Children's Medicaid Dental Services Benefit Limits and Fees

Benefit Limits Key

A = Age range limitations

TID = Tooth ID

Diagnostic Services

Diagnostic services should be performed for all clients, starting within the first six (6) months after the eruption of the first primary tooth, but no later than one (1) year of age.

The provider must document medical necessity and the specific tooth or area of the mouth on the claim for procedure codes D0140, D0160, and D0170.

Documentation supporting medical necessity for procedure codes D0140, D0160, and D0170 must also be maintained by the provider in the member's dental record and must include the following:

- The chief complaint supporting medical necessity for the examination
- The specific area of the mouth that was examined or the tooth involved
- A description of what was done during the visit
- Supporting documentation of medical necessity which may include, but is not limited to, radiographs or photographs

Documentation supporting medical necessity for procedure code D0180 must be maintained by the provider in the member's dental record and must include the following:

- The chief complaint supporting medical necessity for the examination
- A description of what was done during the treatment

Clinical Oral Evaluations

Code	Description	Benefit Limits	Fee
Procedure codes D0140, D0160, D0170, and D0180 are limited dental codes and may be paid in addition to a comprehensive oral exam (procedure code D0150) or periodic oral exam (procedure code D0120), when submitted within a six-month period. When submitting a claim for procedure code D0140, D0160, D0170, or D0180, the provider must indicate documentation of medical necessity on the claim. These claims are subject to retrospective review. If no comments are indicated on the claim form, the payment may be recouped. Effective 1/1/16, payment for CDT codes D0120, D0145, and D0150 will be denied if the appropriate caries risk assessment code is not included on the claim. Please note: D0120, D0145, and D0150 cannot be billed on the same day by the same provider, facility, or group.			
D0120	Periodic oral evaluation	Limited to one (1) every six (6) months by the same provider, facility, or group. Denied when submitted for the same DOS as D0145 by any provider or facility. A Birth-20. As of 10/1/15- 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	Used for problem-focused examination of a specific tooth or area of the mouth. Limited to one (1) service per day by the same provider, facility, or group or to two (2) services per day by different providers. Denied when submitted for the same DOS as D0160 by the same provider, facility, or group. A Birth-20.	$18.78

D0145	Oral evaluation, pt < 3yrs	**Limited to one (1) service a day and 10 times a lifetime, with a minimum of 60 days between dates of service.** Providers must be certified by DSHS Oral Health Program staff to perform this procedure. Procedure codes D0120, D0150, D0160, D0170, D0180, D8660, D1120, D1206, D1208, and D1330 will be denied when submitted by any provider for the same DOS. In addition to establishing a network of Main Dental Home Providers, MCNA must implement a "First Dental Home Initiative" for Medicaid members. This initiative will enhance dental providers' ability to assist members and their primary caregivers in obtaining optimum oral health care through First Dental Home visits. The First Dental Home visit can be initiated as early as six (6) months of age and must include, but is not limited to, the following: Comprehensive oral examination • Oral hygiene instruction with primary caregiver • Dental prophylaxis, if appropriate • Topical fluoride varnish application when teeth are present • Caries risk assessment • Dental anticipatory guidance Medicaid members from six (6) through 35 months of age may be seen for dental checkups by a **certified** First Dental Home Initiative provider as frequently as every 61 days if medically necessary. As of 10/1/15- 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.	$142.07
D0150	Comprehensive oral evaluation	Limited to one (1) every three (3) years by the same provider, facility, or group. Denied when submitted for the same DOS as D0145 by any provider. A Birth-20. As of 10/1/15- 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
D0160	Extensive oral evaluation - problem focused	Used for problem focused. Limited to one (1) service per day by the same provider, facility, or group. Not payable for routine postoperative follow-up. Denied when submitted for the same DOS as D0145 by any provider. A 1-20. Requires rationale.	$14.95

D0170	Re-evaluation, established patient, problem focused	Limited to one (1) service per day by the same provider, facility, or group. When used for emergency claims, refer to general information. Denied when submitted for the same DOS as procedure code D0140 or D0160 for the same provider, facility, or group. Denied when submitted for the same DOS as D0145 by any provider. A Birth-20. Requires rationale.	$16.54
D0180	Comprehensive periodontal evaluation	This procedure is indicated for members showing signs or symptoms of periodontal disease and for members with risk factors such as smoking or diabetes. It includes evaluation or periodontal conditions, probing and charting, evaluation and recording of the member's dental and medical history, and general health assessment. It may include the evaluation and recording of dental caries, missing or unerupted teeth restorations, occlusal relationships, and oral cancer evaluation. Denied when submitted for the same DOS as D0120, D0140, D0145, D0150, D0160, or D0170 by the same provider, facility, or group. A 13-20.	$7.86

Radiographs/Diagnostic Imaging (Including Interpretation)

Code	Description	Benefit Limits	Fee
The Panorex (D0330) with four (4) bitewing radiographs (D0274) will be considered equivalent to full mouth series (D0210), and the submitted amount for either combination is equivalent to the maximum fee of $70.64. 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 must be marked right and left • Must include the member name • Must include the date x-rays were taken One full mouth series is available per member every three (3) years by provider, facility, or group. MCNA will not return x-rays. We require you to make two (2) sets of x-rays and send us the duplicate set.			
D0210	Intraoral-complete series (including bitewings)	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. A 2-20.	$70.64
D0220	Intraoral - periapicalfirst radiographic image	Limited to one (1) service a day by the same provider, facility, or group. When submitting a claim, the tooth number must be indicated. A 1-20.	$12.56
D0230	Intraoral - periapicaleach additional radiographic image	The total cost of periapicals and other radiographs cannot exceed the payment for a complete intraoral series. The fee submitted for any combination of intraoral x-rays in a series meeting or exceeding the fee for a complete intraoral series shall be considered equivalent to the complete series, and processed as procedure code D0120. When submitting a claim, the tooth number must be indicated. A 1-20.	$11.51
D0240	Intraoral - occlusal radiographic image	Limited to two (2) services per day by the same provider, facility, or group. Periapical films taken at an occlusal angle must be submitted as periapical radiograph, procedure code D0230. May be submitted as an emergency service. A Birth-20.	$9.80
D0250	Extraoral - 2D radiographic image	Limited to one (1) service a day by the same provider, facility, or group. A 1-20. Requires rationale.	$18.38
D0270	Bitewing - single radiographic image	Limited to one (1) service a day by the same provider, facility, or group. A 1-20	$4.90
D0272	Bitewings - two (2) radiographic images	Limited to one (1) service a day by the same provider, facility, or group. A 1-20.	$23.38

D0273	Bitewings – three (3) radiographic images	Limited to one (1) service a day by the same provider, facility, or group. A 1-20.	$29.01
D0274	Bitewings - four (4) radiographinc images	Limited to one (1) service a day by the same provider, facility, or group. A 1-20.	$34.61
D0277	Vertical bitewings – seven (7) to eight (8) radiographic images	Limited to one (1) service a day by the same provider, facility, or group. Not to be submitted within 36 months of D0210 or D0330. A 2-20.	$31.12
D0310	Sialography	A 1-20. Requires rationale.	$44.10
D0320	Temporomandibular joint arthrogram, including injection	A 1-20. Requires rationale.	$73.50
D0321	Other temporomandibular joint radiographic images, by report	A 1-20. Requires rationale.	$34.30
D0322	Dental tomographic survey	A 1-20. Requires rationale.	$33.08
D0330	Panoramic radiographic image	Limited to one (1) service a day, any provider/facility, and to one (1) service every three (3) years by the same provider, facility, or group. Not allowed on emergency claims unless third molars or a traumatic condition is involved. For members who are two (2) years of age and younger, must document the necessity of a panoramic film. Not reimbursable separately when a comprehensive orthodontic or crossbite therapy workup is performed. 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. A 3-20. Rationale required if PT is less than two (2) years of age.	$63.78
D0340	2D Cephalometric radiographic image	Limited to one (1) service a day by the same provider, facility, or group or facility at orthodontist only. Not reimbursable separately when a comprehensive orthodontic or crossbite therapy workup is performed. A 1-20	$33.08
Procedure code **D0350** must be used to submit claims for photographs, and will be accepted only when diagnostic-quality radiographs cannot be taken. Supporting documentation and photographs must be maintained in the member's medical record when medical necessity is not evident on radiographs for dental caries or the following procedure codes: D4210, D4211, D4240, D4241, D4245, D4266, D4267, D4270, D4271, D4273, D4275, D4276, D4355, and D4910. Medical necessity must be documented on the electronic or paper claim.			
D0350	2D Oral/facial photographic images	Limited to one (1) service a day by the same provider, facility, or group. Not reimbursable separately when a comprehensive orthodontic or crossbite therapy workup is performed. A Birth-20. Requires rationale.	$18.38
D0367	Cone beam, CT Capture and interpretation with field of view of both jaws; with or without cranium	Pre-authorization is required. Limited to a maximum of three (3) services per year, any provider. Additional services may be considered with documentation of medical necessity. A Birth-20. Requires pre-authorization and rationale.	$269.32

Tests and Examinations

Code	Description	Benefit Limits	Fee
D0415	Collection of microorganisms	A 1-20. Requires rationale.	$24.50
D0425	Caries susceptibility test	Not reimbursable separately. Considered part of another dental procedure.	$0
D0460	Pulp vitality test	Limited to one (1) service a day by the same provider, facility, or group. Not payable for primary teeth. Will deny when submitted for the same DOS as any endodontic procedure. A 1-20.	$12.25
D0470	Diagnostic casts	Not reimbursable separately when crown, fixed prosthodontics, diagnostic workup, or crossbite therapy workup is performed. A 1-20. Requires pre-authorization and rationale.	$22.05

Oral Pathology Laboratory

Code	Description	Benefit Limits	Fee
D0472	Accession of tissue, gross examination, preparation and transmission of written report	By pathology laboratories only (refer to CPT codes).	$0
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	By pathology laboratories only (refer to CPT codes).	$0
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	By pathology laboratories only (refer to CPT codes).	$0
D0480	Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report	By pathology laboratories only (refer to CPT codes)	$0
D0502	Other oral pathology procedures	A 1-20. Requires rationale.	$56.35

Caries Risk Assessment and Documentation

Code	Description	Benefit Limits	Fee
Payment for CDT codes D0120, D0145, and D0150 will be denied if the appropriate caries risk assessment code is not included on the claim.			
D0601	Caries risk assessment and documentation, with a finding of low risk	Claims for this service must include a valid exam code (D0120, D0145, or D0150) on the same claim.	$0
D0602	Caries risk assessment and documentation, with a finding of moderate risk	Claims for this service must include a valid exam code (D0120, D0145, or D0150) on the same claim.	$0
D0603	Caries risk assessment and documentation, with a finding of high risk	Claims for this service must include a valid exam code (D0120, D0145, or D0150) on the same claim.	$0

Other Diagnostic

Code	Description	Benefit Limits	Fee
D0999	Unspecified diagnostic procedure	A 1-20. Requires pre-authorization, x-rays, and rationale.	MP

Preventive Services

Dental Prophylaxis

Code	Description	Benefit Limits	Fee
D1110	Prophylaxis adult	Limited to one (1) prophylaxis per member per six-month period (includes oral health instructions). If submitted on emergency claim, procedure code will be denied. Denied when submitted for the same DOS as any D4000 series periodontal procedure code. A 13-20.	$54.88
D1120	Prophylaxis child	Limited to one (1) prophylaxis per member per six-month period (includes oral health instructions). If submitted on emergency claim, procedure code will be denied. Denied when submitted for the same DOS as any D4000 series periodontal procedure code, or with procedure code D0145. A 6 months - 12 years.	$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 - 20 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 - 20 years.	$14.70

Other Preventive Services

Code	Description	Benefit Limits	Fee
D1310	Nutritional counseling for control of dental disease	Denied as part of all preventative, therapeutic, and diagnostic dental procedures. A member requiring more involved nutrition counseling may be referred to a THSteps primary care physician. Denied with any 1000 through 1999 code.	$0
D1320	Tobacco counseling for control and prevention of oral disease	A member requiring tobacco counseling may be referred to a THSteps primary care provider.	$0
D1330	Oral hygiene instructions	Requires documentation of the type of instructions, number of appointments, and content of instructions. This procedure refers to services above and beyond routine brushing and flossing instruction and requires that additional time and expertise have been directed toward the member's care. Denied when billed for the same DOS as dental prophylaxis, topical fluoride treatments, or D0145 evaluation by the same provider, facility, or group. Limited to once per client, per year by any provider. A 1-20.	$12.25
D1351	Sealant - per tooth	Sealants may be applied to the occlusal, buccal, and lingual pits and fissures of any tooth that is at risk for dental decay and is free of proximal caries and free of restorations on the surface to be sealed. Sealants are a benefit when applied to deciduous (baby or primary) teeth or permanent teeth. Indicate the tooth numbers and surfaces on the claim form. Reimbursement will be considered on a per tooth basis, regardless of the number of surfaces sealed. Denied when billed for the same DOS as any D4000 series periodontal procedure code. Sealants and replacement sealants are limited to one (1) every three (3) years per tooth by the same provider, facility, or group. Per the AAPD periodicity table, sealants to be performed on posterior primary and permanent teeth only. Anterior teeth require a pre-authorization and color diagnostic photos (TIDs 6-11 and 22-27) (TIDs C-H and M-R). A Birth-20.	$28.24
D1352	Preventative Resin Restoration in a moderate to high caries risk patient – permanent tooth	A 1-20.	$0

