Molina Dental Services Provider Appendix

Molina Healthcare of Ohio, Inc. (Molina Healthcare or Molina)

Medicaid 2025

The Provider Appendix is customarily updated annually but may be updated more frequently as policies or regulatory requirements change. Providers can access the most current Provider Manual at MolinaHealthcare.com/OhioProviders.

Last Updated: 12/2024

Table of Contents

I. Welcome and Introduction

Thank you for your participation in delivering quality health care services to Molina Members. We look forward to working with you. The Molina Healthcare Dental Provider Appendix shall serve as a supplement as referenced thereto and incorporated therein into the Molina Healthcare of Ohio, Inc. Services Agreement.

The information contained within this appendix is proprietary. The information is not to be copied in whole or in part. Nor is the information to be distributed without the express written consent of Molina.

The Provider Appendix is a reference tool that contains eligibility, benefits, contact information, and policies/procedures for services that the Molina Medicaid Plan specifically provides and administers on behalf of Molina. For additional information, please see the Next Generation Molina Medicaid Provider Manual located on the Molina Healthcare Public website at: https://www.molinahealthcare.com/providers/oh/medicaid/manual/provman.aspx

Molina Healthcare, Inc., a FORTUNE 500 company, provides managed health care services under the Medicaid and Medicare programs and through the state insurance marketplaces. Through its locally operated health plans, Molina serves approximately 5 million Members. Molina contracts with state governments and serves as a health plan, providing a wide range of quality health care services to families and individuals who qualify for government-sponsored programs, including Medicaid and the State Children's Health Insurance Program (SCHIP).

II. Basic Plan Information

A. General Contact Information

Molina of Ohio Address

Molina Healthcare of Ohio
3000 Corporate Exchange Drive
Columbus, Ohio 43231

Provider Services Department

The Provider Services Department handles telephone and written inquiries from Providers regarding address and Tax Identification (ID) changes, contracting, and training. The department has Provider Services Representatives who serve all of Molina's Provider network. Providers can conduct eligibility verifications at their convenience via the SKYGEN Dental Hub.

- Phone: (855) 322-4079 (7 a.m. to 8 p.m. EST, Monday through Friday)
- Fax: (888) 296-7851

- Providers may submit eligibility inquiries through the Provider Network Management (PNM) system at https://managedcare.medicaid.ohio.gov/managed-care/centralized-credentialing

Member Services Department

The Member Services Department handles all telephone and written inquiries regarding Member Claims, benefits, eligibility/identification, and Member complaints. Member Services Representatives are available Monday through Friday from 7 a.m. to 8 p.m. EST, excluding holidays and the Day after Thanksgiving. Providers can conduct eligibility verifications via the SKYGEN Dental Hub or via phone:

- Medicaid: (800) 642-4168
- TTY/TDD: 711

Claims Department

Providers must submit Claims electronically via the Ohio Department of Medicaid Ohio Medicaid Enterprise System (OMES) system through EDI, or electronically via the SKYGEN Dental Hub or clearinghouse:

- The SKYGEN Dental Hub
- Clearinghouse via EDI Payer ID SKYGN

To verify the status of your Claims, please use the SKYGEN Dental Hub or Contact Provider Services for other questions about Claims.

Molina's payer IDs for outlined OMES EDI transactions are noted in the chart below.

MCE	PAYER NAME (NM103)	837 2010BB NM109	276/277 2100A NM109	270/271 2100A NM109	275 1000A NM109
Molina	Molina Ohio Medicaid	0007316	0007316	0007316	0007316
	Molina SkyGen Dental	D007316	D007316	N/A	D007316
	Molina March Vision	V007316	V007316	N/A	V007316

Providers may submit claims, eligibility inquiries, claim status inquiries and associated attachments using Electronic Data Interchange (EDI) by being a trading partner (TP) authorized by ODM or by contracting with an ODM authorized TP at: https://medicaid.ohio.gov/resources-for-providers/billing/trading-partners/trading- partners

ODM's expectation is that for each Medicaid provider Molina's system and data are current and consistent with information held by ODM's system of record, the PNM system. Therefore, it is important that providers keep their records up to date in ODM's PNM system. With the PNM system as the ODM 's system of record, Molina has been instructed to direct providers to update their ODM record in the PNM system when discrepancies are identified

between Molina's data and the PNM PMF. Molina was instructed by ODM to not accept changes from providers into their own systems that are inconsistent with the PNM system data shared through the PNM for their Medicaid line of business.

Claims Recovery Department

The Claims Recovery Department manages recovery for overpayment and incorrect payment of Claims.

Please direct payment and any correspondence to:

Molina Healthcare
PO Box 641
Milwaukee, WI 53201

Please contact Molina Provider Services with questions at Phone: (855) 322-4079.

For additional information, please see the Next Generation Molina Medicaid Provider Manual located on the Molina Healthcare Public website at:
https://www.molinahealthcare.com/providers/oh/medicaid/manual/provman.aspx

Compliance and Fraud AlertLine

If you suspect cases of fraud, waste, or abuse, you must report it to Molina. You may contact the Molina AlertLine, or an electronic complaint can be submitted using the website listed Molina Healthcare of Ohio Provider Manual Provider Services (855) 322-4079 below.

For additional information on Compliance and Fraud, please see the Next Generation Molina Medicaid Provider Manual located on the Molina Healthcare Public website at:
https://www.molinahealthcare.com/providers/oh/medicaid/manual/provman.aspx

Molina Healthcare of Ohio
Attn: Compliance PO Box 349020
3000 Corporate Exchange Drive
Columbus, OH 43234

Phone: (866) 606-3889

Online: MolinaHealthcare.alertline.com

Molina Healthcare of Ohio, Inc. Service Area

Medicaid:

B. Provider Relations Department

The Provider Relations Department handles telephone and written inquiries from Providers regarding demographics, contracting, education, and training. Eligibility verifications can be conducted at your convenience via the PNM portal or the SKYGEN Dental Hub.

Molina has designated email addresses based on provider requests to help get your questions answered more efficiently or to connect you to training opportunities.

Provider Services inquiries:

MDVSProviderServices@MolinaHealthcare.com
Phone: (855) 322-4079 (7 a.m. to 8 p.m. EST, Monday through Friday)
Fax: (855) 297-3304

Provider Information Management Inquiries:

MDVSPIM@MolinaHealthcare.com
Phone: (855) 322-4079 (7 a.m. to 8 p.m. EST, Monday through Friday) Fax: (844) 891-2865~~III~~.
Provider Resources

C. SKYGEN Dental Hub

The SKYGEN Dental Hub offers quick access to easy-to-use self-service tools for managing daily administration tasks. The SKYGEN Dental Hub offers Providers many benefits including:

- Lower administrative and participation costs.
- Faster payment through streamlined claim and authorization submissions.
- Real-time member eligibility verification.
- Immediate access to member information, claim and authorization history, and payment records at any time, 24 hours a day, 7 days a week.

For help getting started with the SKYGEN Dental Hub, training, or questions about the SKYGEN Dental Hub; contact the SKYGEN Dental Hub Support: (855) 322-4079. A web browser, Internet connection, and a valid user ID and password are required for online access. From the SKYGEN Dental Hub, providers and authorized office staff can log in for secure access anytime from anywhere and handle a variety of day-to-day tasks, including verifying member eligibility and review patient treatment history. Additional benefits are:

- Set up office appointment schedules that automatically verify eligibility and pre-populate claim forms for online submission.
- Submit claims and authorizations using pre-populated electronic forms and data entry shortcuts.

- Step through clinical guidelines as part of submitting authorizations for a quick indication of whether a service request is likely to be approved.
- Attach and securely send supporting documents, such as digital X-rays, EOBs, and treatment plans, for no extra charge.
- Generate a quick pricing estimate before submitting a claim.
- Check the real-time status of in-process claims and authorizations and review historical payment records.
- Review Provider clinical profiling data relative to your peers.
- Download and print Provider Manuals, remittance reports, and more.

Online help is available from every page of the SKYGEN Dental Hub, offering quick answers and step-by-step instructions. If you do not find answers to your questions, or if you want personalized training for yourself or your office staff, call the SKYGEN Dental Hub support for assistance: (855) 322-4079.

D. Listserv Subscriptions

Molina does not have a Listserv available to providers.

E. Claims Payment Systemic Error (CPSE) Report

A CPSE is defined as Molina's claims adjudication incorrectly underpaying, overpaying, or denying claims that impact five or more providers. A report containing all active CPSE's is updated monthly and can be found here Claims Payment Systemic Errors.

F. Provider Advisory Council

For information on the provider advisory council, please see the Next Generation Molina Medicaid Provider Manual located on the Molina Healthcare Public website at: https://www.molinahealthcare.com/providers/oh/medicaid/manual/provman.aspx

G. Provider Policies

Molina posts and maintains Provider policies on our Provider Website under the "Policies" tab. Any material changes to the published policies are communicated in the Molina Provider Bulletin with advance notice prior to implementation. Please visit the Provider Website for the complete list of policies.

Molina posts the SKYGEN Dental Hub clinical policies on the Molina Healthcare Inc. website. These policies are used by Providers as well as Molina's Dental Directors and internal reviewers to make Medical Necessity determinations. Providers may access the Medicaid policies by visiting the website above and clicking the "Ohio Medicaid" button at the bottom of the page, or directly accessing the Ohio Medicaid Policy page through this link: SKYGEN Clinical Policies.

H. Provider Services Call Center Information

Provider Services is available at (855) 322-4079 during the hours of 7 a.m. to 8 p.m. EST, Monday through Friday, except for the following major holidays:

- New Year's Day
- Martin Luther King Jr. Holiday
- Memorial Day Holiday
- Independence Day
- Labor Day
- Thanksgiving Day
- Day after Thanksgiving
- Christmas Eve Day – Open 7 a.m. until Noon
- Christmas Day
- New Year's Eve Day – Open 7 a.m. until Noon

A holiday that falls on a Saturday is observed on the Friday before the holiday. A holiday that falls on a Sunday is observed on the Monday after the holiday.

I. Provider Trainings

The SKYGEN Dental Hub is the exclusive dental Provider portal tool for the Molina Healthcare of Ohio Dental Network.

The SKYGEN Dental Hub modernizes and streamlines dental business interactions, making them faster and easier. With the SKYGEN Dental Hub, dental practices will reduce costs, increase revenue, and improve patient experiences by connecting with multiple insurers all in one place.

Getting started on the SKYGEN Dental Hub is easy. SKYGEN performs Provider trainings on the SKYGEN Dental Hub every Thursday. No need to register. Just join one of the webinars here:

- https://v.ringcentral.com/join/676756200

If you do not have computer speakers, call (650)419-1505 and use Access Code/Meeting ID 676756200. If you are a dental practice that would like a refresher or are new to the SKYGEN Dental Hub, this webinar is for you. A live walkthrough of the SKYGEN Dental Hub will cover these features at a high level:

- Intro to the SKYGEN Dental Hub
- Self-Registration
- Set-up
- Add a Patient

- Check Eligibility
- Treatment Estimate
- Submit Claim
- Reports
- Real-Time Patient Responsibility

Molina also offers training sessions and materials as directed by ODM to both in- and out-of-network Providers, and delegated subcontractors. Training information is also available on the Provider Website and includes a link to access trainings directly via ODM's website at: https://managedcare.medicaid.ohio.gov/Providers/Provider-webinars-training

The ODM Provider Network Management (PNM) module is available for prior authorization, claims submission requirements, and billing guidance/instructions for Providers submitting claims. Molina may request Providers' and delegate subcontractors' attestations that they have received Molina-provided training on applicable program requirements and Molina operational requirements. Providers are also required to attend ODM-delivered Provider trainings, as mandated by ODM.

Find reference materials and registration information on ODM-provided trainings at managedcare.medicaid.ohio.gov/Providers.

J. Forms

All published Molina Provider forms are available on the "Forms" page of our Provider Website. Please see appendix D for the:

- Continuation of Care Ortho Form
- Waiver

III. Provider Responsibilities

For information regarding provider responsibilities, please see the Next Generation Molina Medicaid Provider Manual located on the Molina Healthcare Public website at: https://www.molinahealthcare.com/providers/oh/medicaid/manual/provman.aspx

A. Molina Electronic Solutions Requirements

Molina strongly encourages Providers to utilize electronic solutions and tools whenever possible.

Molina requires all contracted Providers to participate in and comply with Molina's Electronic Solution Requirements, which include, but are not limited to, electronic submission of prior authorization requests, prior authorization status inquiries, health plan access to electronic dental records (EMR), electronic Claims submission, electronic fund transfers (EFT), electronic

remittance advice (ERA), electronic Claims appeals and registration for and use of the SKYGEN Dental Hub

Electronic Claims include Claims submitted via a Clearinghouse using the ODM EDI process and Claims submitted through the SKYGEN Dental Hub

Any Provider entering the network as a Contracted Provider will be required to comply with Molina's Electronic Solution Policy by enrolling for EFT/ERA payments and registering for the SKYGEN Dental Hub within 30 days of entering the Molina network.

Molina is committed to complying with all HIPAA Transactions, Code Sets, and Identifiers (TCI) standards. Providers must comply with all HIPAA requirements when using electronic solutions with Molina. Providers must obtain a National Provider Identifier (NPI) and use their NPI in HIPAA Transactions, including Claims submitted to Molina. Providers may obtain additional information by visiting Molina's HIPAA Resource Center located on our Provider Website at MolinaHealthcare.com.

B. Electronic Solutions/Tools Available to Providers

Electronic solutions/tools available to Molina Providers include:

- Electronic Claims submission options: SKYGEN Dental Hub and OMES EDI
- Electronic Payment: EFT with ERA.

For more information on EDI Claims submission, please see the Next Generation Molina Medicaid Provider Manual located on the Molina Healthcare Public website at: https://www.molinahealthcare.com/providers/oh/medicaid/manual/provman.aspx

C. Electronic Claims Submission Requirement

Providers must submit Medicaid EDI claims via the Fiscal Intermediary (OMES) in Phase 3 of the Next Generation Medicaid program implementation. Providers may submit direct data entry claims via the SKYGEN Dental Hub. Claims submitted directly to Molina through EDI (without passing through the Fiscal Intermediary, OMES) will not be accepted.

Electronic Claims submission provides significant benefits to the Provider, such as:

- Promoting HIPAA compliance.
- Helping to reduce operational costs associated with paper Claims (printing, postage).
- Increasing accuracy of data and efficient information delivery.
- Eliminating mailing time and enabling Claims to reach Molina faster.
- Reducing Claim processing delays as errors can be corrected and resubmitted electronically.

