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and BadgerCare
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Wisconsin Medicaid and BadgerCare Information for Providers

To:
Dental Hygienists
Dentists
HMOs and Other Managed Care Programs

Changes to Dental Prior Authorization Requirements and Coverage

This *Wisconsin Medicaid and BadgerCare Update* announces the following:

- Effective for dates of service on and after September 1, 2006, major changes will be made to prior authorization requirements and coverage for dental services. The attachments of this *Update* summarize the policies that will be in effect for Medicaid-allowable dental procedure codes.
- The National Provider Identifier will be the standard identifier and will be required to be used on all nationally recognized transactions.
- Improvements have been made to Provider Services for dentists.

Effective for dates of service (DOS) on and after September 1, 2006, major changes will be made to prior authorization (PA) requirements and coverage for dental services as a result of a revision to HFS 107.07, Wis. Admin. Code. These changes include the following:

- Removal of and revisions to PA requirements for many dental services.
- Discontinuation of the multidisciplinary temporomandibular joint (TMJ) evaluation program requirement.
- Revision of PA and claims submission requirements for services that are performed by quadrant.
- Addition of alveoloplasty as a reimbursable service for dentists.
- Revision of service limitations on emergency exams and nitrous oxide.

Attachment 1 of this *Wisconsin Medicaid and BadgerCare Update* is a summary of dental services that no longer require PA and services in which PA will still to be required. Attachment 2 summarizes the policies for Medicaid-allowable dental procedure codes on and after September 1, 2006, and completely replaces previously published lists of dental procedure codes. The dental maximum allowable fee schedule will be updated to reflect these changes in October 2006. The fee schedule, which is located on the Medicaid Web site, contains maximum allowable fees for each procedure.

Prior Authorization Changes and Coverage Reminders

Effective on and after September 1, 2006, select dental services will no longer require PA and/or have limitation changes. Providers are reminded that Medicaid reimbursement is allowable only for services that meet all program requirements, including the documentation of medical necessity for services. For those services no longer requiring PA, documentation supporting the medical necessity of the service must be included in the recipient's record.

Panoramic Films (D0330)

Prior authorization is no longer required for panoramic films. Coverage is limited to one per recipient per DOS, and should be taken *only* when another type of radiograph is insufficient for diagnosis. Documentation to support the medical necessity of this service must be included in the recipient's record. As a reminder, when a panoramic film *and* bitewings are taken on the same DOS, claims should be submitted with procedure code D0210 (Intraoral; complete series [including bitewings]) only.

Cephalometric Films, Diagnostic Casts, and Pre-Orthodontic Visits (D0340, D0470, D8660)

Prior authorization is no longer required for cephalometric films, diagnostic casts, and pre-orthodontic treatment visits. These services are limited to recipients with an orthodontic diagnosis only. Providers may submit claims for these services before submitting a PA request for orthodontia.

Oral/Facial Photographic Images (D0350)

Prior authorization is no longer required for oral/facial photographic images. Oral/facial photographic images may be used as a diagnostic tool for oral surgery and orthodontia services and may be submitted as supporting clinical documentation with a PA request.

Prophylaxis and Prophylaxis with Fluoride (D1110, D1120, D1201, D1205)

Prophylaxis and prophylaxis with fluoride application services are limited to one per six-month period for recipients up to age 20 and one per 12-month period for recipients ages 21 and older without PA. For recipients with a permanent physical or developmental disability that impairs their ability to maintain oral hygiene, up to four of these services may be provided per 12-month period without PA. The recipient's disability must be documented in his or her record.

Topical Application of Fluoride (D1203, D1204)

Topical application of fluoride without prophylaxis for recipients ages 0-12 (D1203) is limited to two applications per 12-month period. In cases of demonstrated high need or for recipients with a permanent physical or developmental disability that impairs their ability to maintain oral hygiene, a provider may now give a child up to four applications per 12-month period without PA. Demonstrated high need is defined as visible plaque on the primary incisors, carious lesions, white spot lesions, xerostomia, rampant decay, radiation therapy to the head or neck, root caries or recession, or medication that interferes with salivary flow.

Prior authorization is no longer required for oral/facial photographic images.

Topical application of fluoride without prophylaxis (D1204) no longer requires PA and is allowable for recipients ages 13 and older who have a permanent physical or developmental disability that impairs their ability to maintain oral hygiene. Up to four applications per 12-month period may be provided. Providers are required to document the recipient's disability or demonstrated high need.

Sealants (D1351)

Prior authorization is no longer required for sealants on tooth numbers 1, 4-13, 16, 17, 20-29, 32, 51-82, A-T, and AS-TS. Providers are required to document the medical necessity of the sealants (e.g., due to congenital malformation) when sealants are placed on teeth other than primary or secondary molars. As a reminder, sealants are allowable for recipients up to age 20.

Bilateral Space Maintainers (D1515)

Prior authorization is no longer required for bilateral space maintainers. As a reminder, they are allowable for recipients up to age 20 only.

Crowns (D2390, D2791, D2932, D2933)

Prior authorization is no longer required for anterior resin crowns, full-cast base metal crowns (upgraded crowns), prefabricated resin crowns, and prefabricated stainless steel crowns with resin window. Dentists are not obligated to provide upgraded crowns.

For cases where Medicaid reimbursement for an upgraded crown (D2791) is less than the laboratory fee, providers may initiate reconsideration of an allowed claim by submitting an adjustment request along with a copy of the laboratory bill to receive additional reimbursement — up to the amount of the laboratory fee. Refer to the Claims Information section of the All-Provider Handbook for more information about submitting adjustment requests.

Anterior and Bicuspid Root Canals (D3310, D3320)

Prior authorization is no longer required when providing anterior and bicuspid root canal therapy to recipients ages 21 and older. Root canal therapy should only be provided when there is a strong likelihood that the treatment will be successful and definitive (i.e., that it will not later result in extraction). To receive Medicaid reimbursement for root canal therapy, the recipient's record must include clinical documentation of *all* the following:

- Evidence of good periodontal health (American Academy of Periodontology periodontal classification of Type I or II).
- Evidence visible on radiographs that at least 50 percent of the clinical crown is intact.
- A treatment plan that identifies no more than three teeth for root canal therapy, including molars. Molar root canals (D3330) for recipients ages 21 and older and treatment plans involving root canal therapy on four or more teeth require PA.

Prior authorization is no longer required for anterior resin crowns, full-cast base metal crowns (upgraded crowns), prefabricated resin crowns, and prefabricated stainless steel crowns with resin window.

Anterior or bicuspid root canals (D3310 and D3320) are not reimbursable if any of the following are true:

- The recipient has fewer than two posterior teeth in occlusion per quadrant.
- The recipient is missing six or more teeth in the arch where the root canal is to be performed, including third molars.
- The recipient is missing one or more anterior teeth in the arch where the root canal is to be performed.

If the recipient has one of the previously listed conditions, he or she may qualify for a partial denture and the provider should request PA for the partial denture service.

Apicoectomy and Retrograde Filling (D3410, D3430)

Prior authorization is no longer required for apicoectomy and retrograde filling services. As a reminder, these services are only allowable for permanent anterior teeth (6-11, 22-27, and corresponding supernumerary teeth). Providers are required to retain documentation, such as radiographs, supporting the medical necessity of these services. Examples of medical necessity include, but are not limited to, the following:

- Fractured root tip.
- Periapical pathology not resolved by conventional root canal therapy.
- Broken root canal file.
- Symptomatic files.

Full Mouth Debridement (D4355)

Prior authorization is no longer required for full mouth debridement for recipients ages 13 and older. However, for recipients up to age 12, full mouth debridement still requires PA. As a reminder, providers are required to document in the recipient's record that excess calculus is evident on radiographs. This service is allowable only once per three years for recipients ages 13 and older. Full mouth

debridement is not reimbursable on the same DOS as prophylaxis procedures.

