MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Distribution: Dental 03-01

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Subject: Implementation of CDT-4 Dental Procedure Codes; and Revised Chapter III

Effective: October 1, 2003

Programs Affected: Medicaid, Children's Special Health Care Services (CSHCS)

Conversion to CDT-4 Dental Procedure Codes

This bulletin is to notify you of the CDT-4 (Current Dental Terminology) changes for 2003 that will be implemented by the Department of Community Health (DCH) for dates of service on and after October 1, 2003. The CDT-4 procedure code changes are effective for the Fee For Service (FFS) program administered by DCH and the ***Healthy Kids Dental*** program in the 37 counties where the dental benefit is administered by Delta Dental Plan of Michigan. For those ***Healthy Kids Dental*** counties, while the covered services are the same as the Medicaid FFS program, Delta Dental administers the procedures according to their policies. Dentists should consult their Delta Dental manual for their administrative policies.

Listed below are the CDT-4 procedure codes adopted by the DCH for dental services. Any new CDT-4 procedure code not listed will not be covered at this time. All procedure codes being deleted from the national code set will be eliminated from use for dates of service on or after October 1, 2003. The attached Dental Procedure Codes Appendix lists the covered dental procedure codes. This bulletin also transmits the revised Chapter III (Coverages and Limitations). As a part of the chapter revision process, previously issued policy bulletins have been incorporated.

Please refer to your CDT-4 codebook for the full description of the new codes, as well as the list of deleted codes, revised codes, and code description. You may purchase the national codebook from the American Dental Association at 1-800-947-4746. This book must be referenced for the full code description, as well as additional information regarding coding guidelines.

Information regarding 2003 fees and coverage parameters (when appropriate) for covered codes will be posted on the DCH website when available. The website address is www.michigan.gov/mdch, click on Providers, Information for Medicaid Providers, Medicaid Fee Screens.

Table 1: CDT-4 Additions

Procedure Code	Short Description	Comments
D2390	Anterior resin-based composite crown	Covered for under age 21 only
D2391	Resin-based composite, one surface, posterior	Covered for under age 21 only
D2392	Resin-based composite, two surfaces, posterior	Covered for under age 21 only
D2393	Resin-based composite, three surfaces, posterior	Covered for under age 21 only
D2394	Resin-based composite, four or more surfaces, posterior	Covered for under age 21 only
D2799	Provisional crown	CSHCS only. Prior Authorization required.
D3221	Pulpal debridement, primary and permanent teeth	Covered for under age 13 only
D3230	Pulpal therapy-anterior, primary tooth	Covered for under age 8 only
D3240	Pulpal therapy-posterior, primary	Covered for under age 12 only
D4355	Full mouth debridement	Covered once every 365 days. Age 14 years through 20.
D6053	Implant/Abutment supported removable denture for comp. edentulous arch	CSHCS only. Prior Authorization required.
D6054	Implant/Abutment supported removable denture for partially edentulous arch	CSHCS only. Prior Authorization required.
D6253	Provisional Pontic	CSHCS only. Prior Authorization required.
D6793	Provisional Retainer crown	CSHCS only. Prior Authorization required.
D7111	Coronal Remnants-deciduous tooth	Covered for under age 21 only
D7140	Extraction, erupted tooth or exposed root (Elevation and/or forceps removal)	Covered for all ages
D7261	Primary closure of a sinus perforation	Covered for all ages
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	CSHCS only.
D7471	Removal of lateral exostosis (Maxilla or Mandible)	Quadrant Designation code required, e.g., UR, UL, LR, LL
D7472	Removal of Torus Palatinus	
D7473	Removal of Torus Mandibularis	Quadrant Designation code required, e.g., UR, UL, LR, LL
D7485	Surgical reduction of osseous tuberosity	Quadrant Designation code required, e.g., UR, UL, LR, LL
D7972	Surgical reduction of fibrous tuberosity	Quadrant Designation code required, e.g., UR, UL, LR, LL
D9248	Non-intravenous conscious sedation	Ages 0-5 only

Table 2: CDT-4 Deletions

Procedure Code	Short Description	Comments
D2110	Amalgam-One surface, primary	See revised code, D2140
D2120	Amalgam-Two surface, primary	See revised code, D2150
D2130	Amalgam-Three surface, primary	See revised code, D2160

Table 2: CDT-4 Deletions

Procedure Code	Short Description	Comments
D2131	Amalgam-Four or more surfaces, primary	See revised code, D2161
D2336	Resin-based composite crown, anterior, primary	See new code, D2390
D2337	Resin-based composite crown, anterior, permanent	See new code, D2390
D2380	Resin-based composite, one surface, posterior, primary	See new code, D2391
D2381	Resin-based composite, two surfaces, posterior, primary	See new code, D2392
D2382	Resin-based composite, three or more surfaces, posterior, primary	See new codes, D2393 or D2394
D2385	Resin-based composite, one surface, posterior, permanent	See new code, D2391
D2386	Resin-based composite, two surfaces, posterior, permanent	See new code, D2392
D2387	Resin-based composite, three surfaces, posterior, permanent	See new code, D2393
D2388	Resin-based composite, four or more surfaces, posterior, permanent	See new code, D2394
D4341	Periodontal Scaling and Root Planing	
D7110	Single Tooth	See new code, D7140
D7120	Each Additional Tooth	See new code, D7140

Manual Maintenance

Discard Dental 94-02 "Chapter III," Dental 94-04 "Corrections to Chapter III," and Dental 00-03, "Procedure Code Appendix."

Replace with the attached.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231 or e-mail ProviderSupport@michigan.gov . When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll free 1-800-292-2550.

Approval

Paul Reinhart, Director
Medical Services Administration

GENERAL

The primary objective of the Medicaid Program is to ensure that essential medical/dental services are made available to Medicaid beneficiaries. The Program goals are aimed at making the best use of program resources and assuring the quality of medically necessary health care services provided to Medicaid beneficiaries.

Determination of medical necessity and appropriateness of services is the responsibility of the dentist, within the scope of current accepted dental practice and the limitations of the Program (e.g., prior authorization process).

In cases where the Department of Community Health (DCH) determines that the dentist did not provide a service within the scope of current accepted dental practice or the service was not provided within the limitations of the Program, the DCH may: 1) require the service to be immediately provided, 2) require the dentist to repeat the service at no additional charge, 3) refuse payment to the dentist for the service, or 4) recover from the dentist reimbursement made for the service.

Dental services which may be provided to all Medicaid beneficiaries include emergency, diagnostic, preventive, and therapeutic services for dental disease which, if left untreated, would become acute dental problems or cause irreversible damage to teeth or supportive structures.

Dental benefits are made available to beneficiaries under 21 years of age through the Medicaid Program which provides Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). Beneficiaries age 21 and older receive dental benefits that are more limited in coverage. Dental benefits are provided through the Medicaid Fee For Service Program; Medicaid Health Plans are not responsible for the coverage of dental benefits for their enrolled beneficiaries.

Dentists providing specialty dental services to Children's Special Health Care Services (CSHCS) Program beneficiaries may refer to Section 8 of Chapter III and the Dental Procedure Codes Appendix for coverages and limitations.

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PRIOR AUTHORIZATION

Prior authorization must be obtained for certain services identified in this chapter and those dental services listed in the Dental Procedure Codes Appendix with an "X" in the prior authorization column. A prior authorization request is needed only for those services requiring prior authorization.

