4381) per 1 Day(s) Per patient. One of (D4381) per 6 Month(s) Per patient per tooth.	Operative report (Operative Note)
D4910	periodontal maintenance procedures	0-20		Yes		

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Exhibit A Benefits Covered for MO Healthy Blue Medicaid Children

Periodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D4920	unscheduled dressing change (by someone other than treating dentist or their staff)	0-20		No	Not covered for treating dentist.	
D4921	gingival irrigation with a medicinal agent – per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4921) per 36 Month(s) Per patient per quadrant. Narrative of medical necessity.	narrative of medical necessity
D4999	unspecified periodontal procedure, by report	0-20		Yes		

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Reimbursement includes local anesthesia and routine post-operative care.
Medically necessary partial or full mouth dentures, and related services are covered when they are determined to be the primary treatment of choice or an essential part of the overall treatment plan to alleviate the member's dental problem.
A preformed denture with teeth already mounted forming a denture module is not a covered service. A partial denture that replaces only posterior permanent teeth must include three or more teeth on the dentures that are anatomically correct (natural size, shape and color) to be compensable (excluding third molars). Partial dentures must include one anterior tooth and/or 3 posterior teeth (excluding third molars).
Extractions for asymptomatic teeth are not covered services unless removal constitutes most cost-effective dental procedure for the provision of dentures.
Provision for dentures for cosmetic purposes is not a covered service.
Billing and reimbursement for cast crowns, cast post and cores and laminate veneers or any other fixed prosthetics shall be based on the cementation date.
Fabrication of a removable prosthetic includes multiple steps(appointments) these multiple steps (impressions, try-in appointments, delivery etc.) are inclusive in the fee for the removable prosthetic and as such not eligible for additional compensation.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5110	complete denture - maxillary	0-20	Per Arch (01, UA)	Yes	One of (D5110, D5130) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5120	complete denture - mandibular	0-20	Per Arch (02, LA)	Yes	One of (D5120, D5140) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5130	immediate denture - maxillary	0-20	Per Arch (01, UA)	Yes	One of (D5130) per 1 Lifetime Per patient. One of (D5110, D5130) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5140	immediate denture - mandibular	0-20	Per Arch (02, LA)	Yes	One of (D5140) per 1 Lifetime Per patient. One of (D5120, D5140) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5211	maxillary partial denture, resin base (including retentive/clasping materials, rests, and teeth)	8 - 20		Yes	One of (D5211, D5213, D5225, D5227) per 60 Month(s) Per patient per arch. Minimum of one or more anterior teeth or 3 or more posterior teeth (excluding 3rds).	pre-operative x-ray(s)
D5212	mandibular partial denture, resin base (including retentive/clasping materials, rests, and teeth)	8 - 20		Yes	One of (D5212, D5214, D5226, D5228) per 60 Month(s) Per patient per arch. Minimum of one or more anterior teeth or 3 or more posterior teeth (excluding 3rds).	pre-operative x-ray(s)
D5213	maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	8 - 20		Yes	One of (D5211, D5213, D5225, D5227) per 60 Month(s) Per patient. Minimum of three teeth, excluding molars.	pre-operative x-ray(s)
D5214	mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	8 - 20		Yes	One of (D5212, D5214, D5226, D5228) per 60 Month(s) Per patient. Minimum of three teeth, excluding molars.	pre-operative x-ray(s)

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Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5225	maxillary partial denture-flexible base	8 - 20		Yes	One of (D5211, D5213, D5225, D5227) per 60 Month(s) Per patient. Minimum of three teeth, excluding molars.	pre-operative x-ray(s)
D5226	mandibular partial denture-flexible base	8 - 20		Yes	One of (D5212, D5214, D5226, D5228) per 60 Month(s) Per patient. Minimum of three teeth, excluding molars.	pre-operative x-ray(s)
D5227	immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	8 - 20		Yes	One of (D5211, D5213, D5225, D5227) per 60 Month(s) Per patient. Minimum of three teeth, excluding molars.	pre-operative x-ray(s)
D5228	immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	8 - 20		Yes	One of (D5212, D5214, D5226, D5228) per 60 Month(s) Per patient. Minimum of three teeth, excluding molars.	pre-operative x-ray(s)
D5282	Removable unilateral partial denture--one piececast metal (including clasps and teeth), maxillary	0-20		Yes	One of (D5282) per 60 Month(s) Per patient. Narrative of medical necessity.	narrative of medical necessity
D5283	Removable unilateral partial denture--one piececast metal (including clasps and teeth), mandibular	0-20		Yes	One of (D5283) per 60 Month(s) Per patient. Narrative of medical necessity.	narrative of medical necessity
D5410	adjust complete denture - maxillary	0-20		No	One of (D5410) per 12 Month(s) Per patient. Not covered within 6 months of placement of denture or after rebase/reline.	
D5411	adjust complete denture - mandibular	0-20		No	One of (D5411) per 12 Month(s) Per patient. Not covered within 6 months of placement of denture or after rebase/reline.	
D5421	adjust partial denture-maxillary	0-20		No	One of (D5421) per 12 Month(s) Per patient. Not covered within 6 months of placement of denture or after rebase/reline.	
D5422	adjust partial denture - mandibular	0-20		No	One of (D5422) per 12 Month(s) Per patient. Not covered within 6 months of placement of denture or after rebase/reline.	
D5511	repair broken complete denture base, mandibular	0-20		No		

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Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5512	repair broken complete denture base, maxillary	0-20		No		
D5520	replace missing or broken teeth - complete denture (each tooth)	0-20	Teeth 1 - 32	No		
D5611	repair resin partial denture base, mandibular	0-20		No		
D5612	repair resin partial denture base, maxillary	0-20		No		
D5621	repair cast partial framework, mandibular	8 - 20		No		
D5622	repair cast partial framework, maxillary	8 - 20		No		
D5630	repair or replace broken retentive/clasping materials per tooth	0-20	Teeth 1 - 32	No		
D5640	replace broken teeth-per tooth	0-20	Teeth 1 - 32	No		
D5650	add tooth to existing partial denture	0-20	Teeth 1 - 32	No		
D5660	add clasp to existing partial denture	0-20	Teeth 1 - 32	No		
D5710	rebase complete maxillary denture	0-20		No	One of (D5710) per 36 Month(s) Per patient. Not covered within 12 months of placement.	
D5711	rebase complete mandibular denture	0-20		No	One of (D5711) per 36 Month(s) Per patient. Not covered within 12 months of placement.	
D5720	rebase maxillary partial denture	0-20		No	One of (D5720) per 36 Month(s) Per patient. Not covered within 12 months of placement.	
D5721	rebase mandibular partial denture	0-20		No	One of (D5721) per 36 Month(s) Per patient. Not covered within 12 months of placement.	
D5725	rebase hybrid prosthesis	0-20	Per Arch (01, 02, LA, UA)	No	One of (D5725) per 36 Month(s) Per patient. Not covered within 12 months of placement.	
D5730	reline complete maxillary denture (chairside)	0-20		No	One of (D5730) per 36 Month(s) Per patient. Not covered within 12 months of placement.	

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Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5731	reline complete mandibular denture (chairside)	0-20		No	One of (D5731) per 36 Month(s) Per patient. Not covered within 12 months of placement.	
D5740	reline maxillary partial denture (chairside)	0-20		No	One of (D5740) per 36 Month(s) Per patient. Not covered within 12 months of placement.	
D5741	reline mandibular partial denture (chairside)	0-20		No	One of (D5741) per 36 Month(s) Per patient. Not covered within 12 months of placement.	
D5750	reline complete maxillary denture (laboratory)	0-20		No	One of (D5750) per 36 Month(s) Per patient. Not covered within 12 months of placement.	
D5751	reline complete mandibular denture (laboratory)	0-20		No	One of (D5751) per 36 Month(s) Per patient. Not covered within 12 months of placement.	
D5760	reline maxillary partial denture (laboratory)	0-20		No	One of (D5760) per 36 Month(s) Per patient. Not covered within 12 months of placement.	
D5761	reline mandibular partial denture (laboratory)	0-20		No	One of (D5761) per 36 Month(s) Per patient. Not covered within 12 months of placement.	
D5765	soft liner for complete or partial removable denture – indirect	0-20	Per Arch (01, 02, LA, UA)	No	One of (D5765) per 36 Month(s) Per patient. Not covered within 12 months of placement.	
D5820	interim partial denture (maxillary)	0-20		Yes	One of (D5820) per 1 Lifetime Per patient. Not covered within 24 months of code D5211, D5213, or D5225.	pre-operative x-ray(s)
D5821	interim partial denture-mandibular	0-20		Yes	Not covered within 24 months of code D5212, D5214 or D5226.	pre-operative x-ray(s)
D5850	tissue conditioning, maxillary	0-20		No	One of (D5850) per 60 Month(s) Per patient. Prior to new denture impressions only.	
D5851	tissue conditioning,mandibular	0-20		No	One of (D5851) per 60 Month(s) Per patient. Prior to new denture impressions only.	
D5862	precision attachment, by report	0-20	Teeth 1 - 32	Yes		
D5863	Overdenture - complete maxillary	0-20		Yes		narrative of medical necessity

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Exhibit A Benefits Covered for MO Healthy Blue Medicaid Children

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5864	Overdenture - partial maxillary	0-20	Teeth 1 - 32	Yes		
D5865	Overdenture - complete mandibular	0-20	Teeth 1 - 32	Yes		
D5866	Overdenture - partial mandibular	0-20		Yes	Narrative of medical necessity.	narrative of medical necessity
D5867	Replacement of replaceable part of semi-precision per attachment	0-20	Teeth 1 - 32	Yes		
D5876	Use of metal substructure in removable complete dentures without a framework	0-20	Per Arch (01, 02, LA, UA)	Yes	Narrative of medical necessity.	narrative of medical necessity
D5899	unspecified removable prosthodontic procedure, by report	0-20		Yes		

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Maxillofacial Prosthetics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5913	nasal prosthesis	0-20		Yes		
D5914	auricular prosthesis	0-20		Yes		
D5922	nasal septal prosthesis	0-20		Yes		
D5926	nasal prosthesis, replacement	0-20		Yes		
D5927	auricular prosthesis, replace	0-20		Yes		
D5932	obturator prosthesis, definitive	0-20		Yes		
D5934	mandibular resection prosthesis with guide flange	0-20		Yes		
D5935	mandibular resection prosthesis without guide flange	0-20		Yes		
D5936	obturator prosthesis, interim	0-20		Yes		
D5952	speech aid prosthesis, pediatric	0-20		Yes		
D5953	speech aid prosthesis, adult	0-20		Yes		
D5954	palatal augment prosthesis	0-20		Yes		
D5955	palatal lift prosthesis, definitive	0-20		Yes		
D5958	palatal lift prosthesis, interim	0-20		Yes		
D5959	palatal lift prosthesis, modification	0-20		Yes		
D5960	speech aid prosthesis, modification	0-20		Yes		
D5988	surgical splint	0-20		Yes		
D5992	Adjust maxillofacial prosthetic appliance, by report	0-20	Per Arch (01, 02, LA, UA)	Yes	Narrative of medical necessity.	narrative of medical necessity
D5999	unspecified maxillofacial prosthesis, by report	0-20		Yes		

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Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Implant Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6010	surgical placement of implant body: endosteal implant	0-20	Teeth 1 - 32	Yes	One of (D6010) per 60 Month(s) Per patient per tooth.	
D6040	surgical placement:eposteal implnt	0-20	Per Arch (01, 02, LA, UA)	Yes	One of (D6040) per 60 Month(s) Per patient per arch.	
D6050	surgical placement-transosteal implant	0-20	Teeth 1 - 32	Yes	One of (D6050) per 60 Month(s) Per patient per tooth.	
D6090	repair implant prosthesis	0-20	Teeth 1 - 32	Yes	One of (D6090) per 60 Month(s) Per patient per tooth.	
D6092	re-cement or re-bond implant/abutment supported crown	0-20		Yes	One of (D6092) per 60 Month(s) Per patient.	
D6093	re-cement or re-bond implant/abutment supported fixed partial denture	0-20		Yes	One of (D6093) per 60 Month(s) Per patient.	
D6095	repair implant abutment	0-20	Teeth 1 - 32	Yes	One of (D6095) per 60 Month(s) Per patient per tooth.	
D6100	surgical removal of implant body	0-20	Teeth 1 - 32	Yes	One of (D6100) per 60 Month(s) Per patient per tooth.	

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Reimbursement includes local anesthesia and routine post-operative care.
Billing and reimbursement for cast crowns, cast post and cores and laminate veneers or any other fixed prosthetics shall be based on the cementation date.
The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent teeth.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Prosthodontics, fixed						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6210	pontic - cast high noble metal	0-20	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	
D6211	pontic-cast base metal	0-20	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	
D6212	pontic - cast noble metal	0-20	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	
D6240	pontic-porcelain fused-high noble	0-20	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	
D6241	pontic-porcelain fused to base metal	0-20	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	

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Prosthodontics, fixed						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6242	pontic-porcelain fused-noble metal	0-20	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	
D6245	prosthodontics fixed, pontic - porcelain/ceramic	0-20	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	
D6250	pontic-resin with high noble metal	0-20	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	
D6251	pontic-resin with base metal	0-20	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	
D6252	pontic-resin with noble metal	0-20	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	
D6545	retainer - cast metal fixed	0-20	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	

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Prosthodontics, fixed						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6548	prosthodontics fixed, retainer - porcelain/ceramic for resin bonded fixed prosthodontic	0-20	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	
D6549	Resin retainer-For resin bonded fixed prosthesis	0-20	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	narr. of med. necessity, pre-op x-ray(s)
D6600	inlay - porcelain/ceramic, two surfaces	0-20	Teeth 1 - 32	Yes	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634) per 60 Month(s) Per patient per tooth.	
D6601	inlay - porcelain/ceramic, three or more surfaces	0-20	Teeth 1 - 32	Yes	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634) per 60 Month(s) Per patient per tooth.	
D6602	inlay - cast high noble metal, two surfaces	0-20	Teeth 1 - 32	Yes	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634) per 60 Month(s) Per patient per tooth.	
D6603	inlay - cast high noble metal, three or more surfaces	0-20	Teeth 1 - 32	Yes	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634) per 60 Month(s) Per patient per tooth.	
D6604	inlay - cast predominantly base metal, two surfaces	0-20	Teeth 1 - 32	Yes	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634) per 60 Month(s) Per patient per tooth.	

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Prosthodontics, fixed						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6605	inlay - cast predominantly base metal, three or more surfaces	0-20	Teeth 1 - 32	Yes	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634) per 60 Month(s) Per patient per tooth.	
D6606	inlay - cast noble metal, two surfaces	0-20	Teeth 1 - 32	Yes	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634) per 60 Month(s) Per patient per tooth.	
D6607	inlay - cast noble metal, three or more surfaces	0-20	Teeth 1 - 32	Yes	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634) per 60 Month(s) Per patient per tooth.	
D6608	onlay - porcelain/ceramic, two surfaces	0-20	Teeth 1 - 32	Yes	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634) per 60 Month(s) Per patient per tooth.	
D6609	onlay - porcelain/ceramic, three or more surfaces	0-20	Teeth 1 - 32	Yes	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634) per 60 Month(s) Per patient per tooth.	
D6610	onlay - cast high noble metal, two surfaces	0-20	Teeth 1 - 32	Yes	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634) per 60 Month(s) Per patient per tooth.	
D6611	onlay - cast high noble metal, three or more surfaces	0-20	Teeth 1 - 32	Yes	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634) per 60 Month(s) Per patient per tooth.	
D6612	onlay - cast predominantly base metal, two surfaces	0-20	Teeth 1 - 32	Yes	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634) per 60 Month(s) Per patient per tooth.	

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Prosthodontics, fixed						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6613	onlay - cast predominantly base metal, three or more surfaces	0-20	Teeth 1 - 32	Yes	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634) per 60 Month(s) Per patient per tooth.	
D6614	onlay - cast noble metal, two surfaces	0-20	Teeth 1 - 32	Yes	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634) per 60 Month(s) Per patient per tooth.	
D6615	onlay - cast noble metal, three or more surfaces	0-20	Teeth 1 - 32	Yes	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634) per 60 Month(s) Per patient per tooth.	
D6720	crown-resin with high noble metal	0-20	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	
D6721	crown-resin with base metal	0-20	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	
D6722	crown-resin with noble metal	0-20	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	
D6740	retainer crown, porcelain/ceramic	0-20	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	

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Prosthodontics, fixed						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6750	crown-porcelain fused high noble	0-20	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	
D6751	crown-porcelain fused to base metal	0-20	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	
D6752	crown-porcelain fused noble metal	0-20	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	
D6780	crown-3/4 cst high noble metal	0-20	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	
D6781	prosthodontics fixed, crown ¾ cast predominantly based metal	0-20	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	
D6782	prosthodontics fixed, crown ¾ cast noble metal	0-20	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	

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Prosthodontics, fixed						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6783	prosthodontics fixed, crown ¾ porcelain/ceramic	0-20	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	
D6790	crown-full cast high noble	0-20	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	
D6791	crown - full cast base metal	0-20	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	
D6792	crown - full cast noble metal	0-20	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	
D6920	connector bar	0-20	Per Arch (01, 02, LA, UA)	Yes	One of (D6920) per 1 Year(s) Per patient.	
D6930	re-cement or re-bond fixed partial denture	0-20		No	One of (D6930) per 60 Month(s) Per patient. Not covered within 6 months of placement.	
D6940	stress breaker	0-20	Teeth 1 - 32	Yes	One of (D6940) per 1 Year(s) Per patient.	
D6950	precision attachment	0-20	Teeth 1 - 32	Yes	One of (D6950) per 1 Year(s) Per patient.	
D6980	fixed partial denture repair	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D6980) per 1 Lifetime Per patient per quadrant.	narrative of medical necessity
D6999	fixed prosthodontic procedure	0-20	Teeth 1 - 32	Yes		

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Reimbursement includes local anesthesia and routine post-operative care.
The extraction of asymptomatic impacted teeth is not a covered benefit. Symptomatic conditions would include pain and/or infection or demonstrated malocclusion causing a shifting of existing dentition.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7111	extraction, coronal remnants - primary tooth	0-4	Teeth A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7111	extraction, coronal remnants - primary tooth	5-9	Teeth A - C, H - M, R - T, AS, BS, CS, HS, IS, JS, KS, LS, MS, RS, SS, TS	No		
D7111	extraction, coronal remnants - primary tooth	5 - 20	Teeth D - G, N - Q, DS, ES, FS, GS, NS, OS, PS, QS	Yes		pre-operative x-ray(s)
D7111	extraction, coronal remnants - primary tooth	10 - 20	Teeth A - C, H - M, R - T, AS, BS, CS, HS, IS, JS, KS, LS, MS, RS, SS, TS	Yes		pre-operative x-ray(s)
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0-4	Teeth A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	5-9	Teeth A - C, H - M, R - T, AS, BS, CS, HS, IS, JS, KS, LS, MS, RS, SS, TS	No		
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0-20	Teeth 1 - 32, 51 - 82	No		
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	5 - 20	Teeth D - G, N - Q, DS, ES, FS, GS, NS, OS, PS, QS	Yes		
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	10 - 20	Teeth A - C, H - M, R - T, AS, BS, CS, HS, IS, JS, KS, LS, MS, RS, SS, TS	Yes		
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	0-20	Teeth 1 - 3, 5, 12, 14 - 19, 30 - 32, 51 - 53, 55, 62, 64 - 69, 80 - 82	Yes	Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)

