



May 2025

Dear Medi-Cal Dental Provider:

Enclosed is the most recent update of the Medi-Cal Dental Provider Handbook (Handbook). The pages reflect changes made to Medi-Cal Dental during the month of May 2025.

The following list indicates the pages that have been updated for this month's Handbook release. The latest version of the Handbook can be found on the Medi-Cal Dental website [Provider Handbook page](#).

Handbook Updates
Dear Medi-Cal Dental Provider
01 – Introduction
<ul style="list-style-type: none">• Updates to Gainwell Technologies leadership
Section 05 – MOC and SMA
<ul style="list-style-type: none">• Updates to Procedure D9994<ul style="list-style-type: none">➤ Page 5-194➤ Page 5-234• Updates to Procedure D9995<ul style="list-style-type: none">➤ Page 5-195

Thank you for your continuing participation in Medi-Cal Dental. If you have any questions, please call (800) 423-0507.

Sincerely,

MEDI-CAL DENTAL
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES



May 2025

Dear Medi-Cal Dental Provider:

We are pleased to provide you with the Medi-Cal Dental Provider Handbook (Handbook).

The purpose of this Handbook is to give dental care professionals and their staff a concise explanation of billing instructions and procedures under Medi-Cal Dental. It is designed to assist you in your continued participation in Medi-Cal Dental.

We trust you will find the Handbook useful and that it will be maintained as a working document. Please do not hesitate to visit the [Medi-Cal Dental website](#) for further assistance.

Sincerely,

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Department of Health Care Services

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California Medi-Cal Dental
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Preface

This Handbook contains basic information about Medi-Cal Dental. It is designed to provide detailed information concerning Medi-Cal Dental policies, procedures, and instructions for completing the necessary forms and other related documents.

The criteria and policies contained in this Handbook are subject to the provisions of the Welfare and Institutions (W&I) Code and regulations under the California Code of Regulations (CCR), Title 22. When changes in these criteria and/or policies occur, bulletins and revised pages will be issued for purposes of updating the information in this Handbook.

Please call the Medi-Cal Dental Telephone Service Center toll-free at (800) 423-0507 with any questions you have regarding the contents of this Handbook or participation in California Medi-Cal Dental. Our Provider Services staff will be happy to assist you.

This Handbook, and other valuable information, can be found on the [Medi-Cal Dental website](#).

How to Use This Handbook

This Handbook is your primary reference for information about Medi-Cal Dental, as well as submission and processing of all necessary documents. The Handbook contains detailed instructions for completing Medi-Cal Dental claims, Treatment Authorization Requests, Resubmission Turnaround Documents, Claim Inquiry Forms, and other billing forms for dental services and should be consulted before seeking other sources of information.

The Handbook is organized into 13 major sections:

- Section 1 Introduction
- Section 2 Program Overview
- Section 3 Enrollment Requirements
- Section 4 Treating Members
- Section 5 Manual of Criteria and Schedule of Maximum Allowances
- Section 6 Forms
- Section 7 Codes
- Section 8 Fraud, Abuse, and Quality of Care
- Section 9 Special Programs
- Section 10 CDT Tables
- Section 11 Glossary
- Section 12 Bulletin Index
- Section 13 Index

The Table of Contents provides an overview of all major sections and subsections in the Handbook.

Table of Contents

Contents

Section 1 - Introduction	1-2
Program Background	1-2
Program Objectives.....	1-2
Regulations	1-3
Current Dental Terminology (CDT) Copyright	1-3
 Section 2 - Program Overview	 2-1
Provider Participation in California Medi-Cal Dental.....	2-1
Compliance in Medi-Cal Dental	2-1
Out-of-State Coverage	2-2
Written Correspondence	2-3
Suspended and Ineligible Providers.....	2-4
Enrollment Denied for Failure to Disclose Fraud or Abuse, or Failure to Remediate Deficiencies	2-4
General Telephone Information.....	2-4
Provider Toll-Free Telephone Number.....	2-4
Contact Listings for Medi-Cal Dental	2-6
Internet Access and Websites.....	2-8
Email	2-8
Provider Portal	2-8
Training Program	2-9
Seminars	2-9
On-Site Visits.....	2-10
Provider Appeals Process	2-10
Provider First-Level Appeals	2-11
Health Insurance Portability and Accountability Act (HIPAA) and the National Provider Identifier (NPI)	2-12
Registering NPIs	2-12
Freedom of Information Act (FOIA)-Disclosable Data	2-13
Electronic Data Interchange (EDI).....	2-13
Digitized Images.....	2-13
Overview of TAR and Claim Processing	2-14

Table of Contents

Document Control Number (DCN)	2-14
Edits and Audits	2-14
TAR/Claim Adjudication	2-14
Radiographs	2-15
Prior Authorization.....	2-15
Election of Prior Authorization	2-17
Non-Transfer of Prior Authorization	2-17
Retroactive Prior Authorization	2-17
Clinical Screening.....	2-17
Billing and Payment Policies	2-18
Billing Members.....	2-18
Member Reimbursements	2-20
Not a Benefit/Global	2-22
Dental Materials of Choice	2-22
Payment Policies.....	2-22
Assistant Surgeons	2-23
Providing and Billing for Anesthesia Services.....	2-23
Tamper-Resistant Prescription Pads	2-24
Time Limitations for Billing	2-25
Interim Payments	2-26
Retroactive Reimbursement for Medi-Cal Members for Out-of-Pocket Expenses.....	2-27
Medi-Cal Dental Responsibilities	2-27
Provider Notification of Member Request for Reimbursement	2-27
Provider Responsibility.....	2-27
Claim Submission.....	2-27
Provider Reimbursement	2-28
Medicare/Medi-Cal Crossover Claims	2-28
Orthodontic Services Program	2-29
Dental Restorations for Children Under Age Four and for Developmentally Disabled Members of Any Age.....	2-30
Children Under Age Four	2-30
Developmentally Disabled (DD) Members	2-30
Hospital (Special) Cases	2-31
Hospital Inpatient Dental Services (Overnight or Longer)	2-31
Requesting Hospital Dental Services for Medi-Cal Members Enrolled in the GMC, COHS, or Medi-Cal Managed Care Plans	2-33
Homebound Patients (Place of Service 2).....	2-33
Skilled Nursing and Intermediate Care Facilities (Place of Service 4 or 5)	2-33
Hospital Care (Including Surgical Centers) (Place of Service 6 or 7).....	2-34
Mobile Dental Treatment Vans (Place of Service 8).....	2-35

Table of Contents

Section 3 - Enrollment Requirements	3-1
Rendering Provider Enrollment Process	3-2
Tax Identification Number	3-2
Verify Your Tax Identification Number (TIN)	3-2
Inactivated Providers	3-3
Voluntary Termination of Provider Participation	3-4
Electronic Data Interchange (EDI)	3-4
HIPAA-Compliant Electronic Format Only	3-5
Ineligibility for EDI	3-5
Sample Medi-Cal Dental Telecommunications Provider and Biller Application/Agreement	3-6
Sample Provider Service Office Electronic Data Interchange Option Selection Form	3-7
Sample Electronic Remittance Advice (ERA) Enrollment Form	3-8
Electronic Claims Submission and Payment Services	3-9
What Can Be Sent Electronically to Medi-Cal Dental	3-10
Sending Radiographs and Attachments	3-11
Digitized Images and EDI Documents	3-12
Digitized Imaging Vendor and Document Specifications	3-12
Medi-Cal Dental Provider Directory/Referral Form	3-14
Electronic Funds Transfer of Payment	3-16
Sample Electronic Funds Transfer of Enrollment Form	3-17
 Section 4 - Treating Members	 4-1
Member Identification	4-1
Medi-Cal Benefits Identification Card	4-1
Special Programs Identification Cards	4-2
Medi-Cal Identification Card for Presumptive Eligibility (MC 263 PREMEDCARD (4/96)) for Aid Code 7G	4-2
Immediate Need Cards	4-3
Verifying Member Identification	4-4
Medi-Cal Dental Member Eligibility	4-5
Verifying Member Eligibility	4-6
Internet	4-6
Automated Eligibility Verification System (AEVS)	4-7
Share of Cost (SOC)	4-7
Interactive Voice Response (IVR) System-Gabby	4-8
Member Coverage	4-11
Treating Members	4-11
ACA's Non-Discrimination Policy Applies to Medi-Cal	4-11
Restoration of Adult Dental Services	4-12

Table of Contents

Table 1: Federally Required Adult Dental Services (FRADS)	4-13
Table 3: Restored Adult Dental Services (RADS).....	4-14
Benefits Quick Reference Guide.....	4-14
California Advancing and Innovating Medi-Cal (CalAIM) Oral Health Initiatives	4-15
Proposition 56: Tobacco Tax Funds Supplemental Payments	4-18
\$1,800 Limit per Calendar Year for Member Dental Services, with Exceptions	4-19
Pregnancy-Related Services.....	4-19
Radiograph Requirements for Pregnant and Postpartum Members.....	4-20
Long-Term Care	4-20
Patients With Special Healthcare Needs	4-20
American Sign Language (ASL) Translation Services.....	4-21
Treating Members That Reside in Other Counties	4-22
Non-Medical Transportation (NMT).....	4-22
Community Health Worker (CHW) Preventive Services.....	4-22
Teledentistry.....	4-29
Consent	4-30
Billing for Teledentistry	4-30
Billing for Asynchronous Store and Forward (D9996).....	4-30
Billing for Synchronous or Live Transmissions (D9995)	4-31
Emergency Services	4-32
Table 4: Omnibus Budget Reconciliation Act (OBRA) Emergency Services Only	4-33
Other Health Coverage	4-34
Prepaid Health Plan (PHP)/Health Maintenance Organization (HMO).....	4-34
Child Health and Disability Prevention (CHDP) Gateway.....	4-36
Altered Cards and Other Abuses of Medi-Cal Dental Fraud, Help Stop Altered Cards and Other Abuses	4-37
Misuse of Benefits Identification Card.....	4-38
Prevention of Identity Theft	4-38
Member Complaint or Grievance Procedures	4-38
Initial Appeal to Provider	4-38
Notification to Medi-Cal Dental.....	4-38
Member Medi-Cal Dental Complaint Form (Page 1).....	4-41
Member Medi-Cal Dental Complaint Form (Page 2).....	4-42
State Hearing	4-43
Authorization of Services Through the State Hearing Process.....	4-43
Conditional Withdrawal	4-43
Granted Decision.....	4-43
Contacting Medi-Cal Dental to Postpone or Withdraw a State Hearing	4-44
Aid Codes.....	4-44

Table of Contents

Section 5 - Criteria Manual and Schedule of Maximum Allowances ..5-1

Policy Changes	5-2
Diagnostic General Policies (D0100–D0999)	5-5
Preventive General Policies (D1000–D1999)	5-27
Preventive Procedures (D1000–D1999)	5-28
Restorative General Policies (D2000–D2999)	5-40
Restorative Procedures (D2000–D2999)	5-45
Endodontic General Policies (D3000–D3999)	5-60
Endodontic Procedures (D3000–D3999)	5-61
Periodontal General Policies (D4000–D4999)	5-73
Periodontal Procedures (D4000–D4999)	5-75
Prosthodontics (Removable) General Policies (D5000–D5899)	5-83
Prosthodontic (Removable) Procedures (D5000–D5899)	5-86
Maxillofacial Prosthetics General Policies (D5900–D5999)	5-105
Maxillofacial Prosthetic Procedures (D5900–D5999)	5-106
Implant Services General Policies (D6000–D6199)	5-113
Implant Service Procedures (D6000–D6199)	5-114
Fixed Prosthodontic General Policies (D6200–D6999)	5-124
Fixed Prosthodontic Procedures (D6200–D6999)	5-126
Oral and Maxillofacial Surgery General Policies (D7000–D7999)	5-136
Oral and Maxillofacial Surgery Procedures (D7000–D7999)	5-138
Orthodontic General Policies (D8000–D8999)	5-170
Orthodontic Procedures (D8080, D8660, D8670 and D8680)	5-170
Orthodontic Procedures (D8000–D8999)	5-172
Adjunctive General Policies (D9000–D9999)	5-180
Anesthesia (D9210–D9248)	5-180
Adjunctive Service Procedures (D9000–D9999)	5-183
Medi-Cal Dental Schedule of Maximum Allowances (SMA)	5-196

Section 6 - Forms.....6-1

Medi-Cal Dental Forms	6-1
Ordering Forms	6-2
Optical Character Recognition (OCR)/Intelligent Character Recognition (ICR)	6-3
Correct Use of Medi-Cal Dental Envelopes	6-5

Table of Contents

Treatment Authorization Request (TAR)/Claim Forms	6-7
Sample TAR/Claim Form Submitted as a Treatment Authorization Request (TAR)	6-8
Sample TAR/Claim Form Submitted as a Claim	6-9
How to Complete the TAR/Claim Form	6-10
How to Submit a Claim for a Member with Other Coverage	6-16
How to Submit a TAR for Orthodontic Services	6-17
Notice of Authorization (NOA) (DC-301, Rev. 4/20)	6-19
Sample Notice of Authorization (NOA)	6-21
How to Complete the NOA	6-22
Reevaluation of the Notice of Authorization (NOA) For Orthodontic Services	6-26
Reevaluations	6-27
Outstanding Treatment Authorization Requests (TARs)	6-27
Notice of Medi-Cal Dental Action	6-29
Sample Notice of Medi-Cal Dental Action	6-30
Sample Notice of Medi-Cal Dental Action Insert: Reason for Action Codes	6-32
Resubmission Turnaround Document (RTD) (DC-102, Rev. 10/19)	6-34
Sample Resubmission Turnaround Document (RTD)	6-35
How to Complete the RTD	6-36
Section "A"	6-36
Section "B"	6-36
Claim Inquiry Form (CIF) (DC-003, Rev. 10/19)	6-38
CIF Tracer	6-38
Claim Re-evaluations	6-38
Sample Claim Inquiry Form (CIF)	6-39
How to Complete the CIF	6-40
Claim Inquiry Response (CIR)	6-42
Sample Claim Inquiry Response (CIR)	6-43
Checklists	6-44
Reminders	6-45
Time Limitations for NOAs	6-47
Justification of Need for Prosthesis (DC054, Rev 9/18)	6-48
Sample Justification of Need for Prosthesis	6-49
How to Complete the Justification of Need for Prosthesis Form	6-50
Sample Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet (DC-016, Rev 09/18)	6-52
How to Complete the HLD Index Scoresheet	6-53
Explanation of Benefits (EOB)	6-54
Lost/Misplaced EOBs	6-54
Sample Explanation of Benefits (EOB)	6-55
How to Read the EOB	6-56
Sample Paid Claim, Levy	6-58

Table of Contents

How to Read the Paid Claim with Levy Deduction EOB	6-59
Sample Levy Payment	6-60
How to Read the Levy Payment EOB	6-61
Sample Documents In-Process.....	6-62
How to Read the Documents In-Process EOB	6-63
Sample Accounts Receivable	6-64
How to Read the Accounts Receivable (AR) EOB.....	6-65
Sample Accounts Payable	6-66
How to Read the Accounts Payable (AP) EOB.....	6-67
Sample Readjudicated Claim.....	6-68
How to Read the Readjudicated Claim EOB	6-69
 Section 7 - Codes.....	7-1
Adjudication Reason Codes	7-1
Claim In Process Reason Codes	7-37
Accounts Payable/Accounts Receivable Codes.....	7-38
Payable Codes	7-38
Receivable Codes	7-38
Readjudication Codes	7-38
Claim Correction Codes	7-38
Resubmission Turnaround Document (RTD) Codes and Messages.....	7-39
Member RTD Codes	7-40
Provider RTD Codes	7-40
X-Ray RTD Codes.....	7-40
Clerical RTD Codes.....	7-41
Consultant RTD Codes	7-41
Maxillofacial Program RTD Codes	7-41
TAR/Claim Policy Codes and Messages.....	7-42
Claim Inquiry Response (CIR) Status Codes and Messages/Claim Inquiry Form (CIF) Action Codes and Messages.....	7-44
Prepaid Health Plans (PHP) and Codes.....	7-46
 Section 8 - Fraud, Abuse, and Quality of Care.....	8-1
Compliance Management and Surveillance and Utilization Review Subsystem (CM/SURS)	8-1
Introduction.....	8-1
Methods of Evaluation.....	8-1
Possible CM/SURS Actions	8-2
Help Stop Fraud	8-3
Statutes and Regulations	8-4

Table of Contents

Pertaining to Providers	8-4
Confidentiality	8-4
Record Keeping Criteria	8-4
Identification in Patient Record	8-6
Cause for Recovery.....	8-6
Special Permits	8-7
Utilization of Nurse Anesthetist	8-7
Deep Sedation/General Anesthesia (D9222 and D9223)	8-8
Intravenous Moderate (Conscious) Sedation/Analgesia (Conscious Sedation) (D9239 and D9243) ...	8-9
Non-intravenous Conscious Sedation (Oral Conscious Sedation) (D9248)	8-10
Oral Conscious Sedation for Adult Use	8-11
Billing Medi-Cal Dental	8-12
Billing for Benefits Provided	8-12
Sub-Standard Services	8-12
Excessive Services	8-13
Prohibition of Rebate, Refund, or Discount	8-13
Billing for Suspended Provider.....	8-13
Submission of False Information.....	8-13
Overpayment Recovery	8-14
Civil Money Penalties	8-15
Utilization Controls	8-17
Prior Authorization.....	8-17
Special Claims Review.....	8-18
Administrative Hearings	8-18
Provider Audit Hearing	8-18
Request for Hearing	8-18
Member Fraud.....	8-20
Sharing of Medi-Cal Cards.....	8-20
Provider Assistance for Medi-Cal Fraud	8-20
 Section 9 - Special Programs.....	 9-1
California Children's Services (CCS).....	9-1
Genetically Handicapped Person's Program (GHPP)	9-1
CCS-only and Authorizations and Claims Processing	9-2
CCS/Medi-Cal Authorizations and Claims Processing	9-2
GHPP/Medi-Cal and GHPP-only Authorizations and Claims Processing.....	9-3
Orthodontic Services for CCS-only Members	9-3
Providing Orthodontic Services to Medi-Cal Dental Members.....	9-3
Eligibility	9-4
Changes in the Member's Program Eligibility	9-4
Emergency Treatment.....	9-5

Table of Contents

Other Coverage	9-5
CCS-only, GHPP/Medi-Cal and GHPP only Service Code Groupings (SCG)	9-5
CCS-only Benefits	9-7
Contact Listings for Medi-Cal Dental, Medi-Cal Eligibility, GHPP, and CCS	9-10
CCS-only County Programs and CCS State Regional Offices	9-11
GHPP/Medi-Cal and GHPP-only State Office	9-11
Orthodontic Services Program	9-11
Enrollment and Orthodontic Certification	9-11
Initial Orthodontic Evaluation and Completion of the HLD Index Score Sheet	9-12
Diagnostic Casts	9-13
Clarification of Case Types	9-14
Orthodontic Treatment Plans	9-15
Treatment Plan Authorization and Payment Submission Procedures	9-16
Helpful Hints	9-17
Transfer Cases	9-17
Treatment Plan Authorization and Payment Submission Procedures	9-18
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	9-18
EPSDT: Frequently Asked Questions	9-19
Non-Emergency Medical Transportation (NEMT)	9-23
Non-Medical Transportation (NMT)	9-24
 Section 10 - CDT 25 Tables	10-1
 Section 11 - Glossary	11-1
 Section 12 - Bulletin Index	12-1
 Section 13 - Index	13-1

Section 5 - Manual of Criteria and Schedule of Maximum Allowances

Policy Changes	5-2
Diagnostic General Policies (D0100–D0999).....	5-7
Preventive General Policies (D1000–D1999)	5-26
Preventive Procedures (D1000–D1999).....	5-28
Restorative General Policies (D2000–D2999)	5-40
Restorative Procedures (D2000–D2999)	5-45
Endodontic General Policies (D3000–D3999).....	5-60
Endodontic Procedures (D3000–D3999).....	5-61
Periodontal General Policies (D4000–D4999)	5-73
Periodontal Procedures (D4000–D4999)	5-75
Prosthodontics (Removable) General Policies (D5000–D5899).....	5-83
Prosthodontic (Removable) Procedures (D5000–D5899).....	5-86
Maxillofacial Prosthetics General Policies (D5900–D5999).....	5-105
Maxillofacial Prosthetic Procedures (D5900–D5999).....	5-106
Implant Services General Policies (D6000–D6199)	5-113
Implant Service Procedures (D6000–D6199).....	5-114
Fixed Prosthodontic General Policies (D6200–D6999)	5-124
Fixed Prosthodontic Procedures (D6200–D6999).....	5-126
Oral and Maxillofacial Surgery General Policies (D7000–D7999)	5-136
Oral and Maxillofacial Surgery Procedures (D7000–D7999).....	5-138
Orthodontic General Policies (D8000–D8999)	5-170
Orthodontic Procedures (D8080, D8660, D8670 and D8680)	5-170
Orthodontic Procedures (D8000–D8999)	5-172
Adjunctive General Policies (D9000–D9999)	5-182
Anesthesia (D9210–D9248).....	5-182
Adjunctive Service Procedures (D9000–D9999).....	5-185
Medi-Cal Dental Schedule of Maximum Allowances (SMA).....	5-199

Policy Changes

Current Dental Terminology (CDT) 2025: Effective for dates of service on or after April 1, 2025

- [Manual of Criteria \(MOC\)](#)
- [Medi-Cal Dental Schedule of Maximum Allowances \(SMA\)](#)

For historical references, see table below. All of these changes are incorporated into the current MOC and SMA.

CDT Update	Effective Date	MOC and SMA
CDT-25	On or after April 1, 2025	<ul style="list-style-type: none"> • CDT-25 Manual of Criteria (MOC) • Refer to Provider Bulletin Volume 41, Number 5 for more information.
CDT-24	On or after February 1, 2024	<ul style="list-style-type: none"> • CDT-24 Manual of Criteria (MOC) • Refer to Provider Bulletin Volume 40, Number 3 for more information.
CDT-23	On or after April 1, 2023	<ul style="list-style-type: none"> • CDT-23 Manual of Criteria (MOC) <ul style="list-style-type: none"> ○ Refer to Provider Bulletin Volume 39, Number 4 for more information. ○ Federal approval was received in State Plan Amendment (SPA) 23-0001. • CDT-23 Medi-Cal Dental Schedule of Maximum Allowances (SMA)
CDT-22	On or after May 1, 2022 through June 30, 2022	<ul style="list-style-type: none"> • CDT-22 Manual of Criteria (MOC) <ul style="list-style-type: none"> ○ Refer to Provider Bulletin Volume 38, Number 12 for more information. ○ Federal approval was received in State Plan Amendment (SPA) CA-22-0020. • CDT-22 Medi-Cal Dental Schedule of Maximum Allowances (SMA)

CDT-21	On or after January 1, 2022 through April 30, 2022	<ul style="list-style-type: none"> • CDT-21 Manual of Criteria (MOC) – Updated for California Advancing and Innovating Medi-Cal (CalAIM) on January 1, 2022. <ul style="list-style-type: none"> ○ Adds two new program benefits from the CalAIM initiative: <ul style="list-style-type: none"> ▪ Caries Risk Assessment (CRA) bundle (CDT codes D0601, D0602, and D0603 (exam codes with associated increased frequencies), and D1310 (nutritional counseling) ▪ Silver Diamine Fluoride (SDF) application (D1354) ○ Refer to Provider Bulletin Volume 37, Number 19 for more information. ○ Federal approval was received in State Plan Amendment (SPA) 21-0029. <p>CDT-21 Medi-Cal Dental Schedule of Maximum Allowances (SMA) – Updated for CalAIM on January 1, 2022</p>
CDT-20	On or after July 1, 2021 through September 30, 2021	<ul style="list-style-type: none"> • CDT-20 Manual of Criteria (MOC) • CDT-20 Medi-Cal Dental Schedule of Maximum Allowances (SMA) • Refer to Provider Bulletin Volume 37, Number 12 for more information. • Federal approval was received in SPA 21-0001.
CDT-19	On or after March 14, 2020 and May 16, 2020 through June 30, 2021	<ul style="list-style-type: none"> • CDT-19 Manual of Criteria (MOC) • CDT-19 Medi-Cal Dental Schedule of Maximum Allowances (SMA) • Refer to Provider Bulletins Volume 36, Number 3 and Volume 36, Number 15 for more information. • Federal approval was received in SPA 20-0014.

CDT-13	On or after June 1, 2014 through March 13, 2020	<ul style="list-style-type: none">• CDT-13 Manual of Criteria (MOC)• CDT-13 Schedule of Maximum Allowances (SMA)• Refer to Provider Bulletins Volume 30, Number 8 and Volume 30, Number 14. These can be downloaded from the Medi-Cal Dental Provider Bulletins Archive page by clicking “Medi-Cal Dental Bulletin – 2014”.• Federal approval was received in SPA 19-0039.
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Manual of Criteria for Medi-Cal Authorization (Dental Services)

State of California
Department of Health Care Services
Medi-Cal Policy Division
1501 Capitol Avenue, Building 171
Sacramento, CA 95814
Current Dental Terminology 24 (CDT 25) Codes – Preface

Current Dental Terminology 25 (CDT 25) including procedure codes, definitions (descriptors) and other data is copyrighted by the American Dental Association.

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Diagnostic General Policies (D0100–D0999)

1. Radiographs (D0210-D0340):

- a) According to accepted standards of dental practice, the lowest number of radiographs needed to provide the diagnosis shall be taken.
- b) Original radiographs shall be a part of the patient's clinical record and shall be retained by the provider at all times.
- c) Radiographs shall be made available for review upon the request of the Department of Health Care Services or its fiscal intermediary.
- d) Pursuant to Title 22, CCR, Section 51051, dental radiographic laboratories shall not be considered providers under the Medi-Cal Dental.
- e) Radiographs shall be considered current as follows:
 - i) radiographs for treatment of primary teeth within the last eight months.
 - ii) radiographs for treatment of permanent teeth (as well as over-retained primary teeth where the permanent tooth is congenitally missing or impacted) within the last 14 months.
 - iii) radiographs to establish arch integrity within the last 36 months. Arch radiographs are not required for patients under the age of 21.
- f) All radiographs or paper copies of radiographs shall be of diagnostic quality, properly mounted, labeled with the date the radiograph was taken, the provider's name, the provider's billing number, the patient's name, and with the tooth/quadrant/area (as applicable) clearly indicated.
- g) Multiple radiographs of four or more shall be mounted. Three or fewer radiographs properly identified (as stated in "e" above) in a coin envelope are acceptable when submitted for prior authorization and/or payment.
- h) Paper copies of multiple radiographs shall be combined on no more than four sheets of paper.
- i) All treatment and post treatment radiographs are included in the fee for the associated procedure and are not payable separately.
- j) A panoramic radiograph alone is considered non-diagnostic for prior authorization and/or payment of restorative, endodontic, periodontic, removable partial and fixed prosthodontic procedures.
- k) When arch integrity films are required for a procedure and exposure to radiation should be minimized due to a medical condition, only a periapical radiograph shall be required. Submitted written documentation shall include a statement of the medical condition such as the following:
 - i) pregnancy,
 - ii) recent application of therapeutic doses of ionizing radiation to the head and neck areas,
 - iii) hypoplastic or aplastic anemia.

- l) Prior authorization for procedures other than fixed partial dentures, removable prosthetics and implants is not required when a patient's inability to respond to commands or directions would necessitate sedation or anesthesia in order to accomplish radiographic procedures. However, required radiographs shall be obtained during treatment and shall be submitted for consideration for payment.

2. Photographs (D0350):

- a) Photographs are a part of the patient's clinical record and the provider shall retain original photographs at all times.
- b) Photographs shall be made available for review upon the request of the Department of Health Care Services or its fiscal intermediary.
- c) Paper copies of multiple photographs shall be combined on no more than four sheets of paper.
- d) Photographs may be used in lieu of radiographs for patients with special healthcare needs in situations where radiographs cannot be obtained because of the patient's medical condition, physical ability, or cognitive function. Specific documentation of why radiographs could not be obtained must accompany the TAR or claim.

3. Prior authorization is not required for examinations, radiographs or photographs.

4. All licensed dental hygienists must refer all patients they treat to a Medi-Cal dentist the dental hygienist has a referral agreement with, or to a dentist by submitting a referral to the patient's dental care coordination team within Medi-Cal.

Diagnostic Procedures (D0100–D0999)

PROCEDURE D0120

PERIODIC ORAL EVALUATION – ESTABLISHED PATIENT

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
 - a. for patients age three and over.
 - b. once every six months for patients under the age of 21 and after six months have elapsed following comprehensive oral evaluation (D0150), per provider.
 - c. once every 12 months for patients age 21 and over and after six months have elapsed following comprehensive oral evaluation (D0150), per provider.
3. This procedure is not a benefit when provided on the same date of service with procedures:
 - a. limited oral evaluation – problem focused (D0140),
 - b. comprehensive oral evaluation – new or established patient (D0150),
 - c. detailed and extensive oral evaluation-problem focused, by report (D0160),
 - d. re-evaluation – limited, problem focused (established patient; not post-operative visit) (D0170),
 - e. office visit for observation (during regularly scheduled hours) – no other services performed (D9430).

PROCEDURE D0140

LIMITED ORAL EVALUATION – PROBLEM FOCUSED

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
 - a. for patients under the age of 21.
 - b. once per patient per provider.
 - c. when provided by a Medi-Cal certified orthodontist.
3. Submission of the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (09/18) is not required for payment.
4. The following procedures are not a benefit, for the same rendering provider, when provided on the same date of service with procedure D0140:
 - a. periodic oral evaluation – established patient (D0120),
 - b. comprehensive oral evaluation – new or established patient (D0150),
 - c. detailed and extensive oral evaluation – problem focused, by report (D0160)

- d. re-evaluation – limited, problem focused (established patient; not post-operative visit) (D0170),
 - e. office visit for observation (during regularly scheduled hours) – no other services performed (D9430).
5. This examination procedure shall only be billed for the initial orthodontic evaluation with the completion of the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (09/18).

PROCEDURE D0145**ORAL EVALUATION FOR A PATIENT UNDER THREE YEARS OF AGE AND COUNSELING WITH PRIMARY CAREGIVER**

- 1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
- 2. A benefit:
 - a. for patients under the age of three.
 - b. once every three months, per provider.
- 3. This procedure is for recording the oral and physical health history, evaluation of caries susceptibility, development of an appropriate preventive oral health regimen and communication with and counseling of the child's parent, legal guardian and/or primary caregiver.

PROCEDURE D0150**COMPREHENSIVE ORAL EVALUATION – NEW OR ESTABLISHED PATIENT**

- 1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
- 2. A benefit:
 - a. for patients age three and over.
 - b. once per patient per provider for the initial examination.
 - c. after 36 months from the last periodic oral evaluation (D0120) or comprehensive oral evaluation (D0150) per patient per provider.
- 3. This procedure is not a benefit when provided on the same date of service with procedures:
 - a. limited oral evaluation – problem focused (D0140),
 - b. detailed and extensive oral evaluation – problem focused, by report (D0160),
 - c. re-evaluation – limited, problem focused (established patient; not post-operative visit) (D0170).
- 4. The following procedures are not a benefit when provided on the same date of service with D0150:
 - a. periodic oral evaluation – established patient (D0120),

- b. office visit for observation (during regularly scheduled hours) – no other services performed (D9430).

PROCEDURE D0160**DETAILED AND EXTENSIVE ORAL EVALUATION – PROBLEM FOCUSED, BY REPORT**

1. Written documentation for payment – shall include documentation of findings that supports the existence of one of the following:
 - a. dento-facial anomalies,
 - b. complicated perio-prosthetic conditions,
 - c. complex temporomandibular dysfunction,
 - d. facial pain of unknown origin,
 - e. severe systemic diseases requiring multi-disciplinary consultation.
2. A benefit once per patient per provider.
3. The following procedures are not a benefit when provided on the same date of service with D0160:
 - a. periodic oral evaluation – established patient (D0120),
 - b. limited oral evaluation – problem focused (D0140),
 - c. comprehensive oral evaluation- new or established patient (D0150),
 - d. re-evaluation-limited, problem focused (established patient; not post- operative visit) (D0170),
 - e. office visit for observation (during regularly scheduled hours-no other services performed (D9430).

PROCEDURE D0170**RE-EVALUATION – LIMITED, PROBLEM FOCUSED (ESTABLISHED PATIENT; NOT POST-OPERATIVE VISIT)**

1. Written documentation for payment – shall include an evaluation and diagnosis justifying the medical necessity.
2. A benefit for the ongoing symptomatic care of temporomandibular joint dysfunction:
 - a. up to six times in a three month period.
 - b. up to a maximum of 12 in a 12 month period.
3. This procedure is not a benefit when provided on the same date of service with a detailed and extensive oral evaluation (D0160).
4. The following procedures are not a benefit when provided on the same date of service with procedure D0170:
 - a. periodic oral evaluation – established patient (D0120),
 - b. limited oral evaluation – problem focused (D0140),
 - c. comprehensive oral evaluation-new or established patient (D0150),

- d. office visit for observation (during regularly scheduled hours) – no other services performed (D9430).

PROCEDURE D0171**RE-EVALUATION – POST-OPERATIVE OFFICE VISIT**

This procedure can only be billed as palliative treatment of dental pain- per-visit (D9110) or office visit for observation (during regularly scheduled hours) – no other services performed (D9430) and is not payable separately.

PROCEDURE D0180**COMPREHENSIVE PERIODONTAL EVALUATION – NEW OR ESTABLISHED PATIENT**

This procedure can only be billed as comprehensive oral evaluation – new or established patient (D0150) and is not payable separately.

PROCEDURE D0190 SCREENING OF A PATIENT

This procedure is not a benefit.

PROCEDURE D0191 ASSESSMENT OF A PATIENT

This procedure is not a benefit.

PROCEDURE D0210**INTRAORAL – COMPREHENSIVE SERIES OF RADIOGRAPHIC IMAGES**

1. Submission of radiographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit;
 - a. once per provider every 36 months.
 - b. only for patients age 11 or over. For patients age 10 or under, medically necessary radiographs taken (D0220, D0230, D0240, D0270, D0272 and D0274) shall be billed separately.
3. Not a benefit to the same provider within six months of bitewings (D0272 and D0274).
4. A complete series shall be at least:
 - a. ten (10) periapicals (D0230) and bitewings (D0272 or D0274), or
 - b. eight (8) periapicals (D0230), two (2) occlusals (D0240) and bitewings (D0272 or D0274), or
 - c. a panoramic radiographic image (D0330) plus bitewings (D0272 or D0274) and a minimum of two (2) periapicals (D0230).
5. When multiple radiographs are taken on the same date of service, or if an intraoral-comprehensive series of radiographic images (D0210) has been paid in the last 36 months, the maximum payment shall not exceed the total fee allowed for an intraoral complete series.

PROCEDURE D0220**INTRAORAL – PERIAPICAL FIRST RADIOGRAPHIC IMAGE**

1. Submission of radiographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit to a maximum of 20 periapicals in a 12-month period by the same provider, in any combination of the following: intraoral-periapical first radiographic image (D0220) and intraoral – periapical each additional radiographic image (D0230). Periapicals taken as part of an intraoral-comprehensive series of radiographic images (D0210) are not considered against the maximum of 20 periapicals in a 12 month period.
3. This procedure is payable once per provider per date of service. All additional periapicals shall be billed as intraoral-periapical each additional radiographic image (D0230).
4. Periapicals taken in conjunction with bitewings, occlusal or panoramic radiographs shall be billed as intraoral- periapical each additional radiographic image (D0230).

PROCEDURE D0230**INTRAORAL – PERIAPICAL EACH ADDITIONAL RADIOGRAPHIC IMAGE**

1. Submission of radiographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit to a maximum of 20 periapicals in a 12-month period to the same provider, in any combination of the following: intraoral-periapical first radiographic image (D0220) and intraoral – periapical each additional radiographic image (D0230). Periapicals taken as part of an intraoral complete series of radiographic images (D0210) are not considered against the maximum of 20 periapical films in a 12-month period.
3. Periapicals taken in conjunction with bitewings, occlusal or panoramic radiographs shall be billed as intraoral- periapical each additional radiographic image (D0230).

PROCEDURE D0240**INTRAORAL – OCCLUSAL RADIOGRAPHIC IMAGE**

1. Submission of radiographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit up to a maximum of two in a six-month period per provider.
3. If any film size other than 2 1/4" x 3" (57mm x 76mm) is used for an intraoral – occlusal radiographic image (D0240), it shall be billed as a intraoral-periapical first radiographic image (D0220) or intraoral- periapical each additional radiographic image (D0230) as applicable.

PROCEDURE D0250**EXTRA-ORAL – 2D PROJECTION RADIOGRAPHIC IMAGES CREATED USING A STATIONARY RADIATION SOURCE, AND DETECTOR**

1. Submission of radiographs or written documentation demonstrating medical necessity is not required for payment.

2. A benefit once per date of service.

PROCEDURE D0251**EXTRA-ORAL POSTERIOR DENTAL RADIOGRAPHIC IMAGE**

This procedure is not a benefit.

PROCEDURE D0270**BITEWING – SINGLE RADIOGRAPHIC IMAGE**

1. Submission of radiographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit once per date of service.
3. Not a benefit for a totally edentulous area.

PROCEDURE D0272**BITEWINGS – TWO RADIOGRAPHIC IMAGES**

1. Submission of radiographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit once every six months per provider.
3. Not a benefit:
 - a. within six months of intraoral-complete series of radiographic images (D0210), same provider.
 - b. for a totally edentulous area.

PROCEDURE D0273**BITEWINGS – THREE RADIOGRAPHIC IMAGES**

This procedure can only be billed as bitewing – single radiographic image (D0270) and bitewings – two radiographic images (D0272).

PROCEDURE D0274**BITEWINGS – FOUR RADIOGRAPHIC IMAGES**

1. Submission of radiographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit once every six months per provider.
3. Not a benefit:
 - a. within six months of intraoral-complete series of radiographic images (D0210), same provider.
 - b. for patients under the age of 10.
 - c. for a totally edentulous area.

PROCEDURE D0277**VERTICAL BITEWINGS – 7 TO 8 RADIOGRAPHIC IMAGES**

This procedure can only be billed as bitewings – four radiographic images (D0274). The maximum payment is for four bitewings.

PROCEDURE D0310**SIALOGRAPHY**

Submit radiology report or radiograph(s) for payment.

PROCEDURE D0320**TEMPOROMANDIBULAR JOINT ARTHROGRAM, INCLUDING INJECTION**

1. Submission of radiographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
 - a. for the survey of trauma or pathology
 - b. for a maximum of three per date of service.

PROCEDURE D0321**OTHER TEMPOROMANDIBULAR JOINT RADIOGRAPHIC IMAGES, BY REPORT**

This procedure is not a benefit.

PROCEDURE D0322**TOMOGRAPHIC SURVEY**

1. Written documentation for payment shall include the radiographic findings and diagnosis to justify the medical necessity.
2. The tomographic survey shall be submitted for payment.
3. A benefit twice in a 12 month period per provider.
4. This procedure shall include three radiographic views of the right side and three radiographic views of the left side representing the rest, open and closed positions.

PROCEDURE D0330**PANORAMIC RADIOGRAPHIC IMAGE**

1. Submission of radiographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit once in a 36 month period per provider, except when documented as essential for a follow-up/ post-operative exam (such as after oral surgery).
3. Not a benefit, for the same provider, on the same date of service as an intraoral-comprehensive series of radiographic images (D0210).
4. This procedure shall be considered part of an intraoral – complete series of radiographic images (D0210) when taken on the same date of service with bitewings

(D0272 or D0274) and a minimum of two (2) intraoral – periapicals each additional radiographic image (D0230).

PROCEDURE D0340**2D CEPHALOMETRIC RADIOGRAPHIC IMAGE – ACQUISITION, MEASUREMENT AND ANALYSIS**

1. Submission of radiographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit once in a 24 month period per provider.

PROCEDURE D0350**2D ORAL/FACIAL PHOTOGRAPHIC IMAGES OBTAINED INTRA-ORALLY OR EXTRA ORALLY**

1. Photographs shall be submitted, with the claim or Treatment Authorization Request (TAR) for the procedure that it supports, for payment.
2. A benefit up to a maximum of four per date of service.
3. Not a benefit when used for patient identification, multiple views of the same area, treatment progress and post- operative photographs.
4. Photographs shall be necessary for the diagnosis and treatment of the specific clinical condition of the patient that is not readily apparent on radiographs.
5. Photographs shall be of diagnostic quality, labeled with the date the photograph was taken, the provider's name, the provider's billing number, the patient's name and with the tooth/quadrant/area (as applicable) clearly indicated.
6. This procedure is included in the fee for pre-orthodontic treatment visit (D8660) and comprehensive orthodontic treatment of the adolescent dentition (D8080) and is not payable separately.

PROCEDURE D0364**CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW – LESS THAN ONE WHOLE JAW**

This procedure is not a benefit.

PROCEDURE D0365**CONE BEAM CT CAPTURE AND INTERPRETATION WITH FIELD OF VIEW OF ONE FULL DENTAL ARCH – MANDIBLE**

This procedure is not a benefit.

PROCEDURE D0366**CONE BEAM CT CAPTURE AND INTERPRETATION WITH FIELD OF VIEW OF ONE FULL DENTAL ARCH – MAXILLA, WITH OR WITHOUT CRANIUM**

This procedure is not a benefit.

PROCEDURE D0367**CONE BEAM CT CAPTURE AND INTERPRETATION WITH FIELD OF VIEW OF BOTH JAWS; WITH OR WITHOUT CRANIUM**

This procedure is not a benefit.

PROCEDURE D0368**CONE BEAM CT CAPTURE AND INTERPRETATION FOR TMJ SERIES INCLUDING TWO OR MORE EXPOSURES**

This procedure is not a benefit.

PROCEDURE D0369**MAXILLOFACIAL MRI CAPTURE AND INTERPRETATION**

This procedure is not a benefit.

PROCEDURE D0370**MAXILLOFACIAL ULTRASOUND CAPTURE AND INTERPRETATION**

This procedure is not a benefit.

PROCEDURE D0371**SIALOENDOSCOPY CAPTURE AND INTERPRETATION**

This procedure is not a benefit.

PROCEDURE D0372**INTRAORAL TOMOSYNTHESIS – COMPREHENSIVE SERIES OF RADIOGRAPHIC IMAGES**

This procedure is not a benefit.

PROCEDURE D0373**INTRAORAL TOMOSYNTHESIS – BITEWING RADIOGRAPHIC IMAGE**

This procedure is not a benefit.

PROCEDURE D0374**INTRAORAL TOMOSYNTHESIS – PERIAPICAL RADIOGRAPHIC IMAGE**

This procedure is not a benefit.

PROCEDURE D0380**CONE BEAM CT IMAGE CAPTURE WITH LIMITED FIELD OF VIEW – LESS THAN ONE WHOLE JAW**

This procedure is not a benefit.

PROCEDURE D0381**CONE BEAM CT IMAGE CAPTURE WITH FIELD OF VIEW OF ONE FULL DENTAL ARCH – MANDIBLE**

This procedure is not a benefit.

PROCEDURE D0382**CONE BEAM CT IMAGE CAPTURE WITH FIELD OF VIEW OF ONE FULL DENTAL ARCH – MAXILLA, WITH OR WITHOUT CRANIUM**

This procedure is not a benefit.

PROCEDURE D0383**CONE BEAM CT IMAGE CAPTURE WITH FIELD OF VIEW OF BOTH JAWS, WITH OR WITHOUT CRANIUM**

This procedure is not a benefit.

PROCEDURE D0384**CONE BEAM CT IMAGE CAPTURE FOR TMJ SERIES INCLUDING TWO OR MORE EXPOSURES**

This procedure is not a benefit.

PROCEDURE D0385**MAXILLOFACIAL MRI IMAGE CAPTURE**

This procedure is not a benefit.

PROCEDURE D0386**MAXILLOFACIAL ULTRASOUND IMAGE CAPTURE**

This procedure is not a benefit.

PROCEDURE D0387**INTRAORAL TOMOSYNTHESIS – COMPREHENSIVE SERIES OF RADIOGRAPHIC IMAGES – IMAGE CAPTURE ONLY**

This procedure is not a benefit.

PROCEDURE D0388**INTRAORAL TOMOSYNTHESIS – BITEWING SERIES OF RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY**

This procedure is not a benefit.

PROCEDURE D0389**INTRAORAL TOMOSYNTHESIS – PERIAPICAL SERIES OF RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY**

This procedure is not a benefit.

PROCEDURE D0391**INTERPRETATION OF DIAGNOSTIC IMAGE BY A PRACTITIONER NOT ASSOCIATED WITH CAPTURE OF THE IMAGE, INCLUDING REPORT**

This procedure is not a benefit.

PROCEDURE D0393**VIRTUAL TREATMENT SIMULATION USING 3D IMAGE VOLUME OR SURFACE SCAN**

This procedure is not a benefit.

PROCEDURE D0394**DIGITAL SUBTRACTION OF TWO OR MORE IMAGES OR IMAGE VOLUMES OF THE SAME MODALITY**

This procedure is not a benefit.

PROCEDURE D0395**FUSION OF TWO OR MORE 3D IMAGE VOLUMES OF ONE OR MORE MODALITIES**

This procedure is not a benefit.

PROCEDURE D0396**3D PRINTING OF A 3D DENTAL SURFACE SCAN**

This procedure is not a benefit.

PROCEDURE D0411**HBA1C IN-OFFICE POINT OF SERVICE TESTING**

This procedure is not a benefit.

PROCEDURE D0412**BLOOD GLUCOSE LEVEL TEST – IN-OFFICE USING A GLUCOSE METER**

This procedure is not a benefit.

PROCEDURE D0414**LABORATORY PROCESSING OF MICROBIAL SPECIMEN TO INCLUDE CULTURE AND SENSITIVITY STUDIES, PREPARATION AND TRANSMISSION OF WRITTEN REPORT**

This procedure is not a benefit.

PROCEDURE D0415**COLLECTION OF MICROORGANISMS FOR CULTURE AND SENSITIVITY**

This procedure is not a benefit.

PROCEDURE D0416**VIRAL CULTURE**

This procedure is not a benefit.

PROCEDURE D0417**COLLECTION AND PREPARATION OF SALIVA SAMPLE FOR LABORATORY DIAGNOSTIC TESTING**

This procedure is not a benefit.

PROCEDURE D0418**ANALYSIS OF SALIVA SAMPLE**

This procedure is not a benefit.

PROCEDURE D0419**ASSESSMENT OF SALIVARY FLOW BY MEASUREMENT**

This procedure is not a benefit.

PROCEDURE D0422**COLLECTION AND PREPARATION OF GENETIC SAMPLE MATERIAL FOR LABORATORY ANALYSIS AND REPORT**

This procedure is not a benefit.

PROCEDURE D0423**GENETIC TEST FOR SUSCEPTIBILITY TO DISEASES – SPECIMEN ANALYSIS**

This procedure is not a benefit.

PROCEDURE D0425**CARIES SUSCEPTIBILITY TESTS**

This procedure is not a benefit

PROCEDURE D0431**ADJUNCTIVE PRE-DIAGNOSTIC TEST THAT AIDS IN DETECTION OF MUCOSAL ABNORMALITIES INCLUDING PREMALIGNANT AND MALIGNANT LESIONS, NOT TO INCLUDE CYTOLOGY OR BIOPSY PROCEDURES**

This procedure is not a benefit.

PROCEDURE D0460**PULP VITALITY TESTS**

This procedure is included in the fees for diagnostic, restorative, endodontic and emergency procedures and is not payable separately.

PROCEDURE D0470**DIAGNOSTIC CASTS**

1. Diagnostic casts are for the evaluation of orthodontic benefits only. Unless specifically requested by the Medi-Cal Dental, diagnostic casts submitted for other than orthodontic treatment shall be discarded and not reviewed.
2. Diagnostic casts are required to be submitted for orthodontic evaluation and are

payable only upon authorized orthodontic treatment. Do not send original casts, as casts will not be returned.

3. A benefit:
 - a. once per provider unless special circumstances are documented (such as trauma or pathology which has affected the course of orthodontic treatment).
 - b. for patients under the age of 21.
 - c. for permanent dentition (unless over the age of 13 with primary teeth still present or has a cleft palate or craniofacial anomaly).
 - d. only when provided by a Medi-Cal certified orthodontist.
4. Diagnostic casts shall be free of voids and be properly trimmed with centric occlusion clearly marked on the casts. The patient's name, Medi-Cal identification number and the providers name and/or billing number shall be clearly labeled on each cast. Impressions (and bite registrations if taken) shall be treated with an approved EPA disinfectant before being poured and the casts shall be dried before being placed in a sealed bag for shipping to the Medi-Cal Dental.

PROCEDURE D0472

ACCESSION OF TISSUE, GROSS EXAMINATION, PREPARATION AND TRANSMISSION OF WRITTEN REPORT

This procedure is not a benefit.

PROCEDURE D0473

ACCESSION OF TISSUE, GROSS AND MICROSCOPIC EXAMINATION, PREPARATION AND TRANSMISSION OF WRITTEN REPORT

This procedure is not a benefit.

PROCEDURE D0474

ACCESSION OF TISSUE, GROSS AND MICROSCOPIC EXAMINATION, INCLUDING ASSESSMENT OF SURGICAL MARGINS FOR PRESENCE OF DISEASE, PREPARATION AND TRANSMISSION OF WRITTEN REPORT

This procedure is not a benefit.

PROCEDURE D0475

DECALCIFICATION PROCEDURE

This procedure is not a benefit.

PROCEDURE D0476

SPECIAL STAINS FOR MICROORGANISMS

This procedure is not a benefit.

PROCEDURE D0477

SPECIAL STAINS, NOT FOR MICROORGANISMS

This procedure is not a benefit.

**PROCEDURE D0478
IMMUNOHISTOCHEMICAL STAINS**

This procedure is not a benefit.

**PROCEDURE D0479
TISSUE IN-SITU HYBRIDIZATION, INCLUDING INTERPRETATION**

This procedure is not a benefit.

**PROCEDURE D0480
ACCESSION OF EXFOLIATIVE CYTOLOGIC SMEARS, MICROSCOPIC EXAMINATION,
PREPARATION AND TRANSMISSION OF WRITTEN REPORT**

This procedure is not a benefit.

**PROCEDURE D0481
ELECTRON MICROSCOPY**

This procedure is not a benefit.

**PROCEDURE D0482
DIRECT IMMUNOFLUORESCENCE**

This procedure is not a benefit.

**PROCEDURE D0483
INDIRECT IMMUNOFLUORESCENCE**

This procedure is not a benefit.

**PROCEDURE D0484
CONSULTATION ON SLIDES PREPARED ELSEWHERE**

This procedure is not a benefit.

**PROCEDURE D0485
CONSULTATION, INCLUDING PREPARATION OF SLIDES FROM BIOPSY MATERIAL
SUPPLIED BY REFERRING SOURCE**

This procedure is not a benefit.

**PROCEDURE D0486
LABORATORY ACCESSION OF TRANSEPITHELIAL CYTOLOGIC SAMPLE,
MICROSCOPIC EXAMINATION, PREPARATION AND TRANSMISSION OF WRITTEN
REPORT**

This procedure is not a benefit.

**PROCEDURE D0502
OTHER ORAL PATHOLOGY PROCEDURES, BY REPORT**

1. Submission of the pathology report is required for payment.

2. A benefit only when provided by a Medi-Cal certified oral pathologist.
3. This procedure shall be billed only for a histopathological examination.

PROCEDURE D0600**NON-IONIZING DIAGNOSTIC PROCEDURE CAPABLE OF QUANTIFYING, MONITORING, AND RECORDING CHANGES IN STRUCTURE OF ENAMEL, DENTIN, AND CEMENTUM**

This procedure is not a benefit.

PROCEDURE D0601**CARIES RISK ASSESSMENT AND DOCUMENTATION, WITH A FINDING OF LOW RISK**

1. Submission of radiographs, photographs, CRA form or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
 - a. For patients age 0–6.
 - b. Once every 6 months per member.
3. Providers must:
 - a. Take the Treating Young Kids Everyday (TYKE) training, complete the related attestation form, and provide proof of TYKE course completion to receive payment for the CRA bundle.
 - b. Submit D0601 and D1310 (nutritional counseling) together as a bundle.
 - c. Use the CRA form presented in the TYKE training.
 - d. Ensure that the CRA is rendered and signed by an appropriate dental provider and kept in the patient's chart.

PROCEDURE D0602**CARIES RISK ASSESSMENT AND DOCUMENTATION, WITH A FINDING OF MODERATE RISK**

1. Submission of radiographs, photographs, CRA form or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
 - a. For patients age 0–6.
 - b. Once every 4 months per member.
3. Providers must:
 - a. Take the Treating Young Kids Everyday (TYKE) training, complete the related attestation form, and provide proof of TYKE course completion to receive payment for the CRA bundle.
 - b. Submit D0602 and D1310 (nutritional counseling) together as a bundle.
 - c. Use the CRA form presented in the TYKE training.
 - d. Ensure that the CRA is rendered and signed by an appropriate dental provider and kept in the patient's chart.

PROCEDURE D0603**CARIES RISK ASSESSMENT AND DOCUMENTATION, WITH A FINDING OF HIGH RISK**

1. Submission of radiographs, photographs, CRA form or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
 - a. For patients age 0-6.
 - b. Once every 3 months per member.
3. Providers must:
 - a. Take the Treating Young Kids Everyday (TYKE) training, complete the related attestation form, and provide proof of TYKE course completion to receive payment for the CRA bundle.
 - b. Submit D0601 and D1310 (nutritional counseling) together as a bundle.
 - c. Use the CRA form presented in the TYKE training.
 - d. Ensure that the CRA is rendered and signed by an appropriate dental provider and kept in the patient's chart.

PROCEDURE D0604**ANTIGEN TESTING FOR A PUBLIC HEALTH RELATED PATHOGEN, INCLUDING CORONAVIRUS**

This procedure is not a benefit.

PROCEDURE D0605**ANTIBODY TESTING FOR A PUBLIC HEALTH RELATED PATHOGEN, INCLUDING CORONAVIRUS**

This procedure is not a benefit.

PROCEDURE D0606**MOLECULAR TESTING FOR A PUBLIC HEALTH RELATED PATHOGEN, INCLUDING CORONAVIRUS**

This procedure is not a benefit.

PROCEDURE D0701**PANORAMIC RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY**

This procedure can only be billed as panoramic radiographic image D0330 and is not payable separately.

PROCEDURE D0702**2-D CEPHALOMETRIC RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY**

This procedure can only be billed as 2D cephalometric radiographic image D0340 and is not payable separately.

PROCEDURE D0703**2-D ORAL/FACIAL PHOTOGRAPHIC IMAGE OBTAINED INTRA-ORALLY OR EXTRA-ORALLY – IMAGE CAPTURE ONLY**

This procedure can only be billed as 2D oral/facial photographic image obtained intra-orally or extra-orally D0350 and is not payable separately.

PROCEDURE D0705**EXTRA-ORAL POSTERIOR DENTAL RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY**

This procedure is not a benefit.

PROCEDURE D0706**INTRAORAL – OCCLUSAL RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY**

This procedure can only be billed as intraoral- occlusal radiographic image D0240 and is not payable separately.

PROCEDURE D0707**INTRAORAL – PERIAPICAL RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY**

This procedure can only be billed as intraoral- periapical first radiographic image D0220 and intra-oral periapical each additional radiographic image D0230 and is not payable separately.

PROCEDURE D0708**INTRAORAL – BITEWING RADIOGRAPHIC IMAGE – IMAGE CAPTURE ONLY**

This procedure can only be billed as bitewing – single radiographic image D0270 and bitewings – two radiographic images D0272 and is not payable separately.

PROCEDURE D0709**INTRAORAL – COMPREHENSIVE SERIES OF RADIOGRAPHIC IMAGES – IMAGE CAPTURE ONLY**

This procedure can only be billed as intraoral- complete series of radiographic images D0210 and is not payable separately.

PROCEDURE D0801**3D INTRAORAL SURFACE SCAN – DIRECT**

This procedure is not a benefit.

PROCEDURE D0802**3D DENTAL SURFACE SCAN INDIRECT**

This procedure is not a benefit.

PROCEDURE D0803**3D FACIAL SURFACE SCAN – DIRECT**

This procedure is not a benefit.

PROCEDURE D0804**3D FACIAL SURFACE SCAN – INDIRECT**

This procedure is not a benefit.

PROCEDURE D0999**UNSPECIFIED DIAGNOSTIC PROCEDURE, BY REPORT**

1. This procedure does not require prior authorization.
2. Radiographs for payment - submit radiographs as applicable for the type of procedure.
3. Photographs for payment - submit photographs as applicable for the type of procedure.
4. Written documentation for payment – shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed or actual treatment.
5. Procedure D0999 shall be used:
 - a. for a procedure which is not adequately described by a CDT code, or
 - b. for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the medical condition and the specific CDT code associated with the treatment.

Preventive General Policies (D1000–D1999)

1. Dental Prophylaxis and Fluoride Treatment (D1110–D1208):

- a) Dental prophylaxis (D1110 and D1120) is defined as the preventive dental procedure of coronal scaling and polishing which includes the complete removal of calculus, soft deposits, plaque, stains and smoothing of unattached tooth surfaces.
- b) Fluoride treatment (D1206 and D1208) is a benefit only for prescription strength fluoride products.
- c) Fluoride treatments do not include treatments that incorporate fluoride with prophylaxis paste, topical application of fluoride to the prepared portion of a tooth prior to restoration and applications of aqueous sodium fluoride.
- d) The application of fluoride is only a benefit for caries control and is payable as a full mouth treatment regardless of the number of teeth treated.
- e) Fluoride procedures (D1206 and D1208) are a benefit once in a four month period without prior authorization up to the age of six.
- f) Fluoride procedures (D1206 and D1208) are a benefit once in a six month period without prior authorization from the age of six to under the age of 21.
- g) Prophylaxis procedures (D1120) are a benefit once in a six month period under the age of 21.
- h) Prophylaxis and fluoride procedures (D1110, D1206 and D1208) are a benefit once in a 12 month period without prior authorization for age 21 or older.
- i) Additional requests, beyond the stated frequency limitations, for prophylaxis and fluoride procedures (D1110, D1120, D1206 and D1208) shall be considered for prior authorization when documented medical necessity is justified due to a physical limitation and/or an oral condition that prevents daily oral hygiene.
- j) All licensed dental hygienists must refer all patients they treat to a Medi-Cal dentist the dental hygienist has a referral agreement with, or do a dentist by submitting a referral to the patient's dental care coordination team within Medi-Cal.

2. Application of Caries Arresting Medicament – Per Tooth (D1354):

- a) For application of caries arresting medicament (D1354), photographs may be used in lieu of radiographs for patients with special healthcare needs in situations where radiographs cannot be obtained because of the patient's medical condition, physical ability, or cognitive function. Specific documentation of why radiographs could not be obtained must accompany the TAR or claim.

Preventive Procedures (D1000–D1999)

PROCEDURE D1110

PROPHYLAXIS – ADULT

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
 - a. once in a 12 month period for patients age 21 or older.
 - b. once in a four month period for patients residing in a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF).
3. Frequency limitations shall apply toward prophylaxis procedure D1120.
4. Not a benefit when performed on the same date of service with:
 - a. gingivectomy or gingivoplasty (D4210 and D4211).
 - b. osseous surgery (D4260 and D4261).
 - c. periodontal scaling and root planing (D4341 and D4342).
5. Not a benefit to the same provider who performed periodontal maintenance (D4910) in the same calendar quarter.

PROCEDURE D1120 PROPHYLAXIS – CHILD

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
 - a. once in a six month period for patients under the age of 21.
 - b. once in a four month period for patients residing in a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF).
3. Not a benefit when performed on the same date of service with:
 - a. gingivectomy or gingivoplasty (D4210 and D4211).
 - b. osseous surgery (D4260 and D4261).
 - c. periodontal scaling and root planing (D4341 and D4342).
4. Not a benefit to the same provider who performed periodontal maintenance (D4910) in the same calendar quarter.

PROCEDURE D1206

TOPICAL APPLICATION OF FLUORIDE VARNISH

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
 - a. once in a four month period for patients up to the age of six.

- b. once in a six month period for patients from the age of six to under the age of 21.
 - c. once in a 12 month period for patients age 21 or older.
 - d. once in a four month period for patients residing in a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF).
3. Frequency limitations shall apply toward topical application of fluoride (D1208).
4. Payable as a full mouth treatment regardless of the number of teeth treated.

PROCEDURE D1208**TOPICAL APPLICATION OF FLUORIDE – EXCLUDING VARNISH**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
 - a. once in a four month period for patients up to the age of six.
 - b. once in a six month period for patients from the age of six to under the age of 21.
 - c. once in a 12 month period for patients age 21 or older.
 - d. once in a four month period for patients residing in a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF).
3. Frequency limitations shall apply toward topical application of fluoride varnish (D1206).
4. Payable as a full mouth treatment regardless of the number of teeth treated.

PROCEDURE D1301**IMMUNIZATION COUNSELING**

This procedure is not a benefit.

PROCEDURE D1310**NUTRITIONAL COUNSELING FOR CONTROL OF DENTAL DISEASE**

This procedure is to be performed in conjunction with diagnostic, preventive, and periodontal procedures and is not payable separately.

PROCEDURE D1320**TOBACCO COUNSELING FOR THE CONTROL AND PREVENTION OF ORAL DISEASE**

1. Submission of dental record documenting tobacco counseling is not required for payment.
2. A benefit only in conjunction with at least one of the following procedures: periodic oral evaluation- established patient (D0120); comprehensive oral evaluation - new or established patient (D0150); prophylaxis (D1110 or D1120); scaling and root planing (D4341 or D4342); or periodontal maintenance (D4910).
3. A benefit once per year per provider.

4. Documentation in the provider record of a face-to-face encounter shall include:
 - a. the five A's of tobacco dependence. The five A's are the following:
 - Ask – Ask the patient about tobacco use at every visit and document the response.
 - Advise – Advise the patient to quit in a clear and personalized manner.
 - Assess – Assess the patient's willingness to make a quit attempt at this time.
 - Assist – Assist the patient to set a quit date and make a quit plan
 - Arrange – Arrange to follow up with the patient within the first week, either in person or by phone and take appropriate action to assist them.
 - b. Document patient's expressed roadblocks if unwilling/unable to quit.
5. Refer the patient to the [Department of Public Health's California Tobacco Control Program](#).

PROCEDURE D1321**COUNSELING FOR THE CONTROL AND PREVENTION OF ADVERSE ORAL, BEHAVIORAL, AND SYSTEMIC HEALTH EFFECTS ASSOCIATED WITH HIGH-RISK SUBSTANCE USE**

This procedure is not a benefit.

PROCEDURE D1330**ORAL HYGIENE INSTRUCTIONS**

This procedure is to be performed in conjunction with diagnostic, preventive, and periodontal procedures and is not payable separately.

PROCEDURE D1351**SEALANT – PER TOOTH**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. Requires a tooth code and surface code.
3. A benefit:
 - a. for first, second and third permanent molars that occupy the second molar position.
 - b. only on the occlusal surfaces that are free of decay and/or restorations.
 - c. for patients under the age of 21.
 - d. once per tooth every 36 months per provider regardless of surfaces sealed.
Frequency limitations shall apply toward preventive resin restoration in a moderate to high caries risk patient – permanent tooth (D1352).
4. The original provider is responsible for any repair or replacement during the 36-month period.

PROCEDURE D1352**PREVENTIVE RESIN RESTORATION IN A MODERATE TO HIGH CARIES RISK PATIENT – PERMANENT TOOTH**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. Requires a tooth code and surface code.
3. A benefit:
 - a. for first, second and third permanent molars that occupy the second molar position.
 - b. only for an active cavitated lesion in a pit or fissure that does not cross the DEJ.
 - c. for patients under the age of 21.
 - d. once per tooth every 36 months per provider regardless of surfaces sealed. Frequency limitations shall apply toward sealant – per tooth (D1351).
4. The original provider is responsible for any repair or replacement during the 36-month period.

PROCEDURE D1353**SEALANT REPAIR – PER TOOTH**

This procedure is not a benefit.

PROCEDURE D1354**APPLICATION OF CARIES ARRESTING MEDICAMENT – PER TOOTH**

1. Radiographs and photographs for payment:
 - a. For patients under the age of 7, submit a current intraoral photograph demonstrating the medical necessity.
 - b. For patients age 7 or older, in addition to a current intraoral photograph, submit a current, diagnostic periapical radiograph and document the underlying conditions that exist which indicate that nonrestorative caries treatment is optimal.
 - c. Photographs may be used in lieu of radiographs for patients with special healthcare needs in situations where radiographs cannot be obtained because of the patient's medical condition, physical ability, or cognitive function. Specific documentation of why radiographs could not be obtained must accompany the TAR or claim.
2. Requires a tooth code.
3. A benefit:
 - a. For patients under the age of 7.
 - b. For patients age 7 or older when documentation shows underlying conditions such that nonrestorative caries treatment may be optimal.
 - c. Once every six months, up to ten teeth per visit, for a maximum of four treatments per tooth.

4. Not a benefit:
 - a. When the prognosis of the tooth is questionable due to nonrestorability.
 - b. When a tooth is near exfoliation.

PROCEDURE D1355**CARIES PREVENTIVE MEDICAMENT APPLICATION – PER TOOTH**

This procedure is not a benefit.

PROCEDURE D1510**SPACE MAINTAINER – FIXED – UNILATERAL – PER QUADRANT**

1. This procedure does not require prior authorization.
2. Radiographs for payment – submit a diagnostic pre-operative periapical or bitewing radiograph to verify there is enough space to allow the eruption of the permanent teeth.
3. Written documentation for payment – shall include the identification of the missing primary molar.
4. Requires a quadrant code.
5. A benefit:
 - a. once per quadrant per patient.
 - b. for patients under the age of 18.
 - c. only to maintain the space for a single tooth.
6. Not a benefit:
 - a. when the permanent tooth is near eruption.
 - b. for upper and lower anterior teeth.
 - c. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.
7. Replacement space maintainers shall be considered for payment when documentation identifies an unusual circumstance (such as lost or non-repairable).
8. The fee for space maintainers includes the band and loop.
9. When prefabricated crowns (D2930, D2931, D2932 and D2933) are necessary for space maintainer abutment teeth they first shall meet the Medi-Cal Dental's criteria for prefabricated crowns and shall be billed separately from the space maintainer.

PROCEDURE D1516**SPACE MAINTAINER – FIXED – BILATERAL, MAXILLARY**

1. This procedure does not require prior authorization.
2. Radiographs for payment – submit a diagnostic pre-operative periapical or bitewing radiograph to verify there is enough space to allow the eruption of the permanent teeth.
3. Written documentation for payment – shall include the identification of the missing primary molars.

4. A benefit:
 - a. once per arch when there is a missing primary molar in both quadrants or when there are two missing primary molars in the same quadrant. Bilateral space maintainers shall be attached to teeth on both sides of the arch.
 - b. for patients under the age of 18.
5. Not a benefit:
 - a. when the permanent tooth is near eruption.
 - b. for upper and lower anterior teeth.
 - c. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.
6. Replacement space maintainers shall be considered for payment when documentation identifies an unusual circumstance (such as lost or non-repairable).
7. The fee for space maintainers includes the band and loop.
8. When prefabricated crowns (D2930, D2931, D2932 and D2933) are necessary for space maintainer abutment teeth they first shall meet the Medi-Cal Dental's criteria for prefabricated crowns and shall be billed separately from the space maintainer.

PROCEDURE D1517**SPACE MAINTAINER – FIXED – BILATERAL, MANDIBULAR**

1. This procedure does not require prior authorization.
2. Radiographs for payment – submit a diagnostic pre-operative periapical or bitewing radiograph to verify there is enough space to allow the eruption of the permanent teeth.
3. Written documentation for payment – shall include the identification of the missing primary molars.
4. A benefit:
 - a. once per arch when there is a missing primary molar in both quadrants or when there are two missing primary molars in the same quadrant. Bilateral space maintainers shall be attached to teeth on both sides of the arch.
 - b. for patients under the age of 18.
5. Not a benefit:
 - a. when the permanent tooth is near eruption.
 - b. for upper and lower anterior teeth.
 - c. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.
6. Replacement space maintainers shall be considered for payment when documentation identifies an unusual circumstance (such as lost or non-repairable).
7. The fee for space maintainers includes the band and loop.

8. When prefabricated crowns (D2930, D2931, D2932, and D2933) are necessary for space maintainer abutment teeth they first shall meet the Medi-Cal Dental's criteria for prefabricated crowns and shall be billed separately from the space maintainer.

PROCEDURE D1520**SPACE MAINTAINER – REMOVABLE, UNILATERAL – PER QUADRANT**

This procedure is not a benefit.

PROCEDURE D1526**SPACE MAINTAINER – REMOVABLE – BILATERAL, MAXILLARY**

1. This procedure does not require prior authorization.
2. Radiographs for payment – submit a diagnostic pre-operative periapical or bitewing radiograph to verify there is enough space to allow the eruption of the permanent teeth.
3. Written documentation for payment – shall include the identification of the missing primary molars.
4. A benefit:
 - a. once per arch when there is a missing primary molar in both quadrants or when there are two missing primary molars in the same quadrant. Bilateral space maintainers shall be attached to teeth on both sides of the arch.
 - b. for patients under the age of 18.
5. Not a benefit:
 - a. when the permanent tooth is near eruption.
 - b. for upper and lower anterior teeth.
 - c. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.
6. Replacement space maintainers shall be considered for payment when documentation identifies an unusual circumstance (such as lost or non-repairable).
7. All clasps, rests and adjustments are included in the fee for this procedure.

PROCEDURE D1527**SPACE MAINTAINER – REMOVABLE – BILATERAL, MANDIBULAR**

1. This procedure does not require prior authorization.
2. Radiographs for payment - submit a diagnostic pre-operative periapical or bitewing radiograph to verify there is enough space to allow the eruption of the permanent teeth.
3. Written documentation for payment - shall include the identification of the missing primary molars.
4. A benefit:
 - a. once per arch when there is a missing primary molar in both quadrants or when there are two missing primary molars in the same quadrant. Bilateral space maintainers shall be attached to teeth on both sides of the arch.

- b. for patients under the age of 18.
5. Not a benefit:
 - a. when the permanent tooth is near eruption.
 - b. for upper and lower anterior teeth.
 - c. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.
6. Replacement space maintainers shall be considered for payment when documentation identifies an unusual circumstance (such as lost or non-repairable).
7. All clasps, rests and adjustments are included in the fee for this procedure.

PROCEDURE D1551**RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER – MAXILLARY**

1. This procedure does not require prior authorization.
2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
3. Requires an arch code.
4. A benefit:
 - a. once per provider per arch.
 - b. for patients under the age of 18.
5. Additional requests beyond the stated frequency limitations shall be considered for payment when the medical necessity is documented and identifies an unusual condition (such as displacement due to a sticky food item).

PROCEDURE D1552**RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER – MANDIBULAR**

1. This procedure does not require prior authorization.
2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
3. Requires an arch code.
4. A benefit:
 - a. once per provider per arch.
 - b. for patients under the age of 18.
5. Additional requests beyond the stated frequency limitations shall be considered for payment when the medical necessity is documented and identifies an unusual condition (such as displacement due to a sticky food item).

PROCEDURE D1553**RE-CEMENT OR RE-BOND UNILATERAL SPACE MAINTAINER – PER QUADRANT**

1. This procedure does not require prior authorization.

2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
3. Requires a quadrant code.
4. A benefit:
 - a. once per provider per quadrant.
 - b. for patients under the age of 18.
5. Additional requests beyond the stated frequency limitations shall be considered for payment when the medical necessity is documented and identifies an unusual condition (such as displacement due to a sticky food item).

PROCEDURE D1556**REMOVAL OF FIXED UNILATERAL SPACE MAINTAINER – PER QUADRANT**

1. This procedure does not require prior authorization.
2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
3. Requires a quadrant code.
4. Not a benefit to the original provider who placed the space maintainer.

PROCEDURE D1557**REMOVAL OF FIXED BILATERAL SPACE MAINTAINER – MAXILLARY**

1. This procedure does not require prior authorization.
2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
3. Requires an arch code.
4. Not a benefit to the original provider who placed the space maintainer.

PROCEDURE D1558**REMOVAL OF FIXED BILATERAL SPACE MAINTAINER – MANDIBULAR**

1. This procedure does not require prior authorization.
2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
3. Requires an arch code.
4. Not a benefit to the original provider who placed the space maintainer.

PROCEDURE D1575**DISTAL SHOE SPACE MAINTAINER – FIXED, UNILATERAL – PER QUADRANT**

1. This procedure does not require prior authorization.
2. Radiographs for payment - submit a diagnostic pre-operative periapical or bitewing radiograph to verify there is enough space to allow the eruption of the permanent teeth.

3. Written documentation for payment – shall include the identification of the missing primary molar.
4. Requires a quadrant code.
5. A benefit:
 - a. once per quadrant per patient.
 - b. for patients under the age of 18.
 - c. only to maintain the space for a single tooth.
6. Not a benefit:
 - a. when the permanent tooth is near eruption.
 - b. for upper and lower anterior teeth.
 - c. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.
7. Replacement space maintainers shall be considered for payment when documentation identifies an unusual circumstance (such as lost or non-repairable).
8. The fee for space maintainers includes the band and loop.
9. When prefabricated crowns (D2930, D2931, D2932 and D2933) are necessary for space maintainer abutment teeth they first shall meet the Medi-Cal Dental 's criteria for prefabricated crowns and shall be billed separately from the space maintainer.

PROCEDURE D1701**PFIZER-BIONTECH COVID-19 VACCINE ADMINISTRATION – FIRST DOSE**

This procedure is not a benefit.

PROCEDURE D1702**PFIZER-BIONTECH COVID-19 VACCINE ADMINISTRATION – SECOND DOSE**

This procedure is not a benefit.

PROCEDURE D1703**MODERNA COVID-19 VACCINE ADMINISTRATION – FIRST DOSE**

This procedure is not a benefit.

PROCEDURE D1704**MODERNA COVID-19 VACCINE ADMINISTRATION – SECOND DOSE**

This procedure is not a benefit.

PROCEDURE D1705**ASTRAZENECA COVID-19 VACCINE ADMINISTRATION – FIRST DOSE**

This procedure is not a benefit.

PROCEDURE D1706**ASTRAZENECA COVID-19 VACCINE ADMINISTRATION – SECOND DOSE**

This procedure is not a benefit.

PROCEDURE D1707**JANSSEN COVID-19 VACCINE ADMINISTRATION**

This procedure is not a benefit.

PROCEDURE D1708**PFIZER-BIONTECH COVID-19 VACCINE ADMINISTRATION – THIRD DOSE**

This procedure is not a benefit.

PROCEDURE D1709**PFIZER-BIONTECH COVID-19 VACCINE ADMINISTRATION – BOOSTER DOSE**

This procedure is not a benefit.

PROCEDURE D1710**MODERNA COVID-19 VACCINE ADMINISTRATION – THIRD DOSE**

This procedure is not a benefit.

PROCEDURE D1711**MODERNA COVID-19 VACCINE ADMINISTRATION – BOOSTER DOSE**

This procedure is not a benefit.

PROCEDURE D1712**JANSSEN COVID-19 VACCINE ADMINISTRATION – BOOSTER DOSE**

This procedure is not a benefit.

PROCEDURE D1713**PFIZER-BIONTECH COVID-19 VACCINE ADMINISTRATION – TRIS-SUCROSE
PEDIATRIC – FIRST DOSE**

This procedure is not a benefit.

PROCEDURE D1714**PFIZER-BIONTECH COVID-19 VACCINE ADMINISTRATION – TRIS-SUCROSE
PEDIATRIC – SECOND DOSE**

This procedure is not a benefit.

PROCEDURE D1781**VACCINE ADMINISTRATION – HUMAN PAPILLOMAVIRUS – DOSE 1**

This procedure is not a benefit.

PROCEDURE D1782**VACCINE ADMINISTRATION – HUMAN PAPILLOMAVIRUS – DOSE 2**

This procedure is not a benefit.

PROCEDURE D1783**VACCINE ADMINISTRATION – HUMAN PAPILLOMAVIRUS – DOSE 3**

This procedure is not a benefit.

PROCEDURE D1999**UNSPECIFIED PREVENTIVE PROCEDURE, BY REPORT**

1. This procedure does not require prior authorization.
2. Radiographs for payment – submit radiographs as applicable for the type of procedure.
3. Photographs for payment – submit photographs as applicable for the type of procedure.
4. Written documentation for payment shall describe the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.
5. Procedure D1999 shall be used:
 - a. for a procedure which is not adequately described by a CDT code, or
 - b. for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the medical condition and the specific CDT code associated with the treatment.

Restorative General Policies (D2000–D2999)

1. Amalgam and Resin-Based Composite Restorations (D2140-D2394):

- a) Restorative services shall be a benefit when medically necessary, when carious activity or fractures have extended through the dentinoenamel junction (DEJ) and when the tooth demonstrates a reasonable longevity.
- b) Amalgam and resin-based composite restoration procedures do not require submission of pre-operative radiographs for payment except when requested by the program.
- c) The submitted radiographs shall clearly demonstrate that the destruction of the tooth is due to such conditions as decay, fracture, endodontic access or missing or defective restorations. Payment for restorative procedures shall be modified or denied when the medical necessity is not evident.
- d) Should the submitted radiographs fail to demonstrate the medical necessity for the restoration, intraoral photographs shall also be submitted as further documentation.
- e) Photographs may be used in lieu of radiographs for patients with special healthcare needs in situations where radiographs cannot be obtained because of the patient's medical condition, physical ability, or cognitive function. Specific documentation of why radiographs could not be obtained must accompany the TAR or claim
- f) When radiographs are medically contraindicated due to recent application of therapeutic doses of ionizing radiation to the head and neck areas, the reason for the contraindication shall be fully documented by the patient's attending physician and submitted for payment. If this condition exists, intraoral photographs shall also be submitted to demonstrate the medical necessity for the restoration.
- g) Restorative services provided solely to replace tooth structure lost due to attrition, abrasion, erosion or for cosmetic purposes are not a benefit.
- h) Restorative services are not a benefit when the prognosis of the tooth is questionable due to non- restorability or periodontal involvement.
- i) Restorations for primary teeth near exfoliation are not a benefit.
- j) The five valid tooth surface classifications are mesial, distal, occlusal/incisal, lingual and facial (including buccal and labial).
- k) All surfaces on a single tooth restored with the same restorative material shall be considered connected, for payment purposes, if performed on the same date of service.
- l) Payment is made for a tooth surface only once for the same date of service regardless of the number or combination of restorative materials placed on that surface.
- m) Tooth and soft tissue preparation, crown lengthening, cement bases, direct and indirect pulp capping, bonding agents, lining agents, occlusal adjustments (D9951), polishing, local anesthesia and any other associated procedures are included in the fee for a completed restorative service.

- n) The original provider is responsible for any replacement restorations necessary in primary teeth within the first 12 months and permanent teeth within the first 36 months, except when failure or breakage results from circumstances beyond the control of the provider (such as due to a patient's oral habits). Radiographs (and photographs, as applicable) shall be submitted for payment to demonstrate the need for replacement.
- o) Replacement of otherwise satisfactory amalgam restorations with resin-based composite restorations is not a benefit unless a specific allergy has been documented by a medical specialist (allergist) on their professional letterhead or prescription and submitted for payment.

2. Prefabricated Crowns (D2930-D2933):

A. Primary Teeth:

- a) Prefabricated crowns (D2930, D2932, and D2933) are a benefit only once in a 12 month period.
- b) Primary teeth do not require prior authorization.
- c) Prefabricated crowns do not require submission of pre-operative radiographs for payment except when requested by the program.
- d) At least one of the following criteria shall be met for payment:
 - i) decay, fracture or other damage involving three or more tooth surfaces,
 - ii) decay, fracture or other damage involving one interproximal surface when the damage has extended extensively buccolingually or mesiodistally,
 - iii) the prefabricated crown is submitted for payment in conjunction with therapeutic pulpotomy or pulpal therapy (D3220, D3230 and D3240) or the tooth has had previous pulpal treatment.
- e) Prefabricated crowns for primary teeth near exfoliation are not a benefit.
- f) When prefabricated crowns are utilized to restore space maintainer abutment teeth they shall meet Medi-Cal Dental criteria for prefabricated crowns and shall be submitted separately for payment from the space maintainer.

B. Permanent Teeth:

- a) Prefabricated crowns (D2931, D2932 and D2933) are a benefit only once in a 36 month period.
- b) Permanent teeth do not require prior authorization.
- c) Prefabricated crowns do not require submission of pre-operative radiographs for payment except when requested by the program.
- d) At least one of the following criteria shall be met for payment:
 - i) anterior teeth shall show traumatic or pathological destruction of the crown of the tooth which involves four or more tooth surfaces including at least the loss of one incisal angle,

- ii) premolars shall show traumatic or pathological destruction of the crown of the tooth which involves three or more tooth surfaces including at least one cusp,
 - iii) molars shall show traumatic or pathological destruction of the crown of the tooth which involves four or more tooth surfaces including at least two cusps,
 - iv) the prefabricated crown shall restore an endodontically treated premolars or molar tooth.
- e) Arch integrity and the overall condition of the mouth, including the patient's ability to maintain oral health, shall be considered based upon a supportable 36-month prognosis for the permanent tooth to be crowned.
 - f) Indirectly fabricated or prefabricated posts (D2952 and D2954) are benefits when medically necessary for the retention of prefabricated crowns on root canal treated permanent teeth.
 - g) Prefabricated crowns on root canal treated teeth shall be considered for payment only after satisfactory completion of root canal therapy. Post root canal treatment radiographs shall be submitted for payment of prefabricated crowns.
 - h) Prefabricated crowns are not a benefit for abutment teeth for cast metal framework partial dentures (D5213 and D5214).

c. Primary and Permanent Teeth:

- a) Prefabricated crowns provided solely to replace tooth structure lost due to attrition, abrasion, erosion or for cosmetic purposes are not a benefit.
- b) Prefabricated crowns are not a benefit when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement.
- c) Prefabricated crowns are not a benefit when a tooth can be restored with an amalgam or resin-based composite restoration.
- d) Tooth and soft tissue preparation, crown lengthening, cement bases, direct and indirect pulp capping, amalgam or acrylic buildups, pins (D2951), bonding agents, occlusal adjustments (D9951), local anesthesia (D9210) and any other associated procedures are included in the fee for a prefabricated crown.
- e) The original provider is responsible for any replacement prefabricated crowns necessary in primary teeth within the first 12 months and permanent teeth within the first 36 months, except when failure or breakage results from circumstances beyond the control of the provider (such as due to a patient's oral habits). Radiographs (and photographs, as applicable) shall be submitted for payment to demonstrate the need for replacement.

3. Laboratory Processed Crowns (D2710-D2792):

- a) Laboratory processed crowns on permanent teeth (or over-retained primary teeth with no permanent successor) are a benefit only once in a five-year period except when failure or breakage results from circumstances beyond the control of the provider (such as due to a patient's oral habits).

- b) Prior authorization with current periapical and arch radiographs is required. Arch films are not required for crown authorizations if the Medi-Cal Dental has paid for root canal treatment on the same tooth within the last six months. Only a periapical radiograph of the completed root canal treatment is required.
- c) A benefit for patients age 13 or older when a lesser service will not suffice because of extensive coronal destruction and a crown is medically necessary to restore the tooth back to normal function. The following criteria shall be met for prior authorization:
 - i) Anterior teeth shall show traumatic or pathological destruction to the crown of the tooth, which involves at least one of the following:
 - a. the involvement of four or more surfaces including at least one incisal angle. The facial or lingual surface shall not be considered involved for a mesial or proximal restoration unless the proximal restoration wraps around the tooth to at least the midline,
 - b. the loss of an incisal angle which involves a minimum area of both half the incisal width and half the height of the anatomical crown,
 - c. an incisal angle is not involved but more than 50% of the anatomical crown is involved.
 - ii) Premolars that have not been endodontically treated shall show traumatic or pathological destruction of the crown of the tooth, which involves three or more tooth surfaces including one cusp.
 - iii) Molars that have not been endodontically treated shall show traumatic or pathological destruction of the crown of the tooth, which involves four or more tooth surfaces including two or more cusps.
 - iv) Premolars and molars that have had adequate endodontic treatment.
- d) Restorative services provided solely to replace tooth structure lost due to attrition, abrasion, erosion or for cosmetic purposes are not a benefit.
- e) Laboratory crowns are not a benefit when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement.
- f) Laboratory processed crowns are not a benefit when the tooth can be restored with an amalgam or resin-based composite.
- g) When a tooth has been restored with amalgam or resin-based composite restoration within 36 months, by the same provider, written documentation shall be submitted with the TAR justifying the medical necessity for the crown request. A current periapical radiograph dated after the restoration is required to demonstrate the medical necessity along with arch radiographs.
- h) Tooth and soft tissue preparation, crown lengthening, cement bases, direct and indirect pulp capping, amalgam or acrylic buildups, pins (D2951), bonding agents, lining agents, impressions, temporary crowns, occlusal adjustments (D9951), polishing, local anesthesia (D9210) and any other associated procedures are included in the fee for a completed laboratory processed crown.

- i) Arch integrity and overall condition of the mouth, including the patient's ability to maintain oral health, shall be considered for prior authorization, which shall be based upon a supportable five-year prognosis for the teeth to be crowned.
 - j) Indirectly fabricated or prefabricated posts (D2952 and D2954) are a benefit when medically necessary for the retention of allowable laboratory processed crowns on root canal treated permanent teeth.
 - k) Partial payment will not be made for an undelivered laboratory processed crown. Payment shall be made only upon final cementation.
4. **All licensed dental hygienists must refer all patients they treat to a Medi-Cal dentist the dental hygienist has a referral agreement with, or to a dentist by submitting a referral to the patient's dental care coordination team within Medi-Cal.**

Restorative Procedures (D2000–D2999)

PROCEDURE D2140

AMALGAM – ONE SURFACE, PRIMARY OR PERMANENT

Primary teeth:

1. This procedure does not require prior authorization.
2. Radiographs for payment. Refer to Restorative General Policies for specific requirements.
3. Requires a tooth code and surface code.
4. A benefit once in a 12 month period.

Permanent teeth:

1. This procedure does not require prior authorization.
2. Radiographs for payment – Refer to Restorative General Policies for specific requirements.
3. Requires a tooth code and surface code.
4. A benefit once in a 36 month period.

PROCEDURE D2150

AMALGAM – TWO SURFACES, PRIMARY OR PERMANENT

See the criteria under Procedure D2140.

PROCEDURE D2160

AMALGAM – THREE SURFACES, PRIMARY OR PERMANENT

See the criteria under Procedure D2140.

PROCEDURE D2161

AMALGAM – FOUR OR MORE SURFACES, PRIMARY OR PERMANENT

See the criteria under Procedure D2140.

PROCEDURE D2330

RESIN-BASED COMPOSITE – ONE SURFACE, ANTERIOR

Primary teeth:

1. This procedure does not require prior authorization.
2. Radiographs for payment-refer to Restorative General Policies for specific requirements.
3. Requires a tooth code and surface code.
4. A benefit once in a 12 month period.

Permanent teeth:

1. This procedure does not require prior authorization.
2. Radiographs for payment- Refer to Restorative General Policies for specific requirements.

