Dental Provider Supplement

April 2025

Community HealthChoices

AmeriHealth Caritas Pennsylvania

Coverage by AmeriHealth First.

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Introduction

About AmeriHealth Caritas Pennsylvania Community HealthChoices

Who We Are

AmeriHealth Caritas Pennsylvania (PA) Community HealthChoices (CHC) (hereinafter known as "the Plan") is a Community HealthChoices Managed Care Organization (MCO) that coordinates physical health care and Long-Term Services and Supports (LTSS) for older persons with physical disabilities and Pennsylvanians who are dually eligible for Medicare and Medicaid (Community Well Duals). We are committed to delivering quality care that enables our Participants to live safe and healthy lives with as much independence as possible and to receive services in the community, preserve consumer choice, and allow them to have an active voice in the services they receive.

CHC Participants are:

Individuals 21 and older who are one of the following:

- Dually eligible for Medicare and Medicaid (Community Well Duals)
- Determined nursing facility clinically eligible
- Receiving care in a nursing home paid for by Medicaid

Our Mission

We Help People:
Get Care
Stay Well
Build Healthy Communities

Our Values

Our service is built on these values:
Advocacy
Care of the Poor
Compassion
Competence
Dignity
Diversity
Hospitality
Stewardship

Welcome to the AmeriHealth Caritas PA CHC Dental Provider Network

The information contained in this Dental Provider Supplement is in addition to the information contained in the Plan's Provider Manual and is intended to apply only to Dental Providers and to the Plan's Dental Program. This Dental Provider Supplement includes information on the Plan's Dental Program that may not be otherwise included in the Plan Provider Manual.

Single point of contact

To assist with timely, accurate Provider reimbursement and high-quality services, a Dental Account Executive is assigned to each Provider. Dental Account Executives are responsible for building personal relationships with the office managers at each Provider location in the region. This approach fosters teamwork and cooperation, which results in a shared focus on improving service, Participant participation, and program results.

Support for Participants

To further reduce costs for Providers while promoting satisfaction, AmeriHealth Caritas PA CHC offers support with transportation issues and appointment scheduling for Participants. Providers may also refer Participants with health-related concerns to the Plan to address any questions they may have. This highly successful program reduces administrative costs for dentists and routinely sends satisfied, eligible Participants directly to Provider practice locations.

Consistent, transparent authorization determination logic

The Plan's trained Dental Program team use clinical algorithms, which can be customized to ensure a consistent approach for making Utilization Management (UM) determinations. These algorithms are available to Providers through a Provider Services website so dentists can follow the decision matrix and understand the logic behind UM decisions. In addition, the Plan fosters a sense of partnership by encouraging Providers to offer feedback about the algorithms. A consistent, well-understood approach to UM determinations promotes clarity and transparency for Providers, which in turn reduces Provider administrative costs.

Technology tools

The Plan takes advantage of technology tools to increase speed and efficiency and keep program administration and Provider participation costs as low as possible. The Provider

Services website may be accessed at **https://www.dentaquest.com/en/providers/pennsylvania.**

The Plan provides access to this website which contains a full complement of online Provider resources. The website features an online Provider inquiry tool for real-time eligibility, Claims status, and authorization status. In addition, the website provides helpful information such as required forms, Provider newsletter, electronic remittance advice and electronic funds transfer information, updates, clinical guidelines, and other information to assist Providers in working with the Plan.

The website may be accessed at **https://www.dentaquest.com/en/providers/pennsylvania**. The website allows Network Providers direct access to multiple online services. Utilization of the online services offered through the Provider website lowers program administration and participation costs for Providers.

To access the website, enter a valid user ID and password. Providers and authorized office staff can log in for secured access anytime from anywhere, and handle a variety of day-to-day tasks, including:

- Verify Participant eligibility
- Submit Claims for services rendered by simply entering procedure codes and applicable tooth numbers, etc.
- Submit Prior Authorization requests
- Check the status of submitted Claims and Prior Authorization requests
- Download and print Provider manuals and dental supplement
- Send electronic attachments, such as digital x-rays, Explanation of Benefits (EOBs), and treatment plans
- Check patient treatment history for specific services
- Upload and download documents using a secure encryption protocol

Feedback

At the Plan, feedback from both Participants and Providers is encouraged, logged, and acted upon when appropriate. To measure Provider and Participant satisfaction, and to gather valuable feedback for its quality improvement initiatives, the Plan makes surveys available from its websites and through telephone calls. In addition, to help foster a sense of teamwork and cooperation, the Plan invites feedback from Providers about its UM algorithms by direct communication with the Plan's Dental Director.

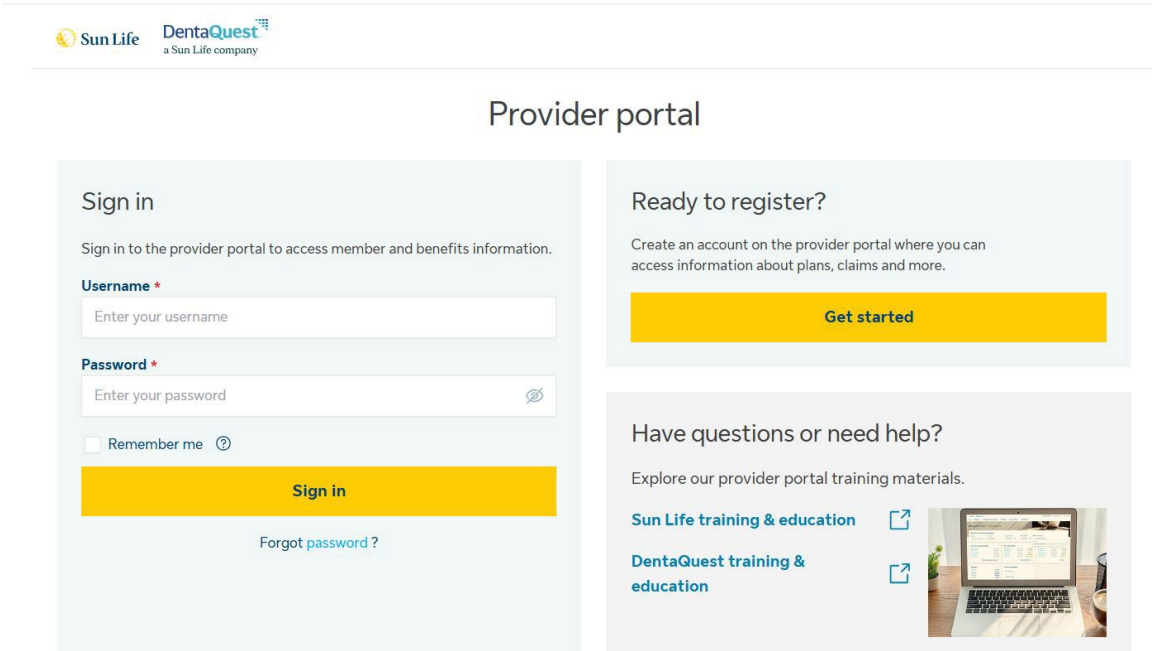
Provider Web Portal Registration & Introduction

The AmeriHealth Caritas PA CHC Web Portal allows us to maintain our commitment to help you keep your office costs low, access information efficiently, get paid quicker, and submit Claims and Prior Authorization requests electronically, along with the many other features, some of which are listed here:

- Check Participant eligibility status
- View up-to-date payment information
- Upload necessary documentation
- Review claims status
- Check benefits
- Message DentaQuest through secure messaging.

To submit claims via the portal, simply log on to **www.dentaquest.com**. Once you have entered the website, click on the "Dentists" 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. The Provider Portal also allows you to attach electronic files (such as X-rays in jpeg format, reports, and charts) to the claim.

To learn more about the features and functions of the Provider Portal, register for the portal, or ask for a training webinar, please contact Systems Operations at **1-800-417-7140** or via e-mail at **EDITeam@greatdentalplans.com**



Participant Eligibility Verification Procedures and Services to Participants

Participant Identification Card

Plan Participants are issued identification cards upon enrollment and when requested by the Participant.

Providers are responsible for verifying that Participants are eligible at the time services are rendered and to determine if Participants have other health insurance.

The Plan Eligibility Systems

Enrolled Network Providers may access Participant eligibility information through:

- The "Providers" section of DentaQuest's website at **https://www.dentaquest.com/en/providers/pennsylvania**.
- DentaQuest's Provider Customer Service Interactive Voice Response (IVR) system at **1-855-343-7401**.
- The Plan's Participant Services Department at **1-855-235-5115; 1-855-5112 TTY**.

The eligibility information received from any of the above sources will be the same information. However, by utilizing the IVR system or the website, you can get information 24 hours a day, 7 days a week, without having to wait for an available Participant Service Representative.

Access to eligibility information via the Internet currently allows Providers to verify a Participant's eligibility as well as submit claims directly to DentaQuest. You can verify the Participant's eligibility on-line by entering:

- Date of birth
- Expected date of service
- Participant's identification number or last name and first initial

To access the eligibility information via DentaQuest's website, simply log on to the website at **www.dentaquest.com**. Once you have entered the website, click on "Dentist". 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
- ZIP code

Once logged in, select “Eligibility look up” and enter the applicable information for each Participant in your inquiry. You can check an unlimited number and print off the summary of eligibility given by the system for your records. If you have questions, contact DentaQuest's Provider Customer Service Department at **1-855-343-7401**.

Access to eligibility information via the IVR phone line

To access the IVR system, simply call **1-855-343-7401** for eligibility and service history. The IVR system will be able to answer all of your eligibility questions for as many Participants as you wish to check. Once you have completed your eligibility checks or history inquiries, you will have the option to transfer to a Customer Service Representative during normal business hours.

Callers will need to enter the appropriate Tax ID or NPI number, the Participant’s recipient identification number, and date of birth. Specific directions for utilizing the IVR to check eligibility are listed below. After our system analyzes the information, the Participant’s eligibility for coverage of dental services will be verified. If the system is unable to verify the Participant information you entered, you will be transferred to a customer service representative.

Directions for using the IVR system to verify eligibility:

- Call the IVR system at **1-855-343-7401.**
- After the greeting, stay on the line for English or press 1 for Spanish.
- When prompted, press or say 2 for Eligibility.
- When prompted, press or say 1 if you know your NPI (National Provider Identification number) and Tax ID number. 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 four digits of your Tax ID number.
- If the Participant’s ID has numbers and letters in it, press or say 1. When prompted, enter the Participant ID. If the Participant’s ID has only numbers, press or say 2. When prompted, enter the Participant ID.

Upon system verification of the Participant’s eligibility, you will be prompted to repeat the information given, verify the eligibility of another Participant, get benefit information, get limited claim history on this Participant, or get fax confirmation of this call. If you choose to verify the eligibility of an additional Participant(s), you will be asked to repeat steps above for each Participant.

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 Participant Service Department at **1-855-235-5115**. They will be able to assist you in utilizing either system.

Transportation Benefits for Certain Participants

Participants who need assistance with transportation should contact the Plan's Participant Service Department directly at **1-855-235-5115**. The Plan offers TTY service for hearing impaired Participants at **1- 855-235-5112**.

