WV Children's Health Insurance Program
Dental Provider Guide
2019

WVCHIP
350 Capitol Street,
Room 251
Charleston, WV 25301
WVCHIP Helpline 1-877-982-2447
www.chip.wv.gov

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DEAR DENTAL PROVIDER:

IMPORTANT!

Please assure your information is accurate on www.InsureKidsNow.gov .

Since passage of the Children's Health Insurance Program Reauthorization Act (CHIPRA) in 2009, all CHIP and Medicaid programs are required to provide an electronic list of dental providers to post on a public website, www.InsureKidsNow.gov . The listing helps CHIP members identify local dental providers who are available to provide services.

The initial posting of an electronic list was on the **InsureKidsNow.gov** website in August 2009. In the past our state maintained unpublicized lists so we could help refer members to a dentist who participates in CHIP and/or Medicaid in their local area. An electronic list now allows the public to access this information and dental practices can show if they are currently accepting new CHIP and/or Medicaid patients.

TO PROVIDE PRACTICE UPDATES:

Please review your listing on the InsureKidsNow.gov website. Contact Molina, Provider Enrollment at 1-888-483-0793 to update or change any information.

ACCEPTING NEW PATIENTS?

Since many dental providers offer CHIP and/or Medicaid services to a limited number of CHIP/Medicaid patients, please review the section that shows whether you currently accept new patients. **We update this list on a quarterly basis.** These regularly scheduled updates will encourage more complete and accurate listings of actively practicing dentists to assure the best possible access for children and families of our state.

Thanks for helping children and families by providing up-to-date information on dental services in the quickest and most convenient way!

Dental Services

The WVCHIP Benefit Plan covers a full range of health care services, including dental care. WVCHIP member families receive a copy of the Summary Plan Description (SPD) each July and upon enrollment in the program. The SPD provides information on benefits, requirements for coverage, and cost participation required by the family. The dental benefit plan year begins on January 1st and ends on December 31st. Benefit maximums and coverage of services is determined based on the Benefit Year. Also, some dental services require prior authorization before the plan will cover them. Prior authorization requirements apply to **all** enrollment groups.

Most dental services require no copays, but WVCHIP Premium members have $25.00 copays for most non-preventive dental procedures with maximum copays of $100.00 per member per benefit year and a $150.00 maximum per family per benefit year. Families are informed that they have met their maximum copayment amount on the Explanation of Benefits (EOB) form. Providers can also check on copay status by calling **Molina at 1-800-479-3310.**

New Medical Oral Health Infant Program: Effective October 1, 2011, the West Virginia Children's Health Insurance Program (WVCHIP) began reimbursing primary care providers for the application of fluoride varnish to children ages six (6) months to under 36 months (3 years) who are at high risk of developing dental caries. ***To be eligible for payment of this service, providers must be certified through training for fluoride varnish application offered by the West Virginia University School of Dentistry***. The medical professional must complete the program in two sequential phases. Phase 1 consists of an on-line training, and Phase 2 consists of a live, face-to-face training led by an Oral Health Champion (dentist and/or dental hygienist). The cost of Phase 1 is $40 and can be accessed by going to http://dentistry.hsc.wvu.edu/Oral-Health/WVInfantOH. Once Phase 1 is successfully completed, WVU School of Dentistry will facilitate scheduling of Phase 2. Phase 2 will be conducted in the local area where the primary care provider practices, preferably in their office or possibly at another local venue.

The application of the fluoride varnish should include communication with and counseling of the child's caregiver, including a referral to a dentist. WVCHIP allows coverage for two fluoride varnish applications per year (one every six months) by their dentist and two applications per year (one every six months) by their primary care practitioner, in conjunction with a comprehensive well-child exam. If you know of a physician who is interested in providing this service, please refer them to www.hsc.wvu.edu/sod/oral-health for more information regarding the required training. please refer to the Medical Infant/Child Health Program Fluoride Varnish by Primary Care Practitioners WVCHIP Coverage Policy found at our web site at www.chip.wv.gov.

WVCHIP Benefit Plans

A member card is issued within 15 days of the child's enrollment in WVCHIP or after any change in coverage. This card is used for medical, dental and prescription drug coverage. Duplicate cards are issued when a card is reported lost, stolen or damaged. Each card shows the insured child's name and WVCHIP identification number.

The benefit plan is marked on the insurance card. All children insured under WVCHIP participate in some level of cost sharing (copayments and premiums) that is indicated by the benefit plan.

WVCHIP Gold Plan – No dental copayments; no deductibles

WVCHIP Blue Plan – No dental copayments; no deductibles

WVCHIP Premium – $25.00 copayments for some non- preventive dental procedures, with maximum copayments of $100.00 per child per benefit year or $150.00 per family per benefit year. Please refer to the Appendix D for procedures that require copayments.

WVCHIP EXEMPT – No dental copayments; no deductibles

NOTE: WVCHIP members that are registered under the federal exception for Native Americans or Alaskan Natives have NO cost sharing, regardless of their benefit plan.

Diagnostic, Preventive and other Dental Services that do **NOT** require prior authorization

The following dental procedures are covered by WVCHIP and require no prior authorization unless benefit maximums are exceeded:

PREVENTIVE/DIAGNOSTIC: Covered 100% - no copayment

- Dental examinations every six months
- Cleaning every six months
- Fluoride treatment every six months
  - D1206 - Topical application of fluoride varnish
  - D1208 - Topical application of fluoride – excluding varnish
- Bitewings (see page 18 for limits)
- Full mouth x-rays every 36 months (Panorex)
  - It is the member's responsibility to provide x-rays for any consults ordered or for additional services ordered from a new dental provider if the plan has already covered the maximum amount during the benefit year
- Sealants (One sealant per tooth per three years)
  - A resinous material designed to be applied to the occlusal surfaces of posterior teeth to prevent occlusal caries.
- Treatment of abscesses, including initial office visit and follow-up
- Other x-rays (covered in connection with another service)
- Space Maintainers

RESTORATIVE: *

- Fillings as needed

ENDODONTICS/ROOT CANALS/PERIODONTICS *

- Pulpotomy
- Root canal

SURGERY/EXTRACTIONS: *

- Simple extractions
- Extractions – impacted (covered under medical and requires PA if performed as outpatient procedure)
- Extractions related to an abscess and root canal therapy
- Removal of dental related cysts under a tooth or on a gum, including x-rays needed to diagnose the condition
- Frenulectomy (frenectomy or frenotomy)
- Biopsy of oral tissue

Dental Services that do NOT require prior authorization (cont.)

