CareSource®

# GEORGIA MEDICAID

## Covered Dental Benefits Quick Reference

The information below is a compendium quick reference grid to the detailed outline of the claims process, covered services, limitations, clinical criteria, prior authorization forms and information located in the Georgia Dental Health Partner Manual. This and other information on services, including dental services, a link to Sciondental.com and other information about providing services to our CareSource members can be accessed via our website at CareSource.com. Please refer to our website and the Scion Portal for more information about prior authorization procedures. Bold highlights under each plan signify expanded coverage offered by CareSource. A fee schedule can be obtained for the provider by logging into the Scion Dental provider web portal at: https://sdsfpwp.wonderboxsystem.com/PWP/Landing

| *Service Category by CDT codes* | Georgia Families (GF) Medicaid or PeachCare for Kids<br>Children (Age 0-20 ) *Health Check* | Georgia Families (GF) Medicaid<br>Adults (Age ≥ 21) | Planning For Healthy Babies (P4HB)<br>IPC Program |
|---|---|---|---|
| **Diagnostic** | D0120 D0140 D0150 D0210<br>D0220 D0230 D0240 D0270<br>D0272 D0274 D0330 | **D0120** D0140 **D0150 D0210**<br>D0220 D0230 **D0240 D0270**<br>**D0272 D0274** D0330<br>**(GF) Medicaid Subcategory –Pregnant Women Additional Benefit**<br>D0180 | D0120 D0150 D0180<br>**D0274 D0220 D0230** |

| Code | Service Description | Benefit Limitations/ Frequency | Prior Auth. Required | Required Documents | Additional Information |
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| The comprehensive D0150 or the periodic exam D0120 may not occur in conjunction with a limited oral evaluation (examination during office hours— D0140 or examination after office hours—D9440). Multiple oral evaluations by the same dentist/dental office on the same day will be disallowed. | | | | | |
| **D0120** | Periodic oral evaluation | May not occur more than **once every 180 days** | No | NONE | The periodic oral evaluation may not occur in combination with the comprehensive oral evaluation and not until 180 days after the comprehensive oral evaluation. |
| **D0140** | Limited oral evaluation-problem focused | This is a benefit **once** per patient per dentist/dental office, per 12 month period. If this limit is exceeded, a narrative of explanation will be needed and reviewed. | No | NONE | Note: This procedure code is to be used for emergency examinations during regularly scheduled office hours.<br>Evaluations solely for the purpose of adjusting dentures or in conjunction with multi-visit procedures are not covered (i.e. endodontics and orthodontia). |
| **D0150** | Comprehensive oral evaluation | Limited to **one** per provider, per location, per patient relationship. | No | NONE | This code is typically used when evaluating a patient comprehensively. As noted, it may not occur in combination with the periodic evaluation. |

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| **D0180** | Comprehensive Periodontal Evaluation | Limited to **one** per provider, per location, per patient relationship. The comprehensive Perio evaluation may not occur in combination with D0140, D0120 or D0150 on same date of service. | No | NONE | As noted in coverage categories above, this benefit is allowed for **PREGNANT WOMEN ONLY.**<br><br>D0180 requires a complete and detailed periodontal evaluation, including full-mouth probing and detailed charting**.** **Reimbursement is not allowed for a comprehensive periodontal evaluation performed in conjunction with either a comprehensive oral evaluation or a periodic oral evaluation.** |
| Diagnostic services such as radiographic images must be necessary for clinical reasons. Radiographic images are adjunctive to diagnostic services and should be prescribed in accordance with the guidelines of the American Dental Association. A panoramic radiographic image D0330 or a panoramic radiographic image with associated periapicals (D0220/D0230) or bitewings D0272/ D0274) should not be submitted for payment as procedure code D0210 **intra-oral complete series.** (See additional information on content of series with PAN.) **Charges for duplication (copying) of radiographic images for insurance purposes are disallowed. Radiographic images used intraoperatively or considered a component of the primary procedure are disallowed for reimbursement.** | | | | | |
| **D0210** | Intraoral – complete set of radiographic images including bitewings | A complete series of radiographs is covered only **once every three years**. | No | NONE | The two types of full-mouth radiographs reimbursable are Full Mouth Series (D0210) and Panoramic (D0330).<br><br>These two types of full mouth radiographs are mutually exclusive within a three (3) calendar year time frame.<br><br>A full-mouth series includes up to **eight frames for children under 12 years** of age and will consist of a **minimum of 12 films**, including all periapical, bitewings and occlusal film necessary for the diagnosis **for 12 years and older.** |
| **D0220** | Intraoral - periapical radiographic image | **One** per day. Any additional periapical films (D0230 should be used) | No | NONE | For endodontic treatment, one pre-operative diagnostic radiograph is benefited.<br><br>Working and post-operative radiographic images by the same dentist/dental office are considered a component of the complete treatment procedure and separate benefits are disallowed. |
| **D0230** | Intraoral - additional periapical image | Intraoral-periapical each additional film is reimbursable up to **six times** per date of service. | No | NONE | Any additional films (D0220 - D0330) performed on the same date of service are considered content of service of the complete series or its equivalent and will not be reimbursed. |
| **D0240** | Intraoral - occlusal radiographic image | Intraoral-occlusal each additional film is reimbursable up to **six times** per date of service. | No | NONE | Any additional films (D0220 - D0330) performed on the same date of service are considered content of service of the complete series or its equivalent and will not be reimbursed. |

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| **D0270** | Bitewing - single image | Bitewing 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. | No | NONE | When billing for three (3) bitewings, use codes D0272 and D0270. |
| **D0272** | Bitewings - two images | | No | NONE | |
| **D0274** | Bitewings - four images | | No | NONE | |
| **D0330** | Panoramic radiographic image | Neither pan D0330 nor FMX/FMS D0210 radiographs are reimbursable more than **once every three (3) calendar years for the same member and not in conjunction with each other.**<br><br>D0220, D0230 and D0240 taken same date of service are considered content of series. | No | NONE | See note above under D0210.<br><br>All periapical or occlusal films taken same date of service needed to render the necessary radiographic diagnosis are included in the fee for panoramic radiograph. If bitewing radiographs D0270, D0272 or D0274 are indicated for additional diagnosis, the amount reimbursed will not exceed the reimbursable amount for D0210. |

