Addendum To

AmeriHealth Caritas District of Columbia Provider Manual

Dental Provider Supplement

Revised: January 2024

Version 25

AmeriHealth Caritas™

District of Columbia

[redacted]

Table of Contents

Addendum Two:
Dental Provider Supplement

Welcome

Welcome to AmeriHealth Caritas District of Columbia (DC) — a mission-driven managed care organization located in Washington, D.C. We offer two products for enrollees in all eight District wards: AmeriHealth Caritas DC Medicaid (for beneficiaries of the D.C. Healthy Families program), AmeriHealth Caritas DC Alliance (for beneficiaries of the D.C. Healthcare Alliance program), and the beneficiaries of the Immigrant Children's Program (ICP).

This supplement to the *Provider Manual* was created to assist you and your office staff with providing services to our enrollees, your patients. As a provider, you agree to use this supplement to the *Provider Manual* as a reference pertaining to the provision of dental services for enrollees of AmeriHealth Caritas DC.

The *Provider Manual* and this supplement may be changed or updated periodically. AmeriHealth Caritas DC will provide you with notice of updates; providers are also responsible to check the plan's website, www.amerihealthcaritasdc.com, regularly for updates.

Thank you for your participation in the AmeriHealth Caritas DC provider network. We look forward to working with you!

Sharing Our Mission

As our provider partner, we invite you to share our mission: **To help people get care, stay well, and build healthy communities.**

Medicaid, Alliance, and Products

AmeriHealth Caritas DC offers three products in the District: a Medicaid product (for beneficiaries of the D.C. Healthy Families program), an Alliance product (for beneficiaries of the D.C. Healthcare Alliance program), and benefits for the Immigrant Children's Program (ICP). The policies and procedures in this Provider Manual apply to all three programs, unless otherwise indicated. Benefit coverage for Medicaid enrollees differs from coverage for Alliance and ICP enrollees. Please refer to the "Provision of Services" section of this Provider Manual for information on covered services for each program. Medicaid and Alliance enrollees are identified by two different enrollee identification cards, as shown in the first section of this publication.

About This Supplement

The information contained in this *Dental Provider Supplement* is in addition to the information contained in the AmeriHealth Caritas DC *Provider Manual* and is intended to apply only to dental providers and to the AmeriHealth Caritas DC dental program. This *Dental Provider Supplement* includes information on the AmeriHealth Caritas DC dental program that may not otherwise appear in the AmeriHealth Caritas DC *Provider Manual*.

Important Contact Information

PROVIDER SERVICES

Telephone: 1-855-609-5170

Email: providerportal@AmeriHealthCaritas DCdental.com

AUTHORIZATIONS

General authorizations:
AmeriHealth Caritas DC — Authorizations
P.O. Box 654
Milwaukee, WI 53201

Outpatient facility authorizations:
AmeriHealth Caritas DC — Authorizations
P.O. Box 654
Milwaukee, WI 53201

CONTINUATION OF CARE

AmeriHealth Caritas DC – Continuation of Care
PO Box 654
Milwaukee, WI 53201

CREDENTIALING

AmeriHealth Caritas
Attn: Credentialing Dept.
200 Stevens Drive
Philadelphia, PA 19113

Credentialing: 1-877-759-6186
Fax: 215-863-6369

ELECTRONIC FUNDS TRANSFER (EFT)

EFT — Applications
Email to: providerservices@skygenusa.com
Fax: 262-721-0722

CLAIMS

Paper claims:
AmeriHealth Caritas DC-Claims
P.O. Box 651
Milwaukee, WI 53201

Electronic claims:
Clearinghouse.
Payer ID: SCION

Provider Web Portal link = pwp.sciondental.com

PROVIDER APPEALS OR COMPLAINTS,

AmeriHealth Caritas DC — Provider Appeals
P.O. Box 1243
Milwaukee, WI 53201

CORRECTED CLAIMS

AmeriHealth Caritas DC
P.O. Box 541
Milwaukee, WI 53201

ENROLLEE SERVICES

Medicaid:
202-408-4720 or toll free at 1-800-408-7511
Alliance:
202-842-2810 or toll free at 1-866-842-2810 **TTY:** 1-800-570-1190

transportation services:
Medicaid enrollees may call:
1-800-315-3485.

Working Together

Supporting providers

To ensure timely, accurate provider reimbursement and high-quality service, AmeriHealth Caritas DC assigns each geographical region a dedicated Dental Program Manager and Dental Director. This proven approach fosters teamwork and cooperation, which results in a shared focus on improving service, enrollee participation, and program results.

Supporting enrollees

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

Providers must offer appointments to enrollees according to Department of Health Care Finance requirements, but in no event less timely than an appointment within 30 days for routine conditions, within 24 hours for urgent conditions, and immediately for emergent situations.

Primary dental providers (PDPs) are required to remind enrollees on their PDP panel of missing, due, and overdue appointments. You can access the provider section of our website to assist you with making these reminders.

Language access services

Our enrollees, your patients, must be provided with competent professional oral interpretation services, free of charge, utilizing the AT&T Language Access Line (or a comparable service) or through on-site professional interpretation services, regardless of the language spoken, at all points of contact, including but not limited to:

- Appointment scheduling.
- Office encounters.
- Provider visits.

This also includes translation of documents and other enrollee records. If you are unable to provide these services, it is imperative that you contact Provider Services at (**1-855-609-5170**), and we will arrange those services for AmeriHealth Caritas DC enrollees.

Consistent, transparent authorization logic

AmeriHealth Caritas DC's trained dental program team enrollees use clinical algorithms, which can be customized to ensure a consistent approach for making Utilization Management (UM) determinations. These algorithms are available to providers through the provider portal at www.amerihealthcaritasdc.com so dentists can follow the decision matrix and understand the logic behind UM decisions. In addition, AmeriHealth Caritas DC fosters a sense of partnership by encouraging providers to offer feedback about the algorithms. A consistent, well- understood approach to UM determinations promotes clarity and transparency for providers, which in turn reduces provider administrative costs.

Technology

AmeriHealth Caritas DC takes advantage of technology tools to increase speed and efficiency and keep program administration and provider participation costs as low as possible.

Provider website

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

The website may be accessed at **www.amerihealthcaritasdc.com**. AmeriHealth Caritas DC's dental provider website allows network providers direct access to multiple online services. Utilization of the online services offered through the website lowers program administration and participation costs for providers.

Internet Explorer and a valid user ID and password are required to access the website. Providers and authorized office staff can log in anytime from anywhere and handle a variety of day-to-day tasks, including:

- Verify enrollee eligibility and service history reports
- View pre-claim estimate reports
- Attach supporting documentation to claims and authorizations
- Search for and view historical claims and authorizations
- Create "provider billed amounts" lists for service codes
- Manage patient rosters and schedule appointments on the patient calendar
- Sign up and manage payee electronic funds transfer (EFT) information
- Create and manage portal subaccounts for staff
- View remittances

Feedback

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

Provider Web Portal

The AmeriHealth Caritas DC provider web portal allows us to maintain our commitment to help you keep your office costs low, access information efficiently, get paid quicker, and submit claims and prior authorization requests electronically.

Registration

To register for the provider web portal, please visit **www.amerihealthcaritasdc.com** or contact the Portal Support team at **1-855-434-9239**. Additionally, you may contact the Portal Support team to schedule a training webinar or to learn more about the portal's features and functions.

No software downloads or purchases

To obtain electronic use of our provider web portal all that is required is internet access and a unique user name and password.

When registering, register "As a payee" so you will have the option to view remittances and be electronically. Contact Provider Support at **1-855-609-5170** paid to obtain your payee ID number.

Getting started

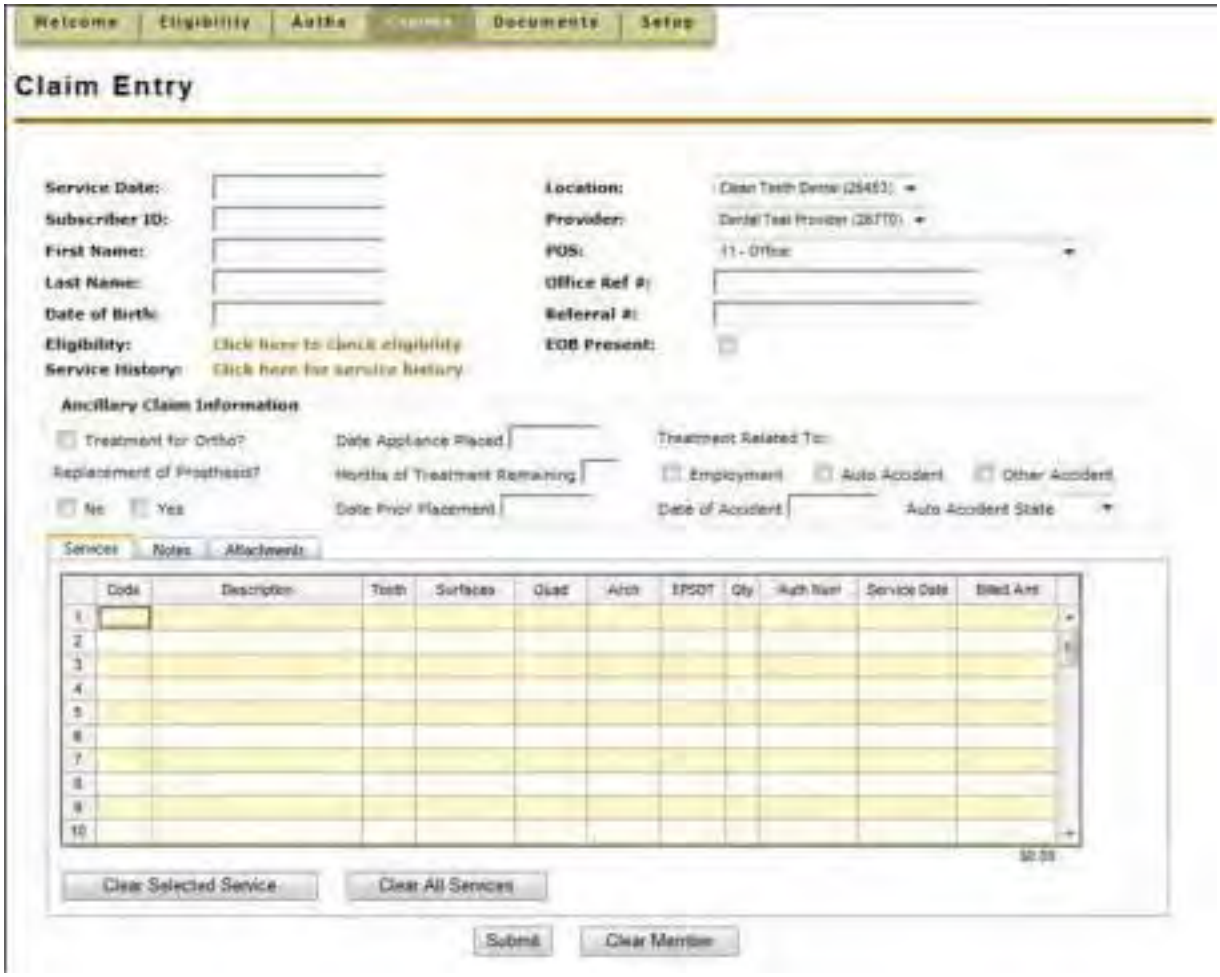
Once registered, you can navigate through the web portal and use the available resources and features to help streamline data entry.

Verify enrollee eligibility

- You have access to one-step enrollee eligibility verification
- You can check on an unlimited number of patients and print off each summary of eligibility generated by the system for your records

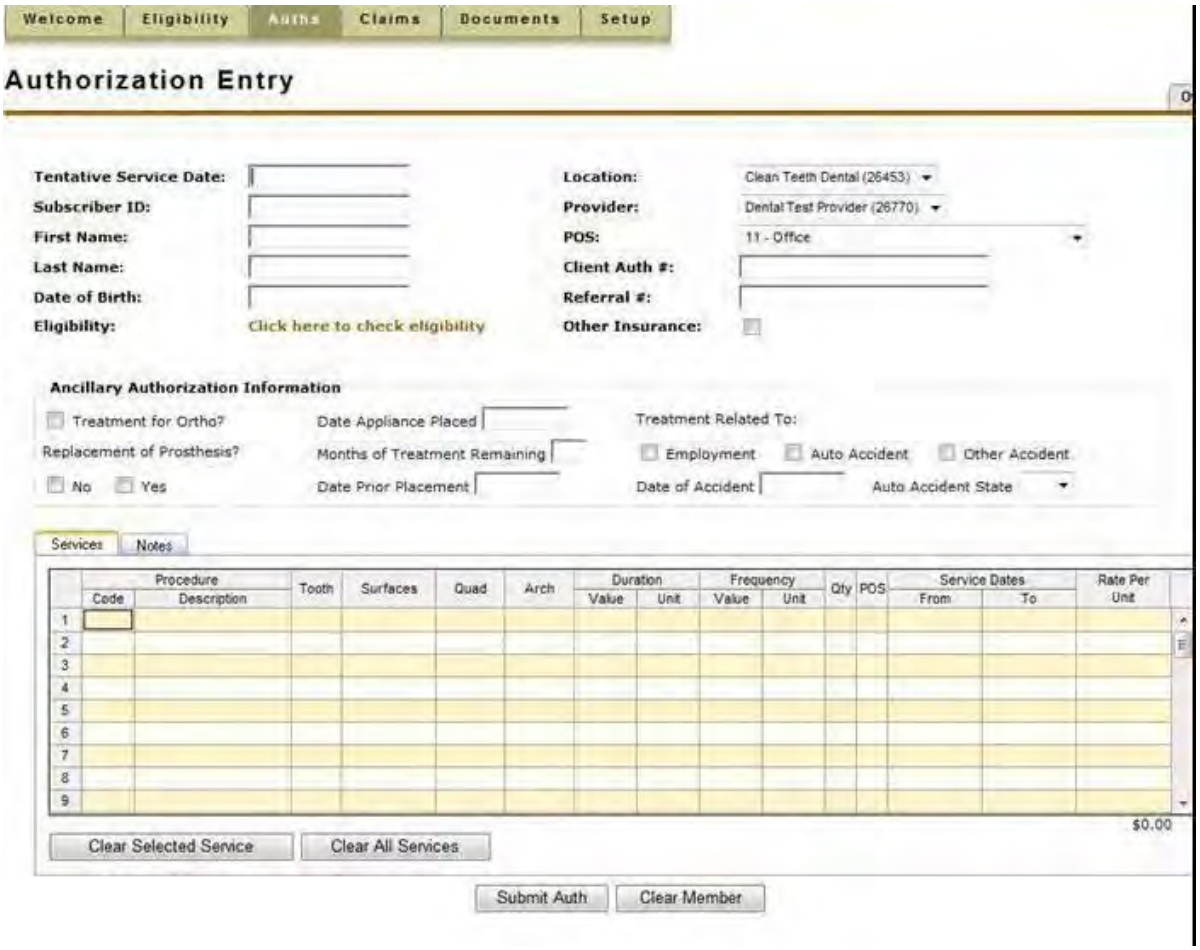
Manage claims

- Submit claims for services performed
- Review and print or save a list of claims submitted today for your records, before they are sent on for processing
- Check the status of previously submitted claims
- Enter additional information, such as National Electronic Attachment LLC (NEA) number, under the Notes tab



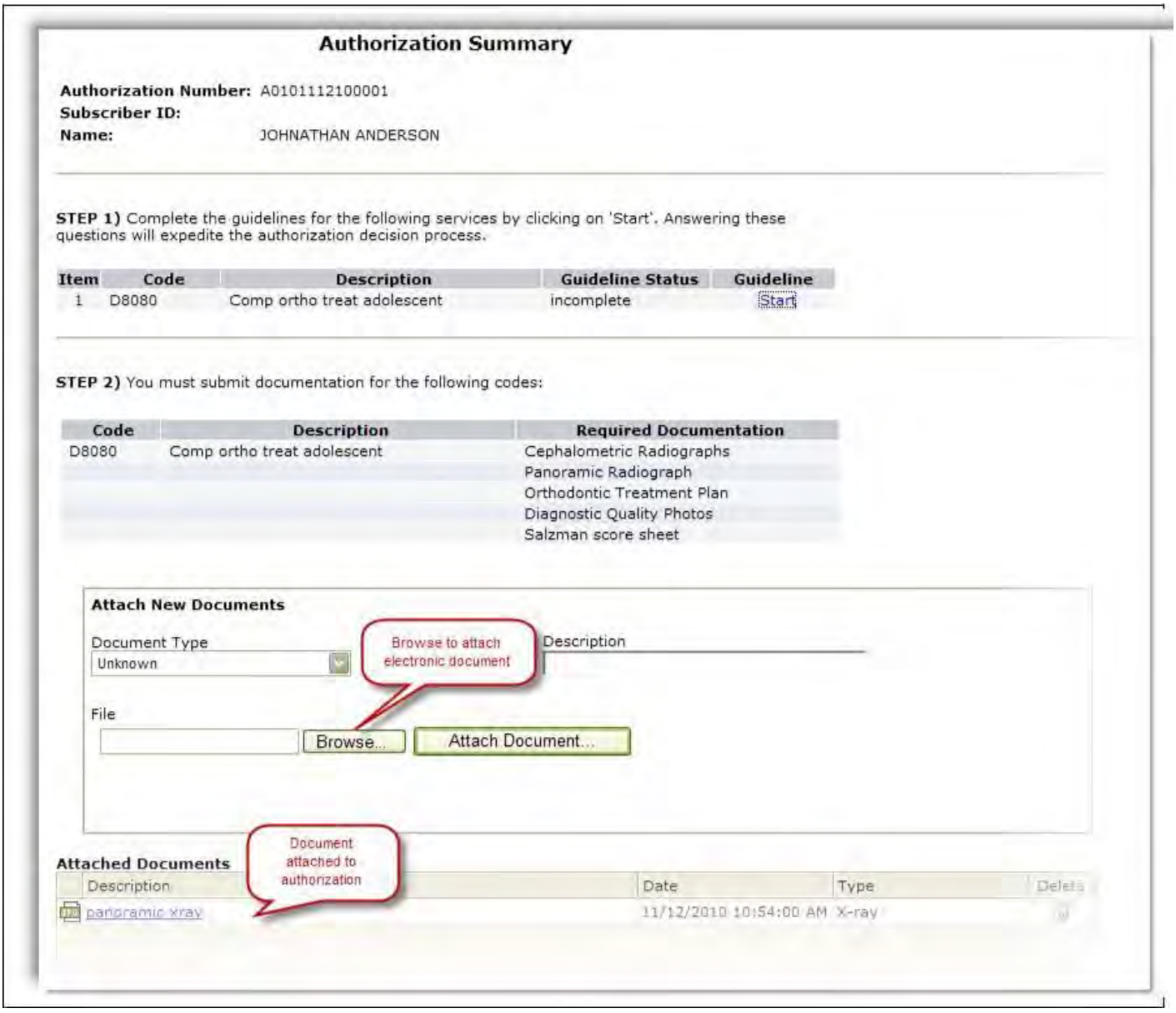
Manage authorizations

- Submit authorizations before performing services to obtain approval
- Attach electronic files, including X-rays, and review authorizations submitted before they are sent on for processing
- Check the status of previously submitted authorizations



From an authorization summary, you can:

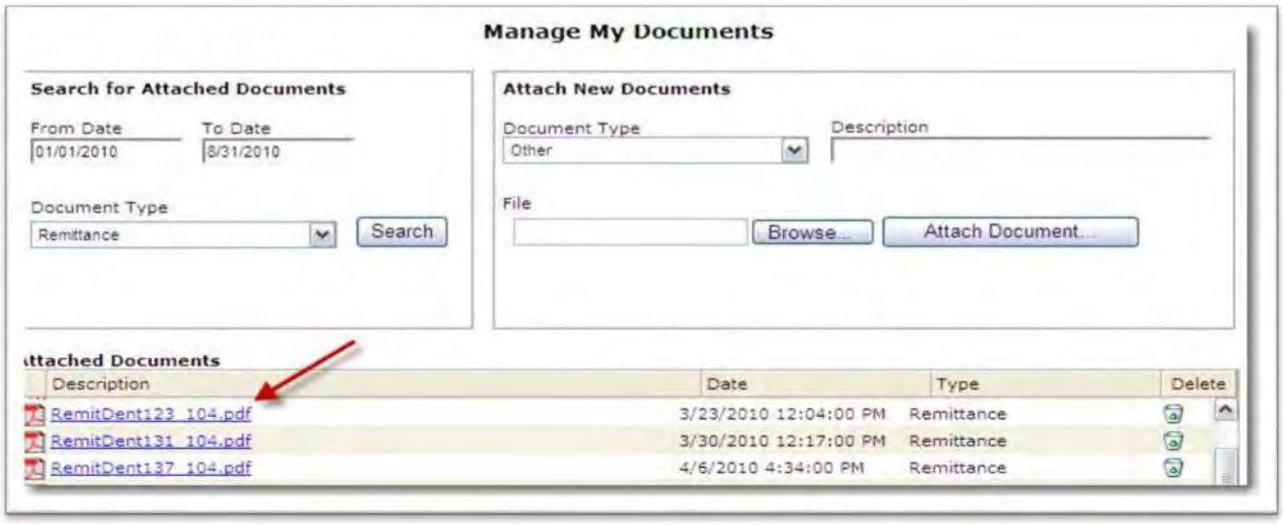
- Run any applicable authorization guidelines
- Review a list of documentation required for each procedure code
- Attach electronic files to the authorization record
- Attach clearinghouse reference information to the authorization record
- Print a copy of the authorization summary for your records



Electronic funds transfer

AmeriHealth Caritas DC provider web portal services allow us to give you quicker payments by EFT. Electronic payment offers the ability to deposit payments directly into your account and allows you to obtain remittances more quickly on your online account.

To obtain your online remittances, navigate to the "Manage My Documents" page from the Documents tab on the toolbar or by the link on the main page.



To enroll in EFT payment, please complete the following page and email at providerservices@skygenusa.com or by faxing to 262-721-0722

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

PART I — REASON FOR SUBMISSION

Reason for submission: ❑ New EFT authorization ❑ Revision to current EFT preferences (e.g., account or bank changes)

PART II — PROVIDER OR SUPPLIER INFORMATION

Payee name:_____

Tax identification number (designate SSN ❑ or EIN ❑):_____

Payee address (city, state, ZIP code):_____

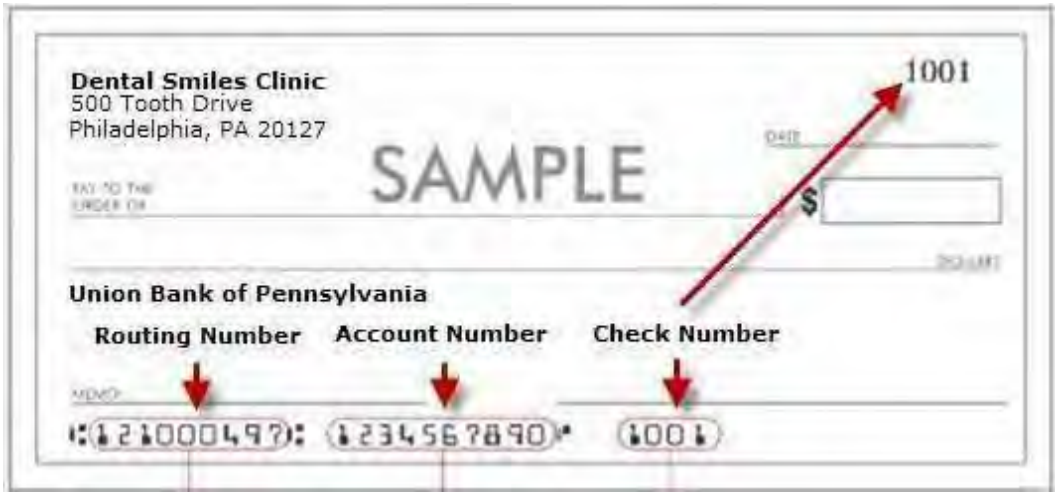
PART III — DEPOSITORY INFORMATION (financial institution)

Bank/depository name:_____

Depository routing transit number (nine digits; include any leading zeros):

Depositor account number (up to 10 digits; include any leading zeros): ___

Account type (check one): ❑ Checking ❑ Savings



PART IV — CONTACT INFORMATION

Billing contact name:_____

Billing contact phone number:_____

Billing contact email address:_____

PART V — AUTHORIZATION

I hereby authorize AmeriHealth Caritas District of Columbia to initiate credit entries, and, in accordance with 31 CFR part 210.6(f), initiate adjustments for any credit entries made in error to the account indicated above. I hereby authorize the financial institution/bank named above, hereinafter called the depository, to credit the same to such account. This authorization agreement is effective as of the signature date below and is to remain in full force and effect until the contractor has received written notification from me of its termination at such time and in such manner as to afford the contractor and the depository a reasonable opportunity to act on it. The contractor will continue to send the direct deposit to the depository indicated above until notified by me that I wish to change the depository receiving the direct deposit. If my depository information changes, I agree to submit to the contractor an

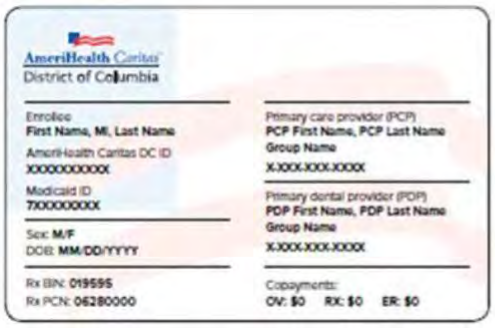
updated EFT Authorization Agreement.

Authorized billing contact signature:_____ Date:_____

Enrollee Eligibility Verification

Enrollee identification card

AmeriHealth Caritas DC enrollees are issued identification cards regularly.



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

AmeriHealth Caritas DC eligibility systems

Enrolled network providers may access enrollee eligibility information by:

- Visiting the provider area of AmeriHealth Caritas DC's website, **www.amerihealthcaritasdc.com**, to access a free, web-based application for electronic transactions and information through a multi-payer portal
- Using the interactive voice response (IVR) system by calling **202-408-2237** or toll free at **1-888-656-2383** and selecting the appropriate prompts
- Calling Provider Services at **202-408-2237** or toll free at **1-888-656-2383**
- Using AmeriHealth Caritas DC's real-time eligibility service. Depending on your clearinghouse or practice management system, our real-time service supports batch access to eligibility verification and system-to-system verification, including point of service (POS) devices.
- Asking to see a enrollee's plan ID card. Enrollees are instructed to keep their ID cards with them at all times. The enrollee's ID card includes:
  - The enrollee's name, AmeriHealth Caritas DC ID number and Medicaid or Alliance ID number
  - The plan's name, address, and Enrollee Services telephone number

NOTE: AmeriHealth Caritas DC ID cards are not returned to the plan when an enrollee becomes ineligible. Presentation of an AmeriHealth Caritas DC ID card is not proof that an individual is currently an enrollee of AmeriHealth Caritas DC. You are encouraged to request a picture ID to verify that the person presenting is the person named on the ID card.

Access to eligibility information via dentists.amerihealthcaritas.com

In addition to the options listed above, AmeriHealth Caritas DC dental providers can access eligibility information via the dental provider website at **www.amerihealthcaritasdc.com**. To access the eligibility information or submit claims, simply log on to the website at **www.amerihealthcaritasdc.com**.

Once you have entered the website, click on Providers. You can then log in using your password and ID. First-time users must register using their AmeriHealth Caritas DC payee ID, office name, and office address. Please refer to your payment remittance or contact Provider Services at **1-855-609-5170** to obtain your payee ID.

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

Transportation benefits for certain enrollees

AmeriHealth Caritas DC Medicaid enrollees who need assistance with transportation may contact **1-800-315-3485. Please call to schedule rides through access to care 2 calendar days prior to the appointment for the most reliable outcomes.**

Specialist Referral Process

A patient requiring a referral to a dental specialist can be referred directly to any specialist contracted with AmeriHealth Caritas DC without authorization from AmeriHealth Caritas DC. The dental specialist is responsible for obtaining prior authorization for services according to Exhibit B of this dental supplement. If you are unfamiliar with the AmeriHealth Caritas DC contracted specialty network or need assistance locating a provider of a certain specialty, please contact Provider Services at **1-855-609-5170**.

Prior Authorization, Retrospective Review, and Documentation Requirements

Authorization procedures

Prior authorization for short procedure unit/ambulatory surgical center (SPU/ASC) admission for dental services is not required when utilizing an AmeriHealth Caritas DC participating facility. Please contact AmeriHealth Caritas DC Provider Services at **1-855-609- 5170** with any questions. Please refer to clinical criteria for guidelines on SPU/ASC admission for dental services.

