DELAWARE HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID & MEDICAL ASSISTANCE

DELAWARE MEDICAL ASSISTANCE PROGRAM

CHILDREN'S DENTAL PROGRAM

PROVIDER SPECIFIC POLICY MANUAL

DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF MEDICAID & MEDICAL ASSISTANCE
Delaware Medical Assistance Program

Children's Dental Program
Provider Specific Policy Manual
Revision Table

Revision Date	Sections Revised	Description
7/1/02	All	Complete manual revision to reflect changes related to the MMIS and HIPAA compliance.
8/19/04	8.1.2.1, 8.1.2.2, 8.1.2.3, 10.0, 11.0 and 12.0	CMS prohibits providers from billing Medicaid members for missed scheduled appointments. Section 8.1.2.3 is being removed since DMAP policy cannot allow providers to impose a charge to members. Local Codes are no longer used by providers when billing DMAP for dental services. Therefore, Appendix A (Section 10.0) is being removed. Also removing reference to 7/1/02 in Sections 11.0 and 12.0 since it is no longer applicable.
9/18/08	Overview	Removed obsolete wording.
2/12/09	11.0 and 12.0	Added required legal wording for use of ADA coding.
4/8/09	Prior to entering the manual	Added the required CDT end user licensing agreement as a pop-up dialogue box.
7/12/10	5.0, 5.1	Added Prior Authorization section.
10/27/10	All	Effective November 1, 2010 - Revised and updated the entire Dental Provider Policy.
1/3/11	4.1 and 8.0	Update to reflect current dental code clarification and addition of 2011 dental codes.
2/4/11	3.2.4, 3.2.3.1 and 8.0	Update to prior authorization documentation requirements for D8060 and update to the comprehensive orthodontic definition.
9/9/11	5.0, 8.0, 3.2, and 10.0	Removed the prior authorization requirement for the following codes: D2951, D2952, and D2954. D8210 and D8220 are no longer covered dental services. Updated guidance for the following codes, D7140, D7210, D7220, D7230, D7240, and D7241. Reduced age limit to 5 years old for D0330. Added billing guidance for orthodontists when member(s) lose eligibility. Updated the Interceptive Orthodontic Prior Authorization Request form to include the following requirement, a panorex and photograph.
9/21/11	8.0	Adjustments completed for accuracy based on the changes dated 09/09/2011.
12/9/11	10.0	Updated the Dental Prior Authorization Forms to reflect that DMMA is no longer receiving them via fax but rather via email.
12/13/11	3.0	Added root canal therapy guidance.
12/13/11	4.2	Updating anesthesia guidelines.
1/11/12	3.2	Clarification for interceptive orthodontics.

Revision Date	Sections Revised	Description
2/21/12	4.2	Added anesthesia guidance.
3/7/12	1.0 and 8.0	Updated policy to support the new DMAP Dental Fee schedule.
4/9/12	8.0	Updated fees in dental fee schedule effective 04/01/2012.
4/20/12	8.0	Wording clarifications made to the dental fee schedule (Codes: D5120, D5211, D5212, D5213, D5214, D5225, D5226, and D6211) to support additional detailed descriptions.
5/21/12	8.0, 9.0, 10.0	Updated the heading for Appendix A and removed Appendix B and Appendix C.
6/11/12	3.2	Updated the Orthodontic Services section.
6/11/12	4.1	Update the instructions for billing a Supernumerary tooth.
7/24/12	2.0	Updated eligibility information
7/24/12	4.0	Updated section on obtaining patient history
7/24/12	5.0	Updated prior authorization information
7/30/12	8.0	Updated rate information
8/07/12	5.0 and 8.0	Updated authorizations and Coverage Guidelines
9/12/12	8.0	Updated Sealant information at the end of the section
9/12/12	Medicaid Prior Authorization Request	Removed Prior Authorization Request Section for Interceptive Orthodontics and for Oral Surgery as Part of Orthodontic Treatment Plan as they are available on the DMAP website.
12/21/12	4.0 and 5.0	Added section 4.1.3.2 for Billing Medicaid Members with Third Party Dental Coverage and added 5.1.6 for Coordination of Dental PA's and Third Party coverage effective 1/2/2013.
1/2/13	8.0	Updated Appendix A with the 2012/2013 Codes and coverage guidelines.
4/1/13	8.0	Updated fees in dental fee schedule effective 04/01/2013.
5/30/13	4.2.2	Added language to clarify billing in a dental office.
5/30/13	4.3	Added language to introduce billing for outpatient services.
11/1/13	8.0	Updated Sealant Information
3/31/14	8.0	Updated fees in dental fee schedule effective 04/01/2014
4/1/2015	8.0	Updated fees in dental fee schedule effective 04/01/2015
4/7/2015	8.0	Updated version of the dental fee schedule effective 4/1/2015
11/01/2015	3.2.4.2 – 3.2.4.3	Updated billing codes, units, and frequency.

Revision Date	Sections Revised	Description
11/01/2015	4.1.3.5	Added language to clarify billing instructions for caries risk assessment.
11/01/2015	4.2.2	Added claims submission clarification in reference to anesthesia services. Update section numbering.
11/01/2015	5.1.3	Added additional instructions for prior authorization.
11/01/2015	7.1.4	Removed obsolete language, updated section numbering.
04/01/2016	8.0	Updated fees in dental fee schedule effective 04/01/2016.
07/01/2016	3.2.4.7	Added additional clarification for the one time reimbursement of a lost or broken retainer.
07/01/2016	4.2.2	Clarifications added regarding anesthesia services.
07/01/2016	4.3	Added clarifications and limitations regarding outpatient hospital services.
07/01/2016	5.1	Removed obsolete language as related to Prior Authorization.
07/01/2016	6.0	Removed obsolete language, reserved section numbering.
07/01/2016	7.1	Clarifications added to reimbursement section.
07/15/2016	3.2.3	Updated language from interceptive orthodontics to limited orthodontics. Clarification added for prior authorization submission.
07/15/2016	8.0	Added clarification for D8020. Prior authorization required effective August 30, 2016.
08/01/2016	Table of Contents	Added Outpatient Hospital Services and Behavior Management Sections to table of contents.
08/01/2016	4.4	Added Behavior Management policy language and billing instruction section.
11/10/2017	4.1.3.5	Added clarifications to Caries Risk Assessment Policy to align with DMES requirements.
1/31/2018	8.0	Removal of DMMA Maximum Allowable Cost, current dental fee schedules and rates have been moved to the Publication Section of the DMAP Provider Portal.
08/01/2018	3.1.1.2	Section added as required by CMS to align dental payment policies and periodicity schedule.
09/01/2018	All	Update links for Delaware Medical Assistance Portal compliance.
09/01/2018	3.2	Clarifications added for prior authorization submission.
09/01/2018	5.1	Clarifications added for prior authorization submission
09/01/2018	All	Universal change from client to member for DMES and Delaware Medical Assistance Portal compliance.
10/21/2019	8.0	Added billing codes D1516, D1517 and D9944 to Appendix A effective 1/1/2019.
10/21/2019	All	Updated links for DMES and Delaware Medical Assistance Portal Compliance.
10/21/2019	All	Removal of paper dental claim information in compliance with DMES and the Delaware Medical Assistance Portal.

Revision Date	Sections Revised	Description
10/21/2019	8.0	Updated codes D3346, D3347 and D3348 to remove limitations effective 5/1/2019.
10/21/2019	8.0	Added D0190 and D0191 effective 04/01/2019, limited to DPH providers only.
10/21/2019	8.0	Added code D1354, effective 04/01/2019.
02/21/2020	All	In compliance with the registered trademark of the American Medical Association added the ® symbol to each instance of CPT®.
10/09/2020	Universal	Manual updated to reflect name change to the 'Children's Dental Program Provider Specific Manual'.
11/23/2020	8.0	Added codes D1551, D1552, D1553, D1556, D1557, D1558, D8703, and D8704 effective 1/1/2020.
11/23/2020	8.0	Updated CDT definition for codes D1510, D5213, and 5214 effective 1/1/2020.
11/23/2020	8.0	Deleted codes D1550, D1555 and D8692 effective 11/23/2020.
11/23/2020	8.0	Added codes D2929 and D2934 effective 7/23/2020.
11/23/2020	8.0	Updated age limitation for D7960 from 14 to 20 years of age to 5 to 20 years of age effective 10/5/2020.
04/01/2021	TOC	Updated Section 8.0 Appendix A - to remove 2016/2017 language.
04/01/2021	3.1.1.3	Added language to announce DMAP's adoption of the American Academy of Pediatric Dentistry Periodicity Schedule in compliance with Delaware's EPSDT guidelines.
04/01/2021	8.0	Updated Section 8.0 Appendix A – to remove 2016/2017 language.
07/01/2021	8.0	Added codes D7961 and D7962 effective 01/01/2021. Added codes D9222 and D9239 effective 10/01/2020. Added code D9944 effective 01/01/2021.
07/01/2021	8.0	Deleted codes D7960 effective 12/31/2020. Deleted code D9940 effective 12/31/2018.
07/01/2021	8.0	Updated Section 8.0 Appendix A to align with Current Dental Terminology (CDT).
11/19/2021	4.2	Updated limitations and billing requirements for Anesthesia Services.
11/19/2021	4.3	Updated Outpatient Hospital Services to include Ambulatory Surgical Center services.
05/25/2022	3.2.3	Updated prior authorization requirements for Limited Orthodontics.
05/25/2022	8.0	Deleted billing codes D4320 and D4321 effective 12/31/2021. Added billing codes D4322 and D4323 effective 01/01/2022. Updated age limitation for D7961 and D7962 from 5 to 20 years of age to 0 to 20 years of age effective 05/01/2022. Updated D8020 prior authorization requirements.
05/26/2023	8.0	Added CDT codes D2740, D3110, D3120 effective 12/01/2022. Added CDT codes D5511 and D5512 effective 01/01/2020. Removed CDT code D5510 effective 12/31/2019.

Revision Date	Sections Revised	Description
		Updated billing requirements for CDT codes D9223 and D9243 effective 10/01/2020. Updated restrictions for CDT codes D3351, D3352, D3353 effective 03/01/2022. Updated prior authorization requirement for CDT code D0322 effective 11/01/2022.
07/01/2023	All	Universal updates to align Delaware Medicaid Enterprise System (DMES) and Delaware Medical Assistance Portal administrative language.
07/01/2023	4.3	Updated section to reflect the removal of paper claims information in compliance with DMES and electronic claims filing requirements.
12/07/2023	3.2	Updated section to reflect electronic claims filing requirements for Orthodontic Services.
12/07/2023	3.2.4	Updated section to require all prior authorization forms and supporting documentation be submitted via the DMAP Provider Portal. In addition, all models must be submitted digitally via the DMAP Provider Portal. DMMA will no longer accept mailed articulated or marked study models with wax bite.
12/20/2024	3.2.4.4	Updated section to remove premium language for the Delaware Healthy Children Program in compliance with the Delaware State Plan.
06/08/2026	1.0, 3.0, 4.0, 5.0, 7.0	Sections updated to reflect Children's Dental Benefits moving from FFS-only to a Managed Care "carve in" benefit.
06/08/2026	4.0	Section updated to reflect current CDT anesthesia codes.
06/08/2026	8.0 APPENDIX A	Added CDT codes D9246, D9247 effective 01/01/2026. Removed CDT code D9248 effective 01/01/2026.

DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF MEDICAID & MEDICAL ASSISTANCE
Delaware Medical Assistance Program

Children's Dental Program
Provider Specific Policy Manual
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Children's Dental Program Provider Specific Policy Manual

1.0 Overview

1.1 General Criteria:

The Children's Dental Program Provider Specific Policy Manual addresses covered benefits and program limitations for pediatric dental providers. This manual is to be used in conjunction with the General Policy Manual, the Dental Billing Manual, and the General Billing Manual. These manuals explain how to bill claims, member eligibility, when a member can be billed, and provider updates. Dental Providers are also encouraged to utilize the Dental Corner, which is available on the DMAP Provider Portal to access newsletters, forms and additional program guidance.

1.1.1 Dental services are covered by the Delaware Medical Assistance Program (DMAP) and are included in Managed Care coverage via the Dental Benefit Managers for children eligible for Medicaid through age 20 years and for children eligible for the Delaware Healthy Children Program (DHCP) through age 18 years. It is the provider's responsibility to verify a member's current eligibility each time a service is provided. The provider should request that the member show a current Medical Assistance card and ID for the patient or guardian to establish identity. Refer to General Policy Manual Section 3.0 Medical Assistance Card for information how to verify eligibility. Eligibility can be verified via the Delaware Medical Assistance Portal for Providers (Provider Portal) or by calling the DMAP Fiscal Agent at 1-800-999-3371, Option 1 for the automated voice response system. To speak with a provider service representative, contact the DMAP Fiscal Agent at 1-800-999-3371, Option 0, Option 2.

Managed Care Organizations (MCO) Dental Benefit Managers (DBM):

- AmeriHealth Caritas: DentaQuest
- Delaware First Health: Centene Dental Services
- Highmark Health Options: United Concordia

1.1.2 Dental providers enrolled with DMAP and contracted with a Managed Care Organization (MCO) may treat any enrolled Medicaid or DHCP child. Providers will bill the member's MCO Dental Benefit Manager or DMAP as appropriate.

Newly enrolled members will have access to dental services during a brief (30 day-60 day) fee-for-service (FFS) period prior to their enrollment in an MCO.

1.1.3 The DMAP dental fee schedule is located on the Provider Portal and also at Section 8.0 Appendix A for CDT Code Coverage Guidelines. Dental providers are only allowed to bill DMAP for services listed in the dental policy manual. If a provider does not normally charge for a service the DMAP cannot be billed for these services. Providers must bill DMAP according to their Usual & Customary charges as indicated on their fee schedule. Dental providers are not to preload the DMAP dental fee schedule or change fees to reflect the Medicaid maximum allowable charge. The DMAP does impose certain limitations and prior authorization requirements for some services. These limitations are listed next to each procedure code and may refer you to specific policy sections.

1.1.4 Exceptions to the DMAP CDT Code limitations may be approved when accompanied by documentation of medical necessity.

2.0 Eligibility

2.1 Criteria

2.1.1 Children through age 20 years who are currently covered by Medicaid and children through age 18 years covered by the DHCP are eligible to receive medically necessary dental services.

2.1.2 Non-qualified non-citizens are covered for life threatening emergency services and labor and delivery care only. On a case-by-case basis, emergency dental services for a non-qualified alien child through age 20 will be considered for payment when a true documented dental emergency has been substantiated by review by the DMAP Dental Consultant. Only the initial triage services necessary to treat the emergency condition (pain, infection, bleeding) are covered. Follow- up care is not considered to be emergency in nature. Refer to General Policy Manual Section 1.24.2, Emergency and Labor/Delivery Services Only, available on the Provider Portal.

3.0 Services

3.1 Dental Services

3.1.1 The DMAP covers medically necessary dental services in appropriate care settings for the relief of pain and infections, restoration of teeth, and maintenance of oral health.

3.1.1.1 Covered dental services may be limited by age range, maximum number of units allowable per day, prior authorization requirements, or other report requirements. For a detailed list of covered services, refer to Section 8.0 Appendix A, which includes a listing of all CDT codes with their coverage status and any restrictions or limitations.

3.1.1.2 The DMAP does impose certain limitations and prior authorization requirements for some services. These limitations are listed next to each procedure code and may refer you to specific policy sections. Exceptions to the DMAP CDT Code limitations may be reviewed on a case-by-case basis when accompanied by documentation of medical necessity.

3.1.1.3 In compliance with the State of Delaware's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Service guidelines, the DMAP endorses the American Academy of Pediatric Dentistry (AAPD) Periodicity Schedule. Refer to AAPD.org for the AAPD Periodicity Schedule for recommended guidance pertaining to pediatric oral health assessments, screenings, counseling, and preventative services for children under twenty-one years of age.

3.1.2 Prior authorization requests for restorative, endodontic, periodontic, prosthodontic, or prosthetic services must include diagnostic quality radiographs and a comprehensive treatment plan for the patient. Faxed and/or photocopies of radiographs will not be accepted.

3.1.2.1 For members enrolled in a Managed Care Organization (MCO), Prior Authorization requests must be sent electronically to the member's MCO Dental Benefit Manager (DBM). For members who have not yet chosen or been assigned to an MCO, prior authorization requests must be submitted electronically via the Delaware Medical Assistance Portal for Providers (Provider Portal).

3.1.2.2 For fee-for-service (FFS) members, Prior Authorization requests must be submitted electronically to DMAP via the DMAP Provider Portal as appropriate.

3.2 Orthodontic Services

3.2.1 DMAP does not require prior authorization for the initial diagnostic visit for orthodontic treatment.

Providers will be reimbursed for the initial diagnostic visit irrespective of the MCO Dental Benefit Manager's or DMAP's decision to approve or deny comprehensive treatment.

- Diagnostic records for comprehensive treatment (pre-orthodontic treatment D8660) are to be paid once to the same orthodontic provider/practice.
- An eligible member is allowed two pre-orthodontic treatment records per lifetime.
- Providers must submit a request for prior authorization if it is determined the condition of the member's dentition has changed and may now qualify for coverage.

3.2.2 All other orthodontic care must receive prior approval. Providers should not begin comprehensive treatment prior to receiving approval from the MCO Dental Benefit Manager for MCO members or DMAP for FFS members. Reimbursement will not be paid claims for comprehensive orthodontic care that did not receive prior authorization.

3.2.3 **Limited Orthodontics**

Covered once per lifetime. Panorex and photographs should be submitted with claim.

3.2.3.1 Claims for Limited Orthodontics must be submitted electronically to the MCO Dental Benefit Manager for MCO members or DMAP via the DMAP Provider Portal for FFS members.

3.2.3.2 Only submit a claim for limited orthodontics if any of the following criteria is met.

- Cross bite of first molar with midline deviation.
- Anterior cross bite associated with clinically apparent severe gingival inflammation or gingival recession or severe enamel wear.
- Impaction causing direct damage to the root of permanent tooth.

3.2.3.3 Limited Orthodontic treatment of transitional dentition is orthodontic treatment with a limited objective, not involving the entire dentition. It may be directed at the only existing problem, or at only one aspect of a larger problem in which a decision is made to defer or forego more comprehensive therapy. This may require brackets or bands on one arch in addition to other modalities. Note: Upper and lower braces exceed the scope of Limited Orthodontics and should be submitted under comprehensive if the member meets the criteria.

3.2.3.4 The MCO Dental Benefit Manager for MCO members or DMAP for FFS members will reimburse the provider for the orthodontic records required for submission. If the provider does not normally charge members for these services, they will not be able to submit these fees for reimbursement. Providers should bill D0150 and panorex code (D0330) if reimbursement is required.

3.2.3.5 The MCO Dental Benefit Manager or DMAP reimbursement is considered payment in full for interceptive and comprehensive orthodontics and is based on a pre-determined rate set by the DMAP. Payment for interceptive orthodontics includes the following:

- Periodic examinations

- Emergency examinations
- Cost for appliances
- Application and removal of appliance
- Retention

3.2.4 **Comprehensive Orthodontics:**

Covered once per lifetime. Comprehensive orthodontics is a covered dental service for Medicaid and DHCP (Delaware Healthy Children Program) eligible individuals who have been diagnosed with a "handicapping" malocclusion.

Prior authorization is required for any comprehensive orthodontic case that meets the criteria listed below. All prior authorizations for comprehensive orthodontics must be submitted electronically to the MCO Dental Benefit Manager for MCO members or DMAP via the DMAP Provider Portal for FFS members:

- Delaware Special Dental Orthodontic Form: Cases that qualify by exception must also be scored. All items on the form must be fully completed or the case will be denied.
- Treatment plan that must include:
  - Cost of treatment
  - Treatment plan
- Photographs
- Panoramic radiograph
- Cephalometric radiograph
- Digital models
- Orthognathic surgery cases: The member must be evaluated by an oral surgeon prior to submission for comprehensive orthodontics. The oral surgeon's report must be submitted with the prior authorization for review. If this report is not included, the case will be denied.

Prior to application of braces the orthodontist must assure that the member has seen a general dentist and is free of all active caries, periodontal disease and maintains good oral hygiene. Members who have poor oral hygiene, active caries, or have not been to a dentist for their six-month checkup will be denied orthodontic treatment until such time as their condition changes. For MCO members, see the MCO Dental Benefit Manager's Provider Policy Manual. For FFS members, see the DMAP Provider Portal Dental Corner for Delaware Special Dental Orthodontic Evaluation Form and guidance when scoring. No treatment should begin without an approval.

Only submit a prior authorization to the MCO Dental Benefit Manager for MCO members or DMAP for FFS members for comprehensive orthodontics when the following criterion is met.

- Permanent dentition only. Primary and transitional dentition cases will not be reviewed.
- A score of 26 or above on the Delaware Special Dental Orthodontic

Evaluation Form.

- When a score of 26 has not been reached but one of the 5 exceptions can be clearly demonstrated.
- When an impacted permanent tooth has caused visible damage to the root of another permanent tooth. (Must be included in the report as well as demonstrate existing damage to root of tooth.)
- When a child has been approved for orthodontic treatment by another state Medicaid program and has been receiving active and consistent treatment.

3.2.4.1 Orthodontics Approved or Denied

Once a case is received by the MCO Dental Benefit Manager for MCO members or DMAP for FFS members for consideration, it will be sent for review to determine if it meets the criteria of a handicapping malocclusion. You should receive a response in 2-3 months once the case is submitted. If approved or denied, a letter will be generated that informs you and the member of the decision from the MCO Dental Benefit Manager for MCO members or DMAP for FFS members.

- If approved, you will receive instructions for billing on the bottom of the prior authorization. The banding date will be valid for three months and the braces will need to be placed during that time period.
- If the case did not meet the criteria and was denied, information will be provided on the prior authorization explaining the reason. Use the notes to help with future submissions.

3.2.4.2 Billing and Payment for Comprehensive Orthodontics

Payment by DMAP and/or the MCO Dental Benefit Manager is considered payment in full for comprehensive orthodontics based on a pre-determined rate. Providers will be paid an initial rate for banding, D8090, and a maximum of 24 periodic visits, D8670. Periodic visits are only to be billed once a month and cannot be billed if the patient has not been receiving treatment. Payment for comprehensive orthodontics includes the following:

- Cost of appliances, (brackets, headgear, bite plane, etc.)
- Periodic visits, emergency visits
- Radiographs, photos, reports and final records
- Application, removal and retention
- All incidentals, (spacers, elastics, chains, arch wires)

Note: The MCO Dental Benefit Manager and DMAP cannot be charged for the member to upgrade to any type of ceramic or tooth-colored braces.

3.2.4.3 Comprehensive Orthodontic billing requirements

- D8670 will be billed at the amount listed in the Dental Fee Schedule for as many units as approved, up to 24 units total. (This code cannot be billed if the member is not receiving consistent care.)

- **Annual Reporting**: Once the member has been in treatment for one year, a summary report must be submitted on the dental claim. The annual report must include the number of appointments the member has received and a statement regarding the member's oral hygiene (excellent, good, fair, or poor).
- **Final Payment**: Once the orthodontic case has been completed photographs must be submitted to the MCO Dental Benefit Manager for MCO members or to the DMAP Dental Administrator for FFS members after the braces have been removed. The photographs must include two side oral photographs, one front oral photograph and one photograph of the member. These photographs are required to monitor the before and after treatment results.

3.2.4.4 Loss of Member Eligibility

Medicaid Loss of Coverage: If a Medicaid member loses eligibility while in active orthodontics for three consecutive months, the orthodontist can bill the DMAP for the remaining balance due.

- First dental providers must contact the dental administrator via the DMAP Provider Portal Secure Correspondence to verify consecutive loss of coverage, the dental administrator will approve the final billing and provide a date for billing.
- Second bill D8670 on one line and indicate how many units are remaining. Calculate the remaining balance due. Notate on the claim, "Final billing for loss of eligibility." *Example D8670 2 units $930.00 Note: Final Billing member loss of eligibility.*

3.2.4.5 Non-Compliance

In order for orthodontics to be successful it is necessary that the member attend all scheduled orthodontic visits. The member should receive routine six-month dental checkups and maintain good oral hygiene. If a member does not comply with the orthodontist by missing appointments, not following treatment, or demonstrating poor oral hygiene notify the MCO Dental Benefit Manager for MCO members or the DMAP Dental Administrator for FFS members (via the DMAP Provider Portal Secure Correspondence) before taking any action. The MCO Dental Benefit Manager or DMAP may allow the orthodontist to remove braces due to non-compliance. If the member's braces are removed due to non-compliance, they will no longer be eligible for the Delaware Orthodontic program nor can they reapply. If a member requests the orthodontist remove their braces before completion, their orthodontic benefits will be exhausted, and the member will be unable to receive orthodontics again.

3.2.4.6 Mid-treatment changes

The MCO Dental Benefit Manager for MCO members or DMAP for FFS members may assume financial responsibility for an individual in mid-treatment. Mid-treatment is defined as: 1.) An individual whose treatment began through a private-pay arrangement with the provider and prior to treatment completion the individual became Medicaid- or DHCP-eligible; or 2.) An individual who moved

to Delaware from another state, whose treatment had already started, and whose treatment had been approved by the other state's medical assistance program.

- If a member had braces placed before becoming eligible for Delaware Medicaid or DHCP and the member's current condition meets the requirements for a handicapping malocclusion, the orthodontist can submit the case. Follow the guidelines for submitting a prior authorization for comprehensive orthodontics.
- For an individual who moved to Delaware from another state and whose orthodontia was approved by the medical assistance program in the other state:
    - The provider must submit the following to the MCO Dental Benefit Manager for MCO members or the DMAP Dental Administrator (via the DMAP Provider Portal Secure Correspondence) for FFS members:
        - Documentation confirming the medical assistance program approval from the other state,
        - Name of previous orthodontist,
        - Treatment plan for the individual, including, cost of orthodontic treatment,
        - Time required to complete treatment, and
        - Photographs.
    - If the member has not been in active treatment in the last four months, the case must be submitted as a new case. Follow the guidelines and criteria to submit a prior authorization for comprehensive orthodontics.
- Providers are not allowed to remove existing orthodontic appliances and replace them with new appliances unless it is medically necessary. For a provider to receive payment, the MCO Dental Benefit Manager for MCO members or DMAP for FFS members must confirm medical necessity before the provider removes the existing appliances.

3.2.4.7 **Retainers**

Retainers are considered included as part of interceptive or comprehensive reimbursement. Coverage includes reimbursement for one replacement of broken or lost retainers if it was within the first year after removal of braces paid for by the MCO Dental Benefit Manager for MCO members or DMAP for FFS members. A prior authorization must be submitted for approval.

3.3 Root Canal Therapy

3.3.1 Root canal therapy (RCT) is only covered when medically necessary. Generally, root canal therapy is necessary when the pulp is infected, when the patient has experienced trauma or fracture that damaged the pulp, or when the tooth is cracked or severely broken and would likely compromise the health of the pulp. While RCT does not require prior authorization, please note that RCT is not considered to be medically necessary simply as a precursor to the

placement of a crown when the above-mentioned conditions do not exist, or where a tooth has a poor prognosis for being retained or the tooth is expected to be extracted as part of an alternate treatment option. DMAP for FFS members or the MCO Dental Benefit Manager for MCO members may deny or void claims where the RCT has been determined not to be medically necessary.

4.0 Billing Information

4.1 General

4.1.1 A valid CDT procedure code is required for billing dental services provided to Medicaid-eligible and DHCP-eligible children. Refer to Section 8.0 Appendix A for CDT Code Coverage Guidelines.

4.1.2 When billing for dental services, the appropriate diagnosis must be maintained in the member's file.

4.1.3 Before rendering services, providers should reference Appendix A, which lists the coverage guidelines for dental services. These guidelines include: whether a service is covered; age, frequency, and quantity limitations for each service; and prior authorization and reporting requirements.

4.1.3.1 Providers should verify an individual patient's treatment history related to services with frequency or quantity limitations before providing that service.

4.1.3.1.1 The provider may obtain patient treatment history from the patient or the patient's parent, guardian, or previous dental provider. The MCO Dental Benefit Manager or DMAP Dental Administrator can assist providers when the member is a foster child; there is a language barrier; and/or the parent, guardian or child does not have this information after the inquiry. The DMAP Dental Administrator for FFS members or the MCO Dental Benefit Manager for MCO members will provide the name of the last dental provider seen by the member. It is the responsibility of the provider to contact the other dental office to inquire about the past history and request x-rays, and to assure that the dental policy guidelines will not be exceeded.

