Dental Provider Supplement

May 2024

AmeriHealth Caritas™
Pennsylvania

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Table of Contents

Introduction

About AmeriHealth Caritas Pennsylvania – Who we are

AmeriHealth Caritas Pennsylvania, part of the AmeriHealth Caritas Family of Companies is headquartered in Harrisburg and serves Medical Assistance recipients in all counties of the Lehigh/Capital, North East, Northwest, and South West Health Choices zones. We are committed to delivering quality care that enables our Members to live safe and healthy lives and to receive services in the community, preserve consumer choice, and be allowed to have active voices in the services they receive.

Our Mission

We Help People:

Get Care

Stay Well

Build Healthy Communities

Our Values

Our service is built on these values:

Advocacy

Care of the Poor

Compassion

Competence

Dignity

Diversity

Hospitality

Stewardship

Welcome to the AmeriHealth Caritas Pennsylvania (hereafter referred to as "the Plan") Dental Provider Network!

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

Single point of contact

To ensure timely, accurate Provider reimbursement and high-quality services, this Plan assigns a dedicated Dental Account Executive. Dental Account Executives are responsible for building personal relationships with the office managers at each Provider location. This proven approach fosters teamwork and cooperation, which results in a shared focus on improving service, Member participation, and program results.

Support for Members

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

Consistent, transparent authorization determination logic

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

Technology Tools

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

Provider Services Website: https://dentists.amerihealthcaritas.com/

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

The website may be accessed at http://dentists.amerihealthcaritas.com. The Plan's Provider Services website allows Network Providers direct access to multiple online services. Utilization of the online services offered through the Provider website lowers program administration and participation costs for Providers.

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

- Verify Member eligibility.
- Set up office appointment schedules, which can automatically verify eligibility and pre-populate Claim forms for online submission.
- Submit Claims for services rendered by simply entering procedure codes and applicable tooth numbers, etc.
- Submit Prior Authorization requests, using interactive clinical algorithms when appropriate.
- Check the status of submitted Claims and Prior Authorization requests.
- Review Provider clinical profiling data relative to peers.
- Download and print Provider Manuals and dental supplement.
- Send electronic attachments, such as digital x-rays, Explanation of Benefits (EOBs), and treatment plans.
- Check patient treatment history for specific services.
- Upload and download documents using a secure encryption protocol.

Feedback

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

Provider Web Portal Registration and Introduction

The Plan's Provider Web Portal allows us to maintain our commitment to help you keep your office costs low, access information efficiently, get paid quicker and to submit Claims and Prior Authorization requests electronically along with the many other features listed here:

- Verify Member eligibility and service history reports
- View Pre-Claim Estimate Reports
- Attach supporting documentation to Claims and authorizations
- Search for and view historical Claims and authorizations
- Create "Provider billed amounts" lists for service codes
- Manage patient rosters and schedule appointments on the patient calendar
- Sign-up and manage payee EFT information
- Create and manage portal subaccounts for staff
- View remittances

To learn more about the features and functions of the Provider Portal, register for the portal, obtain your payee ID number or ask for a training webinar, please contact the Portal Support team at **1-855-434-9239**.

Member Eligibility Verification Procedures and Services to Members

The Plan Member Identification Card

The Plan's Members are issued identification cards regularly. Providers are responsible for verifying that Members are eligible at the time services are rendered and to determine if Members have other health insurance.

The Plan Identification Card lists the following information:

- Member's Name
- Identification Number
- Member's Sex and Date of Birth
- State ID Number
- Lab Name
- Co-pays

To see the current Plan Identification Card template, please visit www.amerihealthcaritaspa.com → Members → Information for You → Your ID Cards

The Plan's Members are issued identification cards regularly.

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

AmeriHealth Caritas Pennsylvania Eligibility Systems:

Enrolled Network Providers may access Member eligibility information through:

- The "Providers" section of the Plan's website http://dentists.amerihealthcaritas.com
- The Plan's Interactive Voice Response (IVR) system eligibility line at: **1-855-434-9241**.
- The Plan's Member Services Department: AmeriHealth Caritas Pennsylvania: **1-888-991-7200**.

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

Access to eligibility information via the Plan's Dental Providers website

The Plan's Dental Provider website: http://dentists.amerihealthcaritas.com currently allows enrolled Network Providers to verify a Member's eligibility as well as submit Claims, by simply logging on to the website at: http://dentists.amerihealthcaritas.com.

Once you have entered the website, click on 'Providers.' You will then be able to log in using your password and ID. First time users will have to self-register by utilizing your Plan's Payee ID, office name and office address. Please refer to your payment remittance or contact the Provider Web Portal team at: **1-855-434-9239** for information regarding your Payee ID.

Once logged in, select "eligibility look up" and enter the applicable information for each Member you are inquiring about. Verify the Member's eligibility by entering the Member's date of birth, the expected date of service and the Member's identification number or last name and first initial. You are able to check on an unlimited number of patients and can print off the summary of eligibility given by the system for your records.

Access to eligibility information via the IVR line

To access the IVR system, simply call the Plan's Provider Service Department at: **1-855-434-9241** for eligibility and service history. The IVR system will be able to answer all your eligibility questions for as many Members as you wish to check. Once you have completed your eligibility checks or history inquiries, you will have the option to transfer to a Customer Service Representative during normal business hours.

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

Directions for using the Plan's IVR system to verify eligibility:

Call the Plan's Member Services at: **1-888-991-7200**.

- When prompted, enter your Provider NPI or Tax ID number.
- Follow the additional prompts and enter the Member's Information using the ID number or SSN.
- When prompted, enter the Member's ID, less any alpha characters that may be part of the ID, or the SSN.
- When prompted, enter the Member's date of birth in MM/DD/YYYY format.
- Upon system verification of the Member's eligibility, you will be prompted to verify the eligibility of another Member, inquire about service history, or choose to speak to a customer service representative.

Please note that due to possible eligibility status changes, the information provided by either system does not guarantee payment. If you are having difficulty accessing either the IVR or website, please contact the Plan's Member Services at **1-888-991-7200**.

Transportation Benefits for Certain Members

Members who need assistance with transportation should contact the Plan's Member Services at **1-888-991-7200.**

The Plan offers TTY service for hearing impaired Members at: **1-800-684-5505**.

Covered Benefits

Dental Benefits for Children under the age of 21

Children under the age of 21 are eligible to receive all Medically Necessary dental services. Members do not need a referral from their PCP and can choose to receive dental care from any Provider who is part of the dental network. Participating dentists can be found in our online Provider Directory at: http://dentists.amerihealthcaritas.com or by calling Member Services at **1-888-991-7200**.

Dental services that are covered for children under the age of 21 include, but are not limited to the following, when Medically Necessary:

- IV or Non-IV conscious sedation; nitrous oxide analgesia**
- Orthodontics (braces)* and **
- Initial and periodic oral examinations
- Periodontal services**
- Dental prophylaxis
- Fluoride Treatments
- Silver Diamine Fluoride
- Endodontics**
- Crowns**
- Sealants.
- Dentures**
- Dental surgical procedures**
- Dental emergencies
- X-rays
- Extractions (tooth removals)
- Fillings

**If braces were put on before the age of 21, AmeriHealth Caritas Pennsylvania will continue to cover services until treatment for braces is complete, or age 23, whichever comes first, as long as the patient remains dental eligible for Medical Assistance and is still a Member of AmeriHealth Caritas Pennsylvania. If the Member changes to another HealthChoices health plan, coverage will be provided by that HealthChoices health plan. If the Member loses dental eligibility, AmeriHealth Caritas Pennsylvania will pay for services through the month that the Member is eligible. If a Member loses eligibility during the course of treatment, you may charge the Member for the remaining term of the treatment after AmeriHealth Caritas Pennsylvania payments cease ONLY IF you obtained a written, signed agreement from the Member prior to the onset of treatment. For case specific clarification, please contact the AmeriHealth Caritas Pennsylvania Dental Director.*

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

Dental Benefits for Adults age 21 and older

See benefit detail grid for procedure codes and eligibility criteria.

Members do not need a referral from their PCP and can choose to receive dental care from any Provider who is part of the dental network.

The following dental services are covered for adult Members 21 years of age and older:

- IV or Non-IV conscious sedation *
- Initial and periodic oral evaluations**
- Periodontal services* and **
- Dental prophylaxis**
- Endodontics *and**
- Crowns* and **
- Dentures*and **
- Dental surgical procedures*
- Dental emergencies.
- X-rays.
- Extractions (tooth removals).
- Fillings

* Authorization is required and medical necessity must be demonstrated.

** Benefit Limit Exceptions may apply.

Please refer to the Benefit Limit Exception Process section of this manual for complete details. Please call Provider Services at **1-855-434-9241** with questions.

- These benefit limit exceptions do not apply if the Member is under age 21, or if the Member is 21 years of age or older and currently resides in a long-term care facility, or intermediate care facility. These Members are exempt from the benefit limitation exception process. However, all current prior authorization policies, parameters and criteria will remain in place. Determination of Member residency can be checked when verifying Member eligibility either by phone or through the Provider web-portal.

Adult Members may be eligible to receive the following services with an approved Benefit Limit Exception:

- Crowns and related services.
- Root canals and other endodontic services.
- Periodontal services.
- Additional cleanings and exams.
- Replacement dentures

Medically Necessary Dental Services for Members under 21 years of age

Such services require authorization and should be prior authorized (following the existing prior authorization process), whenever possible. Claims should be submitted with supporting

documentation such as letters of medical necessity and documentation and/or images to substantiate the need for the services.

