

HEALTH CHOICE ARIZONA 2017 DENTAL BENEFITS FOR MEMBERS UNDER 21



AHCCCS covers clinical oral examinations and radiographs for EPSDT members ages birth through 20 years of age. The following criteria is based on Health Choice Arizona's interpretation of the clinical oral examinations and radiographs when it considers the clinical oral examination medically/dentally necessary. Clinical oral examinations and radiographs do not require authorization. Reimbursement for radiographs includes exposure of radiograph, developing, mounting and radiographic interpretation. The appropriate number of radiographs needed for proper diagnosis and the evaluation of the overall dental condition must accompany all requests for prior authorization.

Claim payment decisions for the number of individual periapical radiographs and/or other radiographs will be made based on the individual patient needs and dental age. Radiographs taken should not exceed the ADA's and FDA's Acceptable Radiographic Examination Guidelines which include but are not limited to:

- a. Child – Primary Dentition: Posterior bitewings and/or upper/lower occlusal films
- b. Child – Transitional dentition: Posterior bitewings, appropriate periapical and occlusal radiographs as needed based on a patient's individual requirement.
- c. Adolescent (ages 16 – 20) – Permanent dentition prior to eruption of third molars: Full mouth periapical series with posterior bitewings or panoramic x-ray with posterior bitewings.

- d. Adult – Periapical x-rays are limited to treatment related to a medical condition such as acute pain, infection or fracture of the jaw. Unless determined medically necessary, adults are not eligible for full mouth or panoramic x-rays.

When the cost of individual periapical x-rays and/or bitewings performed on the same date of service exceed the cost of the intraoral complete series, reimbursement will be limited to the cost of the intraoral complete series.

Radiographs requested for orthodontic treatment are not covered unless orthodontic treatment has been approved by Health Choice Arizona for medical necessity. Radiographs will automatically be included in an approved authorization for orthodontic treatment.

All radiographs must be of good diagnostic quality, properly mounted, dated, positionally oriented and identified with the member's name and AHCCCS ID. Health Choice Arizona will not pay for non-diagnostic x-rays. The cost of all materials and equipment used shall be included in the fee for the radiograph. Radiographs should only be taken when there is an expectation that the diagnostic yield will affect care.

| DIAGNOSTIC | | | | | | |
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| CODE | DESCRIPTION | AGE LIMITATION | TEETH COVERED | AUTHORIZATION REQUIRED | BENEFIT LIMITATIONS | DOCUMENTATION REQUIRED |
| D0120 | periodic oral evaluation - established patient | 0-20 | | No | One of (D0120, D0145, D0150, D0180) per 6 Month(s) Per Provider OR Group. | |
| D0140 | limited oral evaluation-problem focused (Emergency Dental Services only) | 0-20 | | No | Not reimbursable on the same day as D0120, D0145, D0150, D0160, or D0170, D9110, D9310, D9430 | Treatment notes required |
| D0145 | oral evaluation for a patient under three years of age and counseling with primary caregiver | 0-2 | | No | One (D0120, D0145, D0150, D0180) per 6 Month(s) Per Provider OR Location. Not allowed with non-emergency definitive treatment. | |
| D0150 | comprehensive oral evaluation - new or established patient | 0-20 | | No | Limited to one D0150 per Dentist or Group per lifetime. Not payable on same DOS as D0120, D0145 or D0160 | |
| D0160 | detailed and extensive oral eval-problem focused, by report | 0-20 | | Yes | Not allowed on the same DOS as D0120, D0145, D0150, or D0180. | Treatment notes required |
| D0171 | Re-evaluation post-operative office visit | 0-20 | | Yes | | Treatment notes required |
| D0180 | comprehensive periodontal evaluation - new or established patient | 0-20 | | Yes | One of (D0120, D0145, D0150, D0180) per 6 Month(s) Per Provider OR Group. | Treatment notes required |
| D0190 | Screening of a patient | | Not a covered benefit | | | |
| D0191 | Assessment of a patient | | Not a covered benefit | | | |
| D0210 | intraoral - complete series of radiographic images (including bitewings) | 6-20 | | No | Once every 36 Months. Not payable within 12 months of (D0272, D0274, D0277) or within 36 months of (D0330) Minimum of 14 films that consists of a minimum of 2 bitewing x-rays | |
| D0220 | intraoral - periapical first radiographic image | 0-20 | | No | One of (D0220) per 1 Day Per Provider OR Group. | |
| D0230 | intraoral - periapical each additional radiographic image | 0-20 | | No | Two of (D0230) per 1 Day Per patient OR Group. Additional Films Require Documentation to establish medical necessity | |
| D0240 | intraoral - occlusal radiographic image | 0-20 | | No | Limited to two films per DOS in a 12 month period | |
| D0250 | extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector | 0-20 | | Yes | | Treatment notes required; narrative of medical necessity |
| D0251 | Extra-oral posterior dental radiographic image | | Not a covered benefit | | | |
| D0270 | bitewing - single radiographic image | 2-20 | | No | One of (D0270) per 6 Month(s) Per patient. NOT PAYABLE WITHIN 12 MONTHS OF D0210, D0277, OR D0330 | Treatment notes required; narrative of medical necessity |
| D0272 | bitewings - two radiographic images | 2-20 | | No | One of (D0272, D0273, D0274) per 6 Month(s) Per patient. NOT PAYABLE WITHIN 12 MONTHS OF D0210, D0277, OR D0330 | Treatment notes required; narrative of medical necessity |

| DIAGNOSTIC | | | | | | |
|------------|---|----------------|---------------|------------------------|---|---|
| CODE | DESCRIPTION | AGE LIMITATION | TEETH COVERED | AUTHORIZATION REQUIRED | BENEFIT LIMITATIONS | DOCUMENTATION REQUIRED |
| D0273 | bitewings - three radiographic images | 10-20 | | No | One of (D0272, D0273, D0274) per 6 Month(s) Per patient. NOT PAYABLE WITHIN 12 MONTHS OF D0210, D0277, OR D0330 | Treatment notes required; narrative of medical necessity |
| D0274 | bitewings - four radiographic images | 10-20 | | No | One of (D0272, D0273, D0274) per 6 Month(s) Per patient. NOT PAYABLE WITHIN 12 MONTHS OF D0210, D0277, OR D0330 | Treatment notes required; narrative of medical necessity |
| D0277 | vertical bitewings - 7 to 8 films | 0-20 | | No | One of (D0210, D0277, D0330) per 36 Month(s) Per patient. | Treatment notes required; narrative of medical necessity |
| D0290 | posterior-anterior or lateral skull and facial bone survey radiographic image | 0-20 | | Yes | One of (D0290) per 36 months, Not payable within 12 months of (D0210, D0270, D0272, D0273, D0274 or, D0330) | Treatment notes required; narrative of medical necessity |
| D0310 | sialography | 0-20 | | Yes | | Treatment notes required; narrative of medical necessity |
| D0320 | temporomandibular joint arthrogram, including injection | 0-20 | | Yes | | Treatment notes required; narrative of medical necessity |
| D0321 | other temporomandibular joint films, by report | 0-20 | | Yes | | Treatment notes required; narrative of medical necessity |
| D0330 | panoramic radiographic image | 6-20 | | No | One of (D0330) per 36 months Three of (D0330) per lifetime. Not payable within 12 months of (D0270-D0274) when billed by the same provider or group | |
| D0340 | cephalometric radiographic image | 0-20 | | Yes | | Treatment notes required; narrative of medical necessity |
| D0350 | 2D oral/facial photographic image obtained intra-orally or extra-orally | 0-20 | | Yes | | Treatment notes required; narrative of medical necessity |
| D0393 | Treatment simulation using 3D image volume | 0-20 | | Yes | | Treatment notes required; narrative of medical necessity |
| D0470 | diagnostic casts | 0-20 | | Yes | | Treatment notes and pre-operative x-ray(s) |
| D0502 | other oral pathology procedures, by report | 0-20 | | Yes | | Treatment notes required, narrative of medical necessity and x-ray(s) |
| D0999 | unspecified diagnostic procedure, by report | 0-20 | | Yes | Narrative describing service. | Treatment notes required, narrative of medical necessity and x-ray(s) |

AHCCCS covers preventive dental services to members from birth through 20 years of age as specified in the AHCCCS EPSDT Periodicity Schedule and/or when considered medically necessary. The following criteria is based on Health Choice Arizona's interpretation of preventive dental treatment when it considers the treatment necessary based on medical or dental need. Adult (14-20 years) and child (0-13 years) prophylaxis with fluoride treatments are covered once in a 6 month period.

Dental Sealants (D1351) are covered for members 5-14 years of age, when placed on any non-carious permanent first and second molar (i.e. 2, 3, 14, 15, 18, 19, 30, and 31). If decay is present, or there is an existing restoration, the sealant is not payable. HCA will not reimburse a provider for replacing a "lost or missing" dental sealant within 36 months of initial placement when the replacement is billed by the provider or group who initially placed the sealant. In addition, sealants are reimbursed at a maximum of 2 times per tooth per lifetime.

Space maintainers are covered for members 0-14 years of age when determined to be medically/dentally indicated due to

the premature loss of posterior primary molar. HCA will not reimburse a provider for replacing a "lost or damaged" space maintainer within 12 months of initial placement when billed by the provider or group, who originally placed the space maintainer. HCA will not reimburse for re-cementation of a fixed space maintainer when placed by the same provider or group. HCA will not reimburse for the removal of a fixed space maintainer (D1555) when the appliance is placed by the same provider or group. When the posterior primary teeth are lost prematurely on both sides of either the upper or lower arch, HCA will only pay for a bilateral space maintainer. HCA will reduce the benefit of multiple unilateral space maintainers on the same arch when the provider deems it appropriate or, when additional primary teeth are lost prematurely within 12 months. Space maintainers must receive a prior authorization except when billed on the same date of service as an emergency extraction of a primary posterior tooth and when it meets the above described dental criteria. Treatment notes and radiographs are required with claim submission.

| DIAGNOSTIC | | | | | | |
|------------|--|----------------|------------------------------------|------------------------|--|------------------------|
| CODE | DESCRIPTION | AGE LIMITATION | TEETH COVERED | AUTHORIZATION REQUIRED | BENEFIT LIMITATIONS | DOCUMENTATION REQUIRED |
| D1110 | prophylaxis - adult | 14-20 | | No | One of (D1110, D1120) per 6 Month(s) Per patient. Includes scaling and polishing procedures to remove coronal plaque, calculus and stains. | |
| D1120 | prophylaxis - child | 0-13 | | No | One of (D1110, D1120) per 6 Month(s) Per patient. | |
| D1206 | topical application of fluoride varnish | 0-20 | | No | One of (D1206, D1208) per 6 Month(s) Per patient. | |
| D1208 | topical application of fluoride - excluding varnish | 0-20 | | No | One of (D1206, D1208) per 6 Month(s) Per patient. | |
| D1351 | sealant - per tooth | 5-14 | Teeth 2, 3, 14, 15, 18, 19, 30, 31 | No | One of (D1351, D1352) per 36 Month(s) Per patient per tooth. 2 per lifetime per tooth. Teeth must be caries free. Sealants will not be covered when placed on decayed or restored teeth. | |
| D1352 | Preventive resin restoration is a moderate to high caries risk patient perm tooth conservative rest of an active cavitated lesion in a pit or fissure that doesn't extend into dentin: includes placement of a sealant in radiating non-carious fissure or pits. | 5-14 | Teeth 2, 3, 14, 15, 18, 19, 30, 31 | No | One of (D1351, D1352) per 36 Month(s) Per patient per tooth. 2 per lifetime per tooth. Teeth must be caries free. Sealants will not be covered when placed on decayed or restored teeth. | |
| D1354 | Interim caries arresting medicament application | 0-20 | Teeth A-T, 1-32 | No | | |