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|---|---|---|---|
| **Preventive** | D1110 D1120 D1206 D1208 D1351 D1510 D1515 D1525 D1550 | **D1110**<br>**(GF) Medicaid Subcategory –Pregnant Women Additional Benefit**<br>D1208 | D1110 **D1208** |

| Code | Service Description | Benefit Limitations/ Frequency | Prior Auth. Required | Required Documents | Additional Information |
|---|---|---|---|---|---|
| **D1110** | Prophylaxis – Adult | Only **two (2)** prophylaxis are reimbursable in a calendar year. | No | NONE | This service code should primarily be used for permanent dentition.<br>*Age restrictions will not apply for reimbursement of D1110 or D1120.* |
| **D1120** | Prophylaxis – Child | Dental prophylaxis will not be reimbursed more than **once every 180 days.** | No | NONE | This service code should primarily be used for primary dentition. |

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| **D1206** | Topical Fluoride - Varnish | Topical fluoride treatments are limited to **one** application (one of D1206 **or** D1208) **once every 180 days** for patients under the age of 21. and **D1208 twice a calendar year for Pregnant Women** | No | NONE | 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:<br>• topical application of fluoride to the prepared portion of a tooth prior to restoration<br>• application of sodium fluoride as a desensitizing agent.<br>• the use of self or home fluoride application procedures |
| **D1208** | Topical application of fluoride (excluding prophylaxis) | | No | NONE | |
| **D1351** | Sealant - per tooth - unrestored permanent molars | Topical application of sealants is covered **once per tooth** in a four calendar-year period.<br>Sealants coverage is restricted to Members under twenty-one (21) years of age | No | NONE | Sealants are reimbursable for first and second molars only (teeth numbers 2, 3, 14, 15, 18, 19, 30 and 31).<br><br>Sealed teeth must be free of occlusal and proximal caries. Sealants are allowed on occlusal surfaces and sealant material must be ADA approved. |
| **D1510** | Space maintainer – fixed – unilateral | Space management therapy is reimbursable for **Members under twenty-one (21) years of age only**.<br><br>D1510 **One (1)** per 12 months per quadrant.<br>D1515 and D1525 **One (1)** per 12 months per arch | No | NONE | Appropriate code must be put in the tooth number field on the claim form<br><br>UR - upper right<br>LR - lower right<br>UL - upper left<br>LL - lower left.<br>Upper 01 Lower 02 |
| **D1515** | Space maintainer – fixed – bilateral | | No | NONE | |
| **D1525** | Space maintainer - removable – bilateral | | No | NONE | |
| **D1550** | Re-cementation or rebond space maintainer | Not covered within six months of initial placement. | No | NONE | |

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|---|---|---|---|
| **Minor Restorative** | D2140 - D2161; D2330 - D2335: D2391 - D2394 | **D2140 - D2161; D2330 - D2335 D2391 - D2394** | D2140 - D2161 D2330 - D2335: D2391 - D2394 |
| **Major Restorative** | D2920 D2930 D2931 D2932 D2934 D2940* D2951 D2954 | D2931 D2932 **D2940* D2951 D2954** | **D2940* D2951** |

| Code | Service Description | Benefit Limitations/ Frequency | Prior Auth. Required | Required Documents | Additional Information |
|---|---|---|---|---|---|
| Any Amalgam or Resin-Based Composite Restoration that is billed with more than 1 unit for a one service area code will be reconfigured to the defined multiple service surface code (i.e., 2 units of D2140 would be 1 unit of D2150 or 2 units of D2330 would be 1 unit of D2331). 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. Preventive resin-based restorations are not covered services. | | | | | |
| **D2140** | Amalgam - one surface, primary or permanent | For restorations done on the same tooth by the same dentist or provider within a six (6) month period, reimbursement will be subject to post review with narrative.<br><br>Teeth Covered<br>1 – 32; 51 - 82 (SN); A - T; AS - TS (SN) | No | NONE | Composite and amalgam restorations are reimbursable based upon total number of restored surfaces, not to exceed four surfaces per tooth. For example, non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration.<br><br>Each claim line for restorative services must relate to only one tooth number. |
| **D2150** | Amalgam - two surfaces, primary or permanent | | No | NONE | |
| **D2160** | Amalgam - three surfaces, primary or permanent | | No | NONE | |
| **D2161** | Amalgam - four or more surfaces, primary or permanent | | No | NONE | |
| **D2330** | Resin–based composite - one surface, anterior | For restorations done on the same tooth by the same dentist or provider within a six (6) month period, reimbursement will be subject to **post review with narrative**.<br><br>Teeth Covered<br>6 - 11, 22 - 27 56 - 61 (SN) 72 - 77 (SN) C - H, M – R CS - HS (SN) MS - RS (SN) | No | NONE | The fee for resin-based composite restorations will include any necessary acid etching and bonding agents<br><br>Non-contiguous restorations, such as a separate Distal Facial (DF) and Mesial Facial (MF) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number. |
| **D2331** | Resin-based composite - two surfaces, anterior | | No | NONE | |
| **D2332** | Resin-based composite - three surfaces, anterior | | No | NONE | |
| **D2335** | Resin-based composite - four or more surfaces or involving incisal angle (anterior) | | No | NONE | |

