HEALTH CHOICE ARIZONA
DENTAL BENEFITS MATRIX

CODES NOT INCLUDED IN MATRIX REQUIRE PRIOR AUTHORIZATION. In the case of a dental emergency or treatment plan changes, the need for prior authorization (PA) is waived for the codes highlighted in GREEN and are subject to retroactive review. Emergency dental care, and treatment plan change claims REQUIRE treatment notes, and pre-operative radiographs establishing emergent/medical necessity.

Please read the HCA Dental Clinical Review Criteria (CRC) under the provider portal for benefit details-
https://www.healthchoicearizona.com/ProviderPortal/login/

ADULT DENTAL CARE
(AGES 21 AND OVER)

LIMITED DENTAL CARE IS ALLOWED FOR MEMBERS APPROVED FOR AN ORGAN TRANSPLANT, OR MEMBERS WITH CANCER OF THE HEAD, NECK, OR JAW. ADDITIONALLY, DENTAL CARE FOR MEMBERS AGES 21 AND OVER IS LIMITED TO SERVICES FURNISHED BY A DENTIST ONLY TO THE EXTENT THAT SUCH SERVICES MAY BE PERFORMED UNDER STATE LAW EITHER BY A PHYSICIAN OR A DENTIST. TREATMENT MUST BE RELATED TO A MEDICAL CONDITION SUCH AS ACUTE PAIN, INFECTION OR FRACTURE OF THE JAW.
**** ALL SERVICES ARE SUBJECT TO PRE-AUTHORIZATION AND MEDICAL NECESSITY REVIEW.***

T = COVERED ONLY FOR ADULT MEMBERS APPROVED FOR AN ORGAN TRANSPLANT

ADA CODE	PROCEDURE DESCRIPTION	LIMITATIONS	MEMBERS AGES 0-20 PRE-AUTHORIZATION REQUIRED?	MEMBERS AGES 21 & OVER PRE-AUTHORIZATION REQUIRED?	DOCUMENTATION REQUIRED
		ORAL EXAMINATIONS			
D0120	PERIODIC ORAL EVALUATION	BENEFIT **ONCE** EVERY **6** MONTHS (**D0150 or D0145**)	**NO**	**T - YES**	
D0140	LIMITED ORAL EVALUATION - PROBLEM FOCUSED (**EMERGENCY DENTAL SERVICES ONLY**)	**NOT** PAYABLE ON THE **SAME DATE OF SERVICE (DOS)** AS **D0120, D0145, D0150, D0160, D9110, D9310, D9430**	**NO**	**NO**	**TREATMENT NOTES REQUIRED FOR CLAIMS PAYMENT**

D0145	ORAL EVALUATION, UNDER 3 YEARS OF AGE	LIMITED TO **ONE D0120, D0145, or D0150** IN A **6 MONTH PERIOD**. THERE **MUST** BE **6 FULL MONTHS** BETWEEN APPOINTMENTS.	**NO**	**NOT COVERED**	
D0150	COMPREHENSIVE ORAL EVALUATION	LIMITED TO **ONE D0150 PER DENTIST OR DENTAL GROUP PER LIFETIME**. **NOT** PAYABLE ON THE SAME **DOS** AS **D0120, D0145 OR D0160**	**NO**	**T - YES**	
D0160	DETAILED AND EXTENSIVE ORAL EVALUATION	**CLINICAL NARRATIVE REQUIRED**	**YES**	**T - YES**	**TREATMENT NOTES REQUIRED FOR CLAIMS PAYMENT**
D0180	COMPREHENSIVE PERIO EVALUATION	**CLINICAL NARRATIVE REQUIRED** ***Not payable within 6 months of D0120 or D0150****	**YES**	**T - YES**	
		RADIOGRAPHS **Please note: A panoramic radiograph submitted with bitewing radiographs and/or single periapical films are reimbursable at the intraoral complete series rate. A panoramic radiograph is not reimbursable within 12 months of bitewing radiographs when taken by the **same provider or group**.**			
D0210	INTRAORAL-COMPLETE SERIES (INCLUDING BITEWINGS)	**ONCE EVERY 36 MONTHS** FOR **MEMBERS AGED 6-20** WHEN TAKEN BY THE **SAME PROVIDER OR GROUP. NOT PAYABLE WITHIN 12 MONTHS OF D0272, D0274, D0277, OR D0330**	**NO**	**T - YES**	
D0220	INTRAORAL-PERIAPICAL-FIRST FILM	LIMITED TO ONE FILM PER DATE OF SERVICE	**NO**	**NO**	
D0230	INTRAORAL-PERIAPICAL-EACH ADDITIONAL FILM	LIMITED TO **TWO** FILMS **PER DATE OF SERVICE.** (**ADDITIONAL FILMS REQUIRE DOCUMENTATION TO ESTABLISH MEDICAL NECESSITY**)	**NO**	**NO**	
D0240	INTRAORAL-OCCLUSAL	LIMITED TO **TWO** FILMS **PER DATE OF SERVICE** IN A **12 MONTH PERIOD**	**NO**	**NO**	