3. Requires a tooth code and surface code.
4. A benefit once in a 36 month period.

PROCEDURE D2331**RESIN-BASED COMPOSITE – TWO SURFACES, ANTERIOR**Primary teeth:

1. This procedure does not require prior authorization.
2. Radiographs for payment-refer to Restorative General Policies for specific requirements.
3. Requires a tooth code and surface code.
4. A benefit once in a 12 month period.
5. Each unique tooth surface is only payable once per tooth per date of service.

Permanent teeth:

1. This procedure does not require prior authorization.
2. Radiographs for payment- Refer to Restorative General Policies for specific requirements.
3. Requires a tooth code and surface code.
4. A benefit once in a 36 month period.
5. Each unique tooth surface is only payable once per tooth per date of service.

PROCEDURE D2332**RESIN-BASED COMPOSITE – THREE SURFACES, ANTERIOR**

See the criteria under Procedure D2331.

PROCEDURE D2335**RESIN-BASED COMPOSITE – FOUR OR MORE SURFACES OR INVOLVING INCISAL ANGLE (ANTERIOR)**

See the criteria under Procedure D2331.

PROCEDURE D2390**RESIN-BASED COMPOSITE CROWN, ANTERIOR**Primary teeth:

1. This procedure does not require prior authorization.
2. Radiographs for payment- refer to Restorative General Policies for specific requirements.
3. Requires a tooth code.
4. At least four surfaces shall be involved.
5. A benefit once in a 12 month period.

Permanent teeth:

1. This procedure does not require prior authorization.
2. Radiographs for payment – refer to Restorative General Policies for specific requirements.
3. Requires a tooth code.
4. At least four surfaces shall be involved.
5. A benefit once in a 36 month period.

PROCEDURE D2391**RESIN-BASED COMPOSITE – ONE SURFACE, POSTERIOR**Primary teeth:

1. This procedure does not require prior authorization.
2. Radiographs for payment- refer to Restorative General Policies for specific requirements.
3. Requires a tooth code and surface code.
4. A benefit once in a 12 month period.

Permanent teeth:

1. This procedure does not require prior authorization.
2. Radiographs for payment- Refer to Restorative General Policies for specific requirements.
3. Requires a tooth code and surface code.
4. A benefit once in a 36 month period.

PROCEDURE D2392**RESIN-BASED COMPOSITE – TWO SURFACES, POSTERIOR**

See the criteria under Procedure D2391.

PROCEDURE D2393**RESIN-BASED COMPOSITE – THREE SURFACES, POSTERIOR**

See the criteria under Procedure D2391.

PROCEDURE D2394**RESIN-BASED COMPOSITE – FOUR OR MORE SURFACES, POSTERIOR**

See the criteria under Procedure D2391.

PROCEDURE D2410**GOLD FOIL – ONE SURFACE**

This procedure is not a benefit.

PROCEDURE D2420**GOLD FOIL – TWO SURFACES**

This procedure is not a benefit.

PROCEDURE D2430
GOLD FOIL – THREE SURFACES

This procedure is not a benefit.

PROCEDURE D2510
INLAY – METALLIC – ONE SURFACE

This procedure is not a benefit.

PROCEDURE D2520
INLAY – METALLIC – TWO SURFACES

This procedure is not a benefit.

PROCEDURE D2530
INLAY – METALLIC – THREE OR MORE SURFACES

This procedure is not a benefit.

PROCEDURE D2542
ONLAY – METALLIC – TWO SURFACES

This procedure is not a benefit.

PROCEDURE D2543
ONLAY – METALLIC – THREE SURFACES

This procedure is not a benefit.

PROCEDURE D2544
ONLAY – METALLIC – FOUR OR MORE SURFACES

This procedure is not a benefit.

PROCEDURE D2610
INLAY – PORCELAIN/CERAMIC – ONE SURFACE

This procedure is not a benefit.

PROCEDURE D2620
INLAY – PORCELAIN/CERAMIC – TWO SURFACES

This procedure is not a benefit.

PROCEDURE D2630
INLAY – PORCELAIN/CERAMIC – THREE OR MORE SURFACES

This procedure is not a benefit.

PROCEDURE D2642
ONLAY – PORCELAIN/CERAMIC – TWO SURFACES

This procedure is not a benefit.

PROCEDURE D2643**ONLAY – PORCELAIN/CERAMIC – THREE SURFACES**

This procedure is not a benefit.

PROCEDURE D2644**ONLAY – PORCELAIN/CERAMIC – FOUR OR MORE SURFACES**

This procedure is not a benefit.

PROCEDURE D2650**INLAY – RESIN-BASED COMPOSITE – ONE SURFACE**

This procedure is not a benefit.

PROCEDURE D2651**INLAY – RESIN-BASED COMPOSITE – TWO SURFACES**

This procedure is not a benefit.

PROCEDURE D2652**INLAY – RESIN-BASED COMPOSITE – THREE OR MORE SURFACES**

This procedure is not a benefit.

PROCEDURE D2662**ONLAY – RESIN BASED COMPOSITE – TWO SURFACES**

This procedure is not a benefit.

PROCEDURE D2663**ONLAY – RESIN-BASED COMPOSITE – THREE SURFACES**

This procedure is not a benefit.

PROCEDURE D2664**ONLAY – RESIN-BASED COMPOSITE – FOUR OR MORE SURFACES**

This procedure is not a benefit.

PROCEDURE D2710**CROWN – RESIN-BASED COMPOSITE (INDIRECT)**

Permanent anterior teeth and permanent posterior teeth (ages 13 or older)

1. Prior authorization is required.
2. Radiographs for prior authorization – submit arch and periapical radiographs.
3. Requires a tooth code.
4. A benefit:
 - a. once in a five-year period.
 - b. for any resin based composite crown that is indirectly fabricated.

5. Not a benefit:
 - a. for patients under the age of 13.
 - b. for third molars, unless the third molar occupies the first or second molar position or is an abutment for an existing removable partial denture.
 - c. for use as a temporary crown.

PROCEDURE D2712**CROWN – 3/4 RESIN-BASED COMPOSITE (INDIRECT)**

Permanent anterior teeth and permanent posterior teeth (ages 13 or older):

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs.
3. Requires a tooth code.
4. A benefit:
 - a. once in a five-year period.
 - b. for any resin based composite crown that is indirectly fabricated.
5. Not a benefit:
 - a. for patients under the age of 13.
 - b. for third molars, unless the third molar occupies the first or second molar position or is an abutment for an existing removable partial denture.
 - c. for use as a temporary crown

PROCEDURE D2720**CROWN – RESIN WITH HIGH NOBLE METAL**

This procedure is not a benefit.

PROCEDURE D2721**CROWN – RESIN WITH PREDOMINANTLY BASE METAL**

Permanent anterior teeth and permanent posterior teeth (ages 13 or older):

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs.
3. Requires a tooth code.
4. A benefit once in a five-year period.
5. Not a benefit:
 - a. for patients under the age of 13.
 - b. for third molars, unless the third molar occupies the first or second molar position or is an abutment for an existing removable partial denture.

PROCEDURE D2722**CROWN – RESIN WITH NOBLE METAL**

This procedure is not a benefit.

PROCEDURE D2740**CROWN – PORCELAIN / CERAMIC**

Permanent anterior teeth and permanent posterior teeth (ages 13 or older):

1. Prior authorization is required.
2. Radiographs for prior authorization – submit arch and periapical radiographs.
3. Requires a tooth code.
4. A benefit once in a five-year period.
5. Not a benefit:
 - a. for patients under the age of 13.
 - b. for third molars, unless the third molar occupies the first or second molar position or is an abutment for an existing removable partial denture.

PROCEDURE D2750**CROWN – PORCELAIN FUSED TO HIGH NOBLE METAL**

This procedure is not a benefit.

PROCEDURE D2751**CROWN – PORCELAIN FUSED TO PREDOMINANTLY BASE METAL**

Permanent anterior teeth and permanent posterior teeth (ages 13 or older):

1. Prior authorization is required.
2. Radiographs for prior authorization – submit arch and periapical radiographs.
3. Requires a tooth code.
4. A benefit once in a five-year period.
5. Not a benefit:
 - a. for members under the age of 13.
 - b. for third molars, unless the third molar occupies the first or second molar position or is an abutment for an existing removable partial denture.

PROCEDURE D2752**CROWN – PORCELAIN FUSED TO NOBLE METAL**

This procedure is not a benefit.

PROCEDURE D2753**CROWN – PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS**

This procedure is not a benefit.

PROCEDURE D2780**CROWN – 3/4 CAST HIGH NOBLE METAL**

This procedure is not a benefit.

PROCEDURE D2781**CROWN – 3/4 CAST PREDOMINANTLY BASE METAL**

Permanent anterior teeth and permanent posterior teeth (ages 13 or older):

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs.
3. Requires a tooth code.
4. A benefit once in a five-year period.
5. Not a benefit:
 - a. for patients under the age of 13.
 - b. for third molars, unless the third molar occupies the first or second molar position or is an abutment for an existing removable partial denture.

PROCEDURE D2782**CROWN – 3/4 CAST NOBLE METAL**

This procedure is not a benefit.

PROCEDURE D2783**CROWN – 3/4 PORCELAIN / CERAMIC**

Permanent anterior teeth and permanent posterior teeth (ages 13 or older):

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs.
3. Requires a tooth code.
4. A benefit once in a five-year period.
5. Not a benefit:
 - a. for patients under the age of 13.
 - b. for third molars, unless the third molar occupies the first or second molar position or is an abutment for an existing removable partial denture.

PROCEDURE D2790**CROWN – FULL CAST HIGH NOBLE METAL**

This procedure is not a benefit.

PROCEDURE D2791**CROWN – FULL CAST PREDOMINANTLY BASE METAL**

Permanent anterior teeth and permanent posterior teeth (ages 13 or older):

1. Prior authorization is required.

2. Radiographs for prior authorization - submit arch and periapical radiographs.
3. Requires a tooth code.
4. A benefit once in a five-year period.
5. Not a benefit:
 - a. for patients under the age of 13.
 - b. for third molars, unless the third molar occupies the first or second molar position or is an abutment for an existing removable partial denture.

PROCEDURE D2792**CROWN – FULL CAST NOBLE METAL**

This procedure is not a benefit.

PROCEDURE D2794**CROWN – TITANIUM AND TITANIUM ALLOYS**

This procedure is not a benefit.

PROCEDURE D2799**INTERIM CROWN – FURTHER TREATMENT OR COMPLETION OF DIAGNOSIS
NECESSARY PRIOR TO FINAL IMPRESSION**

This procedure is not a benefit.

PROCEDURE D2910**RE-CEMENT OR RE-BOND INLAY, ONLAY, VENEER OR PARTIAL COVERAGE
RESTORATION**

1. This procedure does not require prior authorization.
2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
3. Requires a tooth code.
4. A benefit once in a 12-month period, per provider.

PROCEDURE D2915**RE-CEMENT OR RE-BOND INDIRECTLY FABRICATED OR PREFABRICATED POST AND
CORE**

This procedure is to be performed in conjunction with the re-cementation of an existing crown or of a new crown and is not payable separately.

PROCEDURE D2920**RE-CEMENT OR RE-BOND CROWN**

1. This procedure does not require prior authorization.
2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.

3. Requires a tooth code.
4. The original provider is responsible for all re-cementations within the first 12 months following the initial placement of prefabricated or laboratory processed crowns.
5. Not a benefit within 12 months of a previous re-cementation by the same provider.

PROCEDURE D2921**REATTACHMENT OF TOOTH FRAGMENT, INCISAL EDGE OR CUSP**

This procedure is not a benefit.

PROCEDURE D2928**PREFABRICATED PORCELAIN/CERAMIC CROWN – PERMANENT TOOTH**

This procedure is not a benefit.

PROCEDURE D2929**PREFABRICATED PORCELAIN/CERAMIC CROWN – PRIMARY TOOTH**

This procedure is not a benefit.

PROCEDURE D2930**PREFABRICATED STAINLESS STEEL CROWN – PRIMARY TOOTH**

1. This procedure does not require prior authorization.
2. Radiographs for payment- refer to Restorative General Policies for specific requirements.
3. Requires a tooth code.
4. A benefit once in a 12 month period.

PROCEDURE D2931**PREFABRICATED STAINLESS STEEL CROWN – PERMANENT TOOTH**

1. This procedure does not require prior authorization.
2. Radiographs for payment – refer to Restorative General Policies for specific requirements.
3. Requires a tooth code.
4. A benefit once in a 36 month period.
5. Not a benefit for third molars, unless the third molar occupies the first or second molar position.

PROCEDURE D2932**PREFABRICATED RESIN CROWN**

Primary teeth:

1. This procedure does not require prior authorization.
2. Radiographs for payment-refer to Restorative General Policies for specific requirements.
3. Requires a tooth code.
4. A benefit once in a 12 month period.

Permanent teeth:

1. This procedure does not require prior authorization.
2. Radiographs for payment-refer to Restorative General Policies for specific requirements.
3. Requires a tooth code.
4. A benefit once in a 36 month period.
5. Not a benefit for third molars, unless the third molar occupies the first or second molar position.

PROCEDURE D2933**PREFABRICATED STAINLESS STEEL CROWN WITH RESIN WINDOW**Primary teeth:

1. This procedure does not require prior authorization.
2. Radiographs for payment-refer to Restorative General Policies for specific requirements.
3. Requires a tooth code.
4. A benefit once in a 12 month period.
5. This procedure includes the placement of a resin-based composite.

Permanent teeth:

1. This procedure does not require prior authorization.
2. Radiographs for payment- refer to Restorative General Policies for specific requirements.
3. Requires a tooth code.
4. A benefit once in a 36 month period.
5. Not a benefit for third molars, unless the third molar occupies the first or second molar position.
6. This procedure includes the placement of a resin-based composite.

PROCEDURE D2934**PREFABRICATED ESTHETIC COATED STAINLESS STEEL CROWN – PRIMARY TOOTH**

This procedure is not a benefit.

PROCEDURE D2940 PLACEMENT OF INTERIM DIRECT RESTORATION

1. This procedure cannot be prior authorized.
2. Radiographs for payment – submit pre-operative radiographs. Refer to Restorative General Policies for specific requirements.
3. Requires a tooth code.
4. A benefit once per tooth per lifetime.

5. Not a benefit:
 - a. when performed on the same date of service with a permanent restoration or crown, for same tooth.
 - b. on root canal treated teeth.
6. This procedure is for a temporary restoration and is not to be used as a base or liner under a restoration.

PROCEDURE D2949**RESTORATIVE FOUNDATION FOR AN INDIRECT RESTORATION**

This procedure is included in the fee for restorative procedures and is not payable separately.

PROCEDURE D2950**CORE BUILDUP, INCLUDING ANY PINS WHEN REQUIRED**

This procedure is included in the fee for restorative procedures and is not payable separately.

PROCEDURE D2951**PIN RETENTION – PER TOOTH, IN ADDITION TO RESTORATION**

1. This procedure does not require prior authorization.
2. Radiographs for payment- submit pre-operative radiographs.
3. Requires a tooth code.
4. A benefit:
 - a. for permanent teeth only.
 - b. when billed with an amalgam or composite restoration on the same date of service.
 - c. once per tooth regardless of the number of pins placed.

- d. for a posterior restoration when the destruction involves three or more connected surfaces and at least one cusp, or
- e. for an anterior restoration when extensive coronal destruction involves the incisal angle.

PROCEDURE D2952**POST AND CORE IN ADDITION TO CROWN, INDIRECTLY FABRICATED**

1. This procedure does not require prior authorization.
2. Radiographs for payment- submit arch and periapical radiographs.
3. Requires a tooth code.
4. A benefit:
 - a. once per tooth regardless of number of posts placed.
 - b. only in conjunction with allowable crowns (prefabricated or laboratory processed) on root canal treated permanent teeth.
5. This procedure shall be submitted on the same claim/TAR as the crown request.

PROCEDURE D2953**EACH ADDITIONAL INDIRECTLY FABRICATED POST – SAME TOOTH**

This procedure is to be performed in conjunction with D2952 and is not payable separately.

PROCEDURE D2954**PREFABRICATED POST AND CORE IN ADDITION TO CROWN**

1. This procedure does not require prior authorization.
2. Radiographs for payment – submit arch and periapical radiographs.
3. Requires a tooth code.
4. A benefit:
 - a. once per tooth regardless of number of posts placed.
 - b. only in conjunction with allowable crowns (prefabricated or laboratory processed) on root canal treated permanent teeth.
5. This procedure shall be submitted on the same claim/TAR as the crown request.

PROCEDURE D2955**POST REMOVAL**

This procedure is included in the fee for endodontic and restorative procedures and is not payable separately.

PROCEDURE D2956**REMOVAL OF AN INDIRECT RESTORATION ON A NATURAL TOOTH**

Global

PROCEDURE D2957**EACH ADDITIONAL PREFABRICATED POST – SAME TOOTH**

This procedure is to be performed in conjunction with D2954 and is not payable separately.

PROCEDURE D2960**LABIAL VENEER (RESIN LAMINATE) – DIRECT**

This procedure is not a benefit.

PROCEDURE D2961**LABIAL VENEER (RESIN LAMINATE) – INDIRECT**

This procedure is not a benefit.

PROCEDURE D2962**LABIAL VENEER (PORCELAIN LAMINATE) – INDIRECT**

This procedure is not a benefit.

PROCEDURE D2971**ADDITIONAL PROCEDURES TO CUSTOMIZE CROWN TO FIT UNDER AN EXISTING PARTIAL DENTURE FRAMEWORK**

This procedure is included in the fee for laboratory processed crowns and is not payable separately.

PROCEDURE D2975**COPING**

This procedure is not a benefit.

PROCEDURE D2976**BAND STABILIZATION – PER TOOTH**

This procedure is not a benefit.

PROCEDURE D2980**CROWN REPAIR NECESSITATED BY RESTORATIVE MATERIAL FAILURE**

1. This procedure does not require prior authorization.
2. Radiographs for payment - submit a pre-operative periapical radiograph.
3. Photographs for payment - submit a pre-operative photograph.
4. Written documentation for payment – shall describe the specific conditions addressed by the procedure (such as broken porcelain).
5. Requires a tooth code.
6. A benefit for laboratory processed crowns on permanent teeth.
7. Not a benefit within 12 months of initial crown placement or previous repair for the same provider.

PROCEDURE D2981**INLAY REPAIR NECESSITATED BY RESTORATIVE MATERIAL FAILURE**

This procedure is not a benefit.

PROCEDURE D2982**ONLAY REPAIR NECESSITATED BY RESTORATIVE MATERIAL FAILURE**

This procedure is not a benefit.

PROCEDURE D2983**VENEER REPAIR NECESSITATED BY RESTORATIVE MATERIAL FAILURE**

This procedure is not a benefit.

PROCEDURE D2989**EXCAVATION OF A TOOTH RESULTING IN THE DETERMINATION OF NON-RESTORABILITY**

Global

PROCEDURE D2991**APPLICATION OF HYDROXYAPATITE REGENERATION MEDICAMENT – PER TOOTH**

This procedure is not a benefit.

PROCEDURE D2990**RESIN INFILTRATION OF INCIPIENT SMOOTH SURFACE LESIONS**

This procedure is not a benefit.

PROCEDURE D2999**UNSPECIFIED RESTORATIVE PROCEDURE, BY REPORT**

1. This procedure does not require prior authorization.
2. Radiographs for payment – submit radiographs as applicable for the type of procedure.
3. Photographs for payment – submit photographs as applicable for the type of procedure.
4. Written documentation for payment – shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed or actual treatment.
5. Requires a tooth code.
6. Procedure D2999 shall be used:
 - a. for a procedure which is not adequately described by a CDT code, or
 - b. for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the medical condition and the specific CDT code associated with the treatment.

Endodontic General Policies (D3000–D3999)

- a) Prior authorization with current periapical radiographs is required for patients age 21 or older and not required for patients under the age of 21 for initial root canal therapy (D3310, D3320 and D3330). Prior authorization is required for all ages for partial pulpotomy for apexogenesis (D3222), apexification/recalcification (D3351), apicoectomy (D3410, D3421, D3425 and D3426) and periradicular surgery without apicoectomy (D3427) on permanent teeth.
- b) Prior authorization for root canal therapy (D3310, D3320 and D3330) is not required when it is documented on a claim for payment that the permanent tooth has been accidentally avulsed or there has been a fracture of the crown exposing vital pulpal tissue. Preoperative radiographs (arch and periapicals) shall be submitted for payment.
- c) Root canal therapy (D3310, D3320, D3330, D3346, D3347 and D3348) is a benefit for permanent teeth and over-retained primary teeth with no permanent successor, if medically necessary. It is medically necessary when the tooth is non-vital (due to necrosis, gangrene or death of the pulp) or if the pulp has been compromised by caries, trauma or accident that may lead to the death of the pulp.
- d) The prognosis of the affected tooth and other remaining teeth shall be evaluated in considering endodontic procedures for prior authorization and payment. Endodontic procedures are not a benefit when the prognosis of the tooth is questionable (due to non-restorability or periodontal involvement).
- e) Endodontic procedures are not a benefit when extraction is appropriate for a tooth due to non-restorability, periodontal involvement or for a tooth that is easily replaced by an addition to an existing or proposed prosthesis in the same arch.
- f) Endodontic procedures are not a benefit for third molars, unless the third molar occupies the first or second molar positions or is an abutment for an existing fixed or removable partial denture with cast clasps or rests.
- g) The fee for endodontic procedures includes all treatment and post treatment radiographs, any temporary restorations and/or occlusal seals, medicated treatments, bacteriologic studies, pulp vitality tests, removal of root canal obstructions (such as posts, silver points, old root canal filling material, broken root canal files and broaches and calcifications), internal root repairs of perforation defects and routine postoperative care within 30 days.
- h) Endodontic procedures shall be completed prior to payment. The date of service on the payment request shall reflect the final treatment date. A post treatment radiograph is not required for payment.
- i) Satisfactory completion of endodontic procedures is required prior to requesting the final restoration.

Endodontic Procedures (D3000–D3999)

PROCEDURE D3110

PULP CAP – DIRECT (EXCLUDING FINAL RESTORATION)

This procedure is included in the fees for restorative and endodontic procedures and is not payable separately.

PROCEDURE D3120

PULP CAP – INDIRECT (EXCLUDING FINAL RESTORATION)

This procedure is included in the fees for restorative and endodontic procedures and is not payable separately.

PROCEDURE D3220

THERAPEUTIC PULPOTOMY (EXCLUDING FINAL RESTORATION) – REMOVAL OF PULP CORONAL TO THE DENTINOCEMENTAL JUNCTION AND APPLICATION OF MEDICAMENT

1. This procedure does not require prior authorization.
2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
3. Requires a tooth code.
4. A benefit once per primary tooth.
5. Not a benefit:
 - a. for a primary tooth near exfoliation.
 - b. for a primary tooth with a necrotic pulp or a periapical lesion.
 - c. for a primary tooth that is non-restorable.
 - d. for a permanent tooth.
6. This procedure is for the surgical removal of the entire portion of the pulp coronal to the dentinocemental junction with the aim of maintaining the vitality of the remaining radicular portion by means of an adequate dressing.

PROCEDURE D3221

PULPAL DEBRIDEMENT, PRIMARY AND PERMANENT TEETH

1. This procedure does not require prior authorization.
2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
3. Requires a tooth code.
4. A benefit:
 - a. for permanent teeth.
 - b. for over-retained primary teeth with no permanent successor.

- c. once per tooth.
- 5. Not a benefit on the same date of service with any additional services, same tooth.
- 6. This procedure is for the relief of acute pain prior to conventional root canal therapy and is not a benefit for root canal therapy visits. Subsequent emergency visits, if medically necessary, shall be billed as palliative treatment of dental pain – per-visit (D9110).

PROCEDURE D3222**PARTIAL PULPOTOMY FOR APEXOGENESIS – PERMANENT TOOTH WITH INCOMPLETE ROOT DEVELOPMENT**

- 1. Prior authorization is required.
- 2. Radiographs for prior authorization – submit periapical radiographs.
- 3. Requires a tooth code.
- 4. A benefit:
 - a. once per permanent tooth.
 - b. for patients under the age of 21.
- 5. Not a benefit:
 - a. for primary teeth.
 - b. for third molars, unless the third molar occupies the first or second molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
 - c. on the same date of service as any other endodontic procedures for the same tooth.
- 6. This procedure is for vital teeth only.

PROCEDURE D3230**PULPAL THERAPY (RESORBABLE FILLING) – ANTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION)**

- 1. This procedure does not require prior authorization.
- 2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
- 3. Requires a tooth code.
- 4. A benefit once per primary tooth.
- 5. Not a benefit:
 - a. for a primary tooth near exfoliation.
 - b. with a therapeutic pulpotomy (excluding final restoration) (D3220), same date of service, same tooth.
 - c. with pulpal debridement, primary and permanent teeth (D3221), same date of service, same tooth.

PROCEDURE D3240**PULPAL THERAPY (RESORBABLE FILLING) – POSTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION)**

1. This procedure does not require prior authorization.
2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
3. Requires a tooth code.
4. A benefit once per primary tooth.
5. Not a benefit:
 - a. for a primary tooth near exfoliation.
 - b. with a therapeutic pulpotomy (excluding final restoration) (D3220), same date of service, same tooth.
 - c. with pulpal debridement, primary and permanent teeth (D3221), same date of service, same tooth.

PROCEDURE D3310**ENDODONTIC THERAPY, ANTERIOR TOOTH (EXCLUDING FINAL RESTORATION)**

1. Prior authorization is not required for patients under the age of 21.
2. Prior authorization is required for patients age 21 or older.
3. Radiographs for prior authorization - submit arch and periapical radiographs.
4. Requires a tooth code.
5. A benefit once per tooth for initial root canal therapy treatment. For root canal therapy retreatment use retreatment of previous root canal therapy-anterior (D3346).
6. The fee for this procedure includes all treatment and post treatment radiographs, any temporary restoration and/or occlusal seal.

PROCEDURE D3320**ENDODONTIC THERAPY, PREMOLAR TOOTH (EXCLUDING FINAL RESTORATION)**

1. Prior authorization is not required for patients under the age of 21.
2. Prior authorization is required for patients age 21 or older.
3. Radiographs for prior authorization - submit arch and periapical radiographs.
4. Requires a tooth code.
5. A benefit once per tooth for initial root canal therapy treatment. For root canal therapy retreatment use retreatment of previous root canal therapy-premolar (D3347).
6. The fee for this procedure includes all treatment and post treatment radiographs, any temporary restoration and/or occlusal seal.

PROCEDURE D3330**ENDODONTIC THERAPY, MOLAR TOOTH (EXCLUDING FINAL RESTORATION)**

1. Prior authorization is not required for patients under the age of 21.
2. Prior authorization is required for patients age 21 or older.
3. Radiographs for prior authorization - submit arch and periapical radiographs.
4. Requires a tooth code.
5. A benefit once per tooth for initial root canal therapy treatment. For root canal therapy retreatment use retreatment of previous root canal therapy-molar (D3348).
6. Not a benefit for third molars, unless the third molar occupies the first or second molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
7. The fee for this procedure includes all treatment and post treatment radiographs, any temporary restoration and/or occlusal seal.

PROCEDURE D3331**TREATMENT OF ROOT CANAL OBSTRUCTION; NON-SURGICAL ACCESS**

This procedure is to be performed in conjunction with endodontic procedures and is not payable separately.

PROCEDURE D3332**INCOMPLETE ENDODONTIC THERAPY; INOPERABLE, UNRESTORABLE OR FRACTURED TOOTH**

Endodontic treatment is only payable upon successful completion of endodontic therapy.

PROCEDURE D3333**INTERNAL ROOT REPAIR OF PERFORATION DEFECTS**

This procedure is to be performed in conjunction with endodontic procedures and is not payable separately.

PROCEDURE D3346**RETREATMENT OF PREVIOUS ROOT CANAL THERAPY – ANTERIOR**

1. Prior authorization is not required.
2. Requires a tooth code.
3. Not a benefit to the original provider within 12 months of initial treatment.
4. The fee for this procedure includes all treatment and post treatment radiographs, any temporary restoration and/or occlusal seal.

PROCEDURE D3347**RETREATMENT OF PREVIOUS ROOT CANAL THERAPY – PREMOLAR**

1. Prior authorization is not required.
2. Requires a tooth code.

3. Not a benefit to the original provider within 12 months of initial treatment.
4. The fee for this procedure includes all treatment and post treatment radiographs, any temporary restoration and/or occlusal seal.

PROCEDURE D3348**RETREATMENT OF PREVIOUS ROOT CANAL THERAPY – MOLAR**

1. Prior authorization is not required.
2. Requires a tooth code.
3. Not a benefit:
 - a. to the original provider within 12 months of initial treatment.
 - b. for third molars, unless the third molar occupies the first or second molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
4. The fee for this procedure includes all treatment and post treatment radiographs, any temporary restoration and/or occlusal seal.

PROCEDURE D3351**APEXIFICATION/RECALCIFICATION – INITIAL VISIT (APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, ETC.)**

1. Prior authorization is required.
2. Radiographs for prior authorization - submit periapical radiographs.
3. Requires a tooth code.
4. A benefit:
 - a. once per permanent tooth.
 - b. for patients under the age of 21.
5. Not a benefit:
 - a. for primary teeth.
 - b. for third molars, unless the third molar occupies the first or second molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
 - c. on the same date of service as any other endodontic procedures for the same tooth.
6. This procedure includes initial opening of the tooth, performing a pulpectomy, preparation of canal spaces, placement of medications and all treatment and post treatment radiographs.
7. If an interim medication replacement is necessary, use apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.) (D3352).
8. Upon completion of apexification/recalcification, prior authorization for the final root canal therapy shall be submitted along with the post-treatment radiograph to demonstrate sufficient apical formation.

PROCEDURE D3352**APEXIFICATION/RECALCIFICATION – INTERIM MEDICATION REPLACEMENT**

1. Prior authorization is required for D3351, which shall be completed before D3352 is payable.
2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
3. Requires a tooth code.
4. A benefit:
 - a. only following apexification/recalcification- initial visit (apical closure/calcific repair of perforations, root resorption, etc.) (D3351).
 - b. once per permanent tooth.
 - c. for patients under the age of 21.
5. Not a benefit:
 - a. for primary teeth.
 - b. for third molars, unless the third molar occupies the first or second molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
 - c. on the same date of service as any other endodontic procedures for the same tooth.
6. This procedure includes reopening the tooth, placement of medications and all treatment and post treatment radiographs.
7. Upon completion of apexification/recalcification, prior authorization for the final root canal therapy shall be submitted along with the post treatment radiograph to demonstrate sufficient apical formation.

PROCEDURE D3353**APEXIFICATION/RECALCIFICATION – FINAL VISIT (INCLUDES COMPLETED ROOT CANAL THERAPY – APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, ETC.)**

This procedure is not a benefit. Upon completion of apexification/recalcification, prior authorization for the final root canal therapy shall be submitted along with the post treatment radiograph to demonstrate sufficient apical formation.

PROCEDURE D3355**PULPAL REGENERATION – INITIAL VISIT**

This procedure is not a benefit.

PROCEDURE D3356**PULPAL REGENERATION – INTERIM MEDICATION REPLACEMENT**

This procedure is not a benefit.

PROCEDURE D3357

PULPAL REGENERATION – COMPLETION OF TREATMENT

This procedure is not a benefit.

PROCEDURE D3410**APICOECTOMY – ANTERIOR**

1. Prior authorization is required.
2. Radiographs for prior authorization – submit arch and periapical radiographs demonstrating the medical necessity.
3. Written documentation for prior authorization – if the medical necessity is not evident on the radiographs, documentation shall include the rationale for treatment.
4. Requires a tooth code.
5. A benefit for permanent anterior teeth only.
6. Not a benefit:
 - a. to the original provider within 90 days of root canal therapy except when a medical necessity is documented.
 - b. to the original provider within 24 months of a prior apicoectomy.
 - c. when a periradicular surgery (D3427) has been performed on the same root.
7. The fee for this procedure includes the placement of retrograde filling material and all treatment and post treatment radiographs.

PROCEDURE D3421**APICOECTOMY – PREMOLAR (FIRST ROOT)**

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity.
3. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale and the identity of the root that requires treatment.
4. Requires a tooth code.
5. A benefit for permanent premolar teeth only.
6. Not a benefit:
 - a. to the original provider within 90 days of root canal therapy except when a medical necessity is documented.
 - b. to the original provider within 24 months of a prior apicoectomy, same root.
 - c. when a periradicular surgery (D3427) has been performed on the same root.
7. The fee for this procedure includes the placement of retrograde filling material and all treatment and post treatment radiographs.
8. If more than one root is treated, use apicoectomy- each additional root (D3426).

PROCEDURE D3425**APICOECTOMY – MOLAR (FIRST ROOT)**

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity.
3. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale and the identity of the root that requires treatment.
4. Requires a tooth code.
5. A benefit for permanent first and second molar teeth only.
6. Not a benefit:
 - a. to the original provider within 90 days of root canal therapy except when a medical necessity is documented.
 - b. to the original provider within 24 months of a prior apicoectomy, same root.
 - c. for third molars, unless the third molar occupies the first or second molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
 - d. when a periradicular surgery (D3427) has been performed on the same root.
7. The fee for this procedure includes the placement of retrograde filling material and all treatment and post treatment radiographs.
8. If more than one root is treated, use apicoectomy- each additional root (D3426).

PROCEDURE D3426**APICOECTOMY (EACH ADDITIONAL ROOT)**

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity.
3. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale and the identity of the root that requires treatment.
4. Requires a tooth code.
5. A benefit for permanent teeth only.
6. Not a benefit:
 - a. to the original provider within 90 days of root canal therapy except when a medical necessity is documented.
 - b. to the original provider within 24 months of a prior apicoectomy, same root.
 - c. for third molars, unless the third molar occupies the first or second molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.

- d. when a periradicular surgery (D3427) has been performed on the same root.
- 7. Only payable the same date of service as procedures D3421 or D3425.
- 8. The fee for this procedure includes the placement of retrograde filling material and all treatment and post treatment radiographs.

PROCEDURE D3428**BONE GRAFT IN CONJUNCTION WITH PERIRADICULAR SURGERY – PER TOOTH, SINGLE SITE**

This procedure is not a benefit.

PROCEDURE D3429**BONE GRAFT IN CONJUNCTION WITH PERIRADICULAR SURGERY – EACH ADDITIONAL CONTIGUOUS TOOTH IN THE SAME SURGICAL SITE**

This procedure is not a benefit.

PROCEDURE D3430**RETROGRADE FILLING – PER ROOT**

This procedure is to be performed in conjunction with endodontic procedures and is not payable separately.

PROCEDURE D3431**BIOLOGIC MATERIALS TO AID IN SOFT AND OSSEOUS TISSUE REGENERATION IN CONJUNCTION WITH PERIRADICULAR SURGERY**

This procedure is not a benefit.

PROCEDURE D3432**GUIDED TISSUE REGENERATION, RESORBABLE BARRIER, PER SITE, IN CONJUNCTION WITH PERIRADICULAR SURGERY**

This procedure is not a benefit.

PROCEDURE D3450**ROOT AMPUTATION – PER ROOT**

This procedure is not a benefit.

PROCEDURE D3460**ENDODONTIC ENDOSSEOUS IMPLANT**

This procedure is not a benefit.

PROCEDURE D3470**INTENTIONAL RE-IMPLANTATION (INCLUDING NECESSARY SPLINTING)**

This procedure is not a benefit.

PROCEDURE D3471**SURGICAL REPAIR OF ROOT RESORPTION – ANTERIOR**

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity.
3. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale for treatment.
4. Requires a tooth code.
5. A benefit for permanent teeth only.
6. Not a benefit:
 - a. to the original provider within 90 days of root canal therapy except when a medical necessity is documented.
 - b. to the original provider within 24 months of a prior surgery.
 - c. when an apicoectomy (D3410, D3421, D3425 and D3426) has been performed on the same root.
7. The fee for this procedure includes the placement of retrograde filling material and all treatment and post treatment radiographs.

PROCEDURE D3472**SURGICAL REPAIR OF ROOT RESORPTION – PREMOLAR**

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity.
3. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale for treatment.
4. Requires a tooth code.
5. A benefit for permanent teeth only.
6. Not a benefit:
 - a. to the original provider within 90 days of root canal therapy except when a medical necessity is documented.
 - b. to the original provider within 24 months of a prior surgery.
 - c. when an apicoectomy (D3410, D3421, D3425 and D3426) has been performed on the same root.
7. The fee for this procedure includes the placement of retrograde filling material and all treatment and post treatment radiographs.

PROCEDURE D3473**SURGICAL REPAIR OF ROOT RESORPTION – MOLAR**

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity.
3. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale for treatment.
4. Requires a tooth code.
5. A benefit for permanent teeth only.
6. Not a benefit:
 - a. to the original provider within 90 days of root canal therapy except when a medical necessity is documented.
 - b. to the original provider within 24 months of a prior surgery.
 - c. when an apicoectomy (D3410, D3421, D3425 and D3426) has been performed on the same root.
7. The fee for this procedure includes the placement of retrograde filling material and all treatment and post treatment radiographs.

PROCEDURE D3501**SURGICAL EXPOSURE OF ROOT SURFACE WITHOUT APICOECTOMY OR REPAIR OF ROOT RESORPTION – ANTERIOR**

This procedure is not a benefit.

PROCEDURE D3502**SURGICAL EXPOSURE OF ROOT SURFACE WITHOUT APICOECTOMY OR REPAIR OF ROOT RESORPTION – PREMOLAR**

This procedure is not a benefit.

PROCEDURE D3503**SURGICAL EXPOSURE OF ROOT SURFACE WITHOUT APICOECTOMY OR REPAIR OF ROOT RESORPTION – MOLAR**

This procedure is not a benefit.

PROCEDURE D3910**SURGICAL PROCEDURE FOR ISOLATION OF TOOTH WITH RUBBER DAM**

This procedure is included in the fees for restorative and endodontic procedures and is not payable separately.

PROCEDURE D3911**INTRAORIFICE BARRIER**

This procedure is included in the fees for endodontic procedures and is not payable separately.

PROCEDURE D3920**HEMISECTION (INCLUDING ANY ROOT REMOVAL), NOT INCLUDING ROOT CANAL THERAPY**

This procedure is not a benefit.

PROCEDURE D3921**DECORONATION OR SUBMERGENCE OF AN ERUPTED TOOTH**

1. Prior authorization is required.
2. Radiographs for prior authorization – submit a current, diagnostic, preoperative radiograph or panoramic radiograph depicting the entire tooth.
3. Written documentation for prior authorization – shall describe the specific conditions addressed by the procedure and the rationale demonstrating the medical necessity.
4. Requires a tooth code.

PROCEDURE D3950**CANAL PREPARATION AND FITTING OF PREFORMED DOWEL OR POST**

This procedure is not a benefit.

PROCEDURE D3999**UNSPECIFIED ENDODONTIC PROCEDURE, BY REPORT**

1. This procedure does not require prior authorization.
2. Radiographs for payment – submit arch and pre-operative periapical radiographs as applicable for the type of procedure.
3. Photographs for payment- submit as applicable for the type of procedure.
4. Written documentation for payment – shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the actual treatment.
5. Requires a tooth code.
6. Procedure D3999 shall be used:
 - a) for a procedure which is not adequately described by a CDT code, or
 - b) for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the medical condition and the specific CDT code associated with the treatment.

Periodontal General Policies (D4000–D4999)

- a) Periodontal procedures shall be a benefit for patients age 13 or older. Periodontal procedures shall be considered for patients under the age of 13 when unusual circumstances exist such as aggressive periodontitis and drug-induced hyperplasia and the medical necessity has been fully documented on the TAR.
- b) Prior authorization is required for all periodontal procedures except for unscheduled dressing change (by someone other than the treating dentist) (D4920), periodontal maintenance (D4910) and periodontal scaling and root planing procedures rendered to pregnant/postpartum members regardless of age, aid code and scope of benefits when “Pregnant” or “Postpartum” is documented.
- c) Current periapical radiographs of the involved areas and bitewing radiographs are required for periodontal scaling and root planing (D4341 and D4342) and osseous surgery (D4260 and D4261) for prior authorizations. However, providers may be exempt from providing radiographs for prior authorizations for CDT codes D4341 and D4342 (SRP) when deemed medically appropriate based on a patient’s medical condition, physical ability, or cognitive function. Providers may submit a TAR with documentation along with necessary photographs substantiating why radiographs of the patient are not possible.
- d) Photographs are required for gingivectomy or gingivoplasty (D4210 and D4211) for prior authorizations.
- e) Only teeth that qualify as diseased are to be considered in the count for the number of teeth to be treated in a particular quadrant. A qualifying tooth shall have bone loss, be restorable and have arch integrity and shall meet Medi-Cal Dental criteria for the requested procedure. Qualifying teeth include implants. Teeth shall not be counted as qualifying when they are indicated to be extracted. Full or partial quadrants are defined as follows:
 - i) a full quadrant is considered to have four or more qualifying diseased teeth,
 - ii) a partial quadrant is considered to have one, two, or three diseased teeth,
 - iii) third molars shall not be counted unless the third molar occupies the first or second molar position or is an abutment for an existing fixed or removable partial denture with cast clasps or rests.
- f) Tooth bounded spaces shall only be counted in conjunction with osseous surgeries (D4260 and D4261) that require a surgical flap. Each tooth bounded space shall only count as one tooth space regardless of the number of missing natural teeth in the space.
- g) Scaling and root planing (D4341 and D4342) are a benefit once per quadrant in a 24 month period. Patients shall exhibit radiographic evidence of bone loss.
- h) Gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261) are a benefit once per quadrant in a 36 month period and shall not be authorized until 30 days following scaling and root planing (D4341 and D4342) in the same quadrant. Patients shall exhibit radiographic evidence of moderate to severe bone loss to qualify for osseous surgery.

- i) Gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261) includes three months of post-operative care and any surgical re-entry for 36 months. Documentation of extraordinary circumstances and/or medical conditions will be given consideration on a case-by-case basis.
- j) Scaling and root planing (D4341 and D4342) can be authorized in conjunction with prophylaxis procedures (D1110 and D1120). However, payment shall not be made for any prophylaxis procedure if the prophylaxis is performed on the same date of service as the scaling and root planing.
- k) Gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261) includes frenulectomy (frenectomy or frenotomy) (D7961 and D7962), frenuloplasty (D7963) and/or distal wedge performed in the same area on the same date of service.
- l) Procedures involved in acquiring graft tissues (hard or soft) from extra-oral donor sites are considered part of the fee for osseous surgery (D4260 and D4261) and are not payable separately.
- m) Gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261) performed in conjunction with a laboratory crown, prefabricated crown, amalgam or resin-based composite restoration or endodontic therapy is included in the fee for the final restoration or endodontic therapy and is not payable separately.
- n) The criteria for periodontal procedures shall apply to all dental provider billing types providing services within their scope of practice.
- o) All licensed dental hygienists must refer all patients they treat to a Medi-Cal dentist the dental hygienist has a referral agreement with, or to a dentist by submitting a referral to the patient's dental care coordination team within Medi-Cal.

Periodontal Procedures (D4000–D4999)

PROCEDURE D4210

GINGIVECTOMY OR GINGIVOPLASTY – FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT

1. Prior authorization is required.
2. Photographs for prior authorization- submit photographs of the involved areas.
3. Requires a quadrant code.
4. If three or fewer diseased teeth are present in the quadrant, use gingivectomy or gingivoplasty (D4211).
5. A benefit:
 - a. for patients age 13 or older.
 - b. once per quadrant every 36 months.
6. This procedure cannot be prior authorized within 30 days following periodontal scaling and root planing (D4341 and D4342) for the same quadrant.

PROCEDURE D4211

GINGIVECTOMY OR GINGIVOPLASTY – ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT

1. Prior authorization is required.
2. Photographs for prior authorization- submit photographs of the involved areas.
3. Requires a quadrant code.
4. If four or more diseased teeth are present in the quadrant, use gingivectomy or gingivoplasty (D4210).
5. A benefit:
 - a. for patients age 13 or older.
 - b. once per quadrant every 36 months.
6. This procedure cannot be prior authorized within 30 days following periodontal scaling and root planing (D4341 and D4342) for the same quadrant.

PROCEDURE D4212

GINGIVECTOMY OR GINGIVOPLASTY TO ALLOW ACCESS FOR RESTORATIVE PROCEDURE, PER TOOTH

This procedure is not a benefit.

PROCEDURE D4230

ANATOMICAL CROWN EXPOSURE – FOUR OR MORE CONTIGUOUS TEETH OR BOUNDED TOOTH SPACES PER QUADRANT

This procedure is not a benefit.

PROCEDURE D4231**ANATOMICAL CROWN EXPOSURE – ONE TO THREE TEETH OR BOUNDED TOOTH SPACES PER QUADRANT**

This procedure is not a benefit.

PROCEDURE D4240**GINGIVAL FLAP PROCEDURE, INCLUDING ROOT PLANING – FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT**

This procedure is not a benefit.

PROCEDURE D4241**GINGIVAL FLAP PROCEDURE, INCLUDING ROOT PLANING – ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES, PER QUADRANT**

This procedure is not a benefit.

PROCEDURE D4245**APICALLY POSITIONED FLAP**

This procedure is not a benefit.

PROCEDURE D4249**CLINICAL CROWN LENGTHENING – HARD TISSUE**

This procedure is included in the fee for a completed restorative service.

PROCEDURE D4260**OSSEOUS SURGERY (INCLUDING ELEVATION OF A FULL THICKNESS FLAP AND CLOSURE) – FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT**

1. Prior authorization is required.
2. Radiographs for prior authorization- submit periapical radiographs of the involved areas and bitewing radiographs.
3. Requires a quadrant code.
4. If three or fewer diseased teeth are present in the quadrant, use osseous surgery (D4261).
5. A benefit:
 - a. for patients age 13 or older.
 - b. once per quadrant every 36 months.
6. This procedure cannot be prior authorized within 30 days following periodontal scaling and root planing (D4341 and D4342) for the same quadrant.
7. This procedure can only be prior authorized when preceded by periodontal scaling and root planing (D4341 and D4342) in the same quadrant within the previous 24 months.

PROCEDURE D4261**OSSEOUS SURGERY (INCLUDING ELEVATION OF A FULL THICKNESS FLAP AND CLOSURE)- ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT**

1. Prior authorization is required.
2. Radiographs for prior authorization- submit periapical radiographs of the involved areas and bitewing radiographs.
3. Requires a quadrant code.
4. If four or more diseased teeth are present in the quadrant, use osseous surgery (D4260).
5. A benefit:
 - a. for patients age 13 or older.
 - b. once per quadrant every 36 months.
6. This procedure cannot be prior authorized within 30 days following periodontal scaling and root planing (D4341 and D4342) for the same quadrant.
7. This procedure can only be prior authorized when preceded by periodontal scaling and root planing (D4341 and D4342) in the same quadrant within the previous 24 months.

PROCEDURE D4263**BONE REPLACEMENT GRAFT – RETAINED NATURAL TOOTH – FIRST SITE IN QUADRANT**

This procedure is not a benefit.

PROCEDURE D4264**BONE REPLACEMENT GRAFT – RETAINED NATURAL TOOTH – EACH ADDITIONAL SITE IN QUADRANT**

This procedure is not a benefit.

PROCEDURE D4265**BIOLOGIC MATERIALS TO AID IN SOFT AND OSSEOUS TISSUE REGENERATION, PER SITE**

This procedure is included in the fees for other periodontal procedures and is not payable separately.

PROCEDURE D4266**GUIDED TISSUE REGENERATION, NATURAL TEETH – RESORBABLE BARRIER, PER SITE**

This procedure is not a benefit.

PROCEDURE D4267**GUIDED TISSUE REGENERATION, NATURAL TEETH – NONRESORBABLE BARRIER, PER SITE**

This procedure is not a benefit.

PROCEDURE D4268**SURGICAL REVISION PROCEDURE, PER TOOTH**

This procedure is not a benefit.

PROCEDURE D4270**PEDICLE SOFT TISSUE GRAFT PROCEDURE**

This procedure is not a benefit.

PROCEDURE D4273**AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE (INCLUDING DONOR AND RECIPIENT SURGICAL SITES) FIRST TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN GRAFT**

This procedure is not a benefit.

PROCEDURE D4274**MESIAL/DISTAL WEDGE PROCEDURE, SINGLE TOOTH (WHEN NOT PERFORMED IN CONJUNCTION WITH SURGICAL PROCEDURES IN THE SAME ANATOMICAL AREA)**

This procedure is not a benefit.

PROCEDURE D4275**NON-AUTOGENOUS CONNECTIVE TISSUE GRAFT (INCLUDING RECIPIENT SITE AND DONOR MATERIAL) FIRST TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN GRAFT**

This procedure is not a benefit.

PROCEDURE D4276**COMBINED CONNECTIVE TISSUE AND PEDICLE GRAFT, PER TOOTH**

This procedure is not a benefit.

PROCEDURE D4277**FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING RECIPIENT AND DONOR SURGICAL SITES) FIRST TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN GRAFT**

This procedure is not a benefit.

PROCEDURE D4278

FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING RECIPIENT AND DONOR SURGICAL SITES) EACH ADDITIONAL CONTIGUOUS TOOTH, IMPLANT, OR EDENTULOUS TOOTH POSITION IN SAME GRAFT SITE

This procedure is not a benefit.

PROCEDURE D4283

AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE (INCLUDING DONOR AND RECIPIENT SURGICAL SITES) - EACH ADDITIONAL CONTIGUOUS TOOTH, IMPLANT OR EDENTULOUS TOOTH POSITION IN SAME GRAFT SITE

This procedure is not a benefit.

PROCEDURE D4285

NON-AUTOGENOUS CONNECTIVE TISSUE GRAFT PROCEDURE (INCLUDING DONOR AND RECIPIENT SURGICAL SITES) – EACH ADDITIONAL CONTIGUOUS TOOTH, IMPLANT OR EDENTULOUS TOOTH POSITION IN SAME GRAFT SITE

This procedure is not a benefit.

PROCEDURE D4286

REMOVAL OF NON-RESORBABLE BARRIER

This procedure is not a benefit.

PROCEDURE D4322

SPLINT – INTRA-CORONAL; NATURAL TEETH OR PROSTHETIC CROWNS

This procedure is not a benefit.

PROCEDURE D4323

SPLINT – EXTRA-CORONAL; NATURAL TEETH OR PROSTHETIC CROWNS

This procedure is not a benefit.

PROCEDURE D4341

PERIODONTAL SCALING AND ROOT PLANING – FOUR OR MORE TEETH PER QUADRANT

1. Prior authorization is required.
2. Radiographs for prior authorization- submit periapical radiographs of the involved areas and bitewing radiographs. See radiograph exemption in Periodontal General Policies (D4000-D4999).
3. Requires a quadrant code.
4. If three or fewer diseased teeth are present in the quadrant, use periodontal scaling and root planing (D4342).
5. A benefit:
 - a. for patients age 13 or older.

- b. once per quadrant every 24 months.
- 6. Gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261) cannot be prior authorized within 30 days following this procedure for the same quadrant.
- 7. Prophylaxis (D1110 and D1120) are not payable on the same date of service as this procedure.

PROCEDURE D4342**PERIODONTAL SCALING AND ROOT PLANING – ONE TO THREE TEETH PER QUADRANT**

- 1. Prior authorization is required.
- 2. Radiographs for prior authorization – submit periapical radiographs of the involved areas and bitewing radiographs. See radiograph exemption in Periodontal General Policies (D4000–D4999)
- 3. Requires a quadrant code.
- 4. If four or more diseased teeth are present in the quadrant, use periodontal scaling and root planing (D4341).
- 5. A benefit:
 - a. for patients age 13 or older.
 - b. once per quadrant every 24 months.
- 6. Gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261) cannot be prior authorized within 30 days following this procedure for the same quadrant.
- 7. Prophylaxis (D1110 and D1120) are not payable on the same date of service as this procedure.

PROCEDURE D4346**SCALING IN PRESENCE OF GENERALIZED MODERATE OR SEVERE GINGIVAL INFLAMATION – FULL MOUTH, AFTER ORAL EVALUATION**

This procedure can only be billed as prophylaxis – adult (D1110) or prophylaxis – child (D1120) and is not payable separately.

PROCEDURE D4355**FULL MOUTH DEBRIDEMENT TO ENABLE A COMPREHENSIVE PERIODONTAL EVALUATION AND DIAGNOSIS ON A SUBSEQUENT VISIT**

- 1. This procedure does not require prior authorization.
- 2. A benefit:
 - a. only for patients residing in a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF).
 - b. once in a 12 month period.

3. Not a benefit:
 - a. on the same date of service as periodontal scaling and root planing (D4341 and D4342),
 - b. prophylaxis (D1110 and D1120) or perio maintenance (D4910).
 - c. within 24 months following the last periodontal scaling and root planing.
4. This procedure is considered a full mouth treatment.

PROCEDURE D4381**LOCALIZED DELIVERY OF ANTIMICROBIAL AGENTS VIA A CONTROLLED RELEASE VEHICLE INTO DISEASED CREVICULAR TISSUE, PER TOOTH**

This procedure is included in the fees for other periodontal procedures and is not payable separately.

PROCEDURE D4910**PERIODONTAL MAINTENANCE**

1. This procedure does not require prior authorization.
2. A benefit:
 - a. only when preceded by a periodontal scaling and root planing (D4341-D4342).
 - b. only after completion of all necessary scaling and root planings.
 - c. once in a calendar quarter.
 - d. only in the 24 month period following the last scaling and root planing.
3. Not a benefit in the same calendar quarter as scaling and root planing.
4. Not payable to the same provider in the same calendar quarter as prophylaxis – adult (D1110) or prophylaxis – child (D1120).
5. This procedure is considered a full mouth treatment.

PROCEDURE D4920**UNSCHEDULED DRESSING CHANGE (BY SOMEONE OTHER THAN TREATING DENTIST OR THEIR STAFF)**

1. This procedure cannot be prior authorized.
2. Written documentation for payment –shall include a brief description indicating the medical necessity.
3. A benefit:
 - a. for patients age 13 or older.
 - b. once per patient per provider.
 - c. within 30 days of the date of service of gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261).

4. Unscheduled dressing changes by the same provider are considered part of, and included in the fee for gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261).

PROCEDURE D4921**GINGIVAL IRRIGATION WITH MEDICINAL AGENT – PER QUADRANT**

This procedure is included in the fees for other periodontal procedures and is not payable separately.

PROCEDURE D4999**UNSPECIFIED PERIODONTAL PROCEDURE, BY REPORT**

1. Prior authorization is required.
2. Radiographs for prior authorization- submit as applicable for the type of procedure.
3. Photographs for prior authorization- shall be submitted.
4. Written documentation for prior authorization –shall include the specific treatment requested and etiology of the disease or condition.
5. Requires a tooth or quadrant code, as applicable for the type of procedure.
6. A benefit for patients age 13 or older.
7. Procedure D4999 shall be used:
 - a. for a procedure which is not adequately described by a CDT code, or
 - b. for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the medical condition and the specific CDT code associated with the treatment.

Prosthodontics (Removable) General Policies (D5000–D5899)

1. Complete and Partial Dentures (D5110-D5214, D5863 and D5865):

- a) Prior authorization is required for removable prostheses except for immediate dentures (D5130 and D5140) under certain circumstances. See the criteria for D5130 and D5140.
- b) Prior authorization shall be considered for a new prosthesis only when it is clearly evident that the existing prosthesis cannot be made serviceable by repair, replacement of broken and missing teeth or relines.
- c) Current radiographs of all remaining natural teeth and implants and a properly completed prosthetic Justification of Need for Prosthesis Form, DC054 (2/24) are required for prior authorization. A panoramic radiographic image shall be considered diagnostic for edentulous areas only.
- d) Complete and partial dentures are prior authorized only as full treatment plans. Payment shall be made only when the full treatment has been completed. Any revision of a prior authorized treatment plan requires a new TAR.
- e) New complete or partial dentures shall not be prior authorized when it would be highly improbable for a patient to utilize, care for or adapt to a new prosthesis due to psychological and/or motor deficiencies as determined by a clinical screening dentist (see “g” below).
- f) All endodontic, restorative and surgical procedures for teeth that impact the design of a removable partial denture (D5211, D5212, D5213 and D5214) shall be addressed before prior authorization is considered.
- g) The need for new or replacement prosthesis may be evaluated by a clinical screening dentist.
- h) Providers shall use the laboratory order date as the date of service when submitting for payment of a prior authorized removable prosthesis. The laboratory order date is the date when the prosthesis is sent to the laboratory for final fabrication. Full payment shall not be requested until the prosthesis is delivered and is in use by the patient.
- i) Partial payment of an undeliverable completed removable prosthesis shall be considered when the reason for non-delivery is adequately documented on the Notice of Authorization (NOA) and is accompanied by a laboratory invoice indicating the prosthesis was processed. The completed prosthesis shall be kept in the provider’s office, in a deliverable condition, for a period of at least one year.
- j) A removable prosthesis is a benefit only once in a five-year period. When adequately documented, the following exceptions must apply:
 - i) Circumstances beyond the control of the patient: For a patient that submits a request to replace the appliance based on circumstances beyond their control, those circumstances can be demonstrated by documentation of all of the following: (1) a demonstration of continued medical necessity; (2) an explanation of the circumstances surrounding the loss which clearly explains how the loss occurred and why the loss was beyond the control of the patient; and (3) a clear explanation of the remedial measures the patient will take to

safeguard against subsequent loss. Where loss from an activity wherein there was involvement from a fire department agency, law enforcement agency, or other governmental agency, documentation should include a copy of the official public service agency report, if such a report is relevant and available.

- ii) A need for a new prosthesis due to surgical or traumatic loss of oral-facial anatomic structure.
- iii) The removable prosthesis is no longer serviceable as determined by a clinical screening dentist.
- iv) Dentures no longer fit due to significant medical condition. Documentation from the patient's physician supporting the medical necessity of early replacement and a letter from the dentist stating that the existing denture cannot be made functional.
- v) A non-catastrophic loss or misplacement may be granted twice per lifetime. Documentation must include an explanation of preventive measures instituted to alleviate the need for further replacement. Additional requests, beyond the two lifetime exceptions shall be submitted as procedure code D5899 and will be considered on a case-by-case basis.
- k) Prosthodontic services provided solely for cosmetic purposes are not a benefit.
- l) Temporary or interim dentures to be used while a permanent denture is being constructed are not a benefit.
- m) Spare or backup dentures are not a benefit.
- n) Evaluation of a denture on a maintenance basis is not a benefit.
- o) The fee for any removable prosthesis, reline, tissue conditioning or repair includes all adjustments necessary for six months after the date of service by the same provider.
- p) Immediate dentures should only be considered for a patient when one or more of the following conditions exist:
 - i) extensive or rampant caries are exhibited in the radiographs,
 - ii) severe periodontal involvement is indicated in the radiographs,
 - iii) numerous teeth are missing resulting in diminished masticating ability adversely affecting the patient's health.
- q) There is no insertion fee payable to an oral surgeon who seats an immediate denture.
- r) Preventative, endodontic or restorative procedures are not a benefit for teeth to be retained for overdentures. Only extractions for the retained teeth will be a benefit.
- s) Partial dentures are not a benefit to replace missing third molars.

2. Relines and Tissue Conditioning (D5730-D5761, D5850 and D5851):

- a) Laboratory relines (D5750, D5751, D5760 and D5761) are a benefit six months after the date of service for immediate dentures (D5130 and D5140), and overdentures (D5863 and D5865) and cast metal partial dentures (D5213 and D5214) that **required** extractions.

- b) Laboratory relines (D5750, D5751, D5760 and D5761) are a benefit 12 months after the date of service for complete dentures (D5110 and D5120), overdentures (D5863 and D5865) and cast metal partial dentures (D5213 and D5214) that **did not require** extractions.
- c) Laboratory relines (D5760 and D5761) are not a benefit for resin based partial dentures (D5211 and D5212).
- d) Laboratory relines (D5750, D5751, D5760 and D5761) are not a benefit within 12 months of chairside relines (D5730, D5731, D5740 and D5741).
- e) Chairside relines (D5730, D5731, D5740 and D5741) are a benefit six months after the date of service for immediate dentures (D5130 and D5140), an immediate overdenture (D5863 and D5865), resin based partial dentures (D5211 and D5212) and cast metal partial dentures (D5213 and D5214) that **required** extractions.
- f) Chairside relines (D5730, D5731, D5740 and D5741) are a benefit 12 months after the date of service for complete (remote) dentures (D5110 and D5120), a complete (remote) overdenture (D5863 and D5865), resin based partial dentures (D5211 and D5212) and cast metal partial dentures (D5213 and D5214) that **did not require** extractions.
- g) Chairside relines (D5730, D5731, D5740 and D5741) are not a benefit within 12 months of laboratory relines (D5750, D5751, D5760 and D5761).
- h) Tissue conditioning (D5850 and D5851) is only a benefit to heal unhealthy ridges prior to a definitive prosthodontic treatment.
- i) Tissue conditioning (D5850 and D5851) is a benefit the same date of service as an immediate prosthesis that **required** extractions.

Prosthodontic (Removable) Procedures (D5000–D5899)

PROCEDURE D5110

COMPLETE DENTURE – MAXILLARY

1. Prior authorization is required.
2. Radiographs for prior authorization – submit radiographs of all opposing natural teeth.
3. A current and complete Justification of Need for Prosthesis Form, DC054 (2/24) is required for prior authorization.
4. A benefit once in a five-year period from a previous complete, immediate or overdenture – complete denture.
5. For an immediate denture, use immediate denture-maxillary (D5130) or overdenture – complete maxillary (D5863) as applicable for the type of procedure.
6. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
7. A laboratory reline (D5750) or chairside reline (D5730) is a benefit 12 months after the date of service for this procedure.

PROCEDURE D5120

COMPLETE DENTURE – MANDIBULAR

1. Prior authorization is required.
2. Radiographs for prior authorization – submit radiographs of all opposing natural teeth.
3. A current and complete Justification of Need for Prosthesis Form, DC054 (2/24) is required for prior authorization.
4. A benefit once in a five-year period from a previous complete, immediate or overdenture – complete denture.
5. For an immediate denture, use immediate denture-mandibular (D5140) or overdenture – complete mandibular (D5865) as applicable for the type of procedure.
6. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
7. A laboratory reline (D5751) or chairside reline (D5731) is a benefit 12 months after the date of service for this procedure.

PROCEDURE D5130

IMMEDIATE DENTURE – MAXILLARY

1. Prior authorization is not required except when the prosthesis on the opposing arch requires prior authorization.
2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
3. A benefit once per patient.

4. Not a benefit as a temporary denture. Subsequent complete dentures are not a benefit within a five-year period of an immediate denture.
5. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
6. A laboratory reline (D5750) or chairside reline (D5730) is a benefit six months after the date of service for this procedure.

PROCEDURE D5140**IMMEDIATE DENTURE – MANDIBULAR**

1. Prior authorization is not required except when the prosthesis on the opposing arch requires prior authorization.
2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
3. A benefit once per patient.
4. Not a benefit as a temporary denture. Subsequent complete dentures are not a benefit within a five-year period of an immediate denture.
5. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
6. A laboratory reline (D5751) or chairside reline (D5731) is a benefit six months after the date of service for this procedure.

PROCEDURE D5211**MAXILLARY PARTIAL DENTURE – RESIN BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH)**

1. Prior authorization is required.
2. Radiographs for prior authorization – submit radiographs of all remaining natural teeth and periapical radiographs of abutment teeth.
3. A current and complete Justification of Need For Prosthesis Form, DC054 (2/24) is required for prior authorization.
4. A benefit once in a five-year period.
5. A benefit when replacing a permanent anterior tooth/teeth and/or the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows:
 - a. five posterior permanent teeth are missing, (excluding third molars), or
 - b. all four first and second permanent molars are missing, or
 - c. the first and second permanent molars and second premolar are missing on the same side.
6. A benefit for under the age of 21 when replacing one or more permanent anterior, premolar or first molar tooth/teeth.
7. Not a benefit for replacing missing third molars.

8. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
9. Laboratory reline (D5760) is not a benefit for this procedure.
10. Chairside reline (D5740) is a benefit:
 - a. once in a 12 month period.
 - b. six months after the date of service for a partial denture that required extractions, or
 - c. 12 months after the date of service for a partial denture that did not require extractions.

PROCEDURE D5212**MANDIBULAR PARTIAL DENTURE – RESIN BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH)**

1. Prior authorization is required.
2. Radiographs for prior authorization – submit radiographs of all remaining natural teeth and periapical radiographs of abutment teeth.
3. A current and complete Justification of Need For Prosthesis Form, DC054 (2/24) is required for prior authorization.
4. A benefit once in a five-year period.
5. A benefit when replacing a permanent anterior tooth/teeth and/or the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows:
 - a. five posterior permanent teeth are missing, (excluding third molars), or
 - b. all four first and second permanent molars are missing, or
 - c. the first and second permanent molars and second bicuspid are missing on the same side.
6. A benefit for under the age of 21 when replacing one or more permanent anterior, bicuspid or first molar tooth/teeth.
7. Not a benefit for replacing missing third molars.
8. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
9. Laboratory reline (D5761) is not a benefit for this procedure.
10. Chairside reline (D5741) is a benefit:
 - a. once in a 12 month period.
 - b. six months after the date of service for a partial denture that required extractions, or
 - c. 12 months after the date of service for a partial denture that did not require extractions.

PROCEDURE D5213**MAXILLARY PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)**

1. Prior authorization is required.

2. Radiographs for prior authorization –submit radiographs of all remaining natural teeth and periapical radiographs of abutment teeth.
3. A current and complete Justification of Need for Prosthesis Form, DC054 (2/24) is required for prior authorization.
4. A benefit once in a five-year period.
5. A benefit when opposing a full denture and the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows:
 - a. five posterior permanent teeth are missing, (excluding third molars), or
 - b. all four first and second permanent molars are missing, or
 - c. the first and second permanent molars and second bicuspid are missing on the same side.
6. Not a benefit for replacing missing third molars.
7. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
8. Laboratory reline (D5760) is a benefit:
 - a. once in a 12 month period.
 - b. six months after the date of service for a cast partial denture that required extractions, or
 - c. 12 months after the date of service for a cast partial denture that did not require extractions.
9. Chairside reline (D5740) is a benefit:
 - a. once in a 12 month period.
 - b. six months after the date of service for a partial denture that required extractions, or
 - c. 12 months after the date of service for a partial denture that did not require extractions.

PROCEDURE D5214

MANDIBULAR PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)

1. Prior authorization is required.
2. Radiographs for prior authorization – submit radiographs of all remaining natural teeth and periapical radiographs of abutment teeth.
3. A current and complete Justification of Need for Prosthesis Form, DC054 (2/24) is required for prior authorization.
4. A benefit once in a five-year period.
5. A benefit when opposing a full denture and the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows:
 - a. five posterior permanent teeth are missing, (excluding third molars), or
 - b. all four first and second permanent molars are missing, or

- c. the first and second permanent molars and second bicuspid are missing on the same side.
- 6. Not a benefit for replacing missing third molars.
- 7. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
- 8. Laboratory reline (D5761) is a benefit:
 - a. once in a 12 month period.
 - b. six months after the date of service for a cast partial denture that required extractions, or
 - c. 12 months after the date of service for a cast partial denture that did not require extractions.
- 9. Chairside reline (D5741) is a benefit:
 - a. once in a 12 month period.
 - b. six months after the date of service for a partial denture that required extractions, or
 - c. 12 months after the date of service for a partial denture that did not require extractions.

PROCEDURE D5221**IMMEDIATE MAXILLARY PARTIAL DENTURE – RESIN BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)**

This procedure is not a benefit.

PROCEDURE D5222**IMMEDIATE MANDIBULAR PARTIAL DENTURE – RESIN BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)**

This procedure is not a benefit.

PROCEDURE D5223**IMMEDIATE MAXILLARY PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)**

This procedure is not a benefit.

PROCEDURE D5224**IMMEDIATE MANDIBULAR PARTIAL DENTURE –CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS AND TEETH)**

This procedure is not a benefit.

PROCEDURE D5225**MAXILLARY PARTIAL DENTURE – FLEXIBLE BASE (INCLUDING RETENTIVE/CLASPING MATERIALS RESTS, AND TEETH)**

This procedure is not a benefit.

PROCEDURE D5226**MANDIBULAR PARTIAL DENTURE – FLEXIBLE BASE (INCLUDING RETENTIVE/CLASPING MATERIALS RESTS, AND TEETH)**

This procedure is not a benefit.

PROCEDURE D5227**IMMEDIATE MAXILLARY PARTIAL DENTURE – FLEXIBLE BASE (INCLUDING ANY CLASPS, RESTS AND TEETH)**

This procedure is not a benefit.

PROCEDURE D5228**IMMEDIATE MANDIBULAR PARTIAL DENTURE – FLEXIBLE BASE (INCLUDING ANY CLASPS, RESTS AND TEETH)**

This procedure is not a benefit.

PROCEDURE D5282**REMOVABLE UNILATERAL PARTIAL DENTURE – ONE PIECE CAST METAL (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH), MAXILLARY**

This procedure is not a benefit.

PROCEDURE D5283**REMOVABLE UNILATERAL PARTIAL DENTURE – ONE PIECE CAST METAL (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH), MANDIBULAR**

This procedure is not a benefit.

PROCEDURE D5284**REMOVABLE UNILATERAL PARTIAL DENTURE – ONE PIECE FLEXIBLE BASE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH), PER QUADRANT**

This procedure is not a benefit.

PROCEDURE D5286**REMOVABLE UNILATERAL PARTIAL DENTURE – ONE PIECE RESIN (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH), – PER QUADRANT**

This procedure is not a benefit.

PROCEDURE D5410**ADJUST COMPLETE DENTURE – MAXILLARY**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
 - a. once per date of service provider.
 - b. twice in a 12 month period per provider.
3. Not a benefit:
 - a. same date of service or within six months of the date of service of a complete denture- maxillary (D5110), immediate denture-maxillary (D5130) or overdenture-complete maxillary (D5863).
 - b. same date of service or within six months of the date of service of a reline complete maxillary denture (chairside) (D5730), reline complete maxillary denture (laboratory) (D5750) and tissue conditioning, maxillary (D5850).
 - c. same date of service or within six months of the date of service of repair broken complete denture base, maxillary (D5512) and replace missing or broken teeth-complete denture (D5520).

PROCEDURE D5411**ADJUST COMPLETE DENTURE – MANDIBULAR**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
 - a. once per date of service per provider.
 - b. twice in a 12 month period per provider.
3. Not a benefit:
 - a. same date of service or within six months of the date of service of a complete denture-mandibular (D5120), immediate denture-mandibular (D5140) or overdenture-complete mandibular (D5865).
 - b. same date of service or within six months of the date of service of a reline complete mandibular denture (chairside) (D5731), reline complete mandibular denture (laboratory) (D5751) and tissue conditioning, mandibular (D5851).
 - c. same date of service or within six months of the date of service of repair broken complete denture base, mandibular (D5511) and replace missing or broken teeth-complete denture (D5520).

PROCEDURE D5421**ADJUST PARTIAL DENTURE – MAXILLARY**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.

2. A benefit:
 - a. once per date of service per provider.
 - b. twice in a 12 month period per provider.
3. Not a benefit:
 - a. same date of service or within six months of the date of service of a maxillary partial – resin base (D5211) or maxillary partial denture – cast metal framework with resin denture bases (D5213).
 - b. same date of service or within six months of the date of service of a reline maxillary partial denture (chairside) (D5740), reline maxillary partial denture (laboratory) (D5760) and tissue conditioning, maxillary (D5850).
 - c. same date of service or within six months of the date of service of repair resin partial denture base, maxillary (D5612), repair cast partial denture framework, maxillary (D5622), repair or replace broken clasp-per tooth (D5630), replace broken teeth – per tooth (D5640), add tooth to existing partial denture (D5650) and add clasp to existing partial denture – per tooth (D5660).

PROCEDURE D5422

ADJUST PARTIAL DENTURE – MANDIBULAR

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
 - a. once per date of service per provider.
 - b. twice in a 12 month period per provider.
3. Not a benefit:
 - a. same date of service or within six months of the date of service of a mandibular partial – resin base (D5212) or mandibular partial denture – cast metal framework with resin denture bases (D5214).
 - b. same date of service or within six months of the date of service of a reline mandibular partial denture (chairside) (D5741), reline mandibular partial denture (laboratory) (D5761) and tissue conditioning, mandibular (D5851).
 - c. same date of service or within six months of the date of service of repair resin partial denture base, mandibular (D5611), repair cast partial denture framework, mandibular (D5621), repair or replace broken clasp-per tooth (D5630), replace broken teeth – per tooth (D5640), add tooth to existing partial denture (D5650) and add clasp to existing partial denture – per tooth (D5660).

PROCEDURE D5511

REPAIR BROKEN COMPLETE DENTURE BASE, MANDIBULAR

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.

2. A benefit:
 - a. once per arch, per date of service per provider.
 - b. twice in a 12 month period per provider.
3. Not a benefit on the same date of service as reline complete mandibular denture (chairside) (D5731) and reline complete mandibular denture (laboratory) (D5751).
4. All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.

PROCEDURE D5512**REPAIR BROKEN COMPLETE DENTURE BASE, MAXILLARY**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
 - a. once per arch, per date of service per provider.
 - b. twice in a 12 month period per provider.
3. Not a benefit on the same date of service as reline complete maxillary denture (chairside) (D5730) and reline complete maxillary denture (laboratory) (D5750).
4. All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.

PROCEDURE D5520**REPLACE MISSING OR BROKEN TEETH – COMPLETE DENTURE (PER TOOTH)**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. Requires an arch code.
3. A benefit:
 - a. up to a maximum of four, per arch, per date of service per provider.
 - b. twice per arch, in a 12 month period per provider.
4. All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.

PROCEDURE D5611**REPAIR RESIN PARTIAL DENTURE BASE, MANDIBULAR**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
 - a. once per arch, per date of service per provider.
 - b. twice per arch, in a 12 month period per provider.
 - c. for partial dentures only.

3. Not a benefit same date of service as reline mandibular partial denture (chairside) (D5741) and reline mandibular partial denture (laboratory) (D5761).
4. All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.

PROCEDURE D5612**REPAIR RESIN PARTIAL DENTURE BASE, MAXILLARY**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
 - a. once per arch, per date of service per provider.
 - b. twice per arch, in a 12 month period per provider.
 - c. for partial dentures only.
3. Not a benefit same date of service as reline maxillary partial denture (chairside) (D5740) and reline maxillary partial denture (laboratory) (D5760).
4. All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.

PROCEDURE D5621**REPAIR CAST PARTIAL DENTURE FRAMEWORK, MANDIBULAR**

1. Requires a laboratory invoice for payment.
2. A benefit:
 - a. Once per arch, per date of service per provider.
 - b. Twice per arch, in a 12 month period per provider.
3. All adjustments made for six months after the date of repair, by the same provider and for the same arch, are included in the fee for this procedure.

PROCEDURE D5622**REPAIR CAST PARTIAL DENTURE FRAMEWORK, MAXILLARY**

1. Requires a laboratory invoice for payment.
2. A benefit:
 - a. Once per arch, per date of service per provider.
 - b. Twice per arch, in a 12 month period per provider.
3. All adjustments made for six months after the date of repair, by the same provider and for the same arch, are included in the fee for this procedure.

PROCEDURE D5630**REPAIR OR REPLACE BROKEN RETENTIVE/CLASPING MATERIALS PER TOOTH**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.

2. Requires an arch code.
3. A benefit:
 - a. up to a maximum of three, per date of service per provider.
 - b. twice per arch, in a 12 month period per provider.
4. All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.

PROCEDURE D5640**REPLACE MISSING OR BROKEN TEETH – PARTIAL DENTURE – PER TOOTH**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. Requires an arch code.
3. A benefit:
 - a. up to a maximum of four, per arch, per date of service per provider.
 - b. twice per arch, in a 12 month period per provider.
 - c. for partial dentures only.
4. All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.

PROCEDURE D5650**ADD TOOTH TO EXISTING PARTIAL DENTURE – PER TOOTH**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. Requires a tooth code.
3. A benefit:
 - a. for up to a maximum of three, per date of service per provider.
 - b. once per tooth.
4. Not a benefit for adding third molars.
5. All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.

PROCEDURE D5660**ADD CLASP TO EXISTING PARTIAL DENTURE – PER TOOTH**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. Requires an arch code.
3. A benefit:
 - a. for up to a maximum of three, per date of service per provider.

- b. twice per arch, in a 12 month period per provider.
- 4. All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.

PROCEDURE D5670**REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MAXILLARY)**

This procedure is not a benefit.

PROCEDURE D5671**REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MANDIBULAR)**

This procedure is not a benefit.

PROCEDURE D5710**REBASE COMPLETE MAXILLARY DENTURE**

This procedure is not a benefit.

PROCEDURE D5711**REBASE COMPLETE MANDIBULAR DENTURE**

This procedure is not a benefit.

PROCEDURE D5720**REBASE MAXILLARY PARTIAL DENTURE**

This procedure is not a benefit.

PROCEDURE D5721**REBASE MANDIBULAR PARTIAL DENTURE**

This procedure is not a benefit.

PROCEDURE D5725**REBASE HYBRID PROSTHESIS**

This procedure is not a benefit.

PROCEDURE D5730**RELINE COMPLETE MAXILLARY DENTURE (DIRECT)**

- 1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
- 2. A benefit:
 - a. once in a 12 month period.
 - b. six months after the date of service for an immediate denture – maxillary (D5130) or overdenture – complete maxillary (D5863) that required extractions, or
 - c. 12 months after the date of service for a complete denture – maxillary (D5110) or overdenture – complete maxillary (D5863) that did not require extractions.

3. Not a benefit within 12 months of a reline complete maxillary denture (laboratory) (D5750).
4. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

PROCEDURE D5731**RELINING COMPLETE MANDIBULAR DENTURE (DIRECT)**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
 - a. once in a 12 month period.
 - b. six months after the date of service for an immediate denture – mandibular (D5140) or overdenture – complete mandibular (D5865) that required extractions, or
 - c. 12 months after the date of service for a complete denture – mandibular (D5120) or overdenture complete mandibular (D5865) that did not require extractions.
3. Not a benefit within 12 months of a reline complete mandibular denture (laboratory) (D5751).
4. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

PROCEDURE D5740**RELINING MAXILLARY PARTIAL DENTURE (DIRECT)**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
 - a. once in a 12 month period.
 - b. six months after the date of service for maxillary partial denture – resin base (D5211) or maxillary partial denture – cast metal framework with resin denture bases (D5213) that required extractions.
 - c. 12 months after the date of service for maxillary partial denture – resin base (D5211) or maxillary partial denture – cast metal framework with resin denture bases (D5213) that did not require extractions.
3. Not a benefit within 12 months of a reline maxillary partial denture (laboratory) (D5760).
4. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

PROCEDURE D5741**RELINING MANDIBULAR PARTIAL DENTURE (DIRECT)**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.

2. A benefit:
 - a. once in a 12 month period.
 - b. six months after the date of service for mandibular partial denture – resin base (D5212) or mandibular partial denture – cast metal framework with resin denture bases (D5214) that required extractions, or
 - c. 12 months after the date of service for mandibular partial denture – resin base (D5212) or mandibular partial denture – cast metal framework with resin denture bases (D5214) that did not require extractions.
3. Not a benefit within 12 months of a reline mandibular partial denture (laboratory) (D5761).
4. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

PROCEDURE D5750**RELINING COMPLETE MAXILLARY DENTURE (INDIRECT)**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
 - a. once in a 12 month period.
 - b. six months after the date of service for an immediate denture – maxillary (D5130) or overdenture – complete maxillary (D5863) that required extractions, or
 - c. 12 months after the date of service for a complete denture – maxillary (D5110) or overdenture – complete maxillary (D5863) that did not require extractions.
3. Not a benefit within 12 months of a relining complete maxillary denture (chairside) (D5730).
4. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

PROCEDURE D5751**RELINING COMPLETE MANDIBULAR DENTURE (INDIRECT)**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
 - a. once in a 12 month period.
 - b. six months after the date of service for an immediate denture-mandibular (D5140) or overdenture – complete mandibular (D5865) that required extractions, or
 - c. 12 months after the date of service for a complete denture – mandibular (D5120) or overdenture – complete mandibular (D5865) that did not require extractions.
3. Not a benefit within 12 months of a relining complete mandibular denture (chairside) (D5731).

4. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

PROCEDURE D5760**RELINE MAXILLARY PARTIAL DENTURE (INDIRECT)**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
 - a. once in a 12 month period.
 - b. six months after the date of service for maxillary partial denture – cast metal framework with resin denture bases (D5213) that required extractions, or
 - c. 12 months after the date of service for maxillary partial denture – cast metal framework with resin denture bases (D5213) that did not require extractions.
3. Not a benefit:
 - a. within 12 months of a reline maxillary partial denture (chairside) (D5740).
 - b. for a maxillary partial denture – resin base (D5211).
4. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

PROCEDURE D5761**RELINE MANDIBULAR PARTIAL DENTURE (INDIRECT)**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
 - a. once in a 12 month period.
 - b. six months after the date of service for mandibular partial denture – cast metal framework with resin denture bases (D5214) that required extractions, or
 - c. 12 months after the date of service for mandibular partial denture – cast metal framework with resin denture bases (D5214) that did not require extractions.
3. Not a benefit:
 - a. within 12 months of a reline mandibular partial denture (chairside) (D5741).
 - b. for a mandibular partial denture – resin base (D5212).
4. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

PROCEDURE D5765**SOFT LINER FOR COMPLETE OR PARTIAL REMOVABLE DENTURE – INDIRECT**

This procedure is not a benefit.

PROCEDURE D5810**INTERIM COMPLETE DENTURE (MAXILLARY)**

This procedure is not a benefit.

PROCEDURE D5811**INTERIM COMPLETE DENTURE (MANDIBULAR)**

This procedure is not a benefit.

PROCEDURE D5820**INTERIM PARTIAL DENTURE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH), MAXILLARY**

This procedure is not a benefit.

PROCEDURE D5821**INTERIM PARTIAL DENTURE (INCLUDING RETENTIVE/CLASPING MATERIALS, RESTS, AND TEETH), MANDIBULAR**

This procedure is not a benefit.

PROCEDURE D5850**TISSUE CONDITIONING, MAXILLARY**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit twice per prosthesis in a 36 month period.
3. Not a benefit:
 - a. same date of service as reline complete maxillary denture (chairside) (D5730), reline maxillary partial denture (chairside) (D5740), reline complete maxillary denture (laboratory) (D5750) and reline maxillary partial denture (laboratory) (D5760).
 - b. same date of service as a prosthesis that did not require extractions.
4. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
5. Tissue conditioning is designed to heal unhealthy ridges prior to a more definitive treatment.

PROCEDURE D5851**TISSUE CONDITIONING, MANDIBULAR**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit twice per prosthesis in a 36 month period.

3. Not a benefit:
 - a. same date of service as reline complete mandibular denture (chairside) (D5731), reline mandibular partial denture (chairside) (D5741), reline complete mandibular denture (laboratory) (D5751) and reline mandibular partial denture (laboratory) (D5761).
 - b. same date of service as a prosthesis that did not require extractions.
4. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
5. Tissue conditioning is designed to heal unhealthy ridges prior to a more definitive treatment.

PROCEDURE D5862**PRECISION ATTACHMENT, BY REPORT**

This procedure is included in the fee for prosthetic and restorative procedures and is not payable separately.

PROCEDURE D5863**OVERDENTURE – COMPLETE MAXILLARY**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit all radiographs of remaining natural teeth including periapical radiographs of teeth to be retained.
3. A current and complete Justification of Need For Prosthesis Form, DC054 (2/24) is required, that includes which teeth are to be retained, for prior authorization.
4. A benefit once in a five-year period.
5. Complete denture laboratory relines (D5750) are a benefit:
 - a. six months after the date of service for an immediate overdenture that required extractions, or
 - b. 12 months after the date of service for a complete overdenture that did not require extractions.
6. Complete denture chairside relines (D5730) are a benefit:
 - a. six months after the date of service for an immediate overdenture that required extractions, or
 - b. 12 months after the date of service for a complete overdenture that did not require extractions.
7. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
8. Teeth to be retained are not eligible for preventative, periodontal, endodontic or restorative procedures. Only extractions for the retained teeth shall be a benefit.
9. An overdenture is considered to be a complete denture supported both by mucosa and by a few remaining natural teeth that have been altered to permit the denture to completely fit over them.

**PROCEDURE D5864
OVERDENTURE – PARTIAL MAXILLARY**

This procedure is not a benefit.

**PROCEDURE D5865
OVERDENTURE – COMPLETE MANDIBULAR**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit all radiographs of remaining natural teeth including periapical radiographs of teeth to be retained.
3. A current and complete Justification of Need for Prosthesis Form, DC054 (2/24) is required, that includes which teeth are to be retained, for prior authorization.
4. A benefit once in a five-year period.
5. Complete denture laboratory relines (D5751) are a benefit:
 - a. six months after the date of service for an immediate overdenture that required extractions, or
 - b. 12 months after the date of service for a complete overdenture that did not require extractions.
6. Complete denture chairside relines (D5731) are a benefit:
 - a. six months after the date of service for an immediate overdenture that required extractions, or
 - b. 12 months after the date of service for a complete overdenture that did not require extractions.
7. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
8. Teeth to be retained are not eligible for preventative, periodontal, endodontic or restorative procedures. Only extractions for the retained teeth shall be a benefit.
9. An overdenture is considered to be a complete denture supported both by mucosa and by a few remaining natural teeth that have been altered to permit the denture to completely fit over them.

**PROCEDURE D5866
OVERDENTURE – PARTIAL MANDIBULAR**

This procedure is not a benefit.

**PROCEDURE D5867
REPLACEMENT OF REPLACEABLE PART OF SEMI-PRECISION OR PRECISION
ATTACHMENT, PER ATTACHMENT)**

This procedure is not a benefit.

PROCEDURE D5875**MODIFICATION OF REMOVABLE PROSTHESIS FOLLOWING IMPLANT SURGERY**

This procedure is not a benefit.

PROCEDURE D5876**ADD METAL SUBSTRUCTURE TO ACRYLIC FULL DENTURE (PER ARCH)**

This procedure is not a benefit.

PROCEDURE D5899**UNSPECIFIED REMOVABLE PROSTHODONTIC PROCEDURE, BY REPORT**

1. Prior authorization is required for non-emergency procedures.
2. Radiographs for prior authorization or payment – submit radiographs if applicable for the type of procedure.
3. Photographs for prior authorization or payment – submit photographs if applicable for the type of procedure.
4. Submit a current and complete Justification of Need for Prosthesis Form, DC054 (2/24), if applicable for the type of procedure, for prior authorization.
5. Written documentation for prior authorization or payment – describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed or actual treatment.
6. Procedure D5899 shall be used:
 - a. for a procedure which is not adequately described by a CDT code, or
 - b. for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the medical condition and the specific CDT code associated with the treatment.