Missed Appointments

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

The Plan offers the following suggestions to decrease the number of missed appointments.

- Contact the Member by phone or postcard prior to the appointment to remind the individual of the time and place of the appointment. If a Member exceeds your office policy for missed appointments and you choose to discontinue seeing the Member, please inform them to contact the Plan for a referral to a new dentist. Please refer to your Provider agreement with the Plan for regarding your responsibilities in this regard.

Payment for Non-Covered Services

Network Providers shall hold Members or the Plan harmless for the payment of Non-Covered Services except as provided in this paragraph. Provider may bill a Member for Non-Covered Services, if the Provider obtains an agreement in writing from the Member prior to rendering services that indicate:

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

Please refer to the Dental Benefits Grid for a complete list of covered benefits.

Electronic Attachments

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

For more information, or to sign up for Fast Attach, go to http://www.vynedental.com/fastattach/ or call NEA at: **1-463-218-9150**.

Prior Authorization, Retrospective Review, and Documentation Requirements

Procedures Requiring Prior Authorization

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

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

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

Prior Authorizations may be mailed to:
AmeriHealth Caritas Pennsylvania Health Plan– Prior Authorizations
P.O. Box 651
Milwaukee, WI 53201

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

A service, item, procedure, or level of care compensable under the MA program that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

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

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

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

During the Prior Authorization process, it may become necessary to have your patient clinically evaluated. If this is the case, you will be notified of a date and time for the evaluation examination. It

is the responsibility of the Network Provider to ensure attendance at this appointment. Patient failure to keep an appointment will result in Denial of the Prior Authorization request.

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

Prior authorization for SPU/ASC admission for dental services is not required when utilizing a Plan participating facility. The dental services associated with the admission are governed by the authorization process. Please contact AmeriHealth Caritas Pennsylvania Provider Services (**1-800-521-6007**) with any questions.

Retrospective Review

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

Benefit Limit Exception (BLE) Process (Adults age 21 and over)

You can request a benefit limit exception for services to be provided to adults 21 and over before the services start or after they are finished. You can ask for an exception up to 60 days after the dental services are finished. When submitting the BLE request, only those codes requiring BLE should be on the dated or undated claim form. Inclusion of non-BLE codes may result in denials of those requests.

The Plan mayconsider benefit limit exceptions to the dental benefits when one of the following criteria is met:

- The Member has a serious chronic systemic illness or other serious health condition and denial of the exception will jeopardize the life of the Member; or
- The Member has a serious chronic systemic illness or other serious health condition and denial of the exception will result in the rapid, serious deterioration of the health of the Member; or
- Granting a specific exception is a cost-effective alternative for the Plan; or
- Granting an exception is necessary in order to comply with federal law.

An example for which a Benefit Limit Exception may be allowed for periodontal services is:

The Member is pregnant, has diabetes or has coronary artery disease and meets clinical dental criteria for periodontal services included in the Plan.

The BLE Request Process:

You must send a completed Benefit Limit Exception Request Form AND an approved ADA Claim form by mail or electronically *:

Mail:
AmeriHealth Caritas Pennsylvania Prior Authorizations
P.O. Box 654
Milwaukee, WI 53201

Include the following information:

- Member's name, address and ID number.
- The dental service that is needed (code(s) and description).
- The reason the exception is needed.
- Supporting diagnostic documentation required for the clinical authorization
- Supporting documentation from the Member's primary care or specialty care physician.
- Dentist's name and phone number.
- Diagnosis code Z98.818 in box 34A of the Claim form

**If the dental BLE request identifies that the beneficiary has one of the conditions set forth below, as part of the dental BLE review process, the Plan will review the Member's Claim history to determine if the condition was previously identified on a Claim:

1. Diabetes.
2. Coronary Artery Disease or risk factors for the disease.
3. Cancer of the Face, Neck, and Throat (does not include stage 0 or stage 1 non-invasive basal or sarcoma cell cancers of the skin).
4. Intellectual Disability.
5. Current Pregnancy including post-partum period.

If the condition was previously identified on a Medical Claim, the plan will not require supporting medical record documentation of the condition. If the condition was not previously identified on a Medical Claim, the plan will notify the dental Provider that supporting medical record documentation is needed to review the BLE request. The supporting medical record documentation if the condition was not previously identified on a Medical Claim, and any additional information requested, must be submitted to the plan within 15 days of the date of the plan's request to the dental Provider. Upon receipt of the medical record documentation or additional information, the Plan will review the request for a dental BLE to confirm that one of the criteria for the granting of a BLE is met along with established clinical criteria. The dental Provider and Member will be informed of the Plan's determination by written Notice of Decision. If the BLE request is approved, the services can be provided and paid for as long as the beneficiary maintains MA eligibility.

*You can obtain a Benefit Limit Exception Request Form on-line at: http://dentists.amerihealthcaritas.com or www.amerihealthcaritaspa.com → Provider → Resources → Dental program or by calling Provider Services at: **1-855-434-9241**.

Dental Benefit Limit Exception (BLE) Request Form

AmeriHealth Caritas Pennsylvania

Failure to legibly complete all fields **and** provide required documentation will result in this form being returned. **This form must be attached to a completed ADA dental claim form.**

Please print

Member information	Provider information
Last name:	Last name:
First name:	First name:
Date of birth (mm/dd/yyyy):	NPI number:
Member ID number:	AmeriHealth Caritas ID number:
Phone:	Phone:

Benefit exception request type: ☐ Prospective ☐ Retrospective - Dates of Service: _____

Benefit limit criteria to be reviewed (check all that apply):

☐ Patient has a serious chronic systemic illness or other serious health condition and denial of the exception will jeopardize the life of the patient.

☐ Patient has a serious chronic systemic illness or other serious health condition and denial of the exception will result in the rapid serious deterioration of the health of the patient.

☐ Granting the exception is a cost-effective alternative for AmeriHealth Caritas Pennsylvania.

☐ Granting the exception is necessary in order to comply with federal law.

☐ Patient does not meet any of the benefit limit exception criteria.

Benefit limit exception request for periodontal services only

☐ Patient is pregnant, has diabetes, or has coronary artery disease and meets clinical dental criteria for **periodontal services** included in AmeriHealth Caritas Pennsylvania's benefit program.

This request must include documentation from the **patient's primary care practitioner or specialty care physician** supporting the need for the service, including but not limited to chart documentation, diagnostic study results, radiographs (if applicable), and medical and dental history.

Explain below why the patient meets the criteria for a benefit limit exception. The explanation should be in narrative form and include a comprehensive justification (attach additional pages if necessary).

_____

_____

A BLE requested before the dental service begins will receive an answer, or receive a request for additional information, within 21 business days of our receipt of the request. When additional information is required and received, the exception request will be approved or denied within 21 business days after our receipt of the information. BLE retrospective requests must be submitted no later than 60 days from the date the claim was rejected and will be answered within 30 days. Retrospective exception requests made on or after the 61st day from the claim rejection date will be denied.

I attest that the information provided and statements made herein are true, accurate, and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Provider signature: _____ Date: _____

Mail to:
Request for Benefit Limit Exception
AmeriHealth Caritas Pennsylvania
P.O. Box 654
Milwaukee, WI 53201

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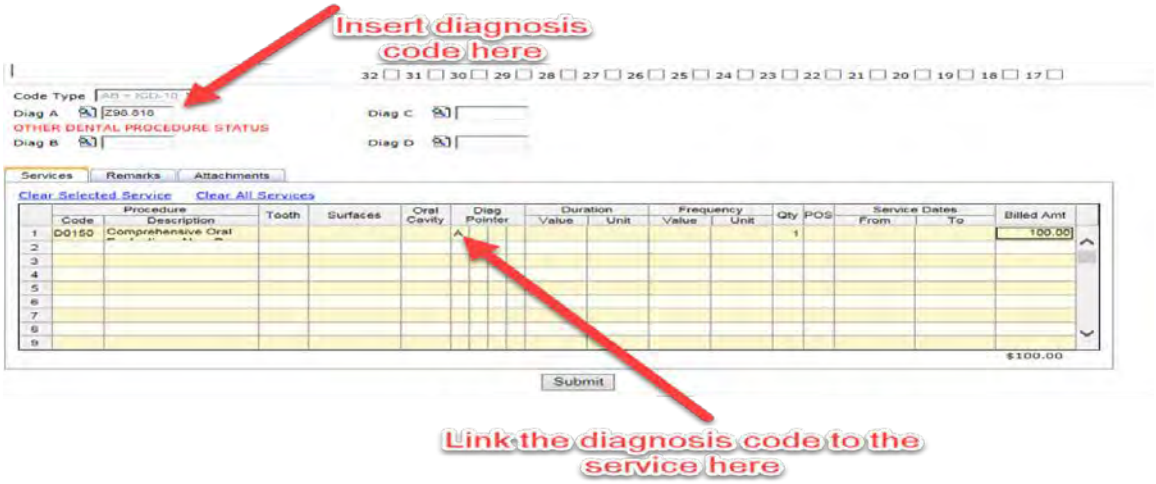
The standard approved American Dental Association (ADA) Claim form that accompanies the BLE form **must include a diagnosis code**. ICD-10 code, Z98.818 must be entered in box 34a of the ADA

Claim form (see example below). The use of a diagnosis code will provide an opportunity to submit your requests electronically and will allow for a more timely response.



When submitting for reimbursement, the diagnosis code must be included on the Claim form associated with an approved BLE request.

Consistent with 55 Pa. Code 1101.31(f)(2)(viii), the Provider may not bill the Plan Member for payment for services rendered in excess of the dental benefit limits unless:

- The Provider informs the Member in writing before the service is rendered that the service requires a BLE and the Member is liable for the payment if the request for a benefit limit exception is denied and;
- The Provider requests a benefit limit exception and the Plan denies the request.

