BlueCross BlueShield Arizona
An Independent Licensee of the Blue Cross Blue Shield Association
Health Choice

BCBSAZ HEALTH CHOICE 2025 DENTAL BENEFITS

FOR MEMBERS UNDER 21

AHCCCS covers clinical oral examinations and radiographs for EPSDT members ages birth through 20 years of age. The following criteria is based on BCBSAZ Health Choice's interpretation of the clinical oral examinations and radiographs when it considers the clinical oral examination medically/ dentally necessary. Clinical oral examinations and radiographs do not require authorization.

Reimbursement for radiographs includes exposure of radiograph, developing, mounting and radiographic interpretation. The appropriate number of radiographs needed for proper diagnosis and the evaluation of the overall dental condition must accompany all requests for prior authorization.

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

a. Child – Primary Dentition: Posterior bitewings and/or upper/lower occlusal films
b. Child – Transitional dentition: Posterior bitewings, appropriate periapical, and occlusal radiographs as needed based on a patient's individual requirement.
c. Adolescent (ages 16 – 20) – Permanent dentition prior to eruption of third molars: Full mouth periapical series with posterior bitewings or panoramic x-ray with posterior bitewings.
d. For Adult (21 and over) emergency dental benefits, radiographs are limited to symptomatic teeth only. Please refer to the Dental Matrix for members over 21.

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

A panoramic radiograph submitted with bitewing radiographs and/or single periapical films are reimbursed at the FMX rate. A panoramic radiograph is not reimbursable within 12 months of bitewing radiographs when taken by the same provider or group.

Radiographs requested for orthodontic treatment are not covered unless orthodontic treatment has been approved by us for medical necessity (i.e., craniofacial deformity or sever handicapping malocclusions). Radiographs will automatically be included in an approved authorization for orthodontic treatment.

BCBSAZ Health Choice reimbursement for CBCT is limited to the following:

a. Endo evaluation or treatment involving multi-rooted teeth and the retreatment of mandibular anterior teeth (endodontic failures).

b. Complete diagnosis and treatment planning of third molars and Supernumerary teeth removal.

c. Complete diagnosis and treatment planning of orthodontic/orthognathic cases involving CRS members or medical exception cases.

All radiographs must be of good diagnostic quality, properly mounted, dated, positionally oriented, and identified with the member's name and AHCCCS ID. Reduced size radiographs (panoramic, bitewings, periapical x-rays) are not acceptable. We will not pay for non-diagnostic x-rays. The cost of all materials and equipment used shall be included in the fee for the radiograph. Radiographs should only be taken when there is an expectation that the diagnostic yield will affect care. Diagnostic and preventive services are subject to retro review.

DIAGNOSTIC					
CODE	DESCRIPTION	AGE LIMITATION	AUTHORIZATION REQUIRED	BENEFIT LIMITATIONS	DOCUMENTATION REQUIRED
D0120	Periodic oral evaluation - established patient	0-20	No	Two per year	
D0140	Limited oral evaluation- problem focused (Emergency Dental Services only)	0-20	No	Not reimbursable on the same day as D0120, D0145, D0150, D0160, or D0170, D9110, D9310, D9430	
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	0-2	No	One (D0120, D0145, D0150, D0180) per 6 months per provider/group. Not allowed with non-emergency definitive treatment.	
D0150	Comprehensive oral evaluation - new or established patient	0-20	No	Limited to one D0150 per provider/ group per lifetime. Not payable on same DOS as D0120, D0145 or D0160	
D0160	Detailed and extensive oral eval-problem focused, by report	0-20	No	Not allowed on the same DOS as D0120, D0145, D0150, or D0180.	
D0171	Re-evaluation post operative office visit	0-20	No		
D0180	Comprehensive periodontal evaluation - new or established patient	0-20	Yes	One of (D0180) per 1 calendar year, per provider/ group.	Treatment notes required
D0190	Screening of a patient		No	One of (D0190, D0191) per 6 months. Not billable within six months of D0120, D0145, D0150.	
D0191	Assessment of a patient		No	One of (D0190, D0191) per 6 months. Not billable within six months of D0120, D0145, D0150.	
D0210	Intraoral - complete series of radiographic images (including bitewings)	6-20	No	Once every 36 Months. Not payable within 12 months of (D0272, D0274, D0277) or within 36 months of (D0330) Minimum of 14 films that consists of a minimum of 2 bitewing x-rays	
D0220	Intraoral - periapical first radiographic image	0-20	No	One of (D0220) per 1 day per provider/ group.	
D0230	Intraoral - periapical each additional radiographic image	0-20	No	Five of (D0230) per 1 day per provider/group. Additional films require documentation to establish medical necessity	
D0240	Intraoral - occlusal radiographic image	0-20	No	Limited to two films per DOS in a 12-month period	
D0250	Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	0-20	Yes	Once per 12 months	Treatment notes required; narrative of medical necessity
D0251	Extra-oral posterior dental radiographic image	0-20	Yes	Once per 12 months.	

CODE	DESCRIPTION	AGE LIMITATION	AUTHORIZATION REQUIRED	BENEFIT LIMITATIONS	DOCUMENTATION REQUIRED
D0270	Bitewing - single radiographic image	2-20	No	One per 6 months. Not payable within 12 months of D0210, D0277, or D0330.	
D0272	Bitewings - two radiographic images	2-20	No	One of (D0272, D0273, D0274) per 6 months. Not payable within 12 months of D0210, D0277, or D0330.	
D0273	Bitewings - three radiographic images	10-20	No	One of (D0272, D0273, D0274) per 6 months. Not payable Within 12 months of D0210, D0277, or D0330.	
D0274	Bitewings - four radiographic images	10-20	No	One of (D0272, D0273, D0274) per 6 months. Not payable Within 12 months of D0210, D0277, or D0330.	
D0277	Vertical bitewings - 7 to 8 films	0-20	No	One of (D0210, D0277, D0330) per 36 months.	
D0290	Posterior-anterior or lateral skull and facial bone survey radiographic image	0-20	Not covered by AHCCCS		
D0310	Sialography	0-20	Yes		Treatment notes required; narrative of medical necessity
D0320	Temporomandibular joint arthrogram, including injection	0-20	Yes		Treatment notes required; narrative of medical necessity
D0321	Other temporomandibular joint films, by report	0-20	Yes		Treatment notes required; narrative of medical necessity
D0330	Panoramic radiographic image	6-20 3-5	No Yes (under 6)	One of (D0330) per 36 months Three of (D0330) per lifetime. Not payable within 12 months of (D0270-D0274) when billed by the same provider or group.	When member is under 6 years of age Treatment notes required; narrative of medical necessity
D0340	Cephalometric radiographic image	0-20	Yes		Treatment notes required; narrative of medical necessity
D0350	2D oral/facial Photographic image obtained intra-orally or extra-orally	0-20	Yes		Treatment notes required; narrative of medical necessity

CODE	DESCRIPTION	AGE LIMITATION	AUTHORIZATION REQUIRED	BENEFIT LIMITATIONS	DOCUMENTATION REQUIRED
D0364	Cone beam CT capture and interpretation with limited field of view-less than one whole jaw	0-20	Yes	Frequency limit is 4 per year and daily limit of 2	Treatment notes required; narrative of medical necessity
D0367	Cone beam CT capture and interpretation with field of view of both jaws	0-20	Yes	Frequency limit is 4 per year and daily limit of 1	Treatment notes required; narrative of medical necessity
D0372	Intraoral tomosynthesis-comprehensive series of radiographic images	0-20	No	Once every 36 months. Cannot be billed with D0210	
D0373	Intraoral tomosynthesis-bitewing radiographic image	0-20	No	Once every 6 months. Cannot be billed with D0272, D0273, or D0274	
D0374	Intraoral tomosynthesis-periapical radiographic image	0-20	No	One of (D0374) per 1 day per provider/group. Cannot be billed with D0220, or D0230	
D0388	Intraoral tomosynthesis-bitewing radiographic image- Image capture only	0-20	No	Once every 6 months. Must be billed with teledentistry codes D9995 or D9996	
D0389	Intraoral tomosynthesis-periapical radiographic image-Image capture only	0-20	No	One of (D0389) per 1 day per Provider or Group. Must be billed with teledentistry codes D9995 or D9996	
D0393	Treatment simulation using 3D image volume	0-20	No		
D0396	3D Printing of a 3D dental surface scan	0-20	**Yes**		Treatment notes and preoperative x-ray(s)
D0470	Diagnostic casts	0-20	Yes		Treatment notes and preoperative x-ray(s)
D0502	Other oral pathology procedures, by report	0-20	No		
D0604	Antigen testing for a public health related pathogen, including coronavirus	0-20	No		
D0605	Antibody testing for a public health related pathogen, including coronavirus	0-20	No		
D0701	Panoramic radiographic image- capture only	6-20 1-5	No Yes (under 6)	Must be billed with one of the teledentistry codes (D9995 or D9996)	When member is under 6 years of age Treatment notes required; narrative of medical necessity
D0702	2-D cephalometric radiographic image-image capture only	0-20	Yes	Must be billed with one of the teledentistry codes (D9995 or D9996)	Treatment notes required; narrative of medical necessity
D0703	2-D oral/facial photographic image obtained intra-orally or extra -orally image capture only	0-20	Yes	Must be billed with one of the teledentistry codes (D9995 or D9996)	Treatment notes required; narrative of medical necessity
D0705	Extra oral posterior dental radiographic	0-20	No	Must be billed with one of the teledentistry codes (D9995 or D9996)	

CODE	DESCRIPTION	AGE LIMITATION	AUTHORIZATION REQUIRED	BENEFIT LIMITATIONS	DOCUMENTATION REQUIRED
D0706	Intraoral-occlusal radiographic image- image capture only	0-20	No	Must be billed with one of the teledentistry codes (D9995 or D9996)	
D0707	Intraoral-periapical radiographic image- image capture only	0-20	No	Must be billed with one of the teledentistry codes (D9995 or D9996)	
D0708	Intraoral-bitewing radiographic image-image capture only.	0-20	No	Must be billed with the teledentistry codes (D9995 or D9996)	
D0709	Intraoral- complete series of radiographic images-image capture only.	0-20	No	Must be billed with the teledentistry codes (D9995 or D9996) One per 36 months	
D0999	Unspecified diagnostic procedure, by report	0-20	**Yes**		Treatment notes required, narrative of medical necessity

AHCCCS covers preventive dental services for members from birth through 20 years of age as specified in the AHCCCS EPSDT Periodicity Schedule and/or when considered medically necessary. The following criteria is based on our interpretation of preventive dental treatment when it considers the treatment necessary based on medical or dental need. Child (0-13 years) and adult (14-20 years) prophylaxis are covered once every 6 months. Fluoride varnish (D1206) may be applied four times a year (i.e., one every three months) for members up to two (2) years of age.

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

Space maintainers are covered for members 0-14 years of age when determined to be medically/dentally indicated due to the premature loss of posterior primary molars and when the following conditions exist:

a. There is bone above the erupting permanent tooth.

b. There is adequate space to be maintained.

c. For missing primary first molars, permanent first molars have not erupted.

We will allow one space maintainer per lifetime when billed by the provider or group who originally placed the space maintainer. We will reimburse for re-cementation of a fixed space maintainer one year following initial placement, if necessary, when placed by the same provider or group. Subsequently re-cementation once per year as needed. The Plan will not reimburse for the removal of a fixed space maintainer (D1556, D1557, D1558) when the appliance is placed by the same provider or group. We will not approve a space maintainer for first primary molars when the first permanent molar has erupted. Space maintainers must receive a prior authorization except when billed on the same date of service as an emergency extraction of a primary posterior tooth and when it meets the above- described dental criteria. Treatment notes and radiographs are required with claim submission.

PREVENTIVE					
CODE	DESCRIPTION	AGE LIMITATION	AUTHORIZATION REQUIRED	BENEFIT LIMITATIONS	DOCUMENTATION REQUIRED
D1110	Prophylaxis - adult	14-20	No	Two of (D1110, D1120) per one year. Includes scaling and polishing procedures to remove coronal plaque, calculus, and stains.	
D1120	Prophylaxis - child	0-13	No	Two of (D1110, D1120) per one year	
D1206	Topical application of fluoride varnish	0-20	No	Allowed 4 times per year per patient	
D1208	Topical application of fluoride - excluding varnish	0-20	No	Allowed 4 times per year per patient	
D1320	Tobacco counseling for the control and prevention of oral disease.	0-20	No	Once per 6 months.	
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use.	0-20	No	Once per 6 months.	
D1351	Sealant - per tooth	5-14	No	Permanent first and second molars only - teeth #2, 3, 14, 15, 18, 19, 30, 31 One of (D1351, D1352) per 36 Months per provider/group per tooth. 2 per lifetime per tooth. Teeth must be caries free. Sealants will not be covered when placed on decayed or restored teeth.	
D1352	Preventive resin restoration is a moderate to high caries risk patient perm tooth conservative rest of an active cavitated lesion in a pit or fissure that doesn't extend into dentin: includes placement of a sealant in radiating non-carious fissure or pits.	5-14	No	Permanent first and second molars only - teeth #2, 3, 14, 15, 18, 19, 30, 31 One of (D1351, D1352) per 36 Months per provider/group per tooth. 2 per lifetime per tooth. Teeth must be caries free. Sealants will not be covered when placed on decayed or restored teeth.	
D1353	Sealant Repair-per tooth	5-14	No	Permanent first and second molars only - teeth #2, 3, 14, 15, 18, 19, 30, 31 One of (D1351 or D1353) per provider/ group, per 36 months.	
D1354	SDF-Interim caries arresting medicament application	0-20	No	Allowed 4 times per year. Limit of 5 teeth per day. Initial placement, 3 months after, 6 months after and 1 year after initial placement. If tooth is restored or extracted within 6 months of D1354, the dollar amount for D1354 may be recouped.	
D1355	Caries preventive medicament application-per tooth.	0-20	No	Allowed 4 times per tooth per year. Limit of 5 teeth per day.	