| DIAGNOSTIC | | | | | | |
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| CODE | DESCRIPTION | AGE LIMITATION | TEETH COVERED | AUTHORIZATION REQUIRED | BENEFIT LIMITATIONS | DOCUMENTATION REQUIRED |
| D1510 | space maintainer-fixed-unilateral | 0-14 | Teeth A, B, I, J, K, L, S, T | Yes | One of (D1510, D1520) per 12 Month(s) Per patient per tooth when billed by the same provider or group. For posterior primary teeth lost prematurely. Indicate missing tooth numbers and arch quadrant on claim. Payable on seat date only. Re-cementation within 12 months not payable when initial placement is by same provider or group. | Treatment notes, pre-operative x-ray(s) |
| D1515 | space maintainer - fixed - bilateral | 0-14 | Teeth A, B, I, J, K, L, S, T | Yes | One of (D1515, D1525) per 12 Month(s) Per patient per arch when billed by the same provider or group. For posterior primary teeth lost prematurely. Indicate missing tooth numbers on claim. Payable on seat date only. Re-cementation within 12 months not payable when initial placement is by same provider or group. | Treatment notes, pre-operative x-ray(s) |
| D1520 | space maintainer-removable-unilateral | 0-14 | Teeth A, B, I, J, K, L, S, T | Yes | One of (D1510, D1520) per 12 Month(s) Per patient per tooth. For posterior primary teeth lost prematurely. Payable on seat date only | Treatment notes, pre-operative x-ray(s) |
| D1520 | space maintainer-removable-unilateral | 0-14 | Teeth A, B, I, J, K, L, S, T | Yes | One of (D1510, D1520) per 12 Month(s) Per patient per tooth. For posterior primary teeth lost prematurely. Payable on seat date only | Treatment notes, pre-operative x-ray(s) |
| D1525 | space maintainer-removable-bilateral | 0-14 | Teeth A, B, I, J, K, L, S, T | Yes | One of (D1515, D1525) per 12 Month(s) Per patient per tooth when billed by the same provider or group. For posterior primary teeth lost prematurely. Payable on seat date only | Treatment notes, pre-operative x-ray(s) |
| D1550 | re-cement or re-bond space maintainer | 0-20 | | Yes | Not allowed within 12 months of placement when billed by the same provider OR group. | Treatment notes |
| D1555 | removal of fixed space maintainer | 0-20 | | Yes | Not allowed by the same provider who placed appliance. | Treatment notes |
| D1575 | distal shoe space maintainer-fixed-unilateral | 0-14 | Teeth A, B, I, J, K, L, S, T | Yes | One of (D1515, D1525) per 12 Month(s) Per patient per arch when billed by the same provider or group. For posterior primary teeth lost prematurely. Indicate missing tooth numbers on claim. Payable on seat date only. Re-cementation within 12 months not payable when initial placement is by same provider or group. | Treatment notes, pre-operative x-ray(s) |
| D1999 | Unspecified preventive procedure, by report | 0-20 | | Yes | Narrative describing service. | Treatment notes narrative of medical necessity |

AHCCCS covers the restoration of carious permanent and primary teeth with accepted dental materials other than cast or porcelain restorations for members, birth through age 20 when the treatment is considered medically/dentally necessary. Cast or porcelain restorations will be considered when a member is 18 through 20 years of age and has had endodontic treatment and when considered medically/dentally necessary. The following criteria are based on Health Choice Arizona's interpretation of tooth restorations when it considers the placement medically/dentally necessary and when a tooth would be considered restorable. Routine restorations do not require authorization.

Health Choice Arizona considers amalgam restorations as an accepted dental material for routine restorations. Fees for amalgam and composite restorations include tooth preparations, all adhesives (including amalgam and composite bonding agents), acid etching, cavity liners, bases and curing. Placement of posterior composite resin restorations are allowed, but will be reimbursed at the posterior amalgam fees. Reimbursement includes local anesthesia. HCA will not reimburse for the replacement of a "lost" or "defective/poor quality" restoration within 24-months of initial placement when the replacement is billed by the provider or group who originally placed the restoration. Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface per tooth, HCA will reimburse for anterior restorations for primary anterior tooth or teeth when it is determined to be medically/dentally necessary upon review by the Dental Director. Restoration of deciduous teeth when exfoliation is reasonably imminent will

not be routinely reimbursable and is determined by the Dental Director. A child who is 5 years of age or older with a decayed primary anterior tooth or teeth regardless of arch location, may be considered for extraction when pain is present or when the tooth or teeth are severely broken down, structurally; or the tooth may be considered for observation at point of exfoliation as determined by the Dental Director.

The Dental Director must consider the overall dental health of the member. A tooth that is determined to be non-restorable may be subject to an alternative treatment plan. A tooth may be deemed non-restorable by the Dental Director if one or more of the following criteria are present:

- i. The tooth presents with greater than a 75% loss of the clinical crown.
- ii. The tooth has less than 50% bone support.
- iii. The tooth exhibits furcal radiolucent lesions or decay.
- iv. The tooth is a primary tooth with exfoliation imminent.
- v. The tooth apex is surrounded by severe pathologic destruction of the bone.
- vi. The overall dental condition (i.e. periodontal and decay experience) of the patient is such that an alternative treatment plan would be better suited to meet the patient's needs.
- vii. The inability to access all canals on a multi-canal tooth for endodontic treatment.
- viii. The tooth presents with external and/or internal root resorption.
- ix. The tooth has a root fracture.
- x. Decay extends below the crest of the bone.

DIAGNOSTIC

| CODE | DESCRIPTION | AGE LIMITATION | TEETH COVERED | AUTHORIZATION REQUIRED | BENEFIT LIMITATIONS | DOCUMENTATION REQUIRED |
|-------|--|----------------|---|------------------------|---|--|
| D2140 | Amalgam - one surface, primary or permanent | 0-20 | Teeth 1 - 32, A - T | No | One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2929, D2930, D2932, D2933, D2934) per 24 Month(s) Per patient per tooth, per surface per provider OR group. | Treatment notes and pre-operative x-ray(s) |
| D2150 | Amalgam - two surfaces, primary or permanent | 0-20 | Teeth 1 -5, 12-16, 17-21, 28-32, A, B, I, J, K, L, S, T | No | One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2929, D2930, D2932, D2933, D2934) per 24 Month(s) Per patient per tooth, per surface per provider OR group. | Treatment notes and pre-operative x-ray(s) of adjacent and opposing teeth. |

| DIAGNOSTIC | | | | | | |
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| CODE | DESCRIPTION | AGE LIMITATION | TEETH COVERED | AUTHORIZATION REQUIRED | BENEFIT LIMITATIONS | DOCUMENTATION REQUIRED |
| D2160 | amalgam - three surfaces, primary or permanent | 0-20 | Teeth 1 -5, 12-16, 17-21, 28-32, A, B, I, J, K, L, S, T | No | One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2929, D2930, D2932, D2933, D2934) per 24 Month(s) Per patient per tooth, per surface per provider OR group. | Treatment notes and pre-operative x-ray(s) |
| D2161 | amalgam - four or more surfaces, primary or permanent | 0-20 | Teeth 1 -5, 12-16, 17-21, 28-32, A, B, I, J, K, L, S, T | No | One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2929, D2930, D2932, D2933, D2934) per 24 Month(s) Per patient per tooth, per surface per provider OR group. | Treatment notes and pre-operative x-ray(s) |
| D2330 | resin-based composite - one surface, anterior | 0-20 | Teeth 6 - 11, 22 - 27, C - H, M - R | No | One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2929, D2930, D2932, D2933, D2934) per 24 Month(s) Per patient per tooth, per surface per provider OR group. | Treatment notes and pre-operative x-ray(s) |
| D2331 | resin-based composite - two surfaces, anterior | 0-20 | Teeth 6 - 11, 22 - 27, C - H, M - R | No | One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2929, D2930, D2932, D2933, D2934) per 24 Month(s) Per patient per tooth, per surface per provider OR group. | Treatment notes and pre-operative x-ray(s) |
| D2332 | resin-based composite - three surfaces, anterior | 0-20 | Teeth 6 - 11, 22 - 27, C - H, M - R | No | One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2929, D2930, D2932, D2933, D2934) per 24 Month(s) Per patient per tooth, per surface per provider OR group. | Treatment notes and pre-operative x-ray(s) |
| D2335 | resin-based composite - four or more surfaces or involving incisal angle (anterior) | 0-20 | Teeth 6 - 11, 22 - 27, C - H, M - R | No | One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2929, D2930, D2932, D2933, D2934) per 24 Month(s) Per patient per tooth, per surface per provider OR group. HCA will not reimburse for additional surfaces performed on the same tooth within 12 months of the initially billed (D2335). | Treatment notes and pre-operative x-ray(s) |

| DIAGNOSTIC | | | | | | |
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| CODE | DESCRIPTION | AGE LIMITATION | TEETH COVERED | AUTHORIZATION REQUIRED | BENEFIT LIMITATIONS | DOCUMENTATION REQUIRED |
| D2390 | resin-based composite crown, anterior | 0-20 | Teeth 6 - 11, 22 - 27 | Yes | One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2929, D2930, D2932, D2933, D2934) per 24 Month(s) Per patient per tooth, per surface per provider OR group. Reduced to D2932 for primary teeth. | Treatment notes and pre-operative x-ray(s) |
| D2391 | resin-based composite - one surface, posterior | 0-20 | Teeth 1 - 5, 12 - 16, 17-21, 28 - 32, A, B, I, J, K, L, S, T | No | One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2929, D2930, D2932, D2933, D2934) per 24 Month(s) Per patient per tooth, per surface per provider OR group. | Treatment notes and pre-operative x-ray(s) |
| D2392 | resin-based composite - two surfaces, posterior | 0-20 | Teeth 1 - 5, 12 - 16, 17-21, 28 - 32, A, B, I, J, K, L, S, T | No | One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2929, D2930, D2932, D2933, D2934) per 24 Month(s) Per patient per tooth, per surface per provider OR group. | Treatment notes and pre-operative x-ray(s) |
| D2393 | resin-based composite - three surfaces, posterior | 0-20 | Teeth 1 - 5, 12 - 16, 17-21, 28 - 32, A, B, I, J, K, L, S, T | No | One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2929, D2930, D2932, D2933, D2934) per 24 Month(s) Per patient per tooth, per surface per provider OR group. | Treatment notes and pre-operative x-ray(s) |
| D2394 | resin-based composite - four or more surfaces, posterior | 0-20 | Teeth 1 - 5, 12 - 16, 17-21, 28 - 32, A, B, I, J, K, L, S, T | No | One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2929, D2930, D2932, D2933, D2934) per 24 Month(s) Per patient per tooth, per surface per provider OR group. | Treatment notes and pre-operative x-ray(s) |

AHCCCS covers the placement of stainless steel crowns on posterior primary and permanent teeth when medically/dentally necessary. The following criteria are based on Health Choice Arizona interpretation of the placement of stainless steel crowns when it considers the placement medically/dentally necessary. All Stainless Steel Crowns (SSC) and anterior resin crowns must be prior authorized except when placed following an emergency pulpotomy on a primary tooth. HCA will not reimburse a provider or group for the replacement

or recementation of a "lost" or damaged crown within 36 months of initial placement when the replacement is billed by the provider or practice who originally placed the crown. HCA will not reimburse an improperly fitted SSC placed by the same provider or group, which has contributed to ectopic eruption of permanent molars. It is the responsibility of the provider or group to replace the SSC at no cost to HCA or the member. Primary molars must have pathologic destruction to the tooth by caries or trauma, and should involve three or

more surfaces with substantial decay resulting in an enamel shell, or hyperplastic teeth following pulpotomy. Permanent molars must have pathologic destruction to the tooth by caries or trauma, and should involve four or more surfaces and two or more cusps, or hyperplastic teeth following endodontic therapy (RCT), teeth with hereditary anomalies. Permanent bicuspids must have pathologic destruction to the tooth by caries or trauma, and should involve three or more surfaces and at least one cusp.