D. Electronic Payment (EFT/ERA) Requirement

Participating Providers are strongly encouraged to enroll in EFT and ERA. Providers enrolled in EFT payments will automatically receive ERAs as well. EFT/ERA services give Providers the ability to reduce paperwork, utilize searchable ERAs, and receive payment and ERA access faster than the paper check and Remittance Advice (RA) processes. There is no cost to the Provider for EFT enrollment, and Providers are not required to be in-network to enroll. Molina uses a vendor to facilitate the HIPAA-compliant EFT payment and ERA delivery processes. Manage your payee EFT information here:

- Email: providerservices@skygenusa.com

If a provider is not already enrolled for 835s with ODM please visit this website to sign up: Required Forms & Technical Letters | Medicaid. The ODM enrollment will provide ERAs from all payers in the Next Generation Medicaid program.

IV. Provider Enrollment, Credentialing, and Contracting

For information regarding provider enrollment, credentialing, recredentialing and contracting, please see the Next Generation Molina Medicaid Provider Manual located on the Molina Healthcare Public website at:
https://www.molinahealthcare.com/providers/oh/medicaid/manual/provman.aspx

A. Provider Contracting (Molina Functions)

Non-Contracted providers who would like to join the Molina network are invited to complete and submit the Ohio Dental Contract Request Form available on the Molina Provider Website. A sample Provider contract is available by visiting the Molina Provider Website, on the "Forms" tab, under "Provider Contract Templates."

- Molina Healthcare Dental Provider Services Agreement

B. Medicaid Addendum

For information regarding the Medicaid Addendum please see the Next Generation Molina Medicaid Provider Manual located on the Molina Healthcare Public website at:
https://www.molinahealthcare.com/providers/oh/medicaid/manual/provman.aspx

C. Termination, Suspension, or Denial of Contract (including appeals process for denied contract)

For information regarding the Termination, Suspension, or Denial of Contract (including appeals process for denied contract), please see the Next Generation Molina Medicaid Provider Manual located on the Molina Healthcare Public website at:
https://www.molinahealthcare.com/providers/oh/medicaid/manual/provman.aspx

D. Out-of-state Providers/Non-Contract Providers

For information regarding Out-of-state Providers/Non-Contract Providers please see the Next Generation Molina Medicaid Provider Manual located on the Molina Healthcare Public website at:
https://www.molinahealthcare.com/providers/oh/medicaid/manual/provman.aspx

V. Covered/Non-covered Services

See Appendix C for covered dental services. See Appendix D for non-covered services.

For additional information on covered services, please see the Next Generation Molina Medicaid Provider Manual located on the Molina Healthcare Public website at:
https://www.molinahealthcare.com/providers/oh/medicaid/manual/provman.aspx

A. Benefit Manager Contact Information and Service Information Dental (SKYGEN USA, LLC Inc.)

Molina partners with SKYGEN USA, LLC, a nationwide leader in managed benefits administration, to administer the dental benefit for our Members. SKYGEN USA, LLC can be reached via:

- Provider Services Phone: (855) 322-4079
- Website: SKYGEN Dental Hub Technical Support: (855) 609-5156, technical support is available during the hours of 8:00 am – 4:30 pm CST Monday through Friday
- Email: providerportal@skygenusa.com

VI. Utilization Management

A. Services that Require Prior Authorization (PA)

Prior Authorization (PA) Code List

Molina Providers are required to comply with electronic service authorization submission requirements through the SKYGEN Dental Hub.

Molina requires prior authorization (PA) for specified services as long as the requirement complies with federal or state regulations and the Molina Hospital or Provider Services Agreement. Services that require prior authorizations are:

- Orthodontic Treatment
- Dentures

- Root Planning
- Surgical Extractions

Molina prior authorization documents are customarily updated quarterly but may be updated more frequently as appropriate and are posted on the Molina website at Molina Healthcare of Ohio Prior Authorization Documents

B. Prior Authorization Submission Process and Format

Molina Providers are required to comply with electronic service authorization submission requirements through the SKYGEN Dental Hub, EDI transactions submitted to Molina, or fax. Instructions for how to submit a prior authorization request are available on the SKYGEN Dental Hub. The benefits of submitting your prior authorization request through the SKYGEN Dental Hub are:

- Create and submit Prior Authorization Requests.
- Check status of Authorization Requests.
- Receive notification of change in status of Authorization Requests.
- Attach medical documentation required for timely medical review and decision making.

For additional information on health care services that require prior authorization, please see the covered services section of this appendix.

VII. Claims Information

Molina generally follows the Ohio Department of Medicaid (ODM) guidelines for Claims processing and payment for the Covered Families and Children (CFC), Adult Extension (AEP), and Aged, Blind or Disabled (ABD) programs. Providers will have 365 days to timely file a claim, including any timely filing exceptions, in accordance with Ohio Administrative Code (OAC) rule 5160-1-19.

A. Process and Requirements for the Submission of Claims

- ODM Provider Network Management System Direct Data Entry
- Providers may submit eligibility inquiries through the Provider Network Management (PNM) system at PNM.
- Electronic Data Interchange (EDI) submission of provider claims
- Providers may submit claims, eligibility inquiries, claim status inquiries and associated attachments using Electronic Data Interchange (EDI) by being a trading partner (TP) authorized by ODM or by contracting with an ODM authorized TP.

Molina provides training sessions and materials to both in-network and out-of-network providers, as well as subcontractors, on electronic prior authorization, claims submission requirements, and billing guidance. This information is available on the Provider Website's It

Matters to Molina page.

There are several new processes and program updates that impact Medicaid Providers. Molina Healthcare strongly encourages providers to subscribe to the Ohio Department of Medicaid (ODM) Next Generation provider newsletter by checking the box next to *ODM Press* at medicaid.ohio.gov/home/govdelivery-subscribe or visit the ODM Provider information page at managedcare.medicaid.ohio.gov/providers.

1. Submission of Claims

Claims can be submitted within 365 days of the date of service and in any of the following formats:

- Electronic submission via clearinghouse (Payer ID: SKYGN)
- SKYGEN Dental Hub
- HIPAA-compliant 837D file

Submitting Claims via the SKYGEN Dental Hub has several significant advantages:

- The online dental form has built-in features that automatically verify Member eligibility and make data entry quick and easy.
- The online process allows you to attach and send electronic documents as part of submitting a Claim.
- Before submitting a Claim, you can generate an online payment estimate.
- Claims enter the benefits administration system faster, which means you receive payment faster.
- As soon as a Claim is paid, the status is instantly updated online, and a remittance report is available for review.

If you have questions about submitting Claims online, attaching electronic documents or accessing the SKYGEN Dental Hub, call Dental Hub Support at (855) 609-5156.

Providers may submit electronic Claims and authorizations to SKYGEN directly via either the Change Healthcare or DentalXChange clearinghouses. If you use a different clearinghouse, your software vendor can provide you with information you may need to ensure electronic files are forwarded to SKYGEN.

By using this unique Payer ID with electronic files, Change Healthcare and DentalXChange can ensure that Claims and authorizations are submitted successfully to SKYGEN.
For more information about Change Healthcare and DentalXChange, visit their websites: www.changehealthcare.com and www.dentalxchange.com.

2. Corrected Claims

Providers may correct any necessary field of the American Dental Association (ADA) claim form. All Corrected Claims:

- Must be submitted electronically via the SKYGEN Dental Hub or via OMES EDI at OMES EDI
- The original Claim number must be inserted in the correct field, or the applicable 837 transaction loop for submitting corrected claims electronically.
- The appropriate frequency code/resubmission code must also be billed on the claim.

Corrected Claims must be sent within 365 calendar days of the most recently adjudicated date of the Claim.

Claims submitted without the correct coding will be rejected. Corrected Claim submissions are not adjustments and should be directed through the original submission process marked as a corrected Claim, as outlined below, or it may result in the Claim being denied. As a reminder: Primary insurance Explanation of Benefits (EOB) and itemized statements are not accepted via Non-Clinical Claim Disputes. Please submit as corrected Claims. Reminders for the Corrected Claims Process:

- Submit electronically.
- Include all elements that need correction, and all originally submitted elements.
- Do not submit only codes edited by Molina.
- Do not submit via the Claim Dispute process.
- Do not submit paper corrected Claims.
- Include the original Molina Claim ID or last paid Claim number.

3. Directions on how to correct or void a Claim

Please visit the ODM website for training and reference materials regarding the corrected Claim, attachments, and void Claim processes for Providers using OMES EDI.

Directions on how to correct or void a claim can be found on the SKYGEN Dental Hub. You can also call Provider Services at (855) 322-4079 Monday through Friday from 7 a.m. to 8 p.m.

4. CDT and HCPCS Codes

Codes must be submitted in accordance with the chapter and code-specific guidelines set forth in the current/applicable version of the American Dental Association 2023 ADA CDT codebooks. In order to ensure proper and timely reimbursement, codes must be effective on the date of service (DOS) for which the procedure or service was rendered and not the date of submission.

B. Process and Requirements for Appeal of Denied Claims (Provider Claims Dispute Process)

For additional information on the process and requirements for appeal of denied claims (provider claims dispute process), please see the Next Generation Molina Medicaid Provider

Manual located on the Molina Healthcare Public website at:
https://www.molinahealthcare.com/providers/oh/medicaid/manual/provman.aspx

Definitions of terms for Provider Appeal and Claim Dispute processes:

- **Authorization Appeal**—Formerly known as an "authorization reconsideration." A provider dispute for the denial of a prior authorization. The Authorization Appeal must be submitted pre-claim and within 30 days of the initial authorization denial. The Authorization Appeal should be submitted on the Authorization Reconsideration Form (Authorization Appeal and Clinical Claim Dispute Request Form) and submitted via fax. Please visit the Utilization Management section of this Appendix for more information. Decisions will be made within forty-eight hours for urgent requests and within 10 calendar days for all other requests. Once the claim is on file, providers must follow the Clinical Claim Dispute process.
- **Clinical Claim Dispute**—Formerly known as an "authorization reconsideration." A post-claim provider dispute for the denial of a prior authorization or for the denial of a retro-authorization request for Extenuating Circumstances. The Clinical Claim Dispute must be submitted on the Authorization Reconsideration Form (Authorization Appeal and Clinical Claim Dispute Request Form). The Clinical Claim Dispute must be post-claim and submitted within 365 days of the date of service or 60 days from the remittance advice; whichever is later. Providers may submit a Clinical Claim Dispute via the SKYGEN Dental Hub, fax, or verbally. Decisions will be made within 30 business days.
- **Peer-to-peer consultations-** Providers may request a peer-to-peer consultation when the MCO denies a prior authorization request. The peer-to-peer consultations will be conducted amongst health care professionals who have clinical experience in treating the member's condition, with the equivalent of a doctorate degree in dentistry. The peer-to-peer consultation must clearly identify what documentation the provider must provide to obtain approval of the specific item, procedure, or service; or a more appropriate course of action based upon accepted clinical guidelines.
- **Retro-Authorization request for Extenuating Circumstances—**This process can occur pre- or post-claim and serves as an initial medical necessity review with a dispute right available after an adverse determination. Both the initial review and dispute processes must be exhausted before the Provider is eligible for an External Medical Review.
- **If Pre-Claim—**Initial dental necessity request and the dispute, follow the Authorization Appeal submission process and timeframes.
- **If Post-Claim—**Initial dental necessity request and the dispute, follow the Clinical Claim Dispute submission process and timeframes.
- **Non-Clinical Claim Dispute—**Formerly known as a "claim reconsideration." This process is used only for disputing a payment denial, payment amount, or a code edit. The Non-Clinical Claim Dispute must be submitted on the Claim Reconsideration Form (Non-Clinical Claim Dispute Form). The Non-Clinical Claim Dispute must be post-claim

and submitted within 365 days of the date of service or 60 days from the remittance advice; whichever is later. Providers may submit a Non-Clinical Claim Dispute via the SKYGEN Dental Hub, fax, or verbally by calling the Provider Services Contact Center. Decisions will be made within 15 business days, or with continued communication if Molina needs more time to address the dispute.

For additional guidance on these processes, please consult the Medicaid Authorization Appeal and Claim Dispute Reference Guide on the Molina Website.

Non-Clinical Claim Disputes (not related to an Authorization/Medical Necessity Review) Provider Claim Dispute Process

- Provider claim disputes are any provider inquiries, complaints, or requests for reconsiderations ranging from general questions about a claim to a provider disagreeing with a claim denial.
- Providers may file a claim dispute within 12 months from the date of service or 60 calendar days after the payment, denial, or partial denial of a timely claim submission, whichever is later.
- Providers may submit claim disputes verbally or in writing, including through the SKYGEN Dental Hub.
- Submit Non-Clinical Claim Disputes only when disputing a payment denial, payment amount, or a code edit. As a reminder: Primary insurance Explanation of Benefits (EOB), corrected Claims, and itemized statements are not accepted via Claim Dispute. Please refer to the Supporting Documents for Claims guide.

External Medical Review (EMR) After exhausting Molina's provider claims dispute resolution process, a provider may request an external medical review (EMR) if the claim payment denial, limitation, reduction, suspension, or termination was based on medical necessity. For additional information on the EMR process, please see the Next Generation Molina Medicaid Provider Manual located on the Molina Healthcare Public website at: https://www.molinahealthcare.com/providers/oh/medicaid/manual/provman.aspx

C. Monitoring Claims and Explanation of Benefits (EOB)

Monitoring Claims

Molina employs various methods and tools for monitoring Claims payment accuracy and timeliness. These checkpoints can take place both pre- and post-payment and sometimes involve third party vendors. Some of the tools utilized are the National Correct Coding Initiative, National and Local Coverage Determinations, as well as high dollar reviews. When a Claim is identified for prepayment review; Providers will receive notice either through a letter or a remittance remark code. When Claims are identified through a post-payment audit Providers will receive a notice giving them the issue identified and the dispute process for our findings. Providers always have reconsideration rights for both pre- and post-payment audits. In addition, Molina analyzes Claims operations reporting to track and trend within the Claims data. The results of these ongoing

reviews are leveraged for Provider outreach, training and education to individual Providers and widespread messaging to address global trends.

Explanation of Benefits

Claims received with an explanation of benefits (EOB) from the primary carrier attached must be submitted to Molina within the greater of 365 from the Claim remit date or within 90 days of the date listed on the EOB from the other carrier. The Provider may request a review for Claims denied for untimely filing by submitting justification for the delay as outlined in the Claim Disputes section of this Manual.

Acceptable proof of timely filing must include documentation with the following:

- The date the Claim was submitted.
- The insurance company billed (address/payer ID) was Molina.
- The Claim record for the specific patient account(s) in question.