OTHER BASIC SERVICES: *

- Analgesia
- IV/Conscious Sedation
- Palliative Treatment
- Other X-rays (covered in connection with another covered service)
- Consultations

PROSTHODONTICS:*

- Complete dentures (including routine post-delivery care)
- Partial dentures (including routine post-delivery care)
- Adjustments to dentures
- Repairs to partial dentures
- Denture rebase procedures
- Denture reline procedures

RESTORATIVE SERVICES:* (Radiographs must be available for post-payment review if required)

- Dental crowns – 1 every five (5) years
- Gingivectomy or gingivoplasty – 1 quadrant/per year
- Osseous surgery – 1 per quadrant/per year
- Peridontal scaling and root planing – 1 per quadrant/per year
- Full mouth debridement – 1 every 6 months
- Prosthodontics – covered for certain medically necessary conditions

*** WVCHIP Premium Copays apply to these categories.**

Dental Services Requiring Prior Authorization

The services listed below are covered when medically necessary and approved through the prior authorization process. Please contact HealthSmart at 1-800-356-2392 **prior** to performing the service to assure it will be covered. **If the request for prior authorization is denied, WVCHIP will not cover the cost of the procedure.**

ACCIDENT RELATED DENTAL SERVICES: The Least Expensive Professional Acceptable Alternative Treatment (LEPAAT) for accident-related dental services is covered when provided within six (6) months of an accident and required to restore damaged tooth structures. The initial treatment must begin within 72 hours of the accident. Biting and chewing accidents are not covered. Services provided more than six (6) months after the accident are not covered. **Note:** For children under the age of 16, the six-month limitation may be extended if a treatment plan is provided within the initial six months and approved by HealthSmart.

EMERGENCY DENTAL SERVICES: Medically necessary adjunctive services that directly support the delivery of dental procedures, which, in the judgment of the dentist, are necessary for the provision of optimal quality therapeutic and preventive oral care to patients with medical, physical or behavioral conditions. These services include but are not limited to sedation, general anesthesia, and utilization of outpatient or inpatient surgical facilities. Contact HealthSmart for more information.

ORTHODONTIC SERVICES: ***** Orthodontic services are covered if medically necessary for WVCHIP members with malocclusion that create disabilities and/or impair their physical development. Coverage is not automatic and service must be prior authorized by WVCHIP. Please mail prior authorization requests to WVCHIP, 350 Capitol Street, Room 251, Charleston, WV 25301, prior to performing the service. Orthodontic coverage is limited to services medically necessary to correct dento-facial anomalies. The following conditions will be considered for coverage with supporting documentation:

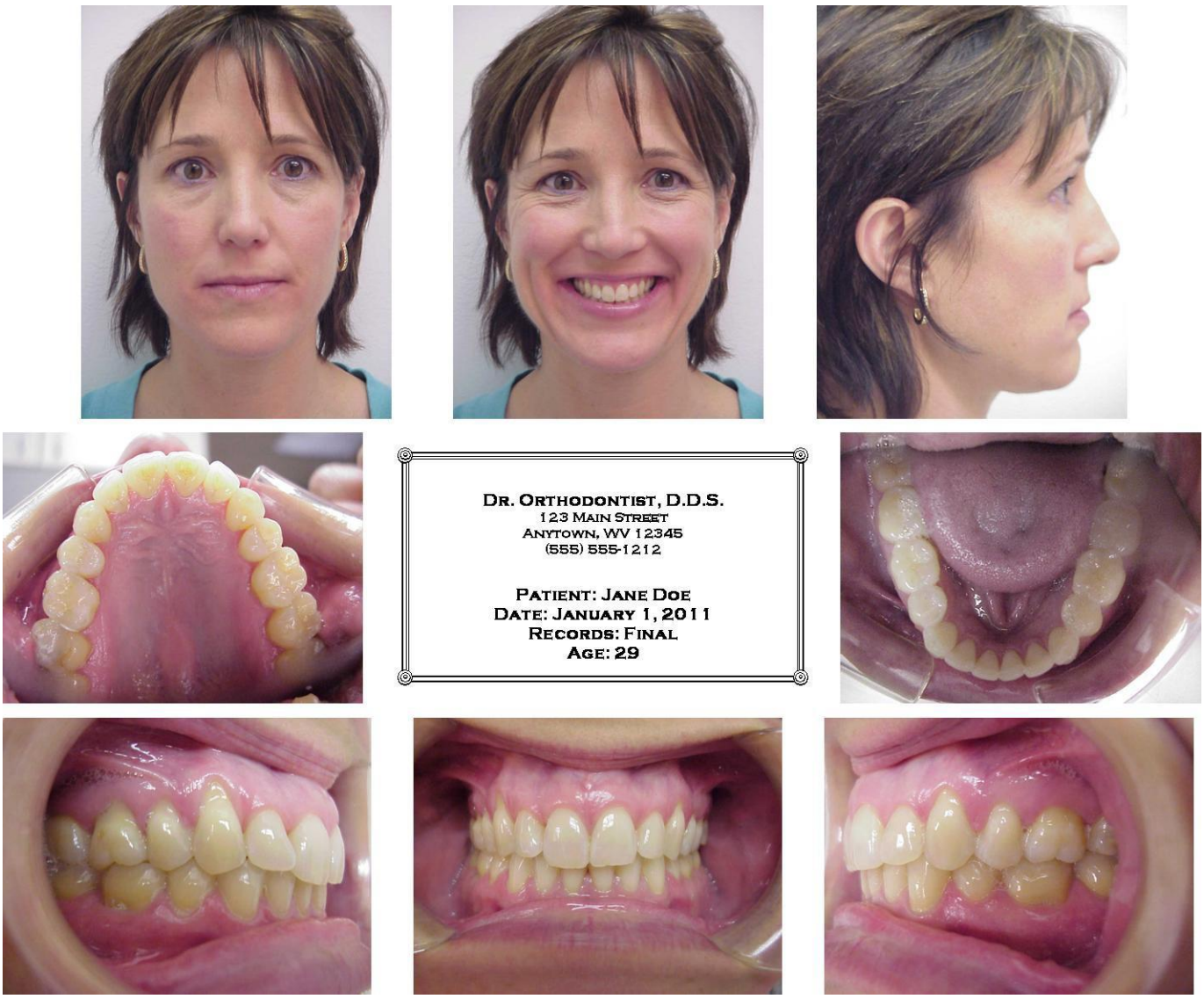
- Member with syndromes or craniofacial anomalies such as cleft palate, Alperst Syndrome or craniofacial dysplasia
- Severe malocclusion associated with dento-facial deformity (e.g. a patient with a full tooth Class II malocclusion with a demonstrable impinging overbite into the palate)

A standard American Board of Orthodontics (ABO) series of photographs, including 3 extra-oral and 5 intro-oral views (see examples on Page 9) must be submitted with all requests for prior authorization. Requests for prior authorization submitted with photographs that are not of diagnostic quality will be returned without review. Failure to submit any of the following documentation will result in a denial of the request for orthodontic services:

- Panoramic Film
- Cephalometric Tracing
- Cephalometric X-ray
- Photographs – A standard series of 5 Intra and 3 Extra Oral photographs that meets the American Board of Orthodontics standards
- Treatment Plan, including findings, diagnosis, prognosis, length of treatment, and phases of treatment

Prior authorization requests that are denied by initial review may be appealed. Upper and lower study casts trimmed to the correct occlusion may be requested for a second level review. Failure to trim study casts to correct occlusion will delay decision.