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Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	0-20	Teeth 4, 6 - 11, 13, 20 - 29, 54, 56 - 61, 63, 70 - 79	Yes	Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7220	removal of impacted tooth-soft tissue	0-20	Teeth 1, 16, 17, 32, 51, 66, 67, 82	Yes	Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7220	removal of impacted tooth-soft tissue	0-20	Teeth 2, 3, 14, 15, 18, 19, 30, 31, 52, 53, 64, 65, 68, 69, 80, 81	Yes	Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7220	removal of impacted tooth-soft tissue	0-20	Teeth 4 - 13, 20 - 29, 54 - 63, 70 - 79	Yes	Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7230	removal of impacted tooth-partially bony	0-20	Teeth 1, 16, 17, 32, 51, 66, 67, 82	Yes	Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7230	removal of impacted tooth-partially bony	0-20	Teeth 2, 3, 14, 15, 18, 19, 30, 31, 52, 53, 64, 65, 68, 69, 80, 81	Yes	Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7230	removal of impacted tooth-partially bony	0-20	Teeth 4 - 13, 20 - 29, 54 - 63, 70 - 79	Yes	Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7240	removal of impacted tooth-completely bony	0-20	Teeth 1, 16, 17, 32, 51, 66, 67, 82	Yes	Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7240	removal of impacted tooth-completely bony	0-20	Teeth 2, 3, 14, 15, 18, 19, 30, 31, 52, 53, 64, 65, 68, 69, 80, 81	Yes	Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7240	removal of impacted tooth-completely bony	0-20	Teeth 4 - 13, 20 - 29, 54 - 63, 70 - 79	Yes	Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7241	removal of impacted tooth-completely bony, with unusual surgical complications	0-20	Teeth 1, 16, 17, 32, 51, 66, 67, 82	Yes	Unusual complications such as nerve dissection, separate closure of the maxillary sinus or aberrant tooth position. Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7241	removal of impacted tooth-completely bony, with unusual surgical complications	0-20	Teeth 2, 3, 14, 15, 18, 19, 30, 31, 52, 53, 64, 65, 68, 69, 80, 81	Yes	Unusual complications such as nerve dissection, separate closure of the maxillary sinus or aberrant tooth position. Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)

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Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7241	removal of impacted tooth-completely bony, with unusual surgical complications	0-20	Teeth 4 - 13, 20 - 29, 54 - 63, 70 - 79	Yes	Unusual complications such as nerve dissection, separate closure of the maxillary sinus or aberrant tooth position. Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7250	surgical removal of residual tooth roots (cutting procedure)	0-4	Teeth A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Will not be paid to the dentists or group that removed the tooth. Removal of asymptomatic tooth not covered.	
D7250	surgical removal of residual tooth roots (cutting procedure)	5-9	Teeth A - C, H - M, R - T, AS, BS, CS, HS, IS, JS, KS, LS, MS, RS, SS, TS	No	Will not be paid to the dentists or group that removed the tooth. Removal of asymptomatic tooth not covered.	
D7250	surgical removal of residual tooth roots (cutting procedure)	0-20	Teeth 1 - 32, 51 - 82	No	Will not be paid to the dentists or group that removed the tooth. Removal of asymptomatic tooth not covered.	
D7250	surgical removal of residual tooth roots (cutting procedure)	5 - 20	Teeth D - G, N - Q, DS, ES, FS, GS, NS, OS, PS, QS	Yes	Will not be paid to the dentists or group that removed the tooth. Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7250	surgical removal of residual tooth roots (cutting procedure)	10 - 20	Teeth A - C, H - M, R - T, AS, BS, CS, HS, IS, JS, KS, LS, MS, RS, SS, TS	Yes	Will not be paid to the dentists or group that removed the tooth. Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7260	oroantral fistula closure	0-20		Yes		pre-operative x-ray(s)
D7261	primary closure of a sinus perforation	0-20		Yes		narrative of medical necessity
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	0-20	Teeth 1 - 32	Yes		narr. of med. necessity, pre-op x-ray(s)
D7280	Surgical access of an unerupted tooth	0-20	Teeth 1 - 32	Yes	Will not be payable unless the orthodontic treatment has been authorized as a covered benefit.	narr. of med. necessity, pre-op x-ray(s)
D7283	placement of device to facilitate eruption of impacted tooth	0-20	Teeth 1 - 32	Yes	One of (D7283) per 1 Lifetime Per patient per tooth. Requires prior approval of D8080; only approved if in conjunction with approved orthodontic treatment.	
D7285	incisional biopsy of oral tissue-hard (bone, tooth)	0-20		Yes		Pathology report
D7286	incisional biopsy of oral tissue-soft	0-20		Yes		Pathology report
D7287	cytology sample collection	0-20		Yes		Pathology report

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Exhibit A Benefits Covered for MO Healthy Blue Medicaid Children

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7290	surgical repositioning of teeth	0-20	Teeth 1 - 32	Yes		narr. of med. necessity, pre-op x-ray(s)
D7291	transseptal fiberotomy, by report	0-20	Teeth 1 - 32	Yes		narr. of med. necessity, pre-op x-ray(s)
D7296	corticotomy – one to three teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7296, D7297) per 1 Lifetime Per patient per quadrant.	narr. of med. necessity, pre-op x-ray(s)
D7297	corticotomy – four or more teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7296, D7297) per 1 Lifetime Per patient per quadrant.	narr. of med. necessity, pre-op x-ray(s)
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7310) per 1 Lifetime Per patient per quadrant. Minimum of three extractions in the affected quadrant.	pre-operative x-ray(s)
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7311) per 1 Lifetime Per patient per quadrant. Minimum of three extractions in the affected quadrant.	pre-operative x-ray(s)
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7320) per 1 Lifetime Per patient per quadrant. No extractions performed in the edentulous area.	narr. of med. necessity, pre-op x-ray(s)
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7321) per 1 Lifetime Per patient per quadrant. No extractions performed in an edentulous area.	narr. of med. necessity, pre-op x-ray(s)
D7340	vestibuloplasty - ridge extension (secondary epithelialization)	0-20	Per Arch (01, 02, LA, UA)	Yes	One of (D7340, D7350) per 1 Lifetime Per patient per quadrant.	
D7350	vestibuloplasty - ridge extension	0-20	Per Arch (01, 02, LA, UA)	Yes	One of (D7340, D7350) per 1 Lifetime Per patient per quadrant.	
D7410	radical excision - lesion diameter up to 1.25cm	0-20		Yes		Pathology report
D7411	excision of benign lesion greater than 1.25 cm	0-20		Yes		Pathology report
D7412	excision of benign lesion, complicated	0-20		Yes		Pathology report
D7413	excision of malignant lesion up to 1.25 cm	0-20		Yes		Pathology report
D7414	excision of malignant lesion greater than 1.25 cm	0-20		Yes		Pathology report
D7415	excision of malignant lesion, complicated	0-20		Yes		Pathology report

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Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7440	excision of malignant tumor - lesion diameter up to 1.25cm	0-20		Yes		
D7441	excision of malignant tumor - lesion diameter greater than 1.25cm	0-20		Yes		
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	0-20		Yes		
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	0-20		Yes		
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	0-20		Yes		
D7461	removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm	0-20		Yes		
D7465	destruction of lesion(s) by physical or chemical method, by report	0-20		Yes		
D7471	removal of exostosis - per site	0-20	Per Arch (01, 02, LA, UA)	Yes		narr. of med. necessity, pre-op x-ray(s)
D7472	removal of torus palatinus	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7473	removal of torus mandibularis	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7485	surgical reduction of osseous tuberosity	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7490	radical resection of maxilla or mandible	0-20		Yes		
D7510	incision and drainage of abscess - intraoral soft tissue	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Not allowed on same date as extraction	narrative of medical necessity
D7520	incision and drainage of abscess - extraoral soft tissue	0-20		Yes		narrative of medical necessity
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	0-20		Yes		

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Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7540	removal of reaction-producing foreign bodies, musculoskeletal system	0-20		Yes		
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes		
D7560	maxillary sinusotomy for removal of tooth fragment or foreign body	0-20		Yes		
D7610	maxilla - open reduction	0-20		Yes		
D7620	maxilla - closed reduction	0-20		Yes		
D7630	mandible-open reduction	0-20		Yes		
D7640	mandible - closed reduction	0-20		Yes		
D7650	malar and/or zygomatic arch-open reduction	0-20		Yes		
D7660	malar and/or zygomatic arch-closed	0-20		Yes		
D7670	alveolus stabilization of teeth, closed reduction splinting	0-20		Yes		
D7671	alveolus - open reduction, may include stabilization of teeth	0-20		Yes		
D7680	facial bones - complicated reduction with fixation and multiple surgical approaches	0-20		Yes		
D7710	maxilla - open reduction	0-20		Yes		
D7720	maxilla - closed reduction	0-20		Yes		
D7730	mandible - open reduction	0-20		Yes		
D7740	mandible - closed reduction	0-20		Yes		
D7750	malar and/or zygomatic arch-open reduction	0-20		Yes		
D7760	malar and/or zygomatic arch-closed reduction	0-20		Yes		
D7770	alveolus-stabilization of teeth, open reduction splinting	0-20		Yes		
D7771	alveolus, closed reduction stabilization of teeth	0-20		Yes		

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Exhibit A Benefits Covered for MO Healthy Blue Medicaid Children

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7780	facial bones - complicated reduction with fixation and multiple surgical approaches	0-20		Yes		
D7810	open reduction of dislocation	0-20		Yes		
D7820	closed reduction dislocation	0-20		Yes		
D7830	manipulation under anesthesia	0-20		Yes		
D7840	condylectomy	0-20		Yes		
D7850	surgical discectomy, with/without implant	0-20		Yes		
D7860	arthrotomy	0-20		Yes		
D7865	arthroplasty	0-20		Yes		
D7870	arthrocentesis	0-20		Yes		
D7871	non-arthroscopic lysis and lavage	0-20		Yes		narrative of medical necessity
D7872	arthroscopy - diagnosis with or without biopsy	0-20		Yes		
D7873	arthroscopy-surgical: lavage and lysis of adhesions	0-20		Yes		
D7874	arthroscopy-surgical: disc repositioning and stabilization	0-20		Yes		
D7875	arthroscopy-surgical synovectomy	0-20		Yes		
D7876	arthroscopy-surgery discectomy	0-20		Yes		
D7877	arthroscopy-surgical debridement	0-20		Yes		
D7880	occlusal orthotic device, by report	0-20		Yes	One of (D7880) per 1 Lifetime Per patient.	
D7910	suture small wounds up to 5 cm	0-20		Yes		
D7911	complicated suture-up to 5 cm	0-20		Yes		
D7912	complex suture - greater than 5cm	0-20		Yes		
D7920	skin graft (identify defect covered, location and type of graft)	0-20		Yes		
D7940	osteoplasty- for orthognathic deformities	0-20		Yes		

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Exhibit A Benefits Covered for MO Healthy Blue Medicaid Children

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7941	osteotomy - madibular rami	0-20		Yes		
D7943	osteotomy- mandibular rami with bone graft; includes obtaining the graft	0-20		Yes		
D7944	osteotomy - segmented or subapical - per sextant or quadrant	0-20		Yes		
D7945	osteotomy - body of mandible	0-20		Yes		
D7946	LeFort I (maxilla - total)	0-20		Yes		
D7947	LeFort I (maxilla - segmented)	0-20		Yes		
D7948	LeFort II or LeFort III - without bone graft	0-20		Yes		
D7949	LeFort II or LeFort III - with bone graft	0-20		Yes		
D7961	buccal / labial frenectomy (frenulectomy)	0-20		Yes	Three of (D7961) per 1 Lifetime Per patient. The frenum may be excised when the tongue has limited mobility; for large diastemas between teeth; or when the frenum interferes with a prosthetic appliance; or when it is the etiology of periodontal tissue disease.	narr. of med. necessity, model or photo
D7962	lingual frenectomy (frenulectomy)	0-20		Yes	One of (D7962) per 1 Lifetime Per patient. The frenum may be excised when the tongue has limited mobility; for large diastemas between teeth; or when the frenum interferes with a prosthetic appliance; or when it is the etiology of periodontal tissue disease.	narr. of med. necessity, model or photo
D7970	excision of hyperplastic tissue - per arch	0-20	Per Arch (01, 02, LA, UA)	Yes	For removal of tissue over a previous edentulous denture bearing area to improve prognosis of a proposed denture.	narr. of med. necessity, model or photo
D7971	excision of pericoronal gingiva	0-20	Teeth 1 - 32	Yes		narr. of med. necessity, model or photo
D7972	surgical reduction of fibrous tuberosity	0-20		Yes		narr. of med. necessity, pre-op x-ray(s)
D7980	surgical sialolithotomy	0-20		Yes		
D7981	excision of salivary gland, by report	0-20		Yes		

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Exhibit A Benefits Covered for MO Healthy Blue Medicaid Children

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7982	sialodochoplasty	0-20		Yes		
D7983	closure of salivary fistula	0-20		Yes		
D7990	emergency tracheotomy	0-20		Yes		
D7991	coronoidectomy	0-20		Yes		
D7995	synthetic graft-mandible or facial bones, by report	0-20		Yes		
D7996	implant-mandible for augmentation purposes, by report	0-20		Yes		
D7997	appliance removal (not by dentist who placed appliance), includes removal of archbar	0-20		Yes		
D7998	intraoral fixation device---non-fracture	0-20		Yes		
D7999	unspecified oral surgery procedure, by report	0-20		Yes		

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Exhibit A Benefits Covered for
MO Healthy Blue Medicaid Children

Medicaid Members age 20 and under may qualify for orthodontic care under the program. Members must have a severe, dysfunctional, handicapping malocclusion.
DentaQuest will reimburse doctors for orthodontic records when denial determinations are made. It is the responsibility of the rendering office to submit a claim for the payment of orthodontic records, as DentaQuest cannot generate claims on the behalf of its network doctors. Claims for orthodontic records payments must be: made in accordance with timely filing protocols, submitted on a HIPAA compliant ADA claim form, billed using CDT code D8660, and have history of a DentaQuest denied orthodontia request on file. As with all claims for payment, orthodontic records are subject to member eligibility, frequency, and benefit limitations outlined herein and in accordance with State regulations.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Orthodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D8010	limited orthodontic treatment of the primary dentition	0-20		Yes		
D8020	limited orthodontic treatment of the transitional dentition	0-20		Yes		
D8030	limited orthodontic treatment of the adolescent dentition	0-20		Yes		
D8040	limited orthodontic treatment of the adult dentition	0-20		Yes		
D8070	comprehensive orthodontic treatment of the transitional dentition	0-20		Yes		
D8080	comprehensive orthodontic treatment of the adolescent dentition	0-20		Yes	Narrative/treatment plan and HLD form.	Study model or OrthoCad, x-rays
D8090	comprehensive orthodontic treatment of the adult dentition	0-20		Yes		
D8210	removable appliance therapy (includes appliances for thumb sucking and tongue thrusting)	0-20		Yes		Study model or OrthoCad, x-rays
D8220	fixed appliance therapy (includes appliances for thumb sucking and tongue thrusting)	0-20		Yes		Study model or OrthoCad, x-rays
D8660	pre-orthodontic treatment examination to monitor growth and development	0-20		Yes	One of (D8660) per 6 Month(s) Per patient.	
D8670	periodic orthodontic treatment visit	0-20		Yes	One of (D8670) per 21 Day(s) Per patient. Maximum of 24 visits reimbursed.	

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Exhibit A Benefits Covered for MO Healthy Blue Medicaid Children

Orthodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D8680	orthodontic retention (removal of appliances)	0-20		Yes		
D8695	removal of fixed orthodontic appliances for reasons other than completion of treatment	0-20		Yes	One of (D8695) per 1 Lifetime Per patient.	narrative of medical necessity
D8696	Repair of orthodontic appliance-maxillary	0-20		Yes	One of (D8696) per 1 Lifetime Per patient.	narrative of medical necessity
D8697	Repair of orthodontic appliance-mandibular	0-20		Yes	One of (D8697) per 1 Lifetime Per patient.	narrative of medical necessity
D8698	Recement or rebond fixed retainer - maxillary	0-20		Yes	One of (D8698) per 1 Lifetime Per patient.	narrative of medical necessity
D8699	Recement or rebond fixed retainer - mandibular	0-20		Yes	One of (D8699) per 1 Lifetime Per patient.	narrative of medical necessity
D8701	Repair of fixed retainer, includes reattachment - maxillary	0-20		Yes	One of (D8701) per 1 Lifetime Per patient.	narrative of medical necessity
D8702	Repair of fixed retainer, includes reattachment - mandibular	0-20		Yes	One of (D8702) per 1 Lifetime Per patient.	narrative of medical necessity
D8703	Replacement of lost or broken retainer - maxillary	0-20		Yes	One of (D8703) per 1 Lifetime Per patient.	narrative of medical necessity
D8704	Replacement of lost or broken retainer - mandibular	0-20		Yes	One of (D8704) per 1 Lifetime Per patient.	narrative of medical necessity

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Exhibit A Benefits Covered for
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Reimbursement includes local anesthesia and routine post-operative care.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9110	palliative treatment of dental pain - per visit	0-20		No	Not allowed with any other services other than radiographs.	
D9120	fixed partial denture sectioning	0-20		Yes		
D9212	trigeminal division block anesthesia	0-20		Yes	Injection for diagnosis purposes. It is not to be used for a second division block.	narrative of medical necessity
D9219	evaluation for moderate sedation, deep sedation or general anesthesia	0-20		No	One of (D9219, D9310) per 12 Month(s) Per Provider OR Location.	
D9222	deep sedation/general anesthesia first 15 minutes	0-20		Yes	One of (D9222) per 1 Day(s) Per patient. Not allowed on same day as (D9230, D9239, D9243, D9248).	narrative of medical necessity
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	0-20		Yes	Additional sedation units covered in the minimum amount necessary to complete the treatment plan. Not to be billed with D9230, D9239, D9243 or D9248.	narrative of medical necessity
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	0-6		No	One of (D9230) per 1 Day(s) Per patient. Not allowed on the same day as (D9222, D9223, D9239, D9243, or D9248).	
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	7 - 20		Yes	One of (D9230) per 1 Day(s) Per patient. Not allowed on the same day as (D9222, D9223, D9239, D9243, or D9248).	narrative of medical necessity
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	0-20		Yes	One of (D9239) per 1 Day(s) Per patient. Not allowed on same day as (D9222, D9223, D9230, D9248).	narrative of medical necessity
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	0-20		Yes	Additional sedation units covered in the minimum amount necessary to complete the treatment plan. Not to be billed with D9222, D9223, D9230 or D9248.	narrative of medical necessity
D9248	non-intravenous moderate sedation	0-20		Yes	Not allowed on the same day with (D9222, D9223, D9230, D9239 or D9243).	narrative of medical necessity
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	0-20		No	Not covered with any other services other than radiographs. Must be performed by provider other than treating dentist.	