Procedures requiring prior authorization

AmeriHealth Caritas DC has specific dental utilization criteria, as well as prior authorization and retrospective review processes to manage utilization of services. Consequently, AmeriHealth Caritas DC's operational focus is on assuring compliance with its dental utilization criteria.

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

To ensure timely processing of prior authorization requests, appropriate supporting documentation must be submitted on a standard American Dental Association (ADA) 2019 or newer form or electronically. Lack of supporting documentation may result in a claim denial. Authorization is a utilization tool that requires participating providers to submit documentation associated with certain dental services for an enrollee. Participating providers will not be paid if this documentation is not submitted.

- Authorization and documentation submitted before provider begins (non-emergency) treatment:
  - Services that require authorization (non-emergency) should not be started prior to the determination of coverage (approval or denial of the authorization). Non-emergency treatment started prior to the determination of coverage will be performed at the financial risk of the dental office. If coverage is denied, the treating dentist will be financially responsible and may not balance bill the enrollee, the health plan, or the health plan's vendors.
  - Your submission of documentation should include:
    - Radiographs, narrative, or other information where requested (see Exhibits for specifics by code)
    - Code on Dental Procedures and Nomenclature (CDT) codes on the claim form
  - Your submission should be sent on an ADA 2019 or new form or electronically. The tables of covered services (Exhibits) contain a column marked Authorization Required. A "yes" in this column indicates that the service listed requires authorization (documentation) to be considered for reimbursement.
  - The authorization number will be provided within two business days from the date the documentation is received. Authorization will be issued to the submitting office by mail and must be submitted with the other required claim information after the treatment is rendered.
- Authorization and documentation submitted with claim (emergency treatment):

- AmeriHealth Caritas DC recognizes that emergency treatment may not permit authorization to be obtained prior to treatment. In these situations, services that require authorization but which are rendered under emergency conditions will require the same documentation be provided when the claim is sent for payment. Claims sent without this documentation will be denied.

During the prior authorization process, it may become necessary to have your patient clinically evaluated. If this is the case, you will be notified of a date and time for the evaluation examination. It is the responsibility of the network provider to ensure attendance at this appointment. Patient failure to keep an appointment will result in denial of the prior authorization request.

Please refer to the prior authorization requirements and benefits grid in the Exhibits of this manual for a detailed list of services requiring prior authorization.

Retrospective review

Services that would normally require prior authorization, but are performed in an emergency situation, will be subject to a retrospective review. Claims for these services should be submitted to the address utilized when submitting requests for prior authorization, accompanied by any required supporting documentation. Any claims for retrospective review submitted without the required documents will be denied and must be resubmitted to obtain reimbursement.

Submitting a corrected claim

Submit a corrected claim on the current ADA Dental Claim Form through the Provider Web Portal or via postal mail.

- Identify the claim as Corrected in the Referral # field on in the Provider Web Portal or write "Corrected" across the top of a paper claim form.
- Identify the original Claim/Encounter Number and itemize all corrections in the Remarks section of the Provider Web Portal or write in the Remarks section (Box 35) on a paper ADA form.
- Attach supporting documentation in the Provider Web Portal or send documentation in the same package with the paper claim form.

If sending by mail:

Claims Reprocessing and Adjustments Requests

P.O. Box 541

Milwaukee, WI 53201

Participating hospitals

Participating providers must administer services at hospitals that participate in AmeriHealth Caritas DC's network when services cannot be rendered in the office. Please contact AmeriHealth Caritas DC for a list of participating hospitals.

Claim Submission Procedures

AmeriHealth Caritas DC receives dental claims in four possible formats:

- Electronic claims via the dental provider web portal at **www.amerihealthcaritasdc.com**
- Electronic submission via clearinghouses
- Health Insurance Portability and Accountability Act (HIPAA)-compliant 837D file
- Paper claims

Electronic claim submission using the website

Enrolled network providers may submit claims directly to AmeriHealth Caritas DC by utilizing the provider section of our website. Submitting claims via the website is very quick and easy, at no additional cost to providers. It is especially easy if you have already accessed the site to check a enrollee's eligibility prior to providing the service. To submit claims via the website, simply log on to **www.amerihealthcaritasdc.com.**
If you have questions on submitting claims or accessing the website, please contact Provider Services at **1-855-609-5170.**

Electronic claim submission via clearinghouse

Dentists may also submit their claims to AmeriHealth Caritas DC via a clearinghouse such as DentalXChange.

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

AmeriHealth Caritas DC's payer ID is "AMERIHEALTH CARITAS DC." DentalXChange will ensure claims are submitted successfully to AmeriHealth Caritas DC using this unique payer ID,.

HIPAA-compliant 837D file

For providers who cannot submit electronically via the internet or a clearinghouse, AmeriHealth Caritas DC will, on a case-by-case basis, work with the provider to receive their claims electronically via a HIPAA-compliant 837D file from the provider's practice management system. Please contact Provider Services at **1-855-609-5170** to inquire about this option for electronic claim submission.

Paper claim submission

Claims may be submitted on 2019 ADA or newer-approved claim forms or other forms approved in advance by AmeriHealth Caritas DC. Please reference the ADA website for the most current claim form and completion instructions. Forms are available through the ADA at:

American Dental Association
211 East Chicago Avenue
Chicago, IL 60611
1-800.947.4746

Enrollee name, identification number, and date of birth must be listed on all claims submitted. If the enrollee identification number is missing or miscoded on the claim form, the enrollee cannot be identified. This will result in the claim being returned to the submitting provider office, causing a delay in payment.

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

- Enrollee name — box #12 or #20

- Enrollee DOB — box #13 or #21
- Enrollee ID number — box #15 or #23
- Provider name — box # 53
- Tax ID number — box #51
- NPI — box #49 and box #54
- Payee location — box #48
- Treating location — box #56
- Box number specific to ADA 2012

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

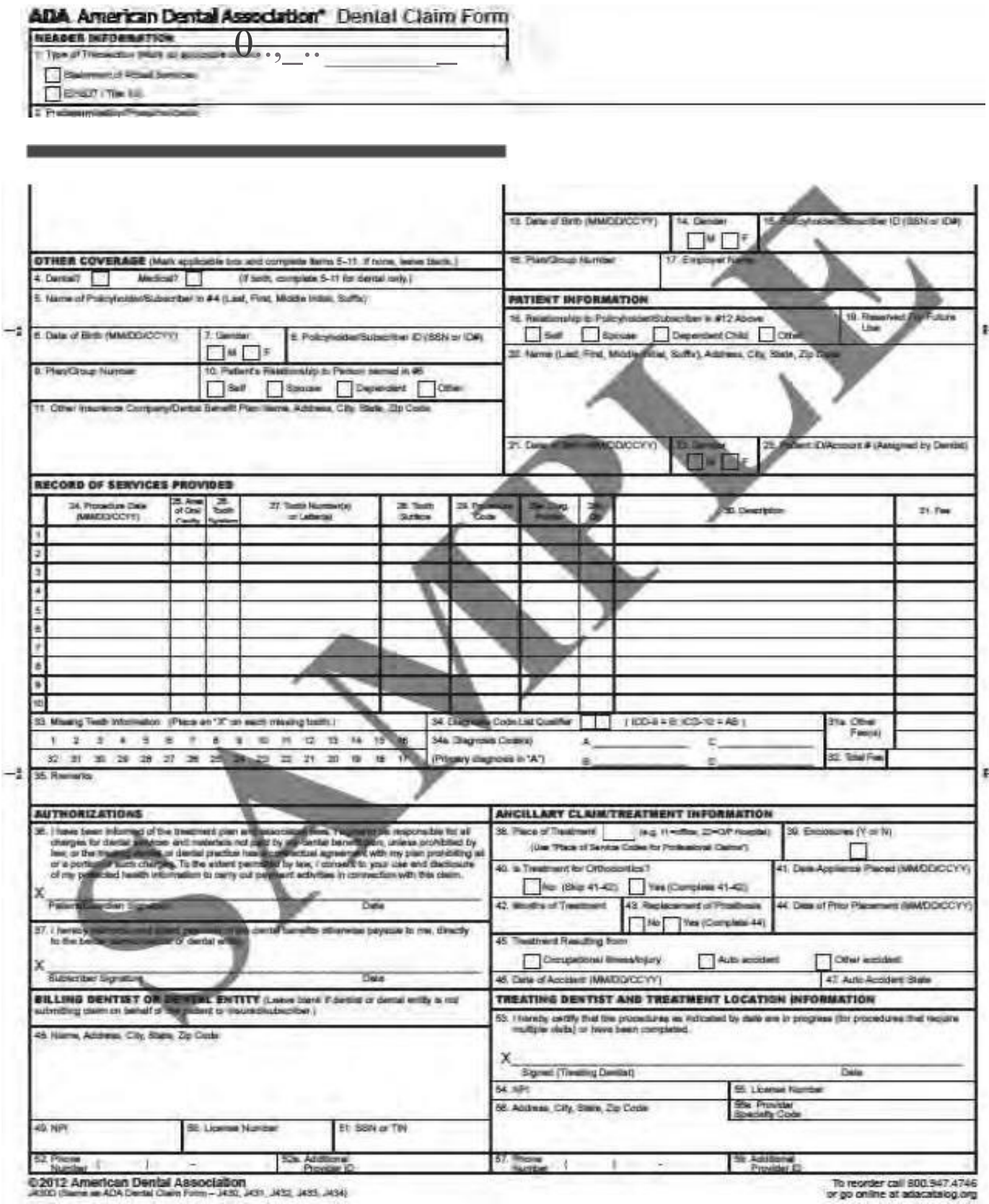
Approved ADA dental codes as published in the current CDT book must be used to define all services.

Providers must list all quadrants, tooth numbers, and surfaces for dental codes that necessitate identification (extractions, root canals, amalgams, and resin fillings). Missing tooth and surface identification codes can result in the delay or denial of claim payment.

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

Claims should be mailed to the following address:

Claim Reprocessing and Adjustment Requests
P.O. Box 541
Milwaukee, WI 53201



ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1 Type of Transaction (Mark all applicable boxes.)
- Statement of Actual Services
- Predetermination / Plan (Est.)

2 Predetermination/Preauthorization

OTHER COVERAGE (Mark applicable box and complete Items 4–11. If none, leave blank.)

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

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

6. Date of Birth (MM/DD/CCYY) | 7. Gender M F | 8. Policyholder/Subscriber ID (SSN or ID#)

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

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

12. Date of Birth (MM/DD/CCYY) | 13. Gender M F | 14. Policyholder/Subscriber ID (SSN or ID#)

15. Plan/Group Number | 16. Employer Name

PATIENT INFORMATION

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

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

20. Date of Service (MM/DD/CCYY) | 21. Gender M F | 22. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

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

31. Missing Teeth Information (Place an "X" on each missing tooth.)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

32. Diagnosis Code List Qualifier (ICD-9 = 0; ICD-10 = AB)

32a. Diagnosis Code(s) (Primary diagnosis in "A")
A _____ C _____
B _____ D _____

33a. Other Fee(s)

33. Total Fee

34. Remarks

AUTHORIZATIONS

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

X _____
Patient/Guardian Signature Date

36. I hereby request that direct payment of my dental benefits otherwise payable to me, directly to the below named provider of dental services.

X _____
Subscriber Signature Date

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

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

38. NPI | 39. License Number | 40. SSN or TIN

41. Phone Number ( ) - | 41a. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

42. Place of Treatment ____ (e.g. 11=office; 22=OP hospital) (Use "Place of Service Codes for Professional Claims") | 43. Enclosures (Y or N)

44. Is Treatment for Orthodontics? No (Skip 44-46) Yes (Complete 44-46) | 45. Date Appliance Placed (MM/DD/CCYY)

46. Months of Treatment | 47. Replacement of Prosthesis No Yes (Complete 48) | 48. Date of Prior Placement (MM/DD/CCYY)

49. Treatment Resulting from: Occupational Illness/Injury Auto accident Other accident

50. Date of Accident (MM/DD/CCYY) | 51. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

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

X _____
Signed (Treating Dentist) Date

53. NPI | 54. License Number

55. Address, City, State, Zip Code | 55a. Provider Specialty Code

56. Phone Number ( ) - | 56a. Additional Provider ID

ADA American Dental Association®
America's leading advocate for oral health

The following information highlights certain form completion instructions. Comprehensive ADA Dental Claim Form completion instructions are printed in the CDT manual. Any updates to these instructions will be posted on the ADA's web site (ADA.org).

GENERAL INSTRUCTIONS

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

B. Complete all items unless noted otherwise on the form or in the CDT manual's instructions.

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

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

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

COORDINATION OF BENEFITS (COB)

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

DIAGNOSIS CODING

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

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

Item 34 – Diagnosis Code List Qualifier (B for ICD-9-CM; AB for ICD-10-CM)

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

PLACE OF TREATMENT

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

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

The full list is available online at "www.cms.gov/Physicians/.../Downloads/Website_POS_database.pdf"

PROVIDER SPECIALTY

This code is entered in Item 58a and indicates the type of dental professional who delivered the treatment. The general code listed as "Dentist" may be used instead of any of the other codes.

Category / Description Code	Code
Dentist A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.), licensed by the state to practice dentistry, and practicing within the scope of that license.	1223D0001X
General Practice	1223G0001X
Dental Specialty (see following list)	Various
Dental Public Health	1223D0001X
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223D0008X
Oral & Maxillofacial Surgery	1223S0112X

Provider taxonomy codes listed above are a subset of the full code set that is posted at "www.wpc-edi.com/reference/taxonomy"

Timely filing limits

Failure to submit claims or failure to submit requested documentation within 365 days from the date of service may result in loss of reimbursement for services provided.

Claims with EOBs from primary insurers must be submitted within 60 days of the date of the primary insurer's EOB. Providers must submit a copy of the primary insurer's EOB. AmeriHealth Caritas DC determines whether a claim has been filed timely by comparing the date of service to the receipt date applied to the claim when the claim is received. If the span between these two dates exceeds the time limitation, the claim is considered to have not been filed timely.

Coordination of benefits (COB)

When AmeriHealth Caritas DC is the secondary insurance carrier, a copy of the primary carrier's Explanation of Benefits (EOB) must be submitted with the claim. For electronic claim submissions, the payment made by the primary carrier must be indicated in the appropriate COB field. When a primary carrier's payment meets or exceeds a provider's AmeriHealth Caritas DC contracted rate or fee schedule, AmeriHealth Caritas DC will consider the claim paid in full, and no further payment will be made on the claim, nor may the enrollee be billed for any outstanding balance.

Third-party liability and coordination of benefits

Third-party liability (TPL) is when the financial responsibility for all or part of a enrollee's health care expenses rests with an individual entity or program (e.g., Medicare, commercial insurance) other than AmeriHealth Caritas DC. COB is a process that establishes the order of payment when an individual is covered by more than one insurance carrier. Medicaid health management organizations (HMOs), such as AmeriHealth Caritas DC, are always the **payer of last resort.** This means that all other insurance carriers (the primary insurers) must consider the health care provider's charges before a claim is submitted to AmeriHealth Caritas DC. Therefore, before billing AmeriHealth Caritas DC when there is a primary insurer, health care providers are required to bill the primary insurer first and obtain an Explanation of Benefits (EOB) statement from the primary insurer. Health care providers may then bill AmeriHealth Caritas DC for the claim by submitting the claim along with a copy of the primary insurer's EOB. See time frames for submitting claims with EOBs from a primary insurer in the section above.

Reimbursement for enrollees with third-party resources

Commercial third-party resources

For services that have been rendered by a network provider, AmeriHealth Caritas DC will pay, up to the AmeriHealth Caritas DC-contracted rate, the lesser of:

- The difference between the AmeriHealth Caritas DC contracted rate and the amount paid by the primary insurer
- The amount of the applicable coinsurance, deductible, and/or copayment.

In any event, the total combined payment made by the primary insurer and AmeriHealth Caritas DC will not exceed AmeriHealth Caritas DC's contracted rate.

If the services are provided by a non-participating provider or if no contracted rate exists, AmeriHealth Caritas DC will pay coinsurance, deductibles, and/ or copayments up to the applicable fee-for-service rate.

Health care providers must comply with all applicable AmeriHealth Caritas DC referral and authorization requirements.

Receipt and audit of claims

To ensure timely, accurate remittances to each dentist, AmeriHealth Caritas DC performs an edit of all claims upon receipt. This edit validates enrollee eligibility, procedure codes and provider identifying information. A dental reimbursement analyst dedicated to AmeriHealth Caritas DC dental offices analyzes any claim conditions that would result in non-payment. When potential problems are identified, your office may be contacted and asked to assist in resolving this problem. Please feel free to contact AmeriHealth Caritas DC's Provider Services at **1-855-609-5170** with any questions you may have regarding claim submission or your remittance.

Each enrolled network provider office receives an EOB report with their remittance. This report includes enrollee information and an allowable fee by date of service for each service rendered during the period.

Payment for non-covered services

Participating providers shall hold enrollees, the health plan, the health plan's vendors, and the state agency harmless for the payment of non-covered services except as provided in this paragraph. Provider may bill an enrollee for non-covered services if the provider obtains a written waiver from the enrollee prior to rendering such service that indicates:

- The services to be provided
- That the health plan, its vendors, and the state agency will not pay for or be liable for said services
- The enrollee will be financially liable for such services

Electronic attachments

FastAttach™ — AmeriHealth Caritas DC's vendor, Skygen, accepts dental radiographs electronically via FastAttach for authorization requests. AmeriHealth Caritas DC, in conjunction with NEA, allows participating providers the opportunity to submit all claims electronically, even those that require attachments. This program allows transmissions via secure Internet lines for radiographs, periodontic charts, intraoral pictures, narratives, and EOBs.

FastAttach is inexpensive and easy to use, reduces administrative costs, eliminates lost or damaged attachments and accelerates claims and prior authorization processing. It is compatible with most claims clearinghouse or practice management systems.

For more information or to sign up for FastAttach, go to **www.nea-fast.com** or call NEA at **1-800-782-5150**.

DentalXChange — DentalXChange's vision is to become the one-stop site for dental providers nationwide who wish to stay at the forefront of technology. They strive to be the best in the dental industry by providing advanced EDI technology and quality customer service.

For more information on DentalXChange, go to **www.dentalxchange.com.**

Dental Connect — Dental Connect's interactive eligibility service enables provider offices to communicate directly with insurance companies to receive patient plan benefits. With Dental Connect, your office is able to check eligibility and benefit information while your patient is still in the office, helping your practice become more efficient. Easily submit all of your insurance claims through your practice management system and quickly check the status of submitted claims with the touch of a button.

For more information on Dental Connect, go to **dental.changehealthcare.com.**

Provider Complaints and Appeals Procedure

Complaints and appeals may be clinical or administrative in nature. Clinical complaints and appeals result from AmeriHealth Caritas DC or health plan actions that were based, in whole or in part, on medical judgment (e.g., medical necessity determinations, experimental or investigational determinations, or cosmetic determinations). Administrative complaints and appeals result from AmeriHealth Caritas DC or health plan actions that are not clinical. Issues for review as administrative appeals or complaints can include, but are not limited to, health plan policy, procedure, claims payment, or any non-clinical aspect of AmeriHealth Caritas DC or health plan functions. Appeals must be filed within 60 days of the action taken by AmeriHealth Caritas DC or the health plan that gave rise to the appeal. Appeals must be filed in writing.

A provider may file an appeal for claims or non-clinical issues at the following submission address:

AmeriHealth Caritas District of Columbia
P.O. Box 231
Milwaukee, WI 53201

A provider may submit a complaint as well. It is beneficial for the provider to clearly outline the reason for their complaint and provide complete information regarding their complaint with supporting documentation. The provider should indicate why a decision should be made in the provider's favor. A written response to an appeal or complaint will be provided within 30 calendar days of receipt.

Providers also have the right to request and receive a written copy of AmeriHealth Caritas DC's utilization management criteria, in cases where the complaint or appeal is related to a clinical decision, denial, or other applicable health plan policies or procedures relevant to the decision or action that the subject of the complaint or is appeal. These can be requested by contacting Provider Services at **1-855-609-5170** or via email at providerservices@scion dental.com.

Operational complaint

An operational complaint is a verbal or written expression that indicates dissatisfaction or dispute with AmeriHealth Caritas DC or the health plan's policies, procedures, or any other aspect of AmeriHealth Caritas DC or health plan functions. A provider has 60 days from the date of the incident, such as the original remit date or date of an adverse determination, to file a complaint.

Enrollee appeal

A enrollee appeal is a request from an enrollee, the enrollee's authorized representative, or a provider acting on the enrollee's behalf for review of a notice of action. A non-legal advocate or the legal representative of a deceased enrollee's estate, with proof of the enrollee's written authorization of consent for the representative to be involved and/or act on the enrollee's behalf, to file an appeal verbally or in writing. The written authorization or consent must comply with applicable laws, contract requirements, and the plan's procedures.

Appeals of denied authorizations and clinical issues can be submitted, with a enrollee's written consent and additional supporting documentation, to the following address:

AmeriHealth Caritas District of Columbia Enrollee Appeals
Enrollee Appeals Coordinator
200 Stevens Drive
Philadelphia, PA 19113

Enrollees may obtain copies (at no charge) of the medical and other documentation on which the decision was based by contacting Enrollee Services at **1-800-408-7510** or **202-408-4823** or by sending a request to AmeriHealth Caritas District of Columbia at the following address:

AmeriHealth Caritas District of Columbia
Attention: Enrollee Advocate
Enrollee Appeal Department
200 Stevens Drive
Philadelphia, PA 19113-1570

If a provider would like to discuss this case with a reviewer, the provider should call the Medical Management department at **1-800-408-7510** or **202-408-4823**.

If an enrollee disagrees with this decision, he or she has the right to appeal it. There are two ways in which an enrollee may appeal: an expedited appeal or standard appeal.

A enrollee may receive assistance from Enrollee Services at **1-800-408-7511** or **202-408-4720** in filing the appeal or to request for an administrative/fair hearing. If an enrollee is not satisfied with the assistance provided by our Enrollee Services department, he or she may contact the District's Ombudsman Program at **202-724-7491** and they will help the enrollee.

Expedited appeal

If an enrollee or the enrollee's provider believes the enrollee's appeal is an emergency and that it would be harmful or painful to the enrollee if the enrollee had to wait for a standard appeal to be decided, the enrollee or the enrollee's provider may request an expedited appeal to AmeriHealth Caritas District of Columbia. If an enrollee wants his or her provider to represent him or her, the enrollee must give the provider written permission.

An expedited appeal can be requested by calling AmeriHealth Caritas District of Columbia's Enrollee Services department at **1-800-408-7511** or **202-408-4720**. A enrollee or his or her provider can fax documents to support the appeal to AmeriHealth Caritas District of Columbia's Quality Management department at **1-888-987-6391**. The enrollee will be notified of AmeriHealth Caritas District of Columbia's decision as soon as possible, but no later than 72 hours after AmeriHealth Caritas District of Columbia's receives the enrollee's request for an expedited appeal.

Standard appeals

A enrollee or his or her provider has the right to appeal this decision to AmeriHealth Caritas District of Columbia within sixty (60) calendar days of the date of the decision by calling Enrollee Services at **1-800-408-7511** or **202 - 408-4720**, by faxing the request to **1-888-987-6391**, or by sending a written notice to:

AmeriHealth Caritas District of Columbia
Attention: Appeal Coordinator
Enrollee Appeal Department
200 Stevens Drive
Philadelphia, PA 19113-1570

If an enrollee files the appeal by telephone, the enrollee must follow up the call with a written, signed appeal letter. AmeriHealth Caritas District of Columbia will help enrollees by writing the appeal letters and sending them to each enrollee for his or her signature.

If the enrollee wants his or her provider to represent him or her, he or she must give the provider written permission.

If a enrollee wishes to have his or her benefits continue during the appeal, the enrollee must file a request within the later of:

- **Ten days from the postmark on the envelope this letter came in**
- **The effective date above**

A enrollee may submit medical information and documents that support his or her appeal and written comments for review to AmeriHealth Caritas District of Columbia. The enrollee will be notified of the decision in writing within 30 calendar days after AmeriHealth Caritas District of Columbia receives the request for a standard appeal.

In addition, an enrollee may file a grievance with AmeriHealth Caritas District of Columbia at any time during the standard appeals process.

A enrollee will receive a call and/or a letter from AmeriHealth Caritas District of Columbia about the results of their appeal within 30 calendar days (for a standard appeal)) or 72 hours (for an expedited appeal) from the date requested.
During a standard or expedited appeal, if the enrollee, his or her advocate, or AmeriHealth Caritas District of Columbia needs more time to review their appeal, the review process can be extended for 14 more days. AmeriHealth Caritas District of Columbia will send a letter within two calendar days of the decision to extend the review time frame.

Administrative/fair hearing

If the enrollee's appeal is upheld, or the enrollee did not received an appeal resolution letter within the time frames noted above, the enrollee has the right to an administrative/fair hearing. An administrative/fair hearing before the District of Columbia Office of Administrative Hearings may be requested by the enrollee, the provider, or other representative (such as a family enrollee or a lawyer). A enrollee must request an administrative/fair hearing within 120 calendar days of the date at the top of the appeal decision letter.

If a enrollee wishes to have his or her benefits continue during the administrative/fair hearing, the enrollee must file the request within the later of:

- **Ten days from the postmark on the envelope this letter came in**
- **The effective date at the top of the appeal decision letter.**

If enrollees still want a service that was not approved through the appeals, expedited appeals, or the fair hearing process, and they do not have written permission from AmeriHealth Caritas District of Columbia, they will have to pay for the service themselves. AmeriHealth Caritas District of Columbia is prohibited from recovering payment for continuation of benefits during a pending appeal or district fair hearing

To request an administrative/fair hearing with the District of Columbia, Office of Administrative Hearings, call or write to:

District of Columbia Office of Administrative Hearings
One Judiciary Square
441 4th Street N.W.
Suite 450 North
Washington, DC 20001
202-442-9094

For assistance in filing a request for an administrative/fair hearing with the District of Columbia, Office of Administrative Hearings, an enrollee may contact Enrollee Services at **1-800-408-7511** or **202-408-4720**. A enrollee may also send a written request to:

AmeriHealth Caritas District of Columbia
Attention: Enrollee Advocate
Enrollee Appeal Department
200 Stevens Drive
Philadelphia, PA 19113-1570

At this administrative/fair hearing, the enrollee may represent him or herself. The enrollee may also have a lawyer, a relative, a friend, or other spokesman represent him or her. The enrollee's representative cannot be a District of Columbia government employee or AmeriHealth Caritas District of Columbia employee. A enrollee may bring witnesses on his or her behalf. AmeriHealth Caritas District of Columbia may pay for a enrollee's reasonable expenses for the hearing, including transportation costs, if the enrollee files a request. The enrollee may also qualify for free legal services from the following free legal service providers:

- **Columbus Community Legal Services**, 3602 John McCormack Road N.E., Washington, DC 20064, (202)-319-6788
- **Neighborhood Legal Services**, 2811 Pennsylvania Ave, S.E., Washington, DC 20020, (202) 832-6577;
- **Legal Aid Society**, 1331 H St. NW, Room 350, Washington, DC 20005, (202) 628-1161
- Terris, Pravlik & Millian, LLP, 1816 12th Street, NW, Washington, DC 20009 (202) 682-0578 (applicable only to children from birth to 20 years of age)

Peer-to-peer review
Providers may contact Provider Services at any time and request a peer-to-peer review regarding a clinical decision made by AmeriHealth Caritas DC.

Peer Review Committee
When submitting a formal appeal, there is an opportunity for providers or their representatives to present their cases in person to the Peer Review Committee.

HIPAA

As a health care provider, you are a covered entity under HIPAA, and you are therefore required to comply with the applicable provisions of HIPAA and its implementing regulations.

In regard to the Administrative Simplification Standards, you will note that the benefit tables included in this *Provider Manual* supplement reflect the most current coding standards recognized by the ADA. Effective the date

of publication of this manual, AmeriHealth Caritas DC will require providers to submit all claims with the proper CDT codes. In addition, all paper claims must be submitted on the current approved ADA 2019 claim form.

For complete detailed information regarding AmeriHealth Caritas DC's HIPAA policies, refer to the *Provider Manual*.

Credentialing

Any D.D.S. or D.M.D. who is interested in participation with AmeriHealth Caritas DC is invited to apply by submitting a credentialing application form for review by the AmeriHealth Caritas DC Credentialing Committee.

Providers who seek participation in the AmeriHealth Caritas DC network must be credentialed prior to participation.

AmeriHealth Caritas DC maintains and adheres to all applicable District and federal laws, regulations, and accreditation requirements governing credentialing and recredentialing functions. All applications reviewed by AmeriHealth Caritas DC must satisfy these requirements, as they apply to dental services, to be admitted to the AmeriHealth Caritas DC provider network.