D. Provider Claim Disputes

Providers may file a claim dispute within 12 months from the date of service or 60 calendar days after the
payment, denial, or partial denial of a timely claim submission, whichever is later. Providers may submit claim disputes verbally or in writing, including through the provider portal.

Non-clinical claim disputes and denials not related to authorization/medical necessity must be submitted on the Molina Claims Request for Reconsideration Form (CRRF) found on the Molina Healthcare Inc. website and the SKYGEN Dental Hub. The form must be filled out completely in order to be processed. and submitted via the SKYGEN Dental Hub or fax.

Additionally, the item(s) being resubmitted should be clearly marked as a dispute and must include the following:

- Any documentation to support the adjustment and a copy of the Authorization form (if applicable) must accompany the dispute request.
- The Claim number is clearly marked on all supporting documents.
- Note if related to Extenuating Circumstances

Requests for Clinical and Non-Clinical Claim Disputes can be submitted via the following methods:

- Online via the SKYGEN Dental Hub**:** SKYGEN Dental Hub
- Via phone: (855) 322-4079
- Via Fax: (800) 499-3406

Claim Disputes and Authorization Appeals are not accepted via email.

According to Ohio regulations, health care Providers are not permitted to balance bill Medicaid Members for services or supplies provided which includes any Member copayment, coinsurance, or plan deductible.

The Provider will be notified of Molina's decision in writing.

1. Untimely Filing

The Provider may request a review for Claims denied for untimely filing (beyond 365 days from the date of service by submitting a justification for the delay. Acceptable proof of timely filing must include documentation with the following:

- The date the Claim was submitted.
- The insurance company billed payer ID was Molina.
- The Claim record for the specific patient account(s) in question.

Refer to the ODM Designated Providers and Non-Contracted Provider Guidelines posted on the "Forms" page of the Provider Website for additional information.

VIII. Care Coordination/Care Management

For information regarding care coordination/management, please see the Next Generation Molina Medicaid Provider Manual located on the Molina Healthcare Public website at: https://www.molinahealthcare.com/providers/oh/medicaid/manual/provman.aspx

IX. Reporting

For information regarding reporting, please see the Next Generation Molina Medicaid Provider Manual located on the Molina Healthcare Public website at: https://www.molinahealthcare.com/providers/oh/medicaid/manual/provman.aspx

X. Next Generation Managed Care Program

For information on the next generation managed care program, please see the Next Generation Molina Medicaid Provider Manual located on the Molina Healthcare Public website at: https://www.molinahealthcare.com/providers/oh/medicaid/manual/provman.aspx

XI. Member Enrollment, Eligibility, Disenrollment

For information regarding member enrollment, eligibility, and disenrollment, please see the Next Generation Molina Medicaid Provider Manual located on the Molina Healthcare Public website at:
https://www.molinahealthcare.com/providers/oh/medicaid/manual/provman.aspx

XII. Quality

For information regarding Quality, please see the Next Generation Molina Medicaid Provider Manual located on the Molina Healthcare Public website:
https://www.molinahealthcare.com/providers/oh/medicaid/manual/provman.aspx

A. Dental Appointment Access

All Providers who oversee the Member's health care are responsible for providing the following appointments to Molina Members in the timeframes noted:

Type of Visit	Description	Minimum
Emergency Dental Service	Services that are needed to evaluate, treat, or stabilize an emergency dental condition.	24 hours, 7 days/week
Urgent Dental Care	Care that is provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include but are not limited to sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain, and severe, non-resolving headache. Acute illness or substance dependence impacts the ability to function but does not present an imminent danger.	24 hours, 7 days/week within 48 hours of request
Dental Appointment	Non-emergent/non-urgent dental services, including routine and preventive care.	Within 6 weeks of request

Additional information on appointment access standards is available from the Molina Quality Department at (855) 322-4079.

XIII. Compliance

For information on compliance, please see the Next Generation Molina Medicaid Provider Manual located on the Molina Healthcare Public website at:
https://www.molinahealthcare.com/providers/oh/medicaid/manual/provman.aspx

XIV. Members' Rights and Responsibilities

For information regarding members rights and responsibilities, please see the Next Generation Molina Medicaid Provider Manual located on the Molina Healthcare Public website at:
https://www.molinahealthcare.com/providers/oh/medicaid/manual/provman.aspx

XV. Pharmacy

For information regarding pharmacy, please see the Next Generation Molina Medicaid Provider Manual located on the Molina Healthcare Public website at:
https://www.molinahealthcare.com/providers/oh/medicaid/manual/provman.aspx

XVI. Risk Adjustment Management Program

For information regarding the risk adjustment management program, please see the Next Generation Molina Medicaid Provider Manual located on the Molina Healthcare Public website:
https://www.molinahealthcare.com/providers/oh/medicaid/manual/provman.aspx

XVII. Delegation

For information regarding delegation, please see the Next Generation Molina Medicaid Provider Manual located on the Molina Healthcare Public website:
https://www.molinahealthcare.com/providers/oh/medicaid/manual/provman.aspx

XVIII. Appendix A

For additional information regarding the medicaid benefit index, please see the Next Generation Molina Medicaid Provider Manual located on the Molina Healthcare Public website at:
https://www.molinahealthcare.com/providers/oh/medicaid/manual/provman.aspx

A. National Provider Identification Number (NPI)

Molina requires all Claims and encounters to include an NPI in all Claim fields that require Provider identification, as provided below, to avoid any unnecessary Claim rejections.
In accordance with 5010 requirements, NPIs are mandated on all electronic transactions per HIPAA. If you do not have an NPI, please visit nppes.cms.hhs.gov to obtain an NPI. Any changes to an NPI should also be reported in the ODM PNM system and to Molina within 30 days of the change.

NPI Required Fields: ADA	Required?	Field Location
Billing Provider NPI	Yes	Box 49
Rendering Provider NPI	Yes	Box 54

Molina recommends all Providers reference the appropriate ODM Companion Guide (837D) found on the ODM Trading Partner website at medicaid.ohio.gov for the appropriate loop and segments to ensure all 5010 requirements are being met.

B. Claim Form Requirements

Providers should follow standard guidance for accurate completion of ADA 2019 claim form prior to submission.

XIX. Appendix B

A. Transition of Care

For information regarding the transition of care, please see the Next Generation Molina Medicaid Provider Manual located on the Molina Healthcare Public website at: https://www.molinahealthcare.com/providers/oh/medicaid/manual/provman.aspx

XX. Appendix C

A. Covered Services

CDT	DESCRIPTION	AGES	TEETH/ARCH/QUAD	LIMITATIONS	AUTH REQ'D	DOCUMENTATION REQ'D
D0120	PERIODIC ORAL EVALUATION - ESTABLISHED PATIENT	0-999		LIMIT TO ONE (1) D0120 EVERY SIX (6) MONTHS (180 DAYS) PER PATIENT OR PROVIDER. DENIED WHEN SUBMITTED ON THE SAME DOS AS D0140, D0150 OR D0180.	NO	
D0140	LIMITED ORAL EVALUATION-PROBLEM FOCUSED	0-999		LIMIT TO ONE (1) D0140 PER PATIENT, PROVIDER, OR LOCATION. DENIED FOR THE SAME DOS IN CONJUNCTION WITH D0120, D0150, D0180. NO PAYMENT IS MADE IF THE EVALUATION IS PERFORMED SOLELY FOR THE PURPOSE OF ADJUSTING DENTURES, EXCEPT AS SPECIFIED IN CHAPTER 5160-28 OF THE ADMINISTRATIVE CODE.	NO	
D0150	COMPREHENSIVE ORAL EVALUATION - NEW OR ESTABLISHED PATIENT	0-999		LIMIT TO ONE (1) D0150 EVERY SIXTY(60) MONTHS, PER PATIENT OR PROVIDER. DENIED WHEN SUBMITTED FOR THE SAME DOS AS D0120, D0140, D0180	NO	
D0180	COMPREHENSIVE ORAL EVALUATION - NEW OR ESTABLISHED PATIENT EVALUATION - NEW OR ESTABLISHED PATIENT	0-999		LIMIT TO ONE (1) D0180 EVERY 365 DAYS PER PATIENT, PROVIDER, OR LOCATION. DENIED WHEN SUBMITTED ON SAME DOS AS D0120, D0140, OR D0150.	NO	NARRATIVE OF MEDICAL NECESSITY REQUIRED WITH CLAIM

CDT	DESCRIPTION	AGES	TEETH/ARCH/QUAD	LIMITATIONS	AUTH REQ'D	DOCUMENTATION REQ'D
D0210	INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGES	0-999		LIMIT TO ONE (1) D0210 EVERY FIVE (5) YEARS PER PATIENT OR PROVIDER.	NO	ALL RADIOGRAPHIC IMAGES MUST BE OF DIAGNOSTIC QUALITY, PROPERLY EXPOSED AND MOUNTED, CLEARLY FOCUSED AND READABLE, (IF APPLICABLE) AND FREE FROM DEFECT FOR THE RELEVANT AREA OF THE MOUTH.
D0220	INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGES	0-999	ALL TEETH (1-32, A-T)	ONE PER DOS. TWELVE PER 12 MONTHS PER PROVIDER. NOT ON THE SAME DOS AS D0250, D0210, D0240 OR D0330.	NO	ALL RADIOGRAPHIC IMAGES MUST BE OF DIAGNOSTIC QUALITY, PROPERLY EXPOSED AND MOUNTED, CLEARLY FOCUSED AND READABLE, (IF APPLICABLE) AND FREE FROM DEFECT FOR THE RELEVANT AREA OF THE MOUTH.
D0230	INTRAORAL - PERIAPICAL EACH ADDITIONAL IMAGE	0-999	ALL TEETH (1-32, A-T)	THREE PER DOS. EIGHT PER 12 MONTHS PER PROVIDER. NOT ON THE SAME DOS AS D0250, D0210, D0240 OR D0330.	NO	ALL RADIOGRAPHIC IMAGES MUST BE OF DIAGNOSTIC QUALITY, PROPERLY EXPOSED AND MOUNTED, CLEARLY FOCUSED AND READABLE, (IF APPLICABLE) AND FREE FROM DEFECT FOR THE RELEVANT AREA OF THE MOUTH.
D0240	INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE	0-999		TWO PER DOS. FOUR PER 12 MONTHS PER PROVIDER. NOT ON THE SAME DOS AS D0210, D0220, D0230 OR D3330.	NO	ALL RADIOGRAPHIC IMAGES MUST BE OF DIAGNOSTIC QUALITY, PROPERLY EXPOSED AND MOUNTED, CLEARLY FOCUSED AND READABLE, (IF APPLICABLE) AND FREE FROM DEFECT FOR THE RELEVANT AREA OF THE MOUTH.
D0250	EXTRAORAL – FIRST RADIOGRAPHIC IMAGE	0-999		LIMIT TO ONE (1) D0250 EVERY FIVE (5) YEARS.	NO	ALL RADIOGRAPHIC IMAGES MUST BE OF DIAGNOSTIC QUALITY, PROPERLY EXPOSED AND MOUNTED, CLEARLY FOCUSED AND READABLE, (IF APPLICABLE) AND FREE FROM DEFECT FOR THE RELEVANT AREA OF THE MOUTH.
D0270	BITEWING -SINGLE RADIOGRAPHIC IMAGE	0-999		LIMIT TO ONE (1) D0270 EVERY SIX (6) MONTHS PER PATIENT, PROVIDER, OR LOCATION. DENIED WHEN	NO	ALL RADIOGRAPHIC IMAGES MUST BE OF DIAGNOSTIC QUALITY, PROPERLY EXPOSED AND MOUNTED, CLEARLY FOCUSED AND

CDT	DESCRIPTION	AGES	TEETH/ARCH/QUAD	LIMITATIONS	AUTH REQ'D	DOCUMENTATION REQ'D
				SUBMITTED ON THE SAME DOS AS D0273, D0274, D0330, D0340		READABLE, (IF APPLICABLE) AND FREE FROM DEFECT FOR THE RELEVANT AREA OF THE MOUTH.
D0272	BITEWINGS - TWO RADIOGRAPHIC IMAGES	0-999		LIMIT TO ONE (1) D0272 EVERY SIX (6) MONTHS PER PATIENT, PROVIDER, OR LOCATION. DENIED WHEN SUBMITTED ON SAME DOS AS D0210, D0270, D0273, D0273, D0274, D0330, OR D0340.	NO	ALL RADIOGRAPHIC IMAGES MUST BE OF DIAGNOSTIC QUALITY, PROPERLY EXPOSED AND MOUNTED, CLEARLY FOCUSED AND READABLE, (IF APPLICABLE) AND FREE FROM DEFECT FOR THE RELEVANT AREA OF THE MOUTH.
D0273	BITEWINGS - THREE RADIOGRAPHIC IMAGES	0-999		LIMIT TO ONE (1) D0273 EVERY SIX (6) MONTHS. DENIED WHEN SUBMITTED ON SAME DOS AS D0210, D0270, D0272, D0274, D0330, OR D0340.	NO	ALL RADIOGRAPHIC IMAGES MUST BE OF DIAGNOSTIC QUALITY, PROPERLY EXPOSED AND MOUNTED, CLEARLY FOCUSED AND READABLE, (IF APPLICABLE) AND FREE FROM DEFECT FOR THE RELEVANT AREA OF THE MOUTH.
D0274	BITEWINGS-FOUR RADIOGRAPHIC IMAGES	0-999		LIMIT TO ONE (1) D0273 EVERY SIX (6) MONTHS. DENIED WHEN SUBMITTED ON SAME DOS AS D0210, D0270, D0272, D0274, D0330, OR D0340.	NO	ALL RADIOGRAPHIC IMAGES MUST BE OF DIAGNOSTIC QUALITY, PROPERLY EXPOSED AND MOUNTED, CLEARLY FOCUSED AND READABLE, (IF APPLICABLE) AND FREE FROM DEFECT FOR THE RELEVANT AREA OF THE MOUTH.
D0321	OTHER TEMPOROMANDIBULAR JOINT RADIOGRAPHIC IMAGES, BY REPORT	0-999		LIMIT TO ONE (1) D0321 EVERY SIX MONTHS IN CONJUNCTION WITH D7899.	NO	FOUR (4) TO SIX (6) IMAGES MUST INCLUDE SUBMISSION OF PATIENT HISTORY AND TREATMENT PLAN. ALL RADIOGRAPHIC OR MAGNETIC IMAGES MUST BE AT DIAGNOSTIC QUALITY, PROPERLY EXPOSED, CLEARLY FOCUSED, CLEARLY READABLE, PROPERLY MOUNTED (IF APPLICABLE) AND FREE FROM DEFECT FOR THE RELEVANT AREA OF THE MOUTH.