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	A 1-20. (TIDs A, B, I, J, K, L, S, T). A 1-20. (TIDs 3, 14, 19, 30). Limited to unilateral fixed appliances which are passive in nature. 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 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.	$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.	$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
D1550	Recementation of space maintainer	A 1-20. (TIDs A, B, I, J, K, L, S, T). A 1-20. (TIDs 3, 14, 19, 30). Requires pre-placement x-rays.	$18.38
D1555	Removal of fixed space maintainer	A 1-20. (TIDs A, B, I, J, K, L, S, T). A 1-20. (TIDs 3, 14, 19, 30).	$49.00
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

Therapeutic Services

Medicaid reimbursement is contingent on compliance with the following limitations:

- Documentation requirements.
- All fees for tooth restorations include local anesthesia and pulp protective media, where indicated, without additional charges. These services are considered part of the restoration.
- More than one (1) restoration on a single surface is considered a single restoration.
- A multiple-surface restoration cannot be submitted as two (2) or more separate restorations.
- If two (2) or more restorations are placed on the same tooth, a maximum restoration fee that can be reimbursed per tooth has been established such that all restored surfaces on a single tooth shall be considered connected.
- Restorations and therapeutic care are provided as Medicaid services based on medical necessity and reimbursed only for therapeutic reasons, not preventive purposes (refer to CDT).
- Total restorative fee per primary tooth for single or multiple dates of service within a six-month period cannot exceed $149.12, which is the fee for a stainless steel crown (exceptions: D2335 and D2933), when provided by the same provider, facility, or group. Exceptions will be considered when pre-treatment x-rays, images, intra-oral photos, and narrative documentation clearly support the medical necessity for the retreatment dental service during pre-payment review.
- If a restoration on a permanent tooth is done within 12 months of another restoration on the same tooth (TID) then chart notes and narrative are required. This should include an explanation of why the additional restoration was needed in such a short time frame.
- Restorations done on primary or permanent teeth within 36 months from the initial placement are reviewed prepayment to ensure compliance with standards of care. These restorations are subject to a fee cutback by subtracting the fee paid for the initial restoration from the new restoration and paying on the difference between the two fees.
    - Identical restorations on the same tooth, exact same surface(s) by the same provider, facility or group require prior authorization for codes D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393 and D2394. Documentation must include a narrative explaining the rationale for the rework and supporting radiographs and/or photographs. Claims must include the

required documentation or a valid pre authorization number included in Box 2 of the claim form.

- Similar restorations on the same tooth, with at least one (1) surface repeated by the same provider, facility or group require prior authorization for codes D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393 and D2394. Documentation must include a narrative explaining the rationale for the rework and supporting radiographs and/or photographs. Claims must include the required documentation or a valid pre authorization number included in Box 2 of the claim form.

All dental restorations and prosthetic appliances that require lab fabrication may be submitted for reimbursement using the date the final impression was made as the date of service. If the member did not return for final seating of the restoration or appliance, a narrative must be included on the claim form and in the member's chart in lieu of a postoperative radiograph. The 95-day filing deadline is in effect from the date of the final impression. If the member returns to the office after the claim has been filed, the provider is obligated to attempt to seat the restoration or appliance at no cost to the member or Texas Medicaid.

Direct pulp caps may be reimbursed separately from any final tooth restoration performed on the same tooth (as noted by the TID) on the same date of service by the same provider, facility, or group.

All restoration placement must extend through the enamel and into dentin to ensure a successful long-term outcome. The restoration must follow established dental protocol in which the preparation and restoration should include all grooves and fissures on the billed surface(s). For providers to bill for a complex occlusal-buccal or occlusal-lingual restoration, the preparation must extend the full length of the buccal or lingual groove or fully restore the buccal or lingual pit in addition to the occlusal surface. If the restoration is mesial-occlusal or distal occlusal, the preparation must extend down the mesial or distal surface far enough for the restoration to be in a cleanable and inspectable area.

Restorative Services

Amalgam Restorations (Including Polishing)

Code	Description	Benefit Limits and Fees
D2140	Amalgam - one (1) surface posterior - primary or permanent	**Primary Teeth:** Reimburse primary TIDs A-T at $59.23. **Permanent Teeth:** Reimburse permanent TIDs 1-5, 12-21, and 28-32 at $62.80. A Birth-20.
D2150	Amalgam - two (2) surfaces posterior - primary or permanent	**Primary Teeth:** Reimburse primary TIDs A-T at $79.21. **Permanent Teeth:** Reimburse permanent TIDs 1-5, 12-21, and 28-32 at $83.57. A Birth-20.
D2160	Amalgam - three (3) surfaces posterior - primary or permanent	**Primary Teeth:** Reimburse primary TIDs A-T at $86.00. **Permanent Teeth:** Reimburse permanent TIDs 1-5, 12-21, and 28-32 at $106.46. A 1-20.
D2161	Amalgam - four (4) or more surfaces posterior - primary or permanent	**Primary Teeth:** Reimburse primary TIDs A-T at $50.35. **Permanent Teeth:** Reimburse permanent TIDs 1-5, 12-21, and 28-32 at $57.37. A 1-20.

Resin-Based Composite Restorations - Direct

Code	Description	Benefit Limits	Fee
Resin restoration includes composites or glass ionomer.			
D2330	Resin-based composite - one (1) surface, anterior	TIDs C-H, M-R, 6-11, 22-27. A Birth-20.	$75.81
D2331	Resin-based composite - two (2) surfaces, anterior	TIDs C-H, M-R, 6-11, 22-27. A Birth-20.	$100.46
D2332	Resin-based composite - three (3) surfaces, anterior	TIDs C-H, M-R, 6-11, 22-27. A 1-20.	$131.17
D2335	Resin-based composite - four (4) or more surfaces or involving incisal angle (anterior)	TIDs C-H, M-R, 6-11, 22-27. A 1-20.	$162.80
D2390	Resin-based composite crown, anterior	**Primary Teeth:** Reimburse primary anterior TIDs C-H, M-R at $65.69. **Permanent Teeth:** Reimburse permanent anterior TIDs 6-11, 22-27 at $143.33. A Birth-20.	

D2391	Resin-based composite – one (1) surface, posterior	**Primary Teeth:** Reimburse primary posterior TIDs A, B, I, J, K, L, S, T at $73.56. **Permanent Teeth:** Reimburse permanent posterior TIDs 1-5, 12-21, 28-32 at $80.34. A Birth-20.
D2392	Resin-based composite – two (2) surfaces, posterior	**Primary Teeth:** Reimburse primary posterior TIDs A, B, I, J, K, L, S, T at $94.58. **Permanent Teeth:** Reimburse permanent posterior TIDs 1-5, 12-21, 28-32 at $105.30. A Birth-20.
D2393	Resin-based composite - three (3) surfaces, posterior	**Primary Teeth:** Reimburse primary posterior TIDs A, B, I, J, K, L, S, T at $83.24. **Permanent Teeth:** Reimburse permanent posterior TIDs 1-5, 12-21, 28-32 at $96.68. A 1-20.
D2394	Resin-based composite – four (4) or more surfaces, posterior	**Primary Teeth:** Reimburse primary posterior TIDs A, B, I, J, K, L, S, T at $61.75. **Permanent Teeth:** Reimburse permanent posterior TIDs 1-5, 12-21, 28-32 at $71.72. A 1-20.

Inlay/Onlay Restorations (Permanent Teeth only)

Code	Description	Benefit Limits	Fee
For procedure codes D2510 through D2664, inlay/onlay (permanent teeth only), porcelain is allowed on all teeth. The following codes require pre-authorization, x-rays, and rationale.			
D2510	Inlay - metallic - one (1) surface	A 13-20.	$173.19
D2520	Inlay - metallic - two (2) surfaces	A 13-20.	$252.25
D2530	Inlay - metallic - three (3) or more surfaces	A 13-20.	$252.25
D2542	Onlay - metallic - two (2) surfaces	Same as D2520. Limited to once per member per tooth every 10 years. A 13-20.	$252.25
D2543	Onlay - metallic - three (3) surfaces	All materials accepted. Limited to once per member per tooth every 10 years. A 13-20.	$252.25
D2544	Onlay - metallic - four (4) or more surfaces	All materials accepted. Limited to once per member per tooth every 10 years. A 13-20.	$252.25
D2650	Inlay – resin-based composite - one (1) surface	All materials accepted. A 13-20.	$252.25
D2651	Inlay - resin-based composite - two (2) surfaces	All materials accepted. A 13-20.	$252.25
D2652	Inlay - resin-based composite – three (3) or more surfaces	All materials accepted. A 13-20.	$252.25
D2662	Onlay - resin-based composite - two (2) surfaces	All materials accepted. Limited to once per member per tooth every 10 years. A 13-20.	$252.25
D2663	Onlay - resin-based composite - three (3) surfaces	All materials accepted. Limited to once per member per tooth every 10 years. A 13-20.	$252.25
D2664	Onlay - resin-based composite – four (4) or more surfaces	All materials accepted. Limited to once per member per tooth every 10 years. A 13-20.	$252.25

Crowns - Single Restorations Only

Code	Description	Benefit Limits	Fee
Procedure codes D2710 through D2799 are covered on permanent teeth only. For procedure codes D2710 through D2794, single crown restorations (permanent teeth only), the following limitations apply: • Prior authorization is required for codes D2710 through D2794; this must include x-rays and rationale. • Reimbursement for crowns and onlay restorations require submission of post-operative bitewing radiograph(s) (for posterior teeth); post-operative periapical radiograph(s) (for anterior teeth) will need to be submitted with the claim to verify that the restoration meets the standard of care. • Radiographs are reviewed to verify that the restoration meets both medical necessity and standard of care to approve reimbursement. • Reimbursement for crowns and onlay restorations are payable once per member, per tooth every 10 years. Stainless steel crowns and permanent all-metal cast crowns are not reimbursed on anterior permanent teeth (6–11, 22–27).			
D2710	Crown - resin-based composite (indirect)	All materials accepted. Covered only on anterior permanent teeth (TIDs 6-11 and 22-27). A 13-20.	$252.25

D2720	Crown - resin with high noble metal	All materials accepted. Covered only on posterior permanent teeth (TIDs 2-5, 12-15, 18-21, 28-31). A 13-20.	$252.25
D2721	Crown - resin with predominantly base metal	All materials accepted. Covered only on posterior permanent teeth (TIDs 2-5, 12-15, 18-21, 28-31). A 13-20.	$252.25
D2722	Crown - resin with noble metal	All materials accepted. Covered only on posterior permanent teeth (TIDs 2-5, 12-15, 18-21, 28-31). A 13-20.	$252.25
D2740	Crown - porcelain/ceramic	All materials accepted. Only covered on tooth numbers 4-13 and 20-29. This procedure requires pre-authorization to include x-rays and rationale. Also, once the crown has been seated, a post-operative film is required to be sent with the claim. A 13-20. *(Beginning on May 1, 2014, the following teeth were added to this benefit: 4, 5, 12, 13, 20, 21, 28, and 29. The age range was also expanded to include ages 13-16 years.)*	$252.25
D2750	Crown - porcelain fused to high noble metal	All materials accepted. Only covered on tooth numbers 4-13 and 20-29. This procedure requires pre-authorization to include x-rays and rationale. Also, once the crown has been seated, a post-operative film is required to be sent with the claim. A 13-20. *(Beginning on May 1, 2014, the following teeth were added to the benefit: 4, 5, 12, 13, 20, 21, 28, and 29. The age range was also expanded to include ages 13-16 years.)*	$504.50
D2751	Crown - porcelain fused to predominantly base metal	All materials accepted. Only covered on tooth numbers 4-13 and 20-29. This procedure requires pre-authorization to include x-rays and rationale. Also, once the crown has been seated, a post-operative film is required to be sent with the claim. A 13-20. *(Beginning on May 1, 2014, the following teeth were added to the benefit: 4, 5, 12, 13, 20, 21, 28, and 29. The age range was also expanded to include ages 13-16 years.)*	$504.50
D2752	Crown - porcelain fused to noble metal	All materials accepted. Only covered on tooth numbers 4-13 and 20-29. This procedure requires pre-authorization to include x-rays and rationale. Also, once the crown has been seated, a post-operative film is required to be sent with the claim. A 13-20. *(Beginning on May 1, 2014, the following teeth were added to the benefit: 4, 5, 12, 13, 20, 21, 28, and 29. The age range was also expanded to include ages 13-16 years.)*	$504.50
D2780	Crown - 3/4 cast high noble metal	Covered only on posterior permanent teeth (TIDs 2-5, 12-15, 18-21, 28-31). A 13-20.	$252.25
D2781	Crown - 3/4 cast base metal	Covered only on posterior permanent teeth (TIDs 2-5, 12-15, 18-21, 28-31). A 13-20.	$252.25

D2782	Crown - 3/4 cast noble metal	Covered only on posterior permanent teeth (TIDs 2-5, 12-15, 18-21, 28-31). A 13-20.	$252.25
D2783	Crown - 3/4 porcelain/ceramic	Anterior teeth only (TIDs 6-11 and 22-27).	$252.25
D2790	Crown - full cast high noble metal	All materials accepted. Covered only on posterior permanent teeth (TIDs 2-5, 12-15, 18-21, 28-31). A 13-20. When submitting a claim, please include a post-operative film and a copy of the lab receipt for this member/procedure.	$504.50
D2791	Crown - full cast base metal	All materials accepted. Covered only on posterior permanent teeth (TIDs 2-5, 12-15, 18-21, 28-31). A 13-20.	$252.25
D2792	Crown - full cast noble metal	All materials accepted. Covered only on posterior permanent teeth (TIDs 2-5, 12-15, 18-21, 28-31). A 13-20.	$252.25
D2794	Crown - titanium	A 13-20.	$252.25
D2799	Provisional crown	Denied as global fee to any crown placed.	$0