Examples of AAO Photographs (extra- oral and intro-oral)



** **Prior authorization from WVCHIP assures that the claim will be paid when submitted EXCEPT when a child has disenrolled from the plan <u>on or</u> <u>before the date of service.</u> If the request for prior authorization is denied, families will be responsible for paying for the procedure if the child has it.***

<u>Note: Comprehensive orthodontic treatment is payable only once in the member's lifetime by WVCHIP, regardless of the payer.</u>

Dental Services **Not** Covered

- Treatment of temporomandibular joint (TMJ) disorders
- Intraoral prosthetic devices or any other method of treatment to alter vertical dimension or for TMJ not caused by disease or physical trauma
- Antibiotic Injections
- Tests/Lab Exams
- Onlays/Inlays
- Orthodontic services for cosmetic purposes
- Gold Restorations
- Precision Attachments
- Replacements of crowns (covered once every 5 years)
- Any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances
- Charges for copies of member records, charts or x-rays, or any costs associated with forwarding/mailing copies of member's records, charts or x-rays
- Fees submitted by a dentist which is for the same services performed on the same date for the same member by another dentist
- Duplicate, provisional and temporary devices, appliances and services
- Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insurance plan
- Adjustment of a denture or bridgework which is made within 6 months after installation by the same dentist who installed it
- Use of material or home health aids to prevent decay, such as toothpaste, fluoride gels, dental floss and teeth whiteners
- Fabrication of athletic mouth guard
- Dental implants and related services
- Experimental/investigational or services for research purposes
- Removal of primary teeth whose exfoliation is imminent
- Anesthesia services when solely for the convenience of the member, the member's caretaker or the provider of the service
- Splinting
- Out of state providers unless enrolled as a WVCHIP provider through Molina Medicaid Solutions.
- Services and treatment not prescribed by or under the direct supervision of a dentist, except in those states where dental hygienists are permitted to practice without supervision by a dentist. In these states, we will pay for eligible covered services provided by an authorized dental hygienist performing within the scope of his or her license and applicable state law
- Telephone consultations
- Any charges/services that are covered in whole or in part by another plan
- Any other procedure not listed as covered

Timely Claims Filing

Dental claims must be filed within **six months** of the date of service. Claims not submitted within this period will not be paid, and WVCHIP will not be responsible for payment.

Members are responsible for presenting the appropriate member card indicating coverage at the time of service. Members are responsible for payment for service if they neglect to provide the appropriate member card for coverage that causes the provider to miss the timely claims filing limitations.

Claims Filing Instructions

Instructions to the Dentist:

If treatment plan includes crowns or bridgework, radiographs must be made available for post-payment review, if requested.

Submit all claim forms and invoices to the address below.

Molina
P.O. Box 3732
Charleston, WV 25337
Toll Free: 1-800-479-3310

Appealing Health Services

APPEAL PROCESS

Each WVCHIP member and provider is assured a right to have a review of health services matters under this Plan. Health services matters may include (but are not limited to) such issues as correct or timely claims payment; a delay, reduction, a denial of a service, including pre-service decisions; and suspension or termination of a service, including the type and level of service. This same process can apply to prescription drugs or supplies available through the Plan.

Appealing Health Services (Cont.)

Exception from Review: WVCHIP does not provide a right to review any matter whose only satisfactory remedy or decision would require automatic changes to the program's State Plan, or in Federal or State law governing eligibility, enrollment, the design of the covered benefits package that affects all applicants or enrollees or groups of applicants or enrollees, without respect to their individual circumstances.

WVCHIP assures the right of appeal in three steps or levels, except for emergencies, as described below.

1st level: The member, provider or representative must start the process within 60 days of learning of the denial of payment for service.

To start the appeal process, contact Molina to explain the issue. This allows Molina to review the issue and present information concerning actions that have been taken (such as a benefit limit, timely filing issue, etc.). In most cases, Molina will give the needed information on the date of this phone contact. Molina will give a response no later than 7 days after the initial phone contact with them.

2nd level: If the information the member or provider receives after taking the first step does not resolve the issue, the member or provider must take it to this next step within 30 days after the 1st level response.

The member or provider must write a letter explaining the problem and why there is continued disagreement with the information or response at the 1st level. All information pertinent to the appeal must be included with the request:

1. a written statement explaining the issue
2. all copies of supporting documents or statements that have been provided about the issue
3. a copy of the denied claim (the Explanation of Benefits) and/or written statement provided to either the member or provider by Molina
4. appeal letters in Level 2 should be mailed to:

Molina
P.O. Box 3732
Charleston, WV 25337
Toll Free: 1-800-479-3310

Incorrect Payment,
Dental Timely Filing

A written response will be issued within 30 days. For payment issues the claim will be reprocessed for payment if that is the proper resolution. For all other issues, a letter explaining the actions that will be taken, or the reasons for the actions with respect to benefits (an Explanation of Benefits).

Appealing Health Services (Cont.)

3rd level: After receiving the written response, the member or provider may appeal this decision to a third level review by requesting that the Executive Director review the Level 2 case file. Copies of all written statements of facts, issues, letters and relevant information provided in the case file must be mailed to:

WVCHIP
Executive Director
350 Capitol Street,
Room 251
Charleston, West Virginia 25301

Within 30 days, the Director will send a written decision which takes into account all written materials provided by both parties at Level 3. The decision will explain whether the actions taken at Level 2 will be upheld or changed. If the issue of appeal is about clinical or medical matters, the Executive Director may consider a review by the consulting Medical Director.

Total Time Limit for the Appeal Process

Many appeals are decided within thirty (30) days; however, any appeal must be completed within ninety (90) days from the date of the initial phone contact to the issuance of a written decision at Step 3.

IMPORTANT NOTE: Emergency Medical Condition Process

In cases when the standard time frame could jeopardize the health or life of a member, an expedited review process may take place within 72 hours (or up to a maximum of 14 days, if the member requests an extension). After starting Level 1, and making a written notice by facsimile copy of a request for an emergency review, you may go directly to Level 3 for resolution.

Appendix A

West Virginia Children's Health Insurance Program Request for Prior Authorization for Comprehensive Orthodontic Treatment

Patient Name: _____DOB:_____

I.D. Number: _____ Exam Date: _____

Provider Name: _____ Provider Phone:_____

Provider Fax: _____ NPI #_____

Provider Address:_____

City:_____State:_____ZIP:_____

Complete Diagnosis:

Current Treatment

Status:

Recommendation for Orthodontic Treatment:

Orthodontic Treatment – Procedure Code_____

Post-Treatment Stabilization – Procedure Code _____

Total Fee (Usual and Customary Fee)_____

Prior authorization from WVCHIP assures claims will be paid when submitted EXCEPT when the child dis-enrolls from the plan on or before the date of service. * If the prior authorization request is denied, the parent or guardian is responsible for paying for procedures completed without a prior authorization.