Note: Please only include BLE eligible codes on requests for benefit limit exceptions.

Claims Submission Procedures

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

- Electronic Claims via the Plan's website: http://dentists.amerihealthcaritas.com
- Electronic submission via clearinghouses.
- Paper Claims.

Electronic Claim Submission Utilizing AmeriHealth Caritas Pennsylvania Website

Enrolled Network Providers may submit Claims directly to the Plan by utilizing the "Provider" section of our website. Submitting Claims via the website is very quick and easy and is at no additional cost to Providers! It is especially easy if you have already accessed the site to check a Member's eligibility prior to providing the service.

To submit Claims via the Website, simply log on to http://dentists.amerihealthcaritas.com

If you have questions on submitting Claims or accessing the Website, please contact our Systems Operations Department at: 1-855-434-9241.

Electronic Claim Submission via Clearinghouse

Dentists may submit their Claims to the Plan via a clearinghouse such as DentalXChange.

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

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

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

Paper Claim Submissions

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

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

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

The Provider and office location information must be clearly identified on the Claim. Frequently, if only the dentist signature is used for identification, the dentist's name cannot be clearly identified. To ensure proper Claim processing, the Claim form must include the following:

- Member name
- Member DOB
- Member ID #
- Provider name
- Tax ID #
- NPI

- Payee location
- Treating location

The date of service must be provided on the Claim form for each service line submitted.

Approved ADA dental codes as published in the Current Dental Terminology (CDT) book or as defined in this Manual must be used to define all services.

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

Affix the proper postage when mailing bulk documentation. The Plan does not accept postage due mail. This mail will be returned to the sender and will result in delay of payment.

Claims should be mailed to the following address:

AmeriHealth Caritas Pennsylvania Health Plan– Claims
P.O. Box 651
Milwaukee, WI 53201

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

AmeriHealth Caritas Pennsylvania Corrected Claims
P.O. Box 541
Milwaukee, WI 53201

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

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

2. Predetermination/Preauthorization Number

DENTAL BENEFIT PLAN INFORMATION

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

3a. Payer ID

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

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

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

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐M ☐F ☐U | 8. Policyholder/Subscriber ID (Assigned by Plan)

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

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

11a. Other Payer ID

POLICYHOLDER/SUBSCRIBER INFORMATION (Assigned by Plan Named in #3)

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

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐M ☐F ☐U | 15. Policyholder/Subscriber ID (Assigned by Plan)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

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

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

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

RECORD OF SERVICES PROVIDED

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

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐☐ (ICD-10 = AB)

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

31a. Other Fee(s)

32. Total Fee

35. Remarks

AUTHORIZATIONS

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

X _____
Patient/Guardian Signature Date

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

X _____
Subscriber Signature Date

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

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

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

52. Phone Number ( ) - | 52a. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION (all dates in MM/DD/CCYY format)

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

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

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

45. Treatment Resulting from ☐ Occupational Illness/Injury ☐ Auto accident ☐ Other accident

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

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

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

X _____
Signed (Treating Dentist) Date

53a. Locum Tenens Treating Dentist? ☐

54. NPI | 55. License Number

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

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

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

To reorder call 800.947.4746 or go online at ADAstore.org

ADA American Dental Association®

America's leading advocate for oral health

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

GENERAL INSTRUCTIONS

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

B. Complete all items unless noted otherwise on the form or in the instructions posted on the ADA's web site (ADA.org).

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

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

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

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

COORDINATION OF BENEFITS (COB)

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

DIAGNOSIS CODING

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

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

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

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

PLACE OF TREATMENT

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

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

The full list is available online at:
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Website-POS-database.pdf

PROVIDER SPECIALTY

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

Category / Description Code	Code
Dentist A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license.	122300000X
General Practice	1223G0001X
Dental Specialty (see following list)	Various
Dental Public Health	1223D0001X
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223X0008X
Oral & Maxillofacial Surgery	1223S0112X

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

Timely Filing Limits

The Provider understands that failure to submit Claims (and any required documentation) within 180 days from the date of service may result in loss of reimbursement for services provided. Claims with Explanation of Benefits (EOBs) from primary insurers must be submitted within 60 days of the date of the primary insurer's EOB. Providers must submit a copy of the primary insurer's EOB. The Plan determines whether a Claim has been filed timely by comparing the date of service to the receipt date applied to the Claim when the Claim is received. If the span between these two dates exceeds the time limitation, the Claim is considered to have not been filed timely.

Coordination of Benefits (COB)

When the Plan is the secondary insurance carrier, a copy of the primary carrier's Explanation of Benefits (EOB) must be submitted with the Claim. For electronic Claim submissions, the payment made by the primary carrier must be indicated in the appropriate COB field. When a primary carrier's payment meets or exceeds the Provider's contracted fee schedule with the Plan, the Plan will consider the Claim paid in full and no further payment will be made on the Claim The Member may not be billed for any outstanding balance.

Third Party Liability and Coordination of Benefits

Third Party Liability (TPL) is when the financial responsibility for all or part of a Member's health care expenses rests with an individual entity or program (e.g., Medicare, commercial insurance) other than the Plan (TPL does not effect the Member's Medicaid eligibility. Members can report TPL to Member Services at **1-888-991-7200**). COB (Coordination of Benefits) is a process that establishes the order of payment when an individual is covered by more than one insurance carrier. A Medicaid HMO, such as the Plan, is always the payer of last resort. This means that Claims must be submitted and processed by all other insurance carriers (the "Primary Insurers") before a Claim is submitted to the Plan. Health Care Providers are required to bill the Primary Insurer first and obtain an Explanation of Benefits (EOB) statement from the Primary Insurer. Health Care Providers then may bill the Plan for the Claim by submitting the Claim along with a copy of the Primary Insurer's EOB. See timeframes for submitting Claims with EOBs from a Primary Insurer in the Timely Filing Limits section above.

Reimbursement for Members with Third Party Resources

Medicare as a Third-Party Resource

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

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

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

If the services are provided by a Non-Participating Provider or if no contracted rate exists, the Plan will pay coinsurance, deductibles and/ or co-payments up to the applicable Medical Assistance (MA) Fee-For-Service rate.

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

Continuation of Care

The Plan provides continuing coverage of care for Members who are engaged in an ongoing course of treatment with a non-participating Practitioner or Provider to promote continuity of care. Please reach out to your Account Executive for non- orthodontic continuation of care.

The process for the continuation of orthodontic coverage can be found at www.amerihealthcaritaspa.com → Provider → Resources → Dental program. Please reach out to your AmeriHealth Caritas Pennsylvania Dental Account Executive for questions regarding this process.

Commercial Third-Party Resource

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

- The difference between the Plan's contracted rate and the amount paid by the Primary Insurer, or
- The amount of the applicable coinsurance, deductible and/or co-payment.

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

Health Care Providers must comply with all applicable Plan referral and prior authorization requirements.

Receipt and Audit of Claims

In order to ensure timely, accurate remittances to each dentist, the Plan performs an edit of all Claims upon receipt. This edit validates Member eligibility, procedure codes, and Provider identifying information. A Dental Reimbursement Analyst dedicated to the Plan's dental offices analyzes any Claim conditions that would result in non-payment. When potential problems are identified, your office may be contacted and asked to assist in resolving this problem. Please feel free to contact the Plan's Provider Services Department at: **1-855- 434-9241** with any questions you may have regarding Claim submission or your remittance.

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

Dentist Appeal Procedures

Providers have the opportunity to request resolution of Disputes or Formal Provider Appeals that have been submitted to the appropriate internal Plan’s department.

Providers may appeal a Plan reimbursement decision by submitting an appeal in writing, along with any necessary additional documentation within 60 days of the date of the explanation of benefit indicating Claim denial:

AmeriHealth Caritas Pennsylvania – Appeals
P.O. Box 1243
Milwaukee, WI 53201

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

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) and Fraud, Waste and Abuse

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

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

Note: Copies of the Plan’s HIPAA policies are available upon request by contacting: The Plan’s Provider Service Department at: **1-855-434-9241**

For complete detailed information regarding the Plan’s HIPAA policies refer to “Compliance with the HIPAA Privacy Regulations” section in the Provider Manual.

Fraud, Waste & Abuse

Under the HealthChoices program, the Plan receives state and federal funding for payment of services provided to our Members. In accepting Claims payment from the Plans, Health Care Providers are receiving state and federal program funds and are therefore subject to all applicable federal and/or state laws and regulations relating to this program. Violations of these laws and

regulations may be considered Fraud, Waste or Abuse against the Medical Assistance program. See the Medical Assistance Manual, Chapter 1101 or go to www.pacode.com/secure/data/055/partIIItoc.html for more information regarding Fraud Waste or Abuse, including "Provider Prohibited Acts" that are specified in §1101.75. Providers are responsible to know and abide by all applicable state and federal regulations.

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

Examples of fraudulent/wasteful/abusive activities:

- Billing for services not rendered or not Medically Necessary.
- Submitting false information to obtain authorization to furnish services or items to Medicaid recipients.
- Prescribing items or referring services which are not Medically Necessary.
- Misrepresenting the services rendered.
- Submitting a Claim for Provider services on behalf of an individual that is unlicensed or has been excluded from participation in the Medicare and Medicaid programs.
- Retaining Medicaid funds that were improperly paid.
- Billing Medicaid recipients for covered services.
- Failure to perform services required under a capitated contractual arrangement.

