DentaQuest
*Serving the Health Safety Net Program**

MassHealth

Health Safety Net Dental Program

Commonwealth of Massachusetts

June 1, 2022

Office Reference Manual
CHC's, HLHC's, & Acute Hospital Outpatient Departments

465 Medford Street
Boston, MA 02129
1.800.207.5019

www.masshealth-dental.net

DentaQuest
*Serving the Health Safety Net Program**

Health Safety Net Dental Provider Quick Reference Directory

masshealth-dental.net

MassHealth

Provider Services	Phone Number	E-mail Address	Mailing Address
Eligibility, Claim Submission & Status	1.800.207.5019	masshealth-dental.net	DentaQuest Health Safety Net- Eligibility & Services P.O. Box 2906 Milwaukee, WI 53201-2906
TDD (Hearing Impaired)	1.800.466.7566		
Health Safety Net Help Desk			
For questions about HSN policy, INET, Dental, HSN remittances on HSN claim payments.	1.800.609.7232	HSNHelpdesk@state.ma.us	
Authorizations			
Prior Authorizations (PA)	1.800.207.5019		Health Safety Net Dental – PA P.O. Box 2906 Milwaukee, WI 53201-2906
Claims			
Paper Claims Submission	1.800.207.5019	claims@masshealth-dental.net	Health Safety Net Dental – Claims P.O. Box 2906 Milwaukee, WI 53201-2906
90 Day Waiver/Final Deadline Waiver Request	1.800.207.5019		Health Safety Net Dental – 90 Day and Final Deadline Waiver/Requests 465 Medford Street P.O. Box 9708 Boston, MA 02114-9708
Electronic Claims			
EDI Claims Submission (837DTransactions) and Remittance Advice	1.800.207.5019	claims@masshealth-dental.net	Health Safety Net Dental – Claims P.O. Box 2906 Milwaukee, WI 53201-2906
Via Website at www.masshealth-dental.net Via Clearinghouse Payer ID CKMA1	1.800.207.5019	EDITeam@greatdentalplans.com	
Provider Complaints and Fraud			
Provider Complaints Fraud Hotline	1.800.207.5019 1.800.237.9139	masshealth-dental.net	Health Safety Net Dental – Claims P.O. Box 2906 Milwaukee, WI 53201-2906

***The Health Safety Net offers you the ability to submit HIPAA-compliant claims to: www.masshealth-dental.net. You may also submit claims through an approved clearinghouse trading partner. Please contact your software vendor to ensure that the Health Safety Net is listed as a payer. The HSN is CKMA1. For greater detail, please contact Customer Service at: 1-800-207-5019 or your Provider Relations Representative.

HSN Team at DentaQuest			
Tracy Gilman (Chase)	1.617.886.1310	tracy.chase@dentaquest.com	Regional Director, MassHealth
Sean Moran	1.617.886.1725	Sean.moran@dentaquest.com	Provider Intervention Specialist
Daniel Archambault	1.617.886.1736	daniel.archambault@dentaquest.com	Provider Relations Representative
Keishia Lopez	1.617.886.1727	keishia.lopez@dentaquest.com	Provider Relations Representative

Thank you to all of the providers who currently participate with the Health Safety Net. Your commitment to serving your community and providing the best possible care to our patients is greatly appreciated. Our goal is to continue to raise the bar in terms of customer service. Please reach out any time you have concerns, suggestions, or praise, as we continue to work together to promote oral health within the Commonwealth of Massachusetts.

Sincerely,
The Health Safety Net Team at DentaQuest

**DentaQuest is the subcontractor to Dental Service of Massachusetts, Inc.*

Health Safety Net Dental Program

The Health Safety Net (HSN) makes payments to Massachusetts hospitals and community health centers for health care services provided to low-income Massachusetts residents who are uninsured or underinsured. The HSN is administered by the Office of Medicaid within the Executive Office of Health and Human Services.

The Health Safety Net pays for the same set of dental services that are covered by MassHealth Standard, plus certain services which used to be covered by MassHealth but are not currently covered by MassHealth. Patients may be determined eligible only for the HSN or may be determined eligible for MassHealth with HSN as a secondary payer for certain services. The Health Safety Net prices dental services using MassHealth's dental fee schedule.

As of November 2016, DentaQuest administers the Health Safety Net Dental program. HSN dental providers submit dental claims directly to DentaQuest for processing and pricing. The Health Safety Net makes a monthly payment to providers, which includes payment for both medical and dental services.

This Office Reference Manual provides important information for HSN providers about eligible dental services, claims, clinical criteria, and other processes.

* * *

The Health Safety Net Dental Program makes every effort to maintain accurate information in this manual; however, the Health Safety Net Dental Program and its administrator will not be held liable for any damages directly or indirectly due to typographical errors. Please contact us should you discover an error.

Office Reference Manual
Table of Contents

What is the Health Safety Net Dental Program?

The Health Safety Net Dental Program is based upon Commonwealth of Massachusetts regulations governing dental services found in 101 CMR 613.00 and 101 CMR 614.00. All Acute Hospitals, Community Health Center (CHC), and Hospital Licensed Health Centers (HLHC) must comply with these regulations. Please refer to the Health Safety Net web page at www.mass.gov/healthsafetynet for additional information and regulations. If there is a conflict between the Office Reference Manual and the regulations, the regulations take precedence in every case.

Health Safety Net Eligibility & Reimbursable Service Provisions

Eligible Services Categories There are three categories of services eligible for payment from the Health Safety Net, as follows:

1. Reimbursable Health Services to Low Income Patients as defined in 101 CMR 613.04.
2. Medical Hardship, pursuant to the requirements in 101 CMR 613.05; and
3. Bad Debt, pursuant to the requirements in 101 CMR 613.06.

Low Income Patients

"Low Income Patient" is the term used in Health Safety Net regulations to refer to a Health Safety Net patient. The Health Safety Net pays for Reimbursable Health Services provided to Low Income Patients for services provided during the Eligibility Period specified in 101 CMR 613.04(5). The Eligibility Period usually starts ten days before the date of application.

Reimbursable Health Services

The Health Safety Net pays only for the Reimbursable Health Services listed in this Office Reference Manual. Providers may submit claims only for Reimbursable Health Services provided by Acute Hospitals and Community Health Centers in accordance with the MassHealth Standard program using the payment codes as listed in Subchapter 6 of the *MassHealth Inpatient and Outpatient Provider Manuals* and other MassHealth Provider manuals unless otherwise specified in 101 CMR 614.00: *Health Safety Net Payments and Funding*.

Acute Hospitals

The Health Safety Net pays acute hospitals and HLHC's only for dental services identified in Subchapter 6 of the MassHealth *Dental Manual* and for Adult Dental Services not covered by MassHealth, as further clarified in Appendix D of this Office Reference Manual.

Community Health Centers

The Health Safety Net pays CHCs only for dental services identified in Subchapter 6 of the MassHealth *Dental Manual* and for Adult Dental Services not covered by MassHealth, as further clarified in Appendix D of this Office Reference Manual.

Community Health Centers may submit claims only for services provided under the Community Health Center's clinic license. A Community Health Center may submit claims only for dental services provided on site, with the exception that a Community Health Center may submit claims for dentures provided on site but manufactured or repaired at an off-site contractor.

Reimbursable Health Services Limitations

The Health Safety Net does not pay for any of the following services: nonmedical services, such as social, educational, and vocational services; cosmetic surgery; canceled or missed appointments; telephone conversations or consultations; court testimony; research or the provision of experimental, cosmetic, unproven, or otherwise medically unnecessary procedures or treatments.

Health Safety Net-Dental Plan Types

HSN Adult – HSN will pay for all HSN eligible dental services that are allowable for adults. Patients may qualify only for the HSN, or may also be enrolled in:

- Private Insurance
- ConnectorCare
- Medicare
- Student Health Insurance
- The Children's Medical Security Program (CMSP)
- Emergency Aid to the Elderly, Disabled, and Children (EAEDC)
- MassHealth Buy-In or Senior Buy-In
- MassHealth Family Assistance (Premium Assistance Only)
- Other insurance not listed above

HSN Under 21 – HSN will pay for all HSN eligible dental services that are allowable for children. Patients may qualify only for the HSN or may also be enrolled in a program or insurance plan listed above.

HSN Secondary to MassHealth Limited Adult – HSN will pay for eligible dental services that are allowable for adults and that are not covered by MassHealth Limited. Patients are eligible for MassHealth Limited as their primary payer, with the HSN as their secondary payer.

HSN Secondary to MassHealth Limited Under 21 – HSN will pay for eligible dental services that are allowable for children and that are not covered by MassHealth Limited. Patients are eligible for MassHealth Limited as their primary payer, with the HSN as their secondary payer.

HSN Secondary to MassHealth Comprehensive (Adult Only) – HSN will pay for certain dental services that MassHealth does not cover for adults at CHCs and hospital-based health centers. Patients may be enrolled in:

- MassHealth Standard
- MassHealth CarePlus
- MassHealth CommonHealth
- Most types of MassHealth Family Assistance

HSN CMSP Wrap- HSN will pay for eligible dental services allowable for eligible CMSP members that are not covered by MassHealth CMSP due to benefit coverage or exceeding the deductible. HSN CMSP wrap coverage does not have a deductible limitation for CMSP members.

1.00 Provider Services

1.01 Dedicated Call Center for Dental Providers

The Health Safety Net Dental Program offers participating providers access to customer service representatives who specialize in areas such as:

- Eligibility, covered services and authorizations
- Claims, and
- Intervention Services

You can reach customer service at 1.800.207.5019.

1.02 Provider Complaints & Reconsiderations

Providers may submit complaints and reconsiderations to the MassHealth Dental Program via the MassHealth Provider Web Portal (www.masshealth-dental.net) under contact us or in writing.

Some examples of complaints and reconsiderations include:
-Denial of a prior authorization that the provider feels should be approved due to new information (information not submitted with the case originally). Submit thorough documentation including a narrative containing new information on office letterhead with the date of submission and clear photographs / radiographs (if appropriate).
-Claim denials due to *tooth previously extracted*, if the tooth in question was not extracted prior and a recent radiograph, clinical notes and a narrative can be submitted.
-*Untimely filing* denials
-Denials for *service not billable due to denture placement* when teeth are still present. Submit a recent radiograph of the tooth / teeth in question, clinical notes and a narrative on office letterhead.
-*Patient not eligible* denials- Provide a copy of proof of eligibility from the member eligibility detail screen or member eligibility list from the date of service. Documentation provided must be time and date stamped for the patient's actual date of service.

Written provider complaints should be directed to:

MassHealth Dental Program
Attention: Intervention Services
P.O. Box 9708
Boston, MA 02114-9708

1.03 Provider Training

The Health Safety Net Dental Program offers free provider training sessions periodically throughout the Commonwealth of Massachusetts. These sessions include important information such as: claims submission procedures (835 & 837 processes / requirements, trading partner portal), prior-authorization criteria, web portal instruction, EOB's, how to access the Health Safety Net's Dental Program clinical personnel, customer service / provider relations contacts, etc. In addition, providers can

contact a Health Safety Net Provider Relations Representative for assistance, or request a personal, in-office visit at 1.800.207.5019.

1.04 Provider Web Portal

The Health Safety Net Dental Program shares the MassHealth Dental Program self-service options through the Internet (www.masshealth-dental.net) that allow Participating Health Safety Net Dental Program providers to access several helpful options including the ability to:

- Check patient eligibility and verification
- Submit prior authorizations
- Submit claims
- View claim status
- Create claim tracking reports
- Submit attachments
- Create and submit general inquiries, complaints, grievances, and reconsiderations
- Log broken appointments
- Access important trainings, forms, and the Office Reference Manual

For more information, contact the DentaQuest Health Safety Net Team at 1.800.207.5019.

1.05 Provider Directory

To obtain a full provider directory to include all providers participating in the HSN provider network contact the Health Safety Net Dental Program customer service team at 1.800.207.5019 or log into the provider portal at www.masshealth-dental.net.

2.00 Eligibility Verification Procedures

2.01 Health Safety Net Dental Program Eligibility

Dental services are payable for Health Safety Net patients as specified in 101 CMR 613.04 and in Appendix D of this manual.

2.02 Health Safety Net Dental Program Eligibility System

Participating Health Safety Net providers may access patient eligibility information 24 hours a day, 7 days a week through the Health Safety Net Dental Program's Interactive Voice Response (IVR) system or through the Internet at www.masshealth-dental.net.

Access to Eligibility Information via the Internet:

The MassHealth / Health Safety Net Dental Program's provider web portal allows providers to verify a patient's eligibility online by entering the patient's date of birth, the expected date of service and the patient's identification number or last name and first initial.

The MassHealth / Health Safety Net Dental Program website is located at www.masshealth-dental.net.
Access to Eligibility Information via the Interactive Voice Response (IVR) line:

To access the IVR, please call the Health Safety Net Dental Program's Customer Service Department at 1.800.207.5019.

The IVR can address eligibility and limited claims history inquiries for as many patients as requested.

Once these checks have been completed, you will have the option to select other choices and if needed, speak to a customer service representative to assist with additional questions, e.g., coverage information or claims inquiries.

After the system analyzes the information, the member's eligibility for covered dental services will be verified. A fax of the member eligibility verification and history is available through the IVR system.

Specific instructions for the IVR to check eligibility are listed below. If the system is unable to verify the member information entered, the caller will be transferred to a Customer Service Representative during normal business hours (8:00 AM-6:00 PM, M-F).If the system is unable to verify the patient information entered, the caller will be transferred to a Customer Service Representative during normal business hours (8:00 AM-6:00 PM, M-F).

Directions for using the Health Safety Net Dental Program's IVR to Verify Eligibility and Check Limited Claims History:
Entering system with Tax and Location ID's

- Dial – 1.800.207.5019
- Greeting: Welcome to the Mass Health Dental Program
- Verify you are a MassHealth provider

****There is a self-service announcement at this point****

- Please enter your NPI Number
- Please enter the last four of your Tax Identification Number

****The system will repeat the NPI for verification****

- If you have a Member ID that is numbers only, please press 1 / If you have a Member ID that contains letters and numbers, please press 2

****The system will repeat the Member ID for verification****

- Enter the Member's Date of Birth

****The system will repeat the Member's Date of Birth****

***At this point, the system will run off a list of options for the caller to hear and choose from.** **

****<u>Please note</u> that eligibility information is only valid on the day for which eligibility is requested. To ensure that the member was showing active plan coverage on the Date of Service in question, proof of eligibility (Member Detail page) via the Provider Web Portal should be retrieved <u>on the actual DOS</u> and saved for your records. A print screen verification, or an OFFICIAL Time Stamp, will automatically appear on either the top/bottom of the member detail page. Before printing screen for your records, please make sure page is in printer friendly format****

Payment is not guaranteed if the service is either not eligible for HSN payment or if the patient's plan type does not pay for dental services. Also, please note limited patient history is available on both the IVR and at www.masshealth-dental.net. The history information is not all inclusive. This information is provided as a convenience to the provider and is not to be considered as a guarantee of payment.
To report any difficulty accessing either the IVR or website, please contact the Customer Service Department at 1.800.207.5019 or contact your provider relations representative directly. They will be able to provide assistance in using either system.

3.00 Authorization for Treatment

3.01 Prior Authorization Request for CPT Codes

Oral Surgery specialists requesting prior authorization for services listed with a Current Procedural Terminology (CPT) code must submit online to medical through the MMIS Provider Online Service Center (POSC) using the **HSN Prior Authorization (PA-1) Form.** Refer to the appendices at the back of your provider manual or the contact page at the front of this provider manual for the mailing address for prior authorization forms.

Oral surgery specialists can register for the Provider Online Service Center (POSC) by completing the Data Collection Form and Registration Instructions (DCFR). Please see the link below.

https://www.mass.gov/files/documents/2018/06/08/poscdc.pdf?_ga=2.263523340.1048447798.1554753108-574009487.1546285523

Refer to the exhibits in the back of this document for prior authorization requirements.

Note: HSN will not process 837D transactions or ADA claim forms with CDT codes. DentaQuest will process all 837D transactions containing CDT codes beginning January 1, 2017. Oral Surgery specialists will continue to submit prior authorization requests and claims with the CDT codes on the ADA-2012 form to DentaQuest for processing.

3.02 Eligible Services Requiring Authorization

Under the Health Safety Net Dental Program, there are several services that require prior authorization or retrospective review. Authorization is a process which requires HSN providers to submit documentation substantiating the medical necessity of a requested dental service for a patient. Participating providers' claims will not be paid if the required prior authorization is not requested and approved.

The Health Safety Net Dental Program uses specific dental criteria as well as an authorization process to provide medically necessary services to Health Safety Net patients. The Health Safety Net Dental Program's operational focus is to assure compliance with the criteria specified in the Health Safety Net Dental regulation at 101 CMR 613.04. The criteria are included in this manual in Section 15.00. Please review these criteria as well as the eligible services to understand the decision-making process used to determine payment for services provided.

- Prior Authorization shall mean authorization requested and documentation submitted before treatment begins.
- Retrospective Review shall mean documentation submitted with a claim after treatment is rendered to determine payment of the service.

Services that require prior authorization should not be started before a determination regarding approval or denial of the authorization. Treatment requiring prior authorization started before this determination is performed at the financial risk of the dental provider.

Services that require retrospective review, but not prior authorization, will require proper documentation before consideration for payment. Documentation will also be required when a service that normally requires prior authorization is done on an emergency basis.

Submission of documentation should include the following:

1. Radiographs, narrative, or other information where requested (See Exhibits A-E for specifics by code).

2. Orthodontic HLD Index Form for orthodontic treatment found in Appendix B-2 and if applicable, supporting medical necessity documentation. (See HLD form for further information.)

Electronic Submission:

Request for prior authorization may be submitted electronically through the MassHealth provider web portal link located at www.masshealth-dental.net. Authorizations are processed within two business days, not to exceed 21 calendar days.

Please see the extensive user manual regarding how to submit claims and prior authorizations at www.masshealth-dental.net.

3.03 Authorization for Operating Room (OR) Elective Cases

Prior authorization (PA) is not required before services can be performed in an operating room (OR) of a Hospital Outpatient Department or a Hospital-Licensed Health Center to allow the patient to be sedated. The facility must be a Health Safety Net provider for the facility fees to be paid by the Health Safety Net.

Patient apprehension alone is not sufficient justification for the use of a hospital (inpatient or outpatient setting). Lack of facilities for administering general anesthesia when the procedure can be routinely performed with local anesthesia does not justify use of a hospital or a freestanding ambulatory surgery center.

The guidelines are available at:
http://www.mass.gov/eohhs/docs/masshealth/providermanual/appx-h-den.pdf.

Trauma, Urgent and Accident (Non-elective) Cases

Services provided in a hospital emergency room are billed by the hospital to the Health Safety Net as a hospital claim and do not require dental prior authorization.

If the dentist/oral surgeon hospital-based, then the hospital may bill for an additional amount for the professional (dental) services as appropriate.

3.04 Payment for Non-Eligible Services

A provider may charge a Health Safety Net patient for dental services which are not eligible services only if the patient knowingly elects to receive the services and enters into an agreement in writing to pay for such services prior to receiving them. Non-eligible services include:

- Services not eligible for payment under the Health Safety Net Program
- Services for which prior-authorization has been denied and deemed not medically necessary.

Substitutions

Program Regulations (130 CMR 420.000); 420.409: Noncovered Circumstances

Providers may upgrade medically necessary services at no additional cost to the MassHealth agency or the member.

MassHealth allows participating dentists to provide a service of greater value and bill for the code covered by the program accepting the allowable rate.

Your office will need to document the service that was provided in the notes section of the claim form and cite the regulation.

3.05 Electronic Attachments

The MassHealth /Health Safety Net Dental Program accepts claim attachments (x-rays, periodontal charts, narratives, pathology reports, EOB's, clinical documentation, etc.) for prior authorization requests and retrospective review electronically via the MassHealth Provider web portal at www.masshealth-dental.net (free of charge) and through National Electronic Attachment, LLC (NEA) otherwise known as **FastAttach™** (fee required).

Provider Web Portal

If you need assistance with the MassHealth provider web portal (www.masshealth-dental,net) please call provider relations to schedule training at 1.800.207.5019.

NEA

If providers have an account with NEA, they may submit requests for prior authorizations through their practice management system. Simply enter the NEA image number(s) in the primary comments/ insurance notes field. Example: NEA# is xxxx. If

submitting a prior authorization or a claim to be reviewed retrospectively via the www.masshealth-dental.net website, simply enter the NEA image number in the notes field. Example: NEA# xxxx. For more information or to sign up for **FastAttach™** providers may go to www.nea-fast.com or contact NEA at 1.800.782.5150.

Why is it important to submit all required / necessary attachments?

To ensure proper and timely processing of any prior authorization or retrospective review request all required documentation outlined within the Office Reference Manual must be submitted.

Additionally, if reconsideration is submitted due to an issue with a prior authorization request or retrospective review, please submit all needed documentation to allow for a full review of your request.

3.07 Orthodontic

Eligible patients under age 21 may qualify for orthodontic care under the Health Safety Net Dental Program. All orthodontic services require prior authorization from the Health Safety Net, with the exception of pre-orthodontic treatment visits. The Health Safety Net approves prior authorization requests for comprehensive orthodontic treatment when: 1) the patient has one of the "autoqualifying" conditions described by the Health Safety Net in the HLD Index; 2) the patient meets or exceeds the threshold score designated by the Health Safety Net on the HLD index; or 3) comprehensive orthodontic treatment is medically necessary for the patient, as demonstrated by a medical necessity narrative and supporting documentation submitted by the requesting provider. Additional details regarding the Health Safety Net's payment for orthodontic treatment and the submission of prior authorization requests can be found in Section 16.00 and Exhibit B.

3.08 Transfer or Release of Authorization

To transfer an unexpired authorization for services from one provider to another *at the same location,* the office must submit this request, in writing, to DentaQuest on office letterhead. The request must include the patient name, patient identification number, the provider name to which the service had been approved, the CDT code and identifying tooth or quadrant, and the name of the new provider who will be performing the service.

To transfer an unexpired authorization to a *new provider at a new location*, the provider who received the authorization must send a request to release the authorization, in writing, to DentaQuest on office letterhead. The request must identify the patient and the authorized service that is being released. The provider to whom the patient is transferring for service must submit a request for authorization on an ADA claim form. These requests can be sent separately or together; however, an authorization will not be transferred until the release from the original provider has been received.

Requests for transfer or release of authorization can be submitted via the provider web portal at www.masshealth-dental.net, mailed or faxed to:

Health Safety Net Prior Authorizations
P.O. Box 2906
Milwaukee, WI 53201-2906
Fax: 1.262.241.7150

*Please expect a 4-6 week time frame from submission to address transfer requests.

4.00 Claim Submission Procedures (Claim Filing Options)

The Health Safety Net Dental Program accepts dental claims through three possible methods. These methods include:

- Electronic claims via direct data entry at www.masshealth-dental.net. This is a secure, HIPAA-compliant, direct data-entry option. Please contact the EDI team at EDIteam@dentaquest.com to ensure your practice has the necessary software to generate a HIPPA compliant 837D file, requirements for set-up are reviewed, necessary configuration takes place and testing of transaction involved is completed.

- Electronic claims in the HIPAA-compliant 837D format via upload to our secure trading partner portal are available at www.masshealth-dental.net.

- Electronic submission via a clearinghouse partner

- Paper claims on the ADA 2012 or newer claim form **only** for those providers who have an approved electronic claim submission waiver on file with MassHealth/DentaQuest.

Required Information

Health Safety Net – Partial Deductibles

- Health Safety Net – Partial Low Income Patients may be responsible for a family deductible. The patient's determination letter will tell them if they have a deductible, the amount of the deductible, and which other family members' services count towards the deductible. Deductibles are also viewable in the Eligibility Verification System (EVS) within the MMIS Provider Online Service Center (POSC).
- At Community Health Centers (and participating HLHC's), patients are responsible for 20% of the rate for their services until their deductible is met. The HSN will pay the remaining 80%. Providers must code each claim for HSN partial patients to indicate whether they are seeking a payment of 80% or 100% from the HSN.
- Deductible Percentage – The deductible percentage (80% or 100%) should be included on every claim for an HSN Partial patient and should be submitted in the 2300 loop in the CN1 segment. If the percentage is not indicated on a claim for a HSN Partial patient, the HSN will pay 80% of the rate for the service(s) billed.
- Edit 7542 has been added to MMIS and set up as a denial edit. Error code message is as follows:

  "Missing deductible"

  Edit 7542 should be mapped to CARC 16 and RARC N130.

More information regarding deductibles can be found within 101 CMR 613.04(6)(c)(1).

4.01 Electronic Claim Submission through Direct Data Entry

Participating Health Safety Net providers may submit claims directly by entering them through our secure provider web portal site at www.masshealth-dental.net. Submitting claims on-line is very quick and easy.

It is essential that providers access the Health Safety Net / MassHealth provider web portal to check a patient's eligibility prior to providing the service, as it provides accurate eligibility information on that day. Providers can also create reports to verify claims submission via the Health Safety Net / MassHealth Provider Web Portal at www.masshealth-dental.net.

Please see the extensive user manual regarding how to submit claims and prior authorizations at www.masshealth-dental.net. For questions on submitting claims or accessing the website, please contact Provider Services at 1.800.207.5019.

4.02 Electronic Claim Submission via Upload to www.masshealth-dental.net.

There are two types of electronic submissions that can take place via the electronic web based tools:

a. Trading Partner Portal: Participating HSN providers may submit EDI HIPAA compliant claims directly via the Trading Partner Portal at www.masshealth-dental.net, trading partner's link. Complete instructions can be found in the associated Companion Guide.
b. MassHealth / Health Safety Net Provider Web Portal: You can submit claims/attachments free of charge via the MassHealth / Health Safety Net Provider Web Portal at www.masshealth-dental.net, provider's link.

4.03 Electronic Claim Submission via Clearinghouse

Providers may submit their claims through an approved Clearinghouse trading partner.

Providers using a Clearinghouse should contact the EDI team at EDITeam@greatdentalplans.com for details.

The software vendor should be contacted to make certain that they have the MassHealth / Health Safety Net Dental Program listed as a payer. The software vendor can provide any information needed to ensure that submitted claims are forwarded to the Health Safety Net Dental Program. The Health Safety Net Dental Program's Payer ID is CKMA1.

4.05 Requirements for Claim Submission

- Member name, identification number, and date of birth must be listed on all claims submitted. If the MassHealth member identification number is missing or miscoded on the claim form, the member may not be able to be identified. This could result in the claim being denied.

- The provider and office location information must be clearly identified on the claim. The MassHealth provider identification number must be included.
- The date of service must be provided on the claim form for each service line submitted.
- Approved ADA dental codes as published in the current CDT book and as defined in the MassHealth dental regulations 130 CMR 420.000 and this manual must be used to define all services.
- List all quadrants, tooth numbers and surfaces for dental codes that necessitate identification (extractions, root canals, amalgams, and resin fillings). Missing tooth and surface identification codes will result in the denial of claim payment.

Clinical & Benefit Rule Definitions

Each covered CDT code has a benefit limitation column within the exhibits in the back of this Office Reference Manual. All benefit limitations are set-up with rules that establish how often services are payable.

Below is a list of core definitions to help guide you in understanding the limitation.

- *Location (L)* – Claims for the same office/location will be crosschecked. Meaning that if a provider submits a procedure and the system finds that the same or other providers in that same location performed any of the procedures in the List group, the system will deny the submitted procedure
- *Provider (P)* – Claims for the same provider regardless of location will crosscheck. So, if provider submits a procedure and system finds that the same provider performed any of the procedures, the system will deny the submitted procedure
- *Provider or Location (R)* – Claims from the same office/location OR from the same provider regardless of location will be crosschecked.
- *Business (B)* – Claims from office/locations tied to the same business entity (tax ID, legal entity) will crosscheck against each other. Thus, the system will crosscheck and deny the submitted procedure if it finds that other providers under the same Business entity performed the procedures. Business is the higher entity that can encompass office locations from a large dental group.
- *Provider and Location (N)* – Claims from the same provider and same location will crosscheck against other claims from the same provider and same location. Thus, system will crosscheck and deny the submitted procedure if it finds that the same provider under the same location performed any of the list group codes.
- *Calendar Year* – When this rule applies, the beginning of the next calendar year starts the new claim submission period. Example: If you have a per 3 calendar year limitation, the next eligible period to submit a claim starts at the beginning of the third calendar year.

4.06 Third Party Liability (TPL)

Determination of a patient's other insurance must be verified before submitting a claim for that patient. To verify other coverage already known to the Health Safety Net provider may access the Health Safety Net / MassHealth Dental Program Website,

access the IVR, or call Member Services at 1.800.207.5019. Evidence of other insurance that has not been recorded by the Health Safety Net should be submitted to the Health Safety Net Dental Program along with the claim.

For insured Low Income Patients, the Health Safety Net does not pay for, and Providers may not submit claims for, services for which the primary insurer has denied payment because of a technical billing error, because the Patient obtained out of network services, because the Patient failed to obtain required prior authorization for services, or because of other administrative reasons. The Health Safety Net does not pay claims for the balance of an insurer's contractual allowance or for late charges for a service that has been paid by another payer.

1. For insured Low Income Patients with other available resources, including but not limited to private health and casualty insurance, the Health Safety Net

    a. does not pay a Provider if it determines that, among other things, the Provider has not made diligent efforts to obtain payment from those resources; and
    b. recovers any payments made if it determines that the Provider has not made diligent efforts to obtain payment from those resources.

2. "Diligent efforts" is defined as making every effort to identify and obtain payment from all other liable parties, including insurers. Diligent efforts include, but are not limited to

    a. determining the existence of insurance that could pay for medical expenses by asking the Patient if he or she has other insurance and by using insurance databases available to the Provider. In the event of a motor vehicle accident, this includes investigating whether the Patient, driver, and/or owner of any motor vehicle involved had a motor vehicle liability policy
    b. verifying the Patient's other health insurance coverage, currently known to the Health Safety Net, through EVS, or any other health insurance resource available to the Provider, on each date of service and at the time of billing
    c. submitting claims to all insurers with the insurer's designated service code for the service provided
    d. complying with the insurer's billing and authorization requirements
    e. appealing a denied claim when the service is payable in whole or in part by an insurer; and
    f. immediately returning any payment received from the Office when any available third-party resource has been identified

3. For insured Low Income Patients with private insurance, including Student Health Plans and Qualified Health Plans other than the Premium Assistance Payment Program Operated by the Health Connector, the Health Safety Net pays only for deductibles, coinsurance, and Reimbursable Health Services not covered by the insurer. The Health Safety Net does not pay for copayments required by a private insurer.

4. For MassHealth members enrolled in MassHealth Limited, EAEDC, CMSP, CMSP plus Limited, and for MassHealth Family Assistance - Children, the Health Safety Net pays only for Reimbursable Health Services not covered by the member's MassHealth benefit. A Provider may submit a claim for Reimbursable Health Services not covered by EAEDC only if

the member's EAEDC eligibility is non-temporary. A Provider may submit a claim for Reimbursable Health Services not covered by CMSP only if the individual's MAGI income is less than or equal to 300% of the FPL.

5. For MassHealth members enrolled in MassHealth Standard, MassHealth CarePlus, CommonHealth, and Family Assistance, excluding MassHealth Family Assistance - Children, the Health Safety Net pays only for Adult Dental Services provided by a Community Health Center, Hospital Licensed Health Center, or other Satellite Clinic that are not covered by MassHealth.

6. For MassHealth members, the Health Safety Net does not pay for, and Providers may not submit claims to the Office for MassHealth copayments.

7. For Low Income Patients enrolled in Medicare, including MassHealth members enrolled in Medicare Buy-In and Senior Buy-In, the Health Safety Net pays for Reimbursable Health Services not covered by Medicare, and for Medicare copayments, coinsurance, and deductibles.

8. The Health Safety Net does not pay copayments for the Premium Assistance Payment Program Operated by the Health Connector.

Electronic claim submission is required for all providers. TPL claims must include the code, description and the dates of service matching the information submitted to the primary carrier along with their payment and it must be indicated in the appropriate TPL field. Instruction on including information from other payers may be obtained from the 837-Dental companion guide. If you have questions please contact the EDI team at EDITeam@greatdentalplans.com.

When the Health Safety Net is not the primary insurance carrier, a copy of the primary carrier's Explanation of Benefits (EOB) must be submitted with the claim. The Health Safety Net is always the payer of last resort, and therefore, any additional payers known to the Health Safety Net or to the provider must be billed first. Each line on the EOB should be listed as a separate claim line. The Remittance Advice will include these claims, and indicate the amount charged, the amount paid by the primary insurer(s) and the Health Safety Net payment. Approved claims are paid up to the Health Safety Net allowed fees or to the charged amount, whichever is lower. *A Third Party Liability Quick Reference flyer is available in the appendices of this manual.*

4.07 Filing Limits

General Requirements: Health Safety Net Dental Program claims must be received within 90 days of the date of service or the date of the explanation of benefits from another insurer. Any claim received beyond the 90 day timely filing limit specified in the contract will be denied for "untimely filing." If a claim is denied for "untimely filing" the provider cannot bill the patient.

90-Day Waiver: For claims that are not submitted within the 90-day period but that meet one of the exceptions specified below, a provider must request a waiver of the billing deadline. The exceptions are as follows:

(1) The service was provided to a person who did not have an HSN determination on the date of service, but later received an HSN determination for a period that includes the date of service.
(2) The service was provided to a Patient who failed to inform the Provider in a timely fashion of the patient's eligibility for MassHealth or status as a Low Income Patient.

For further details, please refer to the MassHealth All Provider Manual at 101 CMR 613.07(2)

Time Limitation on Submission of Claims for Patients with Other Health Insurance: Third party liability (TPL) claims must be received within 90 days of the date of the notice of final disposition from the other insurer and no later than 18 months after the date of service. Corrections may be made to claims that were initially timely received up to 12 months from the date of service. For TPL claims, the correction deadline is extended to 18 months.
Helpful Quick Reference: The following documents are located in Appendix C to assist in billing.

- Corrective Action for Denied Claims Appendix C-2
- Corrective Action for Incorrectly Paid Claims Appendix C-3
- Overpayments of Claims Appendix C-4

Claim Corrections: Claims that have been paid but were submitted incorrectly (i.e., incorrect tooth number, quadrant, etc.) must be voided via the Void Request Form. This form is located in Appendix B of this manual.