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| **D2391** | resin-based composite - one surface, posterior | For restorations done on the same tooth by the same dentist or provider within a six (6) month period, reimbursement will be subject to post review.<br><br>Teeth Covered<br><br>1 - 5, 12 - 21, 28 - 32<br><br>51 - 55 (SN) 62 - 71 (SN) 78 - 82 (SN)<br><br>A, B, I - L, S, T,<br><br>AS (SN), BS (SN), IS - LS (SN), SS (SN),TS (SN) | No | NONE | Composite and amalgam restorations are reimbursable based upon total number of restored surfaces, not to exceed four surfaces per tooth. For example, non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number. |
| **D2392** | resin-based composite - two surfaces, posterior | | No | NONE | |
| **D2393** | resin-based composite - three surfaces, posterior | | No | NONE | |
| **D2394** | resin-based composite - four or more surfaces, posterior | | No | NONE | |
| For the single crown service codes to follow, **prior authorization is not required for members younger than 20**. For adults, codes D2931 and D2932 are expanded coverage benefits and will require prior authorization. | | | | | |
| **D2920** | Re-cement or re-bond crown | Tooth must be indicated on claim. | No* | NONE* | For re-cement or re-bond done on the same tooth by the same dentist or provider within a twelve (12) month period, reimbursement will be ***subject to post review***. |
| **D2930** | Prefabricated stainless steel crown - primary tooth | **Only one (1) unit of** (D2930- D2934) per member, per tooth.<br><br>More than **six (6)** teeth per member per calendar year per provider may be subject to post review. | No | NONE | **See clinical indication guidelines in handbook section.** |
| **D2931** | Prefabricated stainless steel crown - permanent tooth | | No | NONE | |
| **D2932** | Prefabricated resin crown | | No | Radiograph and Narrative if applicable | |
| **D2934** | Prefabricated esthetic coated stainless steel crown - primary tooth | | No | NONE | |

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| **D2940** | Protective Restoration | 1 unit per six (6) months per tooth. | No | NONE | **See clinical indication guidelines in handbook section.** |
| **D2951** | Pin retention - per tooth, in addition to restoration | A maximum of three (3) pins per tooth will be reimbursed. | No | NONE | |
| **D2954** | Prefabricated post and core, in addition to crown | Once per tooth per lifetime except for exception cases of appropriate medical necessity. | No<br><br>Post Review | A periapical radiograph and a pan film or a FMS of X-rays of the involved tooth/teeth to determine the overall health of the teeth and gums. | |

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|---|---|---|---|
| **Endodontics** | D3220 D3221 D3310 D3320 D3410 D3426 | **D3220 D3221 D3310 D3320** | **D3220 D3221** |

| Code | Service Description | Benefit Limitations/ Frequency | Prior Auth. Required | Required Documents | Additional Information |
|---|---|---|---|---|---|
| **D3220** | Therapeutic pulpotomy (excluding final restoration) | To be performed on primary or permanent teeth up until the age of 20 years.<br>Teeth A – T or 1-32<br>Greater than (6) units per member per calendar year may be subject to post review. | No | NONE* | **See clinical guidelines on indications.** |
| **D3221** | Pulpal debridement, primary and permanent teeth | Reimbursable **once per tooth** per provider.<br>This procedure is not to be used when endodon-tic treatment is completed on the same day.<br>This should be used only in the presence of swelling or infection in an emergency situation. | No | NONE | |

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| **D3310** | Anterior root canal (excluding final restoration) | Once per tooth per lifetime except for cases of appropriate medical necessity.<br><br>***The date the RCT is completed should be the date of service.*** | **Yes**<br><br>Post Review allowed if emergency situation | Pre-op radiograph of involved tooth and treatment plan for each case.<br><br>Pre-op and Post-op X-ray - if endodontic treatment is provided on emergency basis. | Reimbursement for a root canal includes opening and drainage, treatment planning, clinical procedures, follow-up care, x-rays during treatment, and postoperative x-rays. CareSource will reimburse for either root canal therapy (codes D3310 or D3320) or Emergency - Open Pulp Chamber (code D3221— pupal debridement, primary and permanent teeth), but not both on same date of service. |
| **D3320** | Bicuspid root canal (excluding final restoration) | | | | |
| **D3410** | Apicoectomy/ periradicular surgery – anterior | **Once per tooth** per lifetime except for exception cases of appropriate medical necessity. | **Yes** | Diagnostic quality pre-op radiograph of involved tooth and treatment plan/ narrative for each case. | This does not include retrograde filling material placement. |
| **D3426** | Apicoectomy/ periradicular surgery (each additional root) | | **Yes** | | Used typically for bicuspids. |

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|---|---|---|---|
| **Periodontics** | D4210 D4240 D4260 D4270 D4341 | **D4341 D4210**<br><br>**(GF) Medicaid Subcategory –Pregnant Women Additional Benefit**<br><br>D4240 D4241 D4342 D4910 | D4240 D4241 D4341 D4342 D4910 |

| Code | Service Description | Benefit Limitations/ Frequency | Prior Auth. Required | Required Documents | Additional Information |
|---|---|---|---|---|---|
| These services are not considered emergency procedures and must be submitted as prior approvals. When requesting prior approval for procedure **codes D4210 - D4341**, the codes should be listed as separate line items for each quadrant needed (on the prior authorization) or each quadrant rendered (when filing for reimbursement on a dental claim). | | | | | |
| **D4210** | Gingivectomy or gingivoplasty – four or more teeth | These services (full mouth - 4 quadrants) are limited to one per member per 24 month period. | Yes | Radiographs of the area and Perio charting, letter of medical necessity and diagnostic photographs, if applicable, must be submitted for review. | Services performed in additional or multiple years are subject to approval based on medical necessity for additional treatments. |

