# Provider Dental Handbook

Dental Benefits: Covered Services and Associated Limitations

September 2011

Dear CareSource Dental Provider,

CareSource values our relationship with you and is working to strengthen that partnership. At CareSource, our goal is to help you improve and maintain the dental health of our members. The revised Dental Handbook is part of an initiative to improve efficiency and consistency in our dental management services and ensure our members have access to needed covered services.

The Dental Handbook is intended to be a resource for you and a helpful link between your office and CareSource. It provides important information on topics, such as covered services, claims submissions tips, attachment guidelines, services that require prior authorization and how to submit a prior authorization. Our intention is to make it easier for you to do business with us.

As always, we are interested in your feedback. We will continue to update information periodically and as necessary. The most recent version of this handbook is available online at www.caresource.com.

Our secure online Provider Portal is FREE and available 24 hours a day. You can access it by going to www.caresource.com and use it for many web-based transactions. Additional web-based services will be available in the months to come.

If you have inquiries about claims issues, covered services, patient eligibility or other member-related concerns, please check our website or contact CareSource Provider Services at 1-800-488-0134 from 8 a.m. to 6 p.m., Monday through Friday.

Your assigned Provider Relations Representative, Diona Taylor, is available to assist you with:

- Contractual questions or concerns
- Provider status information
- CareSource policies and procedures

Diona can be reached at (937) 531-2171 or via email at Diona.Taylor@Caresource.com. Also, you can reach our Manager, External Provider Relations, Mike Rouse at (614) 255-4616, or Chitra Walker, Director, External Provider Relations at (216) 896-8152.

Dental health is important for our members and much of it relies on you. Thank you for being a CareSource provider. We know you have a choice and we are pleased that you are part of our network.

Sincerely,

Terry Torbeck, M.D.
VP, Senior Medical Director

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*Unintentional typographical mistakes requiring correction will be communicated to providers on our website or in writing when needed. Reimbursement and fees are subject to change and will be communicated with a minimum of 60 days notice. Significant policy or procedure changes will be communicated in writing with 60 days notification.*

*Please refer to our provider section on our website, **www.caresource.com**, for the most current information on the CareSource dental program.*

# About Us

Welcome and thank you for becoming a participating provider with CareSource. We are a non-profit, community-based health plan that serves consumers of:

- Covered Families and Children (CFC) Medicaid, including Healthy Start and Healthy Families
- Aged, Blind or Disabled (ABD) Medicaid
- Medicare Advantage Special Needs Plan (SNP), who are full dual eligibles with Medicaid and Medicare benefits

CareSource distributes the member rights and responsibility statements to the following groups upon their enrollment and annually thereafter.

- New members
- Existing members
- New practitioners
- Existing practitioners

Our goal is to create an integrated health care home for our members. This means we focus on prevention and partnering with local health care providers to offer the services our members need to remain healthy.

***Our goal is to create an integrated health care home for our members.***

As a managed health care organization, we strive to improve the health of our members by utilizing a contracted network of participating health care providers. Primary Care Providers (PCPs) within the network provide a range of primary care services to our members, and also coordinate patient care by referring them to specialists when needed, or obtaining prior authorization from CareSource for certain services.

### Who we are

CareSource was founded on the principles of quality and service delivered with compassion and a thorough understanding of caring for underserved consumers. As a non-profit, we are mission-driven to provide quality care to our members. We offer process efficiencies and value-added benefits for our members and participating providers.

### Vision and mission

- Our **vision** is leading the way to healthier communities by empowering our members through advocacy, information and innovative health care.
- Our **mission** is to make a difference in the lives of underserved people by improving their health care.
- At CareSource, our mission is one we take to heart. In fact, we call our mission our “heartbeat.” It is the essence of our company, and our unwavering dedication is the hallmark of our success.

# Contact Us

### Hours of Operation

| | | | |
|---|---|---|---|
| Aged, Blind or Disabled (ABD) | M-F | 8am-5pm | Provider Services |
| Aged, Blind or Disabled (ABD) | M-F | 7am-7pm | Member Services |
| CareSource 24 (All Plans) | 24/7/365 | | Triage |
| Covered Families and Children (CFC) | M-F | 8am-6pm | Provider Services |
| Covered Families and Children (CFC) | M-F | 7am-7pm | Member Services |
| CareSource Advantage® Special Needs Plan (HMO SNP) | M-F | 8am-6pm | Provider Services |
| CareSource Advantage Special Needs Plan (HMO SNP) | M-F | 8am-8pm | Member Services |

Please visit our website for our holiday schedule or contact Provider Services for more information.

### Website

Aged, Blind or Disabled (ABD), Covered Families and Children (CFC), CareSource Advantage (HMO SNP): **www.caresource.com**

### Provider portal

**https://providerportal.caresource.com/OH/**

Providers can review the member's dental history on our free secure Provider Portal, including the specific tooth and four surface areas to all dental procedure codes.

***Providers can review the member's dental history on our secure Provider Portal, including the specific tooth and four surface areas to all dental procedure codes.***

### Correspondence address:

CareSource
P.O. Box 8738
Dayton, OH 45401-8738

### Provider appeals address (Medicaid/Medicare):

Please visit our website for more information on how appeals can be submitted. Appeals can be submitted through our secure Provider Portal, or in writing via the address listed below.

### Please submit written appeals to:

CareSource
P.O. Box 2008
Dayton, OH 45401-2008

**Member appeals & grievances mailing addresses (Medicaid/Medicare):**

CareSource
P.O. Box 1947
Dayton, OH 45401-1947

**Medicare Pharmacy Grievance and Appeals**
CVS Caremark
Attn: Medicare Casework Department
P.O. Box 22524
Salt Lake City, UT 84122-0524

**Claims mailing address (Medicaid/Medicare):**
CareSource
Attn: Claims Department
P.O. Box 8730
Dayton, OH 45401-8730

**Prior authorization address:**
CareSource
Attn: Medical Management Department
P.O. Box 1307
Dayton, OH 45401-1307

**Fraud, waste and abuse address (Medicaid/Medicare):**
CareSource
Attn: Special Investigations Department
P.O. Box 1940
Dayton, OH 45401-1940

Information reported to us can be reported ***anonymously*** and is kept ***confidential*** to the extent permitted by law.

# Dental Services that Require Prior Authorization

- Orthodontia services
- Root canals – if three or more root canal procedures are scheduled within six months
- All dentures
- All partial dentures
- Porcelain crown fused to noble metal (authorized for permanent anterior teeth only)
- Cast post and core in addition to crown (authorized for permanent anterior teeth without sufficient tooth structure to support a crown only)
- Frenulectomy
- Excision hyperplastic tissue
- Gingivectomy or gingivoplasty
- Impacted tooth removal – complete bony with complications
- Surgical removal of a residual tooth root
- Surgical removal of unerupted teeth
- Surgical removal of supernumerary teeth
- Removal of exostosis
- Unspecified Temporomandibular Joint Therapy (TMJ) therapy
- Unspecified TMJ films
- Removable appliances
- Fixed appliances
- All unspecified/miscellaneous dental codes

◗ Any health care provider who is not participating with CareSource must obtain prior authorization for all non-emergency services rendered to a CareSource member.

◗ CareSource accepts high quality diagnostic photographs and x-rays. Plaster models are no longer required for prior authorization.

*Any health care provider who is not participating with CareSource must obtain prior authorization for all non-emergency services rendered to a CareSource member.*

**How to submit for prior authorization**

**Call:** 1-800-488-0134
**Fax:** 1-888-752-0012
**Online:** Submit requests through our secure **Provider Portal**

*How to submit for prior authorization*

**Note:** Please check the charts in the back of this handbook to confirm if services have benefit limits, require prior authorization, or for charges submitted by report.

# D101. Diagnostic Services

## A. Clinical Examination

The following dental examination codes may be billed for any place of service in accordance with the coverage and limitations set forth below.

**D0120 Periodic oral examination**

- This includes an evaluation performed on an established patient to determine whether the patient's dental and medical health has changed since a previous comprehensive or periodic evaluation. The periodic oral examination includes periodontal screening and may require interpretation of information gathered through additional diagnostic procedures. Additional diagnostic procedures should be reported separately.
- The periodic oral evaluation may not occur more than **once every 180 days.** Examinations occurring more frequently will not be reimbursed.
- The periodic oral evaluation may not occur in combination with the comprehensive oral evaluation and not until 180 days after the comprehensive oral evaluation.

***The periodic oral evaluation may not occur more than once every 180 days.***

**D0140 Limited oral evaluation – problem focused**

- This is an evaluation limited to a specific oral health problem or complaint. It may require interpretation of information gathered through additional diagnostic procedures. Additional diagnostic procedures should be reported separately.
- This evaluation will include any necessary palliative treatment.
- Evaluations solely for the purpose of adjusting dentures are not covered.
- **This code may not be billed in conjunction with other dental procedures, with the exception of x-rays, on the same date of service.**

**D0150 Comprehensive oral evaluation – new or established patient**

- This code is typically used by a general dentist and/or specialist when evaluating a patient comprehensively. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. It may require interpretation of information gathered through additional diagnostic procedures. Additional diagnostic procedures should be reported separately.
- This code includes evaluation and recording of the patient's dental and medical history and a general health assessment. It also typically includes evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies and an oral cancer screening.

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**Note**: Please check the charts in the back of this handbook to confirm if services have benefit limits, require prior authorization, or for charges submitted by report.

- The comprehensive oral evaluation is limited to **one per provider-patient relationship.** The comprehensive oral evaluation may not occur in combination with the periodic evaluation.

*The comprehensive oral evaluation is limited to one per provider-patient relationship.*

## B. Radiographs/Diagnostic Imaging (including interpretation)

All radiographs submitted with prior authorization requests must be current and labeled with the member name, date of birth, date taken and indicate left or right side.