The process to be credentialed as an AmeriHealth Caritas DC network provider is fast and easy. AmeriHealth Caritas DC has entered into an agreement with the Council for Affordable Quality Healthcare (CAQH) to offer our providers a platform that simplifies and streamlines the data collection process for credentialing and recredentialing. Through CAQH, you provide credentialing information to a single repository via a secure internet site to fulfill the credentialing requirements of all health plans that participate with CAQH. AmeriHealth Caritas DC's goal is to have all of its network providers enrolled with CAQH. There is no charge to providers to submit applications and participate in CAQH. Please access the credentialing page on **www.amerihealthcaritasdc.com** and follow the instructions to begin the application process.

Please refer to the AmeriHealth Caritas DC *Provider Manual* for complete and detailed credentialing information.

Medical Recordkeeping

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

AmeriHealth Caritas DC's expectation is that every participating provider will submit claims for services in an accurate and ethical fashion reflecting the appropriate level and scope of services performed, and that network k providers are compliant with these requirements.

AmeriHealth Caritas DC will periodically conduct random chart audits to determine network providers' compliance with these conditions and expectations, as a component of AmeriHealth Caritas DC's Quality Management Program. Network providers are expected to supply, upon request, complete copies of enrollee dental records. The records are reviewed by AmeriHealth Caritas DC's Dental Director, or his or her designee, such as a registered dental hygienist, to determine the rate of compliance with medical recordkeeping requirements as well as the accuracy of the dental claims submitted for payment. All dental services performed must be recorded in the patient record, which must be made available as required by your Participating Provider Agreement.

The first part of the audit will consist of the charts being reviewed for compliance with the stated recordkeeping requirements, utilizing a standardized audit tool. The charts are reviewed and a composite score is determined. Offices with scores above 80 percent are considered as passing the audit, but a corrective action letter is sent to them so that they are aware of the areas that need improvement; offices that receive a score of 95 percent or greater are exempt from the audit the following year. Offices with scores less than 80 percent will have a corrective action letter sent and are re-reviewed for compliance within the next 90 days. Offices that do not cooperate with improving their scores are subject to disciplinary action in accordance with AmeriHealth Caritas DC's Provider Sanctioning Policy.

The second portion of the audit consists of a billing reconciliation whereby the patient treatment notes are compared to the actual claims submitted for payment by each dental office. The records are analyzed to determine if the patient record documents the performance of all the dental services that have been submitted for payment. Any

services not documented are recouped, and the records may be subject to additional review and follow-up by AmeriHealth Caritas DC's Special Investigations Unit.

Results of both parts of the audit are entered into a tracking database at AmeriHealth Caritas DC and then reported back to each office in a summary of finding format.

AmeriHealth Caritas DC recognizes tooth letters A through T for primary teeth and tooth numbers 1 to 32 for permanent teeth. Supernumerary teeth should be designated by using codes AS through TS or 51 through 82. Designation of the tooth can be determined by using the nearest erupted tooth. If the tooth closest to the supernumerary tooth is 1, then the supernumerary tooth should be charted as 51; likewise, if the nearest tooth is A, the supernumerary tooth should be charted as AS. These procedure codes must be referenced in the patient's file for record retention and review. Patient records must be kept for a minimum of seven years from the date of the last dental entry.

Please refer to the AmeriHealth Caritas DC Provider Manual for more information.

Health Guidelines — Ages 0 – 20

Recommendations for pediatric oral health assessment, preventive services, and anticipatory guidance/counseling

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

Refer to the guideline below from AAPD for supporting information and references.

DC Medicaid HealthCheck
Dental Periodicity Schedule

The DC HealthCheck Dental Periodicity Schedule follows the American Academy of Pediatrics Dentistry Periodicity Schedule oral health recommendations in consultation with the local dental community. This schedule is designed for the care of children who have no contributing medical conditions and are developing normally. The DC HealthCheck Dental Periodicity Schedule will be modified for children with special health care needs or if disease or trauma manifests variations from normal.

Age	Birth - 11 months	12 - 23 months	24 - 35 months	3 - 5 years	6 - 11 years	12 years & older
Clinical oral screening[1]	•	•	•	•	•	•
Assess oral growth & development[2]	•	•	•	•	•	•
Referral for regular & periodic dental care[3]		•	•	•	•	•
Counseling for nonnutritive habits[4]	•	•	•	•	•	•
Oral hygeine counseling[5]	•	•	•	•		•
Dietary counseling[6]; injury prevention counseling[7]	•	•	•	•	•	•
Fluoride supplementation[8]		•	•	•	•	•
Radiographic assessment[9]			•	•	•	•
Pit & fissure sealants[10]			•	•	•	•
Assessment & treatment of developing malocclusion				•	•	•
Assessment & removal of 3rd molars						•
Substance abuse counseling[11]					•	•
Anticipatory guidance[12]	•	•	•	•	•	•

NOTES

1. The Primary Care Physician (PCP)/Pediatrician should perform the first/initial oral health screening following AAP guidelines.
2. An oral assessment can be done by the PCP/Pediatrician up to age 3. Every infant should receive an oral health risk assessment from his/her primary health care provider or qualified health care professional by 6 months of age that includes: (1) assessing the patient's risk of developing oral disease using the AAPD Caries-risk Assessment Tool; (2) providing education on infant oral health; and (3) evaluating and optimizing fluoride exposure.
3. All children in DC should be referred to a dentist for the establishment of a dental home no later than age 3. Children covered under Medicaid and children determined by the PCP/Pediatrician to be at risk for dental caries should be referred to a dentist as early as 6 months after the first tooth erupts, or 12 months of age (whichever comes first) for establishment of a dental home. Children at risk are defined as:
   - Children with Special Health Care Needs
   - Chidren of mothers with high caries rate
   - Children with demonstrable caries, plaque, demineralization, and/or staining
   - Children who sleep with a bottle or breastfeed throughout the night
   - Later-order offspring
   - Children in families of low socioeconomic status

   Once dental care is established with a dental professional, it is recommended and is the right of every child enrolled in Medicaid to see Dentist every 6 months
4. At first discussion for the need for additional sucking: digits vs. pacifiers; then the need to wean from the habit before malocclusion or skeletal dysphasia occurs.
5. For school-aged children and adolescent patients, counsels regarding any existing habits such as fingernail biting, clenching or bruxism. Counseling is given to parents/guardians/caregivers up to age 2. At age 2, the provider should include the patient/child in the counseling. For children above 12 years and older, counseling need only be done with the child/patient if dentist feels this is appropriate – Otherwise include the parents.
6. At every screening discuss the role of refined carbohydrates, frequency of snacking, etc.
7. Initial discussions should include play objects, pacifiers, and car seats; when learning to walk, include injury prevention. For school-age children and adolescent patients, counseling regarding sports and routine playing.
8. Fluoride varnish, as indicated by the child's risk for caries and periodontal disease and the water source. (Performed by dental professional only).
9. As per AAPD "Clinical guideline on prescribing dental radiographs." (Performed by dental professional only).
10. For caries-susceptible primary molars, permanent molars, premolars and anterior teeth with deep pits and/or fissures; placed as soon as possible after eruption. (Performed by dental professional only).
11. Provide substance abuse counseling on topics such as smoking and smokeless tobacco.
12. Appropriate oral health discussion and counseling should be an integral part of each visit for care. (Performed by dental professional only).

Medicaid Clinical Criteria for Prior Authorization of Treatment and Emergency Treatment

Criteria for dental extractions

Documentation needed for authorization procedure:

- **Do not routinely submit D7210 for all extractions.**
- Submission for D7210 requires consultant review at authorization submission including x-rays and a narrative of medical necessity.
- Treatment documentation may be required for claims reimbursement upon request.
- Appropriate radiographs clearly showing the tooth should be submitted for authorization review: bitewings, periapicals, or panorex
- Treatment rendered under emergency conditions or when authorization is not possible will still require that appropriate radiographs clearly showing the tooth be submitted with the claim for review for payment
- Narrative demonstrating medical necessity should be included, when appropriate and requested

Criteria

- The prophylactic removal of asymptomatic teeth (i.e., third molars) or teeth exhibiting no overt clinical pathology (for orthodontics) may be covered subject to consultant review
- The removal of primary teeth whose exfoliation is imminent does not meet criteria
- Alveoloplasty (code D7310) in conjunction with three or more extractions in the same quadrant will be covered subject to consultant review

Criteria for cast crowns

Documentation needed for authorization of procedure:

- Appropriate radiographs clearly showing the adjacent and opposing teeth should be submitted for authorization review: bitewings, periapicals or panorex
- Treatment rendered without necessary authorization will still require that sufficient and appropriate radiographs clearly showing the tooth be submitted with the claim for review for payment

Criteria

- In general, criteria for crowns will be met only for permanent teeth needing multi-surface restorations where other restorative materials have a poor prognosis
- Permanent molar teeth must have pathologic destruction to the tooth by caries or trauma, and should involve four or more surfaces and two or more cusps
- Permanent bicuspid teeth must have pathologic destruction to the tooth by caries or trauma, and should involve three or more surfaces and at least one cusp
- Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma, and must involve four or more surfaces and at least 50 percent of the incisal edge
- A request for a crown following root canal therapy must meet the following criteria:
    - Request should include a dated post-endodontic radiograph
    - Tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the ability to fill the canal to the apex
    - The filling must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.

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

- The patient must be free from active and advanced periodontal disease
- The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent teeth
- The fee for crowns includes the insertion and adjustment of the permanent crown
- Cast crowns on permanent teeth are expected to last, at minimum, five years.

Authorizations for crowns will not meet criteria if:

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

Criteria for endodontics

Documentation needed:

- Sufficient and appropriate radiographs clearly showing the tooth and a pre-operative radiograph of the tooth to be treated: periapicals or panorex. A dated pre-operative and post-operative radiographs must be submitted for review for payment.
- Treatment rendered under emergency conditions will require that appropriate radiographs clearly showing the pre-operative and post-operative radiographs of the tooth treated with the claim for retrospective review for payment.
- In cases where pathology is not apparent, a written narrative justifying treatment is required

Criteria

Root canal therapy is performed to maintain teeth that have been damaged through trauma or carious exposure.

Root canal therapy must meet the following criteria:

- Fill should be sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the dentist's ability to fill the canal to the apex
- Fill must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.

Authorizations for root canal therapy will not meet criteria if:

- Gross periapical or periodontal pathosis is demonstrated radiographically (caries subcrestal or to the furcation, deeming the tooth non-restorable)
- The general oral condition does not justify root canal therapy due to loss of arch integrity
- Root canal therapy is for third molars, unless they are an abutment for a partial denture
- Tooth does not demonstrate 50 percent bone support
- Root canal therapy is in anticipation of placement of an overdenture
- A filling material is not accepted by the Federal Food and Drug Administration (FDA; e.g., Sargenti filling material)

Other considerations

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

Criteria for stainless steel crowns

In most cases, authorization is not required. Where authorization is required for primary or permanent teeth, the following criteria apply:

Documentation needed for authorization of procedure:

- Appropriate radiographs clearly showing the tooth should be submitted for authorization review: bitewings, periapicals or panorex
- Treatment rendered under emergency conditions, when authorization is not possible, will still require that appropriate radiographs clearly showing the tooth be submitted with the claim for review for payment
- Narrative demonstrating medical necessity should be included if radiographs are not available

Criteria

- In general, criteria for stainless steel crowns will be met only for teeth needing multi-surface restorations where amalgams and other materials have a poor prognosis
- Permanent molar teeth must have pathologic destruction to the tooth by caries or trauma, and should involve four or more surfaces and two or more cusps
- Permanent bicuspid teeth must have pathologic destruction to the tooth by caries or trauma, and should involve three or more surfaces and at least one cusp
- Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma, and should involve four or more surfaces and at least 50 percent of the incisal edge
- Primary molars must have pathologic destruction to the tooth by caries or trauma, and should involve two or more surfaces or substantial occlusal decay resulting in an enamel shell

An authorization for a crown on a permanent tooth following root canal therapy must meet the following criteria:

- Request should include a dated post-endodontic radiograph
- Tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the dentist's ability to fill the canal to the apex
- The filling must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.

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

- The patient must be free from active and advanced periodontal disease
- The permanent tooth must be at least 50 percent supported in bone
- Stainless steel crowns on permanent teeth are expected to last five years
- Authorization and treatment using stainless steel crowns will not meet criteria if:
  - A lesser means of restoration is possible
  - Tooth has subosseous and/or furcation caries
  - Tooth has advanced periodontal disease
  - Tooth is a primary tooth with exfoliation imminent
  - Crowns are being planned to alter vertical dimension

Criteria for removable prosthodontics (full and partial dentures)

Documentation needed for authorization of procedure:

Treatment plan

- Appropriate radiographs clearly showing the adjacent and opposing teeth must be submitted for authorization review: bitewings, periapicals or panorex
- Treatment rendered without necessary authorization will still require appropriate radiographs clearly showing the adjacent and opposing teeth be submitted with the claim for review for payment

Criteria

Prosthetic services are intended to restore oral form and function due to premature loss of permanent teeth that would result in significant occlusal dysfunction.

- A denture is determined to be an initial placement if the patient has never worn a prosthesis. This does not refer to just the time a patient has been receiving treatment from a certain provider.
- Partial dentures are covered only for recipients with good oral health and hygiene, good periodontal health (American Academy of Periodontology [AAP] type I or II), and a favorable prognosis where continuous deterioration is not expected
- Radiographs must show no untreated cavities or active periodontal disease in the abutment teeth, and abutments must be at least 50 percent supported in bone
- As part of any removable prosthetic service, dentists are expected to instruct the patient in the proper care of the prosthesis
- In general, if there is a pre-existing removable prosthesis (including partial and full dentures), it must be at least five years old and unserviceable to qualify for replacement
- A partial denture that replaces only posterior permanent teeth must include three or more teeth on the dentures that are anatomically correct (natural size, shape, and color) to be compensable (excluding third molars). Partial dentures must include one anterior tooth and/or three posterior teeth (excluding third molars).
- Fabrication of a removable prosthetic includes multiple steps (appointments); these multiple steps (e.g., impressions, try-on appointments, delivery, and adjustments) are included in the fee for the removable prosthetic and are not eligible for additional compensation
- The replacement teeth should be anatomically full-sized teeth

Authorizations for removable prosthesis will not meet criteria:

- If there is a pre-existing prosthesis which is not at least five years old and unserviceable
- If good oral health and hygiene, good periodontal health, and a favorable prognosis are not present
- If there are untreated cavities or active periodontal disease in the abutment teeth
- If abutment teeth are less than 50 percent supported in bone
- If the recipient cannot accommodate and properly maintain the prosthesis (e.g., gag reflex, potential for swallowing the prosthesis, or severe disability)
- If the recipient has a history of an inability to wear a prosthesis due to psychological or physiological reasons
- If a partial denture, less than five years old, is converted to a temporary or permanent complete denture
- If extensive repairs are performed on marginally functional partial dentures, or when a new partial denture would be better for the health of the recipient. However, adding teeth and/or a clasp to a partial denture is a covered benefit if the addition makes the denture functional.

Criteria

If there is a pre-existing prosthesis, it must be at least five years old and unserviceable to qualify for replacement.

- Adjustments, repairs, and relines are included with the denture fee within the first six months after insertion.
- There will be no reimbursement within 24 months of a reline or repair of the existing prosthesis unless adequate documentation has been presented that all procedures to render the denture serviceable have been exhausted
- Adjustments will be reimbursed at one per calendar year per denture
- Repairs will be reimbursed at two repairs per denture per year, with five total denture repairs per five years
- Relines will be reimbursed once per denture every 36 months
- Replacement of lost, stolen, or broken dentures less than five years old usually will not meet criteria for pre-authorization of a new denture
- The use of preformed dentures with teeth already mounted (that is, teeth set in acrylic before the initial impression) cannot be used for the fabrication of a new denture
- All prosthetic appliances shall be inserted in the mouth and adjusted before a claim is submitted for payment
- When billing for partial and complete dentures, dentists must list the date that the dentures or partials were inserted as the date of service. Recipients must be eligible on that date for the denture service to be covered.

Criteria for the excision of bone tissue

To ensure the proper seating of a removable prosthetic (partial or full denture) some treatment plans may require the removal of excess bone tissue prior to the fabrication of the prosthesis. Clinical guidelines have been formulated for the dental consultant to ensure that the removal of tori (mandibular and palatal) is an appropriate course of treatment prior to prosthetic treatment.

Code D7471 (CDT–4) is related to the removal of the lateral exostosis. This code is subject to authorization and may be reimbursed for when submitted in conjunction with a treatment plan that includes removable prosthetics. These determinations will be made by the appropriate dental specialist/consultant.

Authorization requirements:

- Appropriate radiographs and/or intraoral photographs or bone scans which clearly identify the lateral exostosis must be submitted for authorization review: bitewings, periapicals, or panorex
- Treatment plan should include prosthetic plan
- Narrative of medical necessity should be included, if appropriate
- Study model or photo clearly identifying the lateral exostosis to be removed should be included

Criteria for the determination of a non-restorable tooth

In the application of clinical criteria for benefit determination, dental consultants must consider overall dental health. A tooth that is determined to be non-restorable may be subject to an alternative treatment plan.

A tooth may be deemed non-restorable if one or more of the following criteria are present:

- The tooth presents with greater than a 75 percent loss of the clinical crown
- The tooth has less than 50 percent bone support
- The tooth has subosseous and/or furcation caries
- The tooth is a primary tooth with exfoliation imminent
- The tooth apex is surrounded by severe pathologic destruction of the bone
- The overall dental condition (i.e., periodontal) of the patient is such that an alternative treatment plan would be better suited to meet the patient's needs

Criteria for general anesthesia and intravenous (IV) sedation

Documentation needed for authorization of procedure:

- Treatment plan (authorized if necessary)
- Narrative describing medical necessity for general anesthesia or IV sedation
- Submission of treatment plan and narrative of medical necessity with the claim for review for payment even for treatment rendered under emergency conditions, when authorization is not possible.
    - Submission of more than three units will require treatment notes for reimbursement and should be submitted with the claim after authorization submission.

Criteria

Requests for general anesthesia or IV sedation will be authorized (for procedures covered by the health plan) if any of the following criteria are met:

- Extensive or complex oral surgical procedures such as:
    - Removal of impacted wisdom teeth
    - Surgical root recovery from maxillary antrum
    - Surgical exposure of impacted or unerupted cuspids
    - Radical excision of lesions in excess of 1.25 cm

- And/or one of the following medical conditions:
    - Medical condition(s) which require monitoring (e.g., cardiac problems or severe hypertension)
    - Underlying hazardous medical condition (cerebral palsy, epilepsy, or mental retardation, including Down syndrome) which would render patient noncompliant
    - Documented failed sedation or a condition where severe periapical infection would render local anesthesia ineffective
    - Patients 9 years old and younger with extensive procedures to be accomplished
    - Four or more teeth in one quadrant
    - Two or more teeth in two or more quadrants

Criteria for short procedure units (SPU)

Criteria

- Young children requiring extensive operative procedures such as multiple restorations, treatment of abscesses, or oral surgical procedures if authorization documentation indicates that in-office treatment (nitrous oxide or IV sedation) is not appropriate and hospitalization is not solely based upon reducing, avoiding, or controlling apprehension
- Patients requiring extensive dental procedures and classified as American Society of Anesthesiologists (ASA) classes III (patients with uncontrolled disease or significant systemic disease; for example, poorly controlled hypertension, poorly controlled diabetes, upper respiratory infection, an arrhythmia, recent myocardial infarction, recent stroke, or new chest pain) and IV (patients with severe systemic disease that is a constant threat to life)
- Medically compromised patients whose medical history indicates that the monitoring of vital signs or the availability of resuscitative equipment is necessary during dental procedures
- Patients requiring extensive dental procedures with a medical history of uncontrolled bleeding, severe cerebral palsy, or other medical condition that renders in-office treatment not medically appropriate
- Patients requiring extensive dental procedures who have documentation of psychosomatic disorders that require special treatment

Criteria for periodontal treatment

Documentation needed for authorization of procedure:

- Radiographs: periapicals or bitewings preferred
- Complete periodontal charting with AAP case type

Treatment plan

Periodontal scaling and root planing per quadrant involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. It is indicated for patients with periodontal disease and is therapeutic, not prophylactic, in nature. Root planning is the definitive procedure designed for the removal of cementum and dentin that is rough and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and as a part of pre-surgical procedures in others.

It is anticipated that this procedure would be requested in cases of severe periodontal conditions (e.g., late type II, III, and IV periodontitis) where definitive comprehensive root planning requiring local or regional block anesthesia and several appointments would be indicated.

From the AAP Policy on Scaling and Root Planning:

"Periodontal scaling is a treatment procedure involving instrumentation of the crown and root surfaces of the teeth to remove plaque, calculus, and stains from these surfaces. It is performed on patients with periodontal disease and is therapeutic, not prophylactic, in nature. Periodontal scaling may precede root planning, which is the definitive, meticulous treatment procedure to remove cementum and/or dentin that is rough and may be permeated by calculus, or contaminated with toxins or microorganisms. Periodontal scaling and root planning are arduous and time consuming. They may need to be repeated and may require local anesthetic."

Criteria

- A minimum of four teeth affected in the quadrant
- Periodontal charting indicating abnormal pocket depths in multiple sites
- Additionally, at least one of the following:
  - Radiographic evidence of root surface calculus
  - Radiographic evidence of noticeable loss of bone support

Orthodontic services for enrollees ages 0 – 20.

Medicaid enrollees age 20 and younger may qualify for orthodontic care under the District of Columbia Medicaid program. Enrollees must have a severe, dysfunctional, handicapping malocclusion. Since a case must be dysfunctional to be accepted for treatment, enrollees whose molars and bicuspids are in good occlusion seldom qualify. Crowding alone is usually not dysfunctional in spite of the aesthetic considerations.

All orthodontic services require prior authorization by a AmeriHealth Caritas DC dental consultant. The enrollee should present with a fully erupted set of permanent teeth. At least ½ to ¾ of the clinical crown should be exposed, unless the tooth is impacted or congenitally missing.

There are three avenues for orthodontic coverage:

(1) Having a minimum score on the Handicapping Labio-Lingual Deviation (HLD) index of 15 or greater

(2) Exhibiting one of six automatic qualifying conditions

(3) Otherwise established a medical need for orthodontic treatment by demonstrating two (2) or more of the conditions below and justified the need in an accompanying narrative prepared by the ordering or referring dentist, orthodontist, primary care physician, speech pathologist, or behavioral health provider:

(1) A speech pathology that has proven non-responsive to medical treatment without orthodontic treatment, which has been diagnosed by a licensed speech therapist;

(2) Dysfunctional masticatory capacity as a result of the existing relationship between the maxillary and mandibular arches;

(3) Significant facial asymmetry;

(4) Severe maxillary, mandibular, or bi-maxillary protrusion or other physical deviation; or

a. (5) Other conditions that affect the medical, social, or emotional function of the patient as demonstrated by objective evidence provided by the patient's primary care physician or behavioral health provider

Before delivering an orthodontic service, each provider shall request prior authorization. To be eligible for orthodontia services, the beneficiary's dental or orthodontia provider shall demonstrate that the beneficiary meets at least one of the following criteria:

1) A enrollee must have an HLD score greater than or equal to 15
2) A enrollee must exhibit one or more of the following automatic qualifying conditions that cause dysfunction due to a handicapping malocclusion and are supported by evidence in the beneficiary's treatment records:
   a) Cleft palate deformity
   b) Cranio-facial anomaly
   c) Deep impinging overbite causing the destruction of soft tissues of the palate where tissue laceration and/or clinical attachment loss are present
   d) Crossbite of individual anterior teeth causing clinical attachment loss where recession of the gingival margins is present
   e) Severe traumatic deviation
   f) Overjet greater than 9 mm or mandibular protrusion greater than 3.5 mm

The following documentation must be submitted with the request for prior authorization services:

- ADA 2019 or newer claim form with service code requested
- Five to seven diagnostic-quality photos
- Cephalometric head film with measurements
- Panoramic or full series periapical radiographs
- Clinical summary with diagnosis
- HLD score sheet completed and signed by the orthodontist
- Treatment plan

Treatment should not begin prior to receiving notification from AmeriHealth Caritas DC indicating coverage or non-coverage for the proposed treatment plan. Orthodontists who begin treatment before receiving their approved (or denied) prior authorization are financially obligated to complete treatment at no charge to the enrollee or face possible termination of their Participating Provider Agreement. Providers cannot bill prior to services being performed. The starting and billing date of orthodontic services is defined as the date when the bands, brackets, or appliances are placed in the enrollee's mouth. The initial payment for orthodontics (code D8080) includes initial banding, de-banding, one set of retainers, and adjustments (the number of adjustments depends on the plan).

All orthodontic providers should provide a document prior to beginning treatment for the signature of the enrollee or their parent/ guardian acknowledging their understanding that the benefit terminates at

age 21. The document should also state that any fees related to the continuation of orthodontic treatment at age 21 will become the responsibility of the signatory to the document or the enrollee at the age of 21. The fees apply regardless of when treatment began.

To guarantee proper and prompt payment of orthodontic cases, please follow the steps below:

- Submit a completed ADA 2019 (or newer) claim for prior authorization of comprehensive orthodontic treatment listing D8080 (comprehensive orthodontic treatment). Do not submit D8660 (orthodontic records) and D8670 (periodic orthodontic treatment visits) on a prior authorization. They are generated automatically with the D8080. Please note that, if an appliance is medically necessary, you should include D8220 (fixed appliance therapy) and/or D8210 (removable appliance therapy) in the prior authorization request with information related to which arch the appliance will be placed at and the medical necessity for the appliance.
- Once the determination has been made on the comprehensive orthodontic treatment, submit a separate claim for reimbursement of records (D8660) with the date records were taken. D8660 will only be paid in conjunction with comprehensive orthodontic treatment (D8080).
- When brackets and bands have been placed in the enrollee's mouth, submit a separate claim for reimbursement for comprehensive orthodontic treatment (D8080) with the banding date
- When the habit appliance is placed in the enrollee's mouth, submit a separate claim for reimbursement of the habit appliance (D8220 or D8210)
- Providers must submit claims for periodic treatment visits (D8670). The enrollee must be eligible on each date of service.
- Electronically file, fax, or mail a copy of the completed ADA form with the date of service filled in. Our fax number is **262-241-7150**.

The maximum case payment for orthodontic treatment is:

- One records fee (D8660)
- One initial payment (D8080)
- One appliance (D8220), if medically necessary
- One removable appliance (D8210), if medically necessary
- Twenty-one monthly adjustments submitted (D8670)
- Two orthodontic retentions (D8680)
- Additional periodic treatment visits beyond 21 monthly adjustments will be the provider’s financial responsibility and not the member’s
- Enrollees may not be billed for broken, repaired, or replacement brackets or wires

Dental Implant Benefit Policy

Revised: July 2016

Version Two

AmeriHealth Caritas District of Columbia

Dental Implant Benefit Criteria and Documentation

AmeriHealth Caritas District of Columbia has implemented a "Dental Implant Benefit" for Medicaid enrollees. In order to enhance the favorable delivery of the dental implant benefit for our Medicaid enrollees and ensure its long-term success, consideration of the following criteria is required:

- A team approach of specialists, who can develop a multi-disciplinary treatment plan.
- Dental Implant placement that is both biologically and restoratively driven.
- Dental Implant placement following a comprehensive examination and accurate diagnosis which will lead to a prognosis for each individual tooth and the overall dentition.
- Dental Implant reconstruction that obtains optimal aesthetics and function.
- Effective communication between the team and the patient.
- Aligning expectations with a correct diagnosis and a logical inter-disciplinary treatment plan.

Options of treatment for tooth loss will be considered in the following order:

- No treatment
- A Removable Denture (Complete or Partial)
- Dental Implant treatment **(Requires a Narrative as to why other options are not suitable)**

The restorative dentist should develop and direct the plan after gathering data, which includes a complete medical and dental history, clinical findings, and radiographs. Consultation with other specialists (such as Periodontist, Oral Surgeon, Orthodontist, Endodontist) regarding the periodontal and endodontic health, and any occlusal, skeletal and space problems may be required. There should be no other routine periodontal or restorative treatment needed when requesting authorization for dental implant placement. A detailed risk analysis should be part of the decision-making process during treatment planning.