Prefabricated resin crowns, prefabricated stainless steel crowns with resin window and prefabricated esthetic coated stainless steel crowns are a benefit only for anterior primary teeth. Health Choice Arizona will allow for the least expensive professionally acceptable alternative treatment as determined by dental review. HCA covers the placement of cast crowns on permanent teeth for members 18-20 years of age when teeth have been successfully treated endodontically, and when treatment is necessary based on medical or dental need. The following criteria is based on Health Choice Arizona's interpretation of the placement of cast crowns when it considers the placement medically/dentally necessary. Prior-authorized is required for all cast crowns. Requests may be denied if the endodontic treatment is inadequate. Prior authorization requests for multiple cast crown restorations may be subject to alternative treatment when the overall dental condition of the patient is such that an alternative treatment plan would be better suited to meet the patient's needs. A crown will not be approved if adequate tooth structure does not remain to establish cleanable margins, poor crown to root ratio, or the tooth appears to retain insufficient amounts of natural tooth structure. Cast dowel cores are not allowed.

Cast crowns following endodontic therapy or when treatment is necessary based on medical or dental need, must meet all of the following criteria:

- a. Request must include a dated and labeled post-endodontic PA x-ray, if appropriate. A crown must be opposed by a tooth or full denture in the opposing arch, or be an abutment for an approved partial denture.
- b. The patient must be free from active and advanced periodontal disease.
- c. The periapical and furcal tissue must be free of pathology.
- d. The tooth exhibits pathology by decay or fracture requiring treatment (i.e., a tooth that has been endodontically treated, which has been restored with a stainless steel crown that is considered functional, will not necessarily be approved for a cast crown).
- e. A diagnostic quality post cementation radiographs (i.e. bitewing and PA) must be submitted with the claim to be considered for payment.
- f. Crown margins must be closed and apical in position to the build-up.
- g. Proximal contacts when present, must be reestablished.
- h. Opposing occlusion must be reestablished.
- i. There can be no decay present.

Cast crowns following endodontic therapy are payable when arch integrity exists, and opposing teeth are present and in good dental health. Arch integrity exists when all anterior teeth are present (a fixed or removable appliance replacing one or more anterior teeth is acceptable) and all first and second bicuspids and first molars are present and free of overt periodontal disease and do not require endodontic treatment (a removable or fixed appliance replacing one or more of these teeth is acceptable). Second and third molars may or may not be present. The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent teeth. HCA reimburses permanent crowns on the seat date. Member must be eligible on the cementation date in order for crown to be paid. A post-cementation bitewing and periapical x-ray must be submitted with the claim. X-rays taken for post-cementation cannot be billed to Health Choice Arizona. Cast crowns are only payable once per lifetime per tooth. Reimbursement for a cast crown on the third molar will be considered only if it is functioning as a second molar. Prior authorization requests for multiple cast crown restorations may be subject to alternative treatment when the overall dental condition of the patient is such that an alternative treatment plan would be better suited to meet the patient's needs.

The build-up is included in the cost of the SSC, composite, plastic, acrylic or cast crowns. Under extreme tooth structure loss conditions, build-ups on permanent teeth after endodontic treatment may be approved by the Dental Director. Build-ups are not considered a "stand-alone" restoration and will not be approved as such.

| DIAGNOSTIC | | | | | | |
|------------|---|----------------|---|------------------------|--|--|
| CODE | DESCRIPTION | AGE LIMITATION | TEETH COVERED | AUTHORIZATION REQUIRED | BENEFIT LIMITATIONS | DOCUMENTATION REQUIRED |
| D2740 | crown - porcelain/ceramic substrate | 18-20 | Teeth 2-15, 18-31 reimbursement for a third molar will be considered only if it is functioning as a second molar. | Yes | One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794) per lifetime per patient per tooth. Endodontic treated teeth only. Pre-operative radiographs of adjacent and opposing teeth. | |
| D2750 | crown - porcelain fused to high noble metal | 18-20 | Teeth 2-15, 18-31 reimbursement for a third molar will be considered only if it is functioning as a second molar. | Yes | One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794) per lifetime per patient per tooth. Endodontic treated teeth only. | Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment (BW and PA) |
| D2751 | crown - porcelain fused to predominantly base metal | 18-20 | Teeth 2-15, 18-31 reimbursement for a third molar will be considered only if it is functioning as a second molar. | Yes | One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794) per lifetime per patient per tooth. Endodontic treated teeth only. | Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment (BW and PA) |
| D2752 | crown - porcelain fused to noble metal | 18-20 | Teeth 2-15, 18-31 reimbursement for a third molar will be considered only if it is functioning as a second molar. | Yes | One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794) per lifetime per patient per tooth. Endodontic treated teeth only. | Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment (BW and PA) |
| D2790 | crown - full cast high noble metal | 18-20 | Teeth 2-15, 18-31 reimbursement for a third molar will be considered only if it is functioning as a second molar. | Yes | One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794) per lifetime per patient per tooth. Endodontic treated teeth only. | Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment (BW and PA) |
| D2791 | crown - full cast predominantly base metal | 18-20 | Teeth 2-15, 18-31 reimbursement for a third molar will be considered only if it is functioning as a second molar. | Yes | One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794) per lifetime per patient per tooth. Endodontic treated teeth only. | Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment (BW and PA) |
| D2792 | crown - full cast noble metal | 18-20 | Teeth 2-15, 18-31 reimbursement for a third molar will be considered only if it is functioning as a second molar. | Yes | One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794) per lifetime per patient per tooth. Endodontic treated teeth only. | Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment (BW and PA) |
| D2794 | crown - titanium | 18-20 | Teeth 2-15, 18-31 reimbursement for a third molar will be considered only if it is functioning as a second molar. | Yes | One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794) per lifetime per patient per tooth. Endodontic treated teeth only. | Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment (BW and PA) |
| D2910 | re-cement or re-bond inlay, onlay, veneer or partial coverage restoration | 0-20 | Teeth 1 - 32 | Yes | Not reimbursed within 6 months of placement. | Treatment notes, pre-operative x-ray(s) |
| D2915 | re-cement or re-bond indirectly fabricated or prefabricated post and core | 0-20 | Teeth 1 - 32 | Yes | Not reimbursed within 6 months of placement. | Treatment notes, pre-operative x-ray(s) |
| D2920 | re-cement or re-bond crown | 0-20 | Teeth 1 - 32, A - T | Yes | Not reimbursed within 6 months of placement. | Treatment notes, pre-operative x-ray(s) |
| D2921 | Reattachment of tooth fragment, incisal edge or cusp | 0-20 | Teeth 1 - 32 | Yes | | Treatment notes, pre-operative x-ray(s) |

| DIAGNOSTIC | | | | | | |
|------------|---|----------------|--------------------------------------|------------------------|---|--|
| CODE | DESCRIPTION | AGE LIMITATION | TEETH COVERED | AUTHORIZATION REQUIRED | BENEFIT LIMITATIONS | DOCUMENTATION REQUIRED |
| D2929 | Prefabricated porcelain/ceramic crown – primary tooth | 0-20 | Teeth C - H, M - R | Yes | Reimbursed at D2932 payable one time per 36 mo, same provider OR group. | Treatment notes, pre-operative x-ray(s) |
| D2930 | prefabricated stainless steel crown - primary tooth | 0-20 | Teeth A, B, I, J, K, L, S, T | Yes | One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2929, D2930, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth, per surface per provider OR group. | Treatment notes, pre-operative x-ray(s) |
| D2931 | prefabricated stainless steel crown-permanent tooth | 0-20 | Teeth 1 - 5, 12 - 16, 17-21, 28 - 32 | Yes | One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2929, D2930, D2932, D2933, D2934) per 36 Month(s) Per patient per tooth, per surface per provider OR group. | Treatment notes, pre-operative x-ray(s) |
| D2932 | prefabricated resin crown | 0-20 | Teeth 6 - 11, 22 - 27, C - H, M - R | Yes | One (D2932) per 36 Month(s) Per patient per tooth, per provider OR group | Treatment notes, pre-operative x-ray(s) |
| D2933 | prefabricated stainless steel crown with resin window | 0-20 | Teeth 6 - 11, 22 - 27, C - H, M - R | Yes | Reimbursed at D2932 payable one time per 36 months, same provider OR group | Treatment notes, pre-operative x-ray(s) |
| D2934 | prefabricated esthetic coated stainless steel crown - primary tooth | 0-20 | Teeth C - H, M - R | Yes | Reimbursed at D2932 payable one time per 36 months, same provider OR group | Treatment notes, pre-operative x-ray(s) |
| D2940 | protective restoration BR on fee schedule | 0-20 | Teeth 1 - 32, A - T | Yes | Not reimbursed on same day as D2140, D2161, D2330-D2335, D3220-D3240. | Treatment notes, pre-operative x-ray(s) |
| D2941 | Interim therapeutic restoration - primary dentition | | Not a covered benefit | | | |
| D2950 | core buildup, including any pins when required | 0-20 | Teeth 1 - 32 | Yes | One of (D2950, D2952, D2954) per 24 Month(s) Per patient per tooth. Buildups are not considered a stand-alone restoration. | Treatment notes, pre-operative x-ray(s) |
| D2951 | pin retention - per tooth, in addition to restoration | 0-20 | Teeth 1 - 32 | Yes | Limit one per tooth. | Treatment notes, pre-operative x-ray(s) |
| D2952 | cast post and core in addition to crown | 0-20 | Teeth 1 - 32 | Yes | One of (D2950, D2952, D2954) per lifetime Per patient per tooth. Same tooth for endodontically treated teeth. | Treatment notes, pre-operative x-ray(s) Post-operative x-ray for payment |
| D2954 | prefabricated post and core in addition to crown | 0-20 | Teeth 1 - 32 | Yes | One of (D2950, D2952, D2954) lifetime Per patient per tooth. Same tooth for endodontically treated teeth. | Treatment notes, pre-operative x-ray(s) |
| D2999 | unspecified restorative procedure, by report | 0-20 | Teeth 1 - 32 | Yes | | narrative of medical necessity |

AHCCCS covers pulp therapy for permanent and primary teeth, except third molars unless it is functioning in place of a missing second molar, for members' ages 0 – 20 years of age when it is considered medically necessary. The following criteria is Health Choice Arizona's interpretation of pulp therapy and root canal therapy when it considers the pulp therapy or root canal treatment to be medically/dentally necessary. Prior-authorization is required for pulp therapy and root canal therapy except in the case of emergency treatment or pulpal exposure during the excavation of decay for a dental filling. A complete treatment plan (to include services that do not require prior authorization) with narrative and documentation demonstrating medical/dental necessity must be included with the request for pulp therapy, root canal therapy or endodontic referral. All radiographs taken during the course of root canal therapy and all post-treatment radiographs are included in the fee for the root canal procedures. The diagnostic radiograph is a separate procedure. Provision of root canal therapy is not considered appropriate when the prognosis of the tooth is questionable. Prior authorization requests for root canal treatment on multiple teeth may be subject to alternative treatment when the overall dental condition of the patient is such that an alternative treatment plan would be better suited to meet the patient's needs.

Health Choice Arizona does not reimburse for a pulpectomy on a primary tooth. Health Choice Arizona will approve an alternative treatment of D3220 when requested. HCA does not generally reimburse for pulpal debridement. Once the pulp has been extirpated (removed), RCT is considered to have been started and should be billed as such (per ADA guidelines). Consideration for payment may be made if this is a stand-alone emergency procedure for the relief of acute pain when member will be subsequently referred to an endodontist. A narrative indicating endodontic referral must accompany the claim in order for it to be considered.

Providers are responsible for any follow-up treatment, including retreatment required by a failed endodontically treated tooth within 12 months post completion. Endodontic therapy is payable only when arch integrity exists and opposing teeth are present and in good dental health. Arch integrity exists when all anterior teeth are present (a fixed or removable appliance replacing one or more anterior teeth is acceptable) and all first and second bicuspid and first molars are present and free of overt periodontal disease and do not require endodontic treatment (a removable or fixed appliance replacing one or more of these teeth is acceptable). Second and third molars may or may not be present.

Retreatment will be considered when periapical pathology persists or enlarges, or when a poorly filled endodontically treated tooth or teeth present with symptoms consistent with treatment

failure. Retreatment will not be allowed on an asymptomatic non pathologic poorly filled tooth or teeth. A tooth or teeth that exhibit both periapical and furcal involvement, will be deemed non-restorable. A treated tooth or teeth, that exhibit external or internal resorption with either periapical or furcal pathology will be deemed non-restorable. Failure of an endodontically retreated tooth or teeth, will be deemed non-restorable.