Denture Reline Laboratory Services (D5750, D5751, D5760, D5761)

Prior authorization is no longer required for denture reline laboratory services. As a reminder, these services are allowable once per three years, per arch, when an existing denture is loose or ill fitting or there is a considerable amount of tissue shrinkage or weight loss. These services are not allowable when occlusal changes are sought to treat TMJ dysfunction.

Note: Denture reline chair-side services are **not** covered by Wisconsin Medicaid.

Cleft Palate Prosthetics (D5932, D5955)

Prior authorization is no longer required for cleft palate prosthetics.

Fixed Pediatric Partial Denture (D6985)

Prior authorization is no longer required for fixed pediatric partial dentures.

Surgical Extractions (D7210, D7220, D7230, D7240, D7250)

Prior authorization is no longer required for surgical extractions. Surgical extractions are allowable for the following conditions:

- Symptomatic or pathologic teeth.
- Orthodontic treatment and stabilization.
- Asymptomatic or non-pathologic teeth for physically or developmentally disabled recipients to prevent future need for hospitalization, if the teeth were to become symptomatic.
- Planned prosthetic cases where the removal of an impacted tooth or root is advisable prior to the placement of the complete or partial denture.

Providers are required to retain documentation, such as radiographs, supporting the medical necessity of these services.

Surgical Procedures for Tooth Eruption (D7280, D7282, D7283)

Prior authorization is no longer required for surgical procedures for tooth eruption. These services are allowable when all the following conditions are met:

- The recipient is age 0-20.
- The teeth are permanent.
- The recipient is receiving active orthodontic treatment.

These services are not allowable for primary teeth or third molars, or for teeth that are not impacted or close to eruption. Providers are required to include a periapical radiograph of the impacted or unerupted tooth in the recipient's record.

Denture reline chair-side services are **not** covered by Wisconsin Medicaid.

Surgical Reduction of Osseous Tuberosity (D7485)

Prior authorization is no longer required for surgical reduction of osseous tuberosity.

Removal of Foreign Bodies (D7530, D7540)

Prior authorization is no longer required for the removal of foreign bodies. Providers are required to retain radiograph documentation that a foreign body is lodged in the skin, that there is a need to remove pins, wires, staples, or other surgical devices placed for treatment of fractures, or in other surgical intervention when procedures to remove foreign bodies are provided. These codes should not be used when billing for the removal of root fragments or bone spicules (D7250).

Hospital Calls (D9420)

Prior authorization is no longer required for hospital calls. Examples of conditions that providers are required to document when

providing treatment in a hospital include, but are not limited to, the following:

- Recipients with physical or developmental disabilities resulting in uncontrolled behavior.
- Children who require extensive operative procedures.
- Recipients who are hospitalized.
- A physician requests a dental consultation.
- Geriatric patients who require monitoring of vital signs.
- Recipients who have a medical history of uncontrolled bleeding, severe cerebral palsy, or uncontrolled diabetes.
- Recipients who require extensive oral and maxillofacial procedures, such as orthognathic surgery, cleft palate, or TMJ surgery.

Treatment in a hospital setting is not allowed for the express purpose of controlling a recipient's apprehension.

Services Requiring Prior Authorization

Prior authorization continues to be required for the following dental services:

Effective September 1, 2006, the multidisciplinary TMJ evaluation requirement will be discontinued.

- Molar root canal therapy (D3330) for recipients ages 21 and older and treatment plans involving root canal therapy on four or more teeth.
- Periodontal scaling, planing, and maintenance (D4341, D4342, D4910).
- Full-mouth debridement (D4355) for recipients ages 12 and under.
- Full and partial dentures (D5110, D5120, D5211-D5226).
- Orthodontia services (D8010 – D8692, excluding D8660).
- Deep sedation/general anesthesia, intravenous conscious sedation/analgesia, and non-intravenous conscious sedation for recipients ages 21 and older (D9220, D9241, D9248).
- Complicated oral surgeries, including TMJ surgery.

Discontinuation of the Multidisciplinary Temporomandibular Joint Evaluation Requirement

Effective September 1, 2006, the multidisciplinary TMJ evaluation requirement will be discontinued. As a result, oral and maxillofacial surgeons and physician surgeons will no longer be required to submit an evaluation by a Department of Health and Family Services-approved multidisciplinary TMJ evaluation program as part of a PA request for TMJ surgery. Providers are still required to include appropriate current clinical physical and dental information about the recipient on the PA request to enable Wisconsin Medicaid to determine whether the surgery is medically necessary.

Providers are reminded that nonsurgical treatment for TMJ disorders are not Medicaid-reimbursable services for dentists. To be considered eligible for TMJ surgery, a recipient must have received appropriate nonsurgical treatment of sufficient duration that has not resolved or significantly improved the recipient's condition and ability to function. Prior authorization requests for TMJ surgery may be approved only after other professionally accepted nonsurgical treatments have been provided and found to be unsuccessful. Professionally accepted nonsurgical treatments include, but are not limited to, the following:

- Short-term medication.
- Home therapy (e.g., soft diet).
- Splint therapy.
- Physical therapy, including correction of myofunctional habits.
- Relaxation or stress management techniques.
- Psychological evaluation or counseling.

Changes to Prior Authorization Requests and Claims for Services Performed by Quadrant

Effective on and after September 1, 2006, providers submitting PA requests and claims for quadrants of periodontal scaling and root planing (D4341, D4342), gingivectomy, or gingivoplasty (D4210, D4211) are required to submit PA requests with each quadrant on a separate detail line. Like commercial dental insurers, Wisconsin Medicaid will now evaluate PA requests and claims for the periodontal, removable prosthodontic, and alveoloplasty services listed based on the quadrants submitted by a provider. Refer to Attachment 2 to determine procedure codes in which providers are required to use the following American Dental Association-approved area of oral cavity codes on claims and PA requests:

- 10 (Upper right quadrant).
- 20 (Upper left quadrant).
- 30 (Lower left quadrant).
- 40 (Lower right quadrant).

Area of oral cavity codes must be indicated on the following forms for the previously mentioned services:

- Prior Authorization Dental Request Form (PA/DRF), HCF 11035 (Rev. 10/03) — Element 15.
- ADA 2002 claim form — Element 25.
- ADA 2000 claim form — Element 59.

Note: Providers should **not** use modifiers "UR," "UL," "LL," or "LR" to designate quadrants.

Providers are still required to include periodontal charting and a comprehensive periodontal treatment plan with PA requests for scaling, root planing, gingivectomies, and gingivoplasties.

Coverage for Alveoloplasty Services

Effective for DOS on and after September 1, 2006, Wisconsin Medicaid will cover alveoloplasty services (D7310, D7311, D7320, D7321) for preparing a ridge for dentures. These services do not require PA. If an alveoloplasty is performed in conjunction with a surgical extraction (D7310, D7311), providers should retain documentation of the medical necessity of performing the alveoloplasty as a separate procedure. For Wisconsin Medicaid to individually price alveoloplasty services, providers are required to submit the following supporting documentation with paper claims:

- Treatment notes.
- Treatment plan.
- Radiographs.

As a reminder, claims for alveoloplasty services must include an area of oral cavity code.

Providers should **not** use modifiers "UR," "UL," "LL," or "LR" to designate quadrants.

Changes to Coverage for Emergency Exams

Effective for DOS on and after September 1, 2006, Wisconsin Medicaid covers limited, problem-focused oral evaluations (D0140) once per six months per recipient.

Changes to Anesthesia Coverage for Children

Effective for DOS on and after September 1, 2006, nitrous oxide inhalation (D9230) for recipients up to age 20 may be provided by oral surgeons and pediatric dentists. Prior authorization is no longer required for oral surgeons or pediatric dentists providing deep sedation or conscious sedation (D9220, D9241, D9248) for recipients up to age 20. Only one of the previously listed anesthesia services may be billed per DOS, per recipient.