PRIOR AUTHORIZATION REQUIREMENTS IN CASES OF OVER-UTILIZATION

The DCH may require a specific dentist found to be misutilizing services to obtain prior authorization for all or selected dental services separate from those generally requiring authorization. The DCH shall set forth, in writing, to the dentist its reasons for applying this requirement.

COMPLETION INSTRUCTIONS

The Dental Prior Approval-Request Authorization form (MSA-1680B) is used to obtain authorization. Chapter IV provides instructions for completing and mailing the form. **NOTE:** When requesting authorization for certain procedures, the dentist may be required to send specific additional information and materials. Information regarding the additional information and/or materials is contained in Chapter IV, Section 2, PA COMPLETION INSTRUCTIONS.

Based on the Dental Prior Approval-Request Authorization and the documentation attached, staff will approve or disapprove the request and return a copy to the dentist. Approved requests will be assigned a Prior Authorization Number. For billing, the Prior Authorization Number must be entered in the appropriate field on the claim.

TOLL-FREE PHONE NUMBER

The DCH has installed a toll-free telephone system for dentists to call the Dental Prior Authorization Unit. The toll-free number is **1-800-622-0276**. Dentists and their staff may call this number for information on previous prior authorization requests, status of their current requests, and to update prior authorization requests.

Dental Prior Authorization Unit staff is available to answer questions Monday through Friday from 8:00 a.m. to 4:00 p.m.

To assist in the efficient use of this service, providers and their office staffs are encouraged to have the beneficiary's file, including all necessary data and information, ready for immediate reference each time a call is made.

All other inquiries, such as billing problems, should be directed to the Provider Inquiry line at **1-800-292-2550**.

APPROVED PRIOR AUTHORIZATION REQUESTS

An approved prior authorization request confirms that the beneficiary meets the program's established medical criteria for the services and that the services are covered benefits of the Medicaid Program. **This approval does not guarantee eligibility nor verify a beneficiary's age. It is also not to be considered an authorization for payment.**

The dentist is responsible for verifying the beneficiary's Medicaid Program eligibility and age by checking the Eligibility Verification System (EVS) operated by MediFAX. Eligibility should be verified prior to each appointment.

Prior authorization is granted to the dentist requesting authorization. It may be transferred or used by another dentist within the same group at the same address without contacting the Prior Authorization Unit. When the patient will be treated at a different location, a new prior authorization request must be submitted to the Prior Authorization Unit.

NOTE: If a Dental Prior Approval-Request Authorization (MSA-1680B) is approved under a given **Provider ID Number** and, in the course of providing the approved services the dentist's **Provider ID Number** is changed by the Provider Enrollment Unit, he/she must contact the Dental Prior Authorization Unit regarding the change and affected prior authorization request(s).

While the beneficiary is eligible, all treatment authorized must be completed within 180 days from the date of authorization. If treatment is not completed within the 180 days, the prior authorization request must be updated before continuing treatment.

Providers may update the prior authorization request by phone or fax if there are no treatment plan changes.

- Providers can call the toll-free number **1-800-622-0276,** or
- Providers may fax their update request to **517-335-0075**

If a change in the treatment plan, submit a new prior authorization request form with appropriate films and information.

If a prior authorization request is denied, the dentist will receive a denial notice. The beneficiary will also receive a notice of denial for the requested service along with their notice of appeal rights.

LOSS OR CHANGE IN ELIGIBILITY

No service is covered after loss of eligibility except for Root Canal Therapy, Dentures, and Laboratory-Processed Crowns. Reimbursement will only be made if the following specific conditions exist:

- Services must have been started prior to the loss of eligibility. For dentures and laboratory-processed crowns, impressions must have been taken prior to the loss of eligibility.
- Services must be completed within 30 days of change and/or loss of eligibility.
- For dentures and laboratory-processed crowns after loss of eligibility, the date of service on the claim should be the date of the initial impression.

NOTE: If a beneficiary's Medicaid eligibility is terminated after extractions have been performed, the extractions themselves do not qualify the beneficiary for dentures.

In the case of a beneficiary's death where denture services have commenced but have not been delivered, the dentist should use the Not Otherwise Classified procedure code, include a copy of the lab bill, and an explanation in the Remarks section of the claim. The provider will be paid a reduced rate to cover the lab costs that he/she has incurred.

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COPAYMENT

Beneficiaries age 21 and older are required to pay a $3.00 copayment for each separately reimbursable visit. Beneficiaries under the age of 21 and those who reside in a long-term care facility are exempt from copayments:

- When more than one reimbursable service is provided during a visit, only one $3.00 copayment may be charged.
- Where several visits are required to complete a service, such as dentures, only one $3.00 copayment may be charged.

NOTE: If the beneficiary is unable to pay the required copayment on the date of service, the dentist cannot refuse to render the service. However, the dentist may bill the beneficiary the copayment amount, and the beneficiary is responsible for paying it. The dentist may refuse to render services in the future if the beneficiary does not pay the copayment.

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It is expected that, whenever possible, the site of treatment will be the dental office. However, special situations may necessitate the provision of services at a different site, such as an inpatient or outpatient hospital setting.

HOSPITAL SETTING

Admission to an inpatient or outpatient hospital setting for any **nonemergency dental service** is covered **only** when one of the following conditions that does not allow the procedure to be performed in the dental office is met:

- the patient has a concurrent hazardous medical condition, or
- the nature of the procedure requires it to be performed in a hospital setting, or
- other contributing factors, such as age, mental impairment, etc., necessitate provision of the procedure in a hospital setting

Authorization Instructions: For Fee For Service (FFS) beneficiaries, no special authorization will be needed for dental services performed in the outpatient setting. For elective inpatient admissions, the dentist must call the MPRO PACER (Prior Authorization Case Evaluation Review) system for a PACER number. The PACER number is placed in the Remarks Section of the Dental Invoice. The toll-free number to access the MPRO PACER system is 1-800-727-7223.

For beneficiaries enrolled in a Medicaid Health Plan, the dentist must contact the appropriate Health Plan to receive authorization to perform dental services in the hospital setting. The health plan will provide authorization when determined medically necessary based on the contributing factors identified above. The Health Plan name and telephone number that the beneficiary is enrolled in can be obtained by calling the EVS.

Hospitalization is not a benefit for the convenience of the dentist or beneficiary or because of apprehension on the part of the beneficiary.

For services performed in the Operating Room (OR) setting, the dentist should use the usual and customary fee for the service as performed in an office setting. In addition, the procedure code **Hospital Call** may also be billed if services are provided in the OR setting. This code may be billed in addition to the appropriate dental procedure code for the actual service performed. This procedure code is not for administrative purposes, such as arranging appointment times, gathering signatures for release forms, etc.

NURSING FACILITY

The dental services that may be provided to a beneficiary in a nursing facility are the same as those identified in COVERED SERVICES, Section 6 of this Chapter.

Dental services (including dental examinations) provided to a beneficiary in a nursing facility must be upon the written order of a licensed physician (M.D. or D.O.). The order must be signed and dated by the physician, and the facility must retain a copy in the beneficiary's medical record.

When an oral examination is provided in a nursing facility, a notation must be made in the beneficiary's medical record of the chief complaint, current oral health status, appropriate health history and services to be rendered.

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PHARMACY SERVICES

The Program has a list of covered drugs which include selected legend and over-the-counter drugs. The intent is to maintain coverage of economical products for most classes. The Program does not reimburse the dentist for drugs dispensed in the office setting. For those beneficiaries enrolled in a Medicaid Health Plan, the dentist should refer to the Health Plan's formulary for the list of approved drugs.