Final Deadline Waiver Requests: Providers may submit a Final Deadline Waiver Request for adjudicated claims with dates of service exceeding the applicable 12 or 18 month correction deadlines if the claim was initially timely submitted and is for a date of service within 36 months. The request must be received within 30 days of the date the claim was denied for exceeding the final submission deadline and the provider must demonstrate that the claim was denied or underpaid as the result of a Health Safety Net error.

4.08 Remittance Information

Providers receive remittance information about their submitted claims in two ways:

- Through the Electronic Remittance Advice – EDI 835 Transaction.
- Through a downloadable PDF Explanation of Benefits (EOB).

Please contact the EDI Team at EDITeam@greatdentalplans.com with any questions about the EDI 835 Transaction or our Customer Service Department for the EOBs at 1.800.207.5019.

The 835 transactions and electronic remittance advice mentioned above will contain accurate adjudication and pricing information. When HSN claims are paid, the HSN Office will create a separate monthly payment remittance advice regarding the claims in the current payment cycle.

4.09 Claim Submission and Payment for Operating Room (OR) Cases

Facility and anesthesia services for operating room cases do not require prior authorization as outlined in Section 3.02.

4.10 Claim Submission for CPT Codes

Hospitals and CHCs billing for services provided by Oral Surgery specialists must transmit claims with CPT codes electronically through MMIS the 837P format in accordance with 101 CMR 613.00 via the MassHealth Provider Online Service Center.

4.11 Behavior Management

Prior Authorization / Retrospective Authorization:

Behavior management, D9920 is set up to require review and DentaQuest will review it either: **prior** to treatment (PA) or **post-treatment** (**Retrospective Review**), using the same clinical criteria. If there is an emergency and your office cannot send a prior authorization the claim will be reviewed upon submission (with narrative).

Retrospective Review Note:

When submitting a claim post-treatment for retrospective review please be sure to include a narrative that meets the requirements below.

Third Party Liability Reminder:

It is important that you remember to send along the primary EOB. Timely Filing Guidelines for TPL Claims- 90 days from primary EOB date

Timely Filing Reminder (Claims other than TPL): 90 Days

Narrative requirements:

- MassHealth Regulation,130 CMR 420.456(B) Behavioral Management. The MassHealth agency pays an additional payment once per member per day for management of a severely and chronically mentally, physically, or developmentally impaired member in the office.
- The provider must document a history of treatment or previous attempts at treatment in the member's medical record
- Every prior authorization must be submitted with a member specific narrative clearly describing the member’s severe and chronic mental, physical, or developmental disability and previous attempts at treatment which included extra staffing and type of behavior management technique utilized
- Generic copy / pasted language that is not member specific will not be accepted.

Number of Units:

Up to 4 units of behavior management can be requested / approved at a time. All approved units must be billed for prior to requesting a new unit. The prior authorization is valid for 12 months from the date of approval. All units must be billed and paid before another prior authorization can be submitted / reviewed.

5.00 Billing Low Income Members and MassHealth Members

Most Health Safety Net and MassHealth members are protected from Collection Action by Health Safety Net Providers. Specifically, HSN Providers may not bill MassHealth patients or Health Safety Net, including:

- Patients enrolled in MassHealth
- Patients eligible for the Health Safety Net
- Patients who receive government benefits under Emergency Aid to the Elderly, Disabled and Children (EAEDC)
- Participants in the Children's Medical Security Plan (CMSP) whose income is equal to or less than 300% of the FPL

This billing restriction includes bills accrued before the patient was determined to be a MassHealth or Low Income member. If a provider becomes aware someone, they are currently billing is a MassHealth or Low Income member, then they must cease collection activity immediately.

There are several exceptions under which a Health Safety Net provider may collect against a MassHealth or HSN patient. Providers may engage in collection activity in the following circumstances:

- The patient agrees in writing to be billed in order to receive a service that is not billable to the HSN
- The patient agrees in writing to be billed in order to meet a MassHealth deductible or MassHealth spend-down
- The patient is a Dental Only Low Income Patient. A Dental Only Low Income Patient is a patient who is eligible for both the Health Safety Net and for ConnectorCare, and who has not enrolled in insurance after 90 days of eligibility. Dental Only Low Income Patients may be billed for services not otherwise billable to the Health Safety Net

For additional information about billing restrictions for HSN patients please refer to the HSN regulations at 101 CMR 613.08.

6.00 Member Complaints

Complaints

Members may submit complaints to the Health Safety Net Dental Program telephonically or in writing on any Health Safety Net Dental Program issue other than decisions that deny, delay, reduce, or terminate dental services. Some examples of complaints include: the quality of care or services received, access to dental care services, provider care and treatment, or

administrative issues. In cases where the complaint cannot be resolved telephonically, the patient will be assisted in submitting a patient complaint form.

Member complaints should be directed to:

Health Safety Net Dental Program
Attention: Intervention Services
P.O. Box 9708
Boston, MA 02114-9708

The complaint form is available on-line and in hard-copy upon request.

The Health Safety Net Dental Program will respond to patient complaints immediately if possible but within no more than 30 working days from the date a written complaint is received.

7.00 Utilization Management Program

7.01 Introduction

The Health Safety Net Dental Program provides for continuing review and evaluation of the care and services paid through HSN, including review of utilization of the services by providers and by patients.

The Health Safety Net Dental Program conducts periodic utilization reviews on all providers. In addition, the MassHealth Dental Program conducts compliance reviews on providers that are found to provide services in excess of established norms, or by referrals and complaints from agencies or individuals.

Participating providers are responsible for ensuring that requirements for services rendered are met to receive payment from the Health Safety Net Dental Program per 101 CMR 613.03 and 101 CMR 613.07. HSN providers must give access to records and facilities to MassHealth / HSN Dental Program representatives upon reasonable request.

10.00 The Patient Record – See HSN Regulations at 101 CMR 613.03(1)(b)

10.01 Medical Record Requirements

HSN Providers must maintain medical records corresponding to or documenting all services for which claims are submitted to the HSN. Each medical record must contain sufficient data to document fully the nature, extent, quality, and necessity of the care provided to a Patient for each service claimed for payment.

11.00 Patient Recall System

11.01 Recall System Recommendation

Each participating Health Safety Net Dental Program provider office may maintain and document a formal system for patient recall. The system can use either written or phone contact. Any system should encompass routine patient check-ups, cleaning appointments, follow-up treatment appointments, and missed appointments for any Health Safety Net patient that has sought dental treatment.

If a written process is used, the following or similar language is *suggested* for missed appointments:

- "We missed you when you did not come for your dental appointment on month/date. Regular check-ups are needed to keep your teeth healthy."
- "Please call to reschedule another appointment. Call us ahead of time if you cannot keep the appointment. Missed appointments are very costly to us. Thank you for your help."

Dental offices indicate that patients sometimes fail to show up for appointments. The Health Safety Net Dental Program offers the following suggestion to decrease the *frequency of these occurrences*.

- Contact the patient by phone or postcard prior to the appointment to remind the individual of the time and place of the appointment.

12.00 Intervention Services Program

The Intervention Services Program will provide assistance to Health Safety Net providers and patients. The components of the program include:

12.01 Dedicated Intervention Specialists

Dedicated Intervention Specialists will respond to complex provider and patient requests that are beyond the scope of issues typically handled by the Customer Services Representatives. The Intervention Specialists will accept referrals from Health Safety Net providers for Health Safety Net patients who require education on subjects such as failure to keep scheduled appointments, proper dental office procedures, the importance of follow-up treatments and good oral hygiene practice. The Intervention Specialists will also assist Health Safety Net providers by coordinating adjunct services prior to the services being performed.

Grievances. A Provider must provide any information or documentation requested by the Health Safety Net Office or DentaQuest related to a grievance request filed in accordance with 101 CMR 613.04(3) within 30 days of the request from the Office.

Please submit complaints, grievances and reconsideration requests via the MassHealth / Health Safety Net Provider Portal through contact us at www.masshealth-dental.net.

12.02 Appointment Assistance

The Health Safety Net Dental Program's Patient Services Department uses technology to link patients to the closest and most appropriate dental provider via the find a provider tool located at www.masshealth-dental.net. On occasion, patients require special assistance making appointments due to geographic or special physical needs. The Intervention Services Department is responsible for locating providers for patients in emergency or difficult situations and assisting patients with making appointments with a participating provider.

13.00 Radiology Requirements

TYPE OF ENCOUNTER	PATIENT AGE AND DENTAL DEVELOPMENTAL STAGE				
	Child with Primary Dentition (prior to eruption of first permanent tooth)	**Child with Transitional Dentition** (after eruption of first permanent tooth)	**Adolescent with Permanent Dentition** (prior to eruption of third molars)	**Adult, Dentate or Partially Edentulous**	**Adult, Edentulous**
New patient* being evaluated for dental diseases and dental development	Individualized radiographic exam consisting of selected periapical/occlusal views and/or posterior bitewings if proximal surfaces cannot be visualized or probed. Patients without evidence of disease and with open proximal contacts may not require a radiographic exam at this time.	Individualized radiographic exam consisting of posterior bitewings with panoramic exam or posterior bitewings and selected periapical images.	Individualized radiographic exam consisting of posterior bitewings with panoramic exam or posterior bitewings and selected periapical images. A full mouth intraoral radiographic exam is preferred when the patient has clinical evidence of generalized dental disease or a history of extensive dental treatment.		Individualized radiographic exam, based on clinical signs and symptoms.
Recall patient* with clinical caries or at increased risk for caries**	Posterior bitewing exam at 6-12 month intervals if proximal surfaces cannot be examined visually or with a probe			Posterior bitewing exam at 6-18 month intervals	Not applicable
Recall patient* with no clinical caries and not at increased risk for caries**	Posterior bitewing exam at 12-24 month intervals if proximal surfaces cannot be examined visually or with a probe		Posterior bitewing exam at 18-36 month intervals	Posterior bitewing exam at 24-36 month intervals	Not applicable
Recall patient* with periodontal disease	Clinical judgment as to the need for and type of radiographic images for the evaluation of periodontal disease. Imaging may consist of, but is not limited to, selected bitewing and/or periapical images of areas where periodontal disease (other than nonspecific gingivitis) can be identified clinically.				Not applicable
Patient for monitoring of growth and development	Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development		Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development. Panoramic or periapical exam to assess developing third molars	Usually not indicated	
Patient with other circumstances including, but not limited to, proposed or existing implants, pathology, restorative/endodontic needs, treated periodontal disease and caries remineralization	Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring in these circumstances.				

14.00 Clinical Criteria

The clinical criteria outlined in the Health Safety Net's Provider Office Reference Manual are based around procedure codes as defined in the American Dental Association Current Dental Terminology (CDT) Manual and on the MassHealth Dental regulation at 130 CMR 420.000. In general, documentation requests for information regarding treatment using these codes are determined by generally accepted dental standards for authorization, such as radiographs, periodontal charting, treatment plans, or descriptive narratives.

These criteria were formulated from information gathered from practicing dentists, dental schools, ADA clinical articles and guidelines, insurance companies, as well as other dental related organizations. These criteria and policies must also satisfy the Health Safety Net Dental Program requirements.

These clinical criteria will be used for making medical necessity determinations for prior authorizations, post payment review and retrospective review. Failure to submit the required documentation may result in a disallowed request and/or a denied payment of a claim related to that request. Some services require prior authorization and some services require pre-payment review; this is detailed in the Eligible Services in the "Review Required" column.

For all procedures, every Provider in the Health Safety Net program is subject to random chart audits. Providers are required to comply with any request for records. These audits may occur in the provider site as well as in the office of DentaQuest. The Provider will be notified in writing of the results and findings of the audit. Health Safety Net providers are required to maintain comprehensive treatment records that meet professional standards for risk management and applicable MassHealth regulations, including 130 CMR 420.000 and 450.000. Please refer to the "Patient Record" section for additional detail.

Documentation in the treatment record must justify the need for the procedure performed due to medical necessity, for all procedures rendered. Appropriate diagnostic pre-operative radiographs clearly showing the adjacent and opposing teeth and substantiating any pathology or caries present are required. Post-operative radiographs are required for endodontic procedures and permanent crown placement to confirm quality of care. In the event that radiographs are not available or cannot be obtained, diagnostic quality intraoral photographs must substantiate the need for procedures rendered.

Multistage procedures are reported and may be reimbursed upon completion. The completion date for removable prosthetic appliances is the date of insertion for removable prosthetic appliances. The completion date for immediate dentures is the date that the remaining teeth are removed, and the denture is inserted. The completion date for fixed partial dentures and crowns is the cementation date regardless of the type of cement utilized. The completion date for endodontic treatment is the date the canals are permanently filled.

Failure to provide the required documentation, adverse audit findings, or the failure to maintain acceptable practice standards may result in sanctions including, but not limited to, adjustment of payments on paid claims or follow-up audits. Please refer to HSN regulation 101 CMR 614.08(1) (b)

We hope that the enclosed criteria will provide a better understanding of the decision-making process for reviews. We also recognize that "local community standards of care" may vary from

region to region and will continue our goal of incorporating generally accepted criteria that will be consistent with both the concept of local community standards and the current ADA concept of national community standards.

Your feedback and input regarding the constant evolution of these criteria is both essential and welcome. The Health Safety Net Dental Program shares your commitment and belief to provide quality care to Health Safety Net Patients and we appreciate your participation.

For additional information on criteria, please reference the MassHealth Dental Manual found on www.mass.gov/masshealth.

14.01 Dental Extractions

Some procedures require prior authorization documentation. Please refer to Exhibits A-E for specific information needed by code. (D7240, D7999)

Documentation needed for procedure:

- Appropriate pre-operative radiographs showing clearly the adjacent and opposing teeth should be submitted: bitewings, periapicals, or panoramic radiograph.
- Narrative demonstrating medical necessity.

Criteria for Dental Extractions

The prophylactic removal of asymptomatic teeth (i.e., third molars) or teeth exhibiting no overt clinical pathology (for orthodontics) may be payable subject to consultant review.

- The removal of primary teeth whose exfoliation is imminent does not meet criteria.
- Alveoloplasty (code D7310) in conjunction with three or more extractions in the same quadrant will be payable.

14.02 Cast Crowns

Some procedures require prior authorization documentation. Please refer to Exhibits A-E for specific information needed by code. (D2999)

Documentation needed for procedure:

- Appropriate pre-operative radiographs showing clearly the adjacent and opposing teeth should be submitted: minimally two bitewings, and at least one periapical; or panoramic radiograph.

Criteria for Cast Crowns

- In general, the criteria for crowns will be met only for permanent teeth needing multi-surface restorations where other restorative materials have a poor prognosis.
- Permanent molar teeth must have pathologic destruction to the tooth by caries or trauma and should involve four or more surfaces and two or more cusps.
- Permanent bicuspid teeth must have pathologic destruction to the tooth by

caries or trauma and should involve three or more surfaces and at least one cusp.
- Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma and must involve four or more surfaces and at least 50% of the incisal edge.

A request for a crown following root-canal therapy must meet the following criteria:

- The request should include a dated post-endodontic radiograph.
- The tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the ability to fill the canal to the apex.
- The filling must be properly condensed/obturated. Filling material should not extend excessively beyond the apex.

To meet the criteria, a crown must be opposed by a tooth or denture in the opposite arch or be an abutment for a partial denture.

- The patient must be free from active and advanced periodontal disease.
- The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent teeth.
- Cast crowns on permanent teeth are expected to last, at a minimum, five years.

Payment for crowns will not meet criteria if:

- a lesser means of restoration is possible
- the tooth has subosseous and/or furcation caries
- the tooth has advanced periodontal disease
- the tooth is a primary tooth; or
- crowns are being planned to alter vertical dimension.

14.03 Endodontic Treatment

Criteria for Endodontic Treatment

Root-canal therapy is performed in order to maintain teeth that have been damaged through trauma or carious exposure.

Root-canal therapy must meet the following criteria (Please document in patient record.)

- Filler material should be sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the dentist's ability to fill the canal to the apex.
- Filler material must be properly condensed/obturated. Filling material should not extend excessively beyond the apex.

Payment for root-canal therapy does not meet criteria if (Please document in patient record.):

- Gross periapical or periodontal pathosis is demonstrated radiographically (e.g. caries subcrestal or to the furcation, deeming the tooth non-restorable).The general oral condition does not justify root-canal therapy because the periodontal condition of the remaining dentition and soft tissue are stable with a favorable prognosis.
- Tooth does not demonstrate 50% bone support.
- Root-canal therapy is in anticipation of placement of an overdenture.

- A filling material not accepted by the federal Food and Drug Administration (e.g., Sargenti filling material) is used.

OTHER CONSIDERATIONS:

- Root-canal therapy for permanent teeth includes diagnosis, extirpation of the pulp, shaping and enlarging the canals, temporary fillings, filling and obliteration of root canal(s), and progress radiographs, including a root-canal fill radiograph.
- In cases where the root-canal filling does not meet the MassHealth Dental Program's treatment standards, the MassHealth Dental Program can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after the MassHealth Dental Program reviews the circumstances.

14.04 Stainless Steel Crowns

Prior authorization or retrospective review is not required.

CRITERIA FOR STAINLESS STEEL CROWNS

DOCUMENT COMPLIANCE WITH THE FOLLOWING GUIDELINES IN PATIENT CHART:

- Primary molars must have pathologic destruction to the tooth by caries or trauma and should involve two or more surfaces or substantial occlusal decay resulting in an enamel shell.
- In the rare circumstance that a stainless steel crown is indicated for a permanent tooth:
- In general, criteria for stainless steel crowns will be met only for teeth needing multi-surface restorations where amalgams and other materials have a poor prognosis.
    - Permanent molar teeth must have pathologic destruction to the tooth by caries or trauma and should involve four or more surfaces and two or more cusps.
    - Permanent bicuspid teeth must have pathologic destruction to the tooth by caries or trauma and should involve three or more surfaces and at least one cusp.
    - Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma and should involve four or more surfaces and at least 50% of the incisal edge.

The MassHealth Dental Program allows no more than four stainless steel or prefabricated resin crowns per date of service except in cases that are treated in a hospital operating room or ambulatory care center.

Treatment using stainless steel crowns <u>will not</u> meet criteria if:

- a lesser means of restoration is possible
- the tooth has subosseous and/or furcation caries
- the tooth has advanced periodontal disease
- the tooth is a primary tooth with exfoliation imminent

the crown is being planned to alter vertical dimension

14.05 Operating Room (OR) Cases

Criteria for Operating Room (OR) Cases

Please refer to the MassHealth Dental Program Manual, 130 CMR 420.000 and Provider Manual Series Transmittal Letter DEN-77.

14.06 Removable Prosthodontics (Full and Partial Dentures)

Some procedures require retrospective review documentation. Please refer to Exhibits A-E Eligible Services tables for specific information needed by code.

Documentation needed for procedure:

Appropriate pre-operative diagnostic quality radiographs are required for members who are completely and partially edentulous. Radiographs such as bitewings, periapicals, panoramic images must clearly show adjacent and opposing teeth, and / or capture the entire mouth, upper and lower jaws surrounding structures and tissues as applicable.

Criteria for Removable Prosthodontics (Full and Partial Dentures)

Prosthetic services are intended to restore oral form and function caused by premature loss of permanent teeth that would result in significant occlusal dysfunction.

A denture is determined to be an initial placement if the patient has never worn a prosthesis or had a prosthesis prescribed by any provider at any time. Dentists are required to take diagnostic quality pre-operative radiographs for all complete denture services.

- Dentists are required to take a diagnostic quality panoramic radiograph for complete dentures services.
- Partial dentures are covered only for members with good oral health and hygiene, good periodontal health (AAP Type I or II), and a favorable prognosis where continuous deterioration is not expected.
- Radiographs must show no untreated cavities or active periodontal disease in the abutment teeth, and abutments must be at least 50% supported in bone.
- As part of any removable prosthetic service, dentists are expected to instruct the patient in the proper care of the prosthesis.
- In general, if there is a pre-existing removable prosthesis (includes partial and full dentures), it must be at least seven years old and unserviceable to qualify for replacement.
- The replacement teeth should be anatomically full sized teeth.
- Immediate dentures will be considered for members under age 21 only when these dentures will be the permanent full dentures.
- Removable prosthesis will not meet criteria if:
- There is a pre-existing prosthesis that is not at least seven years old and unserviceable
- Good oral health and hygiene, good periodontal health, and a favorable prognosis are not present
- There are untreated cavities or active periodontal disease in the abutment teeth
- Abutment teeth are less than 50% supported in bone

- The member cannot accommodate and properly maintain the prosthesis (i.e., gag reflex, potential for swallowing the prosthesis, severely handicapped)
- The member has a history or an inability to wear a prosthesis due to psychological or physiological reasons
- A partial denture, less than seven years old, is converted to a temporary or permanent complete denture; or
- Extensive repairs are performed on marginally functional partial dentures, or when a new partial denture would be better for the health of the member. However, adding teeth and/or a clasp to a partial denture is a covered service if the addition makes the denture functional

Criteria for Replacement Prosthodontics

- If there is a pre-existing prosthesis, it must be at least seven years old and unserviceable to qualify for replacement.
- Adjustments, repairs, and relines are included with the denture fee within the first six months from the date of insertion for members. After that time has elapsed subsequent:
- Relines and rebases will be reimbursed with prior authorization once every two years for patients under age 21.
- Relines and rebases will be reimbursed with prior authorization once every three years for patients age 21 and older
- For members Under 21, more frequent relines and rebased required require prior authorization and evidence that clinical conditions exist that warrant more frequent relines and rebases
- A new prosthesis will not be reimbursed within two years of reline or repair of the existing prosthesis unless adequate documentation has been presented that all procedures to render the denture serviceable have been exhausted; and
- Replacement of lost, stolen, or broken dentures less than seven years of age usually will not meet criteria for pre-authorization of a new denture.
- The use of preformed dentures with teeth already mounted (that is, teeth set in acrylic before the initial impression) cannot be used for the fabrication of a new denture.
- All prosthetic appliances must be inserted in the mouth and adjusted before a claim is submitted for payment.
- **If a member does not return for the insertion of the completed processed denture,** the provider is required to submit to the MassHealth agency written evidence on their office letterhead of at least three attempts to contact the member over a period of one month via certified mail return receipt requested. Upon providing documentation, the provider may be reimbursed a percentage of the denture fee to assist in covering costs. See 130 CMR 450.231: *General Conditions of Payment*.

14.07 Restorative Codes & Determination of a Non-Restorable Tooth

Restorations replaced within one calendar year of the date of completion of the original restoration are not covered.

No combination of services on a single tooth during the same period of treatment is reimbursable in excess of the maximum allowable fee for a four-or-more surface amalgam or composite restoration.

The HSN Dental Program considers all of the following to be components of a completed restoration and includes them in the fee for this service: tooth and soft-tissue preparation, cement bases, etching and bonding agents, pulp capping, impression, local anesthesia and polishing. Billing and reimbursement for cast crowns, cast post & cores or any other fixed prosthetics shall be based on the cementation date. Restorative pins are reimbursed on a per tooth basis, regardless of the number of pins placed. Reinforcing pins are covered only when used in conjunction with a two-or-more-surface restoration on a permanent tooth.

The HSN Dental Program pays for no more than four stainless steel or pre-fabricated resin crowns per date of service in an office setting. This limitation does not apply when stainless steel or pre-fabricated resin crowns are performed in the OR or outpatient facility.

In the application of clinical criteria for payable service determination, dental consultants must consider the overall dental health. A tooth that is determined to be non-restorable may be subject to an alternative treatment plan.

A tooth may be deemed non-restorable if one or more of the following criteria are present:

- The tooth presents with greater than a 75% loss of the clinical crown.
- The tooth has less than 50% bone support.
- The tooth has subosseous and/or furcation caries.
- The tooth is a primary tooth with exfoliation imminent.
- The tooth apex is surrounded by severe pathologic destruction of the bone.
- The overall dental condition (i.e., periodontal) of the patient is such that an alternative treatment plan would be better suited to meet the patient's needs.

14.08 Criteria for General Anesthesia and Intravenous (IV) Sedation

Prior authorization is not required when administered in the office only by a provider who possesses both an anesthesia-administration permit and an anesthesia-facility permit issued by the Massachusetts Board of Registration in Dentistry and when a member is eligible for oral surgery services.

- General anesthesia or IV sedation may only be performed in conjunction with covered oral surgery and maxillofacial procedures.

The administration of inhalation analgesia (nitrous oxide N2O /O2) is reimbursed as a separate procedure. The administration of analgesia (orally (PO), rectally (PR), and local anesthesia is considered part of an operative procedure and is not reimbursable as a separate procedure.

14.09 Periodontal Treatment

Some procedures require retrospective review documentation. Please refer to Exhibits A-E for specific information needed by code.

Documentation needed for procedure:

- Appropriate Diagnostic Quality Radiographs – periapical or bitewings preferred. Panoramic radiographs not preferred.
- Complete periodontal charting supporting with AAP case type. Dentists are required to record a six-point probing with all numbers recorded once per calendar year on all remaining teeth in the mouth for adult patients. Periodontal Screening and Recording (PSR) is not to be used instead of a full- mouth charting.
- Medical necessity narrative- Include a statement concerning the member's periodontal condition, date of service of periodontal evaluation and history of previous periodontal treatment.

Periodontal scaling and root planning, per quadrant, involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. It is indicated for patients with periodontal disease and is therapeutic, not prophylactic, in nature. Root planning is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and as a part of presurgical procedures in others.

It is anticipated that this procedure would be requested in cases of severe periodontal conditions (i.e., late Type II, III, or IV periodontitis) where definitive comprehensive root planning requiring local/regional block anesthesia and several appointments would be indicated.

From the American Academy of Periodontology (AAP) Policy on Scaling and Root Planning:

"Periodontal scaling is a treatment procedure involving instrumentation of the crown and root surfaces of the teeth to remove plaque, calculus, and stains from these surfaces. It is performed on patients with periodontal disease and is therapeutic, not prophylactic, in nature. Periodontal scaling may precede root planning, which is the definitive, meticulous treatment procedure to remove cementum and/or dentin that is rough and may be permeated by calculus or contaminated with toxins or microorganisms. Periodontal scaling and root planning are arduous and time consuming. They may need to be repeated and may require local anesthetic."

Criteria for Periodontal Treatment

- Periodontal charting indicating abnormal pocket depths in multiple sites.
- At least one of the following is present:

1. Radiographic evidence of root surface calculus; or
2. Radiographic evidence of noticeable loss of bone support.

16.00 Orthodontic Treatment

Please refer to CMR 130 420.431 for MassHealth dental program regulations regarding orthodontic treatment.

Comprehensive orthodontic care should commence when the 1st premolars and 1st permanent molars have erupted. It should only include the transitional dentition in cases with craniofacial anomalies such as cleft lip or cleft palate. Comprehensive treatment may commence with second deciduous molars present.

Subject to prior authorization, the MassHealth agency will pay for more than one comprehensive orthodontic treatment for members with cleft lip, cleft palate, cleft lip and palate, and other craniofacial anomalies to the extent treatment cannot be completed within three years.

16.1 ELIGIBILITY

Members under age 21 may qualify for orthodontic treatment. All orthodontic services require prior authorization with the exception of pre-orthodontic treatment visits and orthodontic retention.

Members age 21 and older may qualify for continuation of orthodontic treatment upon prior authorization if they have been fully banded prior to their 21st birthday and remain eligible for MassHealth dental benefits for the duration of the treatment. See section 16.4 for further details.

16.2 Authorization for Comprehensive Orthodontic Treatment

MassHealth approves prior authorization requests for comprehensive orthodontic treatment of handicapping malocclusions. Specifically, treatment is authorized when: 1) the member has one of the "autoqualifying" conditions described by MassHealth in the HLD Index; 2) the member meets or exceeds the threshold score designated by MassHealth on the HLD index; or 3) comprehensive orthodontic treatment is medically necessary for the member, as demonstrated by a medical necessity narrative and supporting documentation submitted by the requesting provider. The process for submitting a prior authorization request for comprehensive orthodontic treatment is described below:

1) Provider performs pre-orthodontic treatment examination to determine if orthodontic treatment is necessary.
2) Provider submits all applicable completed forms and documentation to DentaQuest for review. (See 2a – 2e, below)
    - **a.** 2012 ADA Form – Appendix B
        - i. Providers may request the first two years of treatment in one authorization by doing the following
            1. Request authorization for D8080 / D8070 / D8090
            2. Request authorization for 8 units of D8670

3. Enter Pre-Orthodontic records charge (D8660) with date of service. If Authorization for D8080/D8070 / D8090 is denied, code D8660 will be processed (if a claim is included with your submission) with the date of service entered on the Authorization.

b. Cephalometric radiographs OR photographs with a measurement device are required with every case in addition to the standard set of photos. Providers are encouraged to submit a lateral cephalometric radiograph if it will clearly identify the medical necessity of treatment such as for deep impinging overbite. Models are not required.

i. Measurement Device

A calibration ruler, wire of known length, embedded measurement device, boley gauge, disposable ruler, or periodontal probe, are used to increase the accuracy and objectivity of the HLD scoring. The HLD is intended to be a quantitative, objective method for evaluating prior authorization requests for comprehensive orthodontic treatment.

Providing a scale, or demonstrating measured components, reinforces the objectivity of the evaluation and benefit determination. The scale, or measurements allow accurate objective measures of overjet, open bite, and reverse overjet (mandibular protrusion).

A periodontal probe or measuring device used in photos should be from the ipsilateral (same side) that the measurement is being taken. If a measured wire or object of known length is used on the lateral cephalometric, but not marked, a brief explanation should be included to aid in establishing a scale.

Measurements will then be taken in accordance with the Handicapping Labio-Lingual Deviation Index Scoring Instructions, to scale.

ii. Photographic Prints and Radiographs

Photographs must include lateral and occlusal views.

Photo(s) with a measurement device (Boley gauge, disposable ruler, or periodontal probe) in the patient's mouth, or on models mounted in centric occlusion should be included. When measuring overjet, reverse overjet, or mandibular protrusion, the measurement device should be placed parallel to the occlusal plane involving two directly opposing incisor teeth with the photo taken on the ipsilateral side (same side) being measured.

When measuring open bite, place the measurement device vertically to measure the opening from the incisal edge of the maxillary and mandibular incisors.

A sufficient number of photographs should be submitted with a measurement device, dependent upon the conditions present. The measurement device should be utilized in accordance with the HLD Scoring Instructions.

The following are examples of photos from Draker Handicapping Labio-Lingual Deviations: A Proposed Index for Public Health Purposes, Am J Ortho, 1960, 295-305.

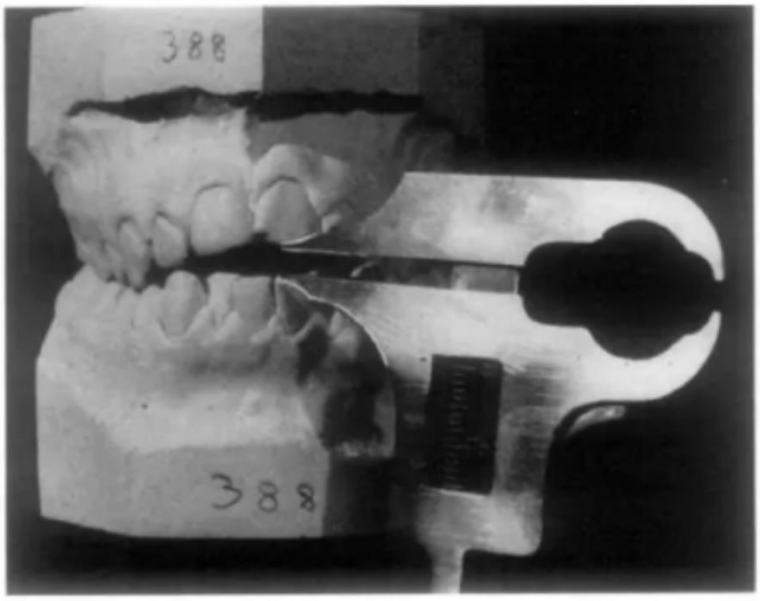


Fig. 5.

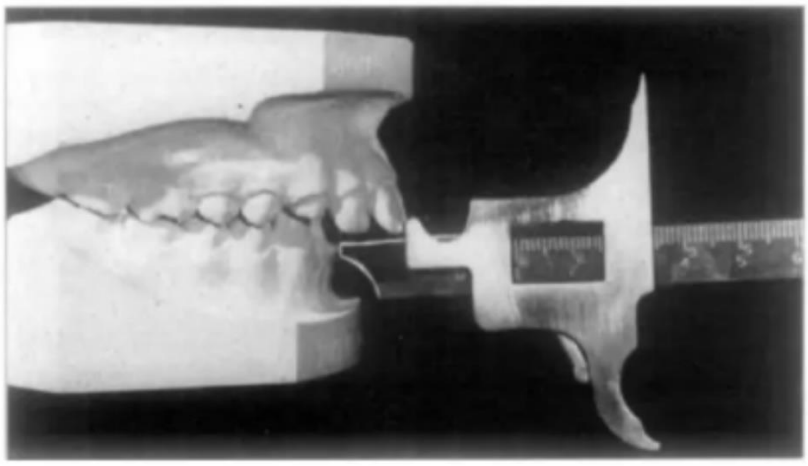


Fig. 2.

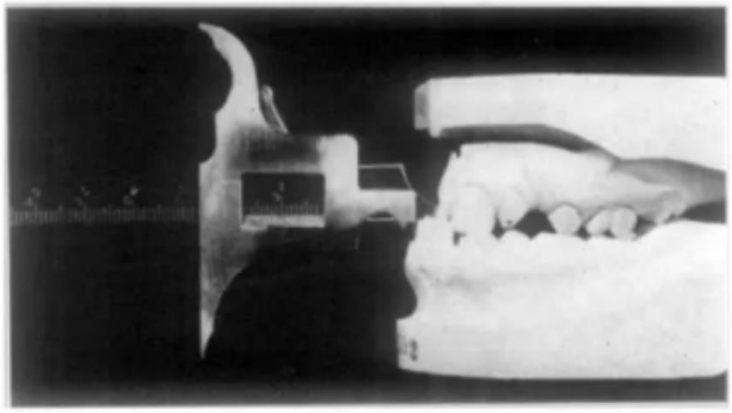


Fig. 1.

c. HLD Index Form – Appendix B

Providers may establish medical necessity for comprehensive orthodontic treatment using the HLD Index by demonstrating that the member 1) has one or more of the "autoqualifying" conditions described on the HLD Index; 2) has measurements that meet or exceed the threshold score of 22 on the HLD Index; or 3) comprehensive orthodontic treatment is medically necessary for the member, as demonstrated by a medical necessity narrative and supporting documentation submitted by the requesting provider. Subject to review and verification, MassHealth will approve comprehensive orthodontic treatment for members that satisfy any of these three criteria.