CODE	DESCRIPTION	AGE LIMITATION	AUTHORIZATION REQUIRED	BENEFIT LIMITATIONS	DOCUMENTATION REQUIRED
D1510	Space maintainer-fixed unilateral	0-14	Yes	Teeth A, B, I, J, K, L, S, T One of (D1510, D1520) per lifetime per patient per tooth when billed by the same provider/ group. For posterior primary teeth lost prematurely. Indicate missing tooth numbers and arch quadrant on claim. Payable on seat date only.	Treatment notes, pre- operative x-ray(s) Indicate missing tooth numbers on claim. Payable on seat date only.
D1516	Space maintainer - fixed – bilateral maxillary	0-14	Yes	Teeth A, B, I, J One of (D1516, D1526) per lifetime per patient per arch when billed by the same provider or group. For posterior primary teeth lost prematurely. Payable on seat date only.	Treatment notes, preoperative x-ray(s) Indicate missing tooth numbers on claim. Payable on seat date only.
D1517	Space maintainer- fixed- bilateral mandibular	0-14	Yes	Teeth K, L, S, T One of (D1517, D1527) per lifetime per patient per arch when billed by the same provider or group. For posterior primary teeth lost prematurely. Payable on seat date only.	Treatment notes, preoperative x-ray(s) Indicate missing tooth numbers on claim. Payable on seat date only.
D1520	Space maintainer removable-unilateral	0-14	Yes	Teeth A, B, I, J, K, L, S, T One of (D1510, D1520) per lifetime per patient per tooth. For posterior primary teeth lost prematurely. Payable on seat date only.	Treatment notes, preoperative x-ray(s) Indicate missing tooth numbers on claim. Payable on seat date only.
D1526	Space maintainer removable-bilateral maxillary	0-14	Yes	Teeth A, B, I, J One of (D1516, D1526) per lifetime per patient per tooth when billed by the same provider or group. For posterior primary teeth lost prematurely. Payable on seat date only.	Treatment notes, pre- operative x-ray(s) Indicate missing tooth numbers on claim. Payable on seat date only.
D1527	Space maintainer removable-bilateral mandibular	0-14	Yes	Teeth K, L, S, T One of (D1527, D1517) per lifetime per patient per tooth when billed by the same provider or group. For posterior primary teeth lost prematurely. Payable on seat date only.	Treatment notes, preoperative x-ray(s)
D1551	Re-cement or re-bond bi-lateral space maintainer-maxillary	0-20	No	Not allowed within 12 months of placement when billed by the same provider/ group.	
D1552	Re-cement or re-bond bi-lateral space maintainer-mandibular	0-20	No	Not allowed within 12 months of placement when billed by the same provider OR group.	
D1553	Re-cement or re-bond unilateral space maintainer- per quadrant	0-20	No	Not allowed within 12 months of placement when billed by the same provider OR group.	

D1556	Removal of fixed unilateral space maintainer per quadrant	0-20	No	Only when completed by dentist or practice that DID NOT place appliance	
D1557	Removal of fixed bi-lateral space maintainer-maxillary	0-20	No	Only when completed by dentist or practice that DID NOT place appliance	
D1558	Removal of fixed bi-lateral space maintainer-mandibular	0-20	No	Only when completed by dentist or practice that DID NOT place appliance	
D1575	Distal shoe space maintainer-fixed-unilateral	0-14	Yes	Teeth A, B, I, J, K, L, S, T One of (D1575) per lifetime per patient per group when billed by the same provider or group. For posterior primary teeth lost prematurely. Indicate missing tooth numbers on claim. Payable on seat date only.	Treatment notes, pre-operative x-ray(s)
D1999	Unspecified preventive procedure, by report	0-20	Yes	Narrative describing service.	Treatment notes narrative of medical necessity

AHCCCS covers the restoration of carious and/or fractured permanent and primary teeth with accepted dental materials other than cast or porcelain restorations for members, birth through age 20 when the treatment is considered medically/dentally necessary. Cast or porcelain restorations will be considered when a member is 18 through 20 years of age and has had endodontic treatment and when considered medically/dentally necessary. A functional stainless- steel crown is considered an acceptable permanent restoration. The following criteria are based on our interpretation of tooth restorations when it considers the placement medically/dentally necessary and when a tooth would be considered restorable. Routine restorations do not based on the number of surfaces restored, not on the number of restorations per surface per tooth. We will reimburse for anterior restorations for primary anterior tooth or teeth when it is determined to be medically/dentally necessary upon review by the Dental Director. Restoration of deciduous teeth when exfoliation is reasonably imminent will not be routinely reimbursable and is determined by the Dental Director.

A child who is 5 years of age or older with a decayed primary anterior tooth or teeth regardless of arch location, may be considered for extraction when pain is

require authorization.

We consider amalgam restorations as an accepted dental material for routine restorations. Fees for amalgam and composite restorations include tooth preparations, all adhesives (including amalgam and composite bonding agents), acid etching, cavity liners, bases and curing. Placement of posterior composite resin restorations are allowed but will be reimbursed at the posterior amalgam fees. Reimbursement We will not reimburse for the replacement of a “lost” or “defective/poor quality” restoration within 24-months of initial placement when the replacement is billed by the provider or group who originally placed the restoration. Payment is made for restorative services

present or when the tooth or teeth are severely broken down, structurally, or the tooth may be considered for observation at point of exfoliation as determined by the Dental Director.

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

i. The tooth presents with greater than a 75% loss of the clinical crown.
ii. The tooth has less than 50% bone support.
iii. The tooth exhibits furcal radiolucent lesions or decay.
iv. The tooth is a primary tooth with exfoliation imminent.
v. The tooth apex is surrounded by severe pathologic destruction of the bone.
vi. The overall dental condition (i.e., periodontal and decay experience) of the patient is such that an alternative treatment plan (LEPAAT) would be better suited to meet the patient's needs.
vii. The inability to access all canals on a multi- canal tooth for endodontic treatment.
viii. The tooth presents with external and/or internal root resorption.
ix. The tooth has a root fracture.
x. Decay extends below the crest of the bone.
xi. Failure of endodontically retreated teeth will be deemed non-restorable.
i. Loss of interproximal space (from adjacent tooth movement) which affects the ability of restoring a tooth to its proper contours and manageable margins.

RESTORATIVE					
CODE	**DESCRIPTION**	**AGE LIMITATION**	**AUTHORIZATION REQUIRED**	**BENEFIT LIMITATIONS**	**DOCUMENTATION REQUIRED**
D2140	Amalgam-One surface, primary or permanent	0-20	No	Teeth 1-5, 12-16, 17-21, 28-32, A, B, I, J, K, L, S, T One of (D2140, D2150, D2160, D2161, D2391, D2392, D2393, D2394) per 24 months per tooth, per surface per provider/ group.	
D2150	Amalgam - two surfaces, primary or permanent	0-20	No	Teeth 1-5, 12-16, 17-21, 28-32, A, B, I, J, K, L, S, T One of (D2140, D2150, D2160, D2161, D2391, D2392, D2393, D2394) per 24 months per tooth, per surface per provider/ group.	
D2160	Amalgam – three surfaces, primary or permanent	0-20	No	Teeth 1-5, 12-16, 17-21, 28-32, A, B, I, J, K, L, S, T One of (D2140, D2150, D2160, D2161, D2391, D2392, D2393, D2394) per 24 months per tooth, per surface per provider/ group.	
D2161	Amalgam - four or more surfaces, primary or permanent	0-20	No	Teeth 1-5, 12-16, 17-21, 28-32, A, B, I, J, K, L, S, T One of (D2140, D2150, D2160, D2161, D2391, D2392 D2393, D2394) per 24 months per tooth, per surface per provider/ group.	
D2330	Resin-based composite - one surface, anterior	0-20	No	Teeth 6 - 11, 22-27, C-H, M-R One of (D2330, D2331, D2332, D2335) per 24 months per tooth, per surface per provider/ group.	
D2331	Resin-based composite	0-20	No	Teeth 6 - 11, 22-27, C-H, M-R One of (D2330, D2331, D2332, D2335) per 24 months per tooth, per surface per provider/ group.	

CODE	DESCRIPTION	AGE LIMITATION	AUTHORIZATION REQUIRED	BENEFIT LIMITATIONS	DOCUMENTATION REQUIRED
D2332	Resin-based composite	0-20	No	Teeth 6 - 11, 22-27, C-H, M-R One of (, D2330, D2331, D2332, D2335) per 24 months per tooth, per surface per provider/ group.	
D2335	Resin-based composite-four or more surfaces or involving incisal angle (anterior)			Teeth 6 -11, 22-27, C-H, M-R One of (D2330, D2331, D2332, D2335, D2390) per 24 months, per tooth, per provider group. BCBSAZ Health Choice will not reimburse for additional surfaces performed on the same tooth within 12 months of initial billed (D2335).	
D2390	Resin-based composite crown anterior	0-20	Yes	Teeth 6 -11, 22-27, C-H, M-R One per 24 months.	Treatment notes and preoperative x-ray(s) of adjacent and opposing teeth for reimbursement.
D2391	Resin-based composite-one surface, posterior	0-20	No	Teeth 1 -5, 12-16, 17-21, 28-32, A, B, I, J, K, L, S, T One of (D2140, D2150, D2160, D2161, D2391, D2392, D2393, D2394,) per 24 months per tooth, per surface per provider/ group.	
D2392	Resin-based composite-two surfaces, posterior	0-20 e	No	Teeth 1 -5, 12-16, 17-21, 28-32, A, B, I, J, K, L, S, T One of (D2140, D2150, D2160, D2161, D2391, D2392, D2393, D2394) per 24 months per tooth, per surface per provider/ group.	
D2393	Resin-based composite- three surfaces, posterior	0-20	No	Teeth 1 -5, 12-16, 17-21, 28-32, A, B, I, J, K, L, S, T One of (D2140, D2150, D2160, D2161, D2391, D2392, D2393, D2394) per 24 months per tooth, per surface per provider/ group.	
D2394	Resin-based composite - four or more surfaces, posterior	0-20	No	Teeth 1 -5, 12-16, 17-21, 28-32, A, B, I, J, K, L, S, T One of (D2140, D2150, D2160, D2161, D2391, D2392, D2393, D2394) per 24 months per tooth, per surface per provider/ group.	

AHCCCS covers the placement of stainless-steel crowns on posterior primary and permanent teeth when medically/ dentally necessary. The following criteria are based on our interpretation of the placement of stainless-steel crowns when it considers the placement medically/ dentally necessary. Endodontic therapy does not always necessitate the placement of a SSC or a SSC done not always necessitate the need for endodontic therapy. The Plan will not reimburse a provider or group for the replacement of a "lost" or damaged crown within 36 months of initial placement when the replacement is billed by the provider or practice who originally placed the crown. We will not reimburse for an improper fitted SSC placed by the same provider or group, which has contributed to ectopic eruption of permanent molars. It is the responsibility of the provider or group to replace the SSC at no cost to the Plan or the member. Permanent molars must have pathologic destruction to the tooth by caries or trauma and should involve four or more surfaces and two or more cusps, or hyperplastic teeth following endodontic therapy (RCT), teeth with hereditary anomalies. Permanent premolars must have pathologic destruction to the tooth by caries or trauma and should involve three or more surfaces and at least one cusp.

Prefabricated resin crowns, prefabricated porcelain/ceramic crowns, prefabricated stainless steel crowns with resin window and prefabricated esthetic coated stainless steel crowns are a benefit only for anterior primary teeth. We will allow for the least expensive professionally acceptable alternative treatment as determined by dental review. BCBSAZ Health Choice covers the placement of cast crowns on permanent teeth for members 18-20 years of age when teeth have been successfully treated endodontically, and when treatment is necessary based on medical or dental need. The following criteria is based on the Plan's interpretation of the placement of cast crowns when it considers the placement medically/dentally necessary.

Prior- authorization is required for all cast crowns. Requests may be denied if the endodontic treatment is inadequate. Prior authorization requests for multiple cast crown restorations may be subject to alternative treatment when the overall dental condition of the patient is such that an alternative treatment plan would be better suited to meet the patient's needs.

A crown will not be approved if adequate tooth structure does not remain to establish cleanable margins, poor crown to root ratio, or the tooth appears to retain insufficient amounts of natural tooth structure. Cast dowel cores are not allowed. A functional SSC is considered an acceptable permanent restoration.

