METHOD OF INDICATING CHANGES

This Accessible PDF version of the proposed Manual of Criteria includes the phrase [begin underline] at the beginning of each addition, [end underline] at the end of each addition, [begin strikeout] at the beginning of each deletion, and [end strikeout] at the end of each deletion.

A standard PDF version of this proposed Manual of Criteria is also available on the Department's Office of Regulations Internet site.

Criteria Manual Chapter 8.1
Criteria for Dental Services

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Diagnostic General Policies (D0100-D0999)

1. Radiographs (D0210-D0340):

a) According to accepted standards of dental practice, the lowest number of radiographs needed to provide the diagnosis shall be taken.

b) Original radiographs shall be a part of the patient's clinical record and shall be retained by the provider at all times.

c) Radiographs shall be made available for review upon the request of the Department of Health Care Services or its fiscal intermediary.

d) Pursuant to Title 22, CCR, Section 51051, dental radiographic laboratories shall not be considered providers under the Medi-Cal Dental Program.

e) Radiographs shall be considered current as follows:

i) radiographs for treatment of primary teeth within the last eight months.

ii) radiographs for treatment of permanent teeth (as well as over-retained primary teeth

where the permanent tooth is congenitally missing or impacted) within the last 14

months.

iii) radiographs to establish arch integrity within the last 36 months. Arch radiographs

are not required for patients under the age of 21.

f) All radiographs or paper copies of radiographs shall be of diagnostic quality, properly mounted, labeled with the date the radiograph was taken, the provider's name, the provider's billing number, the patient's name, and the left and right sides of the patient's mouth clearly indicated with the tooth/quadrant/area (as applicable) clearly indicated.

g) Multiple radiographs of four or more shall be mounted. Three or fewer radiographs properly identified (as stated in "e" above) in a coin envelope are acceptable when submitted for prior authorization and/or payment.

h) Paper copies of multiple radiographs shall be combined on no more than four sheets of paper.

i) All treatment and post treatment radiographs are included in the fee for the associated procedure and are not payable separately.

j) A panoramic radiograph alone is considered non-diagnostic for prior authorization and/ or payment of restorative, endodontic, periodontic, removable partial and fixed prosthodontic procedures.

k) When arch integrity films are required for a procedure and exposure to radiation should be minimized due to a medical condition, only a periapical radiograph shall be required. Submitted written documentation shall include a statement of the medical condition such as the following:

   i) pregnancy,

   ii) recent application of therapeutic doses of ionizing radiation to the head and neck areas,

   iii) hypoplastic or aplastic anemia.

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

2. Photographs (D0350):

a) Photographs are a part of the patient's clinical record and the provider shall retain original photographs at all times.

b) Photographs shall be made available for review upon the request of the Department of Health Care Services or its fiscal intermediary.

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

Diagnostic Procedures (D0100-D0999)

PROCEDURE D0120
PERIODIC ORAL EVALUATION-ESTABLISHED PATIENT

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

PROCEDURE D0140
LIMITED ORAL EVALUATION -PROBLEM FOCUSED

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
   a. for patients under the age of 21.
   b. once per patient per provider.
   c. when provided by a Medi-Cal Dental Program certified orthodontist.
3. Submission of the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (06/09) is not required for payment.
4. The following procedures are not a benefit, for the same rendering provider, when provided on the same date of service with procedure D0140:
   a. periodic oral evaluation (D0120),
   b. comprehensive oral evaluation- new or established patient (D0150),
   c. detailed and extensive oral evaluation- problem focused, by report (D0160),
   d. re-evaluation-limited, problem focused (established patient; not post- operative visit) (D0170),
   e. office visit for observation (during regularly scheduled hours)-no other services performed (D9430).
5. This examination procedure shall only be billed for the initial orthodontic evaluation with the completion of the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (06/09).

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

This procedure can only be billed as periodic oral evaluation-established patient (D0120) or comprehensive oral evaluation-new or established patient (D0150)- and is not payable separately.

PROCEDURE D0150
COMPREHENSIVE ORAL EVALUATION - NEW OR ESTABLISHED PATIENT

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit once per patient per provider for the initial evaluation.

3. This procedure is not a benefit when provided on the same date of service with procedures:
   a. limited oral evaluation (D0140),
   b. detailed and extensive oral evaluation-problem focused, by report (D0160),
   c. re-evaluation-limited, problem focused (established patient; not post-operative visit) (D0170).
4. The following procedures are not a benefit when provided on the same date of service with D0150:
   a. periodic oral evaluation (D0120),
   b. office visit for observation (during regularly scheduled hours)-no other services performed (D9430).

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

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

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

1. Written documentation for payment- shall include an evaluation and diagnosis justifying the medical necessity.
2. A benefit for the ongoing symptomatic care of temporomandibular joint dysfunction:
   a. up to six times in a three month period.
   b. up to a maximum of 12 in a 12-month period.
3. This procedure is not a benefit when provided on the same date of service with a detailed and extensive oral evaluation (D0160).
4. The following procedures are not a benefit when provided on the same date of service with procedure D0170:
   a. periodic oral evaluation (D0120),
   b. limited oral evaluation-problem focused (D0140),
   c. comprehensive oral evaluation-new or established patient (D0150),
   d. office visit for observation (during regularly scheduled hours)-no other services performed (D9430).

PROCEDURE D0180
COMPREHENSIVE PERIODONTAL EVALUATION - NEW OR ESTABLISHED PATIENT

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

[BEGIN UNDERLINE]**PROCEDURE D0190**
SCREENING OF A PATIENT

This procedure is not a benefit.

PROCEDURE D0191
ASSESSMENT OF A PATIENT

This procedure is not a benefit.[END UNDERLINE]

PROCEDURE D0210
INTRAORAL - COMPLETE SERIES [BEGIN UNDERLINE]**OF RADIOGRAPHIC IMAGES**[END UNDERLINE] [BEGIN STRIKEOUT]~~**(INCLUDING BITEWINGS)**~~[END STRIKEOUT]

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit once per provider every 36 months.
3. Not a benefit to the same provider within six months of bitewings (D0272 and D0274).
4. A complete series shall be at least:
   a. ten (10) periapicals (D0230) and bitewings (D0272 or D0274), or
   b. eight (8) periapicals (D0230), two (2) occlusals (D0240) and bitewings (D0272 or D0274), or
   c. a panoramic [BEGIN STRIKEOUT]~~film~~[END STRIKEOUT] [BEGIN UNDERLINE]radiographic image [END UNDERLINE] (D0330) plus bitewings (D0272 or D0274) and a minimum of two (2) periapicals (D0230).
5. When multiple radiographs are taken on the same date of service, or if an intraoral-complete series [BEGIN STRIKEOUT]~~(including bitewings)~~ [END STRIKEOUT] [BEGIN UNDERLINE]of radiographic images [END UNDERLINE] (D0210) has been paid in the last 36 months, the maximum payment shall not exceed the total fee allowed for an intraoral complete series.

PROCEDURE D0220
INTRAORAL - PERIAPICAL FIRST [BEGIN UNDERLINE]**RADIOGRAPHIC IMAGE**[END UNDERLINE] [BEGIN STRIKEOUT]~~**FILM**~~[END STRIKEOUT]

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

STRIKEOUT]~~film~~[END STRIKEOUT] [BEGIN UNDERLINE]radiographic image[END UNDERLINE] (D0230).

4. Periapicals taken in conjunction with bitewings, occlusal or panoramic radiographs shall be billed as intraoral-periapical each additional [BEGIN STRIKEOUT]~~film~~[END STRIKEOUT] [BEGIN UNDERLINE]radiographic image[END UNDERLINE] (D0230).

PROCEDURE D0230
INTRAORAL - PERIAPICAL EACH ADDITIONAL [BEGIN UNDERLINE]**RADIOGRAPHIC IMAGE**[END UNDERLINE] [BEGIN STRIKEOUT]~~**FILM**~~

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

PROCEDURE D0240
INTRAORAL - OCCLUSAL [BEGIN UNDERLINE]**RADIOGRAPHIC IMAGE**[END UNDERLINE] [BEGIN STRIKEOUT]~~**FILM**~~[END STRIKEOUT]

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

PROCEDURE D0250
EXTRAORAL - FIRST [BEGIN UNDERLINE]**RADIOGRAPHIC IMAGE**[END UNDERLINE] [BEGIN STRIKEOUT]~~**FILM**~~[END STRIKEOUT]

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit once per date of service.

PROCEDURE D0260
EXTRAORAL - EACH ADDITIONAL [BEGIN UNDERLINE]**RADIOGRAPHIC IMAGE**[END UNDERLINE] [BEGIN STRIKEOUT]~~**FILM**~~[END STRIKEOUT]

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit up to a maximum of four on the same date of service.

PROCEDURE D0270
BITEWING - SINGLE [BEGIN UNDERLINE]**RADIOGRAPHIC IMAGE**[END UNDERLINE] [BEGIN STRIKEOUT]~~**FILM**~~[END STRIKEOUT]

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

PROCEDURE D0272
BITEWINGS - TWO [BEGIN UNDERLINE]**RADIOGRAPHIC IMAGES**[END UNDERLINE] [BEGIN STRIKEOUT]~~**FILMS**~~[END STRIKEOUT]

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

PROCEDURE D0273
BITEWINGS- THREE [BEGIN UNDERLINE]**RADIOGRAPHIC IMAGES**[END UNDERLINE] [BEGIN STRIKEOUT]~~**FILMS**~~[END STRIKEOUT]

This procedure can only be billed as bitewing- single [BEGIN STRIKEOUT]~~film~~[END STRIKEOUT] [BEGIN UNDERLINE]radiographic image (D0270) and bitewings- two [BEGIN STRIKEOUT]~~film~~[END STRIKEOUT] [BEGIN UNDERLINE]radiographic images[END UNDERLINE] (D0272).

PROCEDURE D0274
BITEWINGS - FOUR [BEGIN UNDERLINE]**RADIOGRAPHIC IMAGES**[END UNDERLINE] [BEGIN STRIKEOUT]~~**FILMS**~~[END STRIKEOUT]

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit once every six months per provider.
3. Not a benefit:
   a. within six months of intraoral-complete series [BEGIN STRIKEOUT]~~(including bitewings)~~ [END STRIKEOUT] [BEGIN UNDERLINE]of radiographic images [END UNDERLINE] (D0210), same provider.

   [BEGIN UNDERLINE]b. for patients under the age of 10.[END UNDERLINE]

   [BEGIN STRIKEOUT]~~b.~~[BEGIN UNDERLINE]c. [END UNDERLINE] for a totally edentulous area.

PROCEDURE D0277
VERTICAL BITEWINGS - 7 TO 8 [BEGIN UNDERLINE]**RADIOGRAPHIC IMAGES**[END UNDERLINE] [BEGIN STRIKEOUT]~~**FILMS**~~[END STRIKEOUT]

This procedure can only be billed as bitewings-four [BEGIN STRIKEOUT]~~film~~[END STRIKEOUT] [BEGIN UNDERLINE]radiographic images[END UNDERLINE] (D0274). The maximum payment is for four bitewings.

PROCEDURE D0290
POSTERIOR - ANTERIOR OR LATERAL SKULL AND FACIAL BONE SURVEY [BEGIN UNDERLINE]**RADIOGRAPHIC IMAGE**[END UNDERLINE] [BEGIN STRIKEOUT]~~**FILM**~~[END STRIKEOUT]

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

a. for the survey of trauma or pathology.

b. for a maximum of three per date of service.

PROCEDURE D0310
SIALOGRAPHY

Submit radiology report or radiograph(s) for payment.

PROCEDURE D0320
TEMPOROMANDIBULAR JOINT ARTHROGRAM, INCLUDING INJECTION

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

PROCEDURE D0321
OTHER TEMPOROMANDIBULAR JOINT [BEGIN UNDERLINE]**RADIOGRAPHIC IMAGES**[END UNDERLINE] [BEGIN STRIKEOUT]~~**FILMS**~~[END STRIKEOUT]**, BY REPORT**

This procedure is not a benefit.

PROCEDURE D0322
TOMOGRAPHIC SURVEY

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

PROCEDURE D0330
PANORAMIC [BEGIN UNDERLINE] **RADIOGRAPHIC IMAGE**[END UNDERLINE] [BEGIN STRIKEOUT]~~**FILM**~~[END STRIKEOUT]

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

2. A benefit once in a 36-month period per provider, except when documented as essential for a follow-up/ post-operative exam (such as after oral surgery).
3. Not a benefit, for the same provider, on the same date of service as an intraoral-complete series [BEGIN STRIKEOUT]~~(including bitewings)~~ [END STRIKEOUT] [BEGIN UNDERLINE]of radiographic images[END UNDERLINE] (D0210).
4. This procedure shall be considered part of an intraoral- complete series [BEGIN STRIKEOUT]~~(including bitewings)~~ [END STRIKEOUT] of [BEGIN UNDERLINE]radiographic images [END UNDERLINE] (D0210) when taken on the same date of service with bitewings (D0272 or D0274) and a minimum of two (2) intraoral- periapicals each additional [BEGIN STRIKEOUT]~~film~~[END STRIKEOUT] [BEGIN UNDERLINE]radiographic image[END UNDERLINE] (D0230).

PROCEDURE D0340
CEPHALOMETRIC [BEGIN UNDERLINE]**RADIOGRAPHIC IMAGE**[END UNDERLINE] [BEGIN STRIKEOUT]~~**FILM**~~[END STRIKEOUT]

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit twice in a 12-month period per provider.

PROCEDURE D0350
ORAL/FACIAL PHOTOGRAPHIC IMAGES

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

[BEGIN STRIKEOUT] ~~**PROCEDURE D0360**~~
~~**CONE BEAM CT- CRANIOFACIAL DATA CAPTURE**~~

~~This procedure is not a benefit.~~

~~**PROCEDURE D0362**~~
~~**CONE BEAM- TWO-DIMENSIONAL IMAGE RECONSTRUCTION USING EXISTING DATA, INCLUDES MULTIPLE IMAGES**~~

~~This procedure is not a benefit~~[END STRIKEOUT].

PROCEDURE D0363
CONE BEAM- THREE-DIMENSIONAL IMAGE RECONSTRUCTION USING EXISTING DATA, INCLUDES MULTIPLE IMAGES

This procedure is not a benefit.

[BEGIN UNDERLINE]**PROCEDURE D0364**
CONE BEAM CT CAPTURE AND INTERPRETATION WITH LIMITED FIELD OF VIEW- LESS THAN ONE WHOLE JAW

This procedure is not a benefit.

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

This procedure is not a benefit.

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

This procedure is not a benefit.

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

This procedure is not a benefit.

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

This procedure is not a benefit.

PROCEDURE D0369
MAXILLOFACIAL MRI CAPTURE AND INTERPRETATION

This procedure is not a benefit.

PROCEDURE D0370
MAXILLOFACIAL ULTRASOUND CAPTURE AND INTERPRETATION

This procedure is not a benefit.

PROCEDURE D0371
SIALOENDOSCOPY CAPTURE AND INTERPRETATION

This procedure is not a benefit.

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

This procedure is not a benefit.

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

This procedure is not a benefit.

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

This procedure is not a benefit.

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

This procedure is not a benefit.

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

This procedure is not a benefit.

PROCEDURE D0385
MAXILLOFACIAL MRI IMAGE CAPTURE

This procedure is not a benefit.

PROCEDURE D0386
MAXILLOFACIAL ULTRASOUND IMAGE CAPTURE

This procedure is not a benefit.

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

This procedure is not a benefit.[END UNDERLINE]

PROCEDURE D0415
COLLECTION OF MICROORGANISMS FOR CULTURE AND SENSITIVITY

This procedure is not a benefit.

PROCEDURE D0416
VIRAL CULTURE

This procedure is not a benefit.

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

This procedure is not a benefit.

PROCEDURE D0418
ANALYSIS OF SALIVA SAMPLE

This procedure is not a benefit.

PROCEDURE D0421
GENETIC TEST FOR SUSCEPTIBILITY TO ORAL DISEASES

This procedure is not a benefit.

PROCEDURE D0425
CARIES SUSCEPTIBILITY TESTS

This procedure is not a benefit.

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

This procedure is not a benefit.

PROCEDURE D0460
PULP VITALITY TESTS

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

PROCEDURE D0470
DIAGNOSTIC CASTS

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

2. Diagnostic casts are required to be submitted for orthodontic evaluation and are payable only upon authorized orthodontic treatment. Do not send original casts, as casts will not be returned.
3. A benefit:
   a. once per provider unless special circumstances are documented (such as trauma or pathology which has affected the course of orthodontic treatment).
   b. for patients under the age of 21.
   c. for permanent dentition (unless over the age of 13 with primary teeth still present or has a cleft palate or craniofacial anomaly).
   d. only when provided by a Medi-Cal Dental Program certified orthodontist.
4. Diagnostic casts shall be free of voids and be properly trimmed with centric occlusion clearly marked on the casts. Casts shall be cleaned, treated with an approved EPA disinfectant and dried before being placed in a sealed bag for shipping to the Medi-Cal Dental Program.

PROCEDURE D0472
ACCESSION OF TISSUE, GROSS EXAMINATION, PREPARATION AND TRANSMISSION OF WRITTEN REPORT

This procedure is not a benefit.

PROCEDURE D0473
ACCESSION OF TISSUE, GROSS AND MICROSCOPIC EXAMINATION, PREPARATION AND TRANSMISSION OF WRITTEN REPORT

This procedure is not a benefit.