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| **D4240** | Gingival flap procedure, four or more teeth | These services (full mouth - 4 quadrants) are limited to one per member per 24 month period. | Yes | Radiographs of the area, Perio charting and letter of medical necessity. | Services performed in additional or multiple years are subject to approval based on medical necessity for additional treatments. |
| **D4241** | Gingival Flap , one to three contiguous teeth | | | | |
| **D4260** | Osseous surgery (including flap entry and closure), four or more contiguous teeth or bounded teeth spaces per quad- rant | These services (full mouth - 4 quadrants) are limited to one per member per 24 month period. | Yes | Radiographs of the area and letter/ narrative of medical necessity must be submitted for review. | Services performed in additional or multiple years are subject to approval based on medical necessity for additional treatments. |
| **D4270** | Pedicle soft tissue graft procedure | 4 UNITS PER 48 MONTHS. | Yes | X-rays, narrative, images, if applicable, and perio charting. | Services performed in additional or multiple years are subject to approval based on medical necessity for additional treatments |
| **D4341** | Periodontal scaling and root planing-four or more teeth per quadrant | These services (full mouth - D4341 or D4342) are limited to one per member per 24 month period. | Yes | Full mouth series of X-rays, or radio-graphs of quadrant(s) to treat and a narrative documenting medical necessity are required. **Periodontal charting as indicated** is required. | Generalized subgingival calculus should be readily visible on radiographs. Additionally, there must be radiographic evidence of bone loss and/or clinical probing depths of 3mm or greater.<br><br>**Periodontal charting performed within 12 months, including six point probing, furcation, mucogingival relationship, bleeding, case type and oral hygiene status is required. |
| **D4342** | Periodontal scaling and root planing- One to three teeth | | | | |
| **D4910** | Periodontal Maintenance | 1) Any combination of D1120, D1110, and D4910 up to four per 12 months.<br><br>2) Covered **following** active treatment (D4342, D4341) only. | Yes | Radiographs of the area, images where applicable and letter of medical necessity must be submitted for review. | This procedure is instituted following periodontal therapy and continues at varying intervals for the life of the dentition. |

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|---|---|---|---|
| **Prosthodontics** | D5110 D5120 D5211 D5212 D5410 D5411 D5421 D5422 D5510 D5640 D5650 D5660 D5750 D5751 D5850 D5851 D6240 D6750 | **D5110 D5120 D5130 D5140 D5211 D5212 D5410 D5411 D5421 D5422 D5510 D5750 D5751** D6240 D6750 | NC |

| Code | Service Description | Benefit Limitations/ Frequency | Prior Auth. Required | Required Documents | Additional Information |
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| Prosthetic devices shall be seated in the mouth before a claim is submitted for payment. The fee for complete and partial dentures includes all necessary corrections and adjustments for six months after the denture has been seated. | | | | | |
| **D5110** | Complete denture – maxillary | **One** per sixty (60) months. | Yes | Panoramic radiograph series (even if edentulous) and narrative/ Tx notes. If a PAN is not available the following must be submitted for review:<br>1) Full Mouth radiograph series<br>2) Photographs of the Member's Mouth<br>3) Narrative/Tx notes | The health partner is responsible for constructing a completely functional denture.<br><br>No reimbursement will be made for dentures/ partial dentures replaced or remade within a five calendar-year period unless prior approval is obtained for exceptional circumstances. |
| **D5120** | Complete denture – mandibular | **One** per sixty (60) months. | Yes | | |
| **D5130** | Immediate denture maxillary ages 21 and older | **One** per sixty (60) months. Includes limited follow up care only; does not include required future rebasing/relining procedure(s) or a complete new denture. | Yes | | Includes limited follow-up care only; does not include required future rebasing/ relining procedure(s) or a complete new denture. |
| **D5140** | Immediate denture mandibular ages 21 and older | | Yes | | |
| **D5211** | Maxillary partial denture - resin base | **One** per sixty (60) months. Partial dentures cannot be re-placed, remade, or exchanged for complete dentures for at least five years (60 months), except in very unusual circumstances for which new dentures can be justified. **One tooth partials** are only covered for **ages ≤ 20** and are **not covered unless** replacing tooth number 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26 or 27.**Age ≥ 21 partials only covered for (3 or more teeth).** | Yes | | Use coding U for upper and L for lower, scheme in the tooth number field on the treatment plan.<br><br>A partial denture that replaces only **posterior permanent teeth must include three of more teeth on the dentures t**hat are anatomically correct (natural size, shape and color) to be reimbursable benefit. |
| **D5212** | Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) | | Yes | | |

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| **D5410** | Adjust complete denture – maxillary | These services may be billed only after the six-month seating period. Maximum of two adjustments per calendar year is reimbursable.<br><br>Exception: Approval is required for additional adjustments. Must submit narrative. | No | NONE | The fee for dentures includes all necessary corrections and adjustments for a period of six months after seating the denture. |
| **D5411** | Adjust complete denture – mandibular | | No | NONE | |
| **D5421** | Adjust partial denture – maxillary | | No | NONE | |
| **D5422** | Adjust partial denture – mandibular | | No | NONE | |
| **D5510** | Repair broken complete denture base | Maximum of two REPAIRS per calendar year is reimbursable. Exception: Approval is required for additional repairs. Must submit narrative. | No | NONE | |
| **D5640** | Replace broken teeth - per tooth | Maximum of two (2) teeth per calendar year is reimbursable. Exception: Approval is required for additional teeth. | No | NONE | The fee for dentures includes all necessary corrections and adjustments for a period of six months after seating the denture. |
| **D5650** | Add tooth to existing partial denture | These services may be billed only after the six-month seating period. Maximum of two units per calendar year is reimbursable. Approval is required for additional units/ teeth to be added. | No | NONE | |
| **D5660** | Add clasp to existing partial denture | These services may be billed only after the six-month seating period. Maximum of two clasps per calendar year is reimbursable. | No | NONE | |

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| **D5750** | Reline complete maxillary denture (laboratory) | A maximum of one total treatment per D5750 and one per D5751 per calendar year may be performed.<br><br>Only 2 relines per D5750 and 2 per D5751 are reimbursable per sixty (60) month period. | No | NONE | All complete and partial denture relining procedures include all necessary corrections for six months after the denture has been relined. |
| **D5751** | Reline complete mandibular denture (laboratory) | | No | NONE | |
| **D5850** | Tissue conditioning (maxillary) | A maximum of one total treatment per D5850 and one per D5851 per calendar year may be performed. Any additional treatments must be prior approved. | No | NONE | |
| **D5851** | Tissue conditioning (mandibular) | | No | None | |
| **D6240** | Pontic - porcelain fused to high noble metal | D6240 and D6750 have limited coverage. Fixed prosthodontics is limited to members whose medical or mental condition precludes the use of removable prosthodontics.<br><br>No more **than three (3) units of combined D6240 and D6750 are reimbursable** per calendar year for same member, same provider. | Yes | Full mouth radiograph series or PAN (individual PA's of area in question).<br><br>Photographs of the member's mouth.<br><br>Narrative/Tx notes and/or letter of medical necessity. | Cases involving four (4) or more crowns and/or fixed bridge units in the same treatment plan require strict guidelines of medical necessity and clinical criteria noted<br>Fixed partial denture replacement reimbursable once after sixty (60) month period from seating date with documentation of failure.<br>All approvals for these procedures must be medically necessary as determined by CareSource dental peer reviewers. |
| **D6750** | Crown - porcelain fused to high noble metal | | | | |

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|---|---|---|---|
| **Oral Surgery** | D7111 D7140 D7210 D7220 D7230<br>D7240 D7250 D7260 D7270 D7280<br>D7286 D7310 D7311 D7320 D7321<br>D7440 D7450 D7451 D7460 D7461<br>D7471 D7510 D7520 D7540 D7550<br>D7610 D7620 D7630 D7640 D7820<br>D7910 D7912 D7960 D7970 D7971 | D7111 D7140 D7210 D7220<br>D7230 D7240 D7250 D7270<br>**D7280** D7286 **D7310 D7311**<br>**D7320 D7321 D7440 D7450**<br>**D7451 D7460 D7461 D7471**<br>D7510 D7520 D7540 D7550<br>D7610 D7620 D7630 D7640<br>D7820 D7910 D7912 **D7960**<br>**D7970 D7971** | **D7140 D7210**<br>D7286 |

| Code | Service Description | Benefit Limitations/ Frequency | Prior Auth. Required | Required Documents | Additional Information |
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| **D7111** | Extraction, coronal remnants - deciduous tooth | _____ | No | NONE | If multiple teeth are being extracted for the same member on the same date of service, procedure code D7111 and D7140 can be used for the first tooth extracted and each additional tooth. |
| **D7140** | Extraction, erupted tooth or exposed root (elevation and/ or forceps removal) | _____ | No | NONE | _____ |
| **D7210** | Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth | Requires **prior approval if done more than four times within one year on same member.** Includes cutting of gingiva and bone, removal of tooth structure and closure. | No<br><br>Exception Noted | Pre-op Radiographs. | _____ |

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| **D7220** | Removal of impacted tooth - soft tissue | Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS RS, SS, TS | No<br><br>Teeth other than 1, 16, 17, 32 may be subject to post review. | Pre-op radiographs. Must be consistent with clinical definition: Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation. | X-rays MUST be submitted for extraction procedure codes D7220, D7230 and D7240 when done on the same date of service with nitrous oxide, general anesthesia, intravenous sedation, other drugs or Nonintravenous sedation.<br><br>The prophylactic removal of an asymptomatic tooth or teeth exhibiting no overt clinical pathology is covered only when at least one tooth is asymptomatic. |
| **D7230** | Removal of impacted tooth – partially bony | Usage of complete bony impaction code for approval should be consistent with the clinical definition: **Part of crown covered by bone; requires mucoperiosteal flap elevation and bone removal.**<br>**Teeth 1 - 32, 51– 82 Supernumerary** | Yes | Pre-op radiographs.<br><br>Panoramic radiograph series or FMX preferred.<br><br>Narrative/Tx notes if applicable. | |
| **D7240** | Removal of impacted tooth– completely bony | Usage of complete bony impaction code for approval should be consistent with the clinical definition: **Most or all of crown covered by bone; requires mucoperiosteal flap elevation, bone removal and may require segmentalization of tooth.**<br><br>**Teeth 1-32, 51-82. Supernumerary** | Yes | Pre-op radiographs. Panoramic radiograph series or FMX preferred. Narrative/Tx notes if applicable. | |
| **D7250** | Surgical removal of residual tooth roots (cutting procedure) | 1 - 32, 51 - 82, A - T, AS – TS | Yes | Pre-op radiographs. | Not reimbursable to dentist or dental group that removed the tooth. |
| **D7260** | Oroantral fistula closure | Reimbursable benefit for Age 0-20 | Post Review Allowed | Pre-op and post-op radiographs. A narrative/Tx notes must be included documenting circumstances. | Excision of fistulous tract between maxillary sinus and oral cavity and closure by advancement flap. |

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| **D7270** | Tooth reimplantation and/ or stabilization of accidentally avulsed or displaced tooth | Reimbursement **is per accident** regardless of the number of teeth involved and covers all needed services (i.e., splints, suturing, and follow-up care).<br>Include tooth numbers. | Post Review Allowed | Pre-op and Post-op radiographs.<br>A narrative/Tx notes must be included documenting circumstances. | _____ |
| **D7280** | Surgical access of an unerupted tooth | Teeth 1 – 32 | Yes | Pre-op radiographs.<br>Narrative.<br>Orthodontic Authorization number if applicable. | An incision is made and the tissue is reflected and bone removed as necessary to expose the crown of an impacted tooth not intended to be extracted.<br><br>Also includes tooth exposure for orthodontic purposes, including the orthodontic attachments. Prior orthodontic authorization must be obtained in this instance. |
| **D7286** | Biopsy of oral tissue – soft | Reimbursement for D7286 — biopsy of oral tissue-soft (all others) is a fixed rate and each additional site is at a prorated fee. (See fee schedule for reimbursement rate.) Use procedure code D7286 and the appropriate coding scheme indicated for each lesion site.10 = upper right 20 = upper left 30 = lower right 40 = lower left | No | A pathology report from the dentist is required. It should be attached to the claim that is submitted for processing. | For surgical removal of an architecturally intact specimen only. |

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| **D7310** | Alveoloplasty in conjunction with extractions - per quadrant | 1) **Once** per lifetime per quadrant.<br>2) Minimum of three (3) extractions in the affected quadrant. | POST REVIEW | Pre-op radiographs. Narrative of medical necessity. | Member is allowed maximum of 1 single unit per UR, UL, LL, LR of either D7310, D7311, D7320 or D7321 per lifetime and not a combination in same quad.<br><br>Surgical preparation of ridge for dentures. The coding scheme below is to be used for alveoplasty in conjunction with or without extractions. These codes are to be used in the tooth number field.<br><br>UR = upper right UL = upper left<br>LR = lower right<br>LL = lower right |
| **D7311** | Alveoloplasty in conjunction with extractions-one to three teeth or tooth spaces, per quadrant | **Once** per lifetime per quadrant. | POST REVIEW | Pre-op radiographs. Narrative of medical necessity. | |
| **D7320** | Alveoloplasty not in conjunction with extractions - per quadrant | **Once** per lifetime. | Yes | Pre-op radiographs. Narrative of medical necessity. | |
| **D7321** | Alveoloplasty not in conjunction with extractions-one to three teeth or tooth spaces, per quadrant | **Once** per lifetime per quadrant | Yes | Pre-op radiographs. Narrative of medical necessity. | |
| **D7440** | Excision of malignant tumor<br>- lesion diameter up to 1.25 cm | **Once** per lifetime per quadrant.<br>May be considered a benefit under the medical program. If submitted under medical, cannot be submitted under dental program.<br><br>Unit of reimbursement is a flat rate per cyst or tumor area. If multiple lesions or compound lesion, a prior authorization is required for multiple units of D7440 - D746. | POST REVIEW | Narrative/Tx notes.<br>Photographic Images.<br>Biopsy report if applicable. | Appropriate code must be put in the tooth number field on the claim form:<br><br>UR - upper right LR - lower right UL - upper left LL - lower left |
| **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 nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm | | | | |
| **D7461** | Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm | | | | |
| **D7471** | Removal of exostosis | Latera .maxilla or mandibular. Reimbursable **once** per lifetime per arch. | Yes | Narrative, photographic images, radiograph(s) | Use proper coding on claim form:<br>Upper Arch (01,UA) Lower Arch (02, LA) |

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| **D7510** | Incision and drainage of abscess - intraoral soft tissue | Specify area Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS. GS, HS, IS, JS, KS, LS. | No | _____ | _____ |
| **D7520** | Incision and drainage of abscess - extraoral soft tissue | | No | _____ | _____ |
| **D7540** | Removal of reaction producing foreign bodies, musculoskeletal system | | Yes | Narrative explaining medical necessity. Radiograph(s) or other info where applicable. | _____ |
| **D7550** | Partial ostectomy/ sequestrectomy for removal of non-vital bone | | Yes | Narrative explaining medical necessity radiographs. | _____ |
| **D7610** | Maxilla - open reduction (teeth immobilized, if present) | D7610 - D7640 are billed for Tx of fractures (simple and compound) to include acrylic splints, any necessary wiring, office and post-operative visits, radiographs and suturing. | POST REVIEW ALLOWED FOR Emergency Situations | Radiographs. Narrative/Tx notes. | _____ |
| **D7620** | Maxilla - closed reduction (teeth immobilized, if present) | | | | |
| **D7630** | Mandible - open reduction (teeth immobilized, if present) | | | | |
| **D7640** | Mandible - closed reduction (teeth immobilized, if present) | | | | |
| **D7820** | Closed reduction of dislocation | Dislocations are billed to include office and post-operative visits, radiographs and suturing. | POST REVIEW ALLOWED FOR Emergency Situations | Radiographs. Narrative/Tx notes. | _____ |
| **D7910** | Suture of recent small wounds up to 5 cm | Traumatic wounds | No | _____ | _____ |
| **D7912** | Complicated suture - greater than 5 cm | Not to be used in conjunction with extractions. | POST REVIEW | Photographic image of area and narrative. | |

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| **D7960** | Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure | _____ | Yes | Narrative/Tx notes. Photographic image(s). | When billing for frenectomy (procedure code D7960) and excision of hyperplastic tissue (procedure code D7970) always use the appropriate coding scheme below in the tooth number field for proper reimbursement.<br>01 = Upper<br>02 = Lower |
| **D7970** | Excision of hyperplastic tissue - per arch | Should be used primarily for removal of tissue over a previous edentulous denture bearing area to improve prognosis of a proposed denture.<br><br>Reimbursable **once** per arch per lifetime. | Yes | Narrative/Tx notes. Photographic image(s). | When billing for frenectomy (procedure code D7960) and excision of hyperplastic tissue (procedure code D7970) always use the appropriate coding scheme below in the tooth number field for proper reimbursement.<br>01 = Upper<br>02 = Lower |
| **D7971** | Excision of pericoronal gingiva | Reimbursable **once** per tooth number area per lifetime. | No | NONE | The coding scheme for this code is per tooth number. |

| ***Service Category by CDT codes*** | **Georgia Families (GF) Medicaid or PeachCare for Kids**<br>**Children (Age 0-20 ) *Health Check*** | **Georgia Families (GF) Medicaid**<br>**Adults (Age ≥ 21)** | **Planning For Healthy Babies (P4HB)**<br>**IPC Program** |
|---|---|---|---|
| **Orthodontia** | D7997 D8080 D8660 D8670 | NC | NC |

| **Code** | **Service Description** | **Benefit Limitations/ Frequency** | **Prior Auth. Required** | **Required Documents** | **Additional Information** |
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| **D7997** | Appliance Removal | Not by dentist who placed appliance, includes removal of archbar. | Yes | Narrative | _____ |