CDT	DESCRIPTION	AGES	TEETH/ARCH/QUAD	LIMITATIONS	AUTH REQ'D	DOCUMENTATION REQ'D
D0330	PANORAMIC RADIOGRAPHIC IMAGES	0-999		LIMIT TO ONE (1) D0330 EVERY FIVE (5 YEARS) PER PATIENT AND PROVIDER. DENIED WHEN SUBMITTED WITH D0210, D0330, D0367	NO	ALL RADIOGRAPHIC IMAGES MUST BE OF DIAGNOSTIC QUALITY, PROPERLY EXPOSED AND MOUNTED, CLEARLY FOCUSED AND READABLE, (IF APPLICABLE) AND FREE FROM DEFECT FOR THE RELEVANT AREA OF THE MOUTH.
D0340	2D CEPHALOMETRIC RADIOGRAPHIC IMAGES	0-999		LIMIT TO ONE (1) D0340 EVERY TWELVE (12)MONTHS PER PATIENT.	NO	ALL RADIOGRAPHIC IMAGES MUST BE OF DIAGNOSTIC QUALITY, PROPERLY EXPOSED AND MOUNTED, CLEARLY FOCUSED AND READABLE, (IF APPLICABLE) AND FREE FROM DEFECT FOR THE RELEVANT AREA OF THE MOUTH.
D0350	ORAL/FACIAL PHOTOGRAPHIC IMAGES	0-999		LIMIT TO ONE (1) D0350 EVERY TWELVE MONTHS (12) PER PATIENT. *LIMIT TO THREE (3) D350 EVERY TWELVE (12) MONTHS PER PATIENT FOR ORAL SURGEONS ONLY IN CONJUNCTION WITH D4210, D4211, D5913, D5915, D5916, D5934, D5935, D5955, D5999, D7471, D7472, D7473, D7960, D7970, D8080.	NO	ALL ORAL AND FACIAL IMAGES MUST BE OF DIAGNOSTIC QUALITY, PROPERLY EXPOSED AND MOUNTED, CLEARLY FOCUSED AND READABLE, (IF APPLICABLE) AND FREE FROM DEFECT FOR THE RELEVANT AREA OF THE MOUTH.
D0367	CONEBEAM CT VIEWS BOTH JAWS W/WO CRANIUM	0-999		LIMIT TO ONE (1) D0367 EVERY FIVE (5 YEARS) PER PATIENT AND PROVIDER.	YES, FOR PROVISION WITHIN 5 YEARS AFTER A PANORAMIC OR COMPLETE SERIES OF IMAGES	NARRATIVE OF MEDICAL NECESSITY
D0372	INTRAORAL TOMOSYNTHESIS – COMPREHENSIVE SERIES OF RADIOGRAPHIC IMAGES	0-999			YES	NARRATIVE OF MEDICAL NECESSITY
D0373	INTRAORAL TOMOSYNTHESIS – BITEWING RADIOGRAPHIC IMAGE	0-999			YES	NARRATIVE OF MEDICAL NECESSITY
D0374	INTRA ORAL TOMOSYNTHESIS – PERIAPICAL RADIOGRAPHIC IMAGE	0-999			YES	NARRATIVE OF MEDICAL NECESSITY

CDT	DESCRIPTION	AGES	TEETH/ARCH/QUAD	LIMITATIONS	AUTH REQ'D	DOCUMENTATION REQ'D
D0387	INTRA ORAL TOMOSYNTHESIS – COMPREHENSIVE SERIES OF RADIOGRAPHIC IMAGES– IMAGE CA	0-999			YES	NARRATIVE OF MEDICAL NECESSITY
D0388	INTRA ORAL TOMOSYNTHESIS – BITEWING RADIOGRAPHIC IMAGE– IMAGE CAPTURE ONLY	0-999			YES	NARRATIVE OF MEDICAL NECESSITY
D0389	INTRA ORAL TOMOSYNTHESIS – PERIAPICAL RADIOGRAPHIC IMAGE– IMAGE CAPTURE ONLY	0-999			YES	NARRATIVE OF MEDICAL NECESSITY
D0396	3D PRINTING OF A 3D DENTAL SURFACE SCAN	0-999			YES	NARRATIVE OF MEDICAL NECESSITY
D0470	DIAGNOSTIC IMAGES OF CASTS	0-999	LIMIT TO TWO (2) D0470 (ONE PER ARCH) EVERY TWELVE (12) MONTHS. IN CONJUNCTION WITH D4210, D4211, D7471, D7472, D7473, D7899, D7960, D7970, D8080, D8999.	NOT COVERED WITHIN 36 MONTHS OF PLACEMENT.		
D0604	ANTIGEN TESTING FOR A PUBLIC HEALTH RELATED PATHOGEN, INCLUDING CORONAVIRUS				NO	NARRATIVE OF MEDICAL NECESSITY
D0605	ANTIGEN TESTING FOR A PUBLIC HEALTH RELATED PATHOGEN, INCLUDING CORONAVIRUS				NO	NARRATIVE OF MEDICAL NECESSITY
D0606	MOLECULAR TESTING A PUBLIC HEALTH RELATED PATHOGEN, INCLUDING CORONAVIRUS	0-999			NO	NARRATIVE OF MEDICAL NECESSITY
D0801	3D DENTAL SURFACE SCAN – DIRECT	0-999			YES	NARRATIVE OF MEDICAL NECESSITY
D0802	3D DENTAL SURFACE SCAN – INDIRECT A SURFACE SCAN OF A DIAGNOSTIC CAST	0-999			YES	NARRATIVE OF MEDICAL NECESSITY
D0803	3D FACIAL SURFACE SCAN – DIRECT	0-999			YES	NARRATIVE OF MEDICAL NECESSITY
D0804	3D FACIAL SURFACE SCAN – INDIRECT A SURFACE SCAN OF CONSTRUCTED FACIAL FEATURE	0-999			YES	NARRATIVE OF MEDICAL NECESSITY
D0999	FQHC ENCOUNTER PAYMENT	0-999			NO	NARRATIVE OF MEDICAL NECESSITY
D1110	PROPHYLAXIS - ADOLESCENT	13-20		EVERY SIX (6) MONTHS PER PATIENT.	NO	
D1110	PROPHYLAXIS - ADULT	21-999		LIMIT TO ONE (1) D1110 EVERY SIX (6) MONTHS PER PATIENT.	NO	
D1120	PROPHYLAXIS - CHILD	0-13		LIMIT TO ONE (1) EVERY SIX (6)	NO	

CDT	DESCRIPTION	AGES	TEETH/ARCH/QUAD	LIMITATIONS	AUTH REQ'D	DOCUMENTATION REQ'D
				MONTHS PER PATIENT.		
D1206	TOPICAL APPLICATION OF FLUORIDE VARNISH	0-20		LIMIT TO ONE (1) 1206 OR 1208 PER PATIENT EVERY SIX (6) MONTHS	YES	
D1208	TOPICAL APPLICATION OF FLUORIDE	0-20		LIMIT TO ONE (1) 1206 OR 1208 PER PATIENT EVERY SIX (6) MONTHS	YES	
D1320	TOBACCO CESSATION COUNSELING	0-999		LIMIT TO TWO (2) D1320 EVERY 365 DAYS PER PATIENT.	YES	COVERAGE LIMITED TO PATIENTS WITH HISTORY OF TOBACCO USE. THIS SERVICE MUST BE IN CONJUNCTION WITH ANOTHER DENTAL SERVICE. DOCUMENTATION OF TOBACCO USE, EXTENT OF COUNSELING SESSION AND PROVISION OF CESSATION ASSISTANCE REFERRAL MUST BE MAINTAINED IN THE CLINICAL RECORD.
D1321	COUNSELING FOR THE CONTROL AND PREVENTION OF ADVERSE ORAL AND BEHAVIORAL SYSTEM	0-999	COUNSELING FOR THE CONTROL AND PREVENTION OF ADVERSE ORAL, BEHAVIORAL, AND SYSTEM	2 EVERY 365 DAYS PER PATIENT.	NO	NARRATIVE OF MEDICAL NECESSITY REQUIRED WITH CLAIM
D1351	SEALANT - PER TOOTH	0-20	Tooth (02, 03, 14, 15, 18, 19, 30, 31)	LIMIT TO ONE (1) PER TOOTH PER FIVE YEARS. OCCLUSAL SURFACES ONLY WITH NO RESTORATIONS OR CARIES PRESENT.	NO	
D1354	INTERIM CARRIES ARRESTING MEDICAMENT APPLICATION	0-999	ALL TEETH (1-32, A-T)	LIMIT TO FOUR (43) D1354 PER TOOTH PER LIFETIME.	NO	NO PAYMENT IS MADE IN CONJUNCTION WITH FLUORIDE TREATMENT, RESTORATION, OR CROWN. PAYMENT IS LIMITED TO ONE UNIT PER TOOTH. MAY BILL UP TO FOUR TEETH PER DATE OF SERVICE. TOOTH NUMBERS ARE REQUIRED ON CLAIM.
D1510	SPACE MAINTAINER -FIXED – UNILATERAL –PER QUADRANT	0-20	QUADRANT (LL, LR, UL, UR)	LIMIT TO ONE (1) D1510 PER TOOTH, PER LIFETIME. MAXIMUM OF FOUR (4) TEETH.	NO	PAYMENT MAY BE MADE FOR A PASSIVE TYPE OF APPLIANCE ONLY.
D1516	SPACE MAINTAINER -FIXED – BILATERAL, MAXILLARY	0-20	TEETH (2-15, A-J)	LIMIT TO ONE (1) D1516 PER TOOTH, PER LIFETIME.	NO	PAYMENT MAY BE MADE FOR A PASSIVE TYPE OF APPLIANCE ONLY.

CDT	DESCRIPTION	AGES	TEETH/ARCH/QUAD	LIMITATIONS	AUTH REQ'D	DOCUMENTATION REQ'D
D1517	SPACE MAINTAINER - FIXED – BILATERAL, MANDIBULAR	0-20	TEETH (18-31, K-T)	LIMIT TO ONE (1) D1516 PER TOOTH, PER LIFETIME WITH A MAXIMUM UP TO FOUR (4) TEETH.	NO	PAYMENT MAY BE MADE FOR A PASSIVE TYPE OF APPLIANCE ONLY.
D1520	SPACE MAINTAINER - REMOVABLE UNILATERAL – PER QUADRANT	0-20	QUADRANT (LL, LR, UL, UR)	LIMIT TO ONE (1) D1520 PER TOOTH, PER LIFETIME. MAXIMUM OF FOUR (4) TEETH.	NO	PAYMENT MAY BE MADE FOR A PASSIVE TYPE OF APPLIANCE ONLY.
D1526	SPACE MAINTAINER - REMOVABLE - BILATERAL, MAXILLARY	0-20			NO	NARRATIVE OF MEDICAL NECESSITY REQUIRED WITH CLAIM
D1527	SPACE MAINTAINER - REMOVABLE - BILATERAL, MANDINULAR	0-20			NO	NARRATIVE OF MEDICAL NECESSITY REQUIRED WITH CLAIM
D2140	AMALGAM - ~~TWO~~ ONE SURFACE~~S~~, PRIMARY OR PERMANENT	0-999	TEETH (01-32, A-T)	LIMIT TO ONE (1) D2140 PER TOOTH EVERY TWELVE MONTHS (12) PER SURFACE, PATIENT, AND PROVIDER OR LOCATION. (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394).	NO	IF A TOOTH HAS DECAY ON THREE SURFACES ON WHICH SEPARATE RESTORATIONS CAN BE PERFORMED, SEPARATE PAYMENTS MAY BE MADE FOR EACH RESTORATION PERFORMED UP TO A MAXIMUM OF THREE RESTORATIONS. A TOOTH SURFACE CAN BE NAMED ONLY ONCE, WHETHER ALONE OR IN COMBINATION WITH RESTORATIONS ON OTHER SURFACES. ON MAXILLARY FIRST AND SECOND MOLARS, THE OCCLUSAL SURFACE CAN BE NAMED TWICE, WHETHER PERFORMED ALONE OR IN COMBINATION WITH RESTORATIONS OF ANOTHER SURFACE.
D2150	AMALGAM - TWO SURFACES, PRIMARY OR PERMANENT	0-999	TEETH (01-32, A-T)	LIMIT TO ONE (1) D2150 AMALGAM/RESIN RESTORATION PER TOOTH PER SURFACE, EVERY 12 MONTHS (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394)	NO	IF A TOOTH HAS DECAY ON THREE SURFACES ON WHICH SEPARATE RESTORATIONS CAN BE PERFORMED, SEPARATE PAYMENTS MAY BE MADE FOR EACH RESTORATION PERFORMED UP TO A MAXIMUM OF THREE RESTORATIONS. A TOOTH SURFACE CAN BE NAMED ONLY ONCE, WHETHER ALONE OR IN COMBINATION WITH RESTORATIONS ON OTHER SURFACES. ON MAXILLARY FIRST AND

CDT	DESCRIPTION	AGES	TEETH/ARCH/QUAD	LIMITATIONS	AUTH REQ'D	DOCUMENTATION REQ'D
						SECOND MOLARS, THE OCCLUSAL SURFACE CAN BE NAMED TWICE, WHETHER PERFORMED ALONE OR IN COMBINATION WITH RESTORATIONS OF ANOTHER SURFACE.
D2160	AMALGAM - THREE SURFACES, PRIMARY OR PERMANENT	0-999	TEETH (01-32, A-T)	LIMIT TO ONE (1) D2160 AMALGAM/RESIN RESTORATION EVERY 12 MONTHS PER TOOTH, PER SURFACE, PER PATIENT, PROVIDER, OR LOCATION. (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394)	NO	IF A TOOTH HAS DECAY ON THREE SURFACES ON WHICH SEPARATE RESTORATIONS CAN BE PERFORMED, SEPARATE PAYMENTS MAY BE MADE FOR EACH RESTORATION PERFORMED UP TO A MAXIMUM OF THREE RESTORATIONS. A TOOTH SURFACE CAN BE NAMED ONLY ONCE, WHETHER ALONE OR IN COMBINATION WITH RESTORATIONS ON OTHER SURFACES. ON MAXILLARY FIRST AND SECOND MOLARS, THE OCCLUSAL SURFACE CAN BE NAMED TWICE, WHETHER PERFORMED ALONE OR IN COMBINATION WITH RESTORATIONS OF ANOTHER SURFACE.
D2161	AMALGAM – FOUR OR MORE SURFACES, PRIMARY OR PERMANENT	0-999	TEETH (01-32, A-T)	LIMIT TO ONE (1) D2161 AMALGAM/RESIN RESTORATION EVERY 12MONTHS PER TOOTH, PER SURFACE, PER PATIENT, PROVIDER, OR LOCATION. (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394)	NO	IF A TOOTH HAS DECAY ON THREE SURFACES ON WHICH SEPARATE RESTORATIONS CAN BE PERFORMED, SEPARATE PAYMENTS MAY BE MADE FOR EACH RESTORATION PERFORMED UP TO A MAXIMUM OF THREE RESTORATIONS. A TOOTH SURFACE CAN BE NAMED ONLY ONCE, WHETHER ALONE OR IN COMBINATION WITH RESTORATIONS ON OTHER SURFACES. ON MAXILLARY FIRST AND SECOND MOLARS, THE OCCLUSAL SURFACE CAN BE NAMED TWICE, WHETHER PERFORMED ALONE OR IN COMBINATION WITH RESTORATIONS OF ANOTHER SURFACE.