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Exhibit A Benefits Covered for MO Healthy Blue Medicaid Children

Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9410	house/extended care facility call	0-20		Yes	One of (D9410) per 1 Day(s) Per patient.	
D9420	hospital or ambulatory surgical center call	0-20		Yes		narrative of medical necessity
D9430	office visit for observation - no other services performed	0-20		Yes		
D9440	office visit - after regularly scheduled hours	0-20		Yes	One of (D9440) per 1 Day(s) Per patient.	
D9610	therapeutic drug injection, by report	0-20		Yes		
D9612	therapeutic drug injection - 2 or more medications by report	0-20		Yes		
D9910	application of desensitizing medicament	0-20		No	Emergency treatment only (not to be used for bases, liners, or adhesives used under restorations.) Narrative of medical necessity shall be maintained in patient records.	
D9911	application of desensitizing resin for cervical and/or root surface, per tooth	0-20	Teeth 1 - 32	No		
D9930	treatment of complications (post-surgical) - unusual circumstances, by report	0-20		Yes		
D9942	repair and/or reline of occlusal guard	0-20		Yes	One of (D9942) per 24 Month(s) Per patient.	
D9944	occlusal guard--hard appliance, full arch	0-20	Per Arch (01, 02, LA, UA)	Yes	One of (D9944, D9945, D9946) per 36 Month(s) Per patient. Narrative of medical necessity.	narrative of medical necessity
D9945	occlusal guard--soft appliance full arch	0-20	Per Arch (01, 02, LA, UA)	Yes	One of (D9944, D9945, D9946) per 36 Month(s) Per patient. Narrative of medical necessity.	narrative of medical necessity
D9946	occlusal guard--hard appliance, partial arch	0-20	Per Arch (01, 02, LA, UA)	Yes	One of (D9944, D9945, D9946) per 36 Month(s) Per patient. Narrative of medical necessity.	narrative of medical necessity
D9995	teledentistry – synchronous; real-time encounter	0-20		No		
D9996	teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	0-20		No		

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Exhibit A Benefits Covered for MO Healthy Blue Medicaid Children

Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9999	unspecified adjunctive procedure, by report	0-20		Yes		

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Exhibit A Benefits Covered for
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Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Medical						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
99429	EPSDT/HCY Dental Screening Without Referral	0-20		No	One of (99429, 99429UC) per 6 Month(s) Per patient. Not billable on the same date of service as D0120, D0140, D0145, D0150, D0171.	
99429UC	EPSDT/HCY Dental Screening With Referral	0-20		No	One of (99429, 99429UC) per 6 Month(s) Per patient. Not billable on the same date of service as D0120, D0140, D0145, D0150, D0171.	

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Exhibit B Benefits Covered for
MO Healthy Blue Medicaid Foster Care

Diagnostic services include the oral examinations, and selected radiographs, needed to assess the oral health, diagnose oral pathology, and develop an adequate treatment plan for the Member's oral health.
Reimbursement for some or multiple radiographs of the same tooth or area may be denied if DentaQuest determines the number to be redundant, excessive or not in keeping with the federal guidelines relating to radiation exposure. The maximum amount paid for individual radiographs taken on the same day will be limited to the allowance for a full mouth series.
Reimbursement for radiographs is limited to when required for proper treatment and/or diagnosis.
DentaQuest utilizes the guidelines published by the Department of Health and Human Services Center for Devices and Radiological Health. However, please consult the following benefit tables for benefit limitations.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0120	periodic oral evaluation - established patient	0-26		No	One of (D0120, D0145, D0150) per 6 Month(s) Per patient.	
D0140	limited oral evaluation-problem focused	0-26		No	Not reimburseable on the same day as D0120 and D0150. Not allowed on same day as Non-Emergency definitive treatment.	
D0145	oral evaluation for a patient under three years of age and counseling with primary caregiver	0-2		No	One of (D0120, D0145, D0150) per 6 Month(s) Per patient.	
D0150	comprehensive oral evaluation - new or established patient	0-26		No	One of (D0150) per 36 Month(s) Per patient. One of (D0120, D0145, D0150) per 6 Month(s) Per patient.	
D0160	detailed and extensive oral eval-problem focused, by report	0-26		No		
D0170	re-evaluation, limited problem focused	0-26		No		
D0171	Re-evaluation post-operative office visit	0-26		No		
D0210	intraoral - comprehensive series of radiographic images	0-26		No	One of (D0210, D0330) per 24 Month(s) Per patient.	
D0220	intraoral - periapical first radiographic image	0-26		No	One of (D0220) per 1 Day(s) Per patient.	
D0230	intraoral - periapical each additional radiographic image	0-26		No		
D0240	intraoral - occlusal radiographic image	0-26		No	Two of (D0240) per 24 Month(s) Per patient.	

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Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0250	extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	0-26		No	One of (D0250) per 1 Day(s) Per patient. Narrative of medical necessity shall be maintained in patient records.	
D0251	extra-oral posterior dental radiographic image	0-26	Teeth 1 - 32	No	One of (D0251) per 1 Day(s) Per patient.	
D0270	bitewing - single radiographic image	0-26		No	Two of (D0270, D0272, D0273, D0274, D0277) per 1 Calendar year(s) Per patient.	
D0272	bitewings - two radiographic images	0-26		No	Two of (D0270, D0272, D0273, D0274, D0277) per 1 Calendar year(s) Per patient.	
D0273	bitewings - three radiographic images	0-26		No	Two of (D0270, D0272, D0273, D0274, D0277) per 1 Calendar year(s) Per patient.	
D0274	bitewings - four radiographic images	0-26		No	Two of (D0270, D0272, D0273, D0274, D0277) per 1 Calendar year(s) Per patient.	
D0277	vertical bitewings - 7 to 8 films	0-26		No	Two of (D0270, D0272, D0273, D0274, D0277) per 1 Calendar year(s) Per patient.	
D0310	sialography	0-26		Yes		narrative of medical necessity
D0330	panoramic radiographic image	6-20		No	One of (D0210, D0330) per 24 Month(s) Per patient.	
D0340	cephalometric radiographic image	0-26		Yes		
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	0-26		No	One of (D0350) per 12 Month(s) Per patient. Narrative of medical necessity shall be maintained in patient records.	
D0364	Cone beam CT capture and interpretation with limited field of view, less than one whole jaw	0-26		Yes	One of (D0364) per 36 Month(s) Per patient.	narrative of medical necessity
D0365	Cone beam CT capture and interpretation with field of view of one full dental arch – mandible	0-26		Yes	One of (D0365) per 36 Month(s) Per patient.	narrative of medical necessity
D0366	Cone beam CT capture and interpretation with field of view of one full dental arch – maxilla, with or without cranium	0-26		Yes	One of (D0366) per 36 Month(s) Per patient.	narrative of medical necessity
D0367	Cone beam CT capture and interpretation with field of view of both jaws, with or without cranium	0-26		Yes	One of (D0367) per 36 Month(s) Per patient.	narrative of medical necessity

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Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0368	Cone beam CT capture and interpretation for TMJ series including two or more exposures	0-26		Yes	One of (D0368) per 36 Month(s) Per patient.	narrative of medical necessity
D0415	bacteriologic studies	0-26		No	Narrative of medical necessity shall be maintained in patient records.	
D0460	pulp vitality tests	0-26		No	Two of (D0460) per 12 Month(s) Per patient. Includes multiple teeth and contralateral comparison(s). Narrative of medical necessity shall be maintained in patient records.	
D0470	diagnostic casts	0-26		No		
D0999	unspecified diagnostic procedure, by report	0-26		Yes		

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Sealants may be placed on the occlusal or occlusal-buccal surfaces of lower molars or occlusal or occlusal-lingual surfaces of upper molars.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1110	prophylaxis - adult	13 - 26		No	Two of (D1110, D1120) per 1 Calendar year(s) Per patient.	
D1120	prophylaxis - child	0-12		No	Two of (D1110, D1120) per 1 Calendar year(s) Per patient.	
D1206	topical application of fluoride varnish	0-26		No	Two of (D1206, D1208) per 1 Calendar year(s) Per patient.	
D1208	topical application of fluoride - excluding varnish	0-26		No	Two of (D1206, D1208) per 1 Calendar year(s) Per patient.	
D1351	sealant - per tooth	5 - 26	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	One of (D1351, D1353) per 3 Year(s) Per patient per tooth. Sealants may be placed on the occlusal or occlusal-buccal surfaces of lower molars or occlusal or occlusal-lingual surfaces of upper molars. Teeth must be caries free. Sealant will not be covered when placed over restorations.	
D1353	Sealant repair - per tooth	0-26	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	Sealants will not be covered when placed over restorations. Teeth must be caries free. Includes buccal surfaces of mandibular molars and lingual surfaces of maxillary molars.	
D1354	application of caries arresting medicament- per tooth	0-20	Teeth 1 - 32, A - T	No	One of (D1354) per 6 Month(s) Per patient per tooth. Four of (D1354) per 1 Lifetime Per patient per tooth. Not allowed with history of any prior or same day D2000, D3000 code on same tooth. D1354 cannot be billed in conjunction with D1355 (caries preventive medicament application – per tooth) on the same tooth within the same six (6)-month period.	
D1355	caries preventive medicament application – per tooth	0-14	Teeth A - T	No	One of (D1355) per 6 Month(s) Per patient per tooth. Four of (D1355) per 1 Lifetime Per patient per tooth. Not allowed with history of any prior or same day D2000, D3000 code on same tooth.	
D1510	space maintainer-fixed, unilateral-per quadrant	0-26	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D1510, D1520) per 24 Month(s) Per patient per quadrant. Indicate missing tooth number and arch/quadrant on claim.	

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Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1516	space maintainer --fixed--bilateral, maxillary	0-26		No	One of (D1516) per 24 Month(s) Per patient per arch.	
D1517	space maintainer --fixed--bilateral, mandibular	0-26		No	One of (D1517) per 24 Month(s) Per patient per arch.	
D1520	space maintainer-removable-unilateral	0-26	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D1510, D1520) per 24 Month(s) Per patient per quadrant. Indicate missing tooth number and arch/quadrant on claim.	narrative of medical necessity
D1526	space maintainer --removable--bilateral, maxillary	0-26		No	One of (D1526) per 24 Month(s) Per patient per arch. Narrative of medical necessity shall be maintained in patient records.	
D1527	space maintainer --removable--bilateral, mandibular	0-26		No	One of (D1527) per 24 Month(s) Per patient per arch.	
D1551	re-cement or re-bond bilateral space maintainer- Maxillary	0-26		No	One of (D1551) per 6 Month(s) Per patient. Not allowed by same provider/location within 6 months of initial placement.	
D1552	re-cement or re-bond bilateral space maintainer- Mandibular	0-26		No	One of (D1552) per 6 Month(s) Per patient. Not allowed by same provider/location within 6 months of initial placement.	
D1553	re-cement or re-bond unilateral space maintainer- Per Quadrant	0-26	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D1553) per 6 Month(s) Per patient per quadrant. Not allowed by same provider/location within 6 months of initial placement.	
D1556	Removal of fixed unilateral space maintainer- Per Quadrant	0-26	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D1556) per 24 Month(s) Per patient per quadrant. Not reimbursable by same dentist or group that placed appliance	
D1557	Removal of fixed bilateral space maintainer- Maxillary	0-26		No	One of (D1557) per 24 Month(s) Per patient per arch. Not reimbursable by same dentist or group that placed appliance	
D1558	Removal of fixed bilateral space maintainer- Mandibular	0-26		No	One of (D1558) per 24 Month(s) Per patient per arch. Not reimbursable by same dentist or group that placed appliance	
D1575	distal shoe space maintainer - fixed - unilateral- Per Quadrant	0-26	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D1575) per 24 Month(s) Per patient per quadrant. Not reimbursable by same dentist or group that placed appliance	

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Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1999	Unspecified preventive procedure, by report	0-26		No		

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Reimbursement includes local anesthesia and routine post-operative care.
Generally, once a particular restoration is placed in a tooth, a similar restoration will not be covered for at least six months, unless there is recurrent decay or material failure.
Payment is made for restorative services based onthe number of services restored, not the number of restorations per surface, or per tooth, per day. A restoration is considered a two or more surface restoration only when two or more actual tooth surfaces are involved, whether they are connected or not.
Tooth preparation, all adhesives (including amalgam and resin bonding agents),acid etching, copalite, liners, bases and curing are included as part of the restoration.
When restorations involving multiple surfaces are requested or performed, that are outside the usual anatomical expectation, the allowance is limited to that of a one-surface restoration. Any fee charged in excess of the allowance for the one-surface restoration is DISALLOWED.
Billing and reimbursement for cast crowns, cast post and cores and laminate veneers or any other fixed prosthetics shall be based on the cementation date.
The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent teeth.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2140	Amalgam - one surface, primary or permanent	0-4	Teeth A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2140	Amalgam - one surface, primary or permanent	5-9	Teeth A - C, H - M, R - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2140	Amalgam - one surface, primary or permanent	0-26	Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2140	Amalgam - one surface, primary or permanent	5 - 26	Teeth D - G, N - Q	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2140	Amalgam - one surface, primary or permanent	10 - 26	Teeth A - C, H - M, R - T	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2150	Amalgam - two surfaces, primary or permanent	0-4	Teeth A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	

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Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2150	Amalgam - two surfaces, primary or permanent	5-9	Teeth A - C, H - M, R - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2150	Amalgam - two surfaces, primary or permanent	0-26	Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2150	Amalgam - two surfaces, primary or permanent	5 - 26	Teeth D - G, N - Q	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2150	Amalgam - two surfaces, primary or permanent	10 - 26	Teeth A - C, H - M, R - T	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2160	amalgam - three surfaces, primary or permanent	0-4	Teeth A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2160	amalgam - three surfaces, primary or permanent	5-9	Teeth A - C, H - M, R - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2160	amalgam - three surfaces, primary or permanent	0-26	Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2160	amalgam - three surfaces, primary or permanent	5 - 26	Teeth D - G, N - Q	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2160	amalgam - three surfaces, primary or permanent	10 - 26	Teeth A - C, H - M, R - T	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2161	amalgam - four or more surfaces, primary or permanent	0-4	Teeth A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	

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Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2161	amalgam - four or more surfaces, primary or permanent	5-9	Teeth A - C, H - M, R - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2161	amalgam - four or more surfaces, primary or permanent	0-26	Teeth 1 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2161	amalgam - four or more surfaces, primary or permanent	5 - 26	Teeth D - G, N - Q	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2161	amalgam - four or more surfaces, primary or permanent	10 - 26	Teeth A - C, H - M, R - T	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2330	resin-based composite - one surface, anterior	0-4	Teeth C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2330	resin-based composite - one surface, anterior	5-9	Teeth C, H, M, R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2330	resin-based composite - one surface, anterior	0-26	Teeth 6 - 11, 22 - 27	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2330	resin-based composite - one surface, anterior	5 - 26	Teeth D - G, N - Q	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2330	resin-based composite - one surface, anterior	10 - 26	Teeth C, H, M, R	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2331	resin-based composite - two surfaces, anterior	0-4	Teeth C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	

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Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2331	resin-based composite - two surfaces, anterior	5-9	Teeth C, H, M, R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2331	resin-based composite - two surfaces, anterior	0-26	Teeth 6 - 11, 22 - 27	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2331	resin-based composite - two surfaces, anterior	5 - 26	Teeth D - G, N - Q	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2331	resin-based composite - two surfaces, anterior	10 - 26	Teeth C, H, M, R	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2332	resin-based composite - three surfaces, anterior	0-4	Teeth C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2332	resin-based composite - three surfaces, anterior	5-9	Teeth C, H, M, R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2332	resin-based composite - three surfaces, anterior	0-26	Teeth 6 - 11, 22 - 27	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2332	resin-based composite - three surfaces, anterior	5 - 26	Teeth D - G, N - Q	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2332	resin-based composite - three surfaces, anterior	10 - 26	Teeth C, H, M, R	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2335	resin-based composite - four or more surfaces (anterior)	0-4	Teeth C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	

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Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2335	resin-based composite - four or more surfaces (anterior)	5-9	Teeth C, H, M, R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2335	resin-based composite - four or more surfaces (anterior)	0-26	Teeth 6 - 11, 22 - 27	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2335	resin-based composite - four or more surfaces (anterior)	5 - 26	Teeth D - G, N - Q	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2335	resin-based composite - four or more surfaces (anterior)	10 - 26	Teeth C, H, M, R	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2390	resin-based composite crown, anterior	0-26	Teeth 6 - 11, 22 - 27, C - H, M - R	No		
D2391	resin-based composite - one surface, posterior	0-9	Teeth A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2391	resin-based composite - one surface, posterior	0-26	Teeth 1 - 5, 12 - 21, 28 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2391	resin-based composite - one surface, posterior	10 - 26	Teeth A, B, I - L, S, T	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2392	resin-based composite - two surfaces, posterior	0-9	Teeth A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2392	resin-based composite - two surfaces, posterior	0-26	Teeth 1 - 5, 12 - 21, 28 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	

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Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2392	resin-based composite - two surfaces, posterior	10 - 26	Teeth A, B, I - L, S, T	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2393	resin-based composite - three surfaces, posterior	0-9	Teeth A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2393	resin-based composite - three surfaces, posterior	0-26	Teeth 1 - 5, 12 - 21, 28 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2393	resin-based composite - three surfaces, posterior	10 - 26	Teeth A, B, I - L, S, T	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2394	resin-based composite - four or more surfaces, posterior	0-9	Teeth A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2394	resin-based composite - four or more surfaces, posterior	0-26	Teeth 1 - 5, 12 - 21, 28 - 32	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2394	resin-based composite - four or more surfaces, posterior	10 - 26	Teeth A, B, I - L, S, T	Yes	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	pre-operative x-ray(s)
D2710	crown - resin-based composite (indirect)	16 - 26	Teeth 1 - 32	Yes	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth.	
D2720	crown-resin with high noble metal	16 - 26	Teeth 1 - 32	Yes	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth.	

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Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2721	crown - resin with predominantly base metal	16 - 26	Teeth 1 - 32	Yes	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth.	
D2722	crown - resin with noble metal	16 - 26	Teeth 1 - 32	Yes	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth.	
D2740	crown - porcelain/ceramic	16 - 26	Teeth 1 - 32	Yes	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2750	crown - porcelain fused to high noble metal	16 - 26	Teeth 1 - 32	Yes	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2751	crown - porcelain fused to predominantly base metal	16 - 26	Teeth 1 - 32	Yes	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2752	crown - porcelain fused to noble metal	16 - 26	Teeth 1 - 32	Yes	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2780	crown - ¾ cast high noble metal	16 - 26	Teeth 1 - 32	Yes	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth.	

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Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2781	crown - ¾ cast predominantly base metal	16 - 26	Teeth 1 - 32	Yes	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth.	
D2782	crown - ¾ cast noble metal	16 - 26	Teeth 1 - 32	Yes	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth.	
D2783	crown - ¾ porcelain/ceramic	16 - 26	Teeth 1 - 32	Yes	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth.	
D2790	crown - full cast high noble metal	16 - 26	Teeth 1 - 32	Yes	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2791	crown - full cast predominantly base metal	16 - 26	Teeth 1 - 32	Yes	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2792	crown - full cast noble metal	16 - 26	Teeth 1 - 32	Yes	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2799	interim crown	16 - 26	Teeth 1 - 32	Yes		
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	0-26	Teeth 1 - 32	No	Not covered within 6 months of placement.	