Diagnosis and Treatment Plan coordination:

- Dental and social history
- Medical history
- Extra-oral examination including lip and smile lines
- Intra-oral examination **including full periodontal charting**
- Diagnostic imaging (may be deferred for construction of a radiological stent)
- Additional investigations as needed
- Diagnosis and treatment plan presentation
- Written treatment plan
- Patient education and signed informed consent form
- Communication with other enrollees of the team and the referring practitioners (The *Restorative Dentists Evaluation Form* will demonstrate the collaboration)

The following risk factors may make implant placement unsuitable and contraindicated and therefore exclude a patient's eligibility for a dental implant:

- Uncontrolled diabetes

- Immunosuppression or certain medication like bisphosphonates
- Smoking
- Poor bone quality and density
- Periodontal disease and/ or poor dental hygiene
- Occlusal trauma
- Parafunctional habits and bruxism
- Endodontic/periapical lesions in adjacent teeth
- Unrealistic patient expectations
- Poor soft tissue biotype
- Radiotherapy to the jaw bone
- Untreated intraoral pathology or malignancy
- Uncontrolled drug or alcohol use (substance abuse)
- Uncontrolled psychiatric disorders
- Recent myocardial infarction (MI) or cerebrovascular accident (CVA)
- Reduced manual dexterity or mental capacity

Other factors will be considered in the authorization process such as:

Age
Dental implants are effectively ankylosed to the bone, for this reason dental implants are not placed until the facial skeleton has stopped growing; this being usually at 18 years of age.
An enrollee must be a minimum of 18 years old for a dental implant placement.

Grafting
The need for grafting to enhance the ridge or augment the sinus or other structures will be considered based on other procedures associated with implant placement.

Mini Dental Implants
Mini Dental Implants are excluded.

Limitations

Overdenture Treatment options will have the following limitations:

2 (two) Dental Implants in the Mandible
4 (four) Dental Implants in the Maxilla

Individual Dental Implants

Maximum two dental implants per arch per lifetime (Three missing teeth are required for a removable partial denture)

Authorization Process

Required Documentation:

D6010 - Surgical Placement of Implant Body: Endosteal Implant

- ☐ Restorative Dentists Evaluation form
- ☐ X-rays/Imaging
- ☐ Periodontal charting
- ☐ Treatment plan (Include discussion on placement of the dental implant in relation to vital structures,
  i.e. inferior alveolar nerve, sinus, adjacent roots, etc.)
- ☐ Signed informed consent form by the enrollee
- ☐ Narrative on the reason for exclusion of other treatment options

The Current Dental Terminology (CDT) code D6010 should be submitted by the Dentist placing the Implant. A waiting period will follow with the subsequent authorization for codes D6056 and D6058. X-rays should demonstrate good sound bone, no pathology of other adjacent teeth, and opposing teeth to the implant area.

D6056 and D6058 - Prefabricated Abutment and Abutment Supported Crown

These CDT codes should be submitted together with an x-ray demonstrating good osseointegration after a sufficient waiting period. The waiting period shall be no less than 90 days. The date of implant placement should be indicated on the authorization request. This should be submitted by the Restoring Dentist.

D6110, D6111, D6112, D6113 – Implant Supported Removable Dentures for Edentulous Arch and Removable Partial Dentures for Partially Edentulous Arch

These CDT codes should be submitted for authorization after the surgical dental implant placement with x-rays to demonstrate good osseointegration, missing teeth to be replaced, and opposing teeth. The restoration of the implants shall not take place less than 90 days from implant placement. The implant placement date should be included on the request for authorization. This should be submitted by the Restoring Dentist.

D5982 Surgical Stent

This code does not apply to implant placement and should not be considered as a surgical guide for implant placement. Do not submit this Code in conjunction with implant placement.

References

Surgical guidelines for dental implant placement
M Handelsman[1] *British Dental Journal* **201**, 139 - 152 (2006)

ADI Implant Placement Guidelines
Association of Dental Implantology

Restorative Dentists Evaluation Form

Enrollee Name and ID: _____

Restoring Dentist: _____
(Should submit for restoration authorization after osseointegration)

Dental Implant Placement Dentist:

_____ _____
(Should submit for Implants)

Number of Dental Implants: Maxilla _____ Mandible_____

Tooth Numbers Being Replaced (3-14, 19-30 only; must be opposed): _____

Age of the Patient: _____(Minimum 18 Years Old)

Submitted Documentation:

_____X-rays/ Imaging
_____Periodontal Charting
_____Treatment Plan
_____Signed Enrollee Informed Consent Form
_____Narrative on Exclusion of Other Treatment Options

Does the patient have one or more of the following conditions?

Yes No
___ ____Diabetes
___ ____Immunosuppression therapy
___ ____Smoker
___ ____Periodontal Disease
___ ____Occlusal trauma
___ ____Parafunctional habits and bruxism
___ ____Endodontic/periapical lesions in adjacent teeth
___ ____Radiotherapy to the jaw bone
___ ____Untreated intraoral pathology or malignancy
___ ____Substance abuse
___ ____Mental Health Condition
___ ____Recent myocardial infarction (MI) or cerebrovascular accident (CVA
___ ____Reduced manual dexterity or mental capacity
___ ____Does the treatment involve grafts/ sinus lift?
___ ____Does the treatment involve an overdenture?

Signature: _____ Date: _____
Restoring Dentist

HANDICAPPING LABIO-LINGUAL DEVIATION (HLD) SCORE SHEET

Patient Name: _____ **DOB:**_____

Treating Orthodontist:_____ **Medicaid ID #:** ___ _____

Date:_____

Conditions	Provider Score	HLD 1st Review	HLD 2nd Review
Cleft palate deformity - Submit a cleft palate in the mixed dentition only if you can justify in a report why the patient should be treated before he or she is in the full dentition. Will there be intermittent treatment? **Score 15 points**			
Craniofacial anomaly- Documentation must include a clinical narrative from a qualified specialist and photographs. **Score 15 points**			
Crossbite of individual anterior teeth causing clinical attachment loss where recession of the gingival margins is present. **Score 15 points**			
Deep impinging overbite causing the destruction of soft tissues of the palate where tissue laceration and/or clinical attachment loss are present. **Score 15 points**			
Severe traumatic deviations- This refers to facial accidents, not congenital deformity. It does not include traumatic occlusion or crossbites. **Score 15 points**			
Overjet greater than nine (9) millimeters or mandibular protrusion greater than three and one half (3.5) millimeters. **Score 15 points**			
Overjet- Measure overjet in millimeters and subtract 2mm from your score. Two mm of overjet is considered normal. Score ___minus 2mm			
Overbite - Measure overbite in millimeters and subtract 3mm from your score. Three mm of overbite is considered normal. Score ___minus 3mm			
Labio-Lingual Spread –Measure the total spacing between the anterior teeth in millimeters. Score_____			

Revised 4/2022

Conditions	Provider Score	HLD 1st Review	HLD 2nd Review
Mandibular protrusion (reverse overjet) Measure the protrusion in millimeters and multiply by 5 (five). Score ____5			
Open bite- Measure the opening between the maxillary and mandibular incisors in millimeters and multiply by 4 (four). Score ____ 4			
Anterior crowding – Anteriors are so crowded that extractions are a prerequisite to treatment. Arch length insufficiency must exceed 3.5 mm to score points. (Score one for MAXILLA, and/or one for MANDIBLE) multiply by 5 (five) for the arch. Maxilla _____/ Mandible____Total _____			
Ectopic eruption - This refers to an unusual pattern of eruption such as high labial cuspids. Do not score teeth in this category if they are scored under maxillary or mandibular crowding. (Identify by tooth number, and count each tooth, excluding third molars) multiply by 3. Score ____ 3			
Posterior unilateral crossbite - Score 5 points for a left or right posterior crossbite. Must involve two or more adjacent teeth, one of which must be a molar. There is a maximum of 5 points for this category. Total____			
A score of 15 or higher indicates a physical handicap. **Total Score**_____			
1st Reviewer Signature/Date _____**Approved/Denied** Comments:_____ _____ _____ _____			
2nd Reviewer Signature/Date _____**Approved /Denied** Comments:_____ _____ _____ _____			

Procedure:

1. Enter a score of zero (0) if the condition is absent.
2. Start by measuring overjet of the most protruding incisor.
3. Measure overbite from the labio-incisal edge of the overlapped front tooth/teeth to point of maximum coverage.
4. Ectopic eruption and Anterior crowding should not be doubled scored. Record only the more serious condition, not both.
5. Deciduous teeth and teeth not fully erupted should not be scored.

Additional documents: Clinical narrative, Cephalometric films, X-rays, Diagnostic oral/intra photos.

AmeriHealth Caritas District of Columbia

Revised 4/2022

HANDICAPPING LABIO-LINGUAL DEVIATION (HLD) INDEX SCORING INSTRUCTIONS

The intent of the HLD index is to measure the presence or absence, and the degree, of the handicapped occlusion caused by the components of the Index, and not to diagnose 'malocclusion.' All measurements are made with a Boley Gauge scaled in millimeters. Absence of any conditions must be recorded by entering '0.' (Refer to the attached score sheet).

The following information should help clarify the categories on the HLD Index:

1. **Cleft Palate Deformity:** Acceptable documentation must include the following: 1) diagnostic casts or digital photographs of orthodontically trimmed study models (include views from all sides while in centric occlusion with wax bite); 2) intraoral photograph of the palate demonstrating soft tissue destruction; 3) written consultation report by a qualified specialist or Craniofacial Panel). Indicate an 'X' on the score sheet. Do not score any further if present. (This condition is automatically considered to qualify fororthodontic services.)

2. **Cranio-facial Anomaly:** Attach description of condition from a credentialed specialist. Indicate an 'X' on the score sheet. Do not score any further if present. (This condition is automatically considered to qualify fororthodontic services.)

3. **Crossbite of Individual Anterior Teeth:** Acceptable clinical documentation must include all the above noted clinical information together with supportive diagnostic intra-oral photographs of the anterior teeth demonstrating clinical attachment loss and gingival margin recession. Indicate an 'X' on the score sheet. Do not score any further if present. (This condition is automatically considered to qualify fororthodontic s ervices.)

4. **Deep Impinging Overbite:** Acceptable clinical documentation must include all the above noted clinical information. . Indicate an 'X' on the score sheet. Do not score any further if present. (This condition is automatically considered to qualify fororthodontic services.)

5. **Severe Traumatic Deviation:** Traumatic deviations are, for example, loss of a premaxilla segment by burns or by accident; the result of osteomyelitis; or other gross pathology. Submit history of prior treatment for any of these conditions to include all diagnostic radiographic i mages including a descri p t i o n of the condition. Indicate an 'X' on the score sheet. Do not score any further if present. (This condition is automatically considered to qualify fororthodontic services.)

6A. **Overjet greater than 9mm or mandibular protrusion (reverse overjet) greater than 3.5mm:** Overjet is recorded with the patient 's teeth in centric occlusion and is measured from the labial surface of the lower incisors to the labial surface of the corresponding upper cent ral incisors. This measurement should record the **greatest** distance between any one upper central incisor and it 's corresponding lower central or lateral incisor. If the overjet is greater than 9mm or mandibular protrusion (reverse overjet) is greater than 3.5mm, indicate an 'X' and score no further. (This condition is automatically considered to qualify fororthodontic services.)

6B. **Overjet equal to or less than 9mm:** Overjet is recorded as in condition #6A above.

7. **Overbite in Millimeters:** A pencil mark on the tooth indicating the extent of overlap facilitates this measurement. It is measured by rounding off to the nearest millimeter and entered on the score sheet. ('Reverse' overbite may exist in certain conditions and should be measured and recorded.)

8. **Labio-Lingual Spread:** A Boley Gauge is used to determine the extent of deviation from a normal arch. Where there is only a protruded or lingually displaced anterior tooth, the measurement should be made from the incisal edge of that tooth to the normal arch line. Otherwise, the total distance between the most protruded anterior tooth and the most lingually displaced adjacent anterior tooth is measured. In the event that multiple anter ior crowding of teeth is observed, all deviations from the normal arch should be measured for labio - lingual spread, but **only the most severe individual measurement should be entered on the score sheet.**

9. **Mandibular Protrusion (reverse overjet) equal to or less than 3.5mm:** Mandibular protrusion (reverse overjet) is recorded as in condition #6A above. The measurement is rounded off to the nearest millimeter. Enter on the score sheet and multiply by five (5).

10. **Open Bite in Millimeters:** This condition is defined as the absence of occlusal contact in the anterior region. It is measured from incisal edge of a maxillary central incisor to incisal edge of a corresponding mandibular incisor, in millimeters. The measurement is entered on the score sheet and multiplied by four (4). In cases of pronounced protrusion associated with open bite, measurement of the open bite is not always possible. In those cases, a close approximation can usually be estimated.

11. **Anterior Crowding:** Arch length insufficiency must exceed 3.5mm. Mild rotations that may react favorably to stripping or mild expansion procedures are not to b e scored as crowded. Score one (1) for a crowded maxillary arch and/or one (1) for a crowded mandibular arch. Enter total on the score sheet and multiply by five (5). If ectopic eruption exists in the anterior region of the same arch, count the condition that scores the most points. **D O NOT SCORE BOTH COND ITIONS.** However, posterior ectopic teeth can still be counted separately from anterior crowding when they occur in the samearch.

12. **Ectopic Eruption:** Count each tooth, **excluding third molars**. Each qualifying tooth must be impeded from full normal eruption and indicate that more than 50% of the crown as blocked and is not within the arch. Count only one tooth when there are mutually blocked out teeth. Enter the number of qualifying teeth on th e sco re sheet and multiply by three (3). If anterior crowding also exists in the same arch, score the condition that scores the mo st poi nt s. **D O NOT COUN T BOTH CONDITIONS.** However, posterior ectopic teeth can still be counted separately from anterior crowding when they occur in the samearch.

13. **Posterior Unilateral Crossbite**: This condition involves two or more adjacent teeth, one of which must be a molar. The crossbite must be one in which the maxillary posterior teeth involved may either be both palatal or both completely buccal in relation to the mandibular p osterior teeth. The pres en ce o f posterior unilateral crossbite is indicated by a score of five (5) on the score sheet. **NO SCORE FOR BI-LATERIALCROSSBITE.**

AmeriHealth Caritas District of Columbia *Revised 4/2022*

Continuation of Care (COC)

For orthodontic continuation of treatment cases that transfer from one provider to another, prior authorization is required for the new provider to start the case. The new provider must submit an AmeriHealth Caritas DC Continuation of Care Form including the following required information:

- Patient information
- Provider information
- Name of previous insurer or managed care organization that issued the original approval
- Number of adjustments remaining

Continuation of Care Submission Form

(Accepted only via the United States Postal Service (USPS))

Date:_____

Patient information

Name (first and last)	Date of birth:	ID number
Address:	City, state, ZIP	Area code and phone number:
Group name:	Plan type:	

Provider information

Dentist name:	Provider NPI number	Location ID number
Address:	City, state, ZIP	Area code and phone number:

Name of previous vendor that issued original approval:

Banding date: **Case rate approved by previous vendor:**

Amount paid for dates of service that occurred prior to AmeriHealth Caritas DC:

Amount owed for dates of service that occurred prior to AmeriHealth Caritas DC:

Balance expected for future dates of service:

Remaining services and quantities to be paid from prior approval:

Additional information required:

- **If the enrollee is transferring from an existing Medicaid program, provide a copy of the original orthodontic approval and diagnostic photos**
- **If the enrollee is private pay or transferring from a commercial insurance program, provide current diagnostic photos or radiographs**

AmeriHealth Caritas DC — Continuation of Care
P.O. Box 654
Milwaukee,WI 53201

Please note this form is accepted via USPS only.

Exhibits A, B, and C

Covered benefits (see Exhibits)

This section identifies covered benefits, provides specific criteria for coverage, and defines individual age and benefit limitations for enrollees under age 21. Providers with benefit questions should contact Provider Services at **1-855-609-5170**.

Dental offices are not allowed to charge enrollees for missed appointments. Plan enrollees are to be allowed the same access to dental treatment as any other patient in the dental practice. Private reimbursement arrangements may be made only for non-covered services after full disclosure to the enrollee in writing and signed by the enrollee acknowledging their financial responsibility for payment. Enrollees will not be reimbursed by the Plan for non-covered services when they have signed the disclosure.

AmeriHealth Caritas DC recognizes tooth letters A through T for primary teeth and tooth numbers 1 to 32 for permanent teeth. Supernumerary teeth should be designated by AS through TS for primary teeth and tooth numbers 51 to 82 for permanent teeth. These codes must be referenced in the patient's file for record retention and review. All dental services performed must be recorded in the patient record, which must be available as required by your Participating Provider Agreement.

For reimbursement, providers should bill only per unique surface regardless of location. For example, when a dentist places separate fillings in both occlusal pits on an upper permanent first molar, the billing should state a one-surface occlusal amalgam, ADA code D2140. Furthermore, AmeriHealth Caritas DC will reimburse for the total number of surfaces restored per tooth, per day (i.e., a separate occlusal and buccal restoration on tooth 30 will be reimbursed as one [OB] two-surface restoration).

The AmeriHealth Caritas DC claim system can only recognize dental services described using the current ADA CDT code list or those defined as covered benefits. All other service codes not contained in the following tables will be rejected when submitted for payment. A complete copy of the CDT book can be purchased from the ADA at the following address:

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

Furthermore, AmeriHealth Caritas DC and its vendor subscribe to the definition of services performed as described in the CDT manual.

The following benefit tables (Exhibits) are all inclusive for covered services. Each category of service is contained in a separate table and lists:

- The ADA-approved service code to submit when billing
- Brief description of the covered service
- Any age limits imposed on coverage
- A description of documentation, in addition to a completed ADA claim form, that must be submitted when a claim or request for prior authorization is submitted
- An indicator of whether or not the service is subject to prior authorization and any other applicable benefit limitations

Authorization Process

IMPORTANT

For procedures where "authorization required" fields indicate "yes," please review the information below on when to submit documentation. The information refers to the "documentation required" field in Exhibits A, B, and C (Benefits Covered). In this section, documentation may be requested to be sent prior to beginning treatment or "with claim" after completing treatment.

When documentation is requested:

"Authorization required" field	"Documentation required" field	Treatment condition	When to submit documentation
Yes	Documentation requested	Non-emergency (routine)	Send documentation prior to beginning treatment
Yes	Documentation requested	Emergency	Send documentation with claim after treatment

When documentation is requested "with claim:"

"Authorization required" field	"Documentation required" field	Treatment condition	When to submit documentation
Yes	Documentation requested with claim	Non-emergency (routine) or emergency	Send documentation with claim after treatment

Exhibit A — Benefits Covered for AmeriHealth Caritas DC: Medicaid Adult

Diagnostic services include the oral examination and selected radiographs needed to assess the oral health, diagnose oral pathology, and develop an adequate treatment plan for the enrollee's oral health.

Reimbursement for some or multiple radiographs of the same tooth or area may be denied if AmeriHealth Caritas DC determines the number to be redundant, excessive, or not in keeping with the federal guidelines relating to radiation exposure. The maximum amount paid for individual radiographs taken on the same day will be limited to the allowance for a full mouth series.

Reimbursement for radiographs is limited to those films required for proper treatment and/or diagnosis.

AmeriHealth Caritas DC utilizes the guidelines published by the Department of Health and Human Services Center for Devices and Radiological Health. However, please consult the following benefit tables for benefit limitations.

All radiographs must be of good diagnostic quality, properly mounted, dated, and identified with the recipient's name and date of birth. Substandard radiographs will not be reimbursed for, or, if already paid for, AmeriHealth Caritas DC will recoup the funds previously paid.

Diagnostic

Code	Description	Age Limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D0120	Periodic oral evaluation — established patient	21 and older		No	One of (D0120, D0150, D0160) per six month(s) per provider or location.	
D0140	Limited oral evaluation — problem focused	21 and older		No	Not reimbursable on the same day as D0120, D0140, D0145, D0150, D0160, D0170 or D0180. Allowed only with emergency treatment. Not allowed with routine treatment. One of (D0140) per six month(s) per provider or location.	
D0150	Comprehensive oral evaluation — new or established patient	21 and older		No	One of (D0150) per lifetime per provider or location. One of (D0120, D0150, D0160) per six month(s) per provider or location.	
D0160	Detailed and extensive oral eval — problem focused, by report	21 and older		Yes	One of (D0120, D0150, D0160, D0170, D0180) per six month(s) per provider or location.	Narrative of medical necessity with claim for pre-payment
D0170	Re-evaluation, limited problem focused	21 and older		Yes	One of (D0120, D0150, D0160, D0170, D0180) per six month(s) per provider or location.	
D0180	Comprehensive periodontal evaluation — new or established patient	21 and older		No	One of (D0180) per 12 month(s) per provider or location.	

D0190	Screening of a patient	21 and older		No	One of (D0190) per 12 month(s) per provider or location	
D0191	Assessment of a patient	21 and older		No	One of (D0191) per 12 month(s) per provider or location	
D0210	Intraoral — complete series of radiographic images	21 and older		No	One of (D0210, D0330) per 36 month(s) per patient.	
D0220	Intraoral — periapical first radiographic image	21 and older		No	One of (D0220) per date of service.	Tooth #

D0230	Intraoral — periapical each additional radiographic image	21 and older		No		Tooth #
D0240	Intraoral — occlusal radiographic image	21 and older		No	Two of (D0240) per 12 month(s) per patient.	
D0270	Bitewing — single radiographic image	21 and older		No	One of (D0270, D0272, D0274) per 12 month(s) per patient.	
D0272	Bitewings — two radiographic images	21 and older		No	One of (D0270, D0272, D0274) per 12 month(s) per patient.	
D0274	Bitewings — four radiographic images	21 and older		No	One of (D0270, D0272, D0274) per 12 month(s) per patient.	
D0330	Panoramic radiographic image	21 and older		No	One of (D0210, D0330) per 36 month(s) per patient.	
D0340	Cephalometric radiographic image	21 and older		Yes	One of (D0340) per 36 month(s) per patient. Narrative of medical necessity with claim for pre-payment review.	Narrative of medical necessity
D0364	Cone beam CT capture and interpretation with limited field of view - less than one whole jaw					
D0365	Cone beam CT interprete man	0-999		No		
D0365	Cone beam CT interprete man	0-999		No		
D0367	Cone beam CT capture and interpretation with field of view of both jaws; with or without cranium	21 and older		No		
D0460	Pulp vitality tests	21 and older		No	One per date of service.	
D0470	Diagnostic casts	21 and older		Yes	Not payable in conjunction with D8660	Narrative of medical necessity
D0601	Caries risk assess low risk	21 and older		No		
D0602	Caries risk assess mod risk	21 and older		No		
D0603	Caries risk assess high risk	21 and older		No		
D0604	Antigen test public health pathogen	0-999		No	4 per lifetime	
D0605	Antibody test public health pathogen	0-999		No	4 per lifetime	
D0606	Molecular Test Public Health	21 and older		No	4 per lifetime	
D1110	Prophylaxis — adult	21 and older		No	One of (D1110) per six month(s) per patient. Includes scaling and polishing procedures to remove coronal plaque, calculus, and stains. Not allowed with D4000 series codes.	
D1206	Topical application of fluoride varnish	21 and older		No	One of (D1206, D1208) per six month(s) per patient	
D1208	Topical application of fluoride — excluding varnish	21 and older		No	One of (D1206, D1208) per six month(s) per patient. Requires accompanying recall code (D1110 or D4910).	
D1354	Interim caries arresting medicament application	21 and older	A-T, 2-31	No	Two applications per 12 months	

Exhibit A — Benefits Covered for AmeriHealth Caritas DC: Medicaid Adult

Reimbursement includes local anesthesia.

Generally, oncea particular restoration is placed in a tooth, a similar restoration will not be covered for at least nine months.

Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day. A restoration is considered a two- or more surface restoration only when two or more actual tooth surfaces are involved, whether they are connected or not.

When restorations involving multiple surfaces are requested or performed that are outside theusual anatomical expectation, t he allowance is limited to that of a one-surface restoration. Any fee charged in excess of the allowance for the one-surfacerestoration is **disallowed**.

Tooth preparation, all adhesives (including amalgam and resin bonding agents), acid etching, copalite, liners, bases, direct and indirect pulp caps, curing, polishing, and adjustment are included as part of the fee for the restoration.

Billing and reimbursement for all crowns, post and cores, and any other prosthetics should be based on the cementation date.

Restorative

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D2140	Amalgam — one surface, primary or permanent	21 and older	Teeth 1 – 32, A – T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per nine month(s) per surface for primary and permanent teeth.	
D2150	Amalgam — two surfaces, primary or permanent	21 and older	Teeth 1 – 32, A – T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per nine month(s) per surface for primary and permanent teeth.	
D2160	Amalgam — three surfaces, primary or permanent	21 and older	Teeth 1 – 32, A – T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per nine month(s) per surface for primary and permanent teeth.	
D2161	Amalgam — four or more surfaces, primary or permanent	21 and older	Teeth 1 – 32, A – T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per nine month(s)	

Exhibit A — Benefits Covered for AmeriHealth Caritas DC: Medicaid Adult

					per surface for primary and permanent teeth.	
D2330	Resin-based composite — one surface, anterior	21 and older	Teeth 6 – 11, 22 – 27, C–H,M–R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per nine month(s) per surface for primary and permanent teeth.	

Restorative

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D2331	Resin-based composite — two surfaces, anterior	21 and older	Teeth 6 – 11, 22 – 27, C–H,M–R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per nine month(s) per surface for primary and permanent teeth.	
D2332	Resin-based composite — three surfaces, anterior	21 and older	Teeth 6 – 11, 22 – 27, C–H,M–R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per nine month(s) per surface for primary and permanent teeth.	
D2335	Resin-based composite — four or more surfaces or involving incisal angle (anterior)	21 and older	Teeth 6 – 11, 22 – 27, C–H,M–R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per nine month(s) per surface for primary and permanent teeth.	
D2391	Resin-based composite — one surface, posterior	21 and older	Teeth 1 – 5, 12 – 21, 28 –32,A,B,I–L,S,T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per nine month(s) per surface for primary and permanent teeth.	
D2392	Resin-based composite — two surfaces, posterior	21 and older	Teeth 1 – 5, 12 – 21, 28 –32,A,B,I–L,S,T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per nine month(s) per surface for primary and permanent teeth.	
D2393	Resin-based composite — three surfaces, posterior	21 and older	Teeth 1 – 5, 12 – 21, 28 –32,A,B,I–L,S,T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per nine month(s) per surface for primary and permanent	

					teeth.	
D2394	Resin-based composite — four or more surfaces, posterior	21 and older	Teeth 1 – 5, 12 – 21, 28 –32,A,B,I–L,S,T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per nine month(s) per surface for primary and permanent teeth.	
D2710	Crown – resin based composite	21 and older	Teeth 1 – 32	Yes	One of (D2710) per 60 month(s) per patient per tooth.	Narrative of medical necessity with claim for prepayment review, pre-op X-ray(s)
D2722	Crown — resin with noble metal	21 and older	Teeth 1 – 32	Yes	One of (D2722, D2750, D2751) per 60 month(s) per patient per tooth.	Narrative of medical necessity, pre-op X-ray(s)
D2750	Crown — porcelain fused to high noble metal	21 and older	Teeth 1 – 32	Yes	One of (D2722, D2750, D2751) per 60 month(s) per patient per tooth. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	Narrative of medical necessity, pre-op X-ray(s)

Exhibit A — Benefits Covered for AmeriHealth Caritas DC: Medicaid Adult

Restorative

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D2751	Crown — porcelain fused to predominantly base metal	21 and older	Teeth 1 – 32	Yes	One of (D2722, D2750, D2751) per 60 month(s) per patient per tooth. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	Narrative of medical necessity, pre-op X-ray(s)
D2753	Crown – porcelain fused to titanium and titanium alloys	21 and older	Teeth 1 – 32	Yes	One of (D2722, D2750, D2751, D2753) per 60 month(s) per patient per tooth.	Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.
D2790	Crown – full cast high noble metal	21 and older		Yes	One of (D2750, D2751, D2790) per 60 month(s) per patient per tooth. Pre-op radiographs of adjacent and opposite teeth with claim for prepayment review	
D2799	Provisional crown	21 and older	Teeth 1 – 32	Yes	Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	Full mouth X-rays or Panorex, treatment plan
D2920	Re-cement or re-bond crown	21 and older	Teeth 1 – 32, A – T	No	One of (D2920) per six month(s) per patient per tooth. Not allowed within six months of initial placement or previous recementation.	
D2931	Prefabricated stainless steel crown — permanent tooth	21 and older	Teeth 1 – 5, 12 – 16, 17–21,28–32	No	One per lifetime	
D2928	Prefab porc/cer crown perm	21 and older	Teeth 1-32	No	One of (D2952, D2954) per 60 month(s) per patient per tooth. Refers to building up of anatomical crown when restorative crown will be placed. Not allowed within nine months of D2140-D2161, D2330-D2335	
D2952	Cast post and core in addition to crown	21 and older	Teeth 1 – 32	No	One of (D2952) per 60 month(s) per patient per tooth. One of (D2952, D2954) per 60 month(s) per patient per tooth. Not allowed within nine months of D2140-D2161, D2330-D2335,	

Exhibit A — Benefits Covered for AmeriHealth Caritas DC: Medicaid Adult

D2954	Prefabricated post and core in addition to crown	21 and older	Teeth 1 – 32	No	One of (D2954) per 60 month(s) per patient per tooth. One of (D2952, D2954) per 60 month(s) per patient per tooth. Not allowed within nine months of D2140-D2161, D2330-D2335,	

Payment for conventional root canal treatment is limited to treatment of permanent teeth.