Reporting and Preventing Fraud, Waste and Abuse

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

- Calling the toll-free MA Provider Compliance Hotline at: **1-866-833-9718**,
- E-mailing to fraudtip@amerihealthcaritas.com; or,
- Mailing a written statement to Special Investigations Unit:
  AmeriHealth Caritas Pennsylvania
  P.O. Box 7317
  London, KY 40742

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

- Contact Information (e.g., name of individual making the allegation, address, telephone number);

- Name and Identification Number of the Suspected Individual;
- Source of the Complaint (including the type of item or service involved in the allegation);
- Approximate Dollars Involved (if known);
- Place of Service;
- Description of the Alleged Fraudulent, Wasteful or Abuse Activities;
- Timeframe of the Allegation(s).

Providers may also report suspected Fraud, Waste, and Abuse to:

AmeriHealth Caritas Pennsylvania
P.O. Box 7317
London, KY 40742

Or

Contact the Pennsylvania Department of Human Services through one of the following methods:

Phone:	**1-844-DHS-TIPS** or **1-844-347-8477**
Online:	https://www.dhs.pa.gov/about/Fraud-And-Abuse/Pages/MA-Fraud-and-Abuse---General-Information.aspx
Fax:	**1-717-214-1200, Attn: OMAP Provider**
Mail:	**Office of Administration** **Bureau of Program Integrity** **P.O. Box 2675** **Harrisburg, PA 17105-2675**

Credentialing

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

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

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

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

Medical Recordkeeping

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

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

The Plan will periodically conduct random chart audits in order to determine Network Providers' compliance with these conditions and expectation, as a component of the Plan's Quality Management Program. Network Providers are expected to supply, upon request, complete copies of Member dental records. The records are reviewed by the Plan's Dental Director, or his/her designee, such as a Registered Dental Hygienist, to determine the rate of compliance with medical recordkeeping requirements as well as the accuracy of the dental Claims submitted for payment. All dental services performed must be recorded in the patient record, which must be made available as required by your Participating Provider Agreement.

The first part of the audit will consist of the charts being reviewed for compliance with the stated record keeping requirements, utilizing a standardized audit tool. The charts are reviewed and a composite score is determined. Offices with scores above 90% are considered as passing the audit but a letter is sent to them so that they are aware of the areas that need improvement; offices that receive a score of 95% or greater are exempt from the audit the following year. Offices with scores less than 90% will have a corrective action letter sent and are re- reviewed for compliance within the next 120 days. Offices that do not cooperate with improving their scores are subject to disciplinary action in accordance with the Plan's Provider Sanctioning Policy as outlined in the Provider Manual.

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

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

The Plan recognizes tooth letters “A” through “T” for primary teeth and tooth numbers “1” to “32” for permanent teeth. Supernumerary teeth should be designated by using Teeth numbers 51 through 82 for permanent teeth and AS through TS for primary teeth. Designation of the tooth can be determined by using the nearest erupted tooth. If the tooth closest to the supernumerary tooth is # 1 then the supernumerary tooth should be charted as #51, likewise if the nearest tooth is A the supernumerary tooth should be charted as AS. These procedure codes must be referenced in the patient’s file for record retention and review. Patient records must be kept for a minimum of 10 years after the end of the termination of the State of client contract.

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

Important Notice For Submitting Paper Authorizations and Claims

All Claims need to be submitted on a current approved ADA form.

All other forms will not be accepted and will result in a rejection of the Claim or Authorization request. Additionally, when making a correction to a previously submitted and paid Claim, please sent it clearly marked to:

"Corrected Claims" on a current version of the ADA form to:

AmeriHealth Caritas Pennsylvania Corrected Claim
P.O. Box 541
Milwaukee, WI 53201

Please contact Provider Services at **1-855-434-9241** if you have questions. If you are in need of the current forms, please visit the ADA website at www.ada.org for ordering information.

Corrected Claim Submission Guidelines

When Should I Submit a Corrected Claim?

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

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

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

What scenarios are subject to the Corrected Claim Process?

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

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

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

- Electronic Corrected Claims via the Plan's website: http://dentists.amerihealthcaritas.com
- Electronic submission via clearinghouses.
- Paper Corrected Claims.

Electronic Claim Submission Utilizing AmeriHealth Caritas Pennsylvania Website

Enrolled Network Providers may make corrections on original claims directly to the Plan by utilizing the "Provider" section of our website. Corrections will be allowed one time on an original dental claim when utilizing the website.

- If additional corrections are required after a corrected claim is submitted, the provider will need to submit the correction based on the most recently submitted corrected claim, not the original claim.
- The website will provide a message stating the claim can no longer be corrected if the provider attempts to correct the original claim more than once.

To submit Claims via the Website, log on to http://dentists.amerihealthcaritas.com

If you have questions on submitting Claims or accessing the Website, please contact our Systems Operations Department at: 1-855-434-9241.

Electronic Claim Submission via Clearinghouse

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

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

Paper Claim Submissions

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

- The ADA form must be clearly noted "Corrected Claim" across the top of the form

- In the remarks field (Box 35) on the ADA form indicate the original paid encounter number and record all corrections you are requesting to be made.

NOTE: If all information does not fit in Box 35, please attach an outline of corrections to the Claim form.

Attach supporting documentation and send documentation in the same package with the Corrected paper claim form.

- Submit to:

AmeriHealth Caritas Pennsylvania Corrected Claims
PO Box 541
Milwaukee, WI 53201

What scenarios ARE NOT subject to the corrected Claim process?

A corrected Claim should not be submitted if the original Claim or service(s) which are the subject of the correction were denied or were not previously submitted.

Some examples of items that are not considered Claim corrections are:

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

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

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

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

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

Please contact Provider Services at: **1-855-434-9241** if you have questions. If you are in need of the current forms, please visit the ADA Website at www.ada.org for ordering information.

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

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

Prior Authorizations with missing or invalid information may be rejected and returned to the Provider. All radiographs including digital prints, duplicates, and originals will not be returned to the dentist unless a self- addressed stamped envelope is included with the Claim/Authorization submission.

Prior Authorizations should be mailed to the following address:

AmeriHealth Caritas Pennsylvania – Prior Authorizations
P.O. Box 654
Milwaukee, WI 53201

HEALTH GUIDELINES-AGES 0-20 YEARS

Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling.

Since each child is unique, these recommendations are designed for the care of children who have no contributing medical conditions and are developing normally. These recommendations will need to be modified for children with special health care needs or if disease or trauma manifests variations from normal. The American Academy of Pediatric Dentistry (AAPD) emphasizes the importance of very early professional intervention and the continuity of care based on the individualized needs of the child.

Refer to the guideline below from the American Academy of Pediatric Dentistry for supporting information and reference.

PEDIATRIC DENTAL PERIODICITY SCHEDULE
RECOMMENDATIONS FOR PREVENTIVE PEDIATRIC ORAL HEALTH CARE
Commonwealth of Pennsylvania, Department of Human Services, Office of Medical Assistance Programs
(Adapted from the American Academy of Pediatric Dentistry)
Effective October 3, 2023

Periodicity Recommendations					
Age	**Infancy 6-12 Months**	**Late infancy 12-24 Months**	**Preschool 2-6 Years**	**School Aged 6-12 Years**	**Adolescence 12-20 Years**
Clinical Oral Examination: ** First examination at the eruption of the first tooth and no later than 12 months of age. Repeat every 6 months or as indicated by the child's risk status/ susceptibility to disease. Includes assessment of pathology and injury.	X	X	X	X	X
Prophylaxis/ Topical Fluoride Treatment Especially for children at high risk for caries and periodontal disease.	X	X	X	X	X
Radiographic Assessment Timing, selection, and frequency determined by child's history, clinical findings and susceptibility to oral disease.	X	X	X	X	X
Assessment for Pit and Fissure Sealants For caries-susceptible primary molars, permanent molars, premolars and anterior teeth with deep pits and fissures, place as soon as possible after the eruption.			X First permanent molars as soon as possible after eruption	X Premolars, first and second permanent molars as soon as possible after eruption	X Second permanent molars and premolars as soon as possible after eruption
Caries Risk Assessment Must be repeated regularly and frequently to maximize effectiveness.	X	X	X	X	X
Tobacco Use and Cessation Counseling Counseling for tobacco, vaping, and substance misuse				X	X

AmeriHealth Caritas Pennsylvania Medicaid Clinical Criteria For Authorization Of Routine And Emergency Treatment

A number of procedures require prior authorization before initiating treatment. When prior authorizing these procedures, please note the documentation requirements when sending in the information to the Plan. The criteria used by dental reviewers for determinations of authorizations requests are listed below. Treatment may be provided if a procedure needs to be initiated under an emergency condition to relieve a patient's pain and suffering. However, to receive reimbursement for the treatment, the Plan will require the same documentation be provided (with the Claim for payment) and the same criteria to be met in order to receive payment for the treatment.

Adults age 21 and older have benefit limitations. Please refer to to Benefit Limit Exception Process section for information on the benefit limit exception criteria or contact Provider Services at: 1-855-434-9241 for more information.