ADA CODE	PROCEDURE DESCRIPTION *all following codes must be billed six months from each other (panoramic and FMX 36 months)	LIMITATIONS	Members Ages 0-20 Pre-authorization Required?	Members Ages 21 & Over Pre-authorization Required?	
D0250	EXTRAORAL-FIRST FILM	CLINICAL NARRATIVE REQUIRED	YES	YES	TREATMENT NOTES AND XRAYS
D0260	EXTRAORAL-EACH ADDITIONAL FILM				
D0270	BITEWING - 1 FILM	LIMITED TO **ONE D0270, D0272, D0273** OR **D0274** PER **6 MONTH** PERIOD. **NOT** PAYABLE **WITHIN 12 MONTHS OF D0210, D0277,** OR **D0330**. **MINIMUM AGE** FOR **D0270, D0272** IS **2** YEARS OF AGE. **MINIMUM AGE** FOR **D0273, D0274** IS 10 YERS OF AGE. **NOT** PAYABLE FOR MEMBERS **21 YERS OF AGE OR OLDER**. WHEN MEDICALLY NECESSARY, BITEWINGS MAY BE PAYABLE WITHIN THE 12 MONTH PERIOD. DOCUMENTATION FOR MEDICAL NECESSITY **MUST BE SUBMITTED W/CLAIM.**	NO	T - YES	
D0272	BITEWINGS - 2 FILMS		NO	T - YES	
D0273	BITEWINGS - 3 FILMS		NO	T - YES	
D0274	BITEWINGS - 4 FILMS		NO	T - YES	
D0277	VERTICAL BITEWINGS- 7 TO 8 FILMS	LIMITED TO **ONE** PER **36** MONTHS AND ARE **NOT** PAYABLE **WITHIN 12** MONTHS OF D0210, D0270, D0272, D0273, D0274 or, D0330.	NO	T - YES	
D0290	POSTERIOR-ANTERIOR OR LATERAL SKULL AND FACIAL BONE SURVEY FILM	CLINICAL NARRATIVE REQUIRED	YES	YES	TREATMENT NOTES INCLUDING DIAGNOSIS AND PROGNOSIS
D0310	SIALOGRAPHRY	CLINICAL NARRATIVE REQUIRED	YES	NOT COVERED	TREATMENT NOTES
D0320	TEMPOROMANDIBULAR JOINT ARTHROGRAM	CLINICAL NARRATIVE REQUIRED	YES	YES	TREATMENT NOTES INCLUDING DIAGNOSIS AND PROGNOSIS
D0321	OTHER TEMPOROMANDIBULAR JOINT FILMS	CLINICAL NARRATIVE REQUIRED	YES	YES	

D0330	PANORAMIC FILM	ROUTINE PANO'S LIMITED TO **ONE** PER **36** MONTH PERIOD FOR CHILDREN **6 YEARS OF AGE AND OLDER**. PANORAMIC FILMS ARE **PAYABLE A MAXIMUM OF 3 TIMES** PER LIFETIME. **IF BILLED SEPERATELY, OR WITHIN 12 MONTHS OF D0270 – D0274; NO PAYMENT IS AUTHORIZED**. **EXCEPTIONS:** PANORAMIC RADIOGRAPHS ARE REIMBURSABLE FOR THE DIAGNOSIS OF IMPACTED TEETH OR FOR ORAL SURGERY TREATMENT PLANNING*. POSTOPERATIVE PANORAMIC RADIOGRAPHS ARE PAYABLE FOR POST-SURGICAL EVALUATION OF FRACTURES OR REMOVAL OF UNUSUALLY LARGE AND/OR COMPLEX CYSTS OR NEOPLASMS WHEN AUTHORIZED*.	**NO** ***PRE-AUTH REQUIRED***	**YES**	**TREATMENT NOTES**
D0340	CEPHALOMETRIC FILM	**CLINICAL NARRATIVE REQUIRED**	**YES**	**NOT COVERED**	**TREATMENT NOTES**
D0350	ORAL/FACIAL IMAGES	**CLINICAL NARRATIVE REQUIRED**	**YES**	**NOT COVERED**	
D0470	DIAGNOSTIC CASTS	**CLINICAL NARRATIVE REQUIRED**	**YES**	**NOT COVERED**	**TREATMENT NOTES AND XRAYS**
D0502	OTHER ORAL PATHOLOGY PROCEDURES	**CLINICAL NARRATIVE REQUIRED**	**YES**	**T - YES**	
PREVENTIVE DENTAL PROCEDURES					
D1110	PROPHYLAXIS-ADULT (AGES 14-20)	BENEFIT **ONCE** EVERY **6 MONTHS**	**NO**	**T - YES**	
D1120	PROPHYLAXIS-CHILD (AGES 0-13)	BENEFIT **ONCE** EVERY **6 MONTHS**	**NO**	**NOT COVERED**	
D1206	TOPICAL FLUORIDE VARNISH (AGES 0-20)	BENEFIT **ONCE** EVERY **6 MONTHS**	**NO**	**NOT COVERED**	
D1208	TOPICAL APPLICATION OF FLUORIDE (AGES 0-20)	BENEFIT **ONCE** EVERY **6 MONTHS**	**NO**	**T - YES**	