***It is the provider's responsibility to verify eligibility of WVCHIP member by calling the WVCHIP Helpline at 1-877-982-2447.**

Information Required for Assessing Handicapping Malocclusion

1. Overjet_____ 2. Overbite_____
3. Molar Relationship R_____ L_____
4. Skeletal Relationship I_____II_____III_____
5. Missing Teeth_____
6. Impacted Teeth _____
7. Crowding_____
8. Cleft Palate Yes_____ No_____
9. Cross Bite
   - A – Anterior Teeth _____
   - B – Posterior Teeth L_____
   - C – Posterior Teeth R_____
10. Open Bite
    - A–Anterior Teeth_____
    - B– Posterior Teeth L _____
    - C – Posterior Teeth R_____
11. Comments: _____

_____

Send prior authorization request form and documentation (panoramic Film; cephalometric tracing; cephalometric x-ray; photographs – a standard series of 5 Intra and 3 Extra Oral photographs that meets the American Board of Orthodontics standards, and treatment plan, including findings, diagnosis, prognosis, length of treatment, and phases of treatment) to:

WVCHIP
350 Capitol Street, Room 251
Charleston, WV 25301

_____ _____

Provider's Signature Date

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Appendix B – Dental Procedure Codes

PRIOR AUTHORIZATION MUST BE OBTAINED WHEN SERVICE LIMITS ARE EXCEEDED

CPT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS	CO-PAY
DIAGNOSTIC				
CLINICAL ORAL EVALUATION				
D0120	Periodic oral examination	1 per 6 months	Not billable with D0140, D0145, D0150 or D9310	
D0140	Limited oral evaluation – problem focused	Emergency	Not billable with D0120, D0145, D0150 or D9310	
D0145	Oral evaluation for patient under three years of age and counseling with primary care giver	1 per 6 months	Age restriction up to 36 months. Not billable with D0120, D0140, D0150 or D9310	
D0150	Comprehensive oral evaluation – new or established patient	1 per year	Not billable with D0120, D0140, D0145 or D9310	
RADIOGRAPH/DIAGNOSTIC IMAGING (INCLUDIN INTERPRETATION				
D0210	Intraoral complete series of radiographic images	1 per 2 years	Not billable with D0220, D0230, D0240, D0250, D0260, D0270, D0272, D0273 or D0274	
D0220	Intraoral periapical – first radiographic image	1 per day	Not billable with D0210 or D0240	
D0230	Intraoral periapical each additional radiographic image	8 per 3 months	Not billable with D0210, D0240. Must be billed with D0220	
D0240	Intraoral occlusal radiographic image	1 per 6 months	Not billable with D0210, D0220, or D0230	
D0250	Extraoral – 2D projection radiographic image created using a stationary radiation source, and detector	1 per 3 years		
D0270	Bitewings – single radiographic image	4 per year	Not billable with D0210, D0272, D0273 or D0274	
D0272	Bitewings – two radiographic images	1 per year	Not billable with D0210, D0273 or D0274	
D0273	Bitewings – three radiographic images	1 per year	Not billable with D0210, D0272 or D0274	
D0274	Bitewings – four radiographic images	1 per year	Not billable with D0210, D0272, or D0273	
D0310	Sialography			
D0330	Panoramic radiographic image	1 per 3 years		
D0340	2 D cephalometric radiographic image-acquisition, measurement and analysis	1 per year		
D0350	Oral/facial photographic image		This code excludes conventional radiographic – For orthodontics	
TESTS AND EXAMINATIONS				
D0470	Diagnostic casts	2 per year		

CPT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS	CO-PAY
D0474	Gross/Micro Exam w/assessment of surgical margins	None		
ORAL PATHOLOGY LABORATORY				
GENERALLY PERFORMED IN A PATHOLOGY LABORATORY AND DOES NOT INCLUDE THE REMOVAL OF THE TISSUE SAMPLE FROM THE PATIENT				
D0486	Accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report		Analysis and written report of findings, of cytological sample of disaggregated transepithelial cells	
PREVENTIVE				
DENTAL PROPHYLAXIS				
D1110	Prophylaxis – adult	1 per 6 mo.	13 – 19 years of age; not reimbursable with D1120	
D1120	Prophylaxis – child	1 per 6 mo.	Up to 13 years of age; not reimbursable with D1110	
TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)				
D1206	Topical application of fluoride varnish	2 per year		
D1208	Topical application of fluoride	2 per year	Replaces Codes D1203 and D1204; effective 1/1/2013	
OTHER PREVENTIVE SERVICES				
D1351	Sealant – per tooth (posterior teeth)	1 sealant per tooth per 3	Tooth numbers 1-32 or A-T must be documented on the claim form for payment consideration. Requires dental areas configuration.	
D1353	Sealant repair per tooth	1 sealant repair per tooth per 3 years	Tooth numbers 1-32 or A-t must be documented on claim form for payment consideration. Requires dental areas configuration.	
D1354	Interim caries arresting medicament application	2 per tooth per year	Tooth numbers 1-32 or A-T must be documented on claim form for payment consideration. Requires dental areas configuration.	
SPACE MAINTENANCE (PASSIVE APPLIANCES)				
D1510	Space maintainer – fixed unilateral	4 per year	Per quadrant – 10=UR, 20=UL, 30=LL, 40=UR must be included on claim form for payment consideration. Must be billed with the number codes	
D1516	Space maintainer-fixed-bilateral, maxillary	1 per year	Upper arch=01, Low arch=02; must be documented on the claim form for payment consideration. Must be billed with the number codes	
D1517	Space maintainer-fixed-bilateral, mandibular	1 per year	Upper arch=01, Low arch=02; must be documented on the claim form for payment consideration. Must be billed with the number codes	
D1520	Space maintainer – removable – unilateral	4 per year	See D1510	
D1526	Space maintainer-removable-bilateral, maxillary	1 per year	Upper arch=01, Low arch=02; must be documented on the claim form for payment	
D1527	Space maintainer-removable-bilateral, mandibular	1 per year	Upper arch=01, Low arch=02; must be documented on the claim form for payment	

CPT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS	CO-PAY
D1550	Re-cementation of space maintainer	1 per year		
RESTORATIVE				
AMALGAM RESTORATIONS (INCLUDING POLISHING)				
D2140	Amalgam – one surface, primary or permanent	5 surfaces per tooth # per 3 years	Tooth numbers 1-32, A-T must be included on the claim form for payment consideration. Tooth preparation, all adhesives (including amalgam bonding agents) liners, bases & local anesthesia are included in the fee and may not be billed separately. Radiographs with documentation must be documented in the medical record for date of service.	**$25**
D2150	Amalgam – two surfaces, primary or permanent	5 surfaces per tooth # per 3 years	Tooth numbers 1-32, A-T must be included on the claim form for payment consideration. Tooth preparation, all adhesives (including amalgam bonding agents) liners, bases & local anesthesia are included in the fee and may not be billed separately. Radiographs with documentation must be documented in the medical record for date of service.	**$25**
D2160	Amalgam – three surfaces, primary or permanent	5 surfaces per tooth # per 3 years	Tooth numbers 1-32, A-T must be included on the claim form for payment consideration. Tooth preparation, all adhesives (including amalgam bonding agents) liners, bases & local anesthesia are included in the fee and may not be billed separately. Radiographs with documentation must be documented in the medical record for date of service.	**$25**
D2161	Amalgam – four or more surfaces, primary or permanent	5 surfaces per tooth # per 3 years	Tooth numbers 1-32, A-T must be included on the claim form for payment consideration. Tooth preparation, all adhesives (including amalgam bonding agents) liners, bases & local anesthesia are included in the fee and may not be billed separately. Radiographs with documentation must be documented in the medical record for date of service. Not billable with D2140, D2150, D2160 on same tooth number	**$25**
RESIN-BASED COMPOSITE RESTORATIONS – DIRECT				
D2330	Resin – based composite – one surface, anterior	5 surfaces per tooth # per 3 years	Tooth numbers 6-11, 22-27, C-H, M-R must be included on the claim form for payment consideration. Fees include bonded composite, light-cured composite, etc., tooth preparation, acid etching, adhesives (included resin bonding agents), liners, bases, curing, glass ionomers and local anesthesia and may not be separately billed. Radiographs with documentation must be documented in the medical record for date of service (DOS).	**$25**