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

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

Cast crowns following endodontic therapy are payable when arch integrity exists, and opposing teeth are present and in good dental health. Arch integrity exists when all anterior teeth are present (a fixed or removable appliance replacing one or more anterior teeth is acceptable) and all first and second bicuspids and first molars are present and free of overt periodontal disease and do not require endodontic treatment (a removable or fixed appliance replacing one or more of these teeth is acceptable).

Second and third molars may or may not be present. The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent teeth. We reimburse permanent crowns on the seat date. The member must be eligible on the cementation date for the crown to be paid. A post-cementation bitewing and periapical x-ray must be submitted with the claim. X-rays taken for post- cementation cannot be billed to BCBSAZ Health Choice. Cast crowns are only payable once per 5 years per tooth. Reimbursement for a cast crown on the third molar will be considered only if it is functioning as a second molar. Prior authorization requests for multiple cast crown restorations may be subject to alternative treatment when the overall dental condition of the patient is such that an alternative treatment plan (LEPAAT) would be better suited to meet the patient's needs.

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

Prior Authorization requests with "Approved Payment Pending X-rays" require appropriate post-operative x-rays for reimbursement consideration.

RESTORATIVE					
CODE	DESCRIPTION	AGE LIMITATION	AUTHORIZATION REQUIRED	BENEFIT LIMITATIONS	DOCUMENTATION REQUIRED
D2740	Crown-porcelain/ ceramic substrate	18-20	Yes	Teeth 2-15, 18-31. Reimbursement for a third molar will be considered only if it is functioning as a second molar. One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794) per 5 years per patient per tooth. Endodontic treated teeth only.	Treatment notes, preoperative x-ray(s) of adjacent and opposing teeth. Postoperative x-ray for payment (BW and PA)
D2750	Crown – porcelain fused to high noble metal	18-20	Yes	Teeth 2-15, 18-31. Reimbursement for a third molar will be considered only if it is functioning as a second molar. One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794) per 5 years per patient per tooth. Endodontic treated teeth only.	Treatment notes, preoperative x-ray(s) of adjacent and opposing teeth. Postoperative x-ray for payment (BW and PA)
D2751	Crown – porcelain fused to predominantly base metal	18-20	Yes	Teeth 2-15, 18-31. Reimbursement for a third molar will be considered only if it is functioning as a second molar. One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794) per 5 years per patient per tooth. Endodontic treated teeth only.	Treatment notes, preoperative x-ray(s) of adjacent and opposing teeth. Postoperative x-ray for payment (BW and PA)
D2752	Crown–porcelain fused to noble	18-20	Yes	Teeth 2-15, 18-31. Reimbursement for a third molar will be considered only if it is functioning as a second molar. One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794) per 5 years per patient per tooth. Endodontic treated teeth only.	Treatment notes, preoperative x-ray(s) of adjacent and opposing teeth. Postoperative x-ray for payment (BW and PA)
D2753	Crown-porcelain fused to titanium and titanium alloys	18-20	Yes	Teeth 2-15, 18-31. Reimbursement for a third molar will be considered only if it is functioning as a second molar. One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794) per 5 years per patient per tooth. Endodontic treated teeth only.	Treatment notes, preoperative x-ray(s) of adjacent and opposing teeth. Postoperative x-ray for payment (BW and PA)
D2790	Crown-full cast high noble metal	18-20	Yes	Teeth 2-15, 18-31. Reimbursement for a third molar will be considered only if it is functioning as a second molar. One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794) per 5 years per patient per tooth. Endodontic treated teeth only.	Treatment notes, preoperative x-ray(s) of adjacent and opposing teeth. Postoperative x-ray for payment (BW and PA)
D2791	Crown - full cast predominantly base metal	18-20	Yes	Teeth 2-15, 18-31. Reimbursement for a third molar will be considered only if it is functioning as a second molar. One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794) per 5 years per patient per tooth. Endodontic treated teeth only.	Treatment notes, preoperative x-ray(s) of adjacent and opposing teeth. Postoperative x-ray for payment (BW and PA)

CODE	DESCRIPTION	AGE LIMITATION	AUTHORIZATION REQUIRED	BENEFIT LIMITATIONS	DOCUMENTATION REQUIRED
D2792	Crown-full cast noble metal	18-20	Yes	Teeth 2-15, 18-31. Reimbursement for a third molar will be considered only if it is functioning as a second molar. One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794) per 5 years per patient per tooth. Endodontic treated teeth only.	Treatment notes, preoperative x-ray(s) of adjacent and opposing teeth. Postoperative x-ray for payment (BW and PA)
D2794	Crown - titanium	18-20	Yes	Teeth 2-15, 18-31. One of (D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794) per 5 years per patient per tooth. Endodontic treated teeth only.	Treatment notes, preoperative x-ray(s) of adjacent and opposing teeth. Postoperative x-ray for payment (BW and PA)
D2910	Re-cement or re- bond inlay, onlay, veneer or partial coverage restoration	0-20	No	Teeth 1 – 32 Not reimbursed within 6 months	
D2915	Re-cement or re- bond indirectly fabricated or prefabricated post and core	0-20	No	Teeth 1 – 32 Not reimbursed within 6 months of delivery date for the same tooth, by the same provider group.	
D2920	Re-cement or rebond crown	0-20	No	Teeth 1 - 32, A - T Not reimbursed within 6 months of delivery date for the same tooth, by the same provider group.	
D2921	Reattachment of tooth fragment, incisal edge, or cusp	0-20	No	Teeth 1 - 32	
D2928	Prefabricated porcelain/ceramic crown-permanent tooth	0-20	Yes	Teeth 2-15, 18-31	Treatment notes, preoperative x-ray(s)
D2929	Prefabricated porcelain/ceramic crown – primary tooth	0-20	Yes	Teeth C - H, M - R Primary anterior teeth only. One per 36 months per tooth per provider/ group.	Treatment notes, preoperative x-ray(s)
D2930	Prefabricated stainless steel crown- primary tooth	0-20	Yes	Teeth A, B, I, J, K, L, S, T Primary teeth only. One per 36 months per tooth per provider/ group.	Treatment notes, preoperative x-ray(s)
D2931	Prefabricated stainless steel crown-permanent tooth	0-20	Yes	Teeth 1 - 5, 12 - 16, 17-21, 28 32 Permanent teeth only. One per 36 Months per tooth, per surface per provider or group.	Treatment notes, preoperative x-ray(s)
D2932	Prefabricated resin crown	0-20	Yes	Teeth 6 - 11, 22 - 27, C - H, M - R One time per 36 months per tooth per provider/ group. Will not be covered for primary anterior teeth for members ages 5 and over.	Treatment notes, preoperative x-ray(s)
D2933	Prefabricated stainless steel crown with resin window	0-20	Yes	Teeth 6 - 11, 22 - 27, C - H, M - R One time per 36 months per tooth per provider/ group. Will not be covered for primary anterior teeth for members ages 5 and over.	Treatment notes, preoperative x-ray(s)

CODE	DESCRIPTION	AGE LIMITATION	AUTHORIZATION REQUIRED	BENEFIT LIMITATIONS	DOCUMENTATION REQUIRED
D2934	Prefabricated esthetic coated stainless-steel crown- primary tooth	0-20	Yes	Teeth C - H, M- R Primary anterior teeth only. Will not be covered for primary anterior teeth for members ages 5 and over.	Treatment notes, preoperative x-ray(s)
D2940	Protective restoration	0-20	Yes	Teeth 1 - 32, A-T Not covered when done in conjunction with pulpotomies, root canals, and/or permanent restorations. Not reimbursed on same day as D2140, D2161, D2330- D2335, D3220- D3240.	Treatment notes, preoperative x-ray(s)
D2941	Interim therapeutic restoration - primary dentition	0-20	Yes	Teeth A - T	Treatment notes, preoperative x-ray(s)
D2950	Core buildup, including any pins when required	0-20	Yes	Teeth 1 – 32 One of (D2950, D2952, D2954) per 5 years Per patient per tooth. Buildups are not considered a stand- alone restoration	Treatment notes, preoperative x-ray(s)
D2951	Pin retention - per tooth, in addition to restoration	0-20	Yes	Teeth 1 – 32 One of (D2950, D2952, D2954) per 5 years Per patient per tooth. Same tooth for endodontically treated teeth.	Treatment notes, preoperative x-ray(s)
D2952	Cast post and core in addition to crown	0-20	Yes		Treatment notes, preoperative x-ray(s)
D2954	Prefabricated post and core in addition to crown	0-20	Yes	One of (D2950, D2952, D2954) per 5 years Per patient per tooth. Same tooth for endodontically treated teeth.	Treatment notes, preoperative x-ray(s)
D2976	Band stabilization-per tooth	0-20	Yes	One per tooth per year. Molar teeth	Treatment notes, preoperative x-ray(s)
D2999	Unspecified restorative procedure, by report	0-20	Yes	Limit one per tooth.	Narrative of medical necessity, x-rays, clinical notes required.

AHCCCS covers pulp therapy for permanent and primary teeth, except third molars unless it is functioning in place of a missing second molar, for members ages 0 – 20 years of age when it is considered medically necessary. The following criteria is our interpretation of pulp therapy and root canal therapy when it considers the pulp therapy or root canal treatment to be medically/dentally necessary. A complete treatment plan (to include services that do not require prior authorization) with narrative and documentation demonstrating medical/dental necessity may be necessary for complex dental care for members ages 16 and older. All radiographs taken during the course of root canal therapy and all post-treatment radiographs are included in the fee for the root canal procedures. Provision of root canal therapy is not considered appropriate when the prognosis of the tooth is questionable. Prior authorization requests for root canal treatment on multiple teeth may be subject to alternative treatment when the overall dental condition of the patient is such that an alternative treatment plan would be better suited to meet the patient's needs.

We don't reimburse for a pulpectomy on a primary tooth. The Plan will approve an alternative treatment of D3220 when requested. We don't generally reimburse for pulpal debridement. Once the pulp has been extirpated(removed), RCT is considered to have been started and should be billed as such (per ADA guidelines).

Consideration for payment may be made if this is a stand- alone emergency procedure for the relief of acute pain when member will be subsequently referred to an endodontist. A narrative indicating endodontic referral must accompany the claim for it to be considered.

Providers are responsible for any follow-up treatment, including retreatment required by a failed endodontically treated tooth within 12 months post completion.

Retreatment of endodontically treated teeth is to be completed by an endodontist. Endodontic therapy is payable only when arch integrity exists and opposing teeth are present and in good dental health. Arch integrity exists when all anterior teeth are present (a fixed or removable appliance replacing one or more anterior teeth is acceptable) and all first and second bicuspids and first molars are present and free of overt periodontal disease and do not require endodontic treatment (a removable or fixed appliance replacing one or more of these teeth is acceptable). Second and third molars may or may not be present. Retreatment will be considered when periapical pathology persists or enlarges, or when a poorly filled endodontically treated tooth or teeth present with symptoms consistent with treatment failure.

Retreatment will not be allowed on an asymptomatic non pathologic poorly filled tooth or teeth.

A tooth or teeth that exhibit both periapical and furcal involvement, will be deemed non-restorable. A treated tooth or teeth, that exhibit external or internal resorption with either periapical or furcal pathology will be deemed non- restorable. Failure of an endodontically retreated tooth or teeth, will be deemed non-restorable.

Root canal therapy must meet the following criteria:

a. Fills should be to within 2 mm of the radiological apex to ensure an apical seal is achieved.
b. Fills must be properly condensed/obturated.
c. Filling material does not extend excessively beyond the apex.

Authorization/payment for root canal therapy will not meet criteria if:

a. Gross periapical or periodontal pathosis is demonstrated radiographically (caries at crestal or sub-crestal bone or to the furcation, deeming the tooth non-restorable)
b. The general oral condition does not justify root canal therapy due to loss of arch integrity.
c. Root canal therapy is not covered for third molars unless they are in abutment for the partial denture or functioning in place of a missing molar.
d. Tooth or teeth do not demonstrate 50% bone support in which case the tooth meets the definition of a non- restorable tooth.
e. Root canal therapy is in anticipation of placement of an overdenture.
f. A filling material not accepted by the Federal Food and Drug Administration (i.e., Sargenti filling material) is used.
g. LEPAAT

Apexification/Apexogenesis (D3351, D3352, and

D3353) may be considered in cases when RCT therapy is indicated on permanent teeth with incompletely formed apices. The type of procedure(s)

used to induce root end closure will be dictated by the clinical and radiographic presentation of pulpal tissue. If the pulp is vital, then the covered procedures will include a partial pulpotomy. If the pulp is non-vital, then the covered procedure will be apexification. Up to three visits may be allowed for apexification. However, if root end closure is accomplished at the initial or the intermediate visit, then additional apexification visits will not be allowed. The published fee for D3352 is the maximum reimbursable amount regardless of the number of visits. We may correct code apexification/apexogenesis to the cost of the partial pulpotomy when medically/dentally indicated.

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

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

Treatment rendered under emergency conditions, when authorization is not possible, will require appropriate radiographs clearly showing the adjacent and opposing teeth, date pre- and post-operative x-ray, bitewing x-ray, and a periapical x-ray of the tooth or teeth treated with the claim for retrospective review for payment. In cases where pathology is not apparent, a written narrative justifying treatment is required. In cases where the root canal filling does not meet our treatment standard, we can require the procedure to be redone at no additional cost to the member. If an endodontic referral is necessary, any reimbursement already made for an inadequate service may be recouped after we review the circumstances.