Other Restorative Services

Code	Description	Benefit Limits	Fee
Stainless steel crowns and permanent all-metal cast crowns are not reimbursed on anterior permanent teeth (6–11, 22–27).			
D2910	Recement inlay, onlay, or partial coverage restoration	A 13-20. Requires x-rays.	$17.92
D2915	Recement indirectly fabricated or prefabricated post and core	A 4-20.	$17.92
D2920	Recement crown	A 1-20.	$19.11
D2930	Prefabricated stainless steel crown - primary tooth	A Birth-20.	$149.12
D2931	Prefabricated stainless steel crown - permanent tooth	A 1-20. Requires x-rays.	$155.27
D2932	Prefabricated resin crown	A 1-20 (primary tooth).	$65.70
D2933	Prefabricated stainless steel crown with resin window	Limited to anterior primary teeth only (TIDs C-H, M-R). A Birth-20.	$149.12
D2934	Prefabricated esthetic coated stainless steel crown primary	Limited to anterior primary teeth only (TIDs C-H, M-R). A Birth-20.	$149.12
D2940	Sedative filling (protective restoration)	Not allowed on the same date as permanent restoration. A Birth-20. Requires x-rays.	$34.95
D2950	Core build-up, including any pins	Provider payments received in excess of $45.00 for restorative work performed within six (6) months of a crown procedure on the same tooth will be deducted from the subsequent crown procedure reimbursement. Not allowed on primary teeth. A 4-20.	$43.00
D2951	Pin retention - per tooth, in addition to restoration	Not allowed on primary teeth. A 4-20. Requires x-rays.	$11.94
D2952	Post and core in addition to crown - indirectly fabricated	Not payable with D2950. Not allowed on primary teeth. A 13-20. Requires x-rays.	$83.61
D2953	Each additional indirectly fabricated post - same tooth	Must be used with D2952. Not allowed on primary teeth. A 13-20. Requires x-rays.	$41.81
D2954	Prefabricated post and core in addition to crown	Not payable with D2952 or D3950 on the same TID by the same provider, facility, or group. Not allowed on primary teeth. A 13-20.	$71.66
D2955	Post removal	For removal of posts (for example, fractured posts); not to be used in conjunction with endodontic retreatment (D3346, D3347, D3348). Not allowed on primary teeth. A 4-20. Requires x-rays.	$71.66
D2957	Each additional prefabricated post - same tooth	Must be used with D2954. Not allowed on primary teeth. A 13-20.	$35.83

D2960	Labial veneer (resin laminate) - chairside	Least Expensive Alternative Treatment (LEAT) applies. Coverage limited to medical necessity such as hypoplastic enamel and fractured incisial. A 13-20. Requires pre-authorization, x-rays, and rationale.	$107.49
D2961	Labial veneer (resin laminate) - laboratory	Least Expensive Alternative Treatment (LEAT) applies. Coverage limited to medical necessity such as hypoplastic enamel and fractured incisial. A 13-20. Requires pre-authorization, x-rays, and rationale.	$173.19
D2962	Labial veneer (porcelain laminate) - laboratory	Least Expensive Alternative Treatment (LEAT) applies. Coverage limited to medical necessity such as hypoplastic enamel and fractured incisial. A 13-20. Requires pre-authorization, x-rays, and rationale.	$203.04
D2971	Additional procedure to construct new crown under existing partial denture framework	May be reimbursed up to four (4) services per lifetime for each tooth. Payable to any THSteps dental provider who performed the original cementation of the crown. A 13-20. Requires pre-authorization, x-rays, and rationale.	$107.49
D2980	Crown repair	A 1-20 (permanent teeth only). Requires pre-authorization, x-rays, and rationale.	$47.78
D2999	Unspecified restorative procedure	A 1-20. Requires pre-authorization, x-rays, and rationale.	MP

Endodontic Services

Therapeutic pulpotomy (procedure code D3220) and apexification and recalcification procedures (procedure codes D3351, D3352, and D3353) are considered part of the root canal (procedure codes D3310, D3320, and D3330) or retreatment of a previous root canal (procedure codes D3346, D3347, and D3348). When therapeutic pulpotomy or apexification and recalcification procedures are submitted with root canal codes, the reimbursement rate is adjusted to ensure that the total amount reimbursed does not exceed the total dollar amount allowed for the root canal procedure.

Reimbursement for a root canal includes all appointments necessary to complete the treatment.

Pulpotomy and radiographs performed pre-, intra-, and postoperatively are included in the root canal reimbursement.

Root canal therapy that has only been initiated or taken to some degree of completion, but not carried to completion with a final filling, may not be submitted as a root canal therapy code. It must be submitted using code D3999 with a narrative description of what procedures were completed in the root canal therapy.

Documentation supporting medical necessity must be kept in the member's record and include the following: the medical necessity as documented through periapical radiographs of tooth treated showing pre-treatment, during treatment, and post-treatment status; the final size of the file to which the canal was enlarged; and the type of filling material used. Any reason that the root canal may appear radiographically unacceptable must be documented in the member's record.

If the member is pregnant and does not want radiographs, use alternative treatment (temporary) until after delivery.

Pulp Capping

Code	Description	Benefit Limits	Fee
Procedure code D3120 will not be reimbursed when submitted with restorations and/or the following procedure codes for the same tooth, for the same DOS, by the same provider, facility, or group: D3220, D3230, D3240, D3310, D3320, or D3330. These codes are not payable if billed as bases/liners.			
D3110	Pulp cap - direct (excluding final restoration)	A 1-20. Permanent teeth only. Requires x-rays.	$15.53
D3120	Pulp cap - indirect (excluding final restoration)	A 1-20. Permanent teeth only. Requires x-rays.	$28.67

Pulpotomy

Code	Description	Benefit Limits	Fee
D3220	Therapeutic pulpotomy (excluding final restoration) removal of pulp coronal	*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.	$84.05
D3221	Pulpal debridement, primary and permanent teeth	Denied as global fee to any endodontic procedure.	$0

Endodontic Therapy on Primary Teeth

Code	Description	Benefit Limits	Fee
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (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.* Anterior primary incisors and cuspids. TIDs C-H; M-R. A 1-20. Requires x-rays.	$37.03
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (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.* Posterior first and second molars. TIDs A, B, I, J, K, L, S, T. A 1-20. Requires x-rays.	$42.02

Endodontic Therapy (including Treatment Plan, Clinical Procedures, and Follow-up Care)			
Code	**Description**	**Benefit Limits**	**Fee**
D3310	Anterior (excluding final restoration)	Permanent teeth only. When submitting claims, please include pre-operative and post-operative films. A 6-20. Requires x-rays.	$340.14
D3320	Pre-molar (excluding final restoration)	Permanent teeth only. When submitting claims, please include pre-operative and post-operative films. A 6-20. Requires x-rays.	$394.14
D3330	Molar (excluding final restoration)	Permanent teeth only. When submitting claims, please include pre-operative and post-operative films. A 6-20. Requires x-rays.	$596.48

Endodontic Retreatment			
Code	**Description**	**Benefit Limits**	**Fee**
The following codes require pre-authorization, x-rays, and rationale.			
D3346	Retreatment of root canal - anterior	When submitting claims, please include pre-operative and post-operative films. A 6-20.	$149.30
D3347	Retreatment of root canal – pre-molar	When submitting claims, please include pre-operative and post-operative films. A 6-20.	$197.08
D3348	Retreatment of root canal - molar	When submitting claims, please include pre-operative and post-operative films. A 6-20.	$262.76

Apexification/Recalcification Procedures

Code	Description	Benefit Limits	Fee
The following codes require pre-authorization, x-rays, and rationale.			
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair	When submitting claims, please include pre-operative and post-operative films. A 6-20.	$71.66
D3352	Apexification/recalcification - interim medication replacement	When submitting claims, please include pre-operative and post-operative films. A 6-20.	$47.78
D3353	Apexification/recalcification - final visit (includes completed root canal therapy)	When submitting claims, please include pre-operative and post-operative films. A 6-20.	$95.55

Apicoectomy/Periradicular Services

Code	Description	Benefit Limits	Fee
The following codes require pre-authorization, x-rays, and rationale.			
D3410	Apicoectomy/periradicular surgery - anterior	When submitting claims, please include pre-operative and post-operative films. A 6-20.	$125.41
D3421	Apicoectomy / periradicular surgery – pre-molar (first root)	When submitting claims, please include pre-operative and post-operative films. A 6-20.	$155.27
D3425	Apicoectomy / periradicular surgery - molar (first root)	When submitting claims, please include pre-operative and post-operative films. A 6-20.	$155.27
D3426	Apicoectomy / periradicular surgery - each additional root	When submitting claims, please include pre-operative and post-operative films. A 6-20.	$71.66
D3430	Retrograde filling - per root	When submitting claims, please include pre-operative and post-operative films. A 6-20.	$47.78
D3450	Root amputation - per root	When submitting claims, please include pre-operative and post-operative films. A 6-20.	$71.66
D3460	Endodontic endosseous implant	When submitting claims, please include pre-operative and post-operative films. A 16-20.	$203.04
D3470	Intentional reimplantation	When submitting claims, please include pre-operative and post-operative films. A 6-20.	$119.44

Other Endodontic Procedures

Code	Description	Benefit Limits	Fee
The following codes require pre-authorization, x-rays, and rationale.			
D3910	Isolation of tooth with rubber dam (surgical procedures only)	When submitting claims, please include pre-operative and post-operative films. A 1-20.	$17.92
D3920	Hemisection (tooth splitting)	When submitting claims, please include pre-operative and post-operative films. A 6-20.	$77.64
D3950	Canal preparation and fitting of dowel or post	When submitting claims, please include pre-operative and post-operative films. A 6-20.	$47.78
D3999	Unspecified Endodontic procedure	When submitting claims, please include pre-operative and post-operative films. A 1-20. Requires pre-authorization, x-rays, and rationale.	MP

Periodontal Services

Procedure codes D4210 and D4211 require pre-authorization, x-rays, and rationale with documentation of medical necessity. Additionally, pre-operative and post-operative photographs are required for the following procedure codes: D4210, D4211, D4270, D4271, D4273, D4275, D4276, D4355, and D4910.

Pre-operative and post-operative photographs are required when medical necessity is not evident on radiographs for the following procedure codes: D4240, D4241, D4245, D4266, and D4267. Documentation is required when medical necessity is not evident on radiographs for the following procedure codes: D4210, D4211, D4240, D4241, D4245, D4266, D4270, D4271, D4273, D4275, D4276, D4267, D4355, and D4910.

Claims for preventive dental procedure codes D1110, D1120, D1208, D1206, D1351, D1510, D1516, D1517, D1520, D1526, D1527, and D1575 will be denied when submitted for the same date of service as any D4000 series periodontal procedure codes.

Procedure codes D4266 and D4267 may be appealed with documentation of medical necessity. Appropriate documentation supporting medical necessity for third molar sites includes:

- Medical or dental history documenting need due to inadequate healing of bone following third molar extraction, including the date of third molar extraction
- Secondary procedure several months post-extraction
- Pre-operative position of the third molar
- Post-extraction probing depth to document continuing bony defect.
- Post-extraction radiographs documenting continuing bony defect.
- Bone graft and barrier material used.

Appropriate documentation supporting medical necessity for non-third molar sites is:

  - Medical or dental history documenting comorbid condition (e.g., juvenile diabetes, cleft palate, avulsed tooth or teeth, traumatic oral injuries)
  - Intra- or extra-oral radiographs of treatment site(s)
  - If not radiographically evident, intraoral photographs are optional unless requested pre-operatively by HHSC or its agent
  - Periodontal probing depths

- Number of intact walls associated with an angular bony defect
- Bone graft and barrier material used

Surgical Services

Code	Description	Benefit Limits	Fee
The following codes in this section require pre-authorization, x-rays, rationale, and pre-operative color photographs. In addition to the above requirements, x-rays are required for the following codes: D4249, D4260, D4261, and D4274.			
D4210	Gingivectomy or gingivoplasty - four (4) or more contiguous teeth	A 13-20.	$155.27
D4211	Gingivectomy or gingivoplasty - one (1) to three (3) contiguous teeth	A 13-20.	$47.78
D4230	Anatomical crown exposure – four (4) or more contiguous teeth or bounded tooth spaces per quadrant	A 13-20.	$155.27
D4231	Anatomical crown exposure – one (1) to three (3) teeth per quadrant	A 13-20.	$93.16
D4240	Gingival flap procedure, including root planing - four (4) or more contiguous teeth	A 13-20.	$173.19
D4241	Gingival flap procedure, including root planing – one (1) to three (3) contiguous teeth	Limited to once per year. A 13-20.	$52.55
D4245	Apically positioned flap	Per quadrant. A 13-20.	$173.19
D4249	Clinical crown lengthening - hard tissue	A six- to eight-week healing period following crown lengthening before final tooth preparation, impression making, and fabrication of a final restoration is required for claims submission of this code. A 13-20.	$155.27
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth	A 13-20.	$214.99
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth	Limited to once per year. A 13-20.	$64.02
D4266	Guided tissue regeneration resorbable barrier per site	A 13-20.	$262.76
D4267	Guided tissue regeneration non-resorbable barrier per site	A 13-20.	$310.54
D4270	Pedicle soft tissue graft procedure	A 13-20.	$185.13
D4273	Subepithelial connective tissue graft procedure	This procedure is performed to create or augment gingiva, to obtain root coverage or to eliminate frenum pull, or to extend the vestibular fornix. A 13-20.	$214.99
D4274	Distal or proximal wedge procedure	This procedure is performed in an edentulous area adjacent to a periodontally involved tooth. Gingival incisions are used to allow removal of a tissue wedge to gain access and correct the underlying osseous defect and to permit close flap adaptation. A 13-20.	$119.44