Prescribed quantities should be limited to an amount necessary to keep the beneficiary supplied during the therapeutic regimen. In certain cases and conditions, more than a month's supply will be appropriate while, for other conditions, more frequent monitoring is essential. However, in no instance may the dentist prescribe a drug for more than a 100-day supply.

The DCH requests the dentist to place his/her DEA number on prescriptions written for Medicaid beneficiaries.

MEDICAL LABORATORY SERVICES

Any medically-necessary laboratory service ordered by a dentist is a Medicaid benefit. Only the provider who performs the service may bill for the service.

The DCH requests the dentist to place his/her nine-digit Medicaid Provider ID Number on medical laboratory service orders written for Medicaid beneficiaries. (The laboratory is required to provide this information when billing.)

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This section provides information on Medicaid covered services and is divided into the following subsections that correspond to the categories of services in *Current Dental Terminology, Fourth Edition* (CDT-4) as published by the American Dental Association.

CATEGORIES OF SERVICE

I. Diagnostic Services

II. Preventive Services

III. Restorative Treatment

IV. Endodontics

V. Periodontics

VI. Prosthodontics (Removable)

VII. Oral Surgery

VIII. Adjunctive General Services

Providers must use the current CDT-4 procedure codes published by the American Dental Association when completing both the claim and prior authorization form. Procedure codes covered by the DCH are listed in the Dental Procedure Codes Appendix. Prior authorization must be obtained for certain services identified in this section.

DIAGNOSTIC SERVICES

Clinical Oral Evaluations (Examinations)

A periodic, comprehensive or problem-focused evaluation is considered a benefit for all beneficiaries only if detailed written documentation of medical and dental findings (both negative and positive) and tests (see Chapter I) are included in the beneficiary's dental record. Typically, it should include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, periodontal conditions, hard and soft tissue anomalies, oral cancer screening, prosthesis condition and usage, etc. Examinations without this documentation are not a covered benefit.

Comprehensive Oral Evaluation

A comprehensive oral evaluation must include a documented medical and dental history, a thorough evaluation and recording of the condition of extraoral and intraoral hard and soft tissues, including a complete charting of the condition of each tooth and supporting tissues, occlusal relationships, periodontal conditions, including periodontal charting, oral cancer screening, and appropriate radiographic studies (which are separately reimbursable). The comprehensive oral evaluation is a covered benefit for beneficiaries under age 21.

Periodic Oral Evaluation

A periodic oral evaluation is an examination to determine any changes in a beneficiary's dental and medical health status since a previous comprehensive or periodic examination. The periodic oral evaluation must include a written update of the beneficiary's dental and medical history, clinically appropriate charting necessary to update and supplement the comprehensive oral examination data, including periodontal screening and appropriate radiographs (which are separately reimbursable) as necessary to update previous radiograph surveys. A periodic oral evaluation is a covered benefit once every six months for beneficiaries under age 21.

Limited Oral Evaluation-Problem Focused

A limited oral evaluation-problem focused exam consists of an examination for diagnosis and observation of a specific oral health problem or complaint, such as injuries to teeth and supporting structures. A limited oral evaluation must include appropriate recording of the beneficiary's medical and dental history, charting that is clinically appropriate for the particular problem.

A limited oral evaluation can be billed in conjunction with radiographs and considered as a covered benefit. Routine restorative procedures, root canal therapy, elective surgery, and denture services are not considered emergency procedures and cannot be billed in conjunction with a limited oral evaluation. Limited oral evaluation-problem focused is a covered benefit for all ages.

Consultation

A consultation provided by a dentist or a physician (M.D. or D.O.) is a benefit for beneficiaries under age 21. The Medicaid program defines a consultation as a service rendered by a physician/dentist whose opinion or advice is formally requested by another appropriate practitioner (e.g., physician, nurse-midwife, dentist) for the further evaluation and/or management of the beneficiary. No patient care or treatment is rendered by the consultant. If a consultant assumes responsibility for any patient management or treatment, then all services subsequent to the consultation must be billed under the appropriate procedure code (e.g., exams, procedures). If a dentist provides a consultation, the only separately reimbursable services that may be provided in addition to the consultation are radiographs.

A consultation service includes examination and evaluation of the beneficiary, documentation of history and physical examination findings, recommendations, and submission of a written formal consultation report to the requesting practitioner.

A consultation related to routine dental treatment (e.g., caries) is not a covered benefit.

Radiographs

Radiographs are benefits for all beneficiaries and are limited to that number necessary to make a diagnosis (other limitations apply to radiographs – see below). The Dental Procedure Codes Appendix lists the radiographic codes for single, multiple or combination radiographs.

A full mouth or complete series is a covered benefit only once every five years for beneficiaries under age 21.

A full mouth series consists of:

- A minimum of 10 intraoral films in conjunction with a minimum of two bitewings, or
- An intraoral/extraoral series of a panoramic film in conjunction with a minimum of two bitewings.

NOTE: If any combination of intraoral films total 10 or more films, or the fee submitted for any set of radiographs exceeds the full mouth series fee, it will be considered a full mouth series.

Bitewing radiographs are a covered benefit only once in a 12-month period for beneficiaries under age 21.

A panoramic radiograph is a covered benefit only once every five years for beneficiaries under age 21. It may be submitted as a separate reimbursable service for prior authorization requests for replacement of existing complete dentures (i.e., the beneficiary is edentulous, has worn dentures for years and needs replacement dentures). In this case, the dentist may submit radiographs if they deem them necessary in the evaluation of the beneficiary's oral condition.

A panoramic film is not acceptable as a diagnostic tool for caries determination, periapical pathology or periodontal pathology. It is not covered for extractions in other than full mouth extraction cases or third molar extractions performed by an oral surgeon.

When a beneficiary changes dental providers and has had a full mouth series of radiographs taken within the previous 12 months, the expectation is that the dental provider will provide a copy of the radiographs to the new dental provider. The beneficiary may be billed a minimal charge for copying and mailing costs.

Radiograph Submission Requirements for Prior Authorization

In some cases, pre-op radiographs are necessary to document the presence and/or absence of teeth, related tooth structure, or related chronic pathology within the alveolar process(es).

A full mouth radiograph series must be submitted with prior authorization requests for complete dentures in cases where beneficiaries are receiving their first denture. A full mouth radiograph series is optional for prior authorization requests for replacement of existing complete dentures (i.e., the beneficiary is edentulous, has worn dentures for years and needs replacement dentures). In this case, the dentist may submit radiographs if they deem them necessary in the evaluation of the beneficiary's oral condition.

A full mouth radiograph series must be submitted with all prior authorization requests for partial dentures.

When requesting prior authorization for procedures, the dentist may be required to send radiographs along with the request. (Information regarding the completion of the prior authorization request and the submission of radiographs is contained in Chapter IV, GENERAL INFORMATION/PRIOR AUTHORIZATION section).

Technical Considerations For Radiographs

The radiographs must meet the following technical considerations:

- All teeth or areas that are indicated on the prior authorization form must be visible on the radiographs.
- Density and clarity of the radiograph must be such that radiographic interpretation can be made without difficulty by use of a conventional view box.
- On a periapical view, the apex of the tooth must be demonstrated clearly, as well as a minimum of one-eighth of an inch of surrounding bone.
- Where pathologic change is in question, healthy bone must be seen surrounding the questionable area.
- Interproximal bone must be visible without the overlapping of interproximal surfaces of teeth under consideration.
- Posterior teeth areas (e.g., demonstrated impactions, developing third molars) must be completely visible.