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

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

All criteria below must be met:

- Tooth to be crowned must have an opposing tooth in occlusion or be an abutment tooth for a partial denture
- Minimum 50% bone support
- The patient must be free of active / advanced periodontal disease
- No subosseous and / or furcation carious involvement
- No periodontal furcation lesion or a furcation involvement
- Clinically acceptable RCT if present and all the criteria below must be met:
    - The tooth is filled within two millimeters of the radiographic apex
    - The root canal is not filled beyond the radiographic apex
    - The root canal filling is adequately condensed and/or filled
    - Healthy periapical tissue (healing PARL or no PARL)
- And 1 of the criteria below must be met:
    - Anterior teeth must have pathological destruction to the tooth by caries or trauma, and involve four (4) or more surfaces and at least 50% of the incisal edge
    - Premolar teeth must have pathological destruction to the tooth by caries or trauma, and must involve three (3) or more surfaces and at least one (1) cusp
    - Molar teeth must have pathological destruction to the tooth by caries or trauma, and must involve four (4) or more surfaces and two (2) or more cusps

Posts and cores (D2952, D2954)

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

- Minimum 50% bone support
- The patient must be free of active / advanced periodontal disease
- No subosseous and / or furcation carious involvement
- No periodontal furcation lesion or a furcation involvement
- Clinically acceptable RCT if present and all the criteria below must be met:
    - The tooth is filled within two millimeters of the radiographic apexThe root canal is not filled beyond the radiographic apex
    - The root canal filling is adequately condensed and/or filled
    - Healthy periapical tissue (healing PARL or no PARL)

Root canal therapy (D3310, D3320, D3330)

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

- Minimum 50% bone support
- The patient must be free of active / advanced periodontal disease
- No subosseous and / or furcation carious involvement
- No periodontal furcation lesion and / or a furcation involvement
- Closed apex
- Tooth must be crucial to arch/occlusion
- And 1 of the criteria below must be met if absence of decay or large restoration on the x-ray
    - Evidence of apical pathology/fistula
    - Narrative describing symptoms of irreversible pulpitis

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

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

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

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

Required documentation – pre-operative radiograph of adjacent and opposing teeth

All criteria below must be met:

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

Decoronation or submergence of an erupted tooth (D3921)

Required documentation – post operative radiograph (excluding bitewings), narrative of medical necessity inclusive of restorative treatment plan for arch(es)

All criteria must be met:

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

Gingivectomy or Gingivoplasty (D4210)

Required documentation – pre-operative radiographs, periodontal charting, narrative of medical necessity, photo (optional) 1 of the criteria below must be met:

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

Periodontal scaling and root planing (D4341 and D4342)

Required documentation – periodontal charting and current diagnostic radiographs of the quadrant(s) to be treated.

All criteria below must be met:

- 5 mm or more pocketing on 2 or more teeth indicated on the involved teeth
- Presence of root surface calculus and/or noticeable loss of bone support on x-rays

Completedentures (D5110, D5120)

Required documentation – Complete series of radiograph images (D0210) or panoramic radiographic image (D0330)

Criteria below must be met:

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

Immediate dentures (D5130, D5140) –

Required documentation – Complete series of radiograph images (D0210) or panoramic radiographic image (D0330)

Criteria below must be met:

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

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

Required documentation –Complete series of radiograph images (D0210) or panoramic radiographic image (D0330)

All criteria below must be met:

- Remaining teeth have greater than 50% bone support and are restorable. If a current denture exists that was not reimbursed by the plan, it must be non-serviceable for reasons other than tooth loss.

In addition 1 of the criteria below must be met

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

Impacted teeth – (D7220, D7230, D7240)

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

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

Surgical removal of residual tooth roots (D7250)

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

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

Oroantral fistula closure (D7260)

Documentation required – Narrative of medical necessity

All criteria below must be met:

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

Tooth reimplantation and / or stabilization (D7270)

Documentation required – Narrative of medical necessity

All criteria below must be met:

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

Exposure of an unerupted tooth (D7280)

Documentation required – Pre-operative radiographs and narrative of medical necessity.

Criteria below must be met:

- Documentation supports impacted/unerupted tooth.

Placement of device to facilitate eruption (D7283)

Documentation required – Narrative of medical necessity

All criteria below must be met:

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

Alveoloplasty without extractions (D7320)

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

Criteria below must be met:

- Documentation supports medical necessity for fabrication of a prosthesis

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

Documentation required – Copy of pathology report

Criteria below must be met:

- Copy of pathology report indicating lesion / tumor

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

Documentation required – Narrative of medical necessity, radiographs or photos

All criteria below must be met:

For Intraoral incision:

- Documentation describes non-vital tooth or foreign body

For Extraoral incision

- Documentation describes periapical or periodontal abscess

Non-arthroscopic lysis and lavage (D7871)

Documentation required – Narrative of medical necessity, radiographs or photos

All criteria below must be met:

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

Lingual Frenectomy (D7962)

Documentation required – Narrative of medical necessity, x-rays or photos

Criteria below must be met:

- Documentation describes tongue tied, diastema or tissue pull condition

Excision of hyperplastic tissue (D7970)

Documentation required – Pre-operative radiographs, narrative of medical necessity, photos

Criteria below must be met:

- Documentation describes medical necessity due to ill-fitting denture

Unspecified oral surgery procedure (D7999)

Documentation required – Narrative of medical necessity, name, license number and tax ID of Asst surgeon

All criteria below must be met:

- Documentation describes medical necessity need for Asst. surgeon
- Name / license number of Assistant surgeon is provided

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

Documentation required – Narrative of medical necessity, anesthesia log (retrospective review)

1 of the criteria below must be met:

- Extractions of impacted or unerupted cuspids or wisdom teeth or surgical exposure of unerupted cuspids
- 2 or more extractions in 2 or more quadrants
- 4 or more extractions in 1 quadrant
- Excision of lesions greater than 1.25 cm
- Surgical recovery from the maxillary antrum
- Documentation of failed local anesthesia
- Documentation of situational anxiety
- Documentation and narrative of medical necessity supported by submitted medical records (cardiac, cerebral palsy, epilepsy, MR or other condition that would render patient noncompliant)

Documentation of existing clinical condition or circumstance making the use of general anesthesia/IV sedation a reasonable inclusion as a Medically Necessary part of the therapeutic regimen.

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

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

Documentation required – Narrative of medical necessity

1 of the criteria below must be met:

- Extractions of impacted or unerupted cuspids or wisdom teeth or surgical exposure of unerupted cuspids
- 2 or more extractions in 2 or more quadrants
- 4 or more extractions in 1 quadrant

- Excision of lesions greater than 1.25 cm
- Surgical recovery from the maxillary antrum
- Documentation of failed local anesthesia
- Documentation of situational anxiety
- Documentation and narrative of medical necessity supported by submitted medical records (cardiac, cerebral palsy, epilepsy, MR or other condition that would render patient noncompliant)

Documentation of existing clinical condition or circumstance making the use of non-intravenous conscious sedation a reasonable inclusion as a Medically Necessary part of the therapeutic regimen.

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

Documentation required – Narrative of medical necessity

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

Custom sleep apnea appliance fabrication and placement - (D9947)

Documentation requirements:

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

Clinical Criteria:

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

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

- Impaired cognition
- Mood disorder
- Insomnia
- Other clinical information (add comment)

and

- Positive airway pressure history of contraindication – skin irritation, claustrophobia or noise generated by the machine

or

- Positive airway pressure history of non-tolerance

or

- Other clinical information (add comment)

Orthodontics

Fixed or removable appliance therapy (D8210, D8220)

Documentation required – Panoramic and/or cephalometric radiographs, narrative of medical necessity

All criteria below must be met:

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

Comprehensive orthodontic services (D8080)

Documentation requirements – Panoramic and /or cephalometric radiographs, 5-7 diagnostic quality photos, completed Salzman Criteria Index Form.

- Documentation supports Salzmann Criteria Index Form score of 25 points or greater when the case is evaluated using the Salzman Index.

Orthodontic Retention (D8680)

Documentation required – diagnostic quality photos

All criteria below must be met:

- Photos show completed orthodontic case.

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

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

Dental Benefit Grid
Procedure Codes and Eligibility Criteria

		Authorization Requirements				Benefit Details					
Code	**Code Description**	**Auth Reqd**	**Age Min**	**Age Max**	**Req Docs**	**Reporting Requirements**	**Age Min**	**Age Max**	**Max Count**	**Period Length**	**Period Type**
D0120	Periodic oral Evaluation-established patient	No				N	0	999	1	180	Days Per patient Additional requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF
D0140	Limited oral evaluation-problem focused	No				N	0	999	1	1	Days Per patient (audio or video teledentistry allowed…pt initiatiated by call in to office for POS
D0150	Comprehensive oral evaluation- new or established patient	No				N	0	999	1	1	Lifetime Per patient per dentist/dental group
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No				N	0	2	1	180	Days 1 per patient
D0210	Intraoral – comprehensive series of radiographic images	No				N	0	999	1	5	Year per patient
D0220	Intraoral- periapical first radiographic image	No				N	0	999	1	1	Day per patient
D0230	Intraoral – periapical each additional radiographic image	No				N	0	999	10	1	Day per patient
D0240	Intraoral -occlusal radiohgraphic image	No				N	0	999	2	1	Day per patient
D0250	Extra oral 2-D radiographic image created using a stationary radiation source, and detector	No				N	0	999	1	1	Day per patient
D0251	Extra oral posterior dental radiographic image	No				N	0	999	10	1	Day per patient
D0270	Bitewing - single radiographic image	No				N	0	999	1	1	Day per patient
D0272	Bitewings -two radiographic images	No				N	0	999	1	1	Day per patient
D0273	Bitewings - three radiographic images	No				N	0	999	1	1	Day per patient
D0274	Bitewings – four radiographic images	No				N	0	999	1	1	Day per patient