Apexification/Apexogenesis (D3351, D3352, D3353) may be considered in cases when RCT therapy is indicated on permanent teeth with incompletely formed apices. The type of procedure(s) used to induce root end closure will be dictated by the clinical and radiographic presentation of pulpal tissue. If the pulp is vital, then the covered procedures will include a partial pulpotomy. If the pulp is non-vital, then the covered procedure will be apexification. Up to three visits may be allowed for apexification. However, if root end closure is accomplished at the initial or the intermediate visit, then additional apexification visits will not be allowed. The published fee for D3352 is the maximum reimbursable amount regardless of the number of visits. HCA may down code apexification/apexogenesis to the cost of the partial pulpotomy when medically/dentally indicated.

Apicoectomy (D3410, D3421, D3426) may be considered in cases where persistent periapical pathology remains or symptoms consistent with root canal failure occurs in an otherwise well treated tooth. Apicoectomy will not be allowed on asymptomatic non pathologic poorly filled teeth. A tooth or teeth that exhibit both periapical and furcation involvement, will be deemed non-restorable. A treated tooth or teeth that exhibit internal resorption with either periapical or furcal pathology, will also be deemed non-restorable. Failures of endodontically retreated teeth will be deemed non-restorable and an apicoectomy will not be approved.

Documentation needed for authorization/payment and specialty referrals for pulp therapy and/or root canal therapy: Diagnostic quality pre-operative periapical and bitewing radiographs of the tooth or teeth, and a full mouth series or panoramic x-ray that clearly shows the overall condition of the member's oral health. A dated and labeled post-operative radiograph must be submitted for review for payment.

Treatment rendered under emergency conditions, when authorization is not possible, will require appropriate radiographs clearly showing the adjacent and opposing teeth, date pre and post-operative x-ray, bitewing x-ray, and a periapical x-ray of the tooth or teeth treated with the claim for retrospective review for payment. In cases where pathology is not apparent, a written narrative justifying treatment is required.

In cases where the root canal filling does not meet HCA's treatment standards, HCA can require the procedure be redone at no additional cost to HCA or to the member. In the event

that an endodontic referral is necessary, any reimbursement already made for an inadequate service may be recouped after HCA reviews the circumstances.

| DIAGNOSTIC | | | | | | |
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| CODE | DESCRIPTION | AGE LIMITATION | TEETH COVERED | AUTHORIZATION REQUIRED | BENEFIT LIMITATIONS | DOCUMENTATION REQUIRED |
| D3110 | pulp cap - direct (excluding final restoration) | 0-20 | Teeth 2-15, 18-31 reimbursement for a third molar will be considered only if it is functioning as a second molar. | No | One of (D3110) per 1 Lifetime Per patient per tooth | Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment |
| D3120 | pulp cap - indirect (excluding final restoration) | 0-20 | Teeth 1 - 32, A - T | No | One of (D3120) per 1 Lifetime Per patient per tooth | Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment |
| D3220 | therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament | 0-20 | Teeth 2-15, 18-31 reimbursement for a third molar will be considered only if it is functioning as a second molar., A - T, | Yes | One of (D3220) per 1 Lifetime Per patient per tooth. | Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth |
| D3221 | pulpal debridement, permanent teeth only | 0-20 | Teeth 1 - 32 when referring to endodontist | No | HCA does not generally reimburse for pulp debridement | Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment |
| D3222 | partial pulpotomy for apexogenesis - permanent tooth with incomplete root development | 0-20 | Teeth 2-15, 18-31 reimbursement for a third molar will be considered only if it is functioning as a second molar. | Yes | Not construed as the first stage of root canal therapy | Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment |
| D3230 | pulpal therapy (restorable filling) - anterior, primary tooth (excluding final restoration) | 0-20 | Teeth C - H, M - R | Yes | HCA does not reimburse for D3230, will approve D3220 1 per lifetime | Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. |
| D3240 | pulpal therapy (restorable filling) - posterior, primary tooth (excluding final restoration) | 0-20 | Teeth A, B, I, J, K, L, S, T | Yes | HCA does not reimburse for D3240, will approve D3220 1 per lifetime | Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth |
| D3310 | endodontic therapy, anterior tooth (excluding final restoration) | 0-20 | Teeth 6 - 11, 22 - 27 | Yes | One of (D3310) per 1 Lifetime Per patient per tooth. | Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment |
| D3320 | endodontic therapy, bicuspid tooth (excluding final restoration) | 0-20 | Teeth 4, 5, 12, 13, 20, 21, 28, 29 | Yes | One of (D3320) per 1 Lifetime Per patient per tooth. | Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment |
| D3330 | endodontic therapy, molar (excluding final restoration) | 0-20 | Teeth 2, 3, 14, 15, 18, 19, 30, 31 | Yes | One of (D3330) per 1 Lifetime Per patient per tooth. | Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment |

| DIAGNOSTIC | | | | | | |
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| CODE | DESCRIPTION | AGE LIMITATION | TEETH COVERED | AUTHORIZATION REQUIRED | BENEFIT LIMITATIONS | DOCUMENTATION REQUIRED |
| D3331 | treatment of root canal obstruction; non-surgical access | 0-20 | Teeth 2-15, 18-31 reimbursement for a third molar will be considered only if it is functioning as a second molar. | Yes | Pre-operative radiographs of adjacent and opposing teeth. | Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment |
| D3332 | incomplete endodontic therapy; inoperable or fractured tooth | 0-20 | Teeth 2-15, 18-31 reimbursement for a third molar will be considered only if it is functioning as a second molar. | Yes | | Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment |
| D3333 | internal root repair of perforation defects | 0-20 | Teeth 2-15, 18-31 reimbursement for a third molar will be considered only if it is functioning as a second molar. | Yes | | Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment |
| D3346 | retreatment of previous root canal therapy-anterior | 0-20 | Teeth 6 - 11, 22 - 27 | Yes | Pre and post-operative radiographs shall be maintained in patient records. | Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment |
| D3347 | retreatment of previous root canal therapy-bicuspid | 0-20 | Teeth 4, 5, 12, 13, 20, 21, 28, 29 | Yes | Pre and post-operative radiographs shall be maintained in patient records. | Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment |
| D3348 | retreatment of previous root canal therapy-molar | 0-20 | Teeth 2-15, 18-31 reimbursement for a third molar will be considered only if it is functioning as a second molar. | Yes | Pre and post-operative radiographs shall be maintained in patient records. | Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment |
| D3351 | apexification/ recalcification - initial visit (apical closure / calcific repair of perforations, root resorption, etc.) | 0-20 | Teeth 2-15, 18-31 reimbursement for a third molar will be considered only if it is functioning as a second molar. | Yes | Pre-operative x-ray(s) with authorization. | Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment |
| D3352 | apexification/ recalcification - interim medication replacement | 0-20 | Teeth 2-15, 18-31 reimbursement for a third molar will be considered only if it is functioning as a second molar. | Yes | Pre-operative x-ray(s) with authorization Fill radiographs with claim. | Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment |
| D3353 | apexification/ recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.) | 0-20 | Teeth 2-15, 18-31 reimbursement for a third molar will be considered only if it is functioning as a second molar. | Yes | Pre-operative x-ray(s) with authorization Fill radiographs with claim. | Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment |
| D3410 | apicoectomy - anterior | 0-20 | Teeth 6 - 11, 22 - 27 | Yes | Pre-operative x-ray(s) with authorization Fill radiographs with claim. 1 per lifetime | Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment |

| DIAGNOSTIC | | | | | | |
|------------|--|----------------|---|------------------------|---|--|
| CODE | DESCRIPTION | AGE LIMITATION | TEETH COVERED | AUTHORIZATION REQUIRED | BENEFIT LIMITATIONS | DOCUMENTATION REQUIRED |
| D3421 | apicoectomy - bicuspid (first root) | 0-20 | Teeth 4, 5, 12, 13, 20, 21, 28, 29 | Yes | Pre-operative x-ray(s) with authorization Fill radiographs with claim. 1 per lifetime | Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment |
| D3425 | apicoectomy - molar (first root) | 0-20 | Teeth 2-15, 18-31 reimbursement for a third molar will be considered only if it is functioning as a second molar. | Yes | Pre-operative x-ray(s) with authorization Fill radiographs with claim. 1 per lifetime | Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment |
| D3426 | apicoectomy (each additional root) | 0-20 | Teeth 2-15, 18-31 reimbursement for a third molar will be considered only if it is functioning as a second molar. | Yes | Pre-operative x-ray(s) with authorization Fill radiographs with claim. 1 per lifetime | Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment |
| D3430 | retrograde filling - per root | 0-20 | Teeth 2-15, 18-31 reimbursement for a third molar will be considered only if it is functioning as a second molar. | Yes | Pre-operative x-ray(s) with authorization Fill radiographs with claim. 1 per lifetime | Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment |
| D3450 | root amputation - per root | 0-20 | Teeth 2-15, 18-31 reimbursement for a third molar will be considered only if it is functioning as a second molar. | Yes | Pre-operative radiographs of adjacent and opposing teeth. 1 per lifetime | Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment |
| D3920 | Hemisection (including root removal), not including root canal therapy | 0-20 | Teeth 2-15, 18-31 reimbursement for a third molar will be considered only if it is functioning as a second molar. | Yes | Pre-operative radiographs of adjacent and opposing teeth. 1 per lifetime | Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment |
| D3999 | unspecified endodontic procedure, by report | 0-20 | Teeth 2-15, 18-31 reimbursement for a third molar will be considered only if it is functioning as a second molar. A - T | Yes | Pre-operative radiographs of adjacent and opposing teeth. 1 per lifetime | Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment |

All periodontal treatment and periodontal referrals must be prior-authorized. Reimbursement includes local anesthetic. Full mouth debridement (D4355) is justified when the comprehensive oral evaluation (D0150) or comprehensive periodontal evaluation (D0180) cannot be performed due to excessive sub and/or supracalculus, heavy plaque, and debris buildup. This preliminary procedure does not preclude the need for additional procedures. A full mouth debridement does not take the place of a regular cleaning when heavy calculus is present.

Justification for scaling and root planning (SC/RP) include, but are not limited to the following:

- i. Radiographic evidence of moderate to heavy subcalculus
- ii. Periodontal pocketing of at least 5mm with bleeding upon probing.
- iii. Radiographic bone loss (horizontal or vertical)
- iv. Clinical attachment loss (CAL) of at least 2mm
- v. Documented (intraoral photographs preferred) gingival inflammation into the adjacent attachment apparatus

Claims for preventive dental procedure codes D1110, D1120, D1206, D1208, D1351 and D1352 will be denied when submitted for the same date of service as any D4000 series periodontal procedure codes.