D1351	SEALANT-PER TOOTH (AGES 5-15)	ONE **D1351** OR **D1352 PER TOOTH**, **PER 36 MONTH PERIOD**. TOOTH NUMBER(S) 2, 3, 14, 15, 18, 19, 30, 31 **ONLY** WHEN **NO DECAY** OR **RESTORATION** IS PRESENT	**NO**	**NOT COVERED**	
D1352	PREVENTIVE RESTORATION IN MODERATE TO HIGH RISK (AGES 5-15)		**NO**	**NOT COVERED**	

ADA CODE	PROCEDURE DESCRIPTION	LIMITATIONS	MEMBERS AGES 0-20 PRE-AUTHORIZATION REQUIRED?	MEMBERS AGES 21 & OVER PRE-AUTHORIZATION REQUIRED?	DOCUMENTATION REQUIRED
D1510	SPACE MAINTAINER - FIXED UNILATERAL	**SEE DENTAL CLINICAL REVIEW CRITERIA** ***ALLOWANCE INCLUDES ALL ADJUSTMENTS WITHIN SIX MONTHS OF INITIAL PLACEMENT***	**YES**	**NOT COVERED**	**PRE-TREATMENT XRAYS AND TREATMENT NOTES REQUIRED FOR PA** ***PAYABLE ON SEAT DATE***
D1515	SPACE MAINTAINER - FIXED BILTERAL		**YES**	**NOT COVERED**	
D1520	SPACE MAINTAINER-REMOVABLE UNILATERAL (0-14 YEARS OF AGE)		**YES**	**NOT COVERED**	
D1525	SPACE MAINTAINER-REMOVABLE BILATERAL (0-14 YEARS OF AGE)		**YES**	**NOT COVERED**	

D1550	RECEMENTATION OF SPACE MAINTAINER	HCA **WILL NOT** REIMBURSE A "LOST OR DAMAGED" SPACE MAINTAINER OR A SPACE MAINTAINER THAT REQUIRES RE-CEMENTATION **WITHIN 12 MONTHS** OF INITIAL PLACEMENT WHEN **BILLED BY THE SAME PROVIDER OR GROUP, WHO ORIGINALLY PLACED THE SPACE MAINTAINER.**	**NO**	**NOT COVERED**	**PRE-TREATMENT XRAYS AND TREATMENT NOTES REQUIRED FOR PA**
D1555	REMOVAL OF FIXED SPACE MAINTAINER	**CLINICAL NARRATIVE REQUIRED**	**NO**	**NOT COVERED**	
RESTORATIVE DENTAL PROCEDURES					
D2140	AMALGAM-1 SURFACE	**SEE DENTAL REVIEW CRITERIA**	**NO**	**T - YES**	
D2150	AMALGAM-2 SURFACES		**NO**	**T - YES**	
D2160	AMALGAM-3 SURFACES		**NO**	**T - YES**	
D2161	AMALGAM – 4+ SURFACES		**NO**	**T - YES**	
D2330	RESIN-1 SURFACE, ANTERIOR		**NO**	**T - YES**	
D2331	RESIN-2 SURFACES, ANTERIOR		**NO**	**T - YES**	
D2332	RESIN-3 SURFACES, ANTERIOR		**NO**	**T - YES**	
D2335	RESIN - 4+ SURFACES OR INVOLVING INCISAL ANGLE	**FOUR OR MORE SURFACES OR INVOLVING INCISAL ANGLE (ANTERIOR). XRAY AND CLINICAL NARRATIVE ARE REQUIRED DENTAL DIRECTOR REVIEW IS REQUIRED.**	**NO**	**T - YES**	**PRE-TREATMENT XRAYS AND TREATMENT NOTES REQUIRED FOR PA**
D2390	RESIN BASED COMPOSITE CROWN, ANTERIOR	**SEE DENTAL CLINICAL REVIEW CRITERIA** .	**YES**	**T - YES**	

D2391	RESIN BASED COMPOSITE, 1 SURFACE, POSTERIOR	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**NO**	**T - YES**	
D2392	RESIN BASED COMPOSITE, 2 SURFACES, POSTERIOR		**NO**	**T - YES**	
D2393	RESIN BASED COMPOSITE, 3 SURFACES, POSTERIOR		**NO**	**T - YES**	
D2394	RESIN BASED COMPOSITE, 4+ SURFACES, POSTERIOR		**NO**	**T - YES**	
FIXED CAST RESTORATIONS ***AGES 18-20, ENDODONTICALLY TREATED TEETH OR, WHEN DEEMED NECESSARY BASED ON NEED**					
D2750	CROWN-PORCELAIN FUSED TO HIGH NOBLE METAL **(AGES 18-20)**	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**NOT COVERED**	**ENDO THERAPY POST OP XRAY WITH FINAL CROWN SEAT FILM FOR CLAIMS PAYMENT**
D2751	CROWN-PORCELAIN FUSED TO BASE METAL **(AGES 18-20)**	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**NOT COVERED**	
D2752	CROWN-PORCELAIN FUSED TO NOBLE METAL **(AGES 18-20)**	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**NOT COVERED**	
D2790	CROWN-FULL CAST HIGH NOBLE METAL **(AGES 18-20)**	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**NOT COVERED**	
D2791	CROWN-FULL CAST PREDOMINANTLY BASE METAL **(AGES 18-20)**	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**NOT COVERED**	
D2792	CROWN-FULL CAST NOBLE METAL **(AGES 18-20)**	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**NOT COVERED**	
D2794	CROWN – TITANIUM **(AGES 18-20)**	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**NOT COVERED**	

	OTHER RESTORATIVE PROCEDURES				
D2910	RECEMENT INLAY	CLINICAL NARRATIVE REQUIRED WITH CLAIM	NO	T - YES	PRE-TREATMENT XRAYS AND TREATMENT NOTES REQUIRED FOR PA; POST-OP XRAY REQUIRED FOR CLAIMS PAYMENT
D2915	RECEMENT CAST OR PREFAB POST AND CORE	CLINICAL NARRATIVE REQUIRED WITH CLAIM	NO	T - YES	
D2920	RECEMENT CROWN	CLINICAL TREATMENT NOTES AND X-RAYS REQUIRED FOR EMERGENT CARE. SEE CLINICAL CRITERIA.	NO	T - YES	
D2929	PREFABRICATED PORCELAIN/CERAMIC CROWN – PRIMARY TOOTH	CLINICAL TREATMENT NOTES AND X-RAYS REQUIRED FOR EMERGENT CARE. SEE CLINICAL CRITERIA	YES	NOT COVERED	PRE-TREATMENT XRAYS, IF REQUEST IS MADE WITHOUT XRAYS, AUTH WILL BE PLACED IN "REVIEW" STATUS AND IS SUBJECT TO REVIEW ONCE XRAYS ARE RECEIVED
D2930	STAINLESS STEEL CROWN-PRIMARY TOOTH	CLINICAL TREATMENT NOTES AND X-RAYS REQUIRED FOR EMERGENT CARE. SEE CLINICAL CRITERIA	YES	NOT COVERED	
D2931	STAINLESS STEEL CROWN-PERMANENT TOOTH	CLINICAL TREATMENT NOTES AND X-RAYS REQUIRED FOR EMERGENT CARE. SEE CLINICAL CRITERIA	YES	T - YES	
D2932	PREFABRICATED RESIN CROWN	CLINICAL TREATMENT NOTES AND X-RAYS REQUIRED FOR EMERGENT CARE. SEE CLINICAL CRITERIA	YES	T - YES	
ADA CODE	**PROCEDURE DESCRIPTION**	**LIMITATIONS**	**MEMBERS AGES 0-20 PRE-AUTHORIZATION REQUIRED?**	**MEMBERS AGES 21 & OVER PRE-AUTHORIZATION REQUIRED?**	**DOCUMENTATION**