Covered Benefits

Dental Benefits

Please refer to the Dental Benefit Grid for procedure codes and eligibility criteria. Participants do not need a referral from their PCP and can choose to receive dental care from any provider who is part of the dental network.

The following dental services are covered when Medically Necessary:

- Exams
- Radiographs
- Fillings
- Silver Diamine Fluoride
- Extractions
- Dentures Full and Partial *
- Dental Surgical Procedures; *
- General Anesthesia/IV or Non-IV Conscious Sedation *
- Periodontal services*
- Dental prophylaxis
- Endodontics*
- Crowns*

*Authorization is required, and medical necessity must be demonstrated.

Missed Appointments

Enrolled Network Providers are not allowed to charge Participants for missed appointments. Please refer to Medical Assistance Bulletin 99-10-14 in the Appendix of the Plan Provider Manual.

To decrease the number of missed appointments, the Plan suggests you can contact the Participant by phone, or postcard prior to the appointment to remind the individual of the time, and place of the appointment. If a Participant exceeds your office policy for missed appointments and you choose to discontinue seeing the Participant, please inform the Participant to contact the Plan at **1-855-235-5115** for a referral to a new dentist. Please refer to your Provider agreement with the Plan for your responsibilities in this regard.

Payment for Non-Covered Services

Network Providers shall hold Participants harmless for the payment of Non-Covered Services except as provided in this paragraph. Providers may bill a Participant for Non-Covered Services if the Provider obtains an agreement in writing from the Participant prior to rendering such service whichindicates all of the following:

- The non-covered services to be provided
- The Plan will not pay for or be liable for said services
- Participant will be financially liable for such services

Please refer to the dental benefit grid for a complete list of covered benefits.

- Plan Authorization Requirements and Benefit Details Grid
    - Network providers may pursue an 1150 Administrative Waiver/Program Exception request to determine possible coverage for services not included on the Benefit Details Grid, or to exceed limits for items that are currently on the fee schedule if the limits are not based in statute or regulation.

Electronic Attachments

FastAttach™ - The Plan accepts dental radiographs electronically via FastAttach™ for authorization requests and Claims submissions. The Plan in conjunction with National Electronic Attachment, Inc. (NEA) and Vyne Dental allows Providers the opportunity to submit all Claims electronically, even those that require attachments. This program allows secure transmissions via the Internet for radiographs, periodontal charts, intraoral pictures, narratives, and EOBs.

For more information, or to sign up for Fast Attach, go to **http://www.vynedental.com/fastattach/** or call Vyne Dental at **463-208-4420.**

Authorizations – Prior Authorization, Retrospective Review, and Documentation Requirements

The Plan has specific dental utilization criteria as well as a Prior Authorization and Retrospective Review process to manage the utilization of services. Consequently, the Plan's operational focus is on assuring compliance with its dental utilization criteria.

In order to timely process Authorization requests, appropriate supporting documentation, and a fully populated and most recently approved version of the ADA Claim form must be submitted (paper or electronic). Lack of supporting documentation may result in denial of the authorization. Paper forms may be mailed to:

AmeriHealth Caritas Pennsylvania Community HealthChoices - Authorizations
c/o DentaQuest-Authorization
Box 2906
Milwaukee, WI 53201-2906

Claims/Authorizations with missing or invalid information may be rejected and returned to the Provider. Authorization requests must include the following:

- Participant name
- Participant DOB
- Participant ID #
- Provider name
- Tax ID #
- NPI
- Payee location
- Treating location

Authorizations with missing or invalid information may be rejected and returned to the Provider.

All radiographs including digital prints, duplicates, and originals will not be returned to the dentist unless a self-addressed stamped envelope is included with the Claim/Authorization submission.

The basis for granting or denying approval shall be whether the item or service is Medically Necessary. Medically Necessary is defined as follows:

- A service or benefit is Medically Necessary if it is compensable under the Medical Assistance Program and if it meets any one of the following standards:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury or disability.
- Will assist the Participant to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Participant and those functional capacities that are appropriate for Participants of the same age

Will provide the opportunity for a Participant receiving LTSS to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of his or her choice.

Determination of medical necessity for covered care and services, whether made on a Prior Authorization, Retrospective, or exception basis, must be documented in writing.

The determination is based on medical information provided by the Participant, the Participant's family/caretaker, and the PCP, as well as any other practitioners, programs, and/or agencies that have evaluated the Participant. All such determinations must be made by qualified and trained practitioners.

Please refer to the Authorization Requirements and Benefits Grid in this manual for a detailed list of services requiring Prior Authorization or Retrospective Review Authorization.

Procedures Requiring Prior Authorization

Prior Authorizations will be honored for 180 days from the date they are issued. An approval does not guarantee payment. The Participant must be eligible for services at the time the services are provided. The Provider should verify eligibility at the time of service.

Prior authorization for Hospital/Special Procedure Unit (SPU)/Ambulatory Surgical Center (ASC) outpatient admission for dental services is required when utilizing a Plan participating facility. The dental services associated with the admission are governed by the authorization process. The Prior Authorization process should be followed listing all dental services that will be provided by the requesting dentist. The authorization request should designate the place of service to indicate that outpatient admission for dental services are planned to be performed. Please contact AmeriHealth Caritas PA CHC Provider Services at **1-855-343-7401** with any questions.

Retrospective Review

Services that would normally require a Prior Authorization, but are performed in an emergency situation, will be subject to a Retrospective Review. Claims for Retrospective Review should be submitted to the address utilized when submitting requests for Prior Authorization, accompanied by any required supporting documentation. Any Claims for Retrospective Review submitted without the required documents will be denied and must be resubmitted to obtain reimbursement.

Some services require only retrospective review due to the documentation requirement or inability to determine medical necessity pre-operatively. An example of such would be the removal of a benign odontogenic cyst or tumor (D7450/D7451). These procedure requires a pathology report describing the lesion (for determination purposes) and should only be submitted for retro authorization. Please refer to the "Medicaid Clinical Criteria for Prior Authorization of Routine and Emergency Treatment" section for a listing of all procedures and the authorization requirements.

Claim Submission Procedures

The Plan receives dental Claims in four possible formats. These formats include:

- Electronic direct entry via DentaQuest's website (**www.dentaquest.com**)
- Electronic submission via clearinghouse
- HIPAA Compliant 837D or 837P File
- Paper claims via U.S. Postal Service or Fax **1-262-834-3589**

Electronic Claim Submission Utilizing DentaQuest's Website

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

To submit claims via the portal, simply log on to **www.dentaquest.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
- Zip Code

If experiencing difficulty logging in or for questions regarding DentaQuest's websiteyou may contact DentaQuest's Provider Service Department at **1-855-343-7401**. Once logged in, select "Claims/Pre-Authorizations" and then "Dental Claim Entry." The Provider Portal allows you to attach electronic files (such as radiographs in jpeg format, reports, and charts) to the claim.

If you have questions on submitting claims or accessing the portal, please contact our Systems Operations at **1-800-417-7140** or via e-mail at **EDITeam@greatdentalplans.com**.

Electronic Claim Submission via Clearinghouse

Dentists may submit their Claims to the Plan via clearinghouse such as DentalXChange. You can contact your software vendor and make certain that they have the Plan listed as a payer. Your software vendor will be able to provide you with any information you may need to ensure that submitted Claims are forwarded to the Plan.

The Plan's Payer ID is "CX014". DentalXChange will ensure that by utilizing this unique payer ID, Claims will be submitted successfully to the Plan.

For more information on DentalXChange, please refer to their website at **www.dentalxchange.com**.

Electronic Claim Submission via HIPAA Compliant 837D or 837P 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. Providers are advised to email **EDITeam@greatdentalplans.com** to inquire about this option for electronic claim submission.

Paper Claim Submission

Claims must be submitted on the most current ADA Claim form or other forms approved in advance by the Plan. Please reference the ADA website for the most current Claim form and completion instructions. Forms are available through the American Dental Association at:

American Dental Association
211 East Chicago Avenue
Chicago, IL 60611
1-800-947-4746

Participant name, identification number, and date of birth must be listed on all Claims submitted. If the Participant identification number is missing or miscoded on the Claim form, the Participant cannot be identified. This could result in the Claim being returned to the submitting Provider office, causing a delay in payment.

All information must be legible and contained within the appropriate boxes to allow for authorizations and claims to be scanned into our system for processing.

Please include contracted fees or UCR charges on all authorization requests and claims for all services to ensure at least your contracted fees are reimbursed. Our plan must reimburse the lesser of contracted fees and billed charges. If a claim is processed at a lower rate than those contracted due to an error with submitted charges, the claim must be voided and resubmitted for accurate reimbursement.

The Provider and office location information must be clearly identified on the Claim. To ensure proper Claim processing, the Claim form must include the following:

- Participant name
- Participant DOB
- Participant ID #
- Provider name
- Tax ID #
- NPI
- Payee location
- Treating location

The date of service must be provided on the Claim form for each service line submitted. Approved ADA dental codes as published in the Current Dental Terminology (CDT) book or as defined in this Manual must be used to define all services.

Providers must list all arches, quadrants, tooth numbers, and surfaces for dental codes that necessitate identification (i.e., fillings, scaling and root planing). Missing tooth and surface identification codes can result in the delay or denial of the Claim payment.

Affix the proper postage when mailing bulk documentation. The Plan 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:

AmeriHealth Caritas Pennsylvania Community HealthChoices – Claims
c/o DentaQuest - Claims

P.O. Box 2906
Milwaukee, WI 53201-2906

Claims that have been previously **paid** and need adjustment should be mailed to the following address:

AmeriHealth Caritas Pennsylvania Community Health Choices
Claims Reprocessing and Adjustments Requests
c/o DentaQuest – Reprocessing and Adjustments
P.O. Box 2906
Milwaukee, WI 53201-2906

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

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

2. Predetermination/Preauthorization Number

DENTAL BENEFIT PLAN INFORMATION

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

3a. Payer ID

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 ☐U | 8. Policyholder/Subscriber ID (Assigned by Plan)

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

11a. Other Payer ID

POLICYHOLDER/SUBSCRIBER INFORMATION (Assigned by Plan 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 ☐U | 15. Policyholder/Subscriber ID (Assigned by Plan)

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 ☐U | 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-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ C _____ B _____ D _____

31a. Other Fee(s)

32. Total Fee

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 (alll dates in MM/DD/CCYY format)

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) | 39a. Date Last SRP

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

53a. Locum Tenens Treating Dentist? ☐

54. NPI | 55. License Number

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

57. Phone Number ( ) - | 58. Additional Provider ID

J43024 (Same as ADA Dental Claim Form – J43124, J43224, J43424, J43024T)

To reorder call 800.947.4746
or go online at ADAstore.org

ADA American Dental Association®

America's leading advocate for oral health

The following information highlights certain form completion instructions. Comprehensive ADA Dental Claim Form completion instructions are posted on the ADA's web site (https://www.ADA.org/en/publications/cdt/ada-dental-claim-form).

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 instructions posted on the ADA's web site (ADA.org).

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.

F. GENDER Codes (Items 7, 14 and 22) – M = Male; F = Female; U = Unknown

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).