D0330	Panoramic radiographic image	No				N	0	999	1	5	Year per patient
D0340	2D Cephalometric radiographic image – acquisition, measurement and analysisf	No				N	0	20	1	1	Day per patient
D0372	intraoral tomosynthesis - comprehensive series of radiographic images; A radiographic survey of the whole mouth intended to display the crowns and roots of all teeth, periapical areas, interproximal areas and alveolar bone including edentulous areas.	No				N	0	999	1	5	Year per patient
D0373	intraoral tomosynthesis - bitewing radiographic image	No				N	0	999	4	1	Day per patient
D0374	intraoral tomosynthesis - periapical radiographic image	No				N	0	999	11	1	Day per patient
D1110	Prophylaxis -adult	No				N	12	999	1	180	DAYS (per patient . Additional requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF

		Authorization Requirements				Benefit Details					
Code	**Code Description**	**Auth Reqd**	**Age Min**	**Age Max**	**Req Docs**	**Reporting Requirements**	**Age Min**	**Age Max**	**Max Count**	**Period Length**	**Period Type**
D1120	Prophylaxis - child	No				N	0	11	1	180	DAYS per patient
D1206	Topical application of Fluoride varnish	No				N	0	20	6	1	Year per patient (teledentistry POS 02,10)
D1208	Topical application of Fluoride – excluding varnish	No				N	0	20	1	180	Days per patient
D1310	Nutritional counseling for control of dental disease	No				N	0	999	1	180	Days per patient (teledentistry P02, 10)
D1320	Tobacco counseling for the control and prevention of dental disease	No				N	0	999	1(D1320 or D1321 or 99407)	1	Day per patient (teledentistry allowed POS 02, 10)
D1320	Tobacco counseling for the control and prevention of dental disease	No				N	0	999	70(D1320 or D1321 or 99407)	1	Year per patient teledentistry allowed POS 02, 10)
D1321	Counseling for the control and prevention of adverse oral behavioral and system health effects associated with high-risk substance abuse	No				N	0	999	1(D1320 or D1321 or 99407)	1	Day per patient
D1321	Counseling for the control and prevention of adverse oral behavioral and system health effects associated with high-risk substance abuse	No				N	0	999	70(D1320 or D1321 or 99407)	1	Year per patient
D1330	Oral hygiene instructions	No				N	0	999	1	180	Days per patient(teledentistry POS 02, 10)
D1351	Sealant per tooth	No				T	0	20	1	1	Lifetime per patient Allowed on 1st and 2nd premolars.Allowed on 1st and second molars and on 1st and second molars where a buccal restoration might existtorations
D1354	Application of caries arresting medicament – per tooth	No				T	0	9990	10 teeth	1	Day per patient
D1354	Application of caries arresting medicament – per tooth	No				T	0	999	4	1	Year per tooth per patient

D1354	Application of caries arresting medicament – per tooth	No				T	0	999	6	1	Lifetime per tooth per patient
D1510	Space maintainer - quadrant	No				Q	0	20	4	1	1 appliance Per quaqdrant 4 per lifetime per patient
D1516	Space maintainer – fixed - bilateral, maxillary	No				T	0	20	4	1	1 appliance Per quaqdrant 4 per lifetime per patient
D1517	Space maintainer – fixed - bilateral, mandibular	No				T	0	20	4	1	1 appliance Per quaqdrant 4 per lifetime per patient
D1551	Re-cement or re-bond bilateral space maintainer – maxillary	No				N	0	20	1	1	Day appliance per patient
D1552	Re-cement or re-bond bilateral space maintainer – mandibular	No				N	0	20	1	1	Day appliance per patient
D1553	Re-cement or re-bond unilateral space maintainer – per quadrant	No				N	0	20	4	1	Day appliances per patient
D1556	Removal of fixed unilateral space maintainer – per quadrant	No				N	0	20	4	1	Day appliances per patient
D1557	Removal of fixed bilateral space maintainer – maxillary	No				N	0	20	1	1	Day appliance per patient
D1558	Removal of fixed bilateral space maintainer – mandibular	No				N	0	20	1	1	Day appliance per patient
D2140	Amalgam - one Surface primary or permanent	No				T	0	999	1	1	Day per patient
D2150	Amalgam – two surface primary or permanent	No				T	0	999	1	1	Day per patient
D2160	Amalgam – three surface primary or permanent	No				T	0	999	1	1	Day per patient
D2161	Amalgam – four surface primary or permanent	No				T	0	999	1	1	Day per patient
D2330	Resin-based composite - 1 surface, Anterior	No				T	0	999	1	1	Day per patient
D2331	Resin-based composite -2	No				T	0	999	1	1	Day per patient
D2332	Resin-based composite 3	No				T	0	999	1	1	Day per patient
D2335	Resin- based composite 4+ surfaces or involving incisal angle (anterior)	No				T	0	999	1	1	Day per patient
D2390	Resin-based composit crown - anterior	No				T	0	20	1	1	Day per patient
D2391	Resin - based Composite - 1 surface, posterior	No				T	0	999	1	1	Day per patient
D2392	Resin - based Composite - 2 surface, posterior	No				T	0	999	1	1	Day per patient
D2393	Resin - based Composite - 3 surface. posterior	No				T	0	999	1	1	Day per patient
D2394	Resin - based composite-4+ surface, posterior	No				T	0	999	1	1	Day per patient

D2710	Crown - resin - based composite (indirect)	Yes	0	999	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity	T	0	999	1	3	Year per patient Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF
D2721	Crown-resin with predominantly base metal	Yes	0	999	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity	T	0	999	1	5	Year per patient 1 per tooth every 5 years regardless of crown procedure code Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF

		Authorization Requirements				Benefit Details					
Code	**Code Description**	**Auth Reqd**	**Age Min**	**Age Max**	**Req Docs**	**Reporting Requirements**	**Age Min**	**Age Max**	**Max Count**	**Period Length**	**Period Type**
D2740	Crown-porcelain/ceramic	Yes	0	999	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity	T	0	999	1	5	Year per patient 1 per tooth every 5 years regardless of crown procedure code. Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF
D2751	Crown-porcelain fused to predominantly base metal	Yes	0	999	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity	T	0	999	1	5	Year per patient 1 per tooth every 5 years regardless of crown procedure code. Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF
D2752	Crown-porcelain fused to noble metal	Yes	0	999	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity	T	0	999	1	5	Year per patient 1 per tooth every 5 years regardless of crown procedure code. Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF
D2791	Crown - full cast predominantly base metal	Yes	0	999	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity	T	0	999	1	5	Year per patient 1 per tooth every 5 years regardless of crown procedure code. Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF
D2910	Recement or rebond inlay, onlay, veneer or partial coverage restoration	No				T	0	999	1	1	Day per tooth per patient
D2915	Recement or re-bond indirectly fabricated or prefabricated post and core	No				T	0	999	1	1	Day per tooth per patient
D2920	Recement or re-bond crown	No				T	0	999	1	1	Day per tooth per patient
D2930	Prefabricated Stainless Steel Crown - primary tooth	No				T	0	20	1	1	Day per tooth per patient
D2931	Prefabricated Stainless Steel Crown - permanent tooth	No				T	0	20	1	1	Day per tooth per patient
D2932	Prefabricatedresin crown	No				T	0	20	1	1	Day per tooth per patient
D2933	Prefabricated Stainless Steel Crown with resin window	No				T	0	20	1	1	Day per tooth per patient

D2934	Prefabricated esthetic coated stainless steel crown-primary tooth	No				T	0	20	1	1	Day per tooth per patient
D2952	Post and core in addition to crown, indirectly fabricated	Yes	0	999	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity	T	0	999	1	1	PER DAY/PER TOOTH/PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF

		Authorization Requirements				Benefit Details					
Code	**Code Description**	**Auth Reqd**	**Age Min**	**Age Max**	**Req Docs**	**Reporting Requirements**	**Age Min**	**Age Max**	**Max Count**	**Period Length**	**Period Type**
D2954	Prefabricated post and core in addition to crown	Yes	0	999	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of	T	0	999	1	1	PER DAY/PER TOOTH/PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF
D2980	Crown repair necessitated by restorative material failure	Yes	0	999	Narrative of medical necessity	T	0	999	1	1	PER DAY/PER TOOTH/PER PATIENT
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	No	0	20		T	0	20	6	1	PER DAY/PER TOOTH/PER PATIENT
D3230	Pulpal therapy (resorbable filling) anterior, primary tooth (excluding final restoration)	No	0	20		T	0	20	1	1	PER DAY/PER TOOTH/PER PATIENT
D3240	Pulpal therapy (resorbable filling) posterior, primary tooth (excluding final restoration)	No	0	20		T	0	20	1	1	PER DAY/PER TOOTH/PER PATIENT
D3310	Endodontic therapy, Anterior tooth (excluding final restoration)	Yes	0	999	Pre-operative x-rays (excluding bitewings), Narrative	T	0	999	1	1	LIFETIME PER TOOTH PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF
D3320	Endodontic therapy, Premolar tooth (excluding final restoration)	Yes	0	999	Pre-operative x-rays (excluding bitewings). Narrative	T	0	999	1	1	LIFETIME PER TOOTH PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF
D3330	Endodontic therapy, molar tooth (excluding final restoration))	Yes	0	999	Pre-operative x-rays (excluding bitewings), narrative	T	0	999	1	1	LIFETIME PER TOOTH PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF
D3410	Apicoectomy anterior	No				T	0	999	2 teeth	1	DAY PER TOOTH PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF

		Authorization Requirements				Benefit Details					
Code	**Code Description**	**Auth Reqd**	**Age Min**	**Age Max**	**Req Docs**	**Reporting Requirements**	**Age Min**	**Age Max**	**Max Count**	**Period Length**	**Period Type**
D3421	Apicoectomy premolar – (first root)	No				T	0	999	2 teeth	1	DAY PER TOOTH PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF
D3425	Apicoectomy molar – first root	No				T	0	999	2 teeth	1	DAY PER TOOTH PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF
D3426	Apicoectomy-(each additional root)	No				T	0	999	2 teeth	1	DAY PER TOOTH PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF
D3471	Surgical repair of root resorption - anterior	YES	0	999	Pre-operative x-rays excluding bitewings. Narrative of medical	T	0	999	1	1	LIFETIME PER TOOTH PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF
D3472	Surgical repair of root resorption - premolar	YES	0	999	Pre-operative x-rays excluding bitewings. Narrative of medical	T	0	999	1	1	LIFETIME PER TOOTH PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF
D3473	Surgical repair of root resorption - molar	YES	0	999	Pre-operative x-rays excluding bitewings. Narrative of medical	T	0	999	1	1	LIFETIME PER TOOTH PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior	YES	0	999	Pre-operative x-rays excluding bitewings. Narrative of medical	T	0	999	1	1	LIFETIME PER TOOTH PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar	YES	0	999	Pre-operative x-rays excluding bitewings. Narrative of medical	T	0	999	1	1	LIFETIME PER TOOTH PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption - molar	YES	0	999	Pre-operative x-rays excluding bitewings. Narrative of medical	T	0	999	1	1	LIFETIME PER TOOTH PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF
D3921	Decoronation or submergence of an erupted tooth	Yes	0	999	Post operative x-rays (excluding bitewings), narrative of medical	T	0	999	1	1	Lifetime per tooth PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	Yes	0	999	Pre-op x-rays and periodontal charting. Narrative of medical necessity, Photo	Q	0	999	4 (different quadrants)	24	MONTHS PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF

D4341	Periodontal scaling and root planing – four or more teeth per quadrant	Yes	0	999	Periodontal charting and pre-op x-rays. Narrative of medical necessity	Q	0	999	2 different quadrants	1	day PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	Yes	0	999	Periodontal charting and pre- op x-rays. Narrative of medical necessity	Q	0	999	4 different quadrants	24	MONTHS PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF
D4342	Periodontal scaling and root planing one to three teeth per quadrant	Yes	0	999	Periodontal charting and pre- op x-rays. Narrative of medical	Q	0	999	4 (different quadrants)	1	Day PER PATIENT PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF
D4342	Periodontal scaling and root planing one to three teeth per quadrant	Yes	0	999	Periodontal charting and pre- op x-rays. Narrative o medical	Q	0	999	4 (different quadra	24	Months PER PATIENT Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	No				N	0	999	1	1	year PER PATIENT No history of prophylaxis or periodontal treatment in past12 months. Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF.
D4346	Scaling in the presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	No				N	0	999	1	180	Days per patient

		Authorization Requirements				Benefit Details					
Code	**Code Description**	**Auth Reqd**	**Age Min**	**Age Max**	**Req Docs**	**Reporting Requirements**	**Age Min**	**Age Max**	**Max Count**	**Period Length**	**Period Type**
D4910	Periodontal maintenance	No				N	0	999	1	90	days per patient
D5110***	Complete denture - maxillary	Yes	0	999	Full mouth or panorex x-rays. Narrative of medical necessity),	N	0	999	1	1	Lifetime appliance per arch per patient *limited to one (full or partial denture) per arch, regardless of procedure (D5110, D5130, D5211, D5213) and one (full or partial denture) per lower arch, regardless of procedure code (D5120, D5140, D5212, D5214) Additional appliance Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF*
D5120***	Complete denture - mandibular	Yes	0	999	Full mouth or panorex x-rays. Narrative of medical necessity,	N	0	999	1	1	Lifetime appliance per arch per patient *limited to one (full or partial denture) per arch, regardless of procedure (D5110, D5130, D5211, D5213) and one (full or partial denture) per lower arch, regardless of procedure code (D5120, D5140, D5212, D5214) Additional appliance Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF*

D5130	Immediate denture - maxillary	Yes	0	999	Full mouth or panorex x-rays. Narrative of medical necessity,	N	0	999	1	1	Lifetime appliance per arch per patient *limited to one (full or partial denture) per arch, regardless of procedure (D5110, D5130, D5211, D5213) and one (full or partial denture) per lower arch, regardless of procedure code (D5120, D5140, D5212, D5214) Additional appliance Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF*
D5140	Immediate denture - mandibular	Yes	0	999	Full mouth or panorex x-rays. Narrative of medical necessity,	N	0	999	1	1	Lifetime appliance per arch per patient *limited to one (full or partial denture) per arch, regardless of procedure (D5110, D5130, D5211, D5213) and one (full or partial denture) per lower arch, regardless of procedure code (D5120, D5140, D5212, D5214) Additional appliance Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or*
D5211***	Maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)	Yes	6	999	Full mouth or panorex x-rays. Narrative of medical necessity,	N	6	999	1	1	Lifetime appliance per arch per patient *limited to one (full or partial denture) per arch, regardless of procedure (D5110, D5130, D5211, D5213) and one (full or partial denture) per lower arch, regardless of procedure code (D5120, D5140, D5212, D5214) Additional appliance Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF*

D5212***	Mandibular partial denture – resin base (including retentive/clasping materials, rests, and teeth)	Yes	6	999	Full mouth or panorex x-rays. Narrative of medical necessity	N	6	999	1	1	Lifetime appliance per arch per patient *limited to one (full or partial denture) per arch, regardless of procedure (D5110, D5130, D5211, D5213) and one (full or partial denture) per lower arch, regardless of procedure code (D5120, D5140, D5212, D5214) Additional appliance Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF*

		Authorization Requirements				Benefit Details					
Code	**Code Description**	**Auth Reqd**	**Age Min**	**Age Max**	**Req Docs**	**Reporting Requirements**	**Age Min**	**Age Max**	**Max Count**	**Period Length**	**Period Type**
D5213***	Maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	Yes	6	999	Full mouth or panorex x-rays. Narrative of medical necessity,	N	6	999	1	1	Lifetime appliance per arch per patient *limited to one (full or partial denture) per arch, regardless of procedure (D5110, D5130, D5211, D5213) and one (full or partial denture) per lower arch, regardless of procedure code (D5120, D5140, D5212, D5214) Additional appliance Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF*

D5214***	Mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	Yes	6	999	Full mouth or panorex x-rays. Narrative of medical necessity,	N	6	999	1	1	Lifetime appliance per arch per patient *limited to one (full or partial denture) per arch, regardless of procedure (D5110, D5130, D5211, D5213) and one (full or partial denture) per lower arch, regardless of procedure code (D5120, D5140, D5212, D5214) Additional appliance Requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF*
D5410	Adjust complete denture – maxillary	No				N	0	999	1	1	DAY per patient ADJUSTMENTS ARE INCLUDED IN THE FEE FOR THE DENTURE; through 180 days post insertion.
D5411	Adjust complete denture – mandibular	No				N	0	999	1	1	DAY per patient ADJUSTMENTS ARE INCLUDED IN THE FEE FOR THE DENTURE; through 180 days post insertion.
D5421	Adjust partial denture – maxillary	No				N	0	999	1	1	DAY per patient ADJUSTMENTS ARE INCLUDED IN THE FEE FOR THE DENTURE; through 180 days post insertion.
D5422	Adjust partial denture – maxillary	No				N	0	999	1	1	DAY per patient ADJUSTMENTS ARE INCLUDED IN THE FEE FOR THE DENTURE; through 180 days post insertion.
D5511	Repair complete broken denture base mandibular	No				N	6	999	1	1	DAY per patient
D5512	Repair complete broken denture base maxillary	No				N	6	999	1	1	DAY per patient
D5520	Replace missing or broken teeth – complete denture (each tooth)	No				T	0	999	3	1	DAY per patient

D5611	Repair resin partial denture base mandibular	No				N	0	999	1	1	DAY per patient
D5612	Repair resin partial denture base maxillary	No				N	0	999	1	1	DAY per patient
D5621	Repair cast partial framework - mandibular	No				N	0	999	1	1	DAY per patient
D5622	Repair cast partial framework - maxillary	No				N	0	999	1	1	DAY per patient
D5630	Repair or replace broken retentive/clasping materials - per tooth	No				T	0	999	1 clasp per tooth	1	DAY per patient
D5630	Repair or replace broken retentive/clasping materials - per tooth	No				T	0	999	4 clasps	1	Year per patient

		Authorization Requirements				Benefit Details					
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D5640	Replace broken teeth-per tooth	No				T	0	999	3 teeth	1	Day per patient
D5650	Add tooth to existing partial denture	No				T	0	999	2 teeth	1	Day per patient
D5660	Add clasp to existing partial denture per tooth	No				T	0	999	1 PER TOTH	1	Lifetime per patient
D5730	Reline complete maxillary denture (direct)	No				N	0	999	1	2	Year Relines are included in the fee for the denture through 180 days post placementDAY (RELINES ARE INCLUDED IN THE FEE FOR THE
D5731	Reline complete mandibular denture (direct)	No				N	0	999	1(per arch)	2	Year Relines are included in the fee for the denture through 180 days post placement
D5740	Reline maxillary partial denture (direct)	NO				N	0	999	1(per arch)	2	Year Relines are included in the fee for the denture through 180 days post placement
D5741	Reline mandibular partial denture (direct)	No				N	0	999	1(per arch)	2	Year Relines are included in the fee for the denture through 180 days post placement
D5750	Reline complete maxillary denture (indirect)	No				N	0	999	1(per arch)	2	Year Relines are included in the fee for the denture through 180 days post placement
D5751	Reline complete mandibular denture (indirect)	No				N	0	999	1(per arch)	2	Year Relines are included in the fee for the denture through 180 days post placement
D5760	Reline maxillary partial denture (indirect)	No				N	0	999	1(per arch)	2	Year Relines are included in the fee for the denture through 180 days post placement
D5761	Reline mandibular partial denture (indirect)	No				N	0	999	1(per arch)	2	Year Relines are included in the fee for the denture through 180 days post placement