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Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core	0-26	Teeth 1 - 32	No		
D2920	re-cement or re-bond crown	0-26	Teeth 1 - 32, A - T	Yes	Not covered within 6 months of placement.	narr. of med. necessity, pre-op x-ray(s)
D2921	Reattachment of tooth fragment, incisal edge or cusp	0-26	Teeth 1 - 32	No	One of (D2921) per 1 Year(s) Per patient per tooth.	
D2929	Prefabricated porcelain/ceramic crown – primary tooth	0-26	Teeth A - T	No	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth.	
D2930	prefabricated stainless steel crown - primary tooth	0-4	Teeth A - T	No	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth.	
D2930	prefabricated stainless steel crown - primary tooth	5-9	Teeth A - C, H - M, R - T	No	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth.	
D2930	prefabricated stainless steel crown - primary tooth	5 - 26	Teeth D - G, N - Q	Yes	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2930	prefabricated stainless steel crown - primary tooth	10 - 26	Teeth A - C, H - M, R - T	Yes	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth.	pre-operative x-ray(s)

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Exhibit B Benefits Covered for
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Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2931	prefabricated stainless steel crown-permanent tooth	0-26	Teeth 1 - 32	No	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2932	prefabricated resin crown	0-4	Teeth A - T	No	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth.	
D2932	prefabricated resin crown	5-9	Teeth A - C, H - M, R - T	No	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth.	
D2932	prefabricated resin crown	0-26	Teeth 1 - 32	No	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth.	
D2932	prefabricated resin crown	5 - 26	Teeth D - G, N - Q	Yes	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2932	prefabricated resin crown	10 - 26	Teeth A - C, H - M, R - T	Yes	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2933	prefabricated stainless steel crown with resin window	0-4	Teeth C - H, M - R	No	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth.	

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Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2933	prefabricated stainless steel crown with resin window	5-9	Teeth C, H, M, R	No	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth.	
D2933	prefabricated stainless steel crown with resin window	0-26	Teeth 6 - 11, 22 - 27	No	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth.	
D2933	prefabricated stainless steel crown with resin window	5 - 26	Teeth D - G, N - Q	Yes	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2933	prefabricated stainless steel crown with resin window	10 - 26	Teeth C, H, M, R	Yes	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	0-4	Teeth A - T	No	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth.	
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	5-9	Teeth A - C, H - M, R - T	No	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth.	
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	5 - 26	Teeth D - G, N - Q	Yes	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth.	pre-operative x-ray(s)

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Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	10 - 26	Teeth A - C, H - M, R - T	Yes	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2940	protective restoration	0-26	Teeth 1 - 32, A - T	Yes	Temporary restoration intended to relieve pain. Not to be used as a base liner or under a restoration.	narr. of med. necessity, pre-op x-ray(s)
D2941	Interim therapeutic restoration - primary dentition	0-26	Teeth 1 - 32	Yes	One of (D2940, D2941) per 36 Month(s) Per patient.	pre-operative x-ray(s)
D2949	Restorative foundation for an indirect restoration	0-26	Teeth 1 - 32	Yes	One of (D2940, D2941) per 36 Month(s) Per patient. Narrative of medical necessity.	pre-operative x-ray(s)
D2950	core buildup, including any pins when required	0-26	Teeth 1 - 32	Yes	One of (D2950, D2952, D2954) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2951	pin retention - per tooth, in addition to restoration	0-26	Teeth 1 - 32	No	One of (D2951) per 1 Lifetime Per patient per tooth.	
D2952	cast post and core in addition to crown	0-26	Teeth 1 - 32	No	One of (D2950, D2952, D2954) per 60 Month(s) Per patient per tooth.	
D2953	each additional cast post - same tooth	0-26	Teeth 1 - 32	Yes		
D2954	prefabricated post and core in addition to crown	0-26	Teeth 1 - 32	Yes	One of (D2950, D2952, D2954) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2955	post removal (not in conjunction with endodontic therapy)	0-26	Teeth 1 - 32	Yes		
D2957	each additional prefabricated post - same tooth	0-26	Teeth 1 - 32	Yes		
D2960	labial veneer (laminate)-chair	0-26	Teeth 1 - 32	Yes	One of (D2960, D2961, D2962) per 60 Month(s) Per patient per tooth.	
D2961	labial veneer (resin laminate) - laboratory	0-26	Teeth 1 - 32	Yes	One of (D2960, D2961, D2962) per 60 Month(s) Per patient per tooth.	
D2962	labial veneer (porc laminate) - laboratory	0-26	Teeth 1 - 32	Yes	One of (D2960, D2961, D2962) per 60 Month(s) Per patient per tooth.	
D2980	crown repair, by report	0-26	Teeth 1 - 32	No	One of (D2980) per 1 Lifetime Per patient per tooth. Narrative of medical necessity shall be maintained in patient records.	

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Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2999	unspecified restorative procedure, by report	0-26	Teeth 1 - 32, A - T	Yes		

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Reimbursement includes local anesthesia and routine post-operative care.
In cases where a root canal filling does not meet DentaQuest's general criteria treatment standards, DentaQuest can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.
A pulpotomy or palliative treatment is not to be billed in conjunction with a root canal treatment on the same date.
Filling material not accepted by the Federal Food and Drug Administration (FDA) (e.g., Sargenti filling material) is not covered.
Complete root canal therapy includes pulpectomy, all appointments necessary to complete treatment, temporary fillings, filling and obturation of canals, intra-operative and fill radiographs.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3110	pulp cap - direct (exluding final restoration)	0-26	Teeth 1 - 32, A - T	No	One of (D3110) per 1 Lifetime Per patient per tooth.	
D3120	pulp cap - indirect (excluding final restoration)	0-26	Teeth 1 - 32, A - T	No	One of (D3120) per 1 Lifetime Per patient per tooth.	
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	0-26	Teeth 1 - 32, A - T	No	Not to be used by provider completing endodontic treatment. D3220, D3221 or D3222.	pre-operative x-ray(s)
D3221	pulpal debridement, primary and permanent teeth	0-26	Teeth 1 - 32, A - T	No	Not to be used by provider completing endodontic treatment. D3220, D3221 or D3222.	
D3222	partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	0-26	Teeth 1 - 32, A - T	No	Not to be used by provider completing endodontic treatment. D3220, D3221 or D3222.	
D3230	pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	0-26	Teeth C - H, M - R	Yes	One of (D3230) per 1 Lifetime Per patient per tooth.	
D3240	pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	0-26	Teeth A, B, I - L, S, T	Yes	One of (D3240) per 1 Lifetime Per patient per tooth.	
D3310	endodontic therapy, anterior tooth (excluding final restoration)	0-26	Teeth 6 - 11, 22 - 27	Yes	One of (D3310) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3320	endodontic therapy, premolar tooth (excluding final restoration)	0-26	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	One of (D3320) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3330	endodontic therapy, molar tooth (excluding final restoration)	0-26	Teeth 1 - 3, 14 - 19, 30 - 32	Yes	One of (D3330) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)

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Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3331	treatment of root canal obstruction; non-surgical access	0-26	Teeth 1 - 32	No	One of (D3331) per 1 Lifetime Per patient per tooth.	
D3332	incomplete endodontic therapy; inoperable or fractured tooth	0-26	Teeth 1 - 32	No	One of (D3332) per 1 Lifetime Per patient per tooth.	
D3333	internal root repair of perforation defects	0-26	Teeth 1 - 32	No	One of (D3333) per 1 Lifetime Per patient per tooth.	
D3346	retreatment of previous root canal therapy-anterior	0-26	Teeth 6 - 11, 22 - 27	Yes	One of (D3346) per 1 Lifetime Per patient per tooth. Same provider may not submit within two years of root canal therapy.	Pre and post-operative x-ray(s)
D3347	retreatment of previous root canal therapy - premolar	0-26	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	One of (D3347) per 1 Lifetime Per patient per tooth. Same provider may not submit within two years of root canal therapy.	Pre and post-operative x-ray(s)
D3348	retreatment of previous root canal therapy-molar	0-26	Teeth 1 - 3, 14 - 19, 30 - 32	Yes	One of (D3348) per 1 Lifetime Per patient per tooth. Same provider may not submit within two years of root canal therapy.	Pre and post-operative x-ray(s)
D3351	apexification/recalcification - initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	0-26	Teeth 1 - 32	Yes		pre-operative x-ray(s)
D3352	apexification/recalcification - interim medication replacement	0-26	Teeth 1 - 32	Yes		pre-operative x-ray(s)
D3353	apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	0-26	Teeth 1 - 32	Yes		pre-operative x-ray(s)
D3410	apicoectomy - anterior	0-26	Teeth 6 - 11, 22 - 27	Yes	One of (D3410) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3421	apicoectomy - premolar (first root)	0-26	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	One of (D3421) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3425	apicoectomy - molar (first root)	0-26	Teeth 1 - 3, 14 - 19, 30 - 32	Yes	One of (D3425) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3426	apicoectomy (each additional root)	0-26	Teeth 1 - 5, 12 - 21, 28 - 32	Yes	One of (D3426) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3428	Bone graft in conjunction with periradicular surgery - per tooth, single site	0-26	Teeth 1 - 32	Yes	One of (D3428) per 1 Year(s) Per patient per tooth.	pre-operative x-ray(s)

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Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3429	Bone graft in conjunction with periradicular surgery - each additional contiguous tooth in the same surgical site	0-26	Teeth 1 - 32	Yes	One of (D3429) per 1 Year(s) Per patient per tooth.	
D3430	retrograde filling - per root	0-26	Teeth 1 - 32	Yes	One of (D3430) per 1 Lifetime Per patient per tooth.	
D3432	Guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery	0-26	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D3432) per 1 Year(s) Per patient per tooth. Narrative of medical necessity.	
D3432	Guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery	0-26	Teeth 1 - 32	Yes	One of (D3432) per 1 Year(s) Per patient per tooth.	
D3450	root amputation - per root	0-26	Teeth 1 - 32	Yes	One of (D3450) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3471	surgical repair of root resorption - anterior	0-26	Teeth 6 - 11, 22 - 27	Yes	One of (D3471) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3472	surgical repair of root resorption – premolar	0-26	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	One of (D3472) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3473	surgical repair of root resorption – molar	0-26	Teeth 1 - 3, 14 - 19, 30 - 32	Yes	One of (D3473) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3501	surgical exposure of root surface without apicoectomy or repair of root resorption – anterior	0-26	Teeth 6 - 11, 22 - 27	Yes	One of (D3501) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3502	surgical exposure of root surface without apicoectomy or repair of root resorption – premolar	0-26	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	One of (D3502) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3503	surgical exposure of root surface without apicoectomy or repair of root resorption – molar	0-26	Teeth 1 - 3, 14 - 19, 30 - 32	Yes	One of (D3503) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3910	surgical procedure for isolation of tooth with rubber dam	0-26	Teeth 1 - 32	Yes	One of (D3910) per 1 Lifetime Per patient per tooth.	
D3999	unspecified endodontic procedure, by report	0-26	Teeth 1 - 32, A - T	Yes		

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Reimbursement includes local anesthesia and routine post-operative care.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Periodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	0-26	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211) per 36 Month(s) Per patient per quadrant. A minimum of four (4) affected teeth in the quadrant.	pre-op x-ray(s), perio charting
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	0-26	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211) per 36 Month(s) Per patient per quadrant. One (1) to three (3) teeth in the affected quadrant.	pre-op x-ray(s), perio charting
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	0-26	Teeth 1 - 32, 51 - 82	Yes	One of (D4212) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4230	anatomical crown exposure – four or more contiguous teeth or tooth bounded spaces per quadrant	0-26		Yes	One of (D4230) per 1 Lifetime Per patient.	
D4231	anatomical crown exposure – one to three teeth or tooth bounded spaces per quadrant	0-26		Yes	One of (D4231) per 1 Lifetime Per patient.	
D4240	gingival flap procedure, including root planing – four or more contiguous teeth or tooth bound spaces per quadrant	0-26	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4240, D4241) per 36 Month(s) Per patient per quadrant. A minimum of four (4) affected teeth in the quadrant.	pre-op x-ray(s), perio charting
D4241	gingival flap procedure, including root planing – one to three contiguous teeth or tooth bound spaces per quadrant	0-26	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4240, D4241) per 36 Month(s) Per patient per quadrant. One (1) to three (3) teeth in the affected quadrant.	pre-op x-ray(s), perio charting
D4245	apically positioned flap	0-26	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4245) per 1 Lifetime Per patient per quadrant.	pre-op x-ray(s), perio charting
D4249	clinical crown lengthening - hard tissue	0-26	Teeth 1 - 32	Yes	One of (D4249) per 1 Lifetime Per patient per tooth.	pre-op x-ray(s), perio charting
D4260	osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	0-26	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4260, D4261) per 36 Month(s) Per patient per quadrant. A minimum of four (4) affected teeth in the quadrant.	pre-op x-ray(s), perio charting

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Periodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D4261	osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	0-26	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4260, D4261) per 36 Month(s) Per patient per quadrant. One (1) to three (3) teeth in the affected quadrant.	pre-op x-ray(s), perio charting
D4263	bone replacement graft - first site in quadrant	0-26	Teeth 1 - 32	Yes	One of (D4263) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4264	bone replacement graft - each additional site in quadrant	0-26	Teeth 1 - 32	Yes	Two of (D4264) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4265	biological materials to aid in soft and osseous tissue regeneration per site	0-26	Teeth 1 - 32	Yes		narrative of medical necessity
D4266	guided tissue regeneration, natural teeth – resorbable barrier, per site	0-26	Teeth 1 - 32	Yes	One of (D4266) per 36 Month(s) Per patient per tooth.	narrative of medical necessity
D4267	guided tissue regeneration, natural teeth – non-resorbable barrier, per site	0-26	Teeth 1 - 32	Yes	One of (D4267) per 36 Month(s) Per patient per tooth.	narrative of medical necessity
D4268	surgical revision procedure	0-26	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4268) per 1 Lifetime Per patient per quadrant.	pre-operative x-ray(s)
D4270	pedicle soft tissue graft procedure	0-26	Teeth 1 - 32	Yes	One of (D4270) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4273	subepithelial connective tissue graft procedure	0-26	Teeth 1 - 32	Yes	One of (D4273) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4274	distal or proximal wedge procedure	0-26	Teeth 1 - 32	Yes	One of (D4274) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4275	soft tissue allograft	0-26	Teeth 1 - 32	Yes	One of (D4275) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4276	combined connective tissue and double pedicle graft	0-26	Teeth 1 - 32	Yes	One of (D4276) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	0-26	Teeth 1 - 32, 51 - 82	Yes	One of (D4277) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	0-26	Teeth 1 - 32, 51 - 82	Yes	One of (D4278) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting

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Periodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D4283	autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	0-26	Teeth 1 - 32	Yes	One of (D4283) per 1 Year(s) Per patient per tooth.	pre-operative x-ray(s)
D4285	non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	0-26	Teeth 1 - 32	Yes	One of (D4285) per 1 Year(s) Per patient per tooth.	pre-operative x-ray(s)
D4286	removal of non-resorbable barrier	0-26	Teeth 1 - 32	Yes	One of (D4286) per 1 Lifetime Per patient.	pre-operative radiographs
D4322	splint – intra-coronal; natural teeth or prosthetic crowns	0-26	Per Arch (01, 02, LA, UA)	Yes		pre-op x-ray(s), perio charting
D4323	splint – extra-coronal; natural teeth or prosthetic crowns	0-26	Per Arch (01, 02, LA, UA)	Yes		pre-op x-ray(s), perio charting
D4341	periodontal scaling and root planing - four or more teeth per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4342	periodontal scaling and root planing - one to three teeth per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant.	pre-operative x-ray(s)
D4346	scaling in presence of generalized moderate or severe gingival inflammation, full mouth, after oral evaluation	0-20		Yes	One of (D4346) per 24 Month(s) Per patient per tooth. Perio charting, radiographs, and intra-oral photos must be submitted with the operative report. D4346 is indicated for participants who have swollen, inflamed gingiva, generalized suprabony pockets, and moderate to severe bleeding on probing.	Radiographs, perio charting and photographs
D4355	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	0-26		Yes	One of (D4355) per 1 Lifetime Per patient. Not allowed within 6 months after D1110.	pre-operative x-ray(s) or digital photograph
D4381	localized delivery of antimicrobial agents	0-26	Teeth 1 - 32	Yes	Eight of (D4381) per 1 Day(s) Per patient. One of (D4381) per 6 Month(s) Per patient per tooth.	Operative report (Operative Note)
D4910	periodontal maintenance procedures	0-26		Yes		

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Periodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D4920	unscheduled dressing change (by someone other than treating dentist or their staff)	0-26		No	Not covered for treating dentist.	
D4921	gingival irrigation with a medicinal agent – per quadrant	0-26	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4921) per 36 Month(s) Per patient per quadrant. Narrative of medical necessity.	narrative of medical necessity
D4999	unspecified periodontal procedure, by report	0-26		Yes		

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Reimbursement includes local anesthesia and routine post-operative care.
Medically necessary partial or full mouth dentures, and related services are covered when they are determined to be the primary treatment of choice or an essential part of the overall treatment plan to alleviate the member's dental problem.
A preformed denture with teeth already mounted forming a denture module is not a covered service. A partial denture that replaces only posterior permanent teeth must include three or more teeth on the dentures that are anatomically correct (natural size, shape and color) to be compensable (excluding third molars). Partial dentures must include one anterior tooth and/or 3 posterior teeth (excluding third molars).
Extractions for asymptomatic teeth are not covered services unless removal constitutes most cost-effective dental procedure for the provision of dentures.
Provision for dentures for cosmetic purposes is not a covered service.
Billing and reimbursement for cast crowns, cast post and cores and laminate veneers or any other fixed prosthetics shall be based on the cementation date.
Fabrication of a removable prosthetic includes multiple steps(appointments) these multiple steps (impressions, try-in appointments, delivery etc.) are inclusive in the fee for the removable prosthetic and as such not eligible for additional compensation.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5110	complete denture - maxillary	0-26	Per Arch (01, UA)	Yes	One of (D5110, D5130) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5120	complete denture - mandibular	0-26	Per Arch (02, LA)	Yes	One of (D5120, D5140) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5130	immediate denture - maxillary	0-26	Per Arch (01, UA)	Yes	One of (D5130) per 1 Lifetime Per patient. One of (D5110, D5130) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5140	immediate denture - mandibular	0-26	Per Arch (02, LA)	Yes	One of (D5140) per 1 Lifetime Per patient. One of (D5120, D5140) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5211	maxillary partial denture, resin base (including retentive/clasping materials, rests, and teeth)	8 - 26		Yes	One of (D5211, D5213, D5225, D5227) per 60 Month(s) Per patient per arch. Minimum of one or more anterior teeth or 3 or more posterior teeth (excluding 3rds).	pre-operative x-ray(s)
D5212	mandibular partial denture, resin base (including retentive/clasping materials, rests, and teeth)	8 - 26		Yes	One of (D5212, D5214, D5226, D5228) per 60 Month(s) Per patient per arch. Minimum of one or more anterior teeth or 3 or more posterior teeth (excluding 3rds).	pre-operative x-ray(s)
D5213	maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	8 - 26		Yes	One of (D5211, D5213, D5225, D5227) per 60 Month(s) Per patient. Minimum of three teeth, excluding molars.	pre-operative x-ray(s)
D5214	mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	8 - 26		Yes	One of (D5212, D5214, D5226, D5228) per 60 Month(s) Per patient. Minimum of three teeth, excluding molars.	pre-operative x-ray(s)