NOTE: All radiographs submitted with the prior authorization form must be mounted in an x-ray mount and identified with:

- The beneficiary's name and Medicaid ID Number,
- The date the radiograph was taken,
- The dentist's name, Provider Identification Number, and address,
- "Right" and "Left" labels.

Technically unacceptable radiographs will be returned to the dentist for replacement with no additional reimbursement provided.

Radiographs are returned to the dentist with the prior authorization form.

Photographs are not reimbursed under the Program, but they may be submitted with the prior authorization form as documentation to make the beneficiary's condition clearly visible.

For CSHCS beneficiaries, photographs are not separately reimbursable. They are part of the pretreatment records for orthodontic services.

PREVENTIVE SERVICES

Prophylaxis

An oral prophylaxis is a benefit for beneficiaries under age 21**.** It includes routine scaling and debridement, as well as stain removal and polishing of the tooth surface.

A prophylaxis is a covered benefit once every six months.

Special Billing Instructions: If a prophylaxis is provided, it must be billed only once, regardless of the number of visits necessary to complete it. If more than one visit is necessary to complete the service, the date of service used on the claim must be the date of the final visit.

Topical Application of Fluoride

This is a benefit for beneficiaries **under age 16**. It must be preceded by a complete oral prophylaxis on the same date of service and is covered only once every six months. The fluoride must be approved by the ADA Council on Dental Therapeutics. The topical application of fluoride via tray application is the only method covered.

The following types of fluoride treatment are **not covered** as a dental benefit:

- Treatment that incorporates fluoride with the polishing compound (this is considered to be part of the prophylaxis procedure and is not separately reimbursable),
- Topical application of fluoride to the prepared portion of a tooth prior to restoration,
- Fluoride rinses,
- The use of self or home fluoride application procedures,
- Fluoride tablets or capsules prescribed by the dentist (may be covered as a pharmacy benefit).

Sealants

Coverage is limited to fully erupted permanent first molars (#3, 14, 19, 30) and second molars (#2, 15, 18, 31) for children **ages 5 through 15**.

Conditions for coverage for eligible beneficiaries include:

- Prevention of pit and fissure caries
- Occlusal surfaces free from any caries
- Occlusal surfaces must be free of any restorations

Medicaid will not cover sealants applied on beneficiaries with:

- Rampant decay
- Previous restoration on identified tooth

Medicaid coverage for sealants is limited to once every three years and the fee includes repair and replacement for three years. Application of sealants may be by a dentist or dental hygienist.

Space Maintainers

Coverage is limited to beneficiaries **under age 13.** They are limited to the necessary maintenance of a posterior space for a permanent successor to a prematurely lost primary tooth.

Only one space maintainer is covered for a quadrant. Frequency limitations are once every two years.

RESTORATIVE TREATMENT

Restorative treatment is a benefit for beneficiaries under age 21. Amalgam or Resin-based Composite materials to restore carious lesions or fractured teeth are a covered benefit.

General Restorative Instructions

Restorative treatment is limited to those services necessary to restore and maintain adequate dental health.

Cement bases, adhesives, liners, local analgesia and anesthesia are not separate benefits and must be included in the total fee for the restoration.

For any restorations that extend to **more than one surface** of a tooth, the dentist must use the multiple surface procedure code. For example, a restoration that extends from the occlusal surface of a permanent molar to the mesial surface of the molar must be billed using the two-surface procedure code, **not** two one-surface procedure codes. The dentist's fee for any restoration must include all the surfaces in which the restoration encompasses.

No reimbursement will be made for any surface more than once in two years. The replacement of restorations within two years of placement is the treating dentist's responsibility.

NOTE: "Double occlusal" restorations, or combinations of surfaces involving "double occlusal" restoration on any tooth, including tooth numbers 2, 3, 14, 15, 21 and 28, will not be separately reimbursed. Payment is made for a given surface one time, irrespective of the number or combination of restorations placed on that surface.

Restorations are **not** covered for deciduous teeth where exfoliation is expected to occur within 180 days. Restorations of deciduous cuspids and molars for beneficiaries age 12 or older and of deciduous incisors for beneficiaries age five or older are **not** benefits where exfoliation is reasonably imminent.

Resin-based Composite Restorations

The requirements for procedure coding and limitations for reimbursement for amalgam restorations apply to resin-based composite restorations.

Resin-based composite restorations are covered for beneficiaries under age 21. Anterior resin-based crown is covered only for beneficiaries **under age 21.**

Crowns

Crowns are benefits only for beneficiaries **under age 21.**

Only the following crowns are considered as covered benefits for beneficiaries under age 21:

- Stainless steel crown – allowed only for primary teeth and permanent molars.
- Stainless steel crown with resin window – allowed only for anterior primary teeth.
- Laboratory-processed resin crown (indirect) – allowed only for anterior permanent teeth; **requires prior authorization**.

Core build-up or post and core substructures are allowed for permanent teeth only.

ENDODONTICS

Endodontics is a benefit only for beneficiaries **under age 21**.

Root Canal Therapy

Program coverage for root canal therapy is solely for the professionally accepted, conventional root canal treatment modalities. These involve complete removal of pulpal tissue to the tooth apex, canal enlargement and debridement, and the obliteration of the entire root canal by the permanent insertion of an inert, nonresorbable filling material. The Sargenti technique is not a covered benefit.

Root canal therapy is a benefit only where otherwise "sound" teeth can be reasonably restored under Program coverages and the condition of the rest of the mouth supports this method of treatment.

The root canal therapy will not be covered if the following conditions exist:

- Where furcation pathology exists, or
- In unopposed posterior teeth, or
- Where teeth are not restorable under Program guidelines.

Pulpotomy

A therapeutic pulpotomy is a benefit for beneficiaries **under age 13** if it is performed on primary teeth or permanent teeth with open apices. It is not considered the first stage of root canal therapy.

Pulpectomy

Endodontic therapy on primary teeth is a benefit for beneficiaries **under age 8** when the tooth is non-vital or hemostasis cannot be established by conventional pulpotomy.

Pulpal Debridement

Pulpal debridement is a benefit for beneficiaries **under age 13** if it is performed on primary teeth or permanent teeth prior to conventional root therapy. It is not covered when root canal therapy is completed on the same day.

Apexification

This service is covered for beneficiaries **under age 13** and is limited to permanent teeth when the apex has not completely closed.

Apicoectomy

An apicoectomy is a benefit for beneficiaries **under age 21**.

PERIODONTICS

Full mouth debridement is performed as a therapeutic, not preventive, treatment for beneficiaries to aid in the evaluation and diagnosis of their oral condition. It is the removal of subgingival and/or supragingival plaque and calculus.

Full mouth debridement is a benefit for **beneficiaries age 14 through age 20** once every 365 days. It is not covered when a prophylaxis is completed on the same day.

No other periodontal procedures are considered to be covered benefits.

PROSTHODONTICS (REMOVABLE)

General Instructions

Complete and partial dentures are benefits for **beneficiaries under age 21. All dentures require prior authorization**. The provider must assess the beneficiary's general oral health and provide a **five-year** prognosis for the prosthesis requested. An upper partial denture prior authorization request must also include the prognosis of six sound teeth.