D2933	SSC WITH RESIN WINDOW – PRIMARY TOOTH	**CLINICAL TREATMENT NOTES AND X-RAYS REQUIRED FOR EMERGENT CARE**	**YES**	**NOT COVERED**	**PRE-TREATMENT XRAYS, IF REQUEST IS MADE WITHOUT XRAYS, AUTH WILL BE PLACED IN "REVIEW"** **STATUS AND SUBJECT TO REVIEW ONCE XRAYS ARE RECEIVED**
D2934	ESTHETIC COATED STAINLESS STEEL CROWN-PRIMARY	**CLINICAL TREATMENT NOTES AND X-RAYS REQUIRED FOR EMERGENT CARE**	**YES**	**NOT COVERED**	
D2940	SEDATIVE FILLING (**This is not considered a permanent restoration. Only protective**)	**CLINICAL TREATMENT NOTES AND X-RAYS REQUIRED FOR EMERGENT CARE** ***NOT PAYABLE IF PERMANENT RESTORATION IS COMPLETED WITHIN 14 DAYS* NOT PAYABLE WITH D3220, D3310-3348***	**NO**	**T - YES**	**PRE-TREATMENT XRAYS AND TREATMENT NOTES**
D2950	CORE BUILD-UP, INCLUDING ANY PINS	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**T - YES**	**ENDO POST OP XRAY, IF REQUEST IS MADE PRIOR TO THE COMPLETION OF THE ENDO THERAPY PLACE IN "REVIEW" STATUS AND IS SUBJECT TO REVIEW ONCE XRAYS ARE RECEIVED**
D2951	PIN RETENTION-PER TOOTH	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**T - YES**	**PRE-TREATMENT XRAYS**
D2952	CAST POST AND CORE IN ADDITION TO CROWN	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**T - YES**	**ENDO POST OP XRAY**
D2954	**PREFAB POST + CORE IN ADDITION TO CROWN**	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**T - YES**	

D2970	TEMPORARY CROWN (FRACTURED TOOTH)	**CLINICAL TREATMENT NOTES, NARRATIVE, AND X-RAYS REQUIRED FOR EMERGENT CARE**	**YES**	**NOT COVERED**	**PRE-TREATMENT XRAYS AND TREATMENT NOTES**
	ENDODONITC PROCEDURES				
D3110	PULP CAP-DIRECT	**CLINICAL TREATMENT NOTES, AND X-RAYS REQUIRED FOR PA** ****NOT PAYABLE IF DONE IN CONJUNCTION WITH ANY RESTORATION OR D3120****	**NO**	**NOT COVERED**	
D3120	PULP CAP-INDIRECT	**CLINICAL TREATMENT NOTES, NARRATIVE, AND X-RAYS REQUIRED WITH CLAIM** ****NOT PAYABLE IF DONE IN CONJUNCTION WITH ANY RESTORATION OR D3110****	**NO**	**NOT COVERED**	
D3220	THERAPEUTIC PULPOTOMY	**CLINICAL TREATMENT NOTES AND X-RAYS REQUIRED FOR EMERGENT CARE**	**YES**	**NOT COVERED**	**PRE-TREATMENT XRAYS AND NARRATIVE FOR PA**
D3221	PULPAL DEBRIDEMENT	**CLINICAL TREATMENT NOTES AND X-RAYS REQUIRED FOR EMERGENT CARE** ****NOT PAYABLE IN CONJUNCTION WITH D3310 – D3330 WHEN COMPLETED BY THE SAME PROVIDER OR GROUP****	**YES**	**T - YES**	
D3222	PARTIAL PULPOTOMY FOR APEXOGENESIS	**CLINICAL TREATMENT NOTES AND X-RAYS REQUIRED FOR EMERGENT CARE**	**YES**	**NOT COVERED**	**PRE-TREATMENT XRAYS AND NARRATIVE FOR PA**
D3230	PULPAL THERAPY - ANTERIOR, PRIMARY TOOTH **(C, D, E, F, G, H, M, N, O, P, Q, R)**	**CLINICAL TREATMENT NOTES AND X-RAYS REQUIRED FOR EMERGENT CARE**	**YES**	**NOT COVERED**	
D3240	PULPAL THERAPY - POSTERIOR, PRIMARY TOOTH **(A, B, I, J, K, L, S ,T)**	**CLINICAL TREATMENT NOTES AND X-RAYS REQUIRED FOR EMERGENT CARE**	**YES**	**NOT COVERED**	
D3310	ANTERIOR (EXCLUDING FINAL RESTORATION) **(6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27)**	**CLINICAL TREATMENT NOTES AND X-RAYS REQUIRED FOR EMERGENT CARE. SEE CLINICAL CRITERIA**	**YES**	**T - YES**	**PRE-TREATMENT XRAYS AND DOCUMENTAITON OF OPPOSING TOOTH AND DOCUMENTAION OF ARCH INTEGRITY**
D3320	BICUSPID (EXCLUDING FINAL RESTORATION) **(4, 5, 12, 13, 20, 21, 28, 29)**	**CLINICAL TREATMENT NOTES AND X-RAYS REQUIRED FOR EMERGENT CARE. SEE CLINICAL CRITERIA**	**YES**	**NOT COVERED**	

D3330	MOLAR (EXCLUDING FINAL RESTORATION) **(2, 3, 14, 15, 18, 19, 30, 31)**	**CLINICAL TREATMENT NOTES AND X-RAYS REQUIRED FOR EMERGENT CARE. SEE CLINICAL CRITERIA**	**YES**	**NOT COVERED**	
D3331 - D3333	OTHER ENDODONTIC PROCEDURES	**CLINICAL TREATMENT NOTES AND X-RAYS REQUIRED**	**YES**	**NOT COVERED**	
D3346	RETREATMENT OF ROOT CANAL THERAPY-ANTERIOR **(6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27)**	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**T - YES**	**PRE-TREATMENT XRAYS AND DOCUMENTAITON OF OPPOSING TOOTH AND DOCUMENTAION OF ARCH INTEGRITY**
D3347	RETREATMENT OF ROOT CANAL THERAPY-BICUSPID **(4, 5, 12, 13, 20, 21, 28, 29)**	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**NOT COVERED**	
D3348	RETREATMENT OF ROOT CANAL THERAPY-MOLAR **(2, 3, 14, 15, 18, 19, 30, 31)**	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**NOT COVERED**	
D3351 – D3353	OTHER ENDODONITC PROCEDURES	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**NOT COVERED**	**SEE D3310-D3348**
D3410	APICOECTOMY/PERIRADICULAR SURGERY-ANTERIOR	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**T - YES**	**PRE-TREATMENT XRAYS AND TREATMENT NOTES FOR PA; AND POST OP XRAYS FOR CLAIM PAYMENT**
D3430	RETROGRADE FILLING-PER ROOT	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**T - YES**	

PERIODONTAL TREATMENT					
ADA CODE	**PROCEDURE DESCRIPTION**	**LIMITATIONS**	**MEMBERS AGES 0-20 PRE-AUTHORIZATION REQUIRED?**	**MEMBERS AGES 21 & OVER PRE-AUTHORIZATION REQUIRED?**	**DOCUMENTATION REQUIRED**
D4210	GINGIVECTOMY OR GINGIVOPLASTY - 4 + TEETH/QUAD	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**T - YES**	**PRE-TREATMENT XRAYS AND TREATMENT NOTES AND COMPLETE PERIO CHARTING**
D4211	GINGIVEC-MY OR GINGIVOPLASTY- 1 - 3 TEETH/ QUAD	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**T - YES**	
D4240	GINGIVAL FLAP PROCEDURE - 4 + TEETH/ QUAD	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**T - YES**	
D4241	GINGIVAL FLAP PROCEDURE - 1 - 3 TEETH/QUAD	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**T - YES**	
D4260	OSSEOUS SURGERY - 4 + TEETH/QUAD	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**T - YES**	
D4261	OSSEOUS SURGERY - 1 - 3 TEETH, PER QUADRANT	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**T - YES**	
D4263 - D4276	OTHER PERIODONTAL SERVICES	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**NOT COVERED**	
D4320	PROVISIONAL SPLINTING-INTRACORONAL	**CLINICAL TREATMENT NOTES AND X-RAYS REQUIRED**	**YES**	**NOT COVERED**	
D4321	PROVISIONAL SPLINTING-EXTRACORONAL	**CLINICAL TREATMENT NOTES AND X-RAYS REQUIRED**	**YES**	**NOT COVERED**	
D4341	SCALING AND ROOT PLANING/QUADRANT	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**T - YES**	
D4342	SCALING AND ROOT PLANING, 1 TO 3 TEETH	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**T - YES**	
D4355	FULL MOUTH DEBRIDEMENT	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**T - YES**	
D4910	PERIODONTAL MAINTENANCE PROCEDURES	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**T - YES**	

D4920	UNSCHEDULED DRESSING CHANGE	**CLINICAL TREATMENT NOTES AND X-RAYS REQUIRED WITH CLAIM**	**YES**	**T - YES**	**TREATMENT NOTES**
D4999	UNSPECIFIED PERIODONTAL TREATMENT	**CLINICAL TREATMENT NOTES AND X-RAYS REQUIRED**	**YES**	**T - YES**	
PROSTHODONTIC PROCEDURES					
D5110	COMPLETE DENTURE – MAXILLARY	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**NOT COVERED**	**TREATMENT NOTES**
D5120	COMPLETE DENTURE – MANDIBULAR	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**NOT COVERED**	
D5130	IMMEDIATE DENTURE – MAXILLARY	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**NOT COVERED**	
D5140	IMMEDIATE DENTURE – MANDIBULAR	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**NOT COVERED**	
D5211 – D5281	OTHER PARTIAL DENTURES	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**NOT COVERED**	
D5410 – D5422	OTHER DENTURE ADJUSTMENTS	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**NOT COVERED**	
D5510 – D5999	OTHER PROSTHODINTIC PROCEDURES	**CLINICAL TREATMENT NOTES AND X-RAYS REQUIRED**	**YES**	**NOT COVERED**	
D6930	RECEMENT FIXED PARTIAL DENTURE	**CLINICAL TREATMENT NOTES AND X-RAYS REQUIRED**	**YES**	**T - YES**	
D6999	UNSPECIFIED FIXED PROSTHODONTIC PROCEDURE	**CLINICAL TREATMENT NOTES AND X-RAYS REQUIRED**	**YES**	**NOT COVERED**	
ORAL SURGERY PROCEDURES					
D7111	CORONAL REMNANT - DECIDUOUS TOOTH	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**NOT COVERED**	**PRE-TREATMENT XRAYS AND TREATMENT NOTES REQUIRED FOR PA**
D7140	EXTRACTION, ERUPTED OR EXPOSED TOOTH	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**T - YES**	
D7210	SURGICAL REMOVAL OF ERUPTED TOOTH	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**T - YES**	
D7220	REMOVAL OF IMPACTED TOOTH-SOFT TISSUE	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**T - YES**	