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Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5225	maxillary partial denture-flexible base	8 - 26		Yes	One of (D5211, D5213, D5225, D5227) per 60 Month(s) Per patient. Minimum of three teeth, excluding molars.	pre-operative x-ray(s)
D5226	mandibular partial denture-flexible base	8 - 26		Yes	One of (D5212, D5214, D5226, D5228) per 60 Month(s) Per patient. Minimum of three teeth, excluding molars.	pre-operative x-ray(s)
D5227	immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	8 - 26		Yes	One of (D5211, D5213, D5225, D5227) per 60 Month(s) Per patient. Minimum of three teeth, excluding molars.	pre-operative x-ray(s)
D5228	immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	8 - 26		Yes	One of (D5212, D5214, D5226, D5228) per 60 Month(s) Per patient. Minimum of three teeth, excluding molars.	pre-operative x-ray(s)
D5282	Removable unilateral partial denture--one piececast metal (including clasps and teeth), maxillary	0-26		Yes	One of (D5282) per 60 Month(s) Per patient. Narrative of medical necessity.	narrative of medical necessity
D5283	Removable unilateral partial denture--one piececast metal (including clasps and teeth), mandibular	0-26		Yes	One of (D5283) per 60 Month(s) Per patient. Narrative of medical necessity.	narrative of medical necessity
D5410	adjust complete denture - maxillary	0-26		No	One of (D5410) per 12 Month(s) Per patient. Not covered within 6 months of placement of denture or after rebase/reline.	
D5411	adjust complete denture - mandibular	0-26		No	One of (D5411) per 12 Month(s) Per patient. Not covered within 6 months of placement of denture or after rebase/reline.	
D5421	adjust partial denture-maxillary	0-26		No	One of (D5421) per 12 Month(s) Per patient. Not covered within 6 months of placement of denture or after rebase/reline.	
D5422	adjust partial denture - mandibular	0-26		No	One of (D5422) per 12 Month(s) Per patient. Not covered within 6 months of placement of denture or after rebase/reline.	
D5511	repair broken complete denture base, mandibular	0-26		No		

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Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5512	repair broken complete denture base, maxillary	0-26		No		
D5520	replace missing or broken teeth - complete denture (each tooth)	0-26	Teeth 1 - 32	No		
D5611	repair resin partial denture base, mandibular	0-26		No		
D5612	repair resin partial denture base, maxillary	0-26		No		
D5621	repair cast partial framework, mandibular	8 - 26		No		
D5622	repair cast partial framework, maxillary	8 - 26		No		
D5630	repair or replace broken retentive/clasping materials per tooth	0-26	Teeth 1 - 32	No		
D5640	replace broken teeth-per tooth	0-26	Teeth 1 - 32	No		
D5650	add tooth to existing partial denture	0-26	Teeth 1 - 32	No		
D5660	add clasp to existing partial denture	0-26	Teeth 1 - 32	No		
D5710	rebase complete maxillary denture	0-26		No	One of (D5710) per 36 Month(s) Per patient. Not covered within 12 months of placement.	
D5711	rebase complete mandibular denture	0-26		No	One of (D5711) per 36 Month(s) Per patient. Not covered within 12 months of placement.	
D5720	rebase maxillary partial denture	0-26		No	One of (D5720) per 36 Month(s) Per patient. Not covered within 12 months of placement.	
D5721	rebase mandibular partial denture	0-26		No	One of (D5721) per 36 Month(s) Per patient. Not covered within 12 months of placement.	
D5725	rebase hybrid prosthesis	0-26	Per Arch (01, 02, LA, UA)	No	One of (D5725) per 36 Month(s) Per patient. Not covered within 12 months of placement.	
D5730	reline complete maxillary denture (chairside)	0-26		No	One of (D5730) per 36 Month(s) Per patient. Not covered within 12 months of placement.	

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Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5731	reline complete mandibular denture (chairside)	0-26		No	One of (D5731) per 36 Month(s) Per patient. Not covered within 12 months of placement.	
D5740	reline maxillary partial denture (chairside)	0-26		No	One of (D5740) per 36 Month(s) Per patient. Not covered within 12 months of placement.	
D5741	reline mandibular partial denture (chairside)	0-26		No	One of (D5741) per 36 Month(s) Per patient. Not covered within 12 months of placement.	
D5750	reline complete maxillary denture (laboratory)	0-26		No	One of (D5750) per 36 Month(s) Per patient. Not covered within 12 months of placement.	
D5751	reline complete mandibular denture (laboratory)	0-26		No	One of (D5751) per 36 Month(s) Per patient. Not covered within 12 months of placement.	
D5760	reline maxillary partial denture (laboratory)	0-26		No	One of (D5760) per 36 Month(s) Per patient. Not covered within 12 months of placement.	
D5761	reline mandibular partial denture (laboratory)	0-26		No	One of (D5761) per 36 Month(s) Per patient. Not covered within 12 months of placement.	
D5765	soft liner for complete or partial removable denture – indirect	0-26	Per Arch (01, 02, LA, UA)	No	One of (D5765) per 36 Month(s) Per patient. Not covered within 12 months of placement.	
D5820	interim partial denture (maxillary)	0-26		Yes	One of (D5820) per 1 Lifetime Per patient. Not covered within 24 months of code D5211, D5213, or D5225.	pre-operative x-ray(s)
D5821	interim partial denture-mandibular	0-26		Yes	Not covered within 24 months of code D5212, D5214 or D5226.	pre-operative x-ray(s)
D5850	tissue conditioning, maxillary	0-26		No	One of (D5850) per 60 Month(s) Per patient. Prior to new denture impressions only.	
D5851	tissue conditioning,mandibular	0-26		No	One of (D5851) per 60 Month(s) Per patient. Prior to new denture impressions only.	
D5862	precision attachment, by report	0-26	Teeth 1 - 32	Yes		
D5863	Overdenture - complete maxillary	0-26		Yes		narrative of medical necessity

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Exhibit B Benefits Covered for
MO Healthy Blue Medicaid Foster Care

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5864	Overdenture - partial maxillary	0-26	Teeth 1 - 32	Yes		
D5865	Overdenture - complete mandibular	0-26	Teeth 1 - 32	Yes		
D5866	Overdenture - partial mandibular	0-26		Yes	Narrative of medical necessity.	narrative of medical necessity
D5867	Replacement of replaceable part of semi-precision per attachment	0-26	Teeth 1 - 32	Yes		
D5876	Use of metal substructure in removable complete dentures without a framework	0-26	Per Arch (01, 02, LA, UA)	Yes	Narrative of medical necessity.	narrative of medical necessity
D5899	unspecified removable prosthodontic procedure, by report	0-26		Yes		

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Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Maxillofacial Prosthetics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5913	nasal prosthesis	0-26		Yes		
D5914	auricular prosthesis	0-26		Yes		
D5922	nasal septal prosthesis	0-26		Yes		
D5926	nasal prosthesis, replacement	0-26		Yes		
D5927	auricular prosthesis, replace	0-26		Yes		
D5932	obturator prosthesis, definitive	0-26		Yes		
D5934	mandibular resection prosthesis with guide flange	0-26		Yes		
D5935	mandibular resection prosthesis without guide flange	0-26		Yes		
D5936	obturator prosthesis, interim	0-26		Yes		
D5952	speech aid prosthesis, pediatric	0-26		Yes		
D5953	speech aid prosthesis, adult	0-26		Yes		
D5954	palatal augment prosthesis	0-26		Yes		
D5955	palatal lift prosthesis, definitive	0-26		Yes		
D5958	palatal lift prosthesis, interim	0-26		Yes		
D5959	palatal lift prosthesis, modification	0-26		Yes		
D5960	speech aid prosthesis, modification	0-26		Yes		
D5988	surgical splint	0-26		Yes		
D5992	Adjust maxillofacial prosthetic appliance, by report	0-26	Per Arch (01, 02, LA, UA)	Yes	Narrative of medical necessity.	narrative of medical necessity
D5999	unspecified maxillofacial prosthesis, by report	0-26		Yes		

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Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Implant Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6010	surgical placement of implant body: endosteal implant	0-26	Teeth 1 - 32	Yes	One of (D6010) per 60 Month(s) Per patient per tooth.	
D6040	surgical placement:eposteal implnt	0-26	Per Arch (01, 02, LA, UA)	Yes	One of (D6040) per 60 Month(s) Per patient per arch.	
D6050	surgical placement-transosteal implant	0-26	Teeth 1 - 32	Yes	One of (D6050) per 60 Month(s) Per patient per tooth.	
D6090	repair implant prosthesis	0-26	Teeth 1 - 32	Yes	One of (D6090) per 60 Month(s) Per patient per tooth.	
D6092	re-cement or re-bond implant/abutment supported crown	0-26		Yes	One of (D6092) per 60 Month(s) Per patient.	
D6093	re-cement or re-bond implant/abutment supported fixed partial denture	0-26		Yes	One of (D6093) per 60 Month(s) Per patient.	
D6095	repair implant abutment	0-26	Teeth 1 - 32	Yes	One of (D6095) per 60 Month(s) Per patient per tooth.	
D6100	surgical removal of implant body	0-26	Teeth 1 - 32	Yes	One of (D6100) per 60 Month(s) Per patient per tooth.	

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Reimbursement includes local anesthesia and routine post-operative care.
Billing and reimbursement for cast crowns, cast post and cores and laminate veneers or any other fixed prosthetics shall be based on the cementation date.
The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent teeth.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Prosthodontics, fixed						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6210	pontic - cast high noble metal	0-26	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	
D6211	pontic-cast base metal	0-26	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	
D6212	pontic - cast noble metal	0-26	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	
D6240	pontic-porcelain fused-high noble	0-26	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	
D6241	pontic-porcelain fused to base metal	0-26	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	

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Prosthodontics, fixed						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6242	pontic-porcelain fused-noble metal	0-26	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	
D6245	prosthodontics fixed, pontic - porcelain/ceramic	0-26	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	
D6250	pontic-resin with high noble metal	0-26	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	
D6251	pontic-resin with base metal	0-26	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	
D6252	pontic-resin with noble metal	0-26	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	
D6545	retainer - cast metal fixed	0-26	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	

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Prosthodontics, fixed						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6548	prosthodontics fixed, retainer - porcelain/ceramic for resin bonded fixed prosthodontic	0-26	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	
D6549	Resin retainer-For resin bonded fixed prosthesis	0-26	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	narr. of med. necessity, pre-op x-ray(s)
D6600	inlay - porcelain/ceramic, two surfaces	0-26	Teeth 1 - 32	Yes	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634) per 60 Month(s) Per patient per tooth.	
D6601	inlay - porcelain/ceramic, three or more surfaces	0-26	Teeth 1 - 32	Yes	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634) per 60 Month(s) Per patient per tooth.	
D6602	inlay - cast high noble metal, two surfaces	0-26	Teeth 1 - 32	Yes	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634) per 60 Month(s) Per patient per tooth.	
D6603	inlay - cast high noble metal, three or more surfaces	0-26	Teeth 1 - 32	Yes	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634) per 60 Month(s) Per patient per tooth.	
D6604	inlay - cast predominantly base metal, two surfaces	0-26	Teeth 1 - 32	Yes	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634) per 60 Month(s) Per patient per tooth.	

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Prosthodontics, fixed						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6605	inlay - cast predominantly base metal, three or more surfaces	0-26	Teeth 1 - 32	Yes	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634) per 60 Month(s) Per patient per tooth.	
D6606	inlay - cast noble metal, two surfaces	0-26	Teeth 1 - 32	Yes	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634) per 60 Month(s) Per patient per tooth.	
D6607	inlay - cast noble metal, three or more surfaces	0-26	Teeth 1 - 32	Yes	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634) per 60 Month(s) Per patient per tooth.	
D6608	onlay - porcelain/ceramic, two surfaces	0-26	Teeth 1 - 32	Yes	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634) per 60 Month(s) Per patient per tooth.	
D6609	onlay - porcelain/ceramic, three or more surfaces	0-26	Teeth 1 - 32	Yes	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634) per 60 Month(s) Per patient per tooth.	
D6610	onlay - cast high noble metal, two surfaces	0-26	Teeth 1 - 32	Yes	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634) per 60 Month(s) Per patient per tooth.	
D6611	onlay - cast high noble metal, three or more surfaces	0-26	Teeth 1 - 32	Yes	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634) per 60 Month(s) Per patient per tooth.	
D6612	onlay - cast predominantly base metal, two surfaces	0-26	Teeth 1 - 32	Yes	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634) per 60 Month(s) Per patient per tooth.	

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Prosthodontics, fixed						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6613	onlay - cast predominantly base metal, three or more surfaces	0-26	Teeth 1 - 32	Yes	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634) per 60 Month(s) Per patient per tooth.	
D6614	onlay - cast noble metal, two surfaces	0-26	Teeth 1 - 32	Yes	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634) per 60 Month(s) Per patient per tooth.	
D6615	onlay - cast noble metal, three or more surfaces	0-26	Teeth 1 - 32	Yes	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634) per 60 Month(s) Per patient per tooth.	
D6720	crown-resin with high noble metal	0-26	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	
D6721	crown-resin with base metal	0-26	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	
D6722	crown-resin with noble metal	0-26	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	
D6740	retainer crown, porcelain/ceramic	0-26	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	

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Prosthodontics, fixed						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6750	crown-porcelain fused high noble	0-26	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	
D6751	crown-porcelain fused to base metal	0-26	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	
D6752	crown-porcelain fused noble metal	0-26	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	
D6780	crown-3/4 cst high noble metal	0-26	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	
D6781	prosthodontics fixed, crown ¾ cast predominantly based metal	0-26	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	
D6782	prosthodontics fixed, crown ¾ cast noble metal	0-26	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	

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Prosthodontics, fixed						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6783	prosthodontics fixed, crown ¾ porcelain/ceramic	0-26	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	
D6790	crown-full cast high noble	0-26	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	
D6791	crown - full cast base metal	0-26	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	
D6792	crown - full cast noble metal	0-26	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	
D6920	connector bar	0-26	Per Arch (01, 02, LA, UA)	Yes	One of (D6920) per 1 Year(s) Per patient.	
D6930	re-cement or re-bond fixed partial denture	0-26		No	One of (D6930) per 60 Month(s) Per patient. Not covered within 6 months of placement.	
D6940	stress breaker	0-26	Teeth 1 - 32	Yes	One of (D6940) per 1 Year(s) Per patient.	
D6950	precision attachment	0-26	Teeth 1 - 32	Yes	One of (D6950) per 1 Year(s) Per patient.	
D6980	fixed partial denture repair	0-26	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D6980) per 1 Lifetime Per patient per quadrant.	narrative of medical necessity
D6999	fixed prosthodontic procedure	0-26	Teeth 1 - 32	Yes		

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Reimbursement includes local anesthesia and routine post-operative care.
The extraction of asymptomatic impacted teeth is not a covered benefit. Symptomatic conditions would include pain and/or infection or demonstrated malocclusion causing a shifting of existing dentition.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7111	extraction, coronal remnants - primary tooth	0-4	Teeth A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7111	extraction, coronal remnants - primary tooth	5-9	Teeth A - C, H - M, R - T, AS, BS, CS, HS, IS, JS, KS, LS, MS, RS, SS, TS	No		
D7111	extraction, coronal remnants - primary tooth	5 - 26	Teeth D - G, N - Q, DS, ES, FS, GS, NS, OS, PS, QS	Yes		pre-operative x-ray(s)
D7111	extraction, coronal remnants - primary tooth	10 - 26	Teeth A - C, H - M, R - T, AS, BS, CS, HS, IS, JS, KS, LS, MS, RS, SS, TS	Yes		pre-operative x-ray(s)
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0-4	Teeth A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	5-9	Teeth A - C, H - M, R - T, AS, BS, CS, HS, IS, JS, KS, LS, MS, RS, SS, TS	No		
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0-26	Teeth 1 - 32, 51 - 82	No		
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	5 - 26	Teeth D - G, N - Q, DS, ES, FS, GS, NS, OS, PS, QS	Yes		
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	10 - 26	Teeth A - C, H - M, R - T, AS, BS, CS, HS, IS, JS, KS, LS, MS, RS, SS, TS	Yes		
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	0-26	Teeth 1 - 3, 5, 12, 14 - 19, 30 - 32, 51 - 53, 55, 62, 64 - 69, 80 - 82	Yes	Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)

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Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	0-26	Teeth 4, 6 - 11, 13, 20 - 29, 54, 56 - 61, 63, 70 - 79	Yes	Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7220	removal of impacted tooth-soft tissue	0-26	Teeth 1, 16, 17, 32, 51, 66, 67, 82	Yes	Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7220	removal of impacted tooth-soft tissue	0-26	Teeth 2, 3, 14, 15, 18, 19, 30, 31, 52, 53, 64, 65, 68, 69, 80, 81	Yes	Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7220	removal of impacted tooth-soft tissue	0-26	Teeth 4 - 13, 20 - 29, 54 - 63, 70 - 79	Yes	Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7230	removal of impacted tooth-partially bony	0-26	Teeth 1, 16, 17, 32, 51, 66, 67, 82	Yes	Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7230	removal of impacted tooth-partially bony	0-26	Teeth 2, 3, 14, 15, 18, 19, 30, 31, 52, 53, 64, 65, 68, 69, 80, 81	Yes	Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7230	removal of impacted tooth-partially bony	0-26	Teeth 4 - 13, 20 - 29, 54 - 63, 70 - 79	Yes	Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7240	removal of impacted tooth-completely bony	0-26	Teeth 1, 16, 17, 32, 51, 66, 67, 82	Yes	Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7240	removal of impacted tooth-completely bony	0-26	Teeth 2, 3, 14, 15, 18, 19, 30, 31, 52, 53, 64, 65, 68, 69, 80, 81	Yes	Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7240	removal of impacted tooth-completely bony	0-26	Teeth 4 - 13, 20 - 29, 54 - 63, 70 - 79	Yes	Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7241	removal of impacted tooth-completely bony, with unusual surgical complications	0-26	Teeth 1, 16, 17, 32, 51, 66, 67, 82	Yes	Unusual complications such as nerve dissection, separate closure of the maxillary sinus or aberrant tooth position. Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7241	removal of impacted tooth-completely bony, with unusual surgical complications	0-26	Teeth 2, 3, 14, 15, 18, 19, 30, 31, 52, 53, 64, 65, 68, 69, 80, 81	Yes	Unusual complications such as nerve dissection, separate closure of the maxillary sinus or aberrant tooth position. Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)