CDT	DESCRIPTION	AGES	TEETH/ARCH/QUAD	LIMITATIONS	AUTH REQ'D	DOCUMENTATION REQ'D
D2330	RESIN-BASED COMPOSITE - ~~THREE~~ONE SURFACE~~S~~, ANTERIOR	0-999	ANTERIOR TEETH (06-11, 22-27, C-H, M-R)	LIMIT TO ONE (1) D2330 AMALGAM/RESIN RESTORATION PER TOOTH, PER SURFACE, 12 MONTHS (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394	NO	IF A TOOTH HAS DECAY ON THREE SURFACES ON WHICH SEPARATE RESTORATIONS CAN BE PERFORMED, SEPARATE PAYMENTS MAY BE MADE FOR EACH RESTORATION PERFORMED UP TO A MAXIMUM OF THREE RESTORATIONS. A TOOTH SURFACE CAN BE NAMED ONLY ONCE, WHETHER ALONE OR IN COMBINATION WITH RESTORATIONS ON OTHER SURFACES. ON ANTERIOR TEETH, THE FACIAL AND LINGUAL SURFACES CAN BE NAMED TWICE, WHETHER PERFORMED ALONE OR IN COMBINATION WITH RESTORATIONS OF ANOTHER SURFACE. IF THE INCISAL ANGLE ON AN ANTERIOR TOOTH IS INVOLVED, THEN ONLY ONE FOUR- SURFACE RESTORATION CAN BE CLAIMED FOR THE TOOTH AND NO ADDITIONAL SURFACES OR RESTORATIONS WILL BE ALLOWED.
D2331	RESIN-BASED COMPOSITE - ~~THREE~~ TWO SURFACES, ANTERIOR	0-999	ANTERIOR TEETH (06-11, 22-27, C-H, M-R)	LIMIT TO TWO (1) D2331 AMALGAM/RESIN RESTORATION PER TOOTH, PER SURFACES,12 MONTHS (D2140, D2150, D2160, D2161, D2331, D2331, D2332, D2335, D2391, D2392, D2393, D2394	NO	IF A TOOTH HAS DECAY ON THREE SURFACES ON WHICH SEPARATE RESTORATIONS CAN BE PERFORMED, SEPARATE PAYMENTS MAY BE MADE FOR EACH RESTORATION PERFORMED UP TO A MAXIMUM OF THREE RESTORATIONS. A TOOTH SURFACE CAN BE NAMED ONLY ONCE, WHETHER ALONE OR IN COMBINATION WITH RESTORATIONS ON OTHER SURFACES. ON ANTERIOR TEETH, THE FACIAL AND LINGUAL SURFACES CAN BE NAMED TWICE, WHETHER PERFORMED ALONE OR IN COMBINATION WITH RESTORATIONS OF

CDT	DESCRIPTION	AGES	TEETH/ARCH/QUAD	LIMITATIONS	AUTH REQ'D	DOCUMENTATION REQ'D
						ANOTHER SURFACE. IF THE INCISAL ANGLE ON AN ANTERIOR TOOTH IS INVOLVED, THEN ONLY ONE FOUR- SURFACE RESTORATION CAN BE CLAIMED FOR THE TOOTH AND NO ADDITIONAL SURFACES OR RESTORATIONS WILL BE ALLOWED.
D2332	RESIN-BASED COMPOSITE - THREE SURFACES, ANTERIOR	0-999	ANTERIOR TEETH (06-11, 22-27, C-H, M-R)	LIMIT TO ONE (1) D2332 AMALGAM/RESIN RESTORATION PER TOOTH, PER SURFACE, EVERY 12 MONTHS (D2140, D2150, D2160, D2161, D2332, D2331, D2332, D2335, D2391, D2392, D2393, D2394	NO	IF A TOOTH HAS DECAY ON THREE SURFACES ON WHICH SEPARATE RESTORATIONS CAN BE PERFORMED, SEPARATE PAYMENTS MAY BE MADE FOR EACH RESTORATION PERFORMED UP TO A MAXIMUM OF THREE RESTORATIONS. A TOOTH SURFACE CAN BE NAMED ONLY ONCE, WHETHER ALONE OR IN COMBINATION WITH RESTORATIONS ON OTHER SURFACES. ON ANTERIOR TEETH, THE FACIAL AND LINGUAL SURFACES CAN BE NAMED TWICE, WHETHER PERFORMED ALONE OR IN COMBINATION WITH RESTORATIONS OF ANOTHER SURFACE. IF THE INCISAL ANGLE ON AN ANTERIOR TOOTH IS INVOLVED, THEN ONLY ONE FOUR- SURFACE RESTORATION CAN BE CLAIMED FOR THE TOOTH AND NO ADDITIONAL SURFACES OR RESTORATIONS WILL BE ALLOWED.
D2335	RESIN-BASED COMPOSITE – ~~THREE~~ FOUR OR MORE SURFACES, ANTERIOR	0-999	TOOTH (06-11, 22-27, C-H, M-R)	LIMIT TO ONE (1) D2335 AMALGAM/RESIN RESTORATION PER TOOTH, PER SURFACE, EVERY 12 MONTHS (D2140, D2150, D2160, D2161, D2332, D2331, D2332, D2335, D2391, D2392, D2393, D2394	NO	PAYMENT IS FOR ONE RESTORATION ONLY

CDT	DESCRIPTION	AGES	TEETH/ARCH/QUAD	LIMITATIONS	AUTH REQ'D	DOCUMENTATION REQ'D
D2390	RESIN-BASED COMPOSITE CROWN, ANTERIOR	0-20	TOOTH (06-11, 22-27, C-H, M-R)		NO	
D2391	RESIN-BASED COMPOSITE - ONE SURFACE, ~~ANTERIOR~~ POSTERIOR	0-999	POSTERIOR TEETH (1-5, 12-21, 28-32, B, I, J, K, L, S, T)	LIMIT TO ONE (1) D2391 AMALGAM/RESIN RESTORATION PER TOOTH, PER SURFACE, PER 12 MONTHS (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394)	NO	IF A TOOTH HAS DECAY ON THREE SURFACES ON WHICH SEPARATE RESTORATIONS CAN BE PERFORMED, SEPARATE PAYMENTS MAY BE MADE FOR EACH RESTORATION PERFORMED UP TO A MAXIMUM OF THREE RESTORATIONS. A TOOTH SURFACE CAN BE NAMED ONLY ONCE, WHETHER ALONE OR IN ~~COMBINA~~ COMBINATION WITH RESTORATIONS ON OTHER SURFACES. ON ANTERIOR TEETH, THE FACIAL AND LINGUAL SURFACES CAN BE NAMED TWICE, WHETHER PERFORMED ALONE OR IN COMBINATION WITH RESTORATIONS OF ANOTHER SURFACE. IF THE INCISAL ANGLE ON AN ANTERIOR TOOTH IS INVOLVED, THEN ONLY ONE FOUR- SURFACE RESTORATION CAN BE CLAIMED FOR THE TOOTH AND NO ADDITIONAL SURFACES OR RESTORATIONS WILL BE ALLOWED.
D2392	RESIN-BASED COMPOSITE - TWO SURFACES, POSTERIOR	0-999	TEETH (01-05, 12-21, 28-32, A-B, I-L, S-T)	LIMIT TO ONE (1) D2392 AMALGAM/RESIN RESTORATION PER TOOTH, PER SURFACE, EVERY 12 MONTHS (D2140, D2150, D2160, D2161, D2332, D2331, D2332, D2335, D2391, D2392, D2393, D2394	NO	IF A TOOTH HAS DECAY ON THREE SURFACES ON WHICH SEPARATE RESTORATIONS CAN BE PERFORMED, SEPARATE PAYMENTS MAY BE MADE FOR EACH RESTORATION PERFORMED UP TO A MAXIMUM OF THREE RESTORATIONS. A TOOTH SURFACE CAN BE NAMED ONLY ONCE, WHETHER ALONE OR IN COMBINATION WITH RESTORATIONS ON OTHER SURFACES. ON MAXILLARY FIRST AND SECOND MOLARS, THE OCCLUSAL SURFACE CAN BE NAMED TWICE, WHETHER PERFORMED

CDT	DESCRIPTION	AGES	TEETH/ARCH/QUAD	LIMITATIONS	AUTH REQ'D	DOCUMENTATION REQ'D
						ALONE OR IN COMBINATION WITH RESTORATIONS OF ANOTHER SURFACE.
D2393	RESIN-BASED COMPOSITE - THREE SURFACES, ANTERIOR	0-999	TEETH (01-05, 12-21, 28-32, A-B, I-L, S-T)	LIMIT TO ONE (1) D2393 AMALGAM/RESIN RESTORATION PER TOOTH, PER SURFACE, EVERY 12 MONTHS (D2140, D2150, D2160, D2161, D2332, D2331, D2332, D2335, D2391, D2392, D2393, D2394	NO	IF A TOOTH HAS DECAY ON THREE SURFACES ON WHICH SEPARATE RESTORATIONS CAN BE PERFORMED, SEPARATE PAYMENTS MAY BE MADE FOR EACH RESTORATION PERFORMED UP TO A MAXIMUM OF THREE RESTORATIONS. A TOOTH SURFACE CAN BE NAMED ONLY ONCE, WHETHER ALONE OR IN COMBINATION WITH RESTORATIONS ON OTHER SURFACES. ON MAXILLARY FIRST AND SECOND MOLARS, THE OCCLUSAL SURFACE CAN BE NAMED TWICE, WHETHER PERFORMED ALONE OR IN COMBINATION WITH RESTORATIONS OF ANOTHER SURFACE.
D2394	RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES OR INVOLVING INCISAL ANGLE POSTERIOR	0-999	TEETH (01-05, 12-21, 28-32, A-B, I-L, S-T)	ONE AMALGAM/RESIN RESTORATION PER TOOTH, PER SURFACE, 12 MONTHS (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394	NO	IF A TOOTH HAS DECAY ON THREE SURFACES ON WHICH SEPARATE RESTORATIONS CAN BE PERFORMED, SEPARATE PAYMENTS MAY BE MADE FOR EACH RESTORATION PERFORMED UP TO A MAXIMUM OF THREE RESTORATIONS. A TOOTH SURFACE CAN BE NAMED ONLY ONCE, WHETHER ALONE OR IN COMBINATION WITH RESTORATIONS ON OTHER SURFACES. ON MAXILLARY FIRST AND SECOND MOLARS, THE OCCLUSAL SURFACE CAN BE NAMED TWICE, WHETHER PERFORMED ALONE OR IN COMBINATION WITH RESTORATIONS OF ANOTHER SURFACE.

CDT	DESCRIPTION	AGES	TEETH/ARCH/QUAD	LIMITATIONS	AUTH REQ'D	DOCUMENTATION REQ'D
D2740	CROWN PORCELAIN/CERAMIC	0-999	TEETH (1-32)	LIMIT TO ONE (1) D2740,D2751, D2752 EVERY 60MONTHS, PER PATIENT, PER ANTERIOR TOOTH	YES	PRE-OPERATIVE X- RAYS OF TOOTH.
D2751	CROWN – PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	0-999	TEETH (1-32)	LIMIT TO ONE (1) D2751, D2751, D2752 PER 60 MONTHS, PER PATIENT, PER ANTERIOR TOOTH	YES	PRE-OPERATIVE X- RAYS OF TOOTH.
D2752	CROWN - PORCELAIN FUSED TO NOBLE METAL	0-999	TEETH (1-32)	ONE D2740, D2751,D2752 PER 60 MONTHS, PER PATIENT, PER ANTERIOR TOOTH. (D2740, D2751, D2752)	YES	PRE-OPERATIVE X- RAYS OF TOOTH.
D2928	PREFABRICATED PORCELAIN/CERAMIC CROWN – PERMANENT TOOTH ANTERIOR	0-999	TEETH (1-32)		NO	
D2929	PREFABRICATED PORCELAIN / CERAMIC CROWN - PRIMARY TOOTH	0-20	TEETH (A-T)	LIMIT TO ONE (1) D2929 EVERY 36 MONTHS PER TOOTH.	NO	A PREFABRICATED PORCELAIN/CERAMIC PRIMARY TOOTH IS REIMBURSED AT DIFFERENT MAXIMUM FEES FOR PRIMARY ANTERIOR AND POSTERIOR TEETH.
D2920	RECEMENT/REBOND CROWN	0-999	TEETH (1-32)		NO	
D2930	PREFABRICATED STAINLESS STEEL CROWN - PRIMARY TOOTH	0-20	TEETH (A-T)	LIMIT TO ONE (1) D2930 EVERY 36 MONTHS PER TOOTH.	NO	
D2931	PREFABRICATED STAINLESS STEEL CROWN - PERMANENT TOOTH	0-999	TEETH (1-32)	ONE D2931 PER 60 MONTHS, PER TOOTH.	NO	
D2933	PREFABRICATED STAINLESS STEEL CROWN WITH RESIN WINDOW	0-20	PRIMARY ANTERIOR (C-H, M-R)	ONE D2933 PER 36 MONTHS, PER ANTERIOR TOOTH.	NO	PAYMENT FOR A CROWN WITH RESIN WINDOW INCLUDES ANY NECESSARY RESTORATION.
D2934	PREFABRICATED ESTHETIC COATED STAINLESS-STEEL CROWN - PRIMARY TOOTH	0-20	TEETH (A-T)	ONE D2934 PER 36 MONTHS, PER TOOTH.	NO	
D2940	PROTECTIVE RESTORATION	0-999	TEETH (1-32, A-T)	LIMIT TO ONE (1) D2940 PER TOOTH EVERY 180 DAYS PER PATIENT	NO	

CDT	DESCRIPTION	AGES	TEETH/ARCH/QUAD	LIMITATIONS	AUTH REQ'D	DOCUMENTATION REQ'D
D2950	CORE BUILDUP, INCLUDING ANY PINS WHEN REQUIRED	0-999	TEETH (1-32)	LIMIT ONE (1) PER TOOTH.	NO	COVERAGE IS LIMITED TO PERMANENT TEETH. THIS SERVICE MUST BE PROVIDED IN PREPARATION FOR OR IN CONJUNCTION WITH AN ADULT CROWN PROCEDURE
D2951	PIN RETENTION - PER	0-999	TEETH (1-32)	THREE D2951 PER LIFETIME PER TOOTH.	NO	COVERAGE IS LIMITED TO PERMANENT TEETH. THIS SERVICE MUST BE PROVIDED IN PREPARATION FOR OR IN CONJUNCTION WITH AN ADULT CROWN PROCEDURE.
D2952	POST AND CORE IN ADDITION TO CROWN, INDIRECTLY FABRICATED	0-999	TEETH (06-11, 22-27)	ONE D2952 PER 60 MONTHS, PER ANTERIOR TOOTH. (D2740, D2751, D2752)	YES	PRE-OPERATIVE X-RAYS OF ENDODONTICALLY TREATED TOOTH.
D2954	PREFABRICATED POST AND CORE IN ADDITION TO CROWN	0-999	TEETH (06-11, 22-27)	ONE D2954 PER 60 MONTHS, PER ANTERIOR TOOTH. (D2740, D2751, D2752)	YES	PRE-OPERATIVE X-RAYS OF ENDODONTICALLY TREATED TOOTH.
D2976	BAND STABILIZATION – PER TOOTH	0-999	TEETH (1-32)	OE PER LIFETIME		
D2989	EXCAVATE TOOTH NON-RESTORABLE	0-999	TEETH (1-32)			
D2991	APPLICATION OF HYDROXYAPATITE REGENERATION MEDICAMENT – PER TOOTH	0-999	TEETH (1-32)	TWO PER YEAR		
D2999	UNSPECIFIED RESTORATIVE PROCEDURE	0-999			YES	MEDICAL NECESSITY AND INVOICE IF APPLICABLE
D3220	THERAPEUTIC PULPOTOMY	0-999			NO	
D3310	ENDODONTIC THERAPY, ANTERIOR TOOTH(EXCLUDING FINAL RESTORATION)	0-999	PERMANENT ANTERIOR (6-11,22-27)	ONE D3330 PER LIFETIME, PER TOOTH.	NO	
D3320	ENDODONTIC THERAPY, BICUSPID TOOTH(EXCLUDING FINAL RESTORATION)	0-999	BICUSPIDS (4, 5, 12, 13, 20, 21, 28, 29)	ONE D3330 PER LIFETIME, PER TOOTH.	NO	
D3330	ENDODONTIC THERAPY, MOLAR (EXCLUDING FINAL RESTORATION)	0-999	PERMANENT ANTERIOR (6-11, 19, 22-27, 30-32)	ONE D3330 PER LIFETIME, PER TOOTH.	NO	
D3351	APEXIFICATION /RECALCIFICATION - INITIAL VISIT	0-999	ALL PERMANENT TEETH	ONE D3330 PER LIFETIME, PER TOOTH.	NO	PRE-OPERATIVE X-RAYS (EXCLUDING BITEWINGS)
D3352	APEXIFICATION /RECALCIFICATION - INTERIM	0-999	TEETH (1-32)	ONE D3353 PER LIFETIME, PER TOOTH.	NO	DATE OF INITIAL APEXIFICATION VISIT FILL X- RAY WITH CLAIM

CDT	DESCRIPTION	AGES	TEETH/ARCH/QUAD	LIMITATIONS	AUTH REQ'D	DOCUMENTATION REQ'D
D3353	APEXIFICATION /RECALCIFICATION - FINAL VISIT	0-999	TEETH (1-32)	ONE D3353 PER LIFETIME, PER TOOTH.	NO	DATE OF INITIAL APEXIFICATION VISIT FILL X- RAY WITH CLAIM
D3410	APICOECTOMY - ANTERIOR	0-999	TEETH (06-11, 22-27)	ONE D3410 PER LIFETIME, PER TOOTH.	NO	PRE-OPERATIVE X-RAYS OF TOOTH
D4210	GINGIVECTOMY OR GINGIVOPLASTY - FOUR OR MORE CONTIGUOUS TEETH	0-999	QUADRANT (LL, LR, UL, UR)	ONE D4341, D4342 PER 24 MONTHS, PER QUADRANT, PER PATIENT. NOT PAYABLE IN CONJUNCTION WITH D1110, D1120, D4210,D4211 AND D4910.	YES	PRE-OP X-RAYS, NARRATIVE OF MEDICAL NECESSITY, DIAGNOSTIC IMAGES OF CASTS OR PHOTOS
D4211	GINGIVECTOMY OR GINGIVOPLASTY - ONE TO THREE CONTIGUOUS TEETH	0-999	QUADRANT (LL, LR, UL, UR)	ONE D4341, D4342 PER 24 MONTHS, PER QUADRANT, PER PATIENT. NOT PAYABLE IN CONJUNCTION WITH D1110, D1120, D4210,D4211 AND D4910.	YES	PRE-OP X-RAYS, NARRATIVE OF MEDICAL NECESSITY, DIAGNOSTIC IMAGES OF CASTS OR PHOTOS
D4286	REMOVE NON-RESORB BARRIER	0-999			YES	NARRATIVE OF MEDICAL NECESSITY
D4341	PERIODONTAL SCALING AND ROOT PLANING -FOUR OR MORE TEETH PER QUADRANT	0-999	QUADRANT (LL, LR, UL, UR)	ONE D4341, D4342 PER 24 MONTHS, PER QUADRANT, PER PATIENT. NOT PAYABLE IN CONJUNCTION WITH D1110, D1120, D4210,D4211 AND D4910.	YES	A PERIODONTAL TREATMENT PLANS. A PERIODONTAL CHARTING OF ORAL CONDITION AND POCKET DEPTHS, WITH ALL SIX SURFACES ON EACH TOOTH CHARTED. CURRENT LABELED, READABLE PERI- APICAL IMAGES OF THE MOUTH AND POSTERIOR BITEWINGS. NO PANOREX IMAGES.
D4342	PERIODONTAL SCALING, ONE TO THREE TEETH	0-999	QUADRANT (LL, LR, UL, UR)	ONE D4341, D4342 PER 24 MONTHS, PER QUADRANT, PER PATIENT. NOT PAYABLE IN CONJUNCTION WITH D1110, D1120, D4210,D4211 AND D4910.	YES	A PERIODONTAL TREATMENT PLAN. A PERIODONTAL CHARTING OF ORAL CONDITION AND POCKET DEPTHS, WITH ALL SIX SURFACES ON EACH TOOTH CHARTED. CURRENT LABELED, READABLE PERI- APICAL IMAGES OF THE MOUTH AND POSTERIOR BITEWINGS. NO PANOREX IMAGES.
D4910	PERIODONTAL MAINTENANCE	0-999	QUADRANT (LL, LR, UL, UR)	TWO D4910 PER 12MONTHS. NO PAYMENT MADE IN CONJUNCTION WITH PROPHYLAXIS OR	NO	

CDT	DESCRIPTION	AGES	TEETH/ARCH/QUAD	LIMITATIONS	AUTH REQ'D	DOCUMENTATION REQ'D
				WITHIN 30 DAYS OF ROOT PLANNING WITHIN LAST 24 MONTHS.		
D5110	COMPLETE DENTURE - MAXILLARY	0-999		ONE D5110, D5130 PER 96 MONTHS.	YES	FULL MOUTH X-RAYS OR PANOREX. WHEN A PRIOR AUTHORIZATION IS SUBMITTED FOR COMPLETE OR PARTIAL DENTURES FOR A RESIDENT OF ALONG-TERM CARE FACILITY IT MUST BE ACCOMPANIED BY THE FOLLOWING: A COPY OF THE RESIDENT'S MOST RECENT NURSING CARE PLAN; A COPY OF A CONSENT FORM SIGNED BY RESIDENT OR GUARDIAN; AND A DENTIST'S NARRATIVE ASSESSING RESIDENT'S ABILITY TO WEAR DENTURES.
D5120	COMPLETE DENTURE - MANDIBULAR	0-999		ONE D5110, D5130 PER 96 MONTHS.	YES	FULL MOUTH X-RAYS OR PANOREX. WHEN A PRIOR AUTHORIZATION IS SUBMITTED FOR COMPLETE OR PARTIAL DENTURES FOR A RESIDENT OF ALONG-TERM CARE FACILITY IT MUST BE ACCOMPANIED BY THE FOLLOWING: A COPY OF THE RESIDENT'S MOST RECENT NURSING CARE PLAN; A COPY OF A CONSENT FORM SIGNED BY RESIDENT OR GUARDIAN; AND A DENTIST'S NARRATIVE ASSESSING RESIDENT'S ABILITY TO WEAR DENTURES.
D5130	IMMEDIATE DENTURE - MAXILLARY	0-999		ONE D5212, D5214 PER 96 MONTHS.	YES	FULL MOUTH X-RAYS OR PANOREX. WHEN A PRIOR AUTHORIZATION IS SUBMITTED FOR COMPLETE OR PARTIAL DENTURES FOR A RESIDENT OF ALONG-TERM CARE FACILITY IT MUST BE ACCOMPANIED BY THE FOLLOWING: A COPY OF THE RESIDENT'S MOST RECENT NURSING CARE PLAN; A COPY OF A CONSENT FORM SIGNED

CDT	DESCRIPTION	AGES	TEETH/ARCH/QUAD	LIMITATIONS	AUTH REQ'D	DOCUMENTATION REQ'D
						BY RESIDENT OR GUARDIAN; AND A DENTIST'S NARRATIVE ASSESSING RESIDENT'S ABILITY TO WEAR DENTURES.
D5140	IMMEDIATE DENTURE - MANDIBULAR	0-999		ONE D5212, D5214 PER 96 MONTHS.	YES	FULL MOUTH X-RAYS OR PANOREX. WHEN A PRIOR AUTHORIZATION IS SUBMITTED FOR COMPLETE OR PARTIAL DENTURES FOR A RESIDENT OF ALONG-TERM CARE FACILITY IT MUST BE ACCOMPANIED BY THE FOLLOWING: A COPY OF THE RESIDENT'S MOST RECENT NURSING CARE PLAN; A COPY OF A CONSENT FORM SIGNED BY RESIDENT OR GUARDIAN; AND A DENTIST'S NARRATIVE ASSESSING RESIDENT'S ABILITY TO WEAR DENTURES.
D5211	MAXILLARY PARTIAL DENTURE - RESIN BASE	0-18		ONE D5212, D5214 PER 96 MONTHS.	YES	FULL MOUTH X-RAYS OR PANOREX. WHEN A PRIOR AUTHORIZATION IS SUBMITTED FOR COMPLETE OR PARTIAL DENTURES FOR A RESIDENT OF ALONG-TERM CARE FACILITY IT MUST BE ACCOMPANIED BY THE FOLLOWING: A COPY OF THE RESIDENT'S MOST RECENT NURSING CARE PLAN; A COPY OF A CONSENT FORM SIGNED BY RESIDENT OR GUARDIAN; AND A DENTIST'S NARRATIVE ASSESSING RESIDENT'S ABILITY TO WEAR DENTURES.
D5212	MANDIBULAR PARTIAL DENTURE - RESIN BASE	0-18		ONE D5212, D5214 PER 96 MONTHS.	YES	FULL MOUTH X-RAYS OR PANOREX. WHEN A PRIOR AUTHORIZATION IS SUBMITTED FOR COMPLETE OR PARTIAL DENTURES FOR A RESIDENT OF ALONG-TERM CARE FACILITY IT MUST BE ACCOMPANIED BY THE FOLLOWING: A COPY OF THE RESIDENT'S MOST RECENT NURSING CARE

CDT	DESCRIPTION	AGES	TEETH/ARCH/QUAD	LIMITATIONS	AUTH REQ'D	DOCUMENTATION REQ'D
						PLAN; A COPY OF A CONSENT FORM SIGNED BY RESIDENT OR GUARDIAN; AND A DENTIST'S NARRATIVE ASSESSING RESIDENT'S ABILITY TO WEAR DENTURES.
D5213	MAXILLARY PARTIAL DENTURE - CAST METAL FRAMEWORK WITH RESIN DENTURE BASES	0-999		ONE D5212, D5214 PER 96 MONTHS.	YES	FULL MOUTH X-RAYS OR PANOREX. WHEN A PRIOR AUTHORIZATION IS SUBMITTED FOR COMPLETE OR PARTIAL DENTURES FOR A RESIDENT OF ALONG-TERM CARE FACILITY IT MUST BE ACCOMPANIED BY THE FOLLOWING: A COPY OF THE RESIDENT'S MOST RECENT NURSING CARE PLAN; A COPY OF A CONSENT FORM SIGNED BY RESIDENT OR GUARDIAN; AND A DENTIST'S NARRATIVE ASSESSING RESIDENT'S ABILITY TO WEAR DENTURES.
D5214	MANDIBULAR PARTIAL DENTURE - CAST METAL FRAMEWORK WITH RESIN DENTURE BASES	0-999		ONE D5212, D5214 PER 96 MONTHS.	YES	FULL MOUTH X-RAYS OR PANOREX. WHEN A PRIOR AUTHORIZATION IS SUBMITTED FOR COMPLETE OR PARTIAL DENTURES FOR A RESIDENT OF ALONG-TERM CARE FACILITY IT MUST BE ACCOMPANIED BY THE FOLLOWING: A COPY OF THE RESIDENT'S MOST RECENT NURSING CARE PLAN; A COPY OF A CONSENT FORM SIGNED BY RESIDENT OR GUARDIAN; AND A DENTIST'S NARRATIVE ASSESSING RESIDENT'S ABILITY TO WEAR DENTURES.
D5225	MAXILLARY PARTIAL DENTURE - FLEXIBLE BASE (INCLUDING ANY RETENTIVE CLASPING MATERIALS)	0-999		ONE PER 96 MONTHS.	YES	NARRATIVE OF MEDICAL NECESSITY
D5226	MANDIBULAR PARTIAL DENTURE - FLEXIBLE BASE (INCLUDING ANY RETENTIVE CLASPING MATERIALS)	0-999		ONE PER 96 MONTHS.	YES	NARRATIVE OF MEDICAL NECESSITY
D5511	REPAIR BROKEN COMPLETE DENTURE BASE - MANDIBULAR	0-999	ARCH (LA)	ONE PER 36 MONTHS	NO	