ENDODONTIC					
CODE	DESCRIPTION	AGE LIMITATION	AUTHORIZATION REQUIRED	BENEFIT LIMITATIONS	DOCUMENTATION REQUIRED
D3110	Pulp cap – direct (excluding final restoration)	0-20	No		
D3120	Pulp cap - indirect (excluding final restoration)	0-20	No		
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the	0-20	Yes	One of (D3220) per 1 Lifetime per tooth. Will not be covered for anterior primary teeth for members ages 5 and over.	Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth
D3221	Pulpal debridement, primary and permanent teeth	0-20	No		
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	5-20	Yes	Permanent teeth Not construed as the first stage of root canal therapy	Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment
D3230	Pulpal therapy (restorable filling) - anterior, primary tooth (excluding final restoration)	0-20	Yes	Teeth C - H, M-R One per lifetime	Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth
D3240	Pulpal therapy (restorable filling) - posterior, primary tooth (excluding final restoration)	0-20	Yes	Teeth A, B, I, J, K, L, S, T One per lifetime	Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	0-20	Yes	Teeth 6 - 11, 22 -27 One year warranty, retreatment to be referred to endodontist	Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	0-20	Yes	Teeth 4, 5, 12, 13, 20, 21, 28, 29 One year warranty, retreatment to be referred to endodontist	Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment
D3330	Endodontic therapy, molar (excluding final restoration)	0-20	Yes	Teeth 2, 3, 14, 15, 18, 19, 30, 31 One year warranty, retreatment to be referred to endodontist	Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment
D3331	Treatment of root canal obstruction. nonsurgical access	0-20	Yes	Teeth 2-15, 18-31 reimbursement for a third molar will be considered only if it is functioning as a second molar. Pre-operative radiographs of adjacent and opposing teeth.	Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment

CODE	DESCRIPTION	AGE LIMITATION	AUTHORIZATION REQUIRED	BENEFIT LIMITATIONS	DOCUMENTATION REQUIRED
D3332	Incomplete endodontic therapy; inoperable or fractured tooth	0-20	No	Teeth 2-15, 18-31 Reimbursement for a third molar will be considered only if it is functioning as a second molar.	
D3333	Internal root repair of perforation defects	0-20	Yes		Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment
D3346	Retreatment of previous root canal therapy-anterior	0-20	Yes	Teeth 6 - 11, 22 – 27 Pre and post-operative radiographs shall be maintained in patient records. Retreatment to be completed by endodontist.	Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment
D3347	Retreatment of previous root canal therapy-bicuspid	0-20	Yes	Teeth 4, 5, 12, 13, 20, 21, 28, 29 Pre- and post-operative radiographs shall be maintained in patient records. Retreatment to be completed by endodontist.	Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment
D3348	Retreatment of previous root canal therapy-molar	0-20	Yes	Teeth 2-15, 18-31 Pre- and post-operative radiographs shall be maintained in patient records. Retreatment to be completed by endodontist.	Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment
D3351	Apexification/ recalcification–initial visit (apical closure / calcific repair of perforations, root resorption, etc.	0-20	Yes	Permanent teeth only. Reimbursement for a third molar will be considered only if it is functioning as a second molar. Pre-operative x-ray(s) with authorization.	Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment
D3352	Apexification/ recalcification - interim medication replacement	0-20	Yes	Permanent teeth only. Reimbursement for a third molar will be considered only if it is functioning as a second molar.	Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth for authorization. Post-operative x-ray for payment
D3353	Apexification/ recalcification - final visit (includes, completed root canal therapy – apical closure/calcific repairs of perforations, root resorption, etc.)	0-20	Yes	Permanent teeth only. Reimbursement for a third molar will be considered only if it is functioning as a second molar. Pre-operative x-ray(s) with authorization. Fill radiographs with claim.	Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment
D3410	Apicoectomy – anterior	0-20	Yes	Teeth 6 - 11, 22 – 27 Pre-operative x-ray(s) with authorization Fill radiographs with claim. One per lifetime	Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post- operative x-ray for payment
D3421	Apicoectomy -bicuspid (first root)	0-20	Yes	Pre-operative x-ray(s) with authorization. Fill radiographs with claim. One per lifetime	Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment
D3425	Apicoectomy -molar (first root)	0-20	Yes	Teeth 2-15, 18-31 Reimbursement for a third molar will be considered only if it is functioning as a second molar. One per lifetime.	Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth with authorization. Post-operative x-ray for payment

CODE	DESCRIPTION	AGE LIMITATION	AUTHORIZATION REQUIRED	BENEFIT LIMITATIONS	DOCUMENTATION REQUIRED
D3426	Apicoectomy (Each additional root)	0-20	Yes	Teeth 2-15, 18-31 Reimbursement for a third molar will be considered only if it is functioning as a second molar. One per lifetime.	Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth with authorization. Post-operative x-ray for payment.
D3430	Retrograde filling – per root	0-20	Yes	Teeth 2-15, 18-31 Reimbursement for a third molar will be considered only if it is functioning as a second molar. One per lifetime.	Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth with authorization. Post-operative x-ray for payment.
D3450	Root amputation - per root	0-20	Yes	Teeth 2-15, 18-31 Reimbursement for a third molar will be considered only if it is functioning as a second molar.	Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth with authorization. Post-operative x-ray for payment.
D3471	Surgical repair of root resorption- anterior	0-20	Yes	Teeth 6-11, 22-27 Does not include placement of restoration.	Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment
D3472	Surgical repair of root resorption- premolar	0-20	Yes	Teeth 4, 5, 12, 13, 20, 21, 28, 29 Does not include placement of restoration.	Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment
D3473	Surgical repair of root resorption- molar	0-20	Yes	Teeth 2-15, 18-31 reimbursement for a third molar will be considered only if it is functioning as a second molar. Does not include placement of restoration.	Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment
D3501	Surgical exposure of roo apicoectomy or repair o anterior	0-20	Yes	Teeth 6-11, 22-27 Not to be used in conjunction with apicoectomy or repair of root resorption.	Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption- premolar	0-20	Yes	Teeth 4, 5, 12, 13, 20, 21, 28, 29 Not to be used in conjunction with apicoectomy or repair of root resorption.	Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption- molar	0-20	Yes	Teeth 2,3,14,15,18,19,30,31 Reimbursement for a third molar will be considered only if it is functioning as a second molar. Not to be used in conjunction with apicoectomy or repair of root resorption.	Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment.
D3920	Hemisection (including root removal), not including root canal therapy	0-20	Yes	Teeth 2-15, 18-31 reimbursement for a third molar will be considered only if it is functioning as a second molar. One per lifetime.	Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment
D3921	Decoronation or submergence of an erupted tooth	0-20	Yes	Teeth 2-15, 18-31	Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment
D3999	Unspecified endodontic procedure, by report	0-20	Yes	Permanent teeth only.	Treatment plan, Treatment notes, pre-operative x-ray(s) of adjacent and opposing teeth. Post-operative x-ray for payment

Reimbursement includes local anesthetic. Full mouth debridement (D4355) is justified when the comprehensive oral evaluation (D0150) or comprehensive periodontal evaluation (D0180) cannot be performed due to excessive sub and/or supracalculus, heavy plaque, and debris buildup. Full mouth debridement criteria include periodontal charting indicating abnormal pockets in multiple sites and radiographic evidence of heavy sub and or supra calculous. This preliminary procedure does not preclude the need for additional procedures. A full mouth debridement does not take the place of a regular cleaning when heavy calculus is present.

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

i. Radiographic evidence of moderate to heavysubcalculus

ii. Periodontal pocketing of at least 5mm with bleeding upon probing

iii. Radiographic bone loss (horizontal orvertical)

iv. Clinical attachment loss (CAL) of at least 2mm

ii. Documented (intraoral photographs preferred) gingival inflammation into the adjacent attachment apparatus.

iii. Gingival recession (i.e., high frenum attachment)

Referral or treatment for periodontal evaluation must include radiographic, intraoral photos of the area of concern in addition to periodontal charting.

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

PERIODONTIC					
CODE	**DESCRIPTION**	**AGE LIMITATION**	**AUTHORIZATION REQUIRED**	**BENEFIT LIMITATIONS**	**DOCUMENTATION REQUIRED**
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	0-20	Yes	One of (D4210, D4211) per 24 Month(s) Per patient per quadrant. A minimum of four affected teeth in the quadrant.	Treatment notes, preoperative full mouth series of x-rays, complete periodontal charting.
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth per quadrant	0-20	Yes	One of (D4210, D4211) per 24 Month(s) Per patient per quadrant. One to three affected teeth in the quadrant.	Treatment notes, preoperative full mouth series of x-rays, complete periodontal charting
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	0-20	Yes	One of (D4240, D4241) per 24 Month(s) Per patient per quadrant. A minimum of four teeth in the affected quadrant.	Treatment notes, preoperative full mouth series of x-rays, complete periodontal charting
D4241	Gingival flap procedure, including root planing - one to three teeth per quadrant	0-20	Yes	One of (D4240, D4241) per 24 Month(s) Per patient per quadrant. One to three affected teeth in the quadrant.	Treatment notes, preoperative full mouth series of x-rays, complete periodontal charting
D4249	Clinical crown lengthening - hard tissue	0-20	Yes	Endodontically treated teeth only	Treatment notes/ narrative required, preoperative full mouth series of x-rays
D4260	Osseous surgery (including elevation of a full-thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quad.	0-20	Yes	One of (D4260, D4261) per 24 Month(s) Per patient per quadrant. A minimum of four (4) affected teeth in the quadrant. There must be radiographic evidence of loss of alveolar bone.	Treatment notes, preoperative full mouth series of x-rays, complete periodontal charting

CODE	DESCRIPTION	AGE LIMITATION	AUTHORIZATION REQUIRED	BENEFIT LIMITATIONS	DOCUMENTATION REQUIRED
D4261	Osseous surgery (including elevation of a full-thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	0-20	Yes	One of (D4260, D4261) per 24 Month(s) Per patient per quadrant. One (1) to three (3) affected teeth in the quadrant. There must be radiographic evidence of loss of alveolar bone.	Treatment notes, preoperative full mouth series of x-rays, complete periodontal charting
D4263	Bone replacement graft - first site in quadrant	0-20	Yes	Teeth 1 - 32	Treatment notes, preoperative full mouth series of x-rays, complete periodontal charting
D4264	Bone replacement graft - each additional site in quadrant	0-20	Yes	Teeth 1 - 32	Treatment notes, preoperative full mouth series of x-rays, complete periodontal charting
D4265	Biological materials to aid in soft and osseous tissue regeneration	0-20	Yes	Teeth 1 - 32	Treatment notes, preoperative full mouth series of x-rays, complete periodontal charting
D4266	Guided tissue regenerate-resorbable barrier, per site, per tooth	0-20	Yes	Teeth 1 - 32	Treatment notes, preoperative full mouth series of x-rays, complete periodontal charting
D4267	Guided tissue regeneration – non-resorbable barrier, per site, per tooth	0-20	Yes	Teeth 1 - 32	Treatment notes, preoperative full mouth series of x-rays, complete periodontal charting
D4270	Pedicle soft tissue graft procedure	0-20	Yes	Teeth 1 - 32	Treatment notes, preoperative full mouth series of x-rays, complete periodontal charting
D4273	Subepithelial connective tissue graft procedure	0-20	Yes	Teeth 1 - 32	Treatment notes, preoperative full mouth series of x-rays, complete periodontal charting
D4274	Distal or proximal wedge procedure	0-20	Yes	Teeth 1 - 32	Treatment notes, preoperative full mouth series of x-rays, complete periodontal charting
D4275	Soft tissue allograft	0-20	Yes	Teeth 1 - 32	Treatment notes, preoperative full mouth series of x-rays, complete periodontal charting
D4276	Combined connective tissue and double pedicle graft	0-20	Yes	Teeth 1 - 32	Treatment notes, preoperative full mouth series of x-rays, complete periodontal charting
D4286	Removal of non-resorbable barrier	0-20	Yes	Frequency limit is 4 per day	Treatment notes, narrative of medical necessity, pre-op x-ray(s)
D4322	Splint-intra-coronal, natural teeth, or prosthetic crowns	0-20	Yes	Per Arch(LA, UA) One (D4322) per lifetime per patient	Treatment notes, narrative of medical necessity, pre-op x-ray(s)

CODE	DESCRIPTION	AGE LIMITATION	AUTHORIZATION REQUIRED	BENEFIT LIMITATIONS	DOCUMENTATION REQUIRED
D4323	Splint-extra-coronal, natural teeth, or prosthetic crowns	0-20	Yes	Per Arch (LA, UA) One (D4323) per lifetime per patient	Treatment notes, narrative of medical necessity, pre-op x- ray(s)
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	0-20	Yes	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. A minimum of four adjacent or bonded teeth in the quadrant. There must be radiographic evidence of root calculus or noticeable loss of bone	Treatment notes, preoperative full mouth series of x-rays, complete periodontal charting
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	0-20	Yes	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. One to three affected teeth per quadrant. There must be radiographic evidence of root calculus or noticeable loss of bone support.	Treatment notes, preoperative full mouth series of x-rays, complete periodontal charting
D4346	Scaling in the presence of generalized moderate or severe gingival inflammation in the absence of periodontitis- full mouth, after oral evaluation.	0-20	Yes		Treatment notes, preoperative full mouth series of x-rays, complete periodontal charting
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	0-20	Yes	One of (D4355) per lifetime per patient	Treatment notes, preoperative full mouth series of x-rays, complete periodontal charting
D4910	Periodontal maintenance procedures	0-20	No	One of (D4910) 3 months after D4341 or D4342) and one (D4910) six months after. After the first six months, one (D4910) and one (D1110) will be allowed at 6-month intervals each calendar year thereafter.	
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	0-20	Yes		Clinical Notes or narrative required
D4999	Unspecified periodontal procedure, by report	0-20	Yes		Treatment notes, preoperative full mouth series of x-rays, complete periodontal charting.