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Exhibit B Benefits Covered for
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Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7241	removal of impacted tooth-completely bony, with unusual surgical complications	0-26	Teeth 4 - 13, 20 - 29, 54 - 63, 70 - 79	Yes	Unusual complications such as nerve dissection, separate closure of the maxillary sinus or aberrant tooth position. Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7250	surgical removal of residual tooth roots (cutting procedure)	0-4	Teeth A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Will not be paid to the dentists or group that removed the tooth. Removal of asymptomatic tooth not covered.	
D7250	surgical removal of residual tooth roots (cutting procedure)	5-9	Teeth A - C, H - M, R - T, AS, BS, CS, HS, IS, JS, KS, LS, MS, RS, SS, TS	No	Will not be paid to the dentists or group that removed the tooth. Removal of asymptomatic tooth not covered.	
D7250	surgical removal of residual tooth roots (cutting procedure)	0-26	Teeth 1 - 32, 51 - 82	No	Will not be paid to the dentists or group that removed the tooth. Removal of asymptomatic tooth not covered.	
D7250	surgical removal of residual tooth roots (cutting procedure)	5 - 26	Teeth D - G, N - Q, DS, ES, FS, GS, NS, OS, PS, QS	Yes	Will not be paid to the dentists or group that removed the tooth. Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7250	surgical removal of residual tooth roots (cutting procedure)	10 - 26	Teeth A - C, H - M, R - T, AS, BS, CS, HS, IS, JS, KS, LS, MS, RS, SS, TS	Yes	Will not be paid to the dentists or group that removed the tooth. Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7260	oroantral fistula closure	0-26		Yes		pre-operative x-ray(s)
D7261	primary closure of a sinus perforation	0-26		Yes		narrative of medical necessity
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	0-26	Teeth 1 - 32	Yes		narr. of med. necessity, pre-op x-ray(s)
D7280	Surgical access of an unerupted tooth	0-26	Teeth 1 - 32	Yes	Will not be payable unless the orthodontic treatment has been authorized as a covered benefit.	narr. of med. necessity, pre-op x-ray(s)
D7283	placement of device to facilitate eruption of impacted tooth	0-26	Teeth 1 - 32	Yes	One of (D7283) per 1 Lifetime Per patient per tooth. Requires prior approval of D8080; only approved if in conjunction with approved orthodontic treatment.	
D7285	incisional biopsy of oral tissue-hard (bone, tooth)	0-26		Yes		Pathology report
D7286	incisional biopsy of oral tissue-soft	0-26		Yes		Pathology report
D7287	cytology sample collection	0-26		Yes		Pathology report

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Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7290	surgical repositioning of teeth	0-26	Teeth 1 - 32	Yes		narr. of med. necessity, pre-op x-ray(s)
D7291	transseptal fiberotomy, by report	0-26	Teeth 1 - 32	Yes		narr. of med. necessity, pre-op x-ray(s)
D7296	corticotomy – one to three teeth or tooth spaces, per quadrant	0-26	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7296, D7297) per 1 Lifetime Per patient per quadrant.	narr. of med. necessity, pre-op x-ray(s)
D7297	corticotomy – four or more teeth or tooth spaces, per quadrant	0-26	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7296, D7297) per 1 Lifetime Per patient per quadrant.	narr. of med. necessity, pre-op x-ray(s)
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	0-26	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7310) per 1 Lifetime Per patient per quadrant. Minimum of three extractions in the affected quadrant.	pre-operative x-ray(s)
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	0-26	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7311) per 1 Lifetime Per patient per quadrant. Minimum of three extractions in the affected quadrant.	pre-operative x-ray(s)
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	0-26	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7320) per 1 Lifetime Per patient per quadrant. No extractions performed in the edentulous area.	narr. of med. necessity, pre-op x-ray(s)
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	0-26	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7321) per 1 Lifetime Per patient per quadrant. No extractions performed in an edentulous area.	narr. of med. necessity, pre-op x-ray(s)
D7340	vestibuloplasty - ridge extension (secondary epithelialization)	0-26	Per Arch (01, 02, LA, UA)	Yes	One of (D7340, D7350) per 1 Lifetime Per patient per quadrant.	
D7350	vestibuloplasty - ridge extension	0-26	Per Arch (01, 02, LA, UA)	Yes	One of (D7340, D7350) per 1 Lifetime Per patient per quadrant.	
D7410	radical excision - lesion diameter up to 1.25cm	0-26		Yes		Pathology report
D7411	excision of benign lesion greater than 1.25 cm	0-26		Yes		Pathology report
D7412	excision of benign lesion, complicated	0-26		Yes		Pathology report
D7413	excision of malignant lesion up to 1.25 cm	0-26		Yes		Pathology report
D7414	excision of malignant lesion greater than 1.25 cm	0-26		Yes		Pathology report
D7415	excision of malignant lesion, complicated	0-26		Yes		Pathology report

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Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7440	excision of malignant tumor - lesion diameter up to 1.25cm	0-26		Yes		
D7441	excision of malignant tumor - lesion diameter greater than 1.25cm	0-26		Yes		
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	0-26		Yes		
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	0-26		Yes		
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	0-26		Yes		
D7461	removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm	0-26		Yes		
D7465	destruction of lesion(s) by physical or chemical method, by report	0-26		Yes		
D7471	removal of exostosis - per site	0-26	Per Arch (01, 02, LA, UA)	Yes		narr. of med. necessity, pre-op x-ray(s)
D7472	removal of torus palatinus	0-26		Yes		narr. of med. necessity, pre-op x-ray(s)
D7473	removal of torus mandibularis	0-26		Yes		narr. of med. necessity, pre-op x-ray(s)
D7485	surgical reduction of osseous tuberosity	0-26		Yes		narr. of med. necessity, pre-op x-ray(s)
D7490	radical resection of maxilla or mandible	0-26		Yes		
D7510	incision and drainage of abscess - intraoral soft tissue	0-26	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Not allowed on same date as extraction	narrative of medical necessity
D7520	incision and drainage of abscess - extraoral soft tissue	0-26		Yes		narrative of medical necessity
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	0-26		Yes		

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Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7540	removal of reaction-producing foreign bodies, musculoskeletal system	0-26		Yes		
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	0-26	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes		
D7560	maxillary sinusotomy for removal of tooth fragment or foreign body	0-26		Yes		
D7610	maxilla - open reduction	0-26		Yes		
D7620	maxilla - closed reduction	0-26		Yes		
D7630	mandible-open reduction	0-26		Yes		
D7640	mandible - closed reduction	0-26		Yes		
D7650	malar and/or zygomatic arch-open reduction	0-26		Yes		
D7660	malar and/or zygomatic arch-closed	0-26		Yes		
D7670	alveolus stabilization of teeth, closed reduction splinting	0-26		Yes		
D7671	alveolus - open reduction, may include stabilization of teeth	0-26		Yes		
D7680	facial bones - complicated reduction with fixation and multiple surgical approaches	0-26		Yes		
D7710	maxilla - open reduction	0-26		Yes		
D7720	maxilla - closed reduction	0-26		Yes		
D7730	mandible - open reduction	0-26		Yes		
D7740	mandible - closed reduction	0-26		Yes		
D7750	malar and/or zygomatic arch-open reduction	0-26		Yes		
D7760	malar and/or zygomatic arch-closed reduction	0-26		Yes		
D7770	alveolus-stabilization of teeth, open reduction splinting	0-26		Yes		
D7771	alveolus, closed reduction stabilization of teeth	0-26		Yes		

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Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7780	facial bones - complicated reduction with fixation and multiple surgical approaches	0-26		Yes		
D7810	open reduction of dislocation	0-26		Yes		
D7820	closed reduction dislocation	0-26		Yes		
D7830	manipulation under anesthesia	0-26		Yes		
D7840	condylectomy	0-26		Yes		
D7850	surgical discectomy, with/without implant	0-26		Yes		
D7860	arthrotomy	0-26		Yes		
D7865	arthroplasty	0-26		Yes		
D7870	arthrocentesis	0-26		Yes		
D7871	non-arthroscopic lysis and lavage	0-26		Yes		narrative of medical necessity
D7872	arthroscopy - diagnosis with or without biopsy	0-26		Yes		
D7873	arthroscopy-surgical: lavage and lysis of adhesions	0-26		Yes		
D7874	arthroscopy-surgical: disc repositioning and stabilization	0-26		Yes		
D7875	arthroscopy-surgical synovectomy	0-26		Yes		
D7876	arthroscopy-surgery discectomy	0-26		Yes		
D7877	arthroscopy-surgical debridement	0-26		Yes		
D7880	occlusal orthotic device, by report	0-26		Yes	One of (D7880) per 1 Lifetime Per patient.	
D7910	suture small wounds up to 5 cm	0-26		Yes		
D7911	complicated suture-up to 5 cm	0-26		Yes		
D7912	complex suture - greater than 5cm	0-26		Yes		
D7920	skin graft (identify defect covered, location and type of graft)	0-26		Yes		
D7940	osteoplasty- for orthognathic deformities	0-26		Yes		

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Exhibit B Benefits Covered for
MO Healthy Blue Medicaid Foster Care

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7941	osteotomy - madibular rami	0-26		Yes		
D7943	osteotomy- mandibular rami with bone graft; includes obtaining the graft	0-26		Yes		
D7944	osteotomy - segmented or subapical - per sextant or quadrant	0-26		Yes		
D7945	osteotomy - body of mandible	0-26		Yes		
D7946	LeFort I (maxilla - total)	0-26		Yes		
D7947	LeFort I (maxilla - segmented)	0-26		Yes		
D7948	LeFort II or LeFort III - without bone graft	0-26		Yes		
D7949	LeFort II or LeFort III - with bone graft	0-26		Yes		
D7961	buccal / labial frenectomy (frenulectomy)	0-26		Yes	Three of (D7961) per 1 Lifetime Per patient. The frenum may be excised when the tongue has limited mobility; for large diastemas between teeth; or when the frenum interferes with a prosthetic appliance; or when it is the etiology of periodontal tissue disease.	narr. of med. necessity, model or photo
D7962	lingual frenectomy (frenulectomy)	0-26		Yes	One of (D7962) per 1 Lifetime Per patient. The frenum may be excised when the tongue has limited mobility; for large diastemas between teeth; or when the frenum interferes with a prosthetic appliance; or when it is the etiology of periodontal tissue disease.	narr. of med. necessity, model or photo
D7970	excision of hyperplastic tissue - per arch	0-26	Per Arch (01, 02, LA, UA)	Yes	For removal of tissue over a previous edentulous denture bearing area to improve prognosis of a proposed denture.	narr. of med. necessity, model or photo
D7971	excision of pericoronal gingiva	0-26	Teeth 1 - 32	Yes		narr. of med. necessity, model or photo
D7972	surgical reduction of fibrous tuberosity	0-26		Yes		narr. of med. necessity, pre-op x-ray(s)
D7980	surgical sialolithotomy	0-26		Yes		
D7981	excision of salivary gland, by report	0-26		Yes		

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Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7982	sialodochoplasty	0-26		Yes		
D7983	closure of salivary fistula	0-26		Yes		
D7990	emergency tracheotomy	0-26		Yes		
D7991	coronoidectomy	0-26		Yes		
D7995	synthetic graft-mandible or facial bones, by report	0-26		Yes		
D7996	implant-mandible for augmentation purposes, by report	0-26		Yes		
D7997	appliance removal (not by dentist who placed appliance), includes removal of archbar	0-26		Yes		
D7998	intraoral fixation device---non-fracture	0-26		Yes		
D7999	unspecified oral surgery procedure, by report	0-26		Yes		

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Exhibit B Benefits Covered for
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Medicaid Members age 20 and under may qualify for orthodontic care under the program. Members must have a severe, dysfunctional, handicapping malocclusion.
DentaQuest will reimburse doctors for orthodontic records when denial determinations are made. It is the responsibility of the rendering office to submit a claim for the payment of orthodontic records, as DentaQuest cannot generate claims on the behalf of its network doctors. Claims for orthodontic records payments must be: made in accordance with timely filing protocols, submitted on a HIPAA compliant ADA claim form, billed using CDT code D8660, and have history of a DentaQuest denied orthodontia request on file. As with all claims for payment, orthodontic records are subject to member eligibility, frequency, and benefit limitations outlined herein and in accordance with State regulations.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Orthodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D8010	limited orthodontic treatment of the primary dentition	0-26		Yes		
D8020	limited orthodontic treatment of the transitional dentition	0-26		Yes		
D8030	limited orthodontic treatment of the adolescent dentition	0-26		Yes		
D8040	limited orthodontic treatment of the adult dentition	0-26		Yes		
D8070	comprehensive orthodontic treatment of the transitional dentition	0-26		Yes		
D8080	comprehensive orthodontic treatment of the adolescent dentition	0-26		Yes	Narrative/treatment plan and HLD form.	Study model or OrthoCad, x-rays
D8090	comprehensive orthodontic treatment of the adult dentition	0-26		Yes		
D8210	removable appliance therapy (includes appliances for thumb sucking and tongue thrusting)	0-26		Yes		Study model or OrthoCad, x-rays
D8220	fixed appliance therapy (includes appliances for thumb sucking and tongue thrusting)	0-26		Yes		Study model or OrthoCad, x-rays
D8660	pre-orthodontic treatment examination to monitor growth and development	0-26		Yes	One of (D8660) per 6 Month(s) Per patient.	
D8670	periodic orthodontic treatment visit	0-26		Yes	One of (D8670) per 21 Day(s) Per patient. Maximum of 24 visits reimbursed.	

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Exhibit B Benefits Covered for
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Orthodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D8680	orthodontic retention (removal of appliances)	0-26		Yes		
D8695	removal of fixed orthodontic appliances for reasons other than completion of treatment	0-26		Yes	One of (D8695) per 1 Lifetime Per patient.	narrative of medical necessity
D8696	Repair of orthodontic appliance-maxillary	0-26		Yes	One of (D8696) per 1 Lifetime Per patient.	narrative of medical necessity
D8697	Repair of orthodontic appliance-mandibular	0-26		Yes	One of (D8697) per 1 Lifetime Per patient.	narrative of medical necessity
D8698	Recement or rebond fixed retainer - maxillary	0-26		Yes	One of (D8698) per 1 Lifetime Per patient.	narrative of medical necessity
D8699	Recement or rebond fixed retainer - mandibular	0-26		Yes	One of (D8699) per 1 Lifetime Per patient.	narrative of medical necessity
D8701	Repair of fixed retainer, includes reattachment - maxillary	0-26		Yes	One of (D8701) per 1 Lifetime Per patient.	narrative of medical necessity
D8702	Repair of fixed retainer, includes reattachment - mandibular	0-26		Yes	One of (D8702) per 1 Lifetime Per patient.	narrative of medical necessity
D8703	Replacement of lost or broken retainer - maxillary	0-26		Yes	One of (D8703) per 1 Lifetime Per patient.	narrative of medical necessity
D8704	Replacement of lost or broken retainer - mandibular	0-26		Yes	One of (D8704) per 1 Lifetime Per patient.	narrative of medical necessity

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Exhibit B Benefits Covered for
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Reimbursement includes local anesthesia and routine post-operative care.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9110	palliative treatment of dental pain - per visit	0-26		No	Not allowed with any other services other than radiographs.	
D9120	fixed partial denture sectioning	0-26		Yes		
D9212	trigeminal division block anesthesia	0-26		Yes	Injection for diagnosis purposes. It is not to be used for a second division block.	narrative of medical necessity
D9219	evaluation for moderate sedation, deep sedation or general anesthesia	0-26		No	One of (D9219, D9310) per 12 Month(s) Per Provider OR Location.	
D9222	deep sedation/general anesthesia first 15 minutes	0-26		Yes	One of (D9222) per 1 Day(s) Per patient. Not allowed on same day as (D9230, D9239, D9243, D9248).	narrative of medical necessity
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	0-26		Yes	Additional sedation units covered in the minimum amount necessary to complete the treatment plan. Not to be billed with D9230, D9239, D9243 or D9248.	narrative of medical necessity
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	0-6		No	One of (D9230) per 1 Day(s) Per patient. Not allowed on the same day as (D9222, D9223, D9239, D9243, or D9248).	
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	7 - 26		Yes	One of (D9230) per 1 Day(s) Per patient. Not allowed on the same day as (D9222, D9223, D9239, D9243, or D9248).	narrative of medical necessity
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	0-26		Yes	One of (D9239) per 1 Day(s) Per patient. Not allowed on same day as (D9222, D9223, D9230, D9248).	narrative of medical necessity
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	0-26		Yes	Additional sedation units covered in the minimum amount necessary to complete the treatment plan. Not to be billed with D9222, D9223, D9230 or D9248.	narrative of medical necessity
D9248	non-intravenous moderate sedation	0-26		Yes	Not allowed on the same day with (D9222, D9223, D9230, D9239 or D9243).	narrative of medical necessity
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	0-26		No	Not covered with any other services other than radiographs. Must be performed by provider other than treating dentist.	

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Exhibit B Benefits Covered for
MO Healthy Blue Medicaid Foster Care

Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9410	house/extended care facility call	0-26		Yes	One of (D9410) per 1 Day(s) Per patient.	
D9420	hospital or ambulatory surgical center call	0-26		Yes		narrative of medical necessity
D9430	office visit for observation - no other services performed	0-26		Yes		
D9440	office visit - after regularly scheduled hours	0-26		Yes	One of (D9440) per 1 Day(s) Per patient.	
D9610	therapeutic drug injection, by report	0-26		Yes		
D9612	therapeutic drug injection - 2 or more medications by report	0-26		Yes		
D9910	application of desensitizing medicament	0-26		No	Emergency treatment only (not to be used for bases, liners, or adhesives used under restorations.) Narrative of medical necessity shall be maintained in patient records.	
D9911	application of desensitizing resin for cervical and/or root surface, per tooth	0-26	Teeth 1 - 32	No		
D9930	treatment of complications (post-surgical) - unusual circumstances, by report	0-26		Yes		
D9942	repair and/or reline of occlusal guard	0-26		Yes	One of (D9942) per 24 Month(s) Per patient.	
D9944	occlusal guard--hard appliance, full arch	0-26	Per Arch (01, 02, LA, UA)	Yes	One of (D9944, D9945, D9946) per 36 Month(s) Per patient. Narrative of medical necessity.	narrative of medical necessity
D9945	occlusal guard--soft appliance full arch	0-26	Per Arch (01, 02, LA, UA)	Yes	One of (D9944, D9945, D9946) per 36 Month(s) Per patient. Narrative of medical necessity.	narrative of medical necessity
D9946	occlusal guard--hard appliance, partial arch	0-26	Per Arch (01, 02, LA, UA)	Yes	One of (D9944, D9945, D9946) per 36 Month(s) Per patient. Narrative of medical necessity.	narrative of medical necessity
D9995	teledentistry – synchronous; real-time encounter	0-26		No		
D9996	teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	0-26		No		

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Exhibit B Benefits Covered for
MO Healthy Blue Medicaid Foster Care

Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9999	unspecified adjunctive procedure, by report	0-26		Yes		

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Exhibit B Benefits Covered for
MO Healthy Blue Medicaid Foster Care

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Medical						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
99429	EPSDT/HCY Dental Screening Without Referral	0-26		No	One of (99429, 99429UC) per 6 Month(s) Per patient. Not billable on the same date of service as D0120, D0140, D0145, D0150, D0171.	
99429UC	EPSDT/HCY Dental Screening With Referral	0-26		No	One of (99429, 99429UC) per 6 Month(s) Per patient. Not billable on the same date of service as D0120, D0140, D0145, D0150, D0171.	

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Exhibit C Benefits Covered for MO Healthy Blue Medicaid Adult

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0120	periodic oral evaluation - established patient	21 and older		No	One of (D0120, D0150) per 1 Year(s) Per patient.	
D0140	limited oral evaluation-problem focused	21 and older		No	Not reimburseable on the same day as D0150. Not allowed on same day as Non-Emergency definitive treatment.	
D0150	comprehensive oral evaluation - new or established patient	21 and older		No	One of (D0150) per 36 Month(s) Per patient. One of (D0120, D0150) per 1 Year(s) Per patient.	
D0220	intraoral - periapical first radiographic image	21 and older		No	One of (D0220) per 1 Day(s) Per patient.	
D0230	intraoral - periapical each additional radiographic image	21 and older		No		
D0272	bitewings - two radiographic images	21 and older		No	Two of (D0272, D0274) per 1 Calendar year(s) Per patient.	
D0274	bitewings - four radiographic images	21 and older		No	Two of (D0272, D0274) per 1 Calendar year(s) Per patient.	
D0330	panoramic radiographic image	21 and older		No	One of (D0210, D0330) per 24 Month(s) Per patient.	