Maxillofacial Prosthetics General Policies (D5900–D5999)

- a) Maxillofacial prosthetic services are for the anatomic and functional reconstruction of those regions of the maxilla and mandible and associated structures that are missing or defective because of surgical intervention, trauma (other than simple or compound fractures), pathology, developmental or congenital malformations.
- b) All maxillofacial prosthetic procedures require written documentation for payment or prior authorization. Refer to the individual procedures for specific requirements.
- c) Prior authorization is required for the following procedures:
 - i) trismus appliance (D5937),
 - ii) palatal lift prosthesis, interim (D5958),
 - iii) fluoride gel carrier (D5986),
 - iv) surgical splint (D5988).
- d) All maxillofacial prosthetic procedures include routine postoperative care, revisions and adjustments for 90 days after the date of delivery.

Maxillofacial Prosthetic Procedures (D5900–D5999)

PROCEDURE D5911

FACIAL MOULAGE (SECTIONAL)

1. Written documentation for payment – shall include:
 - a. the etiology of the disease and/or condition, and
 - b. a description of the associated surgery or an operative report, and
 - c. a description of the prosthesis.

PROCEDURE D5912

FACIAL MOULAGE (COMPLETE)

1. Written documentation for payment – shall include:
 - a. the etiology of the disease and/or condition, and
 - b. a description of the associated surgery or an operative report, and
 - c. a description of the prosthesis.

PROCEDURE D5913

NASAL PROSTHESIS

1. Written documentation for payment – shall include:
 - a. the etiology of the disease and/or condition, and
 - b. a description of the associated surgery or an operative report.

PROCEDURE D5914

AURICULAR PROSTHESIS

1. Written documentation for payment – shall include:
 - a. the etiology of the disease and/or condition, and
 - b. a description of the associated surgery or an operative report.

PROCEDURE D5915

ORBITAL PROSTHESIS

1. Written documentation for payment – shall include:
 - a. the etiology of the disease and/or condition, and
 - b. a description of the associated surgery or an operative report.

PROCEDURE D5916

OCULAR PROSTHESIS

1. Written documentation for payment – shall include:
 - a. the etiology of the disease and/or condition, and

- b. a description of the associated surgery or an operative report.
- 2. Not a benefit on the same date of service as ocular prosthesis, interim (D5923).

PROCEDURE D5919 FACIAL PROSTHESIS

- 1. Written documentation for payment – shall include:
 - a. the etiology of the disease and/or condition, and
 - b. a description of the associated surgery or an operative report, and
 - c. a description of the prosthesis.

PROCEDURE D5922 NASAL SEPTAL PROSTHESIS

- 1. Written documentation for payment – shall include:
 - a. the etiology of the disease and/or condition, and
 - b. a description of the associated surgery or an operative report.

PROCEDURE D5923 OCULAR PROSTHESIS, INTERIM

- 1. Written documentation for payment – shall include:
 - a. the etiology of the disease and/or condition, and
 - b. a description of the associated surgery or an operative report.
- 2. Not a benefit on the same date of service with an ocular prosthesis (D5916).

PROCEDURE D5924 CRANIAL PROSTHESIS

- 1. Written documentation for payment – shall include:
 - a. the etiology of the disease and/or condition, and
 - b. a description of the associated surgery or an operative report.

PROCEDURE D5925 FACIAL AUGMENTATION IMPLANT PROSTHESIS

- 1. Written documentation for payment – shall include:
 - a. the etiology of the disease and/or condition, and
 - b. a description of the associated surgery or an operative report, and
 - c. a description of the prosthesis.

PROCEDURE D5926 NASAL PROSTHESIS, REPLACEMENT

Written documentation for payment – shall include the medical necessity for replacement.

PROCEDURE D5927**AURICULAR PROSTHESIS, REPLACEMENT**

Written documentation for payment – shall include the medical necessity for replacement.

PROCEDURE D5928**ORBITAL PROSTHESIS, REPLACEMENT**

Written documentation for payment – shall include the medical necessity for replacement.

PROCEDURE D5929**FACIAL PROSTHESIS, REPLACEMENT**

Written documentation for payment – shall include the medical necessity for replacement.

PROCEDURE D5931**OBTURATOR PROSTHESIS, SURGICAL**

1. Written documentation for payment – shall include:
 - a. the etiology of the disease and/or condition, and
 - b. a description of the associated surgery or an operative report, and
 - c. a description of the prosthesis.
2. Not a benefit on the same date of service as obturator prosthesis, definitive (D5932) and obturator prosthesis, interim (D5936).

PROCEDURE D5932**OBTURATOR PROSTHESIS, DEFINITIVE**

1. Written documentation for payment – shall include:
 - a. the etiology of the disease and/or condition, and
 - b. a description of the associated surgery or an operative report, and
 - c. a description of the prosthesis.
2. Not a benefit on the same date of service as obturator prosthesis, surgical (D5931) and obturator prosthesis, interim (D5936).

PROCEDURE D5933**OBTURATOR PROSTHESIS, MODIFICATION**

1. Written documentation for payment – shall include the medical necessity for the modification.
2. A benefit twice in a 12 month period.
3. Not a benefit on the same date of service as obturator prosthesis, surgical (D5931), obturator prosthesis, definitive (D5932) and obturator prosthesis, interim (D5936).

PROCEDURE D5934**MANDIBULAR RESECTION PROSTHESIS WITH GUIDE FLANGE**

1. Written documentation for payment – shall include:
 - a. the etiology of the disease and/or condition, and
 - b. a description of the associated surgery or an operative report, and
 - c. a description of the prosthesis.

PROCEDURE D5935**MANDIBULAR RESECTION PROSTHESIS WITHOUT GUIDE FLANGE**

1. Written documentation for payment – shall include:
 - a. the etiology of the disease and/or condition, and
 - b. a description of the associated surgery or an operative report, and
 - c. a description of the prosthesis.

PROCEDURE D5936**OBTURATOR PROSTHESIS, INTERIM**

1. Written documentation for payment – shall include:
 - a. the etiology of the disease and/or condition, and
 - b. a description of the associated surgery or an operative report, and
 - c. a description of the prosthesis.
2. Not a benefit on the same date of service as obturator prosthesis, surgical (D5931) and obturator prosthesis, definitive (D5932).

PROCEDURE D5937**TRISMUS APPLIANCE (NOT FOR TMD TREATMENT)**

1. Prior authorization is required.
2. Written documentation for prior authorization – shall include:
 - a. the etiology of the disease and/or condition, and
 - b. a description of the associated surgery.

PROCEDURE D5951**FEEDING AID**

1. Written documentation for payment – shall include the treatment performed.
2. A benefit for patients under the age of 18.

PROCEDURE D5952**SPEECH AID PROSTHESIS, PEDIATRIC**

1. Written documentation for payment – shall include the treatment performed.

2. A benefit for patients under the age of 18.

PROCEDURE D5953**SPEECH AID PROSTHESIS, ADULT**

1. Written documentation for payment - shall include the treatment performed.
2. A benefit for patients age 18 or older.

PROCEDURE D5954**PALATAL AUGMENTATION PROSTHESIS**

Written documentation for payment – shall include the treatment performed.

PROCEDURE D5955**PALATAL LIFT PROSTHESIS, DEFINITIVE**

1. Written documentation for payment - shall include the treatment performed.
2. Not a benefit on the same date of service as palatal lift prosthesis, interim (D5958).

PROCEDURE D5958**PALATAL LIFT PROSTHESIS, INTERIM**

1. Prior authorization is required.
2. Written documentation for prior authorization - shall include the treatment to be performed.
3. Not a benefit on the same date of service with palatal lift prosthesis, definitive (D5955).

PROCEDURE D5959**PALATAL LIFT PROSTHESIS, MODIFICATION**

1. Written documentation for payment - shall include the treatment performed.
2. A benefit twice in a 12-month period.
3. Not a benefit on the same date of service as palatal lift prosthesis, definitive (D5955) and palatal lift prosthesis, interim (D5958).

PROCEDURE D5960**SPEECH AID PROSTHESIS, MODIFICATION**

1. Written documentation for payment - shall include the treatment performed.
2. A benefit twice in a 12-month period.
3. Not a benefit on the same date of service as speech aid prosthesis, pediatric (D5952) and speech aid prosthesis, adult (D5953).

PROCEDURE D5982**SURGICAL STENT**

Written documentation for payment – shall include the treatment performed.

**PROCEDURE D5983
RADIATION CARRIER**

1. Written documentation for payment – shall include the etiology of the disease and/or condition.
2. Requires an arch code.

**PROCEDURE D5984
RADIATION SHIELD**

Written documentation for payment – shall include the etiology of the disease and/or condition.

**PROCEDURE D5985
RADIATION CONE LOCATOR**

Written documentation for payment – shall include the etiology of the disease and/or condition.

**PROCEDURE D5986
FLUORIDE GEL CARRIER**

1. Prior authorization is required.
2. Written documentation for prior authorization – shall include the etiology of the disease and/or condition and the treatment to be performed.
3. Requires an arch code.
4. A benefit only in conjunction with radiation therapy directed at the teeth, jaws or salivary glands.

**PROCEDURE D5987
COMMISSURE SPLINT**

Written documentation for payment – shall include the etiology of the disease and/or condition.

**PROCEDURE D5988
SURGICAL SPLINT**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit radiographs.
3. Written documentation for prior authorization – shall include the medical necessity and the treatment to be performed.

**PROCEDURE D5991
VESICULOBULLOUS DISEASE MEDICAMENT CARRIER**

1. Written documentation for payment – shall include the etiology of the disease and/or condition.
2. Requires an arch code.

PROCEDURE D5992**ADJUST MAXILLOFACIAL PROSTHETIC APPLIANCE, BY REPORT**

This procedure is not a benefit.

PROCEDURE D5993**MAINTENANCE AND CLEANING OF A MAXILLOFACIAL PROSTHESIS (EXTRA OR INTRAORAL) OTHER THAN REQUIRED ADJUSTMENTS, BY REPORT**

This procedure is not a benefit.

PROCEDURE D5995**PERIODONTAL MEDICAMENT CARRIER WITH PERIPHERAL SEAL – LABORATORY PROCESSED – MAXILLARY**

This procedure is not a benefit.

PROCEDURE D5996**PERIODONTAL MEDICAMENT CARRIER WITH PERIPHERAL SEAL – LABORATORY PROCESSED – MANDIBULAR**

This procedure is not a benefit.

PROCEDURE D5999**UNSPECIFIED MAXILLOFACIAL PROSTHESIS, BY REPORT**

1. Prior authorization is required for non-emergency procedures.
2. Radiographs for prior authorization or payment – submit radiographs if applicable for the type of procedure.
3. Photographs for prior authorization or payment – submit photographs if applicable for the type of procedure.
4. Written documentation or operative report for prior authorization or payment – shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed or actual treatment.
5. Procedure D5999 shall be used:
 - a. for a procedure which is not adequately described by a CDT code, or
 - b. for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the medical condition and the specific CDT code associated with the treatment.

Implant Services General Policies (D6000–D6199)

- a) Implant services are a benefit only when exceptional medical conditions are documented and shall be reviewed by the Medi-Cal Dental for medical necessity for prior authorization. Exceptional medical conditions include, but are not limited to:
 - i) cancer of the oral cavity requiring ablative surgery and/or radiation leading to destruction of alveolar bone, where the remaining osseous structures are unable to support conventional dental prostheses.
 - ii) severe atrophy of the mandible and/or maxilla that cannot be corrected with vestibular extension procedures or osseous augmentation procedures, and the patient is unable to function with conventional prostheses.
 - iii) skeletal deformities that preclude the use of conventional prostheses (such as arthrogryposis, ectodermal dysplasia, partial anodontia and cleidocranial dysplasia).
 - iv) traumatic destruction of jaw, face or head where the remaining osseous structures are unable to support conventional dental prostheses.

Providers shall submit complete case documentation (such as radiographs, scans, operative reports, craniofacial panel reports, diagnostic casts, intraoral/extraoral photographs and tracings) necessary to demonstrate the medical necessity of the requested implant services.

- b) Implant removal D6100 and D6105 is a benefit. Refer to the procedure for specific requirements.

Implant Service Procedures (D6000–D6199)

PROCEDURE D6010

SURGICAL PLACEMENT OF IMPLANT BODY: ENDOSTEAL IMPLANT

1. Implant services are a benefit only when exceptional medical conditions are documented and shall be reviewed for medical necessity. Refer to Implant Services General policies for specific requirements.
2. Prior authorization is required.
3. Radiographs for prior authorization – submit arch, pre-operative periapical and/or panoramic radiographs as applicable.
4. Photographs for prior authorization – submit as applicable.
5. Written documentation for prior authorization – shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed treatment.
6. Requires a tooth or arch code, as applicable for the type of procedure.

PROCEDURE D6011

SURGICAL ACCESS TO AN IMPLANT BODY (SECOND STAGE IMPLANT SURGERY)

This procedure is included in the fee for implant procedures and is not payable separately.

PROCEDURE D6012

SURGICAL PLACEMENT OF INTERIM IMPLANT BODY FOR TRANSITIONAL PROSTHESIS: ENDOSTEAL IMPLANT

This procedure is not a benefit.

PROCEDURE D6013

SURGICAL PLACEMENT OF MINI IMPLANT

See the criteria for procedure D6010.

PROCEDURE D6040

SURGICAL PLACEMENT: EPOSTEAL IMPLANT

See the criteria for Procedure D6010.

PROCEDURE D6050

SURGICAL PLACEMENT: TRANSOSTEAL IMPLANT

See the criteria for Procedure D6010.

PROCEDURE D6051

PLACEMENT OF INTERIM IMPLANT ABUTMENT

This procedure is not a benefit.

PROCEDURE D6055**CONNECTING BAR – IMPLANT SUPPORTED OR ABUTMENT SUPPORTED**

See the criteria for Procedure D6010.

PROCEDURE D6056**PREFABRICATED ABUTMENT – INCLUDES MODIFICATION AND PLACEMENT**

See the criteria for Procedure D6010.

PROCEDURE D6057**CUSTOM FABRICATED ABUTMENT – INCLUDES PLACEMENT**

See the criteria for Procedure D6010.

PROCEDURE D6058**ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN**

See the criteria for Procedure D6010.

PROCEDURE D6059**ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (HIGH NOBLE METAL)**

This procedure is not a benefit.

PROCEDURE D6060**ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINANTLY BASE METAL)**

See the criteria for Procedure D6010.

PROCEDURE D6061**ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (NOBLE METAL)**

This procedure is not a benefit.

PROCEDURE D6062**ABUTMENT SUPPORTED CAST METAL CROWN (HIGH NOBLE METAL)**

This procedure is not a benefit.

PROCEDURE D6063**ABUTMENT SUPPORTED CAST METAL CROWN (PREDOMINANTLY BASE METAL)**

See the criteria for Procedure D6010.

PROCEDURE D6064**ABUTMENT SUPPORTED CAST METAL CROWN (NOBLE METAL)**

This procedure is not a benefit.

PROCEDURE D6065**IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN**

See the criteria for Procedure D6010.

PROCEDURE D6066**IMPLANT SUPPORTED CROWN – PORCELAIN FUSED TO HIGH NOBLE ALLOYS**

This procedure is not a benefit.

PROCEDURE D6067**IMPLANT SUPPORTED CROWN – HIGH NOBLE ALLOYS**

This procedure is not a benefit.

PROCEDURE D6068**ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD**

See the criteria for Procedure D6010.

PROCEDURE D6069**ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL)**

This procedure is not a benefit.

PROCEDURE D6070**ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (PREDOMINANTLY BASE METAL)**

See the criteria for Procedure D6010.

PROCEDURE D6071**ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (NOBLE METAL)**

This procedure is not a benefit.

PROCEDURE D6072**ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (HIGH NOBLE METAL)**

This procedure is not a benefit.

PROCEDURE D6073**ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (PREDOMINANTLY BASE METAL)**

See the criteria for Procedure D6010.

PROCEDURE D6074**ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (NOBLE METAL)**

This procedure is not a benefit.

PROCEDURE D6075**IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD**

See the criteria for Procedure D6010.

PROCEDURE D6076**IMPLANT SUPPORTED RETAINER FOR FPD – PORCELAIN FUSED TO HIGH NOBLE ALLOYS**

This procedure is not a benefit.

PROCEDURE D6077**IMPLANT SUPPORTED RETAINER FOR CAST METAL FPD – HIGH NOBLE ALLOYS**

This procedure is not a benefit.

PROCEDURE D6080**IMPLANT MAINTENANCE PROCEDURES WHEN A FULL ARCH FIXED HYBRID PROSTHESIS IS REMOVED AND REINSERTED, INCLUDING CLEANSING OF PROSTHESIS AND ABUTMENTS**

See the criteria for Procedure D6010.

PROCEDURE D6081**SCALING AND DEBRIDEMENT OF A SINGLE IMPLANT IN THE PRESENCE OF MUCOSITIS, INCLUDING INFLAMMATION, BLEEDING UPON PROBING AND INCREASED POCKET DEPTHS; INCLUDES CLEANING OF THE IMPLANT SURFACES, WITHOUT FLAP ENTRY AND CLOSURE**

This procedure is included in the fees for periodontal procedures and is not payable separately.

PROCEDURE D6082**IMPLANT SUPPORTED CROWN – PORCELAIN FUSED TO PREDOMINATELY BASE ALLOYS**

See the criteria for Procedure D6010.

PROCEDURE D6083**IMPLANT SUPPORTED CROWN – PORCELAIN FUSED TO NOBLE ALLOYS**

This procedure is not a benefit.

PROCEDURE D6084**IMPLANT SUPPORTED CROWN – PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS**

This procedure is not a benefit.

PROCEDURE D6085**INTERIM IMPLANT CROWN**

This procedure is not a benefit.

PROCEDURE D6086**IMPLANT SUPPORTED CROWN – PREDOMINATELY BASE ALLOYS**

See the criteria for Procedure D6010.

PROCEDURE D6087**IMPLANT SUPPORTED CROWN – NOBLE ALLOYS**

This procedure is not a benefit.

PROCEDURE D6088**IMPLANT SUPPORTED CROWN – TITANIUM AND TITANIUM ALLOYS**

This procedure is not a benefit.

PROCEDURE D6089**ACCESSING AND RETORQUING LOOSE IMPLANT SCREW – PER SCREW.**

Global

PROCEDURE D6090**REPAIR OF IMPLANT/ABUTMENT SUPPORTED PROSTHESIS**

See the criteria for Procedure D6010.

PROCEDURE D6091**REPLACEMENT OF REPLACEABLE PART OF SEMI-PRECISION OR PRECISION ATTACHMENT OF IMPLANT/ABUTMENT SUPPORTED PROSTHESIS, PER ATTACHMENT**

See the criteria for Procedure D6010.

PROCEDURE D6092**RE-CEMENT OR RE-BOND IMPLANT/ABUTMENT SUPPORTED CROWN**

1. This procedure does not require prior authorization.
2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
3. Requires a tooth code.
4. The original provider is responsible for all re-cementations within the first 12 months following the initial placement of implant/abutment supported crowns.
5. Not a benefit within 12 months of a previous re-cementation by the same provider.

PROCEDURE D6093**RE-CEMENT OR RE-BOND IMPLANT/ABUTMENT SUPPORTED FIXED PARTIAL DENTURE**

1. This procedure does not require prior authorization.
2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.

3. Requires a quadrant code.
4. The original provider is responsible for all re-cementations within the first 12 months following the initial placement of implant/abutment supported fixed partial dentures.
5. Not a benefit within 12 months of a previous re-cementation by the same provider.

PROCEDURE D6094**ABUTMENT SUPPORTED CROWN – TITANIUM AND TITANIUM ALLOYS**

This procedure is not a benefit.

PROCEDURE D6096**REMOVE BROKEN IMPLANT RETAINING SCREW**

This procedure is not a benefit.

PROCEDURE D6097**ABUTMENT SUPPORTED CROWN – PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS**

This procedure is not a benefit.

PROCEDURE D6098**IMPLANT SUPPORTED RETAINER – PORCELAIN FUSED TO PREDOMINATELY BASE ALLOYS**

See the criteria for Procedure D6010.

PROCEDURE D6099**IMPLANT SUPPORTED RETAINER FOR FPD – PORCELAIN FUSED TO NOBLE ALLOYS**

This procedure is not a benefit.

PROCEDURE D6100**SURGICAL REMOVAL OF IMPLANT BODY**

1. Prior authorization is not required.
2. Radiographs for payment – submit a radiograph of the implant to be removed.
3. Written documentation for payment – shall include the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
4. Requires a tooth code.

PROCEDURE D6101

DEBRIDEMENT OF A PERI-IMPLANT DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT, AND SURFACE CLEANING OF THE OF EXPOSED IMPLANT SERVICES, INCLUDING FLAP ENTRY AND CLOSURE

This procedure is not a benefit.

PROCEDURE D6102

DEBRIDEMENT AND OSSEOUS CONTOURING OF A PERI-IMPLANT DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT AND INCLUDES SURFACE CLEANING OF THE EXPOSED IMPLANT SURFACES, INCLUDING FLAP ENTRY AND CLOSURE

This procedure is not a benefit.

PROCEDURE D6103

BONE GRAFT FOR REPAIR OF PERI-IMPLANT DEFECT – DOES NOT INCLUDE FLAP ENTRY AND CLOSURE

This procedure is not a benefit.

PROCEDURE D6104

BONE GRAFT AT TIME OF IMPLANT PLACEMENT

This procedure is not a benefit.

PROCEDURE D6105

REMOVAL OF IMPLANT BODY NOT REQUIRING BONE REMOVAL NOR FLAP ELEVATION

1. Prior authorization is not required.
2. Radiographs for payment – submit a radiograph of the implant to be removed.
3. Requires a tooth code.

PROCEDURE D6106

GUIDED TISSUE REGENERATION – RESORBABLE BARRIER, PER IMPLANT

This procedure is not a benefit.

PROCEDURE D6107

GUIDED TISSUE REGENERATION – NON-RESORBABLE BARRIER, PER IMPLANT

This procedure is not a benefit.

PROCEDURE D6110

IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH – MAXILLARY

See the criteria for procedure D6010.

PROCEDURE D6111**IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR EDENTULOUS ARCH – MANDIBULAR**

See the criteria for procedure D6010.

PROCEDURE D6112**IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH – MAXILLARY**

See the criteria for procedure D6010.

PROCEDURE D6113**IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH – MANDIBULAR**

See the criteria for procedure D6010.

PROCEDURE D6114**IMPLANT/ABUTMENT SUPPORTED FIXED DENTURE FOR EDENTULOUS ARCH – MAXILLARY**

See the criteria for procedure D6010.

PROCEDURE D6115**IMPLANT/ABUTMENT SUPPORTED FIXED DENTURE FOR EDENTULOUS ARCH – MANDIBULAR**

See the criteria for procedure D6010.

PROCEDURE D6116**IMPLANT/ABUTMENT SUPPORTED FIXED DENTURE FOR PARTIALLY EDENTULOUS ARCH – MAXILLARY**

See the criteria for procedure D6010.

PROCEDURE D6117**IMPLANT/ABUTMENT SUPPORTED FIXED DENTURE FOR PARTIALLY EDENTULOUS ARCH – MANDIBULAR**

See the criteria for procedure D6010.

PROCEDURE D6118**IMPLANT/ABUTMENT SUPPORTED INTERIM FIXED DENTURE FOR EDENTULOUS ARCH – MANDIBULAR**

This procedure is not a benefit.

PROCEDURE D6119**IMPLANT/ABUTMENT SUPPORTED INTERIM FIXED DENTURE FOR EDENTULOUS ARCH – MAXILLARY**

This procedure is not a benefit.

PROCEDURE D6120**IMPLANT SUPPORTED RETAINER – PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS**

This procedure is not a benefit.

PROCEDURE D6121**IMPLANT SUPPORTED RETAINER FOR METAL FPD – PREDOMINATELY BASE ALLOYS**

See the criteria for Procedure D6010.

PROCEDURE D6122**IMPLANT SUPPORTED RETAINER FOR METAL FPD – NOBLE ALLOYS**

This procedure is not a benefit.

PROCEDURE D6123**IMPLANT SUPPORTED RETAINER FOR METAL FPD – TITANIUM AND TITANIUM ALLOYS**

This procedure is not a benefit.

PROCEDURE D6180**IMPLANT MAINTENANCE PROCEDURES WHEN A FULL ARCH FIXED HYBRID PROSTHESIS IS NOT REMOVED, INCLUDING CLEANSING OF PROSTHESIS AND ABUTMENTS.**

Global

PROCEDURE D6190**RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY REPORT**

This procedure is included in the fee for surgical placement of implant body: endosteal implant (D6010).

PROCEDURE D6191**SEMI-PRECISION ABUTMENT – PLACEMENT**

See the criteria for procedure D6010.

PROCEDURE D6192**SEMI-PRECISION ATTACHMENT – PLACEMENT**

See the criteria for procedure D6010.

PROCEDURE D6193**REPLACEMENT OF AN IMPLANT SCREW**

Global

PROCEDURE D6194**ABUTMENT SUPPORTED RETAINER CROWN FOR FPD – TITANIUM AND TITANIUM ALLOYS**

This procedure is not a benefit.

PROCEDURE D6195**ABUTMENT SUPPORTED RETAINER – PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS**

This procedure is not a benefit.

PROCEDURE D6197**REPLACEMENT OF RESTORATIVE MATERIAL USED TO CLOSE AN ACCESS OPENING OF A SCREW-RETAINED IMPLANT SUPPORTED PROSTHESIS, PER IMPLANT**

This procedure is not a benefit.

PROCEDURE D6198**REMOVE INTERIM IMPLANT COMPONENT**

This procedure is not a benefit.

PROCEDURE D6199**UNSPECIFIED IMPLANT PROCEDURE, BY REPORT**

1. Implant services are a benefit only when exceptional medical conditions are documented and shall be reviewed for medical necessity.
2. Prior authorization is required.
3. Radiographs for prior authorization - submit arch and pre-operative periapical radiographs.
4. Photographs for prior authorization - submit as applicable for the type of procedure.
5. Written documentation for prior authorization – shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed treatment.
6. Requires a tooth or arch code, as applicable for the type of procedure.

Fixed Prosthodontic General Policies (D6200–D6999)

- a) Fixed partial dentures (bridgework) are considered beyond the scope of the Medi-Cal Dental . However, the fabrication of a fixed partial denture shall be considered for prior authorization only when medical conditions or employment preclude the use of a removable partial denture. **Most importantly, the patient shall first meet the criteria for a removable partial denture before a fixed partial denture will be considered.**
- b) Medical conditions, which preclude the use of a removable partial denture, include:
 - i) the epileptic patient where a removable partial denture could be injurious to their health during an uncontrolled seizure,
 - ii) the paraplegia patient who utilizes a mouth wand to function to any degree and where a mouth wand is inoperative because of missing natural teeth,
 - iii) patients with neurological disorders whose manual dexterity precludes proper care and maintenance of a removable partial denture.
- c) Documentation for medical conditions shall be submitted for prior authorization that includes a written, signed and dated statement from the patient's physician, on their professional letterhead, describing the patient's medical condition and the reason why a removable partial denture would be injurious to the patient's health.
- d) Documentation for obtaining employment shall be submitted for prior authorization that includes a written statement from the patient's case manager or eligibility worker stating why the nature of the employment precludes the use of a removable partial denture.
- e) Fixed partial dentures are a benefit once in a five-year period only on permanent teeth when the above criteria are met.
- f) Current periapical radiographs of the retainer (abutment) teeth and arch radiographs are required for prior authorization.
- g) Fixed partial dentures are not a benefit when the prognosis of the retainer (abutment) teeth is questionable due to non-restorability or periodontal involvement.
- h) Posterior fixed partial dentures are not a benefit when the number of missing teeth requested to be replaced in the quadrant does not significantly impact the patient's masticatory ability.
- i) Tooth and soft tissue preparation, crown lengthening, cement bases, direct and indirect pulp capping, amalgam or acrylic buildups, pin retention-per tooth, in addition to restoration (D2951), bonding agents, lining agents, impressions, temporary crowns, occlusal adjustment-limited (D9951), polishing, local anesthesia (D9210) and any other associated procedures are included in the fee for a completed fixed partial denture.
- j) Arch integrity and overall condition of the mouth, including the patient's ability to maintain oral health, shall be considered for prior authorization. Prior authorization shall be based upon a supportable five-year prognosis for the fixed partial denture retainer (abutment).

- k) Fixed partial denture retainers (abutments) on root canal treated teeth shall be considered only after satisfactory completion of root canal therapy. Post root canal treatment periapical and arch radiographs shall be submitted for prior authorization of fixed partial dentures.
- l) Partial payment will not be made for an undelivered fixed partial denture. Payment will be made only upon final cementation.
- m) Fixed partial denture inlay/onlay retainers (abutments) (D6545 and D6634) are not a benefit.
- n) Cast resin bonded fixed partial dentures (Maryland Bridges) are not a benefit.

Fixed Prosthodontic Procedures (D6200–D6999)

PROCEDURE D6205

PONTIC – INDIRECT RESIN BASED COMPOSITE

This procedure is not a benefit.

PROCEDURE D6210

PONTIC – CAST HIGH NOBLE METAL

This procedure is not a benefit.

PROCEDURE D6211

PONTIC – CAST PREDOMINANTLY BASE METAL

1. Prior authorization is required.
2. Radiographs for prior authorization –submit arch and periapical radiographs.
3. Written documentation for prior authorization- shall be submitted for employment or medical reasons. Refer to Fixed Prosthodontic General Policies for specific requirements.
4. Requires a tooth code.
5. A benefit:
 - a. once in a five-year period.
 - b. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).
 - c. only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791).
6. Not a benefit for patients under the age of 13.

PROCEDURE D6212

PONTIC – CAST NOBLE METAL

This procedure is not a benefit.

PROCEDURE D6214

PONTIC – TITANIUM AND TITANIUM ALLOYS

This procedure is not a benefit.

PROCEDURE D6240

PONTIC – PORCELAIN FUSED TO HIGH NOBLE METAL

This procedure is not a benefit.

PROCEDURE D6241

PONTIC – PORCELAIN FUSED TO PREDOMINANTLY BASE METAL

1. Prior authorization is required.

2. Radiographs for prior authorization –submit arch and periapical radiographs.
3. Written documentation for prior authorization- shall be submitted for employment or medical reasons. Refer to Fixed Prosthodontic General Policies for specific requirements.
4. Requires a tooth code.
5. A benefit:
 - a. once in a five-year period.
 - b. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).
 - c. only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791).
6. Not a benefit for patients under the age of 13.

PROCEDURE D6242**PONTIC – PORCELAIN FUSED TO NOBLE METAL**

This procedure is not a benefit.

PROCEDURE D6243**PONTIC – PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS**

This procedure is not a benefit.

PROCEDURE D6245**PONTIC – PORCELAIN/CERAMIC**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit arch and periapical radiographs.
3. Written documentation for prior authorization- shall be submitted for employment or medical reasons. Refer to Fixed Prosthodontic General Policies for specific requirements.
4. Requires a tooth code.
5. A benefit:
 - a. once in a five-year period.
 - b. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).
 - c. only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791).
6. Not a benefit for patients under the age of 13.

PROCEDURE D6250**PONTIC – RESIN WITH HIGH NOBLE METAL**

This procedure is not a benefit.

PROCEDURE D6251**PONTIC – RESIN WITH PREDOMINANTLY BASE METAL**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit arch and periapical radiographs.
3. Written documentation for prior authorization- shall be submitted for employment or medical reasons. Refer to Fixed Prosthodontic General Policies for specific requirements.
4. Requires a tooth code.
5. A benefit:
 - a. once in a five-year period.
 - b. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).
 - c. only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791).
6. Not a benefit for patients under the age of 13.

PROCEDURE D6252**PONTIC – RESIN WITH NOBLE METAL**

This procedure is not a benefit.

PROCEDURE D6253**INTERIM PONTIC – FURTHER TREATMENT OR COMPLETION OF DIAGNOSIS
NECESSARY PRIOR TO FINAL IMPRESSION**

This procedure is not a benefit.

PROCEDURE D6545**RETAINER – CAST METAL FOR RESIN BONDED FIXED PROSTHESIS**

This procedure is not a benefit.

PROCEDURE D6548**RETAINER – PORCELAIN/CERAMIC FOR RESIN BONDED FIXED PROSTHESIS**

This procedure is not a benefit.

PROCEDURE D6549**RESIN RETAINER – FOR RESIN BONDED FIXED PROSTHESIS**

This procedure is not a benefit.

PROCEDURE D6600**RETAINER INLAY – PORCELAIN/CERAMIC, TWO SURFACES**

This procedure is not a benefit.

PROCEDURE D6601**RETAINER INLAY – PORCELAIN/CERAMIC, THREE OR MORE SURFACES**

This procedure is not a benefit.

PROCEDURE D6602**RETAINER INLAY – CAST HIGH NOBLE METAL, TWO SURFACES**

This procedure is not a benefit.

PROCEDURE D6603**RETAINER INLAY – CAST HIGH NOBLE METAL, THREE OR MORE SURFACES**

This procedure is not a benefit.

PROCEDURE D6604**RETAINER INLAY – CAST PREDOMINANTLY BASE METAL, TWO SURFACES**

This procedure is not a benefit.

PROCEDURE D6605**RETAINER INLAY – CAST PREDOMINANTLY BASE METAL, THREE OR MORE SURFACES**

This procedure is not a benefit.

PROCEDURE D6606**RETAINER INLAY – CAST NOBLE METAL, TWO SURFACES**

This procedure is not a benefit.

PROCEDURE D6607**RETAINER INLAY – CAST NOBLE METAL, THREE OR MORE SURFACES**

This procedure is not a benefit.

PROCEDURE D6608**RETAINER ONLAY – PORCELAIN/CERAMIC, TWO SURFACES**

This procedure is not a benefit.

PROCEDURE D6609**RETAINER ONLAY – PORCELAIN/CERAMIC, THREE OR MORE SURFACES**

This procedure is not a benefit.

PROCEDURE D6610**RETAINER ONLAY – CAST HIGH NOBLE METAL, TWO SURFACES**

This procedure is not a benefit.

PROCEDURE D6611**RETAINER ONLAY – CAST HIGH NOBLE METAL, THREE OR MORE SURFACES**

This procedure is not a benefit.

PROCEDURE D6612**RETAINER ONLAY – CAST PREDOMINANTLY BASE METAL, TWO SURFACES**

This procedure is not a benefit.

PROCEDURE D6613**RETAINER ONLAY – CAST PREDOMINANTLY BASE METAL, THREE OR MORE SURFACES**

This procedure is not a benefit.

PROCEDURE D6614**RETAINER ONLAY – CAST NOBLE METAL, TWO SURFACES**

This procedure is not a benefit.

PROCEDURE D6615**RETAINER ONLAY – CAST NOBLE METAL, THREE OR MORE SURFACES**

This procedure is not a benefit.

PROCEDURE D6624 RETAINER INLAY – TITANIUM

This procedure is not a benefit.

PROCEDURE D6634 RETAINER ONLAY – TITANIUM

This procedure is not a benefit.

PROCEDURE D6710**RETAINER CROWN – INDIRECT RESIN BASED COMPOSITE**

This procedure is not a benefit.

PROCEDURE D6720**RETAINER CROWN – RESIN WITH HIGH NOBLE METAL**

This procedure is not a benefit.

PROCEDURE D6721**RETAINER CROWN – RESIN WITH PREDOMINANTLY BASE METAL**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit arch and periapical radiographs.
3. Written documentation for prior authorization- shall be submitted for employment or medical reasons. Refer to Fixed Prosthodontic General Policies for specific requirements.
4. Requires a tooth code.

5. A benefit:
 - a. once in a five-year period.
 - b. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).
6. Not a benefit for patients under the age of 13.

PROCEDURE D6722**RETAINER CROWN – RESIN WITH NOBLE METAL**

This procedure is not a benefit.

PROCEDURE D6740**RETAINER CROWN – PORCELAIN/CERAMIC****PRIOR AUTHORIZATION IS REQUIRED.**

1. Radiographs for prior authorization –submit arch and periapical radiographs.
2. Written documentation for prior authorization- shall be submitted for employment or medical reasons. Refer to Fixed Prosthodontic General Policies for specific requirements.
3. Requires a tooth code.
4. A benefit:
 - a. once in a five-year period.
 - b. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).
5. Not a benefit for patients under the age of 13.

PROCEDURE D6750**RETAINER CROWN – PORCELAIN FUSED TO HIGH NOBLE METAL**

This procedure is not a benefit.

PROCEDURE D6751**RETAINER CROWN – PORCELAIN FUSED TO PREDOMINANTLY BASE METAL**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit arch and periapical radiographs.
3. Written documentation for prior authorization- shall be submitted for employment or medical reasons. Refer to Fixed Prosthodontic General Policies for specific requirements.
4. Requires a tooth code.
5. A benefit:
 - a. once in a five-year period.

- b. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).
6. Not a benefit for patients under the age of 13.

PROCEDURE D6752**RETAINER CROWN – PORCELAIN FUSED TO NOBLE METAL**

This procedure is not a benefit.

PROCEDURE D6753**RETAINER CROWN – PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS**

This procedure is not a benefit.

PROCEDURE D6780**RETAINER CROWN – $\frac{3}{4}$ CAST HIGH NOBLE METAL**

This procedure is not a benefit.

PROCEDURE D6781**RETAINER CROWN – $\frac{3}{4}$ CAST PREDOMINANTLY BASE METAL**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit arch and periapical radiographs.
3. Written documentation for prior authorization- shall be submitted for employment or medical reasons. Refer to Fixed Prosthodontic General Policies for specific requirements.
4. Requires a tooth code.
5. A benefit:
 - a. once in a five-year period.
 - b. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).
6. Not a benefit for patients under the age of 13.

PROCEDURE D6782**RETAINER CROWN – $\frac{3}{4}$ CAST NOBLE METAL**

This procedure is not a benefit.

PROCEDURE D6783**RETAINER CROWN – $\frac{3}{4}$ PORCELAIN/CERAMIC**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit arch and periapical radiographs.

3. Written documentation for prior authorization- shall be submitted for employment or medical reasons. Refer to Fixed Prosthodontic General Policies for specific requirements.
4. Requires a tooth code.
5. A benefit:
 - a. once in a five-year period.
 - b. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).
6. Not a benefit for patients under the age of 13.

PROCEDURE D6784**RETAINER CROWN $\frac{3}{4}$ – TITANIUM AND TITANIUM ALLOYS**

This procedure is not a benefit.

PROCEDURE D6790**RETAINER CROWN – FULL CAST HIGH NOBLE METAL**

This procedure is not a benefit.

PROCEDURE D6791**RETAINER CROWN – FULL CAST PREDOMINANTLY BASE METAL**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit arch and periapical radiographs.
3. Written documentation for prior authorization- shall be submitted for employment or medical reasons. Refer to Fixed Prosthodontic General Policies for specific requirements.
4. Requires a tooth code.
5. A benefit:
 - a. once in a five-year period.
 - b. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).
6. Not a benefit for patients under the age of 13.

PROCEDURE D6792**RETAINER CROWN – FULL CAST NOBLE METAL**

This procedure is not a benefit.

PROCEDURE D6793**INTERIM RETAINER CROWN – FURTHER TREATMENT OR COMPLETION OF DIAGNOSIS NECESSARY PRIOR TO FINAL IMPRESSION**

This procedure is not a benefit.

**PROCEDURE D6794
RETAINER CROWN- TITANIUM AND TITANIUM ALLOYS**

This procedure is not a benefit.

**PROCEDURE D6920
CONNECTOR BAR**

This procedure is not a benefit.

**PROCEDURE D6930
RE-CEMENT OR RE-BOND FIXED PARTIAL DENTURE**

1. This procedure does not require prior authorization.
2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
3. Requires a quadrant code.
4. The original provider is responsible for all re-cementations within the first 12 months following the initial placement of a fixed partial denture.
5. Not a benefit within 12 months of a previous re-cementation by the same provider.

**PROCEDURE D6940
STRESS BREAKER**

This procedure is not a benefit.

**PROCEDURE D6950
PRECISION ATTACHMENT**

This procedure is not a benefit.

**PROCEDURE D6980
FIXED PARTIAL DENTURE REPAIR NECESSITATED BY RESTORATIVE MATERIAL FAILURE**

1. This procedure does not require prior authorization.
2. Radiographs for payment –submit pre-operative radiographs of the retainers.
3. Photographs for payment –submit a pre-operative photograph.
4. Written documentation for payment- shall describe the specific conditions addressed by the procedure.
5. Submit a laboratory invoice, if applicable for the type of procedure, for payment.
6. Requires a tooth code.
7. Not a benefit within 12 months of initial placement or previous repair, same provider.

**PROCEDURE D6985
PEDIATRIC PARTIAL DENTURE, FIXED**

This procedure is not a benefit.

PROCEDURE D6999**UNSPECIFIED, FIXED PROSTHODONTIC PROCEDURE, BY REPORT**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit periapical radiographs.
3. Photographs for prior authorization – submit photographs if applicable for the type of procedure.
4. Written documentation for prior authorization – describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed treatment.
5. Requires a tooth code.
6. Not a benefit within 12 months of initial placement, same provider.
7. Procedure D6999 shall be used:
 - a. for a procedure which is not adequately described by a CDT code, or
 - b. for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the medical condition and the specific CDT code associated with the treatment.

Oral and Maxillofacial Surgery General Policies (D7000–D7999)

- a) Diagnostic pre-operative radiographs are required for all hard tissue surgical procedures that are submitted for prior authorization and/or payment. Refer to the individual procedure for specific requirements.
- b) Local anesthetic, sutures and routine postoperative care within 30 days following an extraction procedure (D7111-D7250) are considered part of, and included in, the fee for the procedure. All other oral and maxillofacial surgery procedures include routine postoperative care for 90 days.
- c) The level of payment for multiple surgical procedures performed on the same date of service shall be modified to the most inclusive procedure.

1. Extractions (D7111–D7250):

- a) The following conditions shall be considered medically necessary and shall be a benefit:
 - i) full bony impacted supernumerary teeth or mesiodens that interfere with the alignment of other teeth,
 - ii) teeth which are involved with a cyst, tumor or other neoplasm,
 - iii) unerupted teeth which are severely distorting the normal alignment of erupted teeth or causing the resorption of the roots of other teeth,
 - iv) the extraction of all remaining teeth in preparation for a full prosthesis,
 - v) extraction of third molars that are causing repeated or chronic pericoronitis,
 - vi) extraction of primary teeth required to minimize malocclusion or malalignment when there is adequate space to allow normal eruption of succedaneous teeth,
 - vii) perceptible radiologic pathology that fails to elicit symptoms,
 - viii) extractions that are required to complete orthodontic dental services, excluding prophylactic removal of third molars,
 - ix) when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement.
- b) The prophylactic extraction of third molars is not a benefit.
- c) The fee for surgical extractions includes the removal of bone and/or sectioning of tooth, and elevation of mucoperiosteal flap, if indicated.
- d) Classification of surgical extractions and impactions shall be based on the anatomical position of the tooth rather than the surgical technique employed in the removal.
- e) The level of payment for surgical extractions shall be allowed or modified based on the degree of difficulty as evidenced by the diagnostic radiographs. When radiographs do not accurately depict the degree of difficulty, written documentation and/or photographs shall be considered.

2. Fractures (D7610-D7780):

- a) The placement and removal of wires, bands or splints is included in the fee for the associated procedure.
- b) Routine postoperative care within 90 days is included in the fee for the associated procedure.
- c) When extensive multiple or bilateral procedures are performed at the same operative site, each procedure shall be valued as follows:
 - i) 100% (full value) for the first or major procedure, and
 - ii) 50% for the second procedure, and
 - iii) 25% for the third procedure, and
 - iv) 10% for the fourth procedure, and
 - v) 5% for the fifth procedure, and
 - vi) over five procedures, by report.
- d) Assistant surgeons are paid 20% of the surgical fee allowed to the surgeon. Hospital call (D9420) is not payable to assistant surgeons.

3. Temporomandibular Joint Dysfunctions (D7810-D7899):

- a) TMJ dysfunction procedures are limited to differential diagnosis and symptomatic care. Not included as a benefit are those TMJ treatment modalities that involve prosthodontia, orthodontia and full or partial occlusal rehabilitation.
- b) Most TMJ dysfunction procedures require prior authorization. Submission of sufficient diagnostic information to establish the presence of the dysfunction is required. Refer to the individual procedures for specific submission requirements.
- c) TMJ dysfunction procedures solely for the treatment of bruxism is not a benefit.

4. Repair Procedures (D7910- D7998):

Suture procedures (D7910, D7911 and D7912) are not a benefit for the closure of surgical incisions.

Oral and Maxillofacial Surgery Procedures (D7000–D7999)

PROCEDURE D7111

EXTRACTION, CORONAL REMNANTS – PRIMARY TOOTH

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. Requires a tooth code.
3. Not a benefit for asymptomatic teeth.

PROCEDURE D7140

EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND/OR FORCEPS REMOVAL)

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. Requires a tooth code.
3. Not a benefit to the same provider who performed the initial tooth extraction.

PROCEDURE D7210

EXTRACTION, ERUPTED TOOTH REQUIRING REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF MUCOPERIOSTEAL FLAP IF INDICATED

1. Radiographs for payment – submit a current, diagnostic preoperative periapical or panoramic radiograph depicting the entire tooth.
2. Requires a tooth code.
3. A benefit when the removal of any erupted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone or sectioning of the tooth.

PROCEDURE D7220

REMOVAL OF IMPACTED TOOTH – SOFT TISSUE

1. Radiographs for payment – submit a current, diagnostic preoperative periapical or panoramic radiograph depicting the entire tooth.
2. Requires a tooth code.
3. A benefit when the major portion or the entire occlusal surface is covered by mucogingival soft tissue.

PROCEDURE D7230

REMOVAL OF IMPACTED TOOTH – PARTIALLY BONY

1. Radiographs for payment – submit a current, diagnostic preoperative periapical or panoramic radiograph depicting the entire tooth.
2. Requires a tooth code.

3. A benefit when the removal of any impacted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone. One of the proximal heights of contour of the crown shall be covered by bone.

PROCEDURE D7240**REMOVAL OF IMPACTED TOOTH – COMPLETELY BONY**

1. Radiographs for payment – submit a current, diagnostic preoperative periapical or panoramic radiograph depicting the entire tooth.
2. Requires a tooth code.
3. A benefit when the removal of any impacted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone covering most or all of the crown.

PROCEDURE D7241**REMOVAL OF IMPACTED TOOTH – COMPLETELY BONY, WITH UNUSUAL SURGICAL COMPLICATIONS**

1. Radiographs for payment – submit a current, diagnostic preoperative periapical or panoramic radiograph depicting the entire tooth.
2. Written documentation for payment – shall justify the unusual surgical complication.
3. Requires a tooth code.
4. A benefit when the removal of any impacted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone covering most or all of the crown. Difficulty or complication shall be due to factors such as nerve dissection or aberrant tooth position.

PROCEDURE D7250**REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)**

1. Radiographs for payment – submit a current, diagnostic preoperative periapical or panoramic radiograph depicting the entire root.
2. Requires a tooth code.
3. A benefit when the root is completely covered by alveolar bone.
4. Not a benefit to the same provider who performed the initial tooth extraction.

PROCEDURE D7251**CORONECTOMY – INTENTIONAL PARTIAL TOOTH REMOVAL, IMPACTED TEETH ONLY**

1. Prior authorization is required.
2. Radiographs for prior authorization – submit a current, diagnostic, preoperative radiograph or panoramic radiograph depicting the entire tooth.
3. Written documentation for prior authorization – shall describe the specific conditions addressed by the procedure and the rationale demonstrating the medical necessity.
4. Requires a tooth code.

PROCEDURE D7252**PARTIAL EXTRACTION FOR IMMEDIATE IMPLANT PLACEMENT**

This procedure is not a benefit.

PROCEDURE D7259**NERVE DISSECTION**

Global

PROCEDURE D7260**OROANTRAL FISTULA CLOSURE**

1. Radiographs for payment – submit a current, diagnostic preoperative radiograph.
2. Written documentation or operative report for payment – shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. Requires a quadrant code.
4. A benefit for the excision of a fistulous tract between the maxillary sinus and oral cavity.
5. Not a benefit in conjunction with extraction procedures (D7111 – D7250).

PROCEDURE D7261**PRIMARY CLOSURE OF A SINUS PERFORATION**

1. This procedure cannot be prior authorized.
2. Radiographs for payment – submit a current, diagnostic preoperative radiograph.
Operative report for payment – shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. Requires a tooth code.
4. A benefit in the absence of a fistulous tract requiring the repair or immediate closure of the oroantral or oral nasal communication, subsequent to the removal of a tooth.

PROCEDURE D7270**TOOTH RE-IMPLANTATION AND/OR STABILIZATION OF ACCIDENTALLY EVULSED OR DISPLACED TOOTH**

1. Radiographs for payment –submit a preoperative periapical radiograph.
2. Written documentation for payment – shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the tooth/teeth reimplanted.
3. Requires an arch code.
4. A benefit:
 - a. once per arch regardless of the number of teeth involved, and
 - b. for permanent anterior teeth only.

5. The fee for this procedure includes splinting and/or stabilization, postoperative care and the removal of the splint or stabilization, by the same provider.

PROCEDURE D7272**TOOTH TRANSPLANTATION (INCLUDES RE-IMPLANTATION FROM ONE SITE TO ANOTHER AND SPLINTING AND/OR STABILIZATION)**

This procedure is not a benefit.

PROCEDURE D7280**EXPOSURE OF AN UNERUPTED TOOTH**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a pre-operative radiograph depicting the impacted tooth.
3. Written documentation for prior authorization –shall describe the specific conditions addressed by the procedure and the rationale demonstrating the medical necessity.
4. Requires a tooth code.
5. Not a benefit:
 - a. for patients age 21 or older.
 - b. for third molars.

PROCEDURE D7282**MOBILIZATION OF ERUPTED OR MALPOSITIONED TOOTH TO AID ERUPTION**

This procedure is not a benefit.

PROCEDURE D7283**PLACEMENT OF DEVICE TO FACILITATE ERUPTION OF IMPACTED TOOTH**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a pre-operative radiograph depicting the impacted tooth.
3. Written documentation for prior authorization – shall indicate that the patient is under active orthodontic treatment.
4. Requires a tooth code.
5. A benefit only for patients in active orthodontic treatment.
6. Not a benefit:
 - a. for patients age 21 years or older.
 - b. for third molars unless the third molar occupies the first or second molar position.

PROCEDURE D7284**EXCISIONAL BIOPSY OF MINOR SALIVARY GLANDS**

This procedure is not a benefit.

PROCEDURE D7285**INCISIONAL BIOPSY OF ORAL TISSUE – HARD (BONE, TOOTH)**

1. Radiographs for payment –submit a pre-operative radiograph.
2. A pathology report from a certified pathology laboratory is required for payment.
3. Requires an arch code.
4. A benefit:
 - a. for the removal of the specimen only
 - b. once per arch, per date of service regardless of the areas involved.
5. Not a benefit with an apicoectomy/periradicular surgery (D3410–D3427), an extraction (D7111–D7250) and an excision of any soft tissues or intraosseous lesions (D7410–D7461) in the same area or region on the same date of service.

PROCEDURE D7286**INCISIONAL BIOPSY OF ORAL TISSUE – SOFT**

1. Written documentation for payment – shall include the area or region and individual areas biopsied.
2. A pathology report from a certified pathology laboratory is required for payment.
3. A benefit:
 - a. for the removal of the specimen only.
 - b. up to a maximum of three per date of service.
4. Not a benefit with an apicoectomy/periradicular surgery (D3410–D3427), an extraction (D7111–D7250) and an excision of any soft tissues or intraosseous lesions (D7410–D7461) in the same area or region on the same date of service.

PROCEDURE D7287**EXFOLIATIVE CYTOLOGICAL SAMPLE COLLECTION**

This procedure is not a benefit.

PROCEDURE D7288**BRUSH BIOPSY – TRANSEPITHELIAL SAMPLE COLLECTION****THIS PROCEDURE IS NOT A BENEFIT****PROCEDURE D7290****SURGICAL REPOSITIONING OF TEETH**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a pre-operative radiograph.
3. Written documentation for prior authorization – shall indicate that the patient is under active orthodontic treatment.
4. Requires an arch code.
5. A benefit:
 - a. for permanent teeth only.

- b. once per arch.
- c. only for patients in active orthodontic treatment.
- 6. Not a benefit:
 - a. for patients age 21 years or older.

for third molars unless the third molar occupies the first or second molar position.

PROCEDURE D7291

TRANSSEPTAL FIBEROTOMY/SUPRA CRESTAL FIBEROTOMY, BY REPORT

- 1. Written documentation for payment – shall indicate that the patient is under active orthodontic treatment.
- 2. Requires an arch code.
- 3. A benefit:
 - a. once per arch.
 - b. only for patients in active orthodontic treatment.
- 4. Not a benefit for patients age 21 or older.

PROCEDURE D7292

PLACEMENT OF TEMPORARY ANCHORAGE DEVICE [SCREW RETAINED PLATE] - REQUIRING FLAP

This procedure is not a benefit.

PROCEDURE D7293

PLACEMENT OF TEMPORARY ANCHORAGE DEVICE REQUIRING FLAP

This procedure is not a benefit.

PROCEDURE D7294

PLACEMENT OF TEMPORARY ANCHORAGE DEVICE WITHOUT FLAP

This procedure is not a benefit.

PROCEDURE D7295

HARVEST OF BONE FOR USE IN AUTOGENOUS GRAFTING PROCEDURE

This procedure is not a benefit.

PROCEDURE D7296

CORTICOTOMY – ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT

This procedure is not a benefit.

PROCEDURE D7297

CORTICOTOMY – FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT

This procedure is not a benefit.

PROCEDURE D7298

REMOVAL OF TEMPORARY ANCHORAGE DEVICE [SCREW RETAINED PLATE],

REQUIRING FLAP

This procedure is not a benefit.

PROCEDURE D7299**REMOVAL OF TEMPORARY ANCHORAGE DEVICE, REQUIRING FLAP**

This procedure is not a benefit.

PROCEDURE D7300**REMOVAL OF TEMPORARY ANCHORAGE DEVICE WITHOUT FLAP**

This procedure is not a benefit.

PROCEDURE D7310**ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS – FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT**

1. Radiographs for payment – submit radiographs of the involved areas.
2. Requires a quadrant code.
3. A benefit on the same date of service with two or more extractions (D7140-D7250) in the same quadrant.
4. Not a benefit when only one tooth is extracted in the same quadrant on the same date of service.

PROCEDURE D7311**ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS – ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT**

This procedure can only be billed as alveoloplasty in conjunction with extractions- four or more teeth or tooth spaces, per quadrant (D7310).

PROCEDURE D7320**ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS – FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT**

1. Radiographs for payment- submit radiographs of the involved areas if photographs do not demonstrate the medical necessity.
2. Photographs for payment- submit photographs of the involved areas.
3. Requires a quadrant code.
4. A benefit regardless of the number of teeth or tooth spaces.
5. Not a benefit within six months following extractions (D7140-D7250) in the same quadrant, for the same provider.

PROCEDURE D7321**ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS – ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT**

This procedure can only be billed as alveoloplasty not in conjunction with extractions- four or

more teeth or tooth spaces, per quadrant (D7320).

PROCEDURE D7340

VESTIBULOPLASTY – RIDGE EXTENSION (SECONDARY EPITHELIALIZATION)

1. Prior authorization is required.
2. Radiographs for prior authorization – submit radiographs.
3. Photographs for prior authorization – submit photographs.
4. Written documentation for prior authorization – shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed prosthodontic treatment.
5. Requires an arch code.
6. A benefit once in a five-year period per arch.
7. Not a benefit:
 - a. on the same date of service with a vestibuloplasty – ridge extension (D7350) same arch.
 - b. on the same date of service with extractions (D7111-D7250) same arch.

PROCEDURE D7350

VESTIBULOPLASTY – RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT AND MANAGEMENT OF HYPERTROPHIED AND HYPERPLASTIC TISSUE)

1. Prior authorization is required.
2. Radiographs for prior authorization – submit radiographs.
3. Photographs for prior authorization – submit photographs.
4. Written documentation for prior authorization – shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed prosthodontic treatment.
5. Requires an arch code.
6. A benefit once per arch.
7. Not a benefit:
 - a. on the same date of service with a vestibuloplasty – ridge extension (D7340) same arch.
 - b. on the same date of service with extractions (D7111-D7250) same arch.

PROCEDURE D7410

EXCISION OF BENIGN LESION UP TO 1.25 CM

1. Written documentation for payment – shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
2. A pathology report from a certified pathology laboratory is required for payment.

3. This procedure is included in the fee for an apicoectomy (D3410, D3421, D3425 and D3426) and periradicular surgery (D3427) and is not payable separately.

PROCEDURE D7411**EXCISION OF BENIGN LESION GREATER THAN 1.25 CM**

1. Written documentation for payment – shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
2. A pathology report from a certified pathology laboratory is required for payment.
3. This procedure is included in the fee for an apicoectomy (D3410, D3421, D3425 and D3426) and periradicular surgery (D3427) and is not payable separately.

PROCEDURE D7412**EXCISION OF BENIGN LESION, COMPLICATED**

1. Written documentation for payment – shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
2. A pathology report from a certified pathology laboratory is required for payment.
3. A benefit when there is extensive undermining with advancement or rotational flap closure.

PROCEDURE D7413**EXCISION OF MALIGNANT LESION UP TO 1.25 CM**

1. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
2. A pathology report from a certified pathology laboratory is required for payment.

PROCEDURE D7414**EXCISION OF MALIGNANT LESION GREATER THAN 1.25 CM**

1. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
2. A pathology report from a certified pathology laboratory is required for payment.

PROCEDURE D7415**EXCISION OF MALIGNANT LESION, COMPLICATED**

1. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
2. A pathology report from a certified pathology laboratory is required for payment.
3. A benefit when there is extensive undermining with advancement or rotational flap closure.

PROCEDURE D7440**EXCISION OF MALIGNANT TUMOR – LESION DIAMETER UP TO 1.25 CM**

1. Radiographs for payment- submit a radiograph of the tumor.
2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. A pathology report from a certified pathology laboratory is required for payment.

PROCEDURE D7441**EXCISION OF MALIGNANT TUMOR – LESION DIAMETER GREATER THAN 1.25 CM**

1. Radiographs for payment – submit a radiograph of the tumor.
2. Written documentation for payment – shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, and any pertinent history.
3. A pathology report from a certified pathology laboratory is required for payment.

PROCEDURE D7450**REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR – LESION DIAMETER UP TO 1.25 CM**

1. Radiographs for payment- submit a radiograph of the cyst or tumor.
2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. A pathology report from a certified pathology laboratory is required for payment.

PROCEDURE D7451**REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR – LESION DIAMETER GREATER THAN 1.25 CM**

1. Radiographs for payment- submit a radiograph of the cyst or tumor.
2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. A pathology report from a certified pathology laboratory is required for payment.

PROCEDURE D7460**REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR – LESION DIAMETER UP TO 1.25 CM**

1. Radiographs for payment- submit a radiograph of the cyst or tumor.
2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.

3. A pathology report from a certified pathology laboratory is required for payment.

PROCEDURE D7461**REMOVAL OF BENIGN NONDONTOGENIC CYST OR TUMOR – LESION DIAMETER GREATER THAN 1.25 CM**

1. Radiographs for payment- submit a radiograph of the cyst or tumor.
2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. A pathology report from a certified pathology laboratory is required for payment.

PROCEDURE D7465**DESTRUCTION OF LESION(S) BY PHYSICAL OR CHEMICAL METHOD, BY REPORT**

1. Photographs for payment –submit a pre-operative photograph.
2. Written documentation for payment – shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. Examples include using cryo, laser or electro surgery.

PROCEDURE D7471**REMOVAL OF LATERAL EXOSTOSIS (MAXILLA OR MANDIBLE)**

1. Photographs for payment – submit pre-operative photographs.
2. Written documentation for payment – shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed prosthodontic treatment.
3. Requires a quadrant code.
4. A benefit:
 - a. once per quadrant.
 - b. for the removal of buccal or facial exostosis only.

PROCEDURE D7472**REMOVAL OF TORUS PALATINUS**

1. Photographs for payment – submit pre-operative photographs.
2. Written documentation for payment – shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed prosthodontic treatment.
3. A benefit once in the patient's lifetime.

PROCEDURE D7473**REMOVAL OF TORUS MANDIBULARIS**

1. Photographs for payment – submit pre-operative photographs.

2. Written documentation for payment – shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed prosthodontic treatment.
3. Requires a quadrant code.
4. A benefit once per quadrant.

PROCEDURE D7485**SURGICAL REDUCTION OF OSSEOUS TUBEROSITY**

1. Radiographs for payment – submit preoperative radiographs.
2. Written documentation for payment – shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed prosthodontic treatment.
3. Requires a quadrant code.
4. A benefit once per quadrant.

PROCEDURE D7490**RADICAL RESECTION OF MAXILLA OR MANDIBLE**

1. Radiographs for payment – submit radiographs.
2. Written documentation for payment – shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed or actual treatment.

PROCEDURE D7509**MARSUPIALIZATION OF ODONTOGENIC CYST**

This procedure is not a benefit.

PROCEDURE D7510**INCISION AND DRAINAGE OF ABSCESS – INTRAORAL SOFT TISSUE**

1. Written documentation for payment – shall include the tooth involved, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
2. Requires a quadrant code.
3. A benefit once per quadrant, same date of service.
4. Not a benefit when any other definitive treatment is performed in the same quadrant on the same date of service, except necessary radiographs and/or photographs.
5. The fee for this procedure includes the incision, placement and removal of a surgical draining device.

PROCEDURE D7511**INCISION AND DRAINAGE OF ABSCESS – INTRAORAL SOFT TISSUE – COMPLICATED (INCLUDES DRAINAGE OF MULTIPLE FASCIAL SPACES)**

1. Written documentation for payment – shall include the tooth involved, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical

necessity and any pertinent history.

2. Requires a quadrant code.
3. A benefit once per quadrant, same date of service.
4. Not a benefit when any other definitive treatment is performed in the same quadrant on the same date of service, except necessary radiographs and/or photographs.
5. The fee for this procedure includes the incision, placement and removal of a surgical draining device.

PROCEDURE D7520

INCISION AND DRAINAGE OF ABSCESS – EXTRAORAL SOFT TISSUE

1. Written documentation for payment shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
2. The fee for this procedure includes the incision, placement and removal of a surgical draining device.

PROCEDURE D7521

INCISION AND DRAINAGE OF ABSCESS – EXTRAORAL SOFT TISSUE – COMPLICATED (INCLUDES DRAINAGE OF MULTIPLE FASCIAL SPACES)

1. Written documentation for payment – shall include the tooth involved, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
2. The fee for this procedure includes the incision, placement and removal of a surgical draining device.

PROCEDURE D7530

REMOVAL OF FOREIGN BODY FROM MUCOSA, SKIN, OR SUBCUTANEOUS ALVEOLAR TISSUE

1. Radiographs for payment – submit a pre-operative radiograph.
2. Written documentation for payment – shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. A benefit once per date of service.
4. Not a benefit when associated with the removal of a tumor, cyst (D7440–D7461) or tooth (D7111–D7250).

PROCEDURE D7540

REMOVAL OF REACTION PRODUCING FOREIGN BODIES, MUSCULOSKELETAL SYSTEM

1. Radiographs for payment – submit a pre-operative radiograph.
2. Written documentation for payment – shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.

3. A benefit once per date of service.
4. Not a benefit when associated with the removal of a tumor, cyst (D7440-D7461) or tooth (D7111-D7250).

PROCEDURE D7550**PARTIAL OSTECTOMY/SEQUESTRECTOMY FOR REMOVAL OF NON-VITAL BONE**

1. Radiographs for payment – submit a pre-operative radiograph.
2. Written documentation for payment – shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. Requires a quadrant code.
4. A benefit:
 - a. once per quadrant per date of service.
 - b. only for the removal of loose or sloughed off dead bone caused by infection or reduced blood supply.
5. Not a benefit within 30 days of an associated extraction (D7111–D7250).

PROCEDURE D7560**MAXILLARY SINUSOTOMY FOR REMOVAL OF TOOTH FRAGMENT OR FOREIGN BODY**

1. Radiographs for payment – submit a pre-operative radiograph.
2. Written documentation for payment – shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. Not a benefit when a tooth fragment or foreign body is retrieved from the tooth socket.

PROCEDURE D7610**MAXILLA – OPEN REDUCTION (TEETH IMMOBILIZED, IF PRESENT)**

1. Radiographs for payment – submit a postoperative radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9222-D9248) are a separate benefit when necessary for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7620**MAXILLA – CLOSED REDUCTION (TEETH IMMOBILIZED, IF PRESENT)**

1. Radiographs for payment – submit a postoperative radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.

3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9222–D9248) are a separate benefit when necessary for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7630**MANDIBLE – OPEN REDUCTION (TEETH IMMOBILIZED, IF PRESENT)**

1. Radiographs for payment – submit a postoperative radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9222-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7640**MANDIBLE – CLOSED REDUCTION (TEETH IMMOBILIZED, IF PRESENT)**

1. Radiographs for payment – submit a postoperative radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9222-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7650**MALAR AND/OR ZYGOMATIC ARCH – OPEN REDUCTION**

1. Radiographs for payment – submit a postoperative radiograph
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9222–D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7660**MALAR AND/OR ZYGOMATIC ARCH – CLOSED REDUCTION**

1. Radiographs for payment – submit a postoperative radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9222-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7670**ALVEOLUS – CLOSED REDUCTION, MAY INCLUDE STABILIZATION OF TEETH**

1. Radiographs for payment – submit a postoperative radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. Requires an arch code.
4. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
5. Anesthesia procedures (D9222–D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7671**ALVEOLUS – OPEN REDUCTION, MAY INCLUDE STABILIZATION OF TEETH**

1. Radiographs for payment – submit a postoperative radiograph.
2. Operative report for payment – shall include a copy of the operative report which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. Requires an arch code.
4. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
5. Anesthesia procedures (D9222-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7680**FACIAL BONES – COMPLICATED REDUCTION WITH FIXATION AND MULTIPLE SURGICAL APPROACHES**

1. Radiographs for payment – submit a postoperative radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
3. A benefit for the treatment of simple fractures.

4. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
5. Anesthesia procedures (D9222–D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7710**MAXILLA – OPEN REDUCTION**

1. Radiographs for payment – submit a postoperative radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9222-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7720**MAXILLA – CLOSED REDUCTION**

1. Radiographs for payment – submit a postoperative radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9222-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7730**MANDIBLE – OPEN REDUCTION**

1. Radiographs for payment – submit a postoperative radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9222-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7740**MANDIBLE – CLOSED REDUCTION**

1. Radiographs for payment – submit a postoperative radiograph.
2. Operative report for payment – shall include a copy of the operative report, which

describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.

3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9222-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7750

MALAR AND/OR ZYGOMATIC ARCH – OPEN REDUCTION

1. Radiographs for payment – submit a postoperative radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9222–D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7760

MALAR AND/OR ZYGOMATIC ARCH – CLOSED REDUCTION

1. Radiographs for payment – submit a postoperative radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9222–D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7770

ALVEOLUS – OPEN REDUCTION STABILIZATION OF TEETH

1. Radiographs for payment – submit a radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9222-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7771**ALVEOLUS, CLOSED REDUCTION STABILIZATION OF TEETH**

1. Radiographs for payment – submit a radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9222-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7780**FACIAL BONES – COMPLICATED REDUCTION WITH FIXATION AND MULTIPLE SURGICAL APPROACHES**

1. Radiographs for payment – submit a radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
3. A benefit for the treatment of compound fractures.
4. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
5. Anesthesia procedures (D9222-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7810**OPEN REDUCTION OF DISLOCATION**

Written documentation or operative report for payment – shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.

PROCEDURE D7820**CLOSED REDUCTION OF DISLOCATION**

Written documentation or operative report for payment – shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.

PROCEDURE D7830**MANIPULATION UNDER ANESTHESIA**

1. Written documentation or operative report for payment – shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
2. Anesthesia procedures (D9222-D9248) are a separate benefit, when necessary.

PROCEDURE D7840**CONDYLECTOMY**

1. Prior authorization is required.
2. Radiographs for prior authorization – submit a radiograph.
3. Written documentation for prior authorization – shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.

PROCEDURE D7850**SURGICAL DISCECTOMY, WITH/WITHOUT IMPLANT**

1. Prior authorization is required.
2. Radiographs for prior authorization – submit a radiograph.
3. Written documentation for prior authorization – shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
4. An operative report shall be submitted for payment.

PROCEDURE D7852**DISC REPAIR**

1. Prior authorization is required.
2. Radiographs for prior authorization – submit a radiograph.
3. Written documentation for prior authorization – shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
4. An operative report shall be submitted for payment.

PROCEDURE D7854**SYNOVECTOMY**

1. Prior authorization is required.
2. Radiographs for prior authorization – submit a radiograph.
3. Written documentation for prior authorization – shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
4. An operative report shall be submitted for payment.

PROCEDURE D7856**MYOTOMY**

Written documentation or operative report for payment – shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.

PROCEDURE D7858**JOINT RECONSTRUCTION**

1. Prior authorization is required.
2. Radiographs for prior authorization – submit a radiograph.
3. Written documentation for prior authorization – shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
4. An operative report shall be submitted for payment.

PROCEDURE D7860**ARTHROTOMY**

1. Prior authorization is required.
2. Radiographs for prior authorization – submit a radiograph.
3. Written documentation for prior authorization – shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
4. An operative report shall be submitted for payment.

PROCEDURE D7865**ARTHROPLASTY**

1. Prior authorization is required.
2. Radiographs for prior authorization – submit a radiograph.
3. Written documentation for prior authorization – shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
4. An operative report shall be submitted for payment.

PROCEDURE D7870**ARTHROCENTESIS**

Written documentation or operative report for payment – shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.

PROCEDURE D7871**NON-ARTHROSCOPIC LYSIS AND LAVAGE**

This procedure is included in the fee for other procedures and is not payable separately.

PROCEDURE D7872**ARTHROSCOPY – DIAGNOSIS, WITH OR WITHOUT BIOPSY**

1. Prior authorization is required.
2. Radiographs for prior authorization – submit a radiograph.

3. Written documentation for prior authorization – shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
4. An operative report shall be submitted for payment.
5. This procedure includes the fee for any biopsies performed.

PROCEDURE D7873**ARTHROSCOPY – LAVAGE AND LYSIS OF ADHESIONS**

1. Prior authorization is required.
2. Radiographs for prior authorization – submit a radiograph.
3. Written documentation for prior authorization – shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
4. An operative report shall be submitted for payment.

PROCEDURE D7874**ARTHROSCOPY: DISC REPOSITIONING AND STABILIZATION**

1. Prior authorization is required.
2. Radiographs for prior authorization – submit a radiograph.
3. Written documentation for prior authorization – shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
4. An operative report shall be submitted for payment.

PROCEDURE D7875**ARTHROSCOPY: SYNOVECTOMY**

1. Prior authorization is required.
2. Radiographs for prior authorization – submit a radiograph.
3. Written documentation for prior authorization – shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
4. An operative report shall be submitted for payment.

PROCEDURE D7876**ARTHROSCOPY: DISCECTOMY**

1. Prior authorization is required.
2. Radiographs for prior authorization – submit a radiograph.
3. Written documentation for prior authorization – shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
4. An operative report shall be submitted for payment.

PROCEDURE D7877**ARTHROSCOPY: DEBRIDEMENT**

1. Prior authorization is required.
2. Radiographs for prior authorization – submit a radiograph.
3. Written documentation for prior authorization – shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
4. An operative report shall be submitted for payment.

PROCEDURE D7880**OCCLUSAL ORTHOTIC DEVICE, BY REPORT**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit tomograms or a radiological report.
3. Written documentation for prior authorization – shall include the specific TMJ conditions to be addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
4. A benefit for diagnosed TMJ dysfunction.
5. Not a benefit for the treatment of bruxism.

PROCEDURE D7881**OCCLUSAL ORTHOTIC DEVICE ADJUSTMENT**

This procedure is included in the fee for occlusal orthotic device, by report (D7880) and is not payable separately.

PROCEDURE D7899**UNSPECIFIED TMD THERAPY, BY REPORT**

1. Prior authorization is required for non-emergency procedures.
2. Radiographs for prior authorization – submit radiographs and/or tomograms, if applicable, for the type of procedure.
3. Written documentation for prior authorization – shall include the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
4. Not a benefit for procedures such as acupuncture, acupressure, biofeedback and hypnosis.

PROCEDURE D7910**SUTURE OF RECENT SMALL WOUNDS UP TO 5 CM**

1. Written documentation or operative report for payment – shall include the specific conditions addressed by the procedure and the length of the wound.
2. Not a benefit for the closure of surgical incisions.

PROCEDURE D7911**COMPLICATED SUTURE – UP TO 5 CM**

1. Written documentation or operative report for payment – shall include the specific conditions addressed by the procedure and the length of the wound.
2. Not a benefit for the closure of surgical incisions.

PROCEDURE D7912**COMPLICATED SUTURE – GREATER THAN 5 CM**

1. Written documentation or operative report for payment – shall include the specific conditions addressed by the procedure and the length of the wound.
2. Not a benefit for the closure of surgical incisions.

PROCEDURE D7920**SKIN GRAFT (IDENTIFY DEFECT COVERED, LOCATION AND TYPE OF GRAFT)**

1. Written documentation or operative report for payment – shall include the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the actual treatment.
2. Not a benefit for periodontal grafting.

PROCEDURE D7921**COLLECTION AND APPLICATION OF AUTOLOGOUS BLOOD CONCENTRATE PRODUCT**

This procedure is not a benefit.

PROCEDURE D7922**PLACEMENT OF INTRA-SOCKET BIOLOGICAL DRESSING TO AID IN HEMOSTASIS OR CLOT STABILIZATION, PER SITE**

This procedure is included in the fee for surgical procedures and is not payable separately.

PROCEDURE D7939**INDEXING FOR OSTEOTOMY USING DYNAMIC ROBOTIC ASSISTED OR DYNAMIC NAVIGATION**

This procedure is not a benefit.

PROCEDURE D7940**OSTEOPLASTY – FOR ORTHOGNATHIC DEFORMITIES**

1. Prior authorization is required.
2. Radiographs for prior authorization – submit a radiograph.
3. Written documentation for prior authorization – shall include the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed treatment.
4. An operative report shall be submitted for payment.

PROCEDURE D7941**OSTEOTOMY – MANDIBULAR RAMI**

1. Prior authorization is required.
2. Radiographs for prior authorization – submit a radiograph.
3. Written documentation for prior authorization – shall include the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
4. An operative report shall be submitted for payment.

PROCEDURE D7943**OSTEOTOMY – MANDIBULAR RAMI WITH BONE GRAFT; INCLUDES OBTAINING THE GRAFT**

1. Prior authorization is required.
2. Radiographs for prior authorization – submit a radiograph.
3. Written documentation for prior authorization – shall include the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
4. An operative report shall be submitted for payment.

PROCEDURE D7944**OSTEOTOMY – SEGMENTED OR SUBAPICAL**

1. Prior authorization is required.
2. Radiographs for prior authorization – submit a radiograph.
3. Written documentation for prior authorization – shall include the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
4. Requires a quadrant code.
5. An operative report shall be submitted for payment.

PROCEDURE D7945**OSTEOTOMY – BODY OF MANDIBLE**

1. Prior authorization is required.
2. Radiographs for prior authorization – submit a radiograph.
3. Written documentation for prior authorization – shall include the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
4. An operative report shall be submitted for payment.

PROCEDURE D7946**LEFORT I (MAXILLA – TOTAL)**

1. Radiographs for payment – submit a pre-operative radiograph.
2. An operative report shall be submitted for payment.

PROCEDURE D7947**LEFORT I (MAXILLA – SEGMENTED)**

1. Radiographs for payment – submit a pre-operative radiograph.
2. An operative report shall be submitted for payment.
3. When reporting a surgically assisted palatal expansion without downfracture, use unspecified oral surgery procedure, by report (D7999).

PROCEDURE D7948**LEFORT II OR LEFORT III (OSTEOPLASTY OF FACIAL BONES FOR MIDFACE HYPOPLASIA OR RETRUSION) WITHOUT BONE GRAFT**

1. Radiographs for payment – submit a pre-operative radiograph.
2. An operative report shall be submitted for payment.

PROCEDURE D7949**LEFORT II OR LEFORT III – WITH BONE GRAFT**

1. Radiographs for payment – submit a pre-operative radiograph.
2. An operative report shall be submitted for payment.

PROCEDURE D7950**OSSEOUS, OSTEOPERIOSTEAL, OR CARTILAGE GRAFT OF THE MANDIBLE OR MAXILLA – AUTOGENOUS OR NONAUTOGENOUS, BY REPORT**

1. Prior authorization is required.
2. Radiographs for prior authorization – submit a radiograph.
3. Written documentation for prior authorization – shall include the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed treatment.
4. Not a benefit for periodontal grafting.
5. An operative report shall be submitted for payment.

PROCEDURE D7951**SINUS AUGMENTATION WITH BONE OR BONE SUBSTITUTES VIA A LATERAL OPEN APPROACH**

1. Prior authorization is required.
2. Radiographs for prior authorization – submit a radiograph.

3. Written documentation for prior authorization – shall include the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
4. A benefit only for patients with authorized implant services.
5. An operative report shall be submitted for payment.

PROCEDURE D7952**SINUS AUGMENTATION VIA A VERTICAL APPROACH**

1. Prior authorization is required.
2. Radiographs for prior authorization – submit a radiograph.
3. Written documentation for prior authorization – shall include the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
4. A benefit only for patients with authorized implant services.
5. An operative report shall be submitted for payment.

PROCEDURE D7953**BONE REPLACEMENT GRAFT FOR RIDGE PRESERVATION – PER SITE**

This procedure is not a benefit.

PROCEDURE D7955**REPAIR OF MAXILLOFACIAL SOFT AND/OR HARD TISSUE DEFECT**

1. Prior authorization is required.
2. Radiographs for prior authorization – submit a radiograph.
3. Written documentation for prior authorization – shall include the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed treatment.
4. Not a benefit for periodontal grafting.
5. An operative report shall be submitted for payment.

PROCEDURE D7956**GUIDED TISSUE REGENERATION, EDENTULOUS AREA – RESORBABLE BARRIER, PER SITE**

This procedure is not a benefit.

PROCEDURE D7957**GUIDED TISSUE REGENERATION, EDENTULOUS AREA – NON-RESORBABLE BARRIER, PER SITE**

This procedure is not a benefit.

PROCEDURE D7961**BUCCAL/LABIAL FRENECTOMY (FRENULECTOMY)**

1. Photographs for payment – submit a pre-operative photograph.
2. Written documentation for payment – shall include the rationale demonstrating the medical necessity and the specific area the treatment was performed.
3. Requires an arch code.
4. A benefit:
 - a. once per arch per date of service.
 - b. only when the permanent incisors and cuspids have erupted.

PROCEDURE D7962**LINGUAL FRENECTOMY (FRENULECTOMY)**

1. Photographs for payment – submit a pre-operative photograph.
2. Written documentation for payment – shall include the rationale demonstrating the medical necessity and the specific area the treatment was performed.
3. Requires an arch code.
4. A benefit:
 - a. once per arch per date of service.
 - b. only when the permanent incisors and cuspids have erupted.

PROCEDURE D7963**FRENULOPLASTY**

1. Photographs for payment – submit a pre-operative photograph.
2. Written documentation for payment – shall include the rationale demonstrating the medical necessity and the specific area the treatment was performed.
3. Requires an arch code.
4. A benefit:
 - a. once per arch per date of service.
 - b. only when the permanent incisors and cuspids have erupted.

PROCEDURE D7970**EXCISION OF HYPERPLASTIC TISSUE – PER ARCH**

1. Photographs for payment – submit a pre-operative photograph.
2. Written documentation for payment – shall include the rationale demonstrating the medical necessity and the specific area the treatment was performed.
3. Requires an arch code.
4. A benefit once per arch per date of service.
5. Not a benefit for drug induced hyperplasia or where removal of tissue requires extensive gingival recontouring.
6. This procedure is included in the fees for other surgical procedures that are performed in the same area on the same date of service.

PROCEDURE D7971**EXCISION OF PERICORONAL GINGIVA**

1. Radiographs for payment – submit a pre-operative periapical radiograph.
2. Photographs for payment – submit a pre-operative photograph only when the radiograph does not adequately demonstrate the medical necessity.
3. Written documentation for payment – shall include the rationale demonstrating the medical necessity.
4. Requires a tooth code.
5. This procedure is included in the fee for other associated procedures that are performed on the same tooth on the same date of service.

PROCEDURE D7972**SURGICAL REDUCTION OF FIBROUS TUBEROSITY**

1. Photographs for payment – submit a pre-operative photograph.
2. Written documentation for payment – shall include the rationale demonstrating the medical necessity and the actual or proposed prosthodontic treatment.
3. Requires a quadrant code.

4. A benefit once per quadrant per date of service.
5. This procedure is included in the fees for other surgical procedures that are performed in the same quadrant on the same date of service.

PROCEDURE D7979**NON-SURGICAL SIALOLITHOTOMY**

1. Radiographs for payment – submit a pre-operative radiograph.
2. Written documentation or operative report for payment – shall include the area or region the treatment was performed, the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.

PROCEDURE D7980**SURGICAL SIALOLITHOTOMY**

1. Radiographs for payment – submit a pre-operative radiograph.
2. Written documentation or operative report for payment – shall include the area or region the treatment was performed, the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.

PROCEDURE D7981**EXCISION OF SALIVARY GLAND, BY REPORT**

Operative report for payment – shall include the area or region the treatment was performed, the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.

PROCEDURE D7982**SIALODOCHOPLASTY**

Operative report for payment – shall include the area or region the treatment was performed, the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.

PROCEDURE D7983**CLOSURE OF SALIVARY FISTULA**

Operative report for payment – shall include the area or region the treatment was performed, the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.

PROCEDURE D7990**EMERGENCY TRACHEOTOMY**

Operative report for payment – shall include the specific conditions addressed by the procedure.

PROCEDURE D7991**CORONOIDECTOMY**

1. Prior authorization is required.
2. Radiographs for prior authorization – submit a radiograph.
3. Written documentation for prior authorization – shall include the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
4. An operative report shall be submitted for payment.

PROCEDURE D7993**SURGICAL PLACEMENT OF CRANIOFACIAL IMPLANT – EXTRA ORAL**

1. Implant services are a benefit only when exceptional medical conditions are documented and shall be reviewed for medical necessity. Refer to Implant Services General policies for specific requirements.
2. Prior authorization is required.
3. Radiographs for prior authorization – submit arch, pre-operative periapical and/or panoramic radiographs as applicable.
4. Photographs for prior authorization – submit as applicable.
5. Written documentation for prior authorization – shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed treatment.

PROCEDURE D7994**SURGICAL PLACEMENT: ZYGOMATIC IMPLANT**

1. Implant services are a benefit only when exceptional medical conditions are documented and shall be reviewed for medical necessity. Refer to Implant Services General policies for specific requirements.
2. Prior authorization is required.
3. Radiographs for prior authorization – submit arch, pre-operative periapical and/or panoramic radiographs as applicable.
4. Photographs for prior authorization – submit as applicable.
5. Written documentation for prior authorization – shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed treatment.

PROCEDURE D7995**SYNTHETIC GRAFT – MANDIBLE OR FACIAL BONES, BY REPORT**

1. Prior authorization is required.
2. Radiographs for prior authorization – submit a radiograph.

3. Written documentation for prior authorization – shall include the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
4. Not a benefit for periodontal grafting.
5. An operative report shall be submitted for payment.

PROCEDURE D7996**IMPLANT – MANDIBLE FOR AUGMENTATION PURPOSES (EXCLUDING ALVEOLAR RIDGE), BY REPORT**

This procedure is not a benefit.

PROCEDURE D7997**APPLIANCE REMOVAL (NOT BY DENTIST WHO PLACED APPLIANCE), INCLUDES REMOVAL OF ARCH BAR**

1. Radiographs for payment – submit a pre-operative radiograph.
2. Written documentation for payment – shall include the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. Requires an arch code.
4. A benefit:
 - a. once per arch per date of service.
 - b. for the removal of appliances related to surgical procedures only.
5. Not a benefit for the removal of orthodontic appliances and space maintainers.

PROCEDURE D7998**INTRAORAL PLACEMENT OF A FIXATION DEVICE NOT IN CONJUNCTION WITH A FRACTURE**

This procedure is not a benefit.

PROCEDURE D7999**UNSPECIFIED ORAL SURGERY PROCEDURE, BY REPORT**

1. Radiographs for payment – submit radiographs if applicable for the type of procedure.
2. Photographs for payment – submit photographs if applicable for the type of procedure.
3. Written documentation or operative report – describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the actual treatment.
4. Procedure D7999 shall be used:
 - a. for a procedure which is not adequately described by a CDT code, or for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the medical condition and the specific CDT code associated with the treatment.

Orthodontic General Policies (D8000–D8999)

Orthodontic Procedures (D8080, D8660, D8670 and D8680)

- a) Orthodontic procedures shall only be performed by dentists who qualify as orthodontists under the California Code of Regulations, Title 22, Section 51223(c).
- b) Orthodontic procedures are benefits for medically necessary handicapping malocclusion, cleft palate and facial growth management cases for patients under the age of 21 and shall be prior authorized.
- c) Only those cases with permanent dentition shall be considered for medically necessary handicapping malocclusion, unless the patient is age 13 or older with primary teeth remaining. Cleft palate and craniofacial anomaly cases are a benefit for primary, mixed and permanent dentitions. Craniofacial anomalies are treated using facial growth management.
- d) All necessary procedures that may affect orthodontic treatment shall be completed before orthodontic treatment is considered.
- e) Orthodontic procedures are a benefit only when the diagnostic casts verify a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (09/18) or one of the six automatic qualifying conditions below exist or when there is written documentation of a craniofacial anomaly from a credentialed specialist on their professional letterhead. Refer to procedure D0470 for the criteria for the proper labelling and handling of diagnostic casts.
- f) The automatic qualifying conditions are:
 - i) cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
 - ii) craniofacial anomaly. Written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
 - iii) a deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,
 - iv) a crossbite of individual anterior teeth causing destruction of soft tissue,
 - v) an overjet greater than 9 mm or reverse overjet greater than 3.5 mm,
 - vi) a severe traumatic deviation (such as loss of a premaxilla segment by burns, accident or osteomyelitis or other gross pathology). Written documentation of the trauma or pathology shall be submitted with the prior authorization request.
- g) When a patient transfers from one orthodontist to another orthodontist, a new TAR for prior authorization shall be submitted:
 - i) when the patient has already qualified under the Medi-Cal Dental and has been receiving treatment, the remaining course of the originally authorized treatment shall be authorized to the new orthodontist to complete the case. Diagnostic casts, Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (09/18), and photographs are not required for a transfer case that has already been approved, or

- ii) when a patient has been receiving orthodontic treatment that has not been previously approved by the Medi-Cal Dental , pre-treatment diagnostic casts and current photographs are required. If pre- treatment diagnostic casts are not available then current diagnostic casts shall be submitted. Prior authorization for the remaining course of the orthodontic treatment shall be allowed or denied based on the Medi-Cal Dental 's evaluation of the diagnostic casts and photographs.
- h) When additional periodic orthodontic treatment visit(s) (D8670) are necessary beyond the maximum allowed to complete the case, prior authorization is required. Current photographs are required to justify the medical necessity.
- i) If the patient's orthodontic treatment extends beyond the month of their 21st birthday or they become ineligible during treatment, then it is the patient's responsibility to pay for their continued treatment. The Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form DC016 (09/18) shall be completed within the last three months prior to submitting for prior authorization for orthodontic services.