PROCEDURE D0474
ACCESSION OF TISSUE, GROSS AND MICROSCOPIC EXAMINATION, INCLUDING ASSESSMENT OF SURGICAL MARGINS FOR PRESENCE OF DISEASE, PREPARATION AND TRANSMISSION OF WRITTEN REPORT

This procedure is not a benefit.

PROCEDURE D0475
DECALCIFICATION PROCEDURE

This procedure is not a benefit.

PROCEDURE D0476
SPECIAL STAINS FOR MICROORGANISMS

This procedure is not a benefit.

PROCEDURE D0477
SPECIAL STAINS, NOT FOR MICROORGANISMS

This procedure is not a benefit.

PROCEDURE D0478
IMMUNOHISTOCHEMICAL STAINS

This procedure is not a benefit.

PROCEDURE D0479
TISSUE IN-SITU HYBRIDIZATION, INCLUDING INTERPRETATION

This procedure is not a benefit.

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

This procedure is not a benefit.

PROCEDURE D0481
ELECTRON MICROSCOPY

This procedure is not a benefit.

PROCEDURE D0482
DIRECT IMMUNOFLUORESCENCE

This procedure is not a benefit.

PROCEDURE D0483
INDIRECT IMMUNOFLUORESCENCE

This procedure is not a benefit.

PROCEDURE D0484
CONSULTATION ON SLIDES PREPARED ELSEWHERE

This procedure is not a benefit.

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

This procedure is not a benefit.

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

This procedure is not a benefit.

PROCEDURE D0502
OTHER ORAL PATHOLOGY PROCEDURES BY REPORT

1. Submission of the pathology report is required for payment.
2. A benefit only when provided by a Medi-Cal Dental Program certified oral pathologist.
3. This procedure shall be billed only for a histopathological examination.

PROCEDURE D0999
UNSPECIFIED DIAGNOSTIC PROCEDURE, BY REPORT

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

shall include the medical condition and the specific CDT code associated with the treatment.

Preventive General Policies (D1000-D1999)

1. Dental Prophylaxis and Fluoride Treatment (D1110-[BEGIN STRIKEOUT] **~~D1206~~**[END STRIKEOUT] **D1208):**

a) Dental prophylaxis (D1110 and D1120) is defined as the preventive dental procedure of coronal scaling and polishing which includes the complete removal of calculus, soft deposits, plaque, stains and smoothing of unattached tooth surfaces.

b) Fluoride treatment ([BEGIN STRIKEOUT]~~D1203, D1204 and~~[END STRIKEOUT] D1206 [BEGIN UNDERLINE]and D1208[END UNDERLINE]) is a benefit only for prescription strength fluoride products.

c) Fluoride treatments do not include treatments that incorporate fluoride with prophylaxis paste, topical application of fluoride to the prepared portion of a tooth prior to restoration and applications of aqueous sodium fluoride.

d) The application of fluoride is only a benefit for caries control and is payable as a full mouth treatment regardless of the number of teeth treated.

e) Prophylaxis and fluoride procedures (D1120, [BEGIN STRIKEOUT]~~D1203 and~~[END STRIKEOUT] D1206 [BEGIN UNDERLINE]and D1208[END UNDERLINE]) are a benefit once in a six-month period without prior authorization under the age of 21.

f) Prophylaxis and fluoride procedures (D1110, [BEGIN STRIKEOUT]~~D1204 and~~[END STRIKEOUT] D1206 [BEGIN UNDERLINE]and D1208[END UNDERLINE]) are a benefit once in a 12-month period without prior authorization for age 21 or older.

g) Additional requests, beyond the stated frequency limitations, for prophylaxis and fluoride procedures (D1110, D1120, [BEGIN STRIKEOUT]~~D1203, D1204 and~~[END STRIKEOUT] D1206 [BEGIN UNDERLINE]and D1208[END UNDERLINE]) shall be considered for prior authorization when documented medical necessity is justified due to a physical limitation and/or an oral condition [BEGIN UNDERLINE]that prevents daily oral hygiene[END UNDERLINE].

Preventive Procedures (D1000-D1999)

PROCEDURE D1110
PROPHYLAXIS - ADULT

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

PROCEDURE D1120
PROPHYLAXIS - CHILD

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

[BEGIN STRIKEOUT]~~**PROCEDURE D1203**~~
~~**TOPICAL APPLICATION OF FLUORIDE - CHILD**~~

~~1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.~~
~~2. A benefit once in a six-month period for patients under the age of 21. Frequency limitations shall apply toward topical fluoride varnish; therapeutic application for moderate to high caries risk patients (D1206).~~

~~3. Payable as a full mouth treatment regardless of the number of teeth treated.~~

~~**PROCEDURE D1204**~~
~~**TOPICAL APPLICATION OF FLUORIDE - ADULT**~~

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

~~2. A benefit once in a 12-month period for patients age 21 or older. Frequency limitations shall apply toward topical application of fluoride (D1203) and topical fluoride varnish; therapeutic application for moderate to high caries risk patients (D1206).~~

~~3. Payable as a full mouth treatment regardless of the number of teeth treated.~~ [END STRIKEOUT]

PROCEDURE D1206
TOPICAL [BEGIN UNDERLINE*]*APPLICATION OF[END UNDERLINE] **FLUORIDE VARNISH~~;~~** [BEGIN STRIKEOUT]~~**THERAPEUTIC APPLICATION FOR MODERATE TO HIGH CARIES RISK PATIENTS**~~***[END STRIKEOUT]***

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
   a. once in a six month period for patients under the age of 21. Frequency limitations shall apply toward topical application of fluoride[BEGIN STRIKEOUT]~~-child (D1203)~~ [END STRIKEOUT] [BEGIN UNDERLINE] (D1208) END UNDERLINE].
   b. once in a 12 month period for patients age 21 or older. Frequency limitations shall apply toward topical application of fluoride[BEGIN STRIKEOUT]~~- adult (D1204)~~ [END STRIKEOUT] [BEGIN UNDERLINE] (D1208).
3. Payable as a full mouth treatment regardless of the number of teeth treated.

[BEGIN UNDERLINE]**PROCEDURE D1208**
TOPICAL APPLICATION OF FLUORIDE

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
   a. once in a six month period for patients under the age of 21. Frequency limitations shall apply toward topical application of fluoride varnish (D1206).

b. once in a 12 month period for patients age 21 or older. Frequency limitations shall apply toward topical application of fluoride varnish (D1206).

3. Payable as a full mouth treatment regardless of the number of teeth treated.[END UNDERLINE]

PROCEDURE D1310
NUTRITIONAL COUNSELING FOR CONTROL OF DENTAL DISEASE

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

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

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

PROCEDURE D1330
ORAL HYGIENE INSTRUCTIONS

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

PROCEDURE D1351
SEALANT - PER TOOTH

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. Requires a tooth code and surface code.
3. A benefit:
   a. for first, second and third permanent molars that occupy the second molar position.
   b. only on the occlusal surfaces that are free of decay and/or restorations.
   c. for patients under the age of 21.
   d. once per tooth every 36 months per provider regardless of surfaces sealed.
4. The original provider is responsible for any repair or replacement during the 36-month period.

PROCEDURE D1352
PREVENTIVE RESIN RESTORATIONIN A MODERATE TO HIGH CARIES RISK PATIENT- PERMANENT TOOTH

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

PROCEDURE D1510
SPACE MAINTAINER – FIXED- UNILATERAL

1. This procedure does not require prior authorization.
2. Radiographs for payment - submit a diagnostic pre-operative periapical or bitewing radiograph to document the presence of the erupting permanent tooth and to verify there is enough space to allow the eruption of the permanent tooth.
3. Written documentation for payment - shall include the identification of the missing primary molar.
4. Requires a quadrant code.
5. A benefit:
   a. once per quadrant per patient.
   b. for patients under the age of 18.
   [BEGIN UNDERLINE]c. only to maintain the space for a single tooth. [END UNDERLINE]
6. Not a benefit:
   a. when the permanent tooth is near eruption or is missing.
   b. for upper and lower anterior teeth.

   c. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.

7. Replacement space maintainers shall be considered for payment when documentation identifies an unusual circumstance (such as lost or non-repairable).
8. The fee for space maintainers includes the band and loop.
9. When prefabricated crowns (D2930, D2931, D2932 and D2933) are necessary for space maintainer abutment teeth they first shall meet the Medi-Cal Dental Program's criteria for prefabricated crowns and shall be billed separately from the space maintainer.

PROCEDURE D1515
SPACE MAINTAINER - FIXED - BILATERAL

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

PROCEDURE D1520
SPACE MAINTAINER - REMOVABLE - UNILATERAL

1. This procedure does not require prior authorization.
2. Radiographs for payment - submit a diagnostic pre-operative periapical or bitewing radiograph to document the presence of the erupting permanent tooth and to verify there is enough space to allow the eruption of the permanent tooth.
3. Written documentation for payment - shall include the identification of the missing primary molar.
4. Requires a quadrant code.
5. A benefit:
   a. once per quadrant per patient.
   b. for patients under the age of 18.
   [BEGIN UNDERLINE]c. only to maintain the space for a single tooth. [END UNDERLINE]
6. Not a benefit:
   a. when the permanent tooth is near eruption or is missing.
   b. for upper and lower anterior teeth.
   c. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.
7. Replacement space maintainers shall be considered for payment when documentation identifies an unusual circumstance (such as lost or non-repairable).
8. All clasps, rests and adjustments are included in the fee for this procedure.

PROCEDURE D1525
SPACE MAINTAINER - REMOVABLE - BILATERAL

1. This procedure does not require prior authorization.
2. Radiographs for payment - submit a diagnostic pre-operative periapical or bitewing radiograph to document the presence of the erupting permanent tooth and to verify there is enough space to allow the eruption of the permanent tooth.
3. Written documentation for payment - shall include the identification of the missing primary molars.
4. Requires an arch code.
5. A benefit:
   a. once per arch when there is a missing primary molar in both quadrants or when there are two missing primary molars in the same quadrant.

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

PROCEDURE D1550
RECEMENTATION OF SPACE MAINTAINER

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

PROCEDURE D1555
REMOVAL OF FIXED SPACE MAINTAINER

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

Restorative General Policies (D2000-D2999)

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

a) Restorative services shall be a benefit when medically necessary, when carious activity or fractures have extended through the dentinoenamel junction (DEJ) and when the tooth demonstrates a reasonable longevity.

b) Amalgam and resin-based composite restoration procedures shall require submission of pre-operative radiographs for payment, contingent upon the following rules:

   i) the first three amalgam and/or resin-based composite restorations that a patient receives in a 12-month period do not require radiographs,

   ii) the fourth and additional amalgam and/or resin-based composite restorations that a patient receives in a 12-month period **do** require radiographs. However, when a submitted claim includes the fourth amalgam and/or resin-based composite restoration in a 12-month period then **all** amalgam and/or resin-based composite restorations on that claim require radiographs.

c) The submitted radiographs shall clearly demonstrate that the destruction of the tooth is due to such conditions as decay, fracture, endodontic access or missing or defective restorations. Payment for restorative procedures shall be modified or denied when the medical necessity is not evident.

d) Anterior proximal restorations (amalgam/composite) submitted as a two or three surface restorations shall be clearly demonstrated on radiographs that the tooth structure is involved to a point one-third the mesial–distal width of the tooth.

e) Should the submitted radiographs fail to demonstrate the medical necessity for the restoration, intraoral photographs shall also be submitted as further documentation.

f) When radiographs are medically contraindicated due to recent application of therapeutic doses of ionizing radiation to the head and neck areas, the reason for the contraindication shall be fully documented by the patient's attending physician and submitted for payment. If this condition exists, intraoral photographs shall also be submitted to demonstrate the medical necessity for the restoration.

g) When radiographs fail to demonstrate the medical necessity, providers shall also submit adjunctive documentation for consideration for payment such as: fiber optic transillumination photographs, DIAGNOdent readings, caries detection dye photographs, carries risk assessment data or operating room reports.

h) Restorative services provided solely to replace tooth structure lost due to attrition, abrasion, erosion or for cosmetic purposes are not a benefit.

i) Restorative services are not a benefit when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement.

j) Restorations for primary teeth near exfoliation are not a benefit.

k) The five valid tooth surface classifications are mesial, distal, occlusal/incisal, lingual and facial (including buccal and labial).

l) Each separate non-connecting restoration on the same tooth for the same date of service shall be submitted on separate Claim Service Lines (CSLs). All surfaces on a single tooth restored with the same restorative material shall be considered connected, for payment purposes, if performed on the same date of service.

m) Payment is made for a tooth surface only once for the same date of service regardless of the number or combination of restorative materials placed on that surface.

n) Tooth and soft tissue preparation, crown lengthening, cement bases, direct and indirect pulp capping, bonding agents, lining agents, occlusal adjustments (D9951), polishing, local anesthesia and any other associated procedures are included in the fee for a completed restorative service.

o) The original provider is responsible for any replacement restorations necessary in primary teeth within the first 12 months and permanent teeth within the first 36 months, except when failure or breakage results from circumstances beyond the control of the provider (such as due to a patient's oral habits). Radiographs (and photographs, as applicable) shall be submitted to demonstrate the need for replacement.

p) Replacement of otherwise satisfactory amalgam restorations with resin-based composite restorations is not a benefit unless a specific allergy has been documented by a medical specialist (allergist) on their professional letterhead or prescription and submitted for payment.

2. Prefabricated Crowns ([BEGIN UNDERLINE]**D2929** [END UNDERLINE]~~**D2930**~~**-D2933):**

A. Primary Teeth:

a) Prefabricated crowns ([BEGIN UNDERLINE]D2929, [END UNDERLINE] D2930, D2932, and D2933) are a benefit only once in a 12-month period.

b) Primary teeth do not require prior authorization. Pre-operative radiographs shall be submitted for payment. At least one of the following criteria shall be met for payment:

i) decay, fracture or other damage involving three or more tooth surfaces,

ii) decay, fracture or other damage involving one interproximal surface when the damage has extended extensively buccolingually or mesiodistally,

iii) the prefabricated crown is submitted for payment in conjunction with therapeutic pulpotomy or pulpal therapy (D3220, D3230 and D3240) or the tooth has had previous pulpal treatment.

c) Prefabricated crowns for primary teeth near exfoliation are not a benefit.

d) When prefabricated crowns are utilized to restore space maintainer abutment teeth they shall meet Medi-Cal Dental Program criteria for prefabricated crowns and shall be submitted separately for payment from the space maintainer.

B. Permanent Teeth:

a) Prefabricated crowns (D2931, D2932 and D2933) are a benefit only once in a 36-month period.

b) Permanent teeth do not require prior authorization. Pre-operative periapical and arch radiographs shall be submitted for payment. At least one of the following criteria shall be met for payment:

i) anterior teeth shall show traumatic or pathological destruction of the crown of the tooth which involves four or more tooth surfaces including at least the loss of one incisal angle,

ii) bicuspids (premolars) shall show traumatic or pathological destruction of the crown of the tooth which involves three or more tooth surfaces including at least one cusp,

iii) molars shall show traumatic or pathological destruction of the crown of the tooth which involves four or more tooth surfaces including at least two cusps,

iv) the prefabricated crown shall restore an endodontically treated bicuspid or molar tooth.

c) Arch integrity and the overall condition of the mouth, including the patient’s ability to maintain oral health, shall be considered based upon a supportable 36-month prognosis for the permanent tooth to be crowned.

d) Indirectly fabricated or prefabricated posts (D2952 and D2954) are benefits when medically necessary for the retention of prefabricated crowns on root canal treated permanent teeth.

e) Prefabricated crowns on root canal treated teeth shall be considered for payment only after satisfactory completion of root canal therapy. Post root canal treatment radiographs shall be submitted for prior authorization.

f) Prefabricated crowns are not a benefit for abutment teeth for cast metal framework partial dentures (D5213 and D5214).

C. Primary and Permanent Teeth:

a) Prefabricated crowns provided solely to replace tooth structure lost due to attrition, abrasion, erosion or for cosmetic purposes are not a benefit.

b) Prefabricated crowns are not a benefit when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement.

c) Prefabricated crowns are not a benefit when a tooth can be restored with an amalgam or resin-based composite restoration.

d) Tooth and soft tissue preparation, crown lengthening, cement bases, direct and indirect pulp capping, amalgam or acrylic buildups, pins (D2951), bonding agents, occlusal adjustments (D9951), local anesthesia (D9210) and any other associated procedures are included in the fee for a prefabricated crown.

e) The original provider is responsible for any replacement prefabricated crowns necessary in primary teeth within the first 12 months and permanent teeth within the first 36 months, except when failure or breakage results from circumstances beyond the control of the provider (such as due to a patient's oral habits).