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Exhibit C Benefits Covered for MO Healthy Blue Medicaid Adult

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1110	prophylaxis - adult	21 and older		No	Two of (D1110) per 1 Calendar year(s) Per patient.	

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Exhibit C Benefits Covered for MO Healthy Blue Medicaid Adult

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2140	Amalgam - one surface, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2150	Amalgam - two surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2160	amalgam - three surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D0270) per 6 Month(s) Per patient per tooth, per surface.	
D2161	amalgam - four or more surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2330	resin-based composite - one surface, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2331	resin-based composite - two surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2332	resin-based composite - three surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2335	resin-based composite - four or more surfaces (anterior)	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2390	resin-based composite crown, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No		
D2391	resin-based composite - one surface, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	

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Exhibit C Benefits Covered for MO Healthy Blue Medicaid Adult

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2392	resin-based composite - two surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2393	resin-based composite - three surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2394	resin-based composite - four or more surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2940	protective restoration	21 and older	Teeth 1 - 32, A - T	Yes	Temporary restoration intended to relieve pain. Not to be used as a base liner or under a restoration.	pre-operative x-ray(s)
D2950	core buildup, including any pins when required	21 and older	Teeth 1 - 32	Yes	One of (D2950, D2952, D2954) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)

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Exhibit C Benefits Covered for MO Healthy Blue Medicaid Adult

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Periodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D4341	periodontal scaling and root planing - four or more teeth per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4342	periodontal scaling and root planing - one to three teeth per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant.	pre-operative x-ray(s)
D4355	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	21 and older		Yes	One of (D4355) per 1 Lifetime Per patient.	pre-operative x-ray(s) or digital photograph
D4910	periodontal maintenance procedures	21 and older		Yes		

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Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	21 and older	Teeth 1 - 3, 5, 12, 14 - 19, 30 - 32, 51 - 53, 55, 62, 64 - 69, 80 - 82	Yes	Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	21 and older	Teeth 4, 6 - 11, 13, 20 - 29, 54, 56 - 61, 63, 70 - 79	Yes	Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7220	removal of impacted tooth-soft tissue	21 and older	Teeth 1 - 32, 51 - 82	Yes	Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7230	removal of impacted tooth-partially bony	21 and older	Teeth 1 - 32, 51 - 82	Yes	Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7240	removal of impacted tooth-completely bony	21 and older	Teeth 1 - 32, 51 - 82	Yes	Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7241	removal of impacted tooth-completely bony, with unusual surgical complications	21 and older	Teeth 1 - 32, 51 - 82	Yes	Unusual complications such as a nerve dissection, separate closure of the maxillary sinus, or aberrant tooth position. Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7250	surgical removal of residual tooth roots (cutting procedure)	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Will not be paid to the dentists or group that removed the tooth. Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7260	oroantral fistula closure	21 and older		Yes		pre-operative x-ray(s)
D7261	primary closure of a sinus perforation	21 and older		Yes		narrative of medical necessity
D7285	incisional biopsy of oral tissue-hard (bone, tooth)	21 and older		Yes		Pathology report
D7286	incisional biopsy of oral tissue-soft	21 and older		Yes		Pathology report

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Exhibit C Benefits Covered for MO Healthy Blue Medicaid Adult

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7296	corticotomy – one to three teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7296, D7297) per 1 Lifetime Per patient per quadrant.	narr. of med. necessity, pre-op x-ray(s)
D7297	corticotomy – four or more teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7296, D7297) per 1 Lifetime Per patient per quadrant.	narr. of med. necessity, pre-op x-ray(s)
D7510	incision and drainage of abscess - intraoral soft tissue	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Not allowed on same date as extraction	narrative of medical necessity
D7511	incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	21 and older		Yes		
D7520	incision and drainage of abscess - extraoral soft tissue	21 and older		Yes		narrative of medical necessity
D7521	incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	21 and older		Yes		

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Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9110	palliative treatment of dental pain - per visit	21 and older		No	Not allowed with any other services other than radiographs.	
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	21 and older		Yes	One of (D9230) per 1 Day(s) Per patient. Not allowed on same day as (D9239, D9243 or D9248).	narrative of medical necessity
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	21 and older		Yes	One of (D9239) per 1 Day(s) Per patient. Not allowed on same day as (D9230 or D9248).	narrative of medical necessity
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	21 and older		Yes	Additional sedation units covered in the minimum amount necessary to complete the treatment plan. Not to be billed with D9230 or D9248.	narrative of medical necessity
D9248	non-intravenous moderate sedation	21 and older		Yes	Not allowed on same day as (D9230, D9239 or D9243).	narrative of medical necessity
D9610	therapeutic drug injection, by report	21 and older		Yes	Description and dosage of drug and narrative of medical necessity.	
D9612	therapeutic drug injection - 2 or more medications by report	21 and older		Yes		
D9930	treatment of complications (post-surgical) - unusual circumstances, by report	21 and older		Yes		
D9995	teledentistry – synchronous; real-time encounter	21 and older		No		
D9996	teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	21 and older		No		

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Exhibit D Benefits Covered for
MO Healthy Blue Medicaid Pregnant Women

Diagnostic services include the oral examinations, and selected radiographs, needed to assess the oral health, diagnose oral pathology, and develop an adequate treatment plan for the Member's oral health.
Reimbursement for some or multiple radiographs of the same tooth or area may be denied if DentaQuest determines the number to be redundant, excessive or not in keeping with the federal guidelines relating to radiation exposure. The maximum amount paid for individual radiographs taken on the same day will be limited to the allowance for a full mouth series.
Reimbursement for radiographs is limited to when required for proper treatment and/or diagnosis.
DentaQuest utilizes the guidelines published by the Department of Health and Human Services Center for Devices and Radiological Health. However, please consult the following benefit tables for benefit limitations.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0120	periodic oral evaluation - established patient	21 and older		No	One of (D0120, D0150) per 1 Year(s) Per patient.	
D0140	limited oral evaluation-problem focused	21 and older		No	Not reimburseable on the same day as D0120 and D0150. Not allowed on same day as Non-Emergency definitive treatment.	
D0150	comprehensive oral evaluation - new or established patient	21 and older		No	One of (D0150) per 36 Month(s) Per patient. One of (D0120, D0150) per 1 Year(s) Per patient.	
D0171	Re-evaluation post-operative office visit	21 and older		No		
D0210	intraoral - comprehensive series of radiographic images	21 and older		No	One of (D0210, D0330) per 24 Month(s) Per patient.	
D0220	intraoral - periapical first radiographic image	21 and older		No	One of (D0220) per 1 Day(s) Per patient.	
D0230	intraoral - periapical each additional radiographic image	21 and older		No		
D0240	intraoral - occlusal radiographic image	21 and older		No	Two of (D0240) per 24 Month(s) Per patient.	
D0250	extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	21 and older		No	One of (D0250) per 1 Day(s) Per patient. Narrative of medical necessity shall be maintained in patient records.	
D0270	bitewing - single radiographic image	21 and older		No	Two of (D0270, D0272, D0274, D0277) per 1 Calendar year(s) Per patient.	
D0272	bitewings - two radiographic images	21 and older		No	Two of (D0270, D0272, D0274, D0277) per 1 Calendar year(s) Per patient.	

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Exhibit D Benefits Covered for
MO Healthy Blue Medicaid Pregnant Women

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0274	bitewings - four radiographic images	21 and older		No	Two of (D0270, D0272, D0274, D0277) per 1 Calendar year(s) Per patient.	
D0277	vertical bitewings - 7 to 8 films	21 and older		No	Two of (D0270, D0272, D0274, D0277) per 1 Calendar year(s) Per patient.	
D0310	sialography	21 and older		Yes		narrative of medical necessity
D0330	panoramic radiographic image	21 and older		No	One of (D0210, D0330) per 24 Month(s) Per patient.	
D0351	3D Photographic Image	21 and older		No	One of (D0351) per 12 Month(s) Per patient.	
D0364	Cone beam CT capture and interpretation with limited field of view, less than one whole jaw	21 and older		Yes	One of (D0364) per 36 Month(s) Per patient.	narrative of medical necessity
D0365	Cone beam CT capture and interpretation with field of view of one full dental arch – mandible	21 and older		Yes	One of (D0365) per 36 Month(s) Per patient.	narrative of medical necessity
D0366	Cone beam CT capture and interpretation with field of view of one full dental arch – maxilla, with or without cranium	21 and older		Yes	One of (D0366) per 36 Month(s) Per patient.	narrative of medical necessity
D0367	Cone beam CT capture and interpretation with field of view of both jaws, with or without cranium	21 and older		Yes	One of (D0367) per 36 Month(s) Per patient.	narrative of medical necessity
D0368	Cone beam CT capture and interpretation for TMJ series including two or more exposures	21 and older		Yes	One of (D0368) per 36 Month(s) Per patient.	narrative of medical necessity

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Space maintainers are a covered service when medically indicated due to the premature loss of a posterior primary tooth.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1110	prophylaxis - adult	21 and older		No	Two of (D1110) per 1 Calendar year(s) Per patient.	
D1353	Sealant repair - per tooth	21 and older	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	One of (D1351, D1353) per 3 Year(s) Per patient per tooth. Sealants will not be covered when placed over restorations. Teeth must be caries free. Includes buccal surfaces of mandibular molars and lingual surfaces of maxillary molars.	
D1354	application of caries arresting medicament- per tooth	21 and older	Teeth 1 - 32, A - T	No	One of (D1354) per 6 Month(s) Per patient per tooth. Four of (D1354) per 1 Lifetime Per patient per tooth. Not allowed with history of any prior or same day D2000, D3000 code on same tooth. D1354 cannot be billed in conjunction with D1355 (caries preventive medicament application – per tooth) on the same tooth within the same six (6)-month period.	
D1551	re-cement or re-bond bilateral space maintainer- Maxillary	21 and older		No	One of (D1551) per 6 Month(s) Per patient. Not allowed by same provider/location within 6 months of initial placement.	
D1552	re-cement or re-bond bilateral space maintainer- Mandibular	21 and older		No	One of (D1552) per 6 Month(s) Per patient. Not allowed by same provider/location within 6 months of initial placement.	
D1553	re-cement or re-bond unilateral space maintainer- Per Quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D1553) per 6 Month(s) Per patient per quadrant. Not allowed by same provider/location within 6 months of initial placement.	

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Reimbursement includes local anesthesia and routine post-operative care.
Generally, once a particular restoration is placed in a tooth, a similar restoration will not be covered for at least six months, unless there is recurrent decay or material failure.
Payment is made for restorative services based onthe number of services restored, not the number of restorations per surface, or per tooth, per day. A restoration is considered a two or more surface restoration only when two or more actual tooth surfaces are involved, whether they are connected or not.
Tooth preparation, all adhesives (including amalgam and resin bonding agents),acid etching, copalite, liners, bases and curing are included as part of the restoration.
When restorations involving multiple surfaces are requested or performed, that are outside the usual anatomical expectation, the allowance is limited to that of a one-surface restoration. Any fee charged in excess of the allowance for the one-surface restoration is DISALLOWED.
Billing and reimbursement for cast crowns, cast post and cores and laminate veneers or any other fixed prosthetics shall be based on the cementation date.
The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent teeth.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2140	Amalgam - one surface, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2150	Amalgam - two surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2160	amalgam - three surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2161	amalgam - four or more surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2330	resin-based composite - one surface, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2331	resin-based composite - two surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	

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Exhibit D Benefits Covered for
MO Healthy Blue Medicaid Pregnant Women

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2332	resin-based composite - three surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2335	resin-based composite - four or more surfaces (anterior)	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2390	resin-based composite crown, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No		
D2391	resin-based composite - one surface, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2392	resin-based composite - two surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2393	resin-based composite - three surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2394	resin-based composite - four or more surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 6 Month(s) Per patient per tooth, per surface.	
D2740	crown - porcelain/ceramic	21 and older	Teeth 1 - 32	Yes	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	21 and older	Teeth 1 - 32	No	Not covered within 6 months of initial placement.	
D2920	re-cement or re-bond crown	21 and older	Teeth 1 - 32, A - T	Yes	Not covered within 6 months of initial placement.	narr. of med. necessity, pre-op x-ray(s)

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Exhibit D Benefits Covered for
MO Healthy Blue Medicaid Pregnant Women

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2929	Prefabricated porcelain/ceramic crown – primary tooth	21 and older	Teeth A - T	No	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth.	
D2930	prefabricated stainless steel crown - primary tooth	21 and older	Teeth A - T	No	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2931	prefabricated stainless steel crown-permanent tooth	21 and older	Teeth 1 - 32	No	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2932	prefabricated resin crown	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2933	prefabricated stainless steel crown with resin window	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2929, D2930, D2931, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2940	protective restoration	21 and older	Teeth 1 - 32, A - T	Yes	Temporary restoration intended to relieve pain. Not to be used as a base liner or under a restoration.	pre-operative x-ray(s)
D2950	core buildup, including any pins when required	21 and older	Teeth 1 - 32	Yes	One of (D2950, D2952, D2954) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)
D2951	pin retention - per tooth, in addition to restoration	21 and older	Teeth 1 - 32	No	One of (D2951) per 1 Lifetime Per patient per tooth.	
D2952	cast post and core in addition to crown	21 and older	Teeth 1 - 32	No	One of (D2950, D2952, D2954) per 60 Month(s) Per patient per tooth.	
D2954	prefabricated post and core in addition to crown	21 and older	Teeth 1 - 32	Yes	One of (D2950, D2952, D2954) per 60 Month(s) Per patient per tooth.	pre-operative x-ray(s)

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Reimbursement includes local anesthesia and routine post-operative care.
In cases where a root canal filling does not meet DentaQuest's general criteria treatment standards, DentaQuest can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.
A pulpotomy or palliative treatment is not to be billed in conjunction with a root canal treatment on the same date.
Filling material not accepted by the Federal Food and Drug Administration (FDA) (e.g., Sargenti filling material) is not covered.
Complete root canal therapy includes pulpectomy, all appointments necessary to complete treatment, temporary fillings, filling and obturation of canals, intra-operative and fill radiographs.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	21 and older	Teeth 1 - 32, A - T	No	Not to be used by provider completing endodontic treatment. D3220, D3221 or D3222.	
D3221	pulpal debridement, primary and permanent teeth	21 and older	Teeth 1 - 32, A - T	No	Not to be used by provider completing endodontic treatment. D3220, D3221 or D3222.	
D3222	partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	21 and older	Teeth 1 - 32, A - T	No	Not to be used by provider completing endodontic treatment. D3220, D3221 or D3222.	
D3230	pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	21 and older	Teeth C - H, M - R	Yes	One of (D3230) per 1 Lifetime Per patient per tooth.	
D3240	pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	21 and older	Teeth A, B, I - L, S, T	Yes	One of (D3240) per 1 Lifetime Per patient per tooth.	
D3310	endodontic therapy, anterior tooth (excluding final restoration)	21 and older	Teeth 6 - 11, 22 - 27	Yes	One of (D3310) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3320	endodontic therapy, premolar tooth (excluding final restoration)	21 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	One of (D3320) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3330	endodontic therapy, molar tooth (excluding final restoration)	21 and older	Teeth 1 - 3, 14 - 19, 30 - 32	Yes	One of (D3330) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3346	retreatment of previous root canal therapy-anterior	21 and older	Teeth 6 - 11, 22 - 27	Yes	One of (D3346) per 1 Lifetime Per patient per tooth. Same provider may not submit within two years of root canal therapy.	Pre and post-operative x-ray(s)

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Exhibit D Benefits Covered for
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Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3347	retreatment of previous root canal therapy - premolar	21 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	One of (D3347) per 1 Lifetime Per patient per tooth. Same provider may not submit within two years of root canal therapy.	Pre and post-operative x-ray(s)
D3348	retreatment of previous root canal therapy-molar	21 and older	Teeth 1 - 3, 14 - 19, 30 - 32	Yes	One of (D3348) per 1 Lifetime Per patient per tooth. Same provider may not submit within two years of root canal therapy.	Pre and post-operative x-ray(s)
D3351	apexification/recalcification - initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	21 and older	Teeth 1 - 32	Yes		Pre and post-operative x-ray(s)
D3352	apexification/recalcification - interim medication replacement	21 and older	Teeth 1 - 32	Yes		Pre and post-operative x-ray(s)
D3353	apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	21 and older	Teeth 1 - 32	Yes		pre-operative x-ray(s)
D3410	apicoectomy - anterior	21 and older	Teeth 6 - 11, 22 - 27	Yes	One of (D3410) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3421	apicoectomy - premolar (first root)	21 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	One of (D3421) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3425	apicoectomy - molar (first root)	21 and older	Teeth 1 - 3, 14 - 19, 30 - 32	Yes	One of (D3425) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3426	apicoectomy (each additional root)	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32	Yes	One of (D3426) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)
D3450	root amputation - per root	21 and older	Teeth 1 - 32	Yes	One of (D3450) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)

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Reimbursement includes local anesthesia and routine post-operative care.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Periodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211) per 36 Month(s) Per patient per quadrant. A minimum of four (4) affected teeth in the quadrant.	pre-op x-ray(s), perio charting
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210, D4211) per 36 Month(s) Per patient per quadrant. One (1) to three (3) teeth in the affected quadrant.	pre-op x-ray(s), perio charting
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	21 and older	Teeth 1 - 32, 51 - 82	Yes	One of (D4212) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4240	gingival flap procedure, including root planing – four or more contiguous teeth or tooth bound spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4240, D4241) per 36 Month(s) Per patient per quadrant. A minimum of four (4) affected teeth in the quadrant.	pre-op x-ray(s), perio charting
D4241	gingival flap procedure, including root planing – one to three contiguous teeth or tooth bound spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4240, D4241) per 36 Month(s) Per patient per quadrant. One (1) to three (3) teeth in the affected quadrant.	pre-op x-ray(s), perio charting
D4245	apically positioned flap	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4245) per 1 Lifetime Per patient per quadrant.	pre-op x-ray(s), perio charting
D4260	osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4260, D4261) per 36 Month(s) Per patient per quadrant. A minimum of four (4) affected teeth in the quadrant.	pre-op x-ray(s), perio charting
D4261	osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4260, D4261) per 36 Month(s) Per patient per quadrant. One (1) to three (3) teeth in the affected quadrant.	pre-op x-ray(s), perio charting
D4265	biological materials to aid in soft and osseous tissue regeneration per site	21 and older	Teeth 1 - 32	Yes		narrative of medical necessity
D4275	soft tissue allograft	21 and older	Teeth 1 - 32	Yes	One of (D4275) per 36 Month(s) Per patient per tooth.	narrative of medical necessity
D4276	combined connective tissue and double pedicle graft	21 and older	Teeth 1 - 32	Yes	One of (D4276) per 36 Month(s) Per patient per tooth.	narrative of medical necessity

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Periodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	21 and older	Teeth 1 - 32, 51 - 82	Yes	One of (D4277) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	21 and older	Teeth 1 - 32, 51 - 82	Yes	One of (D4278) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4322	splint – intra-coronal; natural teeth or prosthetic crowns	21 and older	Per Arch (01, 02, LA, UA)	Yes		pre-op x-ray(s), perio charting
D4323	splint – extra-coronal; natural teeth or prosthetic crowns	21 and older	Per Arch (01, 02, LA, UA)	Yes		pre-op x-ray(s), perio charting
D4341	periodontal scaling and root planing - four or more teeth per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4342	periodontal scaling and root planing - one to three teeth per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant.	pre-operative x-ray(s)
D4346	scaling in presence of generalized moderate or severe gingival inflammation, full mouth, after oral evaluation	21 and older		Yes	One of (D4346) per 24 Month(s) Per patient per tooth. Perio charting, radiographs, and intra-oral photos must be submitted with the operative report. D4346 is indicated for participants who have swollen, inflamed gingiva, generalized suprabony pockets, and moderate to severe bleeding on probing.	Radiographs, perio charting and photographs
D4355	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	21 and older		Yes	One of (D4355) per 1 Lifetime Per patient.	pre-operative x-ray(s) or digital photograph
D4920	unscheduled dressing change (by someone other than treating dentist or their staff)	21 and older		No	Not covered for treating dentist.	