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

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

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

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

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

Full or partial dentures will not routinely be replaced when they become unserviceable or are lost within 36 months, except when they become unserviceable through extensive physiological change. If the member can provide documentation that reasonable care has been exercised in the maintenance of the prosthetic appliance, and it did not become unserviceable or lost through negligence, a replacement may be considered. Prior approval requests for such replacements will not be reviewed without supporting documentation. A verbal statement by the member that is then included by the provider on the prior approval request would generally not be considered sufficient.

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

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

Full and partial dentures are not covered under adult Emergency Benefits.

PROSTHODONTIC					
CODE	DESCRIPTION	AGE LIMITATION	AUTHORIZATION REQUIRED	BENEFIT LIMITATIONS	DOCUMENTATION REQUIRED
D5110	Complete denture - maxillary	0-20	Yes	Per Arch (01) One of (D5110, D5130) per 36 Month(s) per provider/group.	Treatment plan, treatment notes, narrative of medical necessity preoperative full mouth series of x-rays
D5120	Complete denture-mandibular	0-20	Yes	Per arch (02) One of (D5120, D5140) per 36 months per provider/group.	Treatment plan, treatment notes, narrative of medical necessity preoperative full mouth series of x-rays
D5130	Immediate denture - maxillary	0-20	Yes	Per arch (01) One of (D5110, D5130) per 36 months per provider/group.	Treatment plan, treatment notes, narrative of medical necessity preoperative full mouth series of x-rays
D5140	Immediate denture - mandibular	0-20	Yes	Per arch (02) One of (D5120, D5140) per 36 months per provider/group.	Treatment plan, treatment notes, Narrative of medical necessity preoperative full mouth series of x-rays
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests, and teeth)	0-20	Yes	Per arch (01) One of (D5211, D5213, D5221, D5223, D5227) per 36 months per provider/group.	Treatment plan, treatment notes, narrative of medical necessity preoperative full mouth series of x-rays
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests, and teeth)	0-20	Yes	Per arch (02) One of (D5212, D5214, D5222, D5224, D5228) per 36 months per provider/group.	Treatment plan, treatment notes, narrative of medical necessity preoperative full mouth series of x-rays
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	0-20	Yes	Per arch (01) One of (D5211, D5213, D5221, D5223, D5227) per 36 months per provider/group.	Treatment plan, treatment notes, narrative of medical necessity preoperative full mouth series of x-rays
D5214	Mandibular partial denture-cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)	0-20	Yes	Per arch (02) One of (D5212, D5214, D5222, D5224, D5228) per 36 months.	Treatment plan, treatment notes, narrative of medical necessity preoperative full mouth series of x-rays)
D5221	Immediate maxillary partial denture – resin base (including any conventional clasps, rests, and teeth)	0-20	Yes	Per arch (01) One of (D5212, D5214, D5222, D5224, D5228) per 36 months per provider/group.	Treatment plan, treatment notes, narrative of medical necessity preoperative full mouth series of x-rays
D5222	Immediate mandibular partial denture – resin base (including any conventional clasps, rests, and teeth)	0-20	Yes	Per arch (02) One of (D5211, D5213, D5221, D5223, D5227) per36 months.	Treatment plan, treatment notes, narrative of medical necessity preoperative full mouth series of x-rays)
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)	0-20	Yes	Per arch (01) One of (D5211, D5213, D5221, D5223, D5227) per 36 months per provider/group.	Treatment plan, treatment notes, narrative of medical necessity preoperative full mouth series of x-rays)
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	0-20	Yes	Per arch (02) One of (D5212, D5214, D5222, D5224, D5228) per 36 months per provider/group.	Treatment plan, treatment notes, narrative of medical necessity preoperative full mouth series of x-rays

CODE	DESCRIPTION	AGE LIMITATION	AUTHORIZATION REQUIRED	BENEFIT LIMITATIONS	DOCUMENTATION REQUIRED
D5227	Immediate maxillary partial denture – flexible base (including any conventional clasps, rests, and teeth)	0-20	Yes	One of (D5211, D5213, D5221, D5223, D5227) per 36 months per provider/group.	Treatment plan, treatment notes, narrative of medical necessity preoperative full mouth series of x-rays
D5228	Immediate mandibular partial denture – flexible base (including any conventional clasps, rests, and teeth)	0-20	Yes	Per arch (02) One of (D5212, D5214, D5222, D5224, D5228) per 36 months per arch per provider/group.	Treatment plan, treatment notes, narrative of medical necessity preoperative full mouth series of x-rays
D5282	Removable unilateral partial denture - one piece cast metal (including clasps and teeth) maxillary	0-20	Yes	Per quadrant (10, 20, 30, 40) One of (D5282) per 36 months per patient per quadrant	Treatment plan, treatment notes, narrative of medical necessity preoperative full mouth series of x-rays
D5283	Removable unilateral partial denture-one piece cast metal (including clasps and teeth) mandibular	0-20	Yes	Per quadrant (10,20,30,40) One of (D5283) per 36 months per patient per quadrant per provider/group	Treatment plan, treatment notes, narrative of medical necessity preoperative full mouth series of x-rays
D5284	Removable unilateral partial denture-one-piece flexible base (including clasps and teeth) per quadrant	0-20	Yes	Per quadrant (10,20,30,40) One of (D5284) per 36 months per patient per quadrant per provider/group	Treatment plan, treatment notes, narrative of medical necessity preoperative full mouth series of x-rays
D5286	Removable unilateral partial denture-one piece resin (including clasps and teeth) per quadrant	0-20	Yes	Per quadrant (10,20,30,40) One of (D5286) per 36 months per patient per quadrant per provider/group	Treatment plan, treatment notes, Narrative of medical necessity, pre-op x-rays
D5410	Adjust complete denture-maxillary	0-20	No	Not covered within 6 months of initial placement.	
D5411	Adjust complete denture-mandibular	0-20	No	Not covered within 6 months of initial placement	
D5421	Adjust partial denture - maxillary	0-20	No	Not covered within 6 months of initial placement.	
D5422	Adjust partial denture - mandibular	0-20	No	Not covered within 6 months of initial placement.	
D5511	Repair broken complete denture base, mandibular	0-20	No	Per arch (02)	
D5512	Repair broken complete denture base, maxillary	0-20	No	Per arch (01)	
D5520	Replace missing or broken teeth - complete denture (each tooth)	0-20	No	Teeth 1 – 32 One of (D5520) per 12 months per patient per tooth.	
D5611	Repair resin partial denture base, mandibular	0-20	No	Per Arch (02)	
D5612	Repair resin partial denture base, maxillary	0-20	No	Per arch (01)	
D5621	Repair cast partial framework, mandibular	0-20	No	Per arch (02)	
D5622	Repair cast partial framework, maxillary	0-20	No	Per arch (01)	
D5630	Repair or replace broken clasp	0-20	No		

CODE	DESCRIPTION	AGE LIMITATION	AUTHORIZATION REQUIRED	BENEFIT LIMITATIONS	DOCUMENTATION REQUIRED
D5640	Replace broken teeth-per tooth	0-20	No		
D5650	Add tooth to existing partial denture	0-20	Yes		Clinical notes, Narrative of medical necessity
D5660	Add clasp to existing partial denture	0-20	Yes		Clinical notes, Narrative of medical necessity
D5710	Rebase complete maxillary denture	0-20	Yes	Not covered within 6 months of placement.	Clinical notes, Narrative of medical necessity
D5711	Rebase complete mandibular denture	0-20	Yes	Not covered within 6 months of placement.	Clinical notes, Narrative of medical necessity
D5720	Rebase maxillary partial denture	0-20	Yes	Not covered within 6 months of placement.	Clinical notes, Narrative of medical necessity
D5721	Rebase mandibular partial denture	0-20	Yes	Not covered within 6 months of placement.	Clinical notes, Narrative of medical necessity
D5730	Reline complete maxillary denture (chairside)	0-20	Yes	Not covered within 6 months of placement.	Clinical notes, Narrative of medical necessity
D5731	Reline complete mandibular denture (chairside)	0-20	Yes	Not covered within 6 months of placement.	Clinical notes, Narrative of medical necessity
D5740	Reline maxillary partial denture (chairside)	0-20	Yes	Not covered within 6 months of placement.	Clinical notes, Narrative of medical necessity
D5741	Reline mandibular partial denture (chairside)	0-20	Yes	Not covered within 6 months of placement.	Clinical notes, Narrative of medical necessity
D5750	Reline complete maxillary denture (laboratory)	0-20	Yes	Not covered within 6 months of placement.	Clinical notes, Narrative of medical necessity
D5751	Reline complete mandibular denture (laboratory)	0-20	Yes	Not covered within 6 months of placement.	Clinical notes, Narrative of medical necessity
D5760	Reline maxillary partial denture (laboratory)	0-20	Yes	Not covered within 6 months of placement.	Clinical notes, Narrative of medical necessity
D5761	Reline mandibular partial denture (laboratory)	0-20	Yes	Not covered within 6 months of placement.	Clinical notes, Narrative of medical necessity
D5765	Soft liner for complete or partial removable denture	0-20	Yes	Not covered within 6 months of placement.	Clinical notes, Narrative of medical necessity
D5820	Interim partial denture (maxillary)	0-20	Yes	Oneof (D5820) per 36 Month(s) Per patient. Pre-operative radiographs of adjacent and opposing teeth.	Clinical notes, Narrative of medical necessity
D5821	Interimpartial denture (mandibular)	0-20	Yes	One of (D5820) per 36 Month(s) Per patient. Pre-operative radiographs of adjacent and opposing teeth.	Clinical notes, Narrative of medical necessity

D5850	Tissue conditioning, maxillary	0-20	Yes		Clinical notes, Narrative of medical necessity
D5851	Tissue conditioning, mandibular	0-20	Yes		Clinical notes, Narrative of medical necessity
D5876	Add metal substructure to acrylic full denture (per arch)	**0-20**	Yes		Treatment plan, treatment notes narrative of medical necessity.
D5899	Unspecified removable prosthodontic procedure, by report	**0-20**	Yes		Treatment plan, treatment notes, Narrative of medical necessity, pre-op x-ray(s) Narrative
D5911	Facial moulage (sectional)	**0-20**	Yes		Narrative of medical necessity
D5912	Facial moulage (complete)	**0-20**	Yes		Narrative of medical necessity
D5913	Nasal prosthesis	**0-20**	Yes		Narrative of medical necessity
D5914	Auricular prosthesis	**0-20**	Yes		Narrative of medical necessity
D5915	Orbital prosthesis	**0-20**	Yes		Narrative of medical necessity
D5916	Ocular prosthesis	**0-20**	Yes		Narrative of medical necessity
D5919	Facial prosthesis	0-20	Yes		Narrative of medical necessity
D5922	Nasal septal prosthesis	0-20	Yes		Narrative of medical necessity
D5923	Ocular prosthesis, interim	0-20	Yes		Narrative of medical necessity
D5924	Cranial prosthesis	0-20	Yes		Narrative of medical necessity
D5925	Facial augment implant prosthesis	0-20	Yes		Narrative of medical necessity
D5926	Nasal prosthesis, replacement	0-20	Yes		Narrative of medical necessity
D5927	Auricular prosthesis, replace	0-20	Yes		Narrative of medical necessity
D5928	Orbital prosthesis, replace	0-20	Yes		Narrative of medical necessity
D5929	Facial prosthesis, replacement	0-20	Yes		Narrative of medical necessity
D5931	Obturator prosthesis, surgical	0-20	Yes		Narrative of medical necessity