All radiographs and diagnostic photographs should be of diagnostic quality, properly mounted, properly exposed, clearly focused, clearly readable, and free from defect for the area of the mouth on which theses studies were performed.

**D0210 Intraoral – complete series (including bitewings)**
- A complete series of radiographs will consist of a minimum of 12 films, **including all periapical, bitewings and occlusal film necessary for the diagnosis.**
- Periapical films must show complete visibility of the periodontal ligament, crown and entire root structure.
- A complete series of radiographs is covered only **once every five years.** If a complete series of radiographs is required more frequently, prior authorization must be obtained.

**D0220 Intraoral periapical – first film**
**D0230 Each additional intraoral periapical film**
**D0240 Intraoral occlusal film**
**D0250 Extraoral first film – extraoral first film is covered as an adjunct to complex treatment**
**D0270 Bitewing – single film**
**D0272 Bitewing – two films**
**D0273 Bitewing – three films**
**D0274 Bitewing – complete series – minimum of four films**
- The complete bitewing series is reimbursable only for patients ages **12 and older** whose permanent second molars have erupted.
- Bitewing films must show complete visibility of clinical crowns with no overlapping. They cannot be substituted for periapical films in cases where endodontic treatment is necessary.
- Bitewings radiographs, in combination with other radiographs or when made alone, are covered **once every six months** as they do not exceed the limitations included in this section.

*Bitewings radiographs, in combination with other radiographs or when made alone, are covered once every six months as they do not exceed the limitations included in this section.*

**D0321 Temporomandibular joint films**
- Must submit letter of medical necessity; requires prior authorization.

**D0330 Panoramic film**
- The panoramic film is an extraoral radiograph on which the maxilla and mandible are depicted on a single film.
- All bitewing and periapical films needed to render the necessary radiographic diagnosis are included in the fee for panoramic radiographs.
- A panoramic radiograph is covered only **once every five years.** A minimum of five years must elapse between the provision of

*A panoramic radiograph is covered only once every five years.*

panoramic radiographs and a complete series of radiographs, or the service will not be reimbursed.

- Panoramic radiographs are covered for patients ages **six and older.** Prior authorization must be obtained for panoramic radiographs of patients younger than six.
- Panoramic films must show complete visibility of tooth crowns, roots, and bony and soft tissues in both arches with little or no overlapping of tooth crowns.

**D0340 Cephalometric film with tracing**

- Prior authorization is not required for cephalometric films and tracings when performed as part of an authorized comprehensive orthodontic treatment plan. Please refer to the section on "Orthodontic Services" for instructions.

***Prior authorization is not required for cephalometric films and tracings when performed as part of an authorized comprehensive orthodontic treatment plan.***

**D0350 Oral/facial images (includes intraoral and extraoral images)**

- Prior authorization is not required for diagnostic photographs when performed as part of an authorized evaluation or workup, or when they are used for evaluating a treatment option that this handbook states requires diagnostic photographs.

## C. Diagnostic Cast

**D0470 Diagnostic cast**

- Diagnostic casts for evaluation of treatment will be reimbursed, but not required to be submitted for review. CareSource only accepts intraoral photographs. Cast models are no longer accepted.

***CareSource only accepts intraoral photographs. Cast models are no longer accepted.***

# D102. Preventive Services

## A. Prophylaxis

Prophylaxis includes the necessary scaling and/or polishing of the teeth to remove coronal plaque, calculus, and stains of primary transitional or permanent dentition.

**D1110 Dental prophylaxis – adult**

- Dental prophylaxis for patients ages **14 years and older** will not be reimbursed more than **once every 180 days.**

**D1120 Dental prophylaxis – child**

- Dental prophylaxis for patients ages **13 and younger** will not be reimbursed more than **once every 180 days.**

## B. Fluoride Treatment

**D1203 Topical application of fluoride (prophylaxis not included) – child** (including sodium, stannous and acid phosphate fluoride, foam, gel, varnish and in-office rinse)

- Topical fluoride treatments are limited to **one application every 180 days** for patients **under the age of 21.**
- Topical fluoride treatments may be provided and billed by PCPs and pediatricians.
- Treatment that incorporates fluoride with the polishing compound is considered part of the prophylaxis procedure and not a separate topical fluoride treatment.
- **The following treatments are not covered**: topical application of fluoride to the prepared portion of a tooth prior to restoration, the use of self or home fluoride application procedures, and the application of sodium fluoride as a desensitizing agent.

## C. Sealants

Pit and fissure sealants are covered on previously unrestored occlusal areas of permanent molars subject to the following limitations:

**D1351 Sealant (permanent, per tooth)**

- Sealants are covered on **permanent first molars** and on **permanent second molars** for patients **under the age of 18**.
- Treatments in all other situations will not be reimbursed.
- Sealants are covered on teeth 2, 3, 14, 15, 18, 19, 30 and 31 only.
- Sealants are covered every two years.

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**Note:** Please check the charts in the back of this handbook to confirm if services have benefit limits, require prior authorization, or for charges submitted by report.

## D. Space Maintenance (passive appliances)

The preservation of arch length should be the main consideration in the evaluation of a patient for a space maintainer. Space maintainers are covered after the loss of a young permanent tooth or the premature loss of a primary tooth if the dentist cannot determine when the permanent tooth will erupt.

**Covered services:**
- **D1510 Space maintainer – fixed – unilateral, per quadrant**
- **D1515 Space maintainer – fixed – bilateral, per arch**
- **D1520 Space maintainer – removable – unilateral, per quadrant**
- **D1525 Space maintainer – removable – bilateral, per arch**

# D103. Restorative Services

## A. Amalgam Restorations (including polishing)

- No more than one occlusal surface restoration will be reimbursed unless the additional restorations are on a maxillary molar.
- Bases and copalite or calcium hydroxide liners placed under a restoration will be considered part of the restoration and are not reimbursable as separate procedures.
- Local anesthesia is included in the fee for all restorative services.
- No more than three restorations per tooth per date of service will be reimbursed regardless of the number of surfaces restored.
- Claims for amalgam restorations must indicate the tooth surface and tooth number treated.

*Local anesthesia is included in the fee for all restorative services.*

**Covered benefit:**

- **D2140 Amalgam – one surface – primary or permanent tooth**
- **D2150 Amalgam – two surfaces – primary or permanent tooth**
- **D2160 Amalgam – three surfaces – primary or permanent tooth**
- **D2161 Amalgam – four or more surfaces – primary or permanent tooth**

## B. Resin-Based Composite Restorations

- Resin-based composite restorations are covered for **anterior teeth** and Class I, Class II or Class V restorations on posterior teeth.
- Posterior resin-based restorations will be reimbursed at the same fee as the comparable amalgam restoration.
- The fee for resin-based composite restorations will include any necessary acid etching.
- No more than three restorations per tooth per date of service will be reimbursed regardless of the number of surfaces restored.
- Bases and copalite or calcium hydroxide liners placed under a restoration will be considered part of the restoration and are not reimbursable as separate procedures.
- Local anesthesia is included in the fee for all restorative services.
- Single surface resin-based composite restorations must involve repair of decay in the dentin.
- Claims for resin-based composite restorations must indicate the tooth surface and tooth number treated.
- Preventive resin-based restorations are not covered services.

*Posterior resin-based restorations will be reimbursed at the same fee as the comparable amalgam restoration.*

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**Covered services:**

- **D2330 Resin-based composite restoration – one surface – anterior**
- **D2331 Resin-based composite restoration – two surfaces – anterior**
- **D2332 Resin-based composite restoration – three surfaces – anterior**
- **D2335 Resin-based composite restoration – four or more surfaces or involving incisal (anterior)**
- **D2391 Resin-based composite restoration – one surface – posterior**
- **D2392 Resin-based composite restoration – two surfaces – posterior**
- **D2393 Resin-based composite restoration – three surfaces – posterior**
- **D2394 Resin-based composite restoration – four or more surfaces – posterior**

## C. Crowns

### D2752 Porcelain fused to noble metal

- Porcelain with metal crowns will be authorized for permanent anterior teeth only.
- Prior authorization is required for porcelain fused to noble metal for **permanent anterior teeth, teeth numbers 6-11 and 22-27** if provided for a functional need. Crowns only for cosmetic reasons will not be reimbursed.
- The fee includes the temporary crown placed on the prepared tooth and worn while the permanent crown is being prepared.
- A periapical radiograph, full mouth x-rays or panoramic film of the involved tooth/teeth must be submitted with each request to determine the overall health of the teeth and gums. See "Radiographs/ Diagnostic Imaging" section (including interpretation) for more information.
- All claims submitted for crowns must indicate the tooth number treated.

***Crowns only for cosmetic reasons will not be reimbursed.***

### D2930 Prefabricated stainless steel crown – primary tooth

- Stainless steel crowns are allowed only for teeth where multi-surface restorations are needed and when amalgam restorations and other materials are unlikely to be effective.

### D2931 Prefabricated stainless steel crown – permanent tooth

- Stainless steel crowns are allowed only for teeth where multi-surface restorations are needed and when amalgam restorations and other materials are unlikely to be effective.

**D2933 Prefabricated open-face stainless steel crowns (or stainless steel crowns with resin window)**

- Open-face prefabricated stainless steel crowns and stainless steel crowns with acrylic facings are covered for **anterior teeth only**.
- Stainless steel crowns are covered only for teeth that need multi-surface restorations and that have a poor prognosis for restoration with amalgam or other materials.
- The fee for open-face stainless steel crowns and stainless steel crowns with acrylic facings includes any necessary composite restoration.