Complete or partial dentures will be authorized:

- When the masticatory deficiencies are likely to impair general health and nutrition status,
- If there is one or more anterior teeth missing, or
- If there are less than eight posterior teeth in occlusion,
- For employment-related duties, taking into account esthetic and phonetic considerations,
- where an existing complete or partial denture cannot be made serviceable through repair, relining, adjustment, or duplicating (rebasing) procedures. If a partial denture can be made serviceable, the dentist should provide the needed restorations to maintain use of the existing partial, extract teeth, add teeth to an existing partial, and remove hyperplastic tissue.

Before final impressions are taken and any construction begun on a complete or partial denture, healing adequate to support a prosthesis must take place following the completion of extractions or surgical procedures. This includes the posterior ridges of any **immediate denture.** An exception is made for the six anterior teeth (cuspid to cuspid) only when an immediate denture is authorized.

Replacement of a complete or partial denture which has been lost or broken beyond repair is not a benefit within five years, whether or not the existing denture was obtained through the Medicaid Program.

Reimbursement for a complete or partial denture includes all necessary adjustments, relines, repairs, and duplications within six months of insertion. This includes such services for an immediate upper denture when authorized.

If a complete or partial denture requires an adjustment, reline, repair, or duplication within six months of insertion, but the services were not provided until after six months of insertion, no additional reimbursement is allowed for these services.

Complete Dentures

Only complete dentures with noncharacterized teeth (i.e., without cosmetic enhancements, such as gold denture teeth) and acrylic resin bases are a benefit of the Program. To be covered by the Program, all of the following procedures must be used to fabricate the dentures:

- individual positioning of the teeth,
- wax up of the entire denture body, and
- conventional laboratory processing.

A denture will **not** be authorized when:

- a previous denture has been provided within five years, whether or not the existing denture was obtained through the Medicaid Program;
- an adjustment, reline, repair, or duplication will make it serviceable.

NOTE: A preformed denture with teeth already mounted (i.e., teeth already set in acrylic prior to initial impressions), forming a denture module, is **not** a covered benefit. Overdentures or Cusil dentures are **not** a covered benefit.

Immediate Denture

An immediate denture is a benefit only **when the immediate extractions involve only the anterior teeth, whether maxillary or mandibular.** When requesting prior authorization, the dentist must state on the request that the denture will be an immediate denture, which teeth will be extracted at the denture insertion visit, and the reason the immediate denture is needed.

NOTE: For reasons of denture stability and retention, an immediate denture is **not** a benefit:

- For the posterior segments of the maxillary or mandibular arch,
- Where cast metal base saddle areas are to be provided.

Partial Denture

Partial dentures are a covered benefit for all beneficiaries over age 16, with the following limitations:

- A one-piece cast metal partial denture is not a benefit;

- Elaborate appliance items, such as semi-precision or precision attachments, stress breakers, hinge saddle areas, or Kennedy (lingual) blankets are not benefits.

All clasps are included in the fee for the partial denture.

To ensure that eruption of the teeth is completed before a permanent appliance is placed, partial dentures are not a covered benefit for beneficiaries under age 16. To replace a lost anterior tooth on a patient under age 16, prior authorization must be submitted for an interim partial denture.

Interim Dentures

For beneficiaries under the age of 16, interim partial dentures (sometimes called a "stay-plate") to replace anterior teeth will be authorized. Otherwise, interim dentures will be authorized only in very unusual situations. The provider must submit justification and explanation of proposed future treatment with the prior authorization request.

Relines

After the initial six-month interval, relines or duplications are covered benefits only once within a two-year period. Relines may be laboratory-processed or chairside. Relines and adjustments are not payable on the same date of service.

Repairs

After the initial six-month interval, repairs and adjustments to complete or partial dentures are covered benefits only twice in a 12-month period. If more repairs are needed, they are the responsibility of the treating dentist.

The allowance for a complete or partial denture repair, including a reline or rebase, will not exceed half the fee for a new denture if repairs are within six months of the replacement date for the dentures.

ORAL SURGERY

Oral surgical procedures are benefits for **all beneficiaries**.

The extraction of a permanent tooth for orthodontic purposes is not a benefit. Reimbursement for operative or surgical procedures includes local anesthesia, analgesia, and routine postoperative care.

Surgical procedures such as surgeries of the jaw or facial bones are considered a medical benefit, not a dental benefit.

Extractions

A surgical extraction is a benefit only when the removal of bone is required to facilitate the extraction.

The extraction of an impacted tooth is a benefit only when conditions arising from such an impaction warrant its removal. The prophylactic removal of asymptomatic teeth or teeth exhibiting no overt pathology is not covered.

Tooth Replantation and Fixation

Tooth replantation and fixation is a benefit for beneficiaries **under age 21** when permanent anterior teeth are avulsed or displaced due to traumatic injury.

ADJUNCTIVE GENERAL SERVICES

Anesthesia

Anesthesia services are the only procedures that may be billed separately from the surgical procedure. Intravenous (I.V.) sedation and general anesthesia are benefits for **beneficiaries under age 21**.

General anesthesia is limited to situations when local anesthesia is medically contraindicated. I.V. sedation and/or general anesthesia are not a benefit for the convenience of the dentist or beneficiary or because of apprehension on the part of the beneficiary.

Intravenous sedation or general anesthesia cannot be billed when given in conjunction with a local anesthesia if the use of the intravenous sedation or general anesthesia is to allow the provision of the local anesthetic as the primary anesthetic agent. Neither intravenous sedation nor general anesthesia may be billed in combination with the other.

Non-intravenous conscious sedation is a benefit for beneficiaries **ages 0-5**. It includes the administration of a sedative and/or analgesic agents and appropriate monitoring in the office setting. It cannot be just the administration of nitrous oxide.

NOTE: Nitrous oxide inhalation, in combination with oxygen alone, is classified as analgesia and is **not** a separately reimbursable procedure. It is included in the reimbursement of the procedure performed.

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EXCLUSIONS

The following dental services are excluded from Medicaid coverage:

- Orthodontics, unless there is a CSHCS qualifying diagnosis
- Gold Crowns, Gold Foil Restorations, Inlay/Onlay restorations
- Fixed Bridges
- Bite Splints, Mouth guards, sports appliances
- TMJ Services
- Services or Surgeries that are experimental in nature
- Dental Devices not approved by the FDA
- Analgesia, Inhalation of Nitrous Oxide

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COVERED SERVICES

Covered CSHCS dental services are primarily for the specialty care of children with complicated congenital defects affecting the oral cavity, such as oral clefts. Dental services are also available for children suffering from cranio-facial anomalies, hemophilia and iatrogenic sequelae of chronic diseases, such as epilepsy and scoliosis. Service coverage determination for the multiple handicapped child or for conditions of spasticity requiring dental services in a hospital setting are made on an individual basis.

Once it is determined that the qualifying diagnosis renders the child eligible for dental care, all the dental services necessary to address the qualifying condition are covered by the CSHCS program. The entire range of specialty services may include treatment by an oral surgeon, orthodontist, pedodontist, and/or prosthodontist. The services of a general dentist may be authorized as supportive service to the specialty care.

The basic Medicaid Program guidelines apply to the CSHCS program. For those children who are dually eligible for the Medicaid Program and the CSHCS Program, general dental services are provided through the Medicaid Program and the specialty care is covered through CSHCS.