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| **D8080** | Comprehensive orthodontic treatment of the adolescent dentition – ages 1-21 | A maximum fee is allowed, per member, for approved comprehensive orthodontic treatment. This treatment now includes D8080, the placement of the appliance with a maximum reimbursement, and monthly visits D8670 that are reimbursed with a maximum of **twelve visits**. The pre-orthodontic visit (D8660), which includes the initial exam, study models (if requested), photographs, and X-rays are reimbursed separately.<br><br>Orthodontic services are limited to **once** per member per lifetime. | Yes | 1. Complete narrative describing member's condition, compliance with and need for treatment.<br>2. Estimated treatment period.<br>3. Study model images.<br>4. Radiographs.<br>5. Completion of the Evaluation for Comprehensive Orthodontic Treatment form. | See Clinical guidelines section for additional requirements and Appendix for forms. |
| **D8660** | Pre-orthodontic treatment examination to monitor growth and development | | | | |
| **D8670** | Periodic orthodontic treatment visit (as part of contract) | | | | |

| *Service Category*<br><br>*by CDT codes* | **Georgia Families (GF) Medicaid or PeachCare for Kids**<br><br>**Children (Age 0-20 )** ***Health Check*** | **Georgia Families (GF) Medicaid**<br><br>**Adults (Age ≥ 21)** | **Planning For Healthy Babies (P4HB)**<br><br>**IPC Program** |
|---|---|---|---|
| **Anesthesia & Adjunct Services** | D9110 D9223 D9230 D9243<br>D9248 D9310 **D9410*** D9420<br>D9440 D9610 D9630 D9920 | D9223 D9243 D9248<br>**D9310 D9410 D9420**<br>D9440 **D9610 D9630**<br><br>**(GF) Medicaid Subcategory –Pregnant Women Additional Benefit**<br><br>D9110 D9215 | D9110 D9215 |

| Code | Service Description | Benefit Limitations/ Frequency | Prior Auth. Required | Required Documents | Additional Information |
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| **D9110** | Palliative treatment of dental pain – minor procedure | Pregnant women and IPC only.<br><br>**1 unit** reimbursable per member per date **of service. Two (2) units** reimbursable per calendar year. | Yes | Post Review allowed in emergency visits with submitted narrative. | This code should not be used in conjunction with D3220 or D3221. |

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| **D9215** | Local Anesthesia | Pregnant women and IPC only.<br><br>**1 unit** reimbursable per member per date of service**. Two (2) units** reimbursable per calendar year. | No | NONE | Not reimbursed separately when billed in conjunction with other anesthesia, endodontic, periodontal, prosthodontic and oral surgical procedures. |
| **D9223** | Deep sedation/ general anesthesia - each 15 minute | D9223 can be billed for **six units (1.5 hours) same date of service**. **A maximum of 12 units (3 hours) are reimbursable** per calendar year per member.<br><br>If **additional** units are necessary and submitted for post approval, the total number of units should be billed on the same claim, same line item with the authorization number to limit claims denial for duplicate units. | Yes<br><br>POST REVIEW Allowed in emergency situations | Whenever anesthesia is requested, **a written narrative detailing the type of anesthesia to be used, rationale of medical necessity, recorded treatment time and when applicable, the nature of the emergency must accompany the request. (CareSource Justification Tool) is required** | The use of general anesthesia will cause a state of unconsciousness. As delineated by DCH, prior approval must be obtained to render this service except in emergency situations.<br><br>**D9223 and D9243** cannot be used on the same date of service and the total maximum units per calendar year combined cannot exceed 12 units without the required documents indicated.<br><br>Anesthesia records should be submitted with the request if an unusual number of **additional** units are submitted for approval. |
| **D9230** | Analgesia, anxiolysis, inhalation of nitrous oxide | Each unit of nitrous oxide must be listed in the quantity field on the claim form, **one unit, per member, per date of service is reimbursable.**<br><br>**Guidelines must be followed to be considered for approval.**<br><br>**Should not be billed in conjunction with D9223 or D9243** | No<br><br>May be subject to Post Review. | A written narrative detailing the rationale of need, treatment rendered or treatment planned is required if subject to Post Review. | ***Guidelines***<br><br>1. Nitrous oxide should be used only when medically necessary to ensure a successful dental appointment.<br>2. One (1) unit of D9230 will be approved per member per date of service for restorative and surgical treatment cases.<br>3. Diagnostic and/or preventive services will be approved based on review of required documentation submitted unless there is documentation from the member's physician that identifies the member as special needs detailing medical necessity. |

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| **D9243** | Intravenous (IV) moderate (conscious) sedation/ analgesia-each 15 minute increment | D9243 can be billed for **six units (1.5 hours) same date of service**.<br><br>**A maximum of 12 units (3 hours) are reimbursable** per calendar year per member.<br><br>If additional units are necessary and submitted for post approval, the total number of units should be billed on the same claim, same line item with the authorization number to limit claims denial for duplicate units. | No<br><br>Post Review *Exception noted* | NONE | Intravenous sedation is limited to treatment situations where local anesthesia is clinically contraindicated or for patient management purposes and must be administered by someone certified in the use of intravenous sedation.<br><br>**D9223 and D9243** cannot be used on the same date of service and the total maximum units per calendar year combined cannot exceed 12 units without the required documents indicated.<br><br>***A narrative, Tx rendered and rationale with recorded anesthesia time is required if post approval indicated.*** |
| **D9248** | Nonintravenous conscious sedation | **One unit** of D9248 per member per provider per date of service. | No | NONE | A medically controlled state of depressed consciousness while maintaining the patient's airway, protective reflexes and the ability to respond to stimulation or verbal commands. It includes non-intravenous administration of sedative and/or analgesic agent(s) and appropriate monitoring. Document sedative agent and administration route used in member's record. |
| **D9310** | Consultation | D9310 -**1 unit** same member, same provider, same calendar year.<br><br>Reimbursements are in 30-minute increments.**1 unit = 30 minutes**<br><br>Consultation diagnostic service provided by dentist, oral maxillofacial surgeon or physician other than the practitioner providing treatment in the hospital setting. | No | Must be retained in the patient's permanent record and provided upon request:<br><br>1. A copy of the written request from the referring provider; and,<br>2. A copy of the written evaluation to the referring provider with the findings and recommendations | A dental consultation (D9310) is: A patient encounter with a practitioner whose opinion or advice regarding evaluation and/or management of a specific problem has been requested by another practitioner.<br><br>The consultation includes an oral evaluation. The consulted practitioner may initiate diagnostic and/or therapeutic services. |