| DIAGNOSTIC | | | | | | |
|------------|---|----------------|-------------------------------|------------------------|---|--|
| CODE | DESCRIPTION | AGE LIMITATION | TEETH COVERED | AUTHORIZATION REQUIRED | BENEFIT LIMITATIONS | DOCUMENTATION REQUIRED |
| D4210 | gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant | 0-20 | Per Quadrant (10, 20, 30, 40) | Yes | One of (D4210, D4211) per 24 Month(s) Per patient per quadrant. A minimum of four (4) affected teeth in the quadrant. | Treatment notes, pre-operative full mouth series of x-rays, complete periodontal charting. |
| D4211 | gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant | 0-20 | Per Quadrant (10, 20, 30, 40) | Yes | One of (D4210, D4211) per 24 Month(s) Per patient per quadrant. One (1) to three (3) affected teeth in the quadrant. | Treatment notes, pre-operative full mouth series of x-rays, complete periodontal charting. |
| D4240 | gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant | 0-20 | Per Quadrant (10, 20, 30, 40) | Yes | One of (D4240, D4241) per 24 Month(s) Per patient per quadrant. A minimum of four (4) teeth in the affected quadrant. | Treatment notes, pre-operative full mouth series of x-rays, complete periodontal charting. |
| D4241 | gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant | 0-20 | Per Quadrant (10, 20, 30, 40) | Yes | One of (D4240, D4241) per 24 Month(s) Per patient per quadrant. One (1) to three (3) affected teeth in the quadrant. | Treatment notes, pre-operative full mouth series of x-rays, complete periodontal charting. |
| D4249 | clinical crown lengthening - hard tissue | 0-20 | Teeth 1 - 32 | Yes | Endodontically treated teeth only | Treatment notes, pre-operative full mouth series of x-rays, complete periodontal charting |
| D4260 | osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant | 0-20 | Per Quadrant (10, 20, 30, 40) | Yes | One of (D4260, D4261) per 24 Month(s) Per patient per quadrant. A minimum of four (4) affected teeth in the quadrant. There must be radiographic evidence of loss of alveolar bone. | Treatment notes, pre-operative full mouth series of x-rays, complete periodontal charting. |
| D4261 | osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant | 0-20 | Per Quadrant (10, 20, 30, 40) | Yes | One of (D4260, D4261) per 24 Month(s) Per patient per quadrant. One (1) to three (3) affected teeth in the quadrant. There must be radiographic evidence of loss of alveolar bone. | Treatment notes, pre-operative full mouth series of x-rays, complete periodontal charting. |
| D4263 | bone replacement graft - first site in quadrant | 0-20 | Teeth 1 - 32 | Yes | | Treatment notes, pre-operative full mouth series of x-rays, complete periodontal charting. |
| D4264 | bone replacement graft - each additional site in quadrant | 0-20 | Teeth 1 - 32 | Yes | | Treatment notes, pre-operative full mouth series of x-rays, complete periodontal charting. |
| D4265 | biological materials to aid in soft and osseous tissue regeneration | 0-20 | Teeth 1 - 32 | Yes | | Treatment notes, pre-operative full mouth series of x-rays, complete periodontal charting. |
| D4266 | guided tissue regenerate-resorbable barrier, per site, per tooth | 0-20 | Teeth 1 - 32 | Yes | | Treatment notes, pre-operative full mouth series of x-rays, complete periodontal charting |
| D4267 | guided tissue regeneration - nonresorbable barrier, per site, per tooth | 0-20 | Teeth 1 - 32 | Yes | | Treatment notes, pre-operative full mouth series of x-rays, complete periodontal charting. |
| D4270 | pedicle soft tissue graft procedure | 0-20 | Teeth 1 - 32 | Yes | | Treatment notes, pre-operative full mouth series of x-rays, complete periodontal charting. |

| DIAGNOSTIC | | | | | | |
|------------|--|----------------|-------------------------------|------------------------|---|--|
| CODE | DESCRIPTION | AGE LIMITATION | TEETH COVERED | AUTHORIZATION REQUIRED | BENEFIT LIMITATIONS | DOCUMENTATION REQUIRED |
| D4273 | subepithelial connective tissue graft procedure | 0-20 | Teeth 1 - 32 | Yes | | Treatment notes, pre-operative full mouth series of x-rays, complete periodontal charting. |
| D4274 | distal or proximal wedge procedure | 0-20 | Teeth 1 - 32 | Yes | | Treatment notes, pre-operative full mouth series of x-rays, complete periodontal charting. |
| D4275 | soft tissue allograft | 0-20 | Teeth 1 - 32 | Yes | | Treatment notes, pre-operative full mouth series of x-rays, complete periodontal charting. |
| D4276 | combined connective tissue and double pedicle graft | 0-20 | Teeth 1 - 32 | Yes | | Treatment notes, pre-operative full mouth series of x-rays, complete periodontal charting |
| D4320 | provision splinting - intracoronal | 0-20 | Per Arch (LA, UA) | Yes | One (D4320) per lifetime per patient | Treatment notes, pre-operative full mouth series of x-rays, complete periodontal charting. |
| D4321 | provision splinting - extracoronal | 0-20 | Per Arch (LA, UA) | Yes | One (D4320) per lifetime per patient | Treatment notes, pre-operative full mouth series of x-rays, complete periodontal charting. |
| D4341 | periodontal scaling and root planing - four or more teeth per quadrant | 0-20 | Per Quadrant (10, 20, 30, 40) | Yes | One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. A minimum of four adjacent or bonded teeth in the quadrant. There must be radiographic evidence of root calculus or noticeable loss of bone support. | Treatment notes, pre-operative full mouth series of x-rays, complete periodontal charting. |
| D4342 | periodontal scaling and root planing - one to three teeth per quadrant | 0-20 | Per Quadrant (10, 20, 30, 40) | Yes | One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. One to three affected teeth per quadrant. There must be radiographic evidence of root calculus or noticeable loss of bone support. | Treatment notes, pre-operative full mouth series of x-rays, complete periodontal charting |
| D4346 | Scaling in the presence of generalized moderate or severe gingival inflammation in the absence of periodontitis-full mouth, after oral evaluation. | | Not a covered benefit | | | |
| D4355 | full mouth debridement to enable comprehensive evaluation and diagnosis | 0-20 | | Yes | One of (D4355) per lifetime per patient | Treatment notes, pre-operative full mouth series of x-rays, complete periodontal charting. |
| D4910 | periodontal maintenance procedures | 0-20 | | No | One of (D4910) 3 months after D4341 or D4342 and one (D4910) six months after D4341 or D4332. After the first six months, one (D4910) and one (D1110) will be allowed at 6 month intervals each calendar year thereafter. | Treatment notes, pre-operative full mouth series of x-rays, complete periodontal charting. |

| DIAGNOSTIC | | | | | | |
|------------|---|----------------|---------------|------------------------|---------------------|--|
| CODE | DESCRIPTION | AGE LIMITATION | TEETH COVERED | AUTHORIZATION REQUIRED | BENEFIT LIMITATIONS | DOCUMENTATION REQUIRED |
| D4920 | unscheduled dressing change (by someone other than treating dentist or their staff) | 0-20 | | Yes | | Treatment notes, pre-operative full mouth series of x-rays, complete periodontal charting. |
| D4999 | unspecified periodontal procedure, by report | 0-20 | | Yes | | Treatment notes, pre-operative full mouth series of x-rays, complete periodontal charting. |

Health Choice Arizona allows for coverage of full and partial dentures for members ages 6-20 years of age, when they are considered medically necessary or as an alternative treatment choice. The following is based on Health Choice Arizona’s interpretation of these services when considered as necessary based on medical and/or dental need.

All full and partial dentures include six months of post-delivery care. Full and/or partial dentures replacement will be considered only when existing full or partial dentures are not serviceable or cannot be relined or rebased.

Reimbursement for all removable partial dentures includes a minimum of two clasps. The total number of clasps is dictated by the retentive requirements of each case, with no additional payment for necessary supplemental clasps.

If a member’s health would be adversely affected by the absence of a prosthetic replacement, and the member could successfully wear a prosthetic replacement, such a replacement will be considered. In the event that the member has a record of not successfully wearing prosthetic replacements in the past, or has gone an extended period of time (three years or longer) without wearing a prosthetic replacement, the prognosis is poor. Mitigating factors surrounding these circumstances should be included with the prior approval request.

Eight natural or prosthetic teeth in occlusion (four maxillary

and four mandibular teeth in functional contact with each other) are generally considered adequate for functional purposes. One missing maxillary anterior tooth or two missing mandibular anterior teeth may be considered a problem that warrants a prosthetic replacement.

Full or partial dentures will not routinely be replaced when they become unserviceable or are lost within four years, except when they become unserviceable through extensive physiological change. If the member can provide documentation that reasonable care has been exercised in the maintenance of the prosthetic appliance, and it did not become unserviceable or lost through negligence, a replacement may be considered. Prior approval requests for such replacements will not be reviewed without supporting documentation. A verbal statement by the member that is then included by the provider on the prior approval request would generally not be considered sufficient.

The relining of a full and/or partial denture will be considered when the prosthetic appliance is deemed unserviceable. The relining of full and partial dentures will be considered within 3-6 months post-delivery. Relining of full and partial dentures will be considered once in a 2-5 year period following the delivery date

Reimbursement of removable full and/or partial dentures will be authorized on delivery date only.

| DIAGNOSTIC | | | | | | |
|------------|---|----------------|-------------------------------|------------------------|---|--|
| CODE | DESCRIPTION | AGE LIMITATION | TEETH COVERED | AUTHORIZATION REQUIRED | BENEFIT LIMITATIONS | DOCUMENTATION REQUIRED |
| D5110 | complete denture - maxillary | 0-20 | Per Arch (01) | No | One of (D5110, D5130) per 60 Month(s) Per patient. | Treatment plan, treatment notes, Narrative of medical necessity, pre-op x-ray(s) |
| D5120 | complete denture - mandibular | 0-20 | Per Arch (02) | Yes | One of (D5120, D5140) per 60 Month(s) Per patient. | Treatment plan, treatment notes, Narrative of medical necessity, pre-op x-ray(s) |
| D5130 | immediate denture - maxillary | 0-20 | Per Arch (01) | Yes | One of (D5110, D5130) per 60 Month(s) Per patient. | Treatment plan, treatment notes, Narrative of medical necessity, pre-op x-ray(s) |
| D5140 | immediate denture - mandibular | 0-20 | Per Arch (02) | Yes | One of (D5110, D5130) per 60 Month(s) Per patient. | Treatment plan, treatment notes, Narrative of medical necessity, pre-op x-ray(s) |
| D5211 | maxillary partial denture - resin base (including any conventional clasps, rests and teeth) | 0-20 | Per Arch (01, 02) | Yes | One of (D5211, D5213, D5221, D5223) per 60 Month(s) Per patient. | Treatment plan, treatment notes, Narrative of medical necessity, pre-op x-ray(s) |
| D5212 | mandibular partial denture - resin base (including any conventional clasps, rests and teeth) | 0-20 | Per Arch (01, 02) | Yes | One of (D5212, D5214, D5222, D5224) per 60 Month(s) Per patient. | Treatment plan, treatment notes, Narrative of medical necessity, pre-op x-ray(s) |
| D5213 | maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | 0-20 | Per Arch (01, 02) | Yes | One of (D5211, D5213, D5221, D5223) per 60 Month(s) Per patient. | Treatment plan, treatment notes, Narrative of medical necessity, pre-op x-ray(s) |
| D5214 | mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | 0-20 | Per Arch (01, 02) | Yes | One of (D5212, D5214, D5222, D5224) per 60 Month(s) Per patient. | Treatment plan, treatment notes, Narrative of medical necessity, pre-op x-ray(s) |
| D5221 | immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth) | 0-20 | Per Arch (01, 02) | Yes | One of (D5211, D5213, D5221, D5223) per 60 Month(s) Per patient per arch. | Treatment plan, treatment notes, Narrative of medical necessity, pre-op x-ray(s) |
| D5222 | immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth) | 0-20 | Per Arch (01, 02) | Yes | One of (D5212, D5214, D5222, D5224) per 60 Month(s) Per patient per arch. | Treatment plan, treatment notes, Narrative of medical necessity, pre-op x-ray(s) |
| D5223 | immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | 0-20 | Per Arch (01, 02) | Yes | One of (D5211, D5213, D5221, D5223) per 60 Month(s) Per patient per arch. | Treatment plan, treatment notes, Narrative of medical necessity, pre-op x-ray(s) |
| D5224 | immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) | 0-20 | Per Arch (01, 02) | Yes | One of (D5212, D5214, D5222, D5224) per 60 Month(s) Per patient per arch. | Treatment plan, treatment notes, Narrative of medical necessity, pre-op x-ray(s) |
| D5281 | removable unilateral partial denture - one piece cast metal | 0-20 | Per Quadrant (10, 20, 30, 40) | Yes | One of (D5281) per 60 Month(s) Per patient per quadrant. | Treatment plan, treatment notes, Narrative of medical necessity, pre-op x-ray(s) |
| D5410 | adjust complete denture - maxillary | 0-20 | | Yes | Not covered within 6 months of initial placement. | |
| D5411 | adjust complete denture - mandibular | 0-20 | | No | Not covered within 6 months of initial placement. | |
| D5421 | adjust partial denture-maxillary | 0-20 | | No | Not covered within 6 months of initial placement. | |