3. Laboratory Processed Crowns (D2710-D2792):

a) Laboratory processed crowns on permanent teeth (or over-retained primary teeth with no permanent successor) are a benefit only once in a 5 year period except when failure or breakage results from circumstances beyond the control of the provider (such as due to a patient's oral habits).

b) Prior authorization with current periapical and arch radiographs is required. Arch films are not required for crown authorizations if the Medi-Cal Dental Program has paid for root canal treatment on the same tooth within the last six months. Only a periapical radiograph of the completed root canal treatment is required.

c) A benefit for patients age 13 or older when a lesser service will not suffice because of extensive coronal destruction. The following criteria shall be met for prior authorization:

i) Anterior teeth shall show traumatic or pathological destruction to the crown of the tooth, which involves at least one of the following:

a. the involvement of four or more surfaces including at least one incisal angle. The facial or lingual surface shall not be considered involved for a

mesial or proximal restoration unless the proximal restoration wraps around the tooth to at least the midline,

b. the loss of an incisal angle which involves a minimum area of both half the incisal width and half the height of the anatomical crown,

c. an incisal angle is not involved but more than 50% of the anatomical crown is involved.

ii) Bicuspids (premolars) shall show traumatic or pathological destruction of the crown of the tooth, which involves three or more tooth surfaces including one cusp.

iii) Molars shall show traumatic or pathological destruction of the crown of the tooth, which involves four or more tooth surfaces including two or more cusps.

iv) Posterior crowns for patients age 21 or older are a benefit only when they act as an abutment for a removable partial denture with cast clasps or rests (D5213 and D5214) or for a fixed partial denture which meets current criteria.

d) Restorative services provided solely to replace tooth structure lost due to attrition, abrasion, erosion or for cosmetic purposes are not a benefit.

e) Laboratory crowns are not a benefit when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement.

f) Laboratory processed crowns are not a benefit when the tooth can be restored with an amalgam or resin-based composite.

g) When a tooth has been restored with amalgam or resin-based composite restoration within 36 months, by the same provider, written documentation shall be submitted with the TAR justifying the medical necessity for the crown request. A current periapical radiograph dated after the restoration is required to demonstrate the medical necessity along with arch radiographs.

h) Tooth and soft tissue preparation, crown lengthening, cement bases, direct and indirect pulp capping, amalgam or acrylic buildups, pins (D2951), bonding agents, lining agents, impressions, temporary crowns, occlusal adjustments (D9951), polishing, local anesthesia (D9210) and any other associated procedures are included in the fee for a completed laboratory processed crown.

i) Arch integrity and overall condition of the mouth, including the patient's ability to maintain oral health, shall be considered for prior authorization, which shall be based upon a supportable 5 year prognosis for the teeth to be crowned.

j) Indirectly fabricated or prefabricated posts (D2952 and D2954) are a benefit when medically necessary for the retention of allowable laboratory processed crowns on root canal treated permanent teeth.

[BEGIN STRIKEOUT]~~k) Laboratory processed crowns on root canal treated teeth shall be considered only after satisfactory completion of root canal therapy~~

~~and require prior authorization. Post root canal treatment periapical and arch radiographs shall be submitted for prior authorization of laboratory processed crowns.~~

~~l)~~ [END STRIKEOUT] [BEGIN UNDERLINE]k)[END UNDERLINE] Partial payment will not be made for an undelivered laboratory processed crown. Payment shall be made only upon final cementation.

Restorative Procedures (D2000-D2999)

PROCEDURE D2140
AMALGAM - ONE SURFACE, PRIMARY OR PERMANENT

Primary teeth:

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

Permanent teeth:

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

PROCEDURE D2150
AMALGAM - TWO SURFACES, PRIMARY OR PERMANENT

See the criteria under Procedure D2140.

PROCEDURE D2160
AMALGAM - THREE SURFACES, PRIMARY OR PERMANENT

See the criteria under Procedure D2140.

PROCEDURE D2161
AMALGAM - FOUR OR MORE SURFACES, PRIMARY OR PERMANENT

See the criteria under Procedure D2140.

PROCEDURE D2330
RESIN-BASED COMPOSITE - ONE SURFACE, ANTERIOR

Primary teeth:

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

Permanent teeth:

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

PROCEDURE D2331
RESIN-BASED COMPOSITE - TWO SURFACES, ANTERIOR

Primary teeth:

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

Permanent teeth:

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

PROCEDURE D2332
RESIN-BASED COMPOSITE - THREE SURFACES, ANTERIOR

See the criteria under Procedure D2331.

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

See the criteria under Procedure D2331.

PROCEDURE D2390
RESIN-BASED COMPOSITE CROWN, ANTERIOR

Primary teeth:

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

Permanent teeth:

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

PROCEDURE D2391
RESIN-BASED COMPOSITE - ONE SURFACE, POSTERIOR

Primary teeth:

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

Permanent teeth:

1. This procedure does not require prior authorization.

2. Radiographs for payment- Refer to Restorative General Policies for specific requirements.
3. Requires a tooth code and surface code.
4. A benefit once in a 36-month period.

PROCEDURE D2392
RESIN-BASED COMPOSITE - TWO SURFACES, POSTERIOR

See the criteria under Procedure D2391.

PROCEDURE D2393
RESIN-BASED COMPOSITE - THREE SURFACES, POSTERIOR

See the criteria under Procedure D2391.

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

See the criteria under Procedure D2391.

PROCEDURE D2410
GOLD FOIL - ONE SURFACE

This procedure is not a benefit.

PROCEDURE D2420
GOLD FOIL - TWO SURFACES

This procedure is not a benefit.

PROCEDURE D2430
GOLD FOIL - THREE SURFACES

This procedure is not a benefit.

PROCEDURE D2510
INLAY - METALLIC - ONE SURFACE

This procedure is not a benefit.

PROCEDURE D2520
INLAY - METALLIC - TWO SURFACES

This procedure is not a benefit.

PROCEDURE D2530
INLAY - METALLIC - THREE OR MORE SURFACES

This procedure is not a benefit.

PROCEDURE D2542
ONLAY - METALLIC - TWO SURFACES

This procedure is not a benefit.

PROCEDURE D2543
ONLAY - METALLIC - THREE SURFACES

This procedure is not a benefit.

PROCEDURE D2544
ONLAY - METALLIC - FOUR OR MORE SURFACES

This procedure is not a benefit.

PROCEDURE D2610
INLAY - PORCELAIN/CERAMIC - ONE SURFACE

This procedure is not a benefit.

PROCEDURE D2620
INLAY - PORCELAIN/CERAMIC - TWO SURFACES

This procedure is not a benefit.

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

This procedure is not a benefit.

PROCEDURE D2642
ONLAY - PORCELAIN/CERAMIC - TWO SURFACES

This procedure is not a benefit.

PROCEDURE D2643
ONLAY - PORCELAIN/CERAMIC - THREE SURFACES

This procedure is not a benefit.

PROCEDURE D2644
ONLAY - PORCELAIN/CERAMIC - FOUR OR MORE SURFACES

This procedure is not a benefit.

PROCEDURE D2650
INLAY - RESIN-BASED COMPOSITE - ONE SURFACE

This procedure is not a benefit.

PROCEDURE D2651
INLAY - RESIN-BASED COMPOSITE - TWO SURFACES

This procedure is not a benefit.

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

This procedure is not a benefit.

PROCEDURE D2662
ONLAY- RESIN BASED COMPOSITE- TWO SURFACES

This procedure is not a benefit.

PROCEDURE D2663
ONLAY - RESIN-BASED COMPOSITE - THREE SURFACES

This procedure is not a benefit.

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

This procedure is not a benefit.

PROCEDURE D2710
CROWN –RESIN- BASED COMPOSITE (INDIRECT)

Permanent anterior teeth (age 13 or older) and permanent posterior teeth (ages 13 through 20):

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

Permanent posterior teeth (age 21 or older):

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs.
3. Photographs for prior authorization – a photograph shall be submitted when there is an existing removable partial denture and the cast clasp or rest is not evident on a radiograph.
4. Requires a tooth code.
5. A benefit:
   a. once in a five-year period.
   b. for any resin based composite crown that is indirectly fabricated.
   c. only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests (D5213 and D5214), or
   d. when the treatment plan includes an abutment crown and removable partial denture (D5213 or D5214). Both shall be submitted on the same TAR for prior authorization.
6. Not a benefit:

a. for 3rd molars, unless the 3rd molar is an abutment for an existing removable partial denture with cast clasps or rests.
b. for use as a temporary crown.

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

Permanent anterior teeth (age 13 or older) and permanent posterior teeth (ages 13 through 20):

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

Permanent posterior teeth (age 21 or older):

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs.
3. Photographs for prior authorization – a photograph shall be submitted when there is an existing removable partial denture and the cast clasp or rest is not evident on a radiograph.
4. Requires a tooth code.
5. A benefit:
   a. once in a five-year period.
   b. for any resin based composite crown that is indirectly fabricated.
   c. only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests (D5213 and D5214), or

d. when the treatment plan includes an abutment crown and removable partial denture (D5213 or D5214). Both shall be submitted on the same TAR for prior authorization.

6. Not a benefit:
   a. for 3rd molars, unless the 3rd molar is an abutment for an existing removable partial denture with cast clasps or rests.
   b. for use as a temporary crown.

PROCEDURE D2720
CROWN - RESIN WITH HIGH NOBLE METAL

This procedure is not a benefit.

PROCEDURE D2721
CROWN - RESIN WITH PREDOMINANTLY BASE METAL

Permanent anterior teeth (age 13 or older) and permanent posterior teeth (ages 13 through 20):

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

Permanent posterior teeth (age 21 or older):

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs.
3. Photographs for prior authorization- a photograph shall be submitted when there is an existing removable partial denture and the cast clasps or rest is not evident on a radiograph.
4. Requires a tooth code.
5. A benefit:
   a. once in a five-year period.

b. only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests (D5213 and D5214), or

c. when the treatment plan includes an abutment crown and removable partial denture (D5213 or D5214). Both shall be submitted on the same TAR for prior authorization.

6. Not a benefit for 3rd molars unless the 3rd molar is an abutment for an existing removable partial denture with cast clasps or rests.

PROCEDURE D2722
CROWN - RESIN WITH NOBLE METAL

This procedure is not a benefit.

PROCEDURE D2740
CROWN - PORCELAIN / CERAMIC SUBSTRATE

Permanent anterior teeth (age 13 or older) and permanent posterior teeth (ages 13 through 20):

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

Permanent posterior teeth (age 21 or older):

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs.
3. Photographs for prior authorization- a photograph shall be submitted when there is an existing removable partial denture and the cast clasps or rest is not evident on a radiograph.
4. Requires a tooth code.
5. A benefit:
   a. once in a five-year period.

b. only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests (D5213 and D5214), or

c. when the treatment plan includes an abutment crown and removable partial denture (D5213 or D5214). Both shall be submitted on the same TAR for prior authorization.

6. Not a benefit for 3rd molars, unless the 3rd molar is an abutment for an existing removable partial denture with cast clasps or rests.

PROCEDURE D2750
CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL

This procedure is not a benefit.

PROCEDURE D2751
CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL

Permanent anterior teeth (age 13 or older) and permanent posterior teeth (ages 13 through 20):

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

Permanent posterior teeth (age 21 or older):

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs.
3. Photographs for prior authorization- a photograph shall be submitted when there is an existing removable partial denture and the cast clasps or rest is not evident on a radiograph.
4. Requires a tooth code.
5. A benefit:
   a. once in a five-year period.

b. only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests (D5213 and D5214), or

c. when the treatment plan includes an abutment crown and removable partial denture (D5213 or D5214). Both shall be submitted on the same TAR for prior authorization.

6. Not a benefit for 3rd molars unless the 3rd molar is an abutment for an existing removable partial denture with cast clasps or rests.

PROCEDURE D2752
CROWN - PORCELAIN FUSED TO NOBLE METAL

This procedure is not a benefit.

PROCEDURE D2780
CROWN - 3/4 CAST HIGH NOBLE METAL

This procedure is not a benefit.

PROCEDURE D2781
CROWN - 3/4 CAST PREDOMINANTLY BASE METAL

Permanent anterior teeth (age 13 or older) and permanent posterior teeth (ages 13 through 20):

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

Permanent posterior teeth (age 21 or older):

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs.
3. Photographs for prior authorization- a photograph shall be submitted when there is an existing removable partial denture and the cast clasps or rest is not evident on a radiograph.

4. Requires a tooth code.
5. A benefit:
   a. once in a five- year period.
   b. only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests (D5213 and D5214), or
   c. when the treatment plan includes an abutment crown and removable partial denture (D5213 or D5214). Both shall be submitted on the same TAR for prior authorization.
6. Not a benefit for 3rd molars, unless the 3rd molar is an abutment for an existing removable partial denture with cast clasps or rests.

PROCEDURE D2782
CROWN - 3/4 CAST NOBLE METAL

This procedure is not a benefit.

PROCEDURE D2783
CROWN - 3/4 PORCELAIN / CERAMIC

Permanent anterior teeth (age 13 or older) and permanent posterior teeth (ages 13 through 20):

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

Permanent posterior teeth (age 21 or older):

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs.
3. Photographs for prior authorization- a photograph shall be submitted when there is an existing removable partial denture and the cast clasps or rest is not evident on a radiograph.
4. Requires a tooth code.

5. A benefit:
   a. once in a five- year period.
   b. only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests (D5213 and D5214), or
   c. when the treatment plan includes an abutment crown and removable partial denture (D5213 or D5214). Both shall be submitted on the same TAR for prior authorization.
6. Not a benefit for 3rd molars unless the 3rd molar is an abutment for an existing removable partial denture with cast clasps or rests.

PROCEDURE D2790
CROWN - FULL CAST HIGH NOBLE METAL

This procedure is not a benefit.

PROCEDURE D2791
CROWN - FULL CAST PREDOMINANTLY BASE METAL

Permanent anterior teeth (age 13 or older) and permanent posterior teeth (ages 13 through 20):

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

Permanent posterior teeth (age 21 or older):

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs.
3. Photographs for prior authorization- a photograph shall be submitted when there is an existing removable partial denture and the cast clasps or rest is not evident on a radiograph.
4. Requires a tooth code.
5. A benefit:

a. once in a five- year period.

b. only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests (D5213 and D5214), or

c. when the treatment plan includes an abutment crown and removable partial denture (D5213 or D5214). Both shall be submitted on the same TAR for prior authorization.

6. Not a benefit for 3rd molars, unless the 3rd molar is an abutment for an existing removable partial denture with cast clasps or rests.

PROCEDURE D2792
CROWN - FULL CAST NOBLE METAL

This procedure is not a benefit.

PROCEDURE D2794
CROWN - TITANIUM

This procedure is not a benefit.

PROCEDURE D2799
PROVISIONAL CROWN[BEGIN UNDERLINE]**- FURTHER TREATMENT OR COMPLETION OF DIAGNOSIS NECESSARY PRIOR TO FINAL IMPRESSION**[END UNDERLINE]

This procedure is not a benefit.

PROCEDURE D2910
RECEMENT INLAY, ONLAY, OR PARTIAL COVERAGE RESTORATION

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

PROCEDURE D2915
RECEMENT CAST OR PREFABRICATED POST AND CORE

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

PROCEDURE D2920
RECEMENT CROWN

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

[BEGIN UNDERLINE]**PROCEDURE D2929**
PREFABRICATED PORCELAIN/CERAMIC CROWN- PRIMARY TOOTH

1. This procedure does not require prior authorization.
2. Radiographs for payment- submit pre-operative radiographs. Refer to Restorative General Policies for specific requirements.
3. Requires a tooth code.
4. A benefit once in a 12-month period. [END UNDERLINE]

PROCEDURE D2930
PREFABRICATED STAINLESS STEEL CROWN - PRIMARY TOOTH

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

PROCEDURE D2931
PREFABRICATED STAINLESS STEEL CROWN - PERMANENT TOOTH

1. This procedure does not require prior authorization.
2. Radiographs for payment- submit arch and pre-operative periapical radiographs. Refer to Restorative General Policies for specific requirements.
3. Requires a tooth code.

4. A benefit once in a 36-month period.
5. Not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.

PROCEDURE D2932
PREFABRICATED RESIN CROWN

Primary teeth:

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

Permanent teeth:

1. This procedure does not require prior authorization.
2. Radiographs for payment- submit arch and pre-operative periapical radiographs. Refer to Restorative General Policies for specific requirements.
3. Requires a tooth code.
4. A benefit once in a 36-month period.
5. Not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.

PROCEDURE D2933
PREFABRICATED STAINLESS STEEL CROWN WITH RESIN WINDOW

Primary teeth:

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

Permanent teeth:

1. This procedure does not require prior authorization.

2. Radiographs for payment- submit arch and pre-operative periapical radiographs. Refer to Restorative General Policies for specific requirements.
3. Requires a tooth code.
4. A benefit once in a 36-month period.
5. Not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.
6. This procedure includes the placement of a resin-based composite.

PROCEDURE D2934
PREFABRICATED ESTHETIC COATED STAINLESS STEEL CROWN - PRIMARY TOOTH

This procedure is not a benefit.

PROCEDURE D2940
PROTECTIVE RESTORATION

1. This procedure cannot be prior authorized.
2. Radiographs for payment - submit pre-operative radiographs. Refer to Restorative General Policies for specific requirements.
3. Requires a tooth code.
4. A benefit once per tooth in a six-month period, per provider.
5. Not a benefit:
   a. when performed on the same date of service with a permanent restoration or crown, for same tooth.
   b. on root canal treated teeth.
6. This procedure is for a temporary restoration and is not to be used as a base or liner under a restoration.

PROCEDURE D2950
CORE BUILDUP, INCLUDING ANY PINS

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

PROCEDURE D2951
PIN RETENTION - PER TOOTH, IN ADDITION TO RESTORATION

1. This procedure does not require prior authorization.
2. Radiographs for payment- submit pre-operative radiographs.
3. Requires a tooth code.
4. A benefit:
   a. for permanent teeth only.
   b. when billed with an amalgam or composite restoration on the same date of service.
   c. once per tooth regardless of the number of pins placed.
   d. for a posterior restoration when the destruction involves three or more connected surfaces and at least one cusp, or
   e. for an anterior restoration when extensive coronal destruction involves the incisal angle.

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

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

PROCEDURE D2953
EACH ADDITIONAL-INDIRECTLY FABRICATED POST - SAME TOOTH

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

PROCEDURE D2954
PREFABRICATED POST AND CORE IN ADDITION TO CROWN

1. This procedure does not require prior authorization.
2. Radiographs for payment- submit arch and periapical radiographs.