D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant or edentulous tooth position in graft	Limited to once per day. A 13-20.	$214.99
D4276	Combined connective tissue and double pedicle graft - per tooth	Pre-authorization is required. Not payable in addition to D4273 or D4275 for the same DOS. A 13-20.	$214.99
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	Pre-authorization required with pre-operative x-rays, photographs, and narrative. Claim submission requires post-operative x-rays, photographs, and prior authorization approval. Limited to three (3) teeth per site on the same day by the same provider, facility, or group. Must be performed in conjunction with procedure D4273. Documentation is required when medical necessity is not evident on radiographs. A 13-20.	$65.70
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	Requires pre-operative and post-operative photographs and narrative. Limited to three (3) teeth per site on the same day by the same provider, facility, or group. Must be billed with procedure D4275. Documentation is required when medical necessity is not evident on radiographs. A 13-20.	$65.70

Nonsurgical Periodontal Services

Code	Description	Benefit Limits	Fee
D4320	Provisional splinting – intracoronal	A 1-20. Requires pre-authorization, x-rays, periodontal charting, and rationale.	$59.72
D4321	Provisional splinting – extracoronal	A 1-20. Requires pre-authorization, x-rays, periodontal charting, and rationale.	$95.55
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 13-20. Requires pre-authorization, x-rays, periodontal charting, and rationale.	$53.75
D4342	Periodontal scaling and root planing - one (1) to three (3) teeth, per quadrant	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 13-20. Requires pre-authorization, x-rays, periodontal charting, and rationale.	$6.69

D4355	Full mouth debridement to enable an oral evaluation and diagnosis on a subsequent visit	Not to be completed on the same date as D0120, D0150, D0145, D0160 or D0180. D4355 is not payable if provided within 21 days of D4341. 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 13-20. Requires pre-authorization, x-rays, color photos, and rationale.	$71.66
D4381	Localized delivery of antimicrobial agents	This procedure does not replace conventional or surgical therapy required for debridement, respective procedures, or regenerative therapy. The use of controlled-release chemotherapeutic agents is an adjunctive therapy or for cases in which systemic disease or other factors preclude conventional or surgical therapy. A 13-20. Requires pre-authorization, x-rays, periodontal charting, and rationale.	$28.67

Other Periodontal Services

Code	Description	Benefit Limits	Fee
The following codes require pre-authorization, x-rays, and rationale.			
D4910	Periodontal maintenance procedures	Payable only following active periodontal therapy by any provider as evidenced either by a submitted claim for procedure code D4240, D4241, D4260, or D4261 or by evidence through client records of periodontal therapy while not Medicaid-eligible. Not payable within 90 days after D4355, not payable for the same DOS as any other evaluation procedure. Limited to once per 12 calendar months by the same provider, facility, or group. A 13-20.	$35.83
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	A 13-20.	$23.89
D4999	Unspecified periodontal procedure	A 13-20. Requires pre-authorization, x-rays, and rationale.	MP

Prosthodontic (Removable) Services

Complete Dentures (Including Routine Post Delivery Care)

Code	Description	Benefit Limits	Fee
The following codes require pre-authorization, x-rays, and rationale.			
D5110	Dentures complete maxillary	A 3-20.	$358.31
D5120	Dentures complete mandibular	A 3-20.	$358.31
D5130	Dentures immediate maxillary	A 13-20.	$370.26
D5140	Dentures immediate mandibular	A 13-20.	$370.26

Partial Dentures (Including Routing Post Delivery Care)

Code	Description	Benefit Limits	Fee
The following codes require pre-authorization, x-rays, and rationale.			
D5211	Maxillary partial denture – resin base (including any conventional clasps, rests, and teeth)	A 6-20.	$262.76
D5212	Mandibular partial denture – resin base (including any conventional clasps, rests, and teeth)	A 6-20.	$262.76
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)	A 9-20.	$382.20
D5214	Mandibular partial denture - cast metal framework with resin denture bases(including any conventional clasps, rests, and teeth)	A 9-20.	$382.20
D5282	Removable unilateral partial denture – one piece cast metal (including clasps and teeth), maxillary	A 9-20.	$238.88
D5283	Removable unilateral partial denture – one piece cast metal (including clasps and teeth), mandibular	A 9-20.	$238.88

Adjustments to Dentures

Code	Description	Benefit Limits	Fee
The following codes require pre-authorization and rationale.			
D5410	Adjust complete denture - maxillary	A 3-20.	$17.92
D5411	Adjust complete denture - mandibular	A 3-20.	$17.92
D5421	Adjust partial denture - maxillary	A 3-20.	$17.92

D5422	Adjust partial denture - mandibular	A 3-20.	$17.92

Repairs to Complete Dentures

Code	Description	Benefit Limits	Fee
D5511	Repair broken complete denture base, mandibular	A 3-20. Cost of repairs cannot exceed replacement costs. Requires pre-authorization and rationale.	$47.78
D5512	Repair broken complete denture base, maxillary	A 3-20. Cost of repairs cannot exceed replacement costs. Requires pre-authorization and rationale.	$47.78
D5520	Replace missing or broken teeth - complete denture (each tooth)	Cost of repairs cannot exceed replacement costs. A 3-20. Requires pre-authorization, x-rays, and rationale.	$41.81

Repairs to Partial Dentures

Code	Description	Benefit Limits	Fee
Cost of repairs cannot exceed replacement costs.			
D5611	Repair resin partial denture base, mandibular	A 3-20. Requires pre-authorization and rationale.	$68.00
D5612	Repair resin partial denture base, maxillary	A 3-20. Requires pre-authorization and rationale.	$68.00
D5630	Repair or replace broken retentive/clasping materials – per tooth	A 6-20. Requires pre-authorization and rationale.	$47.78
D5640	Replace broken teeth - per tooth	A 6-20. Requires pre-authorization and rationale.	$41.81
D5650	Add tooth to existing partial denture	A 6-20. Requires pre-authorization and rationale.	$47.78
D5660	Add clasp to existing partial denture – per tooth	A 6-20. Requires pre-authorization and rationale.	$59.72
D5670	Replace all teeth and acrylic on metal framework (maxillary)	Will be denied as part of procedure codes D5211, D5213, D5282, D5283 and D5640. A 6-20. Requires pre-authorization and rationale.	$167.21
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	Will be denied as part of procedure codes D5212, D5214, D5282, D5283 and D5640. A 6-20. Requires pre-authorization and rationale.	$167.21

Denture Rebase Procedures

Code	Description	Benefit Limits	Fee
The following codes require pre-authorization, x-rays, and rationale.			
D5710	Rebase complete maxillary denture	A 4-20.	$131.38
D5711	Rebase complete mandibular denture	A 4-20.	$131.38
D5720	Rebase maxillary partial denture	A 7-20.	$131.38
D5721	Rebase mandibular partial denture	A 7-20.	$131.38

Denture Reline Procedures

Code	Description	Benefit Limits	Fee
Allowed whether or not the denture was obtained through THSteps or ICF-MR dental services if the reline makes the denture serviceable. The following codes require pre-authorization, x-rays, and rationale. Not covered within six (6) months of initial placement of dentures.			
D5730	Reline complete maxillary denture (chairside)	A 4-20.	$77.64
D5731	Reline lower complete mandibular denture (chairside)	A 4-20.	$77.64
D5740	Reline maxillary partial denture (chairside)	A 7-20.	$71.66
D5741	Reline mandibular partial denture (chairside)	A 7-20.	$71.66
D5750	Reline complete maxillary denture (laboratory)	A 4-20.	$113.47
D5751	Reline complete mandibular denture (laboratory)	A 4-20.	$113.47
D5760	Reline maxillary partial denture (laboratory)	A 7-20.	$113.47
D5761	Reline mandibular partial denture (laboratory)	A 7-20.	$113.47

Interim Prosthesis

Code	Description	Benefit Limits	Fee
The following codes require pre-authorization, x-rays, and rationale.			
D5810	Interim complete denture (maxillary)	A 3-20.	$191.10
D5811	Interim complete denture (mandibular)	A 3-20.	$191.10
D5820	Interim partial denture (maxillary)	A 3-20.	$155.27
D5821	Interim partial denture (mandibular)	A 3-20.	$155.27

Other Removable Prosthetic Services

Code	Description	Benefit Limits	Fee
The following codes require pre-authorization, x-rays, and rationale.			
D5850	Tissue conditioning, maxillary	A 3-20.	$35.83
D5851	Tissue conditioning, mandibular	A 3-20.	$35.83
D5862	Precision attachment - by report	A 4-20.	$155.27
D5863	Overdenture - complete maxillary - by report	A 4-20. Requires preauthorization.	$370.26
D5864	Overdenture - partial maxillary - by report	A 4-20. Requires preauthorization.	$370.26
D5865	Overdenture, complete mandibular-by report	A 4-20. Requires preauthorization.	$370.26

D5866	Overdenture, partial mandibular-by report	A 4-20. Requires preauthorization.	$370.26
D5899	Unspecified removable prosthodontic procedure, by report	A 1-20.	MP

Maxillofacial Prosthetics

Code	Description	Benefit Limits	Fee
The following codes require pre-authorization, x-rays, and rationale.			
D5911	Facial moulage sectional	A 1-20.	$47.78
D5912	Facial moulage complete	A 1-20.	$86.00
D5913	Nasal prosthesis	A 1-20.	$836.06
D5914	Auricular prosthesis	A 1-20.	$836.06
D5915	Orbital prosthesis	A 1-20.	$836.06
D5916	Ocular prosthesis	A 1-20.	$537.47
D5919	Facial prosthesis	A 1-20.	$1,074.94
D5922	Nasal septal prosthesis	A 1-20.	$133.77
D5923	Ocular prosthesis interim	A 1-20.	$322.48
D5924	Cranial prosthesis	A 1-20.	$418.03
D5925	Facial augmentation implant	A 1-20.	$358.31
D5926	Replacement nasal prosthesis	A 1-20.	$429.98
D5927	Auricular prosthesis replacement	A 1-20.	$429.98
D5928	Orbital prosthesis replacement	A 1-20.	$429.98
D5929	Facial prosthesis replacement	A 1-20.	$859.95
D5931	Surgical obturator prosthesis	A 1-20.	$358.31
D5932	Obturator prosthesis, definitive	A 1-20.	$1,242.15
D5933	Obturator prosthesis - modification	A 1-20.	$268.74
D5934	Mandibular resection prosthesis with guide flange	A 1-20.	$537.47
D5935	Mandibular resection prosthesis without guide flange	A 1-20.	$537.47
D5936	Temporary obturator prosthesis	A 1-20.	$597.19
D5937	Trismus appliance	Not for temporo-mandibular dysfunction (TMD) treatment. A 1-20.	$250.82
D5951	Feeding aid	A Birth-20.	$133.77
D5952	Pediatric speech aid	A Birth-20.	$806.21
D5953	Adult speech aid	A 13-20.	$806.21
D5954	Palatal augmentation prosthesis	A Birth-20.	$424.01
D5955	Palatal lift prosthesis, definitive	A Birth-20.	$214.99
D5958	Palatal lift prosthesis, interim	A Birth-20.	$214.99

D5959	Palatal lift prosthesis, modification	A Birth-20.	$95.55
D5960	Speech aid prosthesis modification	A Birth-20.	$95.55
D5982	Surgical stent	A 1-20.	$107.49
D5983	Radiation applicator	A 1-20.	$155.27
D5984	Radiation shield	A 1-20.	$155.27
D5985	Radiation cone locator	A 1-20.	$155.27
D5986	Fluoride applicator	A 1-20.	$47.78
D5987	Commissure splint	A 1-20.	$125.41
D5988	Surgical splint	A 1-20.	$107.49
D5992	Adjust maxillofacial prosthetic appliance - by report	A 1-20.	$268.74
D5993	Maintenance and cleaning of a maxillofacial prosthetic appliance (extra or intra oral) other than required adjustments - by report	A 1-20.	$1,979.16
D5999	Unspecified maxillofacial prosthesis	A 1-20. Requires pre-authorization, x-rays, and rationale.	MP

Prosthodontic (Fixed) Services

Prosthodontic procedure codes require pre-authorization.