4.1.3.1.2 Providers assume the risk of non-payment for services provided that exceed the coverage guidelines as outlined in Section 8.0 Appendix A.

4.1.3.2 **Billing Medicaid Members with Third Party Dental Coverage**

As described in the General Policy Manual, members may not generally be billed for services. Exceptions to billing DMAP members can be found in Section 1.16 of the same manual. Providers must not collect money in advance when primary insurance pays the member directly. When the third-party reimbursement is made directly to the member, the provider may bill the member in order to obtain the third-party payment. Only the amount of the third-party payment and a copy of the insurer's explanation of benefits (EOB) can be obtained.

4.1.3.3 **Billing Instructions for Supernumerary tooth**:

Bill: Use CDT code D7999

Enter the total number of units (when more than one supernumerary tooth is extracted the same day, increase the number of units). DO NOT BILL additional CDT Codes for supernumerary extractions on another line.

Fee: Include the fee for the service (When more than one tooth is extracted the same day, add the cost of all extracted supernumerary teeth.)

Additional Comments: Enter CDT code for type of extraction in comment box add D7140, D7210, etc. Also note in the box on the claim where the tooth/teeth are located.

Example: D7999 units 3 total cost $350.00 (D7210 $150.00, D7140 $100.00 each) Additional Comments: between 8, 9, 24, 25, 6, 7 (D7210 2@D7140)

4.1.3.4 **Billing Instructions for space maintainers**

- All space maintainers D1510, D1515, D1555 must be billed using either arch or quadrant number. See CDT code book for guidance.
- D1510 requires a quadrant of 10, 20, 30, 40. When billing electronically, you can enter this in the Quadrant field.
- D1515 requires an arch of either 01 or 02. When billing electronically, enter this in the Quadrant field.
- D1555 requires 10, 20, 30, 40 or 01 or 02. This code can't be billed by the provider who made the appliance. Only to be billed when removed by a provider from another dental practice. DO NOT BILL USING TOOTH NUMBERS OR LETTERS.

4.1.3.5 **Billing Instructions for Caries Risk Assessment**

When billing any of the following codes D0145, D0120, D0150, or D0160, a caries risk assessment code must be on the same dental claim form. See current CDT code book on correct coding for caries risk assessment. Guidelines on Caries-risk Assessment and Management for Infants, Children, and Adolescents are as follows.
http://www.aapd.org/media/Policies_Guidelines/G_CariesRiskAssessment.pdf

- Table 2 provides guidelines for children ages five years and younger.
- Table 3 provides guidelines for children ages six and above.

Do not submit Caries Risk Assessment Forms to DMAP the MCO Dental Benefit Manager. The form should be kept as part of the member's dental records.

4.2 Anesthesia Services

4.2.1 The DMAP adheres to the requirements of the Delaware Department of State Division of Professional Regulations found at http://regulations.delaware.gov/AdminCode/title24/1100.shtml to determine which providers may administer anesthesia.

4.2.1.1 Only providers who hold a State permit (restricted permit I, restricted permit II, or unrestricted) are permitted to administer and bill for anesthesia services allowed under their specific permit. Anesthesiologists providing dental anesthesia for DMAP members in a dental office must bill for services using their NPI as performing provider and the dental group NPI for reimbursement.

4.2.2 When a dentist requires a member to have anesthesia performed at a location outside of their practice the following criteria must be met:

- The dentist must verify the provider administering the anesthesia is enrolled in DMAP and a Managed Care Organization (MCO) and has the appropriate state license and permits to perform the procedure and;
- The procedure must meet the medical necessity criteria in section 4.2.2.2 and;
- The dentist completing the restorative procedure must include procedure code D9420 on the dental claim submitted.

Reimbursement for anesthesia will not be made unless a corresponding dental claim is on file for the same date of service.

4.2.2.1 As per the requirements of the Division of Professional Regulations, DMAP expects that providers with separate office locations maintain separate permits for each location and for each individual provider.

4.2.2.2 When determining medical necessity for the use of dental anesthesia (Nitrous Oxide, Minimal Sedation, Moderate Sedation, or Deep Sedation/General Anesthesia) at least one of the following criteria must be met:

- A precooperative child six years of age or under.
- A child under the age of 7 who has carious lesions (baby bottle syndrome) which require multiple restorations, extractions, crowns.
- Child of any age with a diagnosed physical, developmental, or emotional disability.
- Children with documented acute situational anxiety where a physical, mental, or medical condition precludes other behavior management choices.
- Surgical extractions for permanent teeth using codes: D7210, D7220, D7230, D7240, D7241, and D7250 (except for partially and completely bony impacted wisdom teeth which must be submitted to the MCO).
- The following codes require documentation on the dental claim listing the criteria for medically necessary anesthesia: D9222, D9223, D9230, D9239, D9243, D9246, and D9247.

Note: When billing medical procedures that require submission to the MCO (ex. partial or bony impacted wisdom teeth) anesthesia services must be billed to the member's MCO. Anesthesia may only be billed to one payer – MCO or DMAP, but not both. CPT® anesthesia code 00170 cannot be billed at the same time as billing for any of the following dental anesthesia codes for the same visit: D9222, D9223, D9230, D9239, D9243, D9246, and D9247.

4.2.2.2.1 For any child that does not meet the criteria listed above, a pre-determination can be filed for review and possible approval. The provider must include the complete treatment plan, the medical necessity for the anesthesia, CDT codes, and referring dentist if applicable.

4.3 Outpatient Hospital and Ambulatory Surgical Center Services

4.3.1 It is important for members to inform medical providers of other health coverage. As a condition of eligibility, the member must sign a statement on the Medicaid application agreeing to inform the Program of other coverage and to allow the DMAP to recover recoup monies paid out where if a liable third party, such as an insurance company, is responsible.

4.3.2 For members who are enrolled with an MCO, billing for dental services performed in Outpatient Hospital and Ambulatory Surgical Center (ASC) settings must be submitted to the member's MCO Dental Benefit Manager. For members who have not yet chosen or been assigned to an MCO or who are fee-for-service (FFS), billing for dental services performed in Outpatient Hospital and ASC settings must be submitted electronically via the DMAP Portal.

4.3.3 Dentists are required to submit electronic claims for services performed in Outpatient Hospital and Ambulatory Surgical Center (ASC) settings using the relevant service location number:

- 22 Outpatient Hospital.
- 24 Ambulatory Surgical Center.

4.3.4 Outpatient Hospital and Ambulatory Surgical Center (ASC) staff must submit an institutional claim form for facility services provided by the Outpatient Hospital and Ambulatory Surgical Center (ASC) including anesthesia.

4.3.4.1 Services for facility or anesthesia will not be paid for members over the age of 18 for DHCP, or over the age of 21 for Medicaid. Reimbursement for anesthesia will not be made unless a corresponding dental claim for the same date of service is received.

4.3.5 Professional claims are required for services performed by any anesthesiologist providing services in an Outpatient Hospital and Ambulatory Surgical Center (ASC) setting.

4.3.6 Dental Services are not reimbursed when completed in Outpatient Hospital and Ambulatory Surgical Center (ASC) settings for DHCP members over the age of 18.

Note: Anesthesia may only be billed to one payer – MCO or DMAP, but not both. CPT® anesthesia code 00170 cannot be billed at the same time as billing for any of the following dental anesthesia codes for the same visit: D9222, D9223, D9230, D9239, D9243, D9246, and D9247.

4.4 Behavior Management

4.4.1 All behavior management decisions must be based on a review of the patient's medical, dental, and social history followed by an evaluation of current behavior. Decisions regarding the use of behavior guidance techniques other than communicative management cannot be made solely by the dentist. They

must involve a parent and, if appropriate, the child. The decision to use any of these methods must include the following.

- Other alternate behavioral modalities;
- Dental needs of the patient;
- Quality of dental care to be provided;
- Patient's emotional development; and
- Patient's physical status.

4.4.2 **Communicative Guidance**

4.4.2.1 Voice control, nonverbal communication, tell-show-do, and positive reinforcement, distraction and Nitrous Oxide.

- Reimbursement is not allowed under D9920 for these techniques.
- Nitrous Oxide is reimbursed under code D9230, informed consent required, refer to anesthesia guidelines for medical necessity.

4.4.3 **Advanced Behavior Guidance**

4.4.3.1 Protective stabilization, deep sedation, and general anesthesia. Only dentists who have completed commensurate advanced postdoctoral training (i.e., residency or continuing education) are permitted to provide these services.

- Protective Stabilization: Restriction of patient's freedom of movement to decrease risk of injury while allowing safe completion of treatment.
- When completed with or without restrictive device led by dentist and performed by dental staff.
- Must obtain and document in the child's record written informed consent from a parent/guardian prior to procedure.

Patient's record must include the following:

- Informed consent;
- Type of stabilization used;
- Indication for stabilization, and
- Duration of stabilization.

5.0 Prior Authorization

5.1 General

5.1.1 Specific dental procedures must be prior authorized before treatment begins. For all prior authorization requests, the provider shall submit the appropriate prior authorization form for the service being requested. See Appendix A for limitations, restrictions, or prior authorizations requirements for each covered CDT code. Prior authorizations for services where the limitations or restrictions are exceeded may be submitted and will be reviewed on a case-by-case basis. All requested documentation must be submitted correctly in advance of the procedure to the MCO Dental Benefit Manager for MCO members or to DMAP for FFS members. All x-rays submitted with a prior authorization must be recent (see requirements in Appendix A) and of diagnostic quality.

5.1.1.1 For members who are enrolled with a Managed Care Organization (MCO), Prior Authorization requests must be submitted to the member's MCO Dental Benefit Manager. For specific instructions on filing a prior authorization with an MCO, see the MCO Dental Benefit Manager's Provider Manual.

5.1.1.2 For members who have not yet chosen or been assigned to an MCO or who are fee-for-service (FFS), Prior Authorization requests must be submitted electronically via the DMAP Provider Portal. Dental prior authorization forms are available on the Dental Corner portion of the DMAP Provider Portal. Specific instructions for electronically filing a prior authorization are located in the Dental Prior Authorization Folder of the DMAP Document Repository.

5.1.2 Prior to submitting a prior authorization for review, the member must receive a six-month dental cleaning and examination. Prior authorization requests must include current diagnostic quality radiographs, photographs and a comprehensive treatment plan for the patient. Additional information may be requested for review. In order to accelerate the process of review, submit full mouth x-ray and complete full mouth treatment plan for members with extensive decay or that require more than two crowns. The DMAP or the MCO Dental Benefit Manager will not accept faxed and/or photocopies of radiographs.

5.1.3 Dental procedures for extractions or surgical access of unerupted teeth which are related to orthodontics on permanent teeth require prior authorization. These procedures are not a covered benefit if the orthodontics have not been approved by Medicaid.

5.1.4 **Coordination of Dental PA's and Third Party Coverage**

Under Federal Law, Medicaid is the payer of last resort. In instances where a Medicaid member has other dental coverage and prior approval is required by both Medicaid and the third-party insurer, prior authorization requests should be submitted to both entities simultaneously. Medicaid will provide a determination either approving or denying the service as should the other carrier. While a Medicaid approval permits the dental provider to proceed with providing care, the potentially liable third party must always be billed prior to the submission of

a dental claim to Medicaid. A prior approval granted by the third-party insurer does not guarantee approval or subsequent payment by Medicaid. Therefore, simultaneous prior approval submissions are required.

6.0 Reserved

7.0 Reimbursement

7.1 Payment Conditions

7.1.1 DMAP for FFS members or MCO Dental Benefit Manager for MCO members reimbursement is considered payment in full for covered services. Therefore, dental providers may not charge members for balances that are not covered, and may not charge members for services and then reimburse members once DMAP or the MCO Dental Benefit Manager pays the claim.

7.1.2 Providers may only bill a member under the conditions described in the Billing DMAP Members section of the General Policy Manual. Refer to DMAP General Policy Manual Section 1.16, Billing DMAP Members.

7.1.3 Dental services will be reimbursed at a pre-determined rate set by the State.

7.1.4 The orthodontic fee may be divided among multiple providers, if necessary, but a member's total orthodontic benefit may not exceed the maximum allowable payment.

7.1.4.1 Once orthodontics are approved, the number of approved payments will be listed on the Prior Authorization approval letter.

7.1.4.2 The DMAP will not assume financial responsibility for any past-due balances between the member and the provider incurred prior to the DMAP's or the MCO Dental Benefit Manger's approval of continued treatment.

CDT Codes

8.0 Appendix A – CDT Codes – Coverage Guidelines

Dental Fee Schedules and rates are available on the DMAP Provider Portal.

Current Dental Terminology, (CDT) (including procedure codes, definitions (descriptors), and other data) is copyrighted by the American Dental Association. ©2015 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

NOTE: Any DMMA Maximum Allowable Cost marked with an * = Prices require Prior Authorization and must be manually inputted.

PROCEDURE CODE	PROCEDURE DESCRIPTION	AGE LIMITATIONS, RESTRICTIONS, PRIOR AUTHORIZATIONS
ORAL EVALUATIONS		
D0120	PERIODIC ORAL EVALUATION – ESTABLISHED PATIENT	**Age 0-20:** 1 in 6 months; Must include caries risk assessment
D0140	LIMITED EXAM	**Age 0-20:** Specific problem not to be billed with other exams
D0145	ORAL EVALUATION AND COUNSELING UNDER 3	**Age 0-2:** 1 in 6 months; Must include caries risk assessment.
D0150	COMPREHENSIVE ORAL EVALUATION – NEW OR ESTABLISHED PATIENT	**Age 0-20:** 1 in 2 years; Must include caries risk assessment.
D0160	EXTENSIVE ORAL EVALUATION PROBLEM FOCUS	**Age 0-20:** Must include caries risk assessment.
D0170	RE-EVALUATION, ESTABLISHED PATIENT, PROBLEM FOCUS	**Age 0-20:** Must include narrative on claim
D0180	PERIODONTAL EVALUATION	**Age 14-20:** 1 in 2 years; Allowed for Periodontist only

D0190	SCREENING OF A PATIENT	**Age 0-20:** Code limited to Division of Public Health (DPH) contracted providers only
D0191	ASSESSMENT OF A PATIENT	**Age 0-20:** Code limited to Division of Public Health (DPH) contracted providers only
D0210	INTRAORAL COMPLETE FILM SERIES	**Age 7-20:** 1 in 3 years, Request patient's x-rays
D0220	INTRAORAL PERIAPICAL FIRST	**Age 0-20:** 15 per year
D0230	INTRAORAL PERIAPICAL EA ADD	**Age 0-20:** Bill code on one line # units and total
D0240	INTRAORAL – OCCLUSAL FILM	**Age 0-20:** Maximum 2 per day
D0270	DENTAL BITEWINGS SINGLE FILM	**Age 0-20:** 4 bitewings in 6 months
D0272	DENTAL BITEWINGS TWO FILMS	**Age 0-20:** 4 bitewings in 6 months
D0273	BITEWINGS – THREE FILMS	**Age 0-20:** 4 bitewings in 6 months
D0274	DENTAL BITEWINGS FOUR FILMS	**Age 0-20:** 4 bitewings in 6 months
D0277	RADIOGRAPHS / DIAGNOSTIC IMAGING	**Age 7-20:** 7-8 x-rays; Cannot bill with D0210 or other bitewing code
D0350	PHOTOGRAPHS	**Age 3-20:** 1 in 6 months if requested for review
D0322	TOMOGRAPHIC SURVERY	**Age 8-20**
D0330	DENTAL PANORAMIC FILM	**Age 5-20:** 1 in 3 years; Request patient's x-rays
D0601	CARIES RISK LOW	Caries code must be billed on same claim with exam
D0602	CARIES RISK MODERATE	AAPD Table 2, 3 completed must be retained in chart
D0603	CARIES RISK HIGH	Fee must be billed for submission
D0999	UNSPECIFIED DIAGNOSTIC PROCEDURE, BY REPORT	**Age 0-20:** Prior authorization required

PREVENTIVE		
D1110	DENTAL PROPHYLAXIS ADULT	**Age 13-20:** 1 in 6 months
D1120	DENTAL PROPHYLAXIS CHILD	**Age 1-12:** 1 in 6 months
D1206	FLUORIDE VARNISH	**Age 0-20:** 1 in 6 months, D1208 or D1206
D1208	TOPICAL APP FLUORIDE	**Age 0 -20:** 1 in 6 months, D1208 or D1206
D1351	DENTAL SEALANT PER TOOTH	For occlusal surface only; Limited to 8 sealants in 12 month period; Same tooth 1 in 5 years Sealants: premolars, primary molars, and permanent molars only **Age 2-6:** Primary molars only **Age 5-15:** Permanent molars and premolars only **Age 5-16:** Allowed on 1, 16, 17, 32; Only if future removal not intended
D1354	INTERIM CARIES ARRESTING MEDICATION APPLICATION – PER TOOTH	**Age 0-20:** 1 in 6 months; 2 times per tooth
D1510	SPACE MAINTAINER-FIXED, UNILATERAL – PER QUADRANT	**Age 2-9:** Quad 10, 20, 30, 40; See Dental Billing Policy Manual
D1515	FIXED BILAT SPACE MAINTAINER	**Age 2-9:** Arch 01, 02; See Dental Billing Policy Manual
D1516	SPACE MAINTAINER – FIXED – BILATERAL, MAXILLARY	**Ages 2-9:** No Prior authorization required
D1517	SPACE MAINTAINER – FIXED – BILATERAL, MANDIBULAR	**Ages 2-9:** No Prior authorization required
D1551	RE CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER-MAXILLARY	**Ages 2-12:** Arch 01, 02 or Quad 10, 20, 30, 40; On claim
D1552	RE CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER – MANDIBULAR	**Ages 2-12:** Arch 01, 02 or Quad 10, 20, 30, 40; On claim
D1553	RE CEMENT OR RE-BOND UNILATERAL SPACE MAINTAINER – PER QUADRANT	**Ages 2-12:** Arch 01, 02 or Quad 10, 20, 30, 40; On claim
D1556	REMOVAL OF FIXED UNILATERAL SPACE MAINTAINER – PER QUADRANT	**Ages 2-12:** Only billed when office did not insert appliance
D1557	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER – MAXILLARY	**Ages 2-12:** Only billed when office did not insert appliance
D1558	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER – MANDIBULAR	**Ages 2-12:** Only billed when office did not insert appliance

RESTORATIVE		
D2140	AMALGAM ONE SURFACE	**Age 1-20:** Same tooth and surface covered 1 in 2 years
D2150	AMALGAM TWO SURFACES	**Age 1-20:** Same tooth and surface covered 1 in 2 years
D2160	AMALGAM THREE SURFACES	**Age 1-20:** Same tooth and surface covered 1 in 2 years
D2161	AMALGAM 4 OR > SURFACES	**Age 1-20:** Same tooth and surface covered 1 in 2 years
D2330	RESIN ONE SURFACE – ANTERIOR	**Age 1-20:** Same tooth and surface covered 1 in 2 years
D2331	RESIN TWO SURFACES – ANTERIOR	**Age 1-20:** Same tooth and surface covered 1 in 2 years
D2332	RESIN THREE SURFACES – ANTERIOR	**Age 1-20:** Same tooth and surface covered 1 in 2 years
D2335	RESIN 4 / > SURF OR WITH INCISOR – ANTERIOR	**Age 1-20:** Same tooth and surface covered 1 in 2 years
D2390	ANT RESIN-BASED CMPST CROWN	**Age 1-20:** 1 time in 5 years
D2391	POST 1 SURFACE RESIN BASED COMPOSITE	**Age 1-20:** Same tooth and surface covered 1 in 2 years
D2392	POST 2 SURFACE RESIN BASED COMPOSITE	**Age 1-20:** Same tooth and surface covered 1 in 2 years
D2393	POST 3 SURFACE RESIN BASED COMPOSITE	**Age 1-20:** Same tooth and surface covered 1 in 2 years
D2394	POST >= 4 SURFACE RESIN BASED COMPOSITE	**Age 1-20:** Same tooth and surface covered 1 in 2 years
D2710	CROWN RESIN BASED COMPOSITE INDIRECT	**Age 14-20:** Prior authorization 30 days or less x-ray; CAD / CAM not covered
D2740	CROWN PORCELAIN/CERAMIC	**Age 14-20:** Prior authorization required; X-ray less than 1 month old
D2751	CROWN PORCELAIN FUSED BASE MOLAR	**Age 14-20:** Prior authorization x-ray less than 1 month old
D2752	CROWN PORCELAIN WITH NOBLE METAL	**Age 14-20:** Prior authorization x-ray less than 1 month old
D2791	CROWN – FULL CAST PREDOMINANTLY BASE METAL	**Age 14-20:** Prior authorization 30 day or less x-ray; CAD / CAM not covered
D2792	CROWN – FULL CAST NOBLE METAL	**Age 14-20:** Prior authorization x-ray less than 1 month old

D2799	PROVISIONAL CROWN	**Age 14-20:** Prior authorization x-ray less than 1 month old
D2910	RECEMENT INLAY, ONLAY	**Age 14-20**
D2915	RECEMENT CASE OR PREFABRICATED POST & CORE	**Age 14-20:** Must include narrative on claim
D2920	RECEMENT CROWN	**Age 2-20**
D2929	PREFABRICATE ESTHETIC COATED STAINLESS STEEL CROWN – PRIMARY TOOTH	**Ages 0-20:** Limited to tooth numbers C, D, E, F, G, H, M, N, O, P, Q, R; 1 per tooth per life
D2930	PREFAB STNLSS STEEL CROWN PRIMARY	**Age 1-20:** 1 in 5 years; Extraction if more than 1/2 root resorbed
D2931	PREFAB STNLSS STEEL CROWN PERMANENT	**Age 6-20:** 1 time in 5 years
D2932	PREFAB RESIN CROWN	**Age 2-20:** 1 in 5 years; Extraction if more than 1/2 root resorbed
D2933	PREFAB STAINLESS STEEL CROWN WITH RESIN WINDOW	**Age 2-20:** 1 in 5 years; Anterior teeth only
D2934	PREFABRICATED PORCELAIN / CERAMIC CROWN – PRIMARY TOOTH	**Ages 0-20:** Limited to tooth numbers C, D, E, F, G, H, M, N, O, P, Q, R; 1 per tooth per life
D2940	PROTECTIVE RESTORATION	**Age 1-20:** Not billable same day as restoration
D2950	CORE BUILD-UP INCLUDING ANY PINS	**Age 6-20:** Not billable with code D2951 or other restorations
D2951	PIN RETENION – PER TOOTH	**Age 6-20**
D2952	POST AND CORE CAST + CROWN	**Age 6-20:** Billed only after endo on tooth
D2953	EACH ADDITIONAL INDIRECTLY FABRICATED POST – SAME TOOTH	**Age 6-20:** Prior authorization with x-ray less than 1 month old
D2954	PREFAB POST / CORE + CROWN	**Age 6-20**
D2955	POST REMOVAL	**Age 6-20:** Must include narrative on claim
D2957	EACH ADDITIONAL PREFAB POST – SAME TOOTH	**Age 6-20:** Prior authorization with x-ray less than 1 month old
D2980	CROWN REPAIR	**Age 14-20:** Must include narrative on claim
D2999	UNSPECIFIED RESTORATIVE PROCEDURE, BY REPORT	**Age 1-20:** Prior authorization with narrative and x-ray if necessary

ENDODONTIC SERVICES		
D3110	PULP CAP – DIRECT (EXCLUDING FINAL RESTORATION)	**Age 0-20:** Once per lifetime per tooth, primary and permanent
D3120	PULP CAP – INDIRECT (EXCLUDING FINAL RESTORATION)	**Age 0-20:** Once per lifetime per tooth, primary and permanent
D3220	THERAPEUTIC PULPOTOMY	**Age 1-10:** Not billable same day as Endodontic Therapy
D3221	GROSS PULPAL DEBRIDEMENT	**Age 6-20:** Not billable same day as Endodontic Therapy
D3222	PARTIAL PULPOTOMY FOR APEXOGENESIS	**Age 6-20:** Not billable same day as Endodontic Therapy
D3230	PULPAL THERAPY ANTERIOR PRIMARY	**Age 2-6:** Not billable same day as Endodontic Therapy
D3240	PULPAL THERAPY POSTERIOR PRIMARY	**Age 2-9:** Not billable same day as Endodontic Therapy
D3310	ENDODONTIC THERAPY, ANTERIOR TOOTH	**Age 6-20:** See Dental Provider Policy Manual - Section 3.3 Root Canal Therapy
D3320	INCOMPLETE ENDODONTIC THERAPY	**Age 8-20:** See Dental Provider Policy Manual - Section 3.3 Root Canal Therapy
D3330	ENDODONTIC THERAPY, MOLAR	**Age 6-20:** See Dental Provider Policy Manual - Section 3.3 Root Canal Therapy
D3332	INCOMPLETE ENDODONTIC THERAPY	**Age 6-20:** See Dental Provider Policy Manual - Section 3.3 Root Canal Therapy
D3333	INTERNAL ROOT REPAIR OF PERFORATION DEFECTS	**Age 6-20:** Not billable with D9110 or D3220 on same day
D3346	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY – ANTERIOR	**Age 8-20**
D3347	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY – PREMOLAR	**Age 10-20**
D3348	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY – MOLAR	**Age 8-20**
D3351	APEXIFICATION / RECALCIFICATION – INITIAL VISIT	**Age 6-16:** Limited to Endodontists and General Dentists
D3352	APEXIFICATION / RECALCIFICATION – INCLUDING X-RAYS	**Age 6-16:** Limited to Endodontists and General Dentists
D3353	APEXIFICATION / RECALCIFICATION – FINAL VISIT	**Age 6-16:** Limited to Endodontists and General Dentists

D3410	APICOECTOMY ANTERIOR	**Age 9-20:** Endodontist and Oral Surgeons only
D3421	APICOECTOMY – BICUSPID	**Age 9-20:** Endodontist and Oral Surgeons only
D3425	APICOECTOMY – MOLAR	**Age 9-20:** Endodontist and Oral Surgeons only
D3426	APICOECTOMY – EACH ADDITIONAL ROOT	**Age 9-20:** Endodontist and Oral Surgeons only
D3430	RETROGRADE FILLING – PER ROOT	**Age 9-20:** Endodontist and Oral Surgeons only
D3999	UNSPECIFIED ENDODONTIC PROCEDURE, BY REPORT	**Age 1-20:** Prior authorization with x-ray
PERIODONTICS		
D4210	GINGIVECTOMY OR GINGIVOPLASTY – 4 < CONTIGUOUS TEETH	**Age 13-20:** Prior authorization with photograph
D4211	GINGIVECTOMY OR GINGIVOPLASTY – 1 TO 3 TEETH	**Age 13-20:** Prior authorization with photograph
D4212	GINGIVECTOMY TO ACCESS FOR RESTORATIVE PROCEDURE	**Age 13-20:** Prior authorization with photograph
D4260	OSSEOUS SURGERY – 4 OR MORE CONTIGUOUS TEETH	**Age 15-20:** Prior authorization with FMX
D4261	OSSEOUS SURGERY – 1 TO 3 CONTIGUOUS TEETH	**Age 15-20:** Prior authorization with FMX
D4263	BONE REPLACEMENT GRAFT – FIRST SITE IN QUADRANT	**Age 13-20:** Prior authorization with FMX
D4264	BONE REPLACEMENT GRAFT – EACH ADDITIONAL SITE IN QUADRANT	**Age 13-20:** Prior authorization with FMX
D4265	BIOLOGIC MATERIALS TO AID IN SOFT & OSSEOUS TISSUE	**Age 13-20:** Prior authorization with FMX
D4266	GUIDED TISSUE REGENERATION – RESORBABLE BARRIER	**Age 13-20:** Prior authorization with FMX
D4267	GUIDED TISSUE REGENERATION – NONRESORBABLE BARRIER	**Age 13-20:** Prior authorization with FMX
D4270	PEDICLE SOFT TISSUE GRAFT	**Age 8-20:** Prior authorization with x-ray or photograph
D4273	SUBEPITHELIAL CONNECTIVE TISSUE GRAFT	**Age 8-20:** Prior authorization with x-ray or photograph

D4274	MESIAL / DISTAL WEDGE PROCEDURE, SINGLE TOOTH	**Age 8-20:** Prior authorization with x-ray or photograph
D4275	NON-AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE	**Age 8-20:** Prior authorization with x-ray or photograph
D4276	COMBINED CONNECTIVE TISSUE & DOUBLE PEDICLE GRAFT – PER TOOTH	**Age 8-20:** Prior authorization with x-ray less than 1 month old
D4322	SPLINT – INTRA-CORONAL: NATURAL TEETH OR PROSTHETIC CROWNS	**Age 13-20:** Prior authorization with x-rays less than 1 month old
D4323	SPLINT – EXTRA-CORONAL: NATURAL TEETH OR PROSTHETIC CROWN	**Age 13-20:** Prior authorization with x-rays less than 1 month old
D4341	PERIODONTAL SCALING & ROOT PLANING – 4 OR MORE TEETH PER QUADRANT	**Age 14-20:** 1 in 2 years; Maximum 2 quadrants billed in 1 day
D4342	PERIODONTAL SCALING & ROOT PLANING – 1 TO 3 TEETH PER QUANDRANT	**Age 14-20:** 1 in 2 years; Maximum 2 quadrants billed in 1 day; Not billable with D4341
D4355	FULL MOUTH DEBRIDEMENT	**Age 14-20:** 1 in 3 years; Cannot bill with D1110, D4341, D4321
D4910	PERIODONTAL MAINTENANCE	**Age 14-20:** 1 time 3 months; Can alternate with D1110
D4920	UNSCHEDULED DRESSING CHANGE	**Age 14-20:** Covered when provider removing is in different practice
D4999	UNSPECIFIED PERIODONTAL PROCEDURE, BY REPORT	**Age 0-20:** Prior authorization required
PROSTHODONTICS (REMOVABLE)		
D5110	COMPLETE DENTURE – MAXILLARY	**Age 14-20:** Codes D5110, D5120; Prior authorization with FMX; Covered 1 in 5 years or within 3 years of partial
D5120	COMPLETE DENTURE – MANDIBULAR	**Age 14-20:** Codes D5110, D5120; Prior authorization with FMX; Covered 1 in 5 years or within 3 years of partial
D5211	MAXILLARY PARTIAL DENTURE – RESIN BASE	**Age 14-20:** Codes D5211, D5212; Prior authorization with FMX; Covered 1 in 5 years
D5212	MANDIBULAR PARTIAL DENTURE – RESIN BASE	**Age 14-20:** Codes D5211, D5212; Prior authorization with FMX; Covered 1 in 5 years
D5213	MAXILLARY PARTIAL DENTURE-CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE / CLASPING MATERIALS, REST AND TEETH)	**Age 16-20:** Codes D5212, D5214; Prior authorization with FMX; Covered 1 in 5 years

D5214	MANDIBULAR PARTIAL DENTURE-CASE METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE / CLASPING MATERIALS, REST AND TEETH)	**Ages 16-20:** Codes D5212, D5214; Prior authorization with FMX; Covered 1 in 5 years
D5225	MAXILLARY PARTIAL DENTURE – FLEXIBLE BASE	**Ages 16-20:** Codes D5212, D5214; Covered 1 in 5 years; Prior authorization with FMX; Includes retentive / clasping material, rests, and teeth
D5226	MANDIBULAR PARTIAL DENTURE – FLEXIBLE BASE	**Ages 16-20:** Codes D5212, D5214; Covered 1 in 5 years; Prior authorization with FMX; Includes retentive / clasping material, rests, and teeth
D5410	ADJUST COMPLETE DENTURE – MAXILLARY	**Age 14-20:** Codes D5410, D5411, D5421, D5422 not billable within 6 months of the delivery of, interim, partial, or complete denture; Covered 1 every 12 months
D5411	ADJUST COMPLETE DENTURE – MANDIBULAR	**Age 14-20:** Codes D5410, D5411, D5421, D5422 not billable within 6 months of the delivery of, interim, partial, or complete denture; Covered 1 every 12 months
D5421	ADJUST PARTIAL DENTURE – MAXILLARY	**Age 14-20:** Codes D5410, D5411, D5421, D5422 not billable within 6 months of the delivery of, interim, partial, or complete denture; Covered 1 every 12 months
D5422	ADJUST PARTIAL DENTURE – MANDIBULAR	**Age 14-20:** Codes D5410, D5411, D5421, D5422 not billable within 6 months of the delivery of, interim, partial, or complete denture; Covered 1 every 12 months
D5511	REPAIR BROKEN COMPLETE DENTURE BASE, MANDIBULAR	**Age 14-20**
D5512	REPAIR BROKEN COMPLETE DENTURE BASE, MAXILLARY	**Age 14-20**
D5520	REPLACE MISSING OR BROKEN TEETH – COMPLETE DENTURE	**Age 14-20**
D5610	REPAIR RESIN DENTURE BASE	**Age 14-20**
D5620	REPAIR CAST FRAMEWORK	**Age 16-20**
D5630	REPAIR OR REPLACE BROKEN CLASP	**Age 14 -20**
D5640	REPLACE BROKEN TEETH – PER TOOTH	**Age 14-20:** Tooth number on claim
D5650	ADD TOOTH TO EXISTING PARTIAL DENTURE	**Age 14-20:** Tooth number on claim

D5660	ADD CLASP TO EXISTING PARTIAL DENTURE	**Age 14-20**
D5670	REPLACE ALL TEETH & ACRYLIC ON CAST METAL FRAMEWORK	**Age 16-20:** Prior authorization with photograph
D5671	REPLACE ALL TEETH & ACRYLIC ON CAST METAL FRAMEWORK	**Age 16-20:** Prior authorization with photograph
D5730	RELINE COMPLETE MAXILLARY DENTURE (DIRECT)	**Age 14-20:** Codes D5730, D5731, D5750, D5751; Covered 1 in 2 years; Bill when chair side reline
D5731	RELINE COMPLETE MANDIBULAR DENTURE (DIRECT)	**Age 14-20:** Codes D5730, D5731, D5750, D5751; Covered 1 in 2 years; Bill when chair side reline
D5740	RELINE MAXILLARY PARTIAL DENTURE (DIRECT)	**Age 14-20:** Codes D5740, D5741; Not billable within 6 months of D5211, D5212, D5213,D5214, D5225, D5226; Bill when chair side reline
D5741	RELINE MANDIBULAR PARTIAL DENTURE (DIRECT)	**Age 14-20:** Codes D5740, D5741; Not billable within 6 months of D5211, D5212, D5213,D5214, D5225, D5226; Bill when chair side reline
D5750	RELINE COMPLETE MAXILLARY DENTURE (INDIRECT)	**Age 14-20:** Codes D5730, D5731, D5750, D5751; Covered 1 in 2 years; Bill when chair side reline; Bill if sent to outside laboratory
D5751	RELINE COMPLETE MANDIBULAR DENTURE (INDIRECT)	**Age 14-20:** Codes D5730, D5731, D5750, D5751; Covered 1 in 2 years; Bill when chair side reline; Bill if sent to outside laboratory
D5760	RELINE MAXILLARY PARTIAL DENTURE (INDIRECT)	**Age 14-20:** D5760, D5761; Bill if sent to outside laboratory; Not billable for 6 months after inserting any partial denture
D5761	RELINE MANDIBULAR PARTIAL DENTURE (INDIRECT)	**Age 14-20:** D5760, D5761; Bill if sent to outside laboratory; Not billable for 6 months after inserting any partial denture
D5810	INTERIM COMPLETE DENTURE (MAXILLARY)	**Age 7-20:** Prior authorization with recent FMX
D5811	INTERIM COMPLETE DENTURE (MANDIBULAR)	**Age 7-20:** Prior authorization with recent FMX
D5820	INTERIM PARTIAL DENTURE (MAXILLARY)	**Age 7-20:** Prior authorization with recent FMX; Includes retentive / clasping material, rests, and teeth
D5821	INTERIM PARTIAL DENTURE (MANDIBULAR)	**Age 7-20:** Prior authorization with recent FMX; Includes retentive / clasping material, rests, and teeth
D5850	TISSUE CONDITIONING MAXILLARY	**Age 14-20:** Not billable within 6 months of any denture
D5851	TISSUE CONDITIONING MANDIBULAR	**Age 14-20:** Not billable within 6 months of any denture
D5899	UNSPECIFIED REMOVABLE PROCEDURE, BY REPORT	**Age 7-20:** Prior authorization required

D5937	TRISMUS APPLIANCE (NOT FOR TMD)	**Age 1-20:** Prior authorization required
D5986	FLOURIDE GEL CARRIER	**Age 1-20:** Prior authorization for patients undergoing radiation
D5991	VESICULOBULLOUS DISEASE MEDICAMENT CARRIER	**Age1-20:** Prior authorization required
D5999 *	UNSPECIFIED MAXILLOFACIAL PROSTHESIS, BY REPORT	**Age 1-20:** Prior authorization required
PROSTHODONTICS (FIXED)		
D6211	PONTIC – CAST HIGH NOBLE METAL	**Age 14-20:** Covered 1 in 5 years; Prior authorization required with FMX and treatment plan; Codes D6211, D6212, D6241, D6242, D6545, D6751, D6752; Allowable when missing only one anterior tooth in the maxillary or mandibular arch
D6212	PONTIC – CAST PREDOMINANTLY BASE METAL	**Age 14-20:** Covered 1 in 5 years; Prior authorization required with FMX and treatment plan; Codes D6211, D6212, D6241, D6242, D6545, D6751, D6752; Allowable when missing only one anterior tooth in the maxillary or mandibular arch
D6241	PONTIC – PORCELAIN FUSED TO PREDOM BASE	**Age 14-20:** Covered 1 in 5 years; Prior authorization required with FMX and treatment plan; Codes D6211, D6212, D6241, D6242, D6545, D6751, D6752; Allowable when missing only one anterior tooth in the maxillary or mandibular arch
D6242	PONTIC – PORCELAIN FUSED TO NOBLE METAL	**Age 14-20:** Covered 1 in 5 years; Prior authorization required with FMX and treatment plan; Codes D6211, D6212, D6241, D6242, D6545, D6751, D6752; Allowable when missing only one anterior tooth in the maxillary or mandibular arch
D6545	RETAINER – CAST METAL FOR RESIN BONDED	**Age 14-20:** Covered 1 in 5 years; Prior authorization required with FMX and treatment plan; Codes D6211, D6212, D6241, D6242, D6545, D6751, D6752; Allowable when missing only one anterior tooth in the maxillary or mandibular arch
D6751	CROWN – PORCELAIN FUSED TO PREDOM BASE	**Age 14-20:** Covered 1 in 5 years; Prior authorization required with FMX and treatment plan; Codes D6211, D6212, D6241, D6242, D6545, D6751, D6752; Allowable when missing only one anterior tooth in the maxillary or mandibular arch
D6752	CROWN – PORCELAIN FUSED TO NOBLE METAL	**Age 14-20:** Covered 1 in 5 years; Prior authorization required with FMX and treatment plan; Codes D6211, D6212, D6241, D6242, D6545, D6751, D6752; Allowable when missing only one anterior tooth in the maxillary or mandibular arch

D6791	CROWN – FULL CAST PREDOMINANTLY BASE METAL	**Age 14-20:** Covered 1 in 5 years; Prior authorization required with FMX and treatment plan; Codes D6211, D6212, D6241, D6242, D6545, D6751, D6752; Allowable when missing only one anterior tooth in the maxillary or mandibular arch
D6792	CROWN – FULL CAST NOBLE METAL	**Age 14-20:** Covered 1 in 5 years; Prior authorization required with FMX and treatment plan; Codes D6211, D6212, D6241, D6242, D6545, D6751, D6752; Allowable when missing only one anterior tooth in the maxillary or mandibular arch
D6930	RECEMENT FIXED PARTIAL DENTURE	**Age 14-20:** Must include narrative on claim
D6980	FIXED PARTIAL DENTURE REPAIR	**Age 14-20:** Must include narrative on claim
D6999 *	UNSPECIFIED FIXED PROSTHODONTIC PROCEDURE, BY REPORT	**Age 14-20:** Prior authorization required
ORAL SURGERY		
D7111	EXTRACTION, CORONAL REMNANTS	**Age 0-20:** Limited to primary dentition
D7140	EXTRACTION, ERUPTED TOOTH / EXPOSED ROOT	**Age 0-20:** Prior authorization if ortho related
D7210	SURGICAL REMOVAL OF ERUPTED TOOTH	**Age 0-20:** Prior authorization if ortho related
D7220	REMOVAL OF TOOTH – SOFT TISSUE	**Age 0-20:** Prior authorization if ortho related
D7230	REMOVAL OF TOOTH – PARTIALLY BONY	**Age 12-20:** Not covered for teeth #1, #16, #17, #32; Bill MCO if teeth #1, #16, #17, #32
D7240	REMOVAL OF TOOTH – COMPLETELY BONY	**Age 12-20:** Not covered for teeth #1, #16, #17, #32; Bill MCO if teeth #1, #16, #17, #32
D7241	REMOVAL OF COMPLETELY BONY WITH UNUSUAL TOOTH	**Age 12-20:** Not covered for teeth #1, #16, #17, #32; Bill MCO if teeth #1, #16, #17, #32
D7250	SURGICAL CUTTING & REMOVAL OF RESIDUAL TOOTH ROOTS	**Age 0-20**
D7270	TOOTH RE-IMPLANTATION	**Age 5-20**
D7272	TOOTH TRANSPLANTATION TO ANOTHER SITE & SPLINTING	**Age 5-20**
D7280	SURGICAL ACCESS OF AUN UNERUPTED TOOTH	**Age 8-20:** Prior authorization; Indicate need and if orthodontics related

D7282	LUXATE TOOTH TO AID ERUPTION	**Age 6-20:** Prior authorization; Not covered for teeth #1, #16, #17, #32
D7283	DEVICE PLACMENT FOR IMPACTED TOOTH	**Age 8-20:** Prior authorization; Indicate need and if ortho related
D7310	ALVEOLOPLASTY WITH EXTRACTIONS – 4 OR MORE	**Age 14-20**
D7320	ALVEOLOPLASTY WITH EXTRACTIONS – 1 TO 3 TEETH	**Age 14-20**
D7510	I & D OF ABSCESS – INTRAORAL SOFT TISSUE	**Age 0-20**
D7511	I & D OF ABSCESS – COMPLICATED – INTRAORAL	**Age 0-20**
D7520	I & D OF ABSCESS – EXTRAORAL SOFT TISSUE	**Age 0-20**
D7521	I & D OF ABSCESS – COMPLICATED – EXTRAORAL	**Age 0-20**
D7910	SUTURE OF RECENTAL SMALL WOUNDS UP TO 5 CM	**Age 14-20**
D7961	BUCCAL / LABIAL FRENULECTOMY	**Age 0-20**
D7962	LINGUAL FRENULECTOMY	**Age 0-20**
D7970	EXCISION OF HYPERPLASTIC TISSUE – PER ARCH	**Age 14-20:** Prior authorization required
D7971	EXCISION OF PERICORONAL GINGIVA	**Age 14-20**
D7999 *	UNSPECIFIED ORAL SURGERY PROCEDURE, BY REPORT	See Dental Provider Specific Manual – Section 4.1.3.3 Billing Instructions for Supernumerary Tooth / other write narrative
ORTHODONTICS		
D8020	LIMITED ORTHODONTIC TRANSITIONAL DENTITION	**Age 7-14:** Submit Panorex and photographs with claim
D8090	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADULT	**Age 10-20:** Prior authorization required; See Dental Provider Specific Manual – Sections 3.2.4 - 7
D8660	INITIAL RECORDS	**Age 10-20:** See Dental Provider Specific Manual – Section 3.2.1
D8670	PERIODIC ORTHODONTIC TREATMENT VISIT	**Age 10-20:** Prior authorization for comprehensive orthodontics

D8680	ORTHODONTIC RETENTION	**Age 8-20:** Not to be billed when approved for D8090 or D8020
D8703	REPLACEMENT OF LOST OR BROKEN RETAINER-MAXILLARY	**Ages 10-20:** Prior authorization required
D8704	REPLACEMENT OF LOST OR BROKEN RETAINER-MANDIBULAR	**Ages 10-20:** Prior authorization required
D9986	MISSED APPOINTMENTS	Report on annual review
D8660,D8090, D8670, D8680 only covered for orthodontist and periodontist that have an orthodontic taxonomy.		
ADJUNCTIVE GENERAL SERVICES		
D9110	PALLIATIVE TREATMENT	**Age 0-20:** Must include narrative on claim
D9222	DEEP SEDATION / GENERAL ANESTHESIA – FIRST 15 MINUTES	See Dental Provider Specific – Section 4.2 Anesthesia Services
D9223	DEEP SEDATION / GENERAL ANESTHESIA – EACH SUBSEQUENT 15 MINUTE INCREMENT	See Dental Provider Specific – Section 4.2 Anesthesia Services Must include D9222 on claim.
D9230	INHALATION OF NITROUS OXIDE / ANALGESIA, ANXIOLYSIS	See Dental Provider Specific – Section 4.2 Anesthesia Services
D9239	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION / ANALGESIA – FIRST 15 MINUTES	See Dental Provider Specific – Section 4.2 Anesthesia Services
D9243	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION / ANALGESIA – EACH SUBSEQUENT 15 MINUTE INCREMENT	See Dental Provider Specific – Section 4.2 Anesthesia Services Must include D9239 on claim.
D9246	ADMINISTRATION OF MODERATE SEDATION – NON-INTRAVENOUS PARENTERAL – FIRST 15 MINUTE INCREMENT	See Dental Provider Specific – Section 4.2 Anesthesia Services
D9247	ADMINISTRATION OF MODERATE SEDATION – NON-INTRAVENOUS PARENTERAL – EACH SUBSEQUENT 15 MINUTE INCREMENT	See Dental Provider Specific – Section 4.2 Anesthesia Services Mu include D9246 on claim.
D9420	HOSPITAL CASE	Code required when seen in OR or at other providers office
D9440	OFFICE VISIT – AFTER REGULARLY SCHEDULED HOURS	**Age 0-20:** 1 visit per day
D9610	THERAPEUTIC PARENTERAL DRUG – SINGLE ADMIN	**Age 0-20:** Note medication on claim

D9612	THERAPEUTIC PARENTERAL DRUG – TWO OR MORE ADMIN	**Age 0-20:** Note medication on claim
D9920	BEHAVIOR MANAGEMENT	**Age 0-20:** Not billable with D9230, D9223, D9243, D9246, D9247
D9930	TREATMENT OF COMPLIATIONS (POST SURGICAL)	**Age 0-20:** Must include narrative on claim
D9944	OCCLUSAL GUARD – HARD APPLIANCE, FULL ARCH	**Age 10-20:** Only 1 per 5 years; No Prior authorization required
D9999	UNSPECIFIED ADJUNCTION PROCEDURE, BY REPORT	**Age 0-20:** Prior authorization required

Reserved

9.0 Reserved

Reserved

10.0 Reserved