The standard of acceptability employed for endodontic procedures requires that the canal(s) be completely filled apically and laterally. In cases where the root canal filling does not meet AmeriHealth Caritas DC's treatment standards, AmeriHealth Caritas DC can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after any post-payment review by the AmeriHealth Caritas DC consultants. A pulpotomy or palliative treatment is not to be billed in conjunction with a root canal treatment by the same provider on the same date of service.

Filling material not accepted by the federal Food and Drug Administration (FDA) (e.g., Sargenti filling material) is not covered.
Pulpotomies will be limited to primary teeth or permanent teeth with incomplete root development.
The fee for root canal therapy for permanent teeth includes diagnosis, extirpation treatment, temporary fillings, filling and obturation of root canals, and progress radiographs. A completed fill radiograph is also included.

Endodontics

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D3110	Pulp cap — direct (excluding final restoration)	21 and older	Teeth 1 – 32, A – T	No		**Pre and Post-operative X-ray showing the completed treatment**
D3220	Therapeutic pulpotomy (excluding final restoration) — removal of pulp coronal to the dentinocemental junction and application of medicament	21 and older	Teeth 1 – 32, A – T	No		**Pre and Post-operative X-ray showing the completed treatment**
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	21 and older	Teeth 6 – 11, 22 – 27	No	One of (D3310) per lifetime per patient per tooth.	Pre and Post-operative X-ray showing the completed treatment
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	21 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	One of (D3320) per lifetime per patient per tooth.	Pre and Post-operative X-ray showing the completed treatment

Exhibit A — Benefits Covered for AmeriHealth Caritas DC: Medicaid Adult

D3330	Endodontic therapy, molar (excluding final restoration)	21 and older	Teeth 1 – 3, 14 – 19, 30 – 32	No	One of (D3330) per lifetime per patient per tooth.	Pre and Post-operative X-ray showing the completed treatment
D3346	Retreatment of previous root canal therapy-anterior	21 and older	Teeth 6 – 11, 22 – 27	No	One of (D3346) per lifetime per patient per tooth. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	Narrative of medical necessity, pre-op and post-op X-ray(s)
D3347	Retreatment of previous root canal therapy-bicuspid	21 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	One of (D3347) per lifetime per patient per tooth. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	Narrative of med. necessity, pre-op and post-op X-ray(s)
D3348	Retreatment of previous root canal therapy — molar	21 and older	Teeth 1 — 3, 14 — 19, 30—32	No	One of (D3348) per lifetime per patient per tooth. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	Narrative of medical necessity, pre-op and post-op X-ray(s)
D3351	Apexification/recalcification — initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	21 and older	Teeth 1 — 32	Yes	Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	Narrative of medical necessity, pre-op and post-op X-ray(s)

Endodontics

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D3410	Apicoectomy — anterior	21 and older	Teeth 6 — 11, 22 — 27	Yes	Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	Narrative of medical necessity, pre-op and post-op X-ray(s)
D3421	Apicoectomy — bicuspid (first root)	21 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	Narrative of medical necessity, pre-op and post-op X-ray(s)
D3425	Apicoectomy — molar (first root)	21 and older	Teeth 1 — 3, 14 – 19, 30–32	Yes	Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	Narrative of medical necessity, pre-op and post-op X-ray(s)
D3426	Apicoectomy (each additional root)	21 and older	Teeth 1 – 5, 12 – 21, 28–32	Yes	Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	Narrative of medical necessity, pre-op and post-op X-ray(s)
D3428	Bone Graft in Conjunction with Periradicular Surgery - Per Tooth, Single Site	21 and older		Yes	One of (D3428)) per lifetime per patient per tooth. Pre and post-operative X-ray(s) with claim for prepayment review.	Pre and post-operative X-ray(s), Narrative of medical necessity
D3429	Bone Graft in Conjunction with Periradicular Surgery - Each Additional Contiguous Tooth in the Same Surgical	21 and older		Yes	One of (D3429)) per lifetime per patient per tooth. Pre and post-operative X-ray(s) with claim for prepayment review.	Pre and post-operative X-ray(s), Narrative of medical necessity

	Site					
D3430	Retrograde filling — per root	21 and older	Teeth 1 – 32	No	Must be billed in conjuction with D3421,D3425, D3426	
D3432	Guided Tissue Regeneration	21 and older		Yes	One of (D3432) per lifetime per patient per tooth. Pre and post-operative X-ray(s) with Claim for prepayment review	
D3450	Root Amputation - Per Root	21 and older		Yes	One per lifetime per patient per tooth.	Pre and post-operative X-ray(s), Narrative of medical necessity
D3471	Surg rep root res anterior	21 and older	Teeth 6 — 11, 22 — 27	yes	one per tooth per lifetime	Pre and post-operative radiographs, narrative of medical necessisty
D3472	Surg rep root res premolar	21 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	yes	one per tooth per lifetime	Pre and post-operative radiographs, narrative of medical necessisty
D3473	Surg rep root res molar	21 and older	Teeth 1 — 3, 14 – 19, 30 – 32	yes	one per tooth per lifetime	Pre and post-operative radiographs, narrative of medical necessisty

Exhibit A — Benefits Covered for AmeriHealth Caritas DC: Medicaid Adult

Periodontics

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D4210	Gingivectomy or gingivoplasty — four or more contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per quadrant (LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4240, D4241, D4249) per 24 month(s) per patient per quadrant. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	Narrative of medical necessity, pre-op X-ray(s)
D4211	Gingivectomy or gingivoplasty — one to three contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per quadrant (LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4240, D4241, D4249) per 24 month(s) per patient per quadrant. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	Narrative of medical necessity, pre-op X-ray(s)
D4212	Gingivectomy/plasty rest	0-999	Per quadrant (LL, LR, UL, UR)	Yes	One D4212 per patient per tooth per lifetime.	Pre-treatment X-ray(s)
D4240	Gingival flap procedure, including root planning — four or more contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per quadrant (LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4240, D4241, D4249) per 24 month(s) per patient per quadrant. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	Narrative of medical necessity, pre-op X-ray(s)
D4240	Gingival flap procedure, including root planning — four or more contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per quadrant (LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4240, D4241, D4249) per 24 month(s) per patient per quadrant. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	Narrative of medical necessity, pre-op X-ray(s)
D4241	Gingival flap procedure, including root planning — one to three contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per quadrant (LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4240, D4241, D4249) per 24 month(s) per patient per quadrant. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	Narrative of medical necessity, pre-op X-ray(s)
D4249	Clinical crown lengthening — hard tissue	21 and older	Teeth 1 – 32	Yes	One of (D4210, D4211, D4240, D4241, D4249) per 24 month(s) per patient per tooth. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	Narrative of medical necessity, pre & post-op X- ray(s)
D4260	Osseous Surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per quadrant (LL, LR, UL, UR)	Yes	One of (D4260) per 24 month(s) per patient per tooth	Narrative of medical necessity, pre-op and post-op X-ray(s)
D4261	Osseous Surgery (including elevation of a full thickness flap and closure) - one to three ontiguous teeth or tooth bounded spaces per quadrant	21 and older	Per quadrant (LL, LR, UL, UR)	Yes	One of (D4260) per 24 month(s) per patient per tooth	Narrative of medical necessity, pre-op and post-op X-ray(s)
D4263	Bone replacement graft — first site in quadrant	21 and older	Teeth 1 – 32	Yes	One of (D4263) per 24 month(s) per patient per tooth. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	Narrative of medical necessity, pre and post-op X- ray(s)
D4264	Bone replacement graft — each additional site in quadrant	21 and older	Teeth 1 – 32	Yes	One of (D4264) per 24 month(s) per patient per tooth. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	Narrative of medical necessity, pre and post-op X- ray(s)
D4265	Biologic materials to aid in soft and osseous	21 and	Teeth 1 – 32	Yes	One of (D4265) per 24 month(s) per patient per	Narrative of medical

	tissue regeneration, per site	older			site.	necessity, pre-op and post-op X-ray(s)
D4266	Guided tissue regeneration - resorbable barrier, per site	21 and older	Teeth 1 – 32	Yes	One of (D4266) per 24 month(s) per patient per site.	Narrative of medical necessity, pre-op and post-op X-ray(s)
D4267	Guided tissue regeneration - non-resorbable barrier, per site (includes membrane removal)	21 and older	Teeth 1 – 32	Yes	One of (D4267) per 24 month(s) per patient per site.	Narrative of medical necessity, pre-op and post-op X-ray(s)

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D4341	Periodontal scaling and root planning — four or more teeth per quadrant	21 and older	Per quadrant (LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 24 month(s) per patient per quadrant. Either D4341 or D4342. A minimum of four affected teeth in the quadrant. Periodontal Charting and pre-operative radiographs with claim for pre-payment review. Not allowed with D1110 with a 6 month period.	Pre-op X-ray(s), perio charting
D4342	Periodontal scaling and root planning — one to three teeth per quadrant	21 and older	Per quadrant (LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 24 month(s) per patient per quadrant. Either D4341 or D4342. One (1) to three (3) affected teeth in the quadrant. Periodontal charting and pre-operative radiographs with claim for pre-payment review. Not allowed with D1110 with a 6 month period.	Pre-op X-ray(s), perio charting
D4346	Scaling in the presence of generalized moderate or severe gingival inflammation — full mouth, after oral evaluation	21 and older		Yes	One of (D4346) per 12 month(s) per patient. Not allowed on the same date as D4341, D4342, D4910 or D1110.	Narrative of medical necessity
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	21 and older		Yes	One of (D4355) per 36 month(s) per patient. Not allowed on the same date as D4341, D4342 or D1110.	
D4910	Periodontal maintenance procedures	21 and older		No	One of (D4910) per six month(s) per patient. Includes scaling and polishing procedures to remove coronal plaque, calculus, and stains. Not allowed on same date as D4000 series codes or D1110. Requires prior D4341 or D4342.	Pre-op X-ray(s), perio charting

Provision for removable prosthesis when masticatory function is impaired, or when existing prosthesis is unserviceable and when evidence is submitted that indicates that the masticatory insufficiencies are likely to impair the general health of theenrollee.

Authorization for partial dentures to replace posterior teeth will not be allowed if there are in each quadrant at least threeperidontially sound posterior teeth in fairly good position and occlusion with opposing dentition.

Authorization for cast partial dentures for anterior teeth generally will not be given unless one or moreanterior teeth in the same arch are missing. Partial dentures are not a covered benefit when eight or more posterior teeth are in occlusion.

Dentures will not be preauthorized when dental history reveals that any or all dentures made in recent years havebeen unsatisfactory for reasons that are not remediable because of physiological or psychological reasons, or repair, relining, or rebasing of the patient's present dentures will ma kethem serviceable.

A preformed denture with teeth already mounted forming a denture module is not a covered service.

Billing and reimbursement for all crowns, post and cores, and any other prosthetics should be based on the cementation date. A partial denture that replaces only posterior permanent teeth must include three or more teeth on the dentures that are anatomically correct (natural size, shape, and color) to be compensable (excluding third molars). Partial dentures must include one anterior tooth and/or three posterior teeth (excluding third molars).

Prosthodontics, removable

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D5110	Complete denture — maxillary	21 and older	Per arch (, UA)	Yes	One of (D5110, D5211, D5213) per 60	Pre-operative full mouth X-

					Months per patient.	ray(s) or panorex
D5120	Complete denture — mandibular	21 and older	Per arch (, LA)	Yes	One of (D5120, D5212, D5214) per 60 Months per patient.	Pre-operative full mouth X-ray(s) or panorex
D5211	Maxillary partial denture — resin base (including any conventional clasps, rests and teeth)	21 and older		Yes	One of (D5110, D5211, D5213) per 60 Months per patient.	Pre-operative full mouth X-ray(s) or panorex
D5212	Mandibular partial denture — resin base (including any conventional clasps, rests and teeth)	21 and older		Yes	One of (D5120, D5212, D5214) per 60 Months per patient.	Pre-operative full mouth X-ray(s) or panorex
D5213	Maxillary partial denture — cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	21 and older		Yes	One of (D5110, D5211, D5213) per 60 Months per patient.	Pre-operative full mouth X-ray(s) or panorex
D5214	Mandibular partial denture — cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	21 and older		Yes	One of (D5120, D5212, D5214) per 60 Months per patient.	Pre-operative full mouth X-ray(s) or panorex
D5221	Immediate maxillary partial denture — resin base (including any conventional clasps, rests, and teeth)	21 and older		Yes	One of D5221 or D5223 per lifetime	Full mouth pre-operative X-ray(s) or panorex
D5222	Immediate mandibular partial denture — resin base (including any conventional clasps, rests, and teeth)	21 and older		Yes	One of D5222 or D5224 per lifetime	Full mouth pre-operative X-ray(s) or panorex

Prosthodontics, removable

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D5223	Immediate maxillary partial denture — cast metal framework with resin dentures bases (including any conventional clasps, rests, and teeth)	21 and older		Yes	One of D5221 or D5223 per lifetime	Full mouth pre-operative X-ray(s) or panorex
D5224	Immediate mandibular partial denture — cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth).	21 and older		Yes	One of D5222 or D5224 per lifetime	Full mouth pre-operative X-ray(s) or panorex
D5511	Repair broken complete denture base — Mandibular	21 and older	Per arch (LA, UA)	No	Repairs will be reimbursed at two repairs per denture per year with five total denture repairs per five years.	
D5512	Repair broken complete denture base — Maxillary	21 and older	Per arch (LA, UA)	No	Repairs will be reimbursed at two repairs per denture per year with five total denture repairs per five years.	
D5520	Replace missing or broken teeth	21 and older	Teeth 1 – 32	No		
D5611	Repair resin denture base — Mandibular	21 and older	Per arch (LA, UA)	No	Repairs will be reimbursed at two repairs per denture per year with five total denture repairs per five years.	
D5612	Repair resin denture base — Maxillary	21 and older	Per arch (LA, UA)	No	Repairs will be reimbursed at two repairs per denture per year with five total denture repairs per five years.	

Exhibit A — Benefits Covered for AmeriHealth Caritas DC: Medicaid Adult

D5621	Repair cast framework — Mandibular	21 and Older	Per arch (LA, UA)	No	Repairs will be reimbursed at two repairs per denture per year with five total denture repairs per five years.	
D5622	Repair cast framework — Maxillary	21 and Older	Per arch (LA, UA)	No	Repairs will be reimbursed at two repairs per denture per year with five total denture repairs per five years.	
D5630	Repair or replace broken clasp	21 and older		No		
D5640	Replace broken teeth-per tooth	21 and older	Teeth 1 – 32	No		
D5650	Add tooth to existing partial denture	21 and older	Teeth 1 – 32	No		
D5660	Add clasp to existing partial denture	21 and older		No		
D5710	Rebase complete maxillary denture	21 and older		No	Two of (D5710, D5730) per 60 month(s) per patient. Not covered within six months of placement.	
D5711	Rebase complete mandibular denture	21 and older		No	Two of (D5711, D5731) per 60 month(s) per patient. Not covered within six months of placement.	
D5720	Rebase maxillary partial denture	21 and older		No	Two of (D5720, D5740) per 60 month(s) per patient. Not covered within six months of placement.	

Prosthodontics, removable

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D5721	Rebase mandibular partial denture	21 and older		No	Two of (D5721, D5741) per 60 month(s) per patient. Not covered within six months of placement.	
D5730	Reline complete maxillary denture (chairside)	21 and older		No	Two of (D5710, D5730) per 60 month(s) per patient. Not covered within six months of placement.	
D5731	Reline complete mandibular denture (chairside)	21 and older		No	Two of (D5711, D5731) per 60 month(s) per patient. Not covered within six months of placement.	
D5740	Reline maxillary partial denture (chairside)	21 and older		No	Two of (D5720, D5740) per 60 month(s) per patient. Not covered within six months of placement.	
D5741	Reline mandibular partial denture	21 and older		No	Two of (D5741) per 60 month(s) per	

	(chairside)				patient. Not covered within six months of placement.	
D5876	Add metal Sub to Acrylic dent	21 and older				
D5982	Surgical stent	21 and older		Yes	Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review. This is not for use in conjunction with implant placement.	Narrative of medical necessity, pre-op X-ray(s)

Exhibit A — Benefits Covered for AmeriHealth Caritas DC: Medicaid Adult

Prosthodontics, fixed

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D6010	Surgical placement of implant body: endosteal implant	18 and older		Yes	Two dental implants in the mandible per lifetime with D6111 and D6113 four dental implants in the maxilla per lifetime with D6110 and D6112 Maximum two dental implants per arch per lifetime. (Three missing teeth are a requirement for a removable partial denture.)	Restorative dentist's eval form, pre-op X-rays, perio charting, treatment plan, signed enrollee informed consent, narrative on exclusion of other treatment options
D6056	Prefabricated abutment — includes modification and placement	18 and older		Yes	One per implant per lifetime. There is a 90-day minimum waiting period after implant placement. Remember to include the Implant placement date on the authorization request.	Pre-op X-rays
D6058	Abutment supported porcelain/ceramic crown	18 and older		Yes	One per implant per 60 months. There is a 90-day minimum waiting period after implant placement. Remember to include the Implant placement date on the authorization request.	Pre-op X-rays
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	18 and older	All permanent teeth (teeth 1 through 32)	Yes	One of (D6081) per 12 month(s) per patient. Not allowed on the same date as D4341, DD4342 or D1110.	Narrative of medical necessity
D6085	Provisional implant crown	18 and older	All permanent teeth (teeth 1 through 32)	Yes	One implant provisional crown per implant per lifetime. Cannot be authorized with D6110, D6111, D6112, D6113.	Restorative dentist evaluation form, pre-op X-rays, perio. charting, signed consent form, tooth (implant) number, associated authorization for D6010 by tooth number.
D6082	Implant supported crown – porcelain fused to predominantly base alloys	18 and older	All permanent teeth (teeth 1 through 32)	Yes	One per implant per 60 months. There is a 90-day minimum waiting period after implant placement.	Prior authorization. Pre-opertative radiographs. Requires implant placement date on the authorization request.
D6083	Implant supported crown – porcelain fused to noble alloys	18 and older	All permanent teeth (teeth 1 through 32)	Yes	One tooth per lifetime	Prior authorization. Pre-opertative radiographs. Requires implant placement date on the authorization request.
D6084	Implant supported crown – porcelain fused to titanium and titanium alloys	18 and older	All permanent teeth (teeth 1 through 32)	Yes	One tooth per lifetime	Prior authorization. Pre-opertative radiographs. Requires implant placement date on the authorization re[redacted]

D6089	Access/Retorque Implant Screw	18-20, 21 and older	2-15, 18-31	No	One per every 3 years	No

D6097	Abutment supported crown – porcelain	18 and older	All permanent teeth (teeth 1 through 32)	Yes	One tooth per lifetime	Prior authorization. Pre-opertative radiographs. Requires implant placement date on the authorization request.
D6096	Remove broken implant retaining screw	18 and older		Yes	One per tooth per lifetime	Narrative of medical necessity, pre-op X-ray(s)
D6100	Surgical Removal of Implant body	18 and older	Teeth 1-32	Yes	Once per implant per lifetime	Pre-op X-rays
D6101	Debridement of a perimplant	0-999		Yes	One of (D6101) per 12 month(s) per patient. Not allowed on the same date as D4341, D4342, D6102, or D1110.	Pre-op X-rays
D6102	Debridement & contouring	0-999		Yes	One of (D6102) per 12 month(s) per patient. Not allowed on the same date as D4341, D4342, D6101, or D1110. Pre-operative x-ray	Pre-op X-rays
D6103	Bone graft repair perimplant	0-999		Yes	One of (D6103) per lifetime per patient per tooth. Narrative of Medical Necessity, Pre-operative x-ray. Must be included with D6101 only.	Narrative of Medical Necessity, Pre-operative x-ray.
D6104	Bone graft time of implant	0-999		Yes	One of (D6104) per lifetime per patient per tooth. Narrative of Medical Necessity, Pre-operative x-ray. Cannot be included with D6101 or D6102. Must be included with D6010.	Narrative of Medical Necessity, Pre-operative x-ray. Must be included with D6101 only.
D6105	Remove implant body	18 and older	Teeth 2-15, 18-31	Yes	Once per lifetime	Pre-op X-ray(s) and all implant placement documentation
D6106	Tissue Regen resorbable	18 and older	Teeth 2-15, 18-31	Yes	Once per lifetime	Pre-op X-ray(s) and all implant placement documentation
D6107	Tissue Regen non-resorbable	18 and older	Teeth 2-15, 18-31	Yes	Once per lifetime	Pre-op X-ray(s) and all implant placement documentation
D6110	Implant/abutment supported removable denture for edentulous arch — maxillary	18 and older		Yes	One per implant per 60 months. There is a 90-day minimum waiting period after implant placement. Remember to include the implant placement date on the authorization request.	Full mouth X-rays or panorex
D6111	Implant/abutment supported removable denture for edentulous arch — mandibular	18 and older		Yes	One per implant per 60 months. There is a 90-day minimum waiting period after implant placement. Remember to include the implant placement date on the authorization request.	Full mouth X-rays or panorex
D6112	Implant/abutment supported removable denture for partially edentulous arch — maxillary	18 and older		Yes	One per implant per 60 months. There is a 90-day minimum waiting period after implant placement. Remember to include the implant placement date on the authorization request.	Full mouth X-rays or panorex
D6190	Radiographic/Surgical Implant Index by Report	18 and older		Yes	One per arch per lifetime	Narrative of medical necessity

D6191	Semi-Precision Abutment - Placement	18 and older		Yes		
D6192	Semi-Precision Abutment - Placement	18 and older		Yes		

Exhibit A — Benefits Covered for AmeriHealth Caritas DC: Medicaid Adult

Prosthodontics, fixed

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D6113	Implant/abutment supported removable denture for partially edentulous arch — mandibular	18 and older		Yes	One per implant per 60 months. There is a 90-day minimum waiting period after implant placement. Remember to include the implant placement date on the authorization request.	Full mouth X-rays or panorex

Reimbursement includes local anesthesia and routine post-operative care.
The extraction of asymptomatic impacted teeth is not a covered benefit. Symptomatic conditions would include pain and/or infection or demonstrated malocclusion causing a shifting of existing dentition.
The incidental removal of a cyst or lesion attached to the root(s) of an extraction is considered part of the extraction or surgical fee and should not be billed as a separate procedure.

Oral and maxillofacial surgery

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D7111	Extraction, coronal remnants		A – T	No		
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	21 and older	Teeth 1 –32,A–T,	No		
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	21 and older	Teeth 1 –32,A–T,	Yes	Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	Narrative of medical necessity, pre-op X-ray(s)
D7220	Removal of impacted tooth — soft tissue	21 and older	Teeth 1 – 32,	Yes	Narrative of medical necessity and pre-operative radiographs of adjacent and opposing teeth with claim for prepayment review.	Pre-operative X-ray(s)
D7230	Removal of impacted tooth-partially bony	21 and older	Teeth 1 – 32,	Yes	Narrative of medical necessity and pre-operative radiographs of adjacent and opposing teeth with claim for prepayment review.	Pre-operative X-ray(s)
D7240	Removal of impacted tooth — completely bony	21 and older	Teeth 1 – 32,	Yes	Narrative of medical necessity and pre-operative radiographs of adjacent and opposing teeth with claim for prepayment review.	Pre-operative X-ray(s)
D7241	Removal of impacted Tooth — completely bony, with unusual surgical complications	21 and older	Teeth 1 – 32, A – T,	Yes	Pre-operative radiographs of adjacent and opposing teeth with claim. **Prior authorization required.**	Pre-operative X-ray(s)
D7250	Surgical removal of residual tooth roots (cutting procedure)	21 and older	Teeth 1 – 32, A – T,	Yes	Will not be paid to the dentist or group that removed the tooth. Removal of asymptomatic tooth not covered. Pre-operative radiographs of adjacent and opposing teeth with claim for prepayment review.	Pre-operative X-ray(s)
D7251	Coronectomy	0-999	Teeth 1 – 32	Yes		Narrative of medical necessity, pre-op X-ray(s)
D7270	Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth	21 and older	Teeth 1 – 32	No	Includes splinting and/or stabilization. Post-operative radiograph and narrative with claim.	Narrative of medical necessity, post-op X-ray(s)
D7280	Surgical access of an unerupted tooth	21 and older	Teeth 1 – 32	Yes	Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	Narrative of medical necessity, pre-op X-ray(s)

Exhibit A — Benefits Covered for AmeriHealth Caritas DC: Medicaid Adult

Oral and maxillofacial surgery

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D7285	Incisional biopsy of oral tissue — hard (bone-tooth)	21 and older		No	Pathology report with claim for prepayment review	Pathology report
D7286	Incisional biopsy of oral tissue — soft	21 and older		No	Pathology report with claim for prepayment review	Pathology report
D7310	Alveoloplasty in conjunction with extractions — four or more teeth or tooth spaces, per quadrant	21 and older	Per quadrant (LL, LR, UL, UR)	Yes	One of (D7310) per lifetime per patient per quadrant. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	Narrative of medical necessity, pre-op X-ray(s)
D7320	Alveoloplasty not in conjunction with extractions — four or more teeth or tooth spaces, per quadrant	21 and older	Per quadrant (LL, LR, UL, UR)	Yes	One of (D7320) per lifetime per patient per quadrant. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	Narrative of medical necessity, pre-op X-ray(s)
D7340	Vestibuloplasty — ridge extension (secondary epithelialization)	21 and older	Per arch (LA, UA)	Yes	One of (D7340) per lifetime per patient per quadrant. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	Narrative of medical necessity, pre-op X-ray(s)
D7350	Vestibuloplasty — ridge extension	21 and older	Per arch (LA, UA)	Yes	One of (D7350) per lifetime per patient per quadrant. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	Narrative of medical necessity, pre-op X-ray(s)
D7410	Radical excision — lesion diameter up to 1.25cm	21 and older		Yes	Pathology report with claim for prepayment review.	Pathology report
D7411	Radical excision — benign lesion diameter up to 1.25cm			No		Copy of the biopsy report for payment.
D7412	Excision benign lesion compl	0-999		No		Pathology report for claims payment
D7413	Excision malig lesion <= 1.25cm	0-999		No		Pathology report for claims payment
D7414	Excision malig lesion > 1.25cm	0-999		No		Pathology report for claims payment
D7415	Excision malig les complicat	0-999		No		Pathology report for claims payment
D7451	Removal of odontogenic cyst or tumor — lesion greater than 1.25cm	21 and older		Yes	Pathology report with claim for prepayment review.	Pathology report
D7460	Removal of nonodontogenic cyst or tumor — lesion diameter up to 1.25cm	21 and older		Yes	Pathology report with claim for prepayment review.	Pathology report
D7471	Removal of exostosis — per site	21 and older	Per arch (LA, UA)	Yes	Pre-operative radiographs with claim for pre-payment review.	Pre-operative X-ray(s)
D7472	Removal of torus palatinus	21 and older		Yes	Pre-operative radiographs with claim for pre-payment review.	Pre-operative X-ray(s)

D7473	Removal of torus mandibularis	21 and older		Yes	Pre-operative radiographs with claim for pre-payment review.	Pre-operative X-ray(s)
D7509	Marsupialization odon cyst			No	Once per lifetime.	
D7510	Incision and drainage of abscess — intraoral soft tissue	21 and older	Teeth 1 – 32, A – T,	No	Not allowed on same day as extraction. Pre-operative radiographs and narrative of medical necessity.	
D7520	Incision and drainage of abscess — extraoral soft tissue	21 and older		No		

D7530	Removal of Foreign Body from Mucosa, Skin, or Subcutaneous Alveolar Tissue	21 and older		No		
D7660	Malar and/or zygomatic arch — closed	21 and older		No		
D7670	Alveolus stabilization of teeth, closed reduction splinting	21 and older		No		
D7820	Closed reduction dislocation	21 and older		No		

Oral and maxillofacial surgery

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D7840	Condylectomy	21 and older		No		
D7850	Surgical discectomy, with/without implant	21 and older		No		
D7860	Arthrotomy	21 and older		No		
D7870	Arthrocentesis	21 and older		No		
D7910	Suture small wounds up to 5 cm	21 and older		Yes	Narrative of wound origin. Primary closure of incision is excluded per CDT description	
D7911	Complicated Suture - Up To 5 Cm	21 and older		Yes	Narrative of wound origin. Primary closure of incision is excluded per CDT description	Narrative of wound origin.
D7940	Osteoplasty — for orthognathic deformities	21 and older		No		
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla — autogenous or nonautogenous, by report	21 and older		No		
D7953	Bone replacement graft for ridge preservation — per site	21 and older	Per quadrant (LL, LR, UL, UR)	Yes	Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review. Must occur at the same time as extraction and implant placement.	
D7956	Tissue regen edent resorb		Teeth 2-15, 18-31	Yes	Once per lifetime per patient.	Narrative of medical necessity and pre-op X-ray
D7957	Tissue regen edent non-resorb		Teeth 2-15, 18-31	Yes	One procedure per lifetime	Narrative of medical necessity and pre-op X-ray
D7961	Buccal/labial frenectomy	21 and older		Yes	One of (D7961) per lifetime per patient. Pre-operative and Post-operative photographs and narrative of medical necessity with claim for pre-payment review.	Narrative of medical necessity
D7962	Lingual frenectomy	21 and older		Yes	One of (D7962) per lifetime per patient. Pre-operative and post operative photographs and narrative of medical necessity with claim for pre-payment review.	Narrative of medical necessity
D7970	Excision of hyperplastic tissue — per arch	21 and older	Per arch (LA, UA)	No	For removal of tissue over a previous edentulous denture bearing area to	Narrative of medical necessity

					improve prognosis of a proposed denture. Narrative of medical necessity shall be maintained in patient records.	