Nitrous oxide inhalation (D9230) is not reimbursable for recipients ages 21 and older.

National Provider Identifier Coming in May 2007

As a result of the federal Health Insurance Portability and Accountability Act of 1996, the federal Department of Health and Human Services adopted a standard identifier for health care providers. The National Provider Identifier (NPI) will be the standard identifier and will be required to be used on all nationally recognized transactions. The August 2005 *Update* (2005-43), titled "National Provider Identifier," contains information about the NPI requirement, and more information will be available in future *Updates*.

Provider Services Improvements

Wisconsin Medicaid recently assigned Provider Services staff to work specifically on dental claims and PA request processing. Wisconsin Medicaid is attempting, wherever possible, to minimize the number of claims and PA requests returned for clerical reasons. Providers and billing staff who are experiencing difficulties or have questions may call the following:

- Provider Services at (800) 947-9627 or (608) 221-9883. Press "6" for a dental correspondent when prompted.
- Dental professional relations representative Joan Buntin at (715) 675-3190 for complex billing issues.

Information Regarding Medicaid HMOs

This *Update* contains Medicaid fee-for-service policy and applies to providers of services to recipients who receive their dental benefits on a fee-for-service basis. For Medicaid HMO or managed care policy, contact the appropriate managed care organization. Wisconsin Medicaid HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

The *Wisconsin Medicaid and BadgerCare Update* is the first source of program policy and billing information for providers.

Although the *Update* refers to Medicaid recipients, all information applies to BadgerCare recipients also.

Wisconsin Medicaid and BadgerCare are administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at *dhfs.wisconsin.gov/medicaid/*.

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ATTACHMENT 1
Summary of Dental Services and Whether Prior Authorization Is Required

This attachment is a summary of Medicaid-allowable dental services that no longer require prior authorization (PA) as of September 1, 2006, and lists services in which PA will continue to be required. Refer to this *Wisconsin Medicaid and BadgerCare Update* for more information on limitations and requirements for these services.

Services No Longer Requiring Prior Authorization

Effective for dates of service on and after September 1, 2006, the following dental services no longer require PA. Information contained in this *Update* gives the limitations and requirements for each of these services:

- Panoramic films (D0330).
- Cephalometric films, diagnostic casts, and pre-orthodontic treatment visits (D0340, D0470, D8660).
- Oral/facial photographic images (D0350).
- Prophylaxis and prophylaxis with fluoride (D1110, D1120, D1201, D1205).
- Topical applications of fluoride (D1203, D1204).
- Sealants (D1351) for tooth numbers 1, 4-13, 16, 17, 20-29, 32, 51-82, A-T, and AS-TS.
- Bilateral space maintainers (D1515).
- Crowns (D2390, D2791, D2932, D2933).
- Anterior and bicuspid root canals (D3310, D3320) for recipients ages 21 and older.
- Apicoectomy and retrograde fillings (D3410, D3430).
- Full-mouth debridement (D4355) for recipients ages 13 and older.
- Denture relining laboratory services (D5750, D5751, D5760, D5761).
- Cleft palate prosthetics (D5932, D5955).
- Fixed pediatric partial denture (D6985).
- Surgical extractions (D7210-D7240, D7250).
- Surgical procedures for tooth eruption (D7280, D7282, D7283).
- Surgical reduction of osseous tuberosity (D7485).
- Removal of foreign bodies (D7530, D7540).
- Hospital calls (D9420).

Services Requiring Prior Authorization

The following dental services continue to require PA:

- Molar root canal therapy (D3330) for recipients ages 21 and over.
- Periodontal scaling, root planing, and periodontal maintenance (D4341, D4342, D4910).
- Full-mouth debridement (D4355) for recipients ages 12 and under.
- Full and partial dentures (D5110, D5120, D5211-D5226).
- Orthodontic services (D8010-D8692, excluding D8660).
- Complicated oral surgeries, including temporomandibular joint surgery.

ATTACHMENT 2
Allowable Dental Services and Limitations

This attachment lists Medicaid-allowable dental services and limitations effective for dates of service (DOS) on and after September 1, 2006, and completely replaces previously published lists of dental procedure codes. Changes to coverage are highlighted. Providers and billing staff who have questions about coverage may call Provider Services at (800) 947-9627 or (608) 221-9883 (press "6" for a dental correspondent when prompted).

Diagnostic Procedures

Code	Description of Service	Prior Authorization?	Limitations and Requirements
Clinical Oral Examinations			
D0120	Periodic oral evaluation	No	One per 12-month period, per provider, for recipients ages 13 and older. One per six-month period, per provider, for recipients up to age 12.
D0140	Limited oral evaluation - problem focused	No	One per six months, per provider.
D0150	Comprehensive oral evaluation — new or established patient	No	One per three years, per provider.
D0160	Detailed and extensive oral evaluation — problem focused, by report	No	One per three years, per provider.
D0170	Re-evaluation — limited, problem focused (established patient; not post-operative visit)	No	Allowed once per year, per provider. Allowable in office or hospital place of service (POS).
Radiographs/Diagnostic Imaging (Including Interpretation)			
D0210	Intraoral; complete series (including bitewings)	No[3]	One per three years, per provider. Not billable within six months of other X-rays including D0220, D0230, D0240, D0270, D0272, D0274, and D0330 except in an emergency.[1] Panorex plus bitewings may be billed under D0210.
D0220	periapical first film	No	One per day. Not payable with D0210 on same DOS or up to six months after.[6]
D0230	periapical each additional film	No	Up to three per day. Must be billed with D0220. Not payable with D0210 on same DOS or up to six months after.[6]
D0240	occlusal film	No	Up to two per day. Not payable with D0210 on same DOS.
D0250	Extraoral; first film	No	*Emergency only*, one per day.[1]
D0260	each additional film	No	*Emergency only*, only two per day.[1] Must be billed with D0250.
D0270	Bitewing(s); single film	No	One per day, up to two per six-month period, per provider. Not payable with D0210, D0270, D0272, or D0274 on same DOS or up to six months after.[6]
D0272	two films	No	One set of bitewings per six-month period, per provider. Not payable with D0210, D0270, D0272, or D0274 on same DOS or up to six months after.[6]
D0274	four films	No	One set of bitewings per six-month period, per provider. Not payable with D0210, D0270, D0272, or D0274 on same DOS or up to six months after.[6]
D0330	Panoramic film	No[3]	One per day when another radiograph is insufficient for proper diagnosis. Not payable with D0210, D0270, D0272, or D0274.
D0340	Cephalometric film	No	Orthodontia diagnosis only. Allowable for recipients up to age 20.
D0350	Oral/facial photographic images	No	Allowable for recipients up to age 20. Allowable for orthodontia or oral surgery.

Diagnostic Procedures (continued)

Code	Description of Service	Prior Authorization?	Limitations and Requirements
Tests and Examinations			
D0470	Diagnostic casts	No	Orthodontia diagnosis only. Allowed with prior authorization (PA) for recipients ages 21 and over, at Wisconsin Medicaid's request (e.g., for dentures).
D0999	Unspecified diagnostic procedure, by report	Yes	HealthCheck "Other Service." Use this code for up to two additional oral exams per year with a HealthCheck referral. Allowable for recipients ages 13-20.