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Reimbursement includes local anesthesia and routine post-operative care.
Medically necessary partial or full mouth dentures, and related services are covered when they are determined to be the primary treatment of choice or an essential part of the overall treatment plan to alleviate the member's dental problem.
A preformed denture with teeth already mounted forming a denture module is not a covered service. A partial denture that replaces only posterior permanent teeth must include three or more teeth on the dentures that are anatomically correct (natural size, shape and color) to be compensable (excluding third molars). Partial dentures must include one anterior tooth and/or 3 posterior teeth (excluding third molars).
Extractions for asymptomatic teeth are not covered services unless removal constitutes most cost-effective dental procedure for the provision of dentures.
Provision for dentures for cosmetic purposes is not a covered service.
Billing and reimbursement for cast crowns, cast post and cores and laminate veneers or any other fixed prosthetics shall be based on the cementation date.
Fabrication of a removable prosthetic includes multiple steps(appointments) these multiple steps (impressions, try-in appointments, delivery etc.) are inclusive in the fee for the removable prosthetic and as such not eligible for additional compensation.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5110	complete denture - maxillary	21 and older	Per Arch (01, UA)	Yes	One of (D5110, D5130) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5120	complete denture - mandibular	21 and older	Per Arch (02, LA)	Yes	One of (D5120, D5140) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5130	immediate denture - maxillary	21 and older	Per Arch (01, UA)	Yes	One of (D5130) per 1 Lifetime Per patient. One of (D5110, D5130) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5140	immediate denture - mandibular	21 and older	Per Arch (02, LA)	Yes	One of (D5140) per 1 Lifetime Per patient. One of (D5120, D5140) per 60 Month(s) Per patient.	pre-operative x-ray(s)
D5211	maxillary partial denture, resin base (including retentive/clasping materials, rests, and teeth)	21 and older	Per Arch (01, 02, LA, UA)	Yes	One of (D5211, D5213, D5225, D5227) per 60 Month(s) Per patient per arch. Minimum of one or more anterior teeth or 3 or more posterior teeth (excluding 3rds).	pre-operative x-ray(s)
D5212	mandibular partial denture, resin base (including retentive/clasping materials, rests, and teeth)	21 and older	Per Arch (01, 02, LA, UA)	Yes	One of (D5212, D5214, D5226, D5228) per 60 Month(s) Per patient per arch. Minimum of one or more anterior teeth or 3 or more posterior teeth (excluding 3rds).	pre-operative x-ray(s)
D5213	maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	21 and older		Yes	One of (D5211, D5213, D5225, D5227) per 60 Month(s) Per patient. Minimum of three teeth, excluding molars.	pre-operative x-ray(s)
D5214	mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	21 and older		Yes	One of (D5212, D5214, D5226, D5228) per 60 Month(s) Per patient. Minimum of three teeth, excluding molars.	pre-operative x-ray(s)

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Exhibit D Benefits Covered for
MO Healthy Blue Medicaid Pregnant Women

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5225	maxillary partial denture-flexible base	21 and older		Yes	One of (D5211, D5213, D5225, D5227) per 60 Month(s) Per patient. Minimum of three teeth, excluding molars.	pre-operative x-ray(s)
D5226	mandibular partial denture-flexible base	21 and older		Yes	One of (D5212, D5214, D5226, D5228) per 60 Month(s) Per patient. Minimum of three teeth, excluding molars.	pre-operative x-ray(s)
D5227	immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	21 and older		Yes	One of (D5211, D5213, D5225, D5227) per 60 Month(s) Per patient. Minimum of three teeth, excluding molars.	pre-op x-ray(s), perio charting
D5228	immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	21 and older		Yes	One of (D5212, D5214, D5226, D5228) per 60 Month(s) Per patient. Minimum of three teeth, excluding molars.	pre-op x-ray(s), perio charting
D5410	adjust complete denture - maxillary	21 and older		No	One of (D5410) per 12 Month(s) Per patient. Not covered within 6 months of placement of denture or after rebase/reline.	
D5411	adjust complete denture - mandibular	21 and older		No	One of (D5411) per 12 Month(s) Per patient. Not covered within 6 months of placement of denture or after rebase/reline.	
D5421	adjust partial denture-maxillary	21 and older		No	One of (D5421) per 12 Month(s) Per patient. Not covered within 6 months of placement of denture or after rebase/reline.	
D5422	adjust partial denture - mandibular	21 and older		No	One of (D5422) per 12 Month(s) Per patient. Not covered within 6 months of placement of denture or after rebase/reline.	
D5511	repair broken complete denture base, mandibular	21 and older		No		
D5512	repair broken complete denture base, maxillary	21 and older		No		
D5520	replace missing or broken teeth - complete denture (each tooth)	21 and older	Teeth 1 - 32	No		
D5611	repair resin partial denture base, mandibular	21 and older		No		
D5612	repair resin partial denture base, maxillary	21 and older		No		

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Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5621	repair cast partial framework, mandibular	21 and older		No		
D5622	repair cast partial framework, maxillary	21 and older		No		
D5630	repair or replace broken retentive/clasping materials per tooth	21 and older	Teeth 1 - 32	No		
D5640	replace broken teeth-per tooth	21 and older	Teeth 1 - 32	No		
D5650	add tooth to existing partial denture	21 and older	Teeth 1 - 32	No		
D5660	add clasp to existing partial denture	21 and older	Teeth 1 - 32	No		
D5710	rebase complete maxillary denture	21 and older		No	One of (D5710) per 36 Month(s) Per patient. Not covered within 12 months of placement.	
D5711	rebase complete mandibular denture	21 and older		No	One of (D5711) per 36 Month(s) Per patient. Not covered within 12 months of placement.	
D5720	rebase maxillary partial denture	21 and older		No	One of (D5720) per 36 Month(s) Per patient. Not covered within 12 months of placement.	
D5721	rebase mandibular partial denture	21 and older		No	One of (D5721) per 36 Month(s) Per patient. Not covered within 12 months of placement.	
D5725	rebase hybrid prosthesis	21 and older	Per Arch (01, 02, LA, UA)	No	One of (D5725) per 36 Month(s) Per patient. Not covered within 12 months of placement.	
D5730	reline complete maxillary denture (chairside)	21 and older		No	One of (D5730) per 36 Month(s) Per patient. Not covered within 12 months of placement.	
D5731	reline complete mandibular denture (chairside)	21 and older		No	One of (D5731) per 36 Month(s) Per patient. Not covered within 12 months of placement.	
D5740	reline maxillary partial denture (chairside)	21 and older		No	One of (D5740) per 36 Month(s) Per patient. Not covered within 12 months of placement.	
D5741	reline mandibular partial denture (chairside)	21 and older		No	One of (D5741) per 36 Month(s) Per patient. Not covered within 12 months of placement.	

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Exhibit D Benefits Covered for
MO Healthy Blue Medicaid Pregnant Women

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5750	reline complete maxillary denture (laboratory)	21 and older		No	One of (D5750) per 36 Month(s) Per patient. Not covered within 12 months of placement.	
D5751	reline complete mandibular denture (laboratory)	21 and older		No	One of (D5751) per 36 Month(s) Per patient. Not covered within 12 months of placement.	
D5760	reline maxillary partial denture (laboratory)	21 and older		No	One of (D5760) per 36 Month(s) Per patient. Not covered within 12 months of placement.	
D5761	reline mandibular partial denture (laboratory)	21 and older		No	One of (D5761) per 36 Month(s) Per patient. Not covered within 12 months of placement.	
D5765	soft liner for complete or partial removable denture – indirect	21 and older	Per Arch (01, 02, LA, UA)	No	One of (D5765) per 36 Month(s) Per patient. Not covered within 12 months of placement.	
D5820	interim partial denture (maxillary)	21 and older		Yes	One of (D5820) per 1 Lifetime Per patient. Not covered within 24 months of code D5211, D5213, or D5225.	pre-operative x-ray(s)
D5821	interim partial denture-mandibular	21 and older		Yes	Not covered within 24 months of code D5212, D5214 or D5226.	pre-operative x-ray(s)
D5850	tissue conditioning, maxillary	21 and older		No	One of (D5850) per 60 Month(s) Per patient. Prior to new denture impressions only.	
D5851	tissue conditioning,mandibular	21 and older		No	One of (D5851) per 60 Month(s) Per patient. Prior to new denture impressions only.	

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Reimbursement includes local anesthesia and routine post-operative care.
Billing and reimbursement for cast crowns, cast post and cores and laminate veneers or any other fixed prosthetics shall be based on the cementation date.
The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent teeth.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Prosthodontics, fixed						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6549	Resin retainer-For resin bonded fixed prosthesis	21 and older	Teeth 1 - 32	Yes	One of (D6205, D6210, D6211, D6212, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6545, D6548, D6549, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792) per 60 Month(s) Per patient per tooth.	narr. of med. necessity, pre-op x-ray(s)
D6930	re-cement or re-bond fixed partial denture	21 and older		No	Not covered within 6 months of initial placement.	
D6980	fixed partial denture repair	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D6980) per 1 Lifetime Per patient per quadrant.	narrative of medical necessity

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Reimbursement includes local anesthesia and routine post-operative care.
The extraction of asymptomatic impacted teeth is not a covered benefit. Symptomatic conditions would include pain and/or infection or demonstrated malocclusion causing a shifting of existing dentition.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7111	extraction, coronal remnants - primary tooth	21 and older	Teeth A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	21 and older	Teeth 1 - 3, 5, 12, 14 - 19, 30 - 32, 51 - 53, 55, 62, 64 - 69, 80 - 82	Yes	Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	21 and older	Teeth 4, 6 - 11, 13, 20 - 29, 54, 56 - 61, 63, 70 - 79	Yes	Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7220	removal of impacted tooth-soft tissue	21 and older	Teeth 1, 16, 17, 32, 51, 66, 67, 82	Yes	Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7220	removal of impacted tooth-soft tissue	21 and older	Teeth 2, 3, 14, 15, 18, 19, 30, 31, 52, 53, 64, 65, 68, 69, 80, 81	Yes	Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7220	removal of impacted tooth-soft tissue	21 and older	Teeth 4 - 13, 20 - 29, 54 - 63, 70 - 79	Yes	Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7230	removal of impacted tooth-partially bony	21 and older	Teeth 1, 16, 17, 32, 51, 66, 67, 82	Yes	Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7230	removal of impacted tooth-partially bony	21 and older	Teeth 2, 3, 14, 15, 18, 19, 30, 31, 52, 53, 64, 65, 68, 69, 80, 81	Yes	Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7230	removal of impacted tooth-partially bony	21 and older	Teeth 4 - 13, 20 - 29, 54 - 63, 70 - 79	Yes	Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)

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Exhibit D Benefits Covered for
MO Healthy Blue Medicaid Pregnant Women

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7240	removal of impacted tooth-completely bony	21 and older	Teeth 1, 16, 17, 32, 51, 66, 67, 82	Yes	Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7240	removal of impacted tooth-completely bony	21 and older	Teeth 2, 3, 14, 15, 18, 19, 30, 31, 52, 53, 64, 65, 68, 69, 80, 81	Yes	Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7240	removal of impacted tooth-completely bony	21 and older	Teeth 4 - 13, 20 - 29, 54 - 63, 70 - 79	Yes	Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7241	removal of impacted tooth-completely bony, with unusual surgical complications	21 and older	Teeth 1, 16, 17, 32, 51, 66, 67, 82	Yes	Unusual complications such as a nerve dissection, separate closure of the maxillary sinus, or aberrant tooth position. Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7241	removal of impacted tooth-completely bony, with unusual surgical complications	21 and older	Teeth 2, 3, 14, 15, 18, 19, 30, 31, 52, 53, 64, 65, 68, 69, 80, 81	Yes	Unusual complications such as a nerve dissection, separate closure of the maxillary sinus, or aberrant tooth position. Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7241	removal of impacted tooth-completely bony, with unusual surgical complications	21 and older	Teeth 4 - 13, 20 - 29, 54 - 63, 70 - 79	Yes	Unusual complications such as a nerve dissection, separate closure of the maxillary sinus, or aberrant tooth position. Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7250	surgical removal of residual tooth roots (cutting procedure)	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Will not be paid to the dentists or group that removed the tooth. Removal of asymptomatic tooth not covered.	pre-operative x-ray(s)
D7260	oroantral fistula closure	21 and older		Yes		pre-operative x-ray(s)
D7261	primary closure of a sinus perforation	21 and older		Yes		narrative of medical necessity
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	21 and older	Teeth 1 - 32	Yes		narr. of med. necessity, pre-op x-ray(s)
D7285	incisional biopsy of oral tissue-hard (bone, tooth)	21 and older		Yes		Pathology report
D7286	incisional biopsy of oral tissue-soft	21 and older		Yes		Pathology report
D7290	surgical repositioning of teeth	21 and older	Teeth 1 - 32	Yes		narr. of med. necessity, pre-op x-ray(s)

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Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7291	transseptal fiberotomy, by report	21 and older	Teeth 1 - 32	Yes		narr. of med. necessity, pre-op x-ray(s)
D7296	corticotomy – one to three teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7296, D7297) per 1 Lifetime Per patient per quadrant.	narr. of med. necessity, pre-op x-ray(s)
D7297	corticotomy – four or more teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7296, D7297) per 1 Lifetime Per patient per quadrant.	narr. of med. necessity, pre-op x-ray(s)
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7310) per 1 Lifetime Per patient per quadrant. Minimum of three extractions in the affected quadrant.	pre-operative x-ray(s)
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	Minimum of three extractions in the affected quadrant.	pre-operative x-ray(s)
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D7320) per 1 Lifetime Per patient per quadrant. No extractions performed in the edentulous area.	narr. of med. necessity, pre-op x-ray(s)
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No extractions performed in an edentulous area.	narr. of med. necessity, pre-op x-ray(s)
D7410	radical excision - lesion diameter up to 1.25cm	21 and older		Yes		Pathology report
D7411	excision of benign lesion greater than 1.25 cm	21 and older		Yes		Pathology report
D7412	excision of benign lesion, complicated	21 and older		Yes		Pathology report
D7413	excision of malignant lesion up to 1.25 cm	21 and older		Yes		Pathology report
D7414	excision of malignant lesion greater than 1.25 cm	21 and older		Yes		Pathology report
D7415	excision of malignant lesion, complicated	21 and older		Yes		Pathology report
D7471	removal of exostosis - per site	21 and older	Per Arch (01, 02, LA, UA)	Yes		narr. of med. necessity, pre-op x-ray(s)
D7472	removal of torus palatinus	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7473	removal of torus mandibularis	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)

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Exhibit D Benefits Covered for
MO Healthy Blue Medicaid Pregnant Women

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7485	surgical reduction of osseous tuberosity	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)
D7510	incision and drainage of abscess - intraoral soft tissue	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Not allowed on same date as extraction	narrative of medical necessity
D7520	incision and drainage of abscess - extraoral soft tissue	21 and older		Yes		narrative of medical necessity
D7871	non-arthroscopic lysis and lavage	21 and older		Yes		narrative of medical necessity
D7961	buccal / labial frenectomy (frenulectomy)	21 and older		Yes	Three of (D7961) per 1 Lifetime Per patient. The frenum may be excised when the tongue has limited mobility; for large diastemas between teeth; or when the frenum interferes with a prosthetic appliance; or when it is the etiology of periodontal tissue disease.	narr. of med. necessity, model or photo
D7962	lingual frenectomy (frenulectomy)	21 and older		Yes	One of (D7962) per 1 Lifetime Per patient. The frenum may be excised when the tongue has limited mobility; for large diastemas between teeth; or when the frenum interferes with a prosthetic appliance; or when it is the etiology of periodontal tissue disease.	narr. of med. necessity, model or photo
D7970	excision of hyperplastic tissue - per arch	21 and older	Per Arch (01, 02, LA, UA)	Yes	For removal of tissue over a previous edentulous denture bearing area to improve prognosis of a proposed denture.	narr. of med. necessity, model or photo
D7971	excision of pericoronal gingiva	21 and older	Teeth 1 - 32	Yes		narr. of med. necessity, model or photo
D7972	surgical reduction of fibrous tuberosity	21 and older		Yes		narr. of med. necessity, pre-op x-ray(s)

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Exhibit D Benefits Covered for MO Healthy Blue Medicaid Pregnant Women

Reimbursement includes local anesthesia and routine post-operative care.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9110	palliative treatment of dental pain - per visit	21 and older		No	Not allowed with any other services other than radiographs.	
D9212	trigeminal division block anesthesia	21 and older		Yes	Injection for diagnosis purposes. It is not to be used for a second division block.	narrative of medical necessity
D9222	deep sedation/general anesthesia first 15 minutes	21 and older		Yes	One of (D9222) per 1 Day(s) Per patient. Not allowed on same day as (D9230, D9239, D9243, D9248).	narrative of medical necessity
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	21 and older		Yes	Additional sedation units covered in the minimum amount necessary to complete the treatment plan. Not to be billed with D9230, D9239, D9243 or D9248.	narrative of medical necessity
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	21 and older		Yes	One of (D9230) per 1 Day(s) Per patient. Not allowed on the same day as (D9222, D9223, D9239, D9243, or D9248).	narrative of medical necessity
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	21 and older		Yes	One of (D9239) per 1 Day(s) Per patient. Not allowed on same day as (D9222, D9223, D9230, D9248).	narrative of medical necessity
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	21 and older		Yes	Additional sedation units covered in the minimum amount necessary to complete the treatment plan. Not to be billed with D9222, D9223, D9230 or D9248.	narrative of medical necessity
D9248	non-intravenous moderate sedation	21 and older		Yes	Not allowed on same day as (D9222, D9230, D9239 or D9243)	narrative of medical necessity
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	21 and older		No	Not covered with any other services other than radiographs. Must be performed by provider other than treating dentist.	
D9420	hospital or ambulatory surgical center call	21 and older		Yes		narrative of medical necessity
D9610	therapeutic drug injection, by report	21 and older		Yes	Description and dosage of drug and narrative of medical necessity.	

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Exhibit D Benefits Covered for
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Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9910	application of desensitizing medicament	21 and older		No	Emergency treatment only (not to be used for bases, liners, or adhesives used under restorations.) Narrative of medical necessity shall be maintained in patient records.	
D9995	teledentistry – synchronous; real-time encounter	21 and older		No		
D9996	teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	21 and older		No		

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