CPT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS	CO-PAY
D2331	Resin – based composite – two surfaces, anterior	5 surfaces per tooth # per 3 years	Tooth numbers 6-11, 22-27, C-H, M-R must be included on the claim form for payment consideration. Fees include bonded composite, light-cured composite, etc., tooth preparation, acid etching, adhesives (included resin bonding agents), liners, bases, curing, glass ionomers and local anesthesia and may not be separately billed. Radiographs with documentation must be documented in the medical record for DOS.	**$25**
D2332	Resin – based composite – three surfaces, anterior	5 surfaces per tooth # per 3 years	Tooth numbers 6-11, 22-27, C-H, M-R must be included on the claim form for payment consideration. Fees include bonded composite, light-cured composite, etc., tooth preparation, acid etching, adhesives (included resin bonding agents), liners, bases, curing, glass ionomers and local anesthesia and may not be separately billed. Radiographs with documentation must be documented in the medical record for DOS.	**$25**
D2335	Resin – based composite – four or more surfaces or involving incisal angle (anterior)	5 surfaces per tooth # per 3 years	Tooth numbers 6-11, 22-27, C-H, M-R must be included on the claim form for payment consideration. Fees include bonded composite, light-cured composite, etc., tooth preparation, acid etching, adhesives (included resin bonding agents), liners, bases, curing, glass ionomers and local anesthesia and may not be separately billed. Radiographs with documentation must be documented in the medical record for DOS.	**$25**
D2390	Resin – based composite crown, anterior	1 tooth # per 3 years	Tooth numbers 6-11, 22-27, C-H, M-R must be included on the claim form for payment consideration. Fees include bonded composite, light-cured composite, etc., tooth preparation, acid etching, adhesives (included resin bonding agents), liners, bases, curing, glass ionomers and local anesthesia and may not be separately billed. Radiographs with documentation must be documented in the medical record for DOS	**$25**
D2391	Resin – based composite – one surface, posterior	5 surfaces per tooth # per 3 years	Tooth numbers 1-5, 12-21, A, B, I, J, K, L, S, T must be included on the claim form for payment consideration. Fees include bonded composite, light-cured composite, etc., tooth preparation, acid etching, adhesives (included resin bonding agents), liners, bases, curing, glass ionomers and local anesthesia and may not be separately billed. Radiographs with documentation must be documented in the medical record for DOS.	**$25**
D2392	Resin – based composite – two surfaces, posterior	5 surfaces per tooth # per 3 years	Tooth numbers 1-5, 12-21, A, B, I, J, K, L, S, T must be included on the claim form for payment consideration. Fees include bonded composite, light-cured composite, etc., tooth preparation, acid etching, adhesives (included resin bonding agents), liners, bases, curing, glass ionomers and local anesthesia and may not be separately billed. Radiographs with documentation must be documented in the medical record for DOS.	**$25**

CPT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS	CO-PAY
D2393	Resin – based composite – three surfaces, posterior	5 surfaces per tooth # per 3 years	Tooth numbers 1-5, 12-21, A, B, I, J, K, L, S, T must be included on the claim form for payment consideration. Fees include bonded composite, light-cured composite, etc., tooth preparation, acid etching, adhesives (included resin bonding agents), liners, bases, curing, glass ionomers and local anesthesia and may not be separately billed. Radiographs with documentation must be documented in the medical record for DOS	**$25**
D2394	Resin – based composite – four or more surfaces (poster)	5 surfaces per tooth # per 3 years	Tooth numbers 1-5, 12-21, A, B, I, J, K, L, S, T must be included on the claim form for payment consideration. Fees include bonded composite, light-cured composite, etc., tooth preparation, acid etching, adhesives (included resin bonding agents), liners, bases, curing, glass ionomers and local anesthesia and may not be separately billed. Radiographs with documentation must be documented in the medical record for DOS.	**$25**
CROWNS – SINGLE RESTORATIONS ONLY				
D2751	Crown – porcelain fused to predominantly based metal	1 tooth # per 5 years	Tooth numbers 1-32 and A, B, I, J, K, L, S & T must be documented in the medical record, and on the claim form for payment consideration. Radiographs with documentation must be documented in the medical record for DOS.	**$25**
D2791	Crown – full cast predominantly base metal	1 tooth # per 5 years	Tooth numbers 1-32 and A, B, I, J, K, L, S & T must be documented on the claim form for payment consideration. Radiographs with documentation must be documented in the medical record for date of service.	**$25**
OTHER RESTORATIVE SERVICES				
D2920	Re-cement crown	1 tooth # per 1 year	Tooth numbers 1-32, A-t must be included on the claim form for payment consideration. Radiographs with documentation must be documented in the medical record for date of service.	**$25**
D2930	Prefabricated stainless steel crown – primary tooth	1 tooth # per 1 year	Tooth number A-T primary teeth must be documented on the claim form for payment consideration. Use only when a regular filling is not applicable. Radiographs with documentation must be documented in the medical record for date of service (DOS)	**$25**
D2931	Prefabricated stainless steel crown – permanent tooth	1 tooth # per 1 year	Tooth number A-T primary teeth must be documented on the claim form for payment consideration. Use only when a regular filling is not applicable. Radiographs with documentation must be documented in the medical record for DOS	**$25**
D2932	Prefabricated resin crown	1 tooth # per 1 year	Tooth number A-T primary teeth must be documented on the claim form for payment consideration. Radiographs with documentation must be documented in the medical record for DOS	**$25**
D2933	Prefabricated stainless steel crown w/resin window	No limit	Tooth numbers required	**$25**
D2940	Protective restoration	2 per year per tooth #	Tooth numbers 1-32, A-T must be documented on claim form for payment consideration. Not allowed in conjunction with root canal therapy, pulpotomy, pulpectomy or on the same DOS as a restoration.	**$25**