- Medical Necessity Narrative and Supporting Documentation (if applicable). Providers may establish that comprehensive orthodontic treatment is medically necessary by submitting a medical necessity narrative and supporting documentation, where applicable. The narrative must establish that comprehensive orthodontic treatment is medically necessary to treat a handicapping malocclusion, including to correct or significantly ameliorate:

    i. a severe deviation affecting the patient's mouth and/or underlying dentofacial structures.
    ii. a diagnosed mental, emotional, or behavioral condition caused by the patient's malocclusion.
    iii. a diagnosed nutritional deficiency and/or a substantiated inability to eat or chew caused by the patient's malocclusion.
    iv. a diagnosed speech or language pathology caused by the patient's malocclusion; or
    v. a condition in which the overall severity or impact of the patient's malocclusion is not otherwise apparent.

The medical necessity narrative must clearly demonstrate why comprehensive orthodontic treatment is medically necessary for the patient. If any part of the requesting provider's justification of medical necessity involves a mental, emotional, or behavioral condition; a nutritional deficiency; a speech or language pathology; or the presence of any other

condition that would typically require the diagnosis, opinion, or expertise of a licensed clinician other than the requesting provider, then the narrative and any attached documentation must:

i. clearly identify the appropriately qualified and licensed clinician(s) who furnished the diagnosis or opinion substantiating the condition or pathology (e.g., general dentist, oral surgeon, physician, clinical psychologist, clinical dietitian, speech therapist);
ii. describe the nature and extent of the identified clinician(s) involvement and interaction with the patient, including dates of treatment.
iii. state the specific diagnosis or other opinion of the patient's condition furnished by the identified clinician(s);
iv. document the recommendation by the clinician(s) to seek orthodontic evaluation or treatment (if such a recommendation was made);
v. discuss any treatments for the patient's condition (other than comprehensive orthodontic treatment) considered or attempted by the clinician(s); and
vi. provide any other relevant information from the clinician(s) that supports the requesting provider's justification of the medical necessity of comprehensive orthodontic treatment.

The medical necessity narrative must be signed and dated by the requesting provider and submitted on the office letterhead of the provider, together with the required HLD Form and signed HLD Form Attestation. If applicable, any supporting documentation from the other involved clinician(s) must also be signed and dated by such clinician(s) and appear on office letterhead of such clinician(s). The requesting Provider is responsible for coordinating with the other involved clinician(s) and is responsible for compiling and submitting any supporting documentation furnished by other involved clinician(s) along with the medical necessity narrative.

16.3 Authorization Determination

The initial prior authorization approval for comprehensive orthodontics (D8080 / D8070) and first two (2) years of treatment visits (D8670 x 8 units) will expire 36 months from the date of the authorization. Approval for the third year of orthodontics will be valid for 36 months. Providers must check the patient's eligibility on each date of service to determine whether it will be an "eligible" service date.

If the case is denied, a determination notice will be sent to the member, and a separate courtesy notice will be sent to the provider along with the reviewer's worksheet indicating that the authorization for comprehensive orthodontic treatment has been denied. However, if a claim is sent in along with the prior authorization, a payment will be issued for code D8690 to cover the pre-orthodontic work-up, including the treatment plan, radiographs, diagnostic prints and/or photos orthodontic records, and diagnostic models.

1) If the prior authorization request is DENIED:

b. DentaQuest will mail the member a denial notice. Additionally, DentaQuest will mail to the provider and post on the Provider Web Portal a separate courtesy notice and will mail the reviewer's worksheet to the provider.
c. DentaQuest will issue a payment for code D8660 if a claim is sent in with the prior authorization to cover pre-orthodontic work-up that includes payment for any diagnostic radiographs or photographs and adjudicate using the date of service submitted on the authorization.
d. Providers may request a second review of a denied prior authorization by submitting to DentaQuest in writing on the provider's office letterhead within thirty days from the date of the denial notice the following information:

    i. A detailed narrative of why the provider believes the prior authorization should have been approved, and
    ii. All documents originally submitted in addition to any new supporting documentation not previously submitted, including, as appropriate, radiographs, photographs, and letters or other documentation from other licensed clinicians involved in the member's treatment or otherwise knowledgeable about the member's condition.

2) If the prior authorization request is APPROVED:

Comprehensive Orthodontic Treatment Requirements:

Insertion of the appliance must occur before the patient's 21st birthday. Providers must submit a claim using the actual appliance insertion date (banding date) as the date of service on the 2012 or newer ADA form.

Payment for Comprehensive Orthodontic Treatment (D8080/D8070/D8090) includes pre orthodontic visit, records, photographic prints, models, insertion of appliance(s), and all orthodontic treatment visits occurred within the calendar month of insertion of appliance(s).

Periodic Orthodontic Treatment Visit Requirements:

Orthodontic treatment visits are paid on a quarterly (90-day) basis, with the first payment available 90 days after banding. Payment for each unit of service (D8670) includes all treatment visits provided to the patient within a quarterly (90-day) billing period. Providers are expected to see patients every four to eight weeks, depending on the particular circumstances of the patient's treatment plan, but may bill a quarterly unit of service if at least one (1) eligible treatment date occurred during the 90-day period. Provider MUST note the actual treatment dates in the Remarks section (Box 35) on the ADA claim form (box 35 of the 2006 ADA claim form), the "Notes" section when using the billing portal or the "Remarks" field on the HIPAA-compliant 837D, specifically 2300/NTE02.

In the event the claim does not contain the actual treatment dates in the appropriate "Remarks" field, MassHealth may deny or recoup the payment and/or require a plan of correction.

If no service is provided in any given billing quarter, the next eligible treatment date should be used as the date of service on the claim. The next quarterly unit of service (D8670) must then be billed at least 90 days from this date of service. Providers may not bill members for broken, repaired, or replacement brackets or wires, and may not charge members “appointment” or “retainer” fees to set appointments regardless if the fee is ultimately refunded to the member.

16.4 Authorization Extension:

Once the authorization period has expired and/or all eight (8) units of quarterly adjustments have been paid, the provider may request a second authorization if continued adjustments are necessary. In the second authorization request, the provider may request up to four (4) additional units of D8670 to complete the case over a subsequent 36 month period.

i. The second request must be submitted as a prior authorization and include a narrative on office letterhead, indicating the number of units being requested and a detailed justification for the additional units, including an explanation of why the initially approved units were insufficient and an updated treatment plan for completion of the case. Additionally, provider must submit a medical necessity summary narrative in box 35 of a completed 2012 ADA claim form with the request, along with any photos or X-rays needed to support the request.

ii. MassHealth/DentaQuest will evaluate the authorization request based upon the submission of all documents, which includes the request and justification on office letterhead, a summary medical necessity narrative in box 35 of the completed 2012 or newer ADA claim form and any photos or X-rays needed to support the request. If the second authorization is APPROVED, then the provider may continue billing using the process described above for the number of adjustments that were approved.

iii. MassHealth will pay for a maximum of four (4) units of D8670 during the second authorization period, which may last up to eighteen months.

If the provider did not request the maximum number of four units in the request for the second authorization period, the provider may subsequently request additional units via the prior authorization process until the maximum number of additional four units have been approved and exhausted.

Any subsequent request for units beyond those approved in a second authorization must be submitted as a prior authorization with a narrative on office letterhead, indicating the number

iv. of units being requested and a detailed justification for the additional units, including an explanation of why the initially approved units were insufficient and an updated treatment plan for completion of the case. Additionally, provider must submit a medical necessity summary narrative in box 35 of a completed 2012 ADA claim form with the request. MassHealth/DentaQuest will evaluate the authorization request based upon the submission of all documents, which

includes the request and justification on office letterhead, a summary medical necessity narrative in box 35 of the completed 2012 ADA claim form and any photos or X-rays needed to support the request.

v. If the second authorization expires prior to the completion of treatment, a provider may request an extension of the time for treatment to allow for the patient's treatment to be completed and all four additional units to be billed. Providers must submit extension requests in writing to DentaQuest and must include the authorization number in the request.

vi. For cases that require additional adjustments to complete treatment beyond the 36 months due to extenuating circumstances: If after the initial and second authorizations have expired AND the maximum units were used AND additional adjustments are still required then the provider will submit a prior authorization request for the specified number of adjustments requested (D8670), a detailed justification as a prior authorization including a narrative on office letterhead demonstrating the need for further treatment, current photographs, and a summary medical necessity narrative in box 35 of the completed 2012 or newer ADA claim form.

*Please allow 4-6 weeks from submission for extensions to be completed.

Retention Visit Requirements:

Retention is reimbursed separately and includes removal of appliances (de-banding), construction and delivery of retainers, and follow up visits. The maximum number of reimbursable retention visits (post-treatment stabilization) is five (5). Prior authorization is not required. If the patient loses or breaks his/her retainer(s), the provider must submit a prior authorization request and receive approval prior to billing for the repair and replacement of the retainer(s).

16.5 Authorization for Continuation of Care

If a member is already receiving comprehensive or interceptive orthodontic treatment and is transferring from another provider and/or state Medicaid program or other insurer, the MassHealth provider that seeks to continue the treatment must submit to DentaQuest a prior authorization request for continuation of care including the following documentation:

a. 2012 or newer ADA claim form listing services to be rendered.
b. Continuation of Care form (page B-7 from the ORM).
c. Copy of the member's original approval (if covered by MassHealth at that time) and current diagnostic documentation (e.g., photographic prints and radiographs, medical necessity narrative, other supporting documentation, etc.).
d. If service was previously approved by MassHealth, a letter from the previous provider authorizing transfer the patient's authorization to the new provider (only if current authorization has not expired or been consumed).

The provider is responsible for compiling and submitting the required information. Authorization for continuation of care may not be available without complete information.

16.6 Authorization for Interceptive / Limited* Orthodontic Treatment

*Please note that Interceptive / Limited Orthodontic Treatment is only covered for members, upon approval, under the age of 21.

The MassHealth agency approves prior authorization requests if the treatment will prevent or minimize a handicapping malocclusion based on the clinical standards described in Appendix F of the *Dental Manual*. The MassHealth agency limits coverage of interceptive orthodontic treatment to primary and transitional dentition with at least one of the following conditions: constricted palate, deep impinging overbite, Class III malocclusion including skeletal Class III cases as defined in Appendix F of the *Dental Manual* when a protraction facemask/reverse pull headgear or other appropriate device is necessary at a young age, craniofacial anomalies, anterior cross bite, or dentition exhibiting results of harmful habits or traumatic interferences between erupting teeth.

Providers are encouraged to treat Class III malocclusions with the appropriate interceptive treatment and may submit for approval of both interceptive and comprehensive treatment of Class III malocclusions at the time interceptive treatment is necessary. Please note the expiration date of the prior approval and submit for an extension of comprehensive treatment if comprehensive treatment is not complete prior to the expiration date.

Continuity of care is important; therefore, please notify DentaQuest if the member discontinues treatment for any reason. The process for requesting authorization and billing for interceptive orthodontic treatment is described below:

a. Provider performs pre-orthodontic treatment examination to determine if orthodontic treatment is necessary.

b. Provider completes and submits the following documentation:
   i. 2012 or newer ADA Form requesting authorization for interceptive orthodontic treatment. The form must include:
      1. The code for the appliance being used (D8010, D8020, D8030, D8040)
      2. The code (D8999) for and number of treatment visits you are requesting for adjustments, up to a maximum of 5.

c. A detailed medical necessity narrative establishing that interceptive orthodontic treatment is medically necessary to prevent or minimize the development of a handicapping malocclusion or will preclude the need for comprehensive orthodontic treatment. This narrative must be submitted on the provider's office letterhead and any supporting documentation or imaging supporting medical necessity of the treatment should be attached.

   If any part of the requesting provider's justification of medical necessity involves a mental, emotional, or behavioral condition; a nutritional deficiency; a speech

or language pathology; or the presence of any other condition that would typically require the diagnosis, opinion, or expertise of a licensed clinician other than the requesting provider, then the medical necessity narrative and any attached documentation must:

i. clearly identify the appropriately qualified and licensed clinician(s) who furnished the diagnosis or opinion substantiating the condition or pathology (e.g., general dentist, oral surgeon, physician, clinical psychologist, clinical dietitian, speech therapist);
ii. describe the nature and extent of the identified clinician(s) involvement and interaction with the patient, including dates of treatment.
iii. state the specific diagnosis or other opinion of the patient's condition furnished by the identified clinician(s).
iv. document the recommendation by the clinician(s) to seek orthodontic evaluation or treatment (if such a recommendation was made).
vii. discuss any treatments for the patient's condition (other than interceptive orthodontic treatment) considered or attempted by the clinician(s); and
viii. provide any other relevant information from the clinician(s) that supports the requesting provider's justification of the medical necessity of interceptive orthodontic treatment.

The medical necessity narrative must be signed and dated by the requesting provider and submitted on the office letterhead of the provider. If applicable, any supporting documentation from the other involved clinician(s) must also be signed and dated by such clinician(s) and appear on office letterhead of such clinician(s). The requesting provider is responsible for coordinating with the other involved clinician(s) and is responsible for compiling and submitting any supporting documentation furnished by other involved clinician(s) along with the medical necessity narrative.

d. The following is a non-exclusive list of medical conditions that may, if documented, be considered in support of a request for PA for interceptive orthodontics:
   i. Two or more teeth numbers 6 through11 in crossbite with photographic evidence documenting 100% of the incisal edge in complete overlap with opposing tooth/teeth;
   ii. Crossbite of teeth numbers 3, 14 or 19,30 with photographic evidence documenting cusp overlap completely in fossa, or completely buccal-lingual of opposing tooth;
   iii. Crossbite of teeth number A, T or J, K with photographic evidence documenting cusp overlap completely in fossa, or completely buccal or lingual of opposing tooth;
   iv. Crowding with radiographic evidence documenting current bony impaction of teeth numbers 6 through 11 or teeth numbers 22 through27 that requires either serial extraction(s) or surgical exposure and guidance for the impacted tooth to erupt into the arch;
   v. Crowding with radiographic evidence documenting resorption of 25% of the root of an adjacent permanent tooth.

vi. Class III malocclusion, as defined by mandibular protrusion of greater than 3.5mm, anterior crossbite of more than 1 tooth/ reverse overjet, or Class III skeletal discrepancy, or hypoplastic maxilla with compensated incisors requiring treatment at an early age with protraction facemask, reverse pull headgear, or other appropriate device.

1. If prior authorization is DENIED.
    a. DentaQuest will send the provider and member a denial notice in the mail and post the denial to the Provider Web Portal.

2. If prior authorization is APPROVED.
    a. Provider can place the appliance for the patient.

    b. Provider can bill for the appliance once the appliance is placed.
    c. Provider can bill for the number of adjustments (D8999) performed, up to a maximum of 5, using the actual dates of treatment as the dates of service.

Additional Resources

Welcome to the Health Safety Net provider forms and attachment resource page. The links below provide methods to access and acquire both electronic and printable forms addressed within this document. To view copies please visit our website at www.masshealth-dental.net. Once you have entered the website, click on the tab called "Dentists" and click on the link to the provider web portal. You will then be able to log in using your password and User ID. Once logged in, select the link "Documents List" to access the following resources:

- Orthodontic Prior Authorization Form.
- Orthodontic Handicapping Labio-Lingual Deviations Form.
- Orthodontic Continuation of Care Form.
- Dental Claim Form and Instructions,
- Void Request Form.
- Initial Clinical Exam Form.
- Recall Examination Form.
- Medical and Dental History.
- Provider Change Form.

Broken Appointments: To notify DentaQuest on Health Safety Net patients breaking appointments please follow below instructions:

- Log into your Provider Web Portal.
- On the Navigation Pane under patient management, click Broken Appointments.
- Fill out page completely with date of service, office information, patient information, and reason why appointment broken.
- Click Submit.

If you do not have internet access, to have a copy mailed, you may also contact DentaQuest Customer Service at 1.800.207.5019.

APPENDIX A

General Definitions

The following definitions apply to this Office Reference Manual:

A. "Agreement" means the contract between the Health Safety Net Program and the provider.

B. "Board of Registration in Dentistry (BORID)" is the dental licensing and disciplinary board in Massachusetts. BORID licenses dentists and dental hygienists, receives and investigates complaints against dentists, and is responsible for implementing state laws and regulations governing licensees' practice of dentistry.

C. "Claim" means an itemized statement requesting Health Safety Net payment for dental services rendered by a dental provider to a patient.

D. "Clean Claim" means a claim that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

E. Collection Action. Any activity by which a Provider or designated agent requests payment for services from a Patient, a Patient's guarantor, or a third party responsible for payment. Collection Actions include activities such as preadmission or pretreatment deposits, billing statements, collection follow-up letters, telephone contacts, personal contacts, and activities of collection agencies and attorneys.

F. "Plan Type" is the scope of medical services, other services, or both that are available to Health Safety Net patients who meet specific Health Safety Net eligibility criteria. Health Safety Net plan types currently include:
   - HSN Adult
   - HSN Under 21
   - HSN Secondary to MassHealth Limited Adult
   - HSN Secondary to MassHealth Limited Under 21
   - HSN Secondary to MassHealth Comprehensive (Adult Only)

   See 101 CMR 613.03(1)(c) for more information.

G. "Eligible Services" means a dental health care service or supply that satisfies all of the following criteria:
   - Is medically necessary
   - Is payable under the Health Safety Net Dental Program
   - Is provided to a Health Safety Net patient by a Health Safety Net provider
   - Is the most appropriate supply or level of care that is consistent with professionally recognized standards of dental practice within the service area and applicable policies and procedures

H. "Customer" is a patient, dental provider or applicant, or other interested party.

I. "Dental Eligible Services" are dental services that are eligible for payment from the Health Safety Net as provided in 101 CMR 613.04.

J. “Dental Provider” is a community health center, hospital-licensed health center, or acute hospital outpatient department enrolled in the Health Safety Net Dental Program to provide eligible dental services to patients.

K. "The Health Safety Net Dental Program Service Area" shall be defined as the Commonwealth of Massachusetts.

L. “Emergency Services” means medically necessary services provide to an individual with an Emergency Medical Condition.

M. “Health Safety Net (HSN)” means the payment program established and administered in accordance with M.G.L. c. 118E, §§ 8A, and 64 through 69 and regulations promulgated thereunder, and other applicable legislation.

N. The “Health Safety Net Dental Program” means the program administered by DentaQuest based upon Commonwealth of Massachusetts regulations governing dental services found in 101 CMR 613.00 and 101 CMR 614.00.

O. “Health Insurance Portability and Accountability Act of 1996 (HIPAA)” is a comprehensive federal law (Pub.L. 104-191) established to protect the security and privacy of individual health information. The law establishes national standards for the electronic exchange of the health information by payers and providers.

P. “Intervention Services” are services designed to assist patients in making and keeping dental appointments, assisting in obtaining transportation in accordance with applicable regulations to and from appointments, and follow-up with patients and dental providers regarding appointments.

Q. “Mass.gov” is a publicly available web portal that connects MassHealth / HSN members, providers, and other entities to certain EOHHS systems.

R. “MassHealth” is he medical assistance and benefit programs administered by the MassHealth Agency pursuant to Title XIX of the Social Security Act (42 U.S.C. 1396), Title XXI of the Social Security Act (42 U.S.C. 1397), M.G.L. c. 118E, and other applicable laws and waivers to provide and pay for medical services to eligible members.

S. “Medically Necessary (or Medical Necessity)” A service that is reasonably expected to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity. Medically Necessary Services include inpatient and outpatient services as authorized under Title XIX of the Social Security Act.

T. “Patient” means an individual determined by the Health Safety Net Dental Program, and for whom dental services are payable pursuant to 101 CMR 613.04.

U. “Prior Authorization (PA)” is the process by which a determination is made, before services are delivered, in accordance with 101 CMR 613.04.

V. “Provider” An Acute Hospital or Community Health Center that provides dental Reimbursable Health Services as defined in 101 CMR 613.03.

W. Third-Party Liability (TPL) is the legal obligation of any person, entity, institution, company, or public or private agency, including a Health Safety Net patient’s own insurer, to pay all or

part of the cost medical services. Except where a specific agreement pursuant to 42 CFR 433.139 exists, Health Safety Net is in all instances the payer of last resort for Health Safety Net patients.

APPENDIX B

AUTHORIZATION FORM FOR COMPREHENSIVE ORTHODONTIC TREATMENT

Health Safety Net Handicapping Labio-Lingual Deviations Index

FOR OFFICE USE ONLY: ☐ First Reviewer: _____ ☐ Second Reviewer: _____ ☐ Third Reviewer:_____

The Handicapping Labio-Lingual Deviations Index (HLD) is a quantitative, objective method for evaluating PA requests for comprehensive orthodontic treatment. The HLD allows for the identification of certain autoqualifying conditions and provides a single score, based on a series of measurements, which represent the presence, absence, and degree of handicap. The HLD **must** be submitted with all PA requests for comprehensive orthodontic treatment.

The following documents **must** also be submitted with this form. ☐ x-rays ☐ photos Lateral Cephalometric radiograph which includes either an embedded measurement device or one added by provider (e.g., ruler, perio probe, measured wire with known length) OR lateral and occlusal photographs with a measurement device. Models are not required. Please include an explanation of the measurement device if it is not marked (e.g. a measured piece of wire).

Cephalometric radiographs OR photographs with a measurement device are required with every case in addition to the standard set of photos. Providers are encouraged to submit a lateral cephalometric radiograph if it will clearly identify the medical necessity of treatment such as for impinging overbite. Photo(s) with a measurement device (Boley gauge, disposable ruler, or periodontal probe) in the patient's mouth, or on models mounted in centric occlusion should be included. When measuring overjet, reverse overjet, or mandibular protrusion, the measurement device should be placed parallel to the occlusal plane involving two directly opposing incisor teeth with the photo taken on the ipsilateral side (same side) being measured. When measuring open bite, place the measurement device vertically to measure the opening from the incisal edge of the maxillary and mandibular incisors.

A sufficient number of photographs should be submitted with a measurement device, dependent upon the conditions present. The measurement device should be utilized in accordance with the Handicapping Labio-Lingual Deviation Index Scoring Instructions and the guidance provided in the previous paragraph.

Procedure

1. Occlude patient or models in centric occlusion.
2. Record all measurements in the order given and rounded off to the nearest millimeter.
3. **Enter score** "0" **if condition is absent**.
4. Start by measuring **overjet** of the most protruding incisor.
5. Measure **overbite** from the labio-incisal edge of overlapped front tooth (or teeth) to point of maximum coverage.
6. **Ectopic eruption** and **anterior crowding: Do not double score**. Record the more serious condition.
7. Deciduous teeth and teeth not fully erupted should not be scored.
8. Score all other conditions listed, and also check "yes" or "no" for all potential autoqualifiers.

Patient's Name (please print) _____ **Member ID**_____

Address _____

Street City/County State Zip Code

AUTOQUALIFERS	**Condition Observed**	
Cleft Lip, Cleft Palate, or other Cranio-Facial Anomaly	Yes ☐ No ☐	
Impinging overbite with evidence of occlusal contact into the opposing soft tissue	Yes ☐ No ☐	
Impactions where eruption is impeded but extraction is not indicated (excluding third molars).	Yes ☐ No ☐	
Severe Traumatic Deviations – This refers to accidents affecting the face and jaw rather than congenital deformity. Do not include traumatic occlusions or crossbites.	Yes ☐ No ☐	
Overjet (greater than 9mm)	Yes ☐ No ☐	
Reverse Overjet (greater than 3.5mm)	Yes ☐ No ☐	
Crowding of 10 mm or more, in either the maxillary or mandibular arch (excluding 3rd molars). Includes the normal complement of teeth.	Yes ☐ No ☐	
Spacing of 10 mm or more, in either the maxillary or mandibular arch (excluding 3rd molars). Includes the normal complement of teeth.	Yes ☐ No ☐	
Anterior crossbite of 3 or more maxillary teeth per arch.	Yes ☐ No ☐	
Posterior crossbite of 3 or more maxillary teeth per arch.	Yes ☐ No ☐	
Two or more congenitally missing teeth (excluding third molars) of at least one tooth per quadrant	Yes ☐ No ☐	
Lateral open bite: 2 mm or more; of 4 or more teeth per arch	Yes ☐ No ☐	
Anterior open bite: 2 mm or more; of 4 or more teeth per arch	Yes ☐ No ☐	
HLD SCORING	**Measurement**	**Score**
Overjet (in mm)	# mm X 1	
Overbite (in mm)	# mm X 1	
Mandibular Protrusion (in mm) – See scoring instructions.	# mm X 5	
Anterior Open Bite – Do not count ectopic eruptions; measure the opening between maxillary and mandibular incisors in mm.	# mm X 4	
Ectopic Eruption (number of teeth, excluding third molars) – Refers to an unusual pattern of eruption, such as high labial cuspids. Do not score teeth in this category if they are scored under maxillary or mandibular crowding.	# of teeth X 3	
Anterior Crowding – If crowding exceeds 3.5mm in an arch, score each arch.	Maxilla: 5 points Mandible: 5 points Both: 10 points	
Labio-Lingual Spread (anterior spacing in mm) – See scoring instructions.	# mm X 1	
Posterior Unilateral Crossbite – Must involve 2 or more teeth, one of which must be a molar	4 points	
Posterior impactions or congenitally missing posterior teeth (excluding 3rd molars)	# teeth X 3	
TOTAL		
Treatment will be authorized for cases with verified autoqualifiers or verified scores of 22 and above.		

Medical Necessity Narrative

MEDICAL NECESSITY NARRATIVE	
Are you submitting a Medical Necessity Narrative?	Yes ☐ No ☐
If yes, are you submitting additional supporting documentation?	Yes ☐ No ☐ The medical necessity determination does not involve any mental, emotional, behavioral or other condition outside the professional expertise of the requesting provider and, therefore, the submitted narrative does not incorporate or rely on the opinion or expertise of anyone other than the requesting provider.

Instructions for Medical Necessity Narrative and Supporting Documentation (if applicable)

Providers may establish that comprehensive orthodontic treatment is medically necessary by submitting a medical necessity narrative and supporting documentation, where applicable. The narrative must establish that comprehensive orthodontic treatment is medically necessary to treat a handicapping malocclusion, including to correct or significantly ameliorate

i. a severe skeletal deviation affecting the patient's mouth and/or underlying dentofacial structures;
ii. a diagnosed mental, emotional, or behavioral condition caused by the patient's malocclusion;
iii. a diagnosed nutritional deficiency and/or a substantiated inability to eat or chew caused by the patient's malocclusion;
iv. a diagnosed speech or language pathology caused by the patient's malocclusion; or
v. a diagnosed condition caused by the overall severity of the patient's malocclusion.

Providers may submit a medical necessity narrative (along with the required completed HLD) in any case where, in the professional judgment of the requesting provider and any other involved clinician(s), comprehensive orthodontic treatment is medically necessary to treat a handicapping malocclusion. Providers must submit this narrative in cases where the patient does not have an autoqualifying condition or meet the threshold score on the HLD, but where, in the professional judgment of the requesting provider and any other involved clinician(s), comprehensive orthodontic treatment is medically necessary to treat a handicapping malocclusion.

The medical necessity narrative must clearly demonstrate why comprehensive orthodontic treatment is medically necessary for the patient. If any part of the requesting provider's justification of medical necessity involves a mental, emotional, or behavioral condition; a nutritional deficiency; a speech or language pathology; or the presence of any other condition that would typically require the diagnosis, opinion, or expertise of a licensed clinician other than the requesting provider, then the narrative and any attached documentation must

i. clearly identify the appropriately qualified and licensed clinician(s) who furnished the diagnosis or opinion substantiating the condition or pathology (e.g., general dentist, oral surgeon, physician, clinical psychologist, clinical dietitian, speech therapist);
ii. describe the nature and extent of the identified clinician(s) involvement and interaction with the patient, including dates of treatment;
iii. state the specific diagnosis or other opinion of the patient's condition furnished by the identified clinician(s);
iv. document the recommendation by the clinician(s) to seek orthodontic evaluation or treatment (if such a recommendation was made);
v. discuss any treatments for the patient's condition (other than comprehensive orthodontic treatment) considered or attempted by the clinician(s); and
vi. provide any other relevant information from the clinician(s) that supports the requesting provider's justification of the medical necessity of comprehensive orthodontic treatment.

The medical necessity narrative must be signed and dated by the requesting provider and submitted on the office letterhead of the provider. If applicable, any supporting documentation from the other involved clinician(s) must also be signed and dated by such clinician(s), and appear on office letterhead of such clinician(s). The requesting provider is responsible for coordinating with the other involved clinician(s) and is responsible for compiling and submitting any supporting documentation furnished by other involved clinician(s) along with the medical necessity narrative.

Attestation

I certify under the pains and penalties of perjury that I am the prescribing provider identified on this form. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Prescribing provider's signature:

_____

(Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

Printed name of prescribing provider _____ Date _____

Handicapping Labio-Lingual Deviation Index Scoring Instructions

1. Occlude patient or models in centric occlusion.
2. Record all measurements in the order given and rounded off to the nearest millimeter.
3. Enter score "0" if condition is absent.
4. Start by measuring overjet of the most protruding incisor.
5. Measure overbite from the labio-incisal edge of overlapped front tooth (or teeth) to point of maximum coverage.
6. Score all other conditions listed.
7. **Ectopic eruption and anterior crowding: Do not double score.** Record the more serious condition.
8. Deciduous teeth and teeth not fully erupted should not be scored.

All measurements are made with a measurement tool scaled in millimeters. Absence of any conditions must be recorded by entering "0."
The following information should help clarify the categories on the HLD Index.

AUTOQUALIFIERS

1. **Cleft Lip, Cleft Palate, or other craniofacial anomalies:** Indicate an "X" on the form. (*This is considered an autoqualifying condition*.)
2. **Impinging Overbite:** Impinging Overbite with evidence of occlusal contact into the opposing soft tissue. Indicate an "X" on the form. (This is considered an autoqualifying condition.)
3. **Impactions:** Impactions (excluding third molars) that are impeding eruption in the maxillary and mandibular arches. Indicate an "X" on the form. *(This is considered an autoqualifying condition.)*
4. **Severe Traumatic Deviations:** Traumatic deviations refer to accidents impacting the face, jaws, and teeth rather than congenital deformity. For example, loss of a premaxilla segment by burns or by accident; the result of osteomyelitis; or other gross pathology. Do not include traumatic occlusions or crossbites. Indicate an "X" on the form. *(This is considered an autoqualifying condition.)*
5. **Overjet Greater Than 9mm:** This is recorded with the patient in the centric occlusion and measured from the labial of the lower incisor to the labial of the upper incisor. The measurement could apply to a protruding single tooth as well as to the whole arch. The measurement is read and rounded off to the nearest millimeter and entered on the form. Indicate an "X" on the form. *(This is considered an autoqualifying condition.)*
6. **Reverse Overjet Greater Than 3.5mm**: This is recorded with the patient in the centric occlusion and measured from the labial of the lower incisor to the labial of the upper incisor. Indicate an "X" on the form. *(This is considered an autoqualifying condition.)*
7. **Crowding or spacing of 10 mm or more**, in either the maxillary or mandibular arch (excluding 3rd molars). Includes the normal complement of teeth. Does not include extracted, congenitally missing, or supernumerary teeth. Indicate an "X" on the form. *(This is considered an autoqualifying condition*.)
8. **Anterior or posterior crossbite** of 3 or more teeth per arch. Indicate an "X" on the form. *(This is considered an autoqualifying condition*.)
9. Two or more **congenitally missing teeth** (excluding 3rd molars). Teeth that are missing due to extraction (or other loss) will not be considered under this section. Indicate an "X" on the form. (This is considered an autoqualifying condition.)
10. **Lateral or anterior (of incisors) open bite** 2 mm or more; of 4 or more fully erupted teeth per arch. Ectopically erupted teeth are not included. Anterior open bite is defined as absence of vertical overlap of maxillary and mandibular permanent incisors. End to end or edge to edge permanent incisors do not count as an open bite. Permanent canines are not scored. To be counted, the entire maxillary incisal edge must not have any end to end contact with a mandibular incisor or any vertical overlap of the mandibular incisor. It is measured from the incisal edge of the permanent maxillary incisor to the nearest point of the incisal edge of the permanent mandibular incisor. To be scored as an autoqualifier, the open bite must involve 4 or more fully erupted teeth per arch. Indicate an "X" on the form. (This is considered an autoqualifying condition.)

HLD SCORING

1. **Overjet in Millimeters:** This is recorded with the patient in the centric occlusion and measured from the labial of the lower incisor to the labial of the upper incisor. The measurement could apply to a protruding single tooth as well as to the whole arch. The measurement is read and rounded off to the nearest millimeter and entered on the form.
2. **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 form. "Reverse" overbite may exist in certain conditions and should be measured and recorded.
3. **Mandibular Protrusion in Millimeters:** Score exactly as measured from the buccal groove of the first mandibular molar to the MB cusp of the first maxillary molar. The measurement in millimeters is entered on the form and multiplied by 5.
4. **Anterior Open Bite in Millimeters**: This condition is defined as absence of vertical overlap of a maxillary and mandibular permanent incisor. End to end or edge to edge permanent incisors do not count as an open bite. Permanent canines are not scored. To be counted, the entire maxillary incisal edge must not have any end to end contact with a mandibular incisor or any vertical overlap of the mandibular incisor. It is measured from the incisal edge of the permanent maxillary incisor to the nearest point of the incisal edge of the permanent mandibular incisor. This measurement is entered on the form and multiplied by 4.
5. **Ectopic Eruption:** Count each tooth, excluding third molars. Each qualifying tooth must be blocked out of the arch. Enter the number of teeth on the form and multiply by 3. If condition no. 6, anterior crowding, is also present, with an ectopic eruption in the anterior portion of the mouth, score only the most severe condition. Do not score both conditions.
6. **Anterior Crowding:** Arch length insufficiency must exceed 3.5 mm. Score only fully erupted incisors and canines. Mild rotations that may react favorably to stripping or mild expansion procedures are not to be scored as crowded. Enter 5 points for maxillary and mandibular anterior crowding. If condition no. 5, ectopic eruption, is also present in the anterior portion of the mouth, score only the most severe condition. Do not score both conditions.
7. **Labio-Lingual Spread:** The measurement tool 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 tooth and the lingually displaced anterior tooth is measured. The labio-lingual spread approximates a measurement of overall deviation from what would have been a normal arch. If 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 index.
    - Additionally, anterior spacing may be measured as the total score in mm from the mesial of cuspid to the mesial of cuspid, totaling both arches.
    - Score only the greater score attained by either of these two methods.
8. **Posterior Crossbite**: This condition involves two or more adjacent maxillary permanent teeth, one of which must be a permanent 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 4 on the form.
9. **Posterior Impactions or Congenitally Missing Posterior Teeth**: Total the number of posterior teeth, excluding third molars that meet this criterion, and multiply by 3.