Periapical radiographs are required for each tooth involved in the pre-authorization request. The criteria used by the Dental Director are:

- At least one (1) abutment tooth requires a crown (based on traditional requirements of medical necessity and dental disease)
- Space cannot be filled with a removable partial denture
- Purpose is to prevent the drifting of teeth in all dimensions (anterior, posterior, lateral, and the opposing arch)
- Each abutment or each pontic constitutes a unit in a bridge
- Porcelain is allowed on all teeth

Fixed Partial Denture Pontics			
Code	**Description**	**Benefit Limits**	**Fee**
D6210	Pontic - cast high noble metal	A 16-20. Requires pre-authorization, x-rays, and rationale.	$252.25
D6211	Pontic - cast predominantly base metal	A 16-20. Requires pre-authorization, x-rays, and rationale.	$252.25
D6212	Pontic - cast noble metal	A 16-20. Requires pre-authorization, x-rays, and rationale.	$252.25
D6240	Pontic - porcelain fused to high noble metal	A 16-20. Requires pre-authorization, x-rays, and rationale.	$252.25
D6241	Pontic - porcelain fused to predominantly base metal	A 16-20. Requires pre-authorization, x-rays, and rationale.	$252.25
D6242	Pontic - porcelain fused to noble metal	A 16-20. Requires pre-authorization, x-rays, and rationale.	$252.25
D6245	Pontic - porcelain/ceramic	A 16-20. Requires pre-authorization, x-rays, and rationale.	$252.25
D6250	Pontic - resin with high noble metal	A 16-20. Requires pre-authorization, x-rays, and rationale.	$252.25
D6251	Pontic - resin with predominantly base metal	A 16-20. Requires pre-authorization, x-rays, and rationale.	$252.25
D6252	Pontic - resin with noble metal	A 16-20. Requires pre-authorization, x-rays, and rationale.	$252.25

Fixed Partial Dental Retainers - Inlays/Onlays			
Code	**Description**	**Benefit Limits**	**Fee**
D6545	Retainer - cast metal for resin bonded fixed prosthesis	A 16-20. Requires pre-authorization, x-rays, and rationale.	$252.25
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	A 16-20. Requires pre-authorization, x-rays, and rationale.	$252.25

Fixed Partial Denture Retainers - Crowns

Code	Description	Benefit Limits	Fee
The following codes require pre-authorization, x-rays, and rationale.			
D6720	Retainer crown - resin with high noble metal	A 16-20.	$252.25
D6721	Retainer crown - resin with predominantly base metal	A 16-20.	$252.25
D6722	Retainer crown - resin with noble metal	A 16-20.	$252.25
D6740	Retainer crown - porcelain/ceramic	A 16-20.	$252.25
D6750	Retainer crown - porcelain fused to high noble metal	A 16-20.	$252.25
D6751	Retainer crown - porcelain fused to predominantly base metal	A 16-20.	$252.25
D6752	Retainer crown - porcelain fused to noble metal	A 16-20.	$252.25
D6780	Retainer crown - 3/4 high noble metal	A 16-20.	$252.25
D6781	Retainer crown - 3/4 cast based metal	A 16-20.	$252.25
D6782	Retainer crown - 3/4 cast noble metal	A 16-20.	$252.25
D6783	Retainer crown - 3/4 porcelain/ceramic	A 16-20.	$252.25
D6790	Retainer crown - full cast high noble metal	Permanent posterior teeth only. A 16-20.	$252.25
D6791	Retainer crown - full cast predominantly base metal	Permanent posterior teeth only. A 16-20.	$252.25
D6792	Retainer crown - full cast noble metal	Permanent posterior teeth only. A 16-20.	$252.25

Other Fixed Partial Dental

Code	Description	Benefit Limits	Fee
The following codes require pre-authorization, x-rays, and rationale.			
D6920	Connector bar	A 16-20.	$128.99
D6930	Recement - fixed partial denture	A 16-20.	$35.83
D6940	Stress breaker	A 16-20.	$83.61
D6950	Precision attachment	A 16-20.	$131.38
D6980	Fixed partial denture repair necessitated by restorative material failure	A 16-20.	$65.70
D6999	Unspecified fixed prosthodontic procedure	A 16-20. Requires pre-authorization, x-rays, and rationale.	MP

Oral and Maxillofacial Surgery Services

All oral surgery procedures include local anesthesia, suturing (if needed) and visits for routine post-operative care.

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**
D7111	Extraction, coronal remnants - primary tooth	TIDs #A-T and AS-TS. A Birth-20.	$29.25
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	Replaces procedure codes D7110, D7120, and D7130. 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, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap, if inidcated	Includes removal of the roots of a previously erupted tooth missing its clinical crown. A 1-20.	$98.23
D7220	Removal of impacted tooth - soft tissue	A 1-20.	$150.49
D7230	Removal of impacted tooth - partially bony	A 1-20.	$171.99
D7240	Removal of impacted tooth - completely bony	A 1-20.	$286.65
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	Document unusual circumstance. A 1-20.	$149.30

D7250	Surgical removal of residual tooth roots (cutting procedure)	Involves tissue incision and removal of bone to remove a permanent or primary tooth root left in the bone from a previous extraction, caries, or trauma. Usually some degree of soft or hard tissue healing has occurred. A 1-20.	$88.38

Other Surgical Procedures

Code	Description	Benefit Limits	Fee
D7260	Oral antral fistula closure	TIDs 1-16 only. A 1-20. Requires pre-authorization, x-rays and rationale.	$131.38
D7261	Primary closure of a sinus perforation	May not be paid for the same DOS as D7260. TIDs 1-16 only. A 1-20. Requires rationale.	$131.38
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or display	A 1-20. Requires pre- and post-operative x-rays and rationale.	$105.11
D7272	Tooth transplantation	A 1-20. Requires pre-authorization, x-rays, and rationale.	$143.33
D7280	Surgical access of an unerupted tooth	A 1-20. Requires pre-authorization, x-rays, and rationale.	$59.72
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	Permanent TIDs 1-32 only. May not be paid for the same DOS as D7280. A 4-20. Requires pre-authorization, x-rays, and rationale.	$59.72
D7283	Placement of device to facilitate eruption of impacted tooth	A 1-20. Requires pre-authorization, x-rays, and rationale.	$23.89
D7285	Biopsy of oral tissue hard	A 1-20. Requires pre-authorization, x-rays, and rationale.	$71.66
D7286	Biopsy of oral tissue soft	A 1-20. Requires pre-authorization, x-rays, and rationale.	$59.72
D7290	Surgical repositioning of teeth	A 1-20. Requires pre-authorization, x-rays, and rationale.	$131.38
D7291	Transseptal fiberotomy - by report	A 1-20. Requires pre-authorization, x-rays, and rationale.	$47.78

Alveoloplasty - Surgical Preparation of Ridge for Dentures

Code	Description	Benefit Limits	Fee
The following codes require pre-authorization, x-rays, and rationale.			
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	A 1-20.	$53.75
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	A 1-20.	$71.66

D7340	Vestibuloplasty ridge extensions	A 1-20.	$119.44
D7350	Vestibuloplasty extensions graft	A 1-20.	$238.88

Surgical Excision of Soft Tissue Lesions

Code	Description	Benefit Limits	Fee
D7410	Excision of benign lesion up to 1.25 cm	A 1-20. Requires pre-authorization and color photos.	$95.55
D7411	Excision of benign lesion > 1.25c	A 1-20. Requires pre-authorization, color photos, and rationale.	$143.33
D7413	Excision of malignant lesion up to 1.25cm	The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee. A 1-20. Requires pre-authorization, color photos, and rationale.	$95.55
D7414	Excision of malignant lesion > 1.25cm	The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee. A 1-20. Requires pre-authorization, color photos, and rationale.	$143.33

Surgical Excision of Intraosseous Lesions

Code	Description	Benefit Limits	Fee
The following codes require pre-authorization, x-rays, and rationale.			
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm	The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee. A 1-20. Requires pathology report.	$173.19
D7441	Excision of malignant tumor - lesion diameter > 1.25 cm	The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee. A 1-20. Requires pathology report.	$226.93
D7450	Removal of benign odontogen cyst up to 1.25cm	The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee. A 1-20. Requires pathology report.	$113.47
D7451	Removal of benign odontogen cyst > 1.25 cm	The incidental removal of cysts/lesions attached to the root(s) of an extracted tooth is considered part of the extraction or surgical fee. A 1-20. Requires pathology report.	$155.27

D7460	Removal of benign nonodonto cyst to 1.25cm	The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee. A Birth-20. Requires pathology report.	$113.47
D7461	Removal of benign nonodonto cyst > 1.25 cm	The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee. A Birth-20. Requires pathology report.	$155.27
D7465	Lesion destruction by physical or chemical method	The incidental removal of cysts/lesions attached to the root(s) of a simple extraction is considered part of the extraction or surgical fee. A 1-20. Requires pathology report.	$65.70

Excision of Bone Tissue

Code	Description	Benefit Limits	Fee
D7471	Removal of lateral exostosis (maxilla or mandible)	Denied as global to all extractions.	$0
D7472	Removal of torus palatinus	A 1-20. Requires pre-authorization and rationale.	$152.88
D7473	Removal of torus mandibularis	Denied as global to other services.	$0
D7485	Surgical reduction of osseous tuberosity	Denied as global to other services.	$0
D7490	Radical resection of maxilla or mandible	Denied as global to other services.	$0

Surgical Incision

Code	Description	Benefit Limits	Fee
D7510	Incision and drainage of abscess - intraoral soft tissue	TID required. A 1-20. Requires x-rays and rationale.	$35.83
D7520	Incision and drainage of abscess - extraoral soft tissue	A 1-20. Requires X-Rays and Rationale.	$119.44
D7530	Removal foreign body from mucosa, skin, or alveolar tissue	A 1-20. Requires pre-authorization, pre-operative x-rays and rationale.	$47.78
D7540	Removal of reaction producing foreign bodies	A 1-20. Requires pre-authorization, pre-operative x-rays, and rationale.	$95.55
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	A 1-20. Requires pre-authorization, pre-operative x-rays, and rationale.	$101.53
D7560	Maxillary sinusotomy for removal of foreign body or tooth fragment	A 1-20. Requires pre-authorization, pre-operative x-rays, and rationale.	$119.44
D7670	Alveolus - closed reduction may include stabilization of teeth	A 1-20. Requires pre-authorization, pre-operative x-rays, and rationale.	$77.64

Reduction of Dislocation of Management of Other Temporomandibular Joint Dysfunctions

Code	Description	Benefit Limits	Fee
D7820	Closed reduction of dislocation	A 1-20. Requires pre-authorization, pre-operative x-ray, and rationale.	$77.64
D7880	Occlusal orthotic appliance	A 1-20. Requires pre-authorization, pre-operative x-ray, and rationale.	$133.77
D7899	Unspecified TMD therapy - by report	A 1-20. Requires pre-authorization, pre-operative x-ray, and rationale.	MP

Repair of Traumatic Wounds

Code	Description	Benefit Limits	Fee
D7910	Suture recent small wound up to 5cm	A 1-20. Requires post-operative color photos and rationale.	$71.66

Complicated Suturing

Code	Description	Benefit Limits	Fee
D7911	Complicated suture wound up to 5 cm	A 1-20. Requires post-operative color photos and rationale.	$77.64
D7912	Complicated suture > 5 cm	A 1-20. Requires post-operative color photos and rationale.	$155.27

Other Repair Procedures

Code	Description	Benefit Limits	Fee
D7955	Repair of maxillofacial defects	A 1-20. Requires pre-authorization and rationale.	MP
D7960	Frenulectomy/frenulotomy	A 1-20. Requires pre-authorization, color photos, and rationale.	$100.33
D7970	Excision of hyperplastic tissue-per arch	A 1-20. Requires pre-authorization, color photos, and rationale.	$107.49
D7971	Excision pericoronal gingiva	A 1-20. Requires pre-authorization, color photos, and rationale.	$41.81
D7972	Surgical reduction of fibrous tuberosity	TIDs 1, 16, 17, and 32 only. May not be paid in addition to D7971 for the same DOS. A 13-20. Requires pre-authorization.	$41.81
D7980	Surgical Sialolithotomy	A 1-20. Requires pre-authorization, pre-operative x-ray, and rationale.	$185.13

D7983	Closure of salivary fistula	A 1-20. Requires pre-authorization, pre-operative x-ray, and rationale.	$155.27
D7997	Appliance removal	Per arch, appliance removal (not by the dentist who placed the appliance). Includes removal of arch bar. A 1-20. Requires pre-authorization, pre-operative x-ray, and rationale.	$47.78
D7999	Unspecified oral surgery procedure	A 1-20. Requires pre-authorization, pre-operative x-ray, and rationale.	MP

Orthodontic Services (Managed Care Orthodontia Review Policy and Procedure)

Purpose

The Dental Contractors established a managed care policy and process to ensure consistent and equitable determination of orthodontic coverage for children's Medicaid dental services. Comprehensive medically necessary orthodontic services are a covered benefit for Texas Medicaid members who have a severe handicapping malocclusion or special medical conditions including cleft palate, post-head trauma injury involving the oral cavity, and/or skeletal anomalies involving the oral cavity.

Orthodontic services are covered for Texas CHIP members for pre- and post-surgical cases related to cleft palate, post-head trauma injury involving the oral cavity, and/or skeletal anomalies involving the oral cavity.

Definitions

Severe handicapping malocclusion is defined as an occlusion that is severely functionally compromised and is described in detail in Levels I, II, III, and IV.

Orthodontic terminology and the extent of orthodontic services are based on the American Dental Association's Current Dental Terminology (CDT) definitions and explanations of the orthodontic codes utilized within this policy. The following definitions of dentition established by the CDT manual are recognized by the children's Medicaid dental services:

Primary Dentition: Deciduous teeth developed and erupted first chronologically.

Transitional Dentition: The final phase of the transition from primary to adult teeth in which the deciduous molars and canines are in the process of shedding and the permanent successors are emerging.

Adolescent Dentition: The dentition that is present after the normal loss of primary teeth and prior to cessation of growth that would affect orthodontic treatment.

Adult Dentition: The dentition that is present after the cessation of growth that would affect orthodontic treatment.

Orthodontic Pre-Authorization Requirements for New Cases

Beginning on March 1, 2012, MCNA will be contacting providers with existing orthodontic cases in order to review for medical necessity. Once contacted, the provider will have 45 days to submit the required documentation to determine if the member meets the minimum criteria for orthodontia care. If the provider fails to respond within the 45-day time frame, the case will be deemed not medically necessary and all claims will be denied. Until the outcome of the review is determined, all authorizations from TMHP will be considered open and valid and will be honored. If the provider does not agree with the decision by MCNA, they will have the option to appeal.

Each provider should log in to the MCNA Provider Portal to begin the process. Our goal is to provide you with a tool that will assist you in determining if the member meets the minimum criteria for orthodontia care. Once you have entered the appropriate data into our system, an on-screen dialogue box will advise you of your next step. If the system concludes that, based on the data you entered, there may be a need for orthodontia care, you may print the form from the system and include it with your pre-authorization request for treatment. MCNA strongly encourages you to use this tool for all new orthodontia cases you submit.