**D2951 Pin retention (per tooth in addition to restoration)**

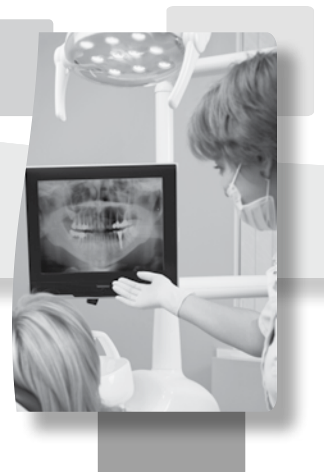
- A maximum of three pins per tooth will be reimbursed.

**D2952 Cast post and core in addition to crown**

- Prior authorization is required for cast post and core.
- Cast post and cores will be approved only for endodontically treated **permanent anterior teeth** that do not have sufficient tooth structure to support a crown. All other cast post and cores will not be reimbursed.

A periapical radiograph, full mouth x-rays or panoramic film of the involved tooth/teeth must be submitted with each request to determine the overall health of the teeth and gums. See “Radiographs/Diagnostic Imaging” section (including interpretation) for more information.

# D104. Endodontic Services



## A. Therapeutic Pulpotomy and Pulpal Therapy

**D3220 Therapeutic pulpotomy/pulpal therapy**

- Therapeutic pulpotomy or pulpal therapy is a covered service.
- Pulpotomy and pulpal therapy will not be reimbursed as separate procedures in combination with root canal therapy.
- Restoration for the completed pulpotomy or therapeutic pulpal therapy should be billed as a separate procedure.

## B. Complete Root Canal Therapy

- Root canal therapy is covered **only for permanent teeth.** Root canal therapy on primary teeth is not a covered service.
- Prior authorization is required for root canal therapy for **three or more procedures** scheduled within six months. Root canal therapy should be performed only when the overall health of the dentition and periodontium is good except for the endodontically indicated tooth or teeth.
- Radiographs, including periapicals, full mouth series or panoramic film submitted must show periapical radiolucency, or widening of periodontal ligament. Symptoms should include chronic pain (as evidenced by sensitivity to hot or cold, percussion or palpation), fistula associated with the tooth or chronic infection. If pathology is not visible on the radiograph, root canal treatment should be clinically documented.
- The fee for root canal therapy includes all diagnostic tests, evaluations, radiographs and postoperative treatments.

***PA is required for root canal therapy for three or more procedures scheduled within six months.***

**Prior authorization required:**

**D3310 Root canal therapy – anterior (excluding final restoration)**

- Prior authorization is required for root canal therapy if **three or more procedures** are scheduled within six months.

**D3320 Root canal therapy – bicuspids (excluding final restoration)**

- Prior authorization is required for root canal therapy if **three or more procedures** are scheduled within six months.

**D3330 Root canal therapy – molars (excluding final restoration)**

- Prior authorization is required for root canal therapy if **three or more procedures** are scheduled within six months.

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**Note:** Please check the charts in the back of this handbook to confirm if services have benefit limits, require prior authorization, or for charges submitted by report.

## C. Apexification/Recalcification Procedures

Apical closure does not include root canal therapy.

**D3351 Apexification/recalcification – initial visit (apical closure/ calcific repair of perforations, root resorption, etc.)**

- Apexification includes opening tooth, pulpectomy, preparation of canal spaces, first placement of medication and necessary radiographs. This procedure is the first phase of complete root canal therapy.

**D3352 Apexification/recalcification – interim medication replacement (apical closure/calcific repair or perforations, root resorption, etc.)**

- This procedure is for visits in which the intracanal medication is replaced with new medication and necessary radiographs are taken.

**D3353 Apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.)**

- This procedure includes removal of intracanal medication, placement of final root canal filling material and necessary radiographs. It is the last phase of root canal therapy.

## D. Apicoectomy/Periradicular Services

*Apicoectomy/ periradicular services are covered only on permanent teeth.*

**D3410 Apicoectomy/periradicular**

- Apicoectomy/periradicular services are covered **only on permanent teeth.**

# D105. Periodontic Services

## A. Gingivectomy or Gingivoplasty

**D4210 Gingivectomy or gingivoplasty – per quadrant**

- Prior authorization is required. Complete radiographs of the mouth, letter of medical necessity and diagnostic photographs must be submitted for review
- Gingivectomy and gingivoplasty surgery is not usually covered by CareSource. One exception is to correct severe hyperplasia or hypertrophic gingivitis associated with drug therapy or hormonal disturbances.

***Gingivectomy and gingivoplasty surgery is not usually covered by CareSource. One exception is to correct severe hyperplasia or hypertrophic gingivitis associated with drug therapy or hormonal disturbances.***

**Note:** Please check the charts in the back of this handbook to confirm if services have benefit limits, require prior authorization, or for charges submitted by report.

# D106. Removable Prosthodontic Services

## <u>A. Complete Dentures (including routine post-delivery care)</u>

- Prior authorization is required for all complete dentures.
- The need for dentures should be based on the total condition of the mouth, the desire to wear dentures and the ability to adjust to dentures. Natural teeth that have healthy bones must not be removed.
- In cases where the recipient is not edentulous prior to requesting dentures, complete radiographs of the mouth must be submitted with each denture request.
    - Radiographs must be taken prior to extractions.
    - Radiographs are not necessary for those individuals edentulous prior to requesting dentures.
- The dentist is responsible for constructing a complete, functional denture.
- A denture – complete, partial or combination – cannot be replaced or remade **within eight years,** except in very unusual circumstances for which new dentures can be justified.
- A preformed denture is <u>not a covered service</u> (e.g., with teeth already mounted or set in acrylic prior to initial impressions).
- A denture will not be authorized if the patient's dental history reveals that any or all dentures made in recent years have been unsatisfactory because of psychological or physiological reasons that cannot be remediated.
- The fee for dentures includes all necessary corrections for six months after the denture has been seated.

***A denture – complete, partial or combination – cannot be replaced or remade within eight years.***

***The fee for dentures includes all necessary corrections for six months after the denture has been seated.***

**Prior authorization required, benefit limits may apply:**
**D5110 Complete upper denture – maxillary**
**D5120 Complete lower denture – mandibular**

## <u>B. Partial Dentures</u>

- Prior authorization is required for all partial dentures.
- Partial dentures are considered medically necessary when several teeth are missing in the arch and masticatory function is severely impaired. Partial dentures are also considered medically necessary when anterior teeth are missing in the arch, affecting the patient's appearance.
- Partial dentures cannot be replaced, remade, or exchanged for complete dentures for **at least eight years,** except in very unusual circumstances for which new dentures can be justified.
- The provider is responsible for constructing a completely functional partial denture.
- The fee for partial dentures includes all necessary corrections and adjustments for six months after the denture has been seated.

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**Note**: Please check the charts in the back of this handbook to confirm if services have benefit limits, require prior authorization, or for charges submitted by report.

**Prior authorization required, benefit limits may apply:**
**D5211 Maxillary upper partial denture (resin-base, including conventional clasps, rests and teeth)**

- This procedure includes acrylic resin-based dentures with resin or wrought-wire clasps.

**D5212 Mandibular lower partial denture (resin-base, including conventional clasps, rests and teeth)**

- This procedure includes acrylic resin-base denture with resin or wrought-wire clasps.

**D5213 Maxillary upper denture partial (cast-metal framework with resin denture bases, including conventional clasps, rests and teeth)**

**D5214 Mandibular lower denture partial (cast-metal framework with resin denture bases, including conventional clasps, rests and teeth)**

## C. Repairs to Dentures

**Repairs to complete dentures:**

- **D5510 Repair broken complete denture base**
- **D5520 Replace missing or broken teeth – complete denture (each tooth)**

**Repairs to partial dentures:**

- **D5610 Repair resin denture base**
- **D5620 Repair cast framework**
- **D5630 Repair or replace broken clasp**
- **D5640 Replace broken teeth – per tooth**
- **D5650 Add tooth to existing partial denture**
- **D5660 Add clasp to existing partial denture**

## D. Denture Reline Procedures

- The reline must consist of the re-adaptation of the denture to the present oral tissues using accepted dental practice standards and procedures. The denture must be processed and finished with materials corresponding to the existing denture. **Chair side self-curing materials are not covered.**
- All complete and partial denture relining procedures include all necessary corrections for six months after the denture has been relined.
- A complete or partial denture reline will not be covered more than **once every four years,** and not until four years after the construction of a complete or partial denture (except in unusual circumstances that must be documented).

**Benefit limits may apply:**

- **D5750 Reline complete maxillary denture**
- **D5751 Reline complete mandibular denture**
- **D5760 Reline partial maxillary denture**
- **D5761 Reline partial mandibular denture**

# D107. Oral Surgery Services

## A. Extractions

- A tooth may be removed only if it cannot be saved because it is broken down, poorly supported by the alveolar bone, and/or affected by a pathological condition.
- Extractions that render a patient edentulous must be deferred until authorization to construct a denture has been given, except in an absolute emergency.
- The extraction of an impacted tooth will be authorized only when the impaction makes removal necessary.
- Prophylactic removal of asymptomatic teeth or teeth exhibiting no overt clinical pathology is covered only when at least one tooth is symptomatic.
- Local anesthesia and routine postoperative care are included in the fee for extractions.

*A tooth may be removed only if it cannot be saved because it is broken down, poorly supported by the alveolar bone, and/or affected by a pathological condition.*

**D7140 Extraction – erupted tooth or exposed root (elevation and/or forceps removal)**

- This code may be billed once per tooth and not in combination with another extraction or root recovery code.

**D7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth**

- This code cannot be billed with any other extraction or root recovery code for the same tooth.

**D7220, Removal of impacted tooth – soft tissue must be teeth 1, 16, 17, 32 (any other teeth require prior authorization)**

- A soft-tissue impaction occurs when a tooth requires an incision of overlying soft tissue and removal of the tooth without necessity of removing bone. Partial eruption of a tooth with portions of the crown at or above the occlusal plane does not disqualify the tooth as a soft-tissue impaction if the tooth's position is such that soft tissue covers portions of the occlusal surface, for example, a distoangular position.
- Third molars do not require prior authorization (teeth 1, 16, 17, 32)
- Removal of all other teeth require prior authorization

*Third molars do not require prior authorization (teeth 1, 16, 17, 32)*

**D7230 Removal of impacted tooth – partially bony (1, 16, 17, 30 – Removal of any other teeth requires prior authorization.)**

- A partial bony impaction occurs when the crown of the tooth is partially covered by bone. This tooth may or may not be partially

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**Note:** Please check the charts in the back of this handbook to confirm if services have benefit limits, require prior authorization, or for charges submitted by report.

erupted. This type of impaction requires an incision of overlying soft tissue, elevation of a flap, removal of bone, and removal of the tooth. Partial eruption of a tooth with portions of the crown at or above the occlusal plane does not disqualify this tooth from being classified a partial bony impaction if bone covers the greatest convexity of the distal portion of the crown. For example, a distoangular position within the ramus of the mandible.
- A radiograph of the impaction must be maintained in the patient's clinical record.
- If the impaction is not visible on a radiograph, it must be documented on a clinical basis.

**D7240 Removal of impacted tooth – complete bony**
- A complete bony impaction occurs when the crown of the tooth is completely covered by bone, or a substantial part of the tooth above the greatest convexity of the crown is covered by bone on both the mesial and distal sides, as demonstrated radiographically.
- For a horizontally impacted lower third molar to be classified as a complete bony impaction, the central groove of the crown must not be above the occlusal plane. This type of impaction requires an incision of overlying soft tissue, elevation of a flap, removal of bone, and sectioning of the tooth, if necessary, for removal.
- A radiograph of the impaction must be maintained in the patient's clinical record.

**D7241 Removal of impacted tooth – complete bony with unusual surgical complications**
- Prior authorization is required for this procedure. A radiograph of the impaction must be submitted with the request. Providers must submit the full mouth series or panoramic film for review.

## B. Other Surgical Procedures

**D7250 Surgical removal of a residual tooth root (cutting procedure)**
- Prior authorization is required for this procedure.
- This procedure involves surgical removal of a residual tooth root.
- A full mouth radiographic series or panoramic film must be submitted with the prior authorization request for review.

**D7270 Tooth reimplantation**
- Prior authorization is not required for reimplantation and/or stabilization of an accidentally avulsed or displaced tooth and/or alveolus.

**D7280 Surgical access of unerupted tooth**
- Prior authorization is required.
- This procedure is limited to situations in which an orthodontic attachment is placed to facilitate eruption.
- Radiographs of the area and treatment plan must be submitted.
- This service will be reimbursed only if **D8080** has been approved.
- Placement of device to facilitate eruption of impacted tooth.
- This procedure is limited to situations in which device is used to facilitate eruption.

*This procedure is limited to situations in which an orthodontic attachment is placed to facilitate eruption.*

- Radiographs of the area and treatment plan must be submitted.
- This service will be reimbursed only if **D8080** has been approved.

**D7999 Surgical removal of supernumerary tooth**

- In order to request prior authorization for removal of supernumerary tooth/teeth, use the code **D7999** and the correct tooth number.
- Prior authorization is required for this procedure. A radiograph must be submitted with the request.

***In order to request prior authorization for removal of supernumerary tooth/teeth, use the code D7999 and the correct tooth number.***

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**How to code D7999**

Providers must use the below codes when submitting supernumerary tooth removal claims:

| | |
|---|---|
| • Teeth 1-4 | Supernumerary 51-54 |
| • Teeth 5-8 | Supernumerary 55-58 |
| • Teeth 9-12 | Supernumerary 59-62 |
| • Teeth 13-16 | Supernumerary 63-66 |
| • Teeth 17-20 | Supernumerary 67-70 |
| • Teeth 21-24 | Supernumerary 71-74 |
| • Teeth 25-28 | Supernumerary 75-78 |
| • Teeth 29-32 | Supernumerary 79-82 |
| • Deciduous teeth A-C | Supernumerary AS-CS |
| • Deciduous teeth D-G | Supernumerary DS-GS |
| • Deciduous teeth H-J | Supernumerary HS-JS |
| • Deciduous teeth K-M | Supernumerary KS-MS |
| • Deciduous teeth N-Q | Supernumerary NS-QS |
| • Deciduous teeth R-T | Supernumerary RS-TS |

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## C. Biopsy

**D7285 Biopsy of oral tissue – hard (bone, tooth) for removal of specimen only**

- This code involves biopsy of osseous lesions and is not used for apicoectomy/periradicular surgery.

**D7286 Biopsy of oral tissue – soft**

- For surgical removal of an architecturally intact specimen only.
- This code is not used at the same time as codes for apicoectomy/periradicular curettage.

## D. Alveoplasty – Surgical Preparation of Ridges for Dentures

Alveoplasty is a covered service only when provided in conjunction with the construction of a prosthodontic appliance.

**Covered benefit:**

- **D7310 Alveoplasty – in conjunction with extractions – per quadrant**
- **D7320 Alveoplasty – not in conjunction with extractions – per quadrant**

## E. Surgical Excision

The removal of cysts or tumors is covered on a by report basis.

**The following charges must be included:**

- **D7450 Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm**
- **D7451 Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm**
- **D7460 Removal of benign non-odontogenic cyst or tumor – lesion diameter up to 1.25 cm**
- **D7461 Removal of benign non-odontogenic cyst or tumor – lesion diameter greater than 1.25 cm**

**D7471 Removal of lateral exostosis (mandible or maxilla)**

- Prior authorization required. Must submit diagnostic photographs with area of treatment marked.

## F. Surgical Incision

Incision and drainage of abscesses is covered on a by-report basis. A detailed explanation of the findings and treatment must be submitted.

- **D7510 Incision and drainage of abscess – intraoral soft tissue**
- **D7520 Incision and drainage of abscess – extraoral soft tissue**

## G. Treatment of Fractures

Treatment of fractures should be billed using codes from the American Medical Association's Current Procedural Terminology book.

***Treatment of fractures should be billed using codes from the American Medical Association's Current Procedural Terminology book.***

**D7671 Alveolus – open reduction (may include stabilization of teeth)**

- This procedure may be billed as a CPT code or dental code.

## H. Other Repair Procedures

**D7960 Frenulectomy (frenectomy or frenotomy) – separate procedure**

- Prior authorization is required for this procedure.
- Must submit diagnostic photographs with areas clearly demonstrated.

**D7970 Excision of hyperplastic tissue – per arch**

- Prior authorization is required for this procedure.
- Prior authorization is required with diagnostic photographs submitted.

## I. Oral Surgery Services

- Oral surgery services should be billed using procedure codes from the surgery section of this handbook, appropriate CPT codes or dental codes.
- Regardless of the code used, all claims must be submitted on the appropriate claim type.

***Regardless of the code used, all claims must be submitted on the appropriate claim type.***

# D108. Orthodontic Services

## A. Tooth Guidance Appliance

Prior authorization is required for all tooth guidance appliances to control harmful habits, including but not limited to, thumb-and finger-sucking, tongue-thrusting, crossbites and bruxism. Complete radiographs and photos of the mouth must be submitted with each request.

**Prior authorization is required:**

- **D8210 Removable appliance**
- **D8220 Fixed or cemented appliance**

## B. Comprehensive Orthodontics

The following policies and conditions must be strictly adhered to:

- As required by the Ohio Administrative Code, coverage of comprehensive orthodontics is limited to the most severe handicapping orthodontic conditions.
- Comprehensive orthodontics should be considered only after eruption of permanent centrals, laterals, first molars and first premolars. Exceptions can be made in the case of severe maxillary and/or mandibular growth abnormalities.
- Coverage is limited to patients younger than 21.
- Only one course of comprehensive orthodontic treatment per person, per lifetime is covered and is capped at a total dollar amount.
- All orthodontia services require prior authorization.

*As required by the Ohio Administrative Code, coverage of comprehensive orthodontics is limited to the most severe handicapping orthodontic conditions.*

*Only one course of comprehensive orthodontic treatment per person, per lifetime is covered and is capped at a total dollar amount.*

## Evaluation for Orthodontia Referral

Members may be referred to a CareSource participating orthodontic provider, or CareSource can assist the member in accessing a participating orthodontic provider, who will provide a comprehensive orthodontic work up.

If the orthodontic provider believes the member may meet the CareSource/ODJFS guidelines as having the most severe handicapping orthodontic condition, the orthodontic provider must submit the following information with the request for comprehensive orthodontic treatment:

**The referring orthodontic provider must submit to CareSource for review:**

- The **CareSource Orthodontia Evaluation and Pre-Determination Form**

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◗ **Appendix B** to verify that a minimum of five symptoms or signs are present, with at least two of the symptoms in the dentofacial abnormality section, and that the patient has a severe handicapping condition.

- A diagnostic complete series of radiographs or a diagnostic panoramic radiograph (**D0210** or **D0330**)
- Cephalometric film **D0340** – with tracings
- Lateral and frontal diagnostic photographs of the patient with lips together
- Any other supporting narrative information

All radiographs, diagnostic photographs, or other information submitted for the evaluation must be clearly labeled with the patient's name and the referring dentist's name.