DentaQuest
*Serving the MassHealth Program**

MassHealth

Orthodontic Continuation of Care Solution Form

Date: _____

Patient Information

Name (First & Last)	Date of Birth	SS or ID#

Address	City, State Zip	Area Code & Phone Number

Provider Information

Dentist Name	Provider NPI #	Location ID#

Address	City, State Zip	Area Code & Phone Number

Name of Previous Insurer that issued original approval:

Banding Date:

Case Rate Approved by Previous Insurer:

Amount Owed for Dates of Service that Occurred Prior to the patient becoming a MassHealth member

Amount Paid for Dates of Service that Occurred Prior to the patient becoming a MassHealth member

Balance Expected for Future Dates of Service:

Numbers of Adjustments Remaining:

Additional Information Required:

- **If the member is transferring from a Medicaid program: Please send a copy of the original orthodontic approval to see the criteria used and/or the condition of the case where it was started if possible and the date treatment began/banding.**
- **If the member is private pay or transferring from a commercial insurance program: Please enclose the original diagnostic and HLD Form if possible and the date treatment began/banding. Models (or OrthoCAD equivalent) are optional.**

Mail to:
Health Safety Net Dental Program
ATTN: Continuation of Care
P.O. Box 2906
Milwaukee, WI 53201-2906

ADA American Dental Association®

America's leading advocate for oral health

The following information highlights certain form completion instructions. Comprehensive ADA Dental Claim Form completion instructions are printed in the CDT manual. Any updates to these instructions will be posted on the ADA's web site (ADA.org).

GENERAL INSTRUCTIONS

A. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard #9 window envelope (window to the left). Please fold the form using the 'tick-marks' printed in the margin.

B. Complete all items unless noted otherwise on the form or in the CDT manual's instructions.

C. Enter the full name of an individual or a full business name, address and zip code when a name and address field is required.

D. All dates must include the four-digit year.

E. If the number of procedures reported exceeds the number of lines available on one claim form, list the remaining procedures on a separate, fully completed claim form.

COORDINATION OF BENEFITS (COB)

When a claim is being submitted to the secondary payer, complete the entire form and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may also note the primary carrier paid amount in the "Remarks" field (Item 35). There are additional detailed completion instructions in the CDT manual.

DIAGNOSIS CODING

The form supports reporting up to four diagnosis codes per dental procedure. This information is required when the diagnosis may affect claim adjudication when specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions. Diagnosis codes are linked to procedures using the following fields:

Item 29a – Diagnosis Code Pointer ("A" through "D" as applicable from Item 34a)

Item 34 – Diagnosis Code List Qualifier (B for ICD-9-CM; AB for ICD-10-CM)

Item 34a – Diagnosis Code(s) / A, B, C, D (up to four, with the primary adjacent to the letter "A")

PLACE OF TREATMENT

Enter the 2-digit Place of Service Code for Professional Claims, a HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are:

11 = Office; 12 = Home; 21 = Inpatient Hospital; 22 = Outpatient Hospital; 31 = Skilled Nursing Facility; 32 = Nursing Facility

The full list is available online at "www.cms.gov/PhysicianFeeSched/Downloads/Website_POS_database.pdf"

PROVIDER SPECIALTY

This code is entered in Item 56a and indicates the type of dental professional who delivered the treatment. The general code listed as "Dentist" may be used instead of any of the other codes.

Category / Description Code	Code
Dentist A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license.	122300000X
General Practice	1223G0001X
Dental Specialty (see following list)	Various
Dental Public Health	1223D0001X
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223D0008X
Oral & Maxillofacial Surgery	1223S0112X

Provider taxonomy codes listed above are a subset of the full code set that is posted at "www.wpc-edi.com/codes/taxonomy"

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐ M ☐ F | 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐ M ☐ F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B; ICD-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ C _____ B _____ D _____

31a. Other Fee(s)

32. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment | 43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) | 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational Illness/Injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) - | 52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

54. NPI | 55. License Number

56. Address, City, State, Zip Code | 56a. Provider Specialty Code

57. Phone Number ( ) - | 58. Additional Provider ID

J430D (Same as ADA Dental Claim Form – J430, J431, J432, J433, J434)

To reorder call 800.947.4746 or go online at adacatalog.org

DentaQuest
*Serving the Health Safety Net Program**

Void Request Form

MassHealth

Paper Voids: To submit a paper void request, please complete this form and attach a photocopy of the **Remittance Advice (RA)** containing the claim lines to be voided. Please *Circle* each claim line to be voided on the coy of the RA.

Send void requests to:

Health Safety Net Dental Program
ATTN: Voids
P.O. Box 2906
Milwaukee, WI 53201-2906

Please note: Previously paid claims can be voided electronically in the HIPAA-Compliant 837 format using the void and replace transaction.

Date of Request

Provider or Facility Name

Health Safety Net Provider Number

Provider Address

Billing Provider's NPI#

Provider City, State, Zip

Amount

Please check off one reason for requesting the void.

Please note: If you need several claims voided for different reasons, please complete a request form for each reason and attach a copy of the RA indicating the claim line to be voided. A void request for serval claims that are being requested for the same reason may be batched together with one request form.

- ☐ Collection from a Primary Health Insurance Name of Insurance Company: _____
- ☐ Collection from Auto Insurance of Worker's Compensation Insurance
- ☐ Claim paid to the wrong provider
- ☐ Wrong Health Safety Net member ID (MID) on the claim
- ☐ Provider billed incorrect service date
- ☐ Duplicate payment
- ☐ Provider performed only a certain component of the entire service billed
- ☐ Other (please explain): _____

The voided claim will be processed on a future remittance advice. The total amount originally paid will appear as a negative amount and that amount will be deducted from the payments until the overpayment is recovered. If applicable, please follow the billing instructions found in your provider manual for resubmitting a replacement claim.

Provider/Facility Authorized Signature

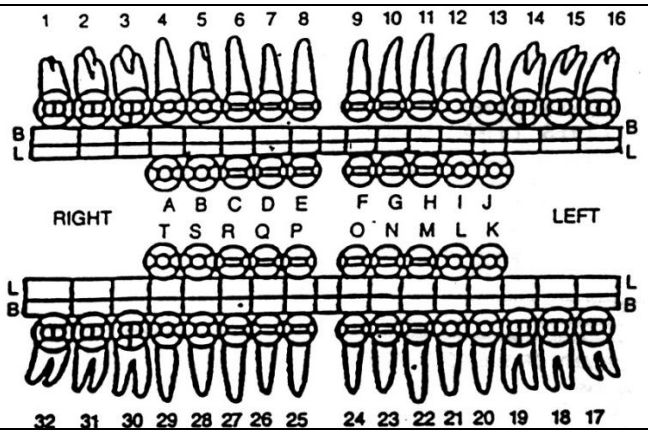
Date

Initial Clinical Exam
(Sample)

Allergy	Pre Med	Medical Alert

Initial Clinical Exam

Patient's Name:_____
Last First Middle



Gingiva
Mobility
Prosthesis Evaluation
Occlusion 1 11 111
Patient's Chief Complaint

	OK
Lymph Nodes	
Pharynx	
Tonsils	
Soft Palate	
Hard Palate	
Floor of Mouth	
Tongue	
Vestibules	
Buccal Mucosa	
Lips	
Skin	
TMJ	
Oral Hygiene	
Perio Exam	

Clinical Findings/Comments

Radiographs	B/P	RDH/DDS

Recommended Treatment Plan

Tooth or Area	Diagnosis	Plan A	Plan B

Signature of Dentist:_____ Date: _____

Recall Examination
(Sample)

Patient's Name:_____

Changes in Health Status/Medical History:_____

Clinical Findings/Comments

	OK		OK
Lymph Nodes		TMJ	
Pharynx		Tongue	
Tonsils		Vestibules	
Soft Palate		Buccal Mucosa	
Hard Palate		Gingiva	
Floor of Mouth		Prosthesis	
Lips		Perio Exam	
Skin		Oral Hygiene	
Radiographs		B/P	RDH/DDS

R							**Work Necessary**								**L**
Tooth	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Service																
Tooth	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
Service																

Comments:_____

_____

Recall Examination

Patient's Name:_____

Changes in Health Status/Medical History:_____

Clinical Findings/Comments

	OK		OK
Lymph Nodes		TMJ	
Pharynx		Tongue	
Tonsils		Vestibules	
Soft Palate		Buccal Mucosa	
Hard Palate		Gingiva	
Floor of Mouth		Prosthesis	
Lips		Perio Exam	
Skin		Oral Hygiene	
Radiographs		B/P	RDH/DDS

R **Work Necessary** **L**

Tooth	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Service																
Tooth	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
Service																

Comments:_____

_____

Medical and Dental History
(Sample)

Patient Name:_____ Date of Birth:_____

Address: _____

Why are you here today?_____

Are you having any pain or discomfort at this time? □ Yes □ No

If yes, what type and where?_____

Have you been under the care of a medical doctor during the past two years? □ Yes □ No

Medical Doctor's Name:_____

Address: _____

Telephone:_____

Have you taken any medication or drugs during the past two years? □ Yes □ No

Are you now taking any medication, drugs, or pills? □ Yes □ No

If yes, please list medications:_____

Are you aware of being allergic to or have you ever reacted badly to any medication or substance? □ Yes □ No

If yes, please list: _____

When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are tired? □ Yes □ No

Do your ankles swell during the day? □ Yes □ No

Have you lost or gained more than 10 pounds in the past year? □ Yes □ No

Do you ever wake up from sleep and feel short of breath? □ Yes □ No

Are you on a special diet? □ Yes □ No

Has you medical doctor ever said you have cancer or a tumor? □ Yes □ No

If yes, where?_____

Do you use tobacco products (smoke or chew tobacco)? □ Yes □ No

If yes, how often and how much?_____

Do you drink alcoholic beverages (beer, wine, whiskey, etc.)? □ Yes □ No

Do you have or have you had any disease, or condition not listed? □ Yes □ No

If yes, please list:_____

Indicate which of the following you have had, or have at present. Check "Yes" or "No" for each item.

Heart Disease or Attack	□ Yes	□ No	Stroke	□ Yes	□ No	Arteriosclerosis (hardening of arteries)	□ Yes	□ No
Heart Failure	□ Yes	□ No	Kidney Trouble	□ Yes	□ No	Ulcers	□ Yes	□ No
Angina Pectoris	□ Yes	□ No	Venereal Disease	□ Yes	□ No	AIDS	□ Yes	□ No
Congenital Heart Disease	□ Yes	□ No	Heart Murmur	□ Yes	□ No	Blood Transfusion	□ Yes	□ No
Diabetes	□ Yes	□ No	Glaucoma	□ Yes	□ No	Cold Sores/Fever Blisters/Herpes	□ Yes	□ No
HIV Positive	□ Yes	□ No	Cortisone Medication	□ Yes	□ No	Artificial Heart Valve	□ Yes	□ No
High Blood Pressure	□ Yes	□ No	Cosmetic Surgery	□ Yes	□ No	Heart Pacemaker	□ Yes	□ No
Mitral Valve Prolapse	□ Yes	□ No	Anemia	□ Yes	□ No	Sickle Cell Disease	□ Yes	□ No
Emphysema	□ Yes	□ No	Heart Surgery	□ Yes	□ No	Asthma	□ Yes	□ No
Chronic Cough	□ Yes	□ No	Bruise Easily	□ Yes	□ No	Yellow Jaundice	□ Yes	□ No
Tuberculosis	□ Yes	□ No	Rheumatic Fever	□ Yes	□ No	Rheumatism	□ Yes	□ No
Liver Disease	□ Yes	□ No	Epilepsy or Seizures	□ Yes	□ No	Fainting or Dizzy Spells	□ Yes	□ No
Arthritis	□ Yes	□ No	Nervousness	□ Yes	□ No	Chemotherapy	□ Yes	□ No
Allergies or Hives	□ Yes	□ No	Radiation Therapy	□ Yes	□ No	Drug Addiction	□ Yes	□ No
Sinus Trouble	□ Yes	□ No	Thyroid Problems	□ Yes	□ No	Psychiatric Treatment	□ Yes	□ No
Pain in Jaw Joints	□ Yes	□ No	Hepatitis A (Infectious)	□ Yes	□ No	Artificial Joints (Hip, Knee, etc.)	□ Yes	□ No
Hay Fever	□ Yes	□ No	Hepatitis B (Serum)	□ Yes	□ No	Hepatitis C	□ Yes	□ No

For Women Only:

Are you pregnant? □ Yes □ No

If yes, what month?_____

Are you nursing? □ Yes □ No

Are you taking birth control pills? □ Yes □ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully.

Patient Signature:_____ Date: _____

Dentist's Signature:_____ Date: _____

(see next page)

Review Date	Changes in Health Status	Patient's Signature	Dentist's Signature

DentaQuest
*Serving the Health Safety Net Program**

APPENDIX C

Third Party Liability

All Providers must comply with the Health Safety Net's Third-Party Liability (TPL) requirements under 101 CMR 613.04. TPL includes the primary insurance on file for a member. If Health Safety Net records indicate the member has other active insurance, you must bill that insurer before billing the Health Safety Net. Certain limited exceptions exist under federal law in the case of prenatal or preventive pediatric care, or where the Department of Revenue is carrying out child-support enforcement. If you have a question about whether you must bill an insurer before billing the Health Safety Net, you may call Customer Service at 1.800.207.5019.

How to determine if TPL Coverage exists

Providers should make diligent efforts to identify other insurers. Diligent efforts include, verifying the member's other health insurance coverage known to HSN, through DentaQuest' s Interactive Voice Response (IVR) system or through the "Providers Only" section of DentaQuest' s website at www.masshealth-dental.net. The eligibility information received from either system will be the same information you would receive by calling DentaQuest' s Customer Service department; however, by utilizing either system you can get information 24 hours a day, 7 days a week without having to wait for an available Customer Service Representative.

How to update the TPL information on file*

Files can be updated when TPL coverage has ended, the information on file is incorrect, or the name of the insurance has changed. Send an explanation of benefits (EOB) showing the correct information, a completed Third Party Indicator (TPLI) form (available from the Provider Forms link on www.mass.gov/masshealth), and any other supporting documentation to the appropriate address below. **Do not send claim forms to these addresses.**

For a Commercial policy:
MassHealth / HSN
Third Party Liability Unit
519 Somerville Ave #372
Somerville, MA 02209
Fax : (617) 451-1332

For a Medicare policy:
Medicare Part C or D Plans-
Customer Support: (800)462-1120, Option 3
MedicareRequests@umassmed.edu

Provider related inquiries:
Customer Support: (888) 628-7526
Fax: (617) 451-1332

- Insurance cannot be removed from the member's file when coverage is active, but does not cover a particular service

Electronic Submissions: Please refer to the Implementation Guide for proper billing of TPL claims. (Rev. 12/06)
Visit our Website at: www.masshealth-dental.net
** DentaQuest, LLC is the subcontractor to Dental Service of Massachusetts, Inc.*

DentaQuest
*Serving the Health Safety Net Program**

MassHealth

Corrective Action for Denied Dental Claims

There are multiply scenarios that would cause a claim to deny.

Claims must be submitted within 90 days of the date of service.

If the claim was received by the Health Safety Net Program within 90 days of the date of service or the date of explanation of benefits (EOB) from the primary insurer, participating HSN providers may submit corrections using the following methods:

1. Electronic claims via the provider web portal at www.masshealth-dental.net.
2. Electronic claims in the HIPAA-compliant 837D or 837P format via upload to our secure website www.masshealth-dental.net.
3. Electronic claims in the HIPAA-complaint 837D or 837P format on CD –ROM, 3.5" floppy disk or DVD
4. Electronic claims submission via a clearinghouse partner.

A claim may be resubmitted as many times as necessary up to 12 months from the date of service. When other insurance is involved, the time period is extended to 18 months from date of service. To resubmit a claim you need to:

- Prepare a corrected claim form or provide documentation with the corrected claim information.
- Attach any documentation that was included with your original submission.
- Enter "Resubmit" and/or "ICN" along with the 13-charcter assigned to the original claim in field 35 of the ADA 2006/2012 form.

Visit our Website at: www.masshealth-dental.net

** DentaQuest, LLC is the subcontractor to Dental Service of Massachusetts, Inc*

DentaQuest
*Serving the Health Safety Net Program**

Corrective Action for
Incorrectly Paid Dental Claims

MassHealth

There are multiply scenarios that would cause a claim to pay incorrectly such as a provider submitting incorrect provider, member or service information.

In order to correct a claim that has been "Paid", but has been paid at an incorrect amount, you must follow the Adjustment procedure:

- Prepare a new claim form or provide documentation with the corrected claim information with the correct information and attach any required documentation.
- Do not subtract the original payment from your usual charge, and do not enter it in the "Other Paid Amount" column (the processing system will perform the necessary calculation.)
- Enter "A" followed by the 10-character TCN or 13 character ICN transaction control number (TCN) from the most recent "Paid" claim in field 35 of the ADA 2012 form.

If the original submission required documentation, you must attach the documentation to the adjusted claim.

Submit the claim to DentaQuest via the provider web portal at www.masshealth-dental.net or via mail at:

The Health Safety Net Dental Program
Attn: Adjustments
P.O. Box 2906
Milwaukee, WI 53201-2906

You cannot follow the adjustment procedure if you are making a change to the member ID number, pay-to provider number, or the invoice type. In these situations, you must request a void of the original payment, and then rebill the corrected claim, if applicable.

Visit our Website at: www.masshealth-dental.net

** DentaQuest, LLC is the subcontractor to Dental Service of Massachusetts, Inc.*

DentaQuest
*Serving the Health Safety Net Program**

Overpayments of Dental Claims

MassHealth

If you receive an overpayment on a claim, you must request that the payment be voided. If all payments on a particular remittance advice need to be refunded to the Health Safety Net Program, do not return the original check received from the State Comptrollers' office. Instead, deposit the check and follow the void procedures outlined below.

Common reasons for requesting a void:

- payment to wrong provider number
- payment for the wrong member
- payment for overstated services
- payment for services for which full reimbursement has been received from other payers

To request a void:

- circle the claim line(s) to be voided on a photocopy of the remittance advice (RA);
- send the photocopy of the RA, and complete a void request form via the Health Safety Net / MassHealth Provider Web Portal at www.masshealth-dental.net or by completing the void Request form and mailing it to:

  Health Safety Net Dental Program
  Attn: Voids
  P.O. Box 2906
  Milwaukee, WI 53201-2906

*Only offices with no access to online services will be permitted to submit void requests via paper after January 1, 2017.

After the void request has been processed:

- voided claims will appear on a remittance advice
- the total amount originally paid will appear as a negative amount
- that amount will be deducted from payments until it is recovered.

Once the claim has been voided:

- a corrected claim can be submitted, if applicable
- you can submit an adjusted claim

(Rev. 12/06)

Visit our Website at: www.masshealthdental.net

** DentaQuest, LLC is the subcontractor to Dental Service of Massachusetts, Inc.*

APPENDIX D

Eligible Services (See Exhibits A-E)

This appendix identifies Eligible Services, provides specific criteria for payment, and defines individual age and service limitations for HSN Dental Program members. **Providers with questions should contact the Health Safety Net Dental Program's Provider Services Department directly at 1.800.207.5019.**

The Health Safety Net Dental Program recognizes tooth letters "A" through "T" for primary teeth and tooth numbers "1" to "32" for permanent teeth. Supernumerary teeth should be designated by "AS through TS" for primary teeth and tooth numbers "51" to "82" for permanent teeth. These codes must be referenced in the patient's file for record retention and review.

The Health Safety Net Dental Program claim system will only process claims with the CDT service codes as described in 130 CMR 420.000 and Exhibits A-E. All other claims with service codes not contained in the following tables will be rejected when submitted for payment. A complete, copy of the CDT book can be purchased from the American Dental Association at the following address:

American Dental Association
211 East Chicago Avenue
Chicago, IL 60611
1-800.947.4746
http://ebusiness.ada.org/default.aspx

Furthermore, the Health Safety Net Dental Program subscribes to the definition of services performed as described in the CDT manual.

The eligible CDT services tables (Exhibits A-E) are all inclusive. Each category of service is contained in a separate table and lists:

1. the ADA approved service code to submit when billing,
2. brief description of the eligible service,
3. any age limits imposed on eligibility,
4. a description of documentation, in addition to a completed claim must be submitted when a claim or request for prior authorization is submitted,
5. An indicator of whether or not the service is subject to prior authorization, retrospective review, or any other applicable limitations.

Refer to Subchapter 6 of the *Dental Manual* for eligible CPT codes.

APPENDIX E

BENEFITS COVERED FOR HSN– UNDER 21

ORTHODONTIC

As detailed in Section 16.00 of the *Office Reference Manual*, Members under age 21 may qualify for orthodontic treatment (Members age 21 and older may qualify for continuation of treatment if they have been fully banded prior to their 21st birthday). All orthodontic services require prior authorization with the exception of pre-orthodontic treatment visits. For information and instructions on submitting prior authorization requests for orthodontic services and other relevant information, please refer to the sections of the *Office Reference Manual* listed below.

- Comprehensive Orthodontic Treatment: Sections 16.01 and 16.02 and Appendix B
- Interceptive Orthodontic Treatment: Section 16.04
- Continuation of Care: Section 16.03
- General Billing Information for Orthodontics: Section 16.05

Transfers

If a member transfers to a new dental provider's office, that new dental provider's office can retake a new series or shall request a copy of the member's radiographs from the previous dental provider. If the films or their copies cannot be provided by the previous dental provider, the new dental provider shall document this fact in the member's record and proceed to take the needed films that are required to diagnose, develop a treatment plan and provide treatment. It is not the intention of the MassHealth agency to impede timely treatment while waiting for the previous dentist to provide the requested radiographs and records.

Emergency or Postoperative

In an emergency, in order to establish a diagnosis which must be recorded, a radiograph may be taken at any time, as dentally necessary. Postoperative radiographs normally taken at the conclusion of dental treatment by a dental provider shall be maintained as part of the member's dental records (Example: final radiographs at completion of endodontic treatment, or certain surgical procedures).

Referrals

Radiological services other than those ordinarily provided by a practitioner in his or her own office may be referred to a dental specialist who will provide radiological services limited to his or her own special field. Radiological services may also be requested from a physician who is a specialist in radiology or a qualified hospital facility. Services provided by another dentist, physician, or hospital facility shall be billed directly to the MassHealth agency by that provider and not by the referring dentist.

Exhibit A Benefits Covered for Under 21 HSN Only

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0120	periodic oral evaluation - established patient	0-20		No	Two of (D0120, D0145) per 1 Calendar year(s) Per Provider OR Location. Not covered with D9110 by same provider or provider group on same date of service.	
D0140	limited oral evaluation-problem focused	0-20		No	Two of (D0140) per 1 Calendar year(s) Per patient. Not covered with D9110, D0160, D0180 by same provider or provider group on same date of service.	
D0145	oral evaluation for a patient under three years of age and counseling with primary caregiver	0-3		No	Two of (D0120, D0145, D0180) per 1 Calendar year(s) Per Provider OR Location. Cannot be billed on the same date of service as D0150.	
D0150	comprehensive oral evaluation - new or established patient	0-20		No	One of (D0150, D0180) per 1 Lifetime Per Provider OR Location. Cannot be billed on the same date of service as D0145.	
D0180	comprehensive periodontal evaluation - new or established patient	0-20		No	One of (D0180) per 1 Calendar year(s) Per Provider OR Location. Not covered with D9110, D0140, D0145, D0150 by same provider or provider group on same date of service.	
D0210	intraoral - complete series of radiographic images	6 - 20		No	One of (D0210) per 3 Calendar year(s) Per Provider OR Location. One complete series every three calendar years per patient per dentist or dental group. Any combination of radiographs that exceedsthe maximum allowable payment for a FMX will be reimbursed at the D0210 rate. Documentation of variation from ADA clinical guidelines to be kept in patient record.	
D0220	intraoral - periapical first radiographic image	0-20		No	One of (D0220) per 1 Day(s) Per Provider OR Location. Twelve of (D0220, D0230) per 12 Month(s) Per patient. Maximum of one per visit. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be reimbursed at the D0210 rate. Documentation of variation from ADA clinical guidelines to be kept in patient record.	

Exhibit A Benefits Covered for Under 21 HSN Only

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0230	intraoral - periapical each additional radiographic image	0-20		No	Three of (D0230) per 1 Day(s) Per Provider OR Location. Twelve of (D0220, D0230) per 12 Month(s) Per patient. Maximum of three per visit. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be reimbursed at the D0210 rate. Documentation of variation from ADA clinical guidelines to be kept in patient record.	
D0240	intraoral - occlusal radiographic image	0-4		No	Two of (D0240) per 1 Calendar year(s) Per Provider OR Location.	
D0270	bitewing - single radiographic image	0-20		No	Two of (D0270, D0272, D0273, D0274) per 1 Calendar year(s) Per Provider OR Location. One of (D0270, D0272, D0273, D0274) per 1 Day(s) Per patient. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be reimbursed at the D0210 rate. Documentation of variation from ADA clinical guidelines to be kept in patient record.	
D0272	bitewings - two radiographic images	0-20		No	Two of (D0270, D0272, D0273, D0274) per 1 Calendar year(s) Per Provider OR Location. One of (D0270, D0272, D0273, D0274) per 1 Day(s) Per patient. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be reimbursed at the D0210 rate. Documentation of variation from ADA clinical guidelines to be kept in patient record.	
D0273	bitewings - three radiographic images	0-20		No	Two of (D0270, D0272, D0273, D0274) per 1 Calendar year(s) Per Provider OR Location. One of (D0270, D0272, D0273, D0274) per 1 Day(s) Per patient. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be reimbursed at the D0210 rate. Documentation of variation from ADA clinical guidelines to be kept in patient record.	

Exhibit A Benefits Covered for Under 21 HSN Only

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0274	bitewings - four radiographic images	0-20		No	Two of (D0270, D0272, D0273, D0274) per 1 Calendar year(s) Per Provider OR Location. One of (D0270, D0272, D0273, D0274) per 1 Day(s) Per patient. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be reimbursed at the D0210 rate. Documentation of variation from ADA clinical guidelines to be kept in patient record.	
D0330	panoramic radiographic image	0-20		No	One of (D0330) per 3 Year(s) Per Provider OR Location. (Not covered when billed with services related to Crowns, Endodontics, Periodontics, Restorations and Orthodontics).Not covered when the treating dentist is an orthodontist, endodontist, prosthodontist and periodontist.Non-surgical conditions. Surgical conditions are payable in excess of the 3 year limitation when used as a diagnostic tool. Any combination of radiographs thatexceeds the max allowable for a FMX will be reimbursed at the D0210 rate. Documentation of variation from ADA clinical guidelines to be kept in patient record.	
D0340	cephalometric radiographic image	0-20		No	Non-orthodontic procedures. Only payable to a dental provider with a specialty in oral surgery.	

Exhibit A Benefits Covered for Under 21 HSN Only

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1110	prophylaxis - adult	14 - 20		No	Two of (D1110, D1120, D4346) per 1 Calendar year(s) Per patient. Includes minor scaling procedures.	
D1120	prophylaxis - child	0-13		No	Two of (D1110, D1120, D4346) per 1 Calendar year(s) Per patient. Includes minor scaling procedures.	
D1206	topical application of fluoride varnish	0-20		No	One of (D1206, D1208) per 90 Day(s) Per Provider OR Location. Cannot be billed with D1208 on same date of service by the same provider or location.	
D1208	topical application of fluoride - excluding varnish	0-20		No	One of (D1206, D1208) per 90 Day(s) Per Provider OR Location. Cannot be billed with D1206 on same date of service by the same provider or location.	
D1351	sealant - per tooth	0-16	Teeth 1 - 3, 14 - 19, 30 - 32	No	One of (D1351) per 3 Year(s) Per Provider OR Location per tooth. Permanent first and second non-carious (occlusal surface) molars and non-carious (occlusal surface)third molars.	
D1354	interim caries arresting medicament application - per tooth	0-20	Teeth 1 - 32, A - T	No	Two of (D1354) per 1 Lifetime Per patient per tooth.	
D1510	space maintainer-fixed-unilateral - per quadrant- Excludes a distal shoe space maintainer.	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Four of (D1510, D1516, D1517, D1520, D1526, D1527, D1575) per 1 Lifetime Per patient. Must maintain radiographs in patient record demonstrating that the tooth has not begun to erupt or that migration of the adjacent tooth has already occurred. Excludes a Distal Shoe Maintainer.	
D1516	space maintainer --fixed--bilateral, maxillary	0-20		No	Four of (D1510, D1516, D1517, D1520, D1526, D1527, D1575) per 1 Lifetime Per patient. Must maintain radiographs in patient record demonstrating that the tooth has not begun to erupt or that the migration of the adjacent tooth has already occurred.	

Exhibit A Benefits Covered for Under 21 HSN Only

Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1517	space maintainer --fixed--bilateral, mandibular	0-20		No	Four of (D1510, D1516, D1517, D1520, D1526, D1527, D1575) per 1 Lifetime Per patient. Must maintain radiographs in patient record demonstrating that the tooth has not begun to erupt or that the migration of the adjacent tooth has already occurred.	
D1520	space maintainer-removable-unilateral – per quadrant.	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Four of (D1510, D1516, D1517, D1520, D1526, D1527, D1575) per 1 Lifetime Per patient. Must maintain radiographs in patient record demonstrating that the tooth has not begun to erupt or that the migration of the adjacent tooth has already occurred.	
D1526	space maintainer --removable--bilateral, maxillary	0-20		No	Four of (D1510, D1516, D1517, D1520, D1526, D1527, D1575) per 1 Lifetime Per patient. Must maintain radiographs in patient record demonstrating that the tooth has not begun to erupt or that the migration of the adjacent tooth has already occurred.	
D1527	space maintainer --removable--bilateral, mandibular	0-20		No	Four of (D1510, D1516, D1517, D1520, D1526, D1527, D1575) per 1 Lifetime Per patient. Must maintain radiographs in patient record demonstrating that the tooth has not begun to erupt or that the migration of the adjacent tooth has already occurred.	
D1575	distal shoe space maintainer - fixed - unilateral- Per Quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Four of (D1510, D1516, D1517, D1520, D1526, D1527, D1575) per 1 Lifetime Per patient. Must maintain radiographs in patient record demonstrating that the tooth has not begun to erupt or that the migration of the adjacent tooth has already occurred.	
D1701	Pfizer-BioNTech Covid-19 vaccine administration – first dose SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 1	0-20		No	One of (D1701) per 1 Lifetime Per patient.	
D1702	Pfizer-BioNTech Covid-19 vaccine administration – second dose SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 2	0-20		No	One of (D1702) per 1 Lifetime Per patient.	

Exhibit A Benefits Covered for Under 21 HSN Only

Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1703	Moderna Covid-19 vaccine administration – first dose SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 1	0-20		No	One of (D1703) per 1 Lifetime Per patient.	
D1704	Moderna Covid-19 vaccine administration – second dose SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 2	0-20		No	One of (D1704) per 1 Lifetime Per patient.	
D1707	Janssen Covid-19 vaccine administration SARSCOV2 COVID-19 VAC Ad26 5x1010 VP/.5mL IM SINGLE DOSE These dental procedure codes	0-20		No	One of (D1707) per 1 Lifetime Per patient.	
D1708	Pfizer-BioNTech Covid-19 vaccine administration – third dose	0-20		No	One of (D1708) per 1 Lifetime Per patient.	
D1709	Pfizer-BioNTech Covid-19 vaccine administration – booster dose	0-20		No		
D1710	Moderna Covid-19 vaccine administration – third dose	0-20		No	One of (D1710) per 1 Lifetime Per patient.	
D1711	Moderna Covid-19 vaccine administration – booster dose	0-20		No		
D1712	Janssen Covid-19 vaccine administration - booster dose	0-20		No		
D1713	Pfizer-BioNTech Covid-19 vaccine administration tris-sucrose pediatric – first dose	0-20		No	One of (D1713) per 1 Lifetime Per patient.	
D1714	Pfizer-BioNTech Covid-19 vaccine administration tris-sucrose pediatric – second dose	0-20		No	One of (D1714) per 1 Lifetime Per patient.	

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2140	Amalgam - one surface, primary or permanent	0-20	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2150	Amalgam - two surfaces, primary or permanent	0-20	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2160	amalgam - three surfaces, primary or permanent	0-20	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2161	amalgam - four or more surfaces, primary or permanent	0-20	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2330	resin-based composite - one surface, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2331	resin-based composite - two surfaces, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	

Exhibit A Benefits Covered for Under 21 HSN Only

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2332	resin-based composite - three surfaces, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2390	resin-based composite crown, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2390) per 12 Month(s) Per patient per tooth.	
D2391	resin-based composite - one surface, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2392	resin-based composite - two surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2393	resin-based composite - three surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	

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Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2394	resin-based composite - four or more surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2710	crown - resin-based composite (indirect)	0-20	Teeth 3 - 14, 19 - 30	No	One of (D2710, D2740, D2750, D2751, D2752, D2790) per 60 Month(s) Per patient per tooth.	
D2740	crown - porcelain/ceramic	0-20	Teeth 2 - 15, 18 - 31	No	One of (D2710, D2740, D2750, D2751, D2752, D2790) per 60 Month(s) Per patient per tooth.	
D2750	crown - porcelain fused to high noble metal	0-20	Teeth 2 - 15, 18 - 31	No	One of (D2710, D2740, D2750, D2751, D2752, D2790) per 60 Month(s) Per patient per tooth.	
D2751	crown - porcelain fused to predominantly base metal	0-20	Teeth 2 - 15, 18 - 31	No	One of (D2710, D2740, D2750, D2751, D2752, D2790) per 60 Month(s) Per patient per tooth.	
D2752	crown - porcelain fused to noble metal	0-20	Teeth 2 - 15, 18 - 31	No	One of (D2710, D2740, D2750, D2751, D2752, D2790) per 60 Month(s) Per patient per tooth.	
D2790	crown - full cast high noble metal	0-20	Teeth 2 - 15, 18 - 31	No	One of (D2710, D2740, D2750, D2751, D2752, D2790) per 60 Month(s) Per patient per tooth.	
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	0-20	Teeth 2 - 15, 18 - 31	No	Not covered within 6 months of initial placement.	
D2920	re-cement or re-bond crown	0-20	Teeth 2 - 15, 18 - 31, A - T	No	Not covered within 6 months of initial placement.	
D2929	Prefabricated porcelain/ceramic crown – primary tooth	0-20	Teeth D - G, N - Q	No	Four of (D2929, D2930, D2931, D2932, D2934) per 1 Day(s) Per patient. Maximum of 4 per day if performed in an office setting. No limitation if performed in the OR or outpatient facility.	
D2930	prefabricated stainless steel crown - primary tooth	0-20	Teeth A - T	No	Four of (D2929, D2930, D2931, D2932, D2934) per 1 Day(s) Per patient. Maximum of 4 per day if performed in an office setting. No limitation if performed in the OR or outpatient facility.	