Orthodontic Procedures (D8000–D8999)

PROCEDURE D8010

LIMITED ORTHODONTIC TREATMENT OF THE PRIMARY DENTITION

This procedure is not a benefit.

PROCEDURE D8020

LIMITED ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION

This procedure is not a benefit.

PROCEDURE D8030

LIMITED ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION

This procedure is not a benefit.

PROCEDURE D8040

LIMITED ORTHODONTIC TREATMENT OF THE ADULT DENTITION

This procedure is not a benefit.

PROCEDURE D8070

COMPREHENSIVE ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION

This procedure is not a benefit.

PROCEDURE D8080

COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION

1. Prior authorization is required. The following shall be submitted together for prior authorization:
 - a. comprehensive orthodontic treatment of the adolescent dentition (D8080), and
 - b. periodic orthodontic treatment visit(s) (D8670), and
 - c. orthodontic retention (D8680), and
 - d. the diagnostic casts (D0470), and
 - e. a completed Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (09/18).
2. No treatment will be authorized and no payment will be allowed after the month of the patient's 21st birthday.
3. Written documentation for prior authorization for cleft palate and facial growth management cases shall be submitted:
 - a. cleft palate cases require documentation from a credentialed specialist, on their professional letterhead, if the cleft palate is not visible on the diagnostic casts, or
 - b. facial growth management cases require documentation from a credentialed specialist, on their professional letterhead, of the craniofacial anomaly.

4. A benefit:
 - a. for handicapping malocclusion, cleft palate and facial growth management cases.
 - b. for patients under the age of 21.
 - c. for permanent dentition (unless the patient has a cleft palate or craniofacial anomaly).
 - d. once per patient per phase of treatment.
5. All appliances (such as bands, arch wires, headgear and palatal expanders) are included in the fee for this procedure. No additional charge to the patient is permitted.
6. This procedure includes the replacement, repair and removal of brackets, bands and arch wires by the original provider.
7. 2D oral/facial photographic images (D0350) are included in the fee for this procedure and are not payable separately.

PROCEDURE D8090**COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADULT DENTITION**

This procedure is not a benefit.

PROCEDURE D8091**COMPREHENSIVE ORTHODONTIC TREATMENT WITH ORTHAGNATHIC SURGERY**

Global

PROCEDURE D8210**REMOVABLE APPLIANCE THERAPY**

1. Prior authorization is required.
2. Photographs are required for prior authorization.
3. Written documentation for prior authorization –shall justify the medical necessity for the appliance and the presence of a harmful oral habit such as thumb sucking and/or tongue thrusting.
4. A benefit:
 - a. for patients ages 6 through 12.
 - b. once per patient.
5. Not a benefit:
 - a. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.
 - b. for space maintainers in the upper or lower anterior region.
6. This procedure includes all adjustments to the appliance.

**PROCEDURE D8220
FIXED APPLIANCE THERAPY**

1. Prior authorization is required.
2. Radiographs for prior authorization –submit current periapical radiographs of the maxillary anterior teeth.
3. Written documentation for prior authorization –shall justify the medical necessity for the appliance and the presence of a harmful oral habit such as thumb sucking and/or tongue thrusting.
4. A benefit:
 - a. for patients ages 6 through 12.
 - b. once per patient.
5. Not a benefit:
 - a. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.
 - b. for space maintainers in the upper or lower anterior region.
6. This procedure includes all adjustments to the appliance.

**PROCEDURE D8660
PRE-ORTHODONTIC TREATMENT EXAMINATION TO MONITOR GROWTH AND DEVELOPMENT**

1. This procedure is for the observation of the patient's oral and/or facial growth for craniofacial anomalies prior to starting orthodontic treatment for facial growth management cases.
2. Prior authorization is required. The following shall be submitted together for authorization:
 - a. comprehensive orthodontic treatment of the adolescent dentition (D8080), and
 - b. pre-orthodontic treatment examination to monitor growth and development (D8660) indicating the quantity of treatment visits required up to a maximum of six during the patient's lifetime, and
 - c. periodic orthodontic treatment visit(s) (D8670), and
 - d. orthodontic retention (D8680), and
 - e. a completed Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (09/18).
3. Written documentation for prior authorization- shall include a letter from a credentialed specialist, on their professional letterhead, confirming a craniofacial anomaly.
4. A benefit:
 - a. prior to comprehensive orthodontic treatment of the adolescent dentition (D8080)

for the initial treatment phase for facial growth management cases regardless of how many dentition phases are required.

- b. once every three months.
 - c. for patients under the age of 21.
 - d. for a maximum of six.
5. 2D oral/facial photographic images (D0350) are included in the fee for this procedure and are not payable separately.

PROCEDURE D8670

PERIODIC ORTHODONTIC TREATMENT VISIT

1. Prior authorization is required. Refer to Orthodontic General Policies for specific authorization requirements.
2. The start of payments for this procedure shall be the next calendar month following the date of service for comprehensive orthodontic treatment of the adolescent dentition (D8080).
3. A benefit:
 - a. for patients under the age of 21.
 - b. for permanent dentition (unless the patient is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly).
 - c. once per calendar quarter.
4. The maximum quantity of monthly treatment visits for the following phases are:
 - a. Malocclusion- up to a maximum of 8 quarterly visits. (4 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity), or
 - b. Cleft Palate:
 - i) Primary dentition – up to a maximum of 4 quarterly visits. (2 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
 - ii) Mixed dentition - up to a maximum of 5 quarterly visits. (3 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
 - iii) Permanent dentition- up to a maximum of 10 quarterly visits. (5 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity), or
 - c. Facial Growth Management:
 - i) Primary dentition- up to a maximum of 4 quarterly visits. (2 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
 - ii) Mixed dentition- up to a maximum of 5 quarterly visits. (3 additional quarterly visits shall be authorized when documentation and photographs justify the

medical necessity).

- iii) Permanent dentition- up to a maximum of 8 quarterly visits. (4 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).

PROCEDURE D8671

PERIODIC ORTHODONTIC VISIT ASSOCIATED WITH ORTHOGNATHIC SURGERY

Global

PROCEDURE D8680

ORTHODONTIC RETENTION (REMOVAL OF APPLIANCES, CONSTRUCTION AND PLACEMENT OF RETAINER(S))

1. Prior authorization is required. Refer to Orthodontic General Policies for specific authorization requirements.
2. Photographs are required only if this procedure is to be performed by an orthodontist other than the original treating orthodontist.
3. This procedure shall be paid only following the completion of periodic orthodontic treatment visit(s) (D8670) which is considered to be the active phase of orthodontic treatment.
4. Requires an arch code.
5. A benefit:
 - a. for patients under the age of 21.
 - b. for permanent dentition (unless the patient is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly).
 - c. once per arch for each authorized phase of orthodontic treatment.
6. Not a benefit until the active phase of orthodontic treatment (D8670) is completed. If fewer than the authorized number of periodic orthodontic treatment visit(s) (D8670) are necessary because the active phase of treatment has been completed early, then this shall be documented on the claim for orthodontic retention (D8680).
7. The removal of appliances, construction and placement of retainers, all observations and necessary adjustments are included in the fee for this procedure.

PROCEDURE D8681

REMOVABLE ORTHODONTIC RETAINER ADJUSTMENT

This procedure is included in the fee for orthodontic retention (D8680) and is not payable separately.

PROCEDURE D8695

REMOVAL OF FIXED ORTHODONTIC APPLIANCES FOR REASONS OTHER THAN COMPLETION OF TREATMENT

1. This procedure does not require prior authorization.
2. Written documentation for payment- shall include a letter from the treating physician, dentist or radiologist, on their professional letterhead, stating the reason why the appliances needed to be temporarily removed shall be submitted.
 1. Requires an arch code.
 2. A benefit:
 - a. for patients under the age of 21.
 - b. if the patient's fixed orthodontic appliances have to be temporarily removed and then replaced due to a medical necessity.

PROCEDURE D8696**REPAIR OF ORTHODONTIC APPLIANCE – MAXILLARY**

1. This procedure does not require prior authorization except for transfer patients, which shall include photographs.
2. Written documentation for payment – indicate the type of orthodontic appliance and a description of the repair.
3. Requires an arch code.
4. A benefit:
 - a. for patients under the age of 21.
 - b. once per appliance.
5. Not a benefit to the original provider for the replacement and/or repair of brackets, bands, or arch wires.

PROCEDURE D8697**REPAIR OF ORTHODONTIC APPLIANCE – MANDIBULAR**

1. This procedure does not require prior authorization except for transfer patients, which shall include photographs.
2. Written documentation for payment – indicate the type of orthodontic appliance and a description of the repair.
3. Requires an arch code.
4. A benefit:
 - a. for patients under the age of 21.
 - b. once per appliance.
5. Not a benefit to the original provider for the replacement and/or repair of brackets, bands, or arch wires.

PROCEDURE D8698**RE-CEMENT OR RE-BOND FIXED RETAINER – MAXILLARY**

1. This procedure does not require prior authorization.
2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
3. Requires an arch code.
4. A benefit:
 - a. for patients under the age of 21.
 - b. once per provider.
5. Additional requests beyond the stated frequency limitations shall be considered for payment when the medical necessity is documented and identifies an unusual condition (such as displacement due to a sticky food item).

PROCEDURE D8699**RE-CEMENT OR RE-BOND FIXED RETAINER – MANDIBULAR**

1. This procedure does not require prior authorization.
2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
3. Requires an arch code.
4. A benefit:
 - a. for patients under the age of 21.
 - b. once per provider.
5. Additional requests beyond the stated frequency limitations shall be considered for payment when the medical necessity is documented and identifies an unusual condition (such as displacement due to a sticky food item).

PROCEDURE D8701**REPAIR OF FIXED RETAINERS, INCLUDES REATTACHMENT – MAXILLARY**

1. This procedure does not require prior authorization except for transfer patients which shall include photographs.
2. Written documentation for payment – indicate the type of orthodontic appliance and a description of the repair.
3. Requires an arch code.
4. A benefit:
 - a. for patients under the age of 21.
 - b. once per appliance.
5. Not a benefit to the original provider for the replacement and/or repair of brackets, bands, or arch wires.

PROCEDURE D8702

REPAIR OF FIXED RETAINERS, INCLUDES REATTACHMENT – MANDIBULAR

1. This procedure does not require prior authorization except for transfer patients which shall include photographs.
2. Written documentation for payment – indicate the type of orthodontic appliance and a description of the repair.
3. Requires an arch code.
4. A benefit:
 - a. for patients under the age of 21.
 - b. once per appliance.
5. Not a benefit to the original provider for the replacement and/or repair of brackets, bands, or arch wires.

PROCEDURE D8703**REPLACEMENT OF LOST OR BROKEN RETAINER – MAXILLARY**

1. This procedure does not require prior authorization except for transfer patients which shall include photographs.
2. Written documentation for payment – indicate how the retainer was lost or why it is no longer serviceable.
3. Requires an arch code.
4. A benefit:
 - a. for patients under the age of 21.
 - b. once per arch.
 - c. only within 24 months following the date of service of orthodontic retention (D8680).

PROCEDURE D8704**REPLACEMENT OF LOST OR BROKEN RETAINER – MANDIBULAR**

1. This procedure does not require prior authorization except for transfer patients which shall include photographs.
2. Written documentation for payment – indicate how the retainer was lost or why it is no longer serviceable.
3. Requires an arch code.
4. A benefit:
 - a. for patients under the age of 21.
 - b. once per arch.
 - c. only within 24 months following the date of service of orthodontic retention (D8680).

PROCEDURE D8999**UNSPECIFIED ORTHODONTIC PROCEDURE, BY REPORT**

1. Prior authorization is required for non-emergency procedures.
2. Radiographs for prior authorization or payment – submit radiographs if applicable for the type of procedure.
3. Photographs for prior authorization or payment – submit photographs if applicable for the type of procedure.
4. Written documentation for prior authorization or payment – describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed or actual treatment.
5. A benefit for patients under the age of 21.
6. Not a benefit to the original provider for the adjustment, repair, replacement or removal of brackets, bands or arch wires.

7. Procedure D8999 shall be used:
 - a. for a procedure which is not adequately described by a CDT code, or
 - b. for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the medical condition and the specific CDT code associated with the treatment.

Adjunctive General Policies (D9000–D9999)

Anesthesia (D9210–D9248)

- a) Deep sedation/general anesthesia (D9222 and D9223) is defined as a controlled state of unconsciousness, accompanied by a partial or complete loss of protective reflexes, including the loss of the ability to independently maintain an airway and respond purposefully to physical stimulation or verbal command, produced by a pharmacologic or non-pharmacologic method or combination thereof.
- b) Intravenous moderate (conscious) sedation/analgesia (D9239 and D9243) is a medically controlled state of depressed consciousness while maintaining the patient's airway, protective reflexes and the ability to respond to stimulation or verbal commands. It includes intravenous (IV) administration of sedative and/or analgesic agent(s) and appropriate monitoring.
- c) Non-intravenous conscious sedation (D9248) is a medically controlled state of depressed consciousness while maintaining the patient's airway, protective reflexes and the ability to respond to stimulation or verbal commands. It includes administration of sedative and/or analgesic agent(s) by a route other than IV (oral, patch, intramuscular or subcutaneous) and appropriate monitoring.
- d) Behavior modification and local anesthesia shall be attempted first before any type of sedation is considered. If this fails or is not possible due to the patient's medical condition, then sedation shall be considered. If sedation is indicated, then the least profound procedure shall be attempted first. The least profound procedure is inhalation of nitrous oxide/analgesia, anxiolysis (D9230) or non-intravenous conscious sedation (D9248), the next profound procedure is intravenous moderate (conscious) sedation/analgesia (D9239 and D9243) and the most profound is deep sedation/general anesthesia (D9222 and D9223).
- e) If the provider provides clear medical/dental documentation of **both** i) and ii) below then the patient shall be considered for prior authorization for deep sedation/general anesthesia (D9222 and D9223) or intravenous moderate (conscious) sedation/analgesia (D9239 and D9243). If the provider documents any **one** of iii) through vi) then the patient shall be considered for prior authorization for deep sedation/general anesthesia (D9222 and D9223) or intravenous moderate (conscious) sedation/analgesia (D9239 and D9243).
 - i) Use of local anesthesia to control pain failed or was not feasible based on the medical needs of the patient. Written documentation from the referring/treating provider shall include a copy of the patient record indicating such a failure or why it was not feasible based on the medical needs of the patient.
 - ii) Use of inhalation of nitrous oxide/analgesia, anxiolysis (D9230) or non- intravenous conscious sedation (D9248) failed or was not feasible based on the medical needs of the patient. Written documentation from the referring/treating provider shall include a copy of the patient record indicating such a failure or why it was not feasible based on the medical needs of the patient.

- iii) Use of effective communicative techniques and the ability for immobilization of the patient (patient is dangerous to self or staff) failed or was not feasible based on the medical needs of the patient. Written documentation from the referring/treating provider shall include a copy of the patient record indicating such a failure or why it was not feasible based on the medical needs of the patient.
- iv) Patient requires extensive dental restorative or surgical treatment that cannot be rendered under local anesthesia or conscious sedation. Radiographs (and photographs, if applicable) shall be submitted demonstrating such proposed treatment and shall be included on the same Treatment Authorization Request (TAR).
- v) Patient has acute situational anxiety due to immature cognitive functioning. Written documentation from the referring/treating provider shall include a copy of the patient record indicating such a condition.
- vi) Patient is uncooperative due to certain physical or mental compromising conditions. Patient is either a Registered Consumer from the Department of Developmental Services or written documentation from the patient's physician (on their professional letterhead) indicates such a condition.
- f) Patients with certain medical conditions such as, but not limited to, moderate to severe asthma, reactive airway disease, congestive heart failure, cardiac arrhythmias and significant bleeding disorders, uncontrolled seizures, and sleep disordered breathing, should be treated in a hospital setting or a licensed facility capable of responding to a serious medical crisis, as determined most appropriate by the provider.
- g) The administration of deep sedation/general anesthesia (D9222 and D9223), inhalation of nitrous oxide/analgesia, anxiolysis (D9230), intravenous moderate (conscious) sedation/analgesia (D9239 and D9243) and therapeutic parenteral drug (D9610) is a benefit in conjunction with payable associated procedures. Prior authorization or payment shall be denied if all associated procedures by the same provider are denied.
- h) Only one anesthesia procedure is payable per date of service regardless of the methods of administration or drugs used. When one or more anesthesia procedures are performed only the most profound procedure will be allowed. The following anesthesia procedures are listed in order from most profound to least profound:
 - i) Procedure D9222/D9223 (Deep Sedation/General Anesthesia),
 - ii) Procedure D9239/D9243 (Intravenous Moderate (Conscious) Sedation/Analgesia),
 - iii) Procedure D9248 (Non-Intravenous Conscious Sedation),
 - iv) Procedure D9230 (Inhalation Of Nitrous Oxide/Analgesia, Anxiolysis).
- i) Providers who administer general anesthesia (D9222 and D9223) and/or intravenous moderate (conscious) sedation/analgesia (D9239 and D9243) shall have valid anesthesia permits with the Dental Board of California.
- j) Evaluation for anesthesia procedures is included in the fees for anesthesia and oral evaluation procedures.
- k) The cost of analgesic and anesthetic agents and supplies are included in the fee for the analgesic/anesthetic procedure.

- l) Anesthesia time for general anesthesia and intravenous conscious sedation is defined as the period between the beginning of the administration of the anesthetic agent and the time that the anesthetist is no longer in personal attendance.
- m) Sedation is a benefit in conjunction with the surgical removal of wires, bands, splints and arch bars.
- n) All licensed dental hygienists must refer all patients they treat to a Medi-Cal dentist the dental hygienist has a referral agreement with, or to a dentist by submitting a referral to the patient's dental care coordination team within Medi-Cal.

Adjunctive Service Procedures (D9000–D9999)

PROCEDURE D9110

PALLIATIVE TREATMENT OF DENTAL PAIN – PER VISIT

1. This procedure cannot be prior authorized.
2. Written documentation for payment –shall include the tooth/area, condition and specific treatment performed.
3. A benefit once per date of service per provider regardless of the number of teeth and/or areas treated.

PROCEDURE D9120

FIXED PARTIAL DENTURE SECTIONING

1. This procedure does not require prior authorization.
2. Radiographs for payment – submit pre-operative radiographs.
3. Requires a tooth code for the retained tooth.
4. A benefit when at least one of the abutment teeth is to be retained.

PROCEDURE D9130

TEMPOROMANDIBULAR JOINT DYSFUNCTION – NON-INVASIVE PHYSICAL THERAPIES

This procedure is only payable as Unspecified TMD Therapy, By Report (D7899).

PROCEDURE D9210

LOCAL ANESTHESIA NOT IN CONJUNCTION WITH OPERATIVE OR SURGICAL PROCEDURES

1. This procedure cannot be prior authorized.
2. Written documentation for payment –shall include the medical necessity for the local anesthetic injection.
3. A benefit:
 - a. once per date of service per provider.
 - b. only for use in order to perform a differential diagnosis or as a therapeutic injection to eliminate or control a disease or abnormal state.
4. Not a benefit when any other treatment is performed on the same date of service, except when radiographs/photographs are needed of the affected area to diagnose and document the emergency condition.

PROCEDURE D9211

REGIONAL BLOCK ANESTHESIA

This procedure is included in the fee for other procedures and is not payable separately.

**PROCEDURE D9212
TRIGEMINAL DIVISION BLOCK ANESTHESIA**

This procedure is included in the fee for other procedures and is not payable separately.

**PROCEDURE D9215
LOCAL ANESTHESIA IN CONJUNCTION WITH OPERATIVE OR SURGICAL
PROCEDURES**

This procedure is included in the fee for other procedures and is not payable separately.

**PROCEDURE D9219
EVALUATION FOR MODERATE SEDATION, DEEP SEDATION OR GENERAL
ANESTHESIA**

Evaluation for anesthesia procedures is included in the fees for anesthesia and oral evaluation procedures and is not payable separately.

**PROCEDURE D9222
DEEP SEDATION/GENERAL ANESTHESIA – FIRST 15 MINUTES**

1. Prior authorization is required.
2. Written documentation for authorization—see the criteria under Adjunctive General Policies e).
3. An anesthesia record that indicates the anesthetic agent(s) and the anesthesia time shall be submitted for payment.
4. The quantity, in 15 minute increments, that was necessary to complete the treatment shall be indicated on the claim.
5. Not a benefit:
 - a. on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide (D9230), intravenous moderate (conscious) sedation/analgesia (D9239 and D9243) or non-intravenous conscious sedation (D9248).
 - b. when all associated procedures on the same date of service by the same provider are denied.

**PROCEDURE D9223
DEEP SEDATION/GENERAL ANESTHESIA – EACH SUBSEQUENT 15 MINUTE
INCREMENT**

1. Prior authorization is required.
2. Written documentation for authorization—see the criteria under Adjunctive General Policies e).
3. An anesthesia record that indicates the anesthetic agent(s) and the anesthesia time shall be submitted for payment.
4. The quantity, in 15 minute increments, that was necessary to complete the treatment shall be indicated on the claim.

5. Not a benefit:
 - a. on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide (D9230), intravenous moderate (conscious) sedation/analgesia (D9239 and D9243) or non-intravenous conscious sedation (D9248).
 - b. when all associated procedures on the same date of service by the same provider are denied.

PROCEDURE D9230**INHALATION OF NITROUS OXIDE /ANALGESIA, ANXIOLYSIS**

1. This procedure does not require prior authorization.
2. Written documentation for payment for patients age 16 or older- shall indicate the physical, behavioral, developmental or emotional condition that prohibits the patient from responding to the provider's attempts to perform treatment. Extensive dental treatment shall also be documented for consideration for payment.
3. A benefit:
 - a. for uncooperative patients under the age of 16, or
 - b. for patients age 16 or older when documentation specifically identifies the physical, behavioral, developmental or emotional condition that prohibits the patient from responding to the provider's attempts to perform treatment. Extensive dental treatment shall also be documented for consideration for payment.
4. Not a benefit:
 - a. on the same date of service as deep sedation/general anesthesia (D9222 and D9223), intravenous moderate (conscious) sedation/analgesia (D9239 and D9243) or non-intravenous conscious sedation (D9248).
 - b. when all associated procedures on the same date of service by the same provider are denied.

PROCEDURE D9239**INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA – FIRST 15 MINUTES**

1. Prior authorization is required.
2. Written documentation for authorization – see the criteria under Adjunctive General Policies e).
3. An anesthesia record that indicates the anesthetic agent(s) and the anesthesia time shall be submitted for payment.
4. The quantity, in 15 minute increments, that was necessary to complete the treatment shall be indicated on the claim.
5. Not a benefit:
 - a. on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide (D9230), deep sedation/general anesthesia (D9222 and D9223) or non-intravenous conscious sedation (D9248).

- b. when all associated procedures on the same date of service by the same provider are denied.

PROCEDURE D9243**INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ANALGESIA – EACH SUBSEQUENT 15 MINUTE INCREMENT**

1. Prior authorization is required.
2. Written documentation for authorization – see the criteria under Adjunctive General Policies e).
3. An anesthesia record that indicates the anesthetic agent(s) and the anesthesia time shall be submitted for payment.
4. The quantity, in 15 minute increments, that was necessary to complete the treatment shall be indicated on the claim.
5. Not a benefit:
 - a. on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide (D9230), deep sedation/general anesthesia (D9222 and D9223) or non-intravenous conscious sedation (D9248).
 - b. when all associated procedures on the same date of service by the same provider are denied.

PROCEDURE D9248**NON-INTRAVENOUS CONSCIOUS SEDATION**

1. This procedure does not require prior authorization.
2. Written documentation for payment for patients of all ages- shall indicate the specific anesthetic agent administered and the method of administration.
3. Written documentation for payment for patients age 13 or older- shall indicate the physical, behavioral, developmental or emotional condition that prohibits the patient from responding to the provider's attempts to perform treatment.
4. A benefit:
 - a. for uncooperative patients under the age of 13, or
 - b. for patients age 13 or older when documentation specifically identifies the physical, behavioral, developmental or emotional condition that prohibits the patient from responding to the provider's attempts to perform treatment.
 - c. for oral, patch, intramuscular or subcutaneous routes of administration.
 - d. once per date of service.
5. Not a benefit:
 - a. on the same date of service as deep sedation/general anesthesia (D9222 and D9223), analgesia, anxiolysis, inhalation of nitrous oxide (D9230) or intravenous moderate (conscious) sedation/analgesia (D9239 and D9243).
 - b. when all associated procedures on the same date of service by the same provider are denied.

PROCEDURE D9310**CONSULTATION – DIAGNOSTIC SERVICE PROVIDED BY DENTIST OR PHYSICIAN
OTHER THAN REQUESTING DENTIST OR PHYSICIAN**

This procedure shall only be billed as diagnostic procedures D0120, D0140, D0150, or D0160.

PROCEDURE D9311**CONSULTATION WITH A MEDICAL HEALTH CARE PROFESSIONAL**

This procedure is not a benefit.

PROCEDURE D9410**HOUSE/EXTENDED CARE FACILITY CALL**

1. Written documentation for payment – shall include the name, phone number, and address of the facility. When requesting treatment for a patient who cannot leave their private residence due to a medical condition, the patient's physician shall submit a letter on their professional letterhead with the following information documented:
 - a. the patient's specific medical condition, and
 - b. the reason why the patient cannot leave their private residence, and
 - c. the length of time the patient will be homebound.
2. A benefit:
 - a. once per patient per date of service.
 - b. only in conjunction with procedures that are payable.
3. When this procedure is submitted for payment without associated procedures, the medical necessity for the visit shall be documented and justified.

PROCEDURE D9420**HOSPITAL OR AMBULATORY SURGICAL CENTER CALL**

1. The operative report for payment – shall include the total time in the operating room or ambulatory surgical center.
2. A benefit for each hour or fraction thereof as documented on the operative report.
3. Not a benefit:
 - a. for an assistant surgeon.
 - b. for time spent compiling the patient history, writing reports or for post-operative or follow up visits.
4. Pre-operative examinations, processing, transportation and set up fees are included in the fee for D9420 and are not payable separately.

PROCEDURE D9430**OFFICE VISIT FOR OBSERVATION (DURING REGULARLY SCHEDULED HOURS) – NO
OTHER SERVICES PERFORMED**

1. This procedure cannot be prior authorized.

2. A benefit once per date of service per provider.
3. Not a benefit for visits to patients residing in a house/extended care facility.

PROCEDURE D9440**OFFICE VISIT – AFTER REGULARLY SCHEDULED HOURS**

1. This procedure cannot be prior authorized.
2. Written documentation for payment – shall include justification of the emergency (chief complaint) and be specific to an area or tooth. The time and day of the week shall also be documented.
3. A benefit:
 - a. once per date of service per provider.
 - b. only with treatment that is a benefit.
4. This procedure is to compensate providers for travel time back to the office for emergencies outside of regular office hours.

PROCEDURE D9450**CASE PRESENTATION, SUBSEQUENT TO DETAILED AND EXTENSIVE TREATMENT PLANNING**

This procedure is not a benefit.

PROCEDURE D9610**THERAPEUTIC PARENTERAL DRUG, SINGLE ADMINISTRATION**

1. Written documentation for payment – shall include the specific drug name and classification.
2. A benefit for up to a maximum of four injections per date of service.
3. Not a benefit:
 - a. for the administration of an analgesic or sedative when used in conjunction with deep sedation/general anesthesia (D9222 and D9223), inhalation of nitrous oxide/analgesia, anxiolysis (D9230), intravenous moderate (conscious) sedation/analgesia (D9239 and D9243) or non-intravenous conscious sedation (D9248).
 - b. when all associated procedures on the same date of service by the same provider are denied.

PROCEDURE D9612**THERAPEUTIC PARENTERAL DRUG, TWO OR MORE ADMINISTRATIONS, DIFFERENT MEDICATIONS**

This procedure can only be billed as therapeutic parenteral drug, single administration (D9610).

PROCEDURE D9613**INFILTRATION OF SUSTAINED RELEASE THERAPEUTIC DRUG, PER QUADRANT**

This procedure is not a benefit.

PROCEDURE D9630**DRUGS OR MEDICAMENTS DISPENSED IN THE OFFICE FOR HOME USE**

This procedure is not a benefit.

PROCEDURE D9910**APPLICATION OF DESENSITIZING MEDICAMENT**

1. This procedure cannot be prior authorized.
2. Written documentation for payment –shall include the tooth/teeth and the specific treatment performed.
3. A benefit:
 - a. once per date of service per provider regardless of the number of teeth and/or areas treated.
 - b. for permanent teeth only.
4. Not a benefit: when any other treatment is performed on the same date of service, except when radiographs/photographs are needed of the affected area to diagnose and document the emergency condition.
5. This procedure is considered to be an emergency treatment only.

PROCEDURE D9911**APPLICATION OF DESENSITIZING RESIN FOR CERVICAL AND/OR ROOT SURFACE, PER TOOTH**

This procedure is not a benefit.

PROCEDURE D9912**PRE-VISIT PATIENT SCREENING**

This procedure is included in the fee for another procedure and is not payable separately.

PROCEDURE D9913**ADMINISTRATION OF NEUROMODULATORS**

This procedure is not a benefit.

PROCEDURE D9914**ADMINISTRATION OF DERMAL FILLERS**

This procedure is not a benefit.

PROCEDURE D9920**BEHAVIOR MANAGEMENT, BY REPORT**

1. Written documentation for payment shall include documentation that the patient is a special needs patient that requires additional time for a dental visit. Special needs patients are defined as those patients who have a physical, behavioral, developmental or emotional condition that prohibits them from adequately responding to a provider's attempts to perform a dental visit. Documentation shall include the patient's medical diagnosis of such a condition and the reason for the need of additional time for a dental visit.
2. A benefit:
 - a. for four visits in a 12 month period to compensate the provider for additional time needed for providing services to patients with special health care needs.
 - b. only in conjunction with procedures that are payable.

PROCEDURE D9930**TREATMENT OF COMPLICATIONS (POST-SURGICAL) – UNUSUAL CIRCUMSTANCES, BY REPORT**

1. This procedure cannot be prior authorized.
2. Written documentation for payment – shall include the tooth, condition and specific treatment performed.
3. Requires a tooth code.
4. A benefit:
 - a. once per date of service per provider.
 - b. for the treatment of a dry socket or excessive bleeding within 30 days of the date of service of an extraction.
 - c. for the removal of bony fragments within 30 days of the date of service of an extraction.
5. Not a benefit:
 - a. for the removal of bony fragments on the same date of service as an extraction.
 - b. for routine post-operative visits.

PROCEDURE D9932**CLEANING AND INSPECTION OF A REMOVABLE COMPLETE DENTURE, MAXILLARY**

This procedure is not a benefit.

PROCEDURE D9933**CLEANING AND INSPECTION OF A REMOVABLE COMPLETE DENTURE, MANDIBULAR**

This procedure is not a benefit.

PROCEDURE D9934**CLEANING AND INSPECTION OF A REMOVABLE PARTIAL DENTURE, MAXILLARY**

This procedure is not a benefit.

PROCEDURE D9935**CLEANING AND INSPECTION OF A REMOVABLE PARTIAL DENTURE, MANDIBULAR**

This procedure is not a benefit.

PROCEDURE D9938**FABRICATION OF A CUSTOM REMOVABLE CLEAR PLASTIC TEMPORARY AESTHETIC APPLIANCE****PROCEDURE D9939****PLACEMENT OF A CUSTOM REMOVABLE CLEAR PLASTIC TEMPORARY AESTHETIC**

This procedure is not a benefit.

PROCEDURE D9941**FABRICATION OF ATHLETIC MOUTHGUARD**

This procedure is not a benefit.

PROCEDURE D9942**REPAIR AND/OR RELINE OF OCCLUSAL GUARD**

This procedure is not a benefit.

PROCEDURE D9943**OCCLUSAL GUARD ADJUSTMENT**

This procedure is not a benefit.

PROCEDURE D9944**OCCLUSAL GUARD – HARD APPLIANCE, FULL ARCH**

This procedure is not a benefit.

PROCEDURE D9945**OCCLUSAL GUARD – SOFT APPLIANCE, FULL ARCH**

This procedure is not a benefit.

PROCEDURE D9946**OCCLUSAL GUARD – HARD APPLIANCE, PARTIAL ARCH**

This procedure is not a benefit.

PROCEDURE D9947**CUSTOM SLEEP APNEA APPLIANCE FABRICATION AND PLACEMENT**

This procedure is not a benefit.

PROCEDURE D9948**ADJUSTMENT OF CUSTOM SLEEP APNEA APPLIANCE**

This procedure is not a benefit.

PROCEDURE D9949**REPAIR OF CUSTOM SLEEP APNEA APPLIANCE**

This procedure is not a benefit.

PROCEDURE D9950**OCCLUSION ANALYSIS – MOUNTED CASE**

1. Prior authorization is required.
2. Written documentation for prior authorization – shall describe the specific symptoms with a detailed history and diagnosis.
3. A benefit:
 - a. once in a 12 month period.
 - b. for patients age 13 or older.
 - c. for diagnosed TMJ dysfunction only.
 - d. for permanent dentition.
4. Not a benefit for bruxism only.
5. The fee for this procedure includes face bow, interocclusal record tracings, diagnostic wax up and diagnostic casts.

PROCEDURE D9951**OCCLUSAL ADJUSTMENT – LIMITED**

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. Requires a quadrant code.
3. A benefit:
 - a. once in a 12 month period per quadrant per provider.
 - b. for patients age 13 or older.
 - c. for natural teeth only.
4. Not a benefit within 30 days following definitive restorative, endodontic, removable and fixed prosthodontic treatment in the same or opposing quadrant.

PROCEDURE D9952**OCCLUSAL ADJUSTMENT – COMPLETE**

1. Prior authorization is required.
2. Written documentation for prior authorization – submit interocclusal record tracings that demonstrate the medical necessity to eliminate destructive occlusal forces.
3. A benefit:
 - a. once in a 12-month period following occlusion analysis- mounted case (D9950).
 - b. for patients age 13 or older.
 - c. for diagnosed TMJ dysfunction only.

d. for permanent dentition.

4. Not a benefit in conjunction with an occlusal orthotic device (D7880).
5. Occlusion analysis-mounted case (D9950) must precede this procedure.

PROCEDURE D9953**RELIN CUSTOM SLEEP APNEAR APPLIANCE (INDIRECT)**

This procedure is not a benefit.

PROCEDURE D9954**FABRICATION AND DELIVERY OF ORAL APPLIANCE THERAPY (OAT) MORNING REPOSITIONING DEVICE**

This procedure is not a benefit.

PROCEDURE D9955**ORAL APPLIANCE THERAPY (OAT) TITRATION VISIT**

This procedure is not a benefit.

PROCEDURE D9956**ADMINISTRATION OF HOME SLEEP APNEA TEST**

This procedure is not a benefit.

PROCEDURE D9957**SCREENING FOR SLEEP RELATED BREATHING DISORDERS**

Global

PROCEDURE D9959**UNSPECIFIED SLEEP APNEA SERVICES PROCEDURE BY REPORT**

This procedure is not a benefit.

PROCEDURE D9961**DUPLICATE/COPY PATIENT'S RECORDS**

This procedure is not a benefit.

PROCEDURE D9970**ENAMEL MICROABRASION**

This procedure is not a benefit.

PROCEDURE D9971**ODONTOPLASTY – PER TOOTH**

This procedure is not a benefit.

PROCEDURE D9972**EXTERNAL BLEACHING – PER ARCH – PERFORMED IN OFFICE**

PROCEDURE D9973

EXTERNAL BLEACHING – PER TOOTH

This procedure is not a benefit.

PROCEDURE D9974

INTERNAL BLEACHING – PER TOOTH

This procedure is not a benefit.

PROCEDURE D9975

EXTERNAL BLEACHING FOR HOME APPLICATION, PER ARCH; INCLUDES MATERIALS AND FABRICATION OF CUSTOM TRAYS

This procedure is not a benefit.

PROCEDURE D9985

SALES TAX

This procedure is not a benefit.

PROCEDURE D9986

MISSED APPOINTMENT

Under federal law, Medi-Cal providers are prohibited from billing a Medi-Cal member for missed appointments (42 CFR 447.15 and SSA 1902 (a)(19)).

PROCEDURE D9987

CANCELLED APPOINTMENT

Under federal law, Medi-Cal providers are prohibited from billing a Medi-Cal member for missed appointments (42 CFR 447.15 and SSA 1902 (a)(19)).

PROCEDURE D9990

CERTIFIED TRANSLATION OR SIGN-LANGUAGE SERVICES – PER VISIT

Translation services are available through Medi-Cal for Medi-Cal members. Please see section 4 of the Provider Handbook under Member Coverage.

PROCEDURE D9991

DENTAL CASE MANAGEMENT- ADDRESSING APPOINTMENT COMPLIANCE BARRIERS

Transportation services are available through Medi-Cal for Medi-Cal members. Please see section 4 and section 9 of the Provider Handbook under Non-Medical Transportation (NMT).

PROCEDURE D9992

DENTAL CASE MANAGEMENT – CARE COORDINATION

Care coordination services are available through Medi-Cal for Medi-Cal members. Please see section 4 of the Provider Handbook under Member Coverage and

https://www.dental.dhcs.ca.gov/Dental_Providers/MediCal_Dental/Dental_Case_Management_Program/

PROCEDURE D9993**DENTAL CASE MANAGEMENT – MOTIVATIONAL INTERVIEWING**

This procedure is not a benefit.

PROCEDURE D9994**DENTAL CASE MANAGEMENT – PATIENT EDUCATION TO IMPROVE ORAL HEALTH LITERACY**

1. Prior Authorization is not required.
2. Written documentation for payment – shall include the name of the CHW that provided the training, the number of patients present at the training, and the time of the training session (e.g. 2:30 PM to 3:00 PM).
3. A benefit:
 - a. For Members:
 - i. With one or more chronic health conditions (including behavioral health) or exposure to violence or trauma which has an impact on the Member's oral health.
 - ii. Who are at risk for a chronic health condition or environmental health exposure which has an impact on the Member's oral health.
 - iii. Who face barriers meeting their oral health or oral health-related social needs and/or would benefit from preventive oral health services.
 - iv. See Provider Handbook (will need to place a link and/or page numbers) for a detailed list of medical necessity eligibility criteria.
 - b. Up to 4 units (two hours) daily per Member.
 - i. Additional units per day may be requested on a TAR with documentation supporting the medical necessity. If the additional units have already been provided, then a claim may be submitted along with documentation supporting the medical necessity.
 - c. Up to 12 units of care (six hours) per Member per year.
 - i. Additional units per year may be requested on a TAR. Documentation shall include a written plan of care.

Refer to Provider Handbook (Section 4 Pages 22-28) for additional information.

PROCEDURE D9995**TELEDENTISTRY – SYNCHRONOUS; REAL-TIME ENCOUNTER**

1. Written documentation for payment shall include the number of minutes that the transmission occurred.
2. Payable once per date of service per patient, per provider up to a maximum of 90 minutes.
3. Providers can bill for services in the Diagnostic (D0100–D0999) and Preventive (D1000–D1999) categories when utilizing Teledentistry as a modality. Teledentistry is NOT allowable for all other service categories and CDT codes (D2000-D9999) except D9995 and D9996, which are the teledentistry modality codes and D9430 and D9994.
4. All services rendered through teledentistry must be in compliance with the Manual of Criteria (MOC), including documentation of requirement to substantiate the corresponding technical and professional components of billed service categories.

PROCEDURE D9996**TELEDENTISTRY – ASYNCHRONOUS; INFORMATION STORED AND FORWARDED TO DENTIST FOR SUBSEQUENT REVIEW**

1. Transmission costs associated with store and forward are not payable.
2. Providers can bill for services in the Diagnostic (D0100-D0999) and Preventive (D1000-D1999) categories when utilizing Teledentistry as a modality. Teledentistry is NOT allowable for all other service categories and CDT codes (D2000-D9999) except D9995 and D9996, which are the teledentistry modality codes.
3. All services rendered through teledentistry must be in compliance with the Manual of Criteria (MOC), including documentation of requirement to substantiate the corresponding technical and professional components of billed service categories.

PROCEDURE D9997**DENTAL CASE MANAGEMENT – PATIENTS WITH SPECIAL HEALTH CARE NEEDS**

This procedure is not a benefit

PROCEDURE D9999**UNSPECIFIED ADJUNCTIVE PROCEDURE, BY REPORT**

1. Prior authorization is required for non-emergency procedures.
2. Radiographs for prior authorization or payment – submit radiographs if applicable for the type of procedure.
3. Photographs for prior authorization or payment – submit photographs if applicable for the type of procedure.
4. Written documentation for prior authorization or payment – shall include a full description of the proposed or actual treatment and the medical necessity.
5. Procedure D9999 shall be used:
 - a. for a procedure which is not adequately described by a CDT code, or
 - b. for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the medical condition and the specific CDT code associated with the treatment.

Medi-Cal Dental Schedule of Maximum Allowances (SMA)

- Fees payable to providers by Medi-Cal Dental for covered services shall be the LESSER of:
 - provider's billed amount
 - the maximum allowance set forth in the schedule below
- Refer to your *Medi-Cal Dental Provider Handbook* for specific procedure instructions and program limitations.

Benefit: Dental or medical health care services covered by the Medi-Cal program.

Not a Benefit: Dental or medical health care services not covered by the Medi-Cal program.

Global: Treatment performed in conjunction with another procedure that is not payable separately.

By Report: Payment amount determined from submitted documentation.

CDT Codes	Procedure Code Description	Maximum \$\$ Allowance	Effective Date
Diagnostic Procedures			
D0120	Periodic oral evaluation – established patient	\$15.00	October 6, 2016
D0140	Limited oral evaluation – problem focused	\$35.00	
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	\$20.00	October 6, 2016
D0150	Comprehensive oral evaluation – new or established patient	\$25.00	October 6, 2016
D0160	Detailed and extensive oral evaluation – problem focused, by report	\$100.00	
D0170	Re-evaluation – limited, problem focused (established patient; not post-operative visit)	\$75.00	
D0171	Re-evaluation post-operative office visit	Global	March 14, 2020
D0180	Comprehensive periodontal evaluation – new or established patient	Global	
D0190	Screening of a patient	Not a Benefit	
D0191	Assessment of a patient	Not a Benefit	
D0210	Intraoral – comprehensive series of radiographic images	\$40.00	June 1, 2019
D0220	Intraoral – periapical first radiographic image	\$10.00	
D0230	Intraoral – periapical each additional radiographic image	\$3.00	
D0240	Intraoral – occlusal radiographic image	\$10.00	

CDT Codes	Procedure Code Description	Maximum \$\$ Allowance	Effective Date
D0250	Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	\$22.00	
D0251	Extra-oral posterior dental radiographic image	Not a Benefit	March 14, 2020
D0270	Bitewing – single radiographic image	\$5.00	
D0272	Bitewings – two radiographic images	\$10.00	
D0273	Bitewings – three radiographic images	Global	
D0274	Bitewings – four radiographic images	\$18.00	
D0277	Vertical bitewings – 7 to 8 radiographic images	Global	
D0310	Sialography	\$100.00	
D0320	Temporomandibular joint arthrogram, including injection	\$76.00	
D0321	Other temporomandibular joint radiographic images, by report	Not a Benefit	
D0322	Tomographic survey	\$100.00	
D0330	Panoramic radiographic image	\$25.00	
D0340	2D Cephalometric radiographic image – acquisition, measurement and analysis	\$50.00	June 1, 2019
D0350	2D Oral/Facial photographic image obtained intra-orally or extra orally	\$6.00	
D0364	Cone beam CT capture and interpretation with limited field of view – less than one whole jaw	Not a Benefit	
D0365	Cone beam CT capture and interpretation with limited field of view of one full dental arch – mandible	Not a Benefit	
D0366	Cone beam CT capture and interpretation with field of view of one full dental arch – maxilla, with or without cranium	Not a Benefit	
D0367	Cone beam CT capture and interpretation with field of view of both jaws with or without cranium	Not a Benefit	
D0368	Cone beam CT capture and interpretation for TMJ series including two or more exposures	Not a Benefit	
D0369	Maxillofacial MRI capture and interpretation	Not a Benefit	
D0370	Maxillofacial ultrasound capture and interpretation	Not a Benefit	
D0371	Sialoendoscopy capture and interpretation	Not a Benefit	

CDT Codes	Procedure Code Description	Maximum \$\$ Allowance	Effective Date
D0372	Intraoral tomosynthesis – comprehensive series of radiographic images	Not a Benefit	
D0373	Intraoral tomosynthesis – bitewing radiographic image	Not a Benefit	
D0374	Intraoral tomosynthesis - periapical radiographic image	Not a Benefit	
D0380	Cone beam CT image capture with limited field of view – less than one whole jaw	Not a Benefit	
D0381	Cone beam CT image capture with field of view of one full dental arch – mandible	Not a Benefit	
D0382	Cone beam CT image capture with field of view of one full dental arch – maxilla with or without cranium	Not a Benefit	
D0383	Cone beam CT image capture with field of view of both jaws, with or without cranium	Not a Benefit	
D0384	Cone beam CT image capture for TMJ series including two or more exposures	Not a Benefit	
D0385	Maxillofacial MRI image capture	Not a Benefit	
D0386	Maxillofacial ultrasound image capture	Not a Benefit	
D0387	Intraoral tomosynthesis – comprehensive series of radiographic images – image capture only	Not a Benefit	
D0388	Intraoral tomosynthesis – bitewing radiographic image – image capture only	Not a Benefit	
D0389	Intraoral tomosynthesis – periapical radiographic image – image capture only	Not a Benefit	
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report	Not a Benefit	
D0393	Virtual treatment simulation using 3D image volume or surface scan	Not a Benefit	March 14, 2020
D0394	Digital subtraction of two or more images or image volumes of the same modality	Not a Benefit	March 14, 2020
D0395	Fusion of two or more 3d image volumes of one or more modalities	Not a Benefit	March 14, 2020
D0396	3D printing of a 3D dental surface scan	Not a Benefit	
D0411	HBA1C in-office point of service testing	Not a Benefit	March 14, 2020
D0412	Blood glucose level test in-office using a glucose meter	Not a Benefit	March 14, 2020

CDT Codes	Procedure Code Description	Maximum \$\$ Allowance	Effective Date
D0414	Laboratory processing of microbial specimen to include culture and sensitivity studies, preparation and transmission of written report	Not a Benefit	March 14, 2020
D0415	Collection of microorganisms for culture and sensitivity	Not a Benefit	
D0416	Viral culture	Not a Benefit	
D0417	Collection and preparation of saliva sample for laboratory diagnostic testing	Not a Benefit	
D0418	Analysis of saliva sample	Not a Benefit	
D0419	Assessment of salivary flow by measurement	Not a Benefit	July 1, 2021
D0422	Collection and preparation of genetic sample material for laboratory analysis and report	Not a Benefit	March 14, 2020
D0423	Genetic test for susceptibility to diseases – specimen analysis	Not a Benefit	March 14, 2020
D0425	Caries susceptibility tests	Not a Benefit	
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	Not a Benefit	
D0460	Pulp vitality tests	Global	
D0470	Diagnostic casts	\$75.00	
D0472	Accession of tissue, gross examination, preparation and transmission of written report	Not a Benefit	
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	Not a Benefit	
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	Not a Benefit	
D0475	Decalcification procedure	Not a Benefit	
D0476	Special stains for microorganisms	Not a Benefit	
D0477	Special stains not for microorganisms	Not a Benefit	
D0478	Immunohistochemical stains	Not a Benefit	
D0479	Tissue in-situ hybridization, including interpretation	Not a Benefit	

CDT Codes	Procedure Code Description	Maximum \$\$ Allowance	Effective Date
D0480	Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report	Not a Benefit	
D0481	Electron microscopy	Not a Benefit	
D0482	Direct immunofluorescence	Not a Benefit	
D0483	Indirect immunofluorescence	Not a Benefit	
D0484	Consultation on slides prepared elsewhere	Not a Benefit	
D0485	Consultation, including preparation of slides from biopsy material supplied by referring source	Not a Benefit	
D0486	Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report	Not a Benefit	
D0502	Other oral pathology procedures, by report	By Report	
D0600	Non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin, and cementum	Not a Benefit	March 14, 2020
D0601 ¹	Caries risk assessment and documentation, with a finding of low risk	\$15.00	January 1, 2022
D0602 ²	Caries risk assessment and documentation, with a finding of moderate risk	\$15.00	January 1, 2022
D0603 ³	Caries risk assessment and documentation, with a finding of high risk	\$15.00	January 1, 2022
D0604	Antigen testing for a public health related pathogen, including coronavirus	Not a Benefit	October 1, 2021
D0605	Antibody testing for a public health related pathogen, including coronavirus	Not a Benefit	October 1, 2021
D0606	Molecular testing for a public health related pathogen, including coronavirus	Not a Benefit	May 1, 2022
D0701	Panoramic radiographic image – image capture only	Global	October 1, 2021
D0702	2-D cephalometric radiographic image – image capture only	Global	October 1, 2021
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally – image capture only	Global	October 1, 2021
D0705	Extra-oral posterior dental radiographic image – image capture only	Not a Benefit	October 1, 2021
D0706	Intraoral - occlusal radiographic image – image capture only	Global	October 1, 2021

CDT Codes	Procedure Code Description	Maximum \$\$ Allowance	Effective Date
D0707	Intraoral – periapical radiographic image – image capture only	Global	October 1, 2021
D0708	Intraoral – bitewing radiographic image – image capture only	Global	October 1, 2021
D0709	Intraoral - comprehensive series of radiographic images – image capture only	Global	October 1, 2021
D0801	3D intraoral surface scan – direct	Not a Benefit	
D0802	3D dental surface scan – indirect	Not a Benefit	
D0803	3D facial surface scan – direct	Not a Benefit	
D0804	3D facial surface scan – indirect- a surface scan of constructed facial features	Not a Benefit	
D0999	Unspecified diagnostic procedure, by report	\$46.00	May 16, 2020
Preventive Procedures			
D1110	Prophylaxis – adult	\$40.00	July 15, 2016
D1120	Prophylaxis – child	\$30.00	July 15, 2016
D1206	Topical application of fluoride varnish - child 0 to 5	\$18.00	June 1, 2019
D1206	Topical application of fluoride varnish - child 6 to 20	\$8.00	June 1, 2019
D1206	Topical application of fluoride varnish - adult 21 and over	\$6.00	June 1, 2019
D1208	Topical application of fluoride - excluding varnish – child 0-5	\$18.00	June 1, 2019
D1208	Topical application of fluoride - excluding varnish – child 6-20	\$8.00	June 1, 2019
D1208	Topical application of fluoride - excluding varnish – adult	\$6.00	June 1, 2019
D1301	Immunization counseling	Not a Benefit	
D1310 ⁴	Nutritional counseling for control of dental disease	\$46.00	January 1, 2022
D1320	Tobacco counseling for the control and prevention of oral disease	\$10.00	June 1, 2019
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systematic health effects associated with high-risk substance use	Not a Benefit	October 1, 2021
D1330	Oral hygiene instructions	Global	
D1351	Sealant – per tooth	\$22.00	

CDT Codes	Procedure Code Description	Maximum \$\$ Allowance	Effective Date
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth	\$22.00	
D1353	Sealant repair – per tooth	Not a Benefit	March 14, 2020
D1354	Application of caries arresting medicament – per tooth	\$12.00	January 1, 2022
D1355	Caries preventive medicament application – per tooth	Not a Benefit	October 1, 2021
D1510	Space maintainer – fixed – unilateral- per quadrant	\$120.00	July 1, 2021
D1516	Space maintainer – fixed – bilateral, maxillary	\$200.00	March 14, 2020
D1517	Space maintainer – fixed – bilateral, mandibular	\$200.00	March 14, 2020
D1520	Space maintainer – removable – unilateral- per quadrant	Not a Benefit	July 1, 2021
D1526	Space maintainer – removable – bilateral, maxillary	\$230.00	March 14, 2020
D1527	Space maintainer – removable – bilateral, mandibular	\$230.00	March 14, 2020
D1551	Re-cement or re-bond bilateral space maintainer – maxillary	\$30.00	July 1, 2021
D1552	Re-cement or re-bond bilateral space maintainer – mandibular	\$30.00	July 1, 2021
D1553	Re-cement or re-bond unilateral space maintainer – per quadrant	\$30.00	July 1, 2021
D1556	Removal of fixed unilateral space maintainer – per quadrant	\$30.00	July 1, 2021
D1557	Removal of fixed bilateral space maintainer – maxillary	\$30.00	July 1, 2021
D1558	Removal of fixed bilateral space maintainer – mandibular	\$30.00	July 1, 2021
D1575	Distal shoe space maintainer – fixed – unilateral – per quadrant	\$120.00	May 16, 2020
D1701	Pfizer-BioNTech Covid-19 vaccine administration – first dose	Not a Benefit	May 1, 2022
D1702	Pfizer-BioNTech Covid-19 vaccine administration – second dose	Not a Benefit	May 1, 2022
D1703	Moderna Covid-19 vaccine administration – first dose	Not a Benefit	May 1, 2022
D1704	Moderna Covid-19 vaccine administration – second dose	Not a Benefit	May 1, 2022

CDT Codes	Procedure Code Description	Maximum \$\$ Allowance	Effective Date
D1705	AstraZeneca Covid-19 vaccine administration – first dose	Not a Benefit	May 1, 2022
D1706	AstraZeneca Covid-19 vaccine administration – second dose	Not a Benefit	May 1, 2022
D1707	Janssen Covid-19 vaccine administration	Not a Benefit	May 1, 2022
D1708	Pfizer-BioNTech Covid-19 vaccine administration – third dose	Not a Benefit	
D1709	Pfizer-BioNTech Covid-19 vaccine administration – booster dose	Not a Benefit	
D1710	Moderna Covid-19 vaccine administration – third dose	Not a Benefit	
D1711	Moderna Covid-19 vaccine administration – booster dose	Not a Benefit	
D1712	Janssen Covid-19 vaccine administration – booster dose	Not a Benefit	
D1713	Pfizer-BioNTech Covid-19 vaccine administration – tris-sucrose pediatric – first dose	Not a Benefit	
D1714	Pfizer-BioNTech Covid-19 vaccine administration – tris-sucrose pediatric – second dose	Not a Benefit	
D1781	Vaccine administration – human papillomavirus – dose 1	Not a Benefit	
D1782	Vaccine administration - human papillomavirus - dose 2	Not a Benefit	
D1783	Vaccine administration – human papillomavirus – dose 3	Not a Benefit	
D1999	Unspecified preventive procedure, by report	\$46.00	March 14, 2020
Restorative Procedures			
D2140	Amalgam – one surface, primary or permanent	\$39.00	January 13, 2016
D2150	Amalgam – two surfaces, primary or permanent	\$48.00	January 13, 2016
D2160	Amalgam – three surfaces, primary or permanent	\$57.00	January 13, 2016
D2161	Amalgam – four or more surfaces, primary or permanent	\$60.00	January 13, 2016
D2330	Resin-based composite – one surface, anterior	\$57.21	March 1, 2023
D2331	Resin-based composite – two surfaces, anterior	\$57.21	March 1, 2023
D2332	Resin-based composite – three surfaces, anterior	\$57.21	March 1, 2023

CDT Codes	Procedure Code Description	Maximum \$\$ Allowance	Effective Date
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)	\$85.00	January 13, 2016
D2390	Resin-based composite crown, anterior	\$75.00	January 13, 2016
D2391	Resin-based composite – one surface, posterior	\$39.00	January 13, 2016
D2392	Resin-based composite – two surfaces, posterior	\$48.00	January 13, 2016
D2393	Resin-based composite – three surfaces, posterior	\$57.00	January 13, 2016
D2394	Resin-based composite – four or more surfaces, posterior	\$60.00	January 13, 2016
D2410	Gold foil – one surface	Not a Benefit	
D2420	Gold foil – two surfaces	Not a Benefit	
D2430	Gold foil – three surfaces	Not a Benefit	
D2510	Inlay – metallic – one surface	Not a Benefit	
D2520	Inlay – metallic – two surfaces	Not a Benefit	
D2530	Inlay – metallic – three surfaces	Not a Benefit	
D2542	Onlay – metallic – two surfaces	Not a Benefit	
D2543	Onlay – metallic – three surfaces	Not a Benefit	
D2544	Onlay – metallic – four or more surfaces	Not a Benefit	
D2610	Inlay – porcelain/ceramic – one surface	Not a Benefit	
D2620	Inlay – porcelain/ceramic – two surfaces	Not a Benefit	
D2630	Inlay – porcelain/ceramic – three or more surfaces	Not a Benefit	
D2642	Onlay – porcelain/ceramic – two surfaces	Not a Benefit	
D2643	Onlay – porcelain/ceramic – three surfaces	Not a Benefit	
D2644	Onlay – porcelain/ceramic – four or more surfaces	Not a Benefit	
D2650	Inlay – resin-based composite – one surface	Not a Benefit	
D2651	Inlay – resin-based composite – two surfaces	Not a Benefit	
D2652	Inlay – resin-based composite – three or more surfaces	Not a Benefit	
D2662	Onlay – resin-based composite – two surfaces	Not a Benefit	
D2663	Onlay – resin-based composite – three surfaces	Not a Benefit	
D2664	Onlay – resin-based composite – four or more surfaces	Not a Benefit	
D2710	Crown – resin - based composite (indirect)	\$150.00	March 1, 2019
D2712	Crown – 3/4 resin-based composite (indirect)	\$150.00	March 1, 2019

CDT Codes	Procedure Code Description	Maximum \$\$ Allowance	Effective Date
D2720	Crown – resin with high noble metal	Not a Benefit	
D2721	Crown – resin with predominantly base metal	\$220.00	March 1, 2019
D2722	Crown – resin with noble metal	Not a Benefit	
D2740	Crown – porcelain/ceramic	\$340.00	March 1, 2019
D2750	Crown – porcelain fused to high noble metal	Not a Benefit	
D2751	Crown – porcelain fused to predominantly base metal	\$340.00	March 1, 2019
D2752	Crown – porcelain fused to noble metal	Not a Benefit	
D2753	Crown – porcelain fused to titanium and titanium alloys	Not a Benefit	July 1, 2021
D2780	Crown – 3/4 cast high noble metal	Not a Benefit	
D2781	Crown – 3/4 cast predominantly base metal	\$340.00	March 1, 2019
D2782	Crown – 3/4 cast noble metal	Not a Benefit	
D2783	Crown – 3/4 porcelain/ceramic	\$340.00	March 1, 2019
D2790	Crown – full cast high noble metal	Not a Benefit	
D2791	Crown – full cast predominantly base metal	\$340.00	March 1, 2019
D2792	Crown – full cast noble metal	Not a Benefit	
D2794	Crown – titanium and titanium alloys	Not a Benefit	July 1, 2021
D2799	Interim crown – further treatment or completion of diagnosis necessary prior to final impression	Not a Benefit	
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	\$30.00	
D2915	Recement or re-bond indirectly fabricated or prefabricated post and core	Global	
D2920	Recement or re-bond crown	\$30.00	
D2921	Reattachment of tooth permanent, incisal edge or cusp	Not a Benefit	March 14, 2020
D2928	Prefabricated porcelain/ceramic crown – permanent tooth	Not a Benefit	October 1, 2021
D2929	Prefabricated porcelain/ceramic crown - primary tooth	Not a Benefit	March 14, 2020
D2930	Prefabricated stainless steel crown – primary tooth	\$75.00	January 13, 2016
D2931	Prefabricated stainless steel crown – permanent tooth	\$90.00	January 13, 2016

CDT Codes	Procedure Code Description	Maximum \$\$ Allowance	Effective Date
D2932	Prefabricated resin crown	\$75.00	January 13, 2016
D2933	Prefabricated stainless steel crown with resin window	\$75.00	January 13, 2016
D2934	Prefabricated esthetic coated stainless steel crown – primary tooth	Not a Benefit	
D2940	Placement of interim direct restoration	\$45.00	March 14, 2020
D2949	Restorative foundation for an indirect restoration	Global	March 14, 2020
D2950	Core buildup, including any pins when required	Global	
D2951	Pin retention – per tooth, in addition to restoration	\$80.00	
D2952	Post and core in addition to crown, indirectly fabricated	\$75.00	
D2953	Each additional indirectly fabricated post – same tooth	Global	
D2954	Prefabricated post and core in addition to crown	\$75.00	
D2955	Post removal	Global	
D2956	Removal of an indirect restoration on a natural tooth	Global	
D2957	Each additional prefabricated post – same tooth	Global	
D2960	Labial veneer (resin laminate) –direct	Not a Benefit	October 1, 2021
D2961	Labial veneer (resin laminate) –indirect	Not a Benefit	October 1, 2021
D2962	Labial veneer (porcelain laminate) –indirect	Not a Benefit	October 1, 2021
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework	Global	
D2975	Coping	Not a Benefit	
D2976	Band Stabilization – per tooth	Not a Benefit	
D2980	Crown repair, necessitated by restorative material failure	\$60.00	
D2981	Inlay repair necessitated by restorative material failure	Not a Benefit	
D2982	Onlay repair necessitated by restorative material failure	Not a Benefit	
D2983	Veneer repair necessitated by restorative material failure	Not a Benefit	
D2989	Restorative service - excavation of a tooth resulting in the determination of non-restorability	Global	February 1, 2024

CDT Codes	Procedure Code Description	Maximum \$\$ Allowance	Effective Date
D2990	Resin infiltration of incipient smooth surface lesions	Not a Benefit	
D2991	Application of hydroxyapatite regeneration medicament – per tooth	Not a Benefit	
D2999	Unspecified restorative procedure, by report	\$50.00	
Endodontic Procedures			
D3110	Pulp cap – direct (excluding final restoration)	Global	
D3120	Pulp cap – indirect (excluding final restoration)	Global	
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction application of medicament	\$71.00	
D3221	Pulpal debridement, primary and permanent teeth	\$45.00	
D3222	Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development	\$71.00	
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	\$71.00	
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	\$71.00	
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	\$216.00	March 15, 2017
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	\$261.00	March 15, 2017
D3330	Endodontic therapy, molar tooth (excluding final restoration)	\$331.00	March 15, 2017
D3331	Treatment of root canal obstruction; non-surgical access	Global	
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	Not a Benefit	
D3333	Internal root repair of perforation defects	Global	
D3346	Retreatment of previous root canal therapy – anterior	\$216.00	March 15, 2017
D3347	Retreatment of previous root canal therapy – premolar	\$261.00	March 15, 2017
D3348	Retreatment of previous root canal therapy – molar	\$331.00	March 15, 2017
D3351	Apexification/Recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	\$100.00	

CDT Codes	Procedure Code Description	Maximum \$\$ Allowance	Effective Date
D3352	Apexification/Recalcification - interim medication replacement	\$100.00	
D3353	Apexification/Recalcification – final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.)	Not a Benefit	
D3355	Pulpal regeneration – initial visit	Not a Benefit	March 14, 2020
D3356	Pulpal regeneration – interim medication replacement	Not a Benefit	March 14, 2020
D3357	Pulpal regeneration – completion of treatment	Not a Benefit	March 14, 2020
D3410	Apicoectomy – anterior	\$100.00	
D3421	Apicoectomy – premolar (first root)	\$100.00	
D3425	Apicoectomy – molar (first root)	\$100.00	
D3426	Apicoectomy – (each additional root)	\$100.00	
D3428	Bone graft in conjunction with periradicular surgery – per tooth, single site	Not a Benefit	March 14, 2020
D3429	Bone graft in conjunction with periradicular surgery – each additional contiguous tooth in the same surgical site	Not a Benefit	March 14, 2020
D3430	Retrograde filling – per root	Global	
D3431	Biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery	Not a Benefit	March 14, 2020
D3432	Guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery	Not a Benefit	March 14, 2020
D3450	Root amputation – per root	Not a Benefit	
D3460	Endodontic endosseous implant	Not a Benefit	
D3470	Intentional reimplantation (including necessary splinting)	Not a Benefit	
D3471	Surgical repair of root resorption – anterior	\$100.00	October 1, 2021
D3472	Surgical repair of root resorption – premolar	\$100.00	October 1, 2021
D3473	Surgical repair of root resorption – molar	\$100.00	October 1, 2021
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption – anterior	Not a Benefit	October 1, 2021

CDT Codes	Procedure Code Description	Maximum \$\$ Allowance	Effective Date
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption – premolar	Not a Benefit	October 1, 2021
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption – molar	Not a Benefit	October 1, 2021
D3910	Surgical procedure for isolation of tooth with rubber dam	Global	
D3911	Intraorifice barrier	Global	May 1, 2022
D3920	Hemisection (including any root removal), not including root canal therapy	Not a Benefit	
D3921	Decoronation or submergence of an erupted tooth	\$135.00	May 1, 2022
D3950	Canal preparation and fitting of preformed dowel or post	Not a Benefit	
D3999	Unspecified endodontic procedure, by report	\$42.00	
Periodontal Procedures			
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bound spaces per quadrant	\$185.00	
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant	\$110.00	
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	Not a Benefit	
D4230	Anatomical crown exposure – four or more contiguous teeth or bounded tooth spaces per quadrant	Not a Benefit	
D4231	Anatomical crown exposure – one to three teeth bounded tooth spaces per quadrant	Not a Benefit	
D4240	Gingival flap procedure, including root planing – four or more contiguous teeth or tooth bounded spaces per quadrant	Not a Benefit	
D4241	Gingival flap procedure, including root planing – one to three contiguous teeth or tooth bounded spaces per quadrant	Not a Benefit	
D4245	Apically positioned flap	Not a Benefit	
D4249	Clinical crown lengthening – hard tissue	Global	
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more	\$350.00	

CDT Codes	Procedure Code Description	Maximum \$\$ Allowance	Effective Date
	contiguous teeth or tooth bounded spaces per quadrant		
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces, per quadrant	\$245.00	
D4263	Bone replacement graft – retained natural tooth-first site in quadrant	Not a Benefit	
D4264	Bone replacement graft – retained natural tooth – each additional site in quadrant	Not a Benefit	
D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site	Global	
D4266	Guided tissue regeneration, natural teeth – resorbable barrier, per site	Not a Benefit	
D4267	Guided tissue regeneration, natural teeth – nonresorbable barrier, per site	Not a Benefit	
D4268	Surgical revision procedure, per tooth	Not a Benefit	
D4270	Pedicle soft tissue graft procedure	Not a Benefit	
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	Not a Benefit	
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	Not a Benefit	
D4275	Non-Autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	Not a Benefit	
D4276	Combined connective tissue and pedicle graft, per tooth	Not a Benefit	
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	Not a Benefit	
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites), each additional contiguous tooth, implant or edentulous tooth position in same graft site	Not a Benefit	
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) –	Not a Benefit	March 14, 2020

CDT Codes	Procedure Code Description	Maximum \$\$ Allowance	Effective Date
	each additional contiguous tooth, implant or edentulous tooth position in same graft site		
D4285	Non-autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in same graft site	Not a Benefit	March 14, 2020
D4286	Removal of non-resorbable barrier	Not a Benefit	
D4322	Splint - intra-coronal; natural teeth or prosthetic crowns	Not a Benefit	May 1, 2022
D4323	Splint - extra-coronal; natural teeth or prosthetic crowns	Not a Benefit	May 1, 2022
D4341	Periodontal scaling and root planing – four or more teeth per quadrant (for members in a SNF or ICF)	\$70.00	
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	\$50.00	
D4342	Periodontal scaling and root planing – one to three teeth, per quadrant (for members in a SNF or ICF)	\$50.00	
D4342	Periodontal scaling and root planing – one to three teeth, per quadrant	\$30.00	
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	Global	May 16, 2020
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	\$75.00	July 15, 2016
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	Global	
D4910	Periodontal maintenance	\$55.00	May 16, 2018
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	\$45.00	
D4921	Gingival irrigation with medicinal agent – per quadrant	Global	March 14, 2020
D4999	Unspecified periodontal procedure, by report	By Report	
Prosthodontic (Removable) Procedures			
D5110	Complete denture – maxillary	\$450.00	

CDT Codes	Procedure Code Description	Maximum \$\$ Allowance	Effective Date
D5120	Complete denture – mandibular	\$450.00	
D5130	Immediate denture – maxillary	\$450.00	
D5140	Immediate denture – mandibular	\$450.00	
D5211	Maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth)	\$250.00	July 10, 2019
D5212	Mandibular partial denture – resin base (including retentive/clasping materials, rest and teeth)	\$250.00	July 10, 2019
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$470.00	July 1, 2021
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$470.00	July 1, 2021
D5221	Immediate maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth)	Not a Benefit	July 1, 2021
D5222	Immediate mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth)	Not a Benefit	July 1, 2021
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	Not a Benefit	July 1, 2021
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	Not a Benefit	July 1, 2021
D5225	Maxillary partial denture – flexible base (including retentive/clasping materials, rests and teeth)	Not a Benefit	October 1, 2021
D5226	Mandibular partial denture – flexible base (including retentive/clasping materials, rests and teeth)	Not a Benefit	October 1, 2021
D5227	Immediate maxillary partial denture – flexible base (including any clasps, rests, and teeth)	Not a Benefit	May 1, 2022
D5228	Immediate mandibular partial denture – flexible base (including any clasps, rests, and teeth)	Not a Benefit	May 1, 2022
D5282	Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests and teeth), maxillary	Not a Benefit	October 1, 2021, March 14, 2020

CDT Codes	Procedure Code Description	Maximum \$\$ Allowance	Effective Date
D5283	Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests and teeth), mandibular	Not a Benefit	October 1, 2021, March 14, 2020
D5284	Removable unilateral partial denture – one-piece flexible base (including retentive/clasping materials, rests and teeth), per quadrant	Not a Benefit	October 1, 2021, July 1, 2021
D5286	Removable unilateral partial denture – one piece resin (including retentive/clasping materials, rests and teeth), per quadrant	Not a Benefit	October 1, 2021, July 1, 2021
D5410	Adjust complete denture – maxillary	\$25.00	
D5411	Adjust complete denture – mandibular	\$25.00	
D5421	Adjust partial denture – maxillary	\$25.00	
D5422	Adjust partial denture – mandibular	\$25.00	
D5511	Repair broken complete denture base, mandibular	\$50.00	March 14, 2020
D5512	Repair broken complete denture base, maxillary	\$50.00	March 14, 2020
D5520	Replace missing or broken teeth – complete denture (per tooth)	\$50.00	
D5611	Repair resin partial denture base, mandibular	\$60.00	March 14, 2020
D5612	Repair resin partial denture base, maxillary	\$60.00	March 14, 2020
D5621	Repair cast partial denture framework, mandibular	\$230.00	March 14, 2020
D5622	Repair cast partial denture framework, maxillary	\$230.00	March 14, 2020
D5630	Repair or replace broken retentive/clasping materials per tooth	\$100.00	
D5640	Replace missing or broken teeth – partial denture per tooth	\$50.00	
D5650	Add tooth to existing partial denture – per tooth	\$60.00	
D5660	Add clasp to existing partial denture – per tooth	\$100.00	
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	Not a Benefit	
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	Not a Benefit	
D5710	Rebase complete maxillary denture	Not a Benefit	
D5711	Rebase complete mandibular denture	Not a Benefit	
D5720	Rebase maxillary partial denture	Not a Benefit	
D5721	Rebase mandibular partial denture	Not a Benefit	

CDT Codes	Procedure Code Description	Maximum \$\$ Allowance	Effective Date
D5725	Rebase hybrid prosthesis	Not a Benefit	May 1, 2022
D5730	Reline complete maxillary denture (direct)	\$70.00	October 1, 2021
D5731	Reline complete mandibular denture (direct)	\$70.00	October 1, 2021
D5740	Reline maxillary partial denture (direct)	\$70.00	October 1, 2021
D5741	Reline mandibular partial denture (direct)	\$70.00	October 1, 2021
D5750	Reline complete maxillary denture (indirect)	\$140.00	October 1, 2021
D5751	Reline complete mandibular denture (indirect)	\$140.00	October 1, 2021
D5760	Reline maxillary partial denture (indirect)	\$140.00	October 1, 2021
D5761	Reline mandibular partial denture (indirect)	\$140.00	October 1, 2021
D5765	Soft liner for complete or partial removable denture – indirect	Not a Benefit	May 1, 2022
D5810	Interim complete denture (maxillary)	Not a Benefit	
D5811	Interim complete denture (mandibular)	Not a Benefit	
D5820	Interim partial denture (including retentive/clasping materials, rests and teeth), maxillary	Not a Benefit	October 1, 2021
D5821	Interim partial denture (including retentive/clasping materials, rests and teeth), mandibular	Not a Benefit	October 1, 2021
D5850	Tissue conditioning, maxillary	\$50.00	
D5851	Tissue conditioning, mandibular	\$50.00	
D5862	Precision attachment, by report	Global	
D5863	Overdenture – complete maxillary	\$450.00	March 14, 2020
D5864	Overdenture – partial maxillary	Not a Benefit	March 14, 2020
D5865	Overdenture – complete mandibular	\$450.00	March 14, 2020
D5866	Overdenture – partial mandibular	Not a Benefit	March 14, 2020
D5867	Replacement of replaceable part of semi-precision or precision attachment, per attachment	Not a Benefit	
D5875	Modification of removable prosthesis following implant surgery	Not a Benefit	
D5876	Add metal substructure to acrylic full denture (per arch)	Not a Benefit	March 14, 2020
D5899	Unspecified removable prosthodontic procedure, by report	By Report	
Maxillofacial Prosthetic Procedures			
D5911	Facial moulage (sectional)	\$425.00	
D5912	Facial moulage (complete)	\$534.00	

CDT Codes	Procedure Code Description	Maximum \$\$ Allowance	Effective Date
D5913	Nasal prosthesis	\$1,200.00	
D5914	Auricular prosthesis	\$1,200.00	
D5915	Orbital prosthesis	\$600.00	
D5916	Ocular prosthesis	\$1,200.00	
D5919	Facial prosthesis	\$1,200.00	
D5922	Nasal septal prosthesis	\$600.00	
D5923	Ocular prosthesis, interim	\$600.00	
D5924	Cranial prosthesis	\$1,440.00	
D5925	Facial augmentation implant prosthesis	\$300.00	
D5926	Nasal prosthesis, replacement	\$300.00	
D5927	Auricular prosthesis, replacement	\$300.00	
D5928	Orbital prosthesis, replacement	\$300.00	
D5929	Facial prosthesis, replacement	\$300.00	
D5931	Obturator prosthesis, surgical	\$1,000.00	
D5932	Obturator prosthesis, definitive	\$1,500.00	
D5933	Obturator prosthesis, modification	\$225.00	
D5934	Mandibular resection prosthesis with guide flange	\$1,700.00	
D5935	Mandibular resection prosthesis without guide flange	\$1,400.00	
D5936	Obturator prosthesis, interim	\$900.00	
D5937	Trismus appliance (not for TMD treatment)	\$125.00	
D5951	Feeding aid	\$200.00	
D5952	Speech aid prosthesis, pediatric	\$800.00	
D5953	Speech aid prosthesis, adult	\$1,450.00	
D5954	Palatal augmentation prosthesis	\$200.00	
D5955	Palatal lift prosthesis, definitive	\$1,400.00	
D5958	Palatal lift prosthesis, interim	\$800.00	
D5959	Palatal lift prosthesis, modification	\$220.00	
D5960	Speech aid prosthesis, modification	\$220.00	
D5982	Surgical stent	\$125.00	
D5983	Radiation carrier	\$80.00	

CDT Codes	Procedure Code Description	Maximum \$\$ Allowance	Effective Date
D5984	Radiation shield	\$200.00	
D5985	Radiation cone locator	\$200.00	
D5986	Fluoride gel carrier	\$80.00	
D5987	Commissure splint	\$125.00	
D5988	Surgical splint	\$205.00	
D5991	Vesiculobullous Disease Medicament Carrier	\$80.00	
D5992	Adjust maxillofacial prosthetic appliance, by report	Not a Benefit	
D5993	Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral) other than required adjustments, by report	Not a Benefit	
D5995	Periodontal medicament carrier with peripheral seal – laboratory processed – maxillary	Not a Benefit	October 1, 2021
D5996	Periodontal medicament carrier with peripheral seal – laboratory processed – mandibular	Not a Benefit	October 1, 2021
D5999	Unspecified maxillofacial prosthesis, by report	By Report	
Implant Service Procedures			
D6010	Surgical placement of implant body: endosteal implant	By Report	
D6011	Surgical access to an implant body (second stage implant surgery)	Global	October 1, 2021, March 14, 2020
D6012	Surgical placement of interim implant body for transitional prosthesis: endosteal implant	Not a Benefit	May 1, 2022
D6013	Surgical placement of mini implant	By Report	March 14, 2020
D6040	Surgical placement: eposteal implant	By Report	
D6050	Surgical placement: transosteal implant	By Report	
D6051	Placement of interim implant abutment	Not a Benefit	
D6055	Connecting bar – implant supported or abutment supported	By Report	
D6056	Prefabricated abutment – includes modification and placement	By Report	
D6057	Custom fabricated abutment – includes placement	By Report	
D6058	Abutment supported porcelain/ceramic crown	By Report	
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	Not a Benefit	July 1, 2021

CDT Codes	Procedure Code Description	Maximum \$\$ Allowance	Effective Date
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	By Report	
D6061	Abutment supported porcelain fused to metal crown (noble metal)	Not a Benefit	July 1, 2021
D6062	Abutment supported cast metal crown (high noble metal)	Not a Benefit	July 1, 2021
D6063	Abutment supported cast metal crown (predominantly base metal)	By Report	
D6064	Abutment supported cast metal crown (noble metal)	Not a Benefit	July 1, 2021
D6065	Implant supported porcelain/ceramic crown	By Report	
D6066	Implant supported crown- porcelain fused to high noble alloys	Not a Benefit	July 1, 2021
D6067	Implant supported crown- high noble alloys	Not a Benefit	July 1, 2021
D6068	Abutment supported retainer for porcelain/ceramic FPD	By Report	
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	Not a Benefit	July 1, 2021
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	By Report	
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	Not a Benefit	July 1, 2021
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	Not a Benefit	July 1, 2021
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	By Report	
D6074	Abutment supported retainer for cast metal FPD (noble metal)	Not a Benefit	July 1, 2021
D6075	Implant supported retainer for ceramic FPD	By Report	
D6076	Implant supported retainer for FPD – porcelain fused to high noble alloys	Not a Benefit	July 1, 2021
D6077	Implant supported retainer for cast metal FPD – high noble alloys	Not a Benefit	July 1, 2021
D6080	Implant maintenance procedures when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments.	By Report	
D6081	Scaling and debridement of a single implant in the presence of mucositis, including inflammation,	Global	March 14, 2020

CDT Codes	Procedure Code Description	Maximum \$\$ Allowance	Effective Date
	bleeding upon probing and increased pocket depths; includes cleaning of the implant surfaces, without flap entry and closure		
D6082	Implant supported crown – porcelain fused to predominately base alloys	By Report	July 1, 2021
D6083	Implant supported crown – porcelain fused to noble alloys	Not a Benefit	July 1, 2021
D6084	Implant supported crown – porcelain fused to titanium or titanium alloys	Not a Benefit	July 1, 2021
D6085	Interim implant crown	Not a Benefit	March 14, 2020
D6086	Implant supported crown – predominately base alloys	By Report	July 1, 2021
D6087	Implant supported crown – noble alloys	Not a Benefit	July 1, 2021
D6088	Implant supported crown – titanium and titanium alloys	Not a Benefit	July 1, 2021
D6089	Implant service - accessing and retorquing loose implant screw	Global	February 1, 2024
D6090	Repair of implant/abutment supported prosthesis	By Report	
D6091	Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment	By Report	October 1, 2021
D6092	Recement or re-bond implant/abutment supported crown	\$30.00	
D6093	Recement or re-bond implant/abutment supported fixed partial denture	\$50.00	
D6094	Abutment supported crown- titanium and titanium alloys	Not a Benefit	July 1, 2021
D6096	Remove broken implant retaining screw	Not a Benefit	March 14, 2020
D6097	Abutment supported crown – porcelain fused to titanium and titanium alloys	Not a Benefit	July 1, 2021
D6098	Implant supported retainer – porcelain fused to predominately base alloys	By Report	July 1, 2021
D6099	Implant supported retainer for FPD – porcelain fused to noble alloys	Not a Benefit	July 1, 2021
D6100	Surgical removal of implant body	\$45.00	
D6101	Debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning	Not a Benefit	

CDT Codes	Procedure Code Description	Maximum \$\$ Allowance	Effective Date
	of the exposed implant services, including flap entry and closure		
D6102	Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure	Not a Benefit	
D6103	Bone graft for repair of peri-implant defect – does not include flap entry and closure	Not a Benefit	
D6104	Bone graft at time of implant placement	Not a Benefit	
D6105	Removal of implant body not requiring bone removal nor flap elevation	\$22.00	April 1, 2023
D6106	Guided tissue regeneration – resorbable barrier, per implant	Not a Benefit	
D6107	Guided tissue regeneration – non-resorbable barrier, per implant	Not a Benefit	
D6110	Implant/abutment supported removable denture for edentulous arch – maxillary	By Report	March 14, 2020
D6111	Implant/abutment supported removable denture for edentulous arch – mandibular	By Report	March 14, 2020
D6112	Implant/abutment supported removable denture for partially edentulous arch – maxillary	By Report	March 14, 2020
D6113	Implant/abutment supported removable denture for partially edentulous arch – mandibular	By Report	March 14, 2020
D6114	Implant/abutment supported fixed denture for edentulous arch – maxillary	By Report	March 14, 2020
D6115	Implant/abutment supported fixed denture for edentulous arch – mandibular	By Report	March 14, 2020
D6116	Implant/abutment supported fixed denture for partially edentulous arch – maxillary	By Report	March 14, 2020
D6117	Implant/abutment supported fixed denture for partially edentulous arch – mandibular	By Report	March 14, 2020
D6118	Implant/abutment supported interim fixed denture for edentulous arch – maxillary	Not a Benefit	March 14, 2020
D6119	Implant/abutment supported interim fixed denture for edentulous arch – mandibular	Not a Benefit	March 14, 2020
D6120	Implant supported retainer – porcelain fused to titanium and titanium alloys	Not a Benefit	July 1, 2021

CDT Codes	Procedure Code Description	Maximum \$\$ Allowance	Effective Date
D6121	Implant supported retainer for metal FPD – predominately base alloys	By Report	July 1, 2021
D6122	Implant supported retainer for metal FPD – noble alloys	Not a Benefit	July 1, 2021
D6123	Implant supported retainer for metal FPD – titanium and titanium alloys	Not a Benefit	July 1, 2021
D6180	Implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing prosthesis and abutments.	Global	
D6190	Radiographic/Surgical implant index, by report	Global	
D6191	Semi-precision abutment – placement	By Report	October 1, 2021
D6192	Semi-precision attachment – placement	By Report	October 1, 2021
D6193	Replacement of an implant screw	Global	
D6194	Abutment supported retainer crown for FPD titanium and titanium alloys	Not a Benefit	July 1, 2021
D6195	Abutment supported retainer – porcelain fused to titanium and titanium alloys	Not a Benefit	July 1, 2021
D6197	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	Not a Benefit	
D6198	Remove interim implant component	Not a Benefit	May 1, 2022
D6199	Unspecified implant procedure, by report	By Report	
Fixed Prosthodontic Procedures			
D6205	Pontic – indirect resin-based composite	Not a Benefit	
D6210	Pontic – cast high noble metal	Not a Benefit	
D6211	Pontic – cast predominantly base metal	\$325.00	
D6212	Pontic – cast noble metal	Not a Benefit	
D6214	Pontic – titanium and titanium alloys	Not a Benefit	July 1, 2021
D6240	Pontic – porcelain fused to high noble metal	Not a Benefit	
D6241	Pontic – porcelain fused to predominantly base metal	\$325.00	
D6242	Pontic – porcelain fused to noble metal	Not a Benefit	
D6243	Pontic – porcelain fused to titanium and titanium alloys	Not a Benefit	July 1, 2021
D6245	Pontic – porcelain/ceramic	\$325.00	

CDT Codes	Procedure Code Description	Maximum \$\$ Allowance	Effective Date
D6250	Pontic – resin with high noble metal	Not a Benefit	
D6251	Pontic – resin with predominantly base metal	\$325.00	
D6252	Pontic – resin with noble metal	Not a Benefit	
D6253	Interim pontic – further treatment or completion of diagnosis necessary prior to final impression	Not a Benefit	
D6545	Retainer – cast metal for resin bonded fixed prosthesis	Not a Benefit	
D6548	Retainer – porcelain/ceramic for resin bonded fixed prosthesis	Not a Benefit	
D6549	Resin Retainer – for Resin Bonded Fixed Prosthesis	Not a Benefit	March 14, 2020
D6600	Retainer Inlay – porcelain/ceramic, two surfaces	Not a Benefit	
D6601	Retainer Inlay – porcelain/ceramic, three or more surfaces	Not a Benefit	
D6602	Retainer Inlay – cast high noble metal, two surfaces	Not a Benefit	
D6603	Retainer Inlay – cast high noble metal, three or more surfaces	Not a Benefit	
D6604	Retainer Inlay – cast predominantly base metal, two surfaces	Not a Benefit	
D6605	Retainer Inlay – cast predominantly base metal, three or more surfaces	Not a Benefit	
D6606	Retainer Inlay – cast noble metal, two surfaces	Not a Benefit	
D6607	Retainer Inlay – cast noble metal, three or more surfaces	Not a Benefit	
D6608	Retainer Onlay – porcelain/ceramic, two surfaces	Not a Benefit	
D6609	Retainer Onlay – porcelain/ceramic, three or more surfaces	Not a Benefit	
D6610	Retainer Onlay – cast high noble metal, two surfaces	Not a Benefit	
D6611	Retainer Onlay – cast high noble metal, three or more surfaces	Not a Benefit	
D6612	Retainer Onlay – cast predominantly base metal, two surfaces	Not a Benefit	

CDT Codes	Procedure Code Description	Maximum \$\$ Allowance	Effective Date
D6613	Retainer Onlay – cast predominantly base metal, three or more surfaces	Not a Benefit	
D6614	Retainer Onlay – cast noble metal, two surfaces	Not a Benefit	
D6615	Retainer Onlay – cast noble metal, three or more surfaces	Not a Benefit	
D6624	Retainer Inlay – titanium	Not a Benefit	
D6634	Retainer Onlay – titanium	Not a Benefit	
D6710	Retainer Crown – indirect resin based composite	Not a Benefit	
D6720	Retainer Crown – resin with high noble metal	Not a Benefit	
D6721	Retainer Crown – resin with predominantly base metal	\$220.00	
D6722	Retainer Crown – resin with noble metal	Not a Benefit	
D6740	Retainer Crown – porcelain/ceramic	\$340.00	
D6750	Retainer Crown – porcelain fused to high noble metal	Not a Benefit	
D6751	Retainer Crown – porcelain fused to predominantly base metal	\$340.00	
D6752	Retainer Crown – porcelain fused to noble metal	Not a Benefit	
D6753	Retainer Crown – porcelain fused to titanium and titanium alloys	Not a Benefit	July 1, 2021
D6780	Retainer Crown – 3/4 cast high noble metal	Not a Benefit	
D6781	Retainer Crown – 3/4 cast predominantly base metal	\$340.00	
D6782	Retainer Crown – 3/4 cast noble metal	Not a Benefit	
D6783	Retainer Crown – 3/4 porcelain/ceramic	\$340.00	
D6784	Retainer Crown 3/4 – titanium and titanium alloys	Not a Benefit	July 1, 2021
D6790	Retainer Crown – full cast high noble metal	Not a Benefit	
D6791	Retainer Crown – full cast predominantly base metal	\$340.00	
D6792	Retainer Crown – full cast noble metal	Not a Benefit	
D6793	Interim retainer crown – further treatment or completion of diagnosis necessary prior to final impression	Not a Benefit	
D6794	Retainer Crown – titanium and titanium alloys	Not a Benefit	July 1, 2021
D6920	Connector bar	Not a Benefit	