The following documentation must be submitted with the request for pre-authorization:

- ADA claim form (2012 or newer) with service codes noted
- Duplicate diagnostic models submitted in centric occlusion and trimmed to ABO specifications or an electronic model/OrthoCad equivalent
- Panoramic x-ray
- Cephalometric x-ray with tracings
- Color photographs in standard eight (8) photo collage template
- Treatment plan and a complete treatment narrative, including total treatment time
- **For CHIP members only** – a copy of the medical pre-authorization approval letter for surgery

Please submit your orthodontia case and all records and documentation in their entirety. If the records and documentation you submit are incomplete or not of diagnostic quality, the case will be denied. These records are not separately reimbursed. They are included in the comprehensive fee structure.

Please do not submit cases involving craniofacial anomalies and/or cleft palates through the Provider Portal. Instead, please send these types of cases directly to MCNA's Case Management Department at tx_case_management@mcna.net.

Providers may evaluate members who they know would not qualify for covered orthodontia treatment via "chair-side" evaluation without the need for submission of a prior authorization request. The member must sign a non-covered treatment form for any services they agree to pay for on a private pay basis.

Policy

The Dental Contractors recognize four (4) orthodontic service levels for severe handicapping malocclusion, and each requires a different amount of time for treatment. Each requires different levels of skill, orthodontic procedures, and time for completion of the treatment plan.

LEVEL I

1.00 **LEVEL I:** Dedicated to resolution of early signs of handicapping malocclusion in the early mixed dentition which may significantly impact the health of the developing dentition, alveolar bone, and symmetrical growth of the skeletal framework. (Presence of the maxillary and mandibular permanent molars, and the maxillary and mandibular incisors fully erupted, and deciduous teeth shall constitute the early mixed dentition.) ONE (1) of the following conditions shall be clearly apparent in the supporting documentation:

- Anterior crossbite that is associated with clinically apparent severe gingival inflammation and/or gingival recession, or severe enamel wear
- Posterior crossbite with an associated midline deviation and asymmetric closure pattern

Disclaimer: *Dental crossbites, other than the above described, shall not be eligible for treatment in Level I. However, special orthodontic appliances are a benefit for minor treatment to control harmful habits.*

1.01 Level I orthodontic services must be completed within 12 months unless an exception is granted.

1.02 Exceptions to the expected treatment time may allow for additional treatment months for one (1) of the following circumstances:

- The member is the child of a migrant farmworker
- The member's orthodontic services were delayed as a result of temporarily being in state custodial care (foster care)

1.03 Providers may submit the following procedure codes for Level I review:

Procedure Code	Description
D8210	Removable appliance therapy. When used for control of harmful habits requires attestation of use of non-invasive attempts to control the harmful habits.
D8220	Fixed appliance therapy. When used for control of harmful habits requires attestation of use of non-invasive attempts to control the harmful habits.

1.04 When billing 8210 and 8220, providers must bill the appropriate DPC codes and a narrative describing the use of each appliance.

1.05 Providers may prior authorize for additional services that may be deemed medically necessary due to the overall health of the member or to extenuating circumstances. Each case will be reviewed and evaluated on a case-by-case basis for medical necessity.

LEVEL II

2.00 **LEVEL II:** Dedicated to resolution of handicapping malocclusion in the transitional dentition; the final phase of the transition from primary to adolescent dentition wherein the succadaneous permanent teeth are emerging or about to emerge.

2.01 Qualification for treatment at Level II requires submission of documentation to support the classification of handicapping malocclusion. FOUR (4) of the following conditions shall be clearly apparent in the supporting documentation:

a. Full cusp Class II malocclusion with the distal buccal cusp of the maxillary first molar occluding in the mesial buccal groove of the mandibular first molar

b. Full cusp Class III malocclusion with the maxillary first molar occluding in the embrasure distal to the mandibular first molar or on the distal incline of mandibular molar distal buccal cusp
c. Overbite measurement shall be in excess of five (5) mm
d. Overjet measurement shall be in excess of eight (8) mm
e. More than four (4) congenitally absent teeth, one (1) or more of which shall include an anterior tooth/teeth
f. Anterior crowding shall be in excess of six (6) mm. in the mandibular arch
g. Anterior crossbite of more than two (2) of the four (4) maxillary incisors
h. Generalized anterior spacing in both arches of greater than six (6) mm. in each arch, as measured from mesial of canine to canine
i. Recognition of early impacted maxillary canine or canines; radiographs shall support the diagnosis demonstrating a severe mesial angulation of the erupting canine and the crown of the canine superimposed and crossing the image of the maxillary lateral incisor

2.02 Level II orthodontic services must be completed within 24 months unless an exception is granted.

2.03 Exceptions to the expected treatment time may allow for additional treatment months for one (1) of the following circumstances:

- The member is the child of a migrant farmworker
- The member's orthodontic services were delayed as a result of temporarily being in state custodial care (foster care)

2.04 Providers must use the appropriate procedure code that is applicable for banding:

Procedure Code	Description
D8050	Interceptive orthodontic treatment of the primary dentition
D8060	Interceptive orthodontic treatment of the transitional dentition
D8070	Comprehensive orthodontic treatment of the transitional dentition (one (1) of D8070, D8080, or D8090 per lifetime)

2.05 Interceptive treatment, growth modification, and/or two-phase treatment shall not be acceptable as modalities of treatment for Medicaid-qualified patients in Levels

II, III, and IV. Comprehensive orthodontic treatment shall be the only treatment available in Levels II, III, and IV for resolution of skeleto-dental and dental malocclusion.

2.06 Providers may apply for exceptions based on documented extraordinary medical necessity. Each case shall be individually reviewed for the necessity and advantages of the proposed extraordinary treatment.

2.07 Providers may prior authorize for additional services that may be deemed medically necessary due to the overall health of the member or to extenuating circumstances. Each case will be reviewed and evaluated on a case-by-case basis for medical necessity.

3.00 Additional Services: There may be extenuating circumstances that warrant additional treatment including, but not limited to, craniofacial anomalies and cleft palate. In the event that the member requires additional treatment, the provider may prior authorize for additional services that may be deemed medically necessary due to the overall health of the member or to extenuating circumstances. Each case will be reviewed and evaluated on a case-by-case basis for medical necessity. Levels III and IV (described below) are the clinical criteria that must be met in order to qualify for additional services.

3.01 To submit for additional services, the provider must complete the following:

a. Submit a pre-authorization request on an ADA claim form (2012 or newer) with the appropriate code(s) requested
b. Utilize code D8670 if additional monthly adjustments are requested
c. Submit recent panoramic and cephlometric x-rays showing the progress made to date
d. Submit color photographs in standard eight-photo collage template
e. Submit a treatment plan and complete treatment narrative, including total treatment time

NOTE: Please submit the case and all records and documentation in their entirety. If the records and documentation are incomplete or not of diagnostic quality, the case will be denied. These records are not separately reimbursed. They are included in the comprehensive fee structure.

LEVEL III

4.00 **LEVEL III:** Dedicated to resolution of handicapping malocclusion in the adolescent dentition; complete eruption of the permanent dentition with the possible exception of full eruption of the second molars.

4.01 Qualification for treatment at Level III requires submission of documentation to support the classification of handicapping malocclusion. FOUR (4) of the following conditions shall be clearly apparent in the supporting documentation.

a. Full cusp Class II molar malocclusion as described in Level II
b. Full cusp Class III molar malocclusion as described in Level II
c. Anterior tooth impaction; unerupted with radiographic evidence to support a diagnosis of impaction (lack of eruptive space, angularly malposed, totally imbedded in the bone) as compared to ectopically erupted anterior teeth which may be malposed but has erupted into the oral cavity and is not a qualifying element
d. Anterior crowding shall be in excess of six (6) mm in the mandibular arch
e. Anterior open bite shall demonstrate that all maxillary and mandibular incisors have no occlusal contact and are separated by a measurement in excess of six (6) mm
f. Posterior open bite shall demonstrate a vertical separation by a measurement in excess of five (5) mm of several posterior teeth and not be confused with the delayed natural eruption of a few teeth
g. Posterior crossbite with an associated midline deviation and mandibular shift, a Brodie bite with a mandibular arch totally encumbered by an overlapping buccally occluding maxillary arch, or a posterior maxillary arch totally lingually malpositioned to the mandibular arch shall qualify
h. Anterior crossbite shall include more than two incisors in crossbite and demonstrate gingival inflammation, gingival recession, or severe enamel wear
i. Overbite shall be in excess of five (5) mm
j. Overjet shall be in excess of eight (8) mm.

4.02 Level III orthodontic services must be completed within 24 months unless an exception is granted.

4.03 Exceptions to the expected treatment time may allow for additional treatment months for one of the following circumstances:

- The member is the child of a migrant farmworker
- The member's orthodontic services were delayed as a result of temporarily being in state custodial care (foster care)

4.04 Providers must use the following procedure code that is applicable for banding:

Procedure Code	Description
D8080	Comprehensive orthodontic treatment of the adolescent dentition (One (1) of D8070, D8080, or D8090 per lifetime)

LEVEL IV

5.00 **LEVEL IV:** Dedicated to resolution of handicapping malocclusion in the adult dentition; complete eruption of the permanent dentition.

5.01 Qualification for treatment at Level IV requires submission of documentation by the Orthodontist to support the classification of handicapping malocclusion. Documentation shall be submitted by an Oral Surgeon supporting the documentation of the orthodontist and justifying the medical necessity of a surgical approach to treatment for:

a. Non-functional Class II malocclusion
b. Non-functional Class III malocclusion

5.02 The correction of the malocclusion shall be beyond that of orthodontics alone and shall require pre-orthodontic and post-orthodontic procedures in conjunction with orthognathic surgery. The member's medical needs shall be based on function and not esthetics.

5.03 Level IV orthodontic services must be completed within 24 months unless an exception is granted.

5.04 Exceptions to the expected treatment time may allow for additional treatment months for one of the following circumstances:

- The member is the child of a migrant farmworker

- The member's orthodontic services were delayed as a result of temporarily being in state custodial care (foster care)

5.05 Providers must use the following procedure code that is applicable for banding:

Procedure Code	Description
D8090	Comprehensive orthodontic treatment of the adult dentition (One (1) of D8070, D8080, or D8090 per lifetime)

6.00 Other Orthodontic Services:

6.01 The following procedure codes are used to bill for other orthodontic services:

Procedure Code	Description
D8670	Periodic orthodontic treatment visit - the number of visits will vary based on which level was approved
D8680	Debanding - Orthodontic retention (removal of appliances, construction and placement of retainers)
D8691	Repair of orthodontic appliance – One (1) per arch per lifetime
D8692	Replacement of lost or broken retainer. Documentation of medical necessity needed. Provider can bill the member if the initial retainer is lost or broken. However, responsible party must sign a **Non-Covered Services Form**, which can be found in the Forms section of this manual.
D8693	Rebonding or recementing, and/or repair, as required, of fixed retainers. Documentation of medical necessity needed. Provider can bill the member if the initial retainer is lost or broken. However, responsible party must sign a **Non-Covered Services Form**, which can be found in the Forms section of this manual.

7.00 Provider Requirements:

7.01 All dental providers must comply with the rules and regulations of the Texas State Board of Dental Examiners (TSBDE), including the standards for documentation and record maintenance that are stated in the TSBDE Rules 108.7 Minimum Standards of Care, General and 108.8 Records of Dentist.

7.02 Dentists (DDS, DMD) who want to provide any of the four (4) levels of orthodontic services addressed in this policy must be enrolled as a dentist or orthodontist in THSteps and must have the qualifications listed below for the relevant level of service:

Level of Orthodontic Service	Qualifications
Level I	Completion of pediatric dental residency; or a minimum of 200 hours of continuing dental education in orthodontics
Level I, II, III, or IV	Dentists who are orthodontic board certified or orthodontic board eligible

** MCNA reserves the right to allow a general dentist or pediatric specialist to perform orthodontics with the requirement that the provider has a minimum of 200 hours of continuing education in orthodontics. If you satisfy this requirement, please contact MCNA's Provider Hotline at 1-855-776-6262.*

7.03 Provider Type 90 – Orthodontist: Board eligible or board certified by an ADA recognized orthodontic specialty board. This provider type is eligible to provide Levels I through IV.

7.04 Provider Type 48 – Texas Health Steps – Dental: In order to perform and be reimbursed for Level I, provider must attest to one of the following:

a. Completion of pediatric specialty residency
b. Minimum of 200 hours of continuing dental education in orthodontics within the last 10 years
c. A general dentist must attest to completion of a minimum of 200 hours of continuing dental education in orthodontics within the last 10 years

8.00 Orthodontic Pre-Authorization Requirements

8.01 Each provider should log in to the MCNA Provider Portal to begin the process. Our goal is to provide you with a tool that will assist you in determining if the member meets the minimum criteria for orthodontia care. Once you have entered the appropriate data into our system, an onc-screen dialogue box will advise you of your next step. If the system concludes that, based on the data you entered, there may be a need for orthodontia care, you may print the form from the system and include it with your pre-authorization request for treatment. MCNA strongly encourages you to use this tool for all new cases you submit.

8.02 The following documentation must be submitted with the request for pre-authorization:

a. ADA claim form (2012 or newer) with service codes noted

b. Duplicate diagnostic models submitted in centric occlusion and trimmed to ABO specifications or an electronic model/OrthoCad equivalent
c. Panoramic x-ray
d. Cephalometric x-ray with tracings
e. Color photographs in standard eight-photo collage template
f. Treatment plan and a complete treatment narrative
g. **For CHIP Members Only** – a copy of the medical pre-authorization approval letter for surgery

9.00 Completion of Comprehensive Orthodontic Services

9.01 Original pre-authorization is required for completion of services (last payment) and must be reviewed for proof of completion of case.