| DIAGNOSTIC | | | | | | |
|------------|---|----------------|-------------------|------------------------|---|------------------------|
| CODE | DESCRIPTION | AGE LIMITATION | TEETH COVERED | AUTHORIZATION REQUIRED | BENEFIT LIMITATIONS | DOCUMENTATION REQUIRED |
| D5422 | adjust partial denture - mandibular | 0-20 | | No | Not covered within 6 months of initial placement. | |
| D5510 | repair broken complete denture base | 0-20 | Per Arch (LA, UA) | No | | |
| D5520 | replace missing or broken teeth - complete denture (each tooth) | 0-20 | Teeth 1 - 32 | Yes | One of (D5520) per 12 Month(s) Per patient per tooth. | |
| D5610 | repair resin denture base | 0-20 | Per Arch (LA, UA) | No | | |
| D5620 | repair cast framework | 0-20 | Per Arch (LA, UA) | No | | |
| D5630 | repair or replace broken clasp | 0-20 | | No | | |
| D5640 | replace broken teeth-per tooth | 0-20 | Teeth 1 - 32 | No | One of (D5640) per 12 Month(s) Per patient per tooth. | |
| D5650 | add tooth to existing partial denture | 0-20 | Teeth 1 - 32 | Yes | | |
| D5660 | add clasp to existing partial denture | 0-20 | | Yes | | |
| D5710 | rebase complete maxillary denture | 0-20 | | Yes | One of (D5710) per 12 Month(s) Per patient. Not covered within 6 months of placement. | |
| D5711 | rebase complete mandibular denture | 0-20 | | Yes | One of (D5711) per 12 Month(s) Per patient. Not covered within 6 months of placement. | |
| D5720 | rebase maxillary partial denture | 0-20 | | Yes | One of (D5720) per 12 Month(s) Per patient. Not covered within 6 months of placement. | |
| D5721 | rebase mandibular partial denture | 0-20 | | Yes | One of (D5721) per 12 Month(s) Per patient. Not covered within 6 months of placement. | |
| D5730 | reline complete maxillary denture (chairside) | 0-20 | | Yes | One of (D5730) per 12 Month(s) Per patient. Not covered within 6 months of placement. | |
| D5731 | reline complete mandibular denture (chairside) | 0-20 | | Yes | One of (D5731) per 12 Month(s) Per patient. Not covered within 6 months of placement. | |
| D5740 | reline maxillary partial denture (chairside) | 0-20 | | Yes | One of (D5740) per 12 Month(s) Per patient. Not covered within 6 months of placement. | |
| D5741 | reline mandibular partial denture (chairside) | 0-20 | | Yes | One of (D5741) per 12 Month(s) Per patient. Not covered within 6 months of placement. | |
| D5750 | reline complete maxillary denture (laboratory) | 0-20 | | Yes | One of (D5750) per 12 Month(s) Per patient. Not covered within 6 months of placement. | |

| DIAGNOSTIC | | | | | | |
|------------|--|----------------|---------------|------------------------|---|--|
| CODE | DESCRIPTION | AGE LIMITATION | TEETH COVERED | AUTHORIZATION REQUIRED | BENEFIT LIMITATIONS | DOCUMENTATION REQUIRED |
| D5751 | reline complete mandibular denture (laboratory) | 0-20 | | No | One of (D5751) per 12 Month(s) Per patient. Not covered within 6 months of placement. | |
| D5760 | reline maxillary partial denture (laboratory) | 0-20 | | Yes | One of (D5760) per 12 Month(s) Per patient. Not covered within 6 months of placement. | |
| D5761 | reline mandibular partial denture (laboratory) | 0-20 | | Yes | One of (D5761) per 12 Month(s) Per patient. Not covered within 6 months of placement. | |
| D5820 | interim partial denture (maxillary) | 0-20 | | Yes | One of (D5820) per 12 Month(s) Per patient. Pre-operative radiographs of adjacent and opposing teeth. | Treatment plan, treatment notes, Narrative of medical necessity, pre-op x-ray(s) |
| D5821 | interim partial denture-mandibular | 0-20 | | Yes | One of (D5821) per 12 Month(s) Per patient per tooth. Pre-operative radiographs of adjacent and opposing teeth. | Treatment plan, treatment notes, Narrative of medical necessity, pre-op x-ray(s) |
| D5850 | tissue conditioning, maxillary | 0-20 | | Yes | | Treatment plan, treatment notes, Narrative of medical necessity, pre-op x-ray(s) |
| D5851 | tissue conditioning, mandibular | 0-20 | | Yes | | Treatment plan, treatment notes, Narrative of medical necessity, pre-op x-ray(s) |
| D5899 | unspecified removable prosthodontic procedure, by report | 0-20 | | Yes | Narrative describing service. | Treatment plan, treatment notes, Narrative of medical necessity, pre-op x-ray(s) |
| D5911 | facial moulage (sectional) | 0-20 | | Yes | | narrative of medical necessity |
| D5912 | facial moulage (complete) | 0-20 | | Yes | | narrative of medical necessity |
| D5913 | nasal prosthesis | 0-20 | | Yes | | narrative of medical necessity |
| D5914 | auricular prosthesis | 0-20 | | Yes | | narrative of medical necessity |
| D5915 | orbital prosthesis | 0-20 | | Yes | | narrative of medical necessity |
| D5916 | ocular prosthesis | 0-20 | | Yes | | narrative of medical necessity |
| D5919 | facial prosthesis | 0-20 | | Yes | | narrative of medical necessity |
| D5922 | nasal septal prosthesis | 0-20 | | Yes | | narrative of medical necessity |
| D5923 | ocular prosthesis, interim | 0-20 | | Yes | | narrative of medical necessity |
| D5924 | cranial prosthesis | 0-20 | | Yes | | narrative of medical necessity |
| D5925 | facial augment implant prosthesis | 0-20 | | Yes | | narrative of medical necessity |
| D5926 | nasal prosthesis, replacement | 0-20 | | Yes | | narrative of medical necessity |
| D5927 | auricular prosthesis, replace | 0-20 | | Yes | | narrative of medical necessity |
| D5928 | orbital prosthesis, replace | 0-20 | | Yes | | narrative of medical necessity |
| D5929 | facial prosthesis, replacement | 0-20 | | Yes | | narrative of medical necessity |
| D5931 | obturator prosthesis, surgical | 0-20 | | Yes | | narrative of medical necessity |
| D5932 | obturator prosthesis, definitive | 0-20 | | Yes | | narrative of medical necessity |
| D5933 | obturator prosthesis, modification | 0-20 | | Yes | | narrative of medical necessity |

| DIAGNOSTIC | | | | | | |
|------------|--|----------------|---------------|------------------------|------------------------|--|
| CODE | DESCRIPTION | AGE LIMITATION | TEETH COVERED | AUTHORIZATION REQUIRED | BENEFIT LIMITATIONS | DOCUMENTATION REQUIRED |
| D5934 | mandibular resection prosthesis with guide flange | 0-20 | | Yes | | narrative of medical necessity |
| D5935 | mandibular resection prosthesis without guide flange | 0-20 | | Yes | | narrative of medical necessity |
| D5936 | obturator prosthesis, interim | 0-20 | | Yes | | narrative of medical necessity |
| D5937 | trismus appliance (not for TMD treatment) | 0-20 | | Yes | Not for TMD Treatment. | narrative of medical necessity |
| D5951 | feeding aid | 0-20 | | Yes | | narrative of medical necessity |
| D5952 | speech aid prosthesis, pediatric | 0-20 | | Yes | | narrative of medical necessity |
| D5953 | speech aid prosthesis, adult | 0-20 | | Yes | | narrative of medical necessity |
| D5954 | palatal augment prosthesis | 0-20 | | Yes | | narrative of medical necessity |
| D5955 | palatal lift prosthesis, definitive | 0-20 | | Yes | | narrative of medical necessity |
| D5958 | palatal lift prosthesis, interim | 0-20 | | Yes | | narrative of medical necessity |
| D5959 | palatal lift prosthesis, modification | 0-20 | | Yes | | narrative of medical necessity |
| D5960 | speech aid prosthesis, modification | 0-20 | | Yes | | narrative of medical necessity |
| D5982 | surgical stent | 0-20 | | Yes | | narrative of medical necessity |
| D5983 | radiation carrier | 0-20 | | Yes | | narrative of medical necessity |
| D5984 | radiation shield | 0-20 | | Yes | | narrative of medical necessity |
| D5985 | radiation cone locator | 0-20 | | Yes | | narrative of medical necessity |
| D5986 | fluoride gel carrier | 0-20 | | Yes | | narrative of medical necessity |
| D5987 | commissure splint | 0-20 | | Yes | | narrative of medical necessity |
| D5988 | surgical splint | 0-20 | | Yes | | narrative of medical necessity |
| D5991 | vesiculobullous disease medicament carrier | 0-20 | | Yes | | narrative of medical necessity |
| D5992 | Adjust maxillofacial prosthetic appliance | 0-20 | | Yes | | narrative of medical necessity |
| D5999 | unspecified maxillofacial prosthesis, by report | 0-20 | | Yes | | narrative of medical necessity |
| D6999 | fixed prosthodontic procedure | 0-20 | Teeth 1 - 32 | Yes | Description of service | narrative of med. necessity, pre-op x-ray(s) |

AHCCCS covers extraction of symptomatic, infected and non-restorable primary and permanent teeth, and other surgical procedures when medically necessary for members up to age 20. The following criteria are based on Health Choice Arizona’s interpretation of dental extractions when it considers the extraction to be medically/dentally necessary. All extractions and oral surgery referrals require prior authorization. The removal of primary teeth whose exfoliation is imminent does not meet criteria. Extractions are covered only if the tooth is symptomatic and/or exhibits pathology

The prophylactic removal of asymptomatic teeth (i.e. third molars) or teeth exhibiting no overt clinical pathology are not a covered benefit. HCA WILL COVER palliative therapy for conditions associated with non-impacted wisdom teeth (i.e. treatment of pericoronitis in partially erupted third molars with adequate space for eruption). If treatment fails or the pericoronitis recurs, subsequent extractions will be considered. Treatment notes documenting attempted palliative therapy (i.e. curettage, antimicrobial subirrigation, and/or antibiotic treatment) must be submitted with a prior authorization or referral request. Suture removal, treatment of dry socket, and removal of bone fragments are considered part of the extraction

treatment when performed by the same dentist or group of dentists who removed the tooth. Palliative treatment would be considered for reimbursement when a dentist other than the original treating dentist or group provides these services.

The removal or exposure of teeth for orthodontic related reasons is not a covered benefit.