D7230	REMOVAL OF IMPACTED TOOTH-PARTIALLY BONY	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**T - YES**	
D7240	REMOVAL OF IMPACTED TOOTH-COMPLETELY BONY	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**T - YES**	
D7241	REMOVAL OF IMPACTED FULL BONY WITH COMPLICATIONS	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**T - YES**	
D7250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**T - YES**	
ADA CODE	**PROCEDURE DESCRIPTION**	**LIMITATIONS**	**Members Ages 0-20 Pre-authorization Required?**	**Members Ages 21 & Over Pre-authorization Required?**	**PRE-TREATMENT XRAYS AND TREATMENT NOTES REQUIRED FOR PA**
D7260 – D7294	OTHER ORAL SURGICAL PROCEDURES	**SEE DENTAL CLINICAL REVIEW CRITERIA *PAYABLE ONLY WHEN DENTURES HAVE BEEN APPROVED***	**YES**	**YES**	
D7310	ALVEOLOPLASTY W/ EXTRACTIONS - PER QUADRANT		**YES**	**NOT COVERED**	
D7311	ALVEOLOPLAST W/ EXTRACTIONS, 1 TO 3 TEETH		**YES**	**NOT COVERED**	
D7320	ALVEOLOPLASTY W/O EXTRACTIONS - PER QUADRANT		**YES**	**NOT COVERED**	
D7321	ALVEOLOPLASTY W/O EXTRACTIONS, 1 TO 3 TEETH	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**NOT COVERED**	**PRE-TREATMENT XRAYS AND TREATMENT NOTES REQUIRED FOR PA**
D7410 – D7490	OTHER ORAL SURGICAL PROCEDURES	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**YES**	

D7510	I & D – INTRAORAL OF ABSCESS, SOFT TISSUE	**SEE DENTAL CLINICAL REVIEW CRITERIA** ***NOT PAYABLE WHEN BILLED ON THE SAME DOS AS EXTRACTIONS***	**YES**	**YES**	**PRE-TREATMENT XRAYS AND TREATMENT NOTES REQUIRED FOR PA**
D7511	I & D – INTRAORAL OF ABSCESS, INTRAORAL, COMPLICATED		**YES**	**YES**	
D7520	I & D – INTRAORAL OF ABSCESS,-EXTRAORAL SOFT TISSUE		**YES**	**YES**	
D7521	I & D – INTRAORAL OF ABSCESS, EXTRAORAL, COMPLICATED		**YES**	**YES**	
D7530 – D7955	OTHER SURGICAL PROCEDURES	**SEE DENTAL CLINICAL REVIEW CRITERIA** ***NOT PAYABLE WHEN BILLED ON THE SAME DOS AS EXTRACTIONS***	**YES**	**YES**	
D7970 – D7999	OTHER SURGICAL PROCEDURES		**YES**	**T - YES**	
ORTHODONITC TREATMENT					
D8010 – D8999	***ALL ORTHODONITC TREATMENT MUST BE PRIOR AUTHORIZED***	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**NOT COVERED**	**PRE-TREATMENT XRAYS AND TREATMENT NOTES**