*All radiographs, diagnostic photographs, or other information submitted for the evaluation must be clearly labeled with the patient's name and the referring dentist's name.*

Diagnostic photographs, cephalometric film and tracing, and the diagnostic photographs performed as part of the orthodontic evaluation or workup do not require prior authorization and will be reimbursed according to the applicable codes.

All information submitted will be reviewed by a CareSource dental reviewer. If the CareSource dental reviewer determines that the patient's condition meets the established CareSource/ODJFS guidelines as having the most severe handicapping orthodontic condition, an authorization for comprehensive orthodontia will be given.

If it is determined that the patient's condition does not meet the established CareSource/ODJFS guidelines as having the most severe handicapping orthodontic condition, a denial for comprehensive orthodontic treatment will be issued and CareSource will notify the member of the denial.

If the request for comprehensive orthodontic treatment is approved, an authorization will be sent to the requesting provider, which will confirm authorization for the entire course of treatment (valid only if the patient remains an eligible CareSource member).

*If the request for comprehensive orthodontic treatment is approved, an authorization will be sent to the requesting provider, which will confirm authorization for the entire course of treatment.*

## Payment Policies and Procedures – For Orthodontia

1. CareSource members who meet the most severe handicapping condition for orthodontia are eligible for a **once in a lifetime orthodontia payment benefit.**
2. Because member's enrollment status may change from month to month, member eligibility must be verified each month during treatment. CareSource cannot provide payment for ineligible members. If the member becomes ineligible during the time that comprehensive orthodontic treatment is being rendered, the monthly payment will cover only the months of treatment the member was eligible.
3. If breaks in service occur for enrollment reasons or otherwise, benefits will be payable only while the patient is being regularly treated and eligible for CareSource. It is the responsibility of the patient and the dentist to determine a payment mechanism for subsequent monthly

payments for treatment provided if/when the patient is ineligible for CareSource.

4. CareSource will work with members and providers to ensure member compliance and continuity of care with the same orthodontic provider.
5. The diagnostics **(D0330, D0340, D0350)** to confirm medical necessity for orthodontia will be reimbursed separately.
6. For cases approved for treatment, CareSource will issue authorization for **D8080** and a total of 23 monthly payments of **D8030**, which will constitute payment for the full course of treatment.
7. The banding and first month of treatment should be billed using code **D8080**.
8. For subsequent months of service, providers should submit claims for the months the member was eligible and in active treatment.
9. Payment will be made for retention services after active treatment is completed utilizing code **D8680**.
10. Payment will not be made for active treatment after retention has begun.

**Special situations:**

11. Requests made by members to change orthodontic providers (because of enrollment changes, orthodontic provider participation changes, or for other reasons) will be discouraged and closely reviewed. The review will also determine further treatment and payment methods.
12. Patients currently enrolled in CareSource who require a change in orthodontic providers will maintain coverage according to the orthodontia benefit limits in effect at time of transfer. Reimbursement arrangements with the accepting orthodontic provider will be arranged on an individual basis up to the remaining benefit maximum upon review of a treatment plan. Please see **Appendix D**.
13. Payment for active treatment will be made for a maximum of 23 monthly payments. In some cases more than 24 months may be necessary to complete treatment. However, the fee associated with 24 months of treatment is the maximum amount reimbursable and is considered payment-in-full. No additional reimbursement can be sought from CareSource, the member, or other source if the treatment requires additional services greater than 24 months.

## Codes to use in submitting claims:

Diagnostic Records (as required)

**Reimbursement (may vary based on Medicaid fee schedule):**
**D0330 Panoramic film**
**D0340 Cephalometric film**
**D0350 Oral/facial images intraoral & extraoral**
**D0470 Diagnostic casts**

**Prior authorization is required:**
**D8030 Monthly orthodontic treatment – limit 23 months**
**D8080 Banding and first month of orthodontic treatment**
**D8680 Post-treatment stabilization visit – up to 2 units – limited to one upper and one lower retainer**

# D109. Other Covered Services

## A. General Anesthesia

**D9220 General anesthesia/deep sedation – first 30 minutes**

- General anesthesia is a covered service when administered by an eligible provider and may be reimbursed separately from the dental procedure.
- The cost of analgesic and local anesthetic agents is included in the fees associated with covered dental services reimbursed by the Medicaid program and is **not reimbursed separately.**
- General anesthesia is defined as a controlled state of unconsciousness accompanied by partial or complete loss of protective reflexes, inability to independently maintain an airway, and inability to respond purposefully to physical stimulation or verbal command, with the result being amnesia related to the surgical procedure.
- General anesthesia will be reimbursed at a flat rate per patient per date of service. A $25 incentive payment will be added if the general anesthesia is provided in an office setting.
- The administration of general anesthesia will be covered for surgical and restorative procedures when performed by an eligible provider as defined in rule 5101:3-5-01 of the Ohio Administrative Code.

***General anesthesia is a covered service when administered by an eligible provider and may be reimbursed separately from the dental procedure.***

***A $25 incentive payment will be added if the general anesthesia is provided in an office setting.***

## B. Dental Service Performed Outside the Office

Dental services rendered to patients in long-term care facilities or private homes are covered and subject to the following policies and limitations:

- Updated copies of the patient's medical and dental history, diagnosis, prognosis and treatment plan must be maintained in the patient's long-term care facility and in the provider's office. These records must include a clinical examination and charting of the oral cavity and teeth, including pulp testing when indicated. The charting diagram must reflect the total condition of the mouth.
- Copies of the request for treatment signed by the patient, family member, responsible guardian, or attending physician, must be maintained with the patient's records at the long-term care facility and the provider's office.
- The request for treatment statement should be as follows:

*I am currently residing at (insert facility) and am requesting that Dr. (insert provider's name) provide me with dental services that I need.*

*Patient's Name*
*Signature of patient, family member, guardian or attending physician*

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**Note:** Please check the charts in the back of this handbook to confirm if services have benefit limits, require prior authorization, or for charges submitted by report.

- When requesting dental services that require prior authorization, a copy of the request for treatment must be submitted along with any necessary diagnostic photographs or radiographs. When requesting complete or partial dentures for patients in long-term care facilities, the dentist must submit a copy of the patient's most recent nursing-care plan with the request.
- The dental exam does not require prior authorization and may be billed for each patient examined. The dental exam may not occur more than once every 180 days per patient.

## C. Inpatient Hospital Services

All inpatient hospital admissions require prior authorization and must be coordinated through the CareSource Medical Management Department.

## D. Temporomandibular Joint Therapy

**D7899 Unspecified TMJ therapy**

- All treatment for Temporomandibular Joint Disorder requires prior authorization. Panoramic radiographs, diagnostic photographs and a report of clinical findings and symptoms must be submitted with each request for pre-determination.
- **The fee** for Temporomandibular Joint Therapy includes **six months of adjustments.**

***The fee for Temporomandibular Joint Therapy includes six months of adjustments.***

## E. Maxillofacial Prosthetics

**D5999 Unspecified maxillofacial prosthesis**

- Prior authorization is required for maxillofacial prosthetics. The dentist must submit a detailed treatment plan, full mouth radiographs, and hospital operative report, if applicable, for authorization.

## F. Miscellaneous

**D9420 Hospital call is not a covered service and is included in the payment for the procedure**

- The administration of general anesthesia will be covered for surgical and restorative procedures when performed by an eligible provider as defined in rule 5101:3-5-01 of the Ohio Administrative Code.
- The cost of analgesic and local anesthetic agents is included in the fees associated with dental services reimbursed by the Medicaid program.

**D9610 Therapeutic drug injection by report**

- Therapeutic drug injections are authorized on a by-report basis. The J-code and/or NDC number and the quantity injected should be included.

**D9999 Miscellaneous services (complications, unspecified adjunctive procedure)**

- This code is used for unusual and/or specialized treatment necessary to safeguard the health of the patient.
- Prior authorization is required for these procedures. The dentist must submit detailed information on the difficulty of the procedure.
- Complete radiographs of the mouth must be included, if indicated, for authorization.
- An estimate of the usual fee charged for the service must also be submitted.

# Appendices

## Appendix A – Summary Grids

- **Diagnostic Services**
- **Preventive Services**
- **Restorative Services**
- **Endodontic and Periodontic Services**
- **Removable Prosthodontic Services**
- **Oral Surgery Services**
- **Orthodontic Services**
- **Other Covered Services**

**Note:** CareSource utilizes the guidelines published by the Ohio Department of Job and Family Services: Medicaid guidelines and the Ohio Administrative Code. Please consult the benefit grid for limitations.