Exhibit A — Benefits Covered for AmeriHealth Caritas DC: Medicaid Adult

D7972	Surgical reduction of fibrous tuberosity	21 and older	Per quadrant (UL,UR)	Yes	One of (D7972) per lifetime per patient.	Narrative of medical necessity
D7979	Non-surgical sialolithotomy	21 and older		Yes	One procedure per lifetime	Narrative of medical necessity
D7982	Sialodochoplasty	21 and older		No		
D8695	Removal of fixed orthodontic appliances for reasons other than completion of treatment	21 and older		Yes	One procedure per lifetime	Narrative of medical necessity
D8090	Compre Dental Tx Adult	21 and older		Yes	One of (D8090) per patient per lifetime. Prior authorization required	

Adjunctive General Services

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D9110	Palliative (emergency) treatment of dental pain — minor procedure	21 and older		No	Not allowed with any other services other than radiographs. Not allowed for prescriptions or medication. One of (D9110) per six month(s) per provider or location.	Narrative of medical necessity
D9222	Deep sedation/general anesthesia — first 15 minutes	21 and older		Yes	Four-unit maximum, D9223 to be used up to two units subsequent to D9222	Narrative of medical necessity
D9223	Deep sedation/general anesthesia — each 15-minute increment	21 and older		Yes	Narrative of medical necessity with claim for prepayment review.	Narrative of medical necessity
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	21 and older		No	Not allowed with D9223. Narrative of medical necessity shall be maintained in patient records. Requires accompanying restorative treatment.	Narrative of medical necessity
D9310	Consultation — diagnostic service provided by dentist or physician other than requesting dentist or physician	21 and older		No	Diagnostic service provided by dentist other than practitioner providing treatment.	
D9420	Hospital or Ambulatory Surgical Center Call	21 and older		No	Not allowed with any other services other than radiographs. One of (D9420) per six month(s) Per provider or location.	
D9430	Office Visit for Observation (During Regularly Scheduled Hours) - No Other Services Performed	21 and older		No	Not allowed with any other services other than radiographs. One of (D9420) per six month(s) Per provider or location.	
D9944	Occlusal guard — Hard appliance, full arch	21 and older		Yes	One of (D9944) per 60 month(s) per patient. Removable dental appliances	Narrative of medical necessity

					which are designed to minimize the effects of bruxism (grinding) and other occlusal factors. Narrative of medical necessity shall be maintained in patient records. Excluded with D9945 and D9946.	
D9945	Occlusal guard — Soft appliance, full arch	21 and older		Yes	One of (D9945) per 24 month(s) per patient. Removable dental appliances which are designed to minimize the effects of bruxism (grinding) and other occlusal factors. Narrative of medical necessity shall be maintained in patient records. Excluded with D9944 and D9946.	Narrative of medical necessity
D9946	Occlusal guard — Hard appliance, partial arch	21 and older		Yes	One of (D9946) per 24 month(s) per patient. Removable dental appliances which are designed to minimize the effects of bruxism (grinding) and other occlusal factors. Narrative of medical necessity shall be maintained in patient records. Excluded with D9945 and D9944.	Narrative of medical necessity
D9951	Occlusal adjustment — limited	21 and older		Yes	Two of (D9951) per 12 month(s) per patient. Not covered with any restorative procedure on same date of service. Narrative of medical necessity shall be maintained in patient records.	Narrative of medical necessity
D9952	Occlusal adjustment — limited	21 and older		Yes	Two of (D9952) per 12 month(s) per patient. Not covered with any restorative procedure on same date of service. Narrative of medical necessity shall be maintained in patient records.	Narrative of medical necessity
D9953	Reline sleep apnea appliance			Yes	Once per 60 months	Narrative of medical necessity with evidence of prior fabricated appliance.
D9955	Oral Appliance Titration Visit	0-20, 21 and older		Yes	3 per year	Narrative of medical necessity.

Exhibit A — Benefits Covered for AmeriHealth Caritas DC: Medicaid Child

Diagnostic services include the oral examination and selected radiographs needed to assess oral health, diagnose oral patholo gy, and develop an adequatetreatment plan for the enrollee's oral health.

Reimbursement for someor multiple radiographs of the same tooth or area may be denied if AmeriHealth Caritas DC determines t he number to be redundant, excessive, or not in keeping with the federal guidelines relating to radiation exposure. Them aximum amount paid for individual radiographs taken on thesame day will be limited to the a llowance for a full mouth series.

Reimbursement for radiographs is limited to thosefilms required for proper treatment and/or diagnosis.

AmeriHealth Caritas DC utilizes the guidelines published by the Department of Health and Human Services Center for Devices and Radiological Health. H owever, please consult the following benefit tables for benefit limitations.

All radiographs must be of good diagnostic quality, properly mounted, dated and identified with therecipient's nameand date of birth. Substandard radiographs will not be reimbursed for, or, if already paid for, AmeriHealth Caritas DC will recoup the funds previously paid.

Diagnostic

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D0120	Periodic oral evaluation — established patient	0–20		No	One of (D0120, D0150, D0160) per six month(s) per provider **or** location.	
D0140	Limited oral evaluation-problem focused	0–20		No	Not reimbursable on the same day as D0120, D0140, D0145, D0150, D0160, D0170 or D0180. Allowed only with emergency treatment. Not allowed with routine treatment. One of (D0140) per six month(s) per provider or location.	
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	0–20		No	One of (D0150) per lifetime per provider **or** location. One of (D0120, D0150, D0160) per six month(s) per provider **or** location.	
D0150	Comprehensive oral evaluation — new or established patient	0–20		No	One of (D0150) per lifetime per provider **or** location. One of (D0120, D0150, D0160) per six month(s) per provider **or** location.	
D0160	Detailed and extensive oral evaluation — problem focused, by report	0–20		Yes	One of (D0160) per lifetime per provider **or** location. One of (D0120, D0150, D0160) per six month(s) per provider **or** location.	Narrative of medical necessity with claim for pre-payment review
D0180	Comprehensive Periodontal Evaluation - New Or Established Patient	0–20		No	One of (D0180) per 12 month(s) per provider or location.	Narrative of medicail necessity, periocharting and radiographs
D0190	Screening of a patient	0–20		No	One of (D0190) per 12 month(s) per	

					provider or location	
D0191	Assessment of a patient	0–20		No	One of (D0191) per 12 month(s) per provider or location	
D0210	Intraoral — complete series of radiographic images	0–20		No	One of (D0210, D0330) per 36 Month(s) per provider.	
D0220	Intraoral — periapical first radiographic image	0–20		No	One of (D0220) per date of service.	Tooth #
D0230	Intraoral — periapical each additional radiographic image	0–20		No		Tooth #

Exhibit A — Benefits Covered for AmeriHealth Caritas DC: Medicaid Child

Diagnostic

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D0240	Intraoral — occlusal radiographic image	0–20		No	Two of (D0240) per 12 month(s) per patient.	
D0270	Bitewing — single radiographic image	0–20		No	One of (D0270) per six month(s) per patient. One of (D0270, D0272, D0274) per six month(s) per patient.	
D0272	Bitewings — two radiographic images	0–20		No	One of (D0272) per six month(s) per patient. One of (D0270, D0272, D0274) per six month(s) per patient.	
D0274	Bitewings — four radiographic images	0–20		No	One of (D0274) per six month(s) per patient. One of (D0270, D0272, D0274) per six month(s) per patient.	
D0330	Panoramic radiographic image	0–20		No	One of (D0210, D0330) per 36 month(s) per patient.	
D0340	Cephalometric radiographic image	0–20		Yes		Narrative of medical necessity
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	0–20		No		
D0364	Cone beam CT capture and interpretation with limited field of view - less than one whole jaw					
D0367	Cone beam ct capture and interpretation with field of view of both jaws; with or without cranium	18–20		No		
D0460	Pulp vitality tests	0–20		No	One per visit. Includes multiple teeth and contralateral comparison(s), as indicated.	
D0470	Diagnostic Casts	0–20		Yes	Not payable inconjunction with D8660	Narrative of medical necessity
D0601	Caries risk assess low risk	0-20		No		
D0602	Caries risk assess mod risk	0-20		No		
D0603	Caries risk assess high risk	0-20		No		
D0604	Antigen test pub hlth pathog	0-20		No	4 per lifetime	
D0605	Antibody test pub hlth path	0-20		No	4 per lifetime	
D0606	Molecular Test Public Hlth	0–20		No		

Exhibit A — Benefits Covered for AmeriHealth Caritas DC: Medicaid Child

Sealants may be placed on the occlusal or occlusal-buccal surfaces of lower molars or occlusal or occlusal-lingual surfaces of upper molars once per tooth, per lifetime.

Space maintainers are a covered service when medically indicated dueto the prematureloss of posterior primary tooth. A lower lingual holding arch placed where there is not premature loss of theprimary molar is considered a transitional orthodontic appliance and not covered by this plan.

The application of topical fluoride treatment is allowed for enrollees up to age 21 onceevery six months when provided in conjunction with a prophylaxis. Treatment that incorporates fluoridewith the polishing compound is considered part of the prophylaxis procedure and not a separate topical fluoride treatment.

Billing and reimbursement for spacemaintainers shall be based on the cementation date.

Preventative

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D1110	Prophylaxis — adult	14–20		No	One of (D1110) per six month(s) per patient. One of (D1110, D1120) per six month(s) Per patient. Includes scaling and polishing procedures to remove coronal plaque, calculus and stains. Excluded from payment with D4355 and 4910.	
D1120	Prophylaxis — child	0–13		No	One of (D1120) per six month(s) per patient. One of (D1110, D1120) per sixmonth(s) per patient. Excluded from payment with D4355 and 4910.	
D1206	Topical application of fluoride varnish	0–20		No	One of (D1206, D1208) per six month(s) per patient.	
D1208	Topical application of fluoride — excluding varnish	0–20		No	One of (D1206, D1208) per six month(s) per patient. Requires accompanying recall code (D1110 or D4910).	
D1351	Sealant — per tooth	6–16	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	One of (D1351) per lifetime per patient per tooth. Covered only for the occlusal surfaces of posterior permanent teeth without restorations or decay.	
D1354	Interim arresting medicament application	0–20	A-T, 2-31	No	Two applications per 12 months	
D1510	Space maintainer — fixed — unilateral	0 –20	Per Quadrant (LL, LR, UL, UR)	No	One of (D1510) per lifetime per patient per quadrant. Indicate missing tooth numbers and arch/quadrant on claim	
D1516	Fixed bilat space maintainer — maxilla	0–20	Per Arch (LA, UA)	No	One of (D1516) per lifetime per patient per arch. Indicate missing tooth numbers and arch/quadrant on claim. Not allowed with D1510 and D1575.	
D1517	Fixed bilat space maintainer — mandible	0–20	Per arch (LA, UA)	No	One of (D1517) per lifetime per	

					patient per arch. Not allowed with D1510 and D1575.	
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	0–12	Per Quadrant (LL, LR, UL, UR)	History of D1551	No limitations	History of D1516

D1552	Re-cement or re-bond bilateral space maintainer – mandibular	0–12	Per Quadrant (LL, LR, UL, UR)	History of D1551	No limitations	History of D1517
D1553	Re-cement or re-bond unilateral space maintainer – per quadrant	0–12	Per Quadrant (LL, LR, UL, UR)	History of D1551	No limitations	History of D1510
D1556	Removal of fixed unilateral space maintainer – per quadrant	0–12	Per Quadrant (LL, LR, UL, UR)	Narrative of medical necessity	One per lifetime associated only with D1510/ D1516/ D1516	
D1557	Removal of fixed bilateral space maintainer – maxillary	0–12	Per Quadrant (LL, LR, UL, UR)	Narrative of medical necessity	One per lifetime associated only with D1510/ D1516/ D1517	
D1558	Removal of fixed bilateral space maintainer – mandibular	0–12	Per Quadrant (LL, LR, UL, UR)	Narrative of medical necessity	One per lifetime associated only with D1510/ D1516/ D1518	
D1575	Distal space maintainer — fixed — unilateral	0–20	Teeth 4, 5, 12, 13, 20, 21, 28, 29 and A, B, I, J, K, L, S, T.	No	One of (D1575) per lifetime per patient per quadrant. Not allowed with D1516 and D1517. Limited to maintaining space for teeth lost: A,B, I,J,K,L,S,T	

Reimbursement includes local anesthesia.

Generally, oncea particular restoration is placed on a tooth, a similar restoration will not be covered for at least nine months.

Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day. A restoration is considered a two-or more surfacerestoration only when two or more actual tooth surfaces are involved, whether they areconnected or not.

When restorations involving multiple surfaces are requested or performed that are outside theusual anatomical expectation, the allowance is limited to that of a one-surfacerestoration. Any fee charged in excess of the allowance for the one-surfacerestoration is **disallowed**.

Tooth preparation, all adhesives (including amalgam and resin bonding agents), acid etching, copalite, liners, bases, direct and indirect pulp caps, curing, polishing, and adjustment are included as part of the fee for therestoration.

Billing and reimbursement for all crowns, post and cores, and any other prosthetics should be based on the cementation date.

Restorative

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D2140	Amalgam — one surface, primary or permanent	0–20	Teeth 1 – 32, A – T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per nine month(s) per surface for primary and permanent teeth.	
D2150	Amalgam — two surfaces, primary or permanent	0–20	Teeth 1 – 32, A – T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per nine month(s) per surface for primary and permanent	

					teeth.	

Exhibit A — Benefits Covered for AmeriHealth Caritas DC: Medicaid Child

D2160	Amalgam — three surfaces, primary or permanent	0–20	Teeth 1 – 32, A – T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per nine month(s) per surface for primary and permanent teeth.	
D2161	Amalgam — four or more surfaces, primary or permanent	0–20	Teeth 1 – 32, A – T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per nine month(s) per surface for primary and permanent teeth.	
D2330	Resin-based composite — one surface, anterior	0–20	Teeth 6 – 11, 22 – 27, C–H,M–R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per nine month(s) per surface for primary and permanent teeth.	
D2331	Resin-based composite — two surfaces, anterior	0–20	Teeth 6 – 11, 22 – 27, C–H,M–R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per nine month(s) per surface for primary and permanent teeth.	

Restorative

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D2332	Resin-based composite — three surfaces, anterior	0–20	Teeth 6 – 11, 22 – 27, C–H,M–R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per nine month(s) per surface for primary and permanent teeth.	
D2335	Resin-based composite — four or more surfaces or involving incisal angle (anterior)	0–20	Teeth 6 – 11, 22 – 27, C–H,M–R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per nine month(s) per surface for primary and permanent teeth.	
D2391	Resin-based composite — one surface, posterior	0–20	Teeth 1 – 5, 12 – 21, 28 -32,A,B,I–L,S,T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per nine month(s) per surface for primary and permanent teeth.	
D2392	Resin-based composite — two surfaces, posterior	0–20	Teeth 1 – 5, 12 – 21, 28 -32,A,B,I–L,S,T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per nine month(s) per surface for primary and permanent teeth.	
D2393	Resin-based composite — three surfaces, posterior	0–20	Teeth 1 – 5, 12 – 21, 28 -32,A,B,I–L,S,T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per nine month(s) per surface for primary and permanent	

					teeth.	
D2394	Resin-based composite — four or more surfaces, posterior	0–20	Teeth 1 – 5, 12 – 21, 28 -32,A,B,I–L,S,T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per nine month(s) per surface for primary and permanent teeth.	

Exhibit A — Benefits Covered for AmeriHealth Caritas DC: Medicaid Child

D2750	Crown — porcelain fused to high noble metal	0–20	Teeth 1 – 32	Yes	One of (D2750, D2751, D2790) per 60 month(s) per patient per tooth. Pre-operative radiographs of adjacent and opposite teeth with claim for prepayment review.	Pre-operative X-ray(s)
D2751	Crown — porcelain fused to predominantly base metal	0–20	Teeth 1 – 32	Yes	One of (D2750, D2751, D2790) per 60 month(s) Per patient per tooth. Pre-operative radiographs with claim for pre-payment review.	Pre-operative X-ray(s)
D2790	Crown – full cast high noble metal	0–20		Yes	One of (D2750, D2751, D2790) per 60 month(s) per patient per tooth. Pre-op radiographs of adjacent and opposite teeth with claim for prepayment review	
D2799	Provisional crown	0–20	Teeth 1 – 32	No	One per lifetime per tooth. Not to be billed in conjunction with D2750 or D2751	Pre-operative X-ray(s)
D2920	Re-cement or re-bond crown	0–20	Teeth 1 – 32, A – T	No	Not allowed within six months of placement.	
D2930	Prefabricated stainless steel crown — primary tooth	0–20	Teeth A – T	No	One of (D2930) per 60 month(s) per patient per tooth. Exclude D2943	
D2931	Prefabricated stainless steel crown — permanent tooth	0–20	Teeth 1 – 32	No	One of (D2931) per 60 month(s) per patient per tooth.	

Restorative

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D2934	Prefabricated esthetic coated stainless steel crown — primary tooth	0–20	Teeth A – T	No	One of (D2934) per 60 month(s) per patient per tooth. Exclude D2940	
D2941	Interim therapeutic restoration – primary dentition	0–20	Teeth A – T	No	One of (D2941) per nine month(s) per patient per tooth.	
D2952	Cast post and core in addition to crown	0–20	Teeth 1 – 32	No	One of (D2952) per 60 month(s) per patient per tooth. One of (D2952, D2954) per 60 month(s) per patient per tooth. Not allowed within 9 months D2140-D2161, D2330-D2335	
D2954	Prefabricated post and core in addition to crown	0–20	Teeth 1 – 32	No	One of (D2954) per 60 month(s) per patient per tooth. One of (D2952, D2954) per 60 month(s) per patient per tooth. Not allowed within 9 months D2140-D2161, D2330-D2335	

Exhibit A — Benefits Covered for AmeriHealth Caritas DC: Medicaid Child

Payment for conventional root canal treatment is limited to treatment of permanent teeth.

The standard of acceptability employed for endodontic procedures requires that the canal(s) be completely filled apically and laterally. In cases where the root canal filling does not meet AmeriHealth Caritas DC's treatment standards, AmeriHealth Caritas DC can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after any post-payment review by the AmeriHealth Caritas DC consultants. A pulpotomy or palliative treatment is not to be billed in conjunction with a root canal treatment by the same provider on the same date of service.

Filling material not accepted by the federal Food and Drug Administration (FDA) (e.g., Sargenti filling material) is not covered.

Pulpotomies will be limited to primary teeth or permanent teeth with incomplete root development.

The fee for root canal therapy for permanent teeth includes diagnosis, extirpation treatment, temporary fillings, filling and obturation of root canals, and progress radiographs. A completed fill radiograph is also included.

Endodontics

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D3110	Pulp cap — direct (excluding final restoration)	0–20	Teeth 1 – 32, A – T	No		
D3220	Therapeutic pulpotomy (excluding final restoration) — removal of pulp coronal to the dentinocemental junction and application of medicament	0–20	Teeth 1 – 32, A – T	No		
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	0–20	Teeth 6 – 11, 22 – 27	No	One of (D3310) per lifetime per patient per tooth.	Pre-op and post op radiographs with claim for pre-payment review.
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	0–20	Teeth 4, 5, 12, 13, 20, 21,28, 29	No	One of (D3320) per lifetime per patient per tooth.	Pre-op and post op radiographs with claim for pre-payment review.
D3330	Endodontic therapy, molar (excluding final restoration)	0–20	Teeth 1 – 3, 14 – 19, 30–32	No	One of (D3330) per lifetime per patient per tooth.	Pre-op and post op radiographs with claim for pre-payment review.
D3346	Retreatment of previous root canal therapy — anterior	0–20	Teeth 6 – 11, 22 – 27	No	One of (D3346) per lifetime per patient per tooth. Pre-operative radiographs with claim for pre-payment review.	Pre and post-operative X-ray(s)
D3347	Retreatment of previous root canal therapy — bicuspid	0–20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	One of (D3347) per lifetime per patient per tooth. Pre-operative radiographs with claim for pre-payment review.	Pre and post-operative X-ray(s)
D3348	Retreatment of previous root canal therapy — molar	0–20	Teeth 1 – 3, 14 – 19, 30–32	No	One of (D3348) per lifetime per patient per tooth. Pre-operative radiographs with	Pre and post -operative X-ray(s)

					claim for pre-payment review.	
D3351	Apexification/recalcification — initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	0–20	Teeth 1 – 32	Yes	One of (D3351) per lifetime per patient per tooth. Pre and post operative radiographs shall be maintained in patient records.	Pre and post-operative X-ray(s)

Exhibit A — Benefits Covered for AmeriHealth Caritas DC: Medicaid Child

Endodontics

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D3410	Apicoectomy — anterior	0–20	Teeth 6 – 11, 22 – 27	Yes	One of (D3410) per lifetime per patient per tooth. Pre and post-operative X-ray(s) with claim for prepayment review.	Pre and post-operative X-ray(s)
D3421	Apicoectomy — bicuspid (first root)	0–20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	One of (D3421) per lifetime per patient.	Pre and post-operative X-ray(s)
D3425	Apicoectomy — molar (first root)	0–20	Teeth 1 – 3, 14 – 19, 30–32	No	One of (D3425) per lifetime per patient.	Pre and post-operative X-ray(s)
D3426	Apicoectomy (each additional root)	0–20	Teeth 1 – 5, 12 – 21, 28–32	Yes	One of (D3426) per lifetime per patient per tooth. Pre and post-operative X-ray(s) with claim for prepayment review.	Pre and post-operative X-ray(s)
D3428	Bone Graft in Conjunction with Periradicular Surgery - Per Tooth, Single Site	0-20		Yes	One of (D3428)) per lifetime per patient per tooth. Pre and post-operative X-ray(s) with claim for prepayment review.	Pre and post-operative X-ray(s), Narrative of medical necessity
D3429	Bone Graft in Conjunction with Periradicular Surgery - Each Additional Contiguous Tooth in the Same Surgical Site	21 and older		Yes	One of (D3428)) per lifetime per patient per tooth. Pre and post-operative X-ray(s) with claim for prepayment review.	Pre and post-operative X-ray(s), Narrative of medical necessity
D3430	Retrograde filling — per root	0–20	Teeth 1 – 32	No	One of (D3430) per lifetime per patient per tooth. Pre and post-operative X-ray(s) with claim for prepayment review.	Pre and post-operative X-ray(s)
D3450	Root amputation — per root	0–20	Teeth 1 – 32	No		Pre and post-operative X-ray(s)
D3471	Surg rep root res anterior	0-20	Teeth 6 — 11, 22 — 27	yes	one per tooth per lifetime	pre and post op radiographs, narrative of medical necessisty
D3472	Surg rep root res premolar	0-20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	yes	one per tooth per lifetime	pre and post op radiographs, narrative of medical necessisty
D3473	Surg rep root res molar	0-20	Teeth 1 — 3, 14 – 19, 30–32	yes	one per tooth per lifetime	pre and post op radiographs, narrative of medical necessisty

Exhibit A — Benefits Covered for AmeriHealth Caritas DC: Medicaid Child

Periodontics

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D4210	Gingivectomy or gingivoplasty — four or more contiguous teeth or tooth bounded spaces per quadrant	18–20	Per quadrant (LL, LR, UL, UR)	Yes	One of (D4210, D4211) per 24 month(s) per patient per quadrant. A minimum of four teeth in the affected quadrant. Periodontal charting, pre-operative radiographs and narrative of medical necessity with claim for prepayment review.	Perio charting, pre-op radiographs and narrative of med necessity
D4211	Gingivectomy or gingivoplasty — one to three contiguous teeth or tooth bounded spaces per quadrant	18–20	Per quadrant (LL, LR, UL, UR)	Yes	One of (D4210, D4211) per 24 month(s) per patient per quadrant. One to three teeth in the affected quadrant.	Pre-op X-ray(s), perio charting and narrative of med necessity
D4240	Gingival flap procedure, including root planning — four or more contiguous teeth or tooth bounded spaces per quadrant	18–20	Per quadrant (LL, LR, UL, UR)	Yes	One of (D4240) per 24 month(s) per patient per quadrant. One of (D4240, D4241) per 24 month(s) per patient per quadrant. A minimum of four teeth in the affected quadrant. For the correction of severe gingival hyperplasia or hypertrophy associated with drug therapy. Perio Charting, pre-operative radiographs and narrative of medical necessity with claims for prepayment review.	Perio charting, pre-op radiographs and narrative of med necessity
D4241	Gingival flap procedure, including root planning — one to three contiguous teeth or tooth bounded spaces per quadrant	18– 20	Per quadrant (LL, LR, UL, UR)	Yes	One of (D4241) per 24 month(s) per patient per quadrant. One of (D4240, D4241) per 24 month(s) per patient per quadrant. A minimum of four teeth in the affected quadrant. For the correction of severe gingival hyperplasia or hypertrophy associated with drug therapy. Perio charting, pre-operative radiographs and narrative of medical necessity with claims for prepayment review.	Perio charting, pre-op radiographs and narrative of med necessity
D4249	Clinical crown lengthening — hard tissue	18– 20	Teeth 1 – 32	Yes	One of (D4249) per 24 month(s) per patient per tooth. Crown lengthening requires reflection of a flap. There must be evidence of restorability. Narrative of medical necessity and pre-operative X-ray(s) with claim for prepayment review.	Narrative of medical necessity, pre-op X-ray(s) and narrative of med necessity
D4263	Bone replacement graft — first site in	18– 20	Teeth 1 – 32	Yes	One of (D4263) per 24 month(s) per patient per tooth. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	Narrative of medical necessity, pre and post-op X-ray(s)
D4264	Bone replacement — each additional	18– 20	Teeth 1 – 32	Yes	One of (D4264) per 24 month(s) per	Narrative of medical

					patient per tooth. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	necessity, pre and post-op X-ray(s)

Exhibit A — Benefits Covered for AmeriHealth Caritas DC: Medicaid Child

Periodontics

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D4341	Periodontal scaling and root planning — four or more teeth per quadrant	18– 20	Per quadrant (LL, LR, UL, UR)	Yes	One of (D4341) per 12 month(s) per patient per quadrant. A minimum of four teeth in the affected quadrant. Periodontal charting and pre-operative radiographs. There must be radiographic evidence of root calculus or noticeable loss of bone support. Pre-operative X-ray(s) and perio charting with claim for prepayment review. Not allowed with D1110 and D1120 with a 6 month period.	Pre-op X-ray(s), perio charting
D4342	Periodontal scaling and root planning — one to three teeth per quadrant	18– 20	Per quadrant (LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 24 month(s) per patient per quadrant. Either D4341 or D4342. One (1) to three (3) affected teeth in the quadrant. Periodontal charting and pre-operative radiographs with claim for pre-payment review. Not allowed with D1110 and D1120 with a 6 month period.	Pre-Op X-ray(s)l perio charting
D4346	Scaling in the presence of generalized moderate or severe gingival inflammation — full mouth, after oral evaluation	18– 20		Yes	One of (D4346) per 12 month(s) per patient. Not allowed on the same date as D4341, DD4342, or D1110.	Medical necessity
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	18– 20		Yes	One of (D4355) per 36 month(s) per patient. Not allowed on the same date as D4341, DD4342, or D1110.	Narrative of medical necessity and photo(s) or pre-operative X-ray(s) with claim for prepayment review.
D4910	Periodontal maintenance procedures	18– 20		No	One of (D4910) per six month(s) per patient. Includes scaling and polishing procedures to remove coronal plaque, calculus, and stains. Not allowed on same date as D4000 series codes D1110 or D1120. Requires prior D4341 or D4342.	Pre-op X-ray(s), perio charting

Exhibit A — Benefits Covered for AmeriHealth Caritas DC: Medicaid Child

Provision for removable prosthesis when masticatory function is impaired, or when existing prosthesis is unserviceable and when evidence is submitted that indicates that the masticatory insufficiencies are likely to impair the general health of theenrollee.