CODE	DESCRIPTION	AGE LIMITATION	AUTHORIZATION REQUIRED	BENEFIT LIMITATIONS	DOCUMENTATION REQUIRED
D5932	Obturator prosthesis, definitive	0-20	Yes		Narrative of medical necessity
D5933	Obturator prosthesis,	0-20	Yes		Narrative of medical necessity
D5934	Mandibular resection prosthesis with guide flange	0-20	Yes		Narrative of medical necessity
D5935	Mandibular resection prosthesis without guide flange	0-20	Yes		Narrative of medical necessity
D5936	Obturator prosthesis, interim	0-20	Yes		Narrative of medical necessity
D5937	Trismus appliance (not for TMD treatment)	0-20	Yes	Not for TMD treatment	Narrative of medical necessity
D5951	Feeding aid	0-20	Yes		Narrative of medical necessity
D5952	Speech aid prosthesis, pediatric	0-20	Yes		Narrative of medical necessity
D5953	Speech aid prosthesis, adult	0-20	Yes		Narrative of medical necessity
D5954	Palatal augment prosthesis	0-20	Yes		Narrative of medical necessity
D5955	Palatal lift prosthesis, definitive	0-20	Yes		Narrative of medical necessity
D5958	Palatal lift prosthesis, interim	0-20	Yes		Narrative of medical necessity
D5959	Palatal lift prosthesis, modification	0-20	Yes		Narrative of medical necessity
D5960	Speech aid prosthesis, modification	0-20	Yes		Narrative of medical necessity
D5982	Surgical stent	0-20	Yes		Narrative of medical necessity
D5983	Radiation carrier	0-20	Yes		Narrative of medical necessity
D5984	Radiation shield	0-20	Yes		Narrative of medical necessity
D5985	Radiation cone locator	0-20	Yes		Narrative of medical necessity
D5986	Fluoride gel carrier	0-20	Yes		Narrative of medical necessity
D5987	Commissure splint	0-20	Yes		Narrative of medical necessity

CODE	DESCRIPTION	AGE LIMITATION	AUTHORIZATION REQUIRED	BENEFIT LIMITATIONS	DOCUMENTATION REQUIRED
D5988	Surgical splint	0-20	Yes		Narrative of medical necessity
D5991	Vesiculobullous disease medicament carrier	0-20	Yes		Narrative of medical necessity
D5992	Adjust maxillofacial prosthetic appliance	0-20	Yes		Narrative of medical necessity
D5999	Unspecified maxillofacial prosthesis, by report	0-20	Yes		Narrative of medical necessity
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	0-20	Yes	Not performed with D1110 or D4910	X-rays, clinical notes/ narrative required
D6089	Accessing and retorquing loose implant screw-per screw	0-20	Yes	One per tooth per day	X-rays, clinical notes/ narrative required
D6105	Removal of implant body not requiring bone removal or flap elevation	0-20	Yes	One of (D6105) per lifetime per patient per tooth.	Clinical notes/ narrative of med. necessity, x-rays
D6193	Replacement of an implant screw.	0-20	Yes	One per day per tooth	Clinical notes/ narrative of med. necessity, x-rays
D6197	Replacement of restorative material used to close and access opening for screw retained implant supported prosthesis, per implant.	0-20	Yes	One of (D6197) Per 24 months per member per provider, or group	
D6999	Fixed prosthodontic procedure	0-20	Yes	Description of service	Clinical notes/ narrative of med. necessity, full mouth x-rays

AHCCCS covers extraction of symptomatic, infected, and non-restorable primary and permanent teeth, and other surgical procedures when medically necessary for members up to age 21.

The following criteria are based on our interpretation of dental extractions when it considers the extraction to be medically/dentally necessary. The removal of primary teeth whose exfoliation is imminent does not meet criteria. Extractions are covered only if the tooth is symptomatic and/or exhibits pathology.

We carefully evaluate and individually assesses each third molar estimating the balance between risk, benefit, and cost. The definition of impaction is a tooth that fails to erupt into the dental arch within the usual range of expected time. Complete eruption of third molars occurs between 20 and 23 years of age but eruption may continue until age 25. Normally developing third molars should be permitted to erupt.

We must see the presence of a disease state, a pathological process), a specific impediment to a normal eruption pattern, or a constant chronic or recurring acute pain. Transient (occasional) pain/discomfort is common and not a justifiable reason for extraction.

Pain must be associated with a localized identifiable causative factor to be a covered benefit. We must see localized pathologic process such as recurring infection, multiple episodes of purulent exudate, adjacent tooth resorption, cyst, or tumor formation.

The prophylactic removal of asymptomatic teeth or teeth exhibiting no overt clinical pathology is an elected surgery and not a covered benefit. We will cover palliative therapy for conditions associated with non-impacted teeth (i.e., treatment of pericoronitis in partially erupted third molars) If treatment fails or the pericoronitis recurs subsequent extractions will be considered. Treatment notes documenting attempted palliative therapy (i.e., curettage, antimicrobial sub-irrigation, and/or antibiotic treatment) must be submitted with a referral request.

Extracting third molars early when individuals are in their teenage or early adult years simply leads to a more invasive surgical procedure increasing the likelihood of complications. It also prematurely commits the member to extractions where the third molars may not cause any problems and erupt normally in the future.

Following the decision not to extract third molars the teeth should be clinically re-evaluated with periodic radiographic examination.

The prophylactic removal of asymptomatic teeth (i.e., third molars) or teeth exhibiting no overt clinical pathology is an elective surgery and is not a covered benefit. We WILL COVER palliative therapy for conditions associated with non-impacted wisdom teeth (i.e., treatment of pericoronitis in partially erupted third molars with adequate space for eruption). If treatment fails or the pericoronitis recurs, subsequent extractions will be considered. Treatment notes documenting attempted palliative therapy (i.e., curettage, antimicrobial sub- irrigation, and/or antibiotic treatment) must be submitted with a referral request.

Suture removal, treatment of dry socket, and removal of bone fragments are considered part of the extraction treatment when performed by the same dentist or group of dentists who removed the tooth. Palliative treatment would be considered for reimbursement when a dentist other than the original treating dentist or group provides these services.

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

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

a. The member has undergone a medical pediatric evaluation.

b. Functional limitations resulting in inadequate feeding or swallowing.

c. Limited tongue mobility resulting in speech disorders, following completion of evaluation and therapy by a qualified speech pathologist.

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

Referral or treatment of TMJ is not covered EXCEPT for the reduction of trauma.

ORAL SURGERY					
CODE	**DESCRIPTION**	**AGE LIMITATION**	**AUTHORIZATION REQUIRED**	**BENEFIT LIMITATIONS**	**DOCUMENTATION REQUIRED**
D7111	Extraction, coronal Remnants deciduous (primary) teeth	0-20	Yes	One of (D7111) per lifetime per patient per tooth.	Treatment notes, preoperative x-ray(s)
D7140	Extraction, erupted tooth, or exposed root (Elevation and/or forceps removal) includes routine removal of tooth structure, minor smoothing of socket bone, and closure as necessary	0-20	Yes	One of (D7140, D7210, D7220, D7230, D7240, D7241, D7250) per lifetime per patient per tooth.	Treatment notes, preoperative x-ray(s)
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated, cutting of gingival and bone, removal of tooth structure, minor smoothing of socket bone, and closure	0-20	Yes	One of (D7140, D7210, D7220, D7230, D7240, D7241, D7250) per lifetime per patient per tooth. Removal of asymptomatic tooth not covered	Treatment notes, preoperative x-ray(s)
D7220	Removal of impacted tooth soft tissue	0-20	Yes	One of (D7140, D7210, D7220, D7230, D7240, D7241, D7250) per lifetime per patient per tooth. Removal of asymptomatic tooth not covered.	Treatment notes, preoperative x-ray(s)
D7230	Removal of impacted tooth	0-20	Yes	One of (D7140, D7210, D7220, D7230, D7240, D7241, D7250) per lifetime per patient per tooth. Removal of asymptomatic tooth not covered.	Treatment notes, preoperative x-ray(s)
D7240	Removal of impacted tooth completely bony	0-20	Yes	One of (D7140, D7210, D7220, D7230, D7240, D7241, D7250) per lifetime per patient per tooth. Removal of asymptomatic tooth not covered.	Treatment notes, preoperative x-ray(s)
D7241	Removal of impacted tooth-completely bony, with unusual surgical complications	0-20	Yes	One of (D7140, D7210, D7220, D7230, D7240, D7241, D7250) per lifetime per patient per tooth. Unusual complications such as nerve dissection, separate closure of maxillary sinus, or aberrant tooth positions. Removal of asymptomatic tooth not covered.	Treatment notes, preoperative x-ray(s)

CODE	DESCRIPTION	AGE LIMITATION	AUTHORIZATION REQUIRED	BENEFIT LIMITATIONS	DOCUMENTATION REQUIRED
D7250	Surgical removal of residual tooth roots	0-20	Yes	One per lifetime Per patient per tooth. Will not be paid to the dentists or group that removed the tooth. Removal of asymptomatic tooth not covered. Roots must be fully encased in bone and gingiva present over the bone.	Treatment notes, preoperative x-ray(s)
D7251	Coronectomy-intentional partial tooth removal is performed when a neurovascular complication is likely if the entire impacted tooth is removed.	0-20	Yes		Treatment notes, preoperative x-ray(s)
D7259	Nerve dissection	0-20	Yes	One per day per tooth or per quadrant.	Treatment notes, narrative of medical necessity
D7260	Oroantral fistula closure	0-20	Yes		Treatment notes, narrative of medical necessity, pre-op x-ray(s)
D7261	Primary closure of a sinus perforation	0-20	Yes	Not payable on the same date of service as the extraction	Treatment notes, narrative of medical necessity, pre-op x-ray(s)
D7270	Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth	0-20	No	Includes splinting and/or stabilization.	
D7280	Surgical access of an unerupted tooth	0-20	Yes	One of (D7280) per 1 Lifetime Per patient per tooth.	Treatment notes, narrative of medical necessity, pre-op x-ray(s)
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	0-20	Yes	One of (D7282) per 1 Lifetime Per patient per tooth.	Treatment notes, narrative of medical necessity, pre-op x-ray(s)
D7283	Placement of device to facilitate eruption of impacted tooth	0-20	Yes	One of (D7283) per 1 Lifetime Per patient per tooth.	Treatment notes, narrative of medical necessity, pre-op x-ray(s)
D7284	**Excisional biopsy of minor salivary glands**	0-20	Yes		Treatment notes, narrative of medical necessity, pre-op x- ray(s)
D7285	Incisional biopsy of oral tissue-hard (bone, tooth)	0-20	Yes		Treatment notes, narrative of medical necessity, pre-op x-ray(s)
D7286	Incisional biopsy of oral tissue-soft	0-20	Yes		Treatment notes, narrative of medical necessity, pre-op x-ray(s)
D7291	Transseptal fibrotomy/ supra crestal fiberotomy, by report	0-20	Yes		Treatment notes, narrative of medical necessity

CODE	DESCRIPTION	AGE LIMITATION	AUTHORIZATION REQUIRED	BENEFIT LIMITATIONS	DOCUMENTATION REQUIRED
D7292	Surgical placement of temporary anchorage device [screw retained plate] requiring flap;	0-20	Yes	One of (D7292) per lifetime per patient per tooth.	Treatment notes, narrative of medical necessity, pre-opx-ray(s)
D7293	Surgical placement of temporary anchorage device requiring flap; includes device	0-20	Yes	One of (D7293) per lifetime per patient per tooth.	Treatment notes, narrative of medical necessity, pre-opx-ray(s)
D7294	Surgical placement of temporary anchorage device without flap; includes device	0-20	Yes	One of (D7294) per lifetime per patient per tooth.	Treatment notes, narrative of medical necessity, pre-opx-ray(s)
D7296	Corticotomy one to three teeth or tooth spaces per quadrant	0-20	Yes	One of (D7296) per lifetime per quadrant	Treatment notes, narrative of medical necessity, pre-opx-ray(s)
D7297	Corticotomy four or more teeth or tooth spaces per quadrant	0-20	Yes	One of (D7297) per lifetime per quadrant	Treatment notes, narrative of medical necessity, pre-opx-ray(s)
D7298	Removal of temporary anchorage device (screw retained plate), requiring flap	0-20	Yes		Treatment notes, narrative of medical necessity, pre-op x- ray(s)
D7299	Removaloftemporary anchorage device, requiring flap	0-20	Yes		Treatment notes, narrative of medical necessity, pre-opx-ray(s)
D7300	Removal of temporary anchorage device, without a flap	0-20	Yes		Treatment notes, narrative o necessity, pre-op x-ray(s)
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	0-20	Yes	Per quadrant (10, 20, 30, 40) One of (D7310, D7311) per lifetime per patient per quadrant. Minimum of three extractions in the affected quadrant.	Treatment notes, narrative of medical necessity, pre- op x-ray(s)
D7311	Alveoloplasty in conjunction with extractions -one to three teeth or tooth spaces, per quadrant	0-20	Yes	Per quadrant (10, 20, 30, 40) One of (D7310, D7311) per lifetime per patient per quadrant. One to three extractions in the affected quadrant.	Treatment notes, narrative of medical necessity, pre- op x-ray(s)
D7320	Alveoloplasty not in conjunction with extractions -four or more teeth or tooth spaces, per quadrant	0-20	Yes	Per quadrant (10, 20, 30, 40) One of (D7320, D7321) per lifetime per patient per quadrant.	Treatment notes, narrative of medical necessity, pre- op x-ray(s)
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	0-20	Yes	Per quadrant (10, 20, 30, 40 One of (D7320, D7321) per lifetime per patient per quadrant.	Treatment notes, narrative of medical necessity, pre- op x-ray(s)
D7410	Radical excision-lesion diameter up to 1.25cm	0-20	Yes	Pathology report in record.	Treatment notes, narrative of medical necessity, Pathology report
D7411	Excision of benign lesion greater than 1.25 cm	0-20	Yes	Pathology report in record.	Treatment notes, narrative of medical necessity, Pathology report