CDT Codes	Procedure Code Description	Maximum \$\$ Allowance	Effective Date
D6930	Re-cement or re-bond fixed partial denture	\$50.00	
D6940	Stress breaker	Not a Benefit	
D6950	Precision attachment	Not a Benefit	
D6980	Fixed partial denture repair, necessitated by restorative material failure	\$75.00	
D6985	Pediatric partial denture, fixed	Not a Benefit	
D6999	Unspecified fixed prosthodontic procedure, by report	By Report	
Oral and Maxillofacial Surgery Procedures			
D7111	Extraction, coronal remnants – primary tooth	\$41.00	
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	\$41.00	
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, AND including elevation of mucoperiosteal flap if indicated	\$85.00	
D7220	Removal of impacted tooth – soft tissue	\$100.00	
D7230	Removal of impacted tooth – partially bony	\$135.00	
D7240	Removal of impacted tooth – completely bony	\$165.00	
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	\$235.00	
D7250	Removal of residual tooth roots (cutting procedure)	\$100.00	
D7251	Coronectomy – intentional partial tooth removal, impacted teeth only	\$135.00	April 1, 2023
D7252	Partial extraction for immediate implant placement	Not a Benefit	
D7259	Nerve dissection	Global	
D7260	Oroantral fistula closure	\$300.00	
D7261	Primary closure of a sinus perforation	\$100.00	
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	\$175.00	
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)	Not a Benefit	
D7280	Exposure of an unerupted tooth	\$100.00	

CDT Codes	Procedure Code Description	Maximum \$\$ Allowance	Effective Date
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	Not a Benefit	
D7283	Placement of device to facilitate eruption of impacted tooth	\$135.00	
D7284	Excisional biopsy of minor salivary glands	Not a Benefit	
D7285	Incisional Biopsy of oral tissue – hard (bone, tooth)	\$100.00	
D7286	Incisional Biopsy of oral tissue – soft	\$30.00	
D7287	Exfoliative cytological sample collection	Not a Benefit	
D7288	Brush biopsy – transepithelial sample collection	Not a Benefit	
D7290	Surgical repositioning of teeth	\$135.00	
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	\$50.00	
D7292	Placement of temporary anchorage device [screw retained plate] requiring flap	Not a Benefit	
D7293	Placement of temporary anchorage device requiring flap	Not a Benefit	
D7294	Placement of temporary anchorage device without flap	Not a Benefit	
D7295	Harvest of bone for use in autogenous grafting procedure	Not a Benefit	
D7296	Corticotomy – one to three teeth or tooth spaces, per quadrant	Not a Benefit	March 14, 2020
D7297	Corticotomy – four or more teeth or tooth spaces, per quadrant	Not a Benefit	March 14, 2020
D7298	Removal of temporary anchorage device [screwed retained plate], requiring flap	Not a Benefit	May 1, 2022
D7299	Removal of temporary anchorage device, requiring flap	Not a Benefit	May 1, 2022
D7300	Removal of temporary anchorage device, without flap	Not a Benefit	May 1, 2022
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	\$50.00	
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	Global	
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	\$100.00	
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	Global	

CDT Codes	Procedure Code Description	Maximum \$\$ Allowance	Effective Date
D7340	Vestibuloplasty – ridge extension (secondary epithelialization)	\$200.00	
D7350	Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	\$500.00	
D7410	Excision of benign lesion up to 1.25 cm	\$100.00	June 1, 2019
D7411	Excision of benign lesion greater than 1.25 cm	\$250.00	June 1, 2019
D7412	Excision of benign lesion, complicated	\$325.00	
D7413	Excision of malignant lesion up to 1.25 cm	\$325.00	
D7414	Excision of malignant lesion greater than 1.25 cm	\$400.00	
D7415	Excision of malignant lesion, complicated	\$450.00	
D7440	Excision of malignant tumor – lesion diameter up to 1.25 cm	\$325.00	
D7441	Excision of malignant tumor – lesion diameter greater than 1.25 cm	\$500.00	
D7450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm	\$100.00	
D7451	Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm	\$200.00	
D7460	Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm	\$100.00	
D7461	Removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm	\$250.00	
D7465	Destruction of lesion(s) by physical or chemical method, by report	\$50.00	
D7471	Removal of lateral exostosis (maxilla or mandible)	\$100.00	
D7472	Removal of torus palatinus	\$200.00	
D7473	Removal of torus mandibularis	\$100.00	
D7485	Surgical reduction of osseous tuberosity	\$75.00	
D7490	Radical resection of maxilla or mandible	\$1,200.00	
D7509	Marsupialization of odontogenic cyst	Not a Benefit	
D7510	Incision and drainage of abscess – intraoral soft tissue	\$50.00	
D7511	Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	\$75.00	

CDT Codes	Procedure Code Description	Maximum \$\$ Allowance	Effective Date
D7520	Incision and drainage of abscess – extraoral soft tissue	\$75.00	
D7521	Incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	\$100.00	
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	\$60.00	
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	\$130.00	
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	\$100.00	
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	\$380.00	
D7610	Maxilla – open reduction (teeth immobilized, if present)	\$1,000.00	
D7620	Maxilla – closed reduction (teeth immobilized, if present)	\$500.00	
D7630	Mandible – open reduction (teeth immobilized, if present)	\$1,200.00	
D7640	Mandible – closed reduction (teeth immobilized, if present)	\$700.00	
D7650	Malar and/or zygomatic arch – open reduction	\$500.00	
D7660	Malar and/or zygomatic arch – closed reduction	\$250.00	
D7670	Alveolus – closed reduction, may include stabilization of teeth	\$225.00	
D7671	Alveolus – open reduction, may include stabilization of teeth	\$275.00	
D7680	Facial bones – complicated reduction with fixation and multiple surgical approaches	By Report	
D7710	Maxilla – open reduction	\$1,200.00	
D7720	Maxilla – closed reduction	\$800.00	
D7730	Mandible – open reduction	\$1,200.00	
D7740	Mandible – closed reduction	\$800.00	
D7750	Malar and/or zygomatic arch – open reduction	\$500.00	
D7760	Malar and/or zygomatic arch – closed reduction	\$250.00	
D7770	Alveolus – open reduction stabilization of teeth	\$1,000.00	

CDT Codes	Procedure Code Description	Maximum \$\$ Allowance	Effective Date
D7771	Alveolus, closed reduction stabilization of teeth	\$500.00	
D7780	Facial bones – complicated reduction with fixation and multiple approaches	By Report	
D7810	Open reduction of dislocation	\$140.00	
D7820	Closed reduction of dislocation	\$140.00	
D7830	Manipulation under anesthesia	\$140.00	
D7840	Condylectomy	\$1,000.00	
D7850	Surgical discectomy, with/without implant	\$1,000.00	
D7852	Disc repair	\$780.00	
D7854	Synovectomy	\$800.00	
D7856	Myotomy	\$810.00	
D7858	Joint reconstruction	\$1,550.00	
D7860	Arthrotomy	\$940.00	
D7865	Arthroplasty	\$1,100.00	
D7870	Arthrocentesis	\$440.00	
D7871	Non-arthroscopic lysis and lavage	Global	
D7872	Arthroscopy – diagnosis, with or without biopsy	\$800.00	
D7873	Arthroscopy – lavage and lysis of adhesions	\$800.00	
D7874	Arthroscopy – disc repositioning and stabilization	\$800.00	
D7875	Arthroscopy – synovectomy	\$800.00	
D7876	Arthroscopy – discectomy	\$1,000.00	
D7877	Arthroscopy – debridement	\$800.00	
D7880	Occlusal orthotic device, by report	\$300.00	
D7881	Occlusal Orthotic Device Adjustment	Global	March 14, 2020
D7899	Unspecified TMD therapy, by report	By Report	
D7910	Suture of recent small wounds up to 5 cm	\$75.00	
D7911	Complicated suture – up to 5 cm	\$85.00	
D7912	Complicated suture – greater than 5 cm	\$95.00	
D7920	Skin graft (identify defect covered, location and type of graft)	\$310.00	
D7921	Collection and application of autologous blood concentrate product	Not a Benefit	

CDT Codes	Procedure Code Description	Maximum \$\$ Allowance	Effective Date
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	Global	July 1, 2021
D7939	Indexing for osteotomy using dynamic robotic assisted or dynamic navigation	Not a Benefit	
D7940	Osteoplasty – for orthognathic deformities	\$1,300.00	
D7941	Osteotomy – mandibular rami	\$2,000.00	
D7943	Osteotomy – mandibular rami with bone graft; includes obtaining the graft	\$2,800.00	
D7944	Osteotomy – segmented or subapical	\$600.00	
D7945	Osteotomy – body of mandible	\$600.00	
D7946	LeFort I (maxilla – total)	\$1,300.00	
D7947	LeFort I (maxilla – segmented)	\$2,000.00	
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) – without bone graft	\$2,300.00	
D7949	LeFort II or LeFort III – with bone graft	\$3,000.00	
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla— autogenous or nonautogenous, by report	\$800.00	
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	\$1,000.00	
D7952	Sinus augmentation via a vertical approach	\$750.00	
D7953	Bone replacement graft for ridge preservation – per site	Not a Benefit	
D7955	Repair of maxillofacial soft and/or hard tissue defect	By Report	
D7956	Guided tissue regeneration, edentulous area – resorbable barrier, per site	Not a Benefit	
D7957	Guided tissue regeneration, edentulous area – non-resorbable barrier, per site	Not a Benefit	
D7961	Buccal/labial frenectomy (frenulectomy)	\$200.00	October 1, 2021
D7962	Lingual frenectomy (frenulectomy)	\$200.00	October 1, 2021
D7963	Frenuloplasty	\$200.00	
D7970	Excision of hyperplastic tissue – per arch	\$100.00	
D7971	Excision of pericoronal gingiva	\$50.00	
D7972	Surgical reduction of fibrous tuberosity	\$50.00	

CDT Codes	Procedure Code Description	Maximum \$\$ Allowance	Effective Date
D7979	Non-surgical Sialolithotomy	\$45.00	May 16, 2020
D7980	Surgical Sialolithotomy	\$235.00	
D7981	Excision of salivary gland, by report	\$521.00	
D7982	Sialodochoplasty	\$365.00	
D7983	Closure of salivary fistula	\$120.00	
D7990	Emergency tracheotomy	\$200.00	
D7991	Coronoidectomy	\$558.00	
D7993	Surgical placement of craniofacial implant – extra oral	By Report	October 1, 2021
D7994	Surgical placement: zygomatic implant	By Report	October 1, 2021
D7995	Synthetic graft – mandible or facial bones, by report	\$335.00	
D7996	Implant – mandible for augmentation purposes (excluding alveolar ridge), by report	Not a Benefit	
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	\$45.00	
D7998	Intraoral placement of a fixation device not in conjunction with a fracture	Not a Benefit	
D7999	Unspecified oral surgery procedure, by report	By Report	
Orthodontic Procedures			
D8010	Limited orthodontic treatment of the primary dentition	Not a Benefit	
D8020	Limited orthodontic treatment of the transitional dentition	Not a Benefit	
D8030	Limited orthodontic treatment of the adolescent dentition	Not a Benefit	
D8040	Limited orthodontic treatment of the adult dentition	Not a Benefit	
D8070	Comprehensive orthodontic treatment of the transitional dentition	Not a Benefit	
D8080	Comprehensive orthodontic treatment of the adolescent dentition Handicapping malocclusion	\$750.00	

CDT Codes	Procedure Code Description	Maximum \$\$ Allowance	Effective Date
D8080	Comprehensive orthodontic treatment of the adolescent dentition cleft palate – primary dentition	\$425.00	
D8080	Comprehensive orthodontic treatment of the adolescent dentition cleft palate – mixed dentition	\$625.00	
D8080	Comprehensive orthodontic treatment of the adolescent dentition cleft palate – permanent dentition	\$925.00	
D8080	Comprehensive orthodontic treatment of the adolescent dentition facial growth management – primary dentition	\$425.00	
D8080	Comprehensive orthodontic treatment of the adolescent dentition facial growth management – mixed dentition	\$625.00	
D8080	Comprehensive orthodontic treatment of the adolescent dentition facial growth management – permanent dentition	\$1,000.00	
D8090	Comprehensive orthodontic treatment of the adult dentition	Not a Benefit	
D8091	Comprehensive orthodontic treatment with orthognathic surgery	Global	
D8210	Removable appliance therapy	\$245.00	
D8220	Fixed appliance therapy	\$245.00	
D8660	Pre-orthodontic treatment examination to monitor growth and development	\$50.00	
D8670	Periodic orthodontic treatment visit Handicapping malocclusion	\$210.00	
D8670	Periodic orthodontic treatment visit cleft palate – primary dentition	\$125.00	
D8670	Periodic orthodontic treatment visit cleft palate – mixed dentition	\$140.00	
D8670	Periodic orthodontic treatment visit facial growth management – mixed dentition	\$140.00	
D8670	Periodic orthodontic treatment visit facial growth management – permanent dentition	\$300.00	
D8671	Periodic orthodontic visit associated with orthognathic surgery	Global	

CDT Codes	Procedure Code Description	Maximum \$\$ Allowance	Effective Date
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	\$244.00	
D8681	Removable orthodontic retainer adjustment	Global	March 14, 2020
D8695	Removal of Fixed Orthodontic Appliance(s) – other than at conclusion of treatment	\$50.00	May 16, 2020
D8696	Repair of orthodontic appliance – maxillary	\$50.00	July 1, 2021
D8697	Repair of orthodontic appliance – mandibular	\$50.00	July 1, 2021
D8698	Re-cement or re-bond fixed retainer – maxillary	\$30.00	July 1, 2021
D8699	Re-cement or re-bond fixed retainer – mandibular	\$30.00	July 1, 2021
D8701	Repair of fixed retainers, includes reattachment – maxillary	\$50.00	July 1, 2021
D8702	Repair of fixed retainers, includes reattachment – mandibular	\$50.00	July 1, 2021
D8703	Replacement of lost or broken retainer – maxillary	\$200.00	July 1, 2021
D8704	Replacement of lost or broken retainer – mandibular	\$200.00	July 1, 2021
D8999	Unspecified orthodontic procedure, by report	By Report	
Adjunctive Service Procedures			
D9110	Palliative treatment of dental pain – per visit	\$45.00	
D9120	Fixed partial denture sectioning	\$50.00	
D9130	Temporomandibular joint dysfunction – non-invasive physical therapies	Global	March 14, 2020
D9210	Local anesthesia not in conjunction with operative or surgical procedures	\$45.00	
D9211	Regional block anesthesia	Global	
D9212	Trigeminal division block anesthesia	Global	
D9215	Local anesthesia in conjunction with operative or surgical procedures	Global	
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	Global	March 14, 2020

CDT Codes	Procedure Code Description	Maximum \$\$ Allowance	Effective Date
D9222	Deep sedation/general anesthesia – first 15 minutes	\$45.68	March 14, 2020
D9223	Deep sedation/general anesthesia – each subsequent 15 minute increment	\$45.68	March 14, 2020
D9230	Inhalation of nitrous oxide/anxiolysis analgesia	\$25.00	
D9239	Intravenous moderate (conscious) sedation/analgesia – first 15 minutes	\$21.07	March 14, 2020
D9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment	\$21.07	March 14, 2020
D9248	Non-intravenous conscious sedation	\$25.00	
D9310	Consultation diagnostic service provided by dentist or physician other than requesting dentist or physician	Global	
D9311	Consultation with medical health care professional	Not a Benefit	March 14, 2020
D9410	House/Extended care facility call	\$20.00	
D9420	Hospital or ambulatory surgical center call	\$50.00	
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed	\$20.00	July 10, 2019
D9440	Office visit – after regularly scheduled hours	\$20.00	
D9450	Case presentation, subsequent to detailed and extensive treatment planning	Not a Benefit	
D9610	Therapeutic parenteral drug, single administration	\$15.00	
D9612	Therapeutic parenteral drug, two or more administrations, different medications	Global	
D9613	Infiltration of sustained release therapeutic drug, per quadrant	Not a Benefit	March 14, 2020
D9630	Drugs or medicaments dispensed in the office for home use	Not a Benefit	
D9910	Application of desensitizing medicament	\$43.00	July 10, 2019
D9911	Application of desensitizing resin for cervical and/or root surface, per tooth	Not a Benefit	

CDT Codes	Procedure Code Description	Maximum \$\$ Allowance	Effective Date
D9912	Pre-visit patient screening	Global	May 1, 2022
D9913	Administration of neuromodulators	Not a Benefit	
D9914	Administration of dermal fillers	Not a Benefit	
D9920	Behavior management, by report	\$100.00	July 1, 2018
D9930	Treatment of complications (post-surgical) – unusual circumstances, by report	\$15.00	
D9932	Cleaning and inspection of a removable complete denture, maxillary	Not a Benefit	March 14, 2020
D9933	Cleaning and inspection of a removable complete denture, mandibular	Not a Benefit	March 14, 2020
D9934	Cleaning and inspection of a removable partial denture, maxillary	Not a Benefit	March 14, 2020
D9935	Cleaning and inspection of a removable partial denture, mandibular	Not a Benefit	March 14, 2020
D9938	Fabrication of a custom removable clear plastic temporary aesthetic appliance	Not a Benefit	
D9939	Placement of a custom removable clear plastic temporary aesthetic appliance	Not a Benefit	
D9941	Fabrication of athletic mouth guard	Not a Benefit	
D9942	Repair and/or relines of occlusal guard	Not a Benefit	
D9943	Occlusal guard adjustment	Not a Benefit	March 14, 2020
D9944	Occlusal guard – hard appliance, full arch	Not a Benefit	March 14, 2020
D9945	Occlusal guard – soft appliance, full arch	Not a Benefit	March 14, 2020
D9946	Occlusal guard – hard appliance, partial arch	Not a Benefit	March 14, 2020
D9947	Custom sleep apnea appliance fabrication and placement	Not a Benefit	May 1, 2022
CDT Codes	Procedure Code Description	Maximum \$\$ Allowance	Effective Date

D9948	Adjustment of custom sleep apnea appliance	Not a Benefit	May 1, 2022
D9949	Repair of custom sleep apnea appliance	Not a Benefit	May 1, 2022
D9950	Occlusion analysis – mounted case	\$180.00	
D9951	Occlusal adjustment – limited	\$25.00	
D9952	Occlusal adjustment – complete	\$400.00	
D9953	Reline custom sleep apnea appliance (indirect)	Not a Benefit	
D9954	Fabrication and delivery of oral appliance therapy (OAT) morning repositioning device	Not a Benefit	
D9955	Oral appliance therapy (OAT) titration visit	Not a Benefit	
D9956	Administration of home sleep apnea test	Not a Benefit	
D9957	Screening for sleep related breathing disorders	Global	February 1, 2024
D9959	Unspecified sleep apnea services procedure, by report	Not a Benefit	
D9961	Duplicate/copy patient records	Not a Benefit	March 14, 2020
D9970	Enamel microabrasion	Not a Benefit	
D9971	Odontoplasty– per tooth	Not a Benefit	October 1, 2021
D9972	External bleaching – per arch – performed in office	Not a Benefit	
D9973	External bleaching – per tooth	Not a Benefit	
D9974	Internal bleaching – per tooth	Not a Benefit	
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays	Not a Benefit	
D9985	Sales tax	Not a Benefit	March 14, 2020
D9986	Missed appointment	Refer to MOC	March 14, 2020
D9987	Cancelled appointment	Refer to MOC	March 14, 2020
D9990	Certified translation or sign language services – per visit	Refer to MOC	May 16, 2020
D9991	Dental Case Management – addressing appointment compliance barriers	Refer to MOC	March 14, 2020
D9992	Dental Case Management – Care Coordination	Refer to MOC	May 16, 2020
D9993	Dental Case Management – motivational Interviewing	Not a Benefit (Benefit in DTI)	March 14, 2020
D9994	Dental Case Management – patient education to improve oral health literacy	\$26.66 up to 12 units (Refer to Section 4 and MOC)	December 14, 2024

CDT Codes	Procedure Code Description	Maximum \$\$ Allowance	Effective Date
D9995	Teledentistry – synchronous; real-time encounter	\$0.24/min up to 90 minutes	May 16, 2020
D9996	Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review * Transmission costs associated with store and forward are not payable	\$0.00*	May 16, 2020
D9997	Dental case management – patients with special health care needs	Refer to MOC	July 1, 2021
D9999	Unspecified adjunctive procedure, by report	By Report	

¹ Must be performed and billed with D1310 concurrently as part of the Caries Risk Assessment Bundle to receive payment.

² Must be performed and billed with D1310 concurrently as part of the Caries Risk Assessment Bundle to receive payment.

³ Must be performed and billed with D1310 concurrently as part of the Caries Risk Assessment Bundle to receive payment.

⁴ Must be performed and billed with D0601, D0602, or D0603 concurrently as part of the Caries Risk Assessment Bundle to receive payment.

Section 6 - Forms

Medi-Cal Dental Forms	6-1
Ordering Forms	6-2
Optical Character Recognition (OCR)/Intelligent Character Recognition (ICR).....	6-3
Correct Use of Medi-Cal Dental Envelopes.....	6-5
Treatment Authorization Request (TAR)/Claim Forms.....	6-7
Sample TAR/Claim Form Submitted as a Treatment Authorization Request (TAR) ...	6-8
Sample TAR/Claim Form Submitted as a Claim.....	6-9
How to Complete the TAR/Claim Form	6-10
How to Submit a Claim for a Member with Other Coverage.....	6-15
How to Submit a TAR for Orthodontic Services	6-16
Notice of Authorization (NOA) (DC-301, Rev. 4/20).....	6-17
Sample Notice of Authorization (NOA)	6-19
How to Complete the NOA.....	6-20
Reevaluation of the Notice of Authorization (NOA) For Orthodontic Services.....	6-23
Reevaluations.....	6-24
Outstanding Treatment Authorization Requests (TARs).....	6-24
Notice of Medi-Cal Dental Action	6-26
Sample Notice of Medi-Cal Dental Action.....	6-27
Sample Notice of Medi-Cal Dental Action Insert: Reason for Action Codes	6-29
Resubmission Turnaround Document (RTD) (DC-102, Rev. 10/19)	6-31
Sample Resubmission Turnaround Document (RTD).....	6-32
How to Complete the RTD	6-33
Section “A”	6-33
Section “B”	6-34
Claim Inquiry Form (CIF) (DC-003, Rev. 10/19)	6-35
CIF Tracer	6-35
Claim Re-evaluations	6-35
Sample Claim Inquiry Form (CIF).....	6-36
How to Complete the CIF.....	6-37
Claim Inquiry Response (CIR).....	6-39
Sample Claim Inquiry Response (CIR).....	6-40
Checklists	6-41
Reminders	6-42
Time Limitations for NOAs.....	6-43

Justification of Need for Prosthesis (DC054, Rev 9/18)	6-44
Sample Justification of Need for Prosthesis	6-45
How to Complete the Justification of Need for Prosthesis Form.....	6-46
Sample Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet (DC-016, Rev 09/18).....	6-48
How to Complete the HLD Index Scoresheet	6-49
Explanation of Benefits (EOB)	6-50
Lost/Misplaced EOBs	6-50
Sample Explanation of Benefits (EOB).....	6-51
How to Read the EOB	6-52
Sample Paid Claim, Levy	6-54
How to Read the Paid Claim with Levy Deduction EOB.....	6-55
Sample Levy Payment	6-56
How to Read the Levy Payment EOB.....	6-57
Sample Documents In-Process	6-58
How to Read the Documents In-Process EOB.....	6-59
Sample Accounts Receivable	6-60
How to Read the Accounts Receivable (AR) EOB	6-61
Sample Accounts Payable	6-62
How to Read the Accounts Payable (AP) EOB	6-63
Sample Readjudicated Claim	6-64
How to Read the Readjudicated Claim EOB.....	6-65

Section 6 - Forms

Medi-Cal Dental Forms

Only Medi-Cal Dental specific, State-approved forms are accepted by Medi-Cal Dental. Any other forms will be returned without processing. Proper use and completion of these forms will expedite authorization or payment for Medi-Cal Dental covered services. No duplicates or photocopies will be accepted or processed. Signatures in blue or black ink are required: rubber signature stamps will not be accepted.

Treatment Authorization Request (TAR)/Claim Forms

- DC-202 – Preimprinted, No Carbon Required (NCR)
- DC-209 – NCR for continuous pin-fed printers
- DC-217 – Single sheet for laser printers

Claim Inquiry Forms (CIFs)

- DC-003

Envelopes for TAR/Claim Forms/Correspondence

- DC-006C – for submitting radiographs/attachments for Electronic Data Interchange (EDI) TAR/Claims forms.
- DC-007 - correspondence
- DC-206 – for submitting TAR/Claim forms that are not EDI

Envelopes for Submitting Radiographs Associated with EDI Documents

- DC-014E – large envelopes for submitting radiographs/documentation for EDI documents
- DC-014F – small envelopes for submitting radiographs/documentation for EDI documents
- DC-006C – large envelopes for mailing multiple large/small envelopes (DC-014E and DC-014F).

EDI Labels

- DC-018A – 12-up sheet of labels for laser printers (order blank or preimprinted)
- DC-018B – 1-up continuous labels
- DC-018C - 3-up continuous labels

Ordering Forms

When ordering forms, be sure to request an adequate supply of TAR/Claim forms, CIFs, and Justification of Need for Prosthesis forms, plus X-ray and mailing envelopes. The [Forms Reorder Request \(DC-204\)](#) is to be used to order forms from Medi-Cal Dental's forms supplier.

The forms vendor will verify that the National Provider Identifier (NPI) number submitted for preimprinting matches what is on record at Medi-Cal Dental. Once confirmed, the inventory will be preimprinted with the NPI. However, if the information found on the Forms Reorder Request does not match what the forms vendor has received from Medi-Cal Dental, the order will not be filled.

The Forms Reorder Request form (DC-204) should be mailed, emailed, or faxed to the warehouse vendor:

Medi-Cal Dental Forms Reorder
P.O. Box 15609 Sacramento, CA 95852-0609
formreorderrequest@gainwelltechnologies.com
Fax: (877) 401-7534

Do not phone the warehouse: they are not staffed to handle telephone requests.

Upon receiving Medi-Cal Dental forms and envelopes, verify that any pre-printed information such as address and/or NPI number is correct. If there are errors, then please call the Telephone Service Center toll-free at (800) 423-0507.

Optical Character Recognition (OCR)/Intelligent Character Recognition (ICR)

OCR/ICR technology allows for a more automated process of capturing information from paper documents and enables Medi-Cal Dental to electronically adjudicate paper forms. Medi-Cal Dental's goal is to decrease processing time, improve responsiveness to provider and member (patient) inquiries, and increase adjudication accuracy.

To ensure optimum results and avoid denials, please follow the specifications listed below.

Do:

- Use only Medi-Cal Dental provided forms
- On TAR/Claim forms, leave boxes 11 through 18 blank, unless indicating "yes." OCR reads any mark in boxes 11 through 18 as a "yes" even if the answer is "no."
- Use a laser printer for best results. If handwritten documents must be submitted, use neat block letters, blue or black ink, and stay within field boundaries.
- Use a 10 point, plain font (such as Arial), and use all capital letters.
- Use a 6-digit date format without dashes or slashes, e.g., mmddyy (123116).
- Use only Medi-Cal Dental TAR/Claim forms
- Print within the lines of the appropriate field
- Submit notes and attachments on 8 ½" by 11" paper. Small attachments must be taped to standard paper in order to go through the scanner.
- Submit notes and attachments on one side of the paper only. Double-sided attachments require copying and additional preparation for the scanners which will cause delays in adjudication.
- Enter quantity information in the quantity field. OCR does not read

Do Not:

- Use correction fluid or tape.
- Use a dot matrix/impact printer.
- Use italics or script fonts.
- Mix fonts on the same form.
- Use fonts smaller than 10 point.
- Use arrows or quote/ditto marks to indicate duplicate dates of service, National Provider Identifier (NPI), etc.
- Use dashes or slashes in date fields.
- Print slashed zeros.
- Use photocopies of any Medi-Cal Dental forms.
- Use highlighters to highlight field information (this causes field data to turn black and become unreadable).
- Submit two-sided attachments.
- Enter quantity information in the description of service field.
- Put notes on the top or bottom of forms.
- Fold any forms.
- Use labels, stickers, or stamps on any Medi-Cal Dental forms.
- Use rubber signature or "signature on file" stamps.
- Place additional forms, attachments, or documentation inside the X-ray envelope. This will cause a delay in adjudication and processing.

the description of service field to pick up the quantity.

- On TAR/Claim forms, complete boxes 19 and 20. Enter the complete Billing Provider Name and NPI to ensure appropriate payment to the correct billing number.
- Remember that the following TAR/Claim forms are no longer available and should not be used: DC-002A, DC-002B, DC-009A, DC-009B, DC-017A, and DC-017B.
- Always apply a handwritten signature in blue or black ink.

Correct Use of Medi-Cal Dental Envelopes

Medi-Cal Dental continues to receive X-ray envelopes that are incorrectly addressed or prepared, have no address, or are empty. Some providers also submit radiographs without using the correct preimprinted or typed X-ray envelopes specifically designed for that purpose. Radiographs and photographs will not be returned.

- When submitting claims for multiple patients in one envelope, ensure that the radiographs/photographs for the respective patient are stapled to the associated claim/TAR. Use only one staple in the upper right or left corner of the claim/TAR to attach radiographs or paper copies.
- Do not print two separate documents on one piece of paper (e.g., an EDI Notice of Authorization for one member on one side, and another EDI Notice of Authorization for a different member on the other side).
- Enclose mounted, dated, and well-marked radiographs and photographs in the appropriate X-ray envelope. Include the dentist's name, Medi-Cal Dental provider number, member name, and Medi-Cal ID number on the X-Ray mount. Duplicate radiographs, paper radiographs, and photographs should also be marked clearly so they are identifiable for processing. The date on all radiographs, paper copies, and photographs must be in month/date/year format.
- Plastic sleeve mounts should be clean and have the label containing the required information placed on the front side of the mount.
- If the provider has a device such as a scanner that can transfer radiographs onto paper, Medi-Cal Dental will accept the paper copy instead of the regular film. Paper copies of radiographs must be of good quality to be accepted and must be larger than 2 inches by 3.5 inches (about the size of a business card). If the resolution of the paper image is inadequate, Medi-Cal Dental will request the original film, which can delay processing. Be sure to indicate on the paper copy the date the radiograph was taken and which side of the mouth. Paper copies of radiographs will not be returned.
- Paper copies should be printed on 20lb or heavier paper, but do not use glossy or photo paper.
- Do not fold radiographs or photographs.
- Only use X-ray envelopes for radiographs or paper radiographs. All other attachments and documentation should be stapled to the TAR/Claim form to reduce processing delays. Do not overfill X-ray envelopes. The appropriately sized envelopes should be used for all radiographs submitted to prevent damaged envelopes and/or lost radiographs.
- Up to three unmounted radiographs may be submitted by placing them in unsealed coin-size envelopes and inserting the coin-size envelopes into the X-ray envelopes provided by Medi-Cal Dental. The coin-sized envelope should be labeled with the provider name, NPI, member name, and date.

Medi-Cal Dental offers the following special envelopes printed with red borders to be used by the dental office for enclosing radiographs, photographs, and other documentation associated with EDI claims and TARs:

- **DC-014E** – Large envelope for submitting radiographs and/or other documentation associated with EDI documents.
- **DC-014F** – Small envelope for submitting radiographs and/or other documentation associated with EDI documents.

Radiographs or paper printouts of digitized images should be placed in these envelopes. Loose radiographs can become separated and lost, which can delay the time it takes Medi-Cal Dental to process documents. One EDI mailing label should be affixed to each envelope: DC-018A (can be ordered partially preimprinted), DC-018B, or C.

Medi-Cal Dental also provides the following envelope for mailing several small or large EDI radiograph envelopes:

- **DC-006C** – Large envelope with red border which should only contain:
 - Multiple EDI X-ray envelopes DC-014E and DC-014F containing radiographs or documentation related to EDI claims and TARs.
- **DC-206** – Large envelope for mailing TAR/Claim forms, which should only contain:
 - TAR/Claim forms
 - Claim Inquiry Forms (CIFs)
 - Resubmission Turnaround Documents (RTDs) relating to TAR/Claim forms.
 - NOAs submitted for payment or reevaluation.
 - EDI NOAs printed onto paper for payment and/or EDI RTDs printed onto paper related to claims (do not attach EDI label)
 - EDI RTDs printed onto paper related to TARs (do not attach EDI label)

Treatment Authorization Request (TAR)/Claim Forms

The TAR/Claim form is used to request authorization for proposed treatment or submit a claim for payment. Accurate completion of this form is required to ensure proper and expeditious handling by Medi-Cal Dental. An incomplete or inaccurate TAR or Claim will delay processing and may result in the generation of an RTD or denial.

Medi-Cal Dental specific forms are the only forms processed under Medi-Cal Dental, whether for authorization of covered services or payment of rendered treatment.

The format of the following forms is identical.

- DC-202 (No Carbon Required (NCR) TAR/Claim forms)
- DC-209 (continuous TAR/Claim forms)
 - Page 1 – Submit first sheet to Medi-Cal Dental
 - Page 2 – Retain second sheet
- DC-217 (single-sheet TAR/Claim forms for use in laser printers)

For scanning purposes, the forms are produced with red ink, and providers are requested to use only blue or black ink on any forms submitted to Medi-Cal Dental.

Please make sure all applicable areas of the forms are filled in completely and accurately. Any claim service line (CSL) submitted with an invalid procedure code, or a blank procedure code field will be denied, whether submitted electronically or as paper documents. Documents received with a missing or incorrect address or NPI can delay the processing of TARs and claims and increase the possibility that payments may be forwarded to the wrong office.


TREATMENT AUTHORIZATION REQUEST (TAR)/CLAIM

HCS | Medi-Cal Dental
PO BOX 15610
SACRAMENTO, CALIFORNIA 95852-0610
Phone (800) 423-0507

DC-217 (R 10/19)

Sample TAR/Claim Form Submitted as a Claim

DO NOT WRITE IN THIS AREA

 **Medi-Cal Dental**
 PO BOX 15610
 SACRAMENTO, CALIFORNIA 95852-0610
 Phone (800) 423-0507

TREATMENT AUTHORIZATION REQUEST (TAR)/CLAIM

1. PATIENT NAME (LAST, FIRST, MI.) MEMBER, JANE		3. SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	4. PATIENT BIRTHDATE MO 07 DAY 04 YR 55	5. MEDI-CAL BENEFITS ID CARD NUMBER 9999999999
6. PATIENT ADDRESS 5498 PRIMROSE WAY				7. PATIENT DENTAL RECORD NUMBER
CITY, STATE ANYTOWN, CA		ZIP CODE 90100		8. REFERRING PROVIDER NPI

9. RADIOGRAPHS ATTACHED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO HOW MANY? _____	11. ACCIDENT/INJURY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO EMPLOYMENT RELATED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13. OTHER DENTAL COVERAGE? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 14. MEDICARE DENTAL COVERAGE? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	16. CHDP CHILD HEALTH AND DISABILITY PREVENTION? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 17. CCS CALIFORNIA CHILDREN SERVICES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
10. OTHER ATTACHMENTS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	12. ELIGIBILITY PENDING? (SEE PROVIDER HANDBOOK) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	15. RETROACTIVE ELIGIBILITY? (EXPLAIN IN COMMENTS SECTION) (SEE PROVIDER HANDBOOK) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	18. MF-O MAXILLOFACIAL - ORTHODONTIC SERVICES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO

19. BILLING PROVIDER NAME (LAST, FIRST, MI.) ADAMS, JAMES	20. BILLING PROVIDER NPI 1234567891
21. SERVICE OFFICE ADDRESS 3157 MAIN ST, STE 320	TELEPHONE NUMBER (888) 555-0188
CITY, STATE ANYTOWN, CA	ZIP CODE 90100
22. PLACE OF SERVICE OFFICE <input checked="" type="checkbox"/> HOME <input type="checkbox"/> CLINIC <input type="checkbox"/> SNF <input type="checkbox"/> ICF <input type="checkbox"/> HOSPITAL IN-PATIENT <input type="checkbox"/> HOSPITAL OUT-PATIENT <input type="checkbox"/> OTHER (PLEASE SPECIFY) _____	

BIC Issue Date: 01/15/10

EVC #: 123456789A1


EXAMINATION AND TREATMENT							
26. TOOTH # (LTR, ARCH, QUAD)	27. SURFACES	28. DESCRIPTION OF SERVICE (INCLUDING RADIOGRAPHS, PROPHYLAXIS, MATERIALS USED, ETC.)	29. DATE SERVICE PERFORMED	30. QUANTITY	31. PROCEDURE NUMBER	32. FEE	33. RENDERING PROVIDER NPI
		1 Exam	111420		D0150	25.00	9912345678
		2 4 BW X-Rays	111420		D0274	18.00	9912345678
		3 Additional PAs	111420	6	D0230	18.00	9912345678
		4					
		5					
		6					
		7					
		8					
		9					
		10					
		11					
		12					
		13					
		14					
		15					

34. COMMENTS

35. TOTAL FEE CHARGED
61.00

39. THIS IS TO CERTIFY THAT TO THE BEST OF MY KNOWLEDGE THE INFORMATION CONTAINED ABOVE AND ANY ATTACHMENTS PROVIDED IS TRUE, ACCURATE, AND COMPLETE AND THE REQUESTED SERVICES ARE NECESSARY TO THE HEALTH OF THE PATIENT. THE PROVIDER HAS READ, UNDERSTANDS, AND AGREES TO BE BOUND BY AND COMPLY WITH THE STATEMENTS AND CONDITIONS CONTAINED ON THE BACK OF THIS FORM.

36. PATIENT SHARE-OF-COST AMOUNT
 37. OTHER COVERAGE AMOUNT
 38. DATE BILLED
11142020

 **Jim Adams**
 SIGNATURE

11/14/20
 DATE

IMPORTANT NOTE:
 In order to process your TAR/Claim an X-ray envelope containing your radiographs, if applicable, **MUST** be attached to this form.

www.denti-cal.ca.gov DC-217 (R 10/19)

How to Complete the TAR/Claim Form

Accurate and complete preparation of this form is essential for processing. Unless otherwise specified, all fields must be completed.

Medi-Cal Dental's evaluation of TARs and Claims will be more accurate when narrative documentation is included. The following reminders and tips help office staff prepare narrative documentation for some common Medi-Cal Dental procedures:

- “Comments” area (Field 34) of the TAR/Claim form is used when written narrative documentation is required. If including narrative documentation on a separate piece of paper, check Field 10 on the treatment form to indicate there are other attachments. Note in Field 34 that written comments are attached.
- Written narrative documentation must be legible; printed or typewritten documentation is always preferred. Avoid strikeovers, erasures, or using correction fluid when printing or typing narrative documentation on the treatment form (Field 34).
- If submitting electronically, abbreviate comments to make optimum use of allotted space.

Fill in each field as follows:

1. **PATIENT NAME:** Enter the member's last name, first name, and middle initial.
2. Field removed.
3. **PATIENT SEX:** Check “M” for male or “F” for female.
4. **PATIENT BIRTHDATE:** Enter the member's birthdate (mmddyy). The birthdate is used to help identify the member. Differences between the birthdate on the Medi-Cal Identification Card and the birthdate given by the member should be brought to the attention of the member for correction by his/her County Social Services office.
5. **MEDI-CAL BENEFITS ID CARD NUMBER:** Enter the member's 14-digit number as it appears on the Medi-Cal identification card. Completion of this field is required.
6. **PATIENT ADDRESS:** Enter the member's current address. If the member resides in a convalescent home or other health care facility, indicate the full name, complete address, and phone number, including area code, of the convalescent home or other health care facility.

Please Note: It is important to accurately document the member's name, birthdate, Medi-Cal Benefits ID Card number, and current address when submitting billing forms to Medi-Cal Dental. Medi-Cal Dental may need to contact the member for screening, and if the member's information is incorrect, it can cause delays in processing the document.

7. **PATIENT DENTAL RECORD NUMBER:** If the provider assigns a Dental Record Number or account number to a member, enter the assigned number here. The number will then appear on all related correspondence from Medi-Cal Dental.

8. **REFERRING PROVIDER NUMBER:** Enter the license number of the dentist who referred the member, if applicable.
9. **RADIOGRAPHS ATTACHED? HOW MANY?** Check if “yes” and indicate the number of films enclosed. All radiographs and any attachments should be clearly identified with the member’s name, the BIC or CIN, the date that the radiograph was taken, and the provider’s name and provider number.
10. **OTHER ATTACHMENTS:** Check “yes” if additional documents are attached to the TAR/Claim form. Examples of other attachments include related correspondence, periodontal charts, operating room reports, or physician’s report describing the member’s specific medical condition. Do not place attachments inside the X-ray envelope.
11. **ACCIDENT/INJURY? EMPLOYMENT RELATED?** Check “yes” if the member was in an accident or incurred an injury that resulted in the need for dental services. Additionally, if the member’s accident or injury was caused by or occurred at work, check “yes.” Please Note: OCR has been set up to read any mark entered in this field as a “yes,” even if the answer is “no.” So please do not check this box unless indicating “yes.”
12. **ELIGIBILITY PENDING? (FOR TAR ONLY)** Check “yes” if the member has applied for Medi-Cal eligibility which has not yet been approved and a TAR has been submitted for that member.
Please Note: OCR has been set up to read any mark entered in this field as a “yes,” even if the answer is “no.” So please do not check this box unless indicating “yes.”
13. **OTHER DENTAL COVERAGE?** Check “yes” if the services performed are either fully or partially covered by a private- or employer-paid dental insurance carrier. The provider must bill the other insurance carrier prior to submitting the TAR/Claim form to Medi-Cal Dental. In the “COMMENTS” section (Field 34), furnish the full name and address of the other insurance carrier, and name and group number of the policy holder. Attach a copy of the other insurance carrier’s Explanation of Benefits, fee schedule, or denial letter. For more information on other coverage, see “Section 9: Special Programs” of this Handbook. Please Note: OCR has been set up to read any mark entered in this field as a “yes,” even if the answer is “no.” So please do not check this box unless indicating “yes.”
14. **MEDICARE DENTAL COVERAGE?** Check “yes” if the service performed is covered by Medicare. Medicare must be billed prior to submitting any Medicare-covered service to Medi-Cal Dental. Attach a copy of the Explanation of Medicare Benefits form or denial letter. Please Note: OCR has been set up to read any mark entered in this field as a “yes,” even if the answer is “no.” So please do not check this box unless indicating “yes.”
15. **RETROACTIVE ELIGIBILITY?** Check “yes” if the services have been performed and the provider is requesting payment for the reason described in the “COMMENTS” section, Field 34. Please Note: OCR has been set up to read any

mark entered in this field as a “yes,” even if the answer is “no.” So please do not check this box unless indicating “yes.”

16. **CHDP (CHILD HEALTH AND DISABILITY PREVENTION)?** Check “yes” if the treatment is related to a previous CHDP screening. The CHDP Children’s Treatment Program (CTP) claims must be submitted with a current PM 160 (health assessment screening form) attached to the Medi-Cal Dental TAR/Claim form. Please Note: OCR has been set up to read any mark entered in this field as a “yes,” even if the answer is “no.” So please do not check this box unless indicating “yes.”
17. **CCS (CALIFORNIA CHILDREN’S SERVICES)?** Check “yes” if any services performed are authorized by CCS. Please Note: OCR has been set up to read any mark entered in this field as a “yes,” even if the answer is “no.” So please do not check this box unless indicating “yes.”
18. **MF-O (MAXILLOFACIAL-ORTHODONTIC) SERVICES?** Check “yes” if the claim is for maxillofacial-orthodontic services. Please Note: OCR has been set up to read any mark entered in this field as a “yes,” even if the answer is “no.” So please do not check this box unless indicating “yes.”
19. **BILLING PROVIDER NAME:** Enter the billing provider's name in either the “doing business as” format, such as HAPPY TOOTH DENTAL CLINIC, or in the last-name, first-name, middle-initial, title format, e.g., SMITH, JOHN J., DDS. This information should be consistent with that used when filing state and federal taxes.
20. **BILLING PROVIDER NUMBER:** Enter the billing Provider Number (NPI). **NOTE:** The Provider Number and correct service office (where the services were administered) must be present and correct on all forms. Also, the NPI must be registered with Medi-Cal Dental prior to submitting claims.
21. **BILLING PROVIDER ADDRESS AND TELEPHONE NUMBER:** Enter the service office address where treatment is rendered. A service office address should be a street address, including city, state, and zip code. A post office box cannot be used as a service office; however, it is acceptable in rural areas only to use a route number with a post office box number.

If the service office address is different from the address where payment is received, please notify Medi-Cal Dental so payment can be directed to the appropriate location.

It is important to include the telephone number of the service office, including area code, so Medi-Cal Dental can contact the provider if questions arise while processing documents.

Please Note: It is important that the billing provider’s name, Medi-Cal provider number (NPI), address and telephone number are accurate and match the information Medi-Cal Dental has recorded on its system. TAR/Claim forms pre-printed with the provider's name/number/address are available at no charge from the Medi-Cal Dental forms supplier. Please check this information for accuracy on all pre-printed supplies. If forms printed from your office computer are being used, please ensure the computer is programmed with the correct provider information.

22. **PLACE OF SERVICE:** Check the appropriate box indicating where service was performed (claim) or will be performed (TAR), i.e., Office, Home, Clinic/Dental School Clinic, SNF (Skilled Nursing Facility), ICF (Intermediate Care Facility), Hospital In-Patient, Hospital Out-Patient or Other (specify place of service). Those providers treating a SNF or ICF member outside the facility in which they reside, must use POS 4 or 5 (only) and must indicate the actual place of service in Box 34.
- BIC ISSUE DATE/EVC# AREA:** This area is only used to record the new issue date for Benefits Identification Cards (BICs).
23. **TOOTH NO./LTR, ARCH, QUAD:** Use universal tooth code numbers 1 through 32 or letters A through T for tooth reference. Use arch code “U” (upper), “L” (lower). Use quadrant code “UR” (upper right), “UL” (upper left), “LR” (lower right), and “LL” (lower left). For permanent supernumerary teeth continue with numbers 33 — 40. For primary supernumerary teeth, continue with letters U — Z.
24. **TOOTH SURFACES:** Use “M” (mesial), “D” (distal), “O” (occlusal), “I” (incisal), “L” (lingual or palatal), “B” (buccal), and “F” (facial).
25. **DESCRIPTION OF SERVICE:** Furnish a brief description for each service. Standard abbreviations are acceptable.
26. **DATE SERVICE PERFORMED:** For TARs, this field is blank. For payment claims only. Indicate the date the service was performed, using the six numerical digits e.g., mmddyy.
27. **QUANTITY:** For the procedures having multiple occurrences, indicate the number of occurrences of the procedure.
28. **PROCEDURE NUMBERS:** Use only the Current Dental Terminology version 2022 (CDT 22) procedure codes.
29. **FEE:** Enter the usual customary and reasonable (UCR) fee for the procedure rather than the Medi-Cal Dental Schedule of Maximum Allowances fee.
30. **RENDERING PROVIDER NO.:** A rendering provider (NPI) number is required in Field 33 on all claim forms and NOAs for each dated line on the form. Rendering provider numbers are not required on undated lines of a TAR. If a rendering provider number (NPI) is not indicated on the TAR/Claim form for dated services, the TAR/Claim form will be delayed and an RTD will be issued to request the missing information. If there is more than one dentist or dental hygienist at a service office billing under a single dentist's provider number, enter the NPI of the dentist or dental hygienist **who performed the service**.
31. **COMMENTS:** Use for additional clinical remarks necessary to document treatment or for requested information regarding other coverage, etc. Narrative documentation should always state facts as they pertain to the case. Printed or typewritten documentation is preferred. It is helpful to note in this area that narrative documentation is attached when including narrative documentation on a separate piece of paper.

When preparing a TAR for a member with an authorized representative who is not identified on the Medi-Cal card, please include the representative's name and address in this area on the TAR form. This will assist Medi-Cal Dental in identifying cases where the TAR status notification should be sent to a representative and will help with correct address information.

This area should also be used to indicate the:

- Submitter ID of the billing intermediary, if applicable
- Eligibility confirmation number given by the AEVS when verifying eligibility
- Name, address, and telephone number of the Skilled Nursing Facility or Intermediate Care Facility

32. **TOTAL FEE CHARGED:** The sum of the fees entered in field 32 for all lines.

33. **PATIENT SHARE OF COST AMOUNT: FOR PAYMENT CLAIMS ONLY.** The dollar amount of the member's share of cost collected by or due from a recipient who has a share of cost obligation. If there is no share of cost, then leave this field blank.

34. **OTHER COVERAGE AMOUNT: FOR PAYMENT CLAIMS ONLY.** The dollar amount of "other coverage" payments the provider has received for the listed procedures. If either Field 13 (OTHER DENTAL COVERAGE) or Field 14 (MEDI-CARE DENTAL COVERAGE) is checked "yes", the amount received from the private dental insurance carrier or Medicare must be entered. The Explanation of Benefits (EOB) or denial from the private dental insurance carrier or Medicare must be attached to the TAR/Claim form for payment.

35. **DATE BILLED:** Enter the date the form is mailed using six numerical digits, e.g., mmddyy.

36. **SIGNATURE BLOCK:** The provider, or person authorized by the provider, must sign his/her own name in this signature field and date the form when requesting prior authorization or payment. An original signature in blue or black ink is also required (stamped signatures will not be accepted).

After providing all necessary information on the form please follow these steps:

1. Detach the "Dentist Copy" (page 2, where applicable) and retain for office records.
2. Check page 1 for completeness and legibility.
3. Place attachments, if any, behind the form or the X-ray envelope. Staple them to the back of the form, in the upper right corner. Only staple the attachments once to the form. Excessive staples will delay processing.
4. Mail completed TAR/Claim forms in the large mailing envelopes. Up to 10 forms can be mailed in a single envelope.

Mail completed TAR/Claim forms to:

Medi-Cal Dental
PO Box 15610
Sacramento, CA 95852-0610

TAR/Claim forms used for authorization (as a Treatment Authorization Request) should be mailed separately from TAR/Claim forms requesting payment for services rendered.

5. If submitting two TAR/Claim forms for the same member, staple them together in the upper right corner.

How to Submit a Claim for a Member with Other Coverage

A member having other coverage does not change the prior authorization requirements under Medi-Cal Dental. Medi-Cal Dental will process the prior authorization, and a Notice of Authorization will indicate the amount Medi-Cal Dental would pay as if there were no other coverage.

When completing the claim for payment or NOA, be sure to include the following:

Field 10. ATTACHMENTS:

Include a copy of other coverage carrier's Explanation of Benefits/Readmittance Advice (EOB/RA) or Proof of Denial letter or fee schedule.

Field 13. OTHER DENTAL COVERAGE?

Check "yes," indicating member has other dental insurance coverage.

Field 34. COMMENTS:

Provide full name and address of other coverage carrier and name, member's ID for that particular carrier, and group number of the policyholder.

Field 37. OTHER COVERAGE AMOUNT:

Fill in amount paid by other coverage carrier.

How to Submit a TAR for Orthodontic Services

Providers must include a complete orthodontic treatment plan containing:

- Comprehensive Orthodontic Treatment of the Adolescent Dentition (Procedure D8080)
- Periodic Orthodontic Treatment Visits (Procedure D8670)
- Orthodontic Retention (Procedure D8680)

The treatment plan may include:

- Radiographs (Procedure D0210)
- Panoramic radiographic image (Procedure D0330)
- Cephalometric head radiographic image and tracings (Procedure D0340)

Include the quantity, number of visits for active treatment (Procedure D8670). The quantity can vary depending on the type of case and the phase of dentition. Also, indicate the “case type” (e.g., cleft palate or craniofacial anomaly) and “Phase of dentition” (primary, mixed or permanent) in Field 34 (COMMENTS).

Note: Craniofacial anomalies cases may request Pre-Orthodontic Treatment Visits (Procedure D8660 – maximum of 6) and must also submit a separate authorization for these services prior to requesting a complete orthodontic treatment plan.

Reminders:

- Attach HLD Score Sheet (DC-016) to TAR
- Properly pack and box diagnostic casts
- Send diagnostic casts separately, approximately 10 days prior to sending the TAR
- Label diagnostic casts with:
 - Member Name
 - Client Index Number (CIN) or Benefits Identification Card (BIC) number
 - Billing Provider Name
 - Service office National Provider Identifier (NPI) number
 - Centric occlusion marked on cast
- Dry and trim diagnostic casts carefully
- Properly pack and box diagnostic casts
- Send diagnostic casts to the address on TAR or RTD form
- Send diagnostic casts separately, approximately ten days prior to sending the TAR

A Medi-Cal Dental orthodontic consultant will determine if the case qualifies for treatment under the Medi-Cal Dental guidelines for orthodontic services.

Please refer to “Section 9: Special Programs” of this Handbook for more information on orthodontic services.

Notice of Authorization (NOA) **(DC-301, Rev. 4/20)**

The NOA, a computer-generated form sent to the provider following final adjudication of a TAR/Claim form for prior authorization, is printed with the same information as originally submitted. Presently the NOA is used either to request payment of authorized services or to request a reevaluation of modified or denied services.

Providers may request a reevaluation for denied and/or additional procedures requested in certain instances. Changes to the billed amount or procedures not requiring prior authorization will not be considered.

Reevaluations may be considered when:

- another procedure requiring prior authorization has been requested.
- there is a reversal of denied procedures, e.g., missing radiographs have been submitted.
- there is a complex treatment plan.

Medi-Cal Dental has created the following NOA message when a reevaluation has been requested:

The submitted changes have been reviewed. Original authorization period still valid.

Medi-Cal Dental has revised the following NOA message when a reevaluation has been re-requested:

Resubmission not processed. No additional information received. Original authorization period still valid.

To expedite processing and prevent delays or possible denial, please remember to check the box found in the upper right corner of the NOA. Only one reevaluation may be requested per NOA and it must be received prior to the expiration date.

Prior to completing the form, verify that the information printed on the form is correct.

The NOA is printed by Medi-Cal Dental with the following information:

1. Authorized period of time (365 days).
2. member information (except Medi-Cal ID Number).
3. Provider information
4. Procedures allowed, modified, disallowed
5. Allowances
6. Adjudication Reason Codes

Medi-Cal Dental will indicate on the NOA if the services requested are allowed, modified, or disallowed. For those allowed services, fill in the appropriate shaded areas on the top portion of the NOA form, including the dates for all services. Submit the

completed and signed form for payment for the services performed. Also, fill in the appropriate shaded areas on a copy and retain this one for office records.

The NOA has a statement printed on the bottom of the form that reads: "NOTE: Authorization does not guarantee payment. Payment subject to member's eligibility." This statement has been added to remind the dentist to verify the member's eligibility prior to providing services.

Time limitations for billing services provided under Medi-Cal Dental are as follows:

- Six calendar months after the end of the month in which the service is authorized will be considered for full payment (100 percent of the SMA).
- Seven to nine months after the end of the month in which the service is authorized will be considered for payment at 75 percent of the SMA amount.
- Ten to twelve months after the end of the month in which the service is authorized will be considered for payment at 50 percent of the SMA amount.

If the allowed period of time on the NOA has expired and none of the authorized services have been completed, please send the expired NOA back to Medi-Cal Dental so it can be deleted from the automated system. If at a later date authorization for these services is requested and there is an outstanding NOA for the same services, processing delays or denial of services can occur.

Note: If a member's 21st birthday occurs during the authorized period of time, most services may be completed with the exception of orthodontic treatment. (See Section 5 – "Manual of Criteria").

Sample Notice of Authorization (NOA)

STAPLE HERE		DO NOT WRITE IN THIS AREA		STAPLE HERE	
<h3 style="margin: 0;">NOTICE OF AUTHORIZATION</h3>			AUTHORIZATION FOR SERVICE BELOW IS: FROM: _____ TO: _____		
			RE-EVALUATION IS REQUESTED <input type="checkbox"/> YES		
PAGE ____ OF ____					
1. MEMBER NAME (LAST, FIRST, M.I.)			3. SEX M <input type="checkbox"/> F <input type="checkbox"/>		4. MEMBER BIRTHDATE MO DAY YR
5. MEMBER MEDI-CAL ID. NO.					
9. RADIOGRAPHS ATTACHED HOW MANY? _____	CHECK IF YES <input type="checkbox"/>	10. OTHER ATTACHMENTS CHECK IF YES <input type="checkbox"/>	11. ACCIDENT/INJURY? EMPLOYMENT RELATED? <input type="checkbox"/>	12. OTHER DENTAL COVERAGE? YES <input type="checkbox"/> NO <input type="checkbox"/>	7. MEMBER DENTAL RECORD NO.
			23. BIC Issue Date: _____ EVC #: _____		
41. DELETE	26. TOOTH NO. OR LETTER	27. SURFACES	28. DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	29. DATE SERVICE PERFORMED	30. QUANTITY
			1		
			2		
			3		
			4		
			5		
			6		
			7		
			8		
			9		
			10		
			11		
			12		
			13		
			14		
			15		
			16		
			17		
			18		
			19		
			20		
			21		
			22		
44. DATE PROSTHESIS ORDERED			35. TOTAL FEE CHARGED		
43. PROSTHESIS LINE ITEM			46. TOTAL ALLOWANCE		
34. COMMENTS			36. MEMBER SHARE-OF-COST AMOUNT		
			37. OTHER COVERAGE AMOUNT		
			38. DATE BILLED		
NOTICE OF AUTHORIZATION <ul style="list-style-type: none"> FILL IN SHADED AREA AS APPLICABLE SIGN AND RETURN FOR PAYMENT MULTIPLE - PAGE NOAs MUST BE RETURNED TOGETHER FOR PAYMENT OR RE-EVALUATION 			39. TREATMENT COMPLETED - PAYMENT REQUESTED THIS IS TO CERTIFY THAT THE INFORMATION CONTAINED ABOVE AND ANY ATTACHMENTS PROVIDED IS TRUE, ACCURATE AND COMPLETE AND THAT THE PROVIDER HAS READ, UNDERSTANDS AND AGREES TO BE BOUND BY AND COMPLY WITH THE STATEMENTS AND CONDITIONS CONTAINED ON THE BACK OF THIS FORM.		
SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.			ORIGINAL SIGNATURE REQUIRED _____ DATE _____		
SIGN ONE COPY AND SEND IT TO MEDI-CAL DENTAL - RETAIN THE OTHER FOR YOUR RECORDS.					
NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO MEMBER'S ELIGIBILITY AT THE TIME SERVICE IS RENDERED.					

301 NOA 4/20

How to Complete the NOA

The shaded fields on the NOA require completion by the dental office. All fields listed below are required unless otherwise stated.

1. **MEMBER NAME (LAST, FIRST, MI):** Preimprinted by Medi-Cal Dental.
2. Field removed
3. **SEX:** Preimprinted by Medi-Cal Dental.
4. **MEMBER BIRTHDATE:** Preimprinted by Medi-Cal Dental.
5. **MEMBER MEDI-CAL IDENTIFICATION NUMBER:** Enter the member's 14-digit State Recipient Identifier as it appears on the Medi-Cal identification card (Benefits Identification Card, "BIC"). Completion of this field is required.
6. Field removed
7. **MEMBER DENTAL RECORD NO.:** Enter the dental record for the member. This field is optional.
8. Field removed
9. **RADIOGRAPHS ATTACHED? HOW MANY?** Check if "yes" and indicate the number of films enclosed. All radiographs and any attachments should be clearly identified with the member's name and BIC, the date the radiograph was taken, and the provider's name and provider number.
10. **OTHER ATTACHMENTS?** Check "yes" if additional documents are attached to include related correspondence, periodontal charts, operating room reports, or physician's report describing the member's specific medical condition.
Please Note: OCR has been set up to read any mark entered in this field as a "yes," even if the answer is "no." So please do not check this box unless indicating "yes."
11. **ACCIDENT/INJURY? EMPLOYMENT RELATED?** Check "yes" if the member was in an accident or incurred an injury that resulted in the need for dental services. Additionally, if the member's accident or injury was "Employment Related" check "yes." Please Note: OCR has been set up to read any mark entered in this field as a "yes," even if the answer is "no." So please do not check this box unless indicating "yes."
12. Field removed
13. **OTHER DENTAL COVERAGE?** Check "yes" if the services performed are either fully or partially covered by a private or employer paid dental insurance carrier. The provider must bill the other insurance carrier prior to submitting the NOA form to Medi-Cal Dental. In the "COMMENTS" section (Field 34), furnish the full name and address of the other insurance carrier, and name, BIC, and group number of the policy holder. Attach a copy of the other insurance carrier's Explanation of Benefits, fee schedule or denial letter. See "Section 2: Program Overview" of this Handbook for additional information on other coverage. Please Note: OCR has been set up to read any mark entered in this field as a "yes," even if the answer is "no." So please do not check this box unless indicating "yes."
14. Field removed

15. Field removed
16. **CHDP -CHILD HEALTH AND DISABILITY PREVENTION?** Check “yes” if the treatment is related to a previous CHDP screening.
Please Note: OCR has been set up to read any mark entered in this field as a “yes,” even if the answer is “no.” So please do not check this box unless indicating “yes.”
17. Field removed
18. Field removed
19. Field removed
20. Field removed
21. Field removed
22. Field removed
23. **BIC ISSUE DATE. EVC #:** This area is only used to record the new issue date for Benefits Identification Cards (BICs).
24. Field removed
25. Field removed
26. **TOOTH NO. OR LETTER ARCH:** The tooth number or letter arch here. For permanent supernumerary teeth continue with numbers 33 — 40. For primary supernumerary teeth, continue with letters U — Z.
27. **SURFACES:** Pre imprinted by Medi-Cal Dental. The surface of the tooth being restored as indicated by tooth surface (F=facial, B=buccal, O=occusal, M=mesial, D=distal, L=lingual).
28. **DESCRIPTION OF SERVICES:** Preimprinted by Medi-Cal Dental. The type of service the provider is authorized to perform (X-rays, teeth cleaning, fillings, etc.).
29. **DATE SERVICE PERFORMED:** Indicate the date the service was performed. Use six numerical digits, e.g., mmddyy.
30. **QUANTITY:** Preimprinted by Medi-Cal Dental. The quantity of the service provided.
31. **PROCEDURE NUMBER:** Preimprinted by Medi-Cal Dental. Enter the CDT 22 procedure code for the service.
32. **FEE:** Preimprinted by Medi-Cal Dental. The fee charged for each rendered service.
33. **RENDERING PROVIDER NO.:** A rendering provider (NPI) number is required in this Field on all TAR/Claim forms and NOAs when requesting payment for dated services. If a rendering provider number (NPI) is not indicated on the NOA, the NOA will be delayed and a RTD will be issued requesting the missing data. If there is more than one dentist or dental hygienist at a service office billing under a single dentist's provider number, enter the NPI of the dentist or dental hygienist **who performed the service.**
34. **COMMENTS:** Use for additional clinical remarks necessary to document treatment or for requested information regarding other coverage, etc. It is helpful to note in this area if additional documentation is attached.
35. **TOTAL FEE CHARGED:** Preimprinted by Medi-Cal Dental. The total dollar amount requested by the provider office on the original TAR.

36. **MEMBER SHARE OF COST AMOUNT:** The dollar amount of the member's share of cost collected by or due from a recipient who has a share of cost obligation. If there is no share of cost, then leave this field blank.
37. **OTHER COVERAGE AMOUNT: FOR PAYMENT CLAIMS ONLY.** The dollar amount of "other coverage" payments the provider has received for the listed procedure. If Field 13 (OTHER DENTAL COVERAGE) is checked "yes," the amount received from the private dental insurance carrier must be entered. The Explanation of Benefits (EOB) or denial letter from the private dental insurance carrier must be attached to the NOA form for payment.
38. **DATE BILLED:** Enter the date the form is mailed using six numerical digits, e.g., mmddyy.
39. **SIGNATURE BLOCK:** The provider, or person authorized by the provider, must sign his/her own name in this signature field and date the form when requesting payment. The signature must be an original signature in blue or black ink. Rubber stamp signatures are not acceptable.

Additional services not requiring prior authorization may be added to the NOA when submitted for payment. However, radiographs or documentation must be sent with the NOA to justify the additional services. After providing all necessary information on the form, please follow these steps:

- Sign and date one copy of the NOA. Mail this one to Medi-Cal Dental. Multi-page NOAs should be returned together.
- Retain the other copy for office records.
- If radiographs are being submitted, enclose them in the green-bordered X-ray envelope and attach it to the NOA.
- Mail completed forms in the large, green-bordered envelopes that have been provided. Up to 10 forms can be mailed in a single envelope.

Mail NOAs to the post office box listed below:

Medi-Cal Dental
California Medi-Cal Dental
PO Box 15609
Sacramento, CA 95852-0609

40. Field removed
41. **DELETE:** If treatment was not performed, place an "X" in the column corresponding to the treatment not performed. Do NOT strike out the entire line.
42. **ALLOWANCE:** Pre imprinted by Medi-Cal Dental. Reflects the dollar amount Medi-Cal Dental will pay for each procedure.
43. **ADJ. REASON CODE:** Pre imprinted by Medi-Cal Dental. Indicates the adjudication reason code (if applicable).
44. **DATE PROSTHESIS ORDERED:** If an approved prosthesis cannot be delivered, indicate the date the prosthesis was ordered from the dental laboratory.

45. **PROSTHESIS LINE FIELD:** Indicate the number of the line corresponding to procedure billed for the undelivered prosthesis.
46. **TOTAL ALLOWANCE:** Pre imprinted by Medi-Cal Dental. Reflects the dollar amount Medi-Cal Dental will pay for the entire NOA.

Please make sure all applicable areas of the forms are filled in completely and accurately. Any claim service line (CSL) submitted with an invalid procedure code, or a blank procedure code field will be denied, whether submitted electronically or as paper documents. Documents received with a missing or incorrect address or NPI can delay the processing of TARs and claims and increase the possibility that payments may be forwarded to the wrong office.

Reevaluation of the Notice of Authorization (NOA) For Orthodontic Services

Under the orthodontic program, providers may request a reevaluation on a denied NOA for the orthodontic treatment plan only. Reevaluations must be received by Medi-Cal Dental on or before the expiration date (within 365 days).

There are no reevaluations on “exploded” NOAs. An explanation of the term “exploded” is: the submitted Treatment Authorization Request (TAR) will include all requested orthodontic treatments but when Medi-Cal Dental sends the NOAs, the NOAs will be sent individually by procedure code(s). The NOAs will be sent in the following order:

- Comprehensive Orthodontic Treatment of the Adolescent Dentition (Procedure D8080)
- Remaining Treatment Visit NOAs (Procedure D8670) will be sent one per quarter over the course of the treatment
- Orthodontic Retention NOA for upper and lower retainers (Procedure D8680 x 2) will follow upon completion of the active phase of treatment

Providers are reminded:

- A reevaluation may only be requested on a denied NOA for the Orthodontic Treatment Plan only
- Check the “Reevaluation Box” on the NOA
- Medi-Cal Dental must receive the NOA prior to the expiration date
- Attach HLD and all additional documentation to NOA
- Do not sign the NOA
- NOA may only be submitted for reevaluation one time
- See “Section 9: Special Programs” of this Handbook for more information on Orthodontic services

Reevaluations

Only one request for reevaluation per NOA is allowed, and it must be received prior to the expiration date.

To request reevaluation of a NOA, follow these steps:

1. Check the box marked "REEVALUATION IS REQUESTED" at the upper right corner of the NOA.
2. Do not sign the NOA.
3. Include additional documentation and/or enclose radiographs, as necessary.
4. Return to:

Medi-Cal Dental
PO Box 15609
Sacramento, CA 95852-0609

5. After the reevaluation is made, a new NOA will be generated and sent to your office.

If a denial is upheld and another review is wanted, a new TAR must be submitted.

Outstanding Treatment Authorization Requests (TARs)

Since TARs can remain outstanding in the automated system for an extended length of time, Medi-Cal Dental may deny authorization or payment of services based on an outstanding authorization. Medi-Cal Dental may reconsider denial of authorization or payment of services that are duplicated on an outstanding TAR under the following circumstances:

- written notification from the member stating that he or she will not be returning to the original provider's office;
- closure of the original provider's office;
- sale of the original provider's practice;
- death of the original provider;
- refusal of the original provider to return the Notice of Authorization;
- treatment (such as extraction) was provided on an emergency basis by one dentist when authorization for the same treatment was granted previously to a different dentist.

For reconsideration of denial of authorization or payment under these circumstances, please follow these guidelines:

Obtain a written statement from the member that treatment will not be provided by the original dentist.

For an Explanation of Benefits (EOB) showing denial of payment: Attach the member's statement to the EOB and follow the normal procedures for the Claim Inquiry Form.

For a NOA showing denial of treatment authorization: Attach the member's statement and any other supporting documentation to the NOA and submit the NOA with necessary radiographs to obtain reauthorization of the services. Medi-Cal Dental will send the provider office a new NOA showing the allowed services and will void the original TAR.

Notice of Medi-Cal Dental Action

Medi-Cal Dental sends all Medi-Cal dental members and/or their authorized representatives written notification when services that require prior authorization have been denied, modified, or deferred. The notification indicates the status of the Treatment Authorization Request (TAR) and explains why the requested service was denied, modified, or deferred. Members do not receive written notification of approved TARs or services that have been performed. Members are notified of any action taken on a TAR, including, but not limited to, a change from one procedure to another (Replaced and Substituted), denial of a procedure for any reason, and a Resubmission Turnaround Document (RTD) request for more information.

When the dental office prepares a TAR for a member with an authorized representative who is not identified on the BIC card, the representative's name and address should be included in the "Comments" box (Field 34) on page 2 of the Medi-Cal Dental TAR form. This will assist Medi-Cal Dental in identifying cases where the TAR status notification should be sent to a representative and will help with correct address information. Medi-Cal Dental must have a written authorization approving the person designated as the member's representative.

Members may contact the provider for assistance with inquiries concerning their Notice of Medi-Cal Dental Action notices. Members are sent an enclosed insert, titled Reason for Action Codes, with each Notice of Medi-Cal Dental Action they receive. This insert provides the code descriptions for each Reason for Action Code listed in the member's notice. To help members better understand the Medi-Cal Dental action taken, providers can match the Reason for Action Code(s) listed in column five of the table in the Notice of Medi-Cal Dental Action against the code descriptions in the Reason for Action Codes insert.

If the provider is unable to answer the member's questions, please refer them directly to Medi-Cal Dental. A Medi-Cal dental member or authorized representative may call the Telephone Services Center toll-free number at (800) 322-6384 for assistance with inquiries about denied, modified, or deferred TARs, including RTD requests.

Sample Notice of Medi-Cal Dental Action



NOTICE OF MEDI-CAL DENTAL ACTION THIS IS NOT A BILL

--	--

SERVICE OFFICE NAME:

MEDS ID:

DCN:

MRDCN:

PAGE OF

DATE OF REQUEST:

MEMBER NAME:

Medi-Cal Dental has processed your dentist's request for your treatment in accordance with Title 22, California Code of Regulations, Sections 51003, 51307, and the Manual of Criteria. At least one of the items cannot be approved or requires modification. Please refer to the enclosed list for an explanation of the REASON FOR ACTION CODE(S) listed. In addition, specific minimum requirements can be found in the Medi-Cal Dental Provider Handbook, under Section 5 entitled "MANUAL OF CRITERIA" under the specific Procedure Number listed below. A copy may be found at any Medi-Cal dentist's office.

Tooth # or Arch	Treatment Description	Procedure Number	Medi-Cal Dental Action	Reason for Action Code(s) (see enclosed for explanation)

- You can discuss different treatment plans with your dentist to obtain the best care allowable under Medi-Cal Dental.
- If you have a question regarding this action, please contact your dentist or Medi-Cal Dental at 1-800-322-6384 for a more detailed explanation.
- If you are dissatisfied with the action described on this notice, you may request a state hearing within 90 days from the Notice Date. Please see the back of this notice for information on filing a hearing.

P.O. Box 15539 • Sacramento, CA 95852-1539 • (800) 322-6384

IF YOU ARE DISSATISFIED WITH THE ACTION DESCRIBED
ON THIS NOTICE, YOU MAY REQUEST A STATE HEARING WITHIN 90
DAYS FROM THE NOTICE DATE.

To Request a Hearing:

SEND BOTH SIDES OF THIS ENTIRE NOTICE TO:

California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 9-17-37
Sacramento, CA 94244-2430

OR

You may call the TOLL-FREE number at the Public Inquiry and Response
Unit. 1-800-952-5253 (ASSISTANCE AVAILABLE IN LANGUAGES
OTHER THAN ENGLISH)

OR

You may call the TDD toll-free number: 1-800-952-8349

State Regulations:

A copy of Title 22, California Code of Regulations, Sections 5095 1, 51014.1, and
51014.2, which covers state hearings, is available at your county social services office or
local library.

Authorized Representative:

You can represent yourself at the hearing or you can be represented by a friend, lawyer
or any other person. You are expected to arrange for the representative yourself. You can
obtain the telephone numbers to legal aid organizations by calling the toll-free number of
the Public Inquiry and Response Unit or from your local Social Security Office.

I WILL NEED A TRANSLATOR (at no cost to me).
MY LANGUAGE OR DIALECT IS: _____

Sample Notice of Medi-Cal Dental Action Insert: Reason for Action Codes



Medi-Cal Dental

WHEN APPLICABLE, ALL SERVICES
SUBMITTED FOR MEMBERS UNDER
21 YEARS OF AGE HAVE BEEN
EVALUATED FOR EPSDT CRITERIA.

REASON FOR ACTION CODES

- | | |
|--|---|
| <p>01 Your eligibility (aid code) covers emergency services only.</p> <p>02 Information sent by your dentist about your current dental condition does not meet the minimum requirements for approval of this service.</p> <p>03 The request for dental treatment was changed. This change was based on the information sent by your dentist about your current dental condition or to follow program guidelines.</p> <p>04 Our records show this service(s), or a similar service(s) was previously approved, paid for, or completed. (For example: In some cases, procedures are limited to once in 12 months or once in five (5) years and cannot be approved again except under special conditions, which must be documented by your dentist.)</p> <p>05 We are unable to verify your dentist's enrollment in the program on the date the request was received.</p> <p>06 The service requested by your dental provider, is not a benefit of the program. Please contact your provider for a different treatment plan.</p> <p>07 You did not appear for a scheduled screening exam or failed to bring existing denture(s) (full or partial) to your appointment. Please contact your dentist to send a new request.</p> <p>08 Your dentist did not send enough information to allow us to process this request. Please contact your dentist for information about this treatment.</p> <p>09 X-rays show that the tooth does not meet the requirements for a crown. The tooth may be fixed with a filling.</p> <p>10 X-rays show that the tooth/teeth may have an infection; please contact your dentist as another service may be needed first.</p> <p>11 Based on x-rays, chart records and/or information confirmed by your clinical screening exam you do not need a deep cleaning.</p> | <p>12 This service cannot be approved because it is related to a denied procedure in the same treatment plan sent by your dentist.</p> <p>13 Based on the information from your dentist and/or a clinical screening exam, your current dental condition is stable, and the requested service is not needed at this time.</p> <p>14 Based on x-rays and/or information confirmed by your clinical screening exam, the tooth/teeth has/have worn down naturally or has been caused by grinding your teeth. The requested service is not a benefit of the program unless there is decay or a broken tooth.</p> <p>15 X-rays show the tooth is too broken down and cannot be fixed. Your dentist may be able to offer a different treatment.</p> <p>16 Our records show that the tooth has been fixed with a filling or stainless steel crown.</p> <p>17 X-rays show the service asked for cannot be approved because gum disease has destroyed the bone around the tooth. Your dentist may be able to offer a different treatment.</p> <p>18 The minimum requirements for braces could not be verified.</p> <p>19 A partial denture can be a benefit only when there is a full denture on the opposite arch.</p> <p>20 Root canal treatment must be satisfactorily done before a crown can be considered.</p> <p>21 The tooth is not fully formed. Your dentist may be able to offer a different treatment.</p> <p>22 Treatment is not needed because the x-rays and documentation show that there is no nerve damage.</p> <p>23 A stayplate can be a benefit only to replace a missing permanent front tooth.</p> |
|--|---|

BTN-002 08/20 AUG

- | | |
|---|---|
| <p>24 X-rays show more extractions are needed before the treatment plan can be approved; please contact your dentist.</p> <p>25 Based on information sent by your dentist, your teeth are in such a poor condition that the requested partial denture is not a benefit under this program.</p> <p>26 Based on the information sent by your dentist, your teeth are fine and should not be replaced by a full denture.</p> <p>27 Based on the information sent by your dentist, you do not have a full denture on the opposite arch; therefore, you do not qualify for a metal partial. However, if you are missing front teeth, you qualify for a stayplate.</p> <p>28 Based on x-rays, documentation, and/ or information received from your screening exam, your teeth and/ or gums are in such poor condition that the requested treatment is not a benefit under this program. Your dentist may be able to offer a different treatment.</p> <p>29 Your request for dental services was returned to your dental provider for more information. Your provider has 45 days to resubmit the information requested. There is no action needed from you, but you may contact your dentist about this request. A request for a State Hearing is not an option at this time.</p> <p>30 Fixed bridges are allowable when a medical condition prevents the use of a removable denture.</p> <p>31 The tooth is not in its normal position and cannot be fixed under this program.</p> <p>32 Based on information received from a screening exam, your current denture is good at this time.</p> <p>33 Based on your recent screening exam, a denture is not the right treatment for you. Please contact your dentist for other options.</p> <p>34 The requested denture is not approved because there are enough teeth remaining in the arch to support the denture.</p> <p>35 During your screening exam, you said you do not want any dental services at this time or that you want to be seen by another dentist.</p> | <p>36 The number of approved visits has been adjusted because you will be 21 years old before treatment is completed. Please contact your dentist.</p> <p>37 The tooth is not shown on the submitted x-rays.</p> <p>38 Based on x-rays and/or information received from your screening exam; you need additional treatment from your dentist before the procedure can be considered.</p> <p>39 X-rays show there is not enough space for the requested false tooth.</p> <p>40 This program does not cover braces when baby teeth are still present.</p> <p>41 Based on x-rays and information received from your screening exam, you grind your teeth. The program does not cover services for this condition.</p> <p>42 The procedure is not a benefit for a baby tooth or for a baby tooth ready to fall out. Your dentist may be able to offer a different treatment for your condition.</p> <p>43 The procedure requested will not fix your dental problem. Your dentist may be able to offer a different treatment for your condition.</p> <p>44 Based on information received from your dentist, the requested service is for cosmetic reasons only. Services for cosmetic purposes only are not a benefit of the program.</p> <p>45 Your current denture can be fixed by replacing the inner side of the denture.</p> <p>46 We are unable to verify your eligibility in this program.</p> <p>47 Your dentist must contact the California Children's Services program before submitting this procedure for payment or approval.</p> <p>48 EPSDT Services are not a benefit for patients 21 years and older.</p> <p>49 The EPSDT service(s) requested is not medically necessary.</p> |
|---|---|

Resubmission Turnaround Document (RTD) (DC-102, Rev. 10/19)

An RTD is a computer-generated form used by Medi-Cal Dental to request missing or additional information on the TAR/Claim form or NOA submitted by the provider.

The form is divided into two sections:

Section “A” notifies the provider of the specific information found in error on the TAR/Claim form or NOA. Each error in Section “A” is assigned a letter of the alphabet under “field.” Section “A” is kept by the provider for office records.

Section “B” is the corrected information filled in by the provider. This section is returned to Medi-Cal Dental.

If necessary, a multi-page RTD may be issued for an individual TAR/Claim form or NOA: Return all pages in one envelope.

Upon receipt of the RTD, Medi-Cal Dental matches the RTD with the associated TAR/Claim form or NOA, and the treatment form is then processed.

Note: If the RTD is not returned within the 45-day time limitation, the TAR, Claim, or NOA will be denied according to Medi-Cal Dental policies.

RESUBMISSION TURNAROUND DOCUMENT

☐ CLAIM ☐ TAR ☐ NOA**Medi-Cal Dental**

P.O. BOX 15609
SACRAMENTO CALIFORNIA 95852-0609
Phone (800) 423-0507

IMPORTANT: LISTED IN SECTION "A" ARE ERROR(S) FOUND ON THE CLAIM/TAR/NOA. TO FACILITATE PROCESSING, TYPE OR PRINT THE CORRECT INFORMATION IN THE CORRESPONDING ITEM IN SECTION "B". SIGN AND DATE FORM AND RETURN SECTION "B" (BOTTOM PORTION) TO MEDICAL DENTAL. PLEASE RESPOND PROMPTLY, AS PROCESSING CANNOT BE ACCOMPLISHED UNLESS CORRECTIONS ARE RECEIVED BY THE DUE DATE INDICATED. FAILURE TO RESPOND WITHIN THE TIME LIMITATION WILL RESULT IN DENIAL OF SERVICES. IF YOU HAVE ANY QUESTIONS CALL 800-423-0507 FOR ASSISTANCE OR REFER TO YOUR PROVIDER HANDBOOK FOR FURTHER EXPLANATION.

BILLING PROVIDER NAME MAILING ADDRESS CITY, STATE, ZIP CODE				MEDI-CAL PROVIDER NO.				NOTICE <div> PAGE PAGES OF </div>	
						RTD ISSUE DATE		RTD DUE DATE	
PATIENT NAME				PATIENT MEDICAL I.D. NUMBER		PATIENT DENTAL RECORD NO.		BEGINNING DATE OF SERVICE	
								AMOUNT BILLED	
								DOCUMENT CONTROL NO.	
ITEM	INFORMATION BLOCK	CLAIM FIELD NO.	CLAIM LINE	SUBMITTED INFORMATION	PROCEDURE CODE	ERROR CODE	ERROR DESCRIPTION		

RETAIN THIS PORTION
DETACH ALONG THIS PERFORATION

[illegible]

RETAIN THIS PORTION TO: **MEDI-CAL DENTAL** P.O. BOX 15609, SACRAMENTO, CA 95852-0609

How to Complete the RTD

Section “A”

The information in Section “A” is computer-generated by Medi-Cal Dental: it is retained by the provider.

The appropriate box (i.e., CLAIM, TAR, or NOA) will be checked to indicate the type of document submitted.

Note: Please read the instructions carefully and verify the information in Section “A” is correct.

1. **BILLING PROVIDER NAME AND MEDI-CAL PROVIDER NUMBER:** As it appears on the document submitted by the provider’s office.
2. **MAILING ADDRESS:** As it appears on the document submitted.
3. **CITY, STATE, ZIP CODE:** As it appears on the document submitted.
4. **PAGE ___ OF ___ PAGES:** A multi-page RTD may be issued for an individual TAR/ Claim form or NOA. Return all pages of the RTD in one envelope.
5. **RTD ISSUE DATE:** The RTD issue date. The RTD must be returned within 45 days of the RTD issue date.
6. **RTD DUE DATE:** The response due date. If not received by this date, the TAR, claim, or NOA will be denied.
7. **PATIENT NAME:** As it appears on the document submitted.
8. **PATIENT MEDI-CAL I.D. NUMBER:** As it appears on the document submitted.
9. **PATIENT DENTAL RECORD NUMBER:** As it appears on the document submitted.
10. **BEGINNING DATE OF SERVICE:** As it appears on the document submitted.
11. **AMOUNT BILLED:** As it appears on the document submitted.
12. **DOCUMENT CONTROL NO.:** The DCN assigned to the document submitted.
13. **ITEM:** The letter of the alphabet assigned by the computer to identify the line in Section “B” where the “Correct Information” should be entered.
14. **INFORMATION BLOCK:** The exact name of the field in question on the claim, TAR, or NOA.
15. **CLAIM FIELD NO.:** Indicates number corresponding to the information block on the claim, TAR, or NOA.
16. **CLAIM LINE:** The line number on the claim, TAR, or NOA.
17. **SUBMITTED INFORMATION:** The description of the incorrect information submitted by the provider’s office.
18. **PROCEDURE CODE:** Procedure codes as reported on the claim, TAR or NOA.
19. **ERROR CODE:** A code identifying the error that has been made on the claim, TAR or NOA.
20. **ERROR DESCRIPTION:** A description of the error that has been made on the claim, TAR or NOA.

Section "B"

This section is completed by the provider and returned to Medi-Cal Dental.

1. **CORRECT INFORMATION:** Enter the correct information on the appropriate line in Section "B" corresponding to the information found in error in Section "A."
2. **SIGNATURE/DATE BLOCK:** The provider, or person authorized by the provider, must sign and date the form prior to its return. Lack of signature will result in disallowance of the document. Rubber stamp signatures are not acceptable.
3. **P.O.E./COMMENTS BLOCK:** This area may be used for any comments.

Return the completed RTD to:

Medi-Cal Dental
California Medi-Cal Dental
PO Box 15609
Sacramento, CA 95852-0609

Claim Inquiry Form (CIF) (DC-003, Rev. 10/19)

The Claim Inquiry Form (CIF) is used to:

- Inquire about the status of a Treatment Authorization Request (TAR) or Claim
- Request re-evaluation of a modified or denied claim or Notice of Authorization (NOA) for payment

Medi-Cal Dental will respond to a CIF with a Claim Inquiry Response (CIR). Use a separate CIF for each claim, TAR, or NOA in question. Please see “Claim Inquiry Response (CIR)” on page 6-33 for more information about CIRs.

CIF Tracer

A CIF tracer is used to request the status of a TAR or claim. Providers should wait one month before submitting a CIF Tracer to allow enough time for the document to be processed. If after one month, the claim or TAR has not been processed or has not appeared in the “Documents In-Process” section of the Explanation of Benefits (EOB), then a CIF tracer should be submitted.

Claim Re-evaluations

A CIF claim re-evaluation is used to request the re-evaluation of a modified or denied claim or NOA. Providers should wait until the status of a processed claim appears on the EOB before submitting a CIF for re-evaluation. A response to the re-evaluation request will appear on the EOB in the “Adjusted Claims” section.

Claim re-evaluations must be received within six months of the date on the EOB. Providers should submit a copy of the disallowed or modified claim or NOA plus any additional radiographs or documentation pertinent to the procedure under reconsideration.

Note: Do not use the CIF to request a first level appeal. Inquiries using the CIF are limited to those reasons indicated on the form. Any other type of inquiry or request should be handled by calling the Telephone Service Center at (800) 423-0507.