Authorization for partial dentures to replace posterior teeth will not be allowed if there are in each quadrant at least threeperidontially sound posterior teeth in fairly good position and occlusion with opposing dentition.
Authorization for cast partial dentures for anterior teeth generally will not be given unless one or moreanterior teeth in the same arch are missing. Partial dentures are not a covered benefit when eight or more posterior teeth are in occlusion.

Dentures will not be preauthorized when dental history reveals that any or all dentures made in recent years havebeen unsatisfactory for reasons that are not remediable because of physiological or psychological reasons, or repair, relining or rebasing of thepatient's present dentures will make them serviceable.

A preformed denture with teeth already mounted forming a denture module is not a covered service.

Billing and reimbursement for all crowns, post and cores, and any other prosthetics should be based on the cementation date. A partial denture that replaces only posterior permanent teeth must include three or more teeth on the dentures that are anatomically correct (natural size, shape, and color) to be compensable (excluding third molars). Partial dentures must includeone anterior tooth and/or threeposterior teeth (excluding third molars).

Prosthodontics, removable

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D5110	Complete denture — maxillary	0–20	Per arch (UA)	Yes	One of (D5110) per 60 month(s) per patient.	Full mouth pre-operative X-ray(s) or panorex
D5120	Complete denture — mandibular	0–20	Per arch (LA)	Yes	One of (D5120) per 60 month(s) per patient.	Full mouth pre-operative X-ray(s) or panorex
D5211	Maxillary partial denture — resin base (including any conventional clasps, rests, and teeth)	0–20		Yes	One of (D5211) per 60 month(s) per patient.	Full mouth pre-operative X-ray(s) or panorex
D5212	Mandibular partial denture — resin base (including any conventional clasps, rests, and teeth)	0–20		Yes	One of (D5212) per 60 month(s) per patient.	Full mouth pre-operative X-ray(s) or panorex
D5213	Maxillary partial denture — cast metal framework with resin	0–20		Yes	One of (D5110, D5211, D5213) per 60 Months per patient.	Pre-operative full mouth X-ray(s) or panorex
D5214	Mandibular partial denture — cast metal framework with resin	0–20		Yes	One of (D5120, D5212, D5214) per 60 Months per patient.	Pre-operative full mouth X-ray(s) or panorex
D5221	Immediate maxillary partial denture — resin base (including any conventional clasps, rests, and teeth)	0–20		Yes	One per lifetime	Full mouth pre-operative X-ray(s) or panorex
D5222	Immediate mandibular partial denture —	0–20		Yes	One per lifetime	Full mouth pre-operative

	resin base (including any conventional clasps, rests, and teeth)					X-ray(s) or panorex

Exhibit A — Benefits Covered for AmeriHealth Caritas DC: Medicaid Child

Prosthodontics, removable

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D5223	Immediate maxillary partial denture — cast metal framework with resin dentures bases (including any conventional clasps, rests, and teeth)	0–20		Yes	One of D5221 or D5223 per lifetime	Full mouth pre-operative X-ray(s) or panorex
D5224	Immediate mandibular partial denture — cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth).	0–20		Yes	One of D5222 or D5224 per lifetime	Full mouth pre-operative X-ray(s) or panorex
D5225	Maxillary part denture flex		Teeth 1-16	Yes	One of D5110, D5211, D5213, D5225 per 60 months per patient	Full mouth pre-operative X-ray(s) or panorex
D5226	Mandibular part denture flex		Teeth 17-32	Yes	One of (D5120, D5212, D5214, D5226) per 60 Months per patient	Full mouth pre-operative X-ray(s) or panorex
D5511	Repair broken complete denture base — Mandibular	0–20	Per arch (LA, UA)	No	Repairs will be reimbursed at two repairs per denture per year with five total denture repairs per five years	
D5512	Repair broken complete denture base — Maxillary	0–20	Per arch (LA, UA)	No	Repairs will be reimbursed at two repairs per denture per year with five total denture repairs per five years	
D5520	Replace missing or broken teeth	0–20	Teeth 1 – 32	No		
D5611	Repair resin denture base — Mandibular	0–20	Per arch (LA, UA)	No	Repairs will be reimbursed at two repairs per denture per year with five total denture repairs per five years	
D5612	Repair resin denture base — Maxillary	0–20	Per arch (LA, UA)	No	Repairs will be reimbursed at two repairs per denture per year with five total denture repairs per five years	
D5621	Repair cast framework — Mandibular	0–20	Per arch (LA, UA)	No	Repairs will be reimbursed at two repairs per denture per year with five total denture repairs per five years	
D5622	Repair cast framework — Maxillary	0–20	Per arch (LA, UA)	No	Repairs will be reimbursed at two repairs per denture per year with five total denture repairs per five years	
D5630	Repair or replace broken clasp	0–20		No		
D5640	Replace broken teeth — per tooth	0–20	Teeth 1 – 32	No		
D5650	Add tooth to existing partial denture	0–20	Teeth 1 – 32	No		
D5660	Add clasp to existing partial denture	0–20		No		
D5710	Rebase complete maxillary denture	0–20		No	One of (D5710, D5730) per 24 month(s) per patient. Not covered within six months of placement.	

D5711	Rebase complete mandibular denture	0–20		No	One of (D5711, D5731) per 24 month(s) per patient. Not covered within six months of placement.	
D5720	Rebase maxillary partial denture	0–20		No	One of (D5720, D5740) per 24 month(s) per patient. Not covered within six months of placement.	

Exhibit A — Benefits Covered for AmeriHealth Caritas DC: Medicaid Child

Prosthodontics, removable

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D5721	Rebase mandibular partial denture	0–20		No	One of (D5721, D5741) per 24 month(s) per patient. Not covered within six months of placement.	
D5730	Reline complete maxillary denture (chairside)	0–20		No	One of (D5710, D5730) per 24 month(s) per patient. Not covered within six months of placement.	
D5731	Reline complete mandibular denture (chairside)	0–20		No	One of (D5711, D5731) per 24 month(s) per patient. Not covered within six months of placement.	
D5740	Reline maxillary partial denture (chairside)	0–20		No	One of (D5720, D5740) per 24 month(s) per patient. Not covered within six months of placement.	
D5741	Reline mandibular partial denture (chairside)	0–20		No	One of (D5721, D5741) per 24 month(s) per patient. Not covered within six months of placement	
D5982	Surgical stent	0–20		Yes	This is not for use in conjunction with implant placement.	Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.

Exhibit A — Benefits Covered for AmeriHealth Caritas DC: Medicaid Child

Prosthodontics, fixed

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D6010	Surgical placement of implant body: Endosteal implant	18–20		Yes	Two dental implants in the mandible per lifetime with D6111 and D6113 Four dental implants in the maxilla per lifetime with D6110 and D6112 Maximum two dental implants per arch per lifetime. (Three missing teeth are a requirement for a removable partial denture)	Restorative dentist's eval form, pre-op X-rays, perio charting, trmt plan, signed enrollee informed consent, narrative on exclusion of other trmt options
D6056	Prefabricated abutment — includes modification and placement	18–20		Yes	One per implant per lifetime. There is a 90-day minimum waiting period after implant placement. Remember to include the implant placement date on the authorization request.	Pre-op X-rays
D6058	Abutment supported porcelain/ceramic crown	18–20		Yes	One per implant per 60 months. There is a 90-day minimum waiting period after implant placement. Remember to include the implant placement date on the authorization request.	Pre-op X-rays
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	18–20	All permanent teeth (teeth 1 through 32)	Yes	One of (D6081) per 12 month(s) per patient. Not allowed on the same date as D4341, DD4342 or D1110.	Medical necessity
D6085	Provisional implant crown	18–20	All permanent teeth (teeth 1 through 32)	Yes	One implant provisional crown per implant per lifetime. Cannot be authorized with D6110, D6111, D6112, D6113.	Restorative dentist evaluation form, pre-op X-rays, Perio. charting, signed consent form, tooth (implant) number, associated authorization for D6010 by tooth number.
D6089	Access/Retorque Implant Screw	18–20, 21 and older	2-15, 18-31	No	One per every 3 years	No
D6096	Remove broken implant retaining screw	18–20		Yes	One per tooth per lifetime	Narrative of medical necessity
D6110	Implant/abutment supported removable denture for edentulous arch — maxillary	18–20		Yes	One per implant per 60 months. There is a 90-day minimum waiting period after implant placement. Remember to include the implant placement date on the authorization request.	Full mouth X-rays or panorex
D6111	Implant/abutment supported removable denture for edentulous arch — mandibular	18–20		Yes	One per implant per 60 months. There is a 90-day minimum waiting period after implant placement. Remember to include the implant placement date on the authorization request.	Full mouth X-rays or panorex

D6112	Implant/abutment supported removable denture for partially edentulous arch — maxillary	18–20		Yes	One per implant per 60 months. There is a 90-day minimum waiting period after implant placement. Remember to include the implant placement date on the authorization request.	Full mouth X-rays or panorex

Exhibit A — Benefits Covered for AmeriHealth Caritas DC: Medicaid Child

Prosthodontics, fixed

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D6113	Implant/abutment supported removable denture for partially edentulous arch — mandibular	18–20		Yes	One per implant per 60 months. There is a 90-day minimum waiting period after implant placement. Remember to include the implant placement date on the authorization request.	Full mouth X-rays or panorex
D6191	Semi precision abutment	18-20	All permanent teeth (teeth 1 through 32)	Yes	One per implant per 60 months. There is a 90-day minimum waiting period after implant placement. Remember to include the Implant placement date on the authorization request.	Pre-op X-rays
D6192	Semi precision attachment	18-20	All permanent teeth (teeth 1 through 32)	Yes	One per implant per 60 months. There is a 90-day minimum waiting period after implant placement. Remember to include the Implant placement date on the authorization request.	Pre-op X-rays

Reimbursement includes local anesthesia and routine post-operative care.

The extraction of asymptomatic impacted teeth is not a covered benefit. Symptomatic conditions would include pain and/or infection or demonstrated malocclusion causing a shifting of existing dentition.

The incidental removal of a cyst or lesion attached to the root(s) of an extraction is considered part of the extraction or surgical fee and should not be billed as a separate procedure.

Oral and maxillofacial surgery

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0–20	Teeth 1 – 32	No		
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated.	0–20	Teeth 1 – 32	No		
D7220	Removal of impacted tooth-soft tissue	0–20	Teeth 1 – 32	Yes		Pre-operative X-ray(s); narrative of med necessity
D7230	Removal of impacted tooth-partially bony	0–20	Teeth 1 – 32	Yes		Pre-operative X-ray(s); narrative of med necessity
D7240	Removal of impacted tooth —	0–20	Teeth 1 – 32	Yes		Pre-operative X-ray(s);

	completely bony					narrative of med necessity
D7241	Removal of impacted tooth — completely bony, unusual surgical	0–20	Teeth 1 – 32	Yes	Pre-operative radiographs of adjacent and opposing teeth with claim. **Prior authorization required.**	Pre-operative X-ray(s); narrative of med necessity
D7250	Surgical removal of residual tooth roots (cutting procedure)	0–20	Teeth 1 – 32	Yes	Will not be paid to the dentist or group that removed the tooth.	Pre-operative X-ray(s)

Exhibit A — Benefits Covered for AmeriHealth Caritas DC: Medicaid Child

					Removal of asymptomatic tooth not covered. Pre-operative radiographs of adjacent and opposing teeth with claim for prepayment review.	
D7270	Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth	0–20	Teeth 1 – 32	No	Includes splinting and/or stabilization. Post-operative radiograph and narrative with claim.	Narrative of medical necessity, post-op X-ray(s)
D7280	Surgical access of an unerupted tooth	0–20	Teeth 1 – 32	Yes	Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	Narrative of medical necessity, pre-op X-ray(s)
D7282	Mobilization of erupted or malpositioned tooth to aid eruption To move/luxate teeth to eliminate ankyolosis; not in conjunction with an extraction.	0-20	Teeth 1 – 32	Yes	This code is covered for credentiled oral surgeons. This code will not pay unless you are credentiled as an oral surgeon. One per lifetime per tooth.	Pre-operative x-ray or CBCT scan for each. No narrative.
D7283	Placement of device to facilitate eruption of impacted tooth Placement of an orthodontic bracket, band or other device on an unerupted tooth, after its exposure, to aid in its eruption. Report the surgical exposure separately using D7280.	0-20	Teeth 1 – 32		This code is covered for credentiled oral surgeons. This code will not pay unless you are credentiled as an oral surgeon. One per lifetime per tooth.	Pre-operative x-ray or CBCT scan for each. No narrative.
D7284	Excision Biopsy of Salivary Gland	0–20, 21 and older		No	One per lifetime	Biopsy report
D7286	Incisional biopsy of oral tissue — soft	0–20		No	Pathology report with claim for prepayment review.	Pathology report
D7310	Alveoloplasty in conjuction with extractions — four or more teeth or tooth	0–20	Per quadrant (UL, UR)	Yes	One of (D7310) per lifetime per patient per quadrant. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	Narrative of medical necessity, pre-op X-ray(s)

Oral and maxillofacial surgery

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D7320	Alveoloplasty not in conjunction with extractions — four or more teeth or tooth spaces, per quadrant	0–20	Per quadrant (LL, LR, UL, UR)	Yes	One of (D7320) per lifetime per patient per quadrant. No extractions performed in an edentulous area. Narrative of medical necessity shall be maintained in patient records. Narrative of medical necessityand pre-operative X-ray(s) with claims for prepayment review.	Narrative of medical necessity, pre-op X-ray(s)
D7340	Vestibuloplasty — ridge extension (secondary epithelialization)	0–20	Per arch (LA, UA)	Yes	Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	Narrative of medical necessity, pre-op X-ray(s)

D7350	Vestibuloplasty — ridge extension	0–20	Per arch (LA, UA)	No		
D7451	Removal of odontogenic cyst or tumor — lesion greater than 1.25cm	0–20		No		Pathology report
D7460	Removal of nonodontogenic cyst or tumor — lesion diameter up to 1.25cm	0–20		Yes	Pathology report with claim for prepayment review.	Pathology report

D7471	Removal of exostosis — per site	0–20	Per arch (LA, UA)	No		Narrative of med necessity
D7472	Removal of torus palatinus	0–20		No		Narrative of med necessity
D7473	Removal of torus mandibularis	0–20		No		Narrative of med necessity
D7510	Incision and drainage of abscess — intraoral soft tissue	0–20	Teeth 1 – 32, A – T.	No	Not allowed on same day as extraction.	Pre-operative radiographs and narrative of medical necessity.
D7520	Incision and drainage of abscess — extraoral soft tissue	0–20	Teeth 1 – 32, A – T.	No		
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	0–20		No		
D7610	Maxilla — open reduction	0–20		No		Narrative of med necessity
D7620	Maxilla — closed reduction	0–20		No		Narrative of med necessity
D7630	Mandible-open reduction	0–20		No		Narrative of med necessity
D7640	Mandible — closed reduction	0–20		No		Narrative of med necessity
D7660	Malar and/or zygomatic arch — closed	0–20		No		
D7670	Alveolus stabilization of teeth, closed reduction splinting	0–20		No		
D7820	Closed reduction dislocation	0–20		No		
D7840	Condylectomy	0–20		No		
D7850	Surgical discectomy, with/without implant	0–20		No		

Oral and maxillofacial surgery

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D7860	Arthrotomy	0–20		No		
D7870	Arthrocentesis	0–20		No		
D7910	Suture small wounds up to 5 cm	0–20		Yes	Narrative of wound origin. Primary closure of incision is excluded per CDT description.	
D7940	Osteoplasty- for orthognathic deformities	0–20		No		
D7911	Complicated Suture - Up To 5 Cm	0-20		Yes	One per lifetime	Narrative of wound origin.
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla — autogenous or nonautogenous, by report	0–20		No		

Exhibit A — Benefits Covered for AmeriHealth Caritas DC: Medicaid Child

D7953	Bone replacement graft for ridge preservation — per site	0–20	Per quadrant (LL, LR, UL, UR)	Yes	Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review. Must occur at the same time as extraction and implant placement.	Narrative of med necessity
D7961	Buccal/labial frenectomy	0-20		Yes	One of (D7961) per lifetime per patient. Pre-operative and Post-operative photographs and narrative of medical necessity with claim for pre-payment review.	Narrative of medical necessity
D7962	Lingual frenectomy	0-20		Yes	One of (D7962) per lifetime per patient. Pre-operative and post operative photographs and narrative of medical necessity with claim for pre-payment review.	Narrative of medical necessity
D7970	Excision of hyperplastic tissue — per arch	0–20	Per arch (LA, UA)	No		
D7979	Non-surgical sialolithotomy	0–20		Yes	One procedure per lifetime	Narrative of medical necessity
D7982	Sialodochoplasty	0–20		No		

Orthodontic Services for Enrollees Ages 0 – 20

Medicaid enrollees age 20 and under may qualify for orthodontic care under the District of Columbia Medicaid program. Enrollees must have a severe, dysfunctional, handicapping malocclusion.

Since a case must be dysfunctional to be accepted for treatment, enrollees whose molars and bicuspids are in good occlusion seldom qualify. Crowding alone is usually not dysfunctional in spite of the aesthetic considerations.

All orthodontic services require prior authorization by one of AmeriHealth Caritas DC's dental consultants. The enrollee should present with a fully erupted set of permanent teeth. At least ½ to ¾ of the clinical crown should be exposed, unless the tooth is impacted or congenitally missing.

There are three avenues for orthodontic coverage:

- Having a minimum score on the Handicapping Labio-Lingual Deviation (HLD) index of 15 or greater
- Exhibiting one of six automatic qualifying conditions
- Otherwise exhibiting a medical need for orthodontia as established in a writing narrative prepared by a qualified dental service provider

Before delivering an orthodontic service, each provider shall request prior authorization. To be e ligible for orthodontia services, the enrollee's dental or orthodontia provider shall demonstrate that the enrollee meets at least one of the following criteria:

- Has an HLD score greater than or equal to 15.
- Exhibits one or more of the following automatic qualifying condition(s) that caused dysfunction due to a handicapping malocclusion and is supported by evidence in the member's treatment records:
    - Cleft palate deformity
    - Cranio-facial anomaly
    - Deep impinging overbite
    - Cross bite of individual anterior teeth
    - Severe traumatic deviation
    - Overjet greater than nine millimeters (9 mm) or mandibular protrusion greater than three and half millimeters (3.5 mm)

The following documentation must be submitted with the request for prior authorization services:

- American Dental Association (ADA) 2019 or newer claim form with service code requested
- Cephalometric head film with measurements
- Panoramic or full series periapical radiographs
- Clinical summary with diagnosis
- HLD score sheet completed and signed by the orthodontist
- Diagnostic quality photos
- Trea tment plan

Trea tment should not begin prior to receiving notification from AmeriHealth Caritas DC in dicating coverage or non-coverage for the proposed treatment plan. Orthodontists who begin treatment before receiving their approved (or denied) prior authorization are financially obligated to complete treatment at no charge to the enrollee or face possible termination of their Participating Provider Agreement. Providers cannot bill prior to services being performed.

The starting and billing date of orthodontic services is defined as the date when the bands, brackets, or appliances are placed in the enrollee's mouth. The enrollee must be eligible on this date of service.

Initial payments for orthodontics (code D8080) includeinitial banding, de-banding, one set of retainers, and adjustments (thenumber of adjustments depends on the plan).

To guarantee proper and prompt payment of orthodontic cases, pleasefollow thesteps below:

- Submit a completed ADA 2019 (or newer) claim for pre-authorization of comprehensive orthodontic treatment listing D8080 (comprehensive orthodontic treatment). Please note that, if an appliance is medically necessary, you should include D8220 (fixed appliance therapy) and/or D8210 (removable appliance therapy) in the prior authorization. You must include information related to which arch the appliance will be placed in and the specific medical necessity of the appliance.
- Once the determination has been made on the comprehensive orthodontic treatment, submit a separate claim for reimbursement of records (D8660) with the daterecords were taken. D 8660 will only be paid in conjunction with comprehensive orthodontic treatment (D8080).
- When brackets and bands have been placed in the enrollee's mouth, submit a separateclaim for reimbursement for comprehensiveorthodontic treatment (D8080) with the banding date
- When the appliance is placed in the enrollee's mouth, submit a separate claim for reimbursement of the appliance (D8220 or D8210)
- Providers must submit claims for periodic treatment visits (D8670). The enrollee must be eligible on each date of service.
- Electronically file, fax, or mail a copy of thecompleted ADA form with the date of service filled in

The maximum case payment for orthodontic treatment is:

- One records fee (D8660)
- One initial payment (D8080)
- One appliance (D8220), if medically necessary
- One removable appliance (D8210), if medically necessary
- Twenty-one monthly adjustments submitted (D8670)
- Two orthodontic retentions (D8680)
- Additional periodic treatment visits beyond 21 monthly adjustments will be the provider's financial responsibility and not the member's
- Enrollees may not be billed for broken, repaired, or replaced brackets or wires

Continuation of treatment

For orthodontic continuation of treatment cases that transfer from one provider to another, prior authorization is required for the new provider to start the case. Thenew provider must submit an AmeriHealth Caritas DC Continuation of Care Form including the following required information:

- Patient information
- Provider information
- Name of previous insurer or managed care organization (MCO) that issued theoriginal approval
- Number of adjustments remaining

In addition, wherepossible, the original banding dateand a copy of the prior approval from the previous vendor or MCO should also beprovided. If the enrollee was approved for orthodontia outside of the state of Maryland, as a privatepay patient, or under a commercial insurance program, the enrollee must obtain original diagnostic models (or Ortho CAD™ equivalent), radiographs, and all records from theoriginal orthodontic provider for AmeriHealth Caritas DC to make a determination on the continuation of care.

Orthodontics

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D8080	Comprehensive orthodontic treatment of the adolescent dentition	0–20		Yes	One of (D8080) per patient per lifetime. **Prior authorization required**.	Diagnostic quality photos, pan or peri X-rays, narrative/treatment plan
D8210	Removable appliance therapy (includes appliances for thumb sucking and tongue thrusting)	0–20		Yes	One of (D8210) per lifetime per patient. Narrative of medical necessity, model or photo with claim for prepayment review.	Narrative of medical necessity
D8220	Fixed appliance therapy (includes appliances for thumb sucking and tongue thrusting)	0–20		Yes	One of (D8220) per lifetime per patient. Narrative of medical necessity, model or photo with claim for prepayment review.	Narrative of medical necessity
D8660	Pre-orthodontic treatment examination to monitor growth and development	0–20		Yes	Used to pay for records on denied and approved cases. Medical record with claim for prepayment review.	
D8670	Periodic orthodontic treatment visit	0–20		Yes	One of (D8670) per 30 day(s) per patient. Maximum of 21 visits reimbursed.	
D8680	Orthodontic retention (removal of appliances)	0–20		Yes	Maximum of two units of retention reimbursed.	
D8695	Removal of fixed orthodontic appliances for reasons other than completion of treatment	0–20		Yes	One per lifetime	Narrative of medical necessity
D8703	Replacement of lost or broken retainer – maxillary	0–21	Upper arch	Yes	Two per lifetime	Narrative of medical necessity, history of D8680
D8704	Replacement of lost or broken retainer – mandibular	0–21	Lower arch	Yes	Two per lifetime	Narrative of medical necessity, history of D8680

Adjunctive General Services

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D9110	Palliative (emergency) treatment of dental pain — minor procedure	0–20		No	Not allowed with any other services other than radiographs. One of (D9110) per six month(s) per provider or location.	Narrative of medical necessity
D9222	Deep sedation/general anesthesia — first 15 minutes	0–20		Yes	Four unit maximum. D9223 to be used up to two units subsequent to D9222	Narrative of medical necessity
D9223	Deep sedation/general anesthesia — each 15-minute increment	0–20		Yes	Narrative of medical necessity with claim for prepayment review.	Narrative of medical necessity
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	0–20		No	Not allowed with D9223. Narrative of medical necessity shall be maintained in patient records. Requires accompanying restorative treatment.	Narrative of medical necessity
D9310	Consultation — diagnostic service provided by dentist or physician other than requesting dentist or physician	0–20		No	Diagnostic service provided by dentist other than practitioner providing treatment.	
D9420	Hospital or Ambulatory Surgical Center Call	0-20		No	Not allowed with any other services other than radiographs. One of (D9420) per six month(s) Per provider or location.	
D9430	Office Visit for Observation	0–20		No	Not allowed with any other services other than radiographs. One of (D9420) per six month(s) Per provider or location.	
D9944	Occlusal guard — Hard appliance, full arch	0–20		Yes	One of (D9944) per 60 month(s) per patient. Removable dental appliances which are designed to minimize the effects of bruxism (grinding) and other occlusal factors. Narrative of medical necessity shall be maintained in patient records. Excluded with D9945 and D9946.	Narrative of medical necessity
D9945	Occlusal guard — Soft appliance, full arch	0–20		Yes	One of (D9945) per 24 month(s) per patient. Removable dental appliances which are designed to minimize the effects of bruxism (grinding) and other occlusal factors. Narrative of medical necessity shall be maintained in patient records. Excluded with D9944 and D9946.	Narrative of medical necessity
D9946	Occlusal guard — Hard appliance, partial arch	0–20		Yes	One of (D9946) per 24 month(s) per patient. Removable dental appliances which are designed to minimize the effects of bruxism (grinding) and other occlusal factors. Narrative of medical necessity shall be maintained in patient records. Excluded with D9945 and	Narrative of medical necessity

					D9944.	
D9951	Occlusal adjustment — limited	0–20		Yes	Two of (D9951) per 12 month(s) per patient. Not covered with any restorative procedure on same date of service. Narrative of medical necessity shall be maintained in patient records.	Narrative of medical necessity

Adjunctive General Services

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D9952	Occlusal adjustment — complete	0–20		Yes	One of (D9952) per 12 month(s) per patient. Not covered with any restorative procedure on same date of service. Narrative of medical necessity shall be maintained in patient records.	Narrative of medical necessity
D9955	Oral Appliance Titration Visit	0–20, 21 and older		Yes	3 per year	Narrative of medical necessity

Exhibit C Benefits Covered for AmeriHealth Caritas DC: Alliance Adult

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Diagnostic services include the oral examinations, and selected radiographs, needed to assess the oral health, diagnose oral pathology, and develop an adequate treatment plan for the enrollee's oral health.

Reimbursement for someor multiple radiographs of the same tooth or area may be denied if AmeriHealth Caritas DC determines the number to be redundant, excessive, or not in keeping with federal guidelines relating to radiation exposure. The maximum amount paid for individual radiographs taken on the same day will be limited to the allowance f or a full mouth series.

Reimbursement for radiographs is limited to that required for proper treatment and/or diagnosis.

AmeriHealth Caritas DC utilizes the guidelines published by the Department of Health and Human Services Center for Devices and Radiological Health. However, please consult the following benefit tables for benefit limitations.

All radiographs must be of diagnostic quality, properly mounted, dated, and identified with theenrollee's name. Radiographs not of diagnostic quality will not be reimbursed for, or, if already paid for, AmeriHealth Caritas DC will recoup thefunds previously paid.

Diagnostic

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D0120	Periodic oral evaluation — established patient	21 and older		No	One of (D0120, D0150, D0160) per six month(s) per provider **or** location.	
D0140	Limited oral evaluation — problem focused	21 and older		No	Not reimbursable on the same day as D0120, D0140, D0145, D0150, D0160, D0170 or D0180. Allowed only with emergency treatment. Not allowed with routine treatment. One of (D0140) per six month(s) per provider or location.	
D0150	Comprehensive oral evaluation — new or established patient	21 and older		No	One of (D0150) per lifetime per provider **or** location. One of (D0120, D0150, D0160) per six month(s) per provider **or** location.	
D0160	Detailed and extensive oral evaluation — problem focused, by report	21 and older		No	One of (D0120, D0150, D0160, D0170, D0180) per six month(s) per provider **or** location.	
D0170	Re-evaluation, limited problem focused	21 and older		Yes	One of (D0120, D0150, D0160, D0170, D0180) per six month(s) per provider or location.	Narrative of medical necessity

D0180	Comprehensive periodontal evaluation — new or established patient	21 and older		No	One of (D0180) per 12 month(s) per provider **or** location.	
D0190	Screening of a patient	21 and older		No	One of (D0190) per 12 month(s) per provider or location	
D0191	Assessment of a patient	21 and older		No	One of (D0191) per 12 month(s) per provider or location	
D0210	Intraoral — complete series of radiographic images	21 and older		No	One of (D0210, D0330) per 36 month(s) per patient.	