3. Requires a tooth code.
4. A benefit:
   a. once per tooth regardless of number of posts placed.
   b. only in conjunction with allowable crowns (prefabricated or laboratory processed) on root canal treated permanent teeth.
5. This procedure shall be submitted on the same claim/TAR as the crown request.

PROCEDURE D2955
POST REMOVAL [BEGIN STRIKEOUT] ~~**(NOT IN CONJUNCTION WITH ENDODONTIC THERAPY)**~~ **[END STRIKEOUT]**

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

PROCEDURE D2957
EACH ADDITIONAL PREFABRICATED POST - SAME TOOTH

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

PROCEDURE D2960
LABIAL VENEER (RESIN LAMINATE) – CHAIRSIDE

This procedure is not a benefit.

PROCEDURE D2961
LABIAL VENEER (RESIN LAMINATE) - LABORATORY

This procedure is not a benefit.

PROCEDURE D2962
LABIAL VENEER (PORCELAIN LAMINATE) - LABORATORY

This procedure is not a benefit.

PROCEDURE D2970
TEMPORARY CROWN (FRACTURED TOOTH)

1. This procedure cannot be prior authorized.
2. Radiographs for payment - submit a pre-operative periapical radiograph.

3. Written documentation for payment - shall include a description of the circumstances leading to the traumatic injury.
4. Requires a tooth code.
5. A benefit:
   a. once per tooth, per provider.
   b. for permanent teeth only.
6. Not a benefit on the same date of service as:
   a. palliative (emergency) treatment of dental pain- minor procedure (D9110).
   b. office visit for observation (during regularly scheduled hours) - no other services performed (D9430).
7. This procedure is limited to the palliative treatment of traumatic injury only and shall meet the criteria for a laboratory processed crown (D2710-D2792).

PROCEDURE D2971
ADDITIONAL PROCEDURES TO CONSTRUCT NEW CROWN UNDER EXISTING PARTIAL DENTURE FRAMEWORK

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

PROCEDURE D2975
COPING

This procedure is not a benefit.

PROCEDURE D2980
CROWN REPAIR[BEGIN STRIKEOUT]**~~, BY REPORT~~[END STRIKEOUT]** [BEGIN UNDERLINE]**NECESSITATED BY RESTORATIVE MATERIAL FAILURE**[END UNDERLINE]

1. This procedure does not require prior authorization.
2. Radiographs for payment - submit a pre-operative periapical radiograph.
3. Photographs for payment - submit a pre-operative photograph.
4. Written documentation for payment - describe the specific conditions addressed by the procedure (such as broken porcelain).
5. Requires a tooth code.
6. A benefit for laboratory processed crowns on permanent teeth.

7. Not a benefit within 12 months of initial crown placement or previous repair for the same provider.

[BEGIN UNDERLINE]**PROCEDURE D2981**
INLAY REPAIR NECESSITATED BY RESTORATIVE MATERIAL FAILURE

This procedure is not a benefit.

PROCEDURE D2982
ONLAY REPAIR NECESSITATED BY RESTORATIVE MATERIAL FAILURE

This procedure is not a benefit.

PROCEDURE D2983
VENEER REPAIR NECESSITATED BY RESTORATIVE MATERIAL FAILURE

This procedure is not a benefit.

PROCEDURE D2990
RESIN INFILTRATION OF INCIPIENT SMOOTH SURFACE LESIONS

This procedure is not a benefit. [END UNDERLINE]

PROCEDURE D2999
UNSPECIFIED RESTORATIVE PROCEDURE, BY REPORT

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

shall include the medical condition and the specific CDT code associated with the treatment.

Endodontic General Policies (D3000-D3999)

a) Prior authorization with current periapical radiographs is required for initial root canal therapy (D3310, D3320 and D3330), root canal retreatment (D3346, D3347 and D3348), partial pulpotomy for apexogenesis (D3222), apexification/recalcification (D3351) and apicoectomy/periradicular surgery (D3410, D3421, D3425 and D3426) on permanent teeth.

b) Prior authorization for root canal therapy (D3310, D3320 and D3330) is not required when it is documented on a claim for payment that the permanent tooth has been accidentally avulsed or there has been a fracture of the crown exposing vital pulpal tissue. Preoperative radiographs (arch and periapicals) shall be submitted for payment.

c) Root canal therapy (D3310, D3320, D3330, D3346, D3347 and D3348) is a benefit for permanent teeth and over-retained primary teeth with no permanent successor, if medically necessary. It is medically necessary when the tooth is non-vital (due to necrosis, gangrene or death of the pulp) or if the pulp has been compromised by caries, trauma or accident that may lead to the death of the pulp.

d) The prognosis of the affected tooth and other remaining teeth shall be evaluated in considering endodontic procedures for prior authorization and payment. Endodontic procedures are not a benefit when the prognosis of the tooth is questionable (due to non-restorability or periodontal involvement).

e) Endodontic procedures are not a benefit when extraction is appropriate for a tooth due to non-restorability, periodontal involvement or for a tooth that is easily replaced by an addition to an existing or proposed prosthesis in the same arch.

f) Endodontic procedures are not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar positions or is an abutment for an existing fixed or removable partial denture with cast clasps or rests.

g) The fee for endodontic procedures includes all treatment and post treatment radiographs, any temporary restorations and/or occlusal seals, medicated treatments, bacteriologic studies, pulp vitality tests, removal of root canal obstructions (such as posts, silver points, old root canal filling material, broken root canal files and broaches and calcifications), internal root repairs of perforation defects and routine postoperative care within 30 days.

h) Endodontic procedures shall be completed prior to payment. The date of service on the payment request shall reflect the final treatment date. A post treatment radiograph is not required for payment.

i) Satisfactory completion of endodontic procedures is required prior to requesting the final restoration.

Endodontic Procedures (D3000-D3999)

PROCEDURE D3110
PULP CAP - DIRECT (EXCLUDING FINAL RESTORATION)

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

PROCEDURE D3120
PULP CAP - INDIRECT (EXCLUDING FINAL RESTORATION)

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

PROCEDURE D3220
THERAPEUTIC PULPOTOMY (EXCLUDING FINAL RESTORATION) - REMOVAL OF PULP CORONAL TO THE DENTINOCEMENTAL JUNCTION AND APPLICATION OF MEDICAMENT

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

PROCEDURE D3221
PULPAL DEBRIDEMENT, PRIMARY AND PERMANENT TEETH

1. This procedure does not require prior authorization.

2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
3. Requires a tooth code.
4. A benefit:
   a. for permanent teeth.
   b. for over-retained primary teeth with no permanent successor.
   c. once per tooth.
5. Not a benefit on the same date of service with any additional services, same tooth.
6. This procedure is for the relief of acute pain prior to conventional root canal therapy and is not a benefit for root canal therapy visits. Subsequent emergency visits, if medically necessary, shall be billed as palliative (emergency) treatment of dental pain- minor procedure (D9110).

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

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

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

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

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

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

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

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs.
3. Requires a tooth code.
4. A benefit once per tooth for initial root canal therapy treatment. For root canal therapy retreatment use retreatment of previous root canal therapy-anterior (D3346).

5. The fee for this procedure includes all treatment and post treatment radiographs, any temporary restoration and/or occlusal seal.

PROCEDURE D3320
ENDODONTIC THERAPY, BICUSPID TOOTH (EXCLUDING FINAL RESTORATION)

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs.
3. Requires a tooth code.
4. A benefit once per tooth for initial root canal therapy treatment. For root canal therapy retreatment use retreatment of previous root canal therapy-bicuspid (D3347).
5. The fee for this procedure includes all treatment and post treatment radiographs, any temporary restoration and/or occlusal seal.

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

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

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

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

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

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

PROCEDURE D3333
INTERNAL ROOT REPAIR OF PERFORATION DEFECTS

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

PROCEDURE D3346
RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - ANTERIOR

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity for retreatment.
3. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale for retreatment.
4. Requires a tooth code.
5. Not a benefit to the original provider within 12 months of initial treatment.
6. The fee for this procedure includes all treatment and post treatment radiographs, any temporary restoration and/or occlusal seal.

PROCEDURE D3347
RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - BICUSPID

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity for retreatment.
3. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale for retreatment.
4. Requires a tooth code.
5. Not a benefit to the original provider within 12 months of initial treatment.
6. The fee for this procedure includes all treatment and post treatment radiographs, any temporary restoration and/or occlusal seal.

PROCEDURE D3348
RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - MOLAR

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity for retreatment.
3. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale for retreatment.
4. Requires a tooth code.
5. Not a benefit:
   a. to the original provider within 12 months of initial treatment.
   b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
6. The fee for this procedure includes all treatment and post treatment radiographs, any temporary restoration and/or occlusal seal.

PROCEDURE D3351
APEXIFICATION/ RECALCIFICATION/PULPAL REGENERATION - INITIAL VISIT (APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, PULP~~AL~~ SPACE DISINFECTION ETC.)

1. Prior authorization is required.
2. Radiographs for prior authorization - submit periapical radiographs.
3. Requires a tooth code.
4. A benefit:
   a. once per permanent tooth.
   b. for patients under the age of 21.
5. Not a benefit:
   a. for primary teeth.
   b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
   c. on the same date of service as any other endodontic procedures for the same tooth.
6. This procedure includes initial opening of the tooth, performing a pulpectomy, preparation of canal spaces, placement of medications and all treatment and post treatment radiographs.

7. If an interim medication replacement is necessary, use apexification/recalcification-interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.) (D3352).
8. Upon completion of apexification/recalcification, prior authorization for the final root canal therapy shall be submitted along with the post-treatment radiograph to demonstrate sufficient apical formation.

PROCEDURE D3352
APEXIFICATION/ RECALCIFICATION /PULPAL REGENERATION - INTERIM MEDICATION REPLACEMENT [BEGIN STRIKEOUT] **~~(APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, PUPAL SPACE DISINFECTION, ETC.)~~ [END STRIKEOUT]**

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

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

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

PROCEDURE D3354
PULPAL REGENERATION- (COMPLETION OF REGENERATIVE TREATMENT IN AN IMMATURE PERMANENT TOOTH WITH A NECROTIC PULP); DOES NOT INCLUDE FINAL RESTORATION

This procedure is not a benefit.

PROCEDURE D3410
APICOECTOMY/ PERIRADICULAR SURGERY - ANTERIOR

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

PROCEDURE D3421
APICOECTOMY/ PERIRADICULAR SURGERY - BICUSPID (FIRST ROOT)

1. Prior authorization is required.

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

PROCEDURE D3425
APICOECTOMY/ PERIRADICULAR SURGERY - MOLAR (FIRST ROOT)

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

7. The fee for this procedure includes the placement of retrograde filling material and all treatment and post treatment radiographs.
8. If more than one root is treated, use apicoectomy/periradicular surgery - each additional root (D3426).

PROCEDURE D3426
APICOECTOMY/ PERIRADICULAR SURGERY (EACH ADDITIONAL ROOT)

1. Prior authorization is required.
2. Radiographs for prior authorization - submit arch and periapical radiographs demonstrating the medical necessity.
3. Written documentation for prior authorization - if the medical necessity is not evident on the radiographs, documentation shall include the rationale and the identity of the root that requires treatment.
4. Requires a tooth code.
5. A benefit for permanent teeth only.
6. Not a benefit:
   a. to the original provider within 90 days of root canal therapy except when a medical necessity is documented.
   b. to the original provider within 24 months of a prior apicoectomy/ periradicular surgery, same root.
   c. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
7. Only payable the same date of service as procedures D3421 or D3425.
8. The fee for this procedure includes the placement of retrograde filling material and all treatment and post treatment radiographs.

PROCEDURE D3430
RETROGRADE FILLING - PER ROOT

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

PROCEDURE D3450
ROOT AMPUTATION – PER ROOT

This procedure is not a benefit.

PROCEDURE D3460
ENDODONTIC ENDOSSEOUS IMPLANT

This procedure is not a benefit.

PROCEDURE D3470
INTENTIONAL REIMPLANTATION (INCLUDING NECESSARY SPLINTING)

This procedure is not a benefit.

PROCEDURE D3910
SURGICAL PROCEDURE FOR ISOLATION OF TOOTH WITH RUBBER DAM

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

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

This procedure is not a benefit.

PROCEDURE D3950
CANAL PREPARATION AND FITTING OF PREFORMED DOWEL OR POST

This procedure is not a benefit.

PROCEDURE D3999
UNSPECIFIED ENDODONTIC PROCEDURE, BY REPORT

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

b. for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the medical condition and the specific CDT code associated with the treatment.

Periodontal General Policies (D4000-D4999)

a) Periodontal procedures shall be a benefit for patients age 13 or older. Periodontal procedures shall be considered for patients under the age of 13 when unusual circumstances exist such as aggressive periodontitis and drug-induced hyperplasia and the medical necessity has been fully documented on the TAR.

b) Prior authorization is required for all periodontal procedures except for unscheduled dressing change (by someone other than the treating dentist) (D4290) and periodontal maintenance (D4910).

[BEGIN STRIKEOUT]~~c)~~ ~~Documentation specifying the definitive periodontal diagnosis is required for prior authorization.~~ [END STRIKEOUT]

[BEGIN STRIKEOUT]~~d)~~ [END STRIKEOUT] **[BEGIN UNDERLINEND]**c) **[END UNDERLINEND]** Current periapical radiographs of the involved areas and [BEGIN STRIKEOUT]~~arch~~[END STRIKEOUT] [BEGIN UNDERLINE]bitewing[END UNDERLINE] radiographs are required for periodontal scaling and root planing (D4341 and D4342) and osseous surgery (D4260 and D4261) for prior authorizations. A panoramic [BEGIN STRIKEOUT]~~film~~[END STRIKEOUT] [BEGIN UNDERLINE]radiographic image[END UNDERLINE] alone is non- diagnostic for periodontal procedures.

[BEGIN STRIKEOUT]~~e)~~ [END STRIKEOUT] [BEGIN UNDERLINE]d) [END UNDERLINE]Photographs are required for gingivectomy or gingivoplasty (D4210 and D4211) for prior authorizations.

[BEGIN STRIKEOUT]~~f)~~ ~~A current and complete periodontal evaluation chart is required with prior authorizations with the following criteria:~~

~~i) periodontal evaluation charts are considered current when dated no more than 12 months before the request for prior authorization and when no subsequent periodontal treatment has been performed, and~~

~~ii) at least four pocket depths (two buccal and two lingual), individual tooth mobilities and teeth to be extracted are recorded on the periodontal evaluation chart.~~ [END STRIKEOUT]

[BEGIN STRIKEOUT]~~g)~~[END STRIKEOUT] [BEGIN UNDERLINE]e) [END UNDERLINE]Only teeth that qualify as diseased are to be considered in the count for the number of teeth to be treated in a particular quadrant. A qualifying tooth shall have[BEGIN STRIKEOUT] ~~the required pocket depths,~~ [END STRIKEOUT] a significant amount of bone loss, presence of calculus deposits, be restorable and have arch integrity and shall meet Medi-Cal Dental Program criteria for the requested procedure. Qualifying teeth include implants. Teeth shall not be counted

as qualifying when they are indicated to be extracted. Full or partial quadrants are defined as follows:

i) a full quadrant is considered to have four or more qualifying diseased teeth,

ii) a partial quadrant is considered to have one, two, or three diseased teeth,

iii) third molars shall not be counted unless the third molar occupies the first or second molar position or is an abutment for an existing fixed or removable partial denture with cast clasps or rests.

[BEGIN STRIKEOUT]~~h)~~ [END STRIKEOUT] [BEGIN UNDERLINE]f) [END UNDERLINE]Tooth bounded spaces shall only be counted in conjunction with osseous surgeries (D4260 and D4261) that require a surgical flap. Each tooth bounded space shall only count as one tooth space regardless of the number of missing natural teeth in the space.

[BEGIN STRIKEOUT]~~i)~~ [END STRIKEOUT] [BEGIN UNDERLINE]g) [END UNDERLINE] Scaling and root planing (D4341 and D4342) are a benefit once per quadrant in a 24 month period. Patients shall exhibit [BEGIN STRIKEOUT]~~a minimum of one 4mm+ pocket,~~ [END STRIKEOUT] connective tissue attachment loss and radiographic evidence of bone loss and/or subgingival calculus deposits on root surfaces.

[BEGIN STRIKEOUT]~~j)~~ [END STRIKEOUT] [BEGIN UNDERLINE]h) [END UNDERLINE] Gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261) are a benefit once per quadrant in a 36 month period and shall not be authorized until 30 days following scaling and root planing (D4341 and D4342) in the same quadrant. Patients shall exhibit [BEGIN STRIKEOUT]~~a minimum of one 5mm+ pocket and~~[END STRIKEOUT] radiographic evidence of moderate to severe bone loss to qualify for osseous surgery.

[BEGIN STRIKEOUT]~~k)~~ [END STRIKEOUT] [BEGIN UNDERLINE]i) [END UNDERLINE] Gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261) includes three months of post-operative care and any surgical re-entry for 36 months. Documentation of extraordinary circumstances and/or medical conditions will be given consideration on a case-by-case basis.

[BEGIN STRIKEOUT]~~l)~~ [END STRIKEOUT] [BEGIN UNDERLINE]j) [END UNDERLINE] Scaling and root planing (D4341 and D4342) can be authorized in conjunction with prophylaxis procedures (D1110 and D1120). However, payment shall not be made for any prophylaxis procedure if the prophylaxis is performed on the same date of service as the scaling and root planing.