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 (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:
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/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	1223X0008X
Oral & Maxillofacial Surgery	1223S0112X

Provider taxonomy codes listed above are a subset of the full code set that is posted at:
https://www.nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40

Timely Filing Limits

The Provider understands that failure to submit Claims (and any required documentation) within 180 days from the date of service may result in loss of reimbursement for services provided.

Claims with Explanation of Benefits (EOBs) from primary insurers must be submitted within 60 days of the date of the primary insurer's EOB. Providers must submit a copy of the primary insurer's EOB. The Plan determines whether a Claim has been filed timely by comparing the date of service to the receipt date applied to the Claim when the Claim is received. If the span between these two dates exceeds the time limitation, the Claim is considered to have not been filed timely.

Coordination of Benefits (COB)

When the Plan is the secondary insurance carrier, a copy of the primary carrier's (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 the Provider's contracted rate or fee with the Plan schedule, the Plan will consider the Claim paid in full. The Participant may not be billed for any outstanding balance.

Third-Party Liability and Coordination of Benefit

Third-Party Liability (TPL) is when the financial responsibility for all or part of a Participant's health care expenses rests with an individual entity or program (e.g., Medicare, commercial insurance) other than the Plan. COB (Coordination of Benefits) is a process that establishes the order of payment when an individual is covered by more than one insurance carrier. A Medicaid HMO, such as the Plan, is always the payer of last resort. This means that Claims must be submitted and processed by all other insurance carriers (the "Primary Insurers") before a Claim is submitted to the Plan. Health Care Providers are required to bill the Primary Insurer first and obtain an Explanation of Benefits (EOB) statement from the Primary Insurer. Health Care Providers then may bill the Plan for the Claim by submitting the Claim along with a copy of the Primary Insurer's EOB. See timeframes for submitting Claims with EOBs from a Primary Insurer in the timely filing limits section above.

Reimbursement for Participants with Third-Party Resources

Medicare as a Third-Party Resource

For Medicare services that are covered by the Plan, the Plan will pay, up to the Plan contracted rate, the lesser of:

- The difference between the Plan contracted rate and the amount paid by Medicare, or
- The amount of the applicable coinsurance, deductible and/or co-payment

In any event, the total combined payment made by Medicare and the Plan will not exceed the Plan contracted rate.

If the Participant and provider participate in both AmeriHealth Caritas VIP Care and AmeriHealth Caritas PA CHC, claims for dental services will be automatically sent to the secondary payer AmeriHealth Caritas PA CHC for claim processing.

The Plan's referral and authorization requirements are applicable if the services are covered by Medicare.

Continuation of Care

The Plan provides continuing coverage of care for Participants who are engaged in an ongoing course of treatment with a non -participating Practitioner or Provider to promote continuity of care. Please reach out to your Account Executive for non-orthodontic continuation of care. The process for the continuation of orthodontic coverage can be found at **www.amerihealthcaritaschc.com → For Providers → Resources → Dental program**. Please reach out to your Dental Account Executive for questions regarding this process.

Commercial Third-Party Resources

For services that have been rendered by a Network Provider, the Plan will pay, up to the Plan contracted rate, the lesser of:

- The difference between the Plan contracted rate and the amount paid by the Primary Insurer, or
- The amount of the applicable coinsurance, deductible and/or copayment

In any event, the total combined payment made by the Primary Insurer and the Plan will not exceed the Plan's contracted rate.

Receipt and Audit of Claims

In order to ensure timely, accurate remittances to each dentist, the Plan performs an edit of all Claims upon receipt. This edit validates Participant eligibility, procedure codes, and

Provider identifying information. A Dental Reimbursement Analyst dedicated to the Plan dental offices 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 feel free to contact the Provider Customer Services Department at **1-855-343-7401** with any questions you may have regarding Claim submission or your remittance.

Each Enrolled Network Provider office receives an "Explanation of Benefit" report with their remittance. This report includes Participant information and an allowable fee by date of service for each service rendered during the period.

Dentist Appeal And Dispute Procedures

Providers have the opportunity to request resolution of Disputes with DentaQuest or request a Formal Appeal on behalf of a Participant through submission to the appropriate internal Plan department. Submissions must be in writing and should be accompanied by any necessary additional documentation within 60 days of the date of the explanation of benefit indicating Claim denial to the following address:

AmeriHealth Caritas Pennsylvania Community HealthChoices – Appeals and Disputes
c/o DentaQuest – Appeals and Disputes
P.O. Box 2906
Milwaukee, WI 53201-2906

Refer to the Provider Manual section on "Provider Dispute/Appeal Procedures" for complete and detailed information.

Health Insurance Portability and Accountability Act (HIPAA) and Fraud, Waste & Abuse

As a healthcare Provider, you are a "Covered Entity" under HIPAA, and you are therefore required to comply with the applicable provisions of HIPAA and its implementing regulations.

In regard to the Administrative Simplification Standards, you will note that the benefit tables included in this Dental Provider Manual reflect the most current coding standards recognized by the ADA. Effective the date of this manual, the Plan will require Providers to submit all Claims with the proper CDT codes listed in this manual. In addition, all paper Claims must be submitted on a current approved ADA Claim form.

Note: Copies of the Plan's HIPAA policies are available upon request by contacting the DentaQuest's Provider Customer Service Department at **1-855-343-7401**.

For complete detailed information regarding the Plan's HIPAA policies, refer to the "Compliance with the HIPAA Privacy Regulations"section in the Provider Manual.

Fraud, Waste & Abuse

Under the Community HealthChoices program, the Plan receives state and federal funding for payment of services provided to our Participants. In accepting Claims payment from the Plan, Healthcare Providers are receiving state and federal program funds and are therefore subject to all applicable federal and/or state laws and regulations relating to this program. Violations of these laws and regulations may be considered Fraud, Waste or Abuse (FWA) against the Medical Assistance program. See the Medical Assistance Manual, Chapter 1101 or go to **www.pacode.com/secure/data/055/partIIItoc.html** for more information regarding Fraud, Waste or abuse, including "Provider Prohibited Acts" that are specified in §1101.75. Providers are responsible to know and abide by all applicable state and federal regulations.

We are dedicated to eradicating Fraud, Waste and Abuse from our programs and cooperate in Fraud, Waste and Abuse investigations conducted by state and/or federal agencies, including the Medicaid Fraud Control Unit of the Pennsylvania Attorney General's Office, the Federal Bureau of Investigation, the Drug Enforcement Administration, the U.S. Department of Health and Human Services (HHS) Office of Inspector General, as well as the Bureau of Program Integrity of the Pennsylvania Department of Human Services (DHS). As part of our responsibilities, the Payment Integrity department is responsible for identifying and recovering Claims overpayments. The department performs several operational activities to detect and prevent fraudulent, wasteful and/or abusive activities. We expect our dental partners to share this same commitment and conduct their businesses similarly, and report suspected noncompliance, Fraud, Waste or Abuse.

Examples of fraudulent/wasteful/abusive activities:

- Billing for services not rendered or not Medically Necessary
- Submitting false information to obtain authorization to furnish services or items to Medicaid recipients
- Prescribing items or referring services which are not Medically Necessary
- Misrepresenting the services rendered

- Submitting a Claim for provider services on behalf of an individual that is unlicensed, or has been excluded from participation in the Medicare and Medicaid programs
- Retaining Medicaid funds that were improperly paid
- Billing Medicaid recipients for covered services
- Failure to perform services required under a capitated contractual arrangement

Reporting and Preventing Fraud, Waste and Abuse

If you, or any entity with which you contract to provide health care services on behalf of the Plan, become concerned about or identifies potential fraud, waste, or abuse, please contact us by:

- Calling the toll-free Fraud, Waste, and Abuse Hotline at **1-866-833-9718**
- E-mailing to **FraudTip@amerihealthcaritas.com**
- Mailing a written statement to Special Investigations Unit:
  AmeriHealth Caritas Pennsylvania Community HealthChoices
  P.O. Box 7317
  London, KY 40742

Below are examples of information that will assist us with an investigation:

- Contact Information (e.g., name of individual making the allegation, address, telephone number)
- Name and Identification Number of the Suspected Individual
- Source of the Complaint (including the type of item or service involved in the allegation)
- Approximate Dollars Involved (if known)
- Place of Service
- Description of the Alleged Fraudulent, Wasteful or Abuse Activities
- Timeframe of the Allegation(s)

Providers may also report suspected Fraud, Waste, and Abuse by contacting The Pennsylvania Department of Human Services through one of the following methods:

Phone:	**1-844-DHS-TIPS** or **1-844-347-8477**
Online:	**https://www.dhs.pa.gov/about/Fraud-And-Abuse/Pages/MA-Fraud-and-Abuse---General-Information.aspx**
Email:	**omaptips@state.pa.us**
Fax:	**1-717-214-1200**, **Attn: OMAP Provider**

Mail:	Department of Human Services Office of Administration Bureau of Program Integrity P.O. Box 2675 Harrisburg, PA 17105-2675

Credentialing

Any Doctor of Dental Surgery (DDS) or Doctor of Medicine in Dentistry (DMD) who is interested in participation with the Plan is invited to apply by submitting a credentialing application form for review by the Plan Credentialing Committee.
Providers who seek participation in the Plan Provider Network must be credentialed prior to participation in the network.

The Plan maintains and adheres to all applicable State and federal laws and regulations, Pennsylvania Department of Human Services requirements, and accreditation requirements governing credentialing and re-credentialing functions. All applications reviewed by the Plan must satisfy these requirements, as they apply to dental services, in order to be admitted in the Plan's Provider Network.

The process to be credentialed as a Plan Network Provider is fast and easy. The Plan has entered into an agreement with the Council for Affordable Quality Healthcare (CAQH) to offer our Providers the Universal Provider Data repository that simplifies and streamlines the data collection process for credentialing and re-credentialing. Through CAQH, you provide credentialing information to a single repository, via a secure Internet site, to fulfill the credentialing requirements of all health plans that participate with CAQH. The Plan's goal is to have all of its Network Providers enrolled with CAQH. There is no charge to Providers to submit applications and participate in CAQH. Please access the credentialing page on **https://www.amerihealthcaritaschc.com/provider/credentialing/index.aspx** and follow the instructions to begin the application process for participation in the Plan's Provider Network.

Refer to the Plan Provider Manual section on Credentialing and Re-credentialing Requirements for complete and detailed information.

Medical Recordkeeping

The Plan adheres to medical record requirements that are consistent with national standards on documentation and applicable laws and regulations. Likewise, the Plan expects that every office will provide quality dental services in a cost-effective manner in keeping with the standards of care in the community and dental profession nationwide.

The Plan's expectation is that every Network Provider will submit Claims for services in an accurate and ethical fashion reflecting the appropriate level and scope of services performed, and that Network Providers are compliant with these requirements.

The Plan will periodically conduct random chart audits in order to determine Network Providers' compliance with these conditions and expectations, as a component of the Plan's Quality Management Program. Network Providers are expected to supply, upon request, complete copies of Participant dental records. The records are reviewed by the Plan's Dental Director, or his/her designee, such as a Registered Dental Hygienist, to determine the rate of compliance with medical recordkeeping requirements as well as the accuracy of the dental Claims submitted for payment. All dental services performed must be recorded in the patient record, which must be made available as required by your Participating Provider Agreement. The first part of the audit will consist of the charts being reviewed for compliance with the stated record keeping requirements, utilizing a standardized audit tool. The charts are reviewed, and a composite score is determined. Offices with scores above 90% are considered as passing the audit but a letter is sent to them so that they are aware of the areas that need improvement. Offices that receive a score of 95% or greater are exempt from the audit the following year. Offices with scores less than 90% will have a corrective action letter sent and are re-reviewed for compliance within the next 120 days. Offices that do not cooperate with improving their scores are subject to disciplinary action in accordance with the Plan's Provider Sanctioning Policy.

The second portion of the audit consists of a billing reconciliation whereby the patient treatment notes and diagnostics are compared to the actual Claims submitted for payment by each dental office. The records are analyzed to determine if the patient record documents the performance of all the dental services that have been submitted for payment. Payment of any services not documented/diagnostics not present are recouped, and the records may be subject to additional review and follow-up by the Plan's Special Investigations Unit.

Results of both parts of the audit are entered into a tracking database at the Plan and then reported back to each office in a summary of finding format.

The Plan recognizes tooth letters “A” through “T” for primary teeth and tooth numbers “1” to “32” for permanent teeth. Supernumerary teeth should be designated by using codes AS through TS for primary teeth or 51 through 82 for permanent teeth.

Designation of the tooth can be determined by using the nearest erupted tooth. If the tooth closest to the supernumerary tooth is # 1 then the supernumerary tooth should be charted as #51, likewise if the nearest tooth is “A” the supernumerary tooth should be charted as “AS”. These procedure codes must be referenced in the patient’s file for record retention and review. Patient records must be kept for a minimum of 10 years after the end of the termination of the State or Client contract.

Refer to the Quality Management, Credentialing and Utilization Management Section of the Provider Manual for more information.

Important Notice for Submitting Paper Authorizations and Claims

All Claims need to be submitted on a current approved ADA form.
All other forms will not be accepted and will result in a rejection of the Claim or Authorization request.

Please contact Provider Services at **1-855-343-7401** if you have questions. If you are in need of the current forms, please visit the ADA website at **www.ada.org** for ordering information.

Corrected Claims

Providers may make corrections to incorrectly submitted claims during the timely filing period. For a claim to be treated as a corrected claim, it must be submitted within the timely filing, or within 60 days from the last adverse action/denial.

- The corrected claim must clearly state the word “Corrected” in box 35 along with the claim number of the claim you are correcting.
- The corrected claim must contain clear and accurate corrections to the erroneous information. (A resubmission of identical claims data is not considered a corrected claim. The corrected claim must include additional or different information.)
- If a claim is resubmitted for correction more than once, each must be submitted within 60 days of the adverse action on the previous submission.

DentaQuest will research the resubmission and adjudicate the corrected claim according to the resubmitted information. Once adjudicated, the corrected claim will appear on the

Provider's Explanation of Benefits (EOB) with a corresponding Processing Policy outlining the reason for denial.

Corrected Claim Submission Guidelines

When Should I Submit a Corrected Claim?

A Corrected Claim should ONLY be submitted when an original claim or service was PAID based upon incorrect information.

A Corrected Claim must be submitted in order for the original paid claim to be adjusted with the correct information. As part of this process, the original claim will be recouped, and a new claim will be processed in its place with any necessary changes.

On the other hand, if a claim or service was originally denied due to incorrect or missing information, or was not previously processed for payment, DO NOT submit a Corrected Claim. Denied services have no impact on Participant tooth history or service accumulators, and, as such, do not require reprocessing.

What scenarios are subject to the Corrected Claim process?

A Corrected Claim should only be submitted if the original service(s) was PAID based on incorrect information. Some examples of correction(s) that need to be made to a prior PAID claim are:

- Incorrect Provider NPI or location
- Incorrect Payee Tax ID
- Incorrect Participant
- Incorrect Procedure codes
- Services originally billed and paid at incorrect fees (including no fees)
- Services originally billed and paid without primary insurance

Corrected Claim Submission Procedure

The Plan receives dental Corrected Claims in three possible formats. These formats include:

- Electronic Corrected Claims via DentaQuest's website at **https://www.dentaquest.com/en/providers/pennsylvania**
- Electronic submission via clearinghouse
- Paper Corrected Claims via U.S. Postal Service or Fax **1-262-834-3589**

Electronic Claim Submission Utilizing Website

- Enrolled Network Providers may make corrections on original claims directly to the Plan by utilizing the "Provider" section of our website. Corrections will be allowed one time on an original dental claim when utilizing the website. If additional corrections are required after a Corrected Claim is submitted, the provider will need to submit the correction based on the most recently submitted Corrected Claim, not the original claim.
- The website will provide a message stating the claim can no longer be corrected if the provider attempts to correct the original claim more than once.

To submit Claims via the Website, log on to
https://www.dentaquest.com/en/providers/pennsylvania

If you have questions on submitting Claims or accessing the Website, please contact Provider Services at: **1-855-343-7401** or Systems Operations at: **1-800-417-7140**.

Electronic Claim Submission via Clearinghouse

Corrected Claims via Clearinghouse File will be accepted when a specific set of criteria is met to ensure the original claim can be identified. In order for a submission to be considered a Corrected Claim, it must include:

- Claim frequency code of 7 (Replacement) or 8 (Void/Cancel) in CLM05-3 element along with claim or encounter identifier in REF*F8 element
- Original claim in a paid status
- Original claim does not have previously resubmitted services or a Corrected Claim already processed
- Original claim does not have associated service adjustments or refunds

Paper Claim Submissions

All Corrected Claims must be submitted on the most current ADA claim form or other forms approved in advance by the Plan to the Corrected Claims PO Box for proper processing and include the following:

- The ADA form must be clearly noted "Corrected Claim" at the top of the form
- In the remarks field (Box 35) on the ADA form indicate the original paid encounter number and record all corrections you are requesting to be made.
    - NOTE: If all information does not fit in Box 35, please attach an outline of corrections to the claim form.
- Attach supporting documentation and send documentation in the same package with the Corrected Claim paper form
- Submit to:

AmeriHealth Caritas Pennsylvania Community HealthChoices Corrected Claims
c/o DentaQuest – Corrected Claims
P.O. Box 2906
Milwaukee, WI 53201-2906

What scenarios ARE NOT subject to the Corrected Claim process?

A Corrected Claim should not be submitted if the original claim or service(s) which are the subject of the correction were denied or were not previously submitted.
Some examples of items that are not considered claim corrections are:

- Any request to "Reprocess" a claim with no changes being made. This includes requests to reprocess a claim based on an expired existing authorization.
- Any changes being made to a claim or service that denied for any reason such as missing tooth, quad, or arch information, incorrect code, age-inappropriate code being billed, missing primary EOB, incorrect provider, etc.
- Any request to recoup a denied service. You DO NOT need to recoup a denied service as denied services are invalid and have no impact on Participant service/tooth history or accumulators.

If you received a claim or service denial due to missing/incomplete/incorrect information or you have since obtained authorization for services, please submit a new claim with the updated information per your normal claim submission channels. Timely filing limitations apply when a denied claim is being resubmitted with additional information for processing.

If you received a claim or service denial which you do not agree with, including denials for no authorization, please refer to your Provider Manual for the proper method for submitting an appeal or reprocess request.

What happens if I submit a Corrected Claim to the wrong PO Box or don't include the required documentation?

Following the above guidelines will allow you to receive payment as expediently as possible. Failure to follow these guidelines may result in unnecessary delay and/or rejection of your submission.

Please contact Provider Services at: **1-855-343-7401** if you have questions. If you are in need of the current forms, please visit the ADA website at **www.ada.org** for ordering information.

Clinical Criteria for Authorization of Routine and Emergency Treatment

A number of procedures (identified in the table below) require prior authorization before initiating treatment or retrospective review following treatment. The section following details the documentation required to obtain authorization for these procedures and the criteria used by dental reviewers for determination. Treatment may be provided if a procedure needs to be initiated under an emergency condition to relieve a patient's pain and suffering; you may provide treatment to alleviate the patient's condition. However, to receive reimbursement for the treatment, the Plan will require the same documentation be provided (with the Claim for payment) and the same criteria to be met in order to receive payment for the treatment.

The Dental Benefit Limit Exception process does not apply to Community HealthChoices Participants.

The Plan will accept requests for Community HealthChoices Participants through the Program Exception Process (1150 Administrative Waiver Process) to exceed limits for items that are currently on the fee schedule if the limits are not based in statute or regulation and for items or services which are included in the Participant's benefit package but are not currently listed on the Medical Assistance (MA) program fee schedule.

Dental Services Requiring Prior Authorization or Retrospective Review

Code	Description
D2710	Crown - resin
D2721	Crown - resin cast base metal
D2740	Crown - porcelain/ceramic
D2751	Crown - porcelain fused to metal
D2752	Crown - porcelain fused to noble metal
D2791	Crown - full cast base metal
D2952	Cast post and core in addition to crown
D2954	Prefabricated post and core in addition to crown
D3310	Endodontic therapy, anterior (excluding final restoration)
D3320	Endodontic therapy, premolar (excluding final restoration)
D3330	Endodontic therapy, molar (excluding final restoration)
D3471	Surgical repair of root resorption - anterior
D3472	Surgical repair of root resorption - premolar
D3473	Surgical repair of root resorption - molar
D3501	Surgical exposure of root surface without apico or repair of root resorption

D3502	Surgical exposure of root surface without apico or repair of root resorption
D3503	Surgical exposure of root surface without apico or repair of root resorption
D3921	Decoronation or submergence of an erupted tooth
D4210	Gingivectomy or gingivoplasty – 4 or more contiguous teeth/quad
D4341	Perio scaling & root planing - 4 or more teeth/quad
D4342	Perio scaling and root planing 1-3 teeth/quad
D5110	Complete denture - maxillary
D5120	Complete denture - mandibular
D5130	Immediate denture - maxillary
D5140	Immediate denture - mandibular
D5211	Maxillary partial denture – resin base
D5212	Mandibular partial denture – resin base
D5213	Maxillary partial denture - cast metal framework
D5214	Mandibular partial denture – cast metal framework
D7220	Removal of impacted tooth – soft tissue
D7230	Removal of impacted tooth - partially bony
D7240	Removal of impacted tooth - completely bony
D7250	Surgical removal of residual roots
D7260	Oroantral fistula closure
D7270	Tooth reimplantation and/or stabilization
D7280	Exposure of an unerupted tooth
D7283	Placement of device to facilitate eruption
D7320	Alveoloplasty without extractions
D7450*	Removal of benign odontogenic cyst or tumor - diameter up to 1.25 cm
D7451*	Removal of benign odontogenic cyst or tumor - diameter greater than 1.25
D7460*	Removal of benign nonodontogenic cyst or tumor - diameter up to 1.25 cm
D7461*	Removal of benign nonodontogenic cyst or tumor - diameter greater than
D7510	Incision and drainage of abscess-intraoral soft tissue
D7511	Incision and drainage of abscess-intraoral soft tissue - complicated
D7520	Incision and drainage of abscess-extraoral soft tissue
D7521	Incision and drainage of abscess-extraoral soft tissue - complicated
D7871	Non-arthroscopic lysis and lavage
D7962	Lingual frenectomy
D7970	Excision of hyperplastic tissue
D7999	Unspecified oral surgery procedure
D8080	Comprehensive orthodontic treatment of the adolescent dentition
D8210	Removable appliance therapy
D8220	Fixed appliance therapy
D8670	Periodic orthodontic treatment visit
D8680	Orthodontic retention
D8703	Replacement lost/broken retainer maxillary
D8704	Replacement lost/broken retainer mandibular
D9222	Deep sedation/general anesthesia – first 15 minutes
D9223**	Deep sedation/general anesthesia – each subsequent 15 minute increment
D9239	Intravenous moderate sedation/analgesia – first 15 minutes
D9243**	Intravenous moderate sedation/analgesia – each subsequent 15 minute
D9248	Non-intravenous conscious sedation
D9930	Treatment of complications (post surgical)
D9947	Custom sleep apnea device fabrication and placement

D9999	Unspecified adjunctive procedcure, by report

*Please submit pathology report with claim and please utilize retrospective authorization process.
**Please submit completed anethesia log with claim for restrospective authorizations.

Crowns (D2710, D2721, D2740, D2751, D2752, D2791)

Required documentation – Periapical radiograph showing the root and crown of the natural tooth. Non-abutment teeth: Current periapical radiographs of the tooth/teeth to be crowned. Abutment teeth: Current periapical radiographs of the tooth/teeth and panoramic or full mouth are needed for evaluation.

All criteria below must be met:

- Tooth to be crowned must have an opposing tooth in occlusion or be an abutment tooth for a partial denture
- Minimum 50% bone support
- The patient must be free of active/advanced periodontal disease
- No subosseous and/or furcation carious involvement
- No periodontal furcation lesion or furcation involvement
- Clinically acceptable RCT if present and all the criteria below must be met:
    1. The tooth is filled within two millimeters of the radiographic apex
    2. The root canal is not filled beyond the radiographic apex
    3. The root canal filling is adequately condensed and/or filled
    4. Healthy periapical tissue (healing PARL or no PARL)

And 1 of the criteria below must be met:

- Anterior teeth must have pathological destruction to the tooth by caries or trauma, and involve four (4) or more surfaces and at least 50% of the incisal edge
- Premolar teeth must have pathological destruction to the tooth by caries or trauma, and must involve three (3) or more surfaces and at least one (1) cusp
- Molar teeth must have pathological destruction to the tooth by caries or trauma, and must involve four (4) or more surfaces and two (2) or more cusps

Posts and cores (D2952, D2954)

Required documentation – Periapical radiograph showing the root and crown of the natural tooth. All criteria below must be met:

- Minimum 50% bone support
- The patient must be free of active/advanced periodontal disease

- No subosseous and/or furcation carious involvement
- No periodontal furcation lesion or a furcation involvement
- Clinically acceptable RCT if present and all the criteria below must be met:
  1. The tooth is filled within two millimeters of the radiographic apex
  2. The root canal is not filled beyond the radiographic apex
  3. The root canal filling is adequately condensed and/or filled
  4. Healthy periapical tissue (healing PARL or no PARL)

Root canal therapy (D3310, D3320, D3330)

Required documentation – Pre-operative periapical radiograph showing the crown and entire root of the tooth
All criteria below must be met:

- Minimum 50% bone support
- The patient must be free of active/advanced periodontal disease
- No subosseous and/or furcation carious involvement
- No periodontal furcation lesion and/or a furcation involvement
- Closed apex
- Tooth must be crucial to arch/occlusion

And 1 of the criteria below must be met if absence of decay or large restoration on the radiograph

- Evidence of apical pathology/fistula
- Narrative describing symptoms of irreversible pulpitis

Surgical Repair of Root Resorption (D3471, D3472, D3473)

Required documentation – pre-operative radiographs of adjacent and opposing teeth
All criteria below must be met:

- Minimum 50% bone support
- History of RCT
- Apical pathology
- The patient must be free of active/advanced periodontal disease
- No periodontal furcation lesion and/or furcation involvement

Surgical exposure of root surface without apicoectomy (D3501, D3502, D3503)

Required documentation – pre-operative radiographs of adjacent and opposing teeth
All criteria below must be met:

- History of pain or discomfort which could not be diagnosed from clinical evaluation or radiographic images
- Minimum 50% bone support
- The patient must be free of active/advanced periodontal disease
- No periodontal furcation lesion and/or furcation involvement
- Tooth must be crucial to arch/occlusion

Decoronation or submergence of an erupted tooth (D3921)

Required documentation – pre-operative periapical radiographs, narrative of medical necessity inclusive of restorative treatment plan for arch(es) of adjacent and opposing teeth
All criteria must be met:

- Clinically acceptable root canal therapy
- The patient must be free of active/advanced periodontal disease
- No periodontal furcation lesion and/or furcation involvement

Gingivectomy or Gingivoplasty (D4210)

Limited to no more than four different quadrant reimbursements within a 24-month period.
Required documentation – pre-operative radiographs, perio charting, narrative of medical necessity, photo (optional)

1 of the criteria below must be met:

- Hyperplasia or hypertrophy from drug therapy, hormonal disturbances, or congenital defects
- Generalized 5 mm or more pocketing indicated on the perio charting

Periodontal scaling and root planing (D4341 and D4342)

Required documentation – periodontal charting and current diagnostic radiographs of the quadrant(s) to be treated
All criteria below must be met:

-
- Pocket depths of 5 mm or greater on 4 or more teeth (for D4341) or on 1 – 3 teeth (for D4342) indicated on the periodontal charting and:
- Presence of root surface calculus and/or noticeable loss of bone support on x-rays

Involved teeth must not have poor prognosis, require or be planned for replacement by denture and/or extraction

Complete dentures (D5110, D5120)

Required documentation – Complete series of radiograph images (D0210) or panoramic radiographic image (D0330)
The criteria below must be met:

- Remaining teeth do not have adequate bone support or are not restorable
- If a current denture exists that was not reimbursed by the Plan, it must be non-serviceable for reasons other than tooth loss

Immediate dentures (D5130, D5140)

Required documentation – complete series of radiograph images (D0210) or panoramic radiograph image (D0330)
The criteria below must be met:

- Remaining teeth do not have adequate bone support or are not restorable

Removable partial dentures (D5211, D5212, D5213, D5214)

Required documentation –Complete series of radiographic images (D0210) or panoramic radiographic image (D0330)
All criteria below must be met:

- Remaining teeth have greater than 50% bone support and are restorable

In addition, 1 of the criteria below must be met:

- Replacing one or more anterior teeth
- Replacing three or more posterior teeth (excluding 3rd molars)

Impacted teeth – (D7220, D7230, D7240)

Documentation required – Pre-operative radiographs (excluding bitewings) and narrative of medical necessity

- Documentation describes pain, swelling, etc. around tooth (symptomatic)
- X-rays match type of impaction code described
- Documentation of clinical evidence indicating impaction, although asymptomatic may not be disease free

Surgical removal of residual tooth roots (D7250)

Documentation required – Pre-operative radiographs (excluding bitewings) and narrative of medical necessity

All criteria below must be met:

- Tooth root is completely covered by bony tissue on radiograph
- Documentation describes pain, swelling, etc. around tooth (must be symptomatic)

Oroantral fistula closure (D7260)

Documentation required - Narrative of medical necessity
All criteria below must be met:

- Narrative must substantiate need due to extraction, oral infection, or sinus infection

Tooth reimplantation and/or stabilization (D7270)

Documentation required - Narrative of medical necessity
All criteria below must be met:

- Documentation describes an accident such as playground fall or bicycle injury
- Documentation describes which teeth were avulsed or loosened and treatment necessary to stabilize them through reimplantation and/or stabilization

Exposure of unerupted tooth (D7280)

Documentation required – Pre-operative radiographs and narrative of medical necessity
The criteria below must be met:

- Documentation supports impacted/unerupted tooth
- Tooth not planned for extraction

Placement of device to facilitate eruption (D7283)

Documentation required – Narrative of medical necessity
All criteria below must be met:

- Documentation describes condition preventing normal eruption
- Documentation describes device type and need for placement of device

Alveoloplasty without extractions (D7320)

Documentation required – Pre-operative radiographs (excluding bitewings) and narrative of medical necessity
The criteria below must be met:

- Documentation supports medical necessity for fabrication of a prosthesis

Removal of benign odontogenic or non-odontogenic cyst or tumor (D7450, D7451, D7460, D7461)

Documentation required – Copy of pathology report
The criteria below must be met:

- Copy of pathology report indicating lesion/tumor

Incision and drainage of abscess (D7510, D7511, D7520, D7521)

Documentation required – Narrative of medical necessity, radiographs, or photos
All criteria below must be met:

For Intraoral incision:

- Documentation describes non-vital tooth or foreign body

For extraoral incision

- Documentation describes periapical or periodontal abscess

Non-arthroscopic lysis and lavage (D7871)

Documentation required – Narrative of medical necessity, radiographs, or photos
All criteria below must be met:

- Documentation describes nature and etiology of TMJ dysfunction
- Documentation describes treatment to manage the TMJ condition

Lingual Frenectomy (D7962)

Documentation required – Narrative of medical necessity, radiographs, or photos
The criteria below must be met:

- Documentation describes tongue tied, spacing, or tissue pull condition

Excision of hyperplastic tissue (D7970)

Documentation required – Pre-operative radiographs, narrative of medical necessity, photos
The criteria below must be met:

- Documentation describes medical necessity due to ill-fitting denture

Unspecified oral surgery procedure (D7999)

Documentation required – Narrative of medical necessity and description of procedure name, license number and tax ID of Assistant surgeon required if D7999 is submitted for this purpose

Fixed or removable appliance therapy (D8210, D8220)

Documentation required – Panoramic and/or cephalometric radiographs, narrative of medical necessity
All criteria below must be met:

- Documentation describes thumb sucking or tongue thrusting habit
- Documentation of existing clinical condition or circumstance making the use of minor orthodontic treatment to control harmful habits a reasonable inclusion as a medically necessary part of the therapeutic regimen

Comprehensive orthodontic services (D8080)

Documentation requirements – Panoramic and/or cephalometric radiographs, 5-7 diagnostic quality photos, completed Salzmann Criteria Index Form
All criteria below must be met:

- Documentation supports Salzmann Criteria Index Form score of 25 points or greater when the case is evaluated using the Salzmann Index
- A full permanent dentition is present, with no primary teeth present (except for primary teeth where there is no permanent succedaneous tooth)
- Dentition must be free of carious lesions
- Patient must demonstrate the ability to maintain adequate oral hygiene

Periodic orthodontic treatment visit (D8670)

Documentation requirements – Completed AmeriHealth Caritas PA CHC Orthodontic Continuation of Care form. Photos of current orthodontic status.

The criteria below must be met:

- Ongoing active comprehensive orthodontic treatment

Orthodontic Retention (D8680)

Documentation required – diagnostic quality photos
All criteria below must be met:

- Photos demonstrate malocclusion was corrected through comprehensive orthodontic treatment

Replacement of lost or broken retainer – Maxillary/Mandibular (D8703/D8704)

Documentation requirements – narrative/evidence of previous lost/broken D8680

General anesthesia/IV sedation (Dental Office Setting) - (D9222, D9223, D9239, D9243)

Documentation required – Narrative of medical necessity, anesthesia log (retrospective review)
1 of the criteria below must be met:

- Extractions of impacted or unerupted cuspids or wisdom teeth or surgical exposure of unerupted cuspids
- 2 or more extractions in 2 or more quadrants
- 4 or more extractions in 1 quadrant
- Excision of lesions greater than 1.25 cm
- Surgical recovery from the maxillary antrum
- Documentation of failed local anesthesia
- Documentation of situational anxiety
- Documentation and narrative of medical necessity supported by submitted medical records (cardiac, cerebral palsy, epilepsy, MR, or other condition that would render patient noncompliant)
- Documentation of existing clinical condition or circumstance making the use of general anesthesia/IV sedation a reasonable inclusion as a Medically Necessary part of the therapeutic regimen

Note that D9222/D9223/D9243/D9239 may be prior authorized as described above and may be retrospectively authorized (with anesthesia log required).

Non-intravenous conscious sedation (Dental Office Setting) (D9248)

Documentation required – Narrative of medical necessity and 1 of the criteria below must be met:

- Extractions of impacted or unerupted cuspids or wisdom teeth or surgical exposure of unerupted cuspids
- 2 or more extractions in 2 or more quadrants
- 4 or more extractions in 1 quadrant
- Excision of lesions greater than 1.25 cm

- Surgical recovery from the maxillary antrum
- Documentation of failed local anesthesia
- Documentation of situational anxiety
- Documentation and narrative of medical necessity supported by submitted medical records (cardiac, cerebral palsy, epilepsy, MR, or other condition that would render patient noncompliant)
- Documentation of existing clinical condition or circumstance making the use of non-intravenous conscious sedation a reasonable inclusion as a Medically Necessary part of the therapeutic regimen

Treatment of complications (post-surgical) – (D9930)

Documentation required – Narrative of medical necessity

- Documentation describes post-surgical condition supporting medical necessity for procedure

Custom sleep apnea appliance fabrication and placement – (D9947)

Documentation requirements:

- Lab Rx for custom appliance with Participant's name
- Letter of Medical Necessity (LOMN) from physician containing clinical criteria listed below

Clinical Criteria:

LOMN from physician describing that all of the following took place within the past 12 months of request for authorization:

- Diagnosis of obstructive sleep apnea (G47.33)
- Face-to-face evaluation of Participant by physician
- Patient attended a facility based polysomnogram or approved home sleep test
- Sleep study results demonstrated API Apnea-hypopnea Index or RDI Respiratory Disturbance Index of 5 or more events per hour
    - If between 5 and 14 events per hour, patient must have one or more of the following systems or findings:
        - Hypertension (HTN)
        - History of stroke
        - Ischemic heart disease
        - Excessive daytime sleepiness
        - Impaired cognition
        - Mood disorder
        - Insomnia

        - Other clinical information (add comment)

And 1 of the following:

- Positive airway pressure history of contraindication – skin irritation, claustrophobia or noise generated by the machine
- Positive airway pressure history of non-tolerance
- Other clinical information (add comment)

Dental Benefit Grid
Procedure Codes and Eligibility Criteria

		Authorization Requirements				Benefit Details					
Code	**Code Description**	**Auth Reqd**	**Age Min**	**Age Max**	**Req Docs**	**Reporting Require-**	**Age Min**	**Age Max**	**Max Count**	**Period Length**	**Period Type**
D0120	Periodic oral Evaluation – established patient	No				N	0	999	1	180	Days per patient per provider
D0140	Limited oral evaluation-problem focused	No				N	0	999	1	1	Days per patient (audio or video teledentistry allowed; pt initiated by call in to office for POS 02)
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No				N	0	2	1	180	Days 1 per patient
D0150	Comprehensive oral evaluation – new or established patient	No				N	0	999	1	1	Once per lifetime Per patient per dentist/dental group
D0160	Detailed and Extensive Oral Evaluation, by report	No			Detailed and extensive oral eval at a Cleft Palate Clinic Only	N	0	999	1	1	Day per provider (complete initial examination at a cleft palate clinic only)

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Code	**Code Description**	**Auth Reqd**	**Age Min**	**Age Max**	**Req Docs**	**Reporting Require-**	**Age Min**	**Age Max**	**Max Count**	**Period Length**	**Period Type**
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No			Re-eval – established cleft palate patient at a Cleft Palate Clinic only-	N	0	999	1	1	Day per patient (cleft palate clinic only)
D0190	Screening of a patient	No				N	0	999	1	1	Year per patient. Not allowed on same DOS as D0120, D0140, D0145, D0150. Only allowed at POS 27
D0191	Assessment of a patient	No				N	0	999	1	1	Year per patient. Not allowed on same DOS as D0120, D0140, D0145, D0150. Only allowed at POS 27
D0210	Intraoral – comprehensive series of radiographic images	No				N	0	999	1	5	Year per patient
D0220	Intraoral - periapical first radiographic image	No				N	0	999	1	1	Day per patient

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D0230	Intraoral – periapical each additional radiographic image	No				N	0	999	10	1	Day per patient
D0240	Intraoral – occlusal radiographic image	No				N	0	999	2	1	Day per patient
D0250	Extra oral 2-D radiographic image created using a stationary radiation source, and detector	No				N	0	999	1	1	Day per patient
D0251	Extra-oral posterior dental radiographic image	No				N	0	999	10	1	Day per patient
D0270	Bitewing – single radiographic image	No				N	0	999	1	1	Day per patient
D0272	Bitewings – two radiographic images	No				N	0	999	1	1	Day per patient
D0273	Bitewings – three radiographic images	No				N	0	999	1	1	Day per patient

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D0274	Bitewings – four radiographic images	No				N	0	999	1	1	Day per patient
D0330	Panoramic radiographic image	No				N	0	999	1	5	Year per patient
D0340	2D Cephalometric radiographic image	No				N	0	20	1	1	Day per patient
D1110	Prophylaxis-adult	No				N	12	999	1	180	Days per patient
D1120	Prophylaxis - child	No				N	0	11	1	180	Days per patient
D1206	Topical application of Fluoride varnish	No				N	0	20	6	1	Year per patient (teledentistry POS 02,10)
D1208	Topical application of Fluoride – excluding varnish	No				N	0	20	1	180	Days per patient
D1310	Nutritional counseling for control of dental disease	No				N	0	999	1	180	Days per patient (teledentistry POS 02,10)

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D1320	Tobacco counseling for the control and prevention of oral disease	No				N	0	999	1(D1320 or D1321 or 99407)	1	Day per patient (teledentistry allowed POS 02,10)
D1320	Tobacco counseling for the control and prevention of oral disease	No				N	0	999	70(D1320 or D1321 or 99407)	1	Year per patient (teledentistry allowed POS 02,10)
D1321	Counseling for the control and prevention of adverse oral behavioral and system health effects associated with high-risk substance abuse	No				N	0	999	1(D1320 or D1321 or 99407)	1	Day per patient
D1321	Counseling for the control and prevention of adverse oral behavioral and system health effects associated with high-risk substance abuse	No				N	0	999	70(D1320 or D1321 or 99407)	1	Year per patient

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D1330	Oral hygiene instructions	No				N	0	999	1	180	Days per patient (teledentistry POS 02,10)
D1351	Sealant per tooth	No				T	0	20	1	1	Lifetime per patient Allowed on 1st and 2nd premolars,1st and 2nd molars, and on 1st and 2nd molars where a buccal restoration might exist
D1354	Application of caries arresting medicament – per tooth Silver Diamine Fluoride	No				T	0	999	10 teeth	1	Dayper patient
D1354	Application of caries arresting medicament – per tooth Silver Diamine Fluoride	No				T	0	999	4	1	Year per tooth per patient)
D1354	Application of caries arresting medicament – per tooth Silver Diamine Fluoride	No				T	0	999	6	1	Lifteime per tooth per patient

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D1510	Space maintainer – fixed, unilateral, per quad	No				Q	0	20	4	1	1 appliance per quad per Lifetime
D1516	Space maintainer – fixed,bilateral, max	No				T	0	20	1	1	1 appliance per arch per Lifetime
D1517	Space maintainer – fixed, bilateral, man	No				T	0	20	1	1	1 appliance per arch per Lifetime
D1551	Re-cement or re-bond bilateral space maintainer - max	No				N	0	20	1	1	Day appliance per patient
D1552	Re-cement or re-bond bilateral space maintainer - man	No				N	0	20	1	1	Day appliance per patient
D1553	Re-cement or re-bond unilateral space maintainer – per quad	No				N	0	20	4	1	Day appliance per patient
D1556	Removal of fixed unilateral space maintainer – per quad	No				N	0	20	4	1	Day appliance per patient

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D1557	Removal of fixed bilateral space maintainer – max	No				N	0	20	1	1	Day appliance per patient
D1558	Removal of fixed bilateral space maintainer – man	No				N	0	20	1	1	Day appliance per patient
D2140	Amalgam - one surface, primary or permanent	No				T	0	999	1	1	Day per patient. No reimbursement if performed within 30 days of a crown.
D2150	Amalgam – two surfaces, primary or permanent	No				T	0	999	1	1	Day per patient. No reimbursement if performed within 30 days of a crown.
D2160	Amalgam - three surfaces, primary or permanent	No				T	0	999	1	1	Day per patient. No reimbursement if performed within 30 days of a crown.
D2161	Amalgam - four surfaces, primary or permanent	No				T	0	999	1	1	Day per patient. No reimbursement if performed within 30 days of a crown.

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D2330	Resin-based composite -1 surface, anterior	No				T	0	999	1	1	Day per patient. No reimbursement if performed within 30 days of a crown.
D2331	Resin-based composite – 2 surfaces, anterior	No				T	0	999	1	1	Day per patient. No reimbursement if performed within 30 days of a crown.
D2332	Resin-based composite - 3 surfaces,anterior	No				T	0	999	1	1	Day per patient. No reimbursement if performed within 30 days of a crown.
D2335	Resin-based composite - 4+ surfaces or involving incisal angle (anterior)	No				T	0	999	1	1	Day per patient. No reimbursement if performed within 30 days of a crown.
D2390	Resin-based composite crown - anterior	No				T	0	20	1	1	Day per patient. No reimbursement if performed within 30 days of a crown.