CODE	DESCRIPTION	AGE LIMITATION	AUTHORIZATION REQUIRED	BENEFIT LIMITATIONS	DOCUMENTATION REQUIRED
D7412	Excision of benign lesion, complicated	0-20	Yes	Pathology report in record.	Treatment notes, narrative of medical necessity, Pathology report
D7413	Excision of malignant lesion up to 1.25 cm	0-20	Yes	Pathology report in record.	Treatment notes, narrative of medical necessity, Pathology report
D7414	Excision of malignant lesion greater than 1.25cm	0-20	Yes	Pathology report in record.	Treatment notes, narrative of medical necessity, Pathology report
D7415	Excision of malignant lesion, complicated	0-20	Yes	Pathology report in record.	Treatment notes, narrative of medical necessity, Pathology report
D7440	Excision of malignant tumor-lesion diameter up to 1.25cm	0-20	Yes	Pathology report in record.	Treatment notes, narrative of medical necessity, Pathology report
D7441	Excision of malignant tumor - lesion diameter greater than 1.25cm	0-20	Yes		Treatment notes, narrative of medical necessity, Pathology report
D7450	Removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	0-20	Yes	Pathology report in record.	Treatment notes, narrative of medical necessity, Pathology report
D7451	Removal of odontogenic cyst or tumor - lesion greater than 1.25cm	0-20	Yes	Pathology report in record.	Treatment notes, narrative of medical necessity, Pathology report
D7460	Removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	0-20	Yes	Pathology report in record.	Treatment notes, narrative of medical necessity, Pathology report
D7461	Removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm	0-20	Yes	Pathology report in record.	Treatment notes, narrative of medical necessity, Pathology report
D7465	Destruction of lesion(s) by physical or chemical method, by report	0-20	Yes		Treatment notes, narrative of medical necessity, Pathology report
D7471	Removal of exostosis - per site	0-20	Yes	Per Arch (01, 02) Limited to removal of exostosis, including the removal of tori, osseous tuberosities, and other osseous protuberances.	Treatment notes, narrative of medical necessity, pre- op x-ray(s)
D7472	Removal of torus palatinus	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x-ray(s)
D7473	Removal of torus mandibularis	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x-ray(s)
D7485	Surgical reduction of osseous tuberosity	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x-ray(s)
D7490	Radical resection of mandible with bone graft	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x-ray

CODE	DESCRIPTION	AGE LIMITATION	AUTHORIZATION REQUIRED	BENEFIT LIMITATIONS	DOCUMENTATION REQUIRED
D7509	Marsupialization of odontogenic cyst	0-20	Yes	One of (D7509) per lifetime per patient per tooth	Treatment notes, narrative of medical necessity
D7510	Incision and drainage of abscess - intraoral soft tissue	0-20	No	One of (D7510, D7511) per lifetime per patient per tooth. Not payable on the same date of service as the extraction	
D7511	Incision and drainage of	0-20	No	One of (D7510, D7511) per lifetime per patient per tooth. Not payable on the same date of service as the extraction	
D7520	Incision and drainage of abscess - extraoral soft tissue	0-20	No	One of (D7520, D7521) per lifetime per patient pe tooth. Not payable on the same date of service as the extraction	
D7521	Incision and drainage of abscess - extraoral soft	0-20	No	One of (D7520, D7521) per lifetime per patient per	
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	0-20	No		
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	0-20	No		
D7550	Partial ostectomy/ sequestrectomy for removal of non-vital bone	0-20	No	Per quadrant (10, 20, 30, 40)	Clinical notes, x-rays, and narrative of medical necessity required with claim
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	0-20	Yes		Treatment notes, narrative of medical necessity, pre-op x-ray(s)
D7610	Maxilla - open reduction	0-20	Yes		Treatment notes, narrative of medical necessity, pre-op x-ray(s)
D7620	Maxilla - closed reduction	0-20	Yes		Treatment notes, narrative of medical necessity, pre-op x-ray(s)
D7630	Mandible-open reduction	0-20	Yes		Treatment notes, narrative of medical necessity, pre-op x-ray(s)
D7640	Mandible-closed reduction	0-20	Yes		Treatment notes, narrative of medical necessity, pre-op x-ray(s)
D7650	Malar and/or zygomatic arch-open reduction	0-20	Yes		Treatment notes, narrative of medical necessity, pre-op x-ray(s)
D7660	Malar and/or zygomatic arch-closed	0-20	Yes		Treatment notes, narrative of medical necessity, pre-op x-ray(s)
D7670	Alveolus stabilization of teeth, closed reduction splinting	0-20	Yes		Treatment notes, narrative of medical necessity, pre-op x-ray(s)

CODE	DESCRIPTION	AGE LIMITATION	AUTHORIZATION REQUIRED	BENEFIT LIMITATIONS	DOCUMENTATION REQUIRED
D7671	Alveolus - open reduction, may include stabilization of teeth	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x-ray(s)
D7680	Facial bones - complicated reduction With fixationand multiple surgical approaches	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x-ray(s)
D7710	Maxilla - open reduction	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x-ray(s)
D7720	Maxilla - closed reduction	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x-ray(s)
D7730	Mandible - open reduction	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x-ray(s)
D7740	Mandible-closed reduction	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x-ray(s)
D7750	Mala rand/or zygomatic arch-open reduction	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x-ray(s)
D7760	Malar and/or zygomatic arch-closed reduction	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x-ray(s)
D7770	Alveolus-stabilization of teeth, open reduction splinting	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x-ray(s)
D7771	Alveolus,closedreduction stabilization of teeth	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x-ray(s)
D7780	Facial bones - complicated reduction with fixation and multiple surgical approaches	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x-ray(s)
D7810	Open reduction of dislocation	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x-ray(s)
D7820	Closed reduction dislocation	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x-ray(s)
D7830	Manipulation under anesthesia	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x-ray(s)
D7840	Condylectomy	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x-ray(s)
D7850	Surgical discectomy, with/ without implant	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x-ray(s)
D7852	Disc repair	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x-ray(s)
D7854	Synovectomy	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x-ray(s)

CODE	DESCRIPTION	AGE LIMITATION	AUTHORIZATION REQUIRED	BENEFIT LIMITATIONS	DOCUMENTATION REQUIRED
D7856	Myotomy	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x- ray(s)
D7858	joint reconstruction	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x- ray(s)
D7860	Arthrotomy	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x- ray(s)
D7865	Arthroplasty	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x- ray(s)
D7870	Arthrocentesis	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x- ray(s)
D7871	Non-arthroscopic lysis and lavage	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x- ray(s)
D7872	Arthroscopy – diagnosis with or without biopsy	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x- ray(s)
D7873	Arthroscopy-surgical: lavage and lysis of adhesions	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x- ray(s)
D7874	Arthroscopy-surgical: disc repositioning and stabilization	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x- ray(s)
D7875	Arthroscopy-surgical synovectomy	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x- ray(s)
D7876	Arthroscopy-surgery discectomy	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x- ray(s)
D7877	Arthroscopy-surgical debridement	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x- ray(s)
D7880	Occlusal orthotic device, by report	0-20	Yes		Treatment notes, narrative of medical necessity, pre - op x-ray(s)
D7899	Unspecified TMD therapy, by report	0-20	Yes		Treatment notes, narrative of medical necessity, pre - op x-ray(s)
D7910	Suture small wounds up to 5 cm	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x- ray(s)
D7911	Complicated suture- up to 5 cm	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x- ray(s)
D7912	Complex suture - greater than 5cm	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x- ray(s)
D7920	Skin graft (identify defect covered, location and type of graft)	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x- ray(s)

CODE	DESCRIPTION	AGE LIMITATIO	AUTHORIZATION REQUIRED	BENEFIT LIMITATIONS	DOCUMENTATION REQUIRED
D7939	Indexing for osteotomy using dynamic robotic assisted or dynamic navigation	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x-ray(s)
D7940	Osteoplasty-for orthognathic deformities	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x-ray(s)
D7941	Osteotomy-mandibular rami	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x-ray(s)
D7943	Osteotomy- mandibular rami with bone graft; includes obtaining the graft	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x-ray(s)
D7944	Osteotomy - segmented or subapical - per sextant orquadrant	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x-ray(s)
D7945	Osteotomy-body of mandible	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x-ray(s)
D7946	LeFort I (maxilla - total)	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x-ray(s)
D7947	LeFort I (maxilla - segmented)	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x-ray(s)
D7948	LeFort II or LeFort III - without bone graft	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x-ray(s)
D7949	LeFort II or LeFort III - with bone graft	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x-ray(s)
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla-autogenous or non-autogenous, by report	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x-ray(s)
D7951	Sinus augmentation	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x-ray(s)
D7953	Bone replacement graft for ridge preservation - per site	0-20	Yes	Per quadrant (10, 20, 30, 40)	Treatment notes, narrative of medical necessity, pre- op x-ray(s)
D7955	Repair of maxillofacial soft and/or hard tissue defect	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x-ray(s)
D7956	Guided tissue regeneration, edentulous area-resorbable barrier, per site	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x-ray(s)
D7957	Guided tissue regeneration, edentulous are-non resorbable barrier per site	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x-ray(s)
D7961	Buccal/labial frenectomy (frenulectomy)	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x-ray(s)

CODE	DESCRIPTION	AGE LIMITATION	AUTHORIZATION REQUIRED	BENEFIT LIMITATIONS	DOCUMENTATION REQUIRED
D7962	Lingual Frenectomy (frenulectomy)	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x-ray(s)
D7963	Frenuloplasty	0-20	Yes		Treatment notes, narrative of medical necessity, pre-op x- ray(s)
D7970	Excision of hyperplastic tissue- per arch	0-20	Yes	Arch (01 Per, 02)	Treatment notes, narrative of medical necessity, pre-op x- ray(s)
D7971	Excision of pericoronal gingiva	0-20	Yes	Teeth 1 - 32	Treatment notes, narrative of medical necessity, pre-op x- ray(s)
D7972	Surgical reduction of fibrous tuberosity	0-20	Yes		Treatment notes, narrative of medical necessity, pre-op x- ray(s)
D7979	Non-surgical sialolithotomy	0-20	Yes		Treatment plan, treatment notes, Narrative of medical necessity
D7980	Sialolithotomy	0-20	Yes		Treatment notes, narrative of medical necessity, pre-op x- ray(s)
D7981	Excision of salivary gland, by report	0-20	Yes		Treatment notes, narrative of medical necessity, pre-op x- ray(s)
D7982	Sialodochoplasty	0-20	Yes		Treatment notes, narrative of medical necessity, pre-op x- ray(s)
D7983	Closure of salivary fistula	0-20	Yes		Treatment notes, narrative of medical necessity, pre-op x- ray(s)
D7990	Emergency tracheotomy	0-20	No		
D7991	Coronoidectomy	0-20	Yes		Treatment notes, narrative of medical necessity, pre-op x- ray(s)
D7995	Synthetic graft-mandible or facial bones, by report	0-20	Yes		Treatment notes, narrative of medical necessity, pre- op x-ray(s)
D7996	Implant-mandible for augmentation purposes, by report	0-20	Yes		Treatment notes, narrative of medical necessity, pre-op x-ray(s)
D7997	Appliance removal(not by dentist who placed appliance), includes removal of arch bar	0-20	Yes	Narrative describing service.	Treatment notes, narrative of medical necessity, pre-op x-ray(s)
D7998	Intraoral fixation device-- non-fracture	0-20	Yes		Treatment notes, narrative of medical necessity, pre-op x-ray(s)
D7999	Unspecified oral surgery procedure, by report	0-20	Yes	Narrative describing service.	Treatment notes, narrative of medical necessity, pre-op x-ray(s)

We cover orthodontics/orthognathic surgery when medically necessary for members ages 18 and younger when determined to be the primary treatment of choice or an essential part of an overall treatment plan designed by the PCP in consultation with the dentist.

Coverage of orthodontic treatment including interceptive orthodontic treatment is limited to children with facial skeletal deformities that resulted in significant malocclusion (i.e., Cleft Palate). In rare instances, children exhibiting a severe malocclusion that is such that normal mastication or function is impossible, or lack of such treatment would impact a member's health/nutritional needs may be approved at the dental director's discretion. Documentation from the child's PCP indicating BMI falling in the underweight range is necessary. All ortho treatment must be completed by age 21 to guarantee reimbursement. The following guideline is based on the Plan's interpretation of orthodontic and orthognathic surgery when it considers the services medically/dentally necessary.

All orthodontic/ orthognathic services must be prior authorized.

Extractions and other surgical procedures (i.e., surgical exposure of an unerupted tooth or procedures to facilitate the eruption of impacted teeth) are not payable by us unless included in an approved orthodontic/orthognathic surgery case.

a. Orthodontic/orthognathic surgery for the treatment of facial skeletal deformities that result in significant malocclusion is considered medically necessary if the medical appropriateness criteria are met.

b. Orthodontic/orthognathic surgery for the treatment for obstructive sleep apnea (OSA) is considered medically necessary if the medical appropriateness criteria are met.

c. Orthodontic/orthognathic surgery for the improvement of an individual's facial structure in the presence of a functional malocclusion in the absence of significant malocclusion is considered cosmetic.

d. Orthodontic/orthognathic surgery for the treatment of temporomandibular joint (TMJ) disorder is considered investigational.