ADJUNCTIVE SERVICES					
D9110	PALLIATIVE (EMERGENCY) TREATMENT OF DENTAL PAIN, MINOR PROCEDURES, AND TREATMENT NOT DEFINED BY AN EXISTING ADA CODE.	**REIMBURSABLE ONLY WITH D0220 AND D0230. NOT REIMBURSABLE WITH ANY OTHER SUBMITTED CODES TREAMENT NOTES REQUIRED WITH CLAIM.**	**NO**	**NOT COVERED**	**PRE-TREATMENT XRAYS AND TREATMENT NOTES**
D9120	FIXED PARTIAL DENTURE SECTIONING	**CLINICAL TREATMENT NOTES AND X-RAYS REQUIRED**	**YES**	**NOT COVERED**	
D9210	LOCAL ANESTHESIA NOT IN CONJUNCTION WITH OPERATIVE OR SURGICAL PROCEDURE	**CLINICAL TREATMENT NOTES AND X-RAYS REQUIRED**	**YES**	**NOT COVERED**	**NARRATIVE REQUIRED FOR CLAIMS PAYMENT**
D9223	GENERAL ANESTHESIA - EACH ADDITIONAL 15 MINUTES	**PROVIDER MUST HAVE APPROPRIATE CERTIFICATE ON FILE WITH HCA IN ORDER TO BE APPROVED FOR THIS SERVICE**	**YES**	**YES**	**TREATMENT PLAN AND NARRATIIVE FOR PA AND SEDATION RECORDS IF SEDATION FAILS**
D9230	ANALGESIA, ANXIOLYSIS, INHALATION OF NITROUS OXIDE	**AUTHORIZATION IS REQUIRED FOR MEMBERS 11 – 20 YEARS OF AGE**	**YES**	**YES**	**TREATMENT PLAN AND NARRATIIVE FOR PA**
D9243	IV CONSCIOUS SEDATION/ANALGESIA	**PROVIDER MUST HAVE APPROPRIATE CERTIFICATE ON FILE WITH HCA IN ORDER TO BE APPROVED FOR THIS SERVICE**	**YES**	**YES**	**TREATMENT PLAN AND NARRATIIVE FOR PA AND SEDATION RECORDS IF SEDATION FAILS**
D9248	NON-INTRAVENOUS CONSCIOUS SEDATION (ORAL MEDS)	**PROVIDER MUST HAVE APPROPRIATE CERTIFICATE ON FILE WITH HCA IN ORDER TO BE APPROVED FOR THIS SERVICE**	**YES**	**YES**	

D9310	CONSULTATION	**NOT REIMBURSABLE ON THE SAME DATE OF SERVICE AS D0120, D0140, D0145, D0150, D0160, D9110, OR D9430**	**YES**	**T - YES**	**TREATMENT NOTES WITH CLAIM**
D9410	HOUSE CALL	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**YES**	
D9420	HOSPITAL CALL	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**YES**	
D9430 – D9440	OTHER ADJUNCTIVE SERVICES	**NOT REIMBURSABLE ON THE SAME DOS AS D0120, D0140, D0145, D0150, D0160, D9110, D9310 OR D9430**	**YES**	**NOT COVERED**	
D9610	THERAPEUTIC DRUG INJECTION, BY REPORT	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**T - YES**	
D9612-D9920	OTHER ADJUNCTIVE SERVICES	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**NOT COVERED**	
D9930	POST OPERATIVE COMPLICATIONS	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**NO**	**T - YES**	
D9940	OCCLUSAL GUARDS, BY REPORT	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**NOT COVERED**	
D9951	OCCLUSAL ADJUSTMENT-LIMITED	**SEE DENTAL CLINICAL REVIEW CRITERIA**	**YES**	**T - YES**	

PRE-AUTHORIZATION REQUESTS:

https://www.healthchoicearizona.com/ProviderPortal/login/

*Benefits of utilizing the provider portal:

- ✓ Your office can check status of authorization immediately
- ✓ Your office can retrieve authorization numbers sooner than "standard-mail"
- ✓ You can schedule your patients sooner
- ✓ You have an electronic record of your transactions with Health Choice
- ✓ It's FREE!

NEED HELP SIGNING UP TO USE THE PROVIDER PORTAL?
CONTACT HEALTH CHOICE FOR ASSISTANCE!
480-968-6866

Standard Mail:
Health Choice Arizona
410 N. 44th Street, Suite 520
Phoenix, AZ 85008

QUESTIONS?

https://www.healthchoicearizona.com/ProviderPortal/login/

PROVIDER SERVICES: (480) 968-6866

NEED HELP SIGNING UP TO USE THE PROVIDER PORTAL?
CONTACT HEALTH CHOICE FOR ASSISTANCE!

ORAL HEALTH PROGRAM MANAGER
Ajfisher@iasishealthcare.com

Please note: **In the event a prior authorization is obtained, clinical notes are no longer required. The exceptions are as follows:**

- **Post-op endo – Please submit radiographs as necessary.**
- **Crown seat – Please provide post-op radiographs – 1 BW and 1 PA – EXCEPT for those completed on primary teeth.**
- **Sedation – Please provide clinical notes for failed sedation.**
- **Post-op complications – Please provide clinical notes**
- **Post-op radiographs are NOT required for D3110, D3120, D3220, D3221**
- **An auth that is in "retro" status or treatment that is rendered on an emergency basis - Please provide clinical notes and applicable radiographs.**