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D2391	Resin-based composite - 1 surface posterior	No				T	0	999	1	1	Day per patient. No reimbursement if performed within 30 days of a crown.
D2392	Resin-based composite - 2 surfaces posterior	No				T	0	999	1	1	Day per patient. No reimbursement if performed within 30 days of a crown.
D2393	Resin-based composite - 3 surfaces posterior	No				T	0	999	1	1	Day per patient. No reimbursement if performed within 30 days of a crown.
D2394	Resin-based composite - 4+ surf, posterior	No				T	0	999	1	1	Day per patient. No reimbursement if performed within 30 days of a crown.
D2710	Crown – resin-based composite (indirect)	Yes	0	999	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity	T	0	999	1	3	Year per patient

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D2721	Crown-resin with predominantly base metal	Yes	0	999	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity	T	0	999	1	5	Year per patient- 1 per tooth every 5 years regardless of crown procedure code
D2740	Crown-porcelain/ceramic	Yes	0	999	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity	T	0	999	1	5	Year per patient - 1 per tooth every 5 years regardless of crown procedure code
D2751	Crown-porcelain fused to predominantly base metal	Yes	0	999	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity	T	0	999	1	5	Year per patient - 1 per tooth every 5 years regardless of crown procedure code
D2752	Crown-porcelain fused to noble metal	Yes	0	999	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity	T	0	999	1	5	Year per patient - 1 per tooth every 5 years regardless of crown procedure code.

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D2791	Crown - full cast predominantly base metal	Yes	0	999	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity	T	0	999	1	5	Year per patient - 1 per tooth every 5 years regardless of crown procedure code
D2910	Recement or rebond inlay, onlay, veneer or partial coverage restoration	No				T	0	999	1	1	Day per tooth per patient
D2915	Recement or rebond indirectly fabricated or prefabricated post and core	No				T	0	999	1	1	Day per tooth per patient
D2920	Recement or rebond crown	No				T	0	999	1	1	Day per tooth per patient
D2929	Prefabricated porcelain or ceramic crown placed on a primary tooth	No				T	0	20	1	1	Day per tooth per patient (C-H, M-R only)

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D2930	Prefabricated Stainless Steel Crown - primary tooth	No				T	0	20	1	1	Day per tooth per patient
D2931	Prefabricated Stainless Steel Crown - permanent tooth	No				T	0	20	1	1	Day per tooth per patient
D2932	Prefabricated resin crown	No				T	0	20	1	1	Day per tooth per patient
D2933	Prefabricated stainless steel crown with resin window	No				T	0	20	1	1	Day per tooth per patient
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	No				T	0	20	1	1	Day per tooth per patient

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D2952	Post and core, in addition to crown, indirectly fabricated	Yes	0	999	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity	T	0	999	1	1	Per day/per tooth/per patient
D2954	Prefabricated post and core in addition to crown	Yes	0	999	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity	T	0	999	1	1	Per day/per tooth/per patient
D2980	Crown repair necessitated by restorative material failure	No				T	0	999	1	1	Per day/per tooth/per patient
D2991	Application of hydroxyappetite regeneration medicament – per tooth	No			N	T	0	999	1	1	Lifetime per tooth per patient. Not allowed if tooth was previously restored (D2140-D2161, D2391-D2394, D2330-D2335)

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D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	No				T	0	20	6	1	Per day/per tooth/per patient
D3230	Pulpal therapy (resorbable filling) anterior, primary tooth (excluding final restoration)	No				T	0	20	1	1	Per day/per tooth/per patient
D3240	Pulpal therapy (resorbable filling) posterior, primary tooth (excluding final restoration)	No				T	0	20	1	1	Per day/per tooth/per patient

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D3310	Endodontic therapy, anterior tooth (excluding final restoration)	Yes	0	999	Pre-operative x-rays (excluding bitewings), Narrative of medical necessity	T	0	999	1	1	Lifetime per tooth
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	Yes	0	999	Pre-operative x-rays (excluding bitewings). Narrative of medical necessity	T	0	999	1	1	Lifetime per tooth
D3330	Endodontic therapy, Molar tooth (excluding final restoration)	Yes	0	999	Pre-operative x-rays (excluding bitewings), narrative of medical necessity	T	0	999	1	1	Lifetime per tooth
D3410	Apicoectomy - anterior	No				T	0	999	2 teeth	1	Day per tooth per patient
D3421	Apicoectomy - premolar (first root)	No				T	0	999	2 teeth	1	Day per tooth per patient

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D3425	Apicoectomy - molar (first root)	No				T	0	999	2 teeth	1	Day per tooth per patient
D3426	Apicoectomy each additional root	No				T	0	999	2 teeth	1	Day per tooth per patient
D3471	Surgical repair of root resorption - anterior	Yes	0	999	Pre-operative x-rays excluding bitewings. Narrative of medical necessity	T	0	999	1	1	Lifetime per tooth
D3472	Surgical repair of root resorption - premolar	Yes	0	999	Pre-operative x-rays excluding bitewings. Narrative of medical necessity	T	0	999	1	1	Lifetime per tooth
D3473	Surgical repair of root resorption - molar	Yes	0	999	Pre-operative x-rays excluding bitewings. Narrative of medical necessity	T	0	999	1	1	Lifetime per tooth

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D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior	Yes	0	999	Pre-operative x-rays excluding bitewings. Narrative of medical necessity	T	0	999	1	1	Lifetime per tooth
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar	Yes	0	999	Pre-operative x-rays excluding bitewings. Narrative of medical necessity	T	0	999	1	1	Lifetime per tooth
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption - molar	Yes	0	999	Pre-operative x-rays excluding bitewings. Narrative of medical necessity	T	0	999	1	1	Lifetime per tooth

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		Authorization Requirements				Benefit Details					
Code	**Code Description**	**Auth Reqd**	**Age Min**	**Age Max**	**Req Docs**	**Reporting Require-**	**Age Min**	**Age Max**	**Max Count**	**Period Length**	**Period Type**
D3921	Decoronation or submergence of an erupted tooth	Yes	0	999	Post operative x-rays (excluding bitewings), narrative of medical necessity inclusive of restorative treatment plan for arch(es)	T	0	999	1	1	Lifetime per tooth
D4210	Gingivectomy or Gingivoplast – four or more contiguous teeth or tooth bounded spaces per quadrant	Yes	0	999	Pre-op x-rays and periodontal charting. Narrative of medical necessity, Photo (optional)	Q	0	999	4 (different quadrants)	24	Months per patient
D4341	Periodontal scaling & root planing – four or more teeth per quadrant	Yes	0	999	Periodontal charting and pre- op x-rays. Narrative of medical necessity	Q	0	999	2 different quadrants	1	Day per patient

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D4341	Periodontal scaling & root Planing – four or more teeth per quadrant	Yes	0	999	Periodontal charting and pre- op x-rays. Narrative of medical necessity	Q	0	999	4 different quadrants inclusive of D4342	24	Months per patient
D4342	Periodontal scaling & root planing - 1 to 3 teeth per quadrant	Yes	0	999	Periodontal charting and pre- op x-rays. Narrative of medical necessity	Q	0	999	4(different quadrants)	1	Day per patient
D4342	Periodontal scaling & root planing - 1 to 3 teeth per quadrant	Yes	0	999	Periodontal charting and pre- op x-rays. Narrative o medical necessity	Q	0	999	4 (different quadrants)	24	Months per patient
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	No				N	0	999	1	1	Year per patient; no history of prophylaxis or periodontal treatment in past 12 months

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D4346	Scaling in the presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	No				N	0	999		180	Days per patient
D4910	Periodontal maintenance	No				N	0	999		90	Days per patient
D5110	Complete denture - maxillary	Yes	0	999	Full mouth or panorex x-rays, Narrative of medical necessity)	N	0	999	1	5	Years per arch per patient - limited to one (full or partial denture) per arch, regardless of procedure (D5110, D5130, D5211, D5213) and one (full or partial denture) per lower arch, regardless of procedure code (D5120, D5140, D5212, D5214) every 5 years

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D5120	Complete denture - mandibular	Yes	0	999	Full mouth or panorex x-rays, Narrative of medical necessity	N	0	999	1	5	Years per arch per patient - limited to one (full or partial denture) per arch, regardless of procedure (D5110, D5130, D5211, D5213) and one (full or partial denture) per lower arch, regardless of procedure code (D5120, D5140, D5212, D5214) every 5 years
D5130	Immediate denture - maxillary	Yes	0	999	Full mouth or panorex x-rays, Narrative of medical necessity	N	0	999	1	1	Lifetime appliance per arch per patient - limited to one (full or partial denture) per arch, regardless of procedure (D5110, D5130, D5211, D5213) and one (full or partial denture) per lower arch, regardless of procedure code (D5120, D5140, D5212, D5214)

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D5140	Immediate denture - mandibular	Yes	0	999	Full mouth or panorex x-rays, Narrative of medical necessity	N	0	999	1	1	Lifetime appliance per arch per patient - limited to one (full or partial denture) per arch, regardless of procedure (D5110, D5130, D5211, D5213) and one (full or partial denture) per lower arch, regardless of procedure code (D5120, D5140, D5212, D5214).
D5211	Maxillary partial denture -resin base (including retentive clasping materials, rests, and teeth)	Yes	6	999	Full mouth or panorex x-rays, Narrative of medical necessity	N	6	999	1	5	Years per arch per patient -limited to one (full or partial denture) per arch, regardless of procedure (D5110, D5130, D5211, D5213) and one (full or partial denture) per lower arch, regardless of procedure code (D5120, D5140, D5212, D5214) every 5 years

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D5212	Mandibular partialdenture – resin base (including retentive/clasping materials, rests, and teeth)	Yes	6	999	Full mouth or panorex x-rays, Narrative of medical necessity	N	6	999	1	5	Years per arch per patient -limited to one (full or partial denture) per arch, regardless of procedure (D5110, D5130, D5211, D5213) and one (full or partial denture) per lower arch, regardless of procedure code (D5120, D5140, D5212, D5214) every 5 years
D5213	Maxillary partial denture - cast metal framework with resin denture base (including retentive/clasping materials, rests, and teeth)	Yes	6	999	Full mouth or panorex x-rays, Narrative of medical necessity	N	6	999	1	5	Years per arch per patient -limited to one (full or partial denture) per arch, regardless of procedure (D5110, D5130, D5211, D5213) and one (full or partial denture) per lower arch, regardless of procedure code (D5120, D5140, D5212, D5214) every 5 years

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D5214	Mandibular partialdenture - cast metal framework with resin denture base (including retentive/clasping materials, rests, and teeth	Yes	6	999	Full mouth or panorex x-rays. Narrative of medical necessity	N	6	999	1	5	Years per arch per patient -limited to one (full or partial denture) per arch, regardless of procedure (D5110, D5130, D5211, D5213) and one (full or partial denture) per lower arch, regardless of procedure code (D5120, D5140, D5212, D5214) every 5 years
D5410	Adjust complete denture - maxillary	No				N	0	999	1	1	Day per patient adjustments are included in the fee for the denture through180 days post insertion

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D5411	Adjust complete denture - mandibular	No				N	0	999	1	1	Day per patient adjustments are included in the fee for the denture through 180 days post insertion
D5421	Adustj partial denture -maxillary	No				N	0	999	1	1	Day per patient adjustments are included in the fee for the denture through 180 days post insertion
D5422	Adjust partial denture - mandibular	No				N	0	999	1	1	Day per patient adjustments are included in the fee for the denture through 180 days post insertion
D5511	Repair complete broken denture base mandibular	No				N	6	999	1	1	Day per patient
D5512	Repair complete broken denture base maxillary	No				N	6	999	1	1	Day per patient