[BEGIN STRIKEOUT]~~m)~~ [END STRIKEOUT] [BEGIN UNDERLINE]k) [END UNDERLINE] Gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261) includes frenulectomy (frenectomy or frenotomy) (D7960), frenuloplasty (D7963) and/or distal wedge performed in the same area on the same date of service.

[BEGIN STRIKEOUT]~~n)~~ [END STRIKEOUT] [BEGIN UNDERLINE]l) [END UNDERLINE] Procedures involved in acquiring graft tissues (hard or soft) from extra-oral donor sites are considered part of the fee for osseous surgery (D4260 and D4261) and are not payable separately.

[BEGIN STRIKEOUT]~~o)~~ [END STRIKEOUT] [BEGIN UNDERLINE]m) [END UNDERLINE] Gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261) performed in conjunction with a laboratory crown, prefabricated crown, amalgam or resin-based composite restoration or endodontic therapy is included in the fee for the final restoration or endodontic therapy and is not payable separately.

Periodontal Procedures (D4000-D4999)

PROCEDURE D4210
GINGIVECTOMY OR GINGIVOPLASTY- FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT

1. Prior authorization is required.
2. Photographs for prior authorization- submit photographs of the involved areas.

[BEGIN STRIKEOUT]~~3. Written documentation for prior authorization - shall include a definitive periodontal diagnosis.~~

~~4. A current and complete periodontal evaluation chart is required for prior authorization except in cases of pseudopockets as a result of gingival hyperplasia, which is demonstrated on a photograph.~~ [END STRIKEOUT]

[BEGIN STRIKEOUT]~~5~~[END STRIKEOUT] [BEGIN UNDERLINE]~~.~~3. [END UNDERLINE] Requires a quadrant code.

[BEGIN STRIKEOUT]~~6.~~ [END STRIKEOUT] [BEGIN UNDERLINE]4. [END UNDERLINE] If three or fewer diseased teeth are present in the quadrant, use gingivectomy or gingivoplasty (D4211).

[BEGIN STRIKEOUT]~~7.~~ [END STRIKEOUT] [BEGIN UNDERLINE]5. [END UNDERLINE]A benefit:

a. for patients age 13 or older.
b. once per quadrant every 36 months.

[BEGIN STRIKEOUT]~~8.~~ [END STRIKEOUT] [BEGIN UNDERLINE]6. [END UNDERLINE] This procedure cannot be prior authorized within 30 days following periodontal scaling and root planing (D4341 and D4342) for the same quadrant.

PROCEDURE D4211
GINGIVECTOMY OR GINGIVOPLASTY- ONE TO THREE CONTIGUOUS TEETH~~,~~ OR TOOTH BOUNDED SPACES PER QUADRANT

1. Prior authorization is required.
2. Photographs for prior authorization- submit photographs of the involved areas.

[BEGIN STRIKEOUT]~~3. Written documentation for prior authorization - shall include a definitive periodontal diagnosis.~~

~~4. A current and complete periodontal evaluation chart is required for prior authorization except in cases of pseudopockets as a result of gingival hyperplasia, which is demonstrated on a photograph.~~ [END STRIKEOUT]

[BEGIN STRIKEOUT] ~~5.~~ [END STRIKEOUT] [BEGIN UNDERLINE]3. [END UNDERLINE] Requires a quadrant code.

[BEGIN STRIKEOUT]~~6)~~[END STRIKEOUT] [BEGIN UNDERLINE]4. [END UNDERLINE] If four or more diseased teeth are present in the quadrant, use gingivectomy or gingivoplasty (D4210).

[BEGIN STRIKEOUT] ~~7.~~ [END STRIKEOUT] [BEGIN UNDERLINE]5. [END UNDERLINE] A benefit:

a. for patients age 13 or older.

b. once per quadrant every 36 months.

[BEGIN STRIKEOUT] ~~8.~~ [END STRIKEOUT] [BEGIN UNDERLINE]6. [END UNDERLINE] This procedure cannot be prior authorized within 30 days following periodontal scaling and root planing (D4341 and D4342) for the same quadrant.

[BEGIN UNDERLINE]PROCEDURE D4212
GINGIVECTOMY OR GINGIVOPLASTY TO ALLOW ACCESS FOR RESTORATIVE PROCEDURE, PER TOOTH

This procedure is not a benefit. [END UNDERLINE]

PROCEDURE D4230
ANATOMICAL CROWN EXPOSURE- FOUR OR MORE CONTIGUOUS TEETH PER QUADRANT

This procedure is not a benefit.

PROCEDURE D4231
ANATOMICAL CROWN EXPOSURE- ONE TO THREE TEETH PER QUADRANT

This procedure is not a benefit.

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

This procedure is not a benefit.

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

This procedure is not a benefit.

PROCEDURE D4245
APICALLY POSITIONED FLAP

This procedure is not a benefit.

PROCEDURE D4249
CLINICAL CROWN LENGTHENING – HARD TISSUE

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

PROCEDURE D4260
OSSEOUS SURGERY (INCLUDING FLAP ENTRY AND CLOSURE)- FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT

1. Prior authorization is required.
2. Radiographs for prior authorization- submit periapical radiographs of the involved areas and ~~arch~~ [BEGIN UNDERLINE]bitewing [END UNDERLINE] radiographs.

[BEGIN STRIKEOUT]~~3. Written documentation for prior authorization- shall include a definitive periodontal diagnosis.~~

~~4. A current and complete periodontal evaluation chart is required for prior authorization.~~ [END STRIKEOUT]

[BEGIN STRIKEOUT]~~5.~~ [END STRIKEOUT] [BEGIN UNDERLINE]3. [END UNDERLINE] Requires a quadrant code.

[BEGIN STRIKEOUT]~~6.~~ [END STRIKEOUT] [BEGIN UNDERLINE]4. [END UNDERLINE] If three or fewer diseased teeth are present in the quadrant, use osseous surgery (D4261).

[BEGIN STRIKEOUT]~~7.~~ [END STRIKEOUT] [BEGIN UNDERLINE]5. [END UNDERLINE] A benefit:

a. for patients age 13 or older.

[BEGIN STRIKEOUT]~~b. when there is a minimum of one 5mm+ pocket on each diseased tooth.~~ [END STRIKEOUT]

[BEGIN STRIKEOUT]~~c.~~ [BEGIN STRIKEOUT] [BEGIN UNDERLINE]b. [END UNDERLINE] Once per quadrant every 36 months.

8. This procedure cannot be prior authorized within 30 days following periodontal scaling and root planing (D4341 and D4342) for the same quadrant.
9. This procedure can only be prior authorized when preceded by periodontal scaling and root planning (D4341 and D4342) in the same quadrant within the previous 24 months.

PROCEDURE D4261
OSSEOUS SURGERY (INCLUDING FLAP ENTRY AND CLOSURE)- ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT

1. Prior authorization is required.
2. Radiographs for prior authorization- submit periapical radiographs of the involved areas and [BEGIN STRIKEOUT]~~arch~~[END STRIKEOUT] [BEGIN UNDERLINE]bitewing[END UNDERLINE] radiographs.

[BEGIN STRIKEOUT]~~3. Written documentation for prior authorization- shall include a definitive periodontal diagnosis.~~ [END STRIKEOUT]

[BEGIN STRIKEOUT]~~4. A current and complete periodontal evaluation chart is required for prior authorization.~~ [END STRIKEOUT]

[BEGIN STRIKEOUT]~~5.~~ [END STRIKEOUT] [BEGIN UNDERLINE]3. [END UNDERLINE] Requires a quadrant code.

[BEGIN STRIKEOUT]~~6.~~ [END STRIKEOUT] [BEGIN UNDERLINE]4. [END UNDERLINE] If four or more diseased teeth are present in the quadrant, use osseous surgery (D4260).

[BEGIN STRIKEOUT]~~7.~~ [END STRIKEOUT] [BEGIN UNDERLINE]5. [END UNDERLINE] A benefit:

a. for patients age 13 or older.

[BEGIN STRIKEOUT]~~b. when there is a minimum of one 5mm+ pocket on each diseased tooth.~~ [END STRIKEOUT]

[BEGIN STRIKEOUT]~~c.~~ [END STRIKEOUT] [BEGIN UNDERLINE]b[END UNDERLINE] once per quadrant every 36 months.

8. This procedure cannot be prior authorized within 30 days following periodontal scaling and root planing (D4341 and D4342) for the same quadrant.
9. This procedure can only be prior authorized when preceded by periodontal scaling and root planing (D4341 and D4342) in the same quadrant within the previous 24 months.

PROCEDURE D4263
BONE REPLACEMENT GRAFT – FIRST SITE IN QUADRANT

This procedure is not a benefit.

PROCEDURE D4264
BONE REPLACEMENT GRAFT – EACH ADDITIONAL SITE IN QUADRANT

This procedure is not a benefit.

PROCEDURE D4265
BIOLOGIC MATERIALS TO AID IN SOFT AND OSSEOUS TISSUE REGENERATION

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

PROCEDURE D4266
GUIDED TISSUE REGENERATION – RESORBABLE BARRIER, PER SITE

This procedure is not a benefit.

PROCEDURE D4267
GUIDED TISSUE REGENERATION – NONRESORBABLE BARRIER, PER SITE (INCLUDES MEMBRANE REMOVAL)

This procedure is not a benefit.

PROCEDURE D4268
SURGICAL REVISION PROCEDURE, PER TOOTH

This procedure is not a benefit.

PROCEDURE D4270
PEDICLE SOFT TISSUE GRAFT PROCEDURE

This procedure is not a benefit.

[BEGIN STRIKEOUT]~~PROCEDURE D4271~~
~~FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING DONOR SITE SURGERY)~~

~~This procedure is not a benefit.~~ [END STRIKEOUT]

PROCEDURE D4273
SUBEPITHELIAL CONNECTIVE TISSUE GRAFT PROCEDURES, PER TOOTH

This procedure is not a benefit.

PROCEDURE D4274
DISTAL OR PROXIMAL WEDGE PROCEDURE (WHEN NOT PERFORMED IN CONJUNCTION WITH SURGICAL PROCEDURES IN THE SAME ANATOMICAL AREA)

This procedure is not a benefit.

PROCEDURE D4275
SOFT TISSUE ALLOGRAFT

This procedure is not a benefit.

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

This procedure is not a benefit.

[BEGIN UNDERLINE]**PROCEDURE D4277**
FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING DONOR SITE SURGERY), FIRST TOOTH OR EDENTULOUS TOOTH POSITION IN GRAFT

This procedure is not a benefit.

PROCEDURE D4278
FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING DONOR SITE SURGERY), EACH ADDITIONAL CONTIGUOUS TOOTH OR EDENTULOUS TOOTH POSITION IN SAME GRAFT SITE

This procedure is not a benefit. [END UNDERLINE]

PROCEDURE D4320
PROVISIONAL SPLINTING – INTRACORONAL

This procedure is not a benefit.

PROCEDURE D4321
PROVISIONAL SPLINTING – EXTRACORONAL

This procedure is not a benefit.

PROCEDURE D4341
PERIODONTAL SCALING AND ROOT PLANING- FOUR OR MORE TEETH PER QUADRANT

1. Prior authorization is required.
2. Radiographs for prior authorization- submit periapical radiographs of the involved areas and ~~arch~~ [BEGIN UNDERLINE]bitewing[END UNDERLINE] radiographs.

[BEGIN STRIKEOUT]~~3. Written documentation for prior authorization - shall include a definitive periodontal diagnosis.~~

~~4. A current and complete periodontal evaluation chart is required for prior authorization.~~

~~5.~~ [END STRIKEOUT] [BEGIN UNDERLINE]3. [END UNDERLINE] Requires a quadrant code.

[BEGIN STRIKEOUT]~~6.~~ [END STRIKEOUT] [BEGIN UNDERLINE]4. [END UNDERLINE] If three or fewer diseased teeth are present in the quadrant, use periodontal scaling and root planing (D4342).

[BEGIN STRIKEOUT]~~7.~~ [END STRIKEOUT] [BEGIN UNDERLINE]5. [END UNDERLINE]A benefit:

a. for patients age 13 or older.

[BEGIN STRIKEOUT]~~b. when there is a minimum of one 4mm+ pocket on each diseased tooth.~~

~~c.~~ [END STRIKEOUT] [BEGIN UNDERLINE]b. [END UNDERLINE] once per quadrant every 24 months.

8. Gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261) cannot be prior authorized within 30 days following this procedure for the same quadrant.
9. Prophylaxis (D1110 and D1120) are not payable on the same date of service as this procedure.

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

1. Prior authorization is required.
2. Radiographs for prior authorization- submit periapical radiographs of the involved areas and [BEGIN STRIKEOUT]~~arch~~ [END STRIKEOUT] [BEGIN UNDERLINE]bitewing[END UNDERLINE] radiographs.

[BEGIN STRIKEOUT]~~3. Written documentation for prior authorization - shall include a definitive periodontal diagnosis.~~

~~4. A current and complete periodontal evaluation chart is required for prior authorization.~~

~~5.~~ [END STRIKEOUT] [BEGIN UNDERLINE]3. [END UNDERLINE] Requires a quadrant code.

[BEGIN STRIKEOUT]~~6.~~ [END STRIKEOUT] [BEGIN UNDERLINE]4. [END UNDERLINE] If four or more diseased teeth are present in the quadrant, use periodontal scaling and root planing (D4341).

[BEGIN STRIKEOUT]~~7.~~ [END STRIKEOUT] [BEGIN UNDERLINE]5. [END UNDERLINE] A benefit:

a. for patients age 13 or older.

[BEGIN STRIKEOUT]~~b. when there is a minimum of one 4mm+ pocket on each diseased tooth.~~

~~c.~~ [END STRIKEOUT] [BEGIN UNDERLINE]b. [END UNDERLINE] once per quadrant every 24 months.

8. Gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261) cannot be prior authorized within 30 days following this procedure for the same quadrant.
9. Prophylaxis (D1110 and D1120) are not payable on the same date of service as this procedure.

PROCEDURE D4355
FULL MOUTH DEBRIDEMENT TO ENABLE COMPREHENSIVE EVALUATION AND DIAGNOSIS

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

PROCEDURE D4381
LOCALIZED DELIVERY OF ANTIMICROBIAL AGENTS VIA A CONTROLLED RELEASE VEHICLE INTO DISEASED CREVICULAR TISSUE, PER TOOTH [BEGIN STRIKEOUT]**~~, BY REPORT~~[END STRIKEOUT]**

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

PROCEDURE D4910
PERIODONTAL MAINTENANCE

1. This procedure does not require prior authorization.
2. A benefit:
   a. only for patients residing in a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF).
   b. only when preceded by a periodontal scaling and root planing (D4341-D4342).

c. only after completion of all necessary scaling and root planings.

d. once in a calendar quarter.

e. only in the 24 month period following the last scaling and root planing.

3. Not a benefit in the same calendar quarter as scaling and root planing.
4. Not payable to the same provider in the same calendar quarter as prophylaxis- adult (D1110) or prophylaxis- child (D1120).
5. This procedure is considered a full mouth treatment.

PROCEDURE D4920
UNSCHEDULED DRESSING CHANGE (BY SOMEONE OTHER THAN TREATING DENTIST)

1. This procedure cannot be prior authorized.
2. Written documentation for payment –shall include a brief description indicating the medical necessity.
3. A benefit:
   a. for patients age 13 or older.
   b. once per patient per provider.
   c. within 30 days of the date of service of gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261).
4. Unscheduled dressing changes by the same provider are considered part of, and included in the fee for gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261).

PROCEDURE D4999
UNSPECIFIED PERIODONTAL PROCEDURE, BY REPORT

1. Prior authorization is required.
2. Radiographs for prior authorization- submit as applicable for the type of procedure.
3. Photographs for prior authorization- shall be submitted.
4. Written documentation for prior authorization –shall include the specific treatment requested and etiology of the disease or condition.

[BEGIN STRIKEOUT]~~5. A current and complete periodontal evaluation chart is required for prior authorization.~~

~~6.~~ [END STRIKEOUT] [BEGIN UNDERLINE]5. [END UNDERLINE] Requires a tooth or quadrant code, as applicable for the type of procedure.

[BEGIN STRIKEOUT]~~7.~~ [END STRIKEOUT] [BEGIN UNDERLINE]6. [END UNDERLINE] A benefit for patients age 13 or older.

[BEGIN STRIKEOUT]~~8.~~ [END STRIKEOUT] [BEGIN UNDERLINE]7. [END UNDERLINE] Procedure D4999 shall be used:

a. for a procedure which is not adequately described by a CDT code, or

b. for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the medical condition and the specific CDT code associated with the treatment.