Sample Claim Inquiry Form (CIF)

CLAIM INQUIRY FORM

IMPORTANT

Before submitting a CIF:

- Allow one month for the status of the document to appear on your Explanation of Benefits (E.O.B.)
- Type or print all information
- Use the appropriate x-ray envelope and attach to this form
- See your Provider Handbook for detailed instructions
- For clarification call MEDI-CAL DENTAL

 **Medi-Cal Dental**
P.O. BOX 15609
SACRAMENTO, CALIFORNIA 95852-0609
Phone 800-423-0507

1	BILLING PROVIDER NAME ADAMS, JAMES DDS	2	MEDI-CAL PROVIDER NUMBER XXXXXXXXXXXX
3	MAILING ADDRESS 30 MAIN STREET	TELEPHONE NUMBER (XXX) XXX-XXXX	
4	CITY, STATE ANYTOWN, CA	ZIP CODE XXXXX-XXXX	

USE THIS FORM FOR ONE CLAIM OR TREATMENT AUTHORIZATION REQUEST ONLY.

5	PATIENT NAME (LAST, FIRST, M.I.)	6	DOCUMENT CONTROL NUMBER (NECESSARY FOR RE-EVALUATION)
7	PATIENT MEDI-CAL I.D. NUMBER	8	PATIENT DENTAL RECORD NUMBER (OPTIONAL)
		9	DATE BILLED

INQUIRY REASON - CHECK ONLY ONE BOX

10	CLAIM/TAR TRACER ONLY Please advise status of: <input type="checkbox"/> Claim for Payment. Attach a copy of form Date of Service _____ <input type="checkbox"/> Treatment Authorization Request (TAR). Attach a copy of form.	CLAIM RE-EVALUATION ONLY <input type="checkbox"/> Please re-evaluate modification/denial of claim for payment. I have attached all necessary radiographs and/or documentation.
----	---	--

11	REMARKS (Corrections or Additional Information)
----	---

12	<p>THIS IS TO CERTIFY THAT THE INFORMATION CONTAINED ABOVE AND ANY ATTACHMENTS PROVIDED IS TRUE, ACCURATE, AND COMPLETE AND THAT THE PROVIDER HAS READ, UNDERSTANDS, AND AGREES TO BE BOUND BY AND COMPLY WITH THE STATEMENTS AND CONDITIONS CONTAINED ON THE BACK OF THIS FORM.</p> <p>_____ SIGNATURE</p> <p>_____ DATE</p> <p>SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.</p>	FOR MEDI-CAL DENTAL USE ONLY OPER. I.D. _____ ACTION CODE _____
----	--	--

DC 003 (R 10/19)



How to Complete the CIF

Use one CIF for each Claim or NOA. Please print or type all information:

1. **BILLING PROVIDER NAME:** Enter the billing provider's name in either the "doing business as" format, such as HAPPY TOOTH DENTAL CLINIC, or in the last-name, first-name, middle-initial, title format, e.g., SMITH, JOHN J., DDS. This information should be consistent with that used when filing state and federal taxes.
2. **MEDI-CAL PROVIDER NUMBER:** Enter the Billing Provider Number (NPI). NOTE: The Provider Number must be present and correct on all forms.
3. **MAILING ADDRESS AND TELEPHONE NUMBER:** Enter the billing provider service office address where treatment is rendered. A service office address should be a street address, including city, state, and zip code. A post office box cannot be used as a service office; however, it is acceptable in rural areas only to use a route number with a post office box number.

If the service office address is different from the address where payment is received, then notify Medi-Cal Dental so payment can be directed to the appropriate location.

It is important to include the telephone number of the service office, including area code, so Medi-Cal Dental can contact the provider if questions arise while processing the documents.

4. **CITY, STATE, ZIP CODE:** Enter the city, state, and zip code where the service office is located.
5. **PATIENT NAME:** Enter the member's last name, first name, and middle initial.
6. **DOCUMENT CONTROL NUMBER (CLAIM REEVALUATION ONLY):** Enter the Document Control Number of the document in question. If you are inquiring about multiple claims submit one CIF only for each document in question.
7. **PATIENT MEDI-CAL ID NUMBER:** Enter the BIC or Client Index Number (CIN).
8. **PATIENT DENTAL RECORD NUMBER (OPTIONAL):** If the provider assigns a Dental Record Number or Account Number to a member, enter the assigned number that will be referenced on any subsequent correspondence from Medi-Cal Dental.
9. **DATE BILLED:** Enter the date the claim or the TAR was originally mailed to Medi-Cal Dental.
10. **INQUIRY REASON - CHECK ONLY ONE BOX:** Indicate if this inquiry is seeking the status of a TAR or Claim ("tracer") or is requesting a reevaluation of a claim.
11. **REMARKS:** Use this area to provide any additional information needed to justify the inquiry being made. Include a copy of the claim, TAR, or NOA in question and any appropriate documentation, radiographs, and photos.

12. **SIGNATURE AND DATE:** The provider, or person authorized by the provider, must sign and date the form using blue or black ink. Rubber stamp signatures are not acceptable.

Mail the form to:

Medi-Cal Dental
California Medi-Cal Dental
PO Box 15609
Sacramento, CA 95852-0609

Claim Inquiry Response (CIR)


Upon resolution of the Claim Inquiry Form (CIF) seeking the status of a TAR or Claim Medi-Cal Dental will issue a Claim Inquiry Response (CIR). The CIR is a computer-generated form used to explain the status of the TAR or Claim.

When the CIR is received, it will be printed with the same information submitted by the provider's office with the following information:

- member name
- member Medi-Cal identification number
- member Dental Record or account number, if applicable
- Document Control Number
- the date the services were billed on the original document.

The section entitled "IN RESPONSE TO YOUR MEDI-CAL DENTAL INQUIRY" will contain a status code and a typed explanation of that code. The status codes are listed in "Section 7: Codes" of this Handbook.

Sample Claim Inquiry Response (CIR)

 DENTI-CAL MEDI-CAL DENTAL PROGRAM P.O. BOX 15609 SACRAMENTO, CA 95852-0609 (800) 423-0507		CORRESPONDENCE REFERENCE NUMBER • FOR DENTI-CAL USE ONLY XXXXXXXXXXXX	
CLAIM INQUIRY RESPONSE			
BILLING PROVIDER NAME / ADDRESS ADAMS, JAMES DDS 30 CENTER STREET ANYTOWN CA 95814-0000		MEDI-CAL PROVIDER NUMBER 1234567891 TELEPHONE NUMBER (XXX)XXX-XXXX	
PATIENT NAME LAST, FIRST		DOCUMENT CONTROL NO. XXXXXXXXXXXX	
PATIENT MEDI-CAL I.D. NO. XXXXXXXXXX	PATIENT DENTAL RECORD NUMBER	DATE BILLED	
IN RESPONSE TO YOUR DENTI-CAL INQUIRY			
STATUS CODE	EXPLANATION		
02	CLAIM IN PROCECSS; AWAITING FINAL ADJUDICATION		
ADDITIONAL EXPLANATION			
BY: 0XX		DATE: 09/15/09	

Checklists

Before submitting a TAR, claim, or NOA to Medi-Cal Dental for payment or authorization, follow this checklist:

1. Submission for Claim (Payment) or TAR (Authorization)

Have you...

- a. Entered the NPI of the rendering provider who provided the services?
- b. completed an original TAR/Claim form?
- c. listed the date services were performed (if applicable)?
- d. indicated the place of service where the procedure was administered?
- e. attached radiographs/photographs?
- f. included any remarks or attachments necessary to document this payment/authorization request?
- g. affixed any paper attachments on a 8.5 x 11 piece of paper?
- h. placed any attachments behind the forms and stapled just once in the upper right-hand corner?
- i. submitted only one-sided attachments?
- j. provided the appropriate signature and date in the signature block?

2. Submission for NOA (For Payment).

Have you...

- a. listed the date of service?
- b. checked the "delete" column for services not performed?
- c. indicated any additions not requiring prior authorization?
- d. included any necessary radiographs/photographs or documentation?
- e. filled in all shaded areas, if applicable?
- f. affixed each paper attachment to an 8.5 x 11 piece of paper?
- g. placed any attachments behind the forms and stapled just once in the upper right-hand corner?
- h. submitted only one-sided attachments?
- i. provided the appropriate signature and date in the signature block?

3. Submission for NOA (For Reevaluation)

Have you...

- a. checked "Reevaluation is Requested" box at upper right corner?
- b. included radiographs/photographs or other documentation?
- c. enclosed your NOA in the appropriate mailing envelope?

Reminders

1. Diagnostic Casts

Diagnostic casts are only for the evaluation of orthodontic benefits. Diagnostic casts submitted for all other procedures (crowns, prosthetics, etc.) will be discarded unless Medi-Cal Dental specifically requested the models to evaluate the claim or authorization request.

Diagnostic casts are required to be submitted for orthodontic evaluation and are payable only upon authorized orthodontic treatment.

As diagnostic casts are not returned, please do not send originals.

2. Paper Copies and Prints of Digitized Radiographs

Paper copies and prints of digitized radiographs should properly identify the member, the date the radiograph was originally taken, and the teeth/area in question. If not properly labeled, this could lead to processing delays as well as denial of treatment.

Paper copies and digitized prints of radiographs must conform to the following specifications:

- a. They must be properly dated with the mmddyy the radiograph was originally taken. This date must be clearly discernible from other dates appearing on the same copy such as the date the copy was made or printed, or dates of previously stored digitized images.
- b. They must be properly labeled with both the member's name and the provider's name.
- c. If the individual teeth are not otherwise identified, copies or digitized prints of full mouth series radiographs and panographic films must be labeled "right" and "left." Copies of individual films or groups of films less than a full mouth series, should have the individual tooth numbers clearly identified.
- d. They must be of diagnostic quality. Many of the copies/prints Medi-Cal Dental receives have poor image quality as a result of poor density, contrast, sharpness, or resolution, and are, therefore, non-diagnostic. The image size should be the size of a standard radiographic film or larger. By reducing the image to be smaller than the size of a standard radiographic film, the diagnostic quality is compromised.

e. More than four sheets of paper are not acceptable

Providers should review copies/prints before submitting to Medi-Cal Dental to ensure the images are of diagnostic quality.

3. State–Approved Forms.

Medi-Cal Dental will only accept original

State-approved forms. No duplicates or photocopies will be accepted or processed.

Time Limitations for NOAs

If the allowed period of time on the NOA has expired and none of the authorized services have been completed, send the expired NOA back to Medi-Cal Dental so it can be deleted from the automated system. If at a later date authorization for these services is requested and there is an outstanding NOA for the same services, processing delays or denial of services can occur.

Justification of Need for Prosthesis (DC054, Rev 02/24)

The Justification of Need for Prosthesis Form (DC054) is designed to provide complete and detailed information necessary for screening and processing prosthetic cases. This form is required when submitting a Treatment Authorization Request (TAR) for complete dentures, immediate dentures (when immediate dentures are rendered in conjunction with an opposing complete denture or partial removable prosthesis), resin base partial dentures, cast metal framework partial dentures, and complete overdentures (Procedures D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5863, D5865).

Providers should document specific information describing the condition of the member's oral condition **and** the condition of any existing prosthetic appliances. Documentation must include:

- both arches;
- missing teeth;
- teeth to be extracted;
- teeth being replaced by the requested partial prosthesis (excluding third molars);
- teeth being clasped (applies to cast framework partial or resin base partial);
- the condition of the soft tissue and hard tissue, e.g., soft tissue inflammation, palatal torus, mandibular tori, atrophied ridge, large fibrous tuberosity, hyperplastic tissue, etc.

It is the provider's responsibility to document conditions that Medi-Cal Dental will need for determining the member's need for the initial placement or replacement of a prosthesis as well as their ability to adapt to a prosthesis.

If a provider fails to submit a Justification of Need for Prosthesis Form, Medi-Cal Dental will issue an RTD for the required form, which will delay processing of the request. If the information on the Justification of Need for Prosthesis is incomplete or contradictory, the requested prosthetic appliance(s) will be denied.

The Justification of Need for Prosthesis Form is provided and may be ordered from the Medi-Cal dental forms supplier free of charge. A sample and instructions for completing the form are as follows:

Sample Justification of Need for Prosthesis

JUSTIFICATION OF NEED FOR PROSTHESIS

Complete Dentures - Resin Base Partial Dentures - Cast Metal Framework Partial Dentures

This form is to be completed by the dentist providing treatment. Submit this form with the associated TAR.

① PATIENT: _____ ② DATE: _____

ADDRESS BOTH ARCHES -- COMPLETE EACH APPROPRIATE SECTION (TYPE OR PRINT CLEARLY)

Checked shaded boxes (e.g. ☒ Yes) require Additional Comments below and may require submission of supporting documentation.

<p>③ MAXILLARY ARCH</p> <p>Appliance Requested: <input type="checkbox"/> FUD <input type="checkbox"/> Cast Metal PUD <input type="checkbox"/> Resin base PUD</p> <p><input type="checkbox"/> Member has never had a maxillary prosthetic appliance</p> <p>④ Has existing appliance: <input type="checkbox"/> FUD <input type="checkbox"/> Cast Metal PUD <input type="checkbox"/> Resin base PUD</p> <p>Age of appliance? _____ Wears appliance? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Reason for replacement of maxillary appliance: (Check all boxes that apply)</p> <p><input type="checkbox"/> Worn/Broken teeth <input type="checkbox"/> Loose <input type="checkbox"/> Broken base / Framework</p> <p><input type="checkbox"/> Extraction of additional teeth <input type="checkbox"/> Other _____</p> <p>Replacement maxillary appliance is needed due to one of the following:</p> <p>Catastrophic Loss? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No See footnote i.</p> <p>Surgical loss of oral-facial structure? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No See footnote ii.</p> <p>Denture no longer serviceable? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No See footnote iii.</p> <p>Significant medical condition? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No See footnote iv.</p> <p>Non-catastrophic loss? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No See footnote v.</p>	<p>MANDIBULAR ARCH</p> <p>Appliance Requested: <input type="checkbox"/> FLD <input type="checkbox"/> Cast Metal PLD <input type="checkbox"/> Resin base PLD</p> <p><input type="checkbox"/> Member has never had a mandibular prosthetic appliance</p> <p>Has existing appliance: <input type="checkbox"/> FLD <input type="checkbox"/> Cast Metal PLD <input type="checkbox"/> Resin base PLD</p> <p>Age of appliance? _____ Wears appliance? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Reason for replacement of mandibular appliance: (Check all boxes that apply)</p> <p><input type="checkbox"/> Worn/Broken teeth <input type="checkbox"/> Loose <input type="checkbox"/> Broken base / Framework</p> <p><input type="checkbox"/> Extraction of additional teeth <input type="checkbox"/> Other _____</p> <p>Replacement mandibular appliance is needed due to one of the following:</p> <p>Catastrophic Loss? <input type="checkbox"/> Yes <input type="checkbox"/> No See footnote i.</p> <p>Surgical loss of oral-facial structure? <input type="checkbox"/> Yes <input type="checkbox"/> No See footnote ii.</p> <p>Denture no longer serviceable? <input type="checkbox"/> Yes <input type="checkbox"/> No See footnote iii.</p> <p>Significant medical condition? <input type="checkbox"/> Yes <input type="checkbox"/> No See footnote iv.</p> <p>Non-catastrophic loss? <input type="checkbox"/> Yes <input type="checkbox"/> No See footnote v.</p>
<p style="text-align: center;">Edentulous: <input type="checkbox"/> Maxillary <input type="checkbox"/> Mandibular</p>	
<p>⑥ <input checked="" type="checkbox"/> Block out missing teeth 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16</p> <p><input type="checkbox"/> Circle teeth to be extracted 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17</p>	
<p>REQUIRED REPAIRS FOR PARTIAL DENTURES (All Types)</p>	
<p>⑦ MAXILLARY ARCH</p> <p>Teeth being replaced: _____</p> <p>Teeth being clasped: _____</p>	<p>MANDIBULAR ARCH</p> <p>Teeth being replaced: _____</p> <p>Teeth being clasped: _____</p>
<p>Does the patient want the requested services? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Does health condition of the patient limit dental adaptability? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes</p>	
<p>⑧ ADDITIONAL COMMENTS PERTAINING TO APPLIANCES/TREATMENT PLAN:</p> <p>_____</p> <p>_____</p> <p>_____</p>	
<p>⑨ Provider Signature: _____</p>	

i. Circumstances beyond the control of the patient: For a patient that submits a request to replace the appliance based on circumstances beyond their control, those circumstances can be demonstrated by documentation of all of the following: (1) a demonstration of continued medical necessity; (2) an explanation of the circumstances surrounding the loss which clearly explains how the loss occurred and why the loss was beyond the control of the patient; and (3) a clear explanation of the remedial measures the patient will take to safeguard against subsequent loss. Where loss from an activity wherein there was involvement from a fire department agency, law enforcement agency, or other governmental agency, documentation should include a copy of the official public service agency report, if such a report is relevant and available.

- ⑩
- ii. A need for a new prosthesis due to surgical or traumatic loss of oral-facial anatomic structure.
 - iii. The removable prosthesis is no longer serviceable as determined by a clinical screening dentist.
 - iv. Dentures no longer fit due to significant medical condition. Documentation from the patient's physician supporting the medical necessity of early replacement and a letter from the dentist stating that the existing denture cannot be made functional.
 - v. A non-catastrophic loss or misplacement may be granted twice per lifetime. Documentation must include an explanation of preventive measures instituted to alleviate the need for further replacement. Additional requests, beyond the two lifetime exceptions shall be submitted as procedure code D5899 and will be considered on a case by case basis.

DC054 (Rev 02/24)

How to Complete the Justification of Need for Prosthesis Form

1. **PATIENT NAME:** Enter the member's name exactly as it appears on the Medi-Cal BIC.
2. **DATE:** Enter the date the member was evaluated.
3. **APPLIANCE REQUESTED:** Enter the type of prosthetic appliance requested on the Treatment Authorization Request (TAR).
4. **EXISTING APPLIANCE:** Enter the type of prosthetic appliance that the member has or had (regardless of the condition of the appliance or whether the appliance has been lost, stolen, or discarded). If the member has never had any type of prosthetic appliance, check the corresponding box.
Indicate whether the member wears the existing appliance and the age of the appliance that the member has (or had). Where loss from an activity wherein there was involvement from a fire department agency, law enforcement agency, or other governmental agency, documentation should include a copy of the official public service agency report, if such a report is relevant and available. If the prosthetic appliance has been lost in a certified facility or hospital, document the date of the incident and the circumstances of the loss. If needed, use the space in the lower part of the Justification of Need for Prosthesis Form for documenting details of the loss.
5. **REASON FOR REPLACEMENT OF EXISTING APPLIANCE:** Document the reason the existing appliance needs to be replaced. Check the boxes that apply. If needed, use the space in the lower part of the Justification of Need for Prosthesis Form for documenting details.
Reminder: When requesting a prosthetic appliance for only one arch, the opposing arch must also be evaluated and addressed as a comprehensive treatment plan.
6. **MISSING TEETH:** Use an "X" to block out missing teeth on the numerical diagram of the dentition. If teeth are to be extracted, circle the appropriate tooth numbers. If the arch is edentulous, check the corresponding box.
7. **CAST FRAMEWORK PARTIAL OR RESIN BASE PARTIAL:** Indicate the teeth being replaced by the requested appliance and the teeth being clasped.
Reminder: Please submit radiographs of all remaining natural teeth and periapical radiographs of abutment teeth.
8. **ADDITIONAL COMMENTS PERTAINING TO TREATMENT PLAN:** Use this section for additional comments/documentation specific to the requested treatment.
Some examples include:
 - a. **NATURAL TEETH BEING RETAINED:** If teeth are being retained in the arch(es), indicate the treatment plan for the remaining teeth (root canals, periodontal treatment, restorative, crowns, etc.).

- b. **DOES THE PATIENT WANT REQUESTED SERVICES?** After discussing the proposed treatment plan with the member, indicate whether the member wants the proposed services.
 - c. **DOES HEALTH CONDITION OF PATIENT LIMIT ADAPTABILITY?** Indicate any conditions that might limit the adaptability of the member to wear a prosthetic appliance. Document if the condition is temporary or permanent.
 - d. **CONVALESCENT CARE:** If the member resides in a convalescent facility, document facility staff comments regarding the resident's ability to benefit by or adapt to the requested treatment. The TAR should include the facility name, address, and phone number.
9. **SIGNATURE:** The dentist completing the form must sign the form.
10. **EXCEPTIONS:** DHCS provides complete and partial dentures as a covered benefit once in a five-year period. When adequately documented, certain exceptions shall apply to this five-year period. Use Section 8 to include additional comments/documentation specific to the requested treatment. The dentist completing the form must sign the form.

Sample Handicapping Labio-Lingual Deviation (HLD) Index California Modification
Score Sheet (DC-016, Rev 09/18)

**HANDICAPPING LABIO-LINGUAL DEVIATION (HLD) INDEX CALIFORNIA MODIFICATION
SCORE SHEET**

(You will need this score sheet and a Boley Gauge or a disposable ruler)

Provider

Patient

Name: _____ Name: _____

Number: _____

Date: _____

- Position the patient's teeth in centric occlusion.
- Record all measurements in the order given and round off to the nearest millimeter (mm).
- ENTER SCORE '0' IF THE CONDITION IS ABSENT

CONDITIONS #1 - #6A ARE AUTOMATIC QUALIFYING CONDITIONS

HLD Score

1. Cleft palate deformity (See scoring instructions for types of acceptable documentation)
Indicate an 'X' if present and score no further.....
2. Cranio-facial anomaly (Attach description of condition from a credentialed specialist)
Indicate an 'X' if present and score no further.....
3. Deep impinging overbite **WHEN LOWER INCISORS ARE DESTROYING THE SOFT TISSUE OF THE PALATE
TISSUE LACERATION AND/OR CLINICAL ATTACHMENT LOSS MUST BE PRESENT.**
Indicate an 'X' if present and score no further.....
4. Crossbite of individual anterior teeth **WHEN CLINICAL ATTACHMENT LOSS AND RECESSON OF THE
GINGIVAL MARGIN ARE PRESENT**
Indicate an 'X' if present and score no further.....
5. Severe traumatic deviation. (Attach description of condition. For example, loss of a premaxilla segment
by burns or by accident, the result of osteomyelitis, or other gross pathology.)
Indicate an 'X' if present and score no further.....
- 6A. Overjet greater than 9mm with incompetent lips or mandibular protrusion (reverse overjet) greater than 3.5mm
with masticatory and speech difficulties. Indicate an 'X' if present and score no further

THE REMAINING CONDITIONS MUST SCORE 26 OR MORE TO QUALIFY

- 6B. Overjet equal to or less than 9 mm.....
7. Overbite in mm
8. Mandibular protrusion (reverse overjet) equal to or less than 3.5 mm x 5 =
9. Open bite in mm x 4 =

IF BOTH ANTERIOR CROWDING AND ECTOPIC ERUPTION ARE PRESENT IN THE ANTERIOR PORTION OF THE SAME ARCH,
SCORE ONLY THE MOST SEVERE CONDITION. DO NOT COUNT BOTH CONDITIONS.

10. Ectopic eruption (Identify by tooth number, and count each tooth, excluding third molars) _____ x 3 = _____
tooth numbers total
11. Anterior crowding (Score one for MAXILLA, and/or one for MANDIBLE) _____ x 5 = _____
maxilla mandible total
12. Labio-Lingual spread in mm.....
13. Posterior unilateral crossbite (must involve two or more adjacent teeth, one of which must be a molar.
No score for bi-lateral posterior crossbite) Score 4

AUTHORIZATION OF SERVICES IS BASED ON MEDICAL NECESSITY. IF A PATIENT DOES NOT HAVE ONE OF THE SIX AUTOMATIC QUALIFYING
CONDITIONS OR DOES NOT SCORE 26 OR ABOVE, THE PATIENT MAY STILL BE ELIGIBLE FOR THESE SERVICES BASED ON EARLY AND
PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) CRITERIA NECESSARY TO CORRECT OR AMELIORATE THE PATIENT'S
CONDITION. FOR A FURTHER EXPLANATION OF EPSDT CRITERIA, PLEASE SEE THE ORTHODONTICS SECTION OF THE CALIFORNIA MEDICAL
DENTAL PROGRAM PROVIDER HANDBOOK.

DC016 (R 09/18)

How to Complete the HLD Index Scoresheet

HANDICAPPING LABIO-LINGUAL DEVIATION (HLD) INDEX CALIFORNIA MODIFICATION SCORING INSTRUCTIONS

The intent of the HLD index is to measure the presence or absence, and the degree, of the handicap caused by the components of the Index, and not to diagnose 'malocclusion.' All measurements are made with a Boley Gauge (or a disposable ruler) scaled in millimeters. Absence of any conditions must be recorded by entering '0.' (Refer to the attached score sheet.)

The following information should help clarify the categories on the HLD Index:

1. **Cleft Palate Deformity:** Acceptable documentation must include at least one of the following: 1) diagnostic casts; 2) intraoral photograph of the palate; 3) written consultation report by a qualified specialist or Craniofacial Panel) Indicate an 'X' on the score sheet. Do not score any further if present. (This condition is automatically considered to qualify for orthodontic services.)
2. **Cranio-facial Anomaly:** (Attach description of condition from a credentialed specialist) Indicate an 'X' on the score sheet. Do not score any further if present. (This condition is automatically considered to qualify for orthodontic services.)
3. **Deep Impinging Overbite:** Indicate an 'X' on the score sheet when lower incisors are destroying the soft tissue of the palate and tissue laceration and/or clinical attachment loss are present. Do not score any further if present. (This condition is automatically considered to be a handicapping malocclusion without further scoring.)
4. **Crossbite of Individual Anterior Teeth:** Indicate an 'X' on the score sheet when clinical attachment loss and recession of the gingival margin are present. Do not score any further if present. (This condition is automatically considered to be a handicapping malocclusion without further scoring.)
5. **Severe Traumatic Deviation:** Traumatic deviations are, for example, loss of a premaxilla segment by burns or by accident, the result of osteomyelitis, or other gross pathology. Indicate an 'X' on the score sheet and attach documentation and description of condition. Do not score any further if present. (This condition is automatically considered to be a handicapping malocclusion without further scoring.)
- 6A. **Overjet greater than 9mm with incompetent lips or mandibular protrusion (reverse overjet) greater than 3.5mm with masticatory and speech difficulties:** Overjet is recorded with the patient's teeth in centric occlusion and is measured from the labial of the lower incisors to the labial of the corresponding upper central incisors. This measurement should record the greatest distance between any one upper central incisor and its corresponding lower central or lateral incisor. If the overjet is greater than 9mm with incompetent lips or mandibular protrusion (reverse overjet) is greater than 3.5mm with masticatory and speech difficulties, indicate an 'X' and score no further. (This condition is automatically considered to be a handicapping malocclusion without further scoring. Photographs shall be submitted for this automatic exception.)
- 6B. **Overjet equal to or less than 9mm:** Overjet is recorded as in condition #6A above. The measurement is rounded off to the nearest millimeter and entered on the score sheet.
7. **Overbite in Millimeters:** A pencil mark on the tooth indicating the extent of overlap facilitates this measurement. It is measured by rounding off to the nearest millimeter and entered on the score sheet. (Reverse overbite may exist in certain conditions and should be measured and recorded.)
8. **Mandibular Protrusion (reverse overjet) equal to or less than 3.5mm:** Mandibular protrusion (reverse overjet) is recorded as in condition #6A above. The measurement is rounded off to the nearest millimeter. Enter on the score sheet and multiply by five (5).
9. **Open Bite in Millimeters:** This condition is defined as the absence of occlusal contact in the anterior region. It is measured from incisal edge of a maxillary central incisor to incisal edge of a corresponding mandibular incisor, in millimeters. The measurement is entered on the score sheet and multiplied by four (4). In cases of pronounced protrusion associated with open bite, measurement of the open bite is not always possible. In those cases, a close approximation can usually be estimated.
10. **Ectopic Eruption:** Count each tooth, excluding third molars. Each qualifying tooth must be more the 50% blocked out of the arch. Count only one tooth when there are mutually blocked out teeth. Enter the number of qualifying teeth on the score sheet and multiply by three (3). If anterior crowding (condition #11) also exists in the same arch, score the condition that scores the most points. **DO NOT COUNT BOTH CONDITIONS.** However, posterior ectopic teeth can still be counted separately from anterior crowding when they occur in the same arch.
11. **Anterior Crowding:** Arch length insufficiency must exceed 3.5mm. Mild rotations that may react favorably to stripping or mild expansion procedures are not to be scored as crowded. Score one (1) for a crowded maxillary arch and/or one (1) for a crowded mandibular arch. Enter total on the score sheet and multiply by five (5). If ectopic eruption (condition #10) exists in the anterior region of the same arch, count the condition that scores the most points. **DO NOT COUNT BOTH CONDITIONS.** However, posterior ectopic teeth can still be counted separately from anterior crowding when they occur in the same arch.
12. **Labio-Lingual Spread:** A Boley Gauge (or a disposable ruler) is used to determine the extent of deviation from a normal arch. Where there is only a protruded or lingually displaced anterior tooth, the measurement should be made from the incisal edge of that tooth to the normal arch line. Otherwise, the total distance between the most protruded anterior tooth and the most lingually displaced adjacent anterior tooth is measured. In the event that multiple anterior crowding of teeth is observed, all deviations from the normal arch should be measured for labio-lingual spread, but only the most severe individual measurement should be entered on the score sheet.
13. **Posterior Unilateral Crossbite:** This condition involves two or more adjacent teeth, one of which must be a molar. The crossbite must be one in which the maxillary posterior teeth involved may either be both palatal or both completely buccal in relation to the mandibular posterior teeth. The presence of posterior unilateral crossbite is indicated by a score of four (4) on the score sheet. **NO SCORE FOR BI-LATERAL CROSSBITE.**

Explanation of Benefits (EOB)

The Explanation of Benefits (EOB) is a computer-generated statement that accompanies each check sent to Medi-Cal dental providers. It lists all paid and denied claims that have been adjudicated or adjusted during the payment cycle, as well as non-claims specific information. Claims and TARs that have been in process over 18 days are also listed.

Lost/Misplaced EOBs


Providers are issued an EOB each week which lists, in detail, all activity on documents for accounting and tracking purposes. Listed on the weekly EOB are all paid claims, adjustments, and current status of pending documents. In addition, the EOB contains seminar information, accounts payable and receivable activity, and notification of electronic funds transfer information.

Each service office with claim activity receives an EOB which should be used for payment posting, account balancing, and monitoring the progress of documents in process as they go through the system. Service offices managed through corporate offices should have internal procedures in place to ensure they receive the most current information relative to their submissions, i.e., FAX, scanned email, etc.

Lost or misplaced EOBs can be reprinted. Please submit your request in writing, including your provider number and the EOB issue date to:

Medi-Cal Dental
Attn: Provider Services General Correspondence
PO Box 15609
Sacramento, CA 95852-0609

Sample Explanation of Benefits (EOB)

EXPLANATION OF BENEFITS												DENTI-CAL CALIFORNIA MEDICAL DENTAL PROGRAM P.O. BOX 15609, SACRAMENTO, CA 95852-0609			
<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>1 → LINES PRECEDED BY "B" CONTAIN BENEFICIARY INFORMATION</p> <p>2 → LINES PRECEDED BY "C" CONTAIN CLAIM INFORMATION RELATIVE TO ABOVE BENEFICIARY</p> </div> <div style="width: 35%;"> <p>5 No CHECK</p> </div> </div>															
<p>3 No PROVIDER</p> <p>4</p>										<p>6 DATE:</p>		<p>7 PAGE NO.</p>			
<p>8 STATUS CODE DEFINITION P = PAID D = DENIED A = ADJUSTED</p>															
<p>PLEASE CALL (800) 423-0507 FOR ANY QUESTIONS REGARDING THIS DOCUMENT</p>															
<p>9 BENEFICIARY NAME</p>				<p>10 MEDICAL I.D. NO.</p>		<p>11 BENE ID</p>		<p>12 SEX</p>		<p>13 BIRTH DATE</p>					
<p>14 DOCUMENT CONTROL NO.</p>				<p>15 TOOTH CODE</p>		<p>16 PROC. CODE</p>		<p>17 DATE OF SERVICE</p>		<p>18 STATUS</p>					
<p>19 REASON CODE</p>				<p>20 AMOUNT BILLED</p>		<p>21 ALLOWED AMOUNT</p>		<p>22 SHARE OF COST</p>		<p>23 OTHER COVERAGE</p>					
<p>24 AMOUNT PAID</p>															
<div style="font-size: 100px; opacity: 0.3; transform: rotate(-10deg);">Sample</div>															
<p>25 CLAIMS SPECIFIC</p>				<p>26 NON CLAIMS SPECIFIC</p>				<p>27</p>							
<p>AMOUNT PAID</p>		<p>ADJUSTMENT AMOUNT</p>		<p>PAYABLES AMOUNT</p>		<p>LEVY AMOUNT</p>		<p>A/R AMOUNT</p>		<p>CHECK AMOUNT</p>					


How to Read the EOB

Following is an explanation of each item shown on the sample EOB. Each item is numbered to correspond with those numbers on the sample EOB.

1. **REFERENCE LINES PRECEDED BY A "B"**: contains member's information.
2. **REFERENCE LINES PRECEDED BY A "C"**: contains claim information for the listed member.
3. **PROVIDER NO.:** The billing provider's NPI.
4. **PROVIDER'S NAME AND ADDRESS:** The provider's name and billing address.
5. **CHECK NO.:** Number of the check issued with the EOB.
6. **DATE:** Date EOB was issued.
7. **PAGE NO.:** Page number of the EOB.
8. **STATUS CODE DEFINITION:** The status code used to identify each claim line. "P" = Paid, "D" = Denied, "A" = Adjusted.
9. **PATIENT NAME:** Each member is listed once per category.
10. **MEDI-CAL I.D. NO.:** The member's Medi-Cal identification number.
11. **BENE ID:** The member's BIC or CIN.
12. **SEX:** The sex code for each member, "M" = male, "F" = female.
13. **BIRTHDATE:** Birthdate of each member.
14. **DOCUMENT CONTROL NUMBER (DCN):** The number assigned to each claim by Medi-Cal Dental.
15. **TOOTH CODE:** Lists the tooth number, letter, arch or quadrant on which the procedure was performed.
16. **PROC. CODE:** The code listed on a claim line that identifies the procedure performed. This code may be different from the procedure code submitted on the TAR/Claim form because the procedure code may have been modified by a professional or paraprofessional in compliance with the Manual of Dental Criteria for successful adjudication of the claim.
17. **DATE OF SERVICE:** The date the service was performed.
18. **STATUS:** Identifies the status of each claim line. The status codes are explained in "Section 7: Codes" of this Handbook.
19. **REASON CODE:** The code explains why a claim was either paid at an amount other than billed; changed; altered during processing; or denied. The reason codes and a written explanation of each one are printed on the EOB.
20. **AMOUNT BILLED:** The amount billed for each claim line.
21. **ALLOWED AMOUNT:** The amount allowed for each claim line; this amount is the lesser of the billed amount or the amount allowed by the Schedule of Maximum Allowances.
22. **SHARE OF COST:** The amount the member paid towards a share of cost obligation.
23. **OTHER COVERAGE:** The amount paid by another carrier or by Medicare.
24. **AMOUNT PAID:** The total amount paid to a provider after deductions, if applicable, as shown in numbers 22 and 23.

25. **CLAIMS SPECIFIC:** Only printed on the last page of the EOB. These amounts are the totals for all adjudicated claim lines listed on the EOB.
26. **NON-CLAIMS SPECIFIC:** The (a) payables amount; (b) levy amounts, (c) accounts receivable amounts. Only printed on the last page of the EOB.
27. **CHECK AMOUNT:** The amount of the check that accompanies this EOB.

Sample Paid Claim, Levy

EXPLANATION OF BENEFITS										DENTI-CAL CALIFORNIA MEDI-CAL DENTAL PROGRAM P.O. BOX 15609, SACRAMENTO, CA 95852-0609		
<div style="display: flex; justify-content: space-between;"> <div> <p>→ LINES PRECEDED BY "B" CONTAIN BENEFICIARY INFORMATION</p> <p>→ LINES PRECEDED BY "C" CONTAIN CLAIM INFORMATION RELATIVE TO ABOVE BENEFICIARY</p> </div> <div> <p>PROVIDER No XXXXXXXXXX</p> <p>TAX ID NO: XXXXXXXXXX</p> </div> <div> <p>CHECK No XXXXXXXXXX</p> <p>DATE: mm/dd/yy PAGE NO. x OF x</p> </div> </div>												
<p>STATUS CODE DEFINITION P = PAID D = DENIED A = ADJUSTED</p>												
<p>PLEASE CALL (800) 423-0507 FOR ANY QUESTIONS REGARDING THIS DOCUMENT</p>												
<div style="display: flex; justify-content: space-between;"> <div> <p>B BENEFICIARY NAME</p> <p>C DOCUMENT CONTROL NO.</p> </div> <div> <p>TOOTH CODE</p> <p>PROC. CODE</p> <p>DATE OF SERVICE</p> <p>STA-TUS</p> </div> <div> <p>MEDI-CAL I.D. NO.</p> <p>REASON CODE</p> <p>AMOUNT BILLED</p> </div> <div> <p>BENE ID</p> <p>ALLOWED AMOUNT</p> <p>SHARE OF COST</p> </div> <div> <p>SEX</p> <p>OTHER COVERAGE</p> </div> <div> <p>BIRTH DATE</p> <p>AMOUNT PAID</p> </div> </div>												
<p>** IF THERE IS A LACK OF RECENT DENTI-CAL ACTIVITY FOR THIS SERVICE OFFICE, THE OUTSTANDING ** BALANCE OF THE RECEIVABLE WILL BE REASSIGNED TO AN ACTIVE SERVICE OFFICE.</p>												
<p>(12) LEVIES (AMOUNT WE PAID FOR YOU)</p>												
CHECK-NO		HOLDER-NO		NAME OF LEVEY HOLDER				AMOUNT				
400012908		000000123		LEVY HOLDER				-100.00				
				*TOTAL LEVIES				-100.00				
Sample												
<div style="display: flex; justify-content: space-around;"> <div> <p>(13)</p> <p>CLAIMS SPECIFIC</p> </div> <div> <p>(14)</p> <p>NON CLAIMS SPECIFIC</p> </div> <div> <p>(15)</p> </div> </div>												
AMOUNT PAID		ADJUSTMENT AMOUNT		PAYABLES AMOUNT		LEVY AMOUNT		A/R AMOUNT		CHECK AMOUNT		
155.00		.00		.00		100.00		.00		55.00		

How to Read the Paid Claim with
Levy Deduction EOB

1. This information, printed on each page of the EOB, is explained on a preceding page entitled "How to Read the EOB."
2. **LEVIES (AMOUNTS MEDI-CAL DENTAL PAID FOR THE PROVIDER):** When an EOB reflects a levy deduction, the levy amount is shown with the following information:

Check Number - The number of the check issued to the levy holder by Medi-Cal Dental.


Holder Number - The number issued by Medi-Cal Dental to the levy holder upon receipt of a levy request.

Name of Levy Holder - The name of the levy holder, e.g., the Internal Revenue Service.

Amount - The amount of the payment issued to the levy holder by Medi-Cal Dental, shown as a negative amount. The levy amount shown in the sample is deducted from the check issued to the provider referenced on this EOB.

3. **CLAIMS SPECIFIC:** Lists the totals for all adjudicated claim lines listed on the sample.
4. **NON-CLAIMS SPECIFIC:** This area on the sample shows the levy amount (\$100.00) deducted from the amount of the check issued to the provider which corresponds to this EOB.
5. **CHECK AMOUNT:** The amount shown for this check (\$55.00) reflects the Claims Specific Amounts paid listed in Field 13 (\$155.00) minus the Non-Claims Specific Levy Amount Shown in Field 14 (\$100.00).

Sample Levy Payment

EXPLANATION OF BENEFITS										DENTI-CAL CALIFORNIA MEDI-CAL DENTAL PROGRAM P.O. BOX 15609, SACRAMENTO, CA 95852-0609													
<div style="display: flex; justify-content: space-between;"> <div> <p>LINES PRECEDED BY "B" CONTAIN BENEFICIARY INFORMATION</p> <p>LINES PRECEDED BY "C" CONTAIN CLAIM INFORMATION RELATIVE TO ABOVE BENEFICIARY</p> </div> <div> <p>PROVIDER No XXXXXXXXXXXX</p> <p>TAX ID NO: XXXXXXXXXX</p> </div> <div> <p>CHECK No XXXXXXXXXXXX</p> <p>DATE: mm/dd/yy PAGE NO. x OF x</p> </div> </div>																							
<p>STATUS CODE DEFINITION P = PAID D = DENIED A = ADJUSTED</p>																							
<p>PLEASE CALL (800) 423-0507 FOR ANY QUESTIONS REGARDING THIS DOCUMENT</p>																							
<div style="display: flex; justify-content: space-between;"> <div> <p>B BENEFICIARY NAME</p> <p>C DOCUMENT CONTROL NO.</p> </div> <div> <p>TOOTH CODE</p> <p>PROC. CODE</p> <p>DATE OF SERVICE</p> <p>STA-TUS</p> <p>REASON CODE</p> </div> <div> <p>MEDI-CAL I.D. NO.</p> <p>AMOUNT BILLED</p> <p>ALLOWED AMOUNT</p> <p>SHARE OF COST</p> </div> <div> <p>BENE ID</p> <p>SEX</p> <p>OTHER COVERAGE</p> </div> <div> <p>BIRTH DATE</p> <p>AMOUNT PAID</p> </div> </div>																							
<p>THE ENCLOSED CHECK IS IN PAYMENT ON THE FOLLOWING LEVY HELD BY YOU:</p>																							
<div style="display: flex; justify-content: space-between;"> <div> <p>① LEVY NBR</p> <p>000000083</p> </div> <div> <p>② ACCOUNT OF</p> <p>JAMES ADAMS</p> </div> <div> <p>③ NPI/TAX-ID</p> <p>XXXXXXXXXXXX</p> </div> <div> <p>④ CHECK NO.</p> <p>010300764</p> </div> <div> <p>⑤ AMOUNT OF PAYMENT</p> <p>50.00</p> </div> </div>																							
Sample																							
<div style="display: flex; justify-content: space-between;"> <div> <p>CLAIMS SPECIFIC</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 25%;">AMOUNT PAID</th> <th style="width: 25%;">ADJUSTMENT AMOUNT</th> <th style="width: 25%;">PAYABLES AMOUNT</th> <th style="width: 25%;">LEVY AMOUNT</th> <th style="width: 25%;">A/R AMOUNT</th> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </table> </div> <div> <p>NON CLAIMS SPECIFIC</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 50%;">CHECK AMOUNT</th> </tr> <tr> <td style="text-align: right;">55.00</td> </tr> </table> </div> </div>												AMOUNT PAID	ADJUSTMENT AMOUNT	PAYABLES AMOUNT	LEVY AMOUNT	A/R AMOUNT						CHECK AMOUNT	55.00
AMOUNT PAID	ADJUSTMENT AMOUNT	PAYABLES AMOUNT	LEVY AMOUNT	A/R AMOUNT																			
CHECK AMOUNT																							
55.00																							

How to Read the Levy Payment EOB

This is an example of an EOB that would accompany a levy payment to a levy holder, e.g., the Internal Revenue Service, made by Medi-Cal Dental on behalf of the provider.

1. **LEVY NBR:** The number issued by Medi-Cal Dental that identifies the levy.
2. **ACCOUNT OF:** The name of the provider for whom the levy payment is being made.
3. **NPI/TAX ID:** The National Provider Identifier or Tax Identification Number of the provider for whom the levy payment is being made.
4. **CHECK NO.:** The number of the check, issued to the provider, from which the levy payment is deducted. The provider's EOB will identify the number of the check issued to the levy holder, the levy number, the name of the levy holder, and the amount of the levy payment issued.
5. **AMOUNT OF PAYMENT:** Shows the amount of the payment to the levy holder.
6. **CHECK AMOUNT:** The amount of the check sent by Medi-Cal Dental to the levy holder.

Sample Documents In-Process

EXPLANATION OF BENEFITS										DENTI-CAL CALIFORNIA MEDI-CAL DENTAL PROGRAM P.O. BOX 15609, SACRAMENTO, CA 95852-0609	
LINES PRECEDED BY "B" CONTAIN BENEFICIARY INFORMATION LINES PRECEDED BY "C" CONTAIN CLAIM INFORMATION RELATIVE TO ABOVE BENEFICIARY										CHECK No XXXXXXXX	
PROVIDER No XXXXXXXX Adams, James, DDS 30 Center Street Anytown, CA xxxxx-xxxx										DATE: mm/dd/yy PAGE NO. x of x STATUS CODE DEFINITION P = PAID D = DENIED A = ADJUSTED	
PLEASE CALL (800) 423-0507 FOR ANY QUESTIONS REGARDING THIS DOCUMENT											
BENEFICIARY NAME MEDI-CAL I.D. NO. BEND ID SEX BIRTH DATE											
DOCUMENT CONTROL NO. TOOTH CODE PROC. CODE DATE OF SERVICE STATUS REASON CODE AMOUNT BILLED ALLOWED AMOUNT SHARE OF COST OTHER COVERAGE AMOUNT PAID											
DOCUMENTS IN-PROCESS											
2	3	4	5	6	7	8	9				
LAST NAME	FIRST NAME	MEDI-CAL ID	BENE - ID	DOB	DCN	AMT BILLED	*CODE				
LAST	FIRST	XXXXX999D	99999999D	mm/dd/yy	08168100450	567.00	C IR				
LAST	FIRST	99999999D	99999999D	mm/dd/yy	08169103850	423.00	T CS				
LAST	FIRST	XXXXX999D	99999999D	mm/dd/yy	08175100684	112.00	C IR				
10 TOTAL DOCUMENTS IN-PROCESS			3			11 TOTAL BILLED			1102.00		
12 * THE FOLLOWING LEGEND HAS BEEN INCLUDED FOR IN-PROCESS STATUS CODES											
C = CLAIM N = NOA T = TAR R = TAR REEVALUATION											
DV - DATA VALIDATION (DOCUMENT IS AWAITING REVIEW OF KEYED DATA AGAINST DOCUMENT INFORMATION) IR - INFORMATION REQUIRED (AN RTD FOR ADDITIONAL INFORMATION OR AN EDI REQUEST FOR X-RAYS ATTACHMENTS WAS SENT TO PROVIDER) RV - RECIPIENT VERIFICATION (DOCUMENT IS AWAITING VALIDATION OF RECIPIENT INFO) PV - PROVIDER VERIFICATION (DOCUMENT IS AWAITING VALIDATION OF PROVIDER INFO) PR - PROFESSIONAL REVIEW (DOCUMENT IS SCHEDULED FOR PROFESSIONAL REVIEW) CS - CLINICAL SCREENING (DOCUMENT IS SCHEDULED FOR CLINICAL SCREENING REVIEW) SR - STATE REVIEW (DOCUMENT IS SCHEDULED FOR REVIEW BY STATE STAFF)											
13 THE NEXT SCHEDULED BASIC SEMINAR WILL BE HELD IN ANYTOWN ON 09/10/08 FROM 9:00 AM TO 12:00 PM. PLEASE CALL (800) 423-0507 FOR RESERVATIONS											
14 THE NEXT SCHEDULED ADVANCED SEMINAR WILL BE HELD IN ANYTOWN ON 09/11/08 FROM 8:00 AM TO 12:00 PM. PLEASE CALL (800) 423-0507 FOR RESERVATIONS											
THE NEXT SCHEDULED WORKSHOP SEMINAR WILL BE HELD IN ANYTOWN ON 10/15/08 FROM 9:00 AM TO 4:00 PM. PLEASE CALL (800) 423-0507 FOR RESERVATIONS											
CLAIMS SPECIFIC AMOUNT PAID ADJUSTMENT AMOUNT PAYABLES AMOUNT LEVY AMOUNT A/R AMOUNT CHECK AMOUNT											

How to Read the Documents In-Process EOB

The “Documents In-Process” section printed on the EOB will list information on all in-process documents grouped together by type of document (C = Claim, N = NOA, T = TAR, and R = TAR Reevaluation) and in-process status (professional review, state review, information required, etc.).

1. **DOCUMENTS-IN-PROCESS:** Information listed in these areas of the sample is a description of each document that has been “in process” for 18 days or longer.
2. **CODE:** The appropriate code listed indicates the reason that the claim is “in process.”
3. **TOTAL CLAIMS IN PROCESS:** The example shows the total number of documents “in process.”
4. **TOTAL BILLED:** Total billed amounts for the documents “in process.”
5. The last page of the EOB containing in-process documents information provides a legend listing the reason codes for documents in process. Beside each code is a printed explanation which defines the reason a particular document is “in process.”
6. Medi-Cal Dental notifies the provider of upcoming provider training seminars with a message appearing at the end of the Explanation of Benefits (EOB) statement.
7. The location of the training seminar(s) nearest the provider’s office is determined automatically and will be printed on the EOB.

Sample Accounts Receivable

EXPLANATION OF BENEFITS										DENTI-CAL CALIFORNIA MEDICAL DENTAL PROGRAM P.O. BOX 15609, SACRAMENTO, CA 95852-0609																																																	
<p>LINES PRECEDED BY "B" CONTAIN BENEFICIARY INFORMATION</p> <p>LINES PRECEDED BY "C" CONTAIN CLAIM INFORMATION RELATIVE TO ABOVE BENEFICIARY</p>																																																											
PROVIDER No XXXXXXXXXX NOT ISSUED REF					CHECK No XXXXXXXXXX																																																						
Adams, James, DDS 30 Center Street Anytown, CA xxxxx-xxxx					TAX ID NO: xxxxxxxxx-		DATE: mm/dd/yy		PAGE NO. x OF x																																																		
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<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th colspan="2" style="text-align: center;">(9) CLAIMS SPECIFIC</th> <th colspan="3" style="text-align: center;">NON CLAIMS SPECIFIC</th> <th colspan="2" style="text-align: center;">(10)</th> </tr> <tr> <th style="text-align: center;">AMOUNT PAID</th> <th style="text-align: center;">ADJUSTMENT AMOUNT</th> <th style="text-align: center;">PAYABLES AMOUNT</th> <th style="text-align: center;">LEVY AMOUNT</th> <th style="text-align: center;">A/R AMOUNT</th> <th colspan="2" style="text-align: center;">CHECK AMOUNT</th> </tr> <tr> <td style="text-align: center;">.00</td> <td style="text-align: center;">.00</td> <td style="text-align: center;">.00</td> <td style="text-align: center;">.00</td> <td style="text-align: center;">.00</td> <td colspan="2" style="text-align: center;">600.00</td> </tr> </table>												(9) CLAIMS SPECIFIC		NON CLAIMS SPECIFIC			(10)		AMOUNT PAID	ADJUSTMENT AMOUNT	PAYABLES AMOUNT	LEVY AMOUNT	A/R AMOUNT	CHECK AMOUNT		.00	.00	.00	.00	.00	600.00																												
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AMOUNT PAID	ADJUSTMENT AMOUNT	PAYABLES AMOUNT	LEVY AMOUNT	A/R AMOUNT	CHECK AMOUNT																																																						
.00	.00	.00	.00	.00	600.00																																																						

How to Read the Accounts Receivable (AR) EOB

1. **A/R NBR:** The number assigned by Gainwell Technologies that identifies the accounts receivable (the amount the provider owes Gainwell Technologies).
2. **EFFECTIVE DATE:** The date the accounts receivable was created.
3. **PRINCIPAL BALANCE:** The amount of the accounts receivable when it was created.
4. **INTEREST APPLIED:** If applicable, is the amount of interest applied to the outstanding A/R. Always factored in, it is now recorded
5. **PD, VOID, OR TRANSFERRED:** The amount the provider has paid or that has been deducted from the provider's check towards the accounts receivable.
6. **CURRENT BALANCE:** The current amount the provider owes on the accounts receivable.
7. **TRANSACTION TYPE:** If applicable, this reflects the type of payment transaction(s).
8. **REMARKS:** This area provides an explanation for the accounts receivable. In this example, Gainwell Technologies issued an overpayment to the provider for a document with DCN 98104100330.
9. **NON-CLAIMS SPECIFIC A/R AMOUNT:** The total of the accounts receivable listed on the EOB or the amounts owed by the provider.
10. **CHECK AMOUNT:** The final amount of the check issued to the provider that corresponds to this EOB.

Sample Accounts Payable

EXPLANATION OF BENEFITS										DENTI-CAL																			
LINES PRECEDED BY "B" CONTAIN BENEFICIARY INFORMATION										CALIFORNIA MEDI-CAL DENTAL PROGRAM																			
LINES PRECEDED BY "C" CONTAIN CLAIM INFORMATION RELATIVE TO ABOVE BENEFICIARY										P.O. BOX 15609, SACRAMENTO, CA 95852-0609																			
No		PROVIDER XXXXXXXXXX				TAX ID NO: XXXXXXXXXX		No		CHECK XXXXXXXXXX																			
Adams, James, DDS 30 Center Street Anytown, CA xxxxx-xxxx						DATE: mm/dd/yy		PAGE NO. x		OF x																			
						STATUS CODE DEFINITION P = PAID D = DENIED A = ADJUSTED																							
PLEASE CALL (800) 423-0507 FOR ANY QUESTIONS REGARDING THIS DOCUMENT																													
B BENEFICIARY NAME MEDICAL I.D. NO. BENE ID SEX BIRTH DATE																													
C DOCUMENT CONTROL NO. TOOTH CODE PROC. CODE DATE OF SERVICE STATUS REASON CODE AMOUNT BILLED ALLOWED AMOUNT SHARE OF COST OTHER COVERAGE AMOUNT PAID																													
** IF THERE IS A LACK OF RECENT DENTI-CAL ACTIVITY FOR THIS SERVICE OFFICE, THE OUTSTANDING ** BALANCE OF THE RECEIVABLE WILL BE REASSIGNED TO AN ACTIVE SERVICE OFFICE.																													
RECEIVABLES (AMOUNT YOU OWE US):																													
***** THE FOLLOWING IS ACCOUNT ACTIVITY NOT RELATED TO SPECIFIC CLAIMS.																													
PAYABLES/CASH RECEIPTS (AMOUNTS OWED TO YOU/PAID BY YOU)																													
1	2	3							5																				
PAYABLE NUMBER	REASON CODE	DESCRIPTION							AMOUNT																				
0000435	5	PAYABLE							50.00																				
0000436	5	4 CHECK # 123456 APPLIED TO ACCOUNT							50.00																				
6																													
TOTAL OF CHECK NUMBER 000123456 50.00																													
<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;"> 7 <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="2" style="text-align: center;">CLAIMS SPECIFIC</th> <th colspan="3" style="text-align: center;">NON CLAIMS SPECIFIC</th> <th style="text-align: center;">8</th> </tr> <tr> <th style="text-align: center;">AMOUNT PAID</th> <th style="text-align: center;">ADJUSTMENT AMOUNT</th> <th style="text-align: center;">PAYABLES AMOUNT</th> <th style="text-align: center;">LEVY AMOUNT</th> <th style="text-align: center;">A/R AMOUNT</th> <th style="text-align: center;">CHECK AMOUNT</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">.00</td> <td style="text-align: center;">.00</td> <td style="text-align: center;">100.00</td> <td style="text-align: center;">.00</td> <td style="text-align: center;">.00</td> <td style="text-align: center;">100.00</td> </tr> </tbody> </table> </div> </div>												CLAIMS SPECIFIC		NON CLAIMS SPECIFIC			8	AMOUNT PAID	ADJUSTMENT AMOUNT	PAYABLES AMOUNT	LEVY AMOUNT	A/R AMOUNT	CHECK AMOUNT	.00	.00	100.00	.00	.00	100.00
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How to Read the Accounts Payable (AP) EOB

1. **PAYABLE NUMBER:** The number assigned by Gainwell Technologies that identifies the accounts payable (the amounts Gainwell Technologies owes the provider).
2. **REASON CODE:** The code that identifies the reason for the payable. See “Section 7: Codes” of this Handbook for the AR/AP Reason Codes and Descriptions.
3. **DESCRIPTION:** An explanation of the transaction.
4. **CHECK #:** The number of the check that the provider sent to Gainwell Technologies.
5. **AMOUNT:** Lists the dollar amount of each payable listed on the EOB.
6. **TOTAL OF CHECK NUMBER:** The amount of the check the provider sent to Gainwell Technologies.
7. **NON-CLAIMS SPECIFIC PAYABLES AMOUNT:** The total amount of the provider accounts payable shown on this EOB.
8. **CHECK AMOUNT:** The final amount of the check issued to the provider that corresponds to this EOB.

Sample Readjudicated Claim

EXPLANATION OF BENEFITS																													
<p>→ LINES PRECEDED BY "B" CONTAIN BENEFICIARY INFORMATION</p> <p>→ LINES PRECEDED BY "C" CONTAIN CLAIM INFORMATION RELATIVE TO ABOVE BENEFICIARY</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>PROVIDER</p> <p>No XXXXXXXXXXXX</p> </div> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>Adams, James, DDS</p> <p>30 Center Street</p> <p>Anytown, CA 95814</p> </div>										<p style="text-align: center;">DENTI-CAL</p> <p style="text-align: center;">CALIFORNIA MEDICAL DENTAL PROGRAM</p> <p style="text-align: center;">P.O. BOX 15609, SACRAMENTO, CA 95852-0609</p>																			
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										<p>STATUS CODE DEFINITION</p> <p>P = PAID</p> <p>D = DENIED</p> <p>A = ADJUSTED</p>																			
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<p>C 14 D2140 06/10/08 A ① - 50.00 - 39.00 ② ③ - 39.00</p>																													
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How to Read the Readjudicated Claim EOB

The original claim is described in the top section of the “ADJUSTMENT CLAIMS” section of the sample. The description of the results of the readjudication of the previously processed claim is found in the lower portion of the “ADJUSTMENT CLAIMS” section. The areas on the sample EOB that distinguish the original claim information from the readjudicated claim information is as follows:

Original Claim Information

1. The status code “A” indicates this claim service line on the original claim was allowed.
2. The amount that was allowed for this claim service line when the claim service line was originally processed.
3. The amount of the payment that was made to the provider for this claim service line when the claim was originally processed by Medi-Cal Dental.

Readjudicated Claim Information

1. The code and description indicate why the claim was readjudicated. Descriptions of Readjudication Codes and Messages (Claim Correction Codes) can be found in “Section 7: Codes” of this Handbook.
2. The status code “P” indicates the claim service line was “paid” after readjudication.
3. This amount (\$85.00) shows the amount allowed for this claim service line after readjudication.
4. The amount listed is the total amount paid to the provider for the readjudicated claim service line.
5. Total adjusted claims: This line shows the amounts allowed and to be paid to the provider after the claim was readjudicated.

Section 7 - Codes

Section 7 - Codes.....	7-1
Adjudication Reason Codes.....	7-1
Diagnostic/Preventive	7-1
Oral Surgery	7-5
Drugs	7-6
Periodontics.....	7-7
Endodontics.....	7-8
Restorative.....	7-9
Prosthodontics	7-11
Space Maintainers.....	7-14
Orthodontic Services.....	7-14
Maxillofacial Services.....	7-15
Miscellaneous	7-17
Payment Policy	7-23
Clinical Screening Codes	7-30
Claim In Process Reason Codes	7-34
Accounts Payable/Accounts Receivable Codes.....	7-35
Payable Codes.....	7-35
Receivable Codes	7-35
Readjudication Codes.....	7-35
Claim Correction Codes	7-35
Resubmission Turnaround Document (RTD) Codes and Messages.....	7-36
Member RTD Codes	7-37
Provider RTD Codes.....	7-37
X-Ray RTD Codes.....	7-37
Clerical RTD Codes	7-37
Consultant RTD Codes.....	7-38
Maxillofacial Program RTD Codes.....	7-38
TAR/Claim Policy Codes and Messages	7-39
Claim Inquiry Response (CIR) Status Codes and Messages/Claim Inquiry Form (CIF)	
Action Codes and Messages	7-41
Prepaid Health Plans (PHP) and Codes.....	7-42

Section 7 - Codes

Adjudication Reason Codes

In adjudicating claim and TAR forms, it is sometimes necessary to clarify the criteria for dental services under Medi-Cal Dental. These processing policies are intended to supplement the criteria. The Adjudication Reason Code is entered during processing to explain unusual action taken (if any) for each claim service line. These codes will be found on Explanations of Benefits (EOBs) and Notices of Authorization (NOAs).

AR C#	Adjudication Reason Code Description
DIAGNOSTIC/PREVENTIVE	
001	Procedure is a benefit once per patient, per provider.
001 A	An orthodontic evaluation is a benefit only once per patient, per provider.
002	Procedure is a benefit once in a six-month period for patients under age 21.
002 A	Evaluation is not a benefit within six months of a previous evaluation to the same provider for members under age 21 or does not meet CRA criteria.
003	Procedure not payable in conjunction with other oral evaluation procedures for the same date of service.
004	Procedure D0120 is only a benefit when there is history of Procedure D0150 to the same provider.
004 A	Procedure D1320 is only a benefit when billed on the same date of service as procedure D0150 or D0120 to the same provider.
005	Procedure is a benefit once in a three-month period for patients under age three.
006	Procedure is a benefit once per tooth.
008	Procedure was not adequately documented.
009	Procedure not a benefit when specific services other than radiographs or photographs are provided on the same day by the same provider.
010	Procedure 020 not a benefit in conjunction with Procedure 030.
011	Procedure 030 is payable only once for a visit to a single facility or other address per day regardless of the number of patients seen.
011 A	Procedure 030 is payable only when other specific services are rendered same date of service.
012	Procedure 030, time of day, must be indicated for office visit.
012 A	Procedure 030, time of day, must be indicated for office visit. Time indicated is not a benefit under Procedure 030
013	Procedure requires an operative report or anesthesia record with the actual time indicated.

AR C#	Adjudication Reason Code Description
013 A	Procedure has been authorized. However, the actual fee allowance cannot be established until payment is requested with the hospital time documented in operating room report.
013 B	Procedure D9410 is not payable when the treatment is performed in the provider's office or provider owned ambulatory surgical center.
013 C	The anesthesia record must be signed by the rendering provider and the rendering provider's name and permit number must be printed and legible.
013 D	The treating provider name on the anesthesia record does not coincide with the Rendering Provider Number (NPI) in field 33 on the claim.
013 E	The treating provider performing the analgesia procedure must have a valid permit from the DBC and the permit number must be on file with Denti-Cal.
014	Procedure is not a benefit to an assistant surgeon.
015	The fee to an assistant surgeon is paid at 20 percent of the primary surgeon's allowable surgery fee.
016	Procedure 040 is payable only to dental providers recognized in any of the special areas of dental practice.
017	Procedure 040 requires copy of the specialist report and must accompany the payment request.
018	Procedure 040 is not a benefit when treatment is performed by the consulting specialist.
019	The procedure has been modified due to the age of the patient and/or previous history to allow the maximum benefit.
020 A	Any combination of procedure 049, 050 (under 21), 061 and 062 are limited to once in a six-month period.
020 B	Procedure 050 (age 21 and over) is limited to once in a twelve-month period.
020 C	Prophy and fluoride procedures are allowable once in a six-month period.
020 D	Prophy and fluoride procedures are allowable once in a 12-month period.
020 E	Procedure will not be considered within 90 days of a previous prophylaxis and/or fluoride procedure.
020 F	Prophy and a topical fluoride treatment performed on the same date of service are not payable separately.
020 G	Topical application of fluoride is payable only for caries control.
020 H	Prophy and fluoride procedures are allowable once in a 4-month period when the patient resides in an intermediate care facility (ICF) or a skilled nursing facility (SNF) that is licensed pursuant to health and safety code (H&S code) section 1250-1264.
020 I	Patients under age 6, fluoride procedures are allowable once in a 4-month period and prophy procedures are allowable once in a 6-month period.

AR C#	Adjudication Reason Code Description
021	Procedure 080 is a benefit once per visit and only when the emergency procedure is documented with arch/tooth code and includes the specific treatment provided.
022	Full mouth or panoramic X-rays are a benefit once in a three year period.
023	A benefit twice in a six-month period per provider.
024	A benefit once in a 12-month period per provider.
024 A	Non-diagnostic X-rays are not payable due to one or more of the following reasons: Cone cutting, creases, stains, distortion, poor density.
024 B	Non-diagnostic X-rays are not payable due to one or more of the following reasons: Apices, crowns, and/or surrounding bone not visible.
024 C	Non-diagnostic X-rays are not payable due to one or more of the following reasons: Interproximal spaces overlapping.
024 D	Non-diagnostic X-rays are not payable due to one or more of the following reasons: Bone structure distal to the last tooth not shown.
024 E	Non-diagnostic X-rays are not payable due to one or more of the following reasons: Complete arch not shown in films submitted.
024 F	Non-diagnostic X-rays are not payable due to one or more of the following reasons: Artifacts obscure teeth.
025	Procedure 125 is not a benefit as a substitute for the periapical radiographs in a complete series.
026	Panographic type films submitted as a diagnostic aid for periodontics, endodontics, operative dentistry or extractions in one quadrant only are paid as single periapical radiographs.
027	Procedure is not a benefit for edentulous areas.
028	A benefit once in a six-month period per provider.
028 A	Procedure D0272 or D0274 is not a benefit within six months of Procedure D0210, D0272, or D0274, same provider.
028 B	Procedure D0210 is not a benefit within six months of Procedure D0272 or D0274, same provider.
029	Payment/Authorization denied due to multiple unmounted radiographs.
029 A	Payment/Authorization denied due to undated radiographs or photographs.
029 B	Payment/Authorization denied. Final endodontic radiograph is dated prior to the completion date of the endodontic treatment.
029 C	Payment/Authorization denied due to multiple, unspecified dates on the X-ray mount/envelope.
029 D	Payment/Authorization denied. Date(s) on X-ray mount, envelope or photograph(s) are not legible or the format is not understandable/decipherable.
029 E	Payment denied due to date of radiographs/photographs is after the date of service or appears to be post operative

AR C#	Adjudication Reason Code Description
029 F	Payment/Authorization denied due to beneficiary name does not match or is not on the X-ray mount, envelope or photograph.
029 G	Payment/Authorization disallowed due to radiographs/photographs dated in the future.
029 H	Payment/Authorization denied due to more than four paper copies of radiographs/photographs submitted.
029 I	Payment/Authorization denied. Radiographs/ photographs shall be of diagnostic quality, properly mounted, labeled with the date the radiograph/photograph was taken, the patient's name, and with the tooth/quadrant/area (as applicable). Submitted Radiographs/Photographs do not meet two or more of the above requirements.
030	An adjustment has been made for the maximum allowable radiographs.
030 A	An adjustment has been made for the maximum allowable X-rays. Bitewings are of the same side.
030 B	Combination of radiographs is equal to a complete series.
030 C	An adjustment has been made for the maximum allowable X-rays. Submitted number of X-rays differ from the number billed.
030 D	Periapicals are limited to 20 in any consecutive 12-month period.
031	Procedure is payable only when submitted.
031 A	Photographs are a benefit only when appropriate and necessary to document associated treatment.
031 B	Photographs are a benefit only when appropriate and necessary to demonstrate a clinical condition that is not readily apparent on the radiographs.
031 C	Photographs are not payable when taken for patient identification, multiple views of the same area, treatment in progress and postoperative views.
031 D	Photographs are not payable when the date does not match the date of service on the claim.
032 A	Endodontic treatment and postoperative radiographs are not a benefit.
032 B	X-rays disallowed for the following reasons: Duplicate X-rays are not a benefit.
032 C	X-rays disallowed for the following reasons: X-rays appear to be of another person.
032 D	X-rays disallowed for the following reasons: X-rays not labeled right or left. Unable to evaluate treatment.
033	Procedure 150 not a benefit in conjunction with the extraction of a tooth, root, excision of any part or neoplasm in the same area or region on the same day.
033 A	Procedure is payable only when a pathology report from a certified pathology laboratory accompanies the request for payment.
034	Emergency procedure cannot be prior authorized.

AR C#	Adjudication Reason Code Description
036	The dental sealant procedure code has been modified to correspond to the submitted tooth code.
037	Replacement/repair of a dental sealant is included in the fee to the original provider for 36 months.
038	Procedure is only a benefit when the tooth surfaces to be sealed are decay/restoration free
039	Dental sealants are only payable when the occlusal surface is included.
039 A	Preventive resin restoration is only payable for the occlusal, buccal, and/or lingual surfaces.
ORAL SURGERY	
043	Resubmit a new authorization request following completion of surgical procedure(s) that may affect prognosis of treatment plan as submitted.
043 A	This ortho case requires orthognathic surgery which is a benefit for patients 16 years or older. Submit a new authorization request following the completion of the surgical procedure(s).
044	First extraction only, payable as procedure 200. Additional extraction(s) in the same treatment series are paid as procedure 201 per dental criteria manual.
045	Due to the absence of a surgical, laboratory, or appropriate report, payment will be made according to the maximum fee allowance.
046	Routine post-operative visits within 30 days are included in the global fee for the surgical procedure.
046 A	Postoperative visits are not payable after 30 days following the surgical procedure.
047	Postoperative care within 90 days by the same provider is not payable.
047 A	Postoperative care within 30 days by the same provider is not payable.
047 B	Postoperative care within 24 months by the same provider is not payable.
048	Extraction of a tooth is not payable when pathology is not demonstrated in the radiograph, or when narrative documentation submitted does not coincide with the radiographic evidence.
049	Extractions are not payable for deciduous teeth near exfoliation.
050	Surgical extraction procedure has been modified to conform with radiographic appearance.
051	Procedure 201 is a benefit for the uncomplicated removal of any tooth beyond the first extraction, regardless of the level of difficulty of the first extraction, in a treatment series.
052	The removal of residual root tips is not a benefit to the same provider who performed the initial extraction.
053	The removal of exposed root tips is not a benefit to the same provider who performed the initial extraction.

AR C#	Adjudication Reason Code Description
054	Routine alveoloplasty procedures in conjunction with extractions are considered part of the extraction procedure.
054 A	Procedure is not a benefit within six months of extractions in the same quadrant.
054 B	Alveoloplasty is not a benefit in conjunction with 2 or more surgical extractions in the same quadrant.
055	Diagnostic X-rays fully depicting subject tooth (teeth) are required for intraoral surgical procedures.
056	A tuberosity reduction is not a benefit in the same quadrant in which extractions and/or an alveoloplasty or alveoloplasty with ridge extension unless justified by documentation.
057	Procedure is only payable to a certified oral pathologist and requires a pathology report.
058	Procedure is a benefit for anterior permanent teeth only.
059	Procedure allowed per Current Procedural Terminology (CPT) code description.
060	Procedure D9410 is payable only when associated with procedures that are a payable benefit.
DRUGS	
063	Only the most profound level of anesthesia is payable per date of service. This procedure is considered global and is included in the fee for the allowed anesthesia procedure.
064	A benefit only for oral, patch, intramuscular or subcutaneous routes of administration.
065	Procedure 300 is a benefit only for injectable therapeutic drugs, when properly documented.
066	The need for 301 must be justified and documented.
067	Procedure 301 requires prior authorization for beneficiaries 13 years of age or older and documentation of mental or physical handicap.
068	Procedure 400 is not a benefit except when the use of local anesthetic is contraindicated or cannot be used as the primary agent. The need for general anesthesia must be documented and justified.
069	Procedure is not a benefit when all additional services are denied or when there are no additional services submitted for the same date of service.
070	Anesthesia procedures are not payable when diagnostic procedures are the only services provided and the medical necessity is not justified.
071	Intravenous Sedation or General Anesthesia is not deemed medically necessary based on the treatment plan and/or documentation submitted. Please submit additional documentation to justify the medical necessity for IV Sedation/GA or attempt treatment under a less profound sedation modality.
071 A	Behavior Modification (D9920) is not payable when sedation is used as a behavior modification modality.

AR C#	Adjudication Reason Code Description
071 B	Behavior Modification (D9920) is only payable when the patient is a special needs patient that requires additional time for a dental visit.
071 C	Documentation submitted does not adequately describe the patient's medical condition that requires additional time for a dental visit.
071 D	This procedure does not have a fee in the Schedule of Maximum Allowance and is not payable through a claim submission. Please see https://dental.dhcs.ca.gov/Providers/Medi_Cal_Dental/Dental_Case_Management/DentalCaseManagementProgram for further instructions.
PERIODONTICS	
072	Periodontal procedure requires documentation specifying the definitive periodontal diagnosis.
073	Periodontal chart not current.
073 A	Periodontal chart not current. Older than 14 months.
073 B	Periodontal chart not current. Periodontal treatment performed after charting date.
073 C	Periodontal chart not current. Charting date missing or illegible.
073 D	Periodontal chart not current. Charting date invalid or dated in the future.
073 E	Periodontal chart not current. Older than 12 months
074 A	Periodontal procedure disallowed due to inadequate charting of: Pocket depths.
074 B	Periodontal procedure disallowed due to inadequate charting of: Mobility.
074 C	Periodontal procedure disallowed due to inadequate charting of: Teeth to be extracted.
074 D	Periodontal procedure disallowed due to inadequate charting of: Two or more of the above.
075	Procedure 451 must be documented as to the emergency condition and the definitive treatment provided.
076	A benefit twice in a 12-month period per provider.
077	Periodontal procedures 452, 472, 473, and 474 are not benefits for beneficiaries under 18 years of age except for cases of drug-induced hyperplasia.
077 A	Periodontal procedures are not benefits for patients under 13 years of age except when unusual circumstances exist and the medical necessity is documented.
078	Procedure 452 is a full mouth treatment not authorized by arch or quadrant.
079	Multiples of Procedure 452 must be performed on different days.

AR C#	Adjudication Reason Code Description
080	A prophylaxis or prophylaxis and fluoride procedure is not payable on the same date of service as a surgical periodontal procedure.
081	Periodontal procedure cannot be justified on the basis of pocket depth, bone loss, and/or degree of deposits as evidenced by the submitted radiographs.
081 A	Periodontal evaluation chart does not coincide with submitted radiographic evidence.
082	Procedure 453 is considered part of completed prosthodontics and/or multiple restorations involving occlusal surfaces.
083	Procedures 472 and 473 may be a benefit following procedure 452 and when the 6-9 month postoperative charting justifies need.
083 A	Surgical periodontal procedure cannot be authorized within 30 days following periodontal scaling and root planing for the same quadrant.
084	Procedure 452, 472, 473, and 474 are not payable as emergency procedures.
085	Procedure 452 requires a minimum of a 3-month healing period prior to evaluation for another 452.
085 A	Periodontal post-operative care is not a benefit when requested within 3 months by the same provider.
085 B	Only one Scaling and Root Planing, or Perio Maintenance or Prophylaxis procedure is allowable within the same calendar quarter.
086	Periodontal scaling and root planing must be performed within 24 months prior to authorization of a surgical periodontal procedure for the same quadrant.
086 A	Perio Maintenance is a benefit only when Scaling and Root Planing has been performed within 24 months.
086 B	Full Mouth Debridement is not payable when rendered within 24 months of a scaling and root planing.
087	Unscheduled dressing change is payable only when the periodontal procedure has been allowed by the program.
087 A	Unscheduled dressing change is not payable to the same provider who performed the surgical periodontal procedure.
087 B	Unscheduled dressing change is not payable after 30 days from the date of the surgical periodontal procedure.
088	Procedure is a benefit once per quadrant every 24 months.
088 A	Procedure is a benefit once per quadrant every 36 months.
089	Procedure is not a benefit for periodontal grafting.
ENDODONTICS	
090	Procedure 503 is not a benefit when permanent restorations are placed before a reasonable length of time following Procedure 503.
091	Procedure(s) require diagnostic radiographs depicting entire subject tooth.
091 A	Procedure(s) require diagnostic radiographs depicting entire subject tooth. Procedure requires diagnostic X-rays depicting furcation.

AR C#	Adjudication Reason Code Description
092	Payment request for root canal treatment and apicoectomy must be accompanied by a final treatment radiograph and include necessary postoperative care within 90 days.
093 A	Endodontic procedure is not payable when root canal filling underfilled.
093 B	Endodontic procedure is not payable when root canal filling overfilled.
093 C	Endodontic procedure is not payable when: Incomplete apical treatment due to inadequate retrograde fill and/or sealing of the apex.
093 D	Endodontic procedure is not payable when: Root canal filling is undercondensed.
093 E	Endodontic procedure is not payable when: Root canal has been filled with silver points. Silver points are not an acceptable filling material.
093 F	Endodontic procedure is not payable when: Root canal therapy has resulted in the gross destruction of the root or crown.
094	Crowns on endodontically treated teeth may be considered for authorization following the satisfactory completion of root canal therapy. Submit a new request for authorization on a separate TAR with the final endodontic radiograph.
095	Procedure 530 submitted is not allowed. Procedure 511, 512 or 513 is authorized per X-ray appearance.
096	Procedure not a benefit in conjunction with a full denture or overdenture.
097	Need for root canal procedure not evident per radiograph appearance, or documentation submitted.
098	Procedures 530 and 531 include retrograde filling.
099	A benefit once per tooth in a six-month period per provider.
100	Procedure is not a benefit for an endodontically treated tooth.
101	This procedure requires a prerequisite procedure.
101 A	Procedure D9999 documented for a live interaction associated with Teledentistry is only payable when procedure D0999 has been rendered.
RESTORATIVE	
109	Procedures D2161, D2335, D2390 and D2394 are the maximum allowances for all restorations of the same material placed in a single tooth for the same date of service.
110	Procedures 603, 614, 641 and 646 are the maximum allowance for all restorations placed in a single tooth for each episode of treatment.
111	Payment is made for an individual surface once for the same date of service regardless of the number or combinations of restorations or materials placed on that surface.
112	Separate restorations of the same material on the same tooth will be considered as connected for payment purposes.

AR C#	Adjudication Reason Code Description
113	Tooth does not meet the Manual of Criteria for a laboratory processed crown. Please re-evaluate for alternate treatment.
113 A	Per history, radiographs or photographs, it has been determined that this tooth has been recently restored with a restoration or pre-fabricated crown.
113 B	Per radiographs, the tooth/eruption pattern is developmentally immature. Please reevaluate for alternate treatment.
113 C	Laboratory processed crowns for adults are not a benefit for posterior teeth except as abutments for any fixed prosthesis or removable prosthesis with cast clasps or rests. Please reevaluate for alternate treatment.
113 E	Prefabricated crowns are not a benefit as abutments for any removable prosthesis with cast clasps or rests. Please reevaluate for a laboratory processed crown.
113 F	Per history, radiographs or photographs, it has been determined that this tooth has been recently restored with a pre-fabricated or laboratory processed crown and the need for the restoration is not justified.
114	Tooth and soft tissue preparation, crown lengthening, cement bases, build-ups, bonding agents, occlusal adjustments, local anesthesia and other associated procedures are included in the fee for a completed restorative service.
115	Amalgam or plastic build-ups are included in the allowance for the completed restorations.
116	Procedures 640/641 are only benefits when placed in anterior teeth or in the buccal (facial) of bicuspid.
117	Procedure not a benefit for a primary tooth near exfoliation.
118	Proximal restorations in anterior teeth are paid as single surface restorations.
119	Payment/Authorization cannot be made as caries not clinically verified by a Clinical Screening Consultant.
120	A panoramic film alone is considered non-diagnostic for authorization or payment of restorative, endodontic, periodontic, fixed and removable partial prosthodontic procedures.
121	Radiographs do not substantiate immediate need for restoration of surface(s) requested.
121 A	Neither radiographs nor photographs substantiate immediate need for restoration of surface(s) requested.
122	Tooth does not meet the Manual of Criteria for a prefabricated crown.
123	Radiograph or photograph does not depict the entire crown or tooth to verify the requested surfaces or procedure.
124	Radiograph or photograph indicate additional surface(s) require treatment.
124 A	Decay not evident on requested surface(s), but decay evident on other surface(s).
125	Replacement restorations are not a benefit within 12 months on primary teeth and within 24 months on permanent teeth.

AR C#	Adjudication Reason Code Description
125 A	Replacement restorations are not a benefit within 12 months on primary teeth and within 36 months on permanent teeth.
125 B	Replacement of otherwise satisfactory amalgam restorations is not a benefit unless a specific allergy has been documented by a medical specialist (allergist).
126	Fillings, stainless steel crowns and/or therapeutic pulpotomies in deciduous lower incisors are not payable when the child is over five years of age.
127	Pin retention is not a benefit for a permanent tooth when a prefabricated or laboratory-processed crown is used to restore the tooth.
128	Cast and prefabricated posts are benefits in endodontically treated devitalized permanent teeth only when crowns have been authorized and/or paid by the program.
129	Procedure is a benefit once in a 5-year period except when special circumstances are adequately documented.
129 A	The Procedure Code is a benefit once in a 5-year period. The member has used their allotted two policy exceptions previously.
129 B	The Procedure Code has been performed previously in less than the 5-year policy period. The request has been denied due to lack of documentation of measures to prevent further replacements.
130	Payment for a crown or fixed partial denture is made only upon final cementation regardless of documentation.
131	Procedure is a benefit only in cases of extensive coronal destruction.
132	Procedure 640/641 has been allowed but priced at zero due to the reduced SMA effective July 1, 1995.
133	Procedure not allowed due to denial of a root canal filled with silver points.
134	This change reflects the maximum benefit for a filling, (Procedure 600-614) placed on a posterior tooth regardless of the material placed, i.e. amalgam, composite resin, glass ionomer cement, or resin ionomer cement.
135	Procedure not a benefit for third molars unless the third molar occupies the first or second molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
136	Procedure not a benefit for prefabricated crowns.
PROSTHODONTICS	
137	Procedure has been performed previously in less than the 5-year policy period. The request has been allowed under special circumstances per documentation.
137 A	The Procedure Code has been performed previously in less than the 5-year policy period. The request has been allowed per an exception that can be granted twice per lifetime.
138	Partial payment for an undeliverable prosthesis requires the reason for non-delivery to be adequately documented and a laboratory invoice indicating the prosthesis was processed.

AR C#	Adjudication Reason Code Description
139	Payment adjustment reflects 80% of the SMA for an undeliverable prosthesis. The prosthesis must be kept in a deliverable condition for at least one year.
140	Payment adjustment reflects 20% of the SMA for delivery only of a previously undeliverable prosthesis.
141	Procedure 724 includes relines, additions to denture base to make appliance serviceable such as repairs, tooth replacement and/or resetting of teeth as necessary.
142	A prosthesis has been paid within the last 12 months. Please refer the patient to the original provider and/or Beneficiary Services at 1 (800) 322-6384.
143	Authorization not granted for a replacement prosthesis within a five-year period. Insufficient documentation substantiating need for prosthesis to prevent a significant disability or prosthesis loss/destruction beyond patient's control.
144	Procedure 720 is a benefit once per visit per day and when documented to describe the specific denture adjustment location.
145	Please submit a separate request for authorization of Procedure 722 when ready to reline denture.
146	A removable partial denture includes all necessary clasps, rests and teeth.
147	Cast framework partial denture is only a benefit when necessary to balance on opposing full denture.
148	Sufficient teeth are present for the balance of the opposing prosthesis.
149	Procedure 706 is a benefit only when necessary to replace a missing anterior permanent tooth (teeth).
149 A	A resin base partial denture is a benefit only when there is a missing anterior tooth and/or there is compromised posterior balanced occlusion.
150	Procedure 722 disallowed; allowance for Procedure 721 is maximum benefit for reline of stayplate.
151	This procedure is not a benefit for a resin base partial denture.
152	Relines are a benefit 6 months following an immediate prosthesis (with extractions).
153	Relines are a benefit 12 months following a non-immediate prosthesis (without extractions).
154	Tissue conditioning is not a benefit when dated the same date of service as a non-immediate prosthetic appliance or reline.
155	Procedure requires a properly completed prosthetic DC054 form.
155 A	Procedure requires a properly completed Prosthetic DC054 form. Information submitted on the DC054 Form does not justify the need for prosthesis.
155 B	Procedure requires a properly completed Prosthetic DC054 form. The information submitted on the DC054 Form does not match the information on the TAR (Treatment Authorization Request).
155 C	Procedure requires a properly completed Prosthetic DC054 Form. Teeth to be replaced and clasped are not indicated or are in conflict on the DC054 form.

AR C#	Adjudication Reason Code Description
156	Evaluation of a removable prosthesis on a maintenance basis is not a benefit.
157	A laboratory invoice is required for payment.
160	Laboratory or chairside relines are a benefit once in a 12-month period per arch.
161	Procedure 722 is a benefit once in a 12-month period per arch.
161	Procedure 724 is not a benefit within 12 months of procedure 722, same arch.
A	
161	Procedure 722 is not a benefit within 12 months of procedure 724, same arch.
B	
162	Patient's existing prosthesis is adequate at this time.
163	Patient returning to original provider for correction and/or modifications of requested procedure(s).
164	Prosthesis serviceable by laboratory reline.
165	Existing prosthesis can be made serviceable by denture duplication ("jump", "reconstruction").
166	The procedure has been modified to reflect the allowable benefit and may be provided at your discretion.
168	Patient does not wish extractions or any other dental services at this time.
A	
168	Patient has selected different provider for treatment.
B	
169	Procedure 723 is limited to two per appliance in a full 12-month period.
169	Procedure is limited to two per prosthesis in a 36-month period.
A	
170	A reline, tissue conditioning, repair, or an adjustment is not a benefit without an existing prosthesis.
171	The repair or adjustment of a removable prosthesis is a benefit twice in a 12-month period, per provider.
172	Payment for a prosthesis is made upon insertion of that prosthesis.
173	Prosthetic appliances (full dentures, partial dentures, reconstructions, and stayplates) are a benefit once in any five-year period.
174	Procedure 724 is a benefit only when the existing denture is at least two years old.
175	The fee allowed for any removable prosthetic appliance, reline, reconstruction or repair includes all adjustments and post-operative exams necessary for 12 months.
175	The fee allowed for any removable prosthesis, reline, tissue conditioning, or repair includes all adjustments and post-operative exams necessary for 6 months.
A	
176	Per radiographs, insufficient tooth space present for the requested procedure.

AR C#	Adjudication Reason Code Description
177	New prosthesis cannot be authorized. Patient's dental history shows prosthesis made in recent years has been unsatisfactory for reasons that are not remediable.
178	The procedure submitted is no longer a benefit under the current criteria manual. The procedure allowed is the equivalent to that submitted under the current Schedule of Maximum Allowances and criteria manual.
179	Procedure requires prior authorization and cannot be considered as an emergency condition.
180	Patient cancelled his/her scheduled clinical screening. Please contact patient for further information.
SPACE MAINTAINERS	
191	Radiograph depicts insufficient space for eruption of the permanent tooth/teeth.
192	Procedure not a benefit when the permanent tooth/teeth are near eruption or congenitally missing.
193	Replacement of previously provided space maintainer is a benefit only when justified by documentation.
194	Tongue thrusting and thumb sucking appliances are not benefits for children with erupted permanent incisors.
195	A space maintainer is not a benefit for the upper or lower anterior region.
196	Procedure not a benefit for orthodontic services, including tooth guidance appliances.
197	Procedure requested is not a benefit when only one tooth space is involved or qualifies. Maximum benefit has been allowed.
197 A	Procedure is only a benefit to maintain the space of a single primary molar.
ORTHODONTIC SERVICES	
198	Procedure is not a benefit when the active phase of treatment has not been completed.
199	Patients under age 13 with mixed dentition do not qualify for handicapping orthodontic malocclusion treatment.
200	Adjustments of banding and/or appliances are allowable once per calendar month.
200 A	Adjustments of banding and/or appliances are allowable once per quarter.
200 B	Procedure D8670 is payable the next calendar month following the date of service for Procedure D8080.
200 C	Procedure D8670 and D8680 are not payable for the same date of service.
201	Procedure 599 - Retainer replacements are allowed only on a one-time basis.