PRIOR AUTHORIZATION

The majority of dental services covered for the CSHCS program require prior authorization. All orthodontic services, except the pre-orthodontic treatment visit, require prior authorization. Other dental procedures, such as crown and bridges, also require prior authorization. The **Dental Procedure Codes Appendix** lists covered procedures for the CSHCS program, and/or Medicaid program and if prior authorization is required.

One prior authorization request is necessary for each stage of orthodontic treatment, such as interceptive treatment and comprehensive treatment. The prior authorization number granted for orthodontic treatment is effective for up to a two-year period. A complete treatment plan, along with the time frame in which the treatment is expected to be completed, is required with the submission of the prior authorization request.

Prior authorization requests approved for crown and/or bridges, or any dental treatment other than orthodontic treatment, are effective for a six-month period.

Providers shall follow the prior authorization completion instructions explained in Section 2 of this Chapter. If providers have questions on a beneficiary's eligibility for the CSHCS program, they should call the CSHCS representative at the local health department.

The prior authorization request must be submitted and treatment started 12 months prior to the 21st birthday of the beneficiary. No treatment will be authorized for beneficiaries beyond age 21.

Orthodontic Services

When completing the prior authorization request, the provider should list the appropriate comprehensive orthodontic treatment procedure code on line one, and then the periodic orthodontic treatment visit procedure code (D8670) should be listed on the subsequent lines. The periodic treatment visit procedure code may be listed up to a total of seven times, depending on the expected time frame for treatment.

BILLING INSTRUCTIONS

Providers shall follow the billing instructions outlined in Chapter IV for claim completion. Providers may submit claims on paper via the ADA Dental claim form or through electronic claims submission.

Orthodontic Services

Comprehensive orthodontic treatment is payable quarterly up to a maximum of two years. Providers bill the appropriate approved procedure code (D8070, D8080, D8090) for the initial payment. For the additional time approved, providers must bill the periodic orthodontic treatment visit procedure code (D8670) at the beginning of each quarter.

Replacement of lost or broken retainer will be allowed twice in a two-year period.

COVERAGE AND SERVICE AREA INFORMATION

Since May 1, 2000, the DCH has contracted with Delta Dental Plan of Michigan to administer the Medicaid dental benefit in 37 counties called ***Healthy Kids Dental***. Delta Dental administers the Medicaid dental benefit to all Medicaid beneficiaries under age 21 in the participating counties. The dental services provided through Delta Dental mimic the dental services provided through the Fee For Service Medicaid program.

Medicaid beneficiaries have access to dentists through Delta Dental's participating dental networks. Beneficiaries must see a participating dentist in the program that they are enrolled in (i.e., Delta Premier or Delta Preferred Option). The Premier plan is offered in 33 counties while the Preferred Provider Option is offered in four counties. Specialty dental services, such as pedodontics or oral surgery, are offered in all 37 counties through the Premier network.

County Name	No.	Program	County Name	No.	Program
Alger	02	Delta Premier	Ionia	34	Delta Premier
Allegan	03	Delta Premier	Iosco	35	Delta Premier
Arenac	06	Delta Premier	Isabella	37	Delta Premier
Barry	08	Delta Premier	Keweenaw	42	Delta Premier
Branch	12	Delta Premier	Lapeer	44	Delta Preferred Option
Charlevoix	15	Delta Premier	Lenawee	46	Delta Premier
Cheboygan	16	Delta Premier	Livingston	47	Delta Preferred Option
Chippewa	17	Delta Premier	Luce	48	Delta Premier
Clare	18	Delta Premier	Midland	56	Delta Premier
Clinton	19	Delta Premier	Monroe	58	Delta Preferred Option
Dickinson	22	Delta Premier	Ontonagon	66	Delta Premier
Eaton	23	Delta Premier	Roscommon	72	Delta Premier
Emmett	24	Delta Premier	St. Clair	74	Delta Preferred Option
Gladwin	26	Delta Premier	St. Joseph	75	Delta Premier
Gogebic	27	Delta Premier	Sanilac	76	Delta Premier
Gratiot	29	Delta Premier	Shiawassee	78	Delta Premier
Hillsdale	30	Delta Premier	Tuscola	79	Delta Premier
Houghton	31	Delta Premier	Van Buren	80	Delta Premier
Huron	32	Delta Premier			

ENROLLMENT INFORMATION

Beneficiaries under age 21 with Scope of Coverage F who reside in the 37 counties are automatically enrolled in ***Healthy Kids Dental***. Beneficiaries with Scope of Coverage T, E or 0 (spend-down) are not covered. Enrollment occurs monthly, and Delta Dental receives the enrollment file at the beginning of each month. A beneficiary must have active Medicaid status by the end of the month to appear on the following

month's enrollment file. Enrollment in ***Healthy Kids Dental*** is always prospective, never retroactive. Beneficiaries have the Medicaid Fee For Service dental benefit until enrolled in ***Healthy Kids Dental***.

Providers may call the Delta Dental Customer and Claims Services department at 1-800-482-8915 to verify a beneficiary's enrollment, or they may call MediFAX, the Michigan Medicaid Eligibility Verification System. MediFAX will provide enrollment information for beneficiaries stating if they have Fee For Service or Delta Dental coverage.

LOSS OF ENROLLMENT

Beneficiaries are enrolled in ***Healthy Kids Dental*** until the last day of the month in which they turn age 21 or move out of the selected county. If the beneficiary loses enrollment and is in active treatment that requires multiple appointments, the provider may bill Delta Dental for the treatment as long as it is completed within 60 days of the loss of eligibility.

Upon turning age 21 or moving out of the selected counties, the dental benefit will no longer be administered by Delta Dental but provided through DCH.

BENEFICIARY IDENTIFICATION

Beneficiaries enrolled in ***Healthy Kids Dental*** receive a Delta Dental identification card. This card is issued only once at the initial enrollment. Beneficiaries are identified with their Social Security Number (SSN), and this number is on the Delta Dental identification card. If the beneficiary does not have a SSN on file, a leading "9" is placed in front of the Medicaid ID number to make a 9-digit number. Providers must use the SSN or identification number on the Delta Dental card when verifying enrollment and for submission of claims.

BENEFIT ADMINISTRATION

Delta Dental administers the Medicaid dental benefit according to their standard policy and procedures, claim submission and reimbursement mechanisms. There is no copayment for beneficiaries under age 21, and there is no yearly maximum. Dental providers must accept Delta Dental's reimbursement as payment in full and cannot balance bill the beneficiary for services rendered. As an agent of the Medicaid program, Delta must use the same regulations and guidelines that the Medicaid program follows.