9.02 Providers must use the following procedure code for debanding:

Procedure Code	Description
D8680	Orthodontic Retention (removal of appliances, construction, and placement of retainer(s))

10.00 Transfer of Comprehensive Orthodontic Services

10.01 Pre-authorization issued to a provider for orthodontic services is not transferable to another provider. The new provider must request a new pre-authorization to complete the treatment initiated by the original provider.

10.02 The new provider must obtain his or her own records. The following supporting documentation of medical necessity must be submitted with the request for transfer of services:

a. All of the documentation that is required for the original request
b. The reason the member left the previous provider
c. Narrative noting the treatment status

11.00 Premature Termination of Comprehensive Orthodontic Services

11.01 Premature termination of comprehensive orthodontic treatment by the original treating provider is included in the comprehensive services.

11.02 Premature termination of orthodontic services includes all of the following:

a. Removal of brackets and arch wires
b. Other special orthodontic appliances

11.03 Premature removal of an orthodontic appliance must be prior authorized. A release form must be signed by the parent or legal guardian, or by the member if he or she is 18 years of age or older or an emancipated minor. A copy of the signed release form and a completed pre-authorization request form must be submitted, and one of the following must be documented on the pre-authorization request:

a. The member is uncooperative or is non-compliant
b. The member requested the removal of the orthodontic appliance(s)
c. The member has requested the removal due to extenuating circumstances to include, but not limited to:

    i. Incarceration
    ii. Mental health complications with a recommendation from the treating physician
    iii. Foster care placement
    iv. Child of a migrant farmworker, with the intent to complete treatment at a later date if Medicaid eligibility for orthodontic services continues

*NOTE: A member for whom removal of an appliance has been authorized due to reason "C" above will be eligible for completion of their Medicaid orthodontic services if the services are re-initiated while Medicaid-eligible. Should the member choose to have the appliances removed for reasons other than those listed under "C," the member may **not** be eligible for any additional Medicaid orthodontic services.*

11.04 The requesting provider is responsible for removal of the orthodontic appliances, photographs, and x-rays at the time of termination. Documentation should be recorded in the member's chart. The member must acknowledge the premature debanding of the orthodontic case.

11.05 Providers must use the following procedure code for premature debanding:

Procedure Code	Description
D8680	Orthodontic Retention (removal of appliances, construction, and placement of retainer(s))

12.00 Reimbursement

12.01 An initial payment is payable when bands are placed. Providers must bill with the appropriate prior authorized procedure code.

12.02 Providers must bill the appropriate monthly adjustment code (D8670). The total number of monthly adjustments allowed will vary by level.

12.03 The last payment is payable when the treatment is complete. Providers must bill with the appropriate prior authorized procedure code (D8680).

13.00 General Information

13.01 Providers may prior authorize for additional services that may be deemed medically necessary due to overall health of the member or extenuating circumstances. Each case will be reviewed and evaluated on a case-by-case basis for medical necessity. For example, debanding in regular treatment would limit retainers and appliance removal to a single episode; however, in the case of cleft palate, craniofacial, or head trauma with dental consequences, the case may involve multiple courses of treatment and would gain additional consideration based on the circumstances.

13.02 Orthodontic services that are performed solely for cosmetic purposes are not a benefit of Texas Medicaid.

13.03 If a member enrolled in the Dental Contractor's plan for at least one (1) month is receiving approved orthodontic treatment and either ages out or loses eligibility, the Dental Contractor is responsible for completion of payment for the course of treatment. The only exception is if the member is disenrolled with cause, but is still Medicaid-eligible. If the member completely loses Medicaid eligibility, the provider must send a letter on office letterhead to accompany the filed claim, and/or reconsideration request/appeal.

If the provider's office contacts MCNA's Provider Hotline about the matter, the office will be instructed to send the information in writing as an attachment to the claim, reconsideration request, or appeal. The letter must be on the provider's office letterhead and must be signed and dated by the office representative attesting to the information provided. The letter should include the following information regarding the member:

- Name
- Medicaid ID number
- Date of birth
- Date of eligibility change
- A statement indicating (a) the loss of Medicaid eligibility, (b) that the member has not obtained coverage by another MCO or any additional dental insurance coverage, and (c) that the provider would like to continue treatment
- The name of the person (parent or guardian) that provided the information that no other dental coverage is in effect

MCNA will utilize this letter to verify that the member has not been changed to another MCO and has not obtained other dental insurance coverage for the purpose of consideration of the case and related claims.

13.04 There will be no payment for denied cases, including no payment for records and the initial exam.

13.05 Payment for banding includes the initial workup.

13.06 MCNA will not return orthodontic models. We require you to make two sets of models and send us the duplicate set.

13.07 MCNA qualifies a comprehensive orthodontic case as a banding visit, a debanding visit, and 22 monthly visits.

Orthodontic Fee Schedule		
Code	**Description**	**Fee**
D8050	Interceptive treatment of primary dentition	$324.87
D8060	Interceptive treatment of transitional dentition	$324.87
D8070	Comprehensive orthodontic treatment of the transitional dentition. (One (1) of D8070, D8080, or D8090 per lifetime) Cases of mixed dentition may only be considered when the treatment plan includes extractions of remaining primary teeth or in the case of cleft palate.	$544.05
D8080	Comprehensive orthodontic treatment of the adolescent dentition. (One (1) of D8070, D8080, or D8090 per lifetime)	$544.05
D8090	Comprehensive orthodontic treatment of the adult dentition. (One (1) of D8070, D8080, or D8090 per lifetime)	$544.05
D8210	Removable appliance therapy (Level I ONLY – One (1) appliance per treatment). When used for control of harmful habits requires attestation of use of non-invasive attempts to control the harmful habits.	Manually Priced
D8220	Fixed appliance therapy (Level I ONLY – One (1) appliance per treatment). When used for control of harmful habits requires attestation of use of non-invasive attempts to control the harmful habits.	Manually Priced
D8670	Periodic orthodontic treatment visit (as part of contract)	$65.07
D8680	Orthodontic retention (removal of appliances, construction, and placement of retainers)	$290.55
D8690	Bracket replacement	$0 *
D8691	Repair of orthodontic appliance	$0 *
D8692	Replacement of lost or broken retainer. Documentation of medical necessity needed. Provider can bill the member if the initial retainer is lost or broken; however, responsible party must sign a **Non-Covered Services Form**, which can be found in the Forms section of this manual	$0 *
D8693	Rebonding or recementing (and/or repair as required to fix retainer). Provider can bill the member if the initial retainer is lost or broken. However, responsible party must sign a **Non-Covered Services Form**, which can be found in the Forms section of this manual	$0 *

Members may not be charged for missed appointments, broken brackets, or broken appliances (except for lost or broken retainers).

** This procedure is included in the payment of the comprehensive orthodontic case.*

Medical Necessity Reviews

MCNA Dental reserves the right to perform medical necessity reviews on any orthodontic provider and any active orthodontic case.

- Review period cases determined between: 1/1/2011 to 9/30/2011
- These cases are to be reviewed for medical necessity using the minimum HLD score of 26

Request for Information Letter

MCNA Dental will send a request for information letter that will request an orthodontic case randomly selected for review of medical necessity. Once in receipt of the letter, the provider will send the following to MCNA Dental:

- Original TMHP authorization
- Study models (cast or E-models)
- Panoramic x-ray
- Cephalometric x-ray with tracings
- Color eight-photo collage template (must be of diagnostic quality)
- Treatment plan and complete treatment narrative including total treatment time
- Any other documentation the provider feels appropriate to submit

Provider documentation for each requested case must be provided to MCNA Dental within 45 days. Failure to comply with the request will result in automatic denial of payment. The more information provided to support medical necessity, the higher the likelihood of approval.

Disclaimer in letter:

- Members should not be charged for copies of records
- Members cannot be charged for orthodontic services or completion of treatment
- Duplicates records are preferred, rather than new or original records, as the records will not be returned to the provider

Provider Determination Letter

Determination Letters are sent to providers for each case MCNA Dental reviews for medical necessity. If medical necessity has been determined as met, the provider will receive an approval letter. If medical necessity has been determined as not met, MCNA Dental will send the provider a denial letter.

- Denial letter will include information stating that the case was determined not medically necessary and payment will no longer be made
- Denial letter will instruct the provider to continue the treatment and services through to completion, in accordance with the Texas Dental Practice Act
- Failure to complete treatment will result in a referral to the Texas State Board of Dental Examiners (TSBDE)

Transfer Cases - Case Before March 1, 2012

All transfer cases will be reviewed for medical necessity. Medical necessity will be determined on a case-by-case basis.

Once MCNA Dental is notified that a member is transferring to another provider, the member's DentalTrac™ record will be updated, prohibiting payment of orthodontic services to the current orthodontic provider.

MCNA Dental will direct the transfer provider to perform an orthodontic evaluation that includes:

- Panoramic x-ray
- Cephalometric x-ray
- Complete set of color diagnostic photographs in an eight-photo collage template
- Texas Medicaid and CHIP Orthodontic Transfer of Care Form and a complete treatment narrative including total treatment time
- Models (if requested by MCNA, or otherwise if the provider deems necessary)

Please submit the case and all records and documentation in their entirety. If the records and documentation are incomplete or not of diagnostic quality, the case will be denied. These records are not separately reimbursed. They are included in the comprehensive fee structure.

An incomplete Texas Medicaid and CHIP Orthodontic Transfer of Care Form or an incomplete (or not of diagnostic quality) record will result in denial of the case.

The Medicaid and CHIP Orthodontic Transfer of Care Form and treatment notes will be reviewed by MCNA orthodontic reviewers to identify cases that may require peer-to-peer clinical discussion on case duration and outcome.

The provider will bill MCNA Dental a claim using CDT Code D8999 and be reimbursed $112.36 for the following components necessary to transfer cases: orthodontic evaluation, transfer form and treatment notes, panoramic x-ray, cephalometric x-ray, and color eight-photo collage template.

- D8999 will be paid once per member
- When billing D8670 in conjunction with D8999, the D8670 will be denied
- D8999 will be used to track transfer cases
- If a provider changes facilities and the member remains with the provider, D8999 is not payable as this does not constitute a transfer
- Separate, billable procedure codes for panoramic x-ray, and cephalometric x-ray billed on the same member by the same provider will not be paid

If the transfer provider requests to deband a completed orthodontic treatment, D8680 will be payable without pre-authorization by MCNA Dental. The following requirements apply:

- If MCNA has not received the approved TMHP pre-authorization and/or member claims history from HHSC, we must receive a copy of the paper TMHP pre-authorization or a TMHP Orthodontic Explanation of Payment (EOP) from the provider to pay D8680
- If the transfer provider's course of treatment is to deband a member with the intention of subsequent rebanding, then that provider must seek approval from MCNA by submitting a panoramic x-ray, cephalometric x-ray, models or a complete set of diagnostic photographs, and care progress report
- If the rebanding is approved by MCNA, then the debanding will not be a separately payable procedure; it is included in the approved case rate for the rebanding.

Rebanding will only be considered in extreme circumstances. Rebanding to use provider's current treatment system is not a valid reason and will not be accepted.

Bracket replacement, D8690, will be covered **for transfer cases only** with a maximum of five (5) claims for D8690 reimbursable at $19.60 per bracket. It is reimbursable only when the provider is **not** approved to reband the member.

Bracket repositioning is at the provider's discretion and will not be separately reimbursed.

CDT codes D8670 and D8680 (2), for transfer cases, are payable at the MCNA Covered Services Fee Schedule, which is 100% of the Medicaid Fee Schedule.

Orthodontic Fee Schedule - Transfer Cases Only		
Code	**Description**	**Fee**
D8670	Periodic orthodontic treatment visit (as part of contract)	$65.07
D8680	Orthodontic retention (for all cases banded after March 1, 2012) - Orthodontic retention (removal of appliances, construction, and placement of retainers)	$290.55
D8690	Bracket Replacement (five (5) brackets ONLY)	$19.11
D8999	Unspecified Orthodontic Procedure (Transfer Cases ONLY; please see specific use in narrative above)	$112.36

Adjunctive General Services

Unclassified Treatment

Code	Description	Benefit Limits	Fee
D9110	Palliative (emergency) treatment of dental pain - minor procedures	Emergency service only. The type of treatment rendered and TID must be indicated. It must be a service other than a prescription or topical medication. The reason for emergency and a narrative of the procedure actually performed must be documented and the appropriate block for emergency must be checked. Refer to the "Emergency or Trauma Related Services for All THSteps Clients and Clients Who Are 5 Months of Age and Younger" section in the Texas Medicaid Provider Procedures Manual for information. Instructions on how to access it online can be found in the Covered Services section (Texas Health Steps Dental Services subsection) of this manual.	$17.92
D9120	Fixed partial denture sectioning		$19.11

Anesthesia Services

Medicaid reimbursement is contingent on compliance with licensing limitations and administrative code compliance.

- 22 TAC § 110.10 (2013) "Use of General Anesthetic Agents"
- 22 TAC § 110.13 (2018) "Required Preoperative Checklist"
- 22 TAC § 110.14 (2018) "Emergency Preparedness Policies and Procedures"
- 22 TAC § 110.15 (2018) "Sedation/Anesthesia Emergency Prevention/Response"
- 22 TAC § 110.16 (2018) "Sedation/Anesthesia of High-Risk Patients"
- 22 TAC § 110.17 (2019) "Sedation/Anesthesia of Pediatric Patients"

Providers providing sedation or general anesthesia services for procedure codes D9222, D9223, D9230, D9239, D9243, and D9248 must have the appropriate permit level from the Texas State Board Dental Examiners (TSBDE) for the level of sedation or general 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. In accordance with RULE §110.16 "High-risk patient" means a patient who has a level 3 or 4 classification according to the American Society of Anesthesiologists Physical Status Classification System (ASA). In accordance with RULE §110.17 "Pediatric patient" means a patient younger than 13 years of age.