| DIAGNOSTIC SERVICES | | | | | | |
|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age limitations** | **Teeth covered** | **Authorization required** | **Benefit limitations** | **Documentation required** |
| D0120 | Periodic oral exam | 0-120 | All | No | One per 6 months | None |
| D0140 | Limited oral evaluation – problem focused | 0-120 | All | No | | None |
| D0150 | Comprehensive oral evaluation – new or established patient | 0-120 | All | No | One per provider-patient relationship | None |
| D0210 | Intraoral – complete series (including bitewings) | 0-120 | All | No | 1 every 5 years. A complete series of radiographs is allowed once every 5 years. | None |
| D0220 | Intraoral periapical – first film | 0-120 | All | No | | None |
| D0230 | Each additional intraoral periapical film | 0-120 | All | No | | None |
| D0240 | Intraoral occlusal film | 0-120 | All | No | | None |
| D0250 | Extraoral first film | 0-120 | All | No | | None |
| D0270 | Bitewing – single film | 0-120 | All | No | 6 months | None |
| D0272 | Bitewing – two films | 0-120 | All | No | 6 months | None |
| D0273 | Bitewing – three films | 0-120 | All | No | 6 months – The complete bitewing series is reimbursable only for patients ages 12 and older whose permanent second molars have erupted. Bitewing films must show complete visibility of clinical crowns with no overlapping. | None |
| D0274 | Bitewing complete series – minimum of 4 films | 0-120 | All | No | 6 months – The complete bitewing series is reimbursable only for patients ages 12 and older whose permanent second molars have erupted. Bitewing films must show complete visibility of clinical crowns with no overlapping. | None |
| D0321 | Temporomandibular joint films | 6-120 | All | Yes | | Must submit letter of medical necessity |
| D0330 | Panoramic film | 6-120 | All | No | One every 5 years.<br>Films must show complete visibility of tooth crowns, roots, and bony and soft tissues. | None |
| D0340 | Cephalometric film with tracing | 0-120 | All | No, if in conjunction with orthodontic treatment | In conjunction with orthodontia treatment. | None |
| D0350 | Oral/facial images – includes intraoral and extraoral images | 0-120 | All | | | None |
| D0470 | Diagnostic cast | 0-120 | All | | | None |

| PREVENTIVE SERVICES | | | | | | |
|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age limitations** | **Teeth covered** | **Authorization required** | **Benefit limitations** | **Documentation required** |
| D1110 | Dental prophylaxis – adult | 14-120 | All | No | One per 6 months | None |
| D1120 | Dental prophylaxis – child | 0-13 | All | No | One per 6 months | None |
| D1203 | Topical application of flouride – child | 0-20 | All | No | One per 6 months. Topical fluoride treatments may be provided and billed by PCPs and pediatricians. | None |
| D1351 | Sealant for tooth (permanent, per tooth) | 6-18 | 2, 3, 14, 15, 18, 19, 30, 31 | No | Permanent, first and second molars for under 18 years of age. | None |
| D1510 | Space maintainer – fixed – unilateral, per quadrant | 0-120 | All | No | Space maintainers are covered after the loss of a young permanent tooth or the premature loss of a primary tooth if the dentist cannot determine when the permanent tooth will erupt. | None |
| D1515 | Space maintainer – fixed bilateral, per arch | 0-120 | All | No | | None |
| D1520 | Space maintainer – removable – unilateral per quadrant | 0-120 | All | No | | None |
| D1525 | Space maintainer – removable – bilateral, per arch | 0-120 | All | No | | None |

| RESTORATIVE SERVICES | | | | | | |
|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age limitations** | **Teeth covered** | **Authorization required** | **Benefit limitations** | **Documentation required** |
| D2140 | Amalgam – one surface – primary or permanent tooth | 0-120 | All | No | No more than 3 restorations per tooth will be reimbursed regardless of the number of surfaces restored. A maximum of 3 pins per tooth restoration will be allowed as a covered service. Bases and copalite or calcium hydroxide liners placed under a restoration will be considered part of restoration and is not reimbursable as separate procedures. | Payment will not be made for separate occlusal restorations, other than on maxillary molars, reimbursement for occlusal surface restorations, other than on maxillary molars, includes 1 or more restorations on that surface. |
| D2150 | Amalgam – two surface – primary or permanent tooth | 0-120 | All – 2 surfaces | No | No more than 3 restorations per tooth will be reimbursed regardless of the number of surfaces restored. A maximum of 3 pins per tooth restoration will be allowed as a covered service. Bases and copalite or calcium hydroxide liners placed under a restoration will be considered part of restoration and is not reimbursable as separate procedures. | Payment will not be made for separate occlusal restorations, other than on maxillary molars. Reimbursement for occlusal surface restorations, other than on maxillary molars, includes 1 or more restorations on that surface. |
| D2160 | Amalgam – three surfaces – primary or permanent tooth | 0-120 | All – 3 surfaces | No | No more than 3 restorations per tooth will be reimbursed regardless of the number of surfaces restored. A maximum of 3 pins per tooth restoration will be allowed as a covered service. Bases and copalite or calcium hydroxide liners placed under a restoration will be considered part of restoration and is not reimbursable as separate procedures. | Payment will not be made for separate occlusal restorations, other than on maxillary molars. Reimbursement for occlusal surface restorations, other than on maxillary molars, includes 1 or more restorations on that surface. |
| D2161 | Amalgam – four or more surfaces – primary or permanent tooth | 0-120 | All – four or more surfaces | No | No more than 3 restorations per tooth will be reimbursed regardless of the number of surfaces restored. A maximum of 3 pins per tooth restoration will be allowed as a covered service. Bases and copalite or calcium hydroxide liners placed under a restoration will be considered part of restoration and is not reimbursable as separate procedures. | Payment will not be made for separate occlusal restorations, other than on maxillary molars. Reimbursement for occlusal surface restorations, other than on maxillary molars, includes 1 or more restorations on that surface. |

**RESTORATIVE SERVICES – continued**

| Code | Description | Age limitations | Teeth covered | Authorization required | Benefit limitations | Documentation required |
|---|---|---|---|---|---|---|
| D2330 | Resin-based composite restoration – one surface – anterior | 0-120 | Tooth #: 6-11, 22-27, C-H, M-R 1 surface | No | Resin-based composite restorations will be permitted for anterior teeth and class I or class V restorations on posterior teeth. Maximum of 3 pins per tooth will be allowed as a covered service. | No more than 3 restorations per tooth, regardless of the number of surfaces restored. Preventive resin restorations are not covered. |
| D2331 | Resin-based composite restoration – two surfaces – anterior | 0-120 | Tooth #: 6-11, 22-27, C-H, M-R 2 surfaces | No | Resin-based composite restorations will be permitted for anterior teeth and class I or class V restorations on posterior teeth. Maximum of 3 pins per tooth will be allowed as a covered service. | No more than 3 restorations per tooth, regardless of the number of surfaces restored. Preventive resin restorations are not covered. |
| D2332 | Resin-based composite restoration – three surfaces – anterior | 0-120 | Tooth #: 6-11, 22-27, C-H, M-R 3 surfaces | No | Resin-based composite restorations will be permitted for anterior teeth and class I or class V restorations on posterior teeth. Maximum of 3 pins per tooth will be allowed as a covered service. | No more than 3 restorations per tooth, regardless of the number of surfaces restored. Preventive resin restorations are not covered. |
| D2335 | Resin-based composite restoration – four or more surfaces – anterior | 0-120 | Tooth #: 6-11, 22-27, C-H, M-R 4 surfaces | No | Resin-based composite restorations will be permitted for anterior teeth and class I or class V restorations on posterior teeth. Maximum of 3 pins per tooth will be allowed as a covered service. | No more than 3 restorations per tooth, regardless of the number of surfaces restored. Preventive resin restorations are not covered. |
| D2391 | Resin-based composite restoration – one surface – posterior | 0-120 | Tooth #: A, B, I, J, K, L, S, T, 1-5, 12-21, 28-32 1 surface | No | Resin-based composite restorations will be permitted for anterior teeth and class I or class V restorations on posterior teeth. Maximum of 3 pins per tooth will be allowed as a covered service. | No more than 3 restorations per tooth, regardless of the number of surfaces restored. Preventive resin restorations are not covered. |
| D2392 | Resin-based composite restoration – two surfaces – posterior | 0-120 | Tooth #: A, B, I, J, K, L, S, T, 1-5, 12-21, 28-32 2 surfaces | No | Resin-based composite restorations will be permitted for anterior teeth and class I or class V restorations on posterior teeth. Maximum of 3 pins per tooth will be allowed as a covered service. | No more than 3 restorations per tooth, regardless of the number of surfaces restored. Preventive resin restorations are not covered. |

**RESTORATIVE SERVICES – continued**

| Code | Description | Age limitations | Teeth covered | Authorization required | Benefit limitations | Documentation required |
|---|---|---|---|---|---|---|
| D2393 | Resin-based composite restoration – three surfaces – posterior | 0-120 | Tooth #: A, B, I, J, K, L, S, T, 1-5, 12-21, 28-32 3 surfaces | No | Resin-based composite restorations are permitted for posterior teeth and class I or class V restorations on posterior teeth. Maximum of 3 pins per tooth will be allowed as a covered service. | No more than 3 restorations per tooth, regardless of the number of surfaces restored. Preventive resin restorations are not covered. |
| D2394 | Resin-based composite restoration – four or more surfaces – posterior | 0-120 | Tooth #: A, B, I, J, K, L, S, T, 1-5, 12-21, 28-32 4 surfaces | No | Resin-based composite restorations will be permitted for posterior teeth and class I or class V restorations on posterior teeth. Maximum of 3 pins per tooth will be allowed as a covered service. | No more than 3 restorations per tooth, regardless of the number of surfaces restored. Preventive resin restorations are not covered. |
| D2752 | Porcelain fused to noble metal | 0-120 | Teeth 6-11 and 22-27 | Yes | Porcelain with metal crowns for all other teeth is not a covered service. The fee for crowns includes the temporary crown placed on the prepared tooth and worn. All claims for crowns must contain the tooth number. | A periapical radiograph, full mouth x-rays or panoramic film of the involved tooth/teeth must be submitted with each request to determine the overall health of the teeth and gums. |
| D2930 | Prefabricated stainless steel crown – primary tooth | 0-120 | Tooth # A-T | No | Open face prefabricated stainless steel crowns and stainless steel crowns with acrylic facings are covered for anterior teeth only. | None |
| D2931 | Prefabricated stainless steel crown – permanent tooth | 0-120 | 1-32 | No | Open face prefabricated stainless steel crowns and stainless steel crowns with acrylic facings are covered for anterior teeth only. | None |
| D2933 | Prefabricated open-face stainless steel crown with resin window | 0-120 | Tooth # C-H, M-R | No | | None |
| D2951 | Pin retention | 0-120 | All | No | Maximum three pins per tooth will be reimbursed. | None |
| D2952 | Cast post and core in addition to crown | 0-120 | Tooth # 6-11, 22-27 | Yes | | A periapical radiograph, full mouth x-rays or panoramic film of the involved tooth/teeth must be submitted with each request to determine the overall health of the teeth and gums. |

