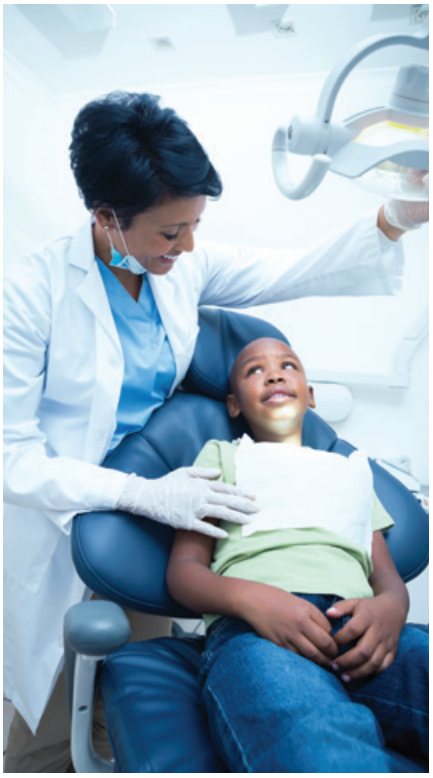
HEALTH CHOICE ARIZONA 2017 DENTAL BENEFITS
FOR MEMBERS UNDER 21



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						
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 arthogram, 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. Reimbursement for panorex taken by oral surgeon to evaluate third molars, oral pathology, jaw fractures subject to retro review	
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						
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 one per lifetime 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 lifetime 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 lifetime 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 lifetime 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 lifetime 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 (D1575) per lifetime per patient per group 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) for reimbursement
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 for reimbursement

DIAGNOSTIC						
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) for reimbursement
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) for reimbursement
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) for reimbursement
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) for reimbursement
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) for reimbursement
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) for reimbursement

DIAGNOSTIC						
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) for reimbursement
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) for reimbursement
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) for reimbursement
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) for reimbursement

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 improper 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 5 years 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)
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 5 years 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 5 years 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 5 years 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 5 years 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 5 years 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 5 years 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 5 years 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 endodonticaly 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 endodonticaly 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. Retreatment of endodontically treated teeth to be completed by an endodontist. 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 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.

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						
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 Life-time 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 Life-time 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 Life-time 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 pulpal de-bridement	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	1 year warranty, retreatment to be referred to endodontist	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	1 year warranty, retreatment to be referred to endodontist	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	1 year warranty, retreatment to be referred to endodontist	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
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. retreatment to be completed by endodontist	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. retreatment to be completed by endodontist	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. retreatment to be completed by endodontist	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 D4341or 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 36 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 36 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 36 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 36 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 36 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 36 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 givgiva 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 osseious 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:

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ORAL HEALTH PROGRAM MANAGER
VWarman@iasishealthcare.com