Providers must maintain a pre-operative checklist in the member record for any level of sedation administrated. This preoperative checklist is subject to review upon request from MCNA for a member's clinical record. Providers are responsible for submitting their correct permit level from the Texas State Board Dental Examiners (TSBDE) for the level of sedation or general anesthesia to MCNA as well as proof of completion of one or both of the High Risk or Pediatric Patient courses, as applicable. Compliance with all TAC rules is mandatory, and is subject to review upon site audit.

No consideration can be made for sedation services performed by a non-MCNA credentialed provider. Level 4 sedation is restricted from reimbursement on the same date of service as restorative care by the same provider.

Anesthesia

Code	Description	Benefit Limits	Fee
Providers providing sedation or general anesthesia services for procedure codes D9222, D9223, D9230, D9239, D9243, and D9248 must have the appropriate permit level from the Texas State Board Dental Examiners (TSBDE) for the level of sedation or general anesthesia provided. Providers are responsible for submitting their correct permit level from the Texas State Board Dental Examiners (TSBDE) for the level of sedation or general anesthesia to MCNA. No consideration can be made for sedation services performed by a non-MCNA credentialed provider. Effective July 1, 2017 pre-authorization is required for all therapeutic/restorative services treatment planned to be performed in conjunction with Level 4 sedation/general anesthesia on children 6 and younger. • The dentist performing the therapeutic dental procedures under general anesthesia is responsible for demonstrating the need for the dental services to be provided under general anesthesia and obtaining prior authorization from MCNA for the dental services. • ONLY the dentist submitting the prior authorization request for the dental treatment may perform the dental treatment services after the case is approved. • The dentist submitting pre-authorization request for dental procedures under general anesthesia is responsible for providing documentation of MCNA's approval for the dental services to the anesthesiology provider. • When general anesthesia services (CPT 00170) are to be provided by an MD, DO, or CRNA, these services are covered by the member's HMO/MCO (Medicaid medical plan). The pre-authorization request must include the MCNA Dental Therapeutic Treatment with Anesthesia Prior Authorization Request Form and all applicable attachments: • Criteria for Dental Therapy Under General Anesthesia Form (22-point form) - Required for all cases • Narrative of medical necessity • Diagnostic radiographs or intraoral images for all procedures to be performed; if unavailable, client specific narrative description of clinically observed diagnostic findings • A complete written treatment plan (electronic ADA form, 2012 or newer ADA claim form) • Narrative documentation of previous attempts resulting in failed in-office sedation (not including inhalation of nitrous oxide/analgesia only) If a provider fails to submit a Level 4 sedation/general anesthesia case for prior authorization, all treatment services will be denied on claims received. Level 4 sedation is restricted from reimbursement on the same date of service as restorative care by the same provider.			
D9210	Local anesthesia	Procedures not covered in conjunction with operative or surgical procedures. Claim form narrative must describe the situation if used as a diagnostic tool. Denied if submitted with D9248. A 1-20.	$0
D9211	Regional block anesthesia	Denied if submitted with D9248. A 1-20.	$17.92
D9212	Trigeminal division block anesthesia	Denied if submitted with D9248. A 1-20.	$29.86
D9215	Local anesthesia in conjunction with operative or surgical procedure	Claim form narrative must explain how the doctor initiated a procedure, but could not complete it, and needs to claim the rendered anesthesia. Denied if submitted with D9248. A 1-20.	$0

D9222	Deep sedation/general anesthesia – first 15 minute increment	May be submitted twice within a 12-month period (prior submission of D9223 will apply to the 12-month limitation). Limited to one (1) per day. Denied if submitted with D9248. Requires anesthesia time record including start and stop times, the printed name of the provider, and the provider's signature. A 1-20. This code requires a Level 4 Anesthesia Permit. Local anesthesia in conjunction with operative or surgical services is all-inclusive with any other dental service and is not reimbursed separately. Pre-authorization is required for the use of general anesthesia while rendering treatment (to include the anesthesia fee and the facility fee), regardless of place of service, for a member who does not meet the requirements of the "Criteria for Dental Therapy Under General Anesthesia" (22 point threshold) and the "Criteria for Dental Therapy Under General Anesthesia" form. **Supporting documentation, including the appropriate narrative, must be submitted for pre-authorization.** Pre-authorization is required for medically necessary dental general anesthesia that exceeds once per six (6) months, per member, per provider. Effective July 1, 2017 pre-authorization is required for all therapeutic/restorative services treatment planned to be performed in conjunction with Level 4 sedation/general anesthesia on children 6 and younger. • The dentist performing the therapeutic dental procedures under general anesthesia is responsible for demonstrating the need for the dental services to be provided under general anesthesia and obtaining prior authorization from MCNA for the dental services. • ONLY the dentist submitting the prior authorization request for the dental treatment may perform the dental treatment services after the case is approved. • The dentist submitting pre-authorization request for therapeutic dental procedures under general anesthesia is responsible for providing documentation of MCNA's approval for the dental services to the anesthesiology provider. When general anesthesia services (CPT 00170) are to be provided by an MD, DO, or CRNA, these services are covered by the member's HMO/MCO.	$58.50

D9223	Deep sedation/general anesthesia – each subsequent 15 minute increment	May be submitted twice within a 12-month period (prior submission of D9223 will apply to the 12-month limitation). Limited to 11 units (2.75 hours) per day. Denied if submitted with D9248. Requires anesthesia time record including start and stop times, the printed name of the provider, and the provider's signature. A 1-20. This code requires a Level 4 Anesthesia Permit. Local anesthesia in conjunction with operative or surgical services is all-inclusive with any other dental service and is not reimbursed separately.	$43.88
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	May not be submitted more than one (1) per member, per day. Denied if submitted with D9248. A 1-20.	$27.11
D9239	Intravenous moderate (conscious) sedation/analgesia – first 15 minute increment	May be considered for reimbursement for additional conscious sedation services. Denied if submitted with D9248. Limited to one (1) per day. When submitting a claim, please include rationale for medical necessity. Requires anesthesia time record including start and stop times, the printed name of the provider, and the provider's signature. A 1-20. This code requires a Level 3 Anesthesia Permit. Local anesthesia in conjunction with operative or surgical services is all-inclusive with any other dental service and is not reimbursed separately.	$57.04
D9243	Intravenous moderate (conscious) sedation/analgesia – each additional 15 minute increment	May be considered for reimbursement for additional conscious sedation services. Denied if submitted with D9248. Limited to no more than five (5) units (one hour and fifteen minutes) per day. When submitting a claim, please include rationale for medical necessity. Requires anesthesia time record including start and stop times, the printed name of the provider, and the provider's signature. A 1-20. This code requires a Level 3 Anesthesia Permit. Local anesthesia in conjunction with operative or surgical services is all-inclusive with any other dental service and is not reimbursed separately.	$42.78
D9248	Non-intravenous conscious sedation	May be submitted twice within a 12-month period. Must comply with all TSBDE rules and AAPD guidelines, including maintaining a current (Level 2 or above) permit to provide non-intravenous (IV) conscious sedation. A 1-20.	$121.88

Professional Consultation

Code	Description	Benefit Limits	Fee
D9310	Dental consultation	An oral evaluation by a specialist of any type who is also providing restorative or surgical services must be submitted as D0160. A 1-20. Requires rationale.	$14.58

Professional Visits

Code	Description	Benefit Limits	Fee
D9410	Dental house call/extended care facility call	Narrative required on claim form. A 1-20.	$23.89

D9420	Hospital or ambulatory surgical center call	Case provided outside the dentist's office to a member who is in a hospital or ambulatory surgical center. One (1) charge per hospital or ASC case; one (1) case per member in a 12-month period. A 1-20. Requires rationale and submission of the Criteria for Dental Therapy Under General Anesthesia Form (found in the Forms section of this manual) with the claim when applicable. Effective July 1, 2017 pre-authorization is required for all therapeutic/restorative services treatment planned to be performed in conjunction with Level 4 sedation/general anesthesia on children 6 and younger. • The dentist performing the therapeutic dental procedures under general anesthesia is responsible for demonstrating the need for the dental services to be provided under general anesthesia and obtaining prior authorization from MCNA for the dental services. • ONLY the dentist submitting the prior authorization request for the dental treatment may perform the dental treatment services after the case is approved. • The dentist submitting pre-authorization request for therapeutic dental procedures under general anesthesia is responsible for providing documentation of MCNA's approval for the dental services to the anesthesiology provider. • When general anesthesia services (CPT 00170) are to be provided by an MD, DO, or CRNA, these services are covered by the member's HMO/MCO. The pre-authorization request must include the MCNA Dental Therapeutic Treatment with Anesthesia Prior Authorization Request Form and all	$36.31

		all applicable attachments: • Criteria for Dental Therapy Under General Anesthesia Form (22-point form)- Required for all cases • Narrative of medical necessity • Diagnostic radiographs or intraoral images for all procedures to be performed; if unavailable, client specific narrative description of clinically observed diagnostic findings • A complete written treatment plan (electronic ADA form, 2012 ADA claim form) • Narrative documentation of previous attempts resulting in failed in-office sedation (not including inhalation of nitrous oxide/analgesia only) If a provider fails to submit a Level 4 sedation/general anesthesia case for prior authorization, all treatment services will be denied on claims received.	
D9430	Office visit during hours	This service is not for evaluations or consultations. Visits for routine post-operative care are included in all therapeutic and oral surgery fees, and any sedation or general anesthesia fees. A 1-20. Requires rationale.	$14.33
D9440	Office visit after hours	Visits for routine post-operative care are included in all therapeutic and oral surgery fees. A 1-20. Requires rationale.	$29.86
D9450	Case presentation, detailed and extensive treatment planning	Denied as global to other services.	$0

Drugs

Code	Description	Benefit Limits	Fee
Procedure code D9630 is not payable for take home fluorides or drugs. Prescriptions should be given to clients to be filled by the pharmacy for these medications as the pharmacy is reimbursed by the Medicaid Vendor Drug Program. Procedure code D9630 is payable for medications (antibiotics, analgesics, etc.) administered to a member in the provider's office. Documentation of dosage and route of administration must be provided in the Remarks section of the claim.			
D9610	Therapeutic parenteral drug - single administration	May not be submitted with code D9222 or D9223. Includes, but is not limited to, anti-inflammatory, steroids, and non-steroids but not anesthesia reversal agents. Documentation of dosage and route of administration must be provided in the Remarks section of the claim. Requires rationale.	$17.92

D9612	Therapeutic parenteral drug - 2 (2) or more administrations, different medications	May not be submitted with code D9222 or D9223. Includes, but is not limited to, anti-inflammatory, steroids, and non-steroids but not anesthesia reversal agents. Documentation of dosage and route of administration must be provided in the Remarks section of the claim. A 1-20. Require rationale.	$35.83
D9630	Other drugs or medications - by report	Includes, but is not limited to, oral antibiotics, oral analgesic, and oral sedatives administered in the office. May not be submitted with codes D9222, D9223, D9230, D9239, D9243, 9248, D9610, and D9920. A 1-20. Requires rationale.	$8.60

Miscellaneous Services

Code	Description	Benefit Limits	Fee
D9910	Application of desensitizing medicament	Per whole mouth application, does not include fluoride. Not to be used for bases, liners, or adhesives under or with restorations. Limited to once per year. A 18-20. Requires rationale.	$11.94
D9911	Application of desensitizing resin for cervical and/or root surface, per tooth	Denied as part of D9910.	$0

D9920	Behavior management - by report	The provider must indicate the member's medical diagnosis of intellectual disability using one of the following diagnosis codes or indicate that the client is ICF-MR eligible in the Remarks section of the claim: • 317 - mild intellectual disability (IQ 50-70) • 3180 - moderate intellectual disability (IQ 35-49) • 3181 - severe intellectual disability (IQ 20-34) • 3182 - profound intellectual disability (IQ under 20) • 319 - unspecified intellectual disability Documentation supporting the medical necessity and appropriateness of dental behavior management must be retained in the member's chart and available to state agencies upon request, and is subject to retrospective review. Documentation of medical necessity must include: • A current physician statement addressing the intellectual disability. The statement must be signed and dated within one (1) year prior to the dental behavior management. • A description of the service performed (including the specific problem and the behavior management technique applied). • Personnel and supplies required to provide the behavioral management. • The duration of the behavior management (including session start and end times). Dental behavior management is not reimbursed with an evaluation, prophylactic treatment, or radiographic procedure. Denied if submitted with D9248. A 1-20	$47.78
D9930	Treatment of complications - by report	A 1-20. Requires pre-authorization and rationale.	$23.89
D9944	Occlusal guard - hard appliance, full arch, by report	A 13-20. Requires x-rays or color photographs, and rationale.	$113.47
D9950	Occlusion analysis - mounted case	A 13-20. Requires pre-authorization and rationale.	$53.75
D9951	Occlusal adjustment - limited	Full mouth procedure. Limited to once per year, per member, any provider. A 13-20. Requires rationale.	$35.83
D9952	Occlusal adjustment - complete	Full mouth procedure. Payable once per lifetime, any provider. A 13-20. Requires pre-authorization and rationale.	$143.33
D9970	Enamel microabrasion	One (1) service per day, any provider. A 13-20. Requires pre-authorization and rationale.	$53.75
D9971	Odontoplasty one (1) to two (2) teeth - includes the removal of enamel projections	Not payable.	$0
D9972	External bleaching - per arch	Not payable.	$0

D9973	External bleaching - per arch	Not payable.	$0
D9974	Internal bleaching per tooth	Claim must include documentation of medical necessity. A 13-20. Requires pre-authorization.	$53.75
D9999	Unspecified adjunctive procedure, by report	A 1-20. Requires pre-authorization, x-rays, and rationale.	MP