Frenectomy/frenuloplasty requires prior authorization. Frenectomy/frenuloplasty for the treatment of oral structural anomalies is considered medically necessary when all of the following criteria are met:

- a. The member has undergone a medical pediatric evaluation
- b. Functional limitations resulting in inadequate feeding or swallowing
- c. Limited tongue mobility resulting in speech disorders, following completion of evaluation and therapy by a qualified speech pathologist

Treatment rendered under emergency conditions will require submission of the pretreatment x-ray(s) and treatment notes showing diagnosis and procedure with claim for pre-payment review unless approved on a prior authorization request.

| DIAGNOSTIC | | | | | | |
|------------|---|----------------|---|------------------------|--|---|
| CODE | DESCRIPTION | AGE LIMITATION | TEETH COVERED | AUTHORIZATION REQUIRED | BENEFIT LIMITATIONS | DOCUMENTATION REQUIRED |
| D7111 | extraction, coronal remnants - deciduous tooth | 0-20 | Teeth A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS | Yes | One of (D7111) per lifetime per patient per tooth | Treatment notes, pre-operative x-ray(s) |
| D7140 | extraction, erupted tooth or exposed root (elevation and/or forceps removal) | 0-20 | Teeth 1, 16, 17, 32 | Yes | One of (D7140, D7210, D7220, D7230, D7240, D7241, D7250) per 1 Lifetime Per patient per tooth. Extractions for teeth 1, 16, 17 and 32 requires prior authorization | Treatment notes, pre-operative x-ray(s) |
| D7140 | extraction, erupted tooth or exposed root (elevation and/or forceps removal) | 0-20 | Teeth 2 - 15, 18 - 31, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS | Yes | One of (D7140, D7210, D7220, D7230, D7240, D7241, D7250) per 1 Lifetime Per patient per tooth. | Treatment notes, pre-operative x-ray(s) |
| D7210 | surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated | 0-20 | Teeth 1, 16, 17, 32 | Yes | One of (D7140, D7210, D7220, D7230, D7240, D7241, D7250) per 1 Lifetime Per patient per tooth. Extractions for teeth 1, 16, 17 and 32 requires prior authorization | Treatment notes, pre-operative x-ray(s) |

| DIAGNOSTIC | | | | | | |
|------------|---|----------------|---|------------------------|---|---|
| CODE | DESCRIPTION | AGE LIMITATION | TEETH COVERED | AUTHORIZATION REQUIRED | BENEFIT LIMITATIONS | DOCUMENTATION REQUIRED |
| D7210 | surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated | 0-20 | Teeth 2 - 15, 18 - 31, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS | Yes | One of (D7140, D7210, D7220, D7230, D7240, D7241, D7250) per 1 Lifetime Per patient per tooth | Treatment notes, pre-operative x-ray(s) |
| D7220 | removal of impacted tooth-soft tissue | 0-20 | Teeth 1, 16, 17, 32 | Yes | One of (D7140, D7210, D7220, D7230, D7240, D7241, D7250) per 1 Lifetime Per patient per tooth. Extractions for teeth 1, 16, 17 and 32 requires prior authorization | Treatment notes, pre-operative x-ray(s) |
| D7220 | removal of impacted tooth-soft tissue | 0-20 | Teeth 2 - 15, 18 - 31, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS | Yes | One of (D7140, D7210, D7220, D7230, D7240, D7241, D7250) per 1 Lifetime Per patient per tooth. Removal of asymptomatic tooth not covered. | Treatment notes, pre-operative x-ray(s) |
| D7230 | removal of impacted tooth-partially bony | 0-20 | Teeth 2 - 15, 18 - 31, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS | Yes | One of (D7140, D7210, D7220, D7230, D7240, D7241, D7250) per 1 Lifetime Per patient per tooth. Removal of asymptomatic tooth not covered. | Treatment notes, pre-operative x-ray(s) |
| D7230 | removal of impacted tooth-partially bony | 0-20 | Teeth 1, 16, 17, 32 | Yes | One of (D7140, D7210, D7220, D7230, D7240, D7241, D7250) per 1 Lifetime Per patient per tooth. Extractions for teeth 1, 16, 17 and 32 requires prior authorization | Treatment notes, pre-operative x-ray(s) |
| D7240 | removal of impacted tooth-completely bony | 0-20 | Teeth 2 - 15, 18 - 31, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS | Yes | One of (D7140, D7210, D7220, D7230, D7240, D7241, D7250) per 1 Lifetime Per patient per tooth. Removal of asymptomatic tooth not covered. | Treatment notes, pre-operative x-ray(s) |
| D7240 | removal of impacted tooth-completely bony | 0-20 | Teeth 1, 16, 17, 32 | Yes | One of (D7140, D7210, D7220, D7230, D7240, D7241, D7250) per 1 Lifetime Per patient per tooth. Extractions for teeth 1, 16, 17 and 32 requires prior authorization | Treatment notes, pre-operative x-ray(s) |
| D7241 | removal of impacted tooth-completely bony, with unusual surgical complications | 0-20 | Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS | Yes | One of (D7140, D7210, D7220, D7230, D7240, D7241, D7250) per 1 Lifetime Per patient per tooth. Unusual complications such as nerve dissection, separate closure of maxillary sinus, or aberrant tooth positions. Removal of asymptomatic tooth not covered. | Treatment notes, pre-operative x-ray(s) |

| DIAGNOSTIC | | | | | | |
|------------|---|----------------|---|------------------------|--|---|
| CODE | DESCRIPTION | AGE LIMITATION | TEETH COVERED | AUTHORIZATION REQUIRED | BENEFIT LIMITATIONS | DOCUMENTATION REQUIRED |
| D7250 | surgical removal of residual tooth roots (cutting procedure) | 0-20 | Teeth 1 - 32, A - T, | Yes | One of (D7140, D7210, D7220, D7230, D7240, D7241, D7250) per 1 Lifetime Per patient per tooth. Will not be paid to the dentists or group that removed the tooth. Removal of asymptomatic tooth not covered. Roots must be fully encased in bone and gingiva present over the bone. | Treatment notes, pre-operative x-ray(s) |
| D7251 | Coronectomy-intentional partial tooth removal is performed when a neurovascular complication is likely if the entire impacted tooth is removed. | 0-20 | Teeth 1 - 32, A - T | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7260 | oroantral fistula closure | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7261 | primary closure of a sinus perforation | 0-20 | | Yes | Not payable on the same date of service as the extraction | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7270 | tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth | 0-20 | Teeth 2-15, 18-31 reimbursement for a third molar will be considered only if it is functioning as a second molar. | Yes | Includes splinting and/or stabilization. | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7280 | Surgical access of an unerupted tooth | 0-20 | Teeth 1 - 32, 51 - 82 | Yes | One of (D7280) per 1 Lifetime Per patient per tooth. | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7282 | mobilization of erupted or malpositioned tooth to aid eruption | 0-20 | Teeth 2-15, 18-31 reimbursement for a third molar will be considered only if it is functioning as a second molar. | Yes | One of (D7282) per 1 Lifetime Per patient per tooth. | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7283 | placement of device to facilitate eruption of impacted tooth | 0-20 | Teeth 2-15, 18-31 reimbursement for a third molar will be considered only if it is functioning as a second molar. | Yes | One of (D7283) per 1 Lifetime Per patient per tooth. | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7285 | incisional biopsy of oral tissue-hard (bone, tooth) | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, Pathology report |
| D7286 | incisional biopsy of oral tissue-soft | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, Pathology report |
| D7292 | surgical placement of temporary anchorage device [screw retained plate] requiring flap; includes device removal | 0-20 | | Yes | One of (D7292) per 1 Lifetime Per patient per tooth. | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7293 | surgical placement of temporary anchorage device requiring flap; includes device removal | 0-20 | | Yes | One of (D7293) per 1 Lifetime Per patient per tooth. | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7294 | surgical placement of temporary anchorage device without flap; includes device removal | 0-20 | | Yes | One of (D7294) per 1 Lifetime Per patient per tooth. | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |

| DIAGNOSTIC | | | | | | |
|------------|--|----------------|-------------------------------|------------------------|---|---|
| CODE | DESCRIPTION | AGE LIMITATION | TEETH COVERED | AUTHORIZATION REQUIRED | BENEFIT LIMITATIONS | DOCUMENTATION REQUIRED |
| D7310 | alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant | 0-20 | Per Quadrant (10, 20, 30, 40) | Yes | One of (D7310, D7311) per 1 Lifetime Per patient per quadrant. Minimum of three extractions in the affected quadrant. | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7311 | alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant | 0-20 | Per Quadrant (10, 20, 30, 40) | Yes | One of (D7310, D7311) per 1 Lifetime Per patient per quadrant. One to three extractions in the affected quadrant. | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7320 | alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant | 0-20 | Per Quadrant (10, 20, 30, 40) | Yes | One of (D7320, D7321) per 1 Lifetime Per patient per quadrant. | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7321 | alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant | 0-20 | Per Quadrant (10, 20, 30, 40) | Yes | One of (D7320, D7321) per 1 Lifetime Per patient per quadrant. | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7410 | radical excision - lesion diameter up to 1.25cm | 0-20 | | Yes | Pathology report in record. | Treatment notes, narrative of medical necessity, Pathology report |
| D7411 | excision of benign lesion greater than 1.25 cm | 0-20 | | Yes | Pathology report in record. | Treatment notes, narrative of medical necessity, Pathology report |
| D7412 | excision of benign lesion, complicated | 0-20 | | Yes | Pathology report in record. | Treatment notes, narrative of medical necessity, Pathology report |
| D7413 | excision of malignant lesion up to 1.25 cm | 0-20 | | Yes | Pathology report in record. | Treatment notes, narrative of medical necessity, Pathology report |
| D7414 | excision of malignant lesion greater than 1.25 cm | 0-20 | | Yes | Pathology report in record. | Treatment notes, narrative of medical necessity, Pathology report |
| D7415 | excision of malignant lesion, complicated | 0-20 | | Yes | Pathology report in record. | Treatment notes, narrative of medical necessity, Pathology report |
| D7440 | excision of malignant tumor - lesion diameter up to 1.25cm | 0-20 | | Yes | Pathology report in record. | Treatment notes, narrative of medical necessity, Pathology report |
| D7441 | excision of malignant tumor - lesion diameter greater than 1.25cm | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, Pathology report |
| D7450 | removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm | 0-20 | | Yes | Pathology report in record. | Treatment notes, narrative of medical necessity, Pathology report |
| D7451 | removal of odontogenic cyst or tumor - lesion greater than 1.25cm | 0-20 | | Yes | Pathology report in record. | Treatment notes, narrative of medical necessity, Pathology report |
| D7460 | removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm | 0-20 | | Yes | Pathology report in record. | Treatment notes, narrative of medical necessity, Pathology report |
| D7461 | removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm | 0-20 | | Yes | Pathology report in record. | Treatment notes, narrative of medical necessity, Pathology report |
| D7465 | destruction of lesion(s) by physical or chemical method, by report | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, Pathology report |

| DIAGNOSTIC | | | | | | |
|------------|---|----------------|--|------------------------|---|--|
| CODE | DESCRIPTION | AGE LIMITATION | TEETH COVERED | AUTHORIZATION REQUIRED | BENEFIT LIMITATIONS | DOCUMENTATION REQUIRED |
| D7471 | removal of exostosis - per site | 0-20 | Per Arch (01, 02, LA, UA) | Yes | Limited to removal of exostosis, including the removal of tori, osseous tuberosities, and other osseous protuberances, when the mass prevents the sealing of denture and does not allow denture seal. | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7472 | removal of torus palatinus | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7473 | removal of torus mandibularis | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7485 | surgical reduction of osseous tuberosity | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7490 | radical resection of mandible with bone graft | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7510 | incision and drainage of abscess - intraoral soft tissue | 0-20 | Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS | No | One of (D7510, D7511) per 1 Lifetime Per patient per tooth. Not payable on the same date of service as the extraction | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7511 | incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces) | 0-20 | Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS | No | One of (D7510, D7511) per 1 Lifetime Per patient per tooth. Not payable on the same date of service as the extraction | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7520 | incision and drainage of abscess - extraoral soft tissue | 0-20 | Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS | No | One of (D7520, D7521) per 1 Lifetime Per patient per tooth. Not payable on the same date of service as the extraction | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7521 | incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces) | 0-20 | Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS | No | One of (D7520, D7521) per 1 Lifetime Per patient per tooth. Not payable on the same date of service as the extraction | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7530 | Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue | 0-20 | | No | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7540 | removal of reaction-producing foreign bodies, musculoskeletal system | 0-20 | | No | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7550 | Partial ostectomy/ sequestrectomy for removal of non-vital bone | 0-20 | Per Quadrant (10, 20, 30, 40) | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |

| DIAGNOSTIC | | | | | | |
|------------|---|----------------|---------------|------------------------|---------------------|--|
| CODE | DESCRIPTION | AGE LIMITATION | TEETH COVERED | AUTHORIZATION REQUIRED | BENEFIT LIMITATIONS | DOCUMENTATION REQUIRED |
| D7560 | maxillary sinusotomy for removal of tooth fragment or foreign body | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7610 | maxilla - open reduction | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7620 | maxilla - closed reduction | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7630 | mandible-open reduction | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7640 | mandible - closed reduction | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7650 | malar and/or zygomatic arch-open reduction | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7660 | malar and/or zygomatic arch-closed | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7670 | alveolus stabilization of teeth, closed reduction splinting | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7671 | alveolus - open reduction, may include stabilization of teeth | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7680 | facial bones - complicated reduction with fixation and multiple surgical approaches | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7710 | maxilla - open reduction | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7720 | maxilla - closed reduction | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7730 | mandible - open reduction | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7740 | mandible - closed reduction | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7750 | malar and/or zygomatic arch-open reduction | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7760 | malar and/or zygomatic arch-closed reduction | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7770 | alveolus-stabilization of teeth, open reduction splinting | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7771 | alveolus, closed reduction stabilization of teeth | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7780 | facial bones - complicated reduction with fixation and multiple surgical approaches | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7810 | open reduction of dislocation | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7820 | closed reduction dislocation | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7830 | manipulation under anesthesia | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7840 | condylectomy | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |

| DIAGNOSTIC | | | | | | |
|------------|--|----------------|---------------|------------------------|-------------------------------|--|
| CODE | DESCRIPTION | AGE LIMITATION | TEETH COVERED | AUTHORIZATION REQUIRED | BENEFIT LIMITATIONS | DOCUMENTATION REQUIRED |
| D7850 | surgical discectomy, with/without implant | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7852 | disc repair | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7854 | synovectomy | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7856 | myotomy | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7858 | joint reconstruction | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7860 | arthrotomy | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7865 | arthroplasty | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7870 | arthrocentesis | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7871 | non-arthroscopic lysis and lavage | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7872 | arthroscopy - diagnosis with or without biopsy | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7873 | arthroscopy-surgical: lavage and lysis of adhesions | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7874 | arthroscopy-surgical: disc repositioning and stabilization | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7875 | arthroscopy-surgical synovectomy | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7876 | arthroscopy-surgery discectomy | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7877 | arthroscopy-surgical debridement | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7880 | occlusal orthotic device, by report | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7899 | unspecified TMD therapy, by report | 0-20 | | Yes | Narrative describing service. | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7910 | suture small wounds up to 5 cm | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |

| DIAGNOSTIC | | | | | | |
|------------|--|----------------|-------------------------------|------------------------|---------------------|--|
| CODE | DESCRIPTION | AGE LIMITATION | TEETH COVERED | AUTHORIZATION REQUIRED | BENEFIT LIMITATIONS | DOCUMENTATION REQUIRED |
| D7911 | complicated suture-up to 5 cm | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7912 | complex suture - greater than 5cm | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7920 | skin graft (identify defect covered, location and type of graft) | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7940 | osteoplasty- for orthognathic deformities | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7941 | osteotomy - madibular rami | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7943 | osteotomy- mandibular rami with bone graft; includes obtaining the graft | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7944 | osteotomy - segmented or subapical - per sextant or quadrant | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7945 | osteotomy - body of mandible | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7946 | LeFort I (maxilla - total) | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7947 | LeFort I (maxilla - segmented) | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7948 | LeFort II or LeFort III - without bone graft | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7949 | LeFort II or LeFort III - with bone graft | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7950 | osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7951 | sinus augmentation | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7953 | bone replacement graft for ridge preservation - per site | 0-20 | Per Quadrant (10, 20, 30, 40) | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7955 | repair of maxillofacial soft and/or hard tissue defect | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7960 | frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure | 0-20 | | Yes | Must meet criteria | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |

| DIAGNOSTIC | | | | | | |
|------------|--|----------------|-------------------|------------------------|-------------------------------|--|
| CODE | DESCRIPTION | AGE LIMITATION | TEETH COVERED | AUTHORIZATION REQUIRED | BENEFIT LIMITATIONS | DOCUMENTATION REQUIRED |
| D7963 | frenuloplasty | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7970 | excision of hyperplastic tissue - per arch | 0-20 | Per Arch (01, 02) | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7971 | excision of pericoronal gingiva | 0-20 | Teeth 1 - 32 | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7972 | surgical reduction of fibrous tuberosity | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7980 | sialolithotomy | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7981 | excision of salivary gland, by report | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7982 | sialodochoplasty | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7983 | closure of salivary fistula | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7990 | emergency tracheotomy | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7991 | coronoidectomy | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7995 | synthetic graft-mandible or facial bones, by report | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7996 | implant-mandible for augmentation purposes, by report | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7997 | appliance removal (not by dentist who placed appliance), includes removal of archbar | 0-20 | | Yes | Narrative describing service. | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7998 | intraoral fixation device---non-fracture | 0-20 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D7999 | unspecified oral surgery procedure, by report | 0-20 | | Yes | Narrative describing service. | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |

Health Choice Arizona covers orthodontics and orthognathic surgery when medically necessary for members ages 18 and younger when determined to be the primary treatment of choice or an essential part of an overall treatment plan designed by the PCP in consultation with the dentist. The following guideline is based on Health Choice Arizona's interpretation of orthodontic, and orthognathic surgery when it considers the services medically/dentally necessary. All orthodontic/ orthognathic services must be prior authorized. Extractions and other surgical procedures (i.e. surgical exposure of an unerupted tooth or procedures to facilitate eruption of impacted teeth) are not payable by Health Choice Arizona unless included in an approved orthodontic/orthognathic surgery case.

POLICY

a. Orthodontic/orthognathic surgery for the treatment of facial skeletal deformities that result in significant

malocclusion is considered medically necessary if the medical appropriateness criteria are met.

- b. Orthodontic/orthognathic surgery for the treatment for obstructive sleep apnea (OSA) is considered medically necessary if the medical appropriateness criteria are met
- c. Orthodontic/orthognathic surgery for the improvement of an individual's facial structure in the presence of a functional malocclusion in the absence of significant malocclusion is considered cosmetic.
- d. Orthodontic/orthognathic surgery for the treatment of temporomandibular joint (TMJ) disorder is considered investigational.

| DIAGNOSTIC | | | | | | |
|------------|--|----------------|---------------|------------------------|---------------------|--|
| CODE | DESCRIPTION | AGE LIMITATION | TEETH COVERED | AUTHORIZATION REQUIRED | BENEFIT LIMITATIONS | DOCUMENTATION REQUIRED |
| D8010 | limited orthodontic treatment of the primary dentition | 0-18 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D8020 | limited orthodontic treatment of the transitional dentition | 0-18 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D8030 | limited orthodontic treatment of the adolescent dentition | 0-18 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D8040 | limited orthodontic treatment of the adult dentition | 0-18 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D8050 | interceptive orthodontic treatment of the primary dentition | 0-18 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D8060 | interceptive orthodontic treatment of the transitional dentition | 0-18 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D8070 | comprehensive orthodontic treatment of the transitional dentition | 0-18 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D8080 | comprehensive orthodontic treatment of the adolescent dentition | 0-18 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D8090 | comprehensive orthodontic treatment of the adult dentition | 0-18 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D8210 | removable appliance therapy (includes appliances for thumb sucking and tongue thrusting) | 0-18 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D8220 | fixed appliance therapy (includes appliances for thumb sucking and tongue thrusting) | 0-18 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |

| DIAGNOSTIC | | | | | | |
|------------|---|----------------|-------------------|------------------------|---------------------|--|
| CODE | DESCRIPTION | AGE LIMITATION | TEETH COVERED | AUTHORIZATION REQUIRED | BENEFIT LIMITATIONS | DOCUMENTATION REQUIRED |
| D8660 | pre-orthodontic treatment examination to monitor growth and development | 0-18 | | No | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D8670 | periodic orthodontic treatment visit | 0-18 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D8680 | orthodontic retention (removal of appliances) | 0-18 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D8690 | orthodontic treatment (alternative billing to a contract fee) | 0-18 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D8691 | repair of orthodontic appliance | 0-18 | Per Arch (01, 02) | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D8692 | replacement of lost or broken retainer | 0-18 | Per Arch (01, 02) | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D8693 | re-cement or re-bond fixed retainer | 0-18 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D8694 | repair of fixed retainers, includes reattachment | 0-18 | Per Arch (01, 02) | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |
| D8999 | unspecified orthodontic procedure, by report | 0-18 | | Yes | | Treatment notes, narrative of medical necessity, pre-op x-ray(s) |

Local anesthesia is a considered part of the treatment procedure and no additional payment will be made for it. General anesthesia and deep sedation are only covered when there is sufficient evidence to support medical necessity. Hospital or surgery center cases require prior authorization

| DIAGNOSTIC | | | | | | |
|------------|---|----------------|-----------------------|------------------------|--|---|
| CODE | DESCRIPTION | AGE LIMITATION | TEETH COVERED | AUTHORIZATION REQUIRED | BENEFIT LIMITATIONS | DOCUMENTATION REQUIRED |
| D9110 | palliative (emergency) treatment of dental pain - minor procedure | 0-20 | | No | One of (D9110) per 1 Day(s) Per patient. Not allowed with any other services other than radiographs or emergency exams, or behavior management. Members 0-20 | |
| D9120 | fixed partial denture sectioning | 0-20 | Not a covered benefit | | | |
| D9210 | local anesthesia not in conjunction with operative or surgical procedures | | Not a covered benefit | | | |
| D9223 | deep sedation/general anesthesia – each 15 minute increment | 0-20 | | Yes | Eight of (D9223) per 1 Day(s) Per patient. Not allowed on same day with D9230, D9243 or D9248. | Complete treatment plan, health history, narrative describing necessity for sedation, x-rays when available, sedation records |
| D9230 | inhalation of nitrous oxide/analgesia | 0-10 | | No | Not allowed on the same day with D9223, D9243 or D9248. Cannot be billed with D9248 | Complete treatment plan, health history, narrative describing necessity for sedation, x-rays when available |

| DIAGNOSTIC | | | | | | |
|------------|---|----------------|-----------------------|------------------------|--|---|
| CODE | DESCRIPTION | AGE LIMITATION | TEETH COVERED | AUTHORIZATION REQUIRED | BENEFIT LIMITATIONS | DOCUMENTATION REQUIRED |
| D9230 | inhalation of nitrous oxide/analgesia | 11-20 | | Yes | Not allowed on the same day with D9223, D9243 or D9248. Cannot be billed with D9248 | Complete treatment plan, health history, narrative describing necessity for sedation, x-rays when available |
| D9243 | intravenous moderate (conscious) sedation/analgesia – each 15 minute increment | 0-20 | | Yes | Eight of (D9243) per treatment plan per patient. Not allowed on same day with D9230, D9223 or D9248 | Complete treatment plan, health history, narrative describing necessity for sedation, x-rays when available, sedation records |
| D9248 | non-intravenous moderate (conscious) sedation | 0-20 | | Yes | Two of (D9248) per treatment plan per patient. Not allowed on the same day with D9223, D9243 or D9230. | Complete treatment plan, health history, narrative describing necessity for sedation, x-rays when available, sedation records |
| D9310 | consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician | | Not a covered benefit | | | |
| D9420 | hospital or ambulatory surgical center call. | | Not a covered benefit | | | |
| D9430 | office visit for observation - no other services performed | 0-20 | | Yes | No other procedures may be billed in conjunction with a D9430. | |
| D9440 | office visit - after regularly scheduled hours | 0-20 | | Yes | | narrative of medical necessity |
| D9610 | therapeutic drug injection, by report | 0-20 | | Yes | One of (D9610, D9612) per 1 Day(s) Per patient. | Description of drugs with claim |
| D9612 | therapeutic drug injection - 2 or more medications by report | | Not a covered benefit | | | |
| D9930 | treatment of complications (post-surgical) - unusual circumstances, by report | 0-20 | | Yes | | narrative of medical necessity |
| D9940 | occlusal guard, by report | 0-20 | | Yes | One of (D9940) per 24 Month(s) Per patient. | narrative of medical necessity |
| D9951 | occlusal adjustment - limited | 0-20 | | Yes | One of (D9951) per 12 Month(s) Per patient. | |
| D9999 | unspecified adjunctive procedure, by report | 0-20 | | Yes | Narrative describing service. | |

PRE-AUTHORIZATION REQUESTS:

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

*Benefits of your 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

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ORAL HEALTH PROGRAM MANAGER

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