| ENDODONTIC AND PERIODONTIC SERVICES | | | | | | |
|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age limitations** | **Teeth covered** | **Authorization required** | **Benefit limitations** | **Documentation required** |
| D3220 | Therapeutic pulpotomy/ pulpal therapy | 0-120 | All | No | Pulpotomy and pulpal therapy will not be reimbursed as separate procedures in combination with root canal therapy. | None |
| D3310 | Root canal therapy – anterior (excluding final restoration) | 0-120 | Tooth # 6-11, 22-27 | Yes, for all ages if 3 or more procedures within 6 months. | All diagnostic tests, evaluations, radiographs, and postoperative treatments are included in the fee. Root canal therapy is authorized only for permanent teeth. | A periapical radiograph, full mouth x-rays or panoramic film of the involved tooth/teeth must be submitted with each request to determine the overall health of the teeth and gums. |
| D3320 | Root canal therapy-bicuspids (excluding final restoration) | 0-120 | Bicuspids Tooth # 5, 12, 13, 20, 21, 28, 29 | Yes, for all ages if 3 or more procedures within 6 months. | All diagnostic tests, evaluations, radiographs, and postoperative treatments are included in the fee. Root canal therapy is authorized only for permanent teeth. | A periapical radiograph, full mouth x-rays or panoramic film of the involved tooth/teeth must be submitted with each request to determine the overall health of the teeth and gums. |
| D3330 | Root canal therapy – molars (excluding final restoration) | 0-120 | Tooth # 1-3, 14-19, 30-32 | Yes, for all ages if 3 or more procedures within 6 months. | All diagnostic tests, evaluations, radiographs and postoperative treatments are included in the fee. | A periapical radiograph, full mouth x-rays or panoramic film of the involved tooth/teeth must be submitted with each request to determine the overall health of the teeth and gums. |
| D3351 | Apexification/recalcification – initial visit | 0-120 | All | No | Apical closure does not include root canal therapy. Prior authorization is not required for each apexification/recalcification procedure. | None |
| D3352 | Apexification/recalcification – interim medication replacement | 0-120 | All | No | This procedure is for visits in which the intracanal medication is replaced with new medication and necessary radiographs are taken. | None |

**ENDODONTIC AND PERIODONTIC SERVICES – continued**

| Code | Description | Age limitations | Teeth covered | Authorization required | Benefit limitations | Documentation required |
|---|---|---|---|---|---|---|
| D3353 | Apexification/recalcification – final visit | 0-120 | All | No | This procedure includes removal of intracanal medication, placement of final root canal filling material and necessary radiographs. It is the last phase of root canal therapy. | None |
| D3410 | Apicoectomy/periradicular | 0-120 | Permanent teeth only | No | | None |
| D4210 | Gingivectomy or gingivoplasty – per quadrant | 0-120 | All | Yes | Covered once per 12 months for a minimum of four teeth in the affected quadrant. Covered to correct severe hyperplastic or hypertrophic gingivitis associated with drug therapy or hormonal disturbances. | Complete radiographs of the mouth, letter of medical necessity and diagnostic photographs. |

| REMOVABLE PROSTHODONTIC SERVICES | | | | | | |
|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age limitations** | **Teeth covered** | **Authorization required** | **Benefit limitations** | **Documentation required** |
| D5110 | Complete upper denture – maxillary | 16-120 | Upper | Yes | A denture – complete, partial or combination – cannot be replaced or remade within eight years, except in very unusual circumstances. A pre-formed denture with teeth already mounted (that is, teeth already set in acrylic prior to initial impressions) is not a covered service. | Panoramic film or complete series of x-rays or documentation of edentulous condition. |
| D5120 | Complete lower denture – mandibular | 16-120 | Lower | Yes | A denture – complete, partial or combination – cannot be replaced or remade within eight years, except in very unusual circumstances. A pre-formed denture with teeth already mounted (that is, teeth already set in acrylic prior to initial impressions) is not a covered service. | Panoramic film or complete series of x-rays or documentation of edentulous condition. |
| D5211 | Maxillary upper partial denture (resin-base, including conventional clasps, rests and teeth) | 16-120 | All | Yes | Procedure includes acrylic resin-based dentures with resin or wrought – wire clasps. | Panoramic film or complete series of x-rays. |
| D5212 | Mandibular lower partial denture (resin-base, including conventional clasps, rests and teeth) | 16-120 | All | Yes | Procedure includes acrylic resin-based dentures with resin or wrought – wire clasps. | Panoramic film or complete series of x-rays. |
| D5213 | Maxillary upper denture partial (cast-metal framework with resin denture bases, including conventional clasps, rests and teeth) | 16-120 | All | Yes | A denture – complete, partial or combination – cannot be replaced or remade within eight years, except in very unusual circumstances. | Panoramic film or complete series of x-rays. |
| D5214 | Mandibular lower denture partial (cast-metal framework with resin denture bases, including conventional clasps, rests and teeth) | 16-120 | All | Yes | A denture – complete, partial or combination – cannot be replaced or remade within eight years, except in very unusual circumstances. | Panoramic film or complete series of x-rays. |
| D5510 | Repair broken complete denture base | 6-120 | All | No | Repair to complete dentures | None |
| D5520 | Replace missing or broken teeth – complete denture (each tooth) | 6-120 | All | No | Repair to complete dentures | None |
| D5610 | Repair resin denture base | 6-120 | All | No | Repair to partial dentures | None |
| D5620 | Repair cast framework | 6-120 | All | No | Repair to partial dentures | None |

**REMOVABLE PROSTHODONTIC SERVICES – continued**

| Code | Description | Age limitations | Teeth covered | Authorization required | Benefit limitations | Documentation required |
|---|---|---|---|---|---|---|
| D5630 | Repair or replace broken clasp | 6-120 | All | No | Repair to partial dentures | None |
| D5640 | Replace broken teeth – per tooth | 6-120 | All | No | Repair to partial dentures | None |
| D5650 | Add tooth to existing partial denture | 6-120 | All | No | Repair to partial dentures | None |
| D5660 | Add clasp to existing partial denture | 6-120 | All | No | Repair to partial dentures | None |
| D5750 | Reline complete maxillary denture | 6-120 | All | No | Reline dentures | None |
| D5751 | Reline complete mandibular denture | 6-120 | All | No | Reline dentures | None |
| D5760 | Reline to partial maxillary denture | 6-120 | All | No | Reline partial dentures | None |
| D5761 | Reline to partial mandibular denture | 6-120 | All | No | Reline partial dentures | None |

| ORAL SURGERY SERVICES | | | | | | |
|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age limitations** | **Teeth covered** | **Authorization required** | **Benefit limitations** | **Documentation required** |
| D7140 | Extraction, erupted tooth or exposed root (elevation and/ or forceps removal) | 0-120 | All | No | | None |
| D7210 | Surgical removal of erupted tooth | 0-120 | All | No | | None |
| D7220 | Removal of impacted tooth – soft tissue | 10-120 | 1, 16, 17 and 32 | Yes if any other tooth number | Removal of asymptomatic tooth not covered. | Panoramic film or complete series of x-rays. |
| D7230 | Removal of impacted tooth – partially bony | 10-120 | 1, 16, 17, and 32 | Yes if any other tooth number | Removal of asymptomatic tooth not covered. | Panoramic film or complete series of x-rays. |
| D7240 | Removal of impacted tooth – complete bony | 10-120 | All | No | Removal of asymptomatic tooth not covered. | Pre-operative radiographs of adjacent and opposing teeth. |
| D7241 | Removal of impacted tooth – complete bony with unusual surgical complications | 10-120 | All | Yes | Used for unusual complications such as nerve dissection, separate closure of the maxillary sinus, or aberrant tooth position. Removal of asymptomatic tooth not covered. | Pre-operative radiographs excluding bitewing radiographs of adjacent and opposing teeth. |
| D7250 | Surgical removal of a residual tooth root (cutting procedure) | 6-120 | All | Yes | Removal of asymptomatic tooth not covered. | Pre-operative radiographs excluding bitewing radiographs of adjacent and opposing teeth. |
| D7270 | Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth | 6-120 | All | No | Includes splinting and or stabilization. | None |
| D7280 | Surgical access of unerupted tooth | 6-20 | All | Yes | Will not be paid unless orthodontia treatment has been authorized as a covered benefit. Treatment plan must be submitted. | Pre-operative radiographs of adjacent and opposing teeth. |
| D7285 | Biopsy of oral tissue – hard | 0-120 | All | No | | None |
| D7286 | Biopsy of oral tissue – soft (all others) | 0-120 | All | No | | None |
| D7310 | Alveoloplasty – in conjunction with extractions – per quadrant | 16-120 | All | No | Alveoloplasty is a covered service only when provided in conjunction with the construction of a prosthodontic appliance. | None |
| D7320 | Alveoloplasty – not in conjunction with extractions – per quadrant | 16-120 | All | No | Alveoloplasty is a covered service only when provided in conjunction with the construction of a prosthodontic appliance. | None |