AR C#	Adjudication Reason Code Description
201 A	Replacement retainer is a benefit only within 24 months of procedure D8680.
202	Procedure is a benefit only once per patient.
203	Procedure 560 is a benefit once for each dentition phase for cleft palate orthodontic services.
204	Procedures 552, 562, 570, 580, 591, 595 and 596 for banding and materials are payable only on a one-time basis unless an unusual situation is documented and justified.
205	Procedures 556 and 592 are allowable once in three months.
205 A	Pre-orthodontic visits are payable for facial growth management cases once every three months prior to the beginning of the active phase of orthodontic treatment.
206	Anterior crossbite not causing clinical attachment loss and recession of the gingival margin.
207	Deep overbite not destroying the soft tissue of the palate.
208	Both anterior crowding and anterior ectopic eruption counted in HLD index.
209	Posterior bilateral crossbite has no point value on HLD index.
MAXILLOFACIAL SERVICES	
210	TMJ X-rays - Procedure 955 is limited to twice in 12 months.
211	Procedures 950 and 952 allowed once per dentist per 12-month period.
212	In the management of temporomandibular joint dysfunction, symptomatic care over a period of three months must be provided prior to major definitive care.
213	Procedure 952 is intended for cleft palate and maxillofacial prosthodontic cases.
214	Procedure must be submitted and requires six views of condyles – open, closed, and rest on the right and left side.
215	Overjet is not greater than 9mm or the reverse overjet is not greater than 3.5mm.
216	Documentation submitted does not qualify for severe traumatic deviation, cleft palate or facial growth management.
217	Procedures 962, 964, 966 and 968 require complete history with documentation for individual case requirements. Documentation and case presentation is not complete.
218	Procedures 962, 964, 966 and 968 include all follow-up and adjustments for 90 days.
220	Procedures 970 and 971 include all follow-up and adjustments for 90 days.
221	Procedure is a benefit only when orthodontic treatment has been allowed by the program.
222	Inadequate description or documentation of appliance to justify requested prosthesis.
223	Procedure is a benefit only when the orthodontic treatment is authorized.

AR C#	Adjudication Reason Code Description
224	Photograph of appliance required upon payment request.
225	Procedure 977 requires complete case work-up with accompanying photographs. Documentation inadequate.
226	Procedure D8692 is a benefit only when procedure D8680 has been paid by the program.
227	Splints and stents are part of the global fee for surgical procedure unless they are extremely complex. Supporting documentation missing.
228	When requesting payment, submit documentation for exact amount of hydroxylapatite material (in grams) used on this patient unless your hospital has provided the material.
229	Procedure 979 (radiation therapy fluoride carriers) is a benefit only when radiation therapy is documented.
230	Procedure is not a benefit for acupuncture, acupressure, biofeedback, or hypnosis.
233	Procedure 985 requires prior authorization.
234	Allowance for grafting procedures includes harvesting at donor site.
235	Degree of functional deficiency does not justify requested procedure.
236	Genioplasty is a benefit only when required to complete restoration of functional deficiency. Requested procedure is cosmetic in nature and does not have a functional component.
237	A vestibuloplasty is a benefit only when X-rays and models demonstrate insufficient alveolar process to support a full upper denture or full lower denture. Diagnostic material submitted reveals adequate bony support for prosthesis.
238	Procedure 990 must be accompanied by a copy of occlusal analysis or study models identifying procedures to convert lateral to vertical forces, correct prematurities, and establish symmetrical contact.
241	Allowance for splints and/or stents includes all necessary adjustments.
242	Procedure 996 Request for payment requires submission of adequate narrative documentation.
243	Procedure is a benefit six times in a three-month period.
245	Authorization disallowed as diagnostic information insufficient to identify TMJ syndrome.
246	Except in documented emergencies, all unlisted therapeutic services (Procedure 998) require prior authorization with sufficient diagnostic and supportive material to justify request.
247	Osteotomies on patients under age 16 are not a benefit unless mitigating circumstances exist and are fully documented.
248	Procedure is not a benefit for the treatment of bruxism in the absence of TMJ dysfunction.

AR C#	Adjudication Reason Code Description
249	Payment for the assistant surgeon is not payable to the provider who performed the surgical procedures. Payment request must be submitted under the assistant surgeon's provider number.
250	Procedure 995 is a benefit once in 24 months.
251	Documentation for Procedure 992 or 994 is inadequate.
253	Combination of Procedures 970, 971 and Procedure 978 are limited to once in six months without sufficient documentation.
254	Procedure disallowed due to absence of one of the following: "CCS approved" stamp, signature, and/or date.
255	Procedure disallowed due to dentition phase not indicated.
256	The orthodontic procedure requested has already received CCS authorization. Submit a claim to CCS when the procedure has been rendered.
257	Procedure is not a benefit for Medi-Cal beneficiaries through the CCS program.
MISCELLANEOUS	
258	Functional limitations or health condition of the patient preclude(s) requested procedure.
259 A	Procedure not a benefit within 6 months to the same provider.
259 B	Procedure not a benefit within 12 months to the same provider.
259 C	Procedure not a benefit within 36 months to the same provider.
259 D	Procedure not a benefit within 24 months to the same provider.
259 E	Procedure not a benefit within 12 months of the initial placement or a previous recementation to the same provider.
260	The requested tooth, surface, arch, or quadrant is not a benefit for this procedure.
261	Procedure is not a benefit of this program.
261 A	Procedure code is missing or is not a valid code.
261 B	CDT codes are not valid for this date of service.
261 C	The billed procedure cannot be processed. Request for payment contains both local and CDT codes. Submit this procedure code on a new claim.
262	Procedure requested is not a benefit for children.
263	Procedure requested is not a benefit for adults.
264	Procedure requested is not a benefit for primary teeth.
265	Procedure requested is not a benefit for permanent teeth.

AR C#	Adjudication Reason Code Description
266 A	Payment and/or prior authorization disallowed. Radiographs or photographs are not current.
266 B	Payment and/or prior authorization disallowed. Lack of radiographs.
266 C	Payment and/or prior authorization disallowed. Radiographs or photographs are non-diagnostic for the requested procedure.
266 D	Payment and/or prior authorization disallowed. Procedure requires current radiographs of the remaining teeth for evaluation of the arches.
266 E	Payment and/or prior authorization disallowed. Lack of postoperative radiographs.
266 F	Payment and/or prior authorization disallowed. Procedure requires current periapicals of the involved areas for the requested quadrant and arch films.
266 G	Payment and/or prior authorization disallowed. Unable to evaluate treatment. Photographs, digitized images, paper copies, or duplicate radiographs are not labeled adequately to determine right or left, or individual tooth numbers.
266 H	Payment and/or prior authorization disallowed. Radiographs submitted to establish arch integrity are non-diagnostic.
266 I	Payment and/or prior authorization disallowed. Radiographs are non-diagnostic due to poor X-ray processing or duplication.
266 J	Payment and/or prior authorization disallowed. Radiographs are non-diagnostic due to elongation.
266 K	Payment and/or prior authorization disallowed. Radiographs are non-diagnostic due to foreshortening.
266 L	Payment and/or prior authorization disallowed. Radiographs are non-diagnostic due to overlapping or cone cutting.
266 M	Current periapical radiographs of the tooth along with arch films to establish arch integrity are required.
266 N	Payment and/or prior authorization disallowed. Pre-operative radiographs are required.
266 P	Payment and/or prior authorization disallowed. Photographs are required.
267	Documentation not submitted.
267 A	Description of service, procedure code and/or documentation are in conflict with each other.
267 B	Documentation insufficient/not submitted. Services disallowed. Required periodontal chart incomplete/not submitted.
267 C	Documentation insufficient/not submitted. Services disallowed. Documentation is illegible.
267 D	Documentation insufficient/not submitted. Study models not submitted.
267 E	Denied by Prior Authorization/Special Claims Review Unit. Patient's record of treatment appears to be altered. Services disallowed.

AR C#	Adjudication Reason Code Description
267 F	Denied by Prior Authorization/Special Claims Review Unit. Patient's record of treatment not submitted. Services disallowed.
267 G	Denied by Prior Authorization/Special Claims Review Unit. Information on patient's record of treatment is not consistent with claim/NOA.
267 H	All required documentation, radiographs and photographs must be submitted with the claim inquiry form.
267 I	Documentation submitted is incomplete.
268	Per radiographs, documentation or photographs, the need for the procedure is not medically necessary.
268 A	Per radiographs, photographs, or study models, the need for the procedure is not medically necessary. The Handicapping Labio-Lingual Deviation Index (HLD Index) score does not meet the criteria to qualify for orthodontic treatment.
268 B	The requested procedure is not medically necessary precedent to the documented medical treatment and is not a covered benefit.
268 C	The requested procedure is not medically necessary precedent to the documented medical treatment and is not a covered benefit. Please re-evaluate for a FRADS that may be a covered benefit.
269 A	Procedure denied for the following reason: Included in the fee for another procedure and is not payable separately.
269 B	Procedure denied for the following reason: This procedure is not allowable in conjunction with another procedure.
269 C	Procedure denied for the following reason: Associated with another denied procedure.
270	Procedure has been modified based on the description of service, procedure code, tooth number or surface(s), or documentation.
271 A	Procedure is disallowed due to the following: Bone loss, mobility, periodontal pathology.
271 B	Procedure is disallowed due to the following: Apical radiolucency.
271 C	Procedure is disallowed due to the following: Arch lacks integrity.
271 D	Procedure is disallowed due to the following: Evidence or history of recurrent or rampant caries.
271 E	Procedure is disallowed due to the following: Tooth/teeth have poor prognosis.
271 F	Procedure is disallowed due to the following: Gross destruction of crown or root.
271 G	Procedure is disallowed due to the following: Tooth has no potential for occlusal function and/or is hyper-erupted.

AR C#	Adjudication Reason Code Description
271 H	Procedure is disallowed due to the following: The replacement of tooth structure lost by attrition, abrasion or erosion is not a covered benefit.
271 I	Procedure is disallowed due to the following: Permanent tooth has deep caries that appears to encroach the pulp. Periapical is required.
271 J	Procedure is disallowed due to the following: Primary tooth has deep caries that appears to encroach the pulp. Radiograph inadequate to evaluate periapical or furcation area.
272	Tooth not present on radiograph.
272 A	Per radiograph, tooth is unerupted.
272 B	Radiographs and/or documentation reveals that tooth number may be incorrect.
273	Procedure denied as beneficiary is returning to original provider.
274	Comprehensive (full mouth) treatment plan is required for consideration of services requested.
274 A	Incomplete treatment plan submitted. Opposing dentition lacks integrity. Consider full denture for opposing arch.
274 B	Authorized treatment plan has been altered; therefore, payment is disallowed.
274 C	Incomplete treatment plan submitted. Opposing prosthesis is inadequate.
274 D	Incomplete treatment plan submitted. All orthodontic procedures for active treatment must be listed on the same TAR.
275	This procedure has been modified/disallowed to reflect the maximum benefit under this program.
276	Procedures, appliances, or restorations (other than those for replacement of structure loss from caries) which alter, restore or maintain occlusion are not benefits.
277	Orthodontics for handicapping malocclusion submitted through the CCS program for Medi-Cal beneficiaries are not payable by Denti-Cal.
278	Preventive control programs are included in the global fee.
279	Procedure(s) beyond scope of program. If you wish, submit alternate treatment plan.
280	Not payable when condition is asymptomatic.
281	Services solely for esthetic purposes are not benefits.
282	By-report procedure documentation missing or insufficient for payment calculations.
283	Payment amount determined from documentation submitted for this by-report procedure.
284	Radiographs reveal that additional procedures are necessary before authorization of the requested service(s) can be considered.

AR C#	Adjudication Reason Code Description
284 A	Radiographs reveal that additional procedures are necessary before authorization of the requested service(s) may be made. Restorative treatment incomplete.
284 B	Radiographs reveal that additional procedures are necessary before authorization of the requested service(s) may be made. Crown treatment incomplete.
284 C	Radiographs reveal that additional procedures are necessary before authorization of the requested service(s) can be considered. Endodontic treatment is necessary.
284 D	Radiographs reveal that additional procedures are necessary before authorization of the requested service(s) can be considered. Additional extraction(s) are necessary.
284 E	Radiographs reveal that additional procedures are necessary before authorization of the requested service(s) may be made. Two or more of the above pertain to your case.
285	Procedure does not show evidence of a reasonable period of longevity.
285 A	Procedure does not show evidence of a reasonable period of longevity. Submit alternate treatment plan, if you wish.
286	Procedure previously rendered.
287	Allowance made for alternate procedure per documentation, radiographs, photographs and/or history.
287 A	Allowance made for alternate procedure per documentation, radiographs and/or photos. Due to patient's age allowance made for permanent restoration on an over retained primary tooth.
288	Procedure cannot be considered an emergency.
289	Procedure requires prior authorization.
290	All services performed in a skilled nursing or intermediate care facility, except diagnostic and emergency services, require prior authorization.
291	Per date of service, procedure was completed prior to date of authorization.
292	Per documentation or radiographs, procedure requiring prior authorization has already been completed.
293	Per radiographs, procedure requested is inadequate to correct problem. Please submit alternate treatment plan.
293 A	Radiographs reveal open, underformed apices. Authorization for root canal therapy will be considered after radiographic evidence of apex closure following apexification.
293 B	Per radiographs, procedure requested is inadequate to correct problem. Please submit alternate treatment plan. Re-evaluate for apicoectomy.
293 C	Per radiographs, procedure requested is inadequate to correct problem. Please submit alternate treatment plan. Root canal should be retreated by conventional endodontics before apical surgery is considered.

AR C#	Adjudication Reason Code Description
293 D	Reevaluate for extraction of primary tooth. Radiolucency evident in periapical or furcation area.
294	Authorization disallowed as patient did not appear for a scheduled clinical screening.
294 A	Authorization disallowed as patient failed to bring existing prosthesis to the clinical screening.
295	Payment cannot be made for services provided after the initial receipt date, because the patient failed the scheduled screening appointment.
296	Patient exhibits lack of motivation to maintain oral hygiene necessary to justify requested services.
297	Procedure 803 not covered as a separate item. Global fee where a benefit.
298	A fee for completion of forms is not a covered benefit.
299	Complete denture procedures have been rendered/authorized for the same arch.
299 A	Extraction procedure has been rendered/authorized for the same tooth.
300	Procedure recently authorized to your office.
300 A	Procedure recently authorized to a different provider. Please submit a letter from the patient if he/she wishes to remain with your office.
301	Procedure(s) billed or requested are a benefit once per patient, per provider, per year.
302	Procedure is not a benefit as coded. Use only one tooth number, one date of service and one procedure number per line.
303	Fixed Partial Dentures are only allowable under special circumstances as defined in the Manual of Dental Criteria.
303 A	Fixed Partial Dentures are not a benefit when the number of missing teeth in the posterior quadrant(s) do not significantly impact the patient's masticatory ability.
304	Mixture of three-digit, four-digit and five-digit procedure codes is not allowed.
305	Procedure not a benefit for tooth/arch/quad indicated.
307	Payment for procedure disallowed per post-operative radiograph evaluation and/or clinical screening.
307 A	Per post-operative radiograph(s), payment for procedure disallowed: Poor quality of treatment.
307 B	Per post-operative radiograph(s), payment for procedure disallowed: Procedure not completed as billed.
308	Procedure disallowed due to a beneficiary identification conflict.
309	Procedures being denied on this claim/TAR due to full denture or extraction procedure(s) previously paid/authorized for the same tooth/arch.
310	Procedure cannot be authorized as it was granted to the patient under the Fair Hearing process. Please contact the patient.

AR C#	Adjudication Reason Code Description
311	Procedure cannot be evaluated at the present time because it is currently pending a Fair Hearing decision.
PAYMENT POLICY	
312	Certified orthodontist not associated to this service office.
313	Payment and/or prior authorization disallowed. Your response to the RTD was invalid or incomplete.
313 A	Payment and/or prior authorization disallowed. Your response to the RTD was invalid or incomplete. No other coverage EOB/RA, fee schedule or proof of denial submitted.
313 B	Payment and/or prior authorization disallowed. Your response to the RTD was invalid or incomplete. No EOMB or proof of Medicare eligibility.
313 C	Payment and/or prior authorization disallowed. Your response to the RTD was invalid or incomplete. Missing/invalid rendering provider ID.
313 D	Study models submitted are non-diagnostic, untrimmed, or broken.
313 E	Payment and/or prior authorization disallowed. Your response to the RTD was invalid or incomplete. PM 160 sent exceeded 36 months from date of issue.
314 A	Per radiographs or documentation, please re-evaluate for: Complete upper denture.
314 B	Per radiographs or documentation, please re-evaluate for: Complete lower denture.
314 C	Per radiographs or documentation, please re-evaluate for: Resin base partial denture.
314 D	Per radiographs or documentation, please re-evaluate for: Cast metal framework partial denture.
314 E	Per radiographs or documentation, please re-evaluate for: Procedure 706
314 F	Per radiographs or documentation, please re-evaluate for: Procedure 708
315	The correction(s) have been made based on the information submitted on the CIF. Payment cannot be made because the CIF was received over 6 months from the date of the EOB.
316	Payment disallowed. Request received over 12 months from end of month service was performed.
317	Request for re-evaluation is not granted. Resubmit undated services on a new Treatment Authorization Request (TAR).
317 A	Orthodontic NOAs cannot be extended. Submit a new Treatment Authorization Request (TAR) to reauthorize the remaining orthodontic treatment.
317 B	Request for reevaluation is not granted due to local and CDT codes on the same document. Resubmit undated service(s) on a new Treatment Authorization Request (TAR).
318	Recipient eligibility not established for dates of services.

AR C#	Adjudication Reason Code Description
318 A	Recipient eligibility not established for dates of services. Share of cost unmet.
319	Rendering or billing provider NPI/ID not on file.
319 A	The submitted rendering provider NPI is not registered with Denti-Cal. Prior to requesting re-adjudication for a dated, denied procedure on a Claim Inquiry Form (CIF), the rendering provider NPI must be registered with Denti-Cal.
320	Rendering or billing provider not enrolled for date of service.
320 A	Rendering or billing provider is not enrolled as a certified orthodontist.
320 B	The billing provider has discontinued practicing at this office location for these Dates of Service.
320 C	Rendering provider has not submitted a proper attestation package.
321	Recipient benefits do not include dental services.
322	Out-of-state services require authorization or an emergency certification statement; payment cannot be made.
323	Authorization period for this procedure as indicated on the top portion of the Notice of Authorization form has expired.
324	Payment cannot be made as prior authorization made to another dentist. Authorization for services is not transferable.
325	Per documentation, service does not qualify as an emergency. For adult beneficiaries, payment may reflect the maximum allowable under the beneficiary services dental cap.
326	Procedures being denied on this document due to invalid response to the RTD or, if applicable, failure to provide radiographs/attachments for this EDI document.
326 A	Procedures being denied on this claim/TAR due to invalid or missing provider signature on the RTD. Rubber stamp or other facsimile of signature cannot be accepted.
327	Payment cannot be made; our records indicate patient deceased.
328	Request for partial payment is not granted. Delete undated services and submit them on a new TAR form.
329	Extension of time is granted once after the original TAR authorization without justification of need for extension.
330	Recipient is enrolled in a managed care program (MCP, PHP, GMC, HMO, or DMC) which includes dental benefits.
330 A	Beneficiary is not eligible for Medi-Cal Dental benefits. Verify beneficiary's enrollment in Healthy Families which may include dental benefits.
331	Authorized services are not a benefit if patient becomes ineligible during authorized period and services are performed after the patient has reached age 18 without continuing eligibility.
332	Share of cost patient must pay for these services.

AR C#	Adjudication Reason Code Description
333	Payment cannot be made for procedures with dates of service after receipt date.
333 A	Payment disallowed. Date of service is after receipt date of first NOA page(s).
334	Out-of-country services require an emergency certification statement, and are a benefit only for approved inpatient services.
335	Billing provider name does not match our files; payment/ authorization cannot be made.
336	Beneficiary is not eligible for dental benefits.
337	The procedure is not a benefit for the age of the beneficiary.
337 A	The number of authorized visits has been adjusted to coincide with beneficiary's 19th/21st birthday.
338	This service will be processed under the former contract separately.
339	The POE label on the claim appears to be altered. Please contact the recipient's county welfare office to validate eligibility. Resubmit the claim with a valid label.
340	This procedure is a duplicate of a previously paid procedure. If you are requesting re-adjudication for a dated, allowed procedure, submit a Claim Inquiry Form (CIF). The denial of this procedure does not extend the time limit to request re-adjudication; you have up to six (6) months from the date of the EOB on the original claim.
341	This procedure is a duplicate of a previously denied procedure. If you are requesting re-adjudication for a dated, denied procedure, submit a Claim Inquiry Form (CIF). This denied, duplicate procedure does not extend the time limit to request re-adjudication; you have up to six (6) months from the date of the EOB on the original claim. (If you are requesting re-evaluation of an undated, denied procedure, submit the Notice of Authorization (NOA).)
342	Rendering provider required for procedure, none submitted.
343	Billing provider is required to submit a TAR for these services unless they were performed as a necessary part of an emergency situation.
344	Rendering provider is required to submit a TAR for these services unless they were performed as a necessary part of an emergency situation.
345	Payment cannot be made for procedures with invalid dates of service.
345 A	The PM 160 form sent was not current. Send claim inquiry form with current PM 160 form or document reason for delay in treatment.
346	Billing provider is not a group provider and cannot submit claims for other rendering providers.
347	Authorization previously denied, payment cannot be made.
348	The billed procedure cannot be paid because there is an apparent discrepancy between it and a service already performed on the same day by the same DDS.

AR C#	Adjudication Reason Code Description
348 A	The billed procedure cannot be paid because there is an apparent discrepancy between it and procedure D0220 already performed on the same day. If you are requesting re-adjudication for this procedure, submit a Claim Inquiry Form (CIF).
349	The billed procedure cannot be paid because there is an apparent discrepancy between it and a service previously processed, performed by the same dentist on the same day in the same arch.
350	Billed procedure is not payable. Our records indicate the date of service is prior to the date on which a related procedure was provided for this patient.
351	Billed procedure is not payable. Our records indicate the date of service is prior to the date on which a related procedure was provided by your office for this patient.
352	The billed service is disallowed because of an apparent discrepancy with a related procedure billed by your office for the same tooth on the same day.
352 a	The billed procedure is not payable because our records indicate a related procedure was provided on the same day.
353	The billed service on this tooth is disallowed because of an apparent discrepancy with a related procedure already provided.
354	The line item is a duplicate of a previous line item on the same claim.
355 A	Procedure does not require prior authorization and has not been reviewed. The zero dollar amount for this procedure does not represent an approval or denial and may be rendered at your discretion.
355 B	Procedure does not require prior authorization and has not been reviewed. The zero dollar amount for this procedure does not represent an approval or denial and may be rendered at your discretion.
355 C	Procedure does not require prior authorization, however, it was reviewed as part of the total treatment plan.
356	EOMB for different recipient, procedure(s) denied.
357	Procedure deleted/disallowed per provider request.
358	Payment for procedure disallowed per claims review.
359	Payment for procedure disallowed per clinical post-payment review.
360	Sign Notice of Authorization for payment of dated lines.
361	CSL has not been paid; NOA never returned for payment.
362	Procedure cannot be paid without explanation of benefits, fee schedule or letter of denial.
363	Procedure on EOMB is not a benefit of the program.
364	Unable to reconcile EOMB procedure code(s). Please reconcile with Medicare prior to billing.
365	The maximum allowance for this service/procedure has been paid by Medicare.
366	Dental benefits cannot be paid without proof of payment/denial from Medicare.

AR C#	Adjudication Reason Code Description
367	Medicare payment/denial notice does not have recipient name and/or date of service.
368	CMSP Aid Code recipient not eligible under Denti-Cal prior to 01/01/90. Forward request for payment to County Medical Services Program.
369	Emergency certification statement is insufficient /not submitted for recipient aid code.
369 A	Provider must sign the emergency certification statement.
370	Procedure not a benefit for recipient aid code.
370 A	Per box "D" marked in dental assessment column of PM 160, recipient is not eligible for any dental services.
371	Procedure(s) cannot be prior authorized for recipient aid code.
372	Recipient is eligible for Delta commercial coverage. Payment is disallowed.
373	Procedure not payable. CTP benefits terminate at age 19.
374	Recipient is not a resident of a CTP/CMSP contract county. Contact recipient county health department for billing procedures.
375	Re-evaluation denied. Insufficient documentation and/or radiographs not submitted. Please sign for payment of dated services and submit a new TAR.
376	Payment reflects a rate adjustment to the current Schedule of Maximum Allowances and may include an adjustment to the billed amount.
377	This procedure is not a benefit for an RDHAP/RDHEF/RDH.
377 A	Procedure requested is only payable when the patient resides in an Intermediate Care Facility (ICF) or a Skilled Nursing Facility (SNF) that is licensed pursuant to Health And Safety Code (H&S Code) Section 1250-1264.
378	CTP recipient. Payment cannot be made for procedures with dates of service after the 120 day authorization period.
379	Procedure(s) cannot be approved when the new issue date and new BIC ID are not valid or provided in the appropriate fields.
380	Fee adjustment, since Other Coverage exists for this claim.
381	Fee adjustment, since Third Party Liability exists for this claim.
382	Fee adjustment, since share of cost exists for this claim.
383	Fee adjustment, since services billed were not provided.
384	Fee adjustment, due to findings of professional peer review.
385	Aid code 80 recipients are eligible only for Medicare-approved procedures.
386	Payment/Authorization disallowed. CMSP dental services for dates of service after September 30, 2005, are the responsibility of Doral Dental Services of California (1-800-341-8478).
386 A	Payment/authorization disallowed. CTP dental benefits are not payable for dates of service after March 31, 2009 or when received after May 31, 2009.

AR C#	Adjudication Reason Code Description
387	Payment disallowed. The request for CMSP dental services was not received before April 1, 2006. Contact Doral Dental Services of California (1-800-341-8478).
387 A	Payment Disallowed. The request for a re-evaluation of denied CTP dental service(s) was not received before December 31, 2009.
389	Pregnancy aid codes require a periodontal chart to perform surgical periodontal procedures. Subgingival curettage and root planing must be in history, or documentation must be submitted stating why a prior subgingival curettage and root planing was not performed.
390	The procedure requested is not on the SAR for this CCS/GHPP beneficiary. Contact CCS/GHPP to obtain a SAR prior to submitting for re-evaluation or payment.
391	Final diagnostic casts are not payable within 6 months of initial diagnostic casts for CCS patients.
392	Beneficiary is not eligible for CCS/GHPP benefits.
393	TAR cannot be processed as part of the university project. Resubmit new TAR using your G billing provider number.
394	A credentialed specialist must submit documentation of cleft palate or the craniofacial anomaly.
395	Payment/authorization denied. Please contact the local governmental financing division at DHCS via general email box: DHCSIMCU@DHCS.CA.GOV for the responsible county for this service.
400	EPSDT services are not a benefit for patients 21 years and older.
401	The EPSDT service requested is primarily cosmetic in nature and not medically necessary per EPSDT criteria.
402	An alternative service is more cost effective than the requested EPSDT service and is a benefit of the Medi-Cal Dental program. Please re-evaluate.
403	The EPSDT service requested is not medically necessary.
403 A	Procedure has been allowed under EPSDT criteria.
403 B	Procedure code was allowed under EPSDT criteria. In addition, procedure code also qualifies for Proposition 56: Tobacco Tax Funds Supplemental Payment of the current SMA. For more details on Proposition 56 and the list of procedures, please refer to the Provider Handbook Section 4 - Treating Members.
403 C	The requested procedure could be considered with EPSDT documentation; however, none was submitted.
404	Procedure is disallowed due to presumptive eligibility card not submitted.
405	Procedure disallowed due to date of service is not within eligibility date(s) on presumptive eligibility card.
437	CRA procedure code must be performed in a DTI domain 2 county.

AR C#	Adjudication Reason Code Description
437 A	CRA procedure code must have the same dates of service and be billed on the same claim.
438 A	CRA procedure code is allowable once every 6 months for low risk patients.
438 B	Procedure D1354 is allowable once every 6 months when CRA includes high risk procedure D0603.
438 C	CRA procedure code is allowable once every 4 months for moderate risk patients.
438 D	CRA procedure code is allowable once every 3 months for high-risk patients.
438 E	Additional services are allowable in conjunction with CRA procedure codes.
439	Data submitted after DTI claims submission due date.
440	Procedure Code D1354 is allowable two visits per year, and lifetime maximum of four times per tooth.
500	Payment for this service reflects the maximum allowable amount as beneficiary services dental cap has been met.
501	Per documentation, service does not qualify as an emergency. Paid amount is applied towards the beneficiary services dental cap. Payment for this service reflects the maximum allowable amount as beneficiary services dental cap may have been met.
502	Per documentation, service qualifies as an emergency. Paid amount has not been applied towards the beneficiary services dental cap.
503 A	Optional Adult Dental procedure is not a benefit
503 B	Optional Adult Dental procedure is not a benefit
505	Procedure code qualifies for Proposition 56: Tobacco Tax Funds Supplemental Payment of the current SMA. For more details on Proposition 56 and the list of procedures, please refer to the Provider Handbook: Section 4 - Treating Members.
505 A	Procedure code qualifies for Proposition 56: Tobacco Tax Funds Supplemental Payment of the current SMA. For more details on Proposition 56 and the list of procedures, please refer to the Provider Handbook: Section 4 – Treating Members. Additional services are allowable in conjunction with CRA procedure codes.
506	Procedure Code qualifies for CalAIM Preventive Services Performance Payment. For more details on CalAIM and the list of procedures, please refer to Provider Handbook: Section 4 – Treating Members.
507	Procedure Code qualifies for CalAIM Continuity of Care Performance Payment. For more details on CalAIM and the list of procedures, please refer to Provider Handbook: Section 4 – Treating Members.

AR C#	Adjudication Reason Code Description
555 A	Authorization of this line no longer valid. Patient is/was being treated elsewhere.
555 B	Authorization of this line is no longer valid: Treatment was performed as an emergency.
555 C	Authorization of this line is no longer valid: A new claim/TAR is being processed.
555 D	The requested procedure has been authorized. However, the procedure has also recently been authorized to a different provider. Contact member to determine treating provider office.
777	A special exception has been made for this procedure based on the documentation submitted.
888	Line allowed but unpaid due to date of service
900	Primary aid code has unmet Share of Cost, and secondary aid code does not cover this procedure code for Medicare Crossover.
901	Primary aid code has unmet Share of Cost, and secondary aid code requires an emergency certification statement that is insufficient/not submitted.
902	Primary aid code has unmet Share of Cost, and secondary aid code does not cover this procedure code.
CLINICAL SCREENING CODES	
603	Per clinical examination, procedure requested is only allowable under special circumstances.
607 A	Per clinical screening, payment for procedure disallowed. Poor quality of treatment.
607 B	Per clinical screening, payment for procedure disallowed. Procedure not completed as billed.
613	Per clinical screening, tooth does not meet the Manual of Criteria for a laboratory processed crown. Please re-evaluate for alternate treatment.
613 A	Per clinical screening, it has been determined that this tooth has been recently restored with a restoration or prefabricated crown.
613 B	Per clinical screening, tooth/eruption pattern is developmentally immature. Please reevaluate for alternate treatment.
614 A	Per clinical screening, please re-evaluate for: Complete upper denture
614 B	Per clinical screening, please re-evaluate for: Complete lower denture
614 C	Per clinical screening, please re-evaluate for: Resin base partial denture
614 D	Per clinical screening, please re-evaluate for: Cast metal framework partial denture
614 E	Per clinical examination, please re-evaluate for: Procedure 706.

AR C#	Adjudication Reason Code Description
614 F	Per clinical examination, please re-evaluate for: Procedure 708.
619	Per clinical screening, caries not clinically verified.
622	Per clinical screening, tooth does not meet the Manual of Criteria for a prefabricated crown.
624	Per clinical screening, radiographs and/or photographs, additional surface(s) require treatment.
628	Per clinical screening, cast and prefabricated posts are benefits in endodontically treated devitalized permanent teeth only when crowns have been authorized and/or paid.
629	Per clinical screening, existing prosthesis was lost/destroyed through carelessness or neglect.
643	Per clinical screening, resubmit a new authorization request following completion of surgical procedure(s) that may affect prognosis of treatment plan as submitted.
644	Per clinical screening, sufficient teeth are present for the balance of the opposing prosthesis.
645	Per clinical screening, TMJ Syndrome is not identified as per the program criteria.
646	Per clinical screening, cast framework partial denture is only a benefit when necessary to balance an opposing full denture.
647	Per clinical screening, bruxism is not associated with diagnosed TMJ dysfunction.
648	Per clinical screening, extraction of a tooth is not payable when pathology is not demonstrated in the radiograph, or when narrative documentation submitted does not coincide with the radiographic evidence.
649	Per clinical screening, procedure 706 is a benefit only when necessary to replace a missing anterior permanent tooth (teeth).
649 A	Per clinical screening, a resin base partial denture is a benefit only when there is a missing anterior tooth and/or there is compromised posterior balanced occlusion.
650	Per clinical screening, surgical extraction procedure has been modified to conform with radiograph appearance.
654	Per clinical screening, routine alveoloplasty procedures in conjunction with extractions are considered part of the extraction procedure.
662	Per clinical screening, existing prosthesis is adequate at this time.
662 A	Per clinical screening, recently constructed prosthesis exhibits deficiencies inherent in all prostheses and cannot be significantly improved by a reline.
663	Per clinical screening, the surgical or traumatic loss of oral-facial anatomic structure is not significant enough to justify a new prosthesis.
664	Per clinical screening, existing prosthetic prosthesis can be made serviceable by laboratory reline.

AR C#	Adjudication Reason Code Description
665	Per clinical screening, existing prosthesis can be made serviceable by reconstruction.
666	Per clinical screening, the procedure has been modified to reflect the allowable benefit and may be provided at your discretion.
666 A	Per clinical screening, the patient's medical condition does not preclude the taking of radiographs.
667	Per clinical screening, functional limitations or health condition of the patient precludes the requested procedure.
667 A	Per clinical screening, patient has expressed a lack of motivation necessary to care for his/her prosthesis.
668	Per clinical screening, the need for procedure is not medically necessary.
668 A	Per clinical screening, patient does not wish extractions or any other dental services at this time.
668 B	Per clinical screening, patient has selected/wishes to select a different provider.
669 A	Per clinical screening, procedure is disallowed due to the following: This procedure is included in the fee for another procedure and is not payable separately.
669 B	Per clinical screening, procedure is disallowed due to the following: This procedure is not allowable in conjunction with another procedure.
669 C	Per clinical screening, procedure is disallowed due to the following: This procedure is associated with another denied procedure.
670	Per clinical screening, a reline, tissue conditioning, repair or an adjustment is not a benefit in conjunction with extractions or without an existing prosthesis.
671 A	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Bone loss, mobility, periodontal pathology.
671 B	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Apical radiolucency.
671 C	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Arch lacks integrity.
671 D	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Evidence or history of recurrent or rampant caries.
671 E	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Tooth/Teeth are in state of poor repair or have poor longevity prognosis.
671 F	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Gross destruction of crown or root.
671 G	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Tooth has no potential for occlusal function and/or is hypererupted.

AR C#	Adjudication Reason Code Description
671 H	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: The replacement of tooth structure lost by attrition or abrasion.
671 I	Per clinical screening and/or radiographs, procedure requested is disallowed due to the following: Deep caries appears to encroach upon pulp. Periapical radiograph is required.
672	Per clinical screening, tooth not present.
672 B	Per clinical screening and/or radiographs, tooth number may be incorrect.
673 A	Per clinical screening, the patient is not currently using the prosthesis provided by the program within the past five years.
674	Per clinical screening, incomplete treatment plan submitted.
674 A	Per clinical screening, opposing dentition lacks integrity. Consider full denture for opposing arch.
674 C	Per clinical screening, incomplete treatment plan submitted. Opposing prosthesis is inadequate.
676	Per clinical screening, insufficient tooth space present for procedure(s) requested.
677	Per clinical screening, prosthesis made in recent years have been unsatisfactory for reasons that are remediable.
680	Per clinical screening, services solely for esthetic purposes are not benefits.
681	Per clinical screening, periodontal procedure cannot be justified on the basis of pocket depths, bone loss and/or degree of deposits.
684	Per clinical screening, additional procedures are necessary before authorization of the requested service(s) can be considered.
684 A	Per clinical screening, additional procedures are necessary before authorization of the requested service(s) can be considered. Restorative treatment incomplete.
684 B	Per clinical screening, additional procedures are necessary before authorization of the requested service(s) can be considered. Crown treatment incomplete.
684 C	Per clinical screening, additional procedures are necessary before authorization of the requested service(s) can be considered. Endodontic treatment incomplete.
684 D	Per clinical screening, additional procedures are necessary before authorization of the requested service(s) can be considered. Additional extraction(s) are necessary.
684 E	Per clinical screening, additional procedures are necessary before authorization of the requested service(s) can be considered. Two or more of the above pertain to your case.
685	Per clinical screening, procedure does not show evidence of a reasonable period of longevity.

AR C#	Adjudication Reason Code Description
685 A	Per clinical screening, procedure does not show evidence of a reasonable period of longevity. Submit alternate treatment plan, if you wish.
687	Per clinical screening, allowance made for alternate procedure.
692	Per clinical screening, documentation or radiographs, procedure already completed.
693	Per clinical screening, procedure requested is inadequate to correct problem.
693 A	Per clinical screening, procedure requested is inadequate to correct problem. Tooth has open, underformed apices. Authorization for root canal will be considered after radiographic evidence of apex closure following apexification.
693 B	Per clinical screening, procedure requested is inadequate to correct problem. Re-evaluate for apicoectomy.
693 C	Per clinical screening, procedure requested is inadequate to correct problem. Root canal should be retreated by conventional endodontics before apical surgery is considered.
694	Authorization disallowed as the patient did not appear for a scheduled clinical screening.
694 A	Authorization disallowed as the patient failed to bring most recent prosthesis to the clinical screening.
695	Authorization disallowed as the patient is no longer at the facility.
696	Per clinical screening, patient exhibits lack of motivation to maintain oral hygiene necessary to justify the requested services.
697	Need for root canal procedure not evident per clinical screening radiographic evidence or documentation submitted.

Claim In Process Reason Codes

The following codes indicate why a claim or TAR is in process in the automated Medical Dental processing system.

Code	Reason
DV	DATA VALIDATION – Document is awaiting review of keyed data against document information.
IR	INFORMATION REQUIRED – Document requires more data from the billing provider. An RTD has been sent to the billing provider.
RV	RECIPIENT VERIFICATION – Document is awaiting validation of recipient information.

- PV PROVIDER VERIFICATION –**
Document is awaiting validation of provider information.
- PR PROFESSIONAL REVIEW –**
Document is scheduled for professional review.
- CS CLINICAL SCREENING –**
Document is scheduled for a clinical screening review.
- SR STATE REVIEW –**
Document is scheduled for review by Department of Health Care Services.

Accounts Payable/Accounts Receivable Codes

These codes identify the reason for a receivable or payable item shown on an EOB.

Payable Codes

Code	Description
1	Replace Lost Check
2	Penalty Payment (Inactivated)
3	Interim Payment
4	S/URS Adjustment
5	Overpayment of Cash Receipt
9	Prior Underpayment

Receivable Codes

Code	Description
1	SUR Adjustment
2	Negative Claim Adjustment
3	Interim Payment Adjustment
4	Penalty Adjustment (Inactivated)
5	Overpayment Adjustment
6	Internal Adjustment
9	S/UR Interest

Readjudication Codes

The following codes represent reasons why a claim is being processed for readjudication.

Claim Correction Codes

Code	Reason
01	Paid wrong provider number

Code	Reason
02	Rendering provider license number missing
20	Corrected tooth number or arch code
21	Retroactive eligibility granted
22	Quantity of service provided or corrected
23	Corrected procedure code/fee
25	Corrected date of service
26	Corrected Medicare crossover amount
27	Share-of-Cost/Other coverage amount provided or corrected
29	Corrected place of service
30	New or additional documentation submitted
39	Denial upheld - See related adjudication/policy code
50	Fair hearing decision
51	Readjudication based on medical appeal
52	Readjudication based on mental appeal
53	Readjudication based on employment appeal
60	Readjudication based upon CDA peer review decision
61	Per post-payment screening, service below standard
62	Per post-payment screening or quality review, service not performed
63	Readjudication based upon professional re-evaluation
64	Readjudication of original underpayment based on ASO Quality Control (QC) Review
65	Readjudication of original overpayment based on Gainwell Technologies Quality Control (QC) review
66	Original payment incorrect due to processing error - Erroneous Payment Correction (EPC) system
70	CRT input error
71	Provider claim preparation error
72	Claim not received within six months from last date of service
73	Overpayment
74	CIF not submitted for reconsideration within 60 days of the EOB date
75	First level appeal not submitted within 90 days of the EOB date
90	Death transaction reversal
95	Original payment of claim adjusted per S/UR
96	Readjudication of orig payment based on Gainwell Technologies review
99	Special message

Resubmission Turnaround Document (RTD) Codes and Messages

The following codes represent missing or incorrect information originally submitted on TAR/Claim forms.

Member RTD Codes

Code	Reason
01	Submit x-rays with EDI label
02	Submit beneficiary's CIN/BIC ID
03	Verify birth date: month/day/year
04	EOMB or proof of denial/ineligibility
05	Verify recipient sex
06	Submit documentation with EDI label
07	Verify beneficiary's CIN/BIC ID
08	CIN belongs to someone else, send copy of BIC card
09	Verify patient name
10	Send photo ID by DMV/credible ID
11	Submit beneficiary facility name/address/phone#.

Provider RTD Codes

Code	Reason
13	Ortho - continuation signature reqd
16	Submit rendering provider number
18	Verify provider name and number
19	Verify billing agent name/number

X-Ray RTD Codes

Code	Reason
30	Submit current x-rays/photos for all restorative tx
31	Submit current x-rays/photos
32	Send x-ray showing apices of tooth
33	Send PAs of all involved areas
34	Send x-rays of remaining teeth
35	Send final root canal x-rays
36	Procedure and description mismatch
37	Procedure tooth/surface mismatch
38	Submit opposing arch treatment plan
39	Submit x-rays of opposing arch
40	Submit BWs and periapical films
41	Submit x-rays/documentation
43	Send PA of present tooth condition

Clerical RTD Codes

Code	Reason
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42	Submit completed HLD Index form
46	Indicate date of service
47	Indicate procedure code
48	Indicate tooth surface
49	Indicate upper/lower arch
50	Submit type of partial, i.e., procedure number
51	Procedure requires tooth code
52	Signature missing or invalid. Sign RTD.
54	Submit date of enrollment in HF
55	Indicate quadrant/area for treatment
56	Need other cov EOB/RA or denial
57	Submit other coverage fee schedule.
58	DOS cannot be after receipt date
59	Submit missing fees
60	POS code missing or invalid
61	Order date after NOA receipt date
62	Tooth number missing or invalid
63	Send copy of surgeon's claim/TAR
64	Submit your usual and customary fee
66	Submit 3-digit procedure code
67	Incomplete DC054 form was submitted
68	List teeth to be replaced & clasped
69	Submit all NOA pages/dates of service

Consultant RTD Codes

Code	Reason
70	Submit completed DC054 form
71	Procedure requires documentation
72	Must document lost/damaged dentures
73	Indicate quadrants for surgery
74	Note repair; send lab bill, if applicable
75	Submit Periodontal Evaluation Form
76	Submit copy of Operative Report
77	DOS needed for completed treatment
78	O.R. report required
79	Submit EOB from primary surgeon

Maxillofacial Program RTD Codes

Code	Reason
81	Submit history/diagnosis/symptom

- 82 Submit narrative report
- 83 Cleft lip/palate or facial anomaly?
- 84 Submit anesthesiologist report
- 85 Submit diagnostic study models
- 86 Submit pre-treatment panorex X-ray
- 87 Submit in-treatment panorex X-ray
- 88 Submit post-treatment panorex
- 89 Submit cephalometric X-ray
- 90 Submit intraoral photograph/slide
- 91 Send post-ortho diagnostic material
- 92 Submit TMJ X-ray
- 93 Submit copy of occlusal analysis
- 94 Send model/photo/film; note need
- 95 Submit documentation
- 96 Use MFO/cleft palate codes in SMA
- 97 Submit invoice for H.A. or appliance
- 98 Submit copy of CCS approval
- 99 Other (unspecified above)

TAR/Claim Policy Codes and Messages

These codes represent reasons that an entire document is being denied. The use of these codes causes all lines of the document to be denied.

Code	Reason
01	Duplicate claims/TARs from same/ different providers cannot be processed.
02	Payment disallowed – exceeds six-month billing limit.
03	NOA cannot be paid; TAR has expired.
04	Cannot process total claim; eligibility not established.
05	Payment disallowed – exceeds 12-month billing limit.
06	Cannot adjust claim received 13 mos or more after adjudication date.
07	Primary carrier paid more than this program allows.
08	POE label is invalid for dental program; contact county office.
09	Pt in Managed Care Program (MCP/PHP/GMC/HMO/DMC) which includes dental benefits.
10	TAR/Claim cannot be processed; no services were entered.
11	TAR/Clm/NOA cannot be processed without valid provider signature.

Code	Reason
12	Unknown procedure codes, document unprocessable.
13	Recipient benefits do not include dental services.
15	Authorized services cannot be transferred between providers; claim denied.
16	Beneficiary not eligible for Medi-Cal; may have benefits through Healthy Families.
17	Procedure service data not submitted; please resubmit.
18	Recipient data not submitted; cannot process TAR/Claim.
19	Authd serv cannot be transferred between recipients; claim denied.
20	Second reeval or reevaluation of expired TAR not granted. Submit new TAR.
21	RTD was unsigned and cannot be used to correct claim errors.
22	Billing provider ID not on file; must be enrolled.
23	Out-of-state providers need prior authorization for non-emerg serv.
24	Out-of-country serv cov only for emerg hospit auth by field office.
25	Recipient eligibility not established for the dates of service.
26	Patient information on TAR/claim does not match State eligibility file.
27	Provider requested document be deleted.
28	Prov name does not match Delta file; no payment/authorization.
29	Recipient not on State eligibility file; payment denied.
30	Billing provider and recipient not on file, TAR/claim denied.
31	Recipient data insufficient to process claim or TAR after RTD.
32	Billing provider not enrolled for dates of svc, TAR/claim denied.
33	Mixture of 3-, 4- & 5-digit procedure codes not allowed.
34	X-rays appear to be of another person – payment disallowed.
35	Payment of inpatient services contingent on submission of an O.R. rpt.
36	Auth disallowed, patient did not appear for a clinical screening.
37	Claims/TARs must be submitted in the English language.
38	Payment disallowed. Procedure(s) are non-benefit for RDHAP/RDHEF/RDH
39	CMSP Code not eligible under Denti-Cal prior 01/01/90. Send to County.
40	Procedures not a benefit for recipient aid code.
41	Pregnancy or emergency documentation is insufficient/not submitted for aid code.
42	Prior authorization not allowed for emergency services or pregnancy aid code.
43	Payment for claim disallowed per S/UR.
44	No EOB/RA, fee schedule, usual & customary fee, or proof of denial submitted.
45	CTP benefits terminate at age 19.
46	Provider not enrolled as certified Orthodontist.
47	Certified Orthodontist not associated to this service office.
48	Procedures allowable under special circumstances only

Code	Reason
49	Payment cannot be made; our records indicate the patient is deceased.
50	Denied due to invalid response to RTD.
51	Document denied due to expired PM 160.
52	Share of cost unmet; not eligible.
53	Patient cancelled scheduled clinical evaluation. Please contact patient.
54	Service(s) granted by Fair Hearing process; please contact patient.
55	Pynt cannot be approved when new Issue Date/BIC ID are not provided or valid.
56	TARs not allowed for univ project; send new TAR with G prov billing number.
57	Authorization disallowed as the patient is no longer at the facility.
58	Emergency services documentation is insufficient. Bene cap applied.
59	Bene cap not applied. Documentation of services qualifies as an emergency.
60	Bill prov has discontinued practicing at this office location for these DOS.
61	Use of beneficiary's SSN is no longer acceptable.
69	Payment calculation based on date of service.
70	For CMSP dental services after 09/30/05 contact Doral Dental (1-800-341-8478).
71	Payment denied. Time limitation for submitting CMSP claims has expired.
72	Unable to screen due to pandemic, disturbance, or disaster.

Claim Inquiry Response (CIR) Status Codes and Messages/Claim Inquiry Form (CIF) Action Codes and Messages

The CIR form is a computer-generated response to a provider's CIF. In addition to provider and patient information, the response will appear as a status code and explanation to the CIF, as follows:

- 1A** Provider indicated wrong DCN on CIF
- 1B** Previous history needs to be updated
- 1C** Provider indicated multiple DCNs on one CIF
- 1D** Check problems needed CIF to correct
- 1E** ASO Input Prep error
- 1F** Other miscellaneous errors
- 5A** Forwarded to on-site queue
- 5B** Secondary review
- 5C** Waiting for State directive
- 5D** Incomplete application – letter sent
- 5E** Request for additional information – 35-day letter sent
- 5F** Denied applications
- 5G** Returned call

- 6A** Use of beneficiary's SSN is no longer acceptable
- 01** Claim never received; please submit new claim
- 02** Claim in process, awaiting final adjudication
- 03** RTD has been sent, please respond on original RTD
- 04** Claim under professional review
- 05** Claim processed EOB_____ DT_____ \$_____
- 08** Insufficient documentation, procedure disallowed
- 09** Requires prior authorization
- 11** Claim not recvd within 6 mos. from last mo. of service
- 12** Claim has been readjudicated for payment
- 13** Submit original NOA for re-evaluation
- 14** TAR never received; please submit new TAR
- 15** TAR in process; awaiting adjudication
- 18** Notice of Authorization (NOA) has been processed
- 19** NOA expired submit new TAR
- 20** Procedure not a benefit of program
- 21** Procedure previously paid to same or other office
- 22** Procedure is adjunctive to another procedure
- 23** NOA has been readjudicated
- 24** Procedures not performed within 120-day time limitation
- 26** Lack of beneficiary eligibility, claim disallowed
- 27** Other coverage payment exceeds SMA
- 28** Denial upheld
- 29** Denial – recipient benefits do not include dental
- 30** Procedures not allowed based on professional review
- 31** Incomplete treatment plan submitted; denial upheld
- 32** Exceeded 6-month time limitation; denial upheld
- 33** Per documentation, claim in process
- 34** Per our records, X-rays returned at time of processing
- 35** Signature missing, adjustment/ correction cannot be made
- 36** Open – no description
- 37** Acknowledged electronic funds transfer complaint
- 38** Please complete Claim Inquiry Form for each claim
- 86** Payment adjusted per Surveillance and Utilization Review (S/UR).
- 93** Original claim overpayment adjusted due to Quality Control (QC) review.
- 94** Original claim underpayment adjusted due to Quality Control (QC) review.
- 95** Original payment incorrect - adjusted by Erroneous Payment Correction (EPC) system.

Prepaid Health Plans (PHP) and Codes

Medi-Cal Dental members who are enrolled in prepaid health plans may be eligible for either comprehensive or non-comprehensive benefits. A member enrolled in a comprehensive prepaid health plan is entitled to both medical and dental benefits as defined by the plan. Services must be performed by a provider enrolled in the prepaid health plan. Emergency services only may be billed to the prepaid health plan. With a non-comprehensive plan, the member has medical benefits only and is eligible for dental benefits through Medi-Cal Dental.

Following is a list of current prepaid health plan codes:

Code	Plan Name
403	Care 1st Health Plan
405	Health Net of California, Inc.
406	Safe Guard Health Plan (Los Angeles)
409	Access Dental Plan (Los Angeles)
410	American Health Group (Los Angeles)
413	Western Dental Services (Los Angeles)
414	Western Dental (Riverside)
415	Western Dental (San Bernardino)
416	Liberty Dental Plan of Calif, Inc. (Los Angeles)
417	Community Dental Services, Inc. (Los Angeles)
421	Access Dental (Sacramento)
424	Western Dental (Sacramento)
425	Liberty Dental Plan of California, Inc. (Sacramento)
426	Community Dental Services (Sacramento)

Section 8 - Fraud, Abuse, and Quality of Care

Compliance Management and Surveillance and Utilization Review Subsystem (CM/SURS)	8-1
Introduction	8-1
Methods of Evaluation	8-1
Possible CM/SURS Actions	8-2
Help Stop Fraud	8-3
Statutes and Regulations	8-4
Pertaining to Providers	8-4
Confidentiality	8-4
Record Keeping Criteria	8-4
Identification in Patient Record	8-6
Cause for Recovery	8-6
Special Permits	8-7
Utilization of Nurse Anesthetist	8-7
Deep Sedation/General Anesthesia (D9222 and D9223)	8-8
Intravenous Moderate (Conscious) Sedation/Analgesia (Conscious Sedation) (D9239 and D9243)	8-9
Non-intravenous Conscious Sedation (Oral Conscious Sedation) (D9248)	8-10
Oral Conscious Sedation for Adult Use	8-11
Billing Medi-Cal Dental	8-12
Billing for Benefits Provided	8-12
Sub-Standard Services	8-12
Excessive Services	8-13
Prohibition of Rebate, Refund, or Discount	8-13
Billing for Suspended Provider	8-13
Submission of False Information	8-13
Overpayment Recovery	8-14
Civil Money Penalties	8-15
Utilization Controls	8-17
Prior Authorization	8-17
Special Claims Review	8-18
Administrative Hearings	8-18
Provider Audit Hearing	8-18
Request for Hearing	8-18
Member Fraud	8-20

Sharing of Medi-Cal Cards..... 8-20

Provider Assistance for Medi-Cal Fraud 8-20

Section 8 - Fraud, Abuse, and Quality of Care

Compliance Management and Surveillance and Utilization Review Subsystem (CM/SURS)

Introduction

Medi-Cal Dental's Compliance Management and Surveillance and Utilization Review (CM/SUR) department monitors for suspected fraud, abuse, and poor quality of care as part of its duties as the Fiscal Intermediary for the Department and California Medi-Cal Dental. In overseeing appropriate utilization in the program, the CM/SUR department helps Medi-Cal Dental meet its ongoing commitment to improving the quality of dental care for Medi-Cal members.

The goal of the CM/SUR department is to ensure providers and members are in compliance with the criteria and regulations of Medi-Cal Dental.

Under the authority of the Federal Medicaid statutes, California Welfare and Institutions Code (W&I), the Business & Professions Code, Dental Practice Act (click [here](#) for details), and the California Code of Regulations (CCR) Title 22, and with the assistance of the California Dental Association's Guidelines for the Assessment of Clinical Quality of Professional Performance, the CM/SUR department reviews treatment forms, written documentation, and radiographs for recurring problems, abnormal billing activity and unusual utilization patterns. The CM/SUR department staff determines potential billing discrepancies, patterns of over-utilization of procedures, incomplete, substandard, and/or unnecessary treatment.

Methods of Evaluation

The CM/SUR department employs several different means to evaluate suspected fraud and abuse of Medi-Cal Dental, including:

- **Utilization Review Analysis:** This statistical analysis compares a provider activity with that of his or her peers within a certain range, such as geographic area or dental specialty.
- **Referrals:** The Department of Health Care Services (DHCS), Medi-Cal Dental Services Division (MDSD), works in collaboration with the Department of Justice, the Bureau of Medi-Cal Fraud & Elder Abuse, and the Dental Board of California on cases of suspected fraud, abuse, and poor quality of care. These agencies often refer provider names for investigation to the CM/SUR department. The CM/SUR department also receives referrals from internal sources such as Professional Review Medi-Cal Dental consultants.
- **Clinical Screening Examinations:** Patients are selected by the CM/SUR department for examination by a Medi-Cal Dental clinical screening consultant to determine if certain procedures for which authorization is requested are medically

necessary, verify if billed procedures were in fact provided, and evaluate the professional quality of the treatment that was provided.

- **Member Fraud Unit:** A part of the CM/SUR department, the Member Fraud unit, monitors conflicts in patient dental histories to determine if Medi-Cal identification cards are being misused or services are being billed improperly.
- **SURS Audits:** When poor quality of care, abuse, over utilization, or fraud is suspected, the CM/SUR department may elect to conduct an audit of patient records, including radiographs, obtained from the provider's office to gather additional information about the provider's activity.

Possible CM/SURS Actions

The CM/SUR department will take appropriate action at the direction of the Department of Health Care Services, Medi-Cal Dental Services Division (MDSD), to address situations where poor quality of care, inappropriate billings, and/or inappropriate utilization of services are identified. Such actions may include one or more of the following:

- **Summary of Findings Letter:** When minor non-conformities to Medi-Cal Dental criteria are detected, the CM/SUR department will send a letter informing and educating the provider of Medi-Cal Dental criteria, including program limitations, exclusions, and special documentation requirements. The letter will also direct the provider to modify his or her performance in accordance with the criteria and standards of Medi-Cal Dental.
- **Corrective Action Letter:** When poor quality of care is identified, Medi-Cal Dental will send a letter to the provider requesting that he or she take immediate action to correct the problem within 60 days. The letter will inform the provider that if the correction is not made within 60 days, Medi-Cal Dental will take action to recover payment for the procedures in question.
- **Prior Authorization/Special Claims Review:** The Department may require providers to obtain prior authorization for certain Medi-Cal Dental procedures to protect members from unnecessary treatment. The prior authorization procedure is described in "Section 2: Program Overview" of this Handbook. The Medi-Cal Dental may place a provider on Prior Authorization (PA) review for non-emergency procedures at any time by the Director upon a determination that the provider has been rendering medically unnecessary services based upon the Program's Manual of Criteria (MOC). If prior authorization review is initiated, there are no appeal rights.

If the CM/SUR department determines that a provider is billing Medi-Cal Dental by submitting improper claims, including claims that incorrectly identify or code services provided, or are for procedures that are of poor quality, or were not provided, the provider may be placed on Special Claims Review. The provider

will then be required to submit pre-operative and/or post-operative radiographs and other documentation to demonstrate the quality of treatment provided and to verify that the procedure provided corresponds to the procedure billed. Utilization control requirements are in addition to the requirements outlined in "Section 2: Program Overview" of this Handbook and may be imposed under the authority of Title 22, California Code of Regulations (CCR), Sections 51159, 51455, and 51460. If Special Claims Review is initiated, there are no appeal rights.

- **Recovery of Payment:** Recovery for paid procedures may be obtained by withholding the amount to be reimbursed from a provider's future Medi-Cal Dental payments. Recovery may occur when a post-operative clinical screening exam or post payment review identifies any discrepancies in the billing or delivery of those services and/or for failure to complete a noticed corrective action.
- **Removal From Referral List:** If a provider's performance is deemed below the standard of professional care for a particular course of treatment, the provider may be subject to removal from the Medi-Cal Dental provider referral list.
- **Other Agency Referral:** When CM/SURS investigations disclose a situation that may require criminal prosecution or action beyond the jurisdiction of Medi-Cal Dental, the matter will be referred to the Department of Health Care Services, MDSO, for possible referral to the Department of Justice, Bureau of Medi-Cal Fraud & Elder Abuse, and/or the Dental Board of California. Referrals to these agencies may result in further investigation, prosecution, and suspension of the provider's license to practice.
- **Suspension from Medi-Cal Dental:** Non-compliance with corrective action and/or continued and persistent substandard care, fraud, and/or abuse as well as violation of any Medi-Cal statute, rule, or regulation relating to the provision of health care services under the California Medical Assistance Program can lead to suspension of a provider's participation in Medi-Cal Dental.

Help Stop Fraud

Providers can help stop fraud and abuse in Medi-Cal Dental. If providers or members of the provider's staff are aware of any suspicious or fraudulent activity, send information to:

Medi-Cal Dental
Compliance Management and Surveillance & Utilization Review
Department
PO Box 13898
Sacramento, CA 95853-4898

Please include the name of the person reporting the incident, the phone number, the provider's name, the location of his/her office, and an explanation of the incident.

Anonymity will be maintained upon request. Because of the confidential nature of

investigations, individuals will not be notified of the outcome of any case. All referrals are appreciated and will contribute significantly to the ongoing efforts of detecting, halting, and preventing fraud and abuse in Medi-Cal Dental.

Statutes and Regulations

Pertaining to Providers

This section details certain State statutes and regulations that are binding on Medi-Cal Dental providers, their designated agents, all public and private agencies, and/or individuals who are engaged in planning, providing, or securing Medi-Cal Dental services for or on the behalf of recipients or applicants.

Confidentiality

The W&I Code, Section 10850 provides that names, addresses, and all other information concerning circumstances of any applicant or recipient of Medi-Cal Dental services for whom, or about whom, information is obtained shall be considered confidential and shall be safeguarded. Both the release and possession of confidential information in violation of this statute are misdemeanors.

Record Keeping Criteria

Through its audit process, the CM/SUR department has found many areas to be deficient in the documentation of treatment for Medi-Cal Dental members. Lack of proper documentation may result in an unfavorable audit and potential recovery of payments. It is also important to note that all documentation on Treatment Authorization Requests (TARs) and claims must be consistent with and supported by documentation in the record of treatment.

Providers should carefully review the full text of regulations regarding the keeping and availability of records.

Title 22, California Code of Regulations (CCR), Section 51476. (a) states:

Each provider shall keep, maintain, and have readily retrievable, such records as are necessary to fully disclose the type and extent of services provided to a Medi-Cal member. Required records shall be made at or near the time at which the service is rendered. Such records shall include, but not be limited to the following:

- (1.) Billings.
- (2.) Treatment authorization requests.
- (3.) All medical records, service reports, and orders prescribing treatment plans.
- (4.) Records of medications, drugs, assistive devices, or appliances prescribed, ordered for, or furnished to members.

- (5.) Copies of original purchase invoices for medication, appliances, assistive devices, written requests for laboratory testing, and all reports of test results, and drugs ordered for or supplied to members.
- (6.) Copies of all remittance advices which accompany reimbursement to providers for services or supplies provided to members.
- (7.) Identification of the person rendering services. Records of each service rendered by nonphysician medical practitioners (as defined in California Code of Regulations (CCR), Title 22, Section 51170) shall include the signature of the nonphysician medical practitioner and the countersignature of the supervising physician.

Title 22, California Code of Regulations (CCR), Section 51476. (d) states:

Every practitioner who issues prescriptions for Medi-Cal members shall maintain, as part of the patient's chart, records which contain the following for each prescription:

- (1.) Name of the patient.
- (2.) Date prescribed.
- (3.) Name, strength, and quantity of the item prescribed.
- (4.) Directions for use.

Title 22, California Code of Regulations (CCR), Section 51476. (g) states:

A provider shall make available, during regular business hours, all pertinent financial books and all records concerning the provision of health care services to a Medi-Cal member, and all records required to be made and retained by this section, to any duly authorized representative of the Department acting in the scope and course of employment including, but not limited to, employees of the Attorney General, Medi-Cal Fraud Unit duly authorized and acting within the scope and course of their employment. Failure to produce records may result in sanctions, audit adjustments, or recovery of overpayments, in accordance with California Code of Regulations (CCR), Title 22, Section 51458.1.

Welfare & Institutions Code, Section 14124.1. states:

Each provider, as defined in Section 14043.1, of health care services rendered under the Medi-Cal program or any other health care program administered by the department or its agents or contractors, shall keep and maintain records of each such service rendered, the member or person to whom rendered, the date the service was rendered, and such additional information as the department may by regulation require. Records herein required to be kept and maintained shall be retained by the provider for a period of ten years from the date the service was rendered.

NOTE: Examples of appropriate documentation to be placed in the services rendered portion of the patient chart include, but are not limited to:

- Type and dosage of local anesthetic;
- Type and dosage of vasoconstrictor;

- Number of carpules used;
- When local anesthetic is not used for procedures which normally call for local anesthetic, but is not used;
- Original radiographs and photographs must be included;
- Specific treatment and materials placed for restorative services;
- Specific service provided for topical fluoride application;
- Written documentation explaining emergency services;
- The extent and complexity of a surgical extraction; and
- Specific documentation for medical necessity, observations and clinical findings, the specific treatment rendered, and medications or drugs used during periodontal procedures.

Identification in Patient Record

Medi-Cal Dental will not pay for services unless the rendering provider is actively enrolled in Medi-Cal Dental at the time of treatment. Treatment of Medi-Cal Dental patients by un-enrolled providers is not covered and will be subject to recovery of payments made.

Business and Professions Code, Section 1683. states:

- (a.) Every dentist, dental health professional, or other licensed health professional who performs a service on a patient in a dental office shall identify himself or herself in the patient record by signing his or her name, or an identification number and initials, next to the service performed and shall date those treatment entries in the record. Any person licensed under this chapter who owns, operates, or manages a dental office shall ensure compliance with this requirement.
- (b.) Repeated violations of this section constitute unprofessional conduct.

NOTE: Billing providers MUST ensure that all their rendering providers are enrolled in Medi-Cal Dental prior to treating Medi-Cal patients. Payments made to billing providers for services performed by unenrolled rendering providers are not covered and will be subject to recovery.

Cause for Recovery

Amounts paid for services provided to Medi-Cal members shall be audited by the department in the manner and form prescribed by the department. The department shall maintain adequate controls to ensure responsibility and accountability for the expenditure of federal and state funds. Overpayments may be recovered when the department discovers information that indicates the provider may have engaged in practices that have resulted in over reimbursement.

Welfare and Institutions Code Title 22, Section 51458.1. states:

- (a.) The Department shall recover overpayments to providers including, but not limited to, payments determined to be:
- (1.) In excess of program payment ceilings or allowable costs.
 - (2.) In excess of the amounts usually charged by a provider.
 - (3.) For services not documented in the provider's records, or for services where the provider's documentation justifies only a lower level of payment.
 - (4.) Based upon false or incorrect claims or cost reports from providers.
 - (5.) For services deemed to have been excessive, medically unnecessary, or inappropriate.
 - (6.) For services prescribed, ordered, or rendered by persons who did not meet the standards for participation in the Medi-Cal program at the time the services were prescribed, ordered, or rendered.
 - (7.) For services not covered by the program.
 - (8.) For services to persons not eligible for program coverage when the services were provided.
 - (9.) For Medi-Cal covered services already paid for by the member, but not yet refunded, or for services already reimbursed by the Department or other coverage.
 - (10.) For services that should have been billed to other coverage.
 - (11.) For services not ordered or prescribed, when an order or prescription is required.
 - (12.) For services not authorized, when a treatment authorization request is required.
 - (13.) In violation of any other Medi-Cal regulation where overpayment has occurred.
 - (14.) The provisions of Sections 51488. and 51488.1. shall prevail in circumstances that conflict with this section.

Special Permits

Providers who administer general anesthesia and/or intravenous conscious sedation/analgesia shall have valid anesthesia permits with the California Dental Board. Provision of these services is not a benefit of the program when provided by persons not holding the appropriate permit and payment is subject to recovery.

Utilization of Nurse Anesthetist

Providers who utilize the services of Nurse Anesthetists in a dental office must also hold the appropriate permit.

Business and Professions Code, Section 2827. states:

The utilization of a nurse anesthetist to provide anesthesia services in an acute care

facility shall be approved by the acute care facility administration and the appropriate committee, and at the discretion of the physician or dentist.

If a general anesthetic agent is administered in a dental office, the dentist shall hold a permit authorized by Section 1646.

Deep Sedation/General Anesthesia (D9222 and D9223)

Deep Sedation/General anesthesia is defined as a controlled state of unconsciousness, accompanied by a partial or complete loss of protective reflexes, including the loss of the ability to independently maintain an airway and respond purposefully to physical stimulation or verbal command, produced by a pharmacologic or non-pharmacologic method or combination thereof.

Business and Professions Code, Section 1646.1. states:

- (a.) No dentist shall administer or order the administration of general anesthesia on an outpatient basis for dental patients unless the dentist either possesses a current license in good standing to practice dentistry in this state and holds a valid general anesthesia permit issued by the board or possesses a current permit under Section 1638 or 1640 and holds a valid general anesthesia permit issued by the board.
- (b.) No dentist shall order the administration of general anesthesia unless the dentist is physically within the dental office at the time of the administration.
- (c.) A general anesthesia permit shall expire on the date provided in Section 1715 which next occurs after its issuance, unless it is renewed as provided in this article.
- (d.) This article does not apply to the administration of local anesthesia or to conscious-patient sedation.

Business and Professions Code, Section 1646.7. states:

- (a.) A violation of this article constitutes unprofessional conduct and is grounds for the revocation or suspension of the dentist's permit, license, or both, or the dentist may be reprimanded or placed on probation.
- (b.) A violation of any provision of this article or Section 1682 is grounds for suspension or revocation of the physician's and surgeon's permit issued pursuant to this article by the Dental Board of California. The exclusive enforcement authority against a physician and surgeon by the Dental Board of California shall be to suspend or revoke the permit issued pursuant to this article. The Dental Board of California shall refer a violation of this article by a physician and surgeon to the Medical Board of California for its consideration as unprofessional conduct and further action, if deemed necessary by the Medical Board of California, pursuant to Chapter 5 (commencing with Section 2000). A suspension or revocation of a physician and surgeon's permit by the Dental Board of California pursuant to this article shall not constitute a disciplinary

proceeding or action for any purpose except to permit the initiation of an investigation or disciplinary action by the Medical Board of California as authorized by Section 2220.5.

- (c.) The proceedings under this section shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the Dental Board of California shall have all the powers granted therein.

Intravenous Moderate (Conscious) Sedation/Analgesia (Conscious Sedation) (D9239 and D9243)

Intravenous conscious sedation/analgesia (Conscious Sedation) is a medically controlled state of depressed consciousness that retains the patient's ability to maintain independently and continuously an airway, protective reflexes, and the ability to respond appropriately to stimulation or verbal commands. It includes intravenous (IV) administration of sedative and/or analgesic agent(s) and appropriate monitoring.

"Intravenous Conscious Sedation/Analgesia" (Conscious Sedation) does not include the administration of oral medications or the administration of a mixture of nitrous oxide and oxygen, whether administered alone or in combination with each other.

Business and Professions Code, Section 1647.2. states:

- (a.) No dentist shall administer or order the administration of conscious sedation on an outpatient basis for dental patients unless one of the following conditions is met:
- (1.) The dentist possesses a current license in good standing to practice dentistry in California and either holds a valid general anesthesia permit or obtains a permit issued by the board authorizing the dentist to administer conscious sedation.
 - (2.) The dentist possesses a current permit under Section 1638 or 1640 and either holds a valid anesthesia permit or obtains a permit issued by the board authorizing the dentist to administer conscious sedation.
- (b.) A conscious sedation permit shall expire on the date specified in Section 1715 which next occurs after its issuance, unless it is renewed as provided in this article.
- (c.) This article shall not apply to the administration of local anesthesia or to general anesthesia.
- (d.) A dentist who orders the administration of conscious sedation shall be physically present in the treatment facility while the patient is sedated.

Business and Professions Code, Section 1647.9. states:

A violation of any provision of this article constitutes unprofessional conduct and is grounds for the revocation or suspension of the dentist's permit, license, or both, or the dentist may be reprimanded or placed on probation. The proceedings under this section

shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the board shall have all the powers granted therein.

Non-intravenous Conscious Sedation (Oral Conscious Sedation) (D9248)

Non-intravenous conscious sedation (Oral Conscious Sedation) is a medically controlled state of depressed consciousness that retains the patient's ability to maintain independently and continuously an airway, protective reflexes, and the ability to respond appropriately to stimulation or verbal commands. It includes administration of sedative and/or analgesic agent(s) orally, by patch, and by intramuscular or subcutaneous injection with appropriate monitoring.

The drugs and techniques used in oral conscious sedation shall have a margin of safety wide enough to render unintended loss of consciousness unlikely. Further, patients whose only response is reflex withdrawal from painful stimuli would not be considered to be in a state of oral conscious sedation.

For very young or handicapped individuals, incapable of the usually expected verbal response, a minimally depressed level of consciousness should be maintained.

"Minor patient" means a dental patient under the age of 13 years.

"Certification" means the issuance of a certificate to a dentist licensed by the board who provides the board with his or her name, and the location where the administration of oral conscious sedation will occur, and fulfills the requirements specified in Sections 1647.12. and 1647.13.

Business and Professions Code, Section 1647.11. states:

- (a.) Notwithstanding subdivision (a) of Section 1647.2, a dentist may not administer oral conscious sedation on an outpatient basis to a minor patient unless one of the following conditions is met:
 - (1.) The dentist possesses a current license in good standing to practice dentistry in California and either holds a valid general anesthesia permit, conscious sedation permit, or has been certified by the board, pursuant to Section 1647.12, to administer oral sedation to minor patients.
 - (2.) The dentist possesses a current permit issued under Section 1638 or 1640 and either holds a valid general anesthesia permit, or conscious sedation permit, or possesses a certificate as a provider of oral conscious sedation to minor patients in compliance with, and pursuant to, this article.
- (b.) Certification as a provider of oral conscious sedation to minor patients expires at the same time the license or permit of the dentist expires unless renewed at the same time the dentist's license or permit is renewed after its issuance, unless certification is renewed as provided in this article.

- (c.) This article shall not apply to the administration of local anesthesia or a mixture of nitrous oxide and oxygen or to the administration, dispensing, or prescription of postoperative medications.

Business and Professions Code, Section 1647.14. states:

- (a.) A physical evaluation and medical history shall be taken before the administration of, oral conscious sedation to a minor. Any dentist who administers, or orders the administration of, oral conscious sedation to a minor shall maintain records of the physical evaluation, medical history, and oral conscious sedation procedures used as required by the board regulations.
- (b.) A dentist who administers, or who orders the administration of, oral conscious sedation for a minor patient shall be physically present in the treatment facility while the patient is sedated and shall be present until discharge of the patient from the facility.
- (c.) The drugs and techniques used in oral conscious sedation to minors shall have a margin of safety wide enough to render unintended loss of consciousness unlikely.

Business and Professions Code, Section 1647.17. states:

A violation of any provision of this article constitutes unprofessional conduct and is grounds for the revocation or suspension of the dentist's permit, certificate, license, or all three, or the dentist may be reprimanded or placed on probation. The proceedings under this section shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part I of Division 3 of Title 2 of the Government Code, and the board shall have all the powers granted therein.

Oral Conscious Sedation for Adult Use

As used in this article, the following terms have the following meanings:

- (a.) Adult patient" means a dental patient 13 years of age or older.
- (b.) Certification" means the issuance of a certificate to a dentist licensed by the board who provides the board with his or her name and the location at which the administration of oral conscious sedation will occur, and fulfills the requirements specified in Sections 1647.12. and 1647.13.
- (c.) Oral conscious sedation" means a minimally depressed level of consciousness produced by oral medication that retains the patient's ability to maintain independently and continuously an airway and respond appropriately to physical stimulation or verbal command. "Oral conscious sedation" does not include dosages less than or equal to the single maximum recommended dose that can be prescribed for home use.
 - (1.) The drugs and techniques used in oral conscious sedation shall have a margin of safety wide enough to render unintended loss of consciousness unlikely. Further, patients whose only response is reflex withdrawal from

painful stimuli would not be considered to be in a state of oral conscious sedation.

- (2.) For the handicapped individual, incapable of the usually expected verbal response, a minimally depressed level of consciousness for that individual should be maintained.

Business and Professions Code, Section 1647.19. states:

- (a.) Notwithstanding subdivision (a) of Section 1647.2, a dentist may not administer oral conscious sedation on an outpatient basis to an adult patient unless the dentist possesses a current license in good standing to practice dentistry in California, and one of the following conditions is met:
 - (1.) The dentist holds a valid general anesthesia permit, holds a conscious sedation permit, has been certified by the board, pursuant to Section 1647.20, to administer oral sedation to adult patients, or has been certified by the board, pursuant to Section 1647.12, to administer oral conscious sedation to minor patients.
 - (2.) The dentist possesses a current permit issued under Section 1638 or 1640 and either holds a valid general anesthesia permit, or conscious sedation permit, or possesses a certificate as a provider of oral conscious sedation to adult patients in compliance with, and pursuant to, this article.
- (b.) Certification as a provider of oral conscious sedation to adult patients expires at the same time the license or permit of the dentist expires unless renewed at the same time the dentist's license or permit is renewed after its issuance, unless certification is renewed as provided in this article.
- (c.) This article shall not apply to the administration of local anesthesia or a mixture of nitrous oxide and oxygen, or to the administration, dispensing, or prescription of postoperative medications.

Billing Medi-Cal Dental

Billing for Benefits Provided

Title 22, California Code of Regulations (CCR), Section 51470. (a) states:

A provider shall not bill or submit a claim to the Department or a fiscal intermediary for Medi-Cal benefits not provided to a Medi-Cal member.

Title 22, California Code of Regulations (CCR), Section 51470. (d) states:

A provider shall not bill or submit a claim to the Department or a fiscal intermediary for Medi-Cal covered benefits provided to a Medi-Cal member:

- (1.) For which the provider has received and retained payment.
- (2.) Which do not meet the requirements of Department regulations.

Sub-Standard Services

Title 22, California Code of Regulations (CCR), Section 51472. states:

No provider shall render to a Medi-Cal member health care services which are below or less than the standard of acceptable quality.

Excessive Services

Title 22, California Code of Regulations (CCR), Section 51473. states:

No provider shall render to any Medi-Cal member, or submit a claim for reimbursement for, any health care service or services clearly in excess of accepted standards of practice.

Business and Professions Code, Section 1685. states:

In addition to other acts constituting unprofessional conduct under this chapter, it is unprofessional conduct for a person licensed under this chapter to require, either directly or through an office policy, or knowingly permit the delivery of dental care that discourages necessary treatment or permits clearly excessive treatment, incompetent treatment, grossly negligent treatment, repeated negligent acts, or unnecessary treatment, as determined by the standard of practice in the community.

Prohibition of Rebate, Refund, or Discount

Title 22, California Code of Regulations (CCR), Section 51478. states:

No provider shall offer, give, furnish, or deliver any rebate, refund, commission preference, patronage dividend, discount, or any other gratuitous consideration, in connection with the rendering of health care service to any Medi-Cal member. No provider shall solicit, request, accept, or receive, any rebate, refund, commission, preference, patronage dividend, discount, or any other gratuitous consideration, in connection with the rendering of health care service to any Medi-Cal member.

Billing for Suspended Provider

Title 22, California Code of Regulations (CCR), Section 51484. states:

No provider shall bill or submit a claim for or on behalf of any provider who has been suspended from participation in the California Medical Assistance Program, for any services rendered in whole or in part by any such suspended provider during the term of such suspension.

Submission of False Information

Title 22, California Code of Regulations (CCR), Section 51485. states:

No provider shall submit or cause to be submitted any false or misleading statement of material fact when complying with departmental regulations, or in connection with any claim for reimbursement, or any request for authorization of services.

Overpayment Recovery

Medi-Cal Dental collects overpayments identified through an audit or examination, or any portion thereof from any provider. A provider may appeal the collection of overpayments under this section pursuant to procedures established in Article 5.3 (commencing with Section 14170). Overpayments collected under this section shall not be returned to the provider during the pendency of any appeal and may be offset to satisfy audit or appeal findings if the findings are against the provider. Overpayments will be returned to a provider with interest if findings are in favor of the provider.

Title 22, California Code of Regulations (CCR), Section 51470. states:

- (a.) When it is established upon audit that an overpayment has been made to a provider, the Department shall begin liquidation of any overpayment to a provider 60 days after issuance of the first Statement of Accountability or demand for repayment. The demand for repayment or Statement of Accountability shall be issued no later than 60 days after the issuance of the audit or examination report establishing such overpayment. The overpayment shall be recovered by any of the following methods:
 - (1.) Lump sum payment by the provider.
 - (2.) Offset against current payments due to the provider.
 - (3.) A repayment agreement executed between the provider and the Department.
 - (4.) Any other method of recovery available to and deemed appropriate by the Director.
- (b.) An offset against current payments shall continue until one of the following occurs:
 - (1.) The overpayment is recovered.
 - (2.) The Department enters into an agreement with the provider for repayment of overpayment.
 - (3.) The Department determines, as a result of proceedings under this article, that there is no overpayment.
- (c.) The provider shall pay interest at the rate of seven percent per annum on any unrecovered overpayment in all cases where the statement of account status was issued before June 28, 1981. In all other cases, the provider shall pay interest as provided by Welfare and Institutions Code Section 14171(f).
- (d.) Nothing in this section shall prohibit a provider from repaying all or a part of the disputed overpayment without prejudice to his right to a hearing under this article.
- (e.) Any recovered overpayment that is subsequently determined to have been erroneously collected shall be promptly refunded to the provider, together with

interest computed at the legal rate of seven percent per annum from the date of such liquidation or 60 days after issuance of the audit or examination findings, whichever is later. The provisions of this paragraph shall apply only to those overpayments determined by audit reports issued after April 6, 1976 and before June 28, 1981. In all other cases, interest shall be paid in accordance with the provisions of Sections 14171(e) and 14172.5, Welfare and Institutions Code.

(f.) (As used in this section, "Statement of Account Status" also includes statement of accountability or demand for repayment.

Civil Money Penalties

Title 22, California Code of Regulations (CCR), Section 51485.1 states:

- (a.) The Director may assess civil money penalties against a person or provider ("provider") pursuant to Welfare and Institutions Code Section 14123.2 after a determination that the provider knows or has reason to know that items or services:
 - (1.) Were not provided as claimed,
 - (2.) Are not reimbursable under the Medi-Cal Program as provided in subsection (d), or
 - (3.) Were claimed in violation of an agreement with the State.
- (b.) The Director's determination of whether a provider "knows or has reason to know" that items or services were not provided, are not reimbursable, or were claimed in violation of an agreement with the State (hereafter "improperly claimed"), shall be based on the following standards:
 - (1.) Knows: The provider is aware of a high probability of the existence of the fact that items or services were improperly claimed, or
 - (2.) Has reason to know: The provider has information from which a reasonable person in that position would infer that items or services were improperly claimed.
- (c.) The Director's determination of whether the provider knows or has reason to know that items or services were "not provided as claimed" shall be based on information available pursuant to Section 51476.
- (d.) The Director shall determine whether or not the provider knows or has reason to know that claimed items or services are "not reimbursable under the Medi-Cal Program" in the following instances:
 - (1.) The provider has been suspended from participation in the Program,
 - (2.) The claimed items or services are substantially in excess of patient needs as defined in Section 51303(a),
 - (3.) The items or services are deficient in quality compared with professionally recognized standards of health care (See Section 51472),
 - (4.) The provider has demonstrated a pattern of abusive overbilling to the Medi-Cal Program. Evidence of such overbilling shall include, but not be limited to:

- (A.) Medi-Cal Dental audit adjustments repeated in two or more fiscal years except if there is a pending appeal where these adjustments are still at issue,
 - (B.) Repeated submission of improperly coded or identified claims. Evidence of such overbilling shall not include repeated submission of claims which have been denied payment previously, even though such payment denial was not contested.
- (e.) The Director's determination of whether the provider knows or has reason to know that items or services were "claimed in violation of an agreement with the State" shall be based on the terms of the written agreement, and on other relevant evidence as that term is defined in Section 51037(e)(1). The Director shall consider only material violations which go to the merits of the agreement as distinguished from those which affect only form.
- (f.) A civil money penalty shall be no more than three times the amount claimed by the provider for each item or service. It shall be within the Director's discretion to assess a lower penalty. In setting the amount of the penalty, the Director may consider evidence of mitigating circumstances submitted by the provider. Examples of such evidence include, but are not limited to:
- (1.) Clerical error.
 - (2.) Good faith mistake.
 - (3.) Reliance on official publications.
 - (4.) Prior record of properly submitted claims.
- (g.) An assessment of civil money penalties shall be effective upon the 60th calendar day after the date that the Department serves notice to the provider of the determination. Such notice shall be in writing and shall include grounds for the determination.
- (h.) A provider shall have the right to appeal the determination by filing a request for hearing pursuant to Section 51022. The effective date of the assessment shall be deferred until this request is rejected or a final administrative decision is adopted.
- (i.) Upon the effective date of assessment, the Director shall collect the civil money penalty in accordance with the procedures set forth in Sections 14115.5 and 14172 of the Welfare and Institutions Code and Section 51047.
- (j.) Interest shall accrue on any unpaid balance of a civil money penalty from the effective date of assessment, at the rate specified in Section 14172(a) of the Welfare and Institutions Code.
- (k.) Civil money penalty appeal hearings shall be conducted pursuant to the procedural guidelines set forth in Section 51016 et seq. (Title 22, CAC, Article 1.5).
- (l.) Assessment of civil money penalties pursuant to Welfare and Institutions Code Section 14123.2 shall not operate to bar imposition of any other applicable penalty provisions, such as those contained in Welfare and Institutions Code Section 14171.5.

Utilization Controls

Title 22, California Code of Regulations (CCR), Section 51159 states:

Utilization controls that may be applied to services set forth in this chapter include:

- (a.) Prior authorization, which is approval in advance of the rendering of service of the medical necessity and program coverage of the requested services, by a Department of Health consultant or PCCM plan. In determining what services shall be subject to prior authorization, the Director shall consider factors which include, but are not limited to:
 - (1.) Whether the services to be controlled are generally considered to be elective procedures.
 - (2.) Whether other physician procedures not subject to prior authorization are sufficient in scope and number to afford members reasonable access to necessary health care services.
 - (3.) The level of program payment for procedures.
 - (4.) The cost effectiveness of applying prior authorization as a utilization control.
- (b.) Postservice prepayment audit, which is review for medical necessity and program coverage after service was rendered but before payment is made. Payment may be withheld or reduced if the service rendered was inappropriate.
- (c.) Postservice postpayment audit, which is review for medical necessity and program coverage after service was rendered and the claim paid. The department may take appropriate steps to recover payments made if subsequent investigation uncovers evidence that the claim should not have been paid.
- (d.) Limitation on number of services, which means certain services may be restricted as to number within a specified time frame.

Prior Authorization

Title 22, California Code of Regulations (CCR), Section 51455 states:

- (a.) Any provider may be subjected to a requirement of prior authorization for all or certain specified services to be rendered under the California Medical Assistance Program, by written notice served on such provider from the Director or a carrier. The requirement for prior authorization may be imposed on such provider by the Director upon a determination that the provider has been rendering unnecessary services to a Medi-Cal member.
- (b.) As used in this regulation, "unnecessary services" includes but is not limited to any of the following which exceed customary and usual practices in terms of frequency, quantity, propriety, or length of treatment:
 - (1.) Office, home, or inpatient visits.
 - (2.) Furnishing, prescribing, or ordering drugs, appliances, services, hospital, skilled nursing facility or intermediate care facility admissions.

- (c.) The written notice of requirement for prior authorization shall state the nature, type, and extent of the services determined by the director to have been unnecessary and shall also state which services shall be subject to prior authorization and the duration that such prior authorization shall remain in force."

Special Claims Review

Title 22, California Code of Regulations (CCR), Section 51460 states:

- (a.) The Department may place any provider on special claims review for specific or all services provided. The special claims review may be performed by the Department, or by the fiscal intermediary under direction of the Department. Special claims review may be imposed on a provider upon a determination that the provider has submitted improper claims, including claims which incorrectly identify, or code services provided.
- (b.) A provider, while on special claims review, shall furnish any material requested by the Department in order to substantiate specific or all claims subject to special claims review.
- (c.) The Department shall provide written notice to any provider placed on special claims review. The written notice shall include the following:
- (1.) Services determined to have been improperly billed by the provider.
 - (2.) Services subject to special claims review.
 - (3.) Documentation to be submitted with all claims subject to special claims review.
 - (4.) Instructions for submission of claims subject to special claims review."