CPT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS	CO-PAY
D2950	Core buildup, including any pins	1 per year per tooth #	Tooth numbers 1-31 , A-T must be documented on claim form for payment Consideration.	**$25**
D2951	Pin retention – per tooth, in addition to restoration	1 tooth # per 3 years	Tooth numbers 1-32, A-T must be documented on claim form for payment consideration.	**$25**
D2952	Cast post and core in addition to crown	1 tooth # per 3 years	Tooth numbers 1-32, A-T must be documented on claim form for payment consideration.	**$25**
D2954	Prefab post and core in addition to crown	1 tooth # per 3 years	Tooth numbers 1-32, A-T must be documented on claim form for payment consideration.	**$25**
ENDODONTICS – INCLUDES LOCAL ANESTHESIA				
PULPOTOMY				
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentiocemental junction and	1 tooth # per 3 years	Tooth numbers 1-32, A-T must be documented on claim form for payment consideration. Not reimbursable with D3310, D3320, or D3330. This is not to be construed as the first stage of root canal therapy. Not to be used for	$25
ENDODONTIC THERAPY (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES AND FOLLOW UP CARE)				
D3310	Endodontic therapy, anterior (excluding final restoration)	1 tooth # per lifetime	Tooth numbers 6-11, 22-27 must be documented on the claim form for payment consideration. Not reimbursed with D3220, D3320 or D3330	**$25**
D3320	Endodontic therapy bicuspid (excluding final restoration)	1 tooth # per lifetime	Tooth numbers 4, 5, 12, 13, 20, 21, 28, 29 or C, H, Q, N must be documented on the claim form for payment consideration. Not reimbursed with D3220, D3310, or D330	**$25**
D3330	Endodontic therapy, molar (excluding final restoration)	1 tooth # per lifetime	Tooth numbers 1-3, 14-19, 30-32 and primary teeth #A, B, I, J, K, L, S and T, if no permanent successor present; must be documented on the claim form for payment consideration. Not reimbursed with D3220, D3310 or D3320	**$25**
ENDODONTIC RETREATMENT				
D3346	Retreatment of previous root canal therapy – anterior	1 tooth # per lifetime	Tooth numbers 6-11 and 22-27 must be documented on the claim form for payment consideration, includes all diagnostic tests, radiographs, and post-operative treatments and may not be billed separately.	**$25**
D3347	Retreatment of previous root canal therapy – bicuspid	1 tooth # per lifetime	Tooth numbers 4, 5, 12, 13, 20, 21, 28 and 29 must be documented on the claim form for payment consideration, includes all diagnostic tests, radiographs, and post-operative treatments and may not be billed separately.	**$25**
D3348	Retreatment of previous root canal therapy – molar	1 tooth # per Lifetime	Tooth numbers 1-3, 14-19, and 30-32 must be documented on the claim form for payment consideration; includes all diagnostic tests, radiographs, and post- Operative treatments and may not be billed separately.	**$25**
APEXIFICATION/RECALCIFICATION PROCEDURES				
D3351	Apexification/recalcification/pulpal regeneration-initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)		Tooth numbers 1-32 must be documented on the claim form for payment consideration. Fees include all diagnostic tests, evaluations, radiographs and post- operative treatment and may not be billed separately.	**$25**

CPT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS	CO-PAY
D3352	Apexification/recalcification/pupal regeneration – interim medication replacement	3 treatment per tooth # per lifetime	Tooth numbers 1-32 must be documented on the claim form for payment consideration. Fees include all diagnostic tests, evaluations, radiographs and post- operative treatment and may not be billed separately.	**$25**
D3353	Apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.)	1 tooth # per lifetime	Tooth numbers 1-32 must be documented on the claim form for payment consideration. Fees include all diagnostic tests, evaluations, radiographs and post-operative treatment and may not be billed separately.	**$25**
APICOCECTOMY/PERIRADICULAR SERVICES				
D3410	Apicocectomy/perriardicular surgery-anterior	1 tooth # per lifetime	Tooth numbers 6-11, 22-27 must be documented on the claim form for payment consideration. Radiographs with documentation must be documented in the medical record for date of service.	**$25**
D3421	Apicoectomy/surg bicuspid (first root)	1 tooth # per lifetime	Tooth numbers 4, 5, 12, 13, 20, 21, 28, 29 must be documented on the claim form for payment consideration. Radiographs with documentation must be documented in the medical record for date of service.	**$25**
PERIODONTICS				
SURGICAL SERVICES (INCLUDING USUAL POST-OPERATIVE CARE)				
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces, per quadrant	Each quadrant; UR, UL, LL, LR, once per year	Identification of the quadrant(s) ; quadrants are defined as 10=UR, 20=UL, 30=LL, 40=LR. Not reimbursed with D4211. Must be billed with the number codes. Radiographs with documentation must be documented in the medical record for date of service.	**$25**
D4211	Gingivectomy or gingivoplasty – one to three teeth	Each quadrant; UR, UL, LL, LR, once per year	Identification of the quadrant; quadrants are defined as 10=UR, 20=UL, 30=LL, 40=LR. Not reimbursed with D4210. Must be billed with the number codes. Radiographs with documentation must be documented in the medical record for date of service.	**$25**
D4260	Osseous surgery (including flap entry and closure) four or more contiguous teeth or tooth bounded spaces per quadrant	Each quadrant; UR, UL, LL, LR, once per year	Identification of the quadrant; quadrants are defined as 10=UR, 20=UL, 30=LL, 40=LR. Not reimbursed with D4210. Must be billed with the number codes. Radiographs with documentation must be documented in the medical record. service	**$25**
D4261	Osseous surgery (including flap entry and closure) one to three continuous teeth or tooth bounded spaces per quadrant	Each quadrant; UR, UL, LL, LR, once per year	Identification of the quadrant, and radiographs as appropriate. Quadrants are defined as 10=UR, 20=UL, 30=LL, 40=LR. Not reimbursed with D4210. Must be billed with the number codes.	**$25**
NON-SURGICAL PERIODONTAL SERVICE				
D4341	Periodontal scaling /root planing – four /more teeth per quadrant	Each quadrant; UR, UL, LL, LR, once per year	Quadrants are defined as 10=UR, 20=UL, 30=LL, 40=LR. Not reimbursed with D4342. Must be billed with the number codes. Radiographs with documentation must be documented in the medical record for date of service.	**$25**

CPT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS	CO-PAY
D4342	Periodontal scaling/root planing – one to three teeth per quadrant	Each quadrant; UR, UL, LL, LR once per year	Quadrants are defined as 10=UR, 20=UL, 30=LL, 40=LR. Not reimbursed with D4341. Must be billed with the number codes. Radiographs with documentation must be documented in the medical record for date of service.	**$25**
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	1 per 6 months	**PA Required.** Only covered when there is substantial gingival inflammation (gingivitis in	**$25**
PROSTHODONTICS (REMOVABLE)				
COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)				
D5110	Complete denture – maxillary	1 per 5 years		**$25**
D5120	Complete denture – mandibular	1 per 5 years		**$25**
D5130	Immediate denture – maxillary	1 per 5 years		**$25**
D5140	Immediate denture – mandibular	1 per 5 years		**$25**
PARTIAL DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)				
D5213	Maxillary partial denture – cast metal base framework with resin denture bases (including any conventional clasps, rests and teeth)	1 per 5 years	Partials and complete dentures may not be re-based or relined with a period of one (1) year after construction)	**$25**
D5214	Mandibular partial denture – cast metal base framework with resin denture bases (including any conventional clasps, rests and teeth)	1 per 5 years	Partials and complete dentures may not be re-based or relined with a period of one (1) year after construction)	**$25**
D5281	Removable unilateral partial denture – one piece cast metal (including clasps and teeth)	1 per 5 years	Partials and complete dentures may not be re-based or relined with a period of one (1) year after construction)	**$25**
D5282	Removable unilateral partial denture-one piece case metal(including clasps and teeth), maxillary	1 per 5 years	Partials and complete dentures may not be re-based or relined with a period of one (1) year after construction)	**$25**
D5283	Removable unilateral partial denture-one piece case metal(including clasps and teeth), mandibular	1 per 5 years	Partials and complete dentures may not be re-based or relined with a period of one (1) year after construction)	**$25**
ADJUSTMENTS TO DENTURES				
D5410	Adjust complete denture upper	3 per year	Adjustments not covered within 3 months of placement	**$25**
D5411	Adjust complete denture lower	3 per year	Adjustments not covered within 3 months of placement	**$25**
D5421	Adjust partial denture upper	3 per year	Adjustments not covered within 3 months of placement	**$25**
D5422	Adjust partial denture lower	3 per year	Adjustments not covered within 3 months of placement	**$25**
REPAIRS TO COMPLETE DENTURES				

CPT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS	CO-PAY
D5510	pair broken complete denture base	2 per year	Upper arch, Low arch must be documented on the claim form for payment consideration.	**$25**
D5511	Repair broken complete denture base - mandibular	2 per year	Upper arch, Low arch must be documented on the claim form for payment consideration.	**$25**
D5512	Repair broken complete denture base - maxillary	2 per year	Upper arch, Low arch must be documented on the claim form for payment consideration.	**$25**
REPAIRS TO PARTIAL DENTURES				
D5611	Repair resin partial denture base, mandibular	2 per year	Upper arch=01, Low arch=02; must be documented on the claim form for payment. consideration. Must be billed with the number codes	**$25**
D5612	Repair resin partial denture base maxillary	2 per year	Upper arch=01, Low arch=02; must be documented on the claim form for payment consideration. Must be billed with the number codes	
D5621	Repair cast partial framework, mandibular	2 per year	Upper arch, Low arch must be documented on the claim form for payment consideration.	**$25**
D5622	Repair case partial framework, maxillary	2 per year	Upper arch, Low arch must be documented on the claim form for payment consideration.	**$25**
D5630	Repair/replace broken retentive/clasping material – per tooth	2 per year		**$25**
D5640	Replace broken tooth – per tooth	2 per year	Tooth numbers 1-32 must be documented on the claim form for payment consideration.	**$25**
D5650	Add tooth to existing partial	2 per year	Tooth numbers 1-32 must be documented on the claim form for payment consideration.	**$25**
D5660	Add tooth to existing partial denture	2 per year	Tooth numbers 1-32 must be documented on the claim form for payment consideration.	**$25**
DENTURE REBASED PROCEDURES				
D5710	Rebase complete maxillary denture	1 per 5 years		**$25**
D5711	Rebase complete mandibular denture	1 per 5 years		**$25**
D5720	Rebase maxillary partial denture	1 per 5 years		**$25**
D5721	Rebase mandibular partial denture	1 per 5 years		**$25**
DENTURE RELINE PROCEDURES				
D5730	Reline complete maxillary denture	1 per 2 years	Not covered within first 6 months of placement unless it is for an immediate denture.	**$25**
D5731	Reline complete mandibular denture (chair side)	1 per 2 years	Not covered within first 6 months of placement unless it is for an immediate denture.	**$25**
D5740	Reline maxillary partial denture (chair side)	1 per 2 years	Not covered within first 6 months of placement.	**$25**

CPT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS	CO-PAY
D5741	Reline mandibular partial denture (chair side)	1 per 2 years	Not covered within first 6 months of placement.	**$25**
D5750	Reline complete maxillary denture (laboratory)	1 per 2 years	Not covered within first 6 months of placement.	**$25**
D5751	Reline complete mandibular denture (laboratory)	1 per 2 years	Not covered within first 6 months of placement.	**$25**
D5760	Reline maxillary partial denture (laboratory)	1 per 2 years	Not covered within first 6 months of placement.	**$25**
D5761	Reline mandibular partial denture (laboratory)	1 per 2 years	Not covered within first 6 months of placement.	**$25**
PROSTHODONTIC FIXED				
FIXED PARTIAL DENTURE PONTICS – EACH ABUTMENT AND EACH PONTIC CONSTITUTE A UNIT IN A BRIDGE				
D6211	Pontic – cast predominantly base metal	1 per 5 years	Tooth numbers 1-32 must be documented on the claim form for payment consideration.	**$25**
D6241	Pontic – Porcelain fused to predominantly based metal	1 per 5 years	Tooth numbers 1-32 must be documented on the claim form for payment consideration.	**$25**
D6545	Retainer – cast metal for resin bonded fixed prosthesis	1 per 5 years	Tooth numbers 1-32 must be documented on the claim form for payment consideration.	**$25**
OTHER FIXED DENTURE SERVICES				
D6930	Recement fixed partial bridge	1 per year		**$25**
ORAL AND MAXILLOFACIAL SURGERY (COVERED UNDER THE MEDICAL PLAN)				
EXTRACTION – INCLUDES LOCAL ANESTHESIA AND POST-OPERATIVE CARE ANY NECESSARY SUTURE INCLUDED IN FEE FOR EXTRACTION				
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	1 tooth # per lifetime	Tooth numbers 1-32 or A-T must be documented on the claim form for payment consideration.	**$25**
D7210	Extraction erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	1 tooth # per lifetime	Tooth numbers 1-32 or A-T must be documented on the claim form for payment consideration.	**$25**
D7220	Removal of impacted tooth – soft tissue	1 tooth # per lifetime	Tooth numbers 1-32 or A-T must be documented on the claim form for payment consideration.	**$25**
D7230	Removal of impacted tooth – partial bony	1 tooth # per lifetime	Tooth numbers 1-32 or A-T must be documented on the claim form for payment consideration.	**$25**
D7240	Removal of impacted tooth – complete bony	1 tooth # per lifetime	Tooth numbers 1-32 or A-T must be documented on the claim form for payment consideration.	**$25**
OTHER SURGICAL PROCEDURES				
D7260	Oroantral fistula closure		**PA required**	**$25**

CPT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS	CO-PAY
D7270	Tooth preimplantation and/or stabilization of accidental avulsed or		Tooth numbers 1-32 and primary teeth #A, B, I, J, K, L, S, and T must also be documented on the claim form for payment consideration.	**$25**
D7280	Exposure of unerupted tooth		Tooth numbers 1-32 must also be documented on the claim form for payment Consideration.	**$25**
D7283	Placement of device to facilitate eruption of impacted tooth		Tooth numbers 1-32 must also be documented on the claim form for payment consideration.	**$25**
D7285	Biopsy of oral tissue – hard (bone, tooth)			**$25**
D7286	Biopsy of oral tissue – soft (all others			**$25**
ALVELOPLASTY – SURGICAL PREPARATION OF RIDGE FOR DENTURE				
D7310	Alveoplasty in conjunction with extractions – four or more teeth or tooth spaces per quadrant	1 quadrant UR, UL, LL, LR per lifetime	Quadrant 10=UR, 20=UL, 30=LL, 40=LR must also be documented on the claim form for payment consideration. Alveoloplasty is distinct (separate procedure) from extractions. Usually in preparation for a prosthesis or other treatments such as radiation therapy and transplant surgery	**$25**
D7320	Alveoplasty not in conjunction with extractions – four or more teeth or tooth spaces per quadrant	1 quadrant UR, UL, LL, LR per lifetime	Quadrant 10=UR, 20=UL, 30=LL, 40=LR must also be documented on the claim form for payment consideration	**$25**
VESTIBULOPLASTY				
D7340	Vestibuloplasty – ridge extension (second epithelization)		**Requires PA** with documentation and radiographs as appropriate	**$25**
D7350	Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachments, revision of soft tissue attachment and management of hypertrophied & hyperplastic tissue)		**Requires PA** with documentation and radiographs as appropriate	**$25**
D7410	Excision of benign lesion up to 1.25 cm			**$25**
D7411	Excision of benign lesion > 1.25 cm			**$25**
D7440	Excision of malignant tumor – lesion diameter up to 1.25 cm			**$25**
D7441	Excision of malignant tumor – lesion diameter > than 1.25 cm			**$25**
D7450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm			**$25**
D7451	Removal benign odontogenic cyst or tumor lesion			**$25**
D7460	Removal of benign nonodontogenic cyst or tumor lesion diameter up to 1.25 cm			**$25**