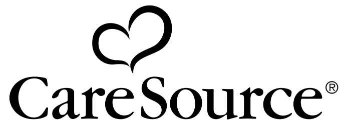
**ORAL SURGERY SERVICES – continued**

| Code | Description | Age limitations | Teeth covered | Authorization required | Benefit limitations | Documentation required |
|---|---|---|---|---|---|---|
| D7450 | Removal of **benign** odontogenic cyst or tumor – lesion diameter up to 1.25 cm | 0-120 | All | No | | None |
| D7451 | Removal of **benign** odontogenic cyst or tumor – lesion diameter greater than 1.25 cm | 0-120 | All | No | | None |
| D7460 | Removal of **benign** non-odontogenic cyst or tumor – lesion diameter up to 1.25 cm | 0-120 | All | No | | None |
| D7461 | Removal of **benign** non-odontogenic cyst or tumor – lesion diameter greater than 1.25 cm | 0-120 | All | No | | None |
| D7471 | Removal of lateral exostosis (mandible or maxilla) | 6-120 | | Yes | | Diagnostic photographs |
| D7510 | Incision and drainage of abscess – intraoral soft tissue | 0-120 | All | No | | None |
| D7520 | Incision and drainage of abscess – extraoral soft tissue | 0-120 | All | No | | None |
| D7671 | Alveolus – open reduction (may include stabilization of teeth) | 16-120 | All | No | | None |
| D7899 | Unspecified TMJ therapy | 6-120 | All | Yes | | Must provide tooth number and clinical panoramic radiograph or x-rays. |
| D7960 | Frenulectomy (or **frenotomy**) – separate procedure | 0-120 | All | Yes | | Diagnostic photographs |
| D7970 | Excision of hyperplastic tissue – per arch | 0-120 | All | Yes | | Diagnostic photographs |
| D7999 | Surgical removal of supernumerary tooth – must use correct tooth number | 0-120 | All super-numerary teeth | Yes | | Panoramic film or complete series of x-rays. |

| ORTHODONTIC SERVICES | | | | | | |
|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age limitations** | **Teeth covered** | **Authorization required** | **Benefit limitations** | **Documentation required** |
| D8030 | Monthly orthodontic treatment – limit 23 months | 7-20 | All | Yes | Monthly payment limit of 23 months. This fee begins 30 days from date of banding. One (1) course per lifetime is covered. | A diagnostic complete series of radiographs or a diagnostic panoramic radiograph (D0210 or D0330) Cephalometric film D0340 – with tracings. Lateral and frontal diagnostic photographs of the patient with lips together. Any other supporting narrative information. |
| D8080 | Banding and first month of orthodontic treatment | 7-20 | All | Yes | Coverage of comprehensive orthodontics is limited to the most severe handicapping orthodontic conditions. Coverage is further limited to individuals under age 21. Only 1 course of orthodontic treatment per individual, per lifetime is covered. | A diagnostic complete series of radiographs or a diagnostic panoramic radiograph (D0210 or D0330) Cephalometric film D0340 – with tracings. Lateral and frontal diagnostic photographs of the patient with lips together. Any other supporting narrative information. |
| D8210 | Removable appliance | 0-120 | All | Yes | Complete radiographs and photos of the mouth must be submitted with each request. | None |
| D8220 | Fixed or cemented appliance | 0-120 | All | Yes | Complete radiographs and photos of the mouth must be submitted with each request. | None |
| D8680 | Post-treatment stabilization visit | 7-20 | All | Yes | Coverage is further limited to individuals under age 21. Only 1 course of orthodontic treatment per individual, per lifetime is covered. | None |
| D8999 | Unspecified orthodontic procedure, by report | 7-20 | All | Yes | | Supporting narrative information. |

| OTHER COVERED SERVICES | | | | | | |
|---|---|---|---|---|---|---|
| **Code** | **Description** | **Age limitations** | **Teeth covered** | **Authorization required** | **Benefit limitations** | **Documentation required** |
| D5999 | Unspecified maxillofacial prothesis | 0-120 | All | Yes | | Clinical Notes |
| D9220 | Deep sedation / general anesthesia – first 30 minutes | 0-120 | All | No | General anesthesia will be reimbursed at a flat rate per patient per date of service. A $25 in-office incentive payment will be added to the reimbursement for general anesthesia provided in an office setting. | None |
| D9610 | Therapeutic drug injection, by report | 0-120 | All | No | | None |
| D9999 | Miscellaneous services (complications, unspecified adjunctive procedure) | 0-120 | All | Yes | | None |

**NOTE**: The administration of general anesthesia will be covered for surgical and restorative procedures when performed by an eligible provider as defined in rule 5101:3-5-01 of the Ohio Administrative Code. The cost of analgesic and local anesthetic agents is included in the fees associated with dental services reimbursed by the Medicaid program.



# Orthodontic Evaluation and Pre-Determination Form

| Patient Name and Address: | CareSource Member ID Number: | |
|---|---|---|
| | Patient Date of Birth: | Patient Phone Number: |
| Provider Name and Address: | Provider Number: | |
| | Date: | Provider Phone Number: |

**Criteria for Comprehensive Orthodontic Treatment**

**REQUIRED**: From the list below, please check the symptoms and signs or physical conditions you observe in this patient. Five checked boxes does not guarantee authorization, but will be considered with other supporting clinical information. Symptoms should be documented with additional supportive information as appropriate.

**Dentofacial Abnormality**

- ☐ Marked protruding upper jaw and teeth
- ☐ Underdeveloped lower jaw and teeth, receding chin
- ☐ Excessively spaced front teeth
- ☐ Upper or lower teeth protruding so much that lips cannot be brought together without strain
- ☐ Marked protruding lower jaw and teeth
- ☐ Extremely "crooked" front teeth
- ☐ Marked asymmetry of lower face or transverse deficiencies
- ☐ Clefts of lip or face
- ☐ Abnormalities of dental development
- ☐ Other______________________________

**Tissue Damage Related to Malocclusion**

- ☐ Marked recession of gums
- ☐ Loosened permanent teeth
- ☐ Other______________________________

**Mastication Related to Malocclusion**

- ☐ Extreme grimacing or excessive motions of the oral-facial muscles during swallowing
- ☐ Socially unacceptable behavior during eating because of necessary compensation or anatomic facial deviations
- ☐ Pain in jaw joints when eating
- ☐ Other______________________________

**Respiration and Speech Related to Malocclusion**

- ☐ Postural abnormalities with breathing difficulties
- ☐ Malocclusion of jaws related to chronic mouth breathing
- ☐ Lisping or other speech articulation errors in children 9 years or older
- ☐ History of or recommendation for speech therapy
- ☐ Other______________________________

**REQUIRED**: Please provide documentation of medical functional impairment directly related to the orthodontic condition. Attach additional pages, if necessary. The presence and degree of impairment can be documented through progress notes, interprofessional consultations, narratives and other diagnostics from the patient's general dentist, orthodontist, primary care provider, behavioral health specialist or speech therapist.

______________________________

______________________________

______________________________

**Is there a participating CareSource orthodontia provider you would like to refer your patient to?

| Orthodontia Provider Signature: | Date: |
|---|---|

**When faxing information, please remember to include all pages of supporting documentation along with this form.**

*Approved prior authorizations are contingent upon the eligibility of member at the time of service and the claim timely filing limits. Authorizations are not a guarantee of payment. Authorizations are based on medical necessity and are contingent upon eligibility and benefits (and other factors). Benefits may be subject to limitations and/or qualifications and will be determined when the claim is received for processing.*

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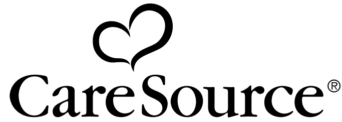
OH-P-157a



# Orthodontist Confirmation Form

Date:

Dear Orthodontia Provider:

(Member name) has been referred to you for an orthodontia workup and possible treatment. S/he will contact your office to make an appointment. Initial evaluation by the referring dentist suggests this patient has a severe handicapping condition** and may benefit from orthodontia treatment. If, after examination, you do not feel that the member meets CareSource/ODJFS criteria as having the most severe handicapping orthodontic condition, or is not a candidate for comprehensive orthodontic treatment at this time, please complete this form and return it to CareSource.

Following your workup of the patient, please confirm:

This patient is not a suitable candidate for orthodontia treatment for the following reason:

______________________________________________________________________

______________________________________________________________________

**(CareSource will notify the patient that services are not authorized.)**

Please fax this letter to CareSource at **1-888-752-0012** or send to:
CareSource
P.O. Box 1307
Dayton, OH 45401-1307

Patient Contact Information: ____________________ Name: ________________________________

CareSource ID Number: ______________________________

Address: ______________________________________________________________________

Phone: ____________________________________________

** CareSource defines a severe handicapping condition as one that severely impairs the patient's ability to eat or speak properly or is associated with significant structural and/or skeletal abnormalities. Imperfections of teeth alignment and bite asymmetry that do not impair mastication and other abnormalities that are primarily cosmetic do not qualify as a severe handicapping condition.

*Note: Approved prior authorizations are contingent upon the eligibility of member at the time of service and the claim timely filing limits. Authorizations are not a guarantee of payment. Authorizations are based on medical necessity and are contingent upon eligibility and benefits (and other factors). Benefits may be subject to limitations and/or qualifications and will be determined when the claim is received for processing.*

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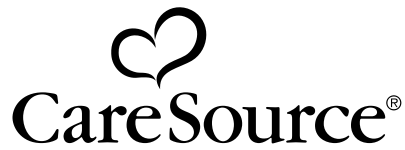

# Orthodontic Continuation of Care Form

Member ID Number:____________________________________________

Member Name: ____________________________________________

Date of Birth:____________________________________________

Name of previous provider that issued approval:______________________

____________________________________________

Banding date:____________________________________________

Balance expected for Future dates of service:______________________

Services remaining to be covered:______________________________

Additional information required:

Documentation listing services to be rendered, which may include ADA form.

If the member is transferring from another insurance or Medicaid program: a copy of original orthodontic approval.

If the member is private pay or transferring from commercial insurance please provide the original diagnostic photographs, radiographs and supportive documentation.

OH-P-487

CareSource®

OH-P-24e
September 2011

www.caresource.com

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