PROCEDURE CODES	DESCRIPTION	Covered Benefit CSHCS Only	Covered Benefit (Under 21)	Covered Benefit (21 & Over)	Prior Authorization Required	Report Tooth/ Number on Claim	Report Tooth/ Surface on Claim	Quadrant Designation Code	Documentation Required w/Claim
	DIAGNOSTIC SERVICES								
	CLINICAL ORAL EXAMINATIONS								
D0120	Periodic Oral Examination		X						
D0140	Limited Oral Evaluation-Problem-Focused		X	X					
D0150	Comprehensive Oral Evaluation- New or Established Patient		X						
	RADIOGRAPHS								
D0210	Intraoral - complete series (including bitewings)		X						
D0220	Intraoral - periapical, first film		X	X					
D0230	Intraoral - periapical, each additional film		X	X					
D0240	Intraoral - occlusal film		X						
D0270	Bitewing - single film		X						
D0272	Bitewing radiographs – two films		X						
D0274	Bitewing radiographs – four films		X						
D0330	Panoramic film		X						
D0340	Cephalometric film	X							
	PREVENTIVE SERVICES								
	DENTAL PROPHYLAXIS								
D1110	Prophylaxis-Adult (age 14 and over)		X						
D1120	Prophylaxis-Child (age 2-13)		X						
	FLUORIDE TREATMENTS								
D1203	Topical application of fluoride-child (under age 16)		X						
	SEALANTS								
D1351	Sealant, per tooth (ages 5-15 only)		X			X			

PROCEDURE CODES	DESCRIPTION	Covered Benefit CSHCS Only	Covered Benefit (Under 21)	Covered Benefit (21 & Over)	Prior Authorization Required	Report Tooth/ Number on Claim	Report Tooth/ Surface on Claim	Quadrant Designation Code	Documentation Required w/Claim
	SPACE MAINTAINERS								
D1510	Space maintainer-Fixed, unilateral (under age 13)		X						
D1515	Space maintainer-Fixed, bilateral (under age 13)		X						
D1550	Recementation of space maintainer		X						
	RESTORATIVE TREATMENT								
	AMALGAM RESTORATIONS								
D2140	Amalgam - one surface, primary or permanent		X			X	X		
D2150	Amalgam - two surfaces, primary or permanent		X			X	X		
D2160	Amalgam - three surfaces, primary or permanent		X			X	X		
D2161	Amalgam - four or more surfaces, primary or permanent		X			X	X		
	RESIN RESTORATIONS								
D2330	Resin - one surface, anterior		X			X	X		
D2331	Resin - two surfaces, anterior		X			X	X		
D2332	Resin - three surfaces, anterior		X			X	X		
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)		X			X	X		
D2390	Resin-based composite crown, anterior		X			X	X		
D2391	Resin-based composite, one surface, posterior		X			X	X		
D2392	Resin-based composite, two surfaces, posterior		X			X	X		
D2393	Resin-based composite, three surfaces, posterior		X			X	X		
D2394	Resin-based composite, four or more surfaces, posterior		X			X	X		
	CROWNS								
D2710	Crown - Resin (indirect)		X		X	X			
D2740	Crown - Porcelain/ceramic substrate	X			X	X			
D2750	Crown - Porcelain fused high noble metal	X			X	X			

PROCEDURE CODES	DESCRIPTION	Covered Benefit CSHCS Only	Covered Benefit (Under 21)	Covered Benefit (21 & Over)	Prior Authorization Required	Report Tooth/ Number on Claim	Report Tooth/ Surface on Claim	Quadrant Designation Code	Documentation Required w/Claim
D2751	Crown-Porcelain fused to predominantly base metal	X			X	X			
D2752	Crown-Porcelain fused to noble metal	X			X	X			
D2790	Crown - full cast high noble metal	X			X	X			
D2791	Crown - full cast predominantly base metal	X			X	X			
D2792	Crown - full cast noble metal	X			X	X			
D2799	Provisional crown	X			X	X			
	OTHER RESTORATIVE SERVICES								
D2910	Recement Inlay		X			X			
D2920	Recement Crown		X			X			
D2930	Prefab. Stainless Steel Crown - primary		X			X			
D2931	Prefab. Stainless Steel crown - permanent		X			X			
D2933	Prefabricated stainless steel crown with resin window		X			X			
D2940	Sedative filling		X			X			
D2950	Core Buildup, including any pins		X			X			
D2951	Pin retention-per tooth, addition to restoration		X			X			
D2952	Cast post and core, in addition to crown		X			X			
D2954	Prefabricated post and core, in addition to crown		X			X			
D2999	Unspecified restorative procedure, by report	X	X		X	X			X
	ENDODONTICS								
	PULP CAPPING								
D3110	Pulp cap - direct (excluding final restoration)		X			X			
	PULPOTOMY								
D3220	Therapeutic Pulpotomy (excluding final restoration) (under age 13)		X			X			

PROCEDURE CODES	DESCRIPTION	Covered Benefit CSHCS Only	Covered Benefit (Under 21)	Covered Benefit (21 & Over)	Prior Authorization Required	Report Tooth/ Number on Claim	Report Tooth/ Surface on Claim	Quadrant Designation Code	Documentation Required w/Claim
D3221	Pulpal Debridement, Primary and Permanent Teeth (under age 13)		X			X			
	ROOT CANAL THERAPY								
D3230	Pulpal therapy, anterior, primary (under age 8)		X			X			
D3240	Pulpal therapy, posterior, primary (under age 12)		X			X			
D3310	Anterior (excluding final restoration)		X			X			
D3320	Bicuspid (excluding final restoration)		X			X			
D3330	Molar root canal (excluding final restoration)		X			X			
D3351	Apexification-intial visit (under age 13)		X			X			
D3352	Apexification/recalcification –interim medication replacement (under age 13)		X			X			
D3353	Apexification-final visit (under age 13)		X			X			
	PERIAPICAL SERVICES								
D3410	Apicoectomy - anterior		X			X			
D3421	Apicoectomy – bicuspid (first root)		X			X			
D3425	Apicoectomy – molar (first root)		X			X			
D3426	Apicoectomy – (each additional root)		X			X			
D3430	Retrograde filling - per root		X			X			
D3999	Unspecified endodontic procedure, by report		X			X			X
	PERIODONTICS								
D4355	Full mouth debridement (Age 14 & older)		X						
	PROSTHODONTICS, REMOVABLE								
	COMPLETE DENTURES								

PROCEDURE CODES	DESCRIPTION	Covered Benefit CSHCS Only	Covered Benefit (Under 21)	Covered Benefit (21 & Over)	Prior Authorization Required	Report Tooth/ Number on Claim	Report Tooth/ Surface on Claim	Quadrant Designation Code	Documentation Required w/Claim
D5110	Complete Denture-Maxillary		X		X				
D5120	Complete Denture-Mandibular		X		X				
D5130	Immediate Denture-Maxillary		X		X				
D5140	Immediate Denture-Mandibular		X		X				
	PARTIAL DENTURES								
D5211	Maxillary partial denture, resin base		X		X				
D5212	Mandibular partial denture, resin base		X		X				
D5213	Maxillary partial denture, cast metal framework with resin denture bases		X		X				
D5214	Mandibular partial denture, cast metal framework with resin denture bases		X		X				
	ADJUSTMENTS								
D5410	Complete denture adjustment - maxillary		X						
D5411	Complete denture adjustment - mandibular		X						
D5421	Partial denture adjustment - maxillary		X						
D5422	Partial denture adjustment - mandibular		X						
	REPAIRS TO COMPLETE DENTURES								
D5510	Repair broken complete denture base		X						
D5520	Replace missing or broken teeth - complete denture (each tooth)		X			X			
	REPAIRS TO PARTIAL DENTURES								
D5610	Repair resin denture base		X						
D5620	Repair cast framework		X						
D5630	Repair or replace broken clasp		X						
D5640	Replace broken teeth - per tooth		X			X			
D5650	Add tooth to existing partial denture		X			X			
D5660	Add clasp to existing partial denture		X						