CDT	DESCRIPTION	AGES	TEETH/ARCH/QUAD	LIMITATIONS	AUTH REQ'D	DOCUMENTATION REQ'D
D5512	REPAIR BROKEN COMPLETE DENTURE BASE - MAXILLARY	0-999	ARCH (UA)	ONE PER 36 MONTHS	NO	
D5520	REPLACE MISSING OR BROKEN TEETH - COMPLETE DENTURE (EACH TOOTH)	0-999	ARCH (UA)	ONE D5520 PER PERMANENT TOOTH, PER 24 MONTHS	NO	
D5611	REPAIR RESIN DENTURE BASE - MANDIBULAR	0-999	ARCH (LA)	ONE PER 36 MONTHS	NO	
D5612	REPAIR RESIN DENTURE BASE - MAXILLARY	0-999	ARCH (UA)	ONE PER 36 MONTHS	NO	
D5621	REPAIR CAST FRAMEWORK - MANDIBULAR	0-999	ARCH (LA)	ONE PER 36 MONTHS.	NO	
D5622	REPAIR CAST FRAMEWORK - MAXILLARY	0-999	ARCH – UA	ONE PER 36 MONTHS.	NO	
D5630	REPAIR OR REPLACE BROKEN CLASP – PER TOOTH	0-999	TEETH (01-32)	TWO D5630 PER 24 MONTHS	NO	
D5640	REPLACE BROKEN TEETH - PER TOOTH	0-999	TEETH (01-32)	ONE D5640 PER PERMANENT TOOTH, PER 24 MONTHS, MAXIMUM EIGHT TEETH.	NO	
D5650	ADD TOOTH TO EXISTING PARTIAL DENTURE	0-999	TEETH (01-32)	ONE D5650 PER PERMANENT TOOTH, PER 24 MONTHS, MAXIMUM EIGHT TEETH.	NO	
D5660	ADD CLASP TO EXISTING PARTIAL DENTURE - PER TOOTH	0-999	TEETH (01-32)	ONE D5660 PER 24 MONTHS	NO	
D5750	RELINE COMPLETE MAXILLARY DENTURE (INDIRECT)	0-999		ONE D5750 PER 36 MONTHS. NOT COVERED WITHIN 36 MONTHS OF PLACEMENT.	NO	
D5751	RELINE COMPLETE MANDIBULAR DENTURE (INDIRECT)	0-999		ONE D5751 PER 36 MONTHS. NOT COVERED WITHIN 36 MONTHS OF PLACEMENT.	NO	
D5760	RELINE MAXILLARY PARTIAL DENTURE (INDIRECT)	0-999		ONE D5760 PER 36 MONTHS.	NO	
D5761	RELINE MANDIBULAR PARTIAL DENTURE (INDIRECT)	0-999		NOT COVERED WITHIN 36 MONTHS OF PLACEMENT.	NO	
D5899	UNSPECIFIED REMOVABLE PROSTHODONTIC PROCEDURE, BY REPORT	0-999	ARCHES (UA, LA)	COVERED ONLY IN CONJUNCTION WITH D5211-D5214. APPROVED DENTURE REQUIRED FOR AUTHORIZATION. MAXIMUM OF TWO PER DENTURE COVERED.	YES	DESCRIPTION OF PROCEDURE AND NARRATIVE OF MEDICAL NECESSITY
D5913	NASAL PROSTHESIS	0-999		ONE D5913 PER 96 MONTHS.	YES	DESCRIPTION OF PROCEDURE AND NARRATIVE OF MEDICAL NECESSITY

CDT	DESCRIPTION	AGES	TEETH/ARCH/QUAD	LIMITATIONS	AUTH REQ'D	DOCUMENTATION REQ'D
D5915	ORBITAL PROSTHESIS	0-999		ONE D5915 PER 96 MONTHS.	YES	NARRATIVE OF MEDICAL NECESSITY
D5916	OCULAR PROSTHESIS	0-999		ONE D5916 PER 96 MONTHS.	YES	NARRATIVE OF MEDICAL NECESSITY
D5931	OBTURATOR PROSTHESIS, SURGICAL	0-999		ONE D5931 PER 96 MONTHS.	YES	NARRATIVE OF MEDICAL NECESSITY
D5932	OBTURATOR PROSTHESIS, DEFINITIVE	0-999		ONE D5932 PER 96 MONTHS.	YES	NARRATIVE OF MEDICAL NECESSITY
D5934	MANDIBULAR RESECTION PROSTHESIS WITH GUIDE FLANGE	0-999		ONE D5934 PER LIFETIME.	YES	NARRATIVE OF MEDICAL NECESSITY
D5935	MANDIBULAR RESECTION PROSTHESIS WITHOUT GUIDE FLANGE	0-999		ONE D5935 PER LIFETIME.	YES	NARRATIVE OF MEDICAL NECESSITY
D5955	PALATAL LIFT PROSTHESIS, DEFINITIVE	0-999		ONE D5955 PER LIFETIME.	YES	NARRATIVE OF MEDICAL NECESSITY
D5999	UNSPECIFIED MAXILLOFACIAL PROSTHESIS, BY REPORT	21-999		ONE D5999 PER 96 MONTHS.	YES	DESCRIPTION OF PROCEDURE AND NARRATIVE OF MEDICAL NECESSITY MEDICAL NECESSITY.
D6089	ACCESS/RETORQUE IMPLANT SCREW	0-999			YES	NARRATIVE OF MEDICAL NECESSITY.
D6105	REMOVAL OF IMPLANT BODY NOT REQUIRING BONE REMOVAL OR FLAP ELEVATION	0-999			YES	NARRATIVE OF MEDICAL NECESSITY.
D6106	GUIDED TISSUE REGENERATION – RESORBABLE BARRIER, PER IMPLANT	0-999			YES	NARRATIVE OF MEDICAL NECESSITY
D6107	GUIDED TISSUE REGENERATION – NON-RESORBABLE BARRIER, PER IMPLANT	0-999			YES	NARRATIVE OF MEDICAL NECESSITY
D6180	IMPLANT MAINTENANCE PROCEDURE	0-999			YES	NARRATIVE OF MEDICAL NECESSITY
6193	REPLACE IMPLANT SCREW	0-999			YES	NARRATIVE OF MEDICAL NECESSITY
D6197	REPLACEMENT OF RESTORATIVE MATERIAL USED TO CLOSE AN ACCESS OPENING OF A SCREW-	0-999			YES	NARRATIVE OF MEDICAL NECESSITY
D7140	EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT	0-999	TEETH (01-32, A-T)		NO	
D7210	EXTRACTION, ERUPTED TOOTH	0-999	TEETH (01-32, A-T,	ONE D7210 PER TOOTH, PER LIFETIME.	NO	
D7220	REMOVAL OF IMPACTED TOOTH - SOFT TISSUE	0-999	TEETH (01-32, A-T, SUPERNUMERARY)	ONE D7220 PER TOOTH, PER LIFETIME.	YES	PRE-OP X-RAY (PERIAPICAL, NO BITEWINGS) AND NARRATIVE OF MEDICAL NECESSITY.

CDT	DESCRIPTION	AGES	TEETH/ARCH/QUAD	LIMITATIONS	AUTH REQ'D	DOCUMENTATION REQ'D
D7230	REMOVAL OF IMPACTED TOOTH - PARTIALLY BONY	0-999	TEETH (01-32, A-T, SUPERNUMERARY)	ONE D7240 PER TOOTH, PER LIFETIME.	YES	PRE-OP X-RAYS (EXCLUDING BITEWINGS) AND NARRATIVE OF MEDICAL NECESSITY.
D7240	REMOVAL OF IMPACTED TOOTH - COMPLETELY BONY	0-999	TEETH (01-32, A-T, SUPERNUMERARY)	ONE D7240 PER TOOTH, PER LIFETIME	YES	PRE-OP X-RAYS (EXCLUDING BITEWINGS) AND NARRATIVE OF MEDICAL NECESSITY.
D7241	REMOVAL OF IMPACTED TOOTH - COMPLETELY BONY, UNUSUAL SURGICAL COMPLICATIONS	0-999	TEETH (01-32, A-T)	ONE D7241 PER TOOTH, PER LIFETIME.	YES	PRE-OP X-RAYS (EXCLUDING BITEWINGS) AND NARRATIVE OF MEDICAL NECESSITY.
D7250	SURGICAL REMOVAL OF RESIDUAL TOOTH (CUTTING PROCEDURE)	0-999	TEETH (01-32, A-T)	ONE D7250 PER TOOTH, PER LIFETIME.	YES	PRE-OP X-RAYS (EXCLUDING BITEWINGS) AND NARRATIVE OF MEDICAL NECESSITY.
D7259	NERVE DISSECTION	0-999	TEETH (01-32, A-T)		YES	PRE-OP X-RAYS (EXCLUDING BITEWINGS) AND NARRATIVE OF MEDICAL NECESSITY.
D7260	OROANTRAL FISTULA CLOSURE	0-999		FOUR D7260 PER LIFETIME.	YES	PRE-OP X-RAYS (EXCLUDING BITEWINGS) AND NARRATIVE OF MEDICAL NECESSITY.
D7270	REIMPLANTATION AND/OR STABILIZATION OF ACCIDENTALLY EVULSED / DISPLACED TOOTH	0-999	TEETH (01-32)	ONE D7270 PER TOOTH, PER LIFETIME.	NO	IMAGES OF THE AREA AND A DETAILED EXPLANATION OF THE FINDINGS AND TREATMENT MUST BE MAINTAINED IN PATIENT'S CLINICAL RECORD.
D7280	EXPOSURE OF AN UNERUPTED TOOTH	0-999	TEETH (02-15, 18-31)	IN CONJUNCTION WITH D8080. ONE PER PERMANENT TOOTH, PER LIFETIME.	YES	PRE-OPERATIVE X-RAY AND ORTHODONTIC TREATMENT APPROVAL.
D7283	PLACEMENT OF DEVICE TO FACILITATE ERUPTION OF IMPACTED TOOTH	0-20	TEETH (02-15, 18-31)	LIMIT ONE PER PERMANENT TOOTH, PER LIFETIME. IN CONJUNCTION WITH D7280.	YES	PRE-OPERATIVE X-RAY AND ORTHODONTIC TREATMENT APPROVAL.
D7284	EXC BIOPSY OF SALIV GLANDS	0-999			YES	NARRATIVE OF MEDICAL NECESSITY
D7285	INCISIONAL BIOPSY OF ORAL TISSUE - HARD (BONE, TOOTH)	0-999		ONE D7285 PER 12 MONTHS.	NO	
D7286	INCISIONAL BIOPSY OF ORAL TISSUE - SOFT	0-999		ONE D7286 PER 12 MONTHS.	NO	
D7310	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS - FOUR OR MORE TEETH	0-999	QUADRANT (LL, LR, UR, UL)	D7310 AND D7320 ARE COVERED ONLY IN CONJUNCTION WITH THE CONSTRUCTION OF A	NO	

CDT	DESCRIPTION	AGES	TEETH/ARCH/QUAD	LIMITATIONS	AUTH REQ'D	DOCUMENTATION REQ'D
				PROSTHODONTIC APPLIANCE.		
D7311	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS – ONE TO THREE TEETH	0-999	QUADRANT (LL, LR, UR, UL)	D7310 AND D7320 ARE COVERED ONLY IN CONJUNCTION WITH THE CONSTRUCTION OF A PROSTHODONTIC APPLIANCE.	NO	
D7320	ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS - FOUR OR MORE TEETH	0-999	QUADRANT (LL, LR, UR, UL)	D7310 AND D7320 ARE COVERED ONLY IN CONJUNCTION WITH THE CONSTRUCTION OF A PROSTHODONTIC APPLIANCE.	NO	
D7450	REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR - DIA UP TO1.25 CM	0-999		REMOVAL OF PERIRADICULAR CYST AND CURETTAGE POST EXTRACTION IS NOT COVERED. ONE D7450 PER 12 MONTHS.	NO	IMAGES OF THE AREA AND A DETAILED EXPLANATION OF THE FINDINGS AND TREATMENT MUST BE MAINTAINED IN PATIENT'S CLINICAL RECORD.
D7451	REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR - DIA GREATER THAN 1.25 CM	0-999		REMOVAL OF PERIARTICULAR CYST AND CURETTAGE POST EXTRACTION IS NOT COVERED. ONE D7451 PER 12 MONTHS.	NO	IMAGES OF THE AREA AND A DETAILED EXPLANATION OF THE FINDINGS AND TREATMENT MUST BE MAINTAINED IN PATIENT'S CLINICAL RECORD.
D7460	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - DIA GREATER THAN 1.25 CM	0-999		REMOVAL OF PERIARTICULAR CYST AND CURETTAGE POST EXTRACTION IS NOT COVERED. ONE D7450 PER 12 MONTHS.	NO	IMAGES OF THE AREA AND A DETAILED EXPLANATION OF THE FINDINGS AND TREATMENT MUST BE MAINTAINED IN PATIENT'S CLINICAL RECORD.
D7461	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR - DIA GREATER THAN 1.25 CM	0-999		REMOVAL OF PERIARTICULAR CYST AND CURETTAGE POST EXTRACTION IS NOT COVERED. ONE D7461 PER 12 MONTHS.	NO	IMAGES OF THE AREA AND A DETAILED EXPLANATION OF THE FINDINGS AND TREATMENT MUST BE MAINTAINED IN PATIENT'S CLINICAL RECORD.
D7471	REMOVAL OF LATERAL EXOSTOSIS (MAXILLA OR MANDIBLE)	0-999	ARCHES (UA, LA)	ONE D7471 PER LIFETIME, PER PATIENT, PER ARCH.	NO	A DIAGNOSTIC IMAGE OF CASTS OR PHOTOGRAPH OF THE MOUTH WITH THE AREA OF SURGERY OUTLINED MUST BE MAINTAINED IN THE PATIENT'S CLINICAL RECORD.