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D5520	Replace teeth-dent/per	No				T	0	999	3	1	Day per patient
D5611	Repair resin partial denture base mandibular	No				N	0	999	1	1	Day per patient
D5612	Repair resin partial denture base maxillary	No				N	0	999	1	1	Day per patient
D5621	Repair cast partial framework - mandibular	No				N	0	999	1	1	Day per patient
D5622	Repair cast partial framework - maxillary	No				N	0	999	1	1	Day per patient
D5630	Repair or replace broken retentive/clasping materials – per tooth	No				T	0	999	1 clasp per tooth	1	Day per patient
D5630	Repair or replace broken retentive/clasping materials – per tooth	No				T	0	999	4 clasps	1	Year per patient
D5640	Replace broken teeth - per tooth	No				T	0	999	3 teeth	1	Day per patient

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D5650	Add tooth to existing partial denture	No				T	0	999	2 teeth	1	Day per patient
D5660	Add clasp to existing partial denture – per tooth	No				T	0	999	1 PER TOOTH	1	Lifetime per patient
D5730	Reline complete maxillary denture (direct)	No				N	0	999	1	2	Year - relines are included in the fee for the denture through 180 days post insertion
D5731	Reline complete mandibulardenture (direct)	No				N	0	999	1(per arch)	2	Year - relines are included in the fee for the denture through 180 days post insertion
D5740	Reline maxillary partial Denture (direct)	No				N	0	999	1(per arch)	2	Year - relines are included in the fee for the denture through180 days post insertion

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D5741	Reline mandibular partial denture (direct)	No				N	0	999	1(per arch)	2	Year - relines are included in the fee for the denture through 180 days post insertion
D5750	Reline complete maxillary denture (indirect)	No				N	0	999	1(per arch)	2	Year - relines are included in the fee for the denture through 180 days post insertion
D5751	Reline complete Mandibular denture (indirect)	No				N	0	999	1(per arch)	2	Year -relines are included in the fee for the denture through 180 days post insertion
D5760	Reline maxillary partial denture (indirect)	No				N	0	999	1(per arch)	2	Year - relines are Included in the fee for the denture through 180 days post insertion
D5761	Reline mandibular partial denture (indirect)	No				N	0	999	1(per arch)	2	Year - relines are included in the fee for the denture through 180 days post insertion
D6930	Recement or rebond fixed partial denture	No				N	0	999	1	1	Day per patient

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D6980	Fixed partial denture repair necessitated by restorative material failure	No				Q	0	999	1	1	Day per patient
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No				T	0	999	1 per tooth	1	Lifetime per patient
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	No				T	0	999	1 per tooth	1	Lifetime per patient
D7220	Removal of impactedtooth – soft tissue	Yes	0	999	Pre-operative x-rays (excluding bitewings) and narrative of medical necessity	T	0	999	1 per tooth	1	Lifetime per patient

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D7230	Removal of impacted tooth - partially bony	Yes	0	999	Pre-operative x-rays (excluding bitewings) and narrative of medical necessity	T	0	999	1 per tooth	1	Lifetime per patient
D7240	Removal of impacted tooth– completely bony	Yes	0	999	Pre-operative x-rays (excluding bitewings) and narrative of medical necessity	T	0	999	1 per tooth	1	Lifetime per patient
D7250	Removal of residual tooth roots (cutting procedure)	Yes	0	999	Pre-operative x-rays (excluding bitewings) and narrative of medical necessity	T	0	999	1 per tooth	1	Lifetime per patient
D7260	Oroantral fistula closure	Yes	0	999	Narrative of medical necessity	N	0	999	1	1	Day per patient

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D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	Yes	0	20	Narrative of medical necessity	T	0	20	1 per tooth	1	Day per patient
D7280	Exposure of unerupted tooth	Yes	0	22	Pre-operative x-rays	T	0	22	1 per tooth	1	Lifetime per patient
D7283	Placement of device to facilitate eruption of impacted tooth	Yes	0	22	x-rays (excluding bitewings)	T	0	22	1 per tooth	1	Day per patient
D7288	Brush biopsy - transepithelial sample collection	No				N	0	999	2	1	Day per patient
D7310	Alveoloplasty in conjunction with extractions – 4 or more teeth or tooth spaces, per quadrant	No				Q	0	999	1 per quadrant)	1	Day per patient

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D7320	Alveoloplasty not in conjunction with extractions – 4 or more teeth or tooth spaces perquadrant	Yes	0	999	Pre-operative x-rays (excluding bitewings) and narrative of medical necessity	Q	0	999	1 per quadrant	1	Day per patient
D7450	Removal of benign odontogenic cyst or tumor-lesion diameter up to 1.25cm	Yes	0	999	Copy of pathology report	N	0	999	2 lesions	1	Day per patient
D7451	Removal of benign odontogenic cyst or tumor-lesion diameter greater than 1.25cm	Yes	0	999	Copy of pathology report	N	0	999	2 lesions	1	Day per patient
D7460	Removal of benign non- odontogenic cyst or tumor-lesion diameter up to 1.25cm	Yes	0	999	Copy of pathology report	N	0	999	2 lesions	1	Day per patient
D7461	Removal of benign non- odontogenic cyst or tumor-lesion diameter greater than 1.25cm	Yes	0	999	Copy of pathology report	N	0	999	2 lesions	1	Day per patient

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D7471	Removal of lateral exostosis – maxilla or mandible	No				A	0	999	2	1	Day per patient
D7472	Removal of torus palatinus	No				N	0	999	2	1	Day per patient
D7473	Removal of torus mandibularis	No				N	0	999	2	1	Day per patient
D7485	Reduction of osseous tuberosity	No				N	0	999	2	1	Day per patient
D7509	Marsupialization of odontogenic cyst	No				N	0	999	1	1	Day per patient
D7510	Incision and drainage of abscess intraoral soft tissue	Yes	0	999	Narrative of medical necessity, xrays or photos optional	N	0	999	2	1	Day per patient

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D7511	Incision and drainage of abscess- intraoral – complicated (includes drainage of multiple fascial spaces)	Yes	0	999	Narrative of medical necessity, xrays or photos optional	N	0	999	2	1	Day per patient
D7520	Incision and drainage of abscess extraoral soft tissue	Yes	0	999	Narrative of medical necessity, xrays or photos optional	N	0	999	2	1	Day per patient
D7521	Incision and drainage of abscess- extraoral – complicated (includes drainage of multiple fascial spaces)	Yes	0	999	Narrative of medical necessity, xrays or photos optional	N	0	999	2	1	Day per patient
D7871	Non-arthroscopic lysis and lavage	Yes	0	999	Narrative of medical necessity, x-rays or photos optional	N	0	999	1	1	Day per patient
D7961	Buccal/ labial frenectomy (frenulectomy)	No				N	0	999	2	1	Lifetime per patient

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D7962	Lingual Frenectomy (frenulectomy)	Yes	0	999	Narrative of medical necessity, xrays or photos optional	N	0	999	1	1	Lifetime per patient
D7970	Excision of hyperplastic tissue per arch	Yes	0	999	Pre-operative x- rays, narrative of medical necessity, photos optional	N	0	999	1 per arch	1	Day per patient
D7999	Unspecified oral surgery procedure, by report	Yes	0	999	Narrative of medical necessity, name, license number and tax ID of Asst surgeon	N	0	999	1	1	Day per patient
D8080	Comprehensive Orthodontic treatment of the adolescent dentition	Yes	0	20	Panorex and/or cephalometric x-rays, 5-7 diagnostic quality photos, completed Salzmann Criteria Index Form	N	0	20	1	1	Lifetime per patient

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D8660	Pre-orthodontic treatment examination to monitor growth and development	No				N	0	20	1	1	Year (per patient per provider)
D8670	Periodic orthodontic treatment visit	Yes	0	22	Panorex and /or cephalometric x-rays, 5-7 diagnostic quality photos, completed Salzman Criteria Index Form.	N	0	22	7	1	Lifetime per patient
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	Yes	0	22	evidence of successful completion of comprehensive orthodontics	N	0	22	1	1	Lifetime per patient
D8703	Replacement of lost or broken retainer - maxillary	Yes	0	22	Evidence of previous lost/broken D8680	N	0	22	1	1	Lifetime per patient

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D8704	Replacement of lost or broken retainer - mandibular	Yes	0	22	Evidence of previous lost/broken D8680	N	0	22	1	1	Lifetime per patient
D8210	Removable appliance therapy	Yes	0	20	Panoramic/cephalometric x-ray, Narr of medical necessity	N	0	20	1 per arch	1	Lifetime per patient (either D8210 or D8220)
D8220	Fixed appliance therapy	Yes	0	20	Panoramic/cephalometric x-ray, Narr of medical necessity	N	0	20	1 per arch	1	Lifetime per patient (either D8210 or D8220)
D9110	Palliative treatment of dental pain – per visit	No				N	0	999	1	1	Day per patient

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D9222	Deep sedation/general anesthesia – first 15 minutes	Yes	0	999	Narrative of medical necessity	N	0	999	1	1	Day per patient
D9223	Deep sedation/general anesthesia – each subsequent 15 minute increment	Yes	0	999	Narrative of medical necessity	N	0	999	7	1	Day per patient
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	No				N	0	20	1	1	Day per patient
D9239	Intravenous moderate (conscious)sedation/ analgesia – first 15 minutes	Yes	0	999	Narrative of medical necessity	N	0	999	1	1	Day per patient

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D9243	Intravenous moderate (conscious)sedation/ analgesia – each subsequent 15 minute increment	Yes	0	999	Narrative of medical necessity	N	0	999	7	1	Day per patient
D9248	Non-intravenous conscious sedation	Yes	0	999	Narrative of medical necessity	N	0	999	1	1	Day per patient
D9920	Behavior management fee (a visit fee for difficult to manage persons with developmental disabilities. Developmental disability- a substantial handicap having its onset before the age of 18 years of indefinite duration and attributable to neuropathy)	No				N	0	999	14	1	Day per patient

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D9920	Behavior management fee (a visit fee for difficult to manage persons with developmental disabilities. Developmental disability- a substantial handicap having its onset before the age of 18 years of indefinite duration and attributable to neuropathy)	No				N	0	999	4	1	Calendar year per patient
D9930	Treatment of complications (postsurgical) – unusual circumstances, by report	Yes	0	999	Narrative of medical necessity	N	0	999	1	1	Day per patient
D9947	Custom sleep apnea appliance fabrication and placement	Yes	0	999	Lab Rx containing Participant name, Physician letter of medical necessity containing clinical criteria	A	0	999	1	1	Lifetime per patient

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D9948	Adjustment of custom sleep apnea appliance	No				A	0	999	1	1	Day per patient at least 180 days post placement
D9949	Repair of custom sleep apnea appliance	No				A	0	999	1	1	Day per patient at least 180 days post placement
D9953	Reline custom sleep apnea appliance (indirect)	No				N	0	999	1	2	Year per patient at least 180 days post placement
D9995	Teledentistry – synchronous; real time encounter	No				N	0	999	1	1	Day per patient
D9996	Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	No				N	0	999	1	1	Day per patient

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