Administrative Hearings

Provider Audit Hearing

Title 22, California Code of Regulations (CCR), Section 51017 states:

A provider may request a hearing under the provisions of this article to examine any disputed audit or examination finding which results in an adjustment to Medi-Cal program reimbursement or reimbursement rates by submitting a Statement of Disputed Issues to the Department in accordance with Section 51022.

Request for Hearing

Title 22, California Code of Regulations (CCR), Section 51022 states:

- (a.) An institutional provider may request a hearing for any disputed audit or examination finding as follows:
- (1.) A written request shall be filed with the Department within 60 calendar days of the receipt of the written notice of the audit or examination findings.

- (2.) This request may be amended at any time during the 60-calendar day period.
- (b.) A Non-institutional provider may request a hearing on any disputed audit or examination finding as follows:
- (1.) A written request shall be filed with the Department within 30 calendar days of the receipt of the audit or examination finding.
- (2.) This request may be amended at any time during the 30-calendar day period.
- (c.) All late requests by either Institutional or Non-institutional providers shall be denied, and the audit or examination findings deemed final unless the provider establishes in writing good cause for late filing within 15 calendar days of being notified of the untimeliness of its request.
- (d.) The request shall be known as "Statement of Disputed Issues." It shall be in writing, signed by the provider or the authorized agent, and shall state the address of the provider and of the agent, if any agent has been designated. A provider or the agent shall specify the name and address of the individual authorized on behalf of the provider to receive any and all documents, including the final decision of the Director, relating to proceedings conducted pursuant to this article. The Statement of Disputed Issues need not be formal, but it shall be specific as to each issue as are in dispute, setting forth the provider's contentions as to those issues and the estimated amount each issue involves. The information specified in subsection (e) shall also be included. If the hearing officer determines that a Statement of Disputed Issues fails to state the specific grounds upon which objection to the specific item is based, the provider or the agent shall be notified that it does not comply with the requirement of this regulation, and the reasons, therefore.
- (1.) An Institutional provider shall be granted 30 calendar days after the date of the mailing of the notice of deficiency to the provider within which to file an amended Statement of Disputed Issues.
- (2.) A Non-institutional provider shall be granted 15 calendar days after the date of mailing of the notice of deficiency within which to file an amended Statement of Disputed Issues.
- (3.) If within the time permitted in (1) or (2) above, the Institutional or Non-institutional provider, respectively, or the agent fails to amend its appeal as notified, the appeal as to those issues shall be rejected.
- (e.) The request shall also specify whether the provider does or does not wish that an informal level of review among the parties be held, together with the reasons, therefore. Either party may request, or the hearing officer may order, that a telephone conference call be initiated among the parties for discussion of the advisability of conducting an informal level of review. The hearing officer shall decide whether an informal level of review would be appropriate and notify the parties of this decision in writing.

Member Fraud

Sharing of Medi-Cal Cards

Welfare & Institutions Code, Section 14026 states:

- (a.) It is a misdemeanor for a Medi-Cal member to furnish, give, or lend his Medi-Cal card or labels to any person other than a provider of service as required under Medi-Cal regulations.
- (b.) It is a misdemeanor for any person to use a Medi-Cal card other than the one which was issued to him or her to obtain health care services. This subdivision shall not apply to the use of a Medi-Cal card of a family member by another family member if the person using the card is, in fact, eligible under this chapter.
- (c.) This section shall not apply to any peace officer while investigating Medi-Cal fraud or other crimes in performance of his official duties or to any person working under the peace officer's immediate direction, supervision, or instruction when such peace officer has been issued a Medi-Cal card pursuant to Section 14026.5.

Provider Assistance for Medi-Cal Fraud

Members suspected of abusing Medi-Cal Dental should be reported to the appropriate authorities. To help deter fraud, providers should be aware of the following:

- Individuals who are not residents of California.
- Individuals who give, lend, or furnish their Medi-Cal cards to any person other than a Medi-Cal provider.

Note: *This example does not apply to family members presenting a card on behalf of a Medi-Cal eligible recipient to obtain services for that recipient (for example, a relative picking up a prescription for the recipient).*

- Any attempt to obtain a prescription or controlled substance through misrepresentation or concealment.
- Individuals suspected of trying to obtain prescriptions to support their drug habit or for resale.
- Individuals who fail to report that they have other health coverage.
- Individuals who appear to have assets that would make them ineligible for Medi-Cal.

**The Statewide Medi-Cal Fraud and Abuse Hotline for reporting recipients or providers is
(800) 822-6222.**

Section 9 - Special Programs

California Children's Services (CCS).....	9-1
Genetically Handicapped Person's Program (GHPP)	9-1
CCS-only and Authorizations and Claims Processing.....	9-2
CCS/Medi-Cal Authorizations and Claims Processing	9-2
GHPP/Medi-Cal and GHPP-only Authorizations and Claims Processing.....	9-3
Orthodontic Services for CCS-only Members	9-3
Providing Orthodontic Services to Medi-Cal Dental Members	9-3
Eligibility	9-4
Changes in the Member's Program Eligibility.....	9-4
Emergency Treatment.....	9-5
Other Coverage	9-5
CCS-only, GHPP/Medi-Cal and GHPP only Service Code Groupings (SCG).....	9-5
CCS-only Benefits.....	9-7
Contact Listings for Medi-Cal Dental, Medi-Cal Eligibility, GHPP, and CCS	9-10
CCS-only County Programs and CCS State Regional Offices.....	9-11
GHPP/Medi-Cal and GHPP-only State Office	9-11
Orthodontic Services Program	9-11
Enrollment and Orthodontic Certification.....	9-11
Initial Orthodontic Evaluation and Completion of the HLD Index Score Sheet	9-12
Diagnostic Casts	9-13
Clarification of Case Types	9-14
Orthodontic Treatment Plans	9-15
Treatment Plan Authorization and Payment Submission Procedures	9-16
Helpful Hints.....	9-17
Transfer Cases	9-17
Treatment Plan Authorization and Payment Submission Procedures	9-18
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	9-18
EPSDT: Frequently Asked Questions	9-19
Non-Emergency Medical Transportation (NEMT)	9-23
Non-Medical Transportation (NMT).....	9-24

Section 9 - Special Programs

California Children's Services (CCS)

The CCS program provides health care to children and adolescents under 21 years of age who have a CCS-eligible medical condition.

The CCS program provides diagnostic and treatment services, medical case management, some dental services, and physical and occupational therapy services. The CCS program only authorizes dental services if the member's CCS-eligible medical condition or oral condition can be affected. Examples of medical conditions of children who are CCS-eligible for dental services include cerebral palsy, cystic fibrosis, hemophilia, certain heart diseases, certain cancers, traumatic injuries to the face and mouth, cleft lip/palate, and other craniofacial anomalies. CCS offers orthodontics to children with medically handicapping malocclusions, cleft lip/palate, and craniofacial anomalies.

Any individual, including a family member, school staff, public health nurse, doctor, or dentist may refer a child to the CCS program for an evaluation. The referral to the CCS county program or CCS State Regional Office may be made by fax, phone call, correspondence, or the [CCS Dental and Orthodontic Client Service Authorization Request \(SAR\)](#) form (CDHS 4516). CCS will not cover any services provided prior to the date the referral was received by the CCS program.

CCS serves approximately 175,000 children who have the following types of program eligibility:

- **CCS/Medi-Cal:** These members are eligible for full scope dental benefits with no share of cost under Medi-Cal. They may have case coordination services provided by CCS. The provider shall submit TARs and Claims directly to Medi-Cal Dental, comply with all program requirements, and obtain prior authorization (when necessary) in order for services to be paid.
- **CCS-only:** These members are children whose family's annual income is below \$40,000, or whose estimated out-of-pocket expenses to treat the CCS eligible condition exceed 20% of a family's income. They receive health care funded by the State and the counties and are limited to the treatment of their CCS-eligible conditions.

Genetically Handicapped Person's Program (GHPP)

The GHPP is a State-funded health care program for adults and some children with certain genetic diseases. GHPP coordinates care and payment for persons usually over the age of 21 years with eligible genetic conditions. Eligible conditions include, but are not limited to, hereditary bleeding disorders, cystic fibrosis, and hereditary metabolic disorders.

The GHPP serves adults and some children who have the following types of program eligibility:

- GHPP/Medi-Cal: These members may be eligible for dental benefits under the GHPP.
- GHPP-only: These members receive comprehensive State-funded dental and health care benefits under GHPP.

CCS-only and Authorizations and Claims Processing

To begin the CCS process for dental services, the provider must submit a [CCS Dental and Orthodontic Client Service Authorization Request \(SAR\)](#) form (DHCS 4516) to the CCS county program. The provider may fax or mail this form to the CCS county program. The CCS county program will review the requested dental services and determine if the patient qualifies for the services based on their CCS-eligible medical condition.

Providers are required to obtain an approved SAR from the CCS county program of the member's county of residence, or CCS State Regional Office, prior to performing dental services. An approved SAR only authorizes the dental scope of benefits.

The CCS County program will issue a CCS SAR to the provider which will indicate the authorized Service Code Group(s) or individual procedure code(s) with a "begin date" and "end date" for up to one year. If the treatment is completed before the "begin date" or after the "end date" indicated on the SAR, payment will be disallowed.

The approved SAR does not guarantee payment. Payment is always subject to the dental criteria and submission requirements of Medi-Cal Dental.

Providers are to adhere to all Medi-Cal Dental policies and TAR/Claim submission requirements. Refer to the Orthodontic Services Program in this section as well as "Section 5: Manual of Criteria and Schedule of Maximum Allowances" of this Handbook.

Providers do not have to attach the SAR to the Medi-Cal Dental TAR/Claim. CCS electronically notifies Medi-Cal Dental providers who have received authorized SARs. If the procedure requested on the TAR/Claim is not on the SAR, payment/authorization will be disallowed with Adjudication Reason Code 390. Providers should contact CCS to obtain a new SAR prior to submitting a re-evaluation.

CCS/Medi-Cal Authorizations and Claims Processing

Members with CCS/Medi-Cal eligibility do not require a CCS SAR. These members have full scope Medi-Cal eligibility and are only case managed by CCS. No CCS SAR request should be submitted.

CCS/Medi-Cal claims and TARs are to be sent directly to the Medi-Cal Dental Providers may submit a TAR requesting EPSDT services for a Medi-Cal member requiring dental

benefits beyond the scope of the Medi-Cal Dental Refer to EPSDT services in this section.

GHPP/Medi-Cal and GHPP-only Authorizations and Claims Processing

To begin the GHPP process for dental services, the provider must submit a GHPP Dental Client Service Authorization Request (SAR) (MC 2361) to the GHPP State office. The provider may fax or mail this form to the GHPP State office. The GHPP will review the requested dental services and determine if requested services are medically necessary.

The GHPP will issue a GHPP SAR to the provider which will indicate the authorized Service Code Group(s) or individual procedure code(s) with a "begin date" and "end date" for up to one year. If the treatment is completed before the "begin date" or after the "end date" indicated on the SAR, payment will be disallowed.

The approved SAR does not guarantee payment. Payment is always subject to the dental criteria and submission requirements of Medi-Cal Dental.

Providers are to adhere to all Medi-Cal Dental policies and TAR/Claim submission requirements. Refer to "Section 5: Manual of Criteria and Schedule of Maximum Allowances" of this Handbook.

Providers do not have to attach the SAR to the Medi-Cal Dental TAR/Claim. GHPP electronically notifies Medi-Cal Dental of providers who have received authorized SARs. If the procedure requested on the TAR/Claim is not on the SAR, payment/authorization will be disallowed with Adjudication Reason Code 390. Providers should contact GHPP to obtain a new SAR prior to submitting a re-evaluation.

Orthodontic Services for CCS-only Members

The CCS program has adopted the Medi-Cal Dental orthodontic criteria for children with handicapping malocclusion, cleft lip/palate, and craniofacial anomalies. Orthodontic diagnostic and treatment criteria are contained within "Section 5: Manual of Criteria and Schedule of Maximum Allowances" for Medi-Cal Authorization (Dental Services) in this Handbook.

Providing Orthodontic Services to Medi-Cal Dental Members

In order to provide orthodontic services to Medi-Cal Dental or CCS members, a provider must be "actively" enrolled in Medi-Cal Dental and be enrolled as a Certified Orthodontist. Refer to "Section 3: Enrollment Requirements" of this Handbook for additional information regarding enrollment. If the provider is uncertain of his/her current Medi-Cal Dental status, he/she may phone the Telephone Service Center at (800) 423-0507 and request an Orthodontic Provider Enrollment Form.

As defined in Title 22, California Code of Regulations, Section 51223(c), a qualified orthodontist is a dentist who confines his/her practice to the specialty of orthodontics and has:

- Successfully completed a course of advanced study on orthodontics of two years or more in a program recognized by the Council on Dental Education of the American Dental Association, or
- Completed advanced training in orthodontics prior to July 1, 1969, and is a member of or eligible for membership in the American Association of Orthodontics.

Eligibility

CCS:

CCS/Medi-Cal Dental providers are to request an approved CCS SAR from the CCS county program or CCS State Regional Offices for CCS-only and dental services and then submit TAR/Claim forms to Medi-Cal Dental.

CCS/Medi-Cal:

Medi-Cal Dental providers are to submit TARs/Claims directly to Medi-Cal Dental and do not require a CCS SAR.

GHPP:

GHPP providers are to request an approved GHPP SAR from the State GHPP office for GHPP/Medi-Cal and GHPP-only dental services and then submit TAR/Claim forms to Medi-Cal Dental.

Note: CCS and GHPP SARs are not transferable between dental providers.

Changes in the Member's Program Eligibility

CCS-only, GHPP-only, CCS/Medi-Cal, and GHPP/Medi-Cal members are issued California Benefits Identification Cards (BIC). The BIC enables providers to determine eligibility through the AEVS, POS Device, and/or the [Medi-Cal website](#). A member's program eligibility may change at any time, and it is the provider's responsibility to verify eligibility prior to treating the member.

When the member changes from the CCS/Medi-Cal program to the CCS-only program, providers must obtain a SAR from the CCS county program. A SAR is not required for members who change from the CCS-only program to CCS/Medi-Cal. Providers are to refer to this Handbook prior to treating CCS-only, CCS/Healthy Families, CCS/Medi-Cal, and GHPP/Medi-Cal members.

Providers will need to submit separate claim forms when a patient's program eligibility changes. This will expedite Medi-Cal reimbursement in the event that a CCS county has insufficient funds to process claims with CCS-only or benefits. If the CCS county

program/State GHPP program does not have sufficient funds, claims will be withheld until sufficient funds are available.

Note: CCS-only members residing in Los Angeles County will not be issued a BIC.

Emergency Treatment

CCS-only Members: If there is an emergency condition, then the provider may treat the member for the emergency. The provider is required to submit the appropriate form (CDHS 4488 or CDHS 4509) to the CCS county program or CCS State Regional Office by the next business day, requesting a SAR.

CCS/Medi-Cal Members: Providers should refer to “Section 4: Treating Members” of this Handbook for procedures for approval and payment for emergency dental services and for obtaining appropriate authorization for services dictated by emergency situations, which preclude timely advance requests for Medi-Cal Dental TAR/Claim forms.

GHPP/Medi-Cal and GHPP-only Members: If there is an emergency condition, then the provider may treat the member for the emergency. The provider is required to submit the appropriate form (MC 2361) to the State GHPP office by the next business day, requesting a SAR.

Other Coverage

A CCS or GHPP member may have other dental coverage (i.e., managed care or indemnity dental insurance coverage). Members must apply their other coverage benefits prior to utilizing CCS or GHPP benefits. Other coverage will be considered as the primary carrier, and CCS or GHPP will be considered as the secondary carrier and payer of last resort.

CCS-only, GHPP/Medi-Cal and GHPP only Service Code Groupings (SCG)

An approved SAR will list the SCGs and/or the individual procedure code(s) based on the provider’s requested treatment plan and the member’s CCS or GHPP-eligible medical condition. These 18 SCGs are grouped by treatment plans and procedure codes to assist the CCS county program or CCS State Regional Office in authorizing services based on the member’s CCS-or GHPP-eligible medical condition. Providers are to request a SAR for one or more of the SCGs when requesting an authorization from the CCS county program or GHPP State office. If the procedure code is not listed in the SCG(s), the provider may request authorization for an individual procedure code from the Medi-Cal Dental scope of benefits.

SCG 01 – Preventive Dental Services

D0120, D0150, D0210, D0220, D0230, D0272, D0274, D0330, D1110, D1120, D1206, D1208, D1320, D1351, D1352, D1999, D9920, D9995, D9996

SCG 02 – Orthodontic Services for Medically Handicapping Malocclusion

D0140, D0210, D0330, D0340, D0350, D0470, D8080, D8670, D8680, D8701, D8702

SCG 03 – Primary Dentition for Cleft Palate and/or Cleft Lip Orthodontic Services

D0140, D0210, D0330, D0340, D0350, D0470, D8080, D8670, D8680, D8701, D8702

SCG 04 – Mixed Dentition for Cleft Palate and/or Cleft Lip Orthodontic Services

D0140, D0210, D0330, D0340, D0340, D0350, D0470, D8080, D8670, D8680, D8701, D8702

SCG 05 – Permanent Dentition for Cleft Palate and/or Cleft Lip Orthodontic Services

D0140, D0210, D0330, D0340, D0350, D0470, D8080, D8670, D8680, D8701, D8702

SCG 06 – Primary Dentition for Facial Growth Management Orthodontic Services

D0140, D0210, D0330, D0340, D0350, D0470, D8080, D8660, D8670, D8680, D8701, D8702

SCG 07 – Mixed Dentition for Facial Growth Management Orthodontic Services

D0140, D0210, D0330, D0340, D0350, D0470, D8080, D8660, D8670, D8680, D8701, D8702

SCG 08 – Permanent Dentition for Facial Growth Management Orthodontic Services

D0140, D0210, D0330, D0340, D0350, D0470, D8080, D8660, D8670, D8680, D8701, D8702

SCG 09 – Oral Surgery Services

D1510, D1516, D1517, D1526, D1527, D1556, D1557, D1558, D1575, D5211, D5212, D7111, D7140, D7210, D7220, D7230, D7240, D7250, D7961, D7962, D9222, D9223, D9230, D9239, D9243, D9248, D9610

SCG 10 – Periodontic Services

D4210, D4211, D4260, D4261, D4341, D4342, D4355, D4910, D9110, D9222, D9223, D9230, D9239, D9243, D9248

SCG 11 – Endodontic Services

D3310, D3320, D3330, D3346, D3347, D3348, D3351, D3352, D3353, D3410, D3421, D3425, D3426, D3471, D3472, D3473, D3921, D9222, D9223, D9230, D9239, D9243, D9248

SCG 12 – Restorative Services

D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2930, D2931, D2932, D2933, D2941, D2951, D3220, D3222, D3230, D3240, D9222, D9223, D9230, D9239, D9243, D9248

SCG 13 – Laboratory Crown Services

D2710, D2712, D2721, D2740, D2751, D2781, D2783, D2791, D9222, D9223, D9230, D9239, D9243, D9248

SCG 14 – Fixed Prosthetic Services

D6211, D6241, D6245, D6251, D6721, D6740, D6751, D6781, D6783, D6791, D9222, D9223, D9230, D9239, D9243, D9248

SCG 15 – Prosthetic Services for Complete Dentures

D5110, D5120, D5130, D5140, D5863, D5865

SCG 16 – Prosthetic Services for Cast Partial Dentures

D5213, D5214

SCG 17 – Prosthetic Services for Resin Partial Denture

D5211, D5212

SCG 18 – Dental Services under General Anesthesia

D0120, D0150, D0210, D0220, D0230, D0272, D0274, D0330, D1110, D1120, D1206, D1208, D1351, D1352, D1510, D1516, D1517, D1526, D1527, D1556, D1557, D1558, D1575, D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2930, D2931, D2932, D2933, D2951, D3220, D3222, D3230, D3240, D3310, D3320, D3330, D3346, D3347, D3348, D3410, D3421, D3425, D3426, D4210, D4211, D4260, D4261, D4341, D4342, D4355, D4910, D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, D9110, D9222, D9223, D9239, D9243, D9420

CCS-only Benefits

The CCS and GHPP programs have the same scope of benefits as Medi-Cal Dental with a few exceptions:

CCS-only, GHPP/Medi-Cal, and GHPP only (if applicable) have additional benefits and modifications based on frequency and age limitations. The table below lists the additional benefits.

Note: The reimbursement rates are the same as those on the Medi-Cal Dental Schedule of Maximum Allowances (SMA).

CDT-21 Procedure Code	Description of Service	Additional Benefits for CCS-only Benefits
D0210	Intraoral - complete series (including bitewings)	Allowed for final records (or procedure code D0330) for orthodontic treatment
D0330	Panoramic radiographic image	One additional benefit for final records (or procedure code D0210) for orthodontic treatment
D0340	2D Cephalometric radiographic image - acquisition, measurement and analysis	Allowed for final records for orthodontic treatment
D0350	2D Oral/Facial photographic images obtained intra-orally or extra orally	A benefit for final records for orthodontic treatment

CDT-21 Procedure Code	Description of Service	Additional Benefits for CCS-only Benefits
D0470	Diagnostic casts	One additional benefit for final records
D1120	Prophylaxis - child	A benefit 4 times per year for prophy or prophy/fluoride
D1206	Topical application of fluoride varnish	A benefit 4 times per year
D1208	Topical application of fluoride - excluding varnish	A benefit 4 times per year
D1351	Sealant – per tooth	A benefit: First deciduous molars (B, I, L, and S)
D1351	Sealant - per tooth	A benefit: Second deciduous molars (A, J, K, and T)
D1351	Sealant – per tooth	A benefit: First bicuspid (5, 12, 21 and 28)
D1351	Sealant - per tooth	A benefit: Second Bicuspid (4, 13, 20, and 29)
D1352	Preventive resin restoration	A benefit: First deciduous molars (B, I, L, and S)
D1352	Preventive resin restoration	A benefit: Second deciduous molars (A, J, K, and T)
D1352	Preventive resin restoration	A benefit: First bicuspid (5, 12, 21 and 28)
D1352	Preventive resin restoration	A benefit: Second Bicuspid (4, 13, 20, and 29)
D1510	Space maintainer-fixed – unilateral – per quadrant	A benefit to hold space for missing permanent posterior tooth.
D1516	Space maintainer - fixed – bilateral, maxillary *Effective March 14, 2020	A benefit to hold space for missing permanent posterior tooth.
D1517	Space maintainer - fixed – bilateral, mandibular *Effective March 14, 2020	A benefit to hold space for missing permanent posterior tooth.
D1526	Space maintainer – removable – bilateral, maxillary *Effective March 14, 2020	A benefit to hold space for missing permanent posterior tooth.
D1527	Space maintainer – removable – bilateral, mandibular *Effective March 14, 2020	A benefit to hold space for missing permanent posterior tooth.

CDT-21 Procedure Code	Description of Service	Additional Benefits for CCS-only Benefits
D1575	Distal shoe space maintainer – fixed – unilateral- per quadrant	A benefit to hold space for missing permanent posterior tooth.
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant	No age restrictions
D4211	Gingivectomy or gingivoplasty – one to three teeth, per quadrant	No age restrictions
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	No age restrictions
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	No age restrictions
D4341	Periodontal scaling and root planing – four or more contiguous teeth or bounded teeth spaces per quadrant	No age restrictions
D4342	Periodontal scaling and root planing – one to three teeth, per quadrant	No age restrictions
D4910	Periodontal maintenance	No age restrictions
D5110	Complete denture – maxillary	A benefit once every year up to age 21 with appropriate documentation due to growth
D5120	Complete denture – mandibular	A benefit once every year up to age 21 with appropriate documentation due to growth
D5130	Immediate denture – maxillary	A benefit once every year up to age 21 with appropriate documentation due to growth
D5140	Immediate denture – mandibular	A benefit once every year up to age 21 with appropriate documentation due to growth
D5211	Maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth)	A benefit once every year up to age 21. May replace

CDT-21 Procedure Code	Description of Service	Additional Benefits for CCS-only Benefits
		any missing tooth/teeth except 3rd molars.
D5212	Mandibular partial denture – resin base (including retentive/clasping materials, rest and teeth)	A benefit once every year up to age 21. May replace any missing tooth/teeth except 3rd molars.
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	A benefit for age 16-21. Does not need to oppose a full denture.
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	A benefit for age 16-21. Does not need to oppose a full denture.
D5863	Overdenture – complete maxillary *Effective March 14, 2020	A benefit once in a five year period.
D5865	Overdenture – complete mandibular *Effective March 14, 2020	A benefit once in a five year period.

Contact Listings for Medi-Cal Dental, Medi-Cal Eligibility, GHPP, and CCS

Medi-Cal Dental Providers are to contact Medi-Cal Dental for CCS/Medi-Cal, GHPP/Medi-Cal, CCS-only, and GHPP-only questions related to payments of claims and/or authorizations of TARs.	
Provider Toll-Free Line	(800) 423-0507
Member Toll-Free Line	800-) 322-6384
Electronic Data Interchange (EDI) Support	((800) 423-0507
Ordering Medi-Cal Dental Forms	Fax (877) 401-7534
Medi-Cal Program Providers are to contact the Medi-Cal Program for CCS/Medi-Cal, GHPP/Medi-Cal, CCS-only, and GHPP-only eligibility, POS, or Internet questions.	
Automated Eligibility Verification System (AEVS)	(800) 456-2387
Eligibility Message Help Desk, POS, and/or Internet Help Desk	(800) 541-5555
Internet Eligibility Website	Click here
GHPP State Office Providers are to contact the State GHPP office for questions related to authorizations for services issued prior to January 31, 2011.	
Toll Free	(800) 639-0597

Toll	916) 327-0470
Fax	916-) 327-1112
Genetically Handicapped Persons Program: MS 8200 PO Box 997413 Sacramento, CA 95899	

CCS-only County Programs and CCS State Regional Offices

- [CCS website and contact information](#)
- Providers are to utilize the following guidelines when selecting the correct CCS county program or CCS State Regional Office:
 - For questions on eligibility, SAR authorizations, and submitting claims in Independent counties, please contact the CCS Independent county office listed on the CCS website [here](#).
 - For questions on eligibility in Dependent counties, please contact the CCS Dependent county office or the appropriate CCS State Regional Office listed above.
 - For questions on prior authorization or submitting claims in independent counties, contact the appropriate CCS State Regional Office listed above.

GHPP/Medi-Cal and GHPP-only State Office

- [GHPP website and contact information](#)

Orthodontic Services Program

Medi-Cal Dental benefits include medically necessary orthodontic services. Services available under this program are limited to only those members who meet the general policies and requirements. These benefits are available to eligible individuals before their 21st birthday. Policies governing the provision of these program benefits are listed in “Section 5: Manual of Criteria and Schedule of Maximum Allowances” of this Handbook.

Qualified orthodontists may provide orthodontic services to eligible Medi-Cal and California Children’s Services (CCS) members. California Code of Regulations, Title 22, Section 51223(c) defines a “qualified orthodontist” as a dentist who “confines his/her practice to the specialty of orthodontics, and, who either has successfully completed a course of advanced study in orthodontics of two years or more in programs recognized by the Council on Dental Education of the American Dental Association” or “who has completed advanced training in orthodontics prior to July 1, 1969 and is a member of, or eligible for membership in the American Association of Orthodontists.”

Enrollment and Orthodontic Certification

1. A provider must be actively enrolled as a Medi-Cal Dental provider to qualify for participation in this program. An orthodontist who wishes to submit claims for services provided to eligible Medi-Cal Dental and/or CCS members must first complete an Orthodontia Provider Certification form. For an enrollment application and information, call the Medi-Cal Dental Telephone Service Center at (800) 423-0507.
2. Complete the Orthodontia Provider Certification form and return it promptly to Medi-Cal Dental. Medi-Cal Dental will enter an appropriate code on an automated provider record to establish and identify the provider under the Orthodontic Services Program.
3. The provider will be notified in writing when the certification has been approved.
Orthodontic services provided to Medi-Cal members prior to an approved certification will not be paid by Medi-Cal Dental.
4. Medi-Cal Dental will furnish an initial supply of the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheets (DC016) upon certification approval. Additional Score Sheets may be obtained through the Medi-Cal Dental forms supplier by checking the appropriate box on the Medi-Cal Dental Forms Reorder Request.

Initial Orthodontic Evaluation and Completion of the HLD Index Score Sheet

An initial orthodontic examination called the Limited Oral Evaluation (Procedure D0140) must be conducted. This examination includes completion of the HLD Score Sheet. The HLD Score Sheet is the preliminary measurement tool used in determining if the patient qualifies for medically necessary orthodontic services. Follow the instructions on the back of the form to assess the medical necessity (example in “Section 6: Forms” of this Handbook). The qualifying conditions for treatment under the Medi-Cal Dental Orthodontic Program are:

1. Cleft palate deformities.
2. Craniofacial anomaly. (A description of the condition from a credentialed specialist must be attached.)
3. Deep impinging overbite, where the lower incisors are destroying the soft tissue of the palate and tissue laceration and/or clinical attachment loss are present. (Contact only does not constitute deep impinging overbite under the Orthodontic Services Program.)
4. Crossbite of individual anterior teeth when clinical attachment loss and recession of the gingival margin are present (e.g., stripping of the labial gingival tissue on the lower incisors). Treatment of bi-lateral posterior crossbite is not a benefit of the program.
5. Severe traumatic deviation must be justified by attaching a description of the condition.

- 6A. Overjet greater than 9mm with incompetent lips or mandibular protrusion (reverse overjet) greater than 3.5mm with reported masticatory and speech difficulties. Submit photographs for this exception.
- 6B. Individual score of at least 26 points.

Children who do not meet the Manual of Criteria requirements for orthodontic services may still be covered if services are documented as medically necessary under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Regulations. Attach the required supporting documentation in addition to completing the “conditions” section of the form. Refer to the EPSDT Services Request for Orthodontic Services of this section for clarification of qualifying factors for EPSDT services.

If one of the above conditions is present, Diagnostic Casts (Procedure D0470) may be provided for members. (Note: Diagnostic Casts are payable only upon authorization of orthodontic treatment plan.)

The Orthodontic Evaluation (Procedure D0140) and/or the Diagnostic Casts (Procedure D0470) do not require prior authorization from Medi-Cal Dental. Please note that all other orthodontic services do require prior authorization.

Diagnostic Casts

Diagnostic Casts (Procedure D0470) are required documentation for all handicapping malocclusion and cleft palate treatment plan requests. Exception: If the patient has a cleft palate that is not visible on the diagnostic casts, submission of the casts to Medi-Cal Dental is not required. However, photographs or documentation from a credentialed specialist must be submitted.

Craniofacial anomalies cases do not require the submission of diagnostic casts for treatment plan requests but do require documentation from a credentialed specialist.

Casts must be of diagnostic quality. To meet diagnostic requirements, casts must be properly poured and adequately trimmed to allow placement into centric occlusion. No large voids or positive bubbles should be present. Casts should be completely dry to prevent mold from forming. A bite registration or the markings of occlusion must be clearly indicated, making it possible to properly occlude the casts.

Careful packaging will help ensure that the casts arrive at Medi-Cal Dental in good condition.

Medi-Cal Dental receives many broken and damaged casts due to poor packaging. Casts that have been broken or damaged due to poor packaging cannot be used for processing and will be destroyed. If Medi-Cal Dental receives broken or damaged casts, a Resubmission Turnaround Document (RTD) will be initiated to request new casts, causing further processing delays. Use a box that has sufficient packaging material (such as Styrofoam “peanuts,” shredded newspaper, “bubble wrap,” etc.) so that the casts will not be jarred or bumped during shipping. Also, place packaging materials

between the upper and lower arches to prevent rubbing and possible chipping and breakage of the teeth.

Additionally, diagnostic casts should be clearly labeled with proper identification so they can be matched with the correct TAR. This identification should clearly indicate:

- The patient's name,
- Client Index Number (CIN) or Benefits Identification Card (BIC) number,
- Billing Provider Name, and
- Service office National Provider Identifier (NPI) number.

If the casts are received without patient identification and billing provider information, they will be destroyed.

Only duplicate or second pour diagnostic casts should be sent to Medi-Cal Dental. The casts will not be returned. Diagnostic casts of denied cases will be kept in the Medi-Cal Dental office for 30 days following a denial and up to one year off-site to enable the provider to request a reevaluation.

Do not mail diagnostic casts in the same envelope or mailing container as the claim for the diagnostic casts, the RTD requesting the diagnostic casts, or the TAR for orthodontic treatment. The diagnostic casts should be packaged separately and mailed to Medi-Cal Dental approximately 10 days prior to mailing the claim, the RTD, or the TAR to the address on the TAR/Claim form. Unless otherwise directed, do not send casts to alternate addresses as they can be misdirected or lost. **Providers must keep diagnostic casts for a minimum of two years after the case is completed.**

Clarification of Case Types

Malocclusion Cases

Malocclusion cases may only be started with permanent dentition, or at 13 years of age. If a malocclusion case requires further treatment beyond 8 quarterly visits, a maximum of 4 additional quarters may be authorized upon review of progress photographs and documentation.

Cleft Palate Cases

Cleft palate cases may be treated from birth in the primary dentition phase, in the mixed dentition phase, and again in the permanent dentition phase. If the cleft palate cannot be demonstrated on the diagnostic casts, documentation from a credentialed specialist must be attached.

If the primary dentition case requires further treatment beyond 4 quarterly visits, a maximum of 2 additional quarters may be authorized upon review of progress photographs and documentation.

If the mixed dentition case requires further treatment beyond 5 quarterly visits, a maximum of 3 additional quarters may be authorized upon review of progress photographs and documentation.

If the permanent dentition case requires further treatment beyond 10 quarterly visits, a maximum of 5 additional quarters may be authorized upon review of progress photographs and documentation.

If retention will not be required for the primary or mixed dentition phase, document this in the comments section (box 34) of the TAR.

Craniofacial Anomaly Cases

Craniofacial anomalies cases may also be treated from birth in the primary dentition phase, again in the mixed dentition, and again in the permanent dentition phase. Documentation from a credentialed specialist is required for all craniofacial anomaly cases. Submission of the diagnostic casts is optional.

Procedure D8660 – Pre-orthodontic Treatment Visits (maximum of 6 quarters) are optional and are a benefit only for craniofacial anomaly cases to monitor the patient's dentition and/or facial growth prior to starting orthodontic treatment.

If the primary dentition case requires further treatment beyond 4 quarterly visits, a maximum of 2 additional quarters may be authorized upon review of progress photographs and documentation.

If the mixed dentition case requires further treatment beyond 5 quarterly visits, a maximum of 3 additional quarters may be authorized upon review of progress photographs and documentation.

If the permanent dentition case requires further treatment beyond 8 quarterly visits, a maximum of 4 additional quarters may be authorized upon review of progress photographs and documentation.

If retention will not be required for the primary or mixed dentition phase, document this in the comments section (box 34) of the TAR.

Orthodontic Treatment Plans

1. A complete orthodontic treatment plan must be submitted to request prior authorization. The orthodontic treatment plan must include:
 - a) TAR:
 - Comprehensive orthodontic treatment of the adolescent dentition (D8080)
 - Periodic orthodontic treatment visit(s) (D8670)
 - Note: Document the case type and dentition phase in the comment section (box 34).
 - Orthodontic retention (D8680)

- Any necessary radiographs such as complete series (D0210) or Panoramic radiographic image (D0330), and cephalometric radiographic images (D0340) should also be requested on the TAR.

b) HLD Score Sheet

c) Diagnostic Casts

Note: For craniofacial anomalies cases only: If Pre-orthodontic treatment visits (Procedure D8660) are necessary prior to starting orthodontic treatment, indicate the quantity and attach all appropriate documentation to the TAR for the complete orthodontic treatment plan.

2. The Medi-Cal Dental orthodontic consultant will evaluate the HLD Score Sheet, and the diagnostic casts or documentation (as applicable for cleft palate and craniofacial anomaly cases) to determine if the case qualifies for treatment under the Medi-Cal Dental guidelines for orthodontic services.

Treatment Plan Authorization and Payment Submission Procedures

1. When the TAR for orthodontic services is approved by Medi-Cal Dental, a series of Notices of Authorization (NOAs) will be issued confirming authorization. NOAs will be sent at the beginning of the authorization date and every quarter thereafter throughout the treatment plan authorization period. A calendar quarter is defined as:
 - a) January through March
 - b) April through June
 - c) July through September
 - d) October through December

These NOAs should be used for billing purposes.

2. Each calendar quarter when services are provided, submit one NOA to Medi-Cal Dental for payment.

Payment for the first quarterly treatment visit shall only be made when it is performed in the next calendar month following banding (Procedure D8080).

Note: On or after July 1, 2008, each incidence of Procedure D8670 will be paid once per quarter. Only one NOA with a date of service in a given quarter needs to be submitted in order to receive the quarterly payment. Treatment visits may occur at any frequency deemed necessary during the quarter to complete the active phase of treatment, e.g., monthly, bimonthly, quarterly.

NOAs for payment will be processed in accordance with general Medi-Cal Dental billing policies and criteria requirements for Orthodontic Services. Please remember that authorization does not guarantee payment. Payment is subject to patient eligibility.

Note: If payment of an NOA is denied, submit a Claim Inquiry Form (CIF) for reevaluation. Do not resubmit for the same date of service using a new NOA.

3. Request a reevaluation for prior authorization of treatment only on a denied NOA for the orthodontic treatment plan. NOAs for the active phase of treatment and retention may not be reevaluated.
4. Under the Medi-Cal Dental orthodontic program, confirmation of continued treatment is required at the end of each 12 months of authorized treatment. Medi-Cal Dental will send a Resubmission Turnaround Document (RTD) requesting a signature to confirm continued treatment for the subsequent 12 months or remaining treatment. Indicate treatment will continue by signing the RTD. If the RTD is not returned according to Medi-Cal Dental policies, the request for continued treatment will be disallowed. A new TAR must then be submitted for all remaining treatments.

Helpful Hints

The following is important information regarding eligibility when providing orthodontic treatment:

Member eligibility must be current for each month and must cover orthodontic benefits.

A member seeking orthodontic treatment may have a SOC obligation to meet each month.

A member may have coverage under another plan that includes orthodontic services. Members with other dental coverage must still have orthodontic services authorized under Medi-Cal Dental.

Each request for payment must have the Explanation of Benefits (EOB), fee schedule, or letter of denial attached.

The information may state that the member is enrolled in a special project or prepaid health plan that includes orthodontic treatment. Refer to “Section 7: Codes” of this Handbook for additional information and a list of current special project codes and prepaid health plan codes.

Refer to “Section 4: Treating Members” of this Handbook for complete information on member eligibility and procedures for verifying eligibility.

Transfer Cases

When transferring from one certified Medi-Cal Dental orthodontist to another certified Medi-Cal Dental orthodontist, prior authorization is necessary before continuing treatment.

Transfer of a case in progress by another carrier also requires prior authorization.

Original diagnostic casts, along with new casts or progress photographs and any other documentation must be submitted for evaluation.

Diagnostic casts are not required if the treatment has already been approved by Medi-Cal Dental.

Only orthodontic cases that meet the program criteria will be authorized for the remaining treatment which will be determined by the Medi-Cal Dental orthodontic consultant.

Treatment Plan Authorization and Payment Submission Procedures

When additional orthodontic services are required or there is a change in the authorized treatment plan, submit a new TAR with documentation and any NOAs that have not been used. Mark all unused NOAs for deletion.

- If the orthodontic treatment is completed in less time than originally authorized, then document this on the NOA for the final quarterly visit.
- If there are remaining NOAs for quarterly visits but there is no NOA for retainers, then submit all the outstanding NOAs for deletion and attach a new TAR for upper and lower retainers along with the request for payment.
- If billing on the NOA for the retainers, then document that the treatment has been completed ahead of schedule and attach any remaining NOAs for deletion.
- When a new TAR is authorized by Medi-Cal Dental, the provider will receive a series of NOAs confirming the authorization. Use the new NOAs for billing purposes.

The TAR submitted for Procedures D8670 and D8660 must list the total quantity or frequency (number of quarters necessary to complete the treatment) in the “Quantity” field, column #30 and the total fee (fee for the procedure times the number of quarters) in the “Fee” field, column #32. The example above shows the correct way to list these procedures to ensure accurate calculation of the Notice of Authorization.

EXAMINATION AND TREATMENT							
26. TOOTH #/LTR, ARCH, QUAD	27. SURFACES	28. DESCRIPTION OF SERVICE (INCLUDING RADIOGRAPHS, PROPHYLAXIS, MATERIALS USED, ETC.)	29. DATE SERVICE PERFORMED	30. QUANTITY	31. PROCEDURE NUMBER	32. FEE	33. RENDERING PROVIDER NPI
		1 Comprehensive Ortho Tx.			D8080	975.00	
		2 Periodic Ortho TX Visits		08	D8670	1000.00	
U		3 Retention		01	D8680	375.00	
L		4 Retention		01	D8680	375.00	
		5 Full Mouth Series			D0210	80.00	
		6					
		7					

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services

In accordance with the requirements in Section 1905(r) of the Social Security Act and Title 42 Code of Federal Regulations Section 441.50 et seq, and specifically CFR 441.56(b)(1)(vi), the Department of Health Care Services (DHCS) is responsible for providing full-scope Medi-Cal members under the age of 21 with a comprehensive,

high-quality array of preventive (such as screening), diagnostic, and treatment services under EPSDT. Further, consistent with state and federal law and regulations for EPSDT, the Medi-Cal Dental covers all services that are medically necessary under EPSDT, including those to “correct or ameliorate” defects and physical and mental illness or conditions. These services are without cost for the member.

EPSDT: Frequently Asked Questions

What is EPSDT?

The EPSDT benefit allows Medi-Cal enrolled children and youth under age 21 to get preventive (screening) dental services and to get diagnostic and treatment services that are medically necessary to correct or ameliorate health conditions found during screening.

What kind of dental services are classified as EPSDT?

EPSDT services are Medicaid-covered services that are medically necessary. These services may or may not be part of the Manual of Criteria.

What is the EPSDT standard for “medically necessity?”

The EPSDT benefit entitles enrolled members under the age of 21 to any treatment or procedure that fits within any of the categories of Medicaid-covered services listed in the SSA, Section 1905(a), regardless of whether or not the service is covered under the Medi-Cal State Plan or is listed in the Manual of Criteria, if that treatment or service is necessary to “correct or ameliorate” defects and physical and mental illnesses or conditions, meaning that the service is medically necessary under EPSDT. Effective January 1, 2019, Welfare and Institutions Code section 14059.5 distinguishes the definition of medical necessity for individuals 21 and older compared with the definition for those under 21. For individuals younger than 21 years of age, services are determined to be medically necessary when needed to correct or ameliorate defects and physical and mental illnesses or conditions. A service need not cure a condition in order to be covered under EPSDT. Services that maintain or improve the child’s current health condition are also covered in EPSDT because they “ameliorate” a condition. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. Services are covered when they prevent a condition from worsening or prevent development of additional health problems. The common definition of “ameliorate” is to “make more tolerable.”

Medi-Cal members under age 21 may require dental services that are not part of the current Medi-Cal Dental scope of benefits. Conversely, the dental service may be part of the Medi-Cal Dental scope of benefits for adult members but not for members under the age of 21, or the dental provider may want to provide the service at a frequency or periodicity greater than currently allowed by Medi-Cal Dental. In these cases, the child member may still be eligible for these services based upon submitted documentation that demonstrates the medical necessity to correct or ameliorate the child’s condition.

When is a Treatment Authorization Request (TAR) required for EPSDT services?

Providers must submit a TAR when a member under the age 21 needs an EPSDT medically necessary service, such as a service to correct or ameliorate (make tolerable) an identified condition, if that service otherwise would not be covered by Medi-Cal Dental. Examples of when a TAR is required include:

1. To perform a dental procedure that is not listed in the Manual of Criteria:
 - Providers should use the appropriate Current Dental Terminology (CDT) procedure code. Providers should not limit their comments to Field 34 of the TAR/Claim form but submit all documents that are needed to describe and support the medical necessity for the requested service(s).

Example: Alicia M. (age 12) has fractured an anterior tooth in an accident. Although only three surfaces were involved in the traumatic destruction, the extent is such that a bonded restoration will not be retentive. With adequate documentation (in this case, intraoral photographs of the fractured tooth) and narrative explanation by the dentist, a prefabricated or laboratory-processed crown may be authorized as an EPSDT service.

2. To perform a dental procedure that is listed in the Manual of Criteria when the member under the age of 21 does not meet the published criteria:
 - Providers should fully document the medical necessity to demonstrate it will correct or ameliorate the member's condition.

Example 1: John S. (age 17) has a craniofacial anomaly with multiple edentulous areas. The edentulous areas cannot be adequately restored using conventional prosthetics – an implant-retained fixed prosthesis may be authorized as an EPSDT service.

Example 2: Cindy T. (age 10) suffers from aggressive periodontitis and requires periodontal scaling and root planning. The Manual of Criteria states this procedure is not a benefit for patients under 13 years of age. However, as a documented medically necessary periodontal procedure, it may be authorized as an EPSDT service when there is radiographic evidence of bone loss.

3. To perform a dental procedure when the member under the age of 21 needs a dental service more frequently than is specified in the Manual of Criteria:
 - Providers should fully document the medical necessity to demonstrate it will correct or ameliorate the member's condition.

What if the procedure has already been rendered and a TAR was not submitted?

In a situation where a TAR was not submitted for a procedure in which an EPSDT medically necessary service was needed, the provider shall submit a claim with all documentation to support the medical necessity. The provider shall also indicate the reason that a TAR was not submitted.

What should I tell my patients about EPSDT?

Using both written materials and in person or over the phone dialogue, dental providers should inform Medi-Cal members under age 21, or their parents, about EPSDT benefits and services and how to access them. Providers should tell eligible patients and their families about all the following:

- The value of preventive services and screenings.
- The services available under EPSDT.
- Where and how to obtain EPSDT services.
- EPSDT services are free to eligible individuals under age 21.

Are dental services to resolve medical conditions covered under EPSDT?

In some cases, dental services are necessary to resolve or improve an associated medical condition. For example, a child's speech therapist determines that a diagnosed speech defect or disorder cannot be resolved without dental treatment. A consultation letter from the speech therapist should be included with the TAR/Claim form.

Example: Andre W. (age 13) does not qualify for orthodontic services per the handicapping malocclusion criteria (he scores below 26 points on the HLD Index Score Sheet or does not have one of the six automatic qualifying conditions). However, a speech pathologist has determined that his malocclusion is a prime etiologic factor in his speech pathosis – resolution cannot be achieved unless his malocclusion is corrected. In this case, orthodontics may be authorized as an EPSDT service.

Are orthodontic services covered under EPSDT?

A TAR for orthodontic services when the child or youth under the age of 21 does not have one of the six automatic qualifying conditions or does not score 26 points or above, must include a completed [Handicapping Labio-Lingual Deviation \(HLD\) Index Score Sheet](#) (DC-016 09/18) in addition to other documentation requirements listed in the Manual of Criteria. The review of active orthodontic services also requires the submission of diagnostic casts.

The provider is required to submit all documentation required for the procedure per the Manual of Criteria and the clinical information required to determine medical necessity under EPSDT guidelines.

What kind of clinical information does Medi-Cal Dental need to determine the medical necessity?

Providers must consult the [Manual of Criteria](#), to identify the documentation and clinical information required for submittal to determine medical necessity under EPSDT guidelines.

Whom can I call to obtain further information about the EPSDT requirements under Medi-Cal?

Please call the Telephone Service Center at (800) 423-0507 for any questions or to obtain more information regarding EPSDT services.

Non-Emergency Medical Transportation (NEMT)

Medi-Cal Dental provides non-emergency transportation services to eligible Medi-Cal members. Members can request transportation from their homes to their appointed dental locations or other facilities; however, such requests are only approved for recipients who are eligible for Medi-Cal on the date of service and whose physicians or dentists have demonstrated medical necessity through prior authorization. Adjudication of claims will be subject to prior authorization and will be approved when the recipient's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and the transportation is required for the purpose of obtaining necessary health care covered by the Medi-Cal program.

Medi-Cal Dental providers are authorized to contact NEMT providers and submit all requests to transportation companies. The transportation company will then submit a TAR to the Department of Health Care Services (DHCS), Clinical Assurance and Administrative Support Division (CAASD), who will review and approve the TAR if medical necessity is demonstrated.

Please note that NEMT necessary for obtaining medical services is covered but subject to the written prescription of a physician or dentist.

Medi-Cal Dental providers are responsible for the submission of the Nonemergency Medical Transportation (NEMT) Required Justification form (DHCS 6182) to the pre-designated transportation companies and every TAR must be accompanied by a legible prescription or order sheet signed by the physician or dentist for the member. The prescription requirements must include the following:

1. Purpose of the trip
2. Frequency of necessary medical visits/trips or the inclusive dates of the requested medical transportation
3. Medical or physical condition that makes normal public or private transportation inadvisable

Note: When transportation is requested on an ongoing basis, the chronic nature of a recipient's medical or physical condition must be indicated and a treatment plan from the physician or therapist must be included. A diagnosis alone, such as "multiple sclerosis" or "stroke," will not satisfy this requirement.

The Medi-Cal field office consultant needs the above information to determine the medical necessity of a specialized medical transport vehicle and the purpose of the trip. Incomplete information will delay approval.

Medi-Cal Dental has provided a list of pre-designated transportation companies in each county for dental providers to contact. Providers are encouraged to refer to work with the NEMT companies if dental providers have questions.

A list of approved NEMT providers is attached to bulletin Volume 31, Number 8.

Non-Medical Transportation (NMT)

Pursuant to Welfare and Institutions Code (W&I Code) Section 14132 (ad) (1), effective for dates of service on or after July 1, 2018, non-medical transportation (NMT) is a covered Medi-Cal benefit, subject to utilization controls and permissible time and distance standards, for a member to obtain covered Medi-Cal services. The NMT benefit is eligible full-scope Medi-Cal fee-for-service members and pregnant women during pregnancy and for 60 days postpartum, including any remaining days in the month in which the 60th postpartum day falls. NMT includes transporting recipients to and from Medi-Cal covered medical, mental health, substance abuse, or dental services. Members enrolled in a Medi-Cal managed care health plan must request NMT services through their Member Services.

W&I Code 14132 (ad)(2)(A)(i) defines NMT as including, at minimum, round trip transportation for a recipient to obtain covered Medi-Cal services by passenger car, taxicab, or any other form of public or private conveyance. NMT services are a benefit only from an enrolled NMT Provider.

NMT does not include the transportation of sick, injured, invalid, convalescent, infirm or otherwise incapacitated recipients by ambulances, litter vans or wheelchair vans licensed, operated and equipped in accordance with state and local statutes, ordinances or regulations, since these would be covered as non-emergency medical transportation (NEMT) services. For more details and information on eligibility for NMT/NEMT services, refer to the guide located [here](#).

Please visit the Medi-Cal website [here](#) to assist your patients with information about their qualifying appointment(s).

Section 10 - CDT Tables

Contents

Section 10 - CDT Tables	1
Table 1: Federally Required Adult Dental Services (FRADS)	1
Table 3: Restored Adult Dental Services (RADS)	7
Table 4: Omnibus Budget Reconciliation Act (OBRA) Emergency Services Only	9
Table 5: Exempt Dental Services	14
Table 6: Exempt Emergency Dental Services	21

Section 10 - CDT Tables

Effective April 1, 2025, Current Dental Terminology 2025 (CDT 25) was implemented which created changes to the Federally Required Adult Dental Services (FRADS), Pregnancy, Omnibus Budget Reconciliation Act (OBRA) member emergency, and Member Cap procedures.

Table 1: Federally Required Adult Dental Services (FRADS)

The following procedure codes are reimbursable procedures for Medi-Cal members 21 years of age and older.

Please note: The procedure codes marked with an asterisk (*) are only payable for Medi-Cal members aged 21 and older who are not otherwise exempt when the procedure is appropriately rendered in conjunction with another FRADS.

Table 1: Federally Required Adult Dental Services (FRADS)

CDT 25 Code	CDT 25 Code Description
D0220	Intraoral - periapical first radiographic image
D0230	Intraoral - periapical each additional radiographic image
D0250*	Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector
D0310*	Sialography
D0320*	Temporomandibular joint arthrogram, including injection
D0322*	Tomographic survey
D0330	Panoramic radiographic image
D0502	Other oral pathology procedures, by report
D0999	Unspecified diagnostic procedure, by report

Table 1: Federally Required Adult Dental Services (FRADS)

CDT 25 Code	CDT 25 Code Description
D2910	Recement inlay or re-bond, onlay, veneer or partial coverage restoration
D2920	Recement or re-bond crown
D2940	Placement of interim direct restoration
D5911	Facial moulage (sectional)
D5912	Facial moulage (complete)
D5913	Nasal prosthesis
D5914	Auricular prosthesis
D5915	Orbital prosthesis
D5916	Ocular prosthesis
D5919	Facial prosthesis
D5922	Nasal septal prosthesis
D5923	Ocular prosthesis, interim
D5924	Cranial prosthesis
D5925	Facial augmentation implant prosthesis
D5926	Nasal prosthesis, replacement

Table 1: Federally Required Adult Dental Services (FRADS)

CDT 25 Code	CDT 25 Code Description
D5927	Auricular prosthesis, replacement
D5928	Orbital prosthesis, replacement
D5929	Facial prosthesis, replacement
D5931	Obturator prosthesis, surgical
D5932	Obturator prosthesis, definitive
D5933	Obturator prosthesis, modification
D5934	Mandibular resection prosthesis with guide flange
D5935	Mandibular resection prosthesis without guide flange
D5936	Obturator prosthesis, interim
D5937	Trismus appliance (not for TMD treatment)
D5953	Speech aid prosthesis, adult
D5954	Palatal augmentation prosthesis
D5955	Palatal lift prosthesis, definitive
D5958	Palatal lift prosthesis, interim
D5959	Palatal lift prosthesis, modification
D5960	Speech aid prosthesis, modification
D5982	Surgical stent
D5983	Radiation carrier
D5984	Radiation shield
D5985	Radiation cone locator
D5986	Fluoride gel carrier
D5987	Commissure splint
D5988	Surgical splint

Table 1: Federally Required Adult Dental Services (FRADS)

CDT 25 Code	CDT 25 Code Description
D5999	Unspecified maxillofacial prosthesis, by report
D6092	Recement or Re-bond implant/abutment supported crown
D6093	Recement or Re-bond implant/abutment supported fixed partial denture
D6100	Surgical removal of implant body
D6105	Removal of implant body not requiring bone removal nor flap elevation
D6930	Re-cement or Re-Bond fixed partial denture
D6999	Unspecified fixed prosthodontic procedure, by report
D7111	Extraction, coronal remnants – primary tooth
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated
D7220	Removal of impacted tooth - soft tissue
D7230	Removal of impacted tooth - partially bony
D7240	Removal of impacted tooth - completely bony
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications

Table 1: Federally Required Adult Dental Services (FRADS)

CDT 25 Code	CDT 25 Code Description
D7250	Removal of residual tooth roots (cutting procedure)
D7251	Coronectomy – Intentional partial tooth removal
D7260	Oroantral fistula closure
D7261	Primary closure of a sinus perforation
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7285	Incisional Biopsy of oral tissue - hard (bone, tooth)
D7286	Incisional Biopsy of oral tissue – soft
D7410	Excision of benign lesion up to 1.25 cm
D7411	Excision of benign lesion greater than 1.25 cm
D7412	Excision of benign lesion, complicated
D7413	Excision of malignant lesion up to 1.25 cm
D7414	Excision of malignant lesion greater than 1.25 cm
D7415	Excision of malignant lesion, complicated
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25cm
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm

Table 1: Federally Required Adult Dental Services (FRADS)

CDT 25 Code	CDT 25 Code Description
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm
D7465	Destruction of lesion(s) by physical or chemical method, by report
D7490	Radical resection of mandible with bone graft
D7510	Incision and drainage of abscess - intraoral soft tissue
D7511	Incision and drainage of abscess – intraoral soft tissue- complicated (includes drainage of multiple fascial spaces)
D7520	Incision and drainage of abscess - extraoral soft tissue
D7521	Incision and drainage of abscess – extraoral soft tissue- complicated (includes drainage of multiple fascial spaces)
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue
D7540	Removal of reaction producing foreign bodies, musculoskeletal system
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone

Table 1: Federally Required Adult Dental Services (FRADS)

CDT 25 Code	CDT 25 Code Description
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body
D7610	Maxilla - open reduction (teeth immobilized, if present)
D7620	Maxilla - closed reduction (teeth immobilized, if present)
D7630	Mandible - open reduction (teeth immobilized, if present)
D7640	Mandible - closed reduction (teeth immobilized, if present)
D7650	Malar and/or zygomatic arch - open reduction
D7660	Malar and/or zygomatic arch - closed reduction
D7670	Alveolus - closed reduction, may include stabilization of teeth
D7671	Alveolus - open reduction, may include stabilization of teeth
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches
D7710	Maxilla - open reduction
D7720	Maxilla - closed reduction
D7730	Mandible - open reduction
D7740	Mandible - closed reduction
D7750	Malar and/or zygomatic arch - open reduction
D7760	Malar and/or zygomatic arch - closed reduction
D7770	Alveolus - open reduction stabilization of teeth

Table 1: Federally Required Adult Dental Services (FRADS)

CDT 25 Code	CDT 25 Code Description
D7771	Alveolus, closed reduction stabilization of teeth
D7780	Facial bones - complicated reduction with fixation and multiple surgical approaches
D7810	Open reduction of dislocation
D7820	Closed reduction of dislocation
D7830	Manipulation under anesthesia
D7840	Condylectomy
D7850	Surgical discectomy, with/without implant
D7852	Disc repair
D7854	Synovectomy
D7856	Myotomy
D7858	Joint reconstruction
D7860	Arthrotomy
D7865	Arthroplasty
D7870	Arthrocentesis
D7872	Arthroscopy - diagnosis, with or without biopsy
D7873	Arthroscopy - lavage and lysis of adhesions
D7874	Arthroscopy - disc repositioning and stabilization
D7875	Arthroscopy - synovectomy
D7876	Arthroscopy - debridement
D7877	Arthroscopy - debridement
D7910	Suture of recent small wounds up to 5 cm
D7911	Complicated suture - up to 5 cm
D7912	Complicated suture - greater than 5 cm

Table 1: Federally Required Adult Dental Services (FRADS)

CDT 25 Code	CDT 25 Code Description
D7920	Skin graft (identify defect covered, location and type of graft)
D7940	Osteoplasty - for orthognathic deformities
D7941	Osteotomy - mandibular rami
D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft
D7944	Osteotomy – segmented or subapical
D7945	Osteotomy - body of mandible
D7946	LeFort I (maxilla - total)
D7947	LeFort I (maxilla - segmented)
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft
D7949	LeFort II or LeFort III - with bone graft
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla – autogenous or nonautogenous, by report
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach
D7955	Repair of maxillofacial soft and/or hard tissue defect
D7971	Excision of pericoronal gingiva
D7979	Non-surgical Sialolithotomy *Effective May 16, 2020
D7980	Surgical Sialolithotomy

Table 1: Federally Required Adult Dental Services (FRADS)

CDT 25 Code	CDT 25 Code Description
D7981	Excision of salivary gland, by report
D7982	Sialodochoplasty
D7983	Closure of salivary fistula
D7990	Emergency tracheotomy
D7991	Coronoidectomy
D7995	Synthetic graft - mandible or facial bones, by report
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar
D7999	Unspecified oral surgery procedure, by report
D9110	Palliative (emergency) treatment of dental pain - minor procedure
D9210	Local anesthesia not in conjunction with operative or surgical procedures
D9222	Deep Sedation/General Anesthesia - First 15 Minutes *Effective March 14, 2020
D9223	Deep Sedation/General Anesthesia - Each subsequent 15-minute increment *Effective March 14, 2020
D9230	Inhalation of nitrous oxide/anxiolysis, analgesia
D9239	Intravenous Moderate (Conscious) Sedation/Analgesia - First 15 Minutes *Effective March 14, 2020

**Table 1: Federally Required Adult
Dental Services (FRADS)**

CDT 25 Code	CDT 25 Code Description
D9243	Intravenous Moderate (Conscious) Sedation/Analgesia - Each subsequent 15-minute increment *Effective March 14, 2020
D9248	Non-intravenous conscious sedation
D9410	House/extended care facility call
D9420	Hospital or ambulatory surgical center call
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed

**Table 1: Federally Required Adult
Dental Services (FRADS)**

CDT 25 Code	CDT 25 Code Description
D9440	Office visit - after regularly scheduled hours
D9610	Therapeutic parenteral drug, single administration
D9910	Application of desensitizing medicament
D9930	Treatment of complications (post - surgical) - unusual circumstances, by report
D9999	Unspecified adjunctive procedure, by report

Table 3: Restored Adult Dental Services (RADS)

Effective May 1, 2014, some adult dental benefits have been restored in accordance with Assembly Bill 82 (AB 82).

Table 3: Restored Adult Dental Services (RADS)

CDT 25 Code	CDT 25 Code Description
D0150	Comprehensive oral evaluation - new or established patient
D0210	Intraoral - complete series of radiographic images
D0220	Intraoral - periapical first radiographic image
D0230	Intraoral - periapical each additional radiographic image
D0270	Bitewing - single radiographic image
D0272	Bitewings - two radiographic images
D0274	Bitewings - four radiographic images
D0330	Panoramic radiographic image
D0350	2D Oral/Facial photographic images obtained intra-orally or extra orally
D1110	Prophylaxis - adult
D1206	Topical application of fluoride varnish
D1208	Topical application of fluoride - excluding varnish
D2140	Amalgam - One Surface, Primary or Permanent
D2150	Amalgam - Two Surfaces, Primary or Permanent

Table 3: Restored Adult Dental Services (RADS)

CDT 25 Code	CDT 25 Code Description
D2160	Amalgam - Three Surfaces, Primary or Permanent
D2161	Amalgam - Four or More Surfaces, Primary or Permanent
D2330	resin-based Composite - One Surface, Anterior
D2331	Resin-based Composite - Two Surfaces, Anterior
D2332	resin-based Composite - Three Surfaces, Anterior
D2335	Resin-based Composite - Four Or More Surfaces or Involving Incisal Angle (Anterior)
D2390	Resin-based Composite Crown, Anterior
D2391	Resin-based Composite - One Surface, Posterior
D2392	Resin-based Composite - Two Surfaces, Posterior
D2393	Resin-based Composite - Three Surfaces, Posterior
D2394	Resin-based Composite - Four Or More Surfaces, Posterior
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth
D2932	Prefabricated Resin Crown

Table 3: Restored Adult Dental Services (RADS)

CDT 25 Code	CDT 25 Code Description
D2933	Prefabricated Stainless Steel Crown with Resin Window
D2952	Post And Core in Addition To Crown, Indirectly Fabricated
D2954	Prefabricated Post and Core In Addition To Crown
D2989	Excavation of a tooth resulting in the determination of non-restorability
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)
D3346	Retreatment Of Previous Root Canal Therapy - Anterior
D5110	Complete Denture – Maxillary
D5120	Complete Denture – Mandibular
D5130	Immediate Denture – Maxillary
D5140	Immediate Denture – Mandibular
D5410	Adjust Complete Denture - Maxillary
D5411	Adjust Complete Denture – Mandibular
D5511	Repair broken complete denture base, mandibular *Effective March 14, 2020

Table 3: Restored Adult Dental Services (RADS)

CDT 25 Code	CDT 25 Code Description
D5512	Repair broken complete denture base, maxillary *Effective March 14, 2020
D5520	Replace Missing or Broken Teeth – Complete Denture – per tooth
D5611	Repair resin partial denture base, mandibular *Effective March 14, 2020
D5612	Repair resin partial denture base, maxillary *Effective March 14, 2020
D5730	Reline Complete Maxillary Denture (direct)
D5731	Reline Complete Mandibular Denture (direct)
D5750	Reline Complete Maxillary Denture (indirect)
D5751	Reline Complete Mandibular Denture (indirect)
D5850	Tissue Conditioning, Maxillary
D5851	Tissue Conditioning, Mandibular
D5863	Overdenture – complete maxillary *Effective March 14, 2020

**Table 3: Restored Adult Dental
Services (RADS)**

CDT 25 Code	CDT 25 Code Description
D5865	Overdenture – complete mandibular *Effective March 14, 2020

Table 4: Omnibus Budget Reconciliation Act (OBRA) Emergency Services Only

Those who qualify for Medi-Cal benefits as OBRA members have limited benefits and are only eligible for emergency dental services.

An emergency dental condition is a dental condition manifesting itself by acute symptoms of sufficient severity including severe pain, which in the absence of immediate dental attention could reasonably be expected to result in any of the following:

- placing the patient's health in serious jeopardy,
- serious impairment to bodily functions,
- serious dysfunction of any bodily organ or part.

. To be officially recognized as an emergency, the condition must be properly documented and confirmed by a qualified professional following specific California rules (Title 22, Section 51056).

Please note that TARs are not allowed and may not be submitted for these members. If a TAR is submitted for any of the procedures described below, it will be denied.

The following are identified as emergency dental procedures for OBRA members:

Table 4: Omnibus Budget Reconciliation Act (OBRA) Emergency Services Only

CDT 25 Code	CDT 25 Code Description
D0220	Intraoral - periapical first radiographic image
D0230	Intraoral - periapical each additional radiographic image
D0250	Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector
D0330	Panoramic radiographic image
D0502	Other oral pathology procedures, by report

Table 4: Omnibus Budget Reconciliation Act (OBRA) Emergency Services Only

CDT 25 Code	CDT 25 Code Description
D0999	Unspecified diagnostic procedure, by report
D2920	Recement or re-bond crown
D2940	Placement of interim direct restoration
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament

**Table 4: Omnibus Budget
Reconciliation Act (OBRA)
Emergency Services Only**

CDT 25 Code	CDT 25 Code Description
D3221	Pulpal debridement, primary and permanent teeth
D6051	Placement of interim implant abutment
D6089	Accessing and retorquing loose implant screw
D6092	Recement or Re-bond implant/abutment supported crown
D6093	Recement or Re-bond implant/abutment supported fixed partial denture
D6930	Recement fixed partial denture
D7111	Extraction, coronal remnants - primary tooth
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated
D7220	Removal of impacted tooth - soft tissue
D7230	Removal of impacted tooth - partially bony
D7240	Removal of impacted tooth - completely bony
D7241	Removal of impacted tooth - completely bony,

**Table 4: Omnibus Budget
Reconciliation Act (OBRA)
Emergency Services Only**

CDT 25 Code	CDT 25 Code Description
	with unusual surgical complications
D7250	Removal of residual tooth roots (cutting procedure)
D7260	Oroantral fistula closure
D7261	Primary closure of a sinus perforation
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7285	Biopsy of oral tissue - hard (bone, tooth)
D7286	Biopsy of oral tissue - soft
D7410	Excision of benign lesion up to 1.25 cm
D7411	Excision of benign lesion greater than 1.25 cm
D7412	Excision of benign lesion, complicated
D7413	Excision of malignant lesion up to 1.25 cm
D7414	Excision of malignant lesion greater than 1.25 cm
D7415	Excision of malignant lesion, complicated
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm
D7450	Removal of benign odontogenic cyst or

**Table 4: Omnibus Budget
Reconciliation Act (OBRA)
Emergency Services Only**

CDT 25 Code	CDT 25 Code Description
	tumor - lesion diameter up to 1.25cm
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm
D7490	Radical resection of mandible with bone graft
D7510	Incision and drainage of abscess - intraoral soft tissue
D7511	Incision and drainage of abscess - intraoral soft tissue- complicated (includes drainage of multiple fascial spaces)
D7520	Incision and drainage of abscess - extraoral soft tissue
D7521	Incision and drainage of abscess - extraoral soft tissue- complicated (includes drainage of multiple fascial spaces)
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue
D7540	Removal of reaction producing foreign

**Table 4: Omnibus Budget
Reconciliation Act (OBRA)
Emergency Services Only**

CDT 25 Code	CDT 25 Code Description
	bodies, musculoskeletal system
D7550	Partial ostectomy/sequestrec- tomy for removal of non- vital bone
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body
D7610	Maxilla - open reduction (teeth immobilized, if present)
D7620	Maxilla - closed reduction (teeth immobilized, if present)
D7630	Mandible - open reduction (teeth immobilized, if present)
D7640	Mandible - closed reduction (teeth immobilized, if present)
D7650	Malar and/or zygomatic arch - open reduction
D7660	Malar and/or zygomatic arch - closed reduction
D7670	Alveolus - closed reduction, may include stabilization of teeth
D7671	Alveolus - open reduction, may include stabilization of teeth
D7710	Maxilla - open reduction
D7720	Maxilla - closed reduction
D7730	Mandible - open reduction
D7740	Mandible - closed reduction

**Table 4: Omnibus Budget
Reconciliation Act (OBRA)
Emergency Services Only**

CDT 25 Code	CDT 25 Code Description
D7750	Malar and/or zygomatic arch - open reduction
D7760	Malar and/or zygomatic arch - closed reduction
D7770	Alveolus - open reduction stabilization of teeth
D7771	Alveolus, closed reduction stabilization of teeth
D7810	Open reduction of dislocation
D7820	Closed reduction of dislocation
D7830	Manipulation under anesthesia
D7910	Suture of recent small wounds up to 5 cm
D7911	Complicated suture - up to 5 cm
D7912	Complicated suture - greater than 5 cm
D7979	Non-surgical Sialolithotomy *Effective May 16, 2020
D7980	Surgical Sialolithotomy
D7983	Closure of salivary fistula
D7990	Emergency tracheotomy
D9110	Palliative (emergency) treatment of dental pain - minor procedure
D9210	Local anesthesia not in conjunction with operative or surgical procedures
D9222	Deep Sedation/General Anesthesia - First 15 Minutes

**Table 4: Omnibus Budget
Reconciliation Act (OBRA)
Emergency Services Only**

CDT 25 Code	CDT 25 Code Description
	*Effective March 14, 2020
D9223	Deep Sedation/General Anesthesia - Each subsequent 15-minute increment *Effective March 14, 2020
D9230	Inhalation of nitrous oxide/anxiolysis, analgesia
D9239	Intravenous Moderate (Conscious) Sedation/Analgesia - First 15 Minutes *Effective March 14, 2020
D9243	Intravenous Moderate (Conscious) Sedation/Analgesia - Each subsequent 15-minute increment *Effective March 14, 2020
D9248	Non-intravenous conscious sedation
D9410	House/extended care facility call
D9420	Hospital or ambulatory surgical center call
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed
D9440	Office visit - after regularly scheduled hours

2025

**Table 4: Omnibus Budget
Reconciliation Act (OBRA)
Emergency Services Only**

CDT 25 Code	CDT 25 Code Description
D9610	Therapeutic parenteral drug, single administration
D9910	Application of desensitizing medicament
D9920	Behavior management, by report
D9930	Treatment of complications (post - surgical) - unusual circumstances, by report
D9951	Occlusal adjustment - limited
D9957	Screening for sleep related breathing disorders

Table 5: Exempt Dental Services

The following procedures have been identified as always exempt from the \$1,800 dental soft cap. For details about the dental soft cap, please refer to “Section 4 – Treating Members, \$1,800 Limit per Calendar Year for Member Dental Services, with Exceptions” of this Handbook.

Table 5: Exempt Dental Services

CDT 25 Code	CDT 25 Code Description
D0310	Sialography
D0320	Temporomandibular joint arthrogram, including injection
D0322	Tomographic survey
D0502	Other oral pathology procedures, by report
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration
D2920	Recement or re-bond crown
D5110	Complete denture - maxillary
D5120	Complete denture - mandibular
D5130	Immediate denture - maxillary
D5140	Immediate denture - mandibular
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)

Table 5: Exempt Dental Services

CDT 25 Code	CDT 25 Code Description
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)
D5410	Adjust complete denture - maxillary
D5411	Adjust complete denture - mandibular
D5421	Adjust partial denture - maxillary
D5422	Adjust partial denture - mandibular
D5660	Add clasp to existing partial denture- per tooth
D5730	Reline complete maxillary denture (direct)
D5731	Reline complete mandibular denture (direct)
D5740	Reline maxillary partial denture (direct)
D5741	Reline mandibular partial denture (direct)
D5850	Tissue conditioning, maxillary
D5851	Tissue conditioning, mandibular
D5863	Overdenture – complete maxillary *Effective March 14, 2020
D5865	Overdenture – complete mandibular *Effective March 14, 2020
D5911	Facial moulage (sectional)

2025

Table 5: Exempt Dental Services

CDT 25 Code	CDT 25 Code Description
D5912	Facial moulage (complete)
D5913	Nasal prosthesis
D5914	Auricular prosthesis
D5915	Orbital prosthesis
D5916	Ocular prosthesis
D5919	Facial prosthesis
D5922	Nasal septal prosthesis
D5923	Ocular prosthesis, interim
D5924	Cranial prosthesis
D5925	Facial augmentation implant prosthesis
D5926	Nasal prosthesis, replacement
D5927	Auricular prosthesis, replacement
D5928	Orbital prosthesis, replacement
D5929	Facial prosthesis, replacement
D5931	Obturator prosthesis, surgical
D5932	Obturator prosthesis, definitive
D5933	Obturator prosthesis, modification
D5934	Mandibular resection prosthesis with guide flange
D5935	Mandibular resection prosthesis without guide flange
D5936	Obturator prosthesis, interim
D5937	Trismus appliance (not for TMD treatment)
D5951	Feeding aid
D5953	Speech aid prosthesis, adult
D5954	Palatal augmentation prosthesis

Table 5: Exempt Dental Services

CDT 25 Code	CDT 25 Code Description
D5955	Palatal lift prosthesis, definitive
D5958	Palatal lift prosthesis, interim
D5959	Palatal lift prosthesis, modification
D5960	Speech aid prosthesis, modification
D5982	Surgical stent
D5983	Radiation carrier
D5984	Radiation shield
D5985	Radiation cone locator
D5986	Fluoride gel carrier
D5987	Commissure splint
D5988	Surgical splint
D5999	Unspecified maxillofacial prosthesis, by report
D6010	Surgical placement of implant body: endosteal implant
D6013	Surgical Placement of Mini Implant *Effective March 14, 2020
D6040	Surgical placement: eposteal implant
D6050	Surgical placement: transosteal implant
D6055	Connecting bar - implant supported or abutment supported
D6056	Prefabricated abutment - includes modification and placement
D6057	Custom fabricated abutment - includes placement
D6058	Abutment supported porcelain/ceramic crown

Table 5: Exempt Dental Services

CDT 25 Code	CDT 25 Code Description
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)
D6063	Abutment supported cast metal crown (predominantly base metal)
D6065	Implant supported porcelain/ceramic crown
D6068	Abutment supported retainer for porcelain/ceramic FPD
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)
D6075	Implant supported retainer for ceramic FPD
D6080	Implant maintenance procedures when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments
D6081	Scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths; includes cleaning of the implant surfaces, without flap entry and closure
D6082	Implant supported crown – porcelain fused to predominately base alloys *Effective July 1, 2021

Table 5: Exempt Dental Services

CDT 25 Code	CDT 25 Code Description
D6086	Implant supported crown – predominately base alloys *Effective July 1, 2021
D6090	Repair of implant/abutment supported prosthesis
D6091	Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment
D6092	Recement or Re-bond implant/abutment supported crown
D6093	Recement or Re-bond implant/abutment supported fixed partial denture
D6098	Implant supported retainer – porcelain fused to predominately base alloys *Effective July 1, 2021
D6100	Surgical removal of implant body
D6110	Implant/Abutment Supported Removable Denture for Edentulous Arch – Maxillary *Effective March 14, 2020
D6111	Implant/Abutment Supported Removable Denture for Edentulous Arch – Mandibular *Effective March 14, 2020

Table 5: Exempt Dental Services

CDT 25 Code	CDT 25 Code Description
D6112	Implant/Abutment Supported Removable Denture for Partially Edentulous Arch – Maxillary *Effective March 14, 2020
D6113	Implant/Abutment Supported Removable Denture for Partially Edentulous Arch – Mandibular *Effective March 14, 2020
D6114	Implant/Abutment Supported Fixed Denture for Edentulous Arch – Maxillary *Effective March 14, 2020
D6115	Implant/Abutment Supported Fixed Denture for Edentulous Arch – Mandibular *Effective March 14, 2020
D6116	Implant/Abutment Supported Fixed Denture for Partially Edentulous Arch – Maxillary *Effective March 14, 2020
D6117	Implant/Abutment Supported Fixed Denture for Partially Edentulous Arch – Mandibular *Effective March 14, 2020
D6121	Implant supported retainer for metal FPD- predominately base alloys *Effective July 1, 2021
D6191	Semi-precision abutment – placement *Effective October 1, 2021

Table 5: Exempt Dental Services

CDT 25 Code	CDT 25 Code Description
D6192	Semi-precision attachment – placement *Effective October 1, 2021
D6199	Unspecified implant procedure, by report
D6930	Recement fixed partial denture
D6980	Fixed partial denture repair, necessitated by restorative material failure
D6999	Unspecified fixed prosthodontic procedure, by report
D7260	Oroantral fistula closure
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7285	Incisional Biopsy of oral tissue - hard (bone, tooth)
D7286	Incisional Biopsy of oral tissue - soft
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25cm
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm

Table 5: Exempt Dental Services

CDT 25 Code	CDT 25 Code Description
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm
D7490	Radical resection of mandible with bone graft
D7510	Incision and drainage of abscess - intraoral soft tissue
D7511	Incision and drainage of abscess - intraoral soft tissue- complicated (includes drainage of multiple fascial spaces)
D7520	Incision and drainage of abscess - extraoral soft tissue
D7521	Incision and drainage of abscess - extraoral soft tissue- complicated (includes drainage of multiple fascial spaces)
D7540	Removal of reaction producing foreign bodies, musculoskeletal system
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body
D7610	Maxilla - open reduction (teeth immobilized, if present)
D7620	Maxilla - closed reduction (teeth immobilized, if present)
D7630	Mandible - open reduction (teeth immobilized, if present)

Table 5: Exempt Dental Services

CDT 25 Code	CDT 25 Code Description
D7640	Mandible - closed reduction (teeth immobilized, if present)
D7650	Malar and/or zygomatic arch - open reduction
D7660	Malar and/or zygomatic arch - closed reduction
D7670	Alveolus - closed reduction, may include stabilization of teeth
D7671	Alveolus - open reduction, may include stabilization of teeth
D7710	Maxilla - open reduction
D7720	Maxilla - closed reduction
D7730	Mandible - open reduction
D7740	Mandible - closed reduction
D7750	Malar and/or zygomatic arch - open reduction
D7760	Malar and/or zygomatic arch - closed reduction
D7770	Alveolus - open reduction stabilization of teeth
D7771	Alveolus, closed reduction stabilization of teeth
D7810	Open reduction of dislocation
D7820	Closed reduction of dislocation
D7830	Manipulation under anesthesia
D7840	Condylectomy
D7850	Surgical discectomy, with/without implant
D7852	Disc repair
D7854	Synovectomy
D7856	Myotomy
D7858	Joint reconstruction
D7860	Arthrotomy

2025

Table 5: Exempt Dental Services

CDT 25 Code	CDT 25 Code Description
D7865	Arthroplasty
D7870	Arthrocentesis
D7872	Arthroscopy - diagnosis, with or without biopsy
D7873	Arthroscopy - lavage and lysis of adhesions
D7874	Arthroscopy - disc repositioning and stabilization
D7875	Arthroscopy - synovectomy
D7876	Arthroscopy - debridement
D7877	Arthroscopy - debridement
D7910	Suture of recent small wounds up to 5 cm
D7911	Complicated suture - up to 5 cm
D7912	Complicated suture - greater than 5 cm
D7920	Skin graft (identify defect covered, location and type of graft)
D7940	Osteoplasty - for orthognathic deformities
D7941	Osteotomy - mandibular rami
D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft
D7944	Osteotomy - segmented or subapical
D7945	Osteotomy - body of mandible
D7946	LeFort I (maxilla - total)
D7947	LeFort I (maxilla - segmented)
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft

Table 5: Exempt Dental Services

CDT 25 Code	CDT 25 Code Description
D7949	LeFort II or LeFort III - with bone graft
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla – autogenous or nonautogenous, by report
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach
D7952	Sinus augmentation via a vertical approach
D7955	Repair of maxillofacial soft and/or hard tissue defect
D7961	Buccal/labial frenectomy (frenulectomy) *Effective October 1, 2021
D7962	Lingual frenectomy (frenulectomy) *Effective October 1, 2021
D7979	Non-surgical Sialolithotomy *Effective May 16, 2020
D7980	Surgical Sialolithotomy
D7981	Excision of salivary gland, by report
D7982	Sialodochoplasty
D7983	Closure of salivary fistula
D7991	Coronoidectomy
D7993	Surgical placement of craniofacial implant – extra oral *Effective October 1, 2021
D7994	Surgical placement: zygomatic implant *Effective October 1, 2021
D7995	Synthetic graft - mandible or facial bones, by report

2025

Table 5: Exempt Dental Services

CDT 25 Code	CDT 25 Code Description
D7997	Appliance removal (not by dentist who placed appliance), includes removal of arch bar
D7999	Unspecified oral surgery procedure, by report
D9222	Deep Sedation/General Anesthesia - First 15 Minutes *Effective March 14, 2020
D9223	Deep Sedation/General Anesthesia - Each subsequent 15-minute increment *Effective March 14, 2020
D9239	Intravenous Moderate (Conscious) Sedation/Analgesia - First 15 Minutes *Effective March 14, 2020
D9243	Intravenous Moderate (Conscious) Sedation/Analgesia - Each subsequent 15-minute increment *Effective March 14, 2020
D9920	Behavior management, by report
D9995	Teledentistry – Synchronous; Real-time encounter *Effective May 16, 2020
D9996	Teledentistry – Asynchronous; Information stored and forwarded to dentist for subsequent review. *Transmission costs associated with store and forward are not payable *Effective May 16, 2020

2025

Table 6: Exempt Emergency Dental Services

The following procedure codes may be exempt from the dental soft cap if they are related to an adequately documented emergency service pursuant to W&I Code 14080(a)(1). An emergency dental service is defined under W&I Code 14080 as a dental condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. For details about the soft dental cap, please refer to “Section 4 – Treating Members, \$1,800 Limit per Calendar Year for Member Dental Services, with Exceptions” of this Handbook.

Table 6: Exempt Emergency Dental Services	
CDT 25 Code	CDT 25 Code Description
D0160	Detailed and extensive oral evaluation - problem focused by report
D0220	Intraoral - periapical first radiographic image
D0230	Intraoral - periapical each additional radiographic image
D0240	Intraoral - occlusal radiographic image
D0250*	Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector
D0270	Bitewing - single radiographic image
D0272	Bitewings - two radiographic images
D0274	Bitewings - four radiographic images
D0330	Panoramic radiographic image
D0999	Unspecified diagnostic procedure by report

Table 6: Exempt Emergency Dental Services	
CDT 25 Code	CDT 25 Code Description
D1551	Re-cement or re-bond bilateral space maintainer – maxillary *Effective July 1, 2021
D1552	Re-cement or re-bond bilateral space maintainer – mandibular *Effective July 1, 2021
D1553	Re-cement or re-bond unilateral space maintainer – per quadrant *Effective July 1, 2021
D2940	Placement of interim direct restoration
D2956	Removal of an indirect restoration on a natural tooth
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament
D3221	Pulpal debridement primary and permanent teeth

Table 6: Exempt Emergency Dental Services	
CDT 25 Code	CDT 25 Code Description
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)
D3240	Pulpal therapy (resorbable filling) - posterior primary tooth (excluding final restoration)
D3999	Unspecified endodontic procedure by report
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)
D4999	Unspecified periodontal procedure by report
D5511	Repair broken complete denture base, mandibular *Effective March 14, 2020
D5512	Repair broken complete denture base, maxillary *Effective March 14, 2020
D5520	Replace missing or broken teeth - complete denture – per tooth
D5611	Repair resin partial denture base, mandibular *Effective March 14, 2020
D5612	Repair resin partial denture base, maxillary *Effective March 14, 2020
D5621	Repair cast partial denture framework, mandibular *Effective March 14, 2020
D5622	Repair cast partial denture framework, maxillary *Effective March 14, 2020
D5630	Repair or replace broken retentive/clasping materials per tooth

Table 6: Exempt Emergency Dental Services	
CDT 25 Code	CDT 25 Code Description
D5640	Replace missing or broken teeth partial denture – per tooth
D5650	Add tooth to existing partial denture
D6100	Surgical removal of implant body
D6180	Implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments
D6193	Replacement of an implant screw
D7111	Extraction coronal remnants - primary tooth
D7140	Extraction erupted tooth or exposed root (elevation and/or forceps removal)
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, AND including elevation of mucoperiosteal flap if indicated
D7220	Removal of impacted tooth - soft tissue
D7230	Removal of impacted tooth - partially bony
D7240	Removal of impacted tooth - completely bony
D7241	Removal of impacted tooth - completely bony with unusual surgical complications
D7250	Removal of residual tooth roots (cutting procedure)

2025

Table 6: Exempt Emergency Dental Services	
CDT 25 Code	CDT 25 Code Description
D7251	Coronectomy – Intentional partial tooth removal
D7259	Nerve Dissection
D7261	Primary closure of a sinus perforation
D7410	Excision of benign lesion up to 1.25 cm
D7411	Excision of benign lesion greater than 1.25 cm
D7412	Excision of benign lesion complicated
D7413	Excision of malignant lesion up to 1.25 cm
D7414	Excision of malignant lesion greater than 1.25 cm
D7415	Excision of malignant lesion complicated
D7465	Destruction of lesion(s) by physical or chemical method by report
D7530	Removal of foreign body from mucosa skin or subcutaneous alveolar tissue
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches
D7780	Facial bones - complicated reduction with fixation and multiple surgical approaches
D7970	Excision of hyperplastic tissue - per arch
D7971	Excision of pericoronal gingiva

Table 6: Exempt Emergency Dental Services	
CDT 25 Code	CDT 25 Code Description
D7990	Emergency tracheotomy
D8091	Comprehensive orthodontic treatment with orthognathic surgery
D8671	Periodic orthodontic visit associated with orthognathic surgery
D8696	Repair of orthodontic appliance – maxillary *Effective July 1, 2021
D8697	Repair of orthodontic appliance – mandibular *Effective July 1, 2021
D9110	Palliative (emergency) treatment of dental pain - minor procedure
D9120	Fixed partial denture sectioning
D9210	Local anesthesia not in conjunction with operative or surgical procedures
D9230	Inhalation of nitrous oxide/anxiolysis analgesia
D9248	Non-intravenous conscious sedation
D9410	House/extended care facility call
D9420	Hospital or ambulatory surgical center call
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed
D9440	Office visit - after regularly scheduled hours
D9610	Therapeutic parenteral drug single administration

Table 6: Exempt Emergency Dental Services	
CDT 25 Code	CDT 25 Code Description
D9910	Application of desensitizing medicament
D9930	Treatment of complications (post - surgical) - unusual circumstances by report
D9999	Unspecified adjunctive procedure by report