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Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2931	prefabricated steel crown-permanent tooth	0-20	Teeth 2 - 5, 12 - 15, 18 - 21, 28 - 31	No	Four of (D2929, D2930, D2931, D2932, D2934) per 1 Day(s) Per patient. Maximum of 4 per day if performed in an office setting. No limitation if performed in the OR or outpatient facility.	
D2932	prefabricated resin crown	0-20	Teeth 1 - 32, A - T	No	Four of (D2929, D2930, D2931, D2932, D2934) per 1 Day(s) Per patient. Maximum of 4 per day if performed in an office setting. No limitation if performed in the OR or outpatient facility.	
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	0-20	Teeth C - H, M - R	No	Four of (D2929, D2930, D2931, D2932, D2934) per 1 Day(s) Per patient. Maximum of 4 per day if performed in an office setting. No limitation if performed in the OR or outpatient facility.	
D2950	core buildup, including any pins when required	0-20	Teeth 2 - 15, 18 - 31	No	One of (D2950, D2954) per 1 Day(s) Per patient per tooth.	
D2951	pin retention - per tooth, in addition to restoration	0-20	Teeth 2 - 15, 18 - 31	No	Must be billed with a two-or-more surface restoration on a permanent tooth.	
D2954	prefabricated post and core in addition to crown	0-20	Teeth 2 - 15, 18 - 31	No	One of (D2950, D2954) per 1 Day(s) Per patient per tooth.	
D2980	crown repair, by report	0-20	Teeth 2 - 15, 18 - 31	No	Chairside	

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Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3120	pulp cap - indirect (excluding final restoration)	0-20	Teeth 1 - 32, A - T	No	Cannot be billed in conjunction with root canals on same date of service. (D3310, D3320 or D3330).	
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	0-20	Teeth 1 - 32, A - T	No	Cannot be billed in conjunction with root canals (D3310, D3320 or D3330).	
D3310	endodontic therapy, anterior tooth (excluding final restoration)	0-20	Teeth 6 - 11, 22 - 27	No	One of (D3310) per 1 Lifetime Per patient per tooth. No limitation on number performed per treatment. Cannot be billed in conjunction with D3120 on the same date of service.	
D3320	endodontic therapy, premolar tooth (excluding final restoration)	0-20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	One of (D3320) per 1 Lifetime Per patient per tooth. Cannot be billed in conjunction with D3120 on the same date of service.	
D3330	endodontic therapy, molar tooth (excluding final restoration)	0-20	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	One of (D3330) per 1 Lifetime Per patient per tooth. Cannot be billed in conjunction with D3120 on the same date of service.	
D3346	retreatment of previous root canal therapy-anterior	0-20	Teeth 6 - 11, 22 - 27	No	Not payable to the same provider who performed the original endodontic therapy (D3310, D3320, or D3330) within 24 months.	
D3347	retreatment of previous root canal therapy - premolar	0-20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	Not payable to the same provider who performed the original endodontic therapy (D3310, D3320, or D3330) within 24 months.	
D3348	retreatment of previous root canal therapy-molar	0-20	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	Not payable to the same provider who performed the original endodontic therapy (D3310, D3320, or D3330) within 24 months.	
D3410	apicoectomy - anterior	0-20	Teeth 6 - 11, 22 - 27	No	One of (D3410) per 1 Lifetime Per patient per tooth. Includes retrograde filling.	pre-operative x-ray(s)
D3421	apicoectomy - premolar (first root)	0-20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	One of (D3421) per 1 Lifetime Per patient per tooth. Includes retrograde filling.	pre-operative x-ray(s)
D3425	apicoectomy - molar (first root)	0-20	Teeth 1 - 3, 14 - 19, 30 - 32	No	One of (D3425) per 1 Lifetime Per patient per tooth. Includes retrograde filling.	

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Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3426	apicoectomy (each additional root)	0-20	Teeth 1 - 5, 12 - 21, 28 - 32	No	One of (D3426) per 1 Lifetime Per patient per tooth for Bicuspids. Two of (D3426) per 1 Lifetime Per patient per tooth for First and Second Molars. Includes retrograde filling.	

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Periodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4210) per 3 Calendar year(s) Per patient per quadrant. Limited to two quadrants on the same date of service in an office setting. Not payable in conjunction with D1110 and D1120 or D4341 and D4342 on same date of service. Documentation Required :Diagnostic Quality Radiographs and Medical Necessity Narrative	narr. of med. necessity, pre-op x-ray(s)
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4211) per 3 Calendar year(s) Per patient per quadrant. Limited to two quadrants on the same date of service in an office setting. Not payable in conjunction with D1110 and D1120 or D4341 and D4342 on same date of service. Documentation Required :Diagnostic Quality Radiographs and Medical Necessity Narrative	narr. of med. necessity, pre-op x-ray(s)
D4341	periodontal scaling and root planing - four or more teeth per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4341, D4342) per 3 Calendar year(s) Per patient per quadrant. Two of (D4341, D4342) per 1 Day(s) Per Provider OR Location in office. Four of (D4341, D4342) per 1 Day(s) Per Provider OR Location in hospital. A minimum of four (4) affected teeth in the quadrant. Not payable in conjunction with D1110 and D1120 or D4210 and D4211 on same date of service.Documentation Required: Medical necessity narrative, date of service of periodontal evaluation, complete periodontal charting,appropriate diagnostic quality radiographs history of previous periodontal treatment and a statement concerning the member'speriodontal condition.	Perio Charting, pre-op radiographs and narr of med necessity

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Periodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D4342	periodontal scaling and root planing - one to three teeth per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4341, D4342) per 3 Calendar year(s) Per patient per quadrant. Two of (D4341, D4342) per 1 Day(s) Per Provider OR Location in office. Four of (D4341, D4342) per 1 Day(s) Per Provider OR Location in hospital. Not payable in conjunction with D1110 and D1120 or D4210 and D4211 on same date of service.Documentation Required: Medical necessity narrative, date of service of periodontal evaluation, complete periodontal charting, appropriate diagnostic quality radiographs history of previous periodontal treatment and a statement concerning the member's periodontal condition.	Perio Charting, pre-op radiographs and narr of med necessity
D4346	scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	0-20		No	Two of (D1110, D1120, D4346) per 1 Calendar year(s) Per patient.	

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Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5110	complete denture - maxillary	0-20		No	One of (D5110) per 84 Month(s) Per patient.	
D5120	complete denture - mandibular	0-20		No	One of (D5120) per 84 Month(s) Per patient.	
D5130	immediate denture - maxillary	0-20		No	One of (D5130) per 1 Lifetime Per patient.	
D5140	immediate denture - mandibular	0-20		No	One of (D5140) per 1 Lifetime Per patient.	
D5211	maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)	0-20		No	One of (D5211) per 84 Month(s) Per patient. One of (D5211, D5213, D5225) per 84 Month(s) Per patient. Pre-op radiographs of all teeth in arch with claim for prepayment review. Documentation must indicate that there are two or more missing posterior teeth or one or more missing anterior teeth, the remaining dentition is sound and there is a good prognosis.	pre-operative x-ray(s)
D5212	mandibular partial denture – resin base (includingretentive/clasping materials, rests, and teeth)	0-20		No	One of (D5212) per 84 Month(s) Per patient. One of (D5212, D5214, D5226) per 84 Month(s) Per patient. Pre-op radiographs of all teeth in arch with claim for prepayment review. Documentation must indicate that there are two or more missing posterior teeth or one or more missing anterior teeth, the remaining dentition is sound and there is a good prognosis.	pre-operative x-ray(s)
D5213	maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	0-20		No	One of (D5213) per 84 Month(s) Per patient. One of (D5211, D5213, D5225) per 84 Month(s) Per patient. Pre-op radiographs of all teeth in arch with claim for prepayment review. Documentation must indicate that there are two or more missing posterior teeth or one or more missing anterior teeth, the remaining dentition is sound and there is a good prognosis.	pre-operative x-ray(s)

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5214	mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	0-20		No	One of (D5214) per 84 Month(s) Per patient. One of (D5212, D5214, D5226) per 84 Month(s) Per patient. Pre-op radiographs of all teeth in arch with claim for prepayment review. Documentation must indicate that there are two or more missing posterior teeth or one or more missing anterior teeth, the remaining dentition is sound and there is a good prognosis.	pre-operative x-ray(s)
D5225	maxillary partial denture-flexible base	0-20		No	One of (D5225) per 84 Month(s) Per patient. One of (D5211, D5213, D5225) per 84 Month(s) Per patient. Pre-op radiographs of all teeth in arch with claim for prepayment review. Documentation must indicate that there are two or more missing posterior teeth or one or more missing anterior teeth, the remaining dentition is sound and there is a good prognosis.	pre-operative x-ray(s)
D5226	mandibular partial denture-flexible base	0-20		No	One of (D5226) per 84 Month(s) Per patient. One of (D5212, D5214, D5226) per 84 Month(s) Per patient. Pre-op radiographs of all teeth in arch with claim for prepayment review. Documentation must indicate that there are two or more missing posterior teeth or one or more missing anterior teeth, the remaining dentition is sound and there is a good prognosis.	pre-operative x-ray(s)
D5511	repair broken complete denture base, mandibular	0-20		No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5512	repair broken complete denture base, maxillary	0-20		No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	

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Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5520	replace missing or broken teeth - complete denture (each tooth)	0-20	Teeth 1 - 32	No	Three of (D5520) per 12 Month(s) Per patient. Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5611	repair resin partial denture base, mandibular	0-20		No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5612	repair resin partial denture base, maxillary	0-20		No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5621	repair cast partial framework, mandibular	0-20		No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5622	repair cast partial framework, maxillary	0-20		No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5630	repair or replace broken retentive/clasping materials per tooth	0-20	Teeth 1 - 32	No	One of (D5630) per 6 Month(s) Per patient per tooth. Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	

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Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5640	replace broken teeth-per tooth	0-20	Teeth 1 - 32	No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5650	add tooth to existing partial denture	0-20	Teeth 1 - 32	No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5660	add clasp to existing partial denture	0-20	Teeth 1 - 32	No	Per tooth, add clasp to existing partial denture. Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5730	reline complete maxillary denture (chairside)	0-20		No	One of (D5730, D5750) per 24 Month(s) Per patient. Fee for denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.	
D5731	reline complete mandibular denture (chairside)	0-20		No	One of (D5731, D5751) per 24 Month(s) Per patient. Fee for denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.	
D5740	reline maxillary partial denture (chairside)	0-20		No	One of (D5740, D5760) per 24 Month(s) Per patient. Fee for denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.	
D5741	reline mandibular partial denture (chairside)	0-20		No	One of (D5741, D5761) per 24 Month(s) Per patient. Fee for denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.	

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Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5750	reline complete maxillary denture (laboratory)	0-20		No	One of (D5750) per 24 Month(s) Per patient. One of (D5730, D5750) per 24 Month(s) Per patient. Fee for denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.	
D5751	reline complete mandibular denture (laboratory)	0-20		No	One of (D5751) per 24 Month(s) Per patient. One of (D5731, D5751) per 24 Month(s) Per patient. Fee for denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.	
D5760	reline maxillary partial denture (laboratory)	0-20		No	One of (D5760) per 24 Month(s) Per patient. One of (D5740, D5760) per 24 Month(s) Per patient. Fee for partial denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.	
D5761	reline mandibular partial denture (laboratory)	0-20		No	One of (D5761) per 24 Month(s) Per patient. One of (D5741, D5761) per 24 Month(s) Per patient. Fee for partial denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.	

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Prosthodontics, fixed						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6241	pontic-porcelain fused metal	0-20	Teeth 6 - 11, 22 - 27	No	One of (D6241) per 60 Month(s) Per patient per tooth.	
D6751	crown-porcelain fused to metal	0-20	Teeth 6 - 11, 22 - 27	No	One of (D6751) per 60 Month(s) Per patient per tooth.	
D6930	re-cement or re-bond fixed partial denture	0-20		No	Not covered within 6 months of placement.	
D6980	fixed partial denture repair	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No		

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Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7111	extraction, coronal remnants - primary tooth	0-20	Teeth A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Erupted surgical extractions are defined as extractions requiring elevation of a mucoperiosteal flap and removal of bone and/or section of the tooth and closure.	
D7220	removal of impacted tooth-soft tissue	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Only covered for teeth that are symptomatic, carious or pathologic.	
D7230	removal of impacted tooth-partially bony	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Only covered for teeth that are symptomatic, carious or pathologic.	
D7240	removal of impacted tooth-completely bony	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Removal of asymptomatic tooth not covered.	Narr of med necessity & full mouth xrays
D7250	surgical removal of residual tooth roots (cutting procedure)	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Only covered for teeth that are symptomatic, carious or pathologic.	

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Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7251	Coronectomy-intentional partial tooth removal intentional partial tooth removal is performed when a neurovascular complication is likely if the entire impacted tooth is removed.	0-20	Teeth 1, 16, 17, 32	No	One of (D7251) per 1 Lifetime Per patient per tooth. Cannot be billed on same date of service with codes D7111, D7140, D7210, D7220, D7230, D7240, D7250, D7241. If D7251 is billed following any history of D7111, D7210, D7140, D7241, D7220, D7230, D7240, D7250 billed on the same tooth as code D7251, then deduct what was paid for D7251 from payment of new code.	
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	0-20	Teeth 1 - 32	No		
D7280	Surgical access of an unerupted tooth	0-20	Teeth 1 - 32	No		
D7283	placement of device to facilitate eruption of impacted tooth	0-20	Teeth 1 - 32	No		
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7310) per 6 Month(s) Per patient per quadrant. One of (D7310, D7311) per 1 Lifetime Per patient per quadrant. Limited to one per quadrant when the second procedure follows the first within 6 months.	
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7311) per 6 Month(s) Per patient per quadrant. One of (D7310, D7311) per 1 Lifetime Per patient per quadrant. Limited to one per quadrant when the second procedure follows the first within 6 months.	
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7320) per 6 Month(s) Per patient per quadrant. One of (D7320, D7321) per 1 Lifetime Per patient per quadrant. No extractions performed in edentulous area. Limited to one per quadrant when the second procedure follows the first within 6 months.	narrative of medical necessity

Exhibit A Benefits Covered for Under 21 HSN Only

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7321) per 6 Month(s) Per patient per quadrant. One of (D7320, D7321) per 1 Lifetime Per patient per quadrant. No extractions performed on edentulous area. Limited to one per quadrant when the second procedure follows the first within 6 months.	
D7340	vestibuloplasty - ridge extension (secondary epithelialization)	0-20	Per Arch (01, 02, LA, UA)	Yes		narrative of medical necessity
D7350	vestibuloplasty - ridge extension	0-20	Per Arch (01, 02, LA, UA)	No	Only payable to a dental provider with a specialty in oral surgery	
D7410	radical excision - lesion diameter up to 1.25cm	0-20		No		
D7411	excision of benign lesion greater than 1.25 cm	0-20		No		
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	0-20		No	Pathology report.	
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	0-20		No	Pathology report.	
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	0-20		No	Pathology report.	
D7461	removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm	0-20		No	Pathology report.	
D7471	removal of exostosis - per site	0-20	Per Arch (01, 02, LA, UA)	No	One of (D7471) per 1 Lifetime Per patient per arch. Only payable to a dental provider with a specialty in oral surgery	
D7472	removal of torus palatinus	0-20		No	One of (D7472) per 1 Lifetime Per patient per arch. Only payable to a dental provider with a specialty in oral surgery	
D7473	removal of torus mandibularis	0-20		No	One of (D7473) per 1 Lifetime Per patient per arch. Only payable to a dental provider with a specialty in oral surgery	

Exhibit A Benefits Covered for Under 21 HSN Only

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7961	buccal / labial frenectomy (frenulectomy)	0-20	Per Arch (01, 02, LA, UA)	No	One of (D7961) per 1 Lifetime Per patient per arch. The frenum may be excised when the tongue has limited mobility; for large diastemas between teeth; or when frenum interferes with a prosthetic appliance; or when it is the etiology of the periodontal tissue disease. Narrative describing location and medical necessity must be maintained in the patient record.	
D7962	lingual frenectomy (frenulectomy)	0-20		No	One of (D7962, D7963) per 1 Lifetime Per patient. The frenum may be excised when the tongue has limited mobility; for large diastemas between teeth; or when frenum interferes with a prosthetic appliance; or when it is the etiology of the periodontal tissue disease. Narrative describing location and medical necessity must be maintained in the patient record.	
D7963	frenuloplasty	0-20		No	One of (D7962, D7963) per 1 Lifetime Per patient. The frenum may be excised when the tongue has limited mobility; for large diastemas between teeth; or when frenum interferes with a prosthetic appliance; or when it is the etiology of the periodontal tissue disease. Narrative describing location and medical necessity must be maintained in the patient record.	
D7970	excision of hyperplastic tissue - per arch	0-20	Per Arch (01, 02, LA, UA)	No	Not payable on the same date of service as an extraction (D7111 - D7240) of the same tooth.	

Exhibit A Benefits Covered for Under 21 HSN Only

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Orthodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D8010	limited orthodontic treatment of the primary dentition	6-14		Yes	Adjustments for interceptive orthodontic treatment must be requested under the D8999 code and will be approved for a maximum of five units. Please see billing instructions in section 16 of the OfficeReference Manual.	narrative of medical necessity
D8020	limited orthodontic treatment of the transitional dentition	6-14		Yes	Adjustments for interceptive orthodontic treatment must be requested under the D8999 code and will be approved for a maximum of five units. Please see billing instructions in section 16 of the OfficeReference Manual.	narrative of medical necessity
D8030	limited orthodontic treatment of the adolescent dentition	6-14		Yes	Adjustments for interceptive orthodontic treatment must be requested under the D8999 code and will be approved for a maximum of five units. Please see billing instructions in section 16 of the OfficeReference Manual.	narrative of medical necessity
D8040	limited orthodontic treatment of the adult dentition	6-14		Yes	Adjustments for interceptive orthodontic treatment must be requested under the D8999 code and will be approved for a maximum of five units. Please see billing instructions in section 16 of the OfficeReference Manual.	narrative of medical necessity
D8070	comprehensive orthodontic treatment of the transitional dentition	6 - 20		Yes	One of (D8070, D8080) per 1 Lifetime Per patient. Only payable to a dental provider with a specialty of Orthodontics. Please see billing instructions in section 16 of the Office Reference Manual.	
D8080	comprehensive orthodontic treatment of the adolescent dentition	6 - 20		Yes	One of (D8070, D8080) per 1 Lifetime Per patient. Only payable to a dental provider with a specialty of Orthodontics. Please see billing instructions in section 16 of the Office Reference Manual.	
D8660	pre-orthodontic treatment examination to monitor growth and development	6-20		Yes	One of (D8660) per 6 Month(s) Per Provider OR Location. Not billable after D8080, D8070, D8090, D8670, D8680 has been paid. Only payable to a dental provider with a speciality in orthodontics. Please see billing instructions in section 16 of the Office Reference Manual.	

Exhibit A Benefits Covered for Under 21 HSN Only

Orthodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D8670	periodic orthodontic treatment visit	6 - 20		Yes	One per 90 Day(s) Per patient. Allowed as quarterly treatment visits. May not be billed less than 90 days from previous periodic orthodontic treatment visit. (D8670). May not be billed less than 90 days from previous banding date. (D8080, D8070, D8090). May not be billed prior to D8080 / D8070 / D8090. Only payable to a dental provider with a specialty of Orthodontics. Please see billing instructions in section 16 of the Office Reference Manual.	
D8680	orthodontic retention (removal of appliances)	6 - 20		No	Five of (D8680) per 1 Lifetime Per patient. Only payable to a dental provider with a specialty of Orthodontics. Please see billing instructions in Section 16 of the Office Reference Manual.	
D8703	Replacement of lost or broken retainer - maxillary	8 - 20		Yes	One of (D8703) per 2 Calendar year(s) Per patient. The MassHealth agency pays for replacement retainers only during the 2 year retention period following orthodontic treatment. Only payable to a dental provider with a specialty of Orthodontics. Statement regarding the date of the onset of retention.	
D8704	Replacement of lost or broken retainer - mandibular	8 - 20		Yes	One of (D8704) per 2 Calendar year(s) Per patient. The MassHealth agency pays for replacement retainers only during the 2 year retention period following orthodontic treatment. Only payable to a dental provider with a specialty of Orthodontics. Statement regarding the date of the onset of retention.	
D8999	unspecified orthodontic procedure, by report	6-14		Yes	Five of (D8999) per 1 Lifetime Per patient. This code is used exclusively for interceptive orthodontic adjustments and units. Please see billing instructions in section 16 of the Office Reference Manual.	

Exhibit A Benefits Covered for Under 21 HSN Only

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9110	palliative (emergency) treatment of dental pain - minor procedure	0-20		No	Other non-emergency medically necessary treatment may be provided during the same visit. Not covered with D0120,D0140,D0160, D0180 by same provider or provider group on same date of service.	
D9222	deep sedation/general anesthesia first 15 minutes	0-20		No		
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	0-20		No		
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	0-20		No	The routine administration of inhalation analgesia or oral sedation is generally considered part of the treatment procedure, unless its use is documented in the patient record as necessary to complete treatment	
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	0-20		No		
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	0-20		No	Five of (D9243) per 1 Day(s) Per patient.	
D9248	non-intravenous moderate (conscious) sedation	0-20		No		
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	6-20		No	One of (D9310) per 6 Month(s) Per patient. Not billable after D8080, D8070, D8090, D8670, D8680, D8660 has paid. Only payable to a dental provider with a specialty of orthodontics. Please see billing instructions in section 16 of the Office Reference Manual.	
D9450	case presentation, detailed and extensive treatment planning	0-20		No	One of (D9450) per 1 Day(s) Per Provider. Per Member. Only payable when submitted with another payable service.	
D9920	behavior management, by report	0-20		Yes	One of (D9920) per 1 Day(s) Per Provider OR Location. Include a description of the members illness or disability and types of services to be furnished.	narrative of medical necessity

Exhibit A Benefits Covered for Under 21 HSN Only

Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9930	treatment of complications (post-surgical) - unusual circumstances, by report	0-20		No	Include with claim the date, the location of the original surgery and the type of procedure.	narrative of medical necessity
D9941	fabrication of athletic mouthguard	0-20		No	One of (D9941) per 1 Calendar year(s) Per patient.	
D9945	occlusal guard--soft appliance full arch	0-20	Per Arch (01, 02, LA, UA)	No	One of (D9945) per 1 Year(s) Per patient.	

Exhibit B Benefits Covered for Adult HSN Only

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0120	periodic oral evaluation - established patient	21 and older		No	Two of (D0120, D0145) per 1 Calendar year(s) Per Provider OR Location. Not covered with D9110 by same provider or provider group on same date of service.	
D0140	limited oral evaluation-problem focused	21 and older		No	Two of (D0140) per 1 Calendar year(s) Per patient. Not covered with D9110, D0160, D0180 by same provider or provider group on same date of service.	
D0150	comprehensive oral evaluation - new or established patient	21 and older		No	One of (D0150, D0180) per 1 Lifetime Per Provider OR Location.	
D0180	comprehensive periodontal evaluation - new or established patient	21 and older		No	One of (D0180) per 1 Calendar year(s) Per Provider OR Location. Not covered with D9110, D0140, D0145, D0150 by same provider or provider group on same date of service.	
D0210	intraoral - complete series of radiographic images	21 and older		No	One of (D0210) per 3 Calendar year(s) Per Provider OR Location. One complete series every three calendar years per patient, per provider or location. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be reimbursed at the D0210 rate.	
D0220	intraoral - periapical first radiographic image	21 and older		No	One of (D0220) per 1 Day(s) Per Provider OR Location. Twelve of (D0220, D0230) per 12 Month(s) Per patient. Maximum of one per 1 day per patient per (Provider or Location). Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be reimbursed at the D0210 rate.	
D0230	intraoral - periapical each additional radiographic image	21 and older		No	Three of (D0230) per 1 Day(s) Per Provider OR Location. Twelve of (D0220, D0230) per 12 Month(s) Per patient. Maximum of 3 per day per patient per (Provider or Location). Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be reimbursed at the D0210 rate.	

Exhibit B Benefits Covered for Adult HSN Only

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0270	bitewing - single radiographic image	21 and older		No	Two of (D0270, D0272, D0273, D0274) per 1 Calendar year(s) Per Provider OR Location. One of (D0270, D0272, D0273, D0274) per 1 Day(s) Per patient. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be reimbursed at the D0210 rate. Documentation of variation from ADA clinical guidelines to be kept in patient record.	
D0272	bitewings - two radiographic images	21 and older		No	Two of (D0270, D0272, D0273, D0274) per 1 Calendar year(s) Per Provider OR Location. One of (D0270, D0272, D0273, D0274) per 1 Day(s) Per patient. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be reimbursed at the D0210 rate. Documentation of variation from ADA clinical guidelines to be kept in patient record.	
D0273	bitewings - three radiographic images	21 and older		No	Two of (D0270, D0272, D0273, D0274) per 1 Calendar year(s) Per Provider OR Location. One of (D0270, D0272, D0273, D0274) per 1 Day(s) Per patient. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be reimbursed at the D0210 rate. Documentation of variation from ADA clinical guidelines to be kept in patient record.	
D0274	bitewings - four radiographic images	21 and older		No	Two of (D0270, D0272, D0273, D0274) per 1 Calendar year(s) Per Provider OR Location. One of (D0270, D0272, D0273, D0274) per 1 Day(s) Per patient. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be reimbursed at the D0210 rate. Documentation of variation from ADA clinical guidelines to be kept in patient record.	

Exhibit B Benefits Covered for Adult HSN Only

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0330	panoramic radiographic image	21 and older		No	One of (D0330) per 3 Year(s) Per Provider OR Location. (Not covered when billed with services related to Crowns, Endodontics, Periodontics, Restorations and Orthodontics).Not covered when the treating dentist is an orthodontist, endodontist, prosthodontist and periodontist.Non-surgical conditions. Surgical conditions are payable in excess of the 3 year limitation when used as a diagnostic tool. Any combination of radiographs thatexceeds the max allowable for a FMX will be reimbursed at the D0210 rate. Documentation of variation from ADA clinical guidelines to be kept in patient record.	narrative of medical necessity
D0340	cephalometric radiographic image	21 and older		Yes	Reimbursable when used in conjunction with surgical condition, including status post-facial trauma such as LaFort, mandibular fractures and jaw dislocation. narrative of medical necessity. Non-orthodontic procedures. Only payable to a dental provider with a specialty in oral surgery.	narrative of medical necessity

Exhibit B Benefits Covered for Adult HSN Only

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Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1110	prophylaxis - adult	21 and older		No	Two of (D1110, D1120, D4346) per 1 Calendar year(s) Per patient.	
D1206	topical application of fluoride varnish	21 and older		Yes	One of (D1206, D1208) per 90 Day(s) Per Provider OR Location. Only allowed for members 21 & older who have medical \ dental conditions that significantly interrupt the flow of saliva.	narrative of medical necessity
D1208	topical application of fluoride - excluding varnish	21 and older		Yes	One of (D1206, D1208) per 90 Day(s) Per Provider OR Location. Only allowed for members 21 & older who have medical \ dental conditions that significantly interrupt the flow of saliva.	narrative of medical necessity
D1354	interim caries arresting medicament application - per tooth	21 and older	Teeth 1 - 32, A - T	No	Two of (D1354) per 1 Lifetime Per patient per tooth.	
D1701	Pfizer-BioNTech Covid-19 vaccine administration – first dose SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 1	21 and older		No	One of (D1701) per 1 Lifetime Per patient.	
D1702	Pfizer-BioNTech Covid-19 vaccine administration – second dose SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 2	21 and older		No	One of (D1702) per 1 Lifetime Per patient.	
D1703	Moderna Covid-19 vaccine administration – first dose SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 1	21 and older		No	One of (D1703) per 1 Lifetime Per patient.	
D1704	Moderna Covid-19 vaccine administration – second dose SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 2	21 and older		No	One of (D1704) per 1 Lifetime Per patient.	
D1707	Janssen Covid-19 vaccine administration SARSCOV2 COVID-19 VAC Ad26 5x1010 VP/.5mL IM SINGLE DOSE These dental procedure codes	21 and older		No	One of (D1707) per 1 Lifetime Per patient.	
D1708	Pfizer-BioNTech Covid-19 vaccine administration – third dose	21 and older		No	One of (D1708) per 1 Lifetime Per patient.	

Exhibit B Benefits Covered for Adult HSN Only

Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1709	Pfizer-BioNTech Covid-19 vaccine administration – booster dose	21 and older		No		
D1710	Moderna Covid-19 vaccine administration – third dose	21 and older		No	One of (D1710) per 1 Lifetime Per patient.	
D1711	Moderna Covid-19 vaccine administration – booster dose	21 and older		No		
D1712	Janssen Covid-19 vaccine administration - booster dose	21 and older		No		
D1713	Pfizer-BioNTech Covid-19 vaccine administration tris-sucrose pediatric – first dose	21 and older		No	One of (D1713) per 1 Lifetime Per patient.	
D1714	Pfizer-BioNTech Covid-19 vaccine administration tris-sucrose pediatric – second dose	21 and older		No	One of (D1714) per 1 Lifetime Per patient.	

Exhibit B Benefits Covered for Adult HSN Only

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2140	Amalgam - one surface, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2150	Amalgam - two surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2160	amalgam - three surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2161	amalgam - four or more surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2330	resin-based composite - one surface, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2331	resin-based composite - two surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	

Exhibit B Benefits Covered for Adult HSN Only

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2332	resin-based composite - three surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2391	resin-based composite - one surface, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2392	resin-based composite - two surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2393	resin-based composite - three surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2394	resin-based composite - four or more surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	

Exhibit B Benefits Covered for Adult HSN Only

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2740	crown - porcelain/ceramic	21 and older	Teeth 2 - 15, 18 - 31	No	One of (D2740, D2751) per 60 Month(s) Per patient per tooth.	
D2751	crown - porcelain fused to predominantly base metal	21 and older	Teeth 2 - 15, 18 - 31	No	One of (D2710, D2740, D2750, D2751, D2752, D2790) per 60 Month(s) Per patient per tooth. Maintain pre-treatment and post-treatment film of the tooth in chart.	
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	21 and older	Teeth 2 - 15, 18 - 31	No	Not covered within 6 months of initial placement.	
D2920	re-cement or re-bond crown	21 and older	Teeth 2 - 15, 18 - 31, A - T	No	Not covered within 6 months of initial placement.	
D2950	core buildup, including any pins when required	21 and older	Teeth 2 - 15, 18 - 31	No	One of (D2950, D2954) per 1 Day(s) Per patient per tooth.	
D2951	pin retention - per tooth, in addition to restoration	21 and older	Teeth 2 - 15, 18 - 31	No	Must be billed with a two-or-more surface restoration on a permanent tooth.	
D2954	prefabricated post and core in addition to crown	21 and older	Teeth 2 - 15, 18 - 31	No	One of (D2950, D2954) per 1 Day(s) Per patient per tooth.	
D2980	crown repair, by report	21 and older	Teeth 2 - 15, 18 - 31	No		

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3120	pulp cap - indirect (excluding final restoration)	21 and older	Teeth 1 - 32, A - T	No	Cannot be billed in conjunction with root canals on same date of service. (D3310, D3320 or D3330).	
D3310	endodontic therapy, anterior tooth (excluding final restoration)	21 and older	Teeth 6 - 11, 22 - 27	No	One of (D3310) per 1 Lifetime Per patient per tooth. No limitation on number performed per treatment period. Total diagnosis and treatment plan supported by radiograph of remaining teeth. Cannot be billed in conjunction with D3120 on the same date of service.	
D3320	endodontic therapy, premolar tooth (excluding final restoration)	21 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	One of (D3320) per 1 Lifetime Per patient per tooth. Cannot be billed in conjunction with D3120 on the same date of service.	
D3330	endodontic therapy, molar tooth (excluding final restoration)	21 and older	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	One of (D3330) per 1 Lifetime Per patient per tooth. Cannot be billed in conjunction with D3120 on the same date of service.	
D3346	retreatment of previous root canal therapy-anterior	21 and older	Teeth 6 - 11, 22 - 27	No	Not payable to the same provider who performed the original endodontic therapy (D3310,D3320 or D3330) within 24 months. Include periapical film of the tooth and date of original root canal treatment.	
D3347	retreatment of previous root canal therapy - premolar	21 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	Not payable to the same provider who performed the original endodontic therapy (D3310, D3320, or D3330) within 24 months.	
D3348	retreatment of previous root canal therapy-molar	21 and older	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	Not payable to the same provider who performed the original endodontic therapy (D3310, D3320, or D3330) within 24 months.	
D3410	apicoectomy - anterior	21 and older	Teeth 6 - 11, 22 - 27	No	One of (D3410) per 1 Lifetime Per patient per tooth. Includes retrograde filling.	
D3421	apicoectomy - premolar (first root)	21 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	One of (D3421) per 1 Lifetime Per patient per tooth. Includes retrograde filling.	
D3425	apicoectomy - molar (first root)	21 and older	Teeth 1 - 3, 14 - 19, 30 - 32	No	One of (D3425) per 1 Lifetime Per patient per tooth. Includes retrograde filling.	

Exhibit B Benefits Covered for Adult HSN Only

Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3426	apicoectomy (each additional root)	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32	No	One of (D3426) per 1 Lifetime Per patient per tooth for Bicuspids. Two of (D3426) per 1 Lifetime Per patient per tooth for First and Second Molars. Includes retrograde filling.	

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Periodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210) per 3 Calendar year(s) Per patient per quadrant. Limited to two quadrants on the same date of service in an office setting. Not payable in conjunction with D1110 and D1120 or D4341 and D4342 on same date of service. Documentation Required :Diagnostic Quality Radiographs and Medical Necessity Narrative	narr. of med. necessity, pre-op x-ray(s)
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4211) per 3 Calendar year(s) Per patient per quadrant. Limited to two quadrants on the same date of service in an office setting. Not payable in conjunction with D1110 and D1120 or D4341 and D4342 on same date of service. Documentation Required :Diagnostic Quality Radiographs and Medical Necessity Narrative	narr. of med. necessity, pre-op x-ray(s)
D4341	periodontal scaling and root planing - four or more teeth per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 3 Calendar year(s) Per patient per quadrant. Two of (D4341, D4342) per 1 Day(s) Per Provider OR Location in office. Four of (D4341, D4342) per 1 Day(s) Per Provider OR Location in hospital. A minimum of four (4) affected teeth in the quadrant. Not payable in conjunction with D1110 and D1120 or D4210 and D4211 on same date of service.Documentation Required: Medical necessity narrative, date of service of periodontal evaluation, complete periodontal charting,appropriate diagnostic quality radiographs history of previous periodontal treatment and a statement concerning the member'speriodontal condition.	Perio Charting, pre-op radiographs and narr of med necessity

Exhibit B Benefits Covered for Adult HSN Only

Periodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D4342	periodontal scaling and root planing - one to three teeth per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 3 Calendar year(s) Per patient per quadrant. Two of (D4341, D4342) per 1 Day(s) Per Provider OR Location in office. Four of (D4341, D4342) per 1 Day(s) Per Provider OR Location in hospital. Not payable in conjunction with D1110 and D1120 or D4210 and D4211 on same date of service.Documentation Required: Medical necessity narrative, date of service of periodontal evaluation, complete periodontal charting, appropriate diagnostic quality radiographs history of previous periodontal treatment and a statement concerning the member's periodontal condition.	Perio Charting, pre-op radiographs and narr of med necessity
D4346	scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	21 and older		No	Two of (D1110, D1120, D4346) per 1 Calendar year(s) Per patient.	

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Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5110	complete denture - maxillary	21 and older		No	One of (D5110) per 84 Month(s) Per patient. Complete treatment plan and prosthetic history. If the member still has natural teeth, a current series of periapical and bitewing films. X-rays are not required if the patient is edentulous.	
D5120	complete denture - mandibular	21 and older		No	One of (D5120) per 84 Month(s) Per patient. Complete treatment plan and prosthetic history. If the member still has natural teeth, a current series of periapical and bitewing films. X-rays are not required if the patient is edentulous.	
D5211	maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)	21 and older		No	One of (D5211) per 84 Month(s) Per patient. Pre-op radiographs of all teeth in arch with claim for prepayment review. Documentation must indicate that there are two or more missing posterior teeth or one or more missing anterior teeth, the remaining dentition is sound and there is a good prognosis.	
D5212	mandibular partial denture – resin base (includingretentive/clasping materials, rests, and teeth)	21 and older		No	One of (D5212) per 84 Month(s) Per patient. Pre-op radiographs of all teeth in arch with claim for prepayment review. Documentation must indicate that there are two or more missing posterior teeth or one or more missing anterior teeth, the remaining dentition is sound and there is a good prognosis.	
D5511	repair broken complete denture base, mandibular	21 and older		No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5512	repair broken complete denture base, maxillary	21 and older		No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	

Exhibit B Benefits Covered for Adult HSN Only

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5520	replace missing or broken teeth - complete denture (each tooth)	21 and older	Teeth 1 - 32	No	Three of (D5520) per 12 Month(s) Per patient. Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5611	repair resin partial denture base, mandibular	21 and older		No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5612	repair resin partial denture base, maxillary	21 and older		No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5621	repair cast partial framework, mandibular	21 and older		No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5622	repair cast partial framework, maxillary	21 and older		No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5630	repair or replace broken retentive/clasping materials per tooth	21 and older	Teeth 1 - 32	No	One of (D5630) per 6 Month(s) Per patient per tooth. Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	

Exhibit B Benefits Covered for Adult HSN Only

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5640	replace broken teeth-per tooth	21 and older	Teeth 1 - 32	No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5650	add tooth to existing partial denture	21 and older	Teeth 1 - 32	No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5660	add clasp to existing partial denture	21 and older	Teeth 1 - 32	No	Per tooth, add clasp to existing partial denture. Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5730	reline complete maxillary denture (chairside)	21 and older		No	One of (D5730, D5750) per 36 Month(s) Per patient. Fee for denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.	
D5731	reline complete mandibular denture (chairside)	21 and older		No	One of (D5731, D5751) per 36 Month(s) Per patient. Fee for denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.	
D5750	reline complete maxillary denture (laboratory)	21 and older		No	One of (D5730, D5750) per 36 Month(s) Per patient. Fee for denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.	
D5751	reline complete mandibular denture (laboratory)	21 and older		No	One of (D5731, D5751) per 36 Month(s) Per patient. Fee for denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.	

Exhibit B Benefits Covered for Adult HSN Only

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Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7111	extraction, coronal remnants - primary tooth	21 and older	Teeth A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Erupted surgical extractions are defined as extractions requiring elevation of a mucoperiosteal flap and removal of bone and/or section of the tooth and closure.	
D7220	removal of impacted tooth-soft tissue	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Only covered for teeth that are symptomatic, carious or pathologic.	
D7230	removal of impacted tooth-partially bony	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Only covered for teeth that are symptomatic, carious or pathologic.	
D7240	removal of impacted tooth-completely bony	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Removal of asymptomatic tooth not covered.	Narr of med necessity & full mouth xrays
D7250	surgical removal of residual tooth roots (cutting procedure)	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Only covered for teeth that are symptomatic, carious or pathologic.	

Exhibit B Benefits Covered for Adult HSN Only

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7251	Coronectomy-intentional partial tooth removal intentional partial tooth removal is performed when a neurovascular complication is likely if the entire impacted tooth is removed.	21 and older	Teeth 1, 16, 17, 32	No	One of (D7251) per 1 Lifetime Per patient per tooth. Cannot be billed on same date of service with codes D7111, D7140, D7210, D7220, D7230, D7240, D7250, D7241. If D7251 is billed following any history of D7111, D7210, D7140, D7241, D7220, D7230, D7240, D7250 billed on the same tooth as code D7251, then deduct what was paid for D7251 from payment of new code.	
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	21 and older	Teeth 1 - 32	No		
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7310) per 6 Month(s) Per patient per quadrant. One of (D7310, D7311) per 1 Lifetime Per patient per quadrant. Limited to one per quadrant when performed within 6 months of initial alveoloplasty.	
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7311) per 6 Month(s) Per patient per quadrant. One of (D7310, D7311) per 1 Lifetime Per patient per quadrant. Limited to one per quadrant when performed within 6 months of initial alveoloplasty. Up to 3 teeth\tooth spaces per quad.	narrative of medical necessity
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7320) per 6 Month(s) Per patient per quadrant. One of (D7320, D7321) per 1 Lifetime Per patient per quadrant. No extractions performed in edentulous area. Limited to two per quadrant when the second procedure follows the first within 6 months.	narrative of medical necessity
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7321) per 6 Month(s) Per patient per quadrant. One of (D7320, D7321) per 1 Lifetime Per patient per quadrant. Limited to one per quadrant when performed within 6 months of initial alveoloplasty. Up to 3 teeth\tooth spaces per quad.	
D7340	vestibuloplasty - ridge extension (secondary epithelialization)	21 and older	Per Arch (01, 02, LA, UA)	Yes	Include justification of the surgical procedure designed to increase alveolar ridge height.	narrative of medical necessity

Exhibit B Benefits Covered for Adult HSN Only

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7350	vestibuloplasty - ridge extension	21 and older	Per Arch (01, 02, LA, UA)	Yes	Only payable to dental provider w\specialty in oral surgery.	
D7410	radical excision - lesion diameter up to 1.25cm	21 and older		No		
D7411	excision of benign lesion greater than 1.25 cm	21 and older		No		
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	21 and older		No		Pathology report
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	21 and older		No		Pathology report
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	21 and older		No		Pathology report
D7461	removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm	21 and older		No		Pathology report
D7471	removal of exostosis - per site	21 and older	Per Arch (01, 02, LA, UA)	No	One of (D7471) per 1 Lifetime Per patient per arch. Only payable to dental provider w\specialty in oral surgery.	
D7472	removal of torus palatinus	21 and older		No	One of (D7472) per 1 Lifetime Per patient per arch. Only payable to a dental provider with a specialty in oral surgery	
D7473	removal of torus mandibularis	21 and older		No	One of (D7473) per 1 Lifetime Per patient per arch. Only payable to a dental provider with a specialty in oral surgery	
D7961	buccal / labial frenectomy (frenulectomy)	21 and older	Per Arch (01, 02, LA, UA)	No	One of (D7961) per 1 Lifetime Per patient per arch. The frenum may be excised when the tongue has limited mobility; for large diastemas between teeth; or when frenum interferes with a prosthetic appliance; or when it is the etiology of the periodontal tissue disease. Narrative describing location and medical necessity must be maintained in the patient record.	

Exhibit B Benefits Covered for Adult HSN Only

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7962	lingual frenectomy (frenulectomy)	21 and older		No	One of (D7962, D7963) per 1 Lifetime Per patient. The frenum may be excised when the tongue has limited mobility; for large diastemas between teeth; or when frenum interferes with a prosthetic appliance; or when it is the etiology of the periodontal tissue disease. Narrative describing location and medical necessity must be maintained in the patient record.	
D7963	frenuloplasty	21 and older		No	One of (D7962, D7963) per 1 Lifetime Per patient. The frenum may be excised when the tongue has limited mobility; for large diastemas between teeth; or when frenum interferes with a prosthetic appliance; or when it is the etiology of the periodontal tissue disease. Narrative describing location and medical necessity must be maintained in the patient record.	
D7970	excision of hyperplastic tissue - per arch	21 and older	Per Arch (01, 02, LA, UA)	No	Not payable on the same date of service as an extraction (D7111 - D7240) of the same tooth.	narrative of medical necessity

Exhibit B Benefits Covered for Adult HSN Only

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Orthodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D8670	periodic orthodontic treatment visit	21 and older		Yes	Only covered for member whose comprehensive treatment had begun prior to age 21. One per 90 Day(s) Per patient. Allowed as quarterly treatment visit. (D8670). May not be billed less than 90 days from previous periodic orthodontic treatment visit. (D8670). May not be billed less than 90 days from previous banding date. (D8080, D8070, D8090). May not be billed prior to D8080 / D8070 / D8090.Only payable to a dental provider with a specialty of Orthodontics. Please see billing instructions in section 16 of the Office Reference Manual.	
D8680	orthodontic retention (removal of appliances)	21 and older		Yes	Five of (D8680) per 1 Lifetime Per patient. Only covered for member whose comprehensive treatment had begun prior to age 21. Only payable to dental provider whith a specialty of Orthodontics. Please see billing instructions in Section 16 of the Office Reference Manual.	
D8703	Replacement of lost or broken retainer - maxillary	21 and older		Yes	One of (D8703) per 2 Calendar year(s) Per patient. The MassHealth agency pays for replacement retainers only during the 2 year retention period following orthodontic treatment. Only payable to a dental provider with a specialty of Orthodontics. Statement regarding the date of the onset of retention.	
D8704	Replacement of lost or broken retainer - mandibular	21 and older		Yes	One of (D8704) per 2 Calendar year(s) Per patient. The MassHealth agency pays for replacement retainers only during the 2 year retention period following orthodontic treatment. Only payable to a dental provider with a specialty of Orthodontics. Statement regarding the date of the onset of retention.	

Exhibit B Benefits Covered for Adult HSN Only

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9110	palliative (emergency) treatment of dental pain - minor procedure	21 and older		No	Other non-emergency medically necessary treatment may be provided during the same visit. Not covered with D0120,D0140,D0160, D0180 by same provider or provider group on same date of service.	
D9222	deep sedation/general anesthesia first 15 minutes	21 and older		No		
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	21 and older		No		
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	21 and older		No		
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	21 and older		No		
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	21 and older		No	Five of (D9243) per 1 Day(s) Per patient.	
D9248	non-intravenous moderate (conscious) sedation	21 and older		No		
D9450	case presentation, detailed and extensive treatment planning	21 and older		No	One of (D9450) per 1 Day(s) Per Provider. Per Member. Only payable when submitted with another payable service.	
D9920	behavior management, by report	21 and older		Yes	One of (D9920) per 1 Day(s) Per Provider OR Location. Narrative of medical necessity. Include a description of the members illness or disability and types of services to be furnished.	narrative of medical necessity
D9930	treatment of complications (post-surgical) - unusual circumstances, by report	21 and older		No	Include with claim the date, the location of the original surgery and the type of procedure.	

Exhibit C Benefits Covered for Under 21 HSN Limited Wrap

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0120	periodic oral evaluation - established patient	0-20		No	Two of (D0120, D0145) per 1 Calendar year(s) Per Provider OR Location. Not covered with D9110 by same provider or provider group on same date of service.	
D0145	oral evaluation for a patient under three years of age and counseling with primary caregiver	0-3		No	Two of (D0120, D0145, D0180) per 1 Calendar year(s) Per Provider OR Location. Cannot be billed on the same date of service as D0150.	
D0150	comprehensive oral evaluation - new or established patient	0-20		No	One of (D0150, D0180) per 1 Lifetime Per Provider OR Location. Cannot be billed on the same date of service as D0145.	
D0180	comprehensive periodontal evaluation - new or established patient	0-20		No	One of (D0180) per 1 Calendar year(s) Per Provider OR Location. Not covered with D9110, D0140, D0145, D0150 by same provider or provider group on same date of service.	
D0210	intraoral - complete series of radiographic images	6 - 20		No	One of (D0210) per 3 Calendar year(s) Per Provider OR Location. One complete series every three calendar years per patient per dentist or dental group. Any combination of radiographs that exceedsthe maximum allowable payment for a FMX will be reimbursed at the D0210 rate. Documentation of variation from ADA clinical guidelines to be kept in patient record.	
D0240	intraoral - occlusal radiographic image	0-4		No	Two of (D0240) per 1 Calendar year(s) Per Provider OR Location.	
D0270	bitewing - single radiographic image	0-20		No	Two of (D0270, D0272, D0273, D0274) per 1 Calendar year(s) Per Provider OR Location. One of (D0270, D0272, D0273, D0274) per 1 Day(s) Per patient. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be reimbursed at the D0210 rate. Documentation of variation from ADA clinical guidelines to be kept in patient record.	

Exhibit C Benefits Covered for Under 21 HSN Limited Wrap

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0272	bitewings - two radiographic images	0-20		No	Two of (D0270, D0272, D0273, D0274) per 1 Calendar year(s) Per Provider OR Location. One of (D0270, D0272, D0273, D0274) per 1 Day(s) Per patient. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be reimbursed at the D0210 rate. Documentation of variation from ADA clinical guidelines to be kept in patient record.	
D0273	bitewings - three radiographic images	0-20		No	Two of (D0270, D0272, D0273, D0274) per 1 Calendar year(s) Per Provider OR Location. One of (D0270, D0272, D0273, D0274) per 1 Day(s) Per patient. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be reimbursed at the D0210 rate. Documentation of variation from ADA clinical guidelines to be kept in patient record.	
D0274	bitewings - four radiographic images	0-20		No	Two of (D0270, D0272, D0273, D0274) per 1 Calendar year(s) Per Provider OR Location. One of (D0270, D0272, D0273, D0274) per 1 Day(s) Per patient. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be reimbursed at the D0210 rate. Documentation of variation from ADA clinical guidelines to be kept in patient record.	
D0340	cephalometric radiographic image	0-20		No	Non-orthodontic procedures. Only payable to a dental provider with a specialty in oral surgery.	

Exhibit C Benefits Covered for Under 21 HSN Limited Wrap

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1110	prophylaxis - adult	14 - 20		No	Two of (D1110, D1120, D4346) per 1 Calendar year(s) Per patient. Includes minor scaling procedures.	
D1120	prophylaxis - child	0-13		No	Two of (D1110, D1120, D4346) per 1 Calendar year(s) Per patient. Includes minor scaling procedures.	
D1206	topical application of fluoride varnish	0-20		No	One of (D1206, D1208) per 90 Day(s) Per Provider OR Location. Cannot be billed with D1208 on same date of service by the same provider or location.	
D1208	topical application of fluoride - excluding varnish	0-20		No	One of (D1206, D1208) per 90 Day(s) Per Provider OR Location. Cannot be billed with D1206 on same date of service by the same provider or location.	
D1351	sealant - per tooth	0-16	Teeth 1 - 3, 14 - 19, 30 - 32	No	One of (D1351) per 3 Year(s) Per Provider OR Location per tooth. Permanent first and second non-carious (occlusal surface) molars and non-carious (occlusal surface)third molars.	
D1354	interim caries arresting medicament application - per tooth	0-20	Teeth 1 - 32, A - T	No	Two of (D1354) per 1 Lifetime Per patient per tooth.	
D1510	space maintainer-fixed-unilateral - per quadrant- Excludes a distal shoe space maintainer.	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Four of (D1510, D1516, D1517, D1520, D1526, D1527, D1575) per 1 Lifetime Per patient. Must maintain radiographs in patient record demonstrating that the tooth has not begun to erupt or that migration of the adjacent tooth has already occurred. Excludes a Distal Shoe Maintainer.	
D1516	space maintainer --fixed--bilateral, maxillary	0-20		No	Four of (D1510, D1516, D1517, D1520, D1526, D1527, D1575) per 1 Lifetime Per patient. Must maintain radiographs in patient record demonstrating that the tooth has not begun to erupt or that the migration of the adjacent tooth has already occurred.	

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Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1517	space maintainer --fixed--bilateral, mandibular	0-20		No	Four of (D1510, D1516, D1517, D1520, D1526, D1527, D1575) per 1 Lifetime Per patient. Must maintain radiographs in patient record demonstrating that the tooth has not begun to erupt or that the migration of the adjacent tooth has already occurred.	
D1520	space maintainer-removable-unilateral – per quadrant.	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Four of (D1510, D1516, D1517, D1520, D1526, D1527, D1575) per 1 Lifetime Per patient. Must maintain radiographs in patient record demonstrating that the tooth has not begun to erupt or that the migration of the adjacent tooth has already occurred.	
D1526	space maintainer --removable--bilateral, maxillary	0-20		No	Four of (D1510, D1516, D1517, D1520, D1526, D1527, D1575) per 1 Lifetime Per patient. Must maintain radiographs in patient record demonstrating that the tooth has not begun to erupt or that the migration of the adjacent tooth has already occurred.	
D1527	space maintainer --removable--bilateral, mandibular	0-20		No	Four of (D1510, D1516, D1517, D1520, D1526, D1527, D1575) per 1 Lifetime Per patient. Must maintain radiographs in patient record demonstrating that the tooth has not begun to erupt or that the migration of the adjacent tooth has already occurred.	
D1575	distal shoe space maintainer - fixed - unilateral- Per Quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Four of (D1510, D1516, D1517, D1520, D1526, D1527, D1575) per 1 Lifetime Per patient. Must maintain radiographs in patient record demonstrating that the tooth has not begun to erupt or that the migration of the adjacent tooth has already occurred.	
D1701	Pfizer-BioNTech Covid-19 vaccine administration – first dose SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 1	0-20		No	One of (D1701) per 1 Lifetime Per patient.	
D1702	Pfizer-BioNTech Covid-19 vaccine administration – second dose SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 2	0-20		No	One of (D1702) per 1 Lifetime Per patient.	

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Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1703	Moderna Covid-19 vaccine administration – first dose SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 1	0-20		No	One of (D1703) per 1 Lifetime Per patient.	
D1704	Moderna Covid-19 vaccine administration – second dose SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 2	0-20		No	One of (D1704) per 1 Lifetime Per patient.	
D1707	Janssen Covid-19 vaccine administration SARSCOV2 COVID-19 VAC Ad26 5x1010 VP/.5mL IM SINGLE DOSE These dental procedure codes	0-20		No	One of (D1707) per 1 Lifetime Per patient.	

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Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2140	Amalgam - one surface, primary or permanent	0-20	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2150	Amalgam - two surfaces, primary or permanent	0-20	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2160	amalgam - three surfaces, primary or permanent	0-20	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2161	amalgam - four or more surfaces, primary or permanent	0-20	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2330	resin-based composite - one surface, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2331	resin-based composite - two surfaces, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	

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Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2332	resin-based composite - three surfaces, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2390	resin-based composite crown, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2390) per 12 Month(s) Per patient per tooth.	
D2391	resin-based composite - one surface, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2392	resin-based composite - two surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2393	resin-based composite - three surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	

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Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2394	resin-based composite - four or more surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2710	crown - resin-based composite (indirect)	0-20	Teeth 3 - 14, 19 - 30	No	One of (D2710, D2740, D2750, D2751, D2752, D2790) per 60 Month(s) Per patient per tooth.	
D2740	crown - porcelain/ceramic	0-20	Teeth 2 - 15, 18 - 31	No	One of (D2710, D2740, D2750, D2751, D2752, D2790) per 60 Month(s) Per patient per tooth.	
D2750	crown - porcelain fused to high noble metal	0-20	Teeth 2 - 15, 18 - 31	No	One of (D2710, D2740, D2750, D2751, D2752, D2790) per 60 Month(s) Per patient per tooth.	
D2751	crown - porcelain fused to predominantly base metal	0-20	Teeth 2 - 15, 18 - 31	No	One of (D2710, D2740, D2750, D2751, D2752, D2790) per 60 Month(s) Per patient per tooth.	
D2752	crown - porcelain fused to noble metal	0-20	Teeth 2 - 15, 18 - 31	No	One of (D2710, D2740, D2750, D2751, D2752, D2790) per 60 Month(s) Per patient per tooth.	
D2790	crown - full cast high noble metal	0-20	Teeth 2 - 15, 18 - 31	No	One of (D2710, D2740, D2750, D2751, D2752, D2790) per 60 Month(s) Per patient per tooth.	
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	0-20	Teeth 2 - 15, 18 - 31	No	Not covered within 6 months of initial placement.	
D2920	re-cement or re-bond crown	0-20	Teeth 2 - 15, 18 - 31, A - T	No	Not covered within 6 months of initial placement.	
D2929	Prefabricated porcelain/ceramic crown – primary tooth	0-20	Teeth D - G, N - Q	No	Four of (D2929, D2930, D2931, D2932, D2934) per 1 Day(s) Per patient. Maximum of 4 per day if performed in an office setting. No limitation if performed in the OR or outpatient facility.	
D2930	prefabricated stainless steel crown - primary tooth	0-20	Teeth A - T	No	Four of (D2929, D2930, D2931, D2932, D2934) per 1 Day(s) Per patient. Maximum of 4 per day if performed in an office setting. No limitation if performed in the OR or outpatient facility.	

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Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2931	prefabricated steel crown-permanent tooth	0-20	Teeth 2 - 5, 12 - 15, 18 - 21, 28 - 31	No	Four of (D2929, D2930, D2931, D2932, D2934) per 1 Day(s) Per patient. Maximum of 4 per day if performed in an office setting. No limitation if performed in the OR or outpatient facility.	
D2932	prefabricated resin crown	0-20	Teeth 1 - 32, A - T	No	Four of (D2929, D2930, D2931, D2932, D2934) per 1 Day(s) Per patient. Maximum of 4 per day if performed in an office setting. No limitation if performed in the OR or outpatient facility.	
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	0-20	Teeth C - H, M - R	No	Four of (D2929, D2930, D2931, D2932, D2934) per 1 Day(s) Per patient. Maximum of 4 per day if performed in an office setting. No limitation if performed in the OR or outpatient facility.	
D2950	core buildup, including any pins when required	0-20	Teeth 2 - 15, 18 - 31	No	One of (D2950, D2954) per 1 Day(s) Per patient per tooth.	
D2951	pin retention - per tooth, in addition to restoration	0-20	Teeth 2 - 15, 18 - 31	No	Must be billed with a two-or-more surface restoration on a permanent tooth.	
D2954	prefabricated post and core in addition to crown	0-20	Teeth 2 - 15, 18 - 31	No	One of (D2950, D2954) per 1 Day(s) Per patient per tooth.	
D2980	crown repair, by report	0-20	Teeth 2 - 15, 18 - 31	No	Chairside	

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Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3120	pulp cap - indirect (excluding final restoration)	0-20	Teeth 1 - 32, A - T	No	Cannot be billed in conjunction with root canals on same date of service. (D3310, D3320 or D3330).	
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	0-20	Teeth 1 - 32, A - T	No	Cannot be billed in conjunction with root canals (D3310, D3320 or D3330).	
D3310	endodontic therapy, anterior tooth (excluding final restoration)	0-20	Teeth 6 - 11, 22 - 27	No	One of (D3310) per 1 Lifetime Per patient per tooth. No limitation on number performed per treatment. Cannot be billed in conjunction with D3120 on the same date of service.	
D3320	endodontic therapy, premolar tooth (excluding final restoration)	0-20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	One of (D3320) per 1 Lifetime Per patient per tooth. Cannot be billed in conjunction with D3120 on the same date of service.	
D3330	endodontic therapy, molar tooth (excluding final restoration)	0-20	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	One of (D3330) per 1 Lifetime Per patient per tooth. Cannot be billed in conjunction with D3120 on the same date of service.	
D3346	retreatment of previous root canal therapy-anterior	0-20	Teeth 6 - 11, 22 - 27	No	Not payable to the same provider who performed the original endodontic therapy (D3310, D3320, or D3330) within 24 months.	
D3347	retreatment of previous root canal therapy - premolar	0-20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	Not payable to the same provider who performed the original endodontic therapy (D3310, D3320, or D3330) within 24 months.	
D3348	retreatment of previous root canal therapy-molar	0-20	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	Not payable to the same provider who performed the original endodontic therapy (D3310, D3320, or D3330) within 24 months.	
D3410	apicoectomy - anterior	0-20	Teeth 6 - 11, 22 - 27	No	One of (D3410) per 1 Lifetime Per patient per tooth. Includes retrograde filling.	pre-operative x-ray(s)
D3421	apicoectomy - premolar (first root)	0-20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	One of (D3421) per 1 Lifetime Per patient per tooth. Includes retrograde filling.	pre-operative x-ray(s)
D3425	apicoectomy - molar (first root)	0-20	Teeth 1 - 3, 14 - 19, 30 - 32	No	One of (D3425) per 1 Lifetime Per patient per tooth. Includes retrograde filling.	

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Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3426	apicoectomy (each additional root)	0-20	Teeth 1 - 5, 12 - 21, 28 - 32	No	One of (D3426) per 1 Lifetime Per patient per tooth for Bicuspids. Two of (D3426) per 1 Lifetime Per patient per tooth for First and Second Molars. Includes retrograde filling.	

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Periodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4210) per 3 Calendar year(s) Per patient per quadrant. Limited to two quadrants on the same date of service in an office setting. Not payable in conjunction with D1110 and D1120 or D4341 and D4342 on same date of service. Documentation Required :Diagnostic Quality Radiographs and Medical Necessity Narrative	narr. of med. necessity, pre-op x-ray(s)
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4211) per 3 Calendar year(s) Per patient per quadrant. Limited to two quadrants on the same date of service in an office setting. Not payable in conjunction with D1110 and D1120 or D4341 and D4342 on same date of service. Documentation Required :Diagnostic Quality Radiographs and Medical Necessity Narrative	narr. of med. necessity, pre-op x-ray(s)
D4341	periodontal scaling and root planing - four or more teeth per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4341, D4342) per 3 Calendar year(s) Per patient per quadrant. Two of (D4341, D4342) per 1 Day(s) Per Provider OR Location in office. Four of (D4341, D4342) per 1 Day(s) Per Provider OR Location in hospital. A minimum of four (4) affected teeth in the quadrant. Not payable in conjunction with D1110 and D1120 or D4210 and D4211 on same date of service.Documentation Required: Medical necessity narrative, date of service of periodontal evaluation, complete periodontal charting,appropriate diagnostic quality radiographs history of previous periodontal treatment and a statement concerning the member'speriodontal condition.	Perio Charting, pre-op radiographs and narr of med necessity

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Periodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D4342	periodontal scaling and root planing - one to three teeth per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4341, D4342) per 3 Calendar year(s) Per patient per quadrant. Two of (D4341, D4342) per 1 Day(s) Per Provider OR Location in office. Four of (D4341, D4342) per 1 Day(s) Per Provider OR Location in hospital. Not payable in conjunction with D1110 and D1120 or D4210 and D4211 on same date of service.Documentation Required: Medical necessity narrative, date of service of periodontal evaluation, complete periodontal charting, appropriate diagnostic quality radiographs history of previous periodontal treatment and a statement concerning the member's periodontal condition.	Perio Charting, pre-op radiographs and narr of med necessity
D4346	scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	0-20		No	Two of (D1110, D1120, D4346) per 1 Calendar year(s) Per patient.	

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5110	complete denture - maxillary	0-20		No	One of (D5110) per 84 Month(s) Per patient.	
D5120	complete denture - mandibular	0-20		No	One of (D5120) per 84 Month(s) Per patient.	
D5130	immediate denture - maxillary	0-20		No	One of (D5130) per 1 Lifetime Per patient.	
D5140	immediate denture - mandibular	0-20		No	One of (D5140) per 1 Lifetime Per patient.	
D5211	maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)	0-20		No	One of (D5211) per 84 Month(s) Per patient. One of (D5211, D5213, D5225) per 84 Month(s) Per patient. Pre-op radiographs of all teeth in arch with claim for prepayment review. Documentation must indicate that there are two or more missing posterior teeth or one or more missing anterior teeth, the remaining dentition is sound and there is a good prognosis.	pre-operative x-ray(s)
D5212	mandibular partial denture – resin base (includingretentive/clasping materials, rests, and teeth)	0-20		No	One of (D5212) per 84 Month(s) Per patient. One of (D5212, D5214, D5226) per 84 Month(s) Per patient. Pre-op radiographs of all teeth in arch with claim for prepayment review. Documentation must indicate that there are two or more missing posterior teeth or one or more missing anterior teeth, the remaining dentition is sound and there is a good prognosis.	pre-operative x-ray(s)
D5213	maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	0-20		No	One of (D5213) per 84 Month(s) Per patient. One of (D5211, D5213, D5225) per 84 Month(s) Per patient. Pre-op radiographs of all teeth in arch with claim for prepayment review. Documentation must indicate that there are two or more missing posterior teeth or one or more missing anterior teeth, the remaining dentition is sound and there is a good prognosis.	pre-operative x-ray(s)

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Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5214	mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	0-20		No	One of (D5214) per 84 Month(s) Per patient. One of (D5212, D5214, D5226) per 84 Month(s) Per patient. Pre-op radiographs of all teeth in arch with claim for prepayment review. Documentation must indicate that there are two or more missing posterior teeth or one or more missing anterior teeth, the remaining dentition is sound and there is a good prognosis.	pre-operative x-ray(s)
D5225	maxillary partial denture-flexible base	0-20		No	One of (D5225) per 84 Month(s) Per patient. One of (D5211, D5213, D5225) per 84 Month(s) Per patient. Pre-op radiographs of all teeth in arch with claim for prepayment review. Documentation must indicate that there are two or more missing posterior teeth or one or more missing anterior teeth, the remaining dentition is sound and there is a good prognosis.	pre-operative x-ray(s)
D5226	mandibular partial denture-flexible base	0-20		No	One of (D5226) per 84 Month(s) Per patient. One of (D5212, D5214, D5226) per 84 Month(s) Per patient. Pre-op radiographs of all teeth in arch with claim for prepayment review. Documentation must indicate that there are two or more missing posterior teeth or one or more missing anterior teeth, the remaining dentition is sound and there is a good prognosis.	pre-operative x-ray(s)
D5511	repair broken complete denture base, mandibular	0-20		No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5512	repair broken complete denture base, maxillary	0-20		No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	

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Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5520	replace missing or broken teeth - complete denture (each tooth)	0-20	Teeth 1 - 32	No	Three of (D5520) per 12 Month(s) Per patient. Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5611	repair resin partial denture base, mandibular	0-20		No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5612	repair resin partial denture base, maxillary	0-20		No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5621	repair cast partial framework, mandibular	0-20		No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5622	repair cast partial framework, maxillary	0-20		No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5630	repair or replace broken retentive/clasping materials per tooth	0-20	Teeth 1 - 32	No	One of (D5630) per 6 Month(s) Per patient per tooth. Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	

Exhibit C Benefits Covered for Under 21 HSN Limited Wrap

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5640	replace broken teeth-per tooth	0-20	Teeth 1 - 32	No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5650	add tooth to existing partial denture	0-20	Teeth 1 - 32	No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5660	add clasp to existing partial denture	0-20	Teeth 1 - 32	No	Per tooth, add clasp to existing partial denture. Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5730	reline complete maxillary denture (chairside)	0-20		No	One of (D5730, D5750) per 24 Month(s) Per patient. Fee for denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.	
D5731	reline complete mandibular denture (chairside)	0-20		No	One of (D5731, D5751) per 24 Month(s) Per patient. Fee for denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.	
D5740	reline maxillary partial denture (chairside)	0-20		No	One of (D5740, D5760) per 24 Month(s) Per patient. Fee for denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.	
D5741	reline mandibular partial denture (chairside)	0-20		No	One of (D5741, D5761) per 24 Month(s) Per patient. Fee for denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.	

Exhibit C Benefits Covered for Under 21 HSN Limited Wrap

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5750	reline complete maxillary denture (laboratory)	0-20		No	One of (D5750) per 24 Month(s) Per patient. One of (D5730, D5750) per 24 Month(s) Per patient. Fee for denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.	
D5751	reline complete mandibular denture (laboratory)	0-20		No	One of (D5751) per 24 Month(s) Per patient. One of (D5731, D5751) per 24 Month(s) Per patient. Fee for denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.	
D5760	reline maxillary partial denture (laboratory)	0-20		No	One of (D5760) per 24 Month(s) Per patient. One of (D5740, D5760) per 24 Month(s) Per patient. Fee for partial denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.	
D5761	reline mandibular partial denture (laboratory)	0-20		No	One of (D5761) per 24 Month(s) Per patient. One of (D5741, D5761) per 24 Month(s) Per patient. Fee for partial denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.	

Exhibit C Benefits Covered for Under 21 HSN Limited Wrap

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Prosthodontics, fixed						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6241	pontic-porcelain fused metal	0-20	Teeth 6 - 11, 22 - 27	No	One of (D6241) per 60 Month(s) Per patient per tooth.	
D6751	crown-porcelain fused to metal	0-20	Teeth 6 - 11, 22 - 27	No	One of (D6751) per 60 Month(s) Per patient per tooth.	
D6930	re-cement or re-bond fixed partial denture	0-20		No	Not covered within 6 months of placement.	
D6980	fixed partial denture repair	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No		

Exhibit C Benefits Covered for Under 21 HSN Limited Wrap

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7111	extraction, coronal remnants - primary tooth	0-20	Teeth A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7220	removal of impacted tooth-soft tissue	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Only covered for teeth that are symptomatic, carious or pathologic.	
D7230	removal of impacted tooth-partially bony	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Only covered for teeth that are symptomatic, carious or pathologic.	
D7240	removal of impacted tooth-completely bony	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Removal of asymptomatic tooth not covered.	Narr of med necessity & full mouth xrays
D7250	surgical removal of residual tooth roots (cutting procedure)	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Only covered for teeth that are symptomatic, carious or pathologic.	
D7251	Coronectomy-intentional partial tooth removal intentional partial tooth removal is performed when a neurovascular complication is likely if the entire impacted tooth is removed.	0-20	Teeth 1, 16, 17, 32	No	One of (D7251) per 1 Lifetime Per patient per tooth. Cannot be billed on same date of service with codes D7111, D7140, D7210, D7220, D7230, D7240, D7250, D7241. If D7251 is billed following any history of D7111, D7210, D7140, D7241, D7220, D7230, D7240, D7250 billed on the same tooth as code D7251, then deduct what was paid for D7251 from payment of new code.	
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	0-20	Teeth 1 - 32	No		
D7280	Surgical access of an unerupted tooth	0-20	Teeth 1 - 32	No		

Exhibit C Benefits Covered for Under 21 HSN Limited Wrap

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7283	placement of device to facilitate eruption of impacted tooth	0-20	Teeth 1 - 32	No		
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7310) per 6 Month(s) Per patient per quadrant. One of (D7310, D7311) per 1 Lifetime Per patient per quadrant. Limited to one per quadrant when the second procedure follows the first within 6 months.	
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7311) per 6 Month(s) Per patient per quadrant. One of (D7310, D7311) per 1 Lifetime Per patient per quadrant. Limited to one per quadrant when the second procedure follows the first within 6 months.	
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7320) per 6 Month(s) Per patient per quadrant. One of (D7320, D7321) per 1 Lifetime Per patient per quadrant. No extractions performed in edentulous area. Limited to one per quadrant when the second procedure follows the first within 6 months.	narrative of medical necessity
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7321) per 6 Month(s) Per patient per quadrant. One of (D7320, D7321) per 1 Lifetime Per patient per quadrant. No extractions performed on edentulous area. Limited to one per quadrant when the second procedure follows the first within 6 months.	
D7340	vestibuloplasty - ridge extension (secondary epithelialization)	0-20	Per Arch (01, 02, LA, UA)	Yes		narrative of medical necessity
D7350	vestibuloplasty - ridge extension	0-20	Per Arch (01, 02, LA, UA)	No	Only payable to a dental provider with a specialty in oral surgery	
D7410	radical excision - lesion diameter up to 1.25cm	0-20		No		
D7411	excision of benign lesion greater than 1.25 cm	0-20		No		
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	0-20		No	Pathology report.	

Exhibit C Benefits Covered for Under 21 HSN Limited Wrap

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	0-20		No	Pathology report.	
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	0-20		No	Pathology report.	
D7461	removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm	0-20		No	Pathology report.	
D7471	removal of exostosis - per site	0-20	Per Arch (01, 02, LA, UA)	No	One of (D7471) per 1 Lifetime Per patient per arch. Only payable to a dental provider with a specialty in oral surgery	
D7472	removal of torus palatinus	0-20		No	One of (D7472) per 1 Lifetime Per patient per arch. Only payable to a dental provider with a specialty in oral surgery	
D7473	removal of torus mandibularis	0-20		No	One of (D7473) per 1 Lifetime Per patient per arch. Only payable to a dental provider with a specialty in oral surgery	
D7961	buccal / labial frenectomy (frenulectomy)	0-20	Per Arch (01, 02, LA, UA)	No	One of (D7961) per 1 Lifetime Per patient per arch. The frenum may be excised when the tongue has limited mobility; for large diastemas between teeth; or when frenum interferes with a prosthetic appliance; or when it is the etiology of the periodontal tissue disease. Narrative describing location and medical necessity must be maintained in the patient record.	
D7962	lingual frenectomy (frenulectomy)	0-20		No	One of (D7962, D7963) per 1 Lifetime Per patient. The frenum may be excised when the tongue has limited mobility; for large diastemas between teeth; or when frenum interferes with a prosthetic appliance; or when it is the etiology of the periodontal tissue disease. Narrative describing location and medical necessity must be maintained in the patient record.	

Exhibit C Benefits Covered for Under 21 HSN Limited Wrap

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7963	frenuloplasty	0-20		No	One of (D7962, D7963) per 1 Lifetime Per patient. The frenum may be excised when the tongue has limited mobility; for large diastemas between teeth; or when frenum interferes with a prosthetic appliance; or when it is the etiology of the periodontal tissue disease. Narrative describing location and medical necessity must be maintained in the patient record.	
D7970	excision of hyperplastic tissue - per arch	0-20	Per Arch (01, 02, LA, UA)	No	Not payable on the same date of service as an extraction (D7111 - D7240) of the same tooth.	

Exhibit C Benefits Covered for Under 21 HSN Limited Wrap

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Orthodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D8010	limited orthodontic treatment of the primary dentition	6-14		Yes	Adjustments for interceptive orthodontic treatment must be requested under the D8999 code and will be approved for a maximum of five units. Please see billing instructions in section 16 of the OfficeReference Manual.	narrative of medical necessity
D8020	limited orthodontic treatment of the transitional dentition	6-14		Yes	Adjustments for interceptive orthodontic treatment must be requested under the D8999 code and will be approved for a maximum of five units. Please see billing instructions in section 16 of the OfficeReference Manual.	narrative of medical necessity
D8030	limited orthodontic treatment of the adolescent dentition	6-14		Yes	Adjustments for interceptive orthodontic treatment must be requested under the D8999 code and will be approved for a maximum of five units. Please see billing instructions in section 16 of the OfficeReference Manual.	narrative of medical necessity
D8040	limited orthodontic treatment of the adult dentition	6-14		Yes	Adjustments for interceptive orthodontic treatment must be requested under the D8999 code and will be approved for a maximum of five units. Please see billing instructions in section 16 of the OfficeReference Manual.	narrative of medical necessity
D8070	comprehensive orthodontic treatment of the transitional dentition	6 - 20		Yes	One of (D8070, D8080) per 1 Lifetime Per patient. Only payable to a dental provider with a specialty of Orthodontics. Please see billing instructions in section 16 of the Office Reference Manual.	
D8080	comprehensive orthodontic treatment of the adolescent dentition	6 - 20		Yes	One of (D8070, D8080) per 1 Lifetime Per patient. Only payable to a dental provider with a specialty of Orthodontics. Please see billing instructions in section 16 of the Office Reference Manual.	
D8660	pre-orthodontic treatment examination to monitor growth and development	6-20		Yes	One of (D8660) per 6 Month(s) Per Provider OR Location. Not billable after D8080, D8070, D8090, D8670, D8680 has been paid. Only payable to a dental provider with a speciality in orthodontics. Please see billing instructions in section 16 of the Office Reference Manual.	

Exhibit C Benefits Covered for Under 21 HSN Limited Wrap

Orthodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D8670	periodic orthodontic treatment visit	0-20		Yes	One per 90 Day(s) Per patient. Allowed as quarterly treatment visits. May not be billed less than 90 days from previous periodic orthodontic treatment visit. (D8670). May not be billed less than 90 days from previous banding date. (D8080, D8070, D8090). May not be billed prior to D8080 / D8070 / D8090. Only payable to a dental provider with a specialty of Orthodontics. Please see billing instructions in section 16 of the Office Reference Manual.	
D8680	orthodontic retention (removal of appliances)	6 - 20		No	Five of (D8680) per 1 Lifetime Per patient. Only payable to a dental provider with a specialty of Orthodontics. Please see billing instructions in Section 16 of the Office Reference Manual.	
D8703	Replacement of lost or broken retainer - maxillary	0-20		Yes	One of (D8703) per 2 Calendar year(s) Per patient. The MassHealth agency pays for replacement retainers only during the 2 year retention period following orthodontic treatment. Only payable to a dental provider with a specialty of Orthodontics. Statement regarding the date of the onset of retention.	
D8704	Replacement of lost or broken retainer - mandibular	0-20		Yes	One of (D8704) per 2 Calendar year(s) Per patient. The MassHealth agency pays for replacement retainers only during the 2 year retention period following orthodontic treatment. Only payable to a dental provider with a specialty of Orthodontics. Statement regarding the date of the onset of retention.	
D8999	unspecified orthodontic procedure, by report	0-20		Yes	Five of (D8999) per 1 Lifetime Per patient. This code is used exclusively for interceptive orthodontic adjustments and units. Please see billing instructions in section 16 of the Office Reference Manual.	

Exhibit C Benefits Covered for Under 21 HSN Limited Wrap

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9222	deep sedation/general anesthesia first 15 minutes	0-20		No		
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	0-20		No		
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	0-20		No	The routine administration of inhalation analgesia or oral sedation is generally considered part of the treatment procedure, unless its use is documented in the patient record as necessary to complete treatment	
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	0-20		No		
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	0-20		No	Five of (D9243) per 1 Day(s) Per patient.	
D9248	non-intravenous moderate (conscious) sedation	0-20		No		
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	6-20		No	One of (D9310) per 6 Month(s) Per patient. Not billable after D8080, D8070, D8090, D8670, D8680, D8660 has paid. Only payable to a dental provider with a specialty of orthodontics. Please see billing instructions in section 16 of the Office Reference Manual.	
D9450	case presentation, detailed and extensive treatment planning	0-20		No	One of (D9450) per 1 Day(s) Per Provider. Per Member. Only payable when submitted with another payable service.	
D9920	behavior management, by report	0-20		Yes	One of (D9920) per 1 Day(s) Per Provider OR Location. Include a description of the members illness or disability and types of services to be furnished.	narrative of medical necessity
D9930	treatment of complications (post-surgical) - unusual circumstances, by report	0-20		No		narrative of medical necessity
D9941	fabrication of athletic mouthguard	0-20		No	One of (D9941) per 1 Calendar year(s) Per patient.	

Exhibit C Benefits Covered for Under 21 HSN Limited Wrap

Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9945	occlusal guard--soft appliance full arch	0-20	Per Arch (01, 02, LA, UA)	No	One of (D9945) per 1 Year(s) Per patient.	

Exhibit D Benefits Covered for Adult HSN Limited Wrap

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0120	periodic oral evaluation - established patient	21 and older		No	Two of (D0120, D0145) per 1 Calendar year(s) Per Provider OR Location. Not covered with D9110 by same provider or provider group on same date of service.	
D0150	comprehensive oral evaluation - new or established patient	21 and older		No	One of (D0150, D0180) per 1 Lifetime Per Provider OR Location.	
D0180	comprehensive periodontal evaluation - new or established patient	21 and older		No	One of (D0180) per 1 Calendar year(s) Per Provider OR Location. Not covered with D9110, D0140, D0145, D0150 by same provider or provider group on same date of service.	
D0210	intraoral - complete series of radiographic images	21 and older		No	One of (D0210) per 3 Calendar year(s) Per Provider OR Location. One complete series every three calendar years per patient, per provider or location. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be reimbursed at the D0210 rate.	
D0270	bitewing - single radiographic image	21 and older		No	Two of (D0270, D0272, D0273, D0274) per 1 Calendar year(s) Per Provider OR Location. One of (D0270, D0272, D0273, D0274) per 1 Day(s) Per patient. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be reimbursed at the D0210 rate. Documentation of variation from ADA clinical guidelines to be kept in patient record.	
D0272	bitewings - two radiographic images	21 and older		No	Two of (D0270, D0272, D0273, D0274) per 1 Calendar year(s) Per Provider OR Location. One of (D0270, D0272, D0273, D0274) per 1 Day(s) Per patient. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be reimbursed at the D0210 rate. Documentation of variation from ADA clinical guidelines to be kept in patient record.	

Exhibit D Benefits Covered for Adult HSN Limited Wrap

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0273	bitewings - three radiographic images	21 and older		No	Two of (D0270, D0272, D0273, D0274) per 1 Calendar year(s) Per Provider OR Location. One of (D0270, D0272, D0273, D0274) per 1 Day(s) Per patient. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be reimbursed at the D0210 rate. Documentation of variation from ADA clinical guidelines to be kept in patient record.	
D0274	bitewings - four radiographic images	21 and older		No	Two of (D0270, D0272, D0273, D0274) per 1 Calendar year(s) Per Provider OR Location. One of (D0270, D0272, D0273, D0274) per 1 Day(s) Per patient. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be reimbursed at the D0210 rate. Documentation of variation from ADA clinical guidelines to be kept in patient record.	
D0340	cephalometric radiographic image	21 and older		Yes	Reimbursable when used in conjunction with surgical condition, including status post-facial trauma such as LaFort, mandibular fractures and jaw dislocation. narrative of medical necessity. Non-orthodontic procedures. Only payable to a dental provider with a specialty in oral surgery.	narrative of medical necessity

Exhibit D Benefits Covered for Adult HSN Limited Wrap

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1110	prophylaxis - adult	21 and older		No	Two of (D1110, D1120, D4346) per 1 Calendar year(s) Per patient.	
D1206	topical application of fluoride varnish	21 and older		Yes	One of (D1206, D1208) per 90 Day(s) Per Provider OR Location. Only allowed for members 21 & older who have medical \ dental conditions that significantly interrupt the flow of saliva.	narrative of medical necessity
D1208	topical application of fluoride - excluding varnish	21 and older		Yes	One of (D1206, D1208) per 90 Day(s) Per Provider OR Location. Only allowed for members 21 & older who have medical \ dental conditions that significantly interrupt the flow of saliva.	narrative of medical necessity
D1354	interim caries arresting medicament application - per tooth	21 and older	Teeth 1 - 32, A - T	No	Two of (D1354) per 1 Lifetime Per patient per tooth.	
D1701	Pfizer-BioNTech Covid-19 vaccine administration – first dose SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 1	21 and older		No	One of (D1701) per 1 Lifetime Per patient.	
D1702	Pfizer-BioNTech Covid-19 vaccine administration – second dose SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 2	21 and older		No	One of (D1702) per 1 Lifetime Per patient.	
D1703	Moderna Covid-19 vaccine administration – first dose SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 1	21 and older		No	One of (D1703) per 1 Lifetime Per patient.	
D1704	Moderna Covid-19 vaccine administration – second dose SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 2	21 and older		No	One of (D1704) per 1 Lifetime Per patient.	
D1707	Janssen Covid-19 vaccine administration SARSCOV2 COVID-19 VAC Ad26 5x1010 VP/.5mL IM SINGLE DOSE These dental procedure codes	21 and older		No	One of (D1707) per 1 Lifetime Per patient.	

Exhibit D Benefits Covered for Adult HSN Limited Wrap

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2140	Amalgam - one surface, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2150	Amalgam - two surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2160	amalgam - three surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2161	amalgam - four or more surfaces, primary or permanent	21 and older	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2330	resin-based composite - one surface, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2331	resin-based composite - two surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	

Exhibit D Benefits Covered for Adult HSN Limited Wrap

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2332	resin-based composite - three surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	21 and older	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Provider OR Location per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2391	resin-based composite - one surface, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Provider OR Location per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2392	resin-based composite - two surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2393	resin-based composite - three surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2394	resin-based composite - four or more surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	

Exhibit D Benefits Covered for Adult HSN Limited Wrap

Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2740	crown - porcelain/ceramic	21 and older	Teeth 2 - 15, 18 - 31	No	One of (D2740, D2751) per 60 Month(s) Per patient per tooth.	
D2751	crown - porcelain fused to predominantly base metal	21 and older	Teeth 2 - 15, 18 - 31	No	One of (D2710, D2740, D2750, D2751, D2752, D2790) per 60 Month(s) Per patient per tooth. Maintain pre-treatment and post-treatment film of the tooth in chart.	
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	21 and older	Teeth 2 - 15, 18 - 31	No	Not covered within 6 months of initial placement.	
D2920	re-cement or re-bond crown	21 and older	Teeth 2 - 15, 18 - 31, A - T	No	Not covered within 6 months of initial placement.	
D2950	core buildup, including any pins when required	21 and older	Teeth 2 - 15, 18 - 31	No	One of (D2950, D2954) per 1 Day(s) Per patient per tooth.	
D2951	pin retention - per tooth, in addition to restoration	21 and older	Teeth 2 - 15, 18 - 31	No	Must be billed with a two-or-more surface restoration on a permanent tooth.	
D2954	prefabricated post and core in addition to crown	21 and older	Teeth 2 - 15, 18 - 31	No	One of (D2950, D2954) per 1 Day(s) Per patient per tooth.	
D2980	crown repair, by report	21 and older	Teeth 2 - 15, 18 - 31	No		

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Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3120	pulp cap - indirect (excluding final restoration)	21 and older	Teeth 1 - 32, A - T	No	Cannot be billed in conjunction with root canals on same date of service. (D3310, D3320 or D3330).	
D3310	endodontic therapy, anterior tooth (excluding final restoration)	21 and older	Teeth 6 - 11, 22 - 27	No	One of (D3310) per 1 Lifetime Per patient per tooth. No limitation on number performed per treatment. Cannot be billed in conjunction with D3120 on the same date of service.	
D3320	endodontic therapy, premolar tooth (excluding final restoration)	21 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	One of (D3320) per 1 Lifetime Per patient per tooth. Cannot be billed in conjunction with D3120 on the same date of service.	
D3330	endodontic therapy, molar tooth (excluding final restoration)	21 and older	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	One of (D3330) per 1 Lifetime Per patient per tooth. Cannot be billed in conjunction with D3120 on the same date of service.	
D3346	retreatment of previous root canal therapy-anterior	21 and older	Teeth 6 - 11, 22 - 27	No	Not payable to the same provider who performed the original endodontic therapy (D3310,D3320 or D3330) within 24 months. Include periapical film of the tooth and date of original root canal treatment.	
D3347	retreatment of previous root canal therapy - premolar	21 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	Not payable to the same provider who performed the original endodontic therapy (D3310, D3320, or D3330) within 24 months.	
D3348	retreatment of previous root canal therapy-molar	21 and older	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	Not payable to the same provider who performed the original endodontic therapy (D3310, D3320, or D3330) within 24 months.	
D3410	apicoectomy - anterior	21 and older	Teeth 6 - 11, 22 - 27	No	One of (D3410) per 1 Lifetime Per patient per tooth. Includes retrograde filling.	
D3421	apicoectomy - premolar (first root)	21 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	One of (D3421) per 1 Lifetime Per patient per tooth. Includes retrograde filling.	
D3425	apicoectomy - molar (first root)	21 and older	Teeth 1 - 3, 14 - 19, 30 - 32	No	One of (D3425) per 1 Lifetime Per patient per tooth. Includes retrograde filling.	pre-operative x-ray(s)
D3426	apicoectomy (each additional root)	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32	No	One of (D3426) per 1 Lifetime Per patient per tooth for Bicuspids. Two of (D3426) per 1 Lifetime Per patient per tooth for First and Second Molars. Includes retrograde filling.	

Exhibit D Benefits Covered for Adult HSN Limited Wrap

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Periodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4210) per 3 Calendar year(s) Per patient per quadrant. Limited to two quadrants on the same date of service in an office setting. Not payable in conjunction with D1110 and D1120 or D4341 and D4342 on same date of service. Documentation Required :Diagnostic Quality Radiographs and Medical Necessity Narrative	narr. of med. necessity, pre-op x-ray(s)
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4211) per 3 Calendar year(s) Per patient per quadrant. Limited to two quadrants on the same date of service in an office setting. Not payable in conjunction with D1110 and D1120 or D4341 and D4342 on same date of service. Documentation Required :Diagnostic Quality Radiographs and Medical Necessity Narrative	narr. of med. necessity, pre-op x-ray(s)
D4341	periodontal scaling and root planing - four or more teeth per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 3 Calendar year(s) Per patient per quadrant. Two of (D4341, D4342) per 1 Day(s) Per Provider OR Location in office. Four of (D4341, D4342) per 1 Day(s) Per Provider OR Location in hospital. A minimum of four (4) affected teeth in the quadrant. Not payable in conjunction with D1110 and D1120 or D4210 and D4211 on same date of service.Documentation Required: Medical necessity narrative, date of service of periodontal evaluation, complete periodontal charting,appropriate diagnostic quality radiographs history of previous periodontal treatment and a statement concerning the member'speriodontal condition.	Perio Charting, pre-op radiographs and narr of med necessity

Exhibit D Benefits Covered for Adult HSN Limited Wrap

Periodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D4342	periodontal scaling and root planing - one to three teeth per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One of (D4341, D4342) per 3 Calendar year(s) Per patient per quadrant. Two of (D4341, D4342) per 1 Day(s) Per Provider OR Location in office. Four of (D4341, D4342) per 1 Day(s) Per Provider OR Location in hospital. Not payable in conjunction with D1110 and D1120 or D4210 and D4211 on same date of service.Documentation Required: Medical necessity narrative, date of service of periodontal evaluation, complete periodontal charting, appropriate diagnostic quality radiographs history of previous periodontal treatment and a statement concerning the member's periodontal condition.	Perio Charting, pre-op radiographs and narr of med necessity
D4346	scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	21 and older		No	Two of (D1110, D1120, D4346) per 1 Calendar year(s) Per patient.	

Exhibit D Benefits Covered for Adult HSN Limited Wrap

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5110	complete denture - maxillary	21 and older		No	One of (D5110) per 84 Month(s) Per patient. Complete treatment plan and prosthetic history. If the member still has natural teeth, a current series of periapical and bitewing films. X-rays are not required if the patient is edentulous.	
D5120	complete denture - mandibular	21 and older		No	One of (D5120) per 84 Month(s) Per patient. Complete treatment plan and prosthetic history. If the member still has natural teeth, a current series of periapical and bitewing films. X-rays are not required if the patient is edentulous.	
D5211	maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)	21 and older		No	One of (D5211) per 84 Month(s) Per patient. Pre-op radiographs of all teeth in arch with claim for prepayment review. Documentation must indicate that there are two or more missing posterior teeth or one or more missing anterior teeth, the remaining dentition is sound and there is a good prognosis.	
D5212	mandibular partial denture – resin base (includingretentive/clasping materials, rests, and teeth)	21 and older		No	One of (D5212) per 84 Month(s) Per patient. Pre-op radiographs of all teeth in arch with claim for prepayment review. Documentation must indicate that there are two or more missing posterior teeth or one or more missing anterior teeth, the remaining dentition is sound and there is a good prognosis.	
D5511	repair broken complete denture base, mandibular	21 and older		No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5512	repair broken complete denture base, maxillary	21 and older		No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	

Exhibit D Benefits Covered for Adult HSN Limited Wrap

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5520	replace missing or broken teeth - complete denture (each tooth)	21 and older	Teeth 1 - 32	No	Three of (D5520) per 12 Month(s) Per patient. Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5611	repair resin partial denture base, mandibular	21 and older		No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5612	repair resin partial denture base, maxillary	21 and older		No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5621	repair cast partial framework, mandibular	21 and older		No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5622	repair cast partial framework, maxillary	21 and older		No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5630	repair or replace broken retentive/clasping materials per tooth	21 and older	Teeth 1 - 32	No	One of (D5630) per 6 Month(s) Per patient per tooth. Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	

Exhibit D Benefits Covered for Adult HSN Limited Wrap

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5640	replace broken teeth-per tooth	21 and older	Teeth 1 - 32	No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5650	add tooth to existing partial denture	21 and older	Teeth 1 - 32	No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5660	add clasp to existing partial denture	21 and older	Teeth 1 - 32	No	Per tooth, add clasp to existing partial denture. Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5730	reline complete maxillary denture (chairside)	21 and older		No	One of (D5730, D5750) per 36 Month(s) Per patient. Fee for denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.	
D5731	reline complete mandibular denture (chairside)	21 and older		No	One of (D5731, D5751) per 36 Month(s) Per patient. Fee for denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.	
D5750	reline complete maxillary denture (laboratory)	21 and older		No	One of (D5730, D5750) per 36 Month(s) Per patient. Fee for denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.	
D5751	reline complete mandibular denture (laboratory)	21 and older		No	One of (D5731, D5751) per 36 Month(s) Per patient. Fee for denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.	

Exhibit D Benefits Covered for Adult HSN Limited Wrap

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Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7111	extraction, coronal remnants - primary tooth	21 and older	Teeth A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7220	removal of impacted tooth-soft tissue	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Only covered for teeth that are symptomatic, carious or pathologic.	
D7230	removal of impacted tooth-partially bony	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Only covered for teeth that are symptomatic, carious or pathologic.	
D7240	removal of impacted tooth-completely bony	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Removal of asymptomatic tooth not covered.	Narr of med necessity & full mouth xrays
D7250	surgical removal of residual tooth roots (cutting procedure)	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Only covered for teeth that are symptomatic, carious or pathologic.	
D7251	Coronectomy-intentional partial tooth removal intentional partial tooth removal is performed when a neurovascular complication is likely if the entire impacted tooth is removed.	21 and older	Teeth 1, 16, 17, 32	No	One of (D7251) per 1 Lifetime Per patient per tooth. Cannot be billed on same date of service with codes D7111, D7140, D7210, D7220, D7230, D7240, D7250, D7241. If D7251 is billed following any history of D7111, D7210, D7140, D7241, D7220, D7230, D7240, D7250 billed on the same tooth as code D7251, then deduct what was paid for D7251 from payment of new code.	
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	21 and older	Teeth 1 - 32	No		

Exhibit D Benefits Covered for Adult HSN Limited Wrap

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7310) per 6 Month(s) Per patient per quadrant. One of (D7310, D7311) per 1 Lifetime Per patient per quadrant. Limited to one per quadrant when performed within 6 months of initial alveoloplasty.	
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7311) per 6 Month(s) Per patient per quadrant. One of (D7310, D7311) per 1 Lifetime Per patient per quadrant. Limited to one per quadrant when performed within 6 months of initial alveoloplasty. Up to 3 teeth\tooth spaces per quad.	narrative of medical necessity
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7320) per 6 Month(s) Per patient per quadrant. One of (D7320, D7321) per 1 Lifetime Per patient per quadrant. No extractions performed in edentulous area. Limited to two per quadrant when the second procedure follows the first within 6 months.	narrative of medical necessity
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7321) per 6 Month(s) Per patient per quadrant. One of (D7320, D7321) per 1 Lifetime Per patient per quadrant. Limited to one per quadrant when performed within 6 months of initial alveoloplasty. Up to 3 teeth\tooth spaces per quad.	
D7340	vestibuloplasty - ridge extension (secondary epithelialization)	21 and older	Per Arch (01, 02, LA, UA)	Yes	Include justification of the surgical procedure designed to increase alveolar ridge height.	narrative of medical necessity
D7350	vestibuloplasty - ridge extension	21 and older	Per Arch (01, 02, LA, UA)	Yes	Only payable to dental provider w\specialty in oral surgery.	
D7410	radical excision - lesion diameter up to 1.25cm	21 and older		No		
D7411	excision of benign lesion greater than 1.25 cm	21 and older		No		
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	21 and older		No		Pathology report
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	21 and older		No		Pathology report

Exhibit D Benefits Covered for Adult HSN Limited Wrap

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	21 and older		No		Pathology report
D7461	removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm	21 and older		No		Pathology report
D7471	removal of exostosis - per site	21 and older	Per Arch (01, 02, LA, UA)	No	One of (D7471) per 1 Lifetime Per patient per arch. Only payable to dental provider w\specialty in oral surgery.	
D7472	removal of torus palatinus	21 and older		No	One of (D7472) per 1 Lifetime Per patient per arch. Only payable to a dental provider with a specialty in oral surgery	
D7473	removal of torus mandibularis	21 and older		No	One of (D7473) per 1 Lifetime Per patient per arch. Only payable to a dental provider with a specialty in oral surgery	
D7961	buccal / labial frenectomy (frenulectomy)	21 and older	Per Arch (01, 02, LA, UA)	No	One of (D7961) per 1 Lifetime Per patient per arch. The frenum may be excised when the tongue has limited mobility; for large diastemas between teeth; or when frenum interferes with a prosthetic appliance; or when it is the etiology of the periodontal tissue disease. Narrative describing location and medical necessity must be maintained in the patient record.	
D7962	lingual frenectomy (frenulectomy)	21 and older		No	One of (D7962, D7963) per 1 Lifetime Per patient. The frenum may be excised when the tongue has limited mobility; for large diastemas between teeth; or when frenum interferes with a prosthetic appliance; or when it is the etiology of the periodontal tissue disease. Narrative describing location and medical necessity must be maintained in the patient record.	
D7963	frenuloplasty	21 and older		No	One of (D7962, D7963) per 1 Lifetime Per patient. The frenum may be excised when the tongue has limited mobility; for large diastemas between teeth; or when frenum interferes with a prosthetic appliance; or when it is the etiology of the periodontal tissue disease. Narrative describing location and medical necessity must be maintained in the patient record.	

Exhibit D Benefits Covered for Adult HSN Limited Wrap

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7970	excision of hyperplastic tissue - per arch	21 and older	Per Arch (01, 02, LA, UA)	No	Not payable on the same date of service as an extraction (D7111-D7240) of the same tooth.	narrative of medical necessity

Exhibit D Benefits Covered for Adult HSN Limited Wrap

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Orthodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D8670	periodic orthodontic treatment visit	21 and older		Yes	Only covered for member whose comprehensive treatment had begun prior to age 21. One per 90 Day(s) Per patient. Allowed as quarterly treatment visit. (D8670). May not be billed less than 90 days from previous periodic orthodontic treatment visit. (D8670). May not be billed less than 90 days from previous banding date. (D8080, D8070, D8090). May not be billed prior to D8080 / D8070 / D8090.Only payable to a dental provider with a specialty of Orthodontics. Please see billing instructions in section 16 of the Office Reference Manual.	
D8680	orthodontic retention (removal of appliances)	21 and older		Yes	Five of (D8680) per 1 Lifetime Per patient. Only covered for member whose comprehensive treatment had begun prior to age 21. Only payable to dental provider whith a specialty of Orthodontics. Please see billing instructions in Section 16 of the Office Reference Manual.	
D8703	Replacement of lost or broken retainer - maxillary	21 and older		Yes	One of (D8703) per 2 Calendar year(s) Per patient. The MassHealth agency pays for replacement retainers only during the 2 year retention period following orthodontic treatment. Only payable to a dental provider with a specialty of Orthodontics. Statement regarding the date of the onset of retention.	
D8704	Replacement of lost or broken retainer - mandibular	21 and older		Yes	One of (D8704) per 2 Calendar year(s) Per patient. The MassHealth agency pays for replacement retainers only during the 2 year retention period following orthodontic treatment. Only payable to a dental provider with a specialty of Orthodontics. Statement regarding the date of the onset of retention.	

Exhibit D Benefits Covered for Adult HSN Limited Wrap

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Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9222	deep sedation/general anesthesia first 15 minutes	21 and older		No		
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	21 and older		No		
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	21 and older		No		
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	21 and older		No		
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	21 and older		No	Five of (D9243) per 1 Day(s) Per patient.	
D9248	non-intravenous moderate (conscious) sedation	21 and older		No		
D9450	case presentation, detailed and extensive treatment planning	21 and older		No	One of (D9450) per 1 Day(s) Per Provider. Per Member. Only payable when submitted with another payable service.	
D9920	behavior management, by report	21 and older		Yes	One of (D9920) per 1 Day(s) Per Provider OR Location. Narrative of medical necessity. Include a description of the members illness or disability and types of services to be furnished.	narrative of medical necessity
D9930	treatment of complications (post-surgical) - unusual circumstances, by report	21 and older		No	Include with claim the date, the location of the original surgery and the type of procedure.	narrative of medical necessity

Exhibit E Benefits Covered for Childrens Medical Security Plan

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0120	periodic oral evaluation - established patient	0-18		No	Two of (D0120, D0145) per 1 Calendar year(s) Per Provider OR Location. Not covered with D9110 by same provider or provider group on same date of service.	
D0140	limited oral evaluation-problem focused	0-18		No	Two of (D0140) per 1 Calendar year(s) Per patient. Not covered with D9110, D0160, D0180 by same provider or provider group on same date of service.	
D0145	oral evaluation for a patient under three years of age and counseling with primary caregiver	0-3		No	Two of (D0120, D0145, D0180) per 1 Calendar year(s) Per Provider OR Location. Cannot be billed on the same date of service as D0150.	
D0150	comprehensive oral evaluation - new or established patient	0-18		No	One of (D0150, D0180) per 1 Lifetime Per Provider OR Location. Cannot be billed on the same date of service as D0145.	
D0180	comprehensive periodontal evaluation - new or established patient	0-18		No	One of (D0180) per 1 Calendar year(s) Per Provider OR Location. Not covered with D9110, D0140, D0145, D0150 by same provider or provider group on same date of service.	
D0210	intraoral - complete series of radiographic images	6 - 18		No	One of (D0210) per 3 Calendar year(s) Per Provider OR Location. One complete series every three calendar years per patient per dentist or dental group. Any combination of radiographs that exceedsthe maximum allowable payment for a FMX will be reimbursed at the D0210 rate. Documentation of variation from ADA clinical guidelines to be kept in patient record.	
D0220	intraoral - periapical first radiographic image	0-18		No	One of (D0220) per 1 Day(s) Per Provider OR Location. Twelve of (D0220, D0230) per 12 Month(s) Per patient. Maximum of one per visit. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be reimbursed at the D0210 rate. Documentation of variation from ADA clinical guidelines to be kept in patient record.	