CDT	DESCRIPTION	AGES	TEETH/ARCH/QUAD	LIMITATIONS	AUTH REQ'D	DOCUMENTATION REQ'D
D7472	REMOVAL OF TORUS PALATINUS	0-999		ONE D7472 PER LIFETIME, PER PATIENT, PER ARCH.	NO	A DIAGNOSTIC IMAGE OF CASTS OR PHOTOGRAPH OF THE MOUTH WITH THE AREA OF SURGERY OUTLINED MUST BE MAINTAINED IN THE PATIENT'S CLINICAL RECORD.
D7473	REMOVE TORUS MANDIBULARIS	0-999	QUADRANTS (LL, LR)	ONE D7473 PER LIFETIME, PER PATIENT, PER QUADRANT.	NO	A DIAGNOSTIC IMAGE OF CASTS OR PHOTOGRAPH OF THE MOUTH WITH THE AREA OF SURGERY OUTLINED MUST BE MAINTAINED IN THE PATIENT'S CLINICAL RECORD.
D7509	MARSUPIALIZATION OF ODONTOGENIC CYST SURGICAL DECOMPRESSION OF A LARGE CYSTIC LESION	0-999			YES	NARRATIVE OF MEDICAL NECESSITY
D7510	INCISION AND DRAINAGE OF ABSCESS- INTRAORAL SOFT TISSUE	0-999		ONE D7510 PER 12 MONTHS.	NO	IMAGES OF THE AREA AND A DETAILED EXPLANATION OF THE FINDINGS AND TREATMENT MUST BE MAINTAINED IN THE PATIENTS' CLINICAL RECORDS.
D7520	INCISION AND DRAINAGE OF ABSCESS- EXTRAORAL SOFT TISSUE	0-999		ONE D7520 PER 12 MONTHS.	NO	IMAGES OF THE AREA AND A DETAILED EXPLANATION OF THE FINDINGS AND TREATMENT MUST BE MAINTAINED IN THE PATIENTS' CLINICAL RECORDS.
D7670	ALVEOLUS - CLOSED REDUCTION, MAY INCLUDE STABILIZATION OF TEETH	0-999			NO	NARRATIVE OF MEDICAL NECESSITY,
D7671	ALVEOLUS - OPEN REDUCTION, MAY INCLUDE STABILIZATION OF TEETH	0-999		ONE D7671 PER 12 MONTHS.	NO	NARRATIVE OF MEDICAL NECESSITY, X-RAY, OR PHOTOS, OPTIONAL. IMAGES OF THE AREA AND A DETAILED EXPLANATION OF THE FINDINGS AND TREATMENT MUST BE MAINTAINED IN THE PATIENT'S CLINICAL RECORDS.
D7899	UNSPECIFIED TMD THERAPY, BY REPORT	0-999		ONE D7899 PER 12 MONTHS.	YES	DESCRIPTION OF PROCEDURE AND NARRATIVE OF MEDICAL NECESSITY, PANORAMIC IMAGES, AND DIAGNOSTIC IMAGES OF CASTS
D7956	GUIDED TISSUE REGENERATION, EDENTULOUS AREA –RESORBABLE BARRIER, PER SITE	0-999			YES	NARRATIVE OF MEDICAL NECESSITY

CDT	DESCRIPTION	AGES	TEETH/ARCH/QUAD	LIMITATIONS	AUTH REQ'D	DOCUMENTATION REQ'D
D7957	GUIDED TISSUE REGENERATION, EDENTULOUS AREA –NON-RESORBABLE BARRIER, PER SITE	0-999			YES	NARRATIVE OF MEDICAL NECESSITY
D7961	BUCCAL / LABIAL FRENECTOMY(FRENULECTOMY)	0-999			NO	
D7962	LINGUAL FRENECTOMY (FRENULECTOMY)	0-999			NO	
D7970	EXCISION OF HYPERPLASTIC TISSUE -PER ARCH	0-999	ARCHES (UA, LA)	ONCE PER ARCH, PER LIFETIME.	NO	A DIAGNOSTIC IMAGE OF CASTS OR PHOTOGRAPH OF THE MOUTH WITH THE AREA OF SURGERY OUTLINED MUST BE MAINTAINED IN THE PATIENT'S CLINICAL RECORD.
D7999	UNSPECIFIED ORAL SURGERY PROCEDURE, BY REPORT	0-999			YES	DESCRIPTION OF PROCEDURE AND NARRATIVE OF MEDICAL NECESSITY. DIAGNOSTIC X-RAYS, PHOTOS, OR OTHER IMAGING ALONG WITH A DETAILED EXPLANATION OF THE FINDINGS.
D8080	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION	0-20		ONE COURSE OF ORTHODONTIC TREATMENT PER LIFETIME. PAYMENT INCLUDES FIRST CALENDAR QUARTER OF TREATMENT.	YES	SIX ITEMS MUST BE SUBMITTED WITH EACH PA REQUEST: 1. DIAGNOSTIC PHOTOS (5-7) WHICH INCLUDE LATERAL & FRONTAL PHOTOGRAPHS OF THE PATIENT WITH LIPS TOGETHER 2. CEPHALOMETRIC FILM AND TRACING WITH LIPS TOGETHER. 3.COMPLETE SERIES OF INTRAORAL IMAGES PANOREX IMAGE MUST BE OF DIAGNOSTIC QUALITY. 4. DIAGNOSTIC MODELS. 5.TREATMENT PLAN TO INCLUDE LENGTH OF TIME OF TREATMENT. 6. COMPLETED EVALUATION AND REFERRAL FORM ODM 3630 (1/2016). COMPLETE SERIES OF INTRAORAL IMAGES OR PANOREX IMAGE MUST BE OF DIAGNOSTIC QUALITY. 4. DIAGNOSTIC MODELS. 5.TREATMENT PLAN TO INCLUDE LENGTH OF TIME OF TREATMENT. 6. COMPLETED

CDT	DESCRIPTION	AGES	TEETH/ARCH/QUAD	LIMITATIONS	AUTH REQ'D	DOCUMENTATION REQ'D
						EVALUATION AND REFERRAL FORM ODM 3630 (1/2016).
D8210	REMOVABLE APPLIANCE THERAPY	0-999	ARCHES (UA, LA)	ONE APPLIANCE PER ARCH EVERY 60 MONTHS	NO	PANOREX AND/OR CEPH X-RAY AND NARRATIVE OF MEDICAL NECESSITY.
D8220	FIXED APPLIANCE THERAPY	0-999		TWO D8220 PER LIFETIME	YES	PANOREX AND/OR CEPH X-RAY AND NARRATIVE OF MEDICAL NECESSITY.
D8670	PERIODIC ORTHODONTIC TREATMENT VISIT	0-20		LIMIT TO SEVEN (7), D8670 PER LIFETIME	YES	HISTORY OF INITIAL BANDING REQUIRED.
D8680	ORTHODONTIC RETENTION (REMOVAL OF APPLIANCES, PLACE RETAINERS)	0-20		ONE TWO D8680, PER ARCH, PER PATIENT PER LIFETIME	YES	SUBMITTED IN CONJUNCTION WITH ORTHODONTIC C APPROVAL, COVERED AFTER ACTIVE ORTHO TREATMENTS HAVE BEEN COMPLETED.
D8999	UNSPECIFIED ORTHODONTIC PROCEDURE, BY REPORT	0-20		LIMIT TO ONE (1) D8999 PER LIFETIME.	YES	DESCRIPTION OF PROCEDURE AND NARRATIVE OF MEDICAL NECESSITY
D9222	DEEP SEDATION/GENERAL ANESTHESIA - FIRST 15MINUTES	0-999		LIMIT FOUR D9223 INCREMENTS PER PATIENT PER DATE OF SERVICE. NOT IN CONJUNCTION WITH D9239 AND D9243.	NO	
D9223	DEEP SEDATION /GENERAL ANESTHESIA -EACH SUBSEQUENT 15MINUTE INCREMENT	0-999		LIMIT FOUR D9223 INCREMENTS PER PATIENT PER DATE OF SERVICE. NOT IN CONJUNCTION WITH D9239 AND D9243.	NO	
D9230	INHALATION OF NITROUS OXIDE /ANXIOLYSIS, ANALGESIA– EACH 15 MINUTE INCREMENT	0-999		LIMIT ONE PER DAY. NOT IN CONJUNCTION WITH D9222, D9223, D9239, AND D9243.	YES (AGES 0-	NARRATIVE OF MEDICAL NECESSITY
D9239	INTRAVENOUS MODERATE (CONSCIOUS)SEDATION/ANALGESIA -FIRST 15 MINUTES	0-999		ONE D9239 PER DAY, PER PATIENT. NOT IN CONJUNCTION WITH D9222 AND D9223	NO	
D9243	INTRAVENOUS MODERATE (CONSCIOUS)SEDATION/ANALGESIA -EACH SUBSEQUENT 15MINUTE	0-999		LIMIT FOUR D9243 INCREMENTS PER PATIENT PER DATE OF SERVICE. NOT IN CONJUNCTION WITH D9222 AND D9223.	NO	

CDT	DESCRIPTION	AGES	TEETH/ARCH/QUAD	LIMITATIONS	AUTH REQ'D	DOCUMENTATION REQ'D
D9610	THERAPEUTIC PARENTERAL DRUG, SINGLE ADMINISTRATION	0-999		ONE D9610 PER DAY, PER PATIENT. NOT IN CONJUNCTION WITH D9612.	NO	
D9612	THERAPEUTIC PARENTERAL DRUGS, TWO OR MORE ADMINISTRATIONS	0-999		ONE D9612 PER DAY, PER PATIENT. NOT IN CONJUNCTION WITH D9610.	NO	
D9920	BEHAVIOR MANAGEMENT, BY REPORT	0-999			YES	NARRATIVE OF MEDICAL NECESSITY.
D9944	OCCLUSAL GUARD – HARD APPLIANCE, FULL ARCH	21-999	EITHER UA OR LA	EITHER D9944, D9945, OR D9946 PER 36 MONTHS.	NO	REMOVABLE DENTAL APPLIANCE TO MINIMIZE EFFECTS OF BRUXISM OR OTHER OCCLUSAL FACTORS. NOT TO BE USED FOR ANY TYPE OF SLEEP APNEA, SNORING OR TMD APPLIANCE.
D9945	OCCLUSAL GUARD – SOFT APPLIANCE, FULL ARCH	21-999	EITHER UA OR LA	EITHER D9944, D9945, OR D9946 PER 36 MONTHS.	NO	REMOVABLE DENTAL APPLIANCE TO MINIMIZE EFFECTS OF BRUXISM OR OTHER OCCLUSAL FACTORS. NOT TO BE USED FOR ANY TYPE OF SLEEP APNEA, SNORING OR TMD APPLIANCE.
D9946	OCCLUSAL GUARD – HARD APPLIANCE, PARTIAL ARCH	21-999	EITHER UA OR LA	EITHER D9944, D9945, OR D9946 PER 36 MONTHS.	NO	REMOVABLE DENTAL APPLIANCE TO MINIMIZE EFFECTS OF BRUXISM OR OTHER OCCLUSAL FACTORS. NOT TO BE USED FOR ANY TYPE OF SLEEP APNEA, SNORING OR TMD APPLIANCE.
D9947	CUSTOM SLEEP APNEA APPLIANCE FABRICATION AND PLACEMENT	0-999			YES	NARRATIVE OF MEDICAL NECESSITY.
D9948	ADJUSTMENT OF CUSTOM SLEEP APNEA APPLIANCE	0-999			YES	NARRATIVE OF MEDICAL NECESSITY.
D9949	REPAIR OF CUSTOM SLEEP APNEA APPLIANCE	0-999			YES	NARRATIVE OF MEDICAL NECESSITY.
D9953	RELINE CUSTOM SLEEP APNEA APPLIANCE (INDIRECT) RESURFACE DENTITION SIDE OF APPLIANCES	0-999			YES	NARRATIVE OF MEDICAL NECESSITY.
D9954	FAB/DEL ORAL APPLIANCE THXPY	0-999			YES	NARRATIVE OF MEDICAL NECESSITY.
D9955	ORAL APP THXPY TITRATION VIS ORAL APP	0-999			YES	NARRATIVE OF MEDICAL NECESSITY.

CDT	DESCRIPTION	AGES	TEETH/ARCH/QUAD	LIMITATIONS	AUTH REQ'D	DOCUMENTATION REQ'D
D9995	TELE DENTISTRY - SYNCHRONOUS; REAL- TIME ENCOUNTER	0-999			NO	NARRATIVE OF MEDICAL NECESSITY WITH CLAIM.
D9997	DENTAL CASE MANAGEMENT	0-999			YES	NARRATIVE OF MEDICAL NECESSITY.
D9999	UNSPECIFIED ADJUNCTIVE PROCEDURE, BY REPORT	0-999		LIMITED TO PROCEDURES THAT REQUIRE HOSPITALIZATION.	YES	DESCRIPTION OF PROCEDURE, NARRATIVE OF MEDICAL NECESSITY. ENTAILS UNUSUAL OR SPECIALIZED TREATMENT REQUIRED TO SAFEGUARD THE HEALTH AND WELFARE OF THE PATIENT. DETAILED INFORMATION ON THE DIFFICULTY AND COMPLICATIONS OF THE SERVICE IS REQUIRED. SUBMIT COMPLETE IMAGES OF THE MOUTH, IF INDICATED.

XXI. Appendix D

A. Non-Covered Service Agreement Form

Non-Covered Services Agreement

Provider_____

Address_____City, State, Zip_____

Telephone_____ Fax_____

Email_____ Website_____

Provider MA#_____

I,_____ , understand that the following procedures are excluded under the Molina Healthcare program. I further understand that by signing this agreement, I am agreeing in advance, in writing, to accept full financial responsibility for all costs associated with these non-covered dental services.

Date of Service	Code	Description of Service	Cost
Total Amount Due by Recipient			

_____/_____
Patient Name/Patient MA#

_____
Patient/Guardian/Beneficiary Name – Relationship to Patient

_____
Patient/Guardian/Beneficiary Signature Date

_____
Dentist Name

_____
Dentist Signature Date

This form must be kept on file and a copy of which available upon request.

Prior to each date of service for the specific service rendered, the provider notifies the Medicaid recipient in writing that the provider will not submit a claim to ODM for the service.

B. Orthodontic Continuation of Care Request Form

Orthodontic Continuation of Care Request Form

Date: _____

Patient Name: _____

Member ID: _____

Member DOB: _____

Code(s) Requiring COC: _____

Current Provider Name: _____

Current Provider NPI#: _____

Banding Date: _____

Total Dollars Paid for Case to Date: _____

Remaining Visits:_____

Balance Requested for Remainder of Case: _____

Previous Carrier (if applicable):_____

Previous Provider Name: _____

Previous Provider Phone #: _____

Previous Provider Address: _____

Procedure:

Complete this form and submit via the SKYGEN Dental Hub, along with required clinical documentation outlined in Provider Appendix Continuation of Care section, as a prior authorization for code D8999 and all applicable orthodontic codes.

The case will be reviewed by Molina Healthcare and approved or denied for the continuation of care. If approved, an approved reimbursement amount will be determined as well.

Required Documentation:

- This form and a Completed 2012 ADA Dental Claim Form listing
- D8999 and all applicable orthodontic codes.
- Narrative that includes reason for leaving previous treating Provider, previous Provider contact information, additional treatment needed, and the approximate amount of additional time needed for treatment.