		Authorization Requirements				Benefit Details					
Code	**Code Description**	**Auth Reqd**	**Age Min**	**Age Max**	**Req Docs**	**Reporting Requirements**	**Age Min**	**Age Max**	**Max Count**	**Period Length**	**Period Type**
D6930	Re-cement or re-bond fixed partial denture	No				N	0	999	1	1	Day per patient
D6980	Fixed partial denture repair necessitated by restorative material failure	No				N	0	999	1	1	Day per patient
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No				T	0	999	1 per tooth	1	Lifetime per patient
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth,	No				T	0	999	1 per tooth	1	Lifetime per patient
D7220	Removal impacted tooth-soft tissue	Yes	0	999	Pre-operative x-rays (excluding	T	0	999	1 per tooth	1	Lifetime per patient
D7230	Remove impacted tooth-partiallybony	Yes	0	999	Pre-operative x-rays (excluding	T	0	999	1 per tooth	1	Lifetime per patient
D7240	Remove impacted tooth – completely bony	Yes	0	999	Pre-operative x-rays (excluding	T	0	999	1 per tooth	1	Lifetime per patient
D7250	Removal of residual tooth roots (cutting procedure)	Yes	0	999	Pre-operative x-rays (excluding bitewings) and narrative of medical necessity	T	0	999	1 per tooth	1	Lifetime per patient
D7260	Oroantral fistula closure	Yes	0	999	Narrative of medical necessity	N	0	999	1	1	Day per patient
D7270	Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth	Yes	0	20	Narrative of medical necessity	T	0	20	1 per tooth	1	Day per patient
D7280	Exposure of unerupted tooth	Yes	0	20	Pre-operative x-	T	0	23	1 per tooth	1	Lifetime per patient
D7283	Placement of device to facilitate eruption of impacted tooth	Yes	0	22	rays (excluding bitewings)	T	0	23	1 per tooth	1	Day per patient
D7288	Brush biopsy - transepithelial sample collection	No				N	0	999	2	1	Day per patient
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	No				Q	0	999	1 per quadrant	1	Day per patient

D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	Yes	0	999	Pre-operative x-rays (excluding bitewings	Q	0	999	1 per quadrant	1	Day per patient
D7450	Removal of benign odontogenic cyst or tumor-lesion diameter up to1.25cm	Yes	0	999	Copy of pathology report	N	0	999	2 lesions	1	Day per patient

		Authorization Requirements				Benefit Details					
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D7451	Removal of benign odontogenic cyst or tumor-lesion diameter greater than 1.25cm	Yes	0	999	Copy of pathology report	N	0	999	2 lesions	1	Day per patient
D7460	Removal of benign non-odontogenic cyst or tumor-lesion diameter up to 1.25cm	Yes	0	999	Copy of pathology report	N	0	999	2 lesions	1	Day per patient
D7461	Removal of benign non-odontogenic cyst or tumor-lesion diameter greater than 1.25cm	Yes	0	999	Copy of pathology report	N	0	999	2 lesions	1	Day per patient
D7471	Removal of lateral exostosis – maxilla or mandible-	No				N	0	999	2	1	Day per patient
D7472	Removal of torus palatinus	No				N	0	999	2	1	Day per patient
D7473	Removal of torus mandibularis	No				N	0	999	2	1	Day per patient
D7485	Reduction of osseous tuberosity	No				N	0	999	2	1	Day per patient
D7509	Marsupialization of odontogenic cyst	No				N	0	999	2	1	Day per patient
D7510	Incision and drainage of abscess - intraoral soft tissue	Yes	0	999	Narrative of medical necessity, xrays	N	0	999	2	1	Day per patient
D7511	Incision and drainage of abscess- intraoral – complicated (includes drainage of multiple fascial spaces)	Yes	0	999	Narrative of medical necessity, xrays	N	0	999	2	1	Day per patient
D7520	Incision and drainage of abscess extraoral soft tissue	Yes	0	999	Narrative of medical necessity, xrays	N	0	999	2	1	Day per patient
D7521	Incision and drainage of abscess-extraoral – complicated (includes drainage of multiple fascial spaces)	Yes	0	999	Narrative of medical necessity, xrays or photos optional	N	0	999	2	1	Day per patient
D7871	Non-arthroscopic lysis and lavage	Yes	0	999	Narrative of medical	N	0	999	1	1	Day per patient
D7961	Buccal/ labial frenectomy (frenulectomy)	No	0	999	Narrative of medical necessit	N	0	999	2	1	Lifetime per patient
D7962	Lingual Frenectomy (frenulectomy)	Yes	0	999	Narrative of medical necessit	N	0	999	1	1	Lifetime per patient

D7970	Excision of hyperplastic tissue - per arch	Yes	0	999	Pre-operative x-rays, narrative of medical necessity	N	0	999	1 per arch	1	Day per patient
D7999	Unspecified oral surgery procedure, by repoirt	Yes	0	999	Narrative of medical necessity, name, license	N	0	999	1	1	Day per patient

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D8080	Comprehensive Orthodontic treatment of the adolescent dentition	YES	0	20	Panorex and /or cephalometric x-rays,	N	0	20	1	1	Lifetime per patient
D8660	Pre-orthodontic treatment examination to monitor growth and	No				N	0	20	1	1	Year(per patient/per provider)
D8670	Periodic orthodontic treatment visit	No	0	22	Panorex and /or cephalometric x-rays,	N	0	22	7	1	Lifetime per patient
D8680	Orthodontic retention (removal of appliances, construction and	Yes	0	22	evidence of successful completion of	N	0	22	1	1	Lifetime per patient
D8703	Replacement of lost/broken retainer - maxillary	Yes	0	22	Evidence of previous lost/broken D8680	N	0	22	1	1	Day per patient
D8704	Replacement of lost/broken retainer - mandibular	Yes	0	22	Evidence of previous lost/broken D8680	N	0	22	1	1	Day per patient
D8210	Removable appliance therapy	Yes	0	20	Panoramic /cephalometric x-ray, Narr of	N	0	20	1 per arch	1	Lifetime per patient (either D8210 or D8220)
D8220	Fixed appliance therapy	Yes	0	20	Panoramic /cephalometric x-ray, Narr of	N	0	20	1 per arch	1	Lifetime per patient (either D8210 or D8220)
D9110	Palliative treatment of dental pain – per visit	No				N	0	999	1	1	Day per patient
D9222	Deep sedation/general anesthesia – first 15 minutes	Yes	0	999	Narrative of medical necessity	N	0	999	1	1	Day per patient
D9223	Deep sedation/general anesthesia – each subsequent 15 minute increment	Yes	0	999	Narrative of medical necessity	N	0	999	7	1	Day per patient
D9230	Inhalation of nitrous oxide / analgesia, anxiolysis	No				N	0	20	1	1	Day per patient
D9239	Intravenous moderate (conscious)sedation/ analgesia – first 15	Yes	0	999	Narrative of medical necessity	N	0	999	1	1	Day per patient
D9243	Intravenous moderate (conscious)sedation/ analgesia – each	Yes	0	999	Narrative of medical necessity	N	0	999	7	1	Day per patient
D9248	Non-intravenous conscious sedation	Yes	0	999	Narrative of medical necessity	N	0	999	1	1	Day per patient
D9920	Behavior management fee (a vist fee for difficult to manage persons with developmental disabilities. Developmental disability- a substantial handicap having its onset before the age of 18 years of indefinite duration and attributable to neuropathy)	No				N	0	999	1	1	Day per patient

D9920	Behavior management fee (a visit fee for difficult to manage persons with developmental disabilities. Developmental disability- a substantial handicap having its onset before the age of 18 years of indefinite duration and attributable to neuropathy)	No				N	0	999	4	1	Calendar Year per patient
D9930	Treatment of complications (postsurgical) – unusual circumstances, by	Yes	0	999	Narrative of medical necessity	N	0	999	1	1	Day per patient
D9947	Custom sleep apnea appliance fabrication and placement	Yes	0	999	Lab Rx containing	N	0	999	1	1	Lifetime per patient
D9948	Adjustment of custom sleep apnea appliance	No				N	0	999	1	1	Day per patient at least 180 days post placement
D9949	Repair of custom sleep apnea appliance	No				N	0	999	1	1	Day per patient at least 180 days post placement
D9953	Reline custom sleep apnea appliance (indirect)	No				N	0	999	1	2	Year per patient at least 180 days post placement
D9995	Teledentistry – synchronous; real time encounter	No				N	0	999	1	1	Day per patient
D9996	Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	No				N	0	999	1	1	Day per patient

		Authorization Requirements				Benefit Details					
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	Cleft Palate Services										
D0160	Detailed and Extensive Oral Evaluation, by report	NO			Complete initial examination at a Cleft Palate Clinic only involving all licensed staff	N	0	20	1	1	Day per provider (Complete initial examination at a Cleft Palate Clinic only) involving all licensed staff
D0170	Re-evaluation, Limited Problem Focused (established patient; not postoperative visit)	NO			Cleft Palate Clinic	N	0	20	1	1	Day per patient

*Retro authorization required

***BLE only required for replacement denture

N = no reporting requirements

T = tooth reporting requirement

Q = quadrant reporting requirement