Preventive

Code	Description of Service	Prior Authorization?	Limitations and Requirements
Dental Prophylaxis			
D1110	Prophylaxis; adult	No	One per 12-month period, per provider, for ages 21 and older. One per six-month period, per provider, for ages 13-20. **Allowable for recipients ages 13 or older.** Not payable with periodontal scaling and root planing or periodontal maintenance procedure. *Special Circumstances: Up to four per 12-month period, per provider, for permanently disabled recipients. Retain documentation of disability that impairs ability to maintain oral hygiene.* *Allowable for Medicaid-certified dental hygienists.*
D1120	child	No	One (D1120 or D1201) per six-month period, per provider. **Allowable for recipients up to age 12.** Not payable with D1201. *Special Circumstances: Up to four per 12-month period, per provider, for permanently disabled recipients. Retain documentation of disability that impairs ability to maintain oral hygiene.* *Allowable for Medicaid-certified dental hygienists.*
Topical Fluoride Treatment (Office Procedure)			
D1201	Topical application of fluoride (including prophylaxis); child	No	One (D1120 or D1201) per 6-month period, per provider. **Allowable for recipients up to age 12.** Not payable with D1120. *Special Circumstances: Up to four per 12-month period, per provider, for permanently disabled recipients. Retain documentation of disability that impairs ability to maintain oral hygiene.* *Allowable for Medicaid-certified dental hygienists.*
D1203	Topical application of fluoride (prophylaxis not included); child	No	Two per 12-month period, per provider. **Allowable for recipients up to age 12.** *Special Circumstances: Up to four per 12-month period, per provider, for cases of demonstrated high need, or for permanently disabled recipients. Retain documentation of disability that impairs ability to maintain oral hygiene or demonstrated high need.* *Allowable for Medicaid-certified dental hygienists, physicians, and nurses.*
D1204	adult	No	Two per 12-month period, per provider, for ages 13-20. *Covered only in special circumstances for ages 21 and older: Up to four per 12-month period, per provider, for permanently disabled recipients. Retain documentation of disability that impairs ability to maintain oral hygiene.* **Allowable for recipients age 13 or older.** *Allowable for Medicaid-certified dental hygienists.*
D1205	Topical application of fluoride (including prophylaxis); adult	No	One per six-month period, per provider, for ages 13-20. *Covered only in special circumstances for ages 21 and older: Up to four per 12-month period, per provider, for permanently disabled recipients. Retain documentation of disability that impairs ability to maintain oral hygiene.* Not payable with periodontal scaling and root planing. **Allowable for recipients ages 13 or older.** *Allowable for Medicaid-certified dental hygienists.*

Preventive (continued)

Code	Description of Service	Prior Authorization?	Limitations and Requirements
Other Preventive Services			
D1351	Sealant — per tooth	No	Retain documentation regarding medical necessity of sealants placed on teeth *other than* primary or secondary molars (1, 4-13, 16, 17, 20-29, 32, 51-82, A-T, AS-TS). **Allowable for recipients up to age 20.** Narrative required in order to exceed once per three-year limitation. *Allowable for Medicaid-certified dental hygienists.*
Space Maintenance (Passive Applicances)			
D1510	Space maintainer; fixed-unilateral	No	First and second primary molar only (tooth letters A, B, I, J, K, L, S, and T only). Limited to four per DOS; once per year, per tooth. Narrative required to exceed frequency limitation. Allowable for recipients up to age 20.
D1515	fixed-bilateral	No	Once per year, per arch. Narrative required to exceed frequency limitation. Allowable for recipients up to age 20.
D1550	Recementation of space maintainer	No	Limited to two per DOS. Allowable for recipients up to age 20.

Restorative Procedures

Code	Description of Service	Prior Authorization?	Limitations and Requirements
Amalgam Restorations (Including Polishing)			
D2140	Amalgam; one surface, primary or permanent	No	Primary teeth: Once per tooth, per year, per provider[7] (tooth letters A-T and AS-TS only). Permanent teeth: Once per tooth, per three years, per provider[7] (tooth numbers 1-32 and 51-82 only).
D2150	two surfaces, primary or permanent	No	Primary teeth: Once per tooth, per year, per provider[7] (tooth letters A-T and AS-TS only). Permanent teeth: Once per tooth, per three years, per provider[7] (tooth numbers 1-32 and 51-82 only).
D2160	three surfaces, primary or permanent	No	Primary teeth: Once per tooth, per year, per provider[7] (tooth letters A-T and AS-TS only). Permanent teeth: Once per tooth, per three years, per provider[7] (tooth numbers 1-32 and 51-82 only).
D2161	four or more surfaces, primary or permanent	No	Primary teeth: Once per tooth, per year, per provider[7] (tooth letters A-T and AS-TS only). Permanent teeth: Once per tooth, per three years, per provider[7] (tooth numbers 1-32 and 51-82 only).
Resin-Based Composite Restorations — Direct			
D2330	Resin-based composite; one surface, anterior	No	Primary teeth: Once per tooth, per year, per provider.[7] Permanent teeth: Once per tooth, per three years, per provider.[7] Allowed for Class I and Class V only (tooth numbers 6-11, 22-27, C-H, M-R, 56-61, 72-77, CS-HS, and MS-RS only).
D2331	two surfaces, anterior	No	Primary teeth: Once per tooth, per year, per provider.[7] Permanent teeth: Once per tooth, per three years, per provider.[7] Allowed for Class III only (tooth numbers 6-11, 22-27, C-H, M-R, 56-61, 72-77, CS-HS, and MS-RS only).
D2332	three surfaces, anterior	No	Primary teeth: Once per tooth, per year, per provider.[7] Permanent teeth: Once per tooth, per three years, per provider.[7] Allowed for Class III and Class IV only (tooth numbers 6-11, 22-27, C-H, M-R, 56-61, 72-77, CS-HS, and MS-RS only).
D2335	four or more surfaces or involving incisal angle (anterior)	No	Primary teeth: Once per tooth, per year, per provider.[7] Permanent teeth: Once per tooth, per three years, per provider.[7] Allowed for Class IV only (tooth numbers 6-11, 22-27, C-H, M-R, 56-61, 72-77, CS-HS, and MS-RS only). Must include incisal angle. Four surface resins may be billed under D2332, unless an incisal angle is included.

Restorative Procedures (continued)

Code	Description of Service	Prior Authorization?	Limitations and Requirements
D2390	Resin-based composite crown, anterior	No	Primary teeth: Once per year, per tooth (tooth letters D-G, DS-GS only). Permanent teeth: Once per five years, per tooth (tooth numbers 6-11, 22-27, 56-61, 72-77 only.) Limitation can be exceeded with narrative for children[7], and with prior authorization (PA) for adults greater than age 20.[3]
D2391	Resin-based composite — one surface, posterior	No	Primary teeth: Once per year, per provider, per tooth[7] (tooth letters A, B, I, J, K, L, S, T, AS, BS, IS, JS, KS, LS, SS, and TS only). Permanent teeth: Once per three years, per provider, per tooth[7] (tooth numbers 1-5, 12-21, 28-32, 51-55, 62-71, and 78-82 only).
D2392	Resin-based composite — two surfaces, posterior	No	Primary teeth: Once per year, per provider, per tooth[7] (tooth letters A, B, I, J, K, L, S, T, AS, BS, IS, JS, KS, LS, SS, and TS only). Permanent teeth: Once per three years, per provider, per tooth[7] (tooth numbers 1-5, 12-21, 28-32, 51-55, 62-71, and 78-82 only).
D2393	Resin-based composite — three surfaces, posterior	No	Primary teeth: Once per year, per provider, per tooth[7] (tooth letters A, B, I, J, K, L, S, T, AS, BS, IS, JS, KS, LS, SS, and TS only). Permanent teeth: Once per three years, per provider, per tooth[7] (tooth numbers 1-5, 12-21, 28-32, 51-55, 62-71, and 78-82 only).
D2394	Resin-based composite — four or more surfaces, posterior	No	Primary teeth: Once per year, per provider, per tooth[7] (tooth letters A, B, I, J, K, L, S, T, AS, BS, IS, JS, KS, LS, SS, and TS only). Permanent teeth: Once per three years, per provider, per tooth[7] (tooth numbers 1-5, 12-21, 28-32, 51-55, 62-71, and 78-82 only).
Crowns - Single Restorations Only			
D2791	Crown — full cast predominantly base metal	No	Once per year, per primary tooth; once per five years, per permanent tooth[3] (tooth numbers 1-32, A-T, 51-82, and AS-TS.) Reimbursement is limited to the rate of code D2933.
Other Restorative Services			
D2910	Recement inlay, onlay or partial coverage restoration	No	Tooth numbers 1-32, 51-82 only.
D2915	Recement cast or prefabricated post and core	No	Tooth numbers 1-32, A-T, 51-82, AS-TS.
D2920	Recement crown	No	Tooth numbers 1-32, A-T, 51-82, AS-TS.
D2930	Prefabricated stainless steel crown; primary tooth	No	Once per year, per tooth (tooth letters, A-T and AS-TS only).[3]
D2931	permanent tooth	No	Once per five years, per tooth (tooth numbers 1-32 and 51-82 only).
D2932	Prefabricated resin crown	No	Primary teeth: Once per year, per tooth (tooth letters D-G and DS-GS only). Permanent teeth: Once per five years, per tooth (tooth numbers 6-11, 22-27, 56-61, and 72-77 only.) Limitation can be exceeded with narrative for children[7], and with PA for adults older than age 20.[3]
D2933	Prefabricated stainless steel crown with resin window	No	Primary teeth: Once per year, per tooth (tooth letters D-G, DS-GS only). Permanent teeth: Once per five years, per tooth (tooth numbers 6-11 and 56-61 only.) Limitation can be exceeded with narrative for children[7], and with PA for adults older than age 20.[3]
D2934	Prefabricated esthetic coated stainless steel crown — primary tooth	No	Once per year, per tooth. Allowable age less than 21. Tooth letters D-G and DS-GS only.
D2940	Sedative filling	No	Not allowed with pulpotomies, permanent restorations, or endodontic procedures (tooth numbers 1-32, A-T, 51-82, and AS-TS).
D2951	Pin retention — per tooth, in addition to restoration	No	Once per three years, per tooth (tooth numbers 1-32 and 51-82 only).[7]
D2952	Cast post and core in addition to crown	No	Once per tooth, per lifetime, per provider. Tooth numbers 2-15, 18-31, 52-65, and 68-81 only. Cannot be billed with D2954.

Restorative Procedures (continued)

Code	Description of Service	Prior Authorization?	Limitations and Requirements
D2954	Prefabricated post and core in addition to crown	No	Once per tooth, per lifetime, per provider. Tooth numbers 2-15, 18-31, 52-65, and 68-81 only. Cannot be billed with D2952.
D2971	Additional procedures to construct new crown under existing partial denture framework	No	Tooth numbers 2-15 and 18-31 only.
D2999	Unspecified restorative procedure, by report	Yes	HealthCheck "Other Service." Use this code for single-unit crown. Allowable for recipients ages 0-20.

Endodontics

Code	Description of Service	Prior Authorization?	Limitations and Requirements
Pulpotomy			
D3220	Therapeutic pulpotomy (excluding final restoration); removal of pulp coronal to the dentinocemental junction and application of medicament	No	Once per tooth, per lifetime. Primary teeth only (tooth letters A-T and AS-TS only).
D3221	Pulpal debridement, primary and permanent teeth	No	Allowable for tooth numbers 2-15, 18-31, 52-65, and 68-81 only. For primary teeth, use D3220. Not to be used by provider completing endodontic treatment.
Endodontic Therapy (Including Treatment Plan, Clinical Procedures and Follow-Up Care)			
D3310	Anterior (excluding final restoration)	No (see limitations)	Normally for permanent anterior teeth. May be used to bill a single canal on a bicuspid or molar (tooth numbers 2-15, 18-31, 52-65, and 68-81 only, once per tooth, per lifetime). Not allowed with sedative filling. Treatment plans involving root canal therapy on four or more teeth require PA.
D3320	Bicuspid (excluding final restoration)	No (see limitations)	Normally for permanent bicuspid teeth. May be used to bill two canals on a bicuspid or molar (tooth numbers 2-5, 12-15, 18-21, 28-31, 52-55, 62-65, 68-71, and 78-81 only, once per tooth, per lifetime). Not allowed with sedative filling. Treatment plans involving root canal therapy on four or more teeth require PA.
D3330	Molar (excluding final restoration)	Yes, if age >20	Not covered for third molars. Permanent teeth only (tooth numbers 2, 3, 14, 15, 18, 19, 30, 31, 53, 53, 64, 65, 68, 69, 80, and 81 only, once per tooth, per lifetime). Not allowed with sedative filling.
Apexification/Recalcification Procedures			
D3351	Apexification/recalcification; initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	No	Permanent teeth only (tooth numbers 2-15, 18-31, 52-65, 68-81 only). Not allowable with root canal therapy. Bill the entire procedure under this code. Allowable for recipients ages less than 21.
Apicoectomy/Periradicular Services			
D3410	Apicoectomy/periradicular surgery; anterior	No	Permanent anterior teeth only (tooth numbers 6-11, 22-27, 56-61, and 72-77 only). Not payable with root canal therapy on the same DOS. Code does not include retrograde filling (D3430), which may be billed separately.
D3430	Retrograde filling — per root	No	Permanent anterior teeth only (tooth numbers 6-11, 22-27, 56-61, and 72-77 only). Not payable with root canal therapy on the same DOS.

Periodontics

Code	Description of Service	Prior Authorization?	Limitations and Requirements
Surgical Services (Including Usual Postoperative Care)			
D4210	Gingivectomy or gingivoplasty — four or more contiguous teeth or bounded teeth spaces per quadrant	Yes	Allowable area of oral cavity codes: 10 (upper right), 20 (upper left), 30 (lower left), and 40 (lower right).
D4211	one to three contiguous teeth or bounded teeth spaces per quadrant	Yes	Allowable area of oral cavity codes: 10 (upper right), 20 (upper left), 30 (lower left), and 40 (lower right).
Non-Surgical Periodontal Service			
D4341	Periodontal scaling and root planing — four or more teeth per quadrant	Yes	Allowable area of oral cavity codes: 10 (upper right), 20 (upper left), 30 (lower left), and 40 (lower right). Allowable for recipients ages 13 and older. Limited in most circumstances to once per three years per quadrant. Up to four quadrants per DOS are allowed when provided in hospital or ambulatory surgical center POS. Limited to two quadrants per DOS in when provided in an office, home, extended-care facility (ECF), or other POS, unless the PA request provides sound medical or other logical reasons, including long distance travel to the dentist or disability, which makes travel to the dentist difficult. Not payable with prophylaxis.
D4342	one to three teeth, per quadrant	Yes	Allowable area of oral cavity codes: 10 (upper right), 20 (upper left), 30 (lower left), and 40 (lower right). Allowable for recipients ages 13 and older. Limited in most circumstances to once per three years per quadrant. Up to four quadrants per DOS are allowed when provided in a hospital or ambulatory surgical center POS. Limited to two quadrants per DOS in when provided in an office, home, ECF, or other POS, unless the PA request provides sound medical or other logical reasons, including long distance travel to the dentist or disability, which makes travel to the dentist difficult. Not payable with prophylaxis.
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	No (see limitations)	Full mouth code. Excess calculus must be evident on an x-ray. One per three years, per provider. Billed on completion date only. May be completed in one long appointment. No other periodontal treatment (D4341, D4342, or D4910) can be authorized immediately after this procedure. Includes tooth polishing. Not payable with prophylaxis. Allowable for recipients ages 13 and older. Allowable with PA for recipients ages 0-12.
Other Periodontal Services			
D4910	Periodontal maintenance	Yes	Prior authorization may be granted up to three years. Not payable with prophylaxis. Once per year in most cases. Allowable for recipients ages 13 and older.
D4999	Unspecified periodontal procedure, by report	Yes	HealthCheck "Other Service." Use this code for up to unspecified periodontal surgical procedure with a HealthCheck referral. Allowable for recipients up to age 20.

Prosthodontics (Removable)

Code	Description of Service	Prior Authorization?	Limitations and Requirements
Complete Dentures (Including Routine Post-Delivery Care)			
D5110	Complete denture — maxillary	Yes	Allowed once per five years.[5, 8]
D5120	mandibular	Yes	Allowed once per five years.[5, 8]

Prosthodontics (Removable) (continued)

Code	Description of Service	Prior Authorization?	Limitations and Requirements
Partial Dentures (Including Routine Post-Delivery Care)			
D5211	Maxillary (upper) partial denture; resin base (including any conventional clasps, rests and teeth)	Yes	Allowed once per five years.[5, 8]
D5212	Mandibular (lower) partial denture; resin base (including any conventional clasps, rests and teeth)	Yes	Allowed once per five years.[5, 8]
D5213	Maxillary partial denture; cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	Yes	Allowed once per five years.[5, 8]
D5214	Mandibular partial denture; cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	Yes	Allowed once per five years.[5, 8]
D5225	Maxillary partial denture — flexible base (including any clasps, rests and teeth)	Yes	Allowed once per five years.[5, 8]
D5226	Mandibular partial denture — flexible base (including any clasps, rests and teeth)	Yes	Allowed once per five years.[5, 8]
Repairs to Complete Dentures			
D5510	Repair broken complete denture base	No	Combined maximum reimbursement limit per six months for repairs. Requires an area of oral cavity code (01=Maxillary or 02=Mandibular) in Element 59 of the ADA 2000 claim form or Element 25 of the ADA 2002 claim form.
D5520	Replace missing or broken teeth — complete denture (each tooth)	No	Combined maximum reimbursement limit per six months for repairs. Requires an area of oral cavity code (01=Maxillary or 02=Mandibular) in Element 59 of the ADA 2000 claim form or Element 25 of the ADA 2002 claim form.
Repairs to Partial Dentures			
D5610	Repair resin denture base	No	Limited to once per DOS. Combined maximum reimbursement limit per six months for repairs. Requires an area of oral cavity code (01=Maxillary or 02=Mandibular) in Element 59 of the ADA 2000 claim form or Element 25 of the ADA 2002 claim form.
D5620	Repair cast framework	No	Combined maximum reimbursement limit per six months for repairs. Requires an area of oral cavity code (01=Maxillary or 02=Mandibular) in Element 59 of the ADA 2000 claim form or Element 25 of the ADA 2002 claim form.
D5630	Repair or replace broken clasp	No	Combined maximum reimbursement limit per six months for repairs. Requires an area of oral cavity code (01=Maxillary or 02=Mandibular) in Element 59 of the ADA 2000 claim form or Element 25 of the ADA 2002 claim form.
D5640	Replace broken teeth — per tooth	No	Combined maximum reimbursement limit per six months for repairs. Requires an area of oral cavity code (01=Maxillary or 02=Mandibular) in Element 59 of the ADA 2000 claim form or Element 25 of the ADA 2002 claim form.
D5650	Add tooth to existing partial denture	No	Combined maximum reimbursement limit per six months for repairs. Requires an area of oral cavity code (01=Maxillary or 02=Mandibular) in Element 59 of the ADA 2000 claim form or Element 25 of the ADA 2002 claim form.

Prosthodontics (Removable) (continued)

Code	Description of Service	Prior Authorization?	Limitations and Requirements
D5660	Add clasp to existing partial denture	No	Combined maximum reimbursement limit per six months for repairs. Requires an area of oral cavity code (01=Maxillary or 02=Mandibular) in Element 59 of the ADA 2000 claim form or Element 25 of the ADA 2002 claim form.
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	Yes	Combined maximum reimbursement limit per six months for repairs.
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	Yes	Combined maximum reimbursement limit per six months for repairs.
Denture Reline Procedures			
D5750	Reline complete maxillary denture (laboratory)	No	Allowed once per three years.[5] Retain documentation of medical necessity.
D5751	Reline complete mandibular denture (laboratory)	No	Allowed once per three years.[5] Retain documentation of medical necessity.
D5760	Reline maxillary partial denture (laboratory)	No	Allowed once per three years.[5] Retain documentation of medical necessity.
D5761	Reline mandibular partial denture (laboratory)	No	Allowed once per three years.[5] Retain documentation of medical necessity.

Maxillofacial Prosthetic

Code	Description of Service	Prior Authorization?	Limitations and Requirements
D5932	Obturator prosthesis; definitive	No	Allowed once per six months.[5] Retain documentation of medical necessity.
D5955	Palatal lift prosthesis, definitive	No	Allowed once per six months.[5] Retain documentation of medical necessity.
D5999	Unspecified maxillofacial prosthesis, by report	Yes	For medically necessary removable prosthodontic procedures not listed in this attachment. Lab bills and narrative required.

Prosthodontic, Fixed

Code	Description of Service	Prior Authorization?	Limitations and Requirements
Fixed Partial Denture Pontics			
D6211	Pontic; cast predominantly base metal	Yes	Permanent teeth only (tooth numbers 1-32 and 51-82 only).
D6241	Pontic — porcelain fused to predominantly base metal	Yes	Permanent teeth only (tooth numbers 1-32 and 51-82 only).
Fixed Partial Denture Retainers — Inlays/Onlays			
D6545	Retainer; cast metal for resin bonded fixed prosthesis	Yes	Tooth numbers 1-32, 51-82 only.
Fixed Partial Denture Retainers — Crowns			
D6751	Crown; porcelain fused to predominantly base metal	Yes	Permanent teeth only (tooth numbers 1-32 and 51-82 only).
D6791	full cast predominantly base metal	Yes	Permanent teeth only (tooth numbers 1-32 and 51-82 only).
Other Fixed Partial Denture Services			
D6930	Recement fixed partial denture	No	
D6940	Stress breaker	Yes	Copy of lab bill required.
D6980	Fixed partial denture repair, by report	Yes	Copy of lab bill required.
D6985	Pediatric partial denture, fixed	No	Allowable up to age 12. Retain documentation of medical necessity.

Oral and Maxillofacial Surgery

Code	Description of Service	Prior Authorization?	Limitations and Requirements
Extractions (Includes local anesthesia, suturing, if needed, and routine postoperative care)			
D7111	Extraction, coronal remnants — deciduous tooth	No	Allowed only once per tooth. Primary teeth only (tooth letters A-T and AS-TS only). Not payable same DOS as D7250 for same tooth letter.
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No	Allowed only once per tooth (tooth numbers 1-32, A-T, 51-82 and AS-TS). Not payable same DOS as D7250 for same tooth number.
Surgical Extractions (Includes local anesthesia, suturing, if needed, and routine postoperative care)			
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	No	Allowed only once per tooth. Covered when performing an emergency service or for orthodontia (tooth numbers 1-32, A-T, 51-82 and AS-TS).[1] Not payable same DOS as D7250 for same tooth number.
D7220	Removal of impacted tooth; soft tissue	No	Allowed only once per tooth. Covered when performing an emergency service or for orthodontia (tooth numbers 1-32, A-T, 51-82 and AS-TS).[1] Not payable same DOS as D7250 for the same tooth number.
D7230	partially bony	No	Allowed only once per tooth. Covered when performing an emergency service or for orthodontia (tooth numbers 1-32, A-T, 51-82 and AS-TS).[1] Not payable same DOS as D7250 for the same tooth number.
D7240	completely bony	No	Allowed only once per tooth. Covered when performing an emergency service or for orthodontia (tooth numbers 1-32, A-T, 51-82 and AS-TS).[1] Not payable same DOS as D7250 for the same tooth number.
D7250	Surgical removal of residual tooth roots (cutting procedure)	No	*Emergency only* (tooth numbers 1-32, A-T, 51-82 and AS-TS).[1] Allowed only once per tooth. Not allowed on the same DOS as tooth extraction of same tooth number.
Other Surgical Procedures			
D7260 or CPT[2]	Oroantral fistula closure	No	
D7261	Primary closure of a sinus perforation	No	
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	No	*Emergency only* (tooth numbers 1-32, C-H, M-R, 51-82, CS-HS, and MS-RS).[1]
D7280	Surgical access of an unerupted tooth	No	Not allowed for primary or wisdom teeth (tooth numbers 2-15, 18-31, 52-65, and 68-81 only). Allowable for recipients ages 0-20.
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	No	Not allowed for primary or wisdom teeth (tooth numbers 2-15, 18-31, 52-65, and 68-81 only). Allowable for recipients ages 0-20.
D7283	Placement of device to facilitate eruption of impacted tooth	No	Not allowed for primary or wisdom teeth (tooth numbers 2-15, 18-31, 52-65, and 68-81 only). Allowable for recipients ages 0-20.
D7285 or CPT[2]	Biopsy of oral tissue; hard (bone, tooth)	No	Once per DOS.[4]
D7286 or CPT[2]	soft	No	Once per DOS.[4]
D7287 or CPT[2]	Exfoliative cytologogical sample collection	No	
D7288	Brush biopsy — transepithelial sample collection	No	Once per DOS.[4]

Oral and Maxillofacial Surgery (continued)

Code	Description of Service	Prior Authorization?	Limitations and Requirements
Alveoloplasty — Surgical Preparation of Ridge for Dentures			
D7310	Alveoloplasty in conjuction with extractions — per quadrant	No	Allowable area of oral cavity codes: 10 (upper right), 20 (upper left), 30 (lower left), 40 (lower right).
D7311	Alveoloplasty in conjuction with extractions — one to three teeth or tooth spaces, per quadrant	No	Allowable area of oral cavity codes: 10 (upper right), 20 (upper left), 30 (lower left), 40 (lower right).
D7320	Alveoloplasty not in conjuction with extractions — per quadrant	No	Allowable area of oral cavity codes: 10 (upper right), 20 (upper left), 30 (lower left), 40 (lower right).
D7321	Alveoloplasty not in conjuction with extractions — one to three teeth or tooth spaces, per quadrant	No	Allowable area of oral cavity codes: 10 (upper right), 20 (upper left), 30 (lower left), 40 (lower right).
Surgical Excision of Soft Tissue Lesions			
D7410 or CPT[2]	Excision of benign lesion up to 1.25 cm	No	
D7411 or CPT[2]	Excision of benign lesion greater than 1.25 cm	No	
D7412 or CPT[2]	Excision of benign lesion, complicated	No	
D7413 or CPT[2]	Excision of malignant lesion up to 1.25 cm	No	
D7414 or CPT[2]	Excision of malignant lesion greater than 1.25 cm	No	
D7415 or CPT[2]	Excision of malignant lesion, complicated	No	
Surgical Excision of Intra-Osseous Lesions			
D7440 or CPT[2]	Excision of malignant tumor; lesion diameter up to 1.25 cm	No	Once per DOS.[4]
D7441 or CPT[2]	lesion diameter greater than 1.25 cm	No	Once per DOS.[4]
D7450 or CPT[2]	Removal of benign odontogenic cyst or tumor; lesion diameter up to 1.25 cm	No	Pathology report required.
D7451 or CPT[2]	lesion diameter greater than 1.25 cm	No	Pathology report required.
D7460 or CPT[2]	Removal of benign nonodontogenic cyst or tumor; lesion diameter up to 1.25 cm	No	Pathology report required.
D7461 or CPT[2]	lesion diameter greater than 1.25 cm	No	Pathology report required.
Excision of Bone Tissue			
D7471 or CPT[2]	Removal of lateral exostosis (maxilla or mandible)	Yes	
D7472 or CPT[2]	Removal of torus palatinus	Yes	
D7473 or CPT[2]	Removal of torus mandibularis	Yes	

Oral and Maxillofacial Surgery (continued)

Code	Description of Service	Prior Authorization?	Limitations and Requirements
D7485 or CPT[2]	Surgical reduction of osseous tuberosity	No	Operative report required.
D7490 or CPT[2]	Radical resection of maxilla or mandible	No	Operative report required. Only allowable in hospital or ambulatory surgical center POS.
Surgical Incision			
D7510 or CPT[2]	Incision and drainage of abscess; intraoral soft tissue	No	Operative report required. Not to be used for periodontal abscess — use D9110.
D7511 or CPT[2]	Incision and drainage of abscess — intraoral soft tissue — complicated (includes drainage of multiple fascial spaces)	No	Operative report required. Not to be used for periodontal abscess — use D9110.
D7520 or CPT[2]	extraoral soft tissue	No	Operative report required.
D7521 or CPT[2]	Incision and drainage of abscess — extraoral soft tissue — complicated (includes drainage of multiple fascial spaces)	No	Operative report required.
D7530 or CPT[2]	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	No	Not allowed for removal of root fragments and bone spicules. Operative report required. (Use D7250 instead.)
D7540 or CPT[2]	Removal of reaction producing foreign bodies, musculoskeletal system	No	Not allowed for removal of root fragments and bone spicules. Operative report required. (Use D7250 instead.)
D7550 or CPT[2]	Partial ostectomy/sequestrectomy for removal of non-vital bone	No	Operative report required.
D7560 or CPT[2]	Maxillary sinusotomy for removal of tooth fragment or foreign body	No	Operative report required.
Treatment of Fractures — Simple			
D7610 or CPT[2]	Maxilla; open reduction (teeth immobilized, if present)	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required.
D7620 or CPT[2]	closed reduction (teeth immobilized, if present)	No	Operative report required.
D7630 or CPT[2]	Mandible; open reduction (teeth immobilized, if present)	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required.
D7640 or CPT[2]	closed reduction (teeth immobilized, if present)	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required.
D7650 or CPT[2]	Malar and/or zygomatic arch; open reduction	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required.
D7660 or CPT[2]	closed reduction	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required.
D7670 or CPT[2]	Alveolus — closed reduction, may include stabilization of teeth	No	Operative report required.
D7671 or CPT[2]	Alveolus — open reduction, may include stabilization of teeth	No	Operative report required.
D7680 or CPT[2]	Facial bones — complicated reduction with fixation and multiple surgical approaches	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required.

Oral and Maxillofacial Surgery (continued)

Code	Description of Service	Prior Authorization?	Limitations and Requirements
Treatment of Fractures — Compound			
D7710 or CPT[2]	Maxilla; open reduction	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required.
D7720 or CPT[2]	closed reduction	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required.
D7730 or CPT[2]	Mandible; open reduction	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required.
D7740 or CPT[2]	closed reduction	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required.
D7750 or CPT[2]	Malar and/or zygomatic arch; open reduction	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required.
D7760 or CPT[2]	closed reduction	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required.
D7770 or CPT[2]	Alveolus — open reduction stabilization of teeth	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required.
D7771 or CPT[2]	Alveolus — closed reduction stabilization of teeth	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required.
D7780 or CPT[2]	Facial bones — complicated reduction with fixation and multiple surgical approaches	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required.
Reduction of Dislocation and Management of Other Temporomandibular Joint Dysfunctions			
D7810 or CPT[2]	Open reduction of dislocation	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required.
D7820 or CPT[2]	Closed reduction of dislocation	No	Once per DOS.[4]
D7830 or CPT[2]	Manipulation under anesthesia	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required.
D7840 or CPT[2]	Condylectomy	Yes	Only allowable in hospital, office, or ambulatory surgical center POS. No operative report required.
D7850 or CPT[2]	Surgical discectomy, with/without implant	Yes	Only allowable in hospital, office, or ambulatory surgical center POS. No operative report required.
D7860 or CPT[2]	Arthrotomy	Yes	Only allowable in hospital, office, or ambulatory surgical center POS. No operative report required.
D7871 or CPT[2]	Non-arthroscopic lysis and lavage	Yes	Allowable only once per side (right and left) per three years.
D7899	Unspecified TMD therapy, by report	Yes	Use this code for billing TMJ assistant surgeon. Procedure must be included in PA request for the surgery itself. Only allowable in hospital or ambulatory surgical center POS.
Repair of Traumatic Wounds			
D7910 or CPT[2]	Suture of recent small wounds up to 5 cm	No	*Emergency only* — operative report required.

Oral and Maxillofacial Surgery (continued)

Code	Description of Service	Prior Authorization?	Limitations and Requirements
Complicated Suturing (Reconstruction requiring delicate handling of tissues and wide undermining for meticulous closure)			
D7911 or CPT[2]	Complicated suture — up to 5 cm	No	Covered for *trauma (emergency) situations only.*[1] Operative report required.
D7912 or CPT[2]	greater than 5 cm	No	Covered for *trauma (emergency) situations only.*[1] Once per DOS.[4] Operative report required.
Other Repair Procedures			
D7940 or CPT[2]	Osteoplasty — for orthognathic deformities	Yes	HealthCheck referral is required. Only allowable in hospital, office, or ambulatory surgical center POS. No operative report required. Allowable age less than 21.
D7950 or CPT[2]	Osseous, osteoperiosteal, or cartilage graft of the mandible or facial bones — autogeneous or nonautogeneous, by report	Yes	Only allowable in hospital, office, or ambulatory surgical center POS. No operative report required.
D7960 or CPT[2]	Frenulectomy (frenectomy or frenotomy) — separate procedure	Yes	HealthCheck referral is required. No operative report required. Allowable age less than 21.
D7970 or CPT[2]	Excision of hyperplastic tissue — per arch	Yes	No operative report required.
D7972 or CPT[2]	Surgical reduction of osseous tuberosity	No	
D7980 or CPT[2]	Sialolithotomy	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required.
D7991 or CPT[2]	Coronoidectomy	Yes	Only allowable in hospital or ambulatory surgical center POS. No operative report required.
D7997 or CPT[2]	Appliance removal (not by dentist who placed appliance), includes removal of archbar	No	Operative report required.
D7999 or CPT[2]	Unspecified oral surgery procedure, by report	Yes	For medically necessary oral and maxillofacial procedures not included on these tables. Operative report required.

Orthodontics

Code	Description of Service	Prior Authorization?	Limitations and Requirements
Limited Orthodontic Treatment			
D8010	Limited orthodontic treatment; of the primary dentition	Yes	HealthCheck referral is required. Allowable age less than 21.
D8020	of the transitional dentition	Yes	HealthCheck referral is required. Allowable age less than 21.
D8030	of the adolescent dentition	Yes	HealthCheck referral is required. Allowable age less than 21.
D8040	of the adult dentition	Yes	HealthCheck referral is required. Allowable age less than 21.
Interceptive Orthodontic Treatment			
D8050	Interceptive orthodontic treatment; of the primary dentition	Yes	HealthCheck referral is required. Allowable age less than 21.
D8060	of the transitional dentition	Yes	HealthCheck referral is required. Allowable age less than 21.

Orthodontics (continued)

Code	Description of Service	Prior Authorization?	Limitations and Requirements
Comprehensive Orthodontic Treatment			
D8070	Comprehensive orthodontic treatment; of the transitional dentition	Yes	HealthCheck referral is required. Allowable age less than 21.
D8080	of the adolescent dentition	Yes	HealthCheck referral is required. Allowable age less than 21.
D8090	of the adult dentition	Yes	HealthCheck referral is required. Allowable age less than 21.
Minor Treatment to Control Harmful Habits			
D8210	Removable appliance therapy	Yes	HealthCheck referral is required. Allowable age less than 21.
D8220	Fixed appliance therapy	Yes	HealthCheck referral is required. Allowable age less than 21.
Other Orthodontic Services			
D8660	Pre-orthodontic treatment visit	No	HealthCheck referral is required. Allowable age less than 21.
D8670	Periodic orthodontic treatment visit (as part of contract)	Yes	HealthCheck referral is required. Allowable age less than 21.
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer[s])	Yes	HealthCheck referral is required. Allowable age less than 21.
D8692	Replacement of lost or broken retainer	Yes	HealthCheck referral is required. Allowable age less than 21.

Adjunctive General Services

Code	Description of Service	Prior Authorization?	Limitations and Requirements
Unclassified Treatment			
D9110	Palliative (emergency) treatment of dental pain — minor procedure	No	Not payable immediately before or after surgery. Emergency only. Limit of $62.50 reimbursement per DOS for all emergency procedures done on a single DOS. Narrative required to override limitations.
Anesthesia			
D9220	Deep sedation/general anesthesia; first 30 minutes	Yes (see limitations)	Prior authorization not required in the following circumstances: 1. For hospital or ambulatory surgical center POS. 2. In an emergency.[1] 3. For children (ages 0-20), when performed by an oral surgeon or pediatric dentist. D9221 "each additional 15 minutes" is not a covered service. Bill only D9220 for general anesthesia. Not payable with D9230, D9241, or D9248.
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	No	Allowable for children (ages 0-20), when performed by an oral surgeon or pediatric dentist. Not payable with D9220, D9241, or D9248.
D9241	Intravenous conscious sedation/analgesia; first 30 minutes	Yes (see limitations)	Prior authorization not required in the following circumstances: 1. For hospital or ambulatory surgical center POS. 2. In an emergency.[1] 3. For children (ages 0-20), when performed by an oral surgeon or pediatric dentist. D9242 "each additional 15 minutes" is not a covered service. Bill only D9241 for intravenous sedation. Not payable with D9220, D9230, or D9248.
D9248	Non-intravenous conscious sedation	Yes (see limitations)	Prior authorization not required for children (ages 0-20), when performed by an oral surgeon or pediatric dentist. Not analgesia. Not payable with D9220, D9230, or D9241. Not inhalation of nitrous oxide.

Adjunctive General Services (continued)

Code	Description of Service	Prior Authorization?	Limitations and Requirements
Professional Visits			
D9420	Hospital call	No	Up to two visits per stay. Only allowable in hospital and ambulatory surgical center POS.
Miscellaneous Services			
D9910	Application of desensitizing medicament	No	Tooth numbers 1-32, A-T, 51-82, and AS-TS. Limit of $62.50 reimbursement per DOS for all emergency procedures done on a single DOS. Narrative required to override limitations. Not payable immediately before or after surgery, or periodontal procedures (D4210, D4211, D4341, D4342, D4355, D4910). Cannot be billed for routine fluoride treatment. *Emergency only.*
D9999	Unspecified adjunctive procedure, by report	Yes	

[1] Retain records in recipient files regarding nature of emergency.
[2] Providers who are Wisconsin Medicaid certified as oral surgeons or oral pathologists and who choose *Current Procedural Terminology* (CPT) billing must use a CPT code to bill for this procedure. Refer to dental publications on the Medicaid Web site for a list of covered CPT procedure codes.
[3] Frequency limitation may be exceeded only with PA.
[4] Frequency limitation may be exceeded if a narrative on the claim demonstrates medical necessity for additional services.
[5] Frequency limitation may be exceeded in exceptional circumstances with written justification on PA request.
[6] Six-month limitation may be exceeded in an emergency. The same DOS limitation may not be exceeded in an emergency.
[7] Limitation may be exceeded if narrative on claim demonstrates medical necessity for replacing a properly completed filling, crown, or adding a restoration on any tooth surface. Limitation may be exceeded for non-prior authorized crowns by indicating medical necessity.
[8] Healing period of six weeks required after last extraction prior to taking impressions for dentures, unless shorter period approved in PA.