ORTHODONTIC					
CODE	DESCRIPTION	AGE LIMITATION	AUTHORIZATION REQUIRED	BENEFIT LIMITATIONS	DOCUMENTATION REQUIRED
D8010	Limited orthodontic treatment of the primary dentition	0-18	Yes		Treatment notes, narrative of medical necessity, pre-op x- ray(s)
D8020	Limited orthodontic treatment of the transitional dentition	0-18	Yes		Treatment notes, narrative of medical necessity, pre-op x- ray(s)
D8030	Limited orthodontic treatment of the adolescent dentition	0-18	Yes		Treatment notes, narrative of medical necessity, pre-op x- ray(s)
D8040	Limited orthodontic treatment of the adult dentition	0-18	Yes		Treatment notes, narrative of medical necessity, pre-op x- ray(s)
D8070	Comprehensive orthodontic treatment of the transitional dentition	0-18	Yes		Treatment notes, narrative of medical necessity, pre-op x- ray(s)
D8080	Comprehensive orthodontic treatment of the adolescent dentition	0-18	Yes		Treatment notes, narrative of medical necessity, pre-op x- ray(s)
D8090	Comprehensive orthodontic treatment of the adult dentition	0-18	Yes		Treatment notes, narrative of medical necessity, pre-op x- ray(s)
D8091	Comprehensive orthodontic treatment with orthognathic surgery	0-20	Yes		Treatment notes, narrative of medical necessity, pre-op x- ray(s)
D8210	Removable appliance therapy (includes appliances for thumb sucking and tongue	0-20	Yes		Treatment notes, narrative of medical necessity, pre-op x- ray(s)
D8220	Fixed appliance therapy	0-20	Yes		Treatment notes, narrative of medical necessity, pre-op x- ray(s)
D8660	Pre-orthodontic treatment examination to monitor growth and development	0-20	Yes	One per year	Treatment notes, narrative of medical necessity, pre-op x- ray(s)
D8670	Periodic orthodontic treatment visit	0-20	No	One a month	
D8671	Periodic orthodontic treatment visit associated with orthognathic surgery	0-20	Yes	One a month	Treatment notes, narrative of medical necessity, pre-op x- ray(s)
D8680	Orthodontic retention (removal of appliances)	0-18	Yes		Treatment notes, narrative of medical necessity, pre-op x-ray(s)
D8690	Orthodontic treatment (alternative billing to	0-18	Yes		Treatment notes, narrative of medical necessity, pre-op x- ray(s)
D8695	Removal of fixed orthodontic appliances for reasons other than completion of treatment	0-20	Yes		Treatment notes, narrative of medical necessity, pre-op x- ray(s)
D8696	Repair of orthodontic appliance- maxillary	0-20	Yes		Treatment notes, narrative of medical necessity, pre-op x- ray(s)
D8697	Repair of orthodontic appliance- mandibular	0-20	Yes		Treatment notes, narrative of medical necessity, pre-op x- ray(s)
D8698	Re-cement or re-bond fixed retainer- maxillary	0-20	Yes	/	Treatment notes, narrative of medical necessity, pre-op x- ray(s)
D8699	Re-cement or re-bond fixed retainer- mandibular	0-20	Yes		Treatment notes, narrative of medical necessity, pre-op x- ray(s)
D8701	Repair of fixed retainers, includes reattachment maxillary	0-20	Yes		Treatment notes, narrative of medical necessity, pre-op x- ray(s)

CODE	DESCRIPTION	AGE LIMITATION	AUTHORIZATION REQUIRED	BENEFIT LIMITATIONS	DOCUMENTATION REQUIRED
D8702	Repair of fixed retainers, includes reattachment mandibular	0-20	Yes		Treatment notes, narrative of medical necessity, pre-op x- ray(s)
D8703	Replacement of lost or broken retainer- maxillary	0-20	Yes		Treatment notes, narrative of medical necessity, pre-op x- ray(s)
D8704	Replacement of lost or broken retainer- mandibular	0-20	Yes		Treatment notes, narrative of medical necessity, pre-op x- ray(s)
D8999	Unspecified orthodontic procedure, by report	0-20	Yes		Treatment notes, narrative of medical necessity, pre-op x- ray(s)

Local anesthesia is considered part of the treatment procedure, and no additional payment will be made for it. We cover GA for specific medical or behavioral conditions. GA may be necessary for very complex or lengthy procedures. The majority of third molars can be extracted without general anesthesia. AHCCCS covers nitrous oxide, oral conscious sedation, intravenous conscious sedation, or general anesthesia when local anesthesia is contraindicated, or the medical/behavioral management of the patient requires it for members 0-20 years of age. Nitrous oxide requires prior authorization for members 11-20 years of age. Only one unit of nitrous oxide can be billed per dental appointment.

Appropriate administering documentation is required. Nitrous Oxide/Oxygen is not payable on the same day of services as oral conscious sedations.

Indications for Deep Sedation/General Anesthesia:

a. Risk of toxicity due to local anesthetic
b. Underlying medical condition, which is clearly documented, and by its nature, would require intravenous conscious sedation or general anesthesia for the dental care to be provided safely i.e., cerebral palsy, epilepsy, developmental delays, or movement disorders.
c. Infants and children where previous levels of anesthesia technique have failed
d. Any alternative “special” situation which is clearly documented, and treatment may be considered when medically/dentally indicated.
e. Medical condition(s), which may require monitoring under anesthesia i.e., cardiac problems, severe hypertension
f. Extreme anxiety or fear
g. Severe dental phobic patients
h. Children or adults who have mental or physical disabilities, disoriented or senile patients
i. Short, traumatic procedures
j. Prolonged traumatic procedures
k. Established allergy to local anesthesia

General Anesthesia authorizations will typically be limited to one (1) visit per patient per treatment plan of no more than 3 ½ hour duration.

Occlusal guard for Bruxism- Intraoral photos and detailed narrative of symptoms are necessary to consider dental needs.

ADJUNCTIVE SERVICES					
CODE	DESCRIPTION	AGE LIMITATION	AUTHORIZATION REQUIRED	BENEFIT LIMITATIONS	DOCUMENTATION REQUIRED
D9110	Palliative (emergency) treatment of dental pain-minor procedure	0-20	No	One of (D9110) per 1 day(s) per patient. Not allowed with any other services other than radiographs or emergency exams, or behavior management	
D9120	Fixed partial denture sectioning	0-20	Yes		Full mouth x-rays, clinical notes/narrative
D9210	Local anesthesia not in conjunction	0-20	Yes	Not covered if other procedures are reported on	Clinical notes/narrative
D9222	Deep sedation/ general anesthesia – first 15 minutes	0-20	Yes	One of (D9222) per 1 day(s) per patient. Not allowed on same day with D9230, D9243 or D9248.	Complete treatment plan, health history, narrative describing necessity for sedation, x-rays when available, sedation records
D9223	Deep sedation/general anesthesia – each additional 15 minutes	0-20	Yes	Maximum of seven of (D9223) per 1 day(s) per patient. Not allowed on same day with D9230, D9243, or D9248.	Complete treatment plan, health history, narrative describing necessity for sedation, x-rays when available, sedation records
D9230	Inhalation of nitrous oxide/ analgesia	0-10 11-20	No Yes	One of(D9230) per 1 day per patient. Not allowed on the same day with D9223, D9243, or D9248. Cannot be billed with D9248	Complete treatment plan, health history, narrative describing necessity
D9239	Intravenous moderate (conscious) sedation/analgesia- first 15 minutes	0-20	Yes	One of (D9239) per treatment plan per patient. Not allowed on same day with D9230, D9223 or D9248	Complete treatment plan, health history, narrative describing necessity for sedation, x-rays when available, sedation records
D9243	Intravenous moderate (conscious) sedation/ analgesia – each additional 15 minutes	0-20	Yes	Maximum of seven (D9243) per treatment plan per patient. Not allowed on same day with D9230, D9223 or D9248	Complete treatment plan, health history, narrative describing necessity for sedation, x-rays when available, sedation records
D9248	Non-intravenous moderate (conscious) sedation	0-20	Yes	Two of (D9248) per treatment plan per patient. Not allowed on the same day with D9223, D9243, or D9230.	Complete treatment plan, health history, narrative describing necessity for sedation
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	0-20	No		
D9410	House/extended care facility call	0-20	Yes		Clinical notes/narrative, medical history
D9420	Hospital or ambulatory surgical center call.	0-20	Yes		Clinical notes/narrative, health history, pre-op x-rays

CODE	DESCRIPTION	AGE LIMITATION	AUTHORIZATION REQUIRED	BENEFIT LIMITATIONS	DOCUMENTATION REQUIRED
D9430	Office visit for observation (during regularly scheduled hours) no other services performed	0-20	No		
D9440	Office visit for observation- after regularly scheduled hours	0-20	No		X-rays and clinical notes/narrative required
D9610	Therapeutic drug injection, by report	0-20	Yes	One of (D9610, D9612) per 1 day per patient.	Clinical notes/narrative, health history, pre-op x-rays
D9612	Therapeutic drug injection - 2 or more medications by report	0-20	Yes	One of (D9610, D9612) per 1 day per patient.	Clinical notes/narrative, health history, pre-op x-rays
D9920	Behavior management, by report	0-20	No		
D9930	Treatment of complications (postsurgical) - unusual circumstances, by report	0-20	No		
D9938	Fabrication of a custom removable clear plastic temporary aesthetic appliance	0-20	Yes	One of (D9938) per 36 months per patient. Pre-operative radiographs of adjacent and opposing teeth	Clinical notes, Narrative of medical necessity
D9944	Occlusal guard hard appliance full arch	0-20	Yes	One of (D9944) per 24 month per patient.	Clinical notes/narrative, x- rays
D9945	Occlusal guard soft appliance, full arch	0-20	Yes	One of (D9945) per 24 months per patient.	Clinical notes/narrative, x- rays
D9946	Occlusal guard hard appliance partial arch	0-20	Yes	One of (D9946) per 24month(s) per patient	Clinical notes/narrative, x- rays
D9951	Occlusal adjustment - limited	0-20	Yes	One of (D9951) per 12 months per patient.	Clinical notes/narrative, full mouth x-rays
D9995	Teledentistry- synchronous	0-20	No		Indicates the use of teledentistry only
D9996	Teledentistry- asynchronous	0-20	No		Indicates the use of teledentistry only
D9999	Unspecified adjunctive procedure, by report	0-20	Yes	Narrative describing service.	X-rays, clinical notes/ narrative

Professionally Accepted Treatment or Alternative Services

Dental providers are required to consider the most cost-effective means by which to replace lost dental functions for qualified members with complex dental disease. We will allow the least expensive professionally acceptable alternative treatment (LEPAAT) when determined by professional review. Applying the LEPAAT standard is not to be considered as a dictation of treatment, but to notify the treating dentist of the services that we will pay for. Complex dental care is defined as the treatment of three or more teeth with root canals, build-ups, and /or cast crowns in a six-month period for dental conditions not related to traumatic injuries. In certain member/ patient situations, extensive dental restorative treatment may not be warranted and alternative benefits to the requested procedures may be applied. In this instance, we require the submission of a complete treatment plan with the appropriate diagnostic radiographs.

Those situations include, but not limited to:

i. Substance abuse.
ii. Rampant caries.
iii. Gross or extensive caries.
iv. Missing teeth.
v. Unrestorable teeth.
vi. Periodontal disease(s) i.e., gingivitis, periodontitis, etc.
vii. Inadequate home care.
viii. Lack of arch integrity.
ix. Poor dental history.
x. Poor prognosis.
xi. Mental /behavioral disorders.
xii. Eating disorders. i.e., Anorexia nervosa, Bulimia nervosa.

Under these situations, we may not approve multiple root canal treatment and subsequent build- ups and crowns. We may consider allowing the extractions of the teeth and placing removable prosthetics when medical necessity can be established, and the Plan's clinical guidelines and criteria are met. Complex dental cases may only be approved when there is documentation for a high probability for success.

PRE-AUTHORIZATION REQUESTS:
https://www.healthchoiceaz.com/ProviderPortal/login/

*Benefits of your provider portal:

- ✓ Your office can submit and check the status of authorization immediately
- ✓ Your office can retrieve authorization numbers sooner than "standard-mail"
- ✓ You can schedule your patients sooner
- ✓ You have an electronic record of your transactions with BCBSAZ Health Choice
- ✓ It's FREE!

NEED HELP SIGNING UP TO USE THE PROVIDER PORTAL?

CONTACT BCBSAZ HEALTH CHOICE FOR ASSISTANCE!
480-968-6866

Standard Mail:
BCBSAZ Health Choice
8220 N. 23rd Ave.
Phoenix, AZ 85021

QUESTIONS?
https://www.azblue.com/health-choice-az/providers/provider-portal

PROVIDER SERVICES:
(480) 968-6866

ORAL HEALTH PROGRAM MANAGER:
sarab.sabagh@azblue.com