Prosthodontics (Removable) General Policies (D5000-D5899)

1. Complete and Partial Dentures (D5110-D5214 and D5860):
   a) Prior authorization is required for removable prostheses[BEGIN UNDERLINE] except for immediate dentures (D5130 and D5140) [END UNDERLINE].
   b) Prior authorization shall be considered for a new prosthesis only when it is clearly evident that the existing prosthesis cannot be made serviceable by repair, replacement of broken and missing teeth or reline.
   c) Current radiographs of all remaining natural teeth and implants and a properly completed prosthetic Justification of Need for Prosthesis Form, DC054 (10/05) are required for prior authorization. A panoramic [BEGIN STRIKEOUT]~~film~~[END STRIKEOUT] [BEGIN UNDERLINE]radiographic image[END UNDERLINE] shall be considered diagnostic for edentulous areas only.
   d) Complete and partial dentures are prior authorized only as full treatment plans. Payment shall be made only when the full treatment has been completed. Any revision of a prior authorized treatment plan requires a new TAR.
   e) New complete or partial dentures shall not be prior authorized when it would be highly improbable for a patient to utilize, care for or adapt to a new prosthesis due to psychological and/or motor deficiencies as determined by a clinical screening dentist (see “g” below).
   f) All endodontic, restorative and surgical procedures for teeth that impact the design of a removable partial denture (D5211, D5212, D5213 and D5214) shall be addressed before prior authorization is considered.
   g) The need for new or replacement prosthesis may be evaluated by a clinical screening dentist.
   h) Providers shall use the laboratory order date as the date of service when submitting for payment of a prior authorized removable prosthesis. The laboratory order date is the date when the prosthesis is sent to the laboratory for final fabrication. Full payment shall not be requested until the prosthesis is delivered and is in use by the patient.
   i) Partial payment of an undeliverable completed removable prosthesis shall be considered when the reason for non-delivery is adequately documented on the Notice of Authorization (NOA) and is accompanied by a laboratory invoice indicating the prosthesis was processed. The completed prosthesis shall be kept in the provider’s office, in a deliverable condition, for a period of at least one year.
   j) A removable prosthesis is a benefit only once in a five year period. When adequately documented, the following exceptions shall apply:
      i) catastrophic loss beyond the control of the patient. Documentation must include a copy of the official public service agency report (fire or police), or

ii) a need for a new prosthesis due to surgical or traumatic loss of oral-facial anatomic structure, or

iii) the removable prosthesis is no longer serviceable as determined by a clinical screening dentist.

k) Prosthodontic services provided solely for cosmetic purposes are not a benefit.
l) Temporary or interim dentures to be used while a permanent denture is being constructed are not a benefit.
m) Spare or backup dentures are not a benefit.
n) Evaluation of a denture on a maintenance basis is not a benefit.
o) The fee for any removable prosthesis, reline, tissue conditioning or repair includes all adjustments necessary for six months after the date of service by the same provider.
p) Immediate dentures [BEGIN STRIKEOUT]~~shall~~ [END STRIKEOUT] [BEGIN UNDERLINE]should only [END UNDERLINE] be considered [BEGIN UNDERLINE]for a patient[END UNDERLINE] when one or more of the following conditions exist:
   i) extensive or rampant caries are exhibited in the radiographs,
   ii) severe periodontal involvement is indicated in the radiographs,
   iii) numerous teeth are missing resulting in diminished masticating ability adversely affecting the patient's health.
q) There is no insertion fee payable to an oral surgeon who seats an immediate denture.
r) Preventative, endodontic or restorative procedures are not a benefit for teeth to be retained for overdentures. Only extractions for the retained teeth will be a benefit.
s) Partial dentures are not a benefit to replace missing 3rd molars.

2. Relines and Tissue Conditioning (D5730-D5761, D5850 and D5851):
   a) Laboratory relines (D5750, D5751, D5760 and D5761) are a benefit six months after the date of service for immediate dentures (D5130 and D5140), an immediate overdenture (D5860) and cast metal partial dentures (D5213 and D5214) that **required** extractions.
   b) Laboratory relines (D5750, D5751, D5760 and D5761) are a benefit 12 months after the date of service for complete (remote) dentures (D5110 and D5120), a complete (remote) overdenture (D5860) and cast metal partial dentures (D5213 and D5214) that **did not require** extractions.
   c) Laboratory relines (D5760 and D5761) are not a benefit for resin based partial dentures (D5211 and D5212).
   d) Laboratory relines (D5750, D5751, D5760 and D5761) are not a benefit within 12 months of chairside relines (D5730, D5731, D5740 and D5741).

e) Chairside relines (D5730, D5731, D5740 and D5741) are a benefit six months after the date of service for immediate dentures (D5130 and D5140), an immediate overdenture (D5860), resin based partial dentures (D5211 and D5212) and cast metal partial dentures (D5213 and D5214) that **required** extractions.
f) Chairside relines (D5730, D5731, D5740 and D5741) are a benefit 12 months after the date of service for complete (remote) dentures (D5110 and D5120), a complete (remote) overdenture (D5860), resin based partial dentures (D5211 and D5212) and cast metal partial dentures (D5213 and D5214) that **did not require** extractions.
g) Chairside relines (D5730, D5731, D5740 and D5741) are not a benefit within 12 months of laboratory relines (D5750, D5751, D5760 and D5761).
h) Tissue conditioning (D5850 and D5851) is only a benefit to heal unhealthy ridges prior to a definitive prosthodontic treatment.
i) Tissue conditioning (D5850 and D5851) is a benefit the same date of service as an immediate prosthesis that **required** extractions.

Prosthodontic (Removable) Procedures (D5000-D5899)

PROCEDURE D5110
COMPLETE DENTURE – MAXILLARY

1. Prior authorization is required.
2. Radiographs for prior authorization –submit radiographs of all opposing natural teeth.
3. A current and complete Justification of Need for Prosthesis Form, DC054 (10/05) is required for prior authorization.
4. A benefit once in a five year period from a previous complete, immediate or overdenture- complete denture.
5. For an immediate denture, use immediate denture-maxillary (D5130) or overdenture- complete, by report (D5860) as applicable for the type of procedure.
6. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
7. A laboratory reline (D5750) or chairside reline (D5730) is a benefit 12 months after the date of service for this procedure.

PROCEDURE D5120
COMPLETE DENTURE – MANDIBULAR

1. Prior authorization is required.
2. Radiographs for prior authorization –submit radiographs of all opposing natural teeth.
3. A current and complete Justification of Need for Prosthesis Form, DC054 (10/05) is required for prior authorization.
4. A benefit once in a five year period from a previous complete, immediate or overdenture- complete denture.
5. For an immediate denture, use immediate denture-mandibular (D5140) or overdenture-complete, by report (D5860) as applicable for the type of procedure.
6. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
7. A laboratory reline (D5751) or chairside reline (D5731) is a benefit 12 months after the date of service for this procedure.

PROCEDURE D5130
IMMEDIATE DENTURE – MAXILLARY

1. Prior authorization is [BEGIN UNDERLINE]not[END UNDERLINE] required.
2. Radiographs for prior authorization –submit radiographs of all remaining natural teeth.
3. A current and complete Justification of Need for Prosthesis Form, DC054 (10/05) is required for prior authorization.

2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
[BEGIN STRIKEOUT]~~4.~~ [END STRIKEOUT] [BEGIN UNDERLINE]3. [END UNDERLINE] A benefit once per patient.
[BEGIN STRIKEOUT]~~5.~~ [END STRIKEOUT] [BEGIN UNDERLINE]4. [END UNDERLINE] Not a benefit as a temporary denture. Subsequent complete dentures are not a benefit within a five-year period of an immediate denture.
[BEGIN STRIKEOUT]~~6.~~ [END STRIKEOUT] [BEGIN UNDERLINE]5. [END UNDERLINE] All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
[BEGIN STRIKEOUT]~~7.~~ [END STRIKEOUT] [BEGIN UNDERLINE]6. [END UNDERLINE] A laboratory reline (D5750) or chairside reline (D5730) is a benefit six months after the date of service for this procedure.

PROCEDURE D5140
IMMEDIATE DENTURE – MANDIBULAR

1. Prior authorization is [BEGIN UNDERLINE]not[END UNDERLINE] required.
2. Radiographs for prior authorization –submit radiographs of all remaining natural teeth.
3. A current and complete Justification of Need for Prosthesis Form, DC054 (10/05) is required for prior authorization.
2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
[BEGIN STRIKEOUT]~~4.~~ [END STRIKEOUT] [BEGIN UNDERLINE]3. [END UNDERLINE] A benefit once per patient.
[BEGIN STRIKEOUT]~~5.~~ [END STRIKEOUT] [BEGIN UNDERLINE]4. [END UNDERLINE] Not a benefit as a temporary denture. Subsequent complete dentures are not a benefit within a five-year period of an immediate denture.
[BEGIN STRIKEOUT]~~6.~~ [END STRIKEOUT] [BEGIN UNDERLINE]5. [END UNDERLINE] All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
[BEGIN STRIKEOUT]~~7.~~ [END STRIKEOUT] [BEGIN UNDERLINE]6. [END UNDERLINE] A laboratory reline (D5751) or chairside reline (D5731) is a benefit 12 months after the date of service for this procedure.

PROCEDURE D5211
MAXILLARY PARTIAL DENTURE – RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)

1. Prior authorization is required.
2. Radiographs for prior authorization –submit radiographs of all remaining natural teeth and periapical radiographs of abutment teeth.

3. A current and complete Justification of Need For Prosthesis Form, DC054 (10/05) is required for prior authorization.
4. A benefit once in a five-year period.
5. A benefit when replacing a permanent anterior tooth/teeth and/or the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows:
   a. five posterior permanent teeth are missing, (excluding 3rd molars), or
   b. all four 1st and 2nd permanent molars are missing, or
   c. the 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side.
6. Not a benefit for replacing missing 3rd molars.
7. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
8. Laboratory reline (D5760) is not a benefit for this procedure.
9. Chairside reline (D5740) is a benefit:
   a. once in a 12-month period.
   b. six months after the date of service for a partial denture that required extractions, or
   c. 12 months after the date of service for a partial denture that did not require extractions.

PROCEDURE D5212
MANDIBULAR PARTIAL DENTURE – RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)

1. Prior authorization is required.
2. Radiographs for prior authorization –submit radiographs of all remaining natural teeth and periapical radiographs of abutment teeth.
3. A current and complete Justification of Need for Prosthesis Form, DC054 (10/05) is required for prior authorization.
4. A benefit once in a five-year period.
5. A benefit when replacing a permanent anterior tooth/teeth and/or the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows:
   a. five posterior permanent teeth are missing, (excluding 3rd molars), or
   b. all four 1st and 2nd permanent molars are missing, or
   c. the 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side.
6. Not a benefit for replacing missing 3rd molars.
7. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
8. Laboratory reline (D5761) is not a benefit for this procedure.

9. Chairside reline (D5741) is a benefit:
   a. once in a 12-month period.
   b. six months after the date of service for a partial denture that required extractions, or
   c. 12 months after the date of service for a partial denture that did not require extractions.

PROCEDURE D5213
MAXILLARY PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)

1. Prior authorization is required.
2. Radiographs for prior authorization –submit radiographs of all remaining natural teeth and periapical radiographs of abutment teeth.
3. A current and complete Justification of Need for Prosthesis Form, DC054 (10/05) is required for prior authorization.
4. A benefit once in a five-year period.
5. A benefit when opposing a full denture and the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows:
   a. five posterior permanent teeth are missing, (excluding 3rd molars), or
   b. all four 1st and 2nd permanent molars are missing, or
   c. the 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side.
6. Not a benefit for replacing missing 3rd molars.
7. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
8. Laboratory reline (D5760) is a benefit:
   a. once in a 12-month period.
   b. six months after the date of service for a cast partial denture that required extractions, or
   c. 12 months after the date of service for a cast partial denture that did not require extractions.
9. Chairside reline (D5740) is a benefit:
   a. once in a 12 month period.
   b. six months after the date of service for a partial denture that required extractions, or
   c. 12 months after the date of service for a partial denture that did not require extractions.

PROCEDURE D5214
MANDIBULAR PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN

DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)

1. Prior authorization is required.
2. Radiographs for prior authorization –submit radiographs of all remaining natural teeth and periapical radiographs of abutment teeth.
3. A current and complete Justification of Need for Prosthesis Form, DC054 (10/05) is required for prior authorization.
4. A benefit once in a five-year period.
5. A benefit when opposing a full denture and the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows:
   a. five posterior permanent teeth are missing, (excluding 3rd molars), or
   b. all four 1st and 2nd permanent molars are missing, or
   c. the 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side.
6. Not a benefit for replacing missing 3rd molars.
7. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
8. Laboratory reline (D5761) is a benefit:
   a. once in a 12-month period.
   b. six months after the date of service for a cast partial denture that required extractions, or
   c. 12 months after the date of service for a cast partial denture that did not require extractions.
9. Chairside reline (D5741) is a benefit:
   a. once in a 12-month period.
   b. six months after the date of service for a partial denture that required extractions, or
   c. 12 months after the date of service for a partial denture that did not require extractions.

PROCEDURE D5225
MAXILLARY PARTIAL DENTURE – FLEXIBLE BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)

This procedure is not a benefit.

PROCEDURE D5226
MANDIBULAR PARTIAL DENTURE – FLEXIBLE BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)

This procedure is not a benefit.

PROCEDURE D5281
REMOVABLE UNILATERAL PARTIAL DENTURE – ONE PIECE CAST METAL (INCLUDING CLASPS AND TEETH)

This procedure is not a benefit.

PROCEDURE D5410
ADJUST COMPLETE DENTURE - MAXILLARY

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
   a. once per date of service per provider.
   b. twice in a 12-month period per provider.
3. Not a benefit:
   a. same date of service or within six months of the date of service of a complete denture- maxillary (D5110), immediate denture- maxillary (D5130) or overdenture- complete (D5860).
   b. same date of service or within six months of the date of service of a reline complete maxillary denture (chairside) (D5730), reline complete maxillary denture (laboratory) (D5750) and tissue conditioning, maxillary (D5850).
   c. same date of service or within six months of the date of service of repair broken complete denture base (D5510) and replace missing or broken teeth-complete denture (D5520).

PROCEDURE D5411
ADJUST COMPLETE DENTURE – MANDIBULAR

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
   a. once per date of service per provider.
   b. twice in a 12-month period per provider.
3. Not a benefit:
   a. same date of service or within six months of the date of service of a complete denture- mandibular (D5120), immediate denture- mandibular (D5140) or overdenture- complete (D5860).
   b. same date of service or within six months of the date of service of a reline complete mandibular denture (chairside) (D5731), reline complete mandibular denture (laboratory) (D5751) and tissue conditioning, mandibular (D5851).
   c. same date of service or within six months of the date of service of repair broken complete denture base (D5510) and replace missing or broken teeth-complete denture (D5520).

PROCEDURE D5421
ADJUST PARTIAL DENTURE – MAXILLARY

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
   a. once per date of service per provider.
   b. twice in a 12-month period per provider.
3. Not a benefit:
   a. same date of service or within six months of the date of service of a maxillary partial- resin base (D5211) or maxillary partial denture- cast metal framework with resin denture bases (D5213).
   b. same date of service or within six months of the date of service of a reline maxillary partial denture (chairside) (D5740), reline maxillary partial denture (laboratory) (D5760) and tissue conditioning, maxillary (D5850).
   c. same date of service or within six months of the date of service of repair resin denture base (D5610), repair cast framework (D5620), repair or replace broken clasp (D5630), replace broken teeth- per tooth (D5640), add tooth to existing partial denture (D5650) and add clasp to existing partial denture (D5660).

PROCEDURE D5422
ADJUST PARTIAL DENTURE - MANDIBULAR

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
   a. once per date of service per provider.
   b. twice in a 12 month period per provider.
3. Not a benefit:
   a. same date of service or within six months of the date of service of a mandibular partial- resin base (D5212) or mandibular partial denture- cast metal framework with resin denture bases (D5214).
   b. same date of service or within six months of the date of service of a reline mandibular partial denture (chairside) (D5741), reline mandibular partial denture (laboratory) (D5761) and tissue conditioning, mandibular (D5851).
   c. same date of service or within six months of the date of service of repair resin denture base (D5610), repair cast framework (D5620), repair or replace broken clasp (D5630), replace broken teeth- per tooth (D5640), add tooth to existing partial denture (D5650) and add clasp to existing partial denture (D5660).

PROCEDURE D5510
REPAIR BROKEN COMPLETE DENTURE BASE

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. Requires an arch code.
3. A benefit:
   a. once per arch, per date of service per provider.
   b. twice in a 12-month period per provider.
4. Not a benefit on the same date of service as reline complete maxillary denture (chairside) (D5730), reline complete mandibular denture (chairside) (D5731), reline complete maxillary denture (laboratory) (D5750) and reline complete mandibular denture (laboratory) (D5751).
5. All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.

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

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

PROCEDURE D5610
REPAIR RESIN DENTURE BASE

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. Requires an arch code.
3. A benefit:
   a. once per arch, per date of service per provider.
   b. twice per arch, in a 12-month period per provider.
   c. for partial dentures only.
4. Not a benefit same date of service as reline maxillary partial denture (chairside) (D5740), reline mandibular partial denture (chairside) (D5741), reline maxillary partial denture (laboratory) (D5760) and reline mandibular partial denture (laboratory) (D5761).
5. All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.

PROCEDURE D5620
REPAIR CAST FRAMEWORK

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

PROCEDURE D5630
REPAIR OR REPLACE BROKEN CLASP

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

PROCEDURE D5640
REPLACE BROKEN TEETH – PER TOOTH

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

PROCEDURE D5650
ADD TOOTH TO EXISTING PARTIAL DENTURE

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

b. once per tooth.
4. Not a benefit for adding 3rd molars.
5. All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.

PROCEDURE D5660
ADD CLASP TO EXISTING PARTIAL DENTURE

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

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

This procedure is not a benefit.

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

This procedure is not a benefit.

PROCEDURE D5710
REBASE COMPLETE MAXILLARY DENTURE

This procedure is not a benefit.

PROCEDURE D5711
REBASE COMPLETE MANDIBULAR DENTURE

This procedure is not a benefit.

PROCEDURE D5720
REBASE MAXILLARY PARTIAL DENTURE

This procedure is not a benefit.

ROCEDURE D5721
REBASE MANDIBULAR PARTIAL DENTURE

This procedure is not a benefit.

PROCEDURE D5730
RELINE COMPLETE MAXILLARY DENTURE (CHAIRSIDE)

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
   a. once in a 12-month period.
   b. six months after the date of service for a immediate denture- maxillary (D5130) or immediate overdenture- complete (D5860) that required extractions, or
   c. 12 months after the date of service for a complete (remote) denture- maxillary (D5110) or overdenture (remote)- complete (D5860) that did not require extractions.
3. Not a benefit within 12 months of a reline complete maxillary denture (laboratory) (D5750).
4. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

PROCEDURE D5731
RELINE COMPLETE MANDIBULAR DENTURE (CHAIRSIDE)

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
   a. once in a 12-month period.
   b. six months after the date of service for a immediate denture- mandibular (D5140) or immediate overdenture- complete (D5860) that required extractions, or
   c. 12 months after the date of service for a complete (remote) denture- mandibular (D5120) or overdenture (remote)- complete (D5860) that did not require extractions.
3. Not a benefit within 12 months of a reline complete mandibular denture (laboratory) (D5751).
4. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

PROCEDURE D5740
RELINE MAXILLARY PARTIAL DENTURE (CHAIRSIDE)

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

PROCEDURE D5741
RELINE MANDIBULAR PARTIAL DENTURE (CHAIRSIDE)

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

PROCEDURE D5750
RELINE COMPLETE MAXILLARY DENTURE (LABORATORY)

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
   a. once in a 12-month period.
   b. six months after the date of service for a immediate denture- maxillary (D5130) or immediate overdenture- complete (D5860) that required extractions, or

c. 12 months after the date of service for a complete (remote) denture- maxillary (D5110) or overdenture (remote)- complete (D5860) that did not require extractions.

3. Not a benefit within 12 months of a reline complete maxillary denture (chairside) (D5730).
4. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

PROCEDURE D5751
RELINE COMPLETE MANDIBULAR DENTURE (LABORATORY)

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit:
   a. once in a 12-month period.
   b. six months after the date of service for a immediate denture- mandibular (D5140) or immediate overdenture- complete (D5860) that required extractions, or
   c. 12 months after the date of service for a complete (remote) denture- mandibular (D5120) or overdenture (remote)- complete (D5860) that did not require extractions.
3. Not a benefit within 12 months of a reline complete mandibular denture (chairside) (D5731).
4. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

PROCEDURE D5760
RELINE MAXILLARY PARTIAL DENTURE (LABORATORY)

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

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

PROCEDURE D5761
RELINE MANDIBULAR PARTIAL DENTURE (LABORATORY)

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

PROCEDURE D5810
INTERIM COMPLETE DENTURE (MAXILLARY)

This procedure is not a benefit.

PROCEDURE D5811
INTERIM COMPLETE DENTURE (MANDIBULAR)

This procedure is not a benefit.

PROCEDURE D5820
INTERIM PARTIAL DENTURE (MAXILLARY)

This procedure is not a benefit.

PROCEDURE D5821
INTERIM PARTIAL DENTURE (MANDIBULAR)

This procedure is not a benefit.

PROCEDURE D5850
TISSUE CONDITIONING, MAXILLARY

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

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

PROCEDURE D5851
TISSUE CONDITIONING, MANDIBULAR

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. A benefit twice per prosthesis in a 36-month period.
3. Not a benefit:
   a. same date of service as reline complete mandibular denture (chairside) (D5731), reline mandibular partial denture (chairside) (D5741), reline complete mandibular denture (laboratory) (D5751) and reline mandibular partial denture (laboratory) (D5761).
   b. same date of service as a prosthesis that did not require extractions.
4. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
5. Tissue conditioning is designed to heal unhealthy ridges prior to a more definitive treatment.

PROCEDURE D5860
OVERDENTURE – COMPLETE, BY REPORT

1. Prior authorization is required.
2. Radiographs for prior authorization –submit all radiographs of remaining natural teeth including periapical radiographs of teeth to be retained.
3. A current and complete Justification of Need For Prosthesis Form, DC054 (10/05) is required, that includes which teeth are to be retained, for prior authorization.
4. Requires an arch code.
5. A benefit once in a five-year period.
6. Complete denture laboratory relines (D5750 and D5751) are a benefit:
   a. six months after the date of service for an immediate overdenture that required extractions, or
   b. 12 months after the date of service for a complete overdenture that did not require extractions.

7. Complete denture chairside relines (D5730 and D5731) are a benefit:
   a. six months after the date of service for an immediate overdenture that required extractions, or
   b. 12 months after the date of service for a complete overdenture that did not require extractions.
8. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
9. Teeth to be retained are not eligible for preventative, periodontal, endodontic or restorative procedures. Only extractions for the retained teeth shall be a benefit.

PROCEDURE D5861
OVERDENTURE – PARTIAL, BY REPORT

This procedure is not a benefit.

PROCEDURE D5862
PRECISION ATTACHMENT, BY REPORT

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

PROCEDURE D5867
REPLACEMENT OF REPLACEABLE PART OF SEMI-PRECISION OR PRECISION ATTACHMENT (MALE OR FEMALE COMPONENT)

This procedure is not a benefit.

PROCEDURE D5875
MODIFICATION OF REMOVABLE PROSTHESIS FOLLOWING IMPLANT SURGERY.

This procedure is not a benefit.

PROCEDURE D5899
UNSPECIFIED REMOVABLE PROSTHODONTIC PROCEDURE, BY REPORT

1. Prior authorization is required for non-emergency procedures.
2. Radiographs for prior authorization or payment – submit radiographs if applicable for the type of procedure.
3. Photographs for prior authorization or payment – submit photographs if applicable for the type of procedure.
4. Submit a current and complete Justification of Need for Prosthesis Form, DC054 (10/05), if applicable for the type of procedure, for prior authorization.
5. Written documentation for prior authorization or payment – describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed or actual treatment.
6. Procedure D5899 shall be used:

a. for a procedure which is not adequately described by a CDT code, or

b. for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the medical condition and the specific CDT code associated with the treatment.

Maxillofacial Prosthetics General Policies (D5900-D5999)

a) Maxillofacial prosthetic services are for the anatomic and functional reconstruction of those regions of the maxilla and mandible and associated structures that are missing or defective because of surgical intervention, trauma (other than simple or compound fractures), pathology, developmental or congenital malformations.

b) All maxillofacial prosthetic procedures require written documentation for payment or prior authorization. Refer to the individual procedures for specific requirements.

c) Prior authorization is required for the following procedures:

   i) trismus appliance (D5937),

   ii) palatal lift prosthesis, interim (D5958),

   iii) fluoride gel carrier (D5986),

   iv) surgical splint (D5988).

d) All maxillofacial prosthetic procedures include routine postoperative care, revisions and adjustments for 90 days after the date of delivery.

Maxillofacial Prosthetic Procedures (D5900-D5999)

PROCEDURE D5911
FACIAL MOULAGE (SECTIONAL)

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

PROCEDURE D5912
FACIAL MOULAGE (COMPLETE)

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

PROCEDURE D5913
NASAL PROSTHESIS

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

PROCEDURE D5914
AURICULAR PROSTHESIS

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

PROCEDURE D5915
ORBITAL PROSTHESIS

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

PROCEDURE D5916
OCULAR PROSTHESIS

1. Written documentation for payment - shall include:
   a. the etiology of the disease and/or condition, and
   b. a description of the associated surgery or an operative report.
2. Not a benefit on the same date of service as ocular prosthesis, interim (D5923).

PROCEDURE D5919
FACIAL PROSTHESIS

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

PROCEDURE D5922
NASAL SEPTAL PROSTHESIS

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

PROCEDURE D5923
OCULAR PROSTHESIS, INTERIM

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

PROCEDURE D5924
CRANIAL PROSTHESIS

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

PROCEDURE D5925
FACIAL AUGMENTATION IMPLANT PROSTHESIS

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

PROCEDURE D5926
NASAL PROSTHESIS, REPLACEMENT

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

PROCEDURE D5927
AURICULAR PROSTHESIS, REPLACEMENT

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

PROCEDURE D5928
ORBITAL PROSTHESIS, REPLACEMENT

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

PROCEDURE D5929
FACIAL PROSTHESIS, REPLACEMENT

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

PROCEDURE D5931
OBTURATOR PROSTHESIS, SURGICAL

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

PROCEDURE D5932
OBTURATOR PROSTHESIS, DEFINITIVE

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

PROCEDURE D5933
OBTURATOR PROSTHESIS, MODIFICATION

1. Written documentation for payment - shall include the medical necessity for the modification.

2. A benefit twice in a 12 month period.
3. Not a benefit on the same date of service as obturator prosthesis, surgical (D5931), obturator prosthesis, definitive (D5932) and obturator prosthesis, interim (D5936).

PROCEDURE D5934
MANDIBULAR RESECTION PROSTHESIS WITH GUIDE FLANGE

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

PROCEDURE D5935
MANDIBULAR RESECTION PROSTHESIS WITHOUT GUIDE FLANGE

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

PROCEDURE D5936
OBTURATOR PROSTHESIS, INTERIM

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

PROCEDURE D5937
TRISMUS APPLIANCE (NOT FOR TMD TREATMENT)

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

PROCEDURE D5951
FEEDING AID

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

PROCEDURE D5952
SPEECH AID PROSTHESIS, PEDIATRIC

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

PROCEDURE D5953
SPEECH AID PROSTHESIS, ADULT

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

PROCEDURE D5954
PALATAL AUGMENTATION PROSTHESIS

Written documentation for payment - shall include the treatment performed.

PROCEDURE D5955
PALATAL LIFT PROSTHESIS, DEFINITIVE

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

PROCEDURE D5958
PALATAL LIFT PROSTHESIS, INTERIM

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

PROCEDURE D5959
PALATAL LIFT PROSTHESIS, MODIFICATION

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

PROCEDURE D5960
SPEECH AID PROSTHESIS, MODIFICATION

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

PROCEDURE D5982
SURGICAL STENT

Written documentation for payment - shall include the treatment performed.

PROCEDURE D5983
RADIATION CARRIER

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

PROCEDURE D5984
RADIATION SHIELD

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

PROCEDURE D5985
RADIATION CONE LOCATOR

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

PROCEDURE D5986
FLUORIDE GEL CARRIER

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

PROCEDURE D5987
COMMISSURE SPLINT

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

PROCEDURE D5988
SURGICAL SPLINT

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

PROCEDURE D5991
TOPICAL MEDICAMENT CARRIER

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

PROCEDURE D5992
ADJUST MAXILLOFACIAL PROSTHETIC APPLIANCE, BY REPORT

This procedure is not a benefit.

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

This procedure is not a benefit.

PROCEDURE D5999
UNSPECIFIED MAXILLOFACIAL PROSTHESIS, BY REPORT

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

Implant Services General Policies (D6000-D6199)

a) Implant services are a benefit only when exceptional medical conditions are documented and shall be reviewed by the Medi-Cal Dental Program for medical necessity for prior authorization. Exceptional medical conditions include, but are not limited to:

i) cancer of the oral cavity requiring ablative surgery and/or radiation leading to destruction of alveolar bone, where the remaining osseous structures are unable to support conventional dental prostheses.

ii) severe atrophy of the mandible and/or maxilla that cannot be corrected with vestibular extension procedures or osseous augmentation procedures, and the patient is unable to function with conventional prostheses.

iii) skeletal deformities that preclude the use of conventional prostheses (such as arthrogryposis, ectodermal dysplasia, partial anaodontia and cleidocranial dysplasia).

iv) traumatic destruction of jaw, face or head where the remaining osseous structures are unable to support conventional dental prostheses.

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

b) Single tooth implants are not a benefit of the Medi-Cal Dental Program.

c) Implant removal, by report (D6100) is a benefit. Refer to the procedure for specific requirements.

Implant Service Procedures (D6000-D6199)

PROCEDURE D6010
SURGICAL PLACEMENT OF IMPLANT BODY: ENDOSTEAL IMPLANT

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

PROCEDURE D6040
SURGICAL PLACEMENT: EPOSTEAL IMPLANT

See the criteria for Procedure D6010.

PROCEDURE D6050
SURGICAL PLACEMENT: TRANSOSTEAL IMPLANT

See the criteria for Procedure D6010.

[BEGIN UNDERLINE]**PROCEDURE D6051**
INTERIM ABUTMENT

This procedure is not
a benefit. [END UNDERLINE]

PROCEDURE D6053
IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR COMPLETELY EDENTULOUS ARCH

See the criteria for Procedure D6010.

PROCEDURE D6054
IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURE FOR PARTIALLY EDENTULOUS ARCH

See the criteria for Procedure D6010.

PROCEDURE D6055
CONNECTING BAR –IMPLANT SUPPORTED OR ABUTMENT SUPPORTED

See the criteria for Procedure D6010.

PROCEDURE D6056
PREFABRICATED ABUTMENT- INCLUDES [BEGIN UNDERLINE]MODIFICATION AND [END UNDERLINE]
PLACEMENT

See the criteria for Procedure D6010.

PROCEDURE D6057
CUSTOM [BEGIN UNDERLINE]FABRICATED[END UNDERLINE]
ABUTMENT- INCLUDES PLACEMENT

See the criteria for Procedure D6010.

PROCEDURE D6058
ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN

See the criteria for Procedure D6010.

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

See the criteria for Procedure D6010.

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

See the criteria for Procedure D6010.

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

See the criteria for Procedure D6010.

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

See the criteria for Procedure D6010.

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

See the criteria for Procedure D6010.

PROCEDURE D6064
ABUTMENT SUPPORTED CAST METAL CROWN (NOBLE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6065
IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN

See the criteria for Procedure D6010.

PROCEDURE D6066
IMPLANT SUPPORTED PORCELAIN FUSED TO METAL CROWN (TITANIUM, TITANIUM ALLOY, HIGH NOBLE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6067
IMPLANT SUPPORTED METAL CROWN (TITANIUM, TITANIUM ALLOY, HIGH NOBLE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6068
ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD

See the criteria for Procedure D6010.

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

See the criteria for Procedure D6010.

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

See the criteria for Procedure D6010.

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

See the criteria for Procedure D6010.

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

See the criteria for Procedure D6010.

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

See the criteria for Procedure D6010.

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

See the criteria for Procedure D6010.

PROCEDURE D6075
IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD

See the criteria for Procedure D6010.

PROCEDURE D6076
IMPLANT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (TITANIUM, TITANIUM ALLOY, OR HIGH NOBLE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6077
IMPLANT SUPPORTED RETAINER FOR CAST METAL FPD (TITANIUM, TITANIUM ALLOY, OR HIGH NOBLE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6078
IMPLANT/ABUTMENT SUPPORTED FIXED DENTURE FOR COMPLETELY EDENTULOUS ARCH

See the criteria for Procedure D6010.

PROCEDURE D6079
IMPLANT/ABUTMENT SUPPORTED FIXED DENTURE FOR PARTIALLY EDENTULOUS ARCH

See the criteria for Procedure D6010.

PROCEDURE D6080
IMPLANT MAINTENANCE PROCEDURES, INCLUDING REMOVAL OF PROSTHESIS, CLEANSING OF PROSTHESIS AND ABUTMENTS AND REINSERTION OF PROSTHESIS

See the criteria for Procedure D6010.

PROCEDURE D6090
REPAIR IMPLANT SUPPORTED PROSTHESIS, BY REPORT

See the criteria for Procedure D6010.

PROCEDURE D6091
REPLACEMENT OF SEMI-PRECISION OR PRECISION ATTACHMENT (MALE OR FEMALE COMPONENT) OF IMPLANT/ABUTMENT SUPPORTED PROSTHESIS, PER ATTACHMENT

See the criteria for Procedure D6010.

PROCEDURE D6092
RECEMENT IMPLANT/ABUTMENT SUPPORTED CROWN

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

PROCEDURE D6093
RECEMENT IMPLANT/ABUTMENT SUPPORTED FIXED PARTIAL DENTURE

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

PROCEDURE D6094
ABUTMENT SUPPORTED CROWN (TITANIUM)

See the criteria for Procedure D6010.

PROCEDURE D6095
REPAIR IMPLANT ABUTMENT, BY REPORT

See the criteria for Procedure D6010.

PROCEDURE D6100
IMPLANT REMOVAL, BY REPORT

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

3. Written documentation for payment –shall include the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
4. Requires a tooth code.

[BEGIN UNDERLINE]PROCEDURE D6101
DEBRIDEMENT OF A PERIIMPLANT DEFECT AND SURFACE CLEANING OF EXPOSED IMPLANT SERVICES, INCLUDING FLAP ENTRY AND CLOSURE

This procedure is not a benefit.

PROCEDURE D6102
DEBRIDEMENT AND OSSEOUS CONTOURING OF A PERIIMPLANT DEFECT; INCLUDES SURFACE CLEANING OF EXPOSED IMPLANT SURFACES AND FLAP ENTRY AND CLOSURE

This procedure is not a benefit.

PROCEDURE D6103
BONE GRAFT FOR REPAIR OF PERIIMPLANT DEFECT- NOT INCLUDING FLAP ENTRY AND CLOSURE OR, WHEN INDICATED, PLACEMENT OF A BARRIER MEMBRANE OR BIOLOGIC MATERIALS TO AID IN OSSEOUS REGENERATION

This procedure is not a benefit.

PROCEDURE D6104
BONE GRAFT AT TIME OF IMPLANT PLACEMENT

This procedure is not a benefit. [END UNDERLINE]

PROCEDURE D6190
RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY REPORT

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

PROCEDURE D6194
ABUTMENT SUPPORTED RETAINER CROWN FOR FPD (TITANIUM)

See the criteria for Procedure D6010.

PROCEDURE D6199
UNSPECIFIED IMPLANT PROCEDURE, BY REPORT

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

Fixed Prosthodontic General Policies (D6200-D6999)

a) Fixed partial dentures (bridgework) are considered beyond the scope of the Medi-Cal Dental Program. However, the fabrication of a fixed partial denture shall be considered for prior authorization only when medical conditions or employment preclude the use of a removable partial denture. **Most importantly, the patient shall first meet the criteria for a removable partial denture before a fixed partial denture will be considered.**

b) Medical conditions, which preclude the use of a removable partial denture, include:

   i) the epileptic patient where a removable partial denture could be injurious to their health during an uncontrolled seizure,

   ii) the paraplegia patient who utilizes a mouth wand to function to any degree and where a mouth wand is inoperative because of missing natural teeth,

   iii) patients with neurological disorders whose manual dexterity precludes proper care and maintenance of a removable partial denture.

c) Documentation for medical conditions shall be submitted for prior authorization that includes a written, signed and dated statement from the patient's physician, on their professional letterhead, describing the patient's medical condition and the reason why a removable partial denture would be injurious to the patient's health.

d) Documentation for obtaining employment shall be submitted for prior authorization that includes a written statement from the patient's case manager or eligibility worker stating why the nature of the employment precludes the use of a removable partial denture.

e) Fixed partial dentures are a benefit once in a five-year period only on permanent teeth when the above criteria are met.

f) Current periapical radiographs of the retainer (abutment) teeth and arch radiographs are required for prior authorization.

g) Fixed partial dentures are not a benefit when the prognosis of the retainer (abutment) teeth is questionable due to non-restorability or periodontal involvement.

h) Posterior fixed partial dentures are not a benefit when the number of missing teeth requested to be replaced in the quadrant does not significantly impact the patient's masticatory ability.

i) Tooth and soft tissue preparation, crown lengthening, cement bases, direct and indirect pulp capping, amalgam or acrylic buildups, pins (D2951), bonding agents, lining agents, impressions, temporary crowns, adjustments (D9951), polishing, local anesthesia (D9210) and any other associated procedures are included in the fee for a completed fixed partial denture.

j) Arch integrity and overall condition of the mouth, including the patient's ability to maintain oral health, shall be considered for prior authorization. Prior authorization shall be based upon a supportable five-year prognosis for the fixed partial denture retainer (abutment).

k) Fixed partial denture retainers (abutments) on root canal treated teeth shall be considered only after satisfactory completion of root canal therapy. Post root canal treatment periapical and arch radiographs shall be submitted for prior authorization of fixed partial dentures.

l) Partial payment will not be made for an undelivered fixed partial denture. Payment will be made only upon final cementation.

m) Fixed partial denture inlay/onlay retainers (abutments) (D6545 and D6634) are not a benefit.

n) Cast resin bonded fixed partial dentures (Maryland Bridges) are not a benefit.

Fixed Prosthodontic Procedures (D6200-D6999)

PROCEDURE D6205
PONTIC – INDIRECT RESIN BASED COMPOSITE

This procedure is not a benefit.

PROCEDURE D6210
PONTIC – CAST HIGH NOBLE METAL

This procedure is not a benefit.

PROCEDURE D6211
PONTIC – CAST PREDOMINANTLY BASE METAL

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

PROCEDURE D6212
PONTIC – CAST NOBLE METAL

This procedure is not a benefit.

PROCEDURE D6214
PONTIC – TITANIUM

This procedure is not a benefit.

PROCEDURE D6240
PONTIC – PORCELAIN FUSED TO HIGH NOBLE METAL

This procedure is not a benefit.

PROCEDURE D6241
PONTIC – PORCELAIN FUSED TO PREDOMINANTLY BASE METAL

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

PROCEDURE D6242
PONTIC – PORCELAIN FUSED TO NOBLE METAL

This procedure is not a benefit.

PROCEDURE D6245
PONTIC – PORCELAIN/CERAMIC

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

b. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).

c. only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791).

6. Not a benefit for patients under the age of 13.

PROCEDURE D6250
PONTIC – RESIN WITH HIGH NOBLE METAL

This procedure is not a benefit.

PROCEDURE D6251
PONTIC – RESIN WITH PREDOMINANTLY BASE METAL

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

PROCEDURE D6252
PONTIC – RESIN WITH NOBLE METAL

This procedure is not a benefit.

PROCEDURE D6253
PROVISIONAL PONTIC- [BEGIN UNDERLINE]**FURTHER TREATMENT OR COMPLETION OF DIAGNOSIS NECESSARY PRIOR TO FINAL IMPRESSION**[END UNDERLINE]

This procedure is not a benefit.

[BEGIN UNDERLINEND] **[BEGIN STRIKEOUT]~~PROCEDURE D6254 INTERIM PONTIC~~[END STRIKEOUT]** [END UNDERLINE]

[BEGIN STRIKEOUT]~~This procedure is not a benefit.~~ [END STRIKEOUT]

PROCEDURE D6545
RETAINER – CAST METAL FOR RESIN BONDED FIXED PROSTHESIS

This procedure is not a benefit.

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

This procedure is not a benefit.

PROCEDURE D6600
INLAY – PORCELAIN/CERAMIC, TWO SURFACES

This procedure is not a benefit.

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

This procedure is not a benefit.

PROCEDURE D6602
INLAY – CAST HIGH NOBLE METAL, TWO SURFACES

This procedure is not a benefit.

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

This procedure is not a benefit.

PROCEDURE D6604
INLAY – CAST PREDOMINANTLY BASE METAL, TWO SURFACES

This procedure is not a benefit.

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

This procedure is not a benefit.

PROCEDURE D6606
INLAY – CAST NOBLE METAL, TWO SURFACES

This procedure is not a benefit.

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

This procedure is not a benefit.

PROCEDURE D6608
ONLAY – PORCELAIN/CERAMIC, TWO SURFACES

This procedure is not a benefit.

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

This procedure is not a benefit.

PROCEDURE D6610
ONLAY – CAST HIGH NOBLE METAL, TWO SURFACES

This procedure is not a benefit.

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

This procedure is not a benefit.

PROCEDURE D6612
ONLAY – CAST PREDOMINANTLY BASE METAL, TWO SURFACES

This procedure is not a benefit.

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

This procedure is not a benefit.

PROCEDURE D6614
ONLAY – CAST NOBLE METAL, TWO SURFACES

This procedure is not a benefit.

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

This procedure is not a benefit.

PROCEDURE D6624
INLAY- TITANIUM

This procedure is not a benefit.

PROCEDURE D6634
ONLAY- TITANIUM

This procedure is not a benefit.

PROCEDURE D6710
CROWN- INDIRECT RESIN BASED COMPOSITE

This procedure is not a benefit.

PROCEDURE D6720
CROWN – RESIN WITH HIGH NOBLE METAL

This procedure is not a benefit.

PROCEDURE D6721
CROWN – RESIN WITH PREDOMINANTLY BASE METAL

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

PROCEDURE D6722
CROWN – RESIN WITH NOBLE METAL

This procedure is not a benefit.

PROCEDURE D6740
CROWN – PORCELAIN/CERAMIC

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

PROCEDURE D6750
CROWN – PORCELAIN FUSED TO HIGH NOBLE METAL

This procedure is not a benefit.

PROCEDURE D6751
CROWN – PORCELAIN FUSED TO PREDOMINANTLY BASE METAL

1. Prior authorization is required.
2. Radiographs for prior authorization –submit arch and periapical radiographs.
3. Written documentation for prior authorization- shall be submitted for employment or medical reasons. Refer to Fixed Prosthodontic General Policies for specific requirements.
4. Requires a tooth code.
5. A benefit:
   a. once in a five year period.
   b. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).

6. Not a benefit for patients under the age of 13.

PROCEDURE D6752
CROWN – PORCELAIN FUSED TO NOBLE METAL

This procedure is not a benefit.

PROCEDURE D6780
CROWN – ¾ CAST HIGH NOBLE METAL

This procedure is not a benefit.

PROCEDURE D6781
CROWN – ¾ CAST PREDOMINANTLY BASE METAL

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

PROCEDURE D6782
CROWN – ¾ CAST NOBLE METAL

This procedure is not a benefit.

PROCEDURE D6783
CROWN – ¾ PORCELAIN/CERAMIC

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

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

PROCEDURE D6790
CROWN – FULL CAST HIGH NOBLE METAL

This procedure is not a benefit.

PROCEDURE D6791
CROWN – FULL CAST PREDOMINANTLY BASE METAL

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

PROCEDURE D6792
CROWN – FULL CAST NOBLE METAL

This procedure is not a benefit.

PROCEDURE D6793
PROVISIONAL RETAINER CROWN [BEGIN UNDERLINE]- FURTHER TREATMENT OR COMPLETION OF DIAGNOSIS NECESSARY PRIOR TO FINAL IMPRESSION[END UNDERLINE]

This procedure is not a benefit.

PROCEDURE D6794
CROWN- TITANIUM

This procedure is not a benefit.

[BEGIN UNDERLINEND] **[BEGIN STRIKEOUT]~~PROCEDURE D6795~~**
~~INTERIM PONTIC~~[END STRIKEOUT] [END UNDERLINE]

[BEGIN STRIKEOUT]~~This procedure is not a benefit.~~ [END STRIKEOUT]

PROCEDURE D6920
CONNECTOR BAR

This procedure is not a benefit.

PROCEDURE D6930
RECEMENT FIXED PARTIAL DENTURE

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

PROCEDURE D6940
STRESS BREAKER

This procedure is not a benefit.

PROCEDURE D6950
PRECISION ATTACHMENT

This procedure is not a benefit.

[BEGIN UNDERLINEND] [BEGIN STRIKEOUT]
~~Procedure D6970~~
~~post and core in addition to fixed partial denture retainer, indirectly fabricated~~[END STRIKEOUT] **[END UNDERLINE]**

[BEGIN STRIKEOUT]~~1. Prior authorization is required.~~

~~2. Radiographs for prior authorization – submit arch and periapical radiographs.~~

~~3. Requires a tooth code.~~

~~4. A benefit:~~

~~a. once per tooth regardless of the number of posts placed,~~

~~b. only in conjunction with allowable retainers on root canal treated permanent teeth.~~

~~5. Shall be submitted on the same TAR with the fixed partial denture request.~~ [END STRIKEOUT]

[BEGIN UNDERLINEND] [BEGIN STRIKEOUT]
~~Procedure D6972~~
~~prefabricated post and core in addition to fixed partial denture retainer~~[END STRIKEOUT] **[END UNDERLINE]**

[BEGIN STRIKEOUT]~~1. Prior authorization is required.~~

~~2. Radiographs for prior authorization – submit arch and periapical radiographs.~~

~~3. Requires a tooth code.~~

~~4. A benefit:~~

~~a. once per tooth regardless of the number of posts placed.~~

~~b. only in conjunction with allowable retainers on root canal treated permanent teeth.~~

~~5. Shall be submitted on the same TAR with the fixed partial denture request.~~ [END STRIKEOUT]

[BEGIN UNDERLINEND] [BEGIN STRIKEOUT]
~~Procedure D6973~~
~~core build up for retainer, including any pins~~[END STRIKEOUT] **[END UNDERLINE]**

[BEGIN STRIKEOUT]~~This procedure is included in the fee for restorative and fixed prosthodontic procedures and is not payable separately.~~ [END STRIKEOUT]

PROCEDURE D6975
COPING [BEGIN STRIKEOUT]~~– METAL~~[END STRIKEOUT]

This procedure is not a benefit.

[BEGIN UNDERLINEND] [BEGIN STRIKEOUT]
~~Procedure D6976~~
~~each additional indirectly fabricated post – same tooth~~[END STRIKEOUT] **[END UNDERLINE]**

[BEGIN STRIKEOUT]~~This procedure is to be performed in conjunction with D6970 or D6972 and is not payable separately.~~ [END STRIKEOUT]

[BEGIN UNDERLINEND] [BEGIN STRIKEOUT]
~~Procedure D6977~~
~~each additional prefabricated post – same tooth~~[END STRIKEOUT] **[END UNDERLINE]**

[BEGIN STRIKEOUT]~~This procedure is to be performed in conjunction with D6972 and is not payable separately.~~ [END STRIKEOUT]

PROCEDURE D6980
FIXED PARTIAL DENTURE REPAIR [BEGIN STRIKEOUT]~~**, BY REPORT**~~**[END STRIKEOUT]** [BEGIN UNDERLINE]**NECESSITATED BY RESTORATIVE MATERIAL FAILURE**[END UNDERLINE]

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

PROCEDURE D6985
PEDIATRIC PARTIAL DENTURE, FIXED

This procedure is not a benefit.

PROCEDURE D6999
UNSPECIFIED, FIXED PROSTHODONTIC PROCEDURE, BY REPORT

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

Oral and Maxillofacial Surgery General Policies (D7000-D7999)

a) Diagnostic pre-operative radiographs are required for all hard tissue surgical procedures that are submitted for prior authorization and/or payment. Refer to the individual procedure for specific requirements.

b) Local anesthetic, sutures and routine postoperative care within 30 days following an extraction procedure (D7111-D7250) are considered part of, and included in, the fee for the procedure. All other oral and maxillofacial surgery procedures include routine postoperative care for 90 days.

c) The level of payment for multiple surgical procedures performed on the same date of service shall be modified to the most inclusive procedure.

1. Extractions (D7111-D7250):

a) The following conditions shall be considered medically necessary and shall be a benefit:

i) full bony impacted supernumerary teeth or mesiodens [BEGIN UNDERLINE]that interfere with the alignment of other teeth[END UNDERLINE],

ii) teeth which are involved with a cyst, tumor or other neoplasm,

iii) unerupted teeth which are severely distorting the normal alignment of erupted teeth or causing the resorption of the roots of other teeth,

iv) the extraction of all remaining teeth in preparation for a full prosthesis,

v) [BEGIN STRIKEOUT]~~maligned teeth which cause intermittent pericornitis~~[END STRIKEOUT] [BEGIN UNDERLINE]extraction of third molars that are causing repeated or chronic pericoronitis[END UNDERLINE],

vi) extraction of primary teeth required to minimize malocclusion or malalignment when there is adequate space to allow normal eruption of succedaneous teeth,

vii) perceptible radiologic pathology that fails to elicit symptoms,

viii) extractions that are required to complete orthodontic dental services[BEGIN UNDERLINE], excluding prophylactic removal of third molars,[END UNDERLINE]

ix) when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement.

b) The prophylactic extraction of 3rd molars is not a benefit.

c) The fee for surgical extractions includes the removal of bone and/or sectioning of tooth, and elevation of mucoperiosteal flap, if indicated.

d) Classification of surgical extractions and impactions shall be based on the anatomical position of the tooth rather than the surgical technique employed in the removal.

e) The level of payment for surgical extractions shall be allowed or modified based on the degree of difficulty as evidenced by the diagnostic radiographs. When radiographs do not accurately depict the degree of difficulty, written documentation and/or photographs shall be considered.

2. Fractures (D7610-D7780):

a) The placement and removal of wires, bands or splints is included in the fee for the associated procedure.

b) Routine postoperative care within 90 days is included in the fee for the associated procedure.

c) When extensive multiple or bilateral procedures are performed at the same operative session, each procedure shall be valued as follows:

i) 100% (full value) for the first or major procedure, and

ii) 50% for the second procedure, and

iii) 25% for the third procedure, and

iv) 10% for the fourth procedure, and

v) 5% for the fifth procedure, and

vi) over five procedures, by report.

d) Assistant surgeons are paid 20% of the surgical fee allowed to the surgeon. Hospital call (D9420) is not payable to assistant surgeons.

3. Temporomandibular Joint Dysfunctions (D7810-D7899):

a) TMJ dysfunction procedures are limited to differential diagnosis and symptomatic care. Not included as a benefit are those TMJ treatment modalities that involve prosthodontia, orthodontia and full or partial occlusal rehabilitation.

b) Most TMJ dysfunction procedures require prior authorization. Submission of sufficient diagnostic information to establish the presence of the dysfunction is required. Refer to the individual procedures for specific submission requirements.

c) TMJ dysfunction procedures solely for the treatment of bruxism is not a benefit.

4. Repair Procedures (D7910- D7998):

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

Oral and Maxillofacial Surgery Procedures (D7000-D7999)

PROCEDURE D7111
EXTRACTION, CORONAL REMNANTS – DECIDUOUS TOOTH

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

PROCEDURE D7140
EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND/OR FORCEPS REMOVAL)

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

PROCEDURE D7210
SURGICAL REMOVAL OF ERUPTED TOOTH REQUIRING REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF MUCOPERIOSTEAL FLAP IF INDICATED

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

PROCEDURE D7220
REMOVAL OF IMPACTED TOOTH – SOFT TISSUE

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

PROCEDURE D7230
REMOVAL OF IMPACTED TOOTH – PARTIALLY BONY

1. Radiographs for payment –submit a current, diagnostic preoperative periapical or panoramic radiograph depicting the entire tooth.
2. Requires a tooth code.
3. A benefit when the removal of any impacted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone. One of the proximal heights of contour of the crown shall be covered by bone.

PROCEDURE D7240
REMOVAL OF IMPACTED TOOTH – COMPLETELY BONY

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

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

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

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

1. Radiographs for payment –submit a current, diagnostic preoperative periapical or panoramic radiograph depicting the entire root.

2. Requires a tooth code.
3. A benefit when the root is completely covered by alveolar bone.
4. Not a benefit to the same provider who performed the initial tooth extraction.

PROCEDURE D7251
CORONECTOMY- INTENTIONAL PARTIAL TOOTH REMOVAL

This procedure is not a benefit.

PROCEDURE D7260
OROANTRAL FISