CHIP Dental Services Benefit Limits and Fees

Benefit Limits Key

A = Age range limitations

TID = Tooth ID

Member Annual Maximums

Covered dental services are subject to a $564 annual benefit limit unless an exception applies. In addition, some of the benefits identified in the schedule below are subject to annual limits. Limitations are based on a 12-month coverage period.

CHIP members who have exhausted the $564 annual benefit limit continue to receive the following covered dental services in excess of the $564 annual benefit maximum:

1. The preventive services due under the 2009 American Academy of Pediatric Dentistry periodicity schedule (Volume 32, Issue Number 6 at pp. 93-100).
2. Other medically necessary covered dental services approved by the Dental Contractor through a pre-authorization process. These services must be necessary to allow a CHIP member to return to normal, pain- and infection-free oral functioning. Typically, this includes:
    a. Services related to the relief of significant pain or to eliminate acute infection
    b. Services related to treat traumatic clinical conditions
    c. Services that allow the CHIP member to attain the basic human functions (e.g., eating, speech, etc.)
    d. Services that prevent a condition from seriously jeopardizing the CHIP member's health/functioning or deteriorating in an imminent time frame to a more serious and costly dental problem

When services are being requested in excess of the $564 annual benefit limit, all requests must be pre-authorized. The requests must include x-rays and narratives, even for services that otherwise do not require them.

Diagnostic Services

Clinical Oral Evaluations

Code	Description	Benefit Limits	Fee
D0120	Periodic Oral Evaluation – established patient	Limited to one (1) every six (6) months by the same provider, facility, or group. Denied when submitted for the same DOS as D0150 or D0140 by any provider, group, or facility. Claims for this service must include a caries risk assessment code (D0601, D0602, or D0603). Effective 1/1/2016, a caries risk assessment must be submitted on the same claim in order to be reimbursed.	$28.85
D0140	Limited Oral Evaluation – problem focused	An evaluation limited to a specific oral health problem or complaint. This may require interpretation of information acquired through additional diagnostic procedures. A benefit if documentation of need for the provider to take time out to see the member for a specific reason. Limited to one (1) service per day. Denied when submitted for the same DOS as D0120 or D0150 by any provider, group, or facility.	$18.78
D0150	Comprehensive Oral Evaluation	A benefit once per patient per provider, facility, or group for the initial examination when the claim form indicates a complete examination was rendered. Includes examination of all hard and soft tissue of the oral cavity, including periodontal charting and oral cancer exam. Limited to one (1) per member per provider, facility, or group. Subsequent submissions of D0150 will be the equivalent of periodic oral evaluations (D0120). Denied when submitted for the same DOS as D0120 or D0140 by any provider, group, or facility. Claims for this service must include a caries risk assessment code (D0601, D0602, or D0603). Effective 1/1/2016, a caries risk assessment must be submitted on the same claim in order to be reimbursed.	$35.32

Radiographs/Diagnostic Imaging (Including Interpretation)

An alternate benefit of a full mouth series x-ray (D0210) will be applied when an office submits any combination of periapical, panoramic, and bitewing x-rays exceeding the reimbursable value of the full mouth series x-ray.

Requirements when submitting x-rays:

- Must be of diagnostic quality
- All panorex must be marked right and left
- Must include the member name
- Must include the date x-rays were taken

MCNA will not return x-rays. We require you to make two (2) sets of x-rays and send us the duplicate set.

Code	Description	Benefit Limits	Fee
D0210	Intraoral Complete Series (including bitewings) – Limited to one (1)	MCNA will pay for a full mouth series x-ray (D0210) once every three (3) years by the same provider, facility, or group. An alternate benefit of a full mouth series x-ray (D0210) will be applied when an office submits any combination of periapical, panoramic, and bitewing x-rays exceeding the reimbursable value of the full mouth series x-ray. Not allowed as an emergency service.	$70.64
D0220	Intraoral - periapical, first radiographic image	1. The procedure applies to the first periapical film, including oral evaluation and diagnosis. 2. When submitting a claim, the tooth number must be indicated.	$12.56
D0230	Intraoral - periapical, each additional radiographic image	1. When the fee submitted for any combination of intraoral x-rays in a series meets or exceeds the fee for a complete intraoral series, it is considered that the films to be the equivalent of a complete series, procedure D0210. 2. Periapical films provided in conjunction with a panoramic film on the same date of service are considered a complete intraoral series and will be processed as procedure D0210. 3. When submitting a claim, the tooth number must be indicated.	$11.51
D0270	Bitewings - single radiographic image	Single bitewing x-rays are allowed on an emergency or episodic basis.	$4.90
D0272	Bitewings – two (2) radiographic images	Not a benefit for edentulous area.	$23.38
D0274	Bitewings – four (4) radiographic images	Not a benefit for edentulous area.	$34.61

D0330	Panoramic radiographic image	1. Panoramic radiographs alone, when appropriate to the diagnosis of extractions in multiple quadrants (two (2) or more), shall be benefits only once for members aged five (5) through nine (9) years and once for members aged 10 through 18 years, except when documented as essential for follow-up or post-operative care in a treatment series. 2. Limited to one (1) per five (5) years. 3. Procedure D0330 is not a benefit on the same date of service as procedure D0210 (Intraoral, Complete Series). 4. Requires rationale for children less than 3 years of age. 5. An alternate benefit of a full mouth series x-ray (D0210) will be applied when an office submits a combination of periapical, panoramic, and bitewing x-rays exceeding the reimbursable value of the full mouth series x-ray.	$63.78

Preventive Services

Dental Prophylaxis

Code	Description	Benefit Limits	Fee
D1110	Prophylaxis - adult	Per the AAPD periodicity table, cleanings allowed once every six (6) months. A 13-18.	$54.88
D1120	Prophylaxis - child	Per the AAPD periodicity table, cleanings allowed once every six (6) months. A 1-12.	$36.75

Topical Fluoride Treatment (Office Procedure)

Code	Description	Benefit Limits	Fee
D1206	Topical application of fluoride varnish	Includes oral health instructions. Denied when submitted for the same DOS as any D4000 series periodontal procedure code or with procedure code D0145. Per the AAPD periodicity table, application of fluoride allowed once every six (6) months. A 6 months - 19 years.	$14.70
D1208	Topical application of fluoride – excluding varnish	Includes oral health instructions. Denied when submitted for the same DOS as any D4000 series periodontal procedure. Per the AAPD periodicity table, application of fluoride allowed once every six (6) months. A 6 months - 19 years.	$14.70

Other Preventive Services

Code	Description	Benefit Limits	Fee
D1351	Sealant - per tooth	1. Sealants are limited to once per tooth per lifetime. 2. Sealants are a benefit for permanent first and second molars and maxillary premolars; tooth numbers 2, 3, 4, 5, 12, 13, 14, 15, 18, 19, 30, and 31.	$28.24

Space Maintenance (Passive Appliances)

Code	Description	Benefit Limits	Fee
Space maintainers are a benefit of Texas Medicaid after premature loss of primary or secondary molars (TID A, B, I, J, K, L, S, and T for members who are one (1) through 12 years of age, and after loss of permanent molars (TID 3, 14, 19, and 30) for clients who are three (3) through 20 years of age. Limited to one (1) space maintainer per TID per member. When procedure code D1510, D1516, D1517 or D1575 have been previously reimbursed, the recementation of space maintainers (procedure code D1550) may be considered for reimbursement to either the same or different THSteps dental provider. A space maintainer will not be reimbursed if the space will be maintained for less than six (6) months. Replacement space maintainers may be considered upon appeal with documentation supporting medical necessity. Removal of a fixed space maintainer is not payable to the provider or dental group practice that originally placed the device (D1555).			
D1510	Space maintainer – fixed unilateral	Limited to fixed appliances which are passive in nature. A space maintainer will not be reimbursed if the space will be maintained for less than six (6) months. Requires x-rays and rationale with TID, quadrant, and/or arch.	$156.80
D1516	Space maintainer-fixed bilateral, maxillary	A 1-20. (TIDs A, B, I, J,). A 1-20. (TIDs 3, 14). Limited to bilateral fixed appliances which are passive in nature. Requires x-rays and rationale with TID or quadrant.	$232.75
D1517	Space maintainer-fixed bilateral, mandibular	A 1-20. (TIDs K, L, S, T). A 1-20. (TIDs 19, 30). Limited to bilateral fixed appliances which are passive in nature. Requires x-rays and rationale with TID or quadrant.	$232.75
D1520	Space maintainer – removable unilateral	A space maintainer will not be reimbursed if the space will be maintained for less than six (6) months. Requires x-rays and rationale with TID, quadrant, and/or arch.	$73.50
D1526	Space maintainer - removable -– bilateral, maxillary	A 1-20. (TIDs A, B, I, J). A 1-20. (TIDs 3, 14). Limited to bilateral fixed appliances which are passive in nature. Requires x-rays and rationale with TID, or quadrant, and/or arch.	$104.13

D1527	Space maintainer- removable – bilateral, mandibular	A 1-20. (TIDs K, L, S, T). A 1-20. (TIDs 19, 30). Limited to bilateral fixed appliances which are passive in nature. Requires x-rays and rationale with TID or quadrant.	$104.13
D1575	Distal Shoe space maintainer – fixed - unilateral	A 1-20. (TIDs A, B, I, J, K, L, S, T). A 1-20. (TIDs 3, 14, 19, 30). Requires x-rays and rationale with TID, quadrant, and/or arch.	$156.80

Restorative Services

Amalgam Restorations (Including Polishing)			
Code	**Description**	**Benefit Limits**	**Fee**
D2140	Amalgam – one (1) surface, primary	Limited to one (1) per tooth per 12 months.	$59.23
D2140	Amalgam – one (1) surface, permanent	Limited to one (1) per tooth per 12 months.	$62.80
D2150	Amalgam – two (2) surfaces, primary	Limited to one (1) per tooth per 12 months.	$79.21
D2150	Amalgam – two (2) surfaces, permanent	Limited to one (1) per tooth per 12 months.	$83.57
D2160	Amalgam – three (3) surfaces, primary	Limited to one (1) per tooth per 12 months.	$86.00
D2160	Amalgam – three (3) surfaces permanent	Limited to one (1) per tooth per 12 months.	$106.46
D2161	Amalgam – four (4) or more surfaces, primary or permanent	Limited to one (1) per tooth per 12 months.	$57.37
Resin-Based Composite Restorations - Direct			
Code	**Description**	**Benefit Limits**	**Fee**
D2330	Resin-based composite – one (1) surface, anterior	Limited to one (1) per tooth per 12 months	$75.81
D2331	Resin-based composite – two (2) surfaces, anterior	Limited to one (1) per tooth per 12 months	$100.46
D2332	Resin-based composite – three (3) surfaces, anterior	Limited to one (1) per tooth per 12 months.	$131.17
D2335	Resin-based composite – four (4) or more surfaces or involving incisal angle, anterior	Limited to one (1) per tooth per 12 months.	$162.80
D2391	Resin-based composite – one (1) surface, posterior, primary	Limited to one (1) per tooth per 12 months.	$73.56
D2391	Resin-based composite – one (1) surface, posterior, permanent	Limited to one (1) per tooth per 12 months.	$80.34
D2392	Resin-based composite – two (2) surfaces, posterior, primary	Limited to one (1) per tooth per 12 months.	$94.58
D2392	Resin-based composite – two (2) surfaces, posterior, permanent	Limited to one (1) per tooth per 12 months.	$105.30

D2393	Resin-based composite - three (3) surfaces, posterior, primary	Limited to one (1) per tooth per 12 months.	$83.24
D2393	Resin-based composite - three (3) surfaces, posterior, permanent	Limited to one (1) per tooth per 12 months.	$96.68
D2394	Resin-based composite - four (4) or more surfaces, posterior	Limited to one (1) per tooth per 12 months.	$71.72

Crowns - Single Restorations Only

Code	Description	Benefit Limits	Fee
The following codes require pre-authorization, x-rays, and rationale.			
D2710	Crown – resin-based composite (indirect)	Limited to one (1) per tooth per five (5) years.	$252.25
D2720	Crown – resin with high noble metal	Limited to one (1) per tooth per five (5) years.	$252.25
D2721	Crown – resin with predominantly base metal	Limited to one (1) per tooth per five (5) years.	$252.25
D2722	Crown – resin with noble metal	Limited to one (1) per tooth per five (5) years.	$252.25
D2740	Crown – porcelain/ceramic	Limited to one (1) per tooth per five (5) years.	$252.25
D2750	Crown – porcelain fused to high noble metal	Limited to one (1) per tooth per five (5) years.	$504.50
D2751	Crown – porcelain fused to predominantly base metal	Limited to one (1) per tooth per five (5) years.	$504.50
D2752	Crown – porcelain fused to noble metal	Limited to one (1) per tooth per five (5) years.	$504.50
D2790	Crown – full cast high noble metal	Limited to one (1) per tooth per five (5) years.	$504.50
D2791	Crown – full cast predominantly base metal	Limited to one (1) per tooth per five (5) years.	$252.25

Other Restorative Services

Code	Description	Benefit Limits	Fee
D2930	Prefabricated stainless steel crown – primary tooth.	Limited to one (1) per tooth per lifetime.	$149.12
D2931	Prefabricated stainless steel crown – permanent tooth.	Limited to one (1) per tooth per lifetime.	$155.27

Endodontic Services

Pulpotomy

Code	Description	Benefit Limits	Fee
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pup coronal to the dentinocemental junction and application of medicament	1. Any acceptable and recognized method is a benefit where the procedure is justified and the coronal portion of the pulp is completely extirpated. 2. Procedure D3220 may be performed on primary or permanent teeth. 3. This is not to be billed as the first stage of root canal therapy. 4. Not payable in conjunction with procedures D3310 - D3330 done within six (6) to 12 months. 5. Payable once per tooth per lifetime by the same provider, group, or facility.	$84.05

Endodontic Therapy on Primary Teeth

Code	Description	Benefit Limits	Fee
D3230	Pulpal therapy (resorbable filling) - anterior primary incisors and cuspids (excluding final restoration)	1. A benefit without pre-authorization for a primary tooth. 2. The pulp must be completely extirpated. 3. Must include the placement of a resorbable filling. 4. If done in conjunction with D3220, MCNA will deny or recover payment if pulpotomy was paid. 5. Anterior primary incisors and cuspids. TIDs C-H; M-R. A 1-20. Requires x-rays. 6. Payable per tooth once per lifetime by the same provider, group, or facility.	$37.03
D3240	Pulpal therapy (resorbable filling) – posterior primary first and second molars (excluding final restoration)	1. A benefit without pre-authorization for a primary tooth. 2. The pulp must be completely extirpated. 3. Must include the placement of a resorbable filling. 4. If done in conjunction with D3220, MCNA will deny or recover payment if pulpotomy was paid. 5. Posterior first and second molars. TIDs A, B, I, J, K, L, S, T. A 1-20. Requires x-rays. 6. Payable per tooth once per lifetime by the same provider, group, or facility.	$42.02

Endodontic Therapy (including Treatment Plan, Clinical Procedures, and Follow-up Care)			
Code	**Description**	**Benefit Limits**	**Fee**
The following codes require x-rays.			
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	Permanent teeth only. Limited to one (1) per tooth per lifetime. When submitting claims, please include pre-operative and post-operative films. Payable once per tooth, per lifetime.	$340.14
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	Permanent teeth only. Limited to one (1) per tooth per lifetime. When submitting claims, please include pre-operative and post-operative films. Payable once per tooth, per lifetime.	$394.14
D3330	Endodontic therapy, molar (excluding final restoration)	Permanent teeth only. Limited to one (1) per tooth per lifetime. When submitting claims, please include pre-operative and post-operative films. Payable once per tooth, per lifetime.	$596.48

Periodontal Services

Surgical Services (Including Routing Post Delivery Care)			
Code	**Description**	**Benefit Limits**	**Fee**
D4210	Gingivectomy or gingivoplasty – four (4) or more contiguous teeth or tooth-bounded spaces per quadrant	Requires pre-authorization, color photos, and rationale.	$155.27

Nonsurgical Periodontal Services			
Code	**Description**	**Benefit Limits**	**Fee**
D4341	Periodontal scaling and root planing – four (4) or more teeth per quadrant	D4341 is denied if provided within 21 days of D4355. Denied when submitted for the same DOS as other D4000 series codes. When submitted with D1110, D1120, D1206, D1208, D1351, D1510, D1516, D1517, D1520, D1526, D1527 or D1575, the preventive services will be denied. A 13-18. Requires pre-authorization, x-rays, periodontal charting, and rationale.	$53.75
D4355	Full mouth debridement to enable comprehensive evaluation on a subsequent visit	D4355 is not payable if provided within 21 days of D4341. Denied when submitted for the same DOS as other D4000 series codes. When billed with D1110, D1120, D1206, D1208, D1351, D1510, D1516, D1517, D1520, D1526, D1527 or D1575, the preventive services will be denied. A 13-18. Requires pre-authorization, x-rays, color photos, and rationale.	$71.66

Prosthodontic (Removable) Services

Complete Dentures (Including Routing Post Delivery Care)

Code	Description	Benefit Limits	Fee
D5110	Complete denture – maxillary (upper)	Requires pre-authorization, x-rays, and rationale.	$358.31
D5120	Complete denture – mandibular (lower)	Requires pre-authorization, x-rays, and rationale.	$358.31

Partial Dentures (Including Routine Post Delivery Care)

Code	Description	Benefit Limits	Fee
D5211	Maxillary partial denture – resin base (including any conventional clasps, rests, and teeth)	Requires pre-authorization, x-rays, and rationale.	$262.76
D5212	Mandibular partial denture – resin base (including any conventional clasps, rests, and teeth)	Requires pre-authorization, x-rays, and rationale.	$262.76
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)	Requires pre-authorization, x-rays, and rationale.	$382.20
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)	Requires pre-authorization, x-rays, and rationale.	$382.20

Oral and Maxillofacial Surgery Services

MCNA requires a pre-authorization for the following dental procedures when reported on tooth letters A through T, AS through TS, and all permanent teeth: D7210, D7220, D7230, D7240, and D7241. Additionally, MCNA requires a pre-authorization on the extractions of tooth numbers 1, 16, 17, and 32.

There is no benefit for the extraction of asymptomatic teeth. Extractions are not payable for deciduous teeth when normal loss is imminent.

Oral and Maxillofacial Surgery Services

Code	Description	Benefit Limits	Fee
D7140	Extraction, erupted tooth or exposed root (Elevation and/or forceps removal)	A Birth-20. All primary teeth within the normal exfoliation period will require submission of an x-ray (or intraoral photograph if the tooth cannot be seen radiographically) and rationale. All permanent teeth require submission of an x-ray.	$64.06

Surgical Extractions

Code	Description	Benefit Limits	Fee
The following codes require pre-authorization, x-rays, and rationale.			
D7210	Extraction of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap, if inidcated	*1.* A benefit when removal of any erupted tooth requires both of the following: • The retraction of a mucoperiosteal flap • The removal of substantial alveolar bone in order to effect the extraction Examples include, when documented, but are not limited to: • Crown undermined by caries which prohibits normal forceps technique • Divergent, thin, curved, or brittle roots which require separate and individual manipulation or extraction • Hypercementosis • Partial ankylosis *2.* The fee for multiple surgical extractions includes any necessary alveoloplasty. *3.* Requires x-rays.	$98.23
D7220	Removal of impacted tooth – soft tissue	*1.* A benefit if a permanent tooth is removed by the open method and if: • The major portion or all of the crown of the tooth is covered by mucogingival tissue • The major portion or the entire crown of the tooth is not covered by alveolar bone *2.* Requires pre-authorization and x-rays..	$150.49
D7230	Removal of impacted tooth – partially bony	A benefit if removal of alveolar bone to expose any portion of the crown of the permanent tooth is necessary to effect extraction by the open method. Requires pre-authorization and x-rays..	$171.99
D7240	Removal of impacted tooth – completely bony	A benefit if removal of alveolar bone to expose the major portion of the crown of the permanent tooth is necessary to effect extraction by the open method. Requires pre-authorization and x-rays.	$286.65

Dental Guidelines

MCNA's Utilization Management Criteria uses components of dental standards from the American Academy of Pediatric Dentistry (www.aapd.org) and the American Dental Association (www.ada.org). MCNA's criteria are changed and enhanced as needed.

The procedure codes used by MCNA are described in the American Dental Association's Code Manual. Requests for documentation of these codes are determined by community accepted dental standards for authorization such as treatment plans, narratives, radiographs and periodontal charting.

These criteria are approved and annually reviewed by MCNA's Dental Management Committee. They are designed as guidelines for authorization and payment decisions and are not intended to be absolute.

Guidelines for General Dentists and Pediatric Dentists

As part of the Main Dental Home Program, general and pediatric dentists must register referrals with MCNA when referring members to another in-network general or pediatric dentist that is not the member's Main Dental Home. ***If a referral is not submitted to MCNA, the treating provider's claims for services will be denied. The treating provider must include the referral number in Box 2 of the ADA Claim Form, or in the "Pre-Authorization Number" field of the claim in MCNA's online Provider Portal. Failure to include the referral number may result in denial of the claim.***

Emergency services do not require a referral.

Referrals should be requested through the MCNA online Provider Portal at http://portal.mcna.net. All referral determinations can be viewed on the Portal. A referral may be utilized by any in-network general or pediatric dentist at the facility listed on the referral.

Guidelines for Specialists

The role of the Specialist (Endodontist, Orthodontist, Oral Surgeon, Periodontist, Prosthodontist) is to provide covered services to members for medically necessary treatment. Members have direct access to in-network dental specialists. A referral is not necessary for members to access in-network dental specialists, but referrals are encouraged as part of MCNA's Main Dental Home Program. All referrals will be processed within 72 hours.

Once treatment is complete, the specialist is to discharge the member back to their Main Dental Home for follow-up.

Emergency services do not require a referral.

Referrals should be requested through the MCNA Provider Portal at http://portal.mcna.net. All referral determinations can be viewed on the Portal.

Guidelines for Oral Surgery

Uncomplicated extractions, removal of soft tissue impactions or minor surgical procedures are considered basic services and are the responsibility of the Main Dental Home Provider (MDHP). The member may be referred to a contracted MCNA oral surgeon when it is beyond the scope of the MDHP.

Criteria

- A tooth broken below the bone level
- Supernumerary tooth
- Dentigerous cyst
- Untreatable Periodontal disease
- Pathology not treatable by other means
- Recurrent pericoronitis
- Non-restorable carious lesion
- Pain and/or swelling due to impeded eruption
- Orthodontic related services (requires approval)
- Exfoliation of a deciduous tooth not anticipated within six (6) months
- No extractions of third molars if roots are not substantially formed
- Alveolplasty (7310) in conjunction with four (4) or more extractions in the same quadrant
- There is no benefit for the extraction of asymptomatic teeth
- Extractions are not payable for deciduous teeth when normal loss is imminent

Documentation Required for Authorization

- Submit appropriate radiographs with authorization request: bitewings, periapical or panorex
- Narrative demonstrating medical necessity

Procedure Codes

- D7210, D7220 - extraction, erupted tooth; radiographs and narrative
- D7230, D7240, D7241 - removal of impacted teeth; radiographs and narrative
- D7250 - surgical removal of residual roots; radiographs and narrative
- D7280 - surgical access of unerupted tooth; radiographs and narrative
- D7310, D7311, D7320, D7321 - alveoloplasty in conjunction with extraction; radiographs and narrative
- D7510, D7511 - incision and drainage of abscess; radiographs and narrative (will not be considered on same date with extraction of tooth related to incision and drainage)

Code Descriptions

- **D7140 - extractions, erupted tooth or exposed root (elevation and/or forceps removal)**
  Includes routine removal of tooth structure, minor smoothing of socket or socket bone, and closure, as necessary.
- **D7210 - extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated**
  Includes related cutting of gingival and bone, removal of tooth structures, minor smoothing of socket bone and closure.
- **D7220 - removal of impacted - soft tissue**
  Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation.
- **D7230 - removal of impacted tooth - partially bony**
  Part of crown covered by bone; requires mucoperiosteal flap elevation and bone removal.
- **D7240 - removal of impacted tooth - completely bony**
  Most or all crown covered by bone; requires mucoperiosteal flap elevation and bone removal.
- **D7241 - removal of impacted tooth-complete bony, with unusual surgical complications**
  Most or all of crown covered by bone; usually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required, or aberrant tooth position.

- **D7250 - surgical removal of residual tooth roots (cutting procedure)**
  Includes cutting of soft tissue and bone, removal of tooth structure, and closure.

Criteria for Excision of Bone Tissue

Code D7471 is related to the removal of the lateral exostosis. This code is subject to authorization and may be reimbursed for when submitted in conjunction with a treatment plan that includes removable prosthetics. This determination will be made by a licensed dentist.

Documentation Required for Authorization of Excision of Bone Tissue

- Appropriate radiographs and/or intraoral photographs which clearly identify the lateral exostosis must be submitted for authorization review; bitewings, periapical or panorex.
- Study models identifying the lateral exostosis (es) to be removed.

Guidelines for Endodontics

Criteria

- The tooth is infected and/or abscessed
- Trauma or fracture that damages the pulp
- The pulp of the primary tooth is infected and the exfoliation of the deciduous tooth is not anticipated within six months (for pulpotomy or pulpectomy only)
- A third molar that will be used as an abutment for a partial denture that requires root canal therapy
- Tooth must demonstrate at least 50% bone support and cannot have mobility grades +2 or +3
- Root canal therapy not in anticipation of placement of an overdenture

Criteria for Retreatment of Root Canal

- Overfilled canal
- Underfilled canal
- Broken instrument in canal, that is not retrievable
- Root canal filling material lying free in periapical tissues and acting as an irritant
- Perforation of the root in the apical one-third of the canal therefore this will cause a denial for a retreatment
- Fractured root tip is not reachable therefore this will cause a denial for a retreatment

Criteria for Apexification

- The apex of the root is not closed and needs to be treated so closure can be achieved (usually after trauma)

Criteria for Apicoectomy and Retrograde Filling

- The apex of the tooth needs to be removed because the surrounding area is infected and/or has an abscess; it requires a filling to be placed in the apical part of the tooth to seal that part of the root canal
- Perforation of the root in the apical one-third of the canal

Documentation Required for Authorization

- Submit appropriate radiographs with authorization request: periapical or panorex
- Emergency treatment will require a dated pre- and post-operative radiograph for claims review
- In situations where pathology is not apparent, a written narrative justifying treatment is required

Other Considerations

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

Procedure Codes

- D3310 - anterior routine endodontic therapy
- D3320 - bicuspid endodontic therapy
- D3330 - molar endodontic therapy
- D3220 - therapeutic pulpotomy
- D3221 - pulpal debridement on primary and permanent teeth
- D3230 - pupal therapy on primary anterior teeth (resorbable filling)
- D3240 - pupal therapy on primary teeth (resorbable filling)
- D3331 - treatment of root canal obturation; non surgical access
- D3351 - apexification/recalcification initial visit
- D3352 - apexification/recalcification interim visit
- D3353 - apexification/recalcification final visit
- D3410 - apicoectomy
- D3430 - retrograde filling

Guidelines for Non-Intravenous and IV Sedation

Requirements

- Dentists providing sedation or anesthesia services must have the appropriate certification from the Texas State Board Dental Examiners (TSBDE) for the level of sedation or anesthesia provided
- After September 1, 2019, a permit holder may not administer sedation/anesthesia under a level 2, level 3, or level 4 permit to a pediatric patient or a high risk patient unless the permit holder has completed the requirements and has received authorization from the Board to administer sedation/anesthesia to high-risk or pediatric patients.

MCNA must have on file a copy of the certification as well as proof of completion of one or both of the High Risk or Pediatric Patient courses, as applicable prior to rendering sedation services

Criteria

Acceptable conditions include, but are not limited to, one (1) or more of the following:

- Documented local anesthesia toxicity
- Severe cognitive impairment or developmental disability
- Severe physical disability
- Uncontrolled management problem
- Extensive or complicated surgical procedures
- Failure of local anesthesia
- Documented medical complications
- Acute infections

Documentation Required for Claims Processing

- Certain procedures require submission of narrative stating medical necessity (refer to the CHIP Dental Services Benefit Limits and Fees section of this manual).

Note: Sedation will be restricted to two (2) procedures within a 12-month period without prior authorization.

Procedure Codes

- D9222 - deep sedation/general anesthesia - first 15 minutes
- D9223 - deep sedation/ general - each additional 15 minutes
- D9239 - intravenous conscious sedation/analgesia - first 15 minutes
- D9243 - intravenous conscious sedation/ analgesia - each additional 15 minutes
- D9248 - non-intravenous conscious sedation

Criteria for Dental Therapy Under General Anesthesia

The dental provider is responsible for determining whether a member meets the minimum criteria medically necessary for receiving general anesthesia. The “Criteria for Dental Therapy under General Anesthesia” form (22-point scale) is located in the Forms section of this manual. The completion of this form is mandatory for all members requiring treatment under general anesthesia and must be submitted with the claims for processing and approval for payment.

Criteria for Medical Immobilization Including Papoose Boards

The provider must obtain a written informed consent from the legal guardian and documented in the member’s dental record prior to medical immobilization.

The member’s record should include:

- Informed consent
- Type of immobilization used
- Indication for immobilization
- The duration of application

Goals of behavior management:

- Establish communication
- Alleviate fear and anxiety
- Deliver quality dental care
- Build a trusting relationship between dentist and child
- Promote the child’s positive attitude toward oral/dental health

Guidelines for Core Build Up

Criteria

- The foundation of the tooth is insufficient to place a crown
- Performed on a previously endodontic treated tooth to provide a foundation to place a crown
- Not covered on primary teeth

Documentation Required for Authorization

- Submit appropriate radiographs with authorization request: periapical or panorex
- Requires post-operative endodontic x-ray in order to approve prefabricated post and core

Procedure Codes

- D2940 - sedative filling
- D2950 - core build up
- D2951 - pin retention per tooth
- D2954 - prefab post and core in addition to a crown

Guidelines for Crowns

Criteria

- Criteria for crowns will be met only for permanent teeth needing multisurface restorations where other restorative materials have a poor prognosis.
- Permanent molar teeth must have pathologic destruction to the tooth by caries or trauma, and should involve four (4) or more surfaces and two (2) or more cusps.
- Permanent bicuspid teeth must have pathologic destruction to the tooth by caries or trauma, and should involve three (3) or more surfaces and at least one (1) cusp.
- Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma, and must involve four (4) or more surfaces and at least 50% of the incisal edge.

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

Cast crowns will not meet criteria if:

- A lesser invasive restoration is possible
- Tooth has subosseous and/or furcation caries
- Tooth has advanced periodontal disease
- A primary tooth
- Crowns are being planned to alter vertical dimension

Guidelines for Crowns following Root Canal Therapy

Criteria

- Tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the dentist's ability to fill the canal to the apex
- Filling must be properly condensed/obturated and filling material must not extend excessively beyond the apex
- The permanent tooth must be at least 50% supported in bone and cannot have mobility grades +2 or +3

Documentation Required for Authorization

- Submit appropriate radiographs with authorization request: periapical or panorex
- Require submission of radiographs clearly showing the adjacent and opposing teeth submitted with the claim for review of payment
- Claims request should include a dated radiograph of RCT (if RCT was done by submitting provider)

Procedure Codes

- D2750 - crown - porcelain fused to high noble metal
- D2751 - crown - porcelain fused to predominantly base metal
- D2752 - crown - porcelain fused to noble metal
- D2790 - full cast high noble metal
- D2791 - full cast predominantly base metal
- D2792 - full cast noble metal
- D2930 - prefabricated stainless steel crown primary tooth
- D2931 - prefabricated stainless steel crown permanent tooth
- D2932 - prefabricated resin crown
- All other crowns

Guidelines for Periodontal Treatment

Criteria

- Periodontal charting indicates abnormal pocket depths in multiple sites; probing depths must be 4mm or greater
- Radiographic evidence of root surface calculus
- Radiographic evidence of noticeable loss of bone support; attachment loss with the appearance of reduction of the alveolar crest beyond 1-1 1/2mm proximity to the cement-enamel junction (CEJ) exclusive of gingival recession

Criteria for Gingivectomy

- Presence of diseased malformed or excess gingival tissue due to systemic disease or pharmacological induced gingival hyperplasia

Criteria for Full Mouth Debridement

- Presence of significant gingival inflammation and/or supragingival calculus

Documentation Required for Authorization

- Submit appropriate radiographs with authorization request: bitewings or periapical preferred
- Complete periodontal charting
- Narrative
- Photograph is required for CDT codes D4355, D4210, and D4211

Procedure Codes

- D4341, D4342 - periodontal scaling and root planing; radiographs and perio chart
- D4355 - gross debridement; radiographs, narrative, and photos
- D4210, D4211 - gingivectomy and/or gingivoplasty
- D4240, D4241- gingival flap procedures
- D4260, D4261 - osseous surgery

Guidelines for Orthodontics

Please see the “Orthodontic Services” section.

Guidelines for X-Rays

Criteria

- Must be of diagnostic quality
- All panorex must be marked right and left
- Must include the member name
- Must include the date x-rays were taken

Guidelines for Removable Prosthodontics (Full and Partial Dentures)

Criteria

- If favorable prognosis is present
- If abutment teeth are more than 50% supported in bone
- Adjustments, repairs, and relines are allowed when there are extenuating circumstances, and/or medical necessity
- All prosthetic appliances shall be inserted in the mouth before a claim is submitted for payment
- If more than one (1) posterior tooth will be replaced not including third molars
- A denture is determined to be an initial placement if the member has never worn a prosthesis (This refers to the member's entire lifetime, not only the time the member has been receiving treatment from a certain provider)
- Relines will be reimbursed once per denture every 36 months and will not be covered within the first six (6) months of the placement of the denture

Authorizations for removable prosthesis will not meet criteria if extensive repairs are performed on marginally functional partial dentures, or when a new partial denture would be better for the health of the recipient. However, adding teeth and/or clasp to a partial denture is a covered benefit if the addition makes the dentures functional.

Documentation Required for Authorization

- Submit appropriate radiographs with authorization request: bitewings, periapical, or panorex

Procedure Codes

Complete Dentures

- D5110 - complete denture maxillary (upper)
- D5120 - complete denture mandibular (lower)

Partial Dentures

- D5211 - upper partial resin base
- D5212 - lower partial resin base
- D5213 - maxillary partial denture - cast metal framework with resin denture base
- D5214 - mandibular partial denture - cast metal framework with resin denture base

Adjustments to Dentures

- D5410 - adjust complete denture - maxillary
- D5411 - adjust complete denture - mandibular
- D5421 - adjust partial denture - maxillary
- D5422 - adjust partial denture - mandibular

Repairs to Complete Dentures

- D5511 - repair broken complete denture base, mandibular
- D5512 – repair broken complete denture base, maxillary
- D5520 - replace missing or broken teeth - complete denture (each tooth)

Repairs to Partial Dentures

- D5611 - repair resin denture base, mandibular
- D5612 – repair resin denture base, maxillary
- D5630 - repair or replace broken clasp
- D5640 - replace broken teeth - per tooth
- D5650 - add tooth to existing partial denture
- D5660 - add clasp to existing partial denture

Denture Rebase Procedures

- D5710 - rebase complete maxillary denture
- D5711 - rebase complete mandibular denture
- D5720 - rebase maxillary partial denture
- D5721 - rebase mandibular partial denture

Denture Reline Procedures

- D5730 - reline complete maxillary denture (chairside)
- D5731 - reline complete mandibular denture (chairside)
- D5740 - reline maxillary partial denture (chairside)
- D5741 - reline mandibular partial denture
- D5750 - reline complete maxillary denture (laboratory)
- D5751 - reline complete mandibular (laboratory)
- D5760 - reline maxillary partial denture (laboratory)
- D5761 - reline mandibular partial denture (laboratory)

Interim Prosthesis

- D5820 - interim partial denture - maxillary
- D5821 - interim partial denture - mandibular

XVII. REVISION HISTORY

Version	Date	Revision
1.10	10/09/2019	Revised language for 36 months restorations review, made edits to the sedation language including TAC 110.16 and 110.17, corrected fee for D8999 and removed signed statement for completion of treatment requirement for D8680.
1.9	07/03/2019	Replaced D1515 with D1516/D1517, D1525 with D1526/D1527, D5281 with D5282/D5283 and D9940 with D9944 per the 2019 CDT code book. Added language for the new restorations process, mirroring the MCNA Provider Bulletin posted February 7, 2019. Changed Ortho PA to valid for 180 days. Updated CHIP copay language.
1.8	04/24/2019	Added D1206 as a covered CHIP Service per UMCM Chapter 16.1.25.3.
1.7	03/12/2019	Updated the Therapeutic Services limitations.
1.6	10/08/2018	Added section about Equipment for Sedation Services and information about new value-added service (Children's Book and Backpack). Updated information about Second Level Appeals. Revised description of D4355 and its limitations. Updated descriptor of service D7980. Removed pre-authorization requirement for D9222. Adjusted fees throughout the Medicaid and CHIP Covered Services sections. Updated Forms section.
1.5	02/27/2018	Added required pre-authorization language associated with D9222 and updated requirements for D9223 and D9243. Deleted D5510, D5610 and D5620 from Medicaid and added D5511, D5512, D5611 and D5612 to Medicaid. Updated what will pay/deny for 4xxx codes vs preventive services. Added D1575 to Medicaid and CHIP.
1.4	08/28/2017	Updated policy added for Level 4 sedation/general anesthesia.
1.3	01/05/2017	Corrected submission requirements for D9243 (removed requirement of submission of D9241).
1.2	12/22/2016	Removed pre-authorization requirement from D9223.
1.1	12/02/2016	Added information about the Medicaid Transportation Program (MTP); updated information about member appeal process; removed time limitation on stainless steel crowns and permanent all-metal cast crowns; clarified requirements for D0120, D0140, and D0150; added service codes D4283, D4285, D9223, and D9243 to covered benefits grid;

		removed Implant Services (codes D6010 – 6199), D9220, D9221, D9241, and D9242 from covered benefits grid.
1.0	2/19/2016	Clarification to multiple restorations in Therapeutic Services. Addition of requirement to include D0601, D0602, or D0603 on all claims for D0120, D0145, and D0150. Incorporates policy change to restorative limit for primary teeth.

XVIII. FORMS

The following forms can be downloaded using the links provided.

- **Member Registration Form**
  - http://docs.mcna.net/forms/member-registration
- **Member Health History**
  - http://docs.mcna.net/forms/member-health-history
- **Dental Charting and Treatment Planning Form**
  - http://docs.mcna.net/forms/dental-charting
- **Member Outreach Form**
  - http://forms.mcna.net/tx-member-outreach
- **Member Request to Change Main Dentist Form**
  - http://forms.mcna.net/texaschangedentist
- **Incident Report**
  - http://forms.mcna.net/texasincident
- **Patient Responsibility Form**
  - http://docs.mcna.net/forms/patient-responsibility
- **Pre-Authorization Form**
  - http://forms.mcna.net/texaspreauth
- **Criteria for Dental Therapy Under General Anesthesia**
  - http://forms.mcna.net/texasanesthesia
- **Therapeutic Treatment with Anesthesia Prior Authorization Request Form**
  - http://forms.mcna.net/tx-pa-form-anesthesia
- **Orthodontic Transfer of Care Form**
  - http://forms.mcna.net/texasorthotransfer
- **Referral Form**
  - http://forms.mcna.net/referral
- **Provider Complaint Form**
  - http://forms.mcna.net/texasprovidercomplaint
- **Provider Appeal Form**
  - http://forms.mcna.net/tx-provider-appeal