PROCEDURE CODES	DESCRIPTION	Covered Benefit CSHCS Only	Covered Benefit (Under 21)	Covered Benefit (21 & Over)	Prior Authorization Required	Report Tooth/ Number on Claim	Report Tooth/ Surface on Claim	Quadrant Designation Code	Documentation Required w/Claim
	REBASE AND RELINING								
D5710	Rebase complete maxillary denture		X						
D5711	Rebase complete mandibular denture		X						
D5720	Rebase maxillary partial denture		X						
D5721	Rebase mandibular partial denture		X						
D5730	Reline complete maxillary denture (chairside)		X						
D5731	Reline complete mandibular denture (chairside)		X						
D5740	Reline maxillary partial denture (chairside)		X						
D5741	Reline mandibular partial denture (chairside)		X						
D5750	Reline complete maxillary denture (laboratory)		X						
D5751	Reline complete mandibular denture (laboratory)		X						
D5760	Reline maxillary partial denture (laboratory)		X						
D5761	Reline mandibular partial denture (laboratory)		X						
	OTHER PROSTHETIC SERVICES								
D5810	Interim complete denture (maxillary)		X		X				
D5811	Interim complete denture (mandibular)		X		X				
D5820	Interim partial denture (maxillary)		X		X				
D5821	Interim partial denture (mandibular)		X		X				
D5899	Not otherwise classified prosthetic procedures		X						X
	PROSTHODONTICS, FIXED								
	BRIDGE PONTICS								
D6053	Implant/Abutment supported removable denture for completely edentulous arch	X			X				
D6054	Implant/Abutment supported removable denture for partially edentulous arch	X			X				

PROCEDURE CODES	DESCRIPTION	Covered Benefit CSHCS Only	Covered Benefit (Under 21)	Covered Benefit (21 & Over)	Prior Authorization Required	Report Tooth/ Number on Claim	Report Tooth/ Surface on Claim	Quadrant Designation Code	Documentation Required w/Claim
D6210	Pontic –cast high noble metal	X			X	X			
D6211	Pontic-cast predominantly base metal	X			X	X			
D6212	Pontic-cast noble metal	X			X	X			
D6240	Pontic-porcelain fused to high noble metal	X			X	X			
D6241	Pontic-porcelain fused to predominantly base metal	X			X	X			
D6242	Pontic-porcelain fused to noble metal	X			X	X			
D6245	Pontic – porcelain/ceramic	X			X	X			
D6253	Provisional Pontic	X			X				
	CROWNS								
D6740	Porcelain/ceramic	X			X	X			
D6750	Porcelain fused to high noble metal	X			X	X			
D6751	Porcelain fused to predominantly base metal	X			X	X			
D6752	Porcelain fused to noble metal	X			X	X			
D6790	Full cast - high noble metal	X			X	X			
D6791	Full cast- predominantly base metal	X			X	X			
D6792	Full cast - noble metal	X			X	X			
D6793	Provisional Retainer Crown	X			X	X			
	OTHER FIXED PROSTHETIC SERVICES								
D6930	Recement fixed partial denture		X						
D6970	Cast post and core, in addition to fixed partial denture retainer	X			X	X			
D6971	Cast post, as part of fixed partial denture retainer	X			X	X			
D6972	Prefabricated post and core, in addition to fixed partial denture retainer	X			X	X			
D6973	Core build-up for retainer, including any pins	X			X	X			
D6980	Fixed partial denture repair, by report	X			X				

PROCEDURE CODES	DESCRIPTION	Covered Benefit CSHCS Only	Covered Benefit (Under 21)	Covered Benefit (21 & Over)	Prior Authorization Required	Report Tooth/ Number on Claim	Report Tooth/ Surface on Claim	Quadrant Designation Code	Documentation Required w/Claim
	ORAL SURGERY								
	SIMPLE EXTRACTIONS								
D7111	Coronal Remnants-deciduous tooth		X			X			
D7140	Extraction, erupted tooth or exposed root (Elevation and/or forceps removal)		X	X		X			
	SURGICAL EXTRACTIONS								
D7210	Extraction of tooth, erupted		X	X		X			
D7220	Extraction of tooth, soft tissue impaction		X	X		X			
D7230	Extraction of tooth, partial bony impaction		X	X		X			
D7240	Extraction of tooth, complete bony impaction		X	X		X			
D7250	Surgical removal of residual tooth roots (cutting procedure)		X	X		X			
	OTHER SURGICAL PROCEDURES								
D7260	Oroantral fistula closure		X	X					
D7261	Primary closure of a sinus perforation		X	X					
D7270	Tooth replantation and/or stabilization		X			X			
D7280	Surgical access of an unerupted tooth	X				X			
D7281	Surgical exposure of impacted or unerupted tooth to aid eruption	X				X			
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	X				X			
D7310	Alveoplasty, in conj. with extractions (per quadrant		X					X	
D7320	Alveoplasty, not in conjunction with extractions (per quadrant)		X					X	
D7471	Removal of lateral exostosis (maxilla or mandible)		X					X	
D7472	Removal of Torus Palatinus		X						
D7473	Removal of Torus Mandibularis		X					X	
D7485	Surgical reduction of osseous tuberosity		X					X	

PROCEDURE CODES	DESCRIPTION	Covered Benefit CSHCS Only	Covered Benefit (Under 21)	Covered Benefit (21 & Over)	Prior Authorization Required	Report Tooth/ Number on Claim	Report Tooth/ Surface on Claim	Quadrant Designation Code	Documentation Required w/Claim
D7510	Incision and Drainage (intraoral soft tissue)		X	X					
D7970	Excision of hyperplastic tissue – per arch		X						
D7971	Excision of pericoronal gingiva		X			X			
D7972	Surgical reduction of fibrous tuberosity		X					X	
D7999	Unspecified oral surgery procedure, by report		X						X
	ADJUNCTIVE GENERAL SERVICES								
	UNCLASSIFIED TREATMENT								
D9110	Palliative treatment		X						
	ANESTHESIA								
D9220	Deep Sedation/General Anesthesia – first 30 minutes		X						X
D9221	Deep Sedation/General Anesthesia – each additional 15 minutes		X						X
D9241	IV Conscious Sedation/Analgesia- first 30 minutes		X						X
D9242	IV Conscious Sedation/Analgesia – each additional 15 minutes		X						X
D9248	Non-intravenous conscious sedation (ages 0-5)		X						X
	PROFESSIONAL VISITS								
D9310	Consultation (service rendered by provider other than dentist providing treatment)		X						
D9420	Hospital Calls		X						
	MISCELLANEOUS SERVICES								
D9930	Complication (post surgical - unusual circumstances)		X						
	ORTHODONTICS								
D8050	Interceptive orthodontic treatment of the primary dentition	X			X				

PROCEDURE CODES	DESCRIPTION	Covered Benefit CSHCS Only	Covered Benefit (Under 21)	Covered Benefit (21 & Over)	Prior Authorization Required	Report Tooth/ Number on Claim	Report Tooth/ Surface on Claim	Quadrant Designation Code	Documentation Required w/Claim
D8060	Interceptive orthodontic treatment of the transitional dentition	X			X				
D8070	Comprehensive orthodontic treatment of the transitional dentition	X			X				
D8080	Comprehensive orthodontic treatment of the adolescent dentition	X			X				
D8090	Comprehensive orthodontic treatment of the adult dentition	X			X				
	OTHER ORTHODONTIC SERVICES								
D8660	Pre-orthodontic treatment visit	X							
D8670	Periodic orthodontic treatment visit (as part of contract)	X			X				
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	X			X				
D8692	Replacement of lost or broken retainer	X			X				
D8999	Unspecified orthodontic procedure, by report	X			X				X