Exhibit E Benefits Covered for Childrens Medical Security Plan

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0230	intraoral - periapical each additional radiographic image	0-18		No	Three of (D0230) per 1 Day(s) Per Provider OR Location. Twelve of (D0220, D0230) per 12 Month(s) Per patient. Maximum of three per visit. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be reimbursed at the D0210 rate. Documentation of variation from ADA clinical guidelines to be kept in patient record.	
D0240	intraoral - occlusal radiographic image	0-4		No	Two of (D0240) per 1 Calendar year(s) Per Provider OR Location.	
D0270	bitewing - single radiographic image	0-18		No	Two of (D0270, D0272, D0273, D0274) per 1 Calendar year(s) Per Provider OR Location. One of (D0270, D0272, D0273, D0274) per 1 Day(s) Per patient. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be reimbursed at the D0210 rate. Documentation of variation from ADA clinical guidelines to be kept in patient record.	
D0272	bitewings - two radiographic images	0-18		No	Two of (D0270, D0272, D0273, D0274) per 1 Calendar year(s) Per Provider OR Location. One of (D0270, D0272, D0273, D0274) per 1 Day(s) Per patient. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be reimbursed at the D0210 rate. Documentation of variation from ADA clinical guidelines to be kept in patient record.	
D0273	bitewings - three radiographic images	0-18		No	Two of (D0270, D0272, D0273, D0274) per 1 Calendar year(s) Per Provider OR Location. One of (D0270, D0272, D0273, D0274) per 1 Day(s) Per patient. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be reimbursed at the D0210 rate. Documentation of variation from ADA clinical guidelines to be kept in patient record.	

Exhibit E Benefits Covered for Childrens Medical Security Plan

Diagnostic						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D0274	bitewings - four radiographic images	0-18		No	Two of (D0270, D0272, D0273, D0274) per 1 Calendar year(s) Per Provider OR Location. One of (D0270, D0272, D0273, D0274) per 1 Day(s) Per patient. Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be reimbursed at the D0210 rate. Documentation of variation from ADA clinical guidelines to be kept in patient record.	
D0330	panoramic radiographic image	0-18		No	One of (D0330) per 3 Year(s) Per Provider OR Location. (Not covered when billed with services related to Crowns, Endodontics, Periodontics, Restorations and Orthodontics).Not covered when the treating dentist is an orthodontist, endodontist, prosthodontist and periodontist.Non-surgical conditions. Surgical conditions are payable in excess of the 3 year limitation when used as a diagnostic tool. Any combination of radiographs thatexceeds the max allowable for a FMX will be reimbursed at the D0210 rate. Documentation of variation from ADA clinical guidelines to be kept in patient record.	
D0340	cephalometric radiographic image	0-18		No	Non-orthodontic procedures. Only payable to a dental provider with a specialty in oral surgery.	

Exhibit E Benefits Covered for Childrens Medical Security Plan

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1110	prophylaxis - adult	14 - 18		No	Two of (D1110, D1120, D4346) per 1 Calendar year(s) Per patient. Includes minor scaling procedures.	
D1120	prophylaxis - child	0-13		No	Two of (D1110, D1120, D4346) per 1 Calendar year(s) Per patient. Includes minor scaling procedures.	
D1206	topical application of fluoride varnish	0-18		No	One of (D1206, D1208) per 90 Day(s) Per Provider OR Location. Cannot be billed with D1208 on same date of service by the same provider or location.	
D1208	topical application of fluoride - excluding varnish	0-18		No	One of (D1206, D1208) per 90 Day(s) Per Provider OR Location. Cannot be billed with D1206 on same date of service by the same provider or location.	
D1351	sealant - per tooth	0-16	Teeth 1 - 3, 14 - 19, 30 - 32	No	One of (D1351) per 3 Year(s) Per Provider OR Location per tooth. Permanent first and second non-carious (occlusal surface) molars and non-carious (occlusal surface)third molars.	
D1354	interim caries arresting medicament application - per tooth	0-18	Teeth 1 - 32, A - T	No	Two of (D1354) per 1 Lifetime Per patient per tooth.	
D1510	space maintainer-fixed-unilateral - per quadrant- Excludes a distal shoe space maintainer.	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Four of (D1510, D1516, D1517, D1520, D1526, D1527, D1575) per 1 Lifetime Per patient. Must maintain radiographs in patient record demonstrating that the tooth has not begun to erupt or that migration of the adjacent tooth has already occurred. Excludes a Distal Shoe Maintainer.	
D1516	space maintainer --fixed--bilateral, maxillary	0-18		No	Four of (D1510, D1516, D1517, D1520, D1526, D1527, D1575) per 1 Lifetime Per patient. Must maintain radiographs in patient record demonstrating that the tooth has not begun to erupt or that migration of the adjacent tooth has already occurred. Excludes a Distal Shoe Maintainer.	

Exhibit E Benefits Covered for Childrens Medical Security Plan

Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1517	space maintainer --fixed--bilateral, mandibular	0-18		No	Four of (D1510, D1516, D1517, D1520, D1526, D1527, D1575) per 1 Lifetime Per patient. Must maintain radiographs in patient record demonstrating that the tooth has not begun to erupt or that migration of the adjacent tooth has already occurred. Excludes a Distal Shoe Maintainer.	
D1520	space maintainer-removable-unilateral – per quadrant.	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Four of (D1510, D1516, D1517, D1520, D1526, D1527, D1575) per 1 Lifetime Per patient. Must maintain radiographs in patient record demonstrating that the tooth has not begun to erupt or that migration of the adjacent tooth has already occurred. Excludes a Distal Shoe Maintainer.	
D1526	space maintainer --removable--bilateral, maxillary	0-18		No	Four of (D1510, D1516, D1517, D1520, D1526, D1527, D1575) per 1 Lifetime Per patient. Must maintain radiographs in patient record demonstrating that the tooth has not begun to erupt or that migration of the adjacent tooth has already occurred. Excludes a Distal Shoe Maintainer.	
D1527	space maintainer --removable--bilateral, mandibular	0-18		No	Four of (D1510, D1516, D1517, D1520, D1526, D1527, D1575) per 1 Lifetime Per patient. Must maintain radiographs in patient record demonstrating that the tooth has not begun to erupt or that migration of the adjacent tooth has already occurred. Excludes a Distal Shoe Maintainer.	
D1575	distal shoe space maintainer - fixed - unilateral- Per Quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	Four of (D1510, D1516, D1517, D1520, D1526, D1527, D1575) per 1 Lifetime Per patient. Must maintain radiographs in patient record demonstrating that the tooth has not begun to erupt or that the migration of the adjacent tooth has already occurred.	
D1701	Pfizer-BioNTech Covid-19 vaccine administration – first dose SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 1	0-18		No	One of (D1701) per 1 Lifetime Per patient.	
D1702	Pfizer-BioNTech Covid-19 vaccine administration – second dose SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 2	0-18		No	One of (D1702) per 1 Lifetime Per patient.	

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Preventative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D1703	Moderna Covid-19 vaccine administration – first dose SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 1	0-18		No	One of (D1703) per 1 Lifetime Per patient.	
D1704	Moderna Covid-19 vaccine administration – second dose SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 2	0-18		No	One of (D1704) per 1 Lifetime Per patient.	
D1707	Janssen Covid-19 vaccine administration SARSCOV2 COVID-19 VAC Ad26 5x1010 VP/.5mL IM SINGLE DOSE These dental procedure codes	0-18		No	One of (D1707) per 1 Lifetime Per patient.	
D1708	Pfizer-BioNTech Covid-19 vaccine administration – third dose	0-18		No	One of (D1708) per 1 Lifetime Per patient.	
D1709	Pfizer-BioNTech Covid-19 vaccine administration – booster dose	0-18		No		
D1710	Moderna Covid-19 vaccine administration – third dose	0-18		No	One of (D1710) per 1 Lifetime Per patient.	
D1711	Moderna Covid-19 vaccine administration – booster dose	0-18		No		
D1712	Janssen Covid-19 vaccine administration - booster dose	0-18		No		
D1713	Pfizer-BioNTech Covid-19 vaccine administration tris-sucrose pediatric – first dose	0-18		No	One of (D1713) per 1 Lifetime Per patient.	
D1714	Pfizer-BioNTech Covid-19 vaccine administration tris-sucrose pediatric – second dose	0-18		No	One of (D1714) per 1 Lifetime Per patient.	

Exhibit E Benefits Covered for Childrens Medical Security Plan

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Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2140	Amalgam - one surface, primary or permanent	0-18	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2150	Amalgam - two surfaces, primary or permanent	0-18	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2160	amalgam - three surfaces, primary or permanent	0-18	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2161	amalgam - four or more surfaces, primary or permanent	0-18	Teeth 1 - 32, A - T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2330	resin-based composite - one surface, anterior	0-18	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2331	resin-based composite - two surfaces, anterior	0-18	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	

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Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2332	resin-based composite - three surfaces, anterior	0-18	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	0-18	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2390	resin-based composite crown, anterior	0-18	Teeth 6 - 11, 22 - 27, C - H, M - R	No	One of (D2390) per 12 Month(s) Per patient per tooth.	
D2391	resin-based composite - one surface, posterior	0-18	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2392	resin-based composite - two surfaces, posterior	0-18	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2393	resin-based composite - three surfaces, posterior	0-18	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	

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Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2394	resin-based composite - four or more surfaces, posterior	0-18	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 1 Calendar year(s) Per Business per tooth, per surface. MH will not pay more than the multisurface rate for a restoration greater than 1 surface.	
D2710	crown - resin-based composite (indirect)	0-18	Teeth 3 - 14, 19 - 30	No	One of (D2710, D2740, D2750, D2751, D2752, D2790) per 60 Month(s) Per patient per tooth.	
D2740	crown - porcelain/ceramic	0-18	Teeth 2 - 15, 18 - 31	No	One of (D2710, D2740, D2750, D2751, D2752, D2790) per 60 Month(s) Per patient per tooth.	
D2750	crown - porcelain fused to high noble metal	0-18	Teeth 2 - 15, 18 - 31	No	One of (D2710, D2740, D2750, D2751, D2752, D2790) per 60 Month(s) Per patient per tooth.	
D2751	crown - porcelain fused to predominantly base metal	0-18	Teeth 2 - 15, 18 - 31	No	One of (D2710, D2740, D2750, D2751, D2752, D2790) per 60 Month(s) Per patient per tooth.	
D2752	crown - porcelain fused to noble metal	0-18	Teeth 2 - 15, 18 - 31	No	One of (D2710, D2740, D2750, D2751, D2752, D2790) per 60 Month(s) Per patient per tooth.	
D2790	crown - full cast high noble metal	0-18	Teeth 2 - 15, 18 - 31	No	One of (D2710, D2740, D2750, D2751, D2752, D2790) per 60 Month(s) Per patient per tooth.	
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	0-18	Teeth 2 - 15, 18 - 31	No	Not covered within 6 months of initial placement.	
D2920	re-cement or re-bond crown	0-18	Teeth 2 - 15, 18 - 31, A - T	No	Not covered within 6 months of initial placement.	
D2929	Prefabricated porcelain/ceramic crown – primary tooth	0-18	Teeth D - G, N - Q	No	Four of (D2929, D2930, D2931, D2932, D2934) per 1 Day(s) Per patient. Maximum of 4 per day if performed in an office setting. No limitation if performed in the OR or outpatient facility.	
D2930	prefabricated stainless steel crown - primary tooth	0-18	Teeth A - T	No	Four of (D2929, D2930, D2931, D2932, D2934) per 1 Day(s) Per patient. Maximum of 4 per day if performed in an office setting. No limitation if performed in the OR or outpatient facility.	

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Restorative						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D2931	prefabricated steel crown-permanent tooth	0-18	Teeth 2 - 5, 12 - 15, 18 - 21, 28 - 31	No	Four of (D2929, D2930, D2931, D2932, D2934) per 1 Day(s) Per patient. Maximum of 4 per day if performed in an office setting. No limitation if performed in the OR or outpatient facility.	
D2932	prefabricated resin crown	0-18	Teeth 1 - 32, A - T	No	Four of (D2929, D2930, D2931, D2932, D2934) per 1 Day(s) Per patient. Maximum of 4 per day if performed in an office setting. No limitation if performed in the OR or outpatient facility.	
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	0-18	Teeth C - H, M - R	No	Four of (D2929, D2930, D2931, D2932, D2934) per 1 Day(s) Per patient. Maximum of 4 per day if performed in an office setting. No limitation if performed in the OR or outpatient facility.	
D2950	core buildup, including any pins when required	0-18	Teeth 2 - 15, 18 - 31	No	One of (D2950, D2954) per 1 Day(s) Per patient per tooth.	
D2951	pin retention - per tooth, in addition to restoration	0-18	Teeth 2 - 15, 18 - 31	No	Must be billed with a two-or-more surface restoration on a permanent tooth.	
D2954	prefabricated post and core in addition to crown	0-18	Teeth 2 - 15, 18 - 31	No	One of (D2950, D2954) per 1 Day(s) Per patient per tooth.	
D2980	crown repair, by report	0-18	Teeth 2 - 15, 18 - 31	No	Chairside	

Exhibit E Benefits Covered for Childrens Medical Security Plan

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Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3120	pulp cap - indirect (excluding final restoration)	0-18	Teeth 1 - 32, A - T	No	Cannot be billed in conjunction with root canals on same date of service. (D3310, D3320 or D3330).	
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	0-18	Teeth 1 - 32, A - T	No	Cannot be billed in conjunction with root canals (D3310, D3320 or D3330).	
D3310	endodontic therapy, anterior tooth (excluding final restoration)	0-18	Teeth 6 - 11, 22 - 27	No	One of (D3310) per 1 Lifetime Per patient per tooth. No limitation on number performed per treatment. Cannot be billed in conjunction with D3120 on the same date of service.	
D3320	endodontic therapy, premolar tooth (excluding final restoration)	0-18	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	One of (D3320) per 1 Lifetime Per patient per tooth. Cannot be billed in conjunction with D3120 on the same date of service.	
D3330	endodontic therapy, molar tooth (excluding final restoration)	0-18	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	One of (D3330) per 1 Lifetime Per patient per tooth. Cannot be billed in conjunction with D3120 on the same date of service.	
D3346	retreatment of previous root canal therapy-anterior	0-18	Teeth 6 - 11, 22 - 27	No	Not payable to the same provider who performed the original endodontic therapy (D3310, D3320, or D3330) within 24 months.	
D3347	retreatment of previous root canal therapy - premolar	0-18	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	Not payable to the same provider who performed the original endodontic therapy (D3310, D3320, or D3330) within 24 months.	
D3348	retreatment of previous root canal therapy-molar	0-18	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	Not payable to the same provider who performed the original endodontic therapy (D3310, D3320, or D3330) within 24 months.	
D3410	apicoectomy - anterior	0-18	Teeth 6 - 11, 22 - 27	No	One of (D3410) per 1 Lifetime Per patient per tooth. Includes retrograde filling.	pre-operative x-ray(s)
D3421	apicoectomy - premolar (first root)	0-18	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	One of (D3421) per 1 Lifetime Per patient per tooth. Includes retrograde filling.	pre-operative x-ray(s)
D3425	apicoectomy - molar (first root)	0-18	Teeth 1 - 3, 14 - 19, 30 - 32	No	One of (D3425) per 1 Lifetime Per patient per tooth. Includes retrograde filling.	

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Endodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D3426	apicoectomy (each additional root)	0-18	Teeth 1 - 5, 12 - 21, 28 - 32	No	One of (D3426) per 1 Lifetime Per patient per tooth for Bicuspids. Two of (D3426) per 1 Lifetime Per patient per tooth for First and Second Molars. Includes retrograde filling.	

Exhibit E Benefits Covered for Childrens Medical Security Plan

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Periodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4210) per 3 Calendar year(s) Per patient per quadrant. Limited to two quadrants on the same date of service in an office setting. Not payable in conjunction with D1110 and D1120 or D4341 and D4342 on same date of service. Documentation Required :Diagnostic Quality Radiographs and Medical Necessity Narrative	narr. of med. necessity, pre-op x-ray(s)
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4211) per 3 Calendar year(s) Per patient per quadrant. Limited to two quadrants on the same date of service in an office setting. Not payable in conjunction with D1110 and D1120 or D4341 and D4342 on same date of service. Documentation Required :Diagnostic Quality Radiographs and Medical Necessity Narrative	narr. of med. necessity, pre-op x-ray(s)
D4341	periodontal scaling and root planing - four or more teeth per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4341, D4342) per 3 Calendar year(s) Per patient per quadrant. Two of (D4341, D4342) per 1 Day(s) Per Provider OR Location in office. Four of (D4341, D4342) per 1 Day(s) Per Provider OR Location in hospital. A minimum of four (4) affected teeth in the quadrant. Not payable in conjunction with D1110 and D1120 or D4210 and D4211 on same date of service.Documentation Required: Medical necessity narrative, date of service of periodontal evaluation, complete periodontal charting,appropriate diagnostic quality radiographs history of previous periodontal treatment and a statement concerning the member'speriodontal condition.	Perio Charting, pre-op radiographs and narr of med necessity

Exhibit E Benefits Covered for Childrens Medical Security Plan

Periodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D4342	periodontal scaling and root planing - one to three teeth per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D4341, D4342) per 3 Calendar year(s) Per patient per quadrant. Two of (D4341, D4342) per 1 Day(s) Per Provider OR Location in office. Four of (D4341, D4342) per 1 Day(s) Per Provider OR Location in hospital. Not payable in conjunction with D1110 and D1120 or D4210 and D4211 on same date of service.Documentation Required: Medical necessity narrative, date of service of periodontal evaluation, complete periodontal charting, appropriate diagnostic quality radiographs history of previous periodontal treatment and a statement concerning the member's periodontal condition.	Perio Charting, pre-op radiographs and narr of med necessity
D4346	scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	0-18		No	Two of (D1110, D1120, D4346) per 1 Calendar year(s) Per patient.	

Exhibit E Benefits Covered for Childrens Medical Security Plan

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5110	complete denture - maxillary	0-18		No	One of (D5110) per 84 Month(s) Per patient.	
D5120	complete denture - mandibular	0-18		No	One of (D5120) per 84 Month(s) Per patient.	
D5130	immediate denture - maxillary	0-18		No	One of (D5130) per 1 Lifetime Per patient.	
D5140	immediate denture - mandibular	0-18		No	One of (D5140) per 1 Lifetime Per patient.	
D5211	maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)	0-18		No	One of (D5211) per 84 Month(s) Per patient. One of (D5211, D5213, D5225) per 84 Month(s) Per patient. Pre-op radiographs of all teeth in arch with claim for prepayment review. Documentation must indicate that there are two or more missing posterior teeth or one or more missing anterior teeth, the remaining dentition is sound and there is a good prognosis.	pre-operative x-ray(s)
D5212	mandibular partial denture – resin base (includingretentive/clasping materials, rests, and teeth)	0-18		No	One of (D5212) per 84 Month(s) Per patient. One of (D5212, D5214, D5226) per 84 Month(s) Per patient. Pre-op radiographs of all teeth in arch with claim for prepayment review. Documentation must indicate that there are two or more missing posterior teeth or one or more missing anterior teeth, the remaining dentition is sound and there is a good prognosis.	pre-operative x-ray(s)
D5213	maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	0-18		No	One of (D5213) per 84 Month(s) Per patient. One of (D5211, D5213, D5225) per 84 Month(s) Per patient. Pre-op radiographs of all teeth in arch with claim for prepayment review. Documentation must indicate that there are two or more missing posterior teeth or one or more missing anterior teeth, the remaining dentition is sound and there is a good prognosis.	pre-operative x-ray(s)

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5214	mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	0-18		No	One of (D5214) per 84 Month(s) Per patient. One of (D5212, D5214, D5226) per 84 Month(s) Per patient. Pre-op radiographs of all teeth in arch with claim for prepayment review. Documentation must indicate that there are two or more missing posterior teeth or one or more missing anterior teeth, the remaining dentition is sound and there is a good prognosis.	pre-operative x-ray(s)
D5225	maxillary partial denture-flexible base	0-18		No	One of (D5225) per 84 Month(s) Per patient. One of (D5211, D5213, D5225) per 84 Month(s) Per patient. Pre-op radiographs of all teeth in arch with claim for prepayment review. Documentation must indicate that there are two or more missing posterior teeth or one or more missing anterior teeth, the remaining dentition is sound and there is a good prognosis.	pre-operative x-ray(s)
D5226	mandibular partial denture-flexible base	0-18		No	One of (D5226) per 84 Month(s) Per patient. One of (D5212, D5214, D5226) per 84 Month(s) Per patient. Pre-op radiographs of all teeth in arch with claim for prepayment review. Documentation must indicate that there are two or more missing posterior teeth or one or more missing anterior teeth, the remaining dentition is sound and there is a good prognosis.	pre-operative x-ray(s)
D5511	repair broken complete denture base, mandibular	0-18		No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5512	repair broken complete denture base, maxillary	0-18		No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	

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Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5520	replace missing or broken teeth - complete denture (each tooth)	0-18	Teeth 1 - 32	No	Three of (D5520) per 12 Month(s) Per patient. Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5611	repair resin partial denture base, mandibular	0-18		No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5612	repair resin partial denture base, maxillary	0-18		No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5621	repair cast partial framework, mandibular	0-18		No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5622	repair cast partial framework, maxillary	0-18		No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5630	repair or replace broken retentive/clasping materials per tooth	0-18	Teeth 1 - 32	No	One of (D5630) per 6 Month(s) Per patient per tooth. Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	

Exhibit E Benefits Covered for Childrens Medical Security Plan

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5640	replace broken teeth-per tooth	0-18	Teeth 1 - 32	No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5650	add tooth to existing partial denture	0-18	Teeth 1 - 32	No	Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5660	add clasp to existing partial denture	0-18	Teeth 1 - 32	No	Per tooth, add clasp to existing partial denture. Not allowed within 6 months of initial placement. All adjustments, repairs to acrylic or framework, as well as replacement and/or addition of any teeth to the prosthesis are considered part of the prosthetic code fee and are not billable.	
D5730	reline complete maxillary denture (chairside)	0-18		No	One of (D5730, D5750) per 24 Month(s) Per patient. Fee for denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.	
D5731	reline complete mandibular denture (chairside)	0-18		No	One of (D5731, D5751) per 24 Month(s) Per patient. Fee for denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.	
D5740	reline maxillary partial denture (chairside)	0-18		No	One of (D5740, D5760) per 24 Month(s) Per patient. Fee for denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.	
D5741	reline mandibular partial denture (chairside)	0-18		No	One of (D5741, D5761) per 24 Month(s) Per patient. Fee for denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.	

Exhibit E Benefits Covered for Childrens Medical Security Plan

Prosthodontics, removable						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D5750	reline complete maxillary denture (laboratory)	0-18		No	One of (D5750) per 24 Month(s) Per patient. One of (D5730, D5750) per 24 Month(s) Per patient. Fee for denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.	
D5751	reline complete mandibular denture (laboratory)	0-18		No	One of (D5751) per 24 Month(s) Per patient. One of (D5731, D5751) per 24 Month(s) Per patient. Fee for denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.	
D5760	reline maxillary partial denture (laboratory)	0-18		No	One of (D5760) per 24 Month(s) Per patient. One of (D5740, D5760) per 24 Month(s) Per patient. Fee for partial denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.	
D5761	reline mandibular partial denture (laboratory)	0-18		No	One of (D5761) per 24 Month(s) Per patient. One of (D5741, D5761) per 24 Month(s) Per patient. Fee for partial denture includes payment for any relines or rebases necessary within 6 months of dispensing date of the denture.	

Exhibit E Benefits Covered for Childrens Medical Security Plan

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Prosthodontics, fixed						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D6241	pontic-porcelain fused metal	0-18	Teeth 6 - 11, 22 - 27	No	One of (D6241) per 60 Month(s) Per patient per tooth.	
D6751	crown-porcelain fused to metal	0-18	Teeth 6 - 11, 22 - 27	No	One of (D6751) per 60 Month(s) Per patient per tooth.	
D6930	re-cement or re-bond fixed partial denture	0-18		No	Not covered within 6 months of placement.	
D6980	fixed partial denture repair	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No		

Exhibit E Benefits Covered for Childrens Medical Security Plan

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7111	extraction, coronal remnants - primary tooth	0-18	Teeth A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0-18	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No		
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	0-18	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Erupted surgical extractions are defined as extractions requiring elevation of a mucoperiosteal flap and removal of bone and/or section of the tooth and closure.	
D7220	removal of impacted tooth-soft tissue	0-18	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Only covered for teeth that are symptomatic, carious or pathologic.	
D7230	removal of impacted tooth-partially bony	0-18	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Only covered for teeth that are symptomatic, carious or pathologic.	
D7240	removal of impacted tooth-completely bony	0-18	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	Removal of asymptomatic tooth not covered.	Narr of med necessity & full mouth xrays
D7250	surgical removal of residual tooth roots (cutting procedure)	0-18	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	Only covered for teeth that are symptomatic, carious or pathologic.	

Exhibit E Benefits Covered for Childrens Medical Security Plan

Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7251	Coronectomy-intentional partial tooth removal intentional partial tooth removal is performed when a neurovascular complication is likely if the entire impacted tooth is removed.	0-18	Teeth 1, 16, 17, 32	No	One of (D7251) per 1 Lifetime Per patient per tooth. Cannot be billed on same date of service with codes D7111, D7140, D7210, D7220, D7230, D7240, D7250, D7241. If D7251 is billed following any history of D7111, D7210, D7140, D7241, D7220, D7230, D7240, D7250 billed on the same tooth as code D7251, then deduct what was paid for D7251 from payment of new code.	
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	0-18	Teeth 1 - 32	No		
D7280	Surgical access of an unerupted tooth	0-18	Teeth 1 - 32	No		
D7283	placement of device to facilitate eruption of impacted tooth	0-18	Teeth 1 - 32	No		
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7310) per 6 Month(s) Per patient per quadrant. One of (D7310, D7311) per 1 Lifetime Per patient per quadrant. Limited to one per quadrant when the second procedure follows the first within 6 months.	
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7311) per 6 Month(s) Per patient per quadrant. One of (D7310, D7311) per 1 Lifetime Per patient per quadrant. Limited to one per quadrant when the second procedure follows the first within 6 months.	
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7320) per 6 Month(s) Per patient per quadrant. One of (D7320, D7321) per 1 Lifetime Per patient per quadrant. No extractions performed in edentulous area. Limited to one per quadrant when the second procedure follows the first within 6 months.	narrative of medical necessity

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Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D7321) per 6 Month(s) Per patient per quadrant. One of (D7320, D7321) per 1 Lifetime Per patient per quadrant. No extractions performed on edentulous area. Limited to one per quadrant when the second procedure follows the first within 6 months.	
D7340	vestibuloplasty - ridge extension (secondary epithelialization)	0-18	Per Arch (01, 02, LA, UA)	Yes		narrative of medical necessity
D7350	vestibuloplasty - ridge extension	0-18	Per Arch (01, 02, LA, UA)	No	Only payable to a dental provider with a specialty in oral surgery	
D7410	radical excision - lesion diameter up to 1.25cm	0-18		No		
D7411	excision of benign lesion greater than 1.25 cm	0-18		No		
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	0-18		No	Pathology report.	
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	0-18		No	Pathology report.	
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	0-18		No	Pathology report.	
D7461	removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm	0-18		No	Pathology report.	
D7471	removal of exostosis - per site	0-18	Per Arch (01, 02, LA, UA)	No	One of (D7471) per 1 Lifetime Per patient per arch. Only payable to a dental provider with a specialty in oral surgery	
D7472	removal of torus palatinus	0-18		No	One of (D7472) per 1 Lifetime Per patient per arch. Only payable to a dental provider with a specialty in oral surgery	
D7473	removal of torus mandibularis	0-18		No	One of (D7473) per 1 Lifetime Per patient per arch. Only payable to a dental provider with a specialty in oral surgery	

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Oral and Maxillofacial Surgery						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D7961	buccal / labial frenectomy (frenulectomy)	0-18	Per Arch (01, 02, LA, UA)	No	One of (D7961) per 1 Lifetime Per patient per arch. The frenum may be excised when the tongue has limited mobility; for large diastemas between teeth; or when frenum interferes with a prosthetic appliance; or when it is the etiology of the periodontal tissue disease. Narrative describing location and medical necessity must be maintained in the patient record.	
D7962	lingual frenectomy (frenulectomy)	0-18		No	One of (D7962, D7963) per 1 Lifetime Per patient. The frenum may be excised when the tongue has limited mobility; for large diastemas between teeth; or when frenum interferes with a prosthetic appliance; or when it is the etiology of the periodontal tissue disease. Narrative describing location and medical necessity must be maintained in the patient record.	
D7963	frenuloplasty	0-18		No	One of (D7962, D7963) per 1 Lifetime Per patient. The frenum may be excised when the tongue has limited mobility; for large diastemas between teeth; or when frenum interferes with a prosthetic appliance; or when it is the etiology of the periodontal tissue disease. Narrative describing location and medical necessity must be maintained in the patient record.	
D7970	excision of hyperplastic tissue - per arch	0-18	Per Arch (01, 02, LA, UA)	No	Not payable on the same date of service as an extraction (D7111 - D7240) of the same tooth.	

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Orthodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D8010	limited orthodontic treatment of the primary dentition	6-14		Yes	Adjustments for interceptive orthodontic treatment must be requested under the D8999 code and will be approved for a maximum of five units. Please see billing instructions in section 16 of the OfficeReference Manual.	narrative of medical necessity
D8020	limited orthodontic treatment of the transitional dentition	6-14		Yes	Adjustments for interceptive orthodontic treatment must be requested under the D8999 code and will be approved for a maximum of five units. Please see billing instructions in section 16 of the OfficeReference Manual.	narrative of medical necessity
D8030	limited orthodontic treatment of the adolescent dentition	6-14		Yes	Adjustments for interceptive orthodontic treatment must be requested under the D8999 code and will be approved for a maximum of five units. Please see billing instructions in section 16 of the OfficeReference Manual.	narrative of medical necessity
D8040	limited orthodontic treatment of the adult dentition	6-14		Yes	Adjustments for interceptive orthodontic treatment must be requested under the D8999 code and will be approved for a maximum of five units. Please see billing instructions in section 16 of the OfficeReference Manual.	narrative of medical necessity
D8070	comprehensive orthodontic treatment of the transitional dentition	6 - 18		Yes	One of (D8070, D8080) per 1 Lifetime Per patient. Only payable to a dental provider with a specialty of Orthodontics. Please see billing instructions in section 16 of the Office Reference Manual.	
D8080	comprehensive orthodontic treatment of the adolescent dentition	6 - 18		Yes	One of (D8070, D8080) per 1 Lifetime Per patient. Only payable to a dental provider with a specialty of Orthodontics. Please see billing instructions in section 16 of the Office Reference Manual.	
D8660	pre-orthodontic treatment examination to monitor growth and development	6-20		Yes	One of (D8660) per 6 Month(s) Per Provider OR Location. Not billable after D8080, D8070, D8090, D8670, D8680 has been paid. Only payable to a dental provider with a speciality in orthodontics. Please see billing instructions in section 16 of the Office Reference Manual.	

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Orthodontics						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D8670	periodic orthodontic treatment visit	6 - 18		Yes	One per 90 Day(s) Per patient. Allowed as quarterly treatment visits. May not be billed less than 90 days from previous periodic orthodontic treatment visit. (D8670). May not be billed less than 90 days from previous banding date. (D8080, D8070, D8090). May not be billed prior to D8080 / D8070 / D8090. Only payable to a dental provider with a specialty of Orthodontics. Please see billing instructions in section 16 of the Office Reference Manual.	
D8680	orthodontic retention (removal of appliances)	6 - 18		No	Five of (D8680) per 1 Lifetime Per patient. Only payable to a dental provider with a specialty of Orthodontics. Please see billing instructions in Section 16 of the Office Reference Manual.	
D8703	Replacement of lost or broken retainer - maxillary	8 - 18		Yes	One of (D8703) per 2 Calendar year(s) Per patient. The MassHealth agency pays for replacement retainers only during the 2 year retention period following orthodontic treatment. Only payable to a dental provider with a specialty of Orthodontics. Statement regarding the date of the onset of retention.	
D8704	Replacement of lost or broken retainer - mandibular	8 - 18		Yes	One of (D8704) per 2 Calendar year(s) Per patient. The MassHealth agency pays for replacement retainers only during the 2 year retention period following orthodontic treatment. Only payable to a dental provider with a specialty of Orthodontics. Statement regarding the date of the onset of retention.	
D8999	unspecified orthodontic procedure, by report	6-14		Yes	Five of (D8999) per 1 Lifetime Per patient. This code is used exclusively for interceptive orthodontic adjustments and will be approved for up to a maximum of 5 units. When requesting other unspecified orthodontic services please use the D9999 code. Please see billing instructions in section 16 of the Office Reference Manual.	

Exhibit E Benefits Covered for Childrens Medical Security Plan

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Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9110	palliative (emergency) treatment of dental pain - minor procedure	0-18		No	Other non-emergency medically necessary treatment may be provided during the same visit. Not covered with D0120,D0140,D0160, D0180 by same provider or provider group on same date of service.	
D9222	deep sedation/general anesthesia first 15 minutes	0-18		No		
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	0-18		No		
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	0-18		No	The routine administration of inhalation analgesia or oral sedation is generally considered part of the treatment procedure, unless its use is documented in the patient record as necessary to complete treatment	
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	0-18		No		
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	0-18		No	Five of (D9243) per 1 Day(s) Per patient.	
D9248	non-intravenous moderate (conscious) sedation	0-18		No		
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	6-20		No	One of (D9310) per 6 Month(s) Per patient. Not billable after D8080, D8070, D8090, D8670, D8680, D8660 has paid. Only payable to a dental provider with a specialty of orthodontics. Please see billing instructions in section 16 of the Office Reference Manual.	
D9410	house/extended care facility call	0-18		No	One of (D9410) per 1 Day(s)Per Business,Per facility. Claim must be submitted with one of the following place of service (POS)codes to be considered for payment (03,04,12,13,14,31,32,33,34,or 99). Facility name and address must be placed on the claim form in the narratives section.	

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Adjunctive General Services						
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Authorization Required**	**Benefit Limitations**	**Documentation Required**
D9450	case presentation, detailed and extensive treatment planning	0-18		No	One of (D9450) per 1 Day(s) Per Provider. Per Member. Only payable when submitted with another payable service.	
D9920	behavior management, by report	0-18		Yes	One of (D9920) per 1 Day(s) Per Provider OR Location. Include a description of the members illness or disability and types of services to be furnished.	narrative of medical necessity
D9930	treatment of complications (post-surgical) - unusual circumstances, by report	0-18		No		narrative of medical necessity
D9941	fabrication of athletic mouthguard	0-18		No	One of (D9941) per 1 Calendar year(s) Per patient.	
D9945	occlusal guard--soft appliance full arch	0-18	Per Arch (01, 02, LA, UA)	No	One of (D9945) per 1 Year(s) Per patient.	