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| **D9410** | House/extended care facility call | D9410- **6 units, same member, same calendar year One (1) unit equals- 30 minutes** (See unit exceptions below)<br>1) Fee for service reimbursement will not be made for those members who reside in facilities where dental services are included in the facility rate. Reimbursement should be sought from the facility. Includes visits to long-term care facilities, nursing homes, hospice sites, or other institutions.<br>2) This service code may be approved on a case by case basis for In-house facility call in place of hospital setting call when General Anesthesia/Deep Sedation D9223 (max. units of D9410 - 6) and D9243 ( max units of D9410 - 4) are used in facility by anesthetizing provider with the maximum units of D9410 allowable respectively. | YES | 1. Treatment plan, All planned dental services should be included on the request<br>2. Complete. Radiographs of the mouth.<br>3. Letter of medical necessity must be submitted for review.<br>4. CareSource Scoring Tool.<br>5. Facility precertification by CareSource.<br>6. Recorded treatment time must be documented<br><br>Please see additional required guidelines in **SPECIAL CODES SECTION Pg. 85-86 of Handbook** | If a treatment plan is not able to be obtained prior to sedation due to inability to examine or x-ray patient for behavioral or medical handicapping restraints, **a** narrative must be submitted with some indication of extent of services needed for patient and post approval adjudication will be subject to review. **(This code is not reimbursable when used in conjunction with diagnostic procedure codes only.)**<br>When D9410 is used for in-house facility general anesthesia call, every attempt should be made to complete all treatment necessary during one facility visit call, between OMFS, general/pediatric dentist and/or provider should be coordinated in effort**,** as this code is only reimbursable for **a maximum allowable amount per member, not per facility.** |
| **D9420** | Hospital or ambulatory surgical center call | D9420-**6 units**, same member, same provider, same calendar year.<br><br>D9420 - This code must be in conjunction with the procedure codes for actual services planned. Hospital call is calculated by determining the time needed to prepare for and render the dental services and is reimbursable in 30-minute increments. **One unit equals 30 minutes**<br><br>**Coordination of services – every attempt should be made to complete all treatment necessary during one hospital/ surgical center call. Surgeries between OMFS, general/ pediatric dentist and/ or physician should be coordinated in effort.** | YES<br><br>See emergency Exception | 1. Treatment plan, complete radiographs of the mouth.<br>2. Letter of medical necessity must be submitted for review.<br>3. **CareSource Scoring Tool.**<br>4. All planned dental services should be included on the request**.** | All dental services rendered as an inpatient or outpatient admission must be prior approved and/or pre-certified for members regardless of age and service being performed. It is the responsibility of the attending dentist to obtain prior approval and/or precertification.<br>**EXCEPTION:**<br>Situations that require emergency hospital or ambulatory surgical center admissions do not require prior approval. These cases are subject to post- treatment review and a hospital precertification must be submitted on Scion Web Portal within thirty (30) days of admit date. All emergent dental treatment and surgical procedures rendered must be on the request. Operative notes, x-rays and narrative of medical necessity. |

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| **D9440** | Office visit - after regularly scheduled hours | Use of this service is not to exceed **two (2)** times per member, per calendar year.<br>The comprehensive or the periodic exam may not occur in conjunction with a limited oral evaluation (examination during office hours — D0140 or examination after office hours — D9440). | No | NONE | ———————— |
| **D9610** | Therapeutic drug injection, by report | Use of this service is not to exceed **two (2) times** per member, per calendar year, without prior authorization. | No | Prior authorization is required for any additional use of D9610 within a 12 month calendar period and is subject to medical necessity. Submit narrative, treatment notes. | Therapeutic parenteral drug, single administration. Includes antibiotic or injection of sedative. |
| **D9630** | Other drugs & medication, by report | Use of this service is not to exceed **two (2) times** per member, per calendar year, without prior authorization. | No | When submitting a request for procedure D9630, a narrative is required to identify the dosage and the technique for administering the drug or preventive product.<br>Coverage is subject to medical necessity. | By report, includes but is not limited to, oral antibiotics, oral analgesics and topical fluoride dispensed in the office for home use. Does not include writing prescriptions. |
| **D9920** | Behavior management, by report | D9920 - **2 units** same member, same provider, same calendar year.<br><br>D9920 - **one unit equals 15 minutes.**<br>Management time is calculated by determining the additional time to be spent beyond the normal time required to complete the service. The minutes or time requested must be only for the additional time - **Not for the full appointment** | No<br><br>POST REVIEW ALLOWED | Describe the highest level of behavior management technique used for the member in the comments field of your claim.<br>Comments such as “additional staff and time” or “protective stabilization" will be sufficient.<br><br>Submit treatment plan or treatment rendered. | If additional units of the aforementioned services are found to be medically necessary, a post approval request for the remaining units should be submitted within thirty (30) calendar days of the date of service. You must include any narratives as required and all procedures provided in conjunction with these services. Approval is subject to review. |



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