Exhibit C Benefits Covered for AmeriHealth Caritas DC: Alliance Adult

Diagnostic

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D0220	Intraoral — periapical first radiographic image	21 and older		No	One of (D0220) per date of service.	Tooth #
D0230	Intraoral — periapical each additional radiographic image	21 and older		No		Tooth #
D0240	Intraoral — occlusal radiographic image	21 and older		No	Two of (D0240) per 12 month(s) per patient.	
D0270	Bitewing — single radiographic image	21 and older		No	One of (D0270, D0272, D0274) per 12 month(s) per patient.	
D0272	Bitewings — two radiographic images	21 and older		No	One of (D0270, D0272, D0274) per 12 month(s) per patient.	
D0274	Bitewings — four radiographic images	21 and older		No	One of (D0270, D0272, D0274) per 12 month(s) per patient.	
D0330	Panoramic radiographic image	21 and older		No	One of (D0210, D0330) per 36 month(s) per patient.	
D0340	Cephalometric radiographic image	21 and older		Yes	One of (D0340) per 36 month(s) per patient. Narrative of medical necessity with claim for prepayment review	Narrative of medical necessity
D0364	Cone beam CT capture and interpretation with limited field of view - less than one whole jaw	21 and older		No		
D0367	Cone beam CT capture and interpretation with field of view of both jaws; with or without cranium	21 and older		No		
D0460	Pulp vitality tests	21 and older		No	One per visit. Includes multiple teeth and contralateral comparison(s), as indicated.	
D0606	Molecular Test Public Hlth	21 and older		No	4 per lifetime	

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Space maintainers are a covered service when medically indicated dueto the prematureloss of a posterior primary tooth. A lower lingual holding arch placed where there is not prematureloss of the primary molar is considered a transitional orthodontic applianceand not covered by this Plan.

Preventative

Code	Description	Age limita tion	Teeth covered	Authorization required	Benefit limitations	Documentation required
D1110	Prophylaxis — adult	21 and older		No	One of (D1110) per six Month(s) Per patient. Includes scaling and polishing procedures to remove coronal plaque, calculus, and stains. Not allowed with D4000 Series codes.	
D1206	Topical application of fluoride varnish	21 and older		No	One of (D1206, D1208) per six month(s) per patient	
D1208	Topical application of fluoride — excluding varnish	21 and older		No	One of (D1208) per six month(s) per patient. Requires accompanying recall code (D1110 or D4910).	
D1354	Interim caries arresting medicament application	21 and older	A–T,2–31	No	Two (2) applications per 12 months	

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Reimbursement includes local anesthesia.

Generally, oncea particular restoration is placed on a tooth, a similar restoration will not be covered for at least nine months.

Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day. A restoration is considered a two-or more surfacerestoration only when two or more actual tooth surfaces are involved, whether they areconnected or not.

When restorations involving multiple surfaces are requested or performed that are outside theusual anatomical expectation, the allowance is limited to that of a o ne-surfacerestoration. Any fee charged in excess of the allowance for the one-surfacerestoration is **disallowed**.

Tooth preparation, all adhesives (including amalgam and resin bonding agents), acid etching, copalite, liners, bases, direct and indirect pulp caps, curing, polishing, and adjustment are included as part of the fee for therestoration.

Billing and reimbursement for all crowns, post and cores, and any other prosthetics should be based on the cementation date.

Restorative

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D2140	Amalgam — one surface, primary or permanent	21 and older	Teeth 1 – 32, A – T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per nine month(s) per surface for primary and permanent teeth.	
D2150	Amalgam — two surfaces, primary or permanent	21 and older	Teeth 1 – 32, A – T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per nine month(s) per surface for primary and permanent teeth.	
D2160	Amalgam — three surfaces, primary or permanent	21 and older	Teeth 1 – 32, A – T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per nine month(s) per surface for primary and permanent teeth.	
D2161	Amalgam — four or more surfaces, primary or permanent	21 and older	Teeth 1 – 32, A – T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per nine month(s) per surface for primary and permanent	

					teeth.	
D2330	Resin-based composite — one surface, anterior	21 and older	Teeth 6 – 11, 22 – 27, C–H,M–R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per nine month(s)	

Exhibit C Benefits Covered for AmeriHealth Caritas DC: Alliance Adult

					per surface for primary and permanent teeth.	

Restorative

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D2331	Resin-based composite — two surfaces, anterior	21 and older	Teeth 6 – 11, 22 – 27, C–H,M–R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per nine month(s) per surface for primary and permanent teeth.	
D2332	Resin-based composite — three surfaces, anterior	21 and older	Teeth 6 – 11, 22 – 27, C–H,M–R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per nine month(s) per surface for primary and permanent teeth.	
D2335	Resin-based composite — four or more surfaces or involving incisal angle (anterior)	21 and older	Teeth 6 – 11, 22 – 27, C–H,M–R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per nine month(s) per surface for primary and permanent teeth.	
D2391	Resin-based composite — one surface, posterior	21 and older	Teeth 1 – 5, 12 – 21, 28-32, A, B, I – L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per nine month(s) per surface for primary and permanent teeth.	
D2392	Resin-based composite — two surfaces, posterior	21 and older	Teeth 1 – 5, 12 – 21, 28-32, A, B, I – L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per nine month(s) per surface for primary and permanent teeth.	
D2393	Resin-based composite — three surfaces, posterior	21 and older	Teeth 1 – 5, 12 – 21, 28-32, A, B, I – L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per nine month(s) per surface for primary and permanent teeth.	
D2394	Resin-based composite — four or more surfaces, posterior	21 and older	Teeth 1 – 5, 12 – 21, 28 –32,A,B,I–L,S,T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per nine month(s) per surface for primary and permanent teeth.	
D2710	Crown – resin based composite	21 and older	Teeth 1 – 32	Yes	One of (D2710) per 60 month(s) per patient per tooth.	Narrative of medical necessity with claim for prepayment

						review, pre-op X-ray(s)

Exhibit C Benefits Covered for AmeriHealth Caritas DC: Alliance Adult

D2740	Crown porcelain/ceramin		Teeth 1 – 32	Yes	Limit One of D2740, D2750, D2751, D2790 per 60 month(s) per patient per tooth.	Pre-op xrays of adjacent and opposite teeth with claim for prepayment review
D2751	Crown — porcelain fused to predominantly base metal	21 and older	Teeth 1 – 32	Yes	One of (D2750, D2751, D2790) per 60 month(s) per patient per tooth. Pre-operative radiographs of completed root canal for pre-payment review when restorative crown will be placed. Not allowed within nine months D2140-D2161, D2330-D2335.	Pre-operative X-ray(s)
D2790	Crown – full cast high noble metal	21 and older		Yes	One of (D2750, D2751, D2790) per 60 month(s) per patient per tooth. Pre-op radiographs of adjacent and opposite teeth with claim for prepayment review	
D2950	Core build-up including any pins		Teeth 1 – 32	No	One of D2950, D2952, D2954 per 60 Months per patient per tooth. Must be with D2740, D2750, D2751, D2790.	
D2954	Prefabricated post and core in addition to crown	21 and older	Teeth 1 – 32		One of (D2954) per 60 Month(s) per patient per tooth. One of (D2952, D2954) per 60 month(s) per patient per tooth. Refers to building up of anatomical crown when restorative crown will be placed.	

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Reimbursement includes local anesthesia.

In cases where a root canal filling does not meet AmeriHealth Caritas DC's general criteria treatment standards, AmeriHealth Caritas DC can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after the AmeriHealth Caritas DC consultant reviews the circumstances.

A pulpotomy or palliative treatment is not to be billed in conjunction with a root canal treatment by the same provider on thesame date of service.

Filling material not accepted by thefederal Food and Drug Administration (FDA) (e.g., Sargenti filling material) is not covered.

The fee for root canal therapy for permanent teeth includes diagnosis, extirpation treatment, temporary fillings, filling and obturation of root canals, and progress radiographs. A completed fill radiograph is also included.

Endodontics

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D3110	Pulp cap — direct (excluding final restoration)	21 and older	Teeth 1 – 32, A – T	No		Pre and Post-operative X-ray showing the completed treatment
D3220	Therapeutic pulpotomy (excluding final restoration) — removal of pulp coronal to the dentinocemental junction and application of medicament	21 and older	Teeth 1 – 32, A – T	No		Pre and Post-operative X-ray showing the completed treatment
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	21 and older	Teeth 6 – 11, 22 – 27	No	One of (D3310) per lifetime per patient per tooth.	Pre and Post-operative X-ray showing the completed treatment
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	21 and older	Teeth 4, 5, 12, 13, 20,21,28, 29	No	One of (D3320) per lifetime per patient per tooth.	Pre and Post-operative X-ray showing the completed treatment
D3330	Endodontic therapy, molar (excluding final restoration)	21 and older	Teeth 1 – 3, 14 – 19, 30–32	No	One of (D3330) per lifetime per patient per tooth.	Pre and Post-operative X-ray showing the completed treatment
D3346	Retreatment of previous root canal therapy — anterior	21 and older	Teeth 6 – 11, 22 – 27	No	One of (D3346) per lifetime per patient per tooth. Not allowed by same provider or dental office that performed original	Narrative of medical necessity, pre-op X-ray(s)

					root canal therapy.	
D3347	Retreatment of previous root canal therapy — bicuspid	21 and older	Teeth 4, 5, 12, 13, 20, 21,28, 29	No	One of (D3347) per lifetime per patient per tooth. Not allowed by same provider or dental office that performed original root canal therapy.	Narrative of medical necessity, pre-op and post-op X-ray(s)

Exhibit C Benefits Covered for AmeriHealth Caritas DC: Alliance Adult

Endodontics

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D3348	Retreatment of previous root canal therapy — molar	21 and older	Teeth 1 – 3, 14 – 19, 30–32	No	One of (D3348) per lifetime per patient per tooth. Not allowed by same provider or dental office that performed original root canal therapy.	Narrative of medical necessity, pre-op and post-op X-ray(s)
D3351	Apexification/recalcification — initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	21 and older	Teeth 1 – 32	Yes		Narrative of medical necessity, pre-op and post-op X-ray(s)
D3410	Apicoectomy — anterior	21 and older	Teeth 6 – 11, 22 – 27	No		Narrative of medical necessity, pre-op X-ray(s)
D3421	Apicoectomy — bicuspid (first root)	21 and older	Teeth 4, 5, 12, 13, 20, 21,28, 29	No		Narrative of medical necessity, pre-op X-ray(s)
D3425	Apicoectomy — molar (first root)	21 and older	Teeth 1 – 3, 14 – 19, 30–32	No		Narrative of medical necessity, pre-op X-ray(s)
D3426	Apicoectomy (each additional root)	21 and older	Teeth 1 – 5, 12 – 21, 28–32	No		Narrative of medical necessity, pre-op X-ray(s)
D3430	Retrograde filling — per root	21 and older	Teeth 1 – 32	No		Narrative of medical necessity, pre-op X-ray(s)
D3432	Guided Tissue Regeneration	21 and older		Yes	One of (D3432) per lifetime per patient per tooth. Pre and post-operative X-ray(s) with Claim for prepayment review	
D3450	Root amputation — per root	21 and older	Teeth 1 – 32	No		Narrative of medical necessity, pre-op X-ray(s)

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Reimbursement includes local anesthesia.

Periodontics

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D4210	Gingivectomy or gingivoplasty — four or more contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per quadrant (LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4240, D4241, D4249) per 24 month(s) per patient per quadrant. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	Narrative of medical necessity, pre-op X-ray(s)
D4211	Gingivectomy or gingivoplasty — one to three contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per quadrant (LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4240, D4241, D4249) per 24 month(s) per patient per quadrant. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	Narrative of medical necessity, pre-op X-ray(s)
D4240	Gingival flap procedure, including root planning — four or more contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per quadrant (LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4240, D4241, D4249) per 24 month(s) per patient per quadrant. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	Narrative of medical necessity, pre-op X-ray(s)
D4241	Gingival flap procedure, including root planning — one to three contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per quadrant (LL, LR, UL, UR)	Yes	One of (D4210, D4211, D4240, D4241, D4249) per 24 month(s) per patient per quadrant. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	Narrative of medical necessity, pre-op X-ray(s)
D4249	Clinical crown lengthening — hard tissue	21 and older	Teeth 1 – 32	Yes	One of (D4210, D4211, D4240, D4241, D4249) per 24 month(s) per patient per quadrant. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	Narrative of medical necessity, pre-op X-ray(s)
D4263	Bone replacement graft — first site in quadrant	21 and older	Teeth 1 – 32	Yes	One of (D4263) per 24 month(s) per patient per tooth. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	Narrative of medical necessity, pre and post-op X-ray(s)
D4264	Bone replacement graft — each additional site in quadrant	21 and older	Teeth 1 – 32	Yes	One of (D4264) per 24 month(s) per patient per tooth. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment	Narrative of medical necessity, pre and post-op X-ray(s)

					review.	

Exhibit C Benefits Covered for AmeriHealth Caritas DC: Alliance Adult

Periodontics

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D4341	Periodontal scaling and root planning — four or more teeth per quadrant	21 and older	Per quadrant (LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 24 month(s) per patient per quadrant. A minimum of four teeth in the affected quadrant. Periodontal charting and pre-operative radiographs. There must be radiographic evidence of root calculus or noticeable loss of bone support. Pre-operativeX-ray(s) and perio charting with claim for prepayment review. Not allowed with D1110 within a 6 month period.	Pre-op X-ray(s), perio charting
D4342	Periodontal scaling and root planning — one to three teeth per quadrant	21 and older	Per quadrant (LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 24 month(s) per patient per quadrant. One to three teeth in the affected quadrant. Periodontal charting and pre-operative radiographs. There must be evidence of root calculus and noticeable loss of bone support. Pre-operative X-ray(s) and perio charting with claim for prepayment review. Not allowed with D1110 with a 6 month period.	Pre-op X-ray(s), perio charting
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	21 and older		Yes	One of (D4355) per 36 month(s) per patient. Not allowed on the same date as D4341, DD4342, or D1110.	
D4910	Periodontal maintenance procedures	21 and older		No	One of (D4910) per six month(s) per patient. Includes scaling and polishing procedures to remove coronal plaque, calculus, and stains. Not allowed on same date as D4000 series codes or D1110. Requires prior D4341 or D4342.	Pre-op X-ray(s), perio charting

Exhibit C Benefits Covered for AmeriHealth Caritas DC: Alliance Adult

The Alliance plan has a $1,000 maximum annual benefit effective from January 1 through December 31. The benefit will renrew on January 1 each year. Covered services listed within this section can be rendered up to the $1,000 annual maximum based upon your contracted fee schedule with AmeriHealth Caritas DC. Enrollee s areresponsible for payment of any services beyond the$1,000 annual maximum. The enrollee must be eligible on the date of service. All listed benefit limitations, authorizations requirements, and age limitations remain as listed below.

Medically necessary partial or full mouth dentures and related services are covered when they are determined to be the primary treatment of choice or an essential part of the overall treatment plan to alleviate the enrollee's dental problem.

A preformed denture with teeth already mounted forming a denture module is not a covered service.

Extractions for asymptomatic teeth are not covered services unless removal constitutes themost cost-effective dental procedure for the provision of dentures. Provision of dentures for cosmetic purposes is not a covered service.

Billing and reimbursement for all crowns, post and cores, and any other prosthetics should be based on the cementation date. A partial denture that replaces only posterior permanent teeth must include three or more teeth on the dentures that areanatomically correct (natural size, shape, and color) to be compensable (excluding third molars). Partial dentures must include one anterior tooth and/or three posterior teeth (excluding third molars).

Prosthodontics, removable

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D5110	Complete denture — maxillary	21 and older	Per arch (UA)	Yes	One of (D5110, D5211, D5213) per 60 month(s) per patient.	Pre-operative X-ray(s)
D5120	Complete denture — mandibular	21 and older	Per arch (LA)	Yes	One of (D5120, D5212, D5214) per 60 month(s) per patient.	Pre-operative X-ray(s)
D5211	Maxillary partial denture — resin base (including any conventional clasps, rests, and teeth)	21 and older		Yes	One of (D5110, D5211, D5213) per 60 month(s) per patient.	Pre-operative X-ray(s)
D5212	Mandibular partial denture — resin base (including any conventional clasps, rests, and teeth)	21 and older		Yes	One of (D5120, D5212, D5214) per 60 month(s) per patient.	Pre-operative X-ray(s)
D5213	Maxillary partial denture — cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)	21 and older		Yes	One of (D5110, D5211, D5213) per 60 month(s) per patient.	Pre-operative X-ray(s)
D5214	Mandibular partial denture — cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	21 and older		Yes	One of (D5120, D5212, D5214) per 60 month(s) per patient.	Pre-operative X-ray(s)
D5221	Immediate maxillary partial denture —	21 and older		Yes	One of D5221 or D5223 per lifetime	Full mouth pre-operative

	resin base (including any conventional clasps, rests, and teeth)					X-ray(s) or panorex
D5222	Immediate mandibular partial denture — resin base (including any conventional clasps, rests, and teeth)	21 and older		Yes	One of D5222 or D5224 per lifetime	Full mouth pre-operative X-ray(s) or panorex

Exhibit C Benefits Covered for AmeriHealth Caritas DC: Alliance Adult

Prosthodontics, removable

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D5223	Immediate maxillary partial denture — cast metal framework with resin dentures bases (including any conventional clasps, rests, and teeth)	21 and older		Yes	One of D5221 or D5223 per lifetime	Full mouth pre-operative X-ray(s) or panorex
D5224	Immediate mandibular partial denture — cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth).	21 and older		Yes	One of D5222 or D5224 per lifetime	Full mouth pre-operative X-ray(s) or panorex
D5511	Repair broken complete denture base — Mandibular	21 and older	Per arch (LA, UA)	No	Repairs will be reimbursed at two repairs per denture per year with five total denture repairs per five years	
D5512	Repair broken complete denture base — Maxillary	21 and older	Per arch (LA, UA)	No	Repairs will be reimbursed at two repairs per denture per year with five total denture repairs per five years	
D5520	Replace missing or broken teeth — complete denture (each tooth)	21 and older	Teeth 1 – 32	No		
D5611	Repair resin denture base — Mandibular	21 and older	Per arch (LA, UA)	No	Repairs will be reimbursed at two repairs per denture per year with five total denture repairs per five years	
D5612	Repair resin denture base — Maxillary	21 and older	Per arch (LA, UA)	No	Repairs will be reimbursed at two repairs per denture per year with five total denture repairs per five years	
D5621	Repair cast framework — Mandibular	21 and older	Per arch (LA, UA)	No	Repairs will be reimbursed at two repairs per denture per year with five total denture repairs per five years	
D5622	Repair cast framework — Maxillary	21 and older	Per arch (LA, UA)	No	Repairs will be reimbursed at two repairs per denture per year with five total denture repairs per five years	
D5630	Repair or replace broken clasp	21 and older		No		
D5640	Replace broken teeth-per tooth	21 and older	Teeth 1 – 32	No		
D5650	Add tooth to existing partial denture	21 and older	Teeth 1 – 32	No		
D5660	Add clasp to existing partial denture	21 and older		No		
D5710	Rebase complete maxillary denture	21 and older		No	Two of (D5710, D5730) per 60 month(s) per patient. Not covered within six months of placement.	

D5711	Rebase complete mandibular denture	21 and older		No	Two of (D5711, D5731) per 60 month(s) per patient. Not covered within six months of placement.	

Exhibit C Benefits Covered for AmeriHealth Caritas DC: Alliance Adult

D5720	Rebase maxillary partial denture	21 and older		No	Two of (D5720, D5740) per 60 month(s) per patient. Not covered within six months of placement.	

Prosthodontics, removable

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D5721	Rebase mandibular partial denture	21 and older		No	Two of (D5721, D5741) per 60 month(s) per patient. Not covered within six months of placement.	
D5730	Reline complete maxillary denture (chairside)	21 and older		No	Two of (D5710, D5730) per 60 month(s) per patient. Not covered within six months of placement.	
D5731	Reline complete mandibular denture (chairside)	21 and older		No	Two of (D5711, D5731) per 60 month(s) per patient. Not covered within six months of placement.	
D5740	Reline maxillary partial denture (chairside)	21 and older		No	Two of (D5720, D5740) per 60 month(s) per patient. Not covered within six months of placement.	
D5741	Reline mandibular partial denture (chairside)	21 and older		No	Two of (D5741) per 60 month(s) per patient. Not covered within six months of placement.	
D5876	Add metal Sub to Acrylc dent	21 and older		No	One of (D5876) per 24 month(s) per patient. Not covered within six months of placement	
D5982	Surgical stent	21 and older		Yes	Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	Narrative of medical necessity, pre-op X-ray(s)
D6089	Access/Retorque Implant Screw	18-20, 21 and older	2-15, 18-31	No	One per every 3 years	

Exhibit C Benefits Covered for AmeriHealth Caritas DC: Alliance Adult

Reimbursement includes local anesthesia and routine post-operative care.

The extraction of asymptomatic impacted teeth is not a covered benefit. Symptomatic conditions would include pain and/or infection or demonstrated malocclusion causing a shifting of existing dentition.

Oral and maxillofacial surgery

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	21 and older	Teeth 1 – 32,	No		
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	21 and older	Teeth 1 – 32,	Yes	Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	Narrative of medical necessity, pre-op X-ray(s)
D7220	Removal of impacted tooth-soft tissue	21 and older	Teeth 1 – 32,	Yes	Narrative of medical necessity and Pre-operative radiographs of adjacent and opposing teeth with claim for prepayment review.	Pre-operative X-ray(s)
D7230	Removal of impacted tooth-partially bony	21 and older	Teeth 1 – 32,	Yes	Narrative of medical necessity and Pre-operative radiographs of adjacent and opposing teeth with claim for prepayment review.	Pre-operative X-ray(s)
D7240	Removal of impacted tooth — completely bony	21 and older	Teeth 1 – 32,	Yes	Narrative of medical necessity and Pre-operative radiographs of adjacent and opposing teeth with claim for prepayment review.	Pre-operative X-ray(s)
D7241	Removal of impacted Tooth — completely bony, with unusual surgical complications	21 and older	Teeth 1 – 32,	Yes	Pre-operative radiographs of adjacent and opposing teeth with claim. **Prior authorization required.**	Pre-operative X-ray(s)
D7250	Surgical removal of residual tooth roots (cutting procedure)	21 and older	Teeth 1 – 32,	Yes	Will not be paid to the dentist or group that removed the tooth. Removal of asymptomatic tooth not covered. Pre-operative radiographs of adjacent and opposing teeth with claim for prepayment review.	Pre-operative X-ray(s)
D7270	Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth	21 and older	Teeth 1 – 32	No	Includes splinting and/or stabilization. Post-operative radiograph and narrative with claim.	Narrative of medical necessity, post-op X-ray(s)
D7280	Surgical access of an unerupted tooth	21 and older	Teeth 1 – 32	Yes	Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	Narrative of medical necessity, pre-op X-ray(s)

D7284	Excision Biopsy of Salivary Gland	0-20, 21 and older		No	One per lifetime	Biopsy Report
D7285	Incisional biopsy of oral tissue — hard (bone-tooth)	21 and older		Yes		Narrative of medical necessity, Panorex
D7286	Incisional biopsy of oral tissue-soft	21 and older		No		Pathology report

Exhibit C Benefits Covered for AmeriHealth Caritas DC: Alliance Adult

Oral and maxillofacial surgery

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D7310	Alveoloplasty in conjunction with extractions — four or more teeth or tooth spaces, per quadrant	21 and older	Per auadrant (LL, LR, UL, UR)	Yes	One of (D7310) per lifetime per patient per quadrant. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	Narrative of medical necessity, pre-op X-ray(s)
D7320	Alveoloplasty not in conjunction with extractions — four or more teeth or tooth spaces, per quadrant	21 and older	Per quadrant (LL, LR, UL, UR)	Yes	One of (D7320) per lifetime per patient per quadrant. No extractions performed in an edentulous area. Narrative of medical necessity shall be maintained in patient records. Narrative of medical necessityand pre-operative X-ray(s) with claims for prepayment review.	Narrative of medical necessity
D7340	Vestibuloplasty — ridge extension (secondary epithelialization)	21 and older	Per arch (LA, UA)	Yes	One of (D7340) per lifetime per patient per quadrant. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	Narrative of medical necessity, pre-op X-ray(s)
D7350	Vestibuloplasty — ridge extension	21 and older	Per arch (LA, UA)	Yes	One of (D7350) per lifetime per patient per quadrant. Pre-operative radiographs and narrative of medical necessity with claim for pre-payment review.	Narrative of medical necessity, pre-op X-ray(s)
D7410	Radical excision — lesion diameter up to 1.25cm	21 and older		Yes	Pathology report with claim for prepayment review.	Pathology report
D7451	Removal of odontogenic cyst or tumor — lesion greater than 1.25cm	21 and older		No		
D7460	Removal of nonodontogenic cyst or tumor — lesion diameter up to 1.25cm	21 and older		Yes	Pathology report with claim for prepayment review.	Pathology report
D7471	Removal of exostosis — per site	21 and older	Per arch (LA, UA)	Yes	Pre-operative radiographs with claim for pre-payment review.	Pre-operative X-ray(s)
D7472	Removal of torus palatinus	21 and older		Yes	Pre-operative radiographs with claim for pre-payment review.	Pre-operative X-ray(s)
D7473	Removal of torus mandibularis	21 and older		Yes	Pre-operative radiographs with claim for pre-payment review.	Pre-operative X-ray(s)
D7510	Incision and drainage of abscess — intraoral soft tissue	21 and older	Teeth 1 – 32,	No	Not allowed on same day as extraction.	
D7520	Incision and drainage of abscess — extraoral soft tissue	21 and older		No		
D7660	Malar and/or zygomatic arch — closed	21 and older		No		

D7670	Alveolus stabilization of teeth, closed reduction splinting	21 and older		No		
D7820	Closed reduction dislocation	21 and older		No		
D7840	Condylectomy	21 and older		No		

Exhibit C Benefits Covered for AmeriHealth Caritas DC: Alliance Adult

Oral and maxillofacial surgery

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D7850	Surgical discectomy, with/without implant	21 and older		No		
D7860	Arthrotomy	21 and older		No		
D7870	Arthrocentesis	21 and older		No		
D7910	Suture small wounds up to 5 cm	21 and older		Yes	Narrative of wound origin. Primary closure of incision is excluded per CDT description.	
D7940	Osteoplasty — for orthognathic deformities	21 and older		No		
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla — autogenous or nonautogenous, by report	21 and older		No		
D7953	Bone replacement graft for ridge preservation — per site	21 and older	Per quadrant (LL, LR, UL, UR)	Yes	Narrative of medical necessity with claim for prepayment review.	
D7970	Excision of hyperplastic tissue — per arch	21 and older	Per arch (LA, UA)	No	For removal or tissue over a previous edentulous denture bearing area to improve prognosis of a proposed denture. Narrative of medical necessity shall be maintained in patient records.	Narrative of medical necessity
D7972	Surgical reduction of fibrous tuberosity	21 and older		No		
D7979	Non-surgical sialolithotomy	21 and older		Yes	One procedure per lifetime	Narrative of medical necessity
D7982	Sialodochoplasty	21 and older		No		
D8090	Compre Dental Tx Adult	21 and older		Yes	One of (D8090) per patient per lifetime. Prior authorization required	

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Reimbursement includes local anesthesia.

Exhibit C Benefits Covered for

AmeriHealth Caritas DC: Alliance Adult

Adjunctive General Services

Code	Description	Age limitation	Teeth covered	Authorization required	Benefit limitations	Documentation required
D9110	Palliative (emergency) treatment of dental pain — minor procedure	21 and older		No	Not allowed with any other services other than radiographs. One of (D9110) per six month(s) per provider or location. Not allowed for prescriptions or medication.	Narrative of medical necessity
D9222	Deep sedation/general anesthesia — first 15 minutes	21 and older		Yes	Four unit maximum. D9223 to be used up to two units subsequent to D9222	Narrative of medical necessity
D9223	Deep sedation/general anesthesia — first 15 minutes	21 and older		Yes	Narrative of medical necessity with claim for payment review	Narrative of medical necessity
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	21 and older		No	Narrative of medical necessity shall be maintained in patient records. Requires accompanying restorative treatment.	Narrative of medical necessity
D9310	Consultation — diagnostic service provided by dentist or physician other than requesting dentist or physician	21 and older		No	Diagnostic service provided by dentist other than practitioner providing treatment.	
D9420	Hospital or Ambulatory Srg Ctr Call	21 and older		No	Not allowed with any other services other than radiographs. One of (D9420) per six month(s) Per provider or location.	
D9430	Office Visit for Observation	21 and older		No	Not allowed with any other services other than radiographs. One of (D9420) per six month(s) Per provider or location.	
D9955	Oral Appliance Titration Visit	0-20, 21 and older		Yes	3 per year	Narrative of medical necessity