CPT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS	CO-PAY
D7461	Removal of benign nonodontogenic cyst or tumor lesion diameter greater > 1.25			**$25**
EXCISION OF BONE TISSUE				
D7471	Removal of lateral exostosis (maxilla or mandible)		UA=01, LA=02 must be documented on the claim form for payment consideration. Must be billed with the number codes	**$25**
D7472	Removal of torus palatines			**$25**
D7473	Removal of torus mandibularis			**$25**
D7485	Reduction of osseous tuberosity			**$25**
D7490	Radical resection of mandible with bone graft		**Requires PA** with documentation and radiographs as appropriate	**$25**
SURGICAL INCISION				
D7510	Incision of Drainage (I&D) of abscess – intraoral soft tissue			**$25**
D7520	I&D of abscess – extraoral soft tissue			**$25**
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue			**$25**
D7550	Partial ostectomy - sequestrectomy for removal of		**Requires** PA with documentation. This code should only be used if a more specific code is not available	**$25**
D7560	Maxillary sinusotomy for removal of tooth fragment of foreign body			**$25**
TREATMENT OF SIMPLE FRACTURES				
D7610	Maxilla – open reduction			**$25**
D7620	Maxilla – closed reduction			**$25**
D7630	Mandible – open reduction			**$25**
D7640	Mandible – closed reduction			**$25**
D7671	Alvelous – open reduction			**$25**
D7680	Facial bones – complicated reduction with fixation and multiple surgical approaches		**Requires PA** with documentation and radiographs as appropriate	**$25**
TREATMENT OF FRACTURES (COMPOUND)				

CPT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS	CO-PAY
D7710	Maxilla – open reduction			**$25**
D7720	Maxilla – closed reduction			**$25**
D7730	Mandible – open reduction			**$25**
D7740	Mandible – closed reduction			**$25**
D7750	Malar and/or zygomatic arch – open reduction			**$25**
D7770	Alveolus – open reduction stabilization of teeth			**$25**
D7780	Facial bones – complicated reduction with fixation		**Requires PA**	**$25**
D7910	Suture of recent small wounds up to 5 cm		Excludes closure of surgical incisions	**$25**
D7911	Complicated suture – up to 5 cm	1unit; not reimbursable with D7912	Excludes closure of surgical incisions	**$25**
D7912	Complicated suture – greater than 5 cm	1 unit; not reimbursable with D7911	Excludes closure of surgical incisions	**$25**
D7920	Skin graft		**Requires PA**	**$25**
D7941	Osteotomy mandibular rami		**Requires PA**	**$25**
D7943	Osteotomy – mandibular rami with bone graft; includes obtaining the graft		**Requires PA**	**$25**
D7944	Osteotomy – segmented or subapical – per sextant or quadrant		**Requires PA**	**$25**
D7946	LeFort I (maxilla-total)		**Requires PA**	**$25**
D7947	LeFort I (maxilla – segmented)		**Requires PA**	**$25**
D7948	LeFort II or LeFort III (osteoplasty of facial bones for mid-face hypoplasia or retrusion) – without bone graft		**Requires PA**	**$25**
D7949	LeFort II or LeFort III – with bone graft		**Requires PA**	**$25**

CPT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS	CO-PAY
D7950	Osseous, osteoperiosteal or cartilage graft of the mandible or facial tones		**Requires PA**	**$25**
D7955	Repair of maxillofacial soft and/or hard tissue defect		**Requires PA**	**$25**
D7960	Frenulectomy			**$25**
D7970	Excision of hyperplastic tissue – per arch		**Requires PA.** UALA must be documented on the claim form for payment consideration. Must be billed with the number codes.	**$25**
D7979	Non-surgical silaolithotomy			
D7980	Sialolithotomy		**Requires PA**	**$25**
D7981	Excision of Salivary gland		**Requires PA**	**$25**
D7982	Sialodochoplasty		**Requires PA**	**$25**
D7991	Coronoidectomy		**Requires PA**	**$25**
ORTHODONTICS				
D8010	Limited orthodontic treatment of the primary dentition	2 per year	**Requires PA** with documentation, radiographs	**$25**
D8020	Limited orthodontic treatment of the transitional dentition	2 per year	**Requires PA** with documentation, radiographs	**$25**
D8030	Limited orthodontic treatment of the adolescent dentition	2 per year	**Requires PA** with documentation, radiographs	**$25**
D8040	Limited orthodontic treatment of the adult dentition	2 per year	**Requires PA** with documentation, radiographs	**$25**
D8050	Interceptive orthodontic treatment of the primary	2 per year	**Requires PA** with documentation, radiographs	**$25**
D8060	Interceptive orthodontic treatment of the transitional dentition	2 per year	**Requires PA** with documentation, radiographs	**$25**
D8070	Comprehensive orthodontic treatment of the transitional dentition	1 per lifetime	**Requires PA** with documentation, radiographs	**$25**
D8080	Comprehensive orthodontic treatment of the adolescent dentition	1 per lifetime	**Requires PA** with documentation, radiographs	**$25**
D8090	Comprehensive orthodontic treatment of the adult	1 per lifetime	**Requires PA** with documentation, radiographs	**$25**
D8210	Removable Appliance therapy	2 per lifetime		**$25**

CPT CODE	DESCRIPTION	SERVICE LIMITS	SPECIAL INSTRUCTIONS	CO-PAY
D8220	Fixed appliance therapy	2 per year	**Requires PA with documentation, radiographs**	$25
D8680	Orthodontic retention (removal of appliances construction and placement of retainer		**Requires PA with documentation, radiographs**	$25
D8692	Replacement of lost or broken retainer	2 per Lifetime		$25
D8693	Rebonding or recementing; and/or repair, as required of fixed retainers	1 per lifetime		$25
D8695	Removal of fixed orthodontic appliance(s) – other than at conclusion of treatment			**$25**
PALLATIVE TEATREATMENT				
D9110	Palliative (emergency) treatment of dental pain – minor procedure			**$25**
ANESTHESIA				
D9222	Deep sedation/general anesthesia – first 15 minutes			**$25**
D9223	Deep sedation/general anesthesia – each 15 minute increment		Class 4 anesthesia permit required. **Replaces codes D9220 and D9221.**	**$25**
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	Maximum 1 unit/day		**$25**
D9239	Intravenous moderate (conscious) sedation	No limit		**$25**
D9243	Intravenous moderate conscious sedation/analgesia – each 15-minute increment	No limit	**Replaces codes D9241 and D9242**.	**$25**
OTHER				
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)		Not reimbursable on same day as D1020, D1040, D1045, D1050	**$25**
D9420	Hospital or ambulatory surgical center call			**$25**

***Prior authorization must be obtained when service limits are exceeded**

Revised: March 2019
Corrected Version: 3/20/19

WVCHIP
350 Capitol Street
Room 251
Charleston, WV 25301

Healthy Teeth are Important!

Teeth help you eat, talk, and smile.

Dental Care should begin early, even before the first tooth appears. It is important to develop good oral hygiene habits early in order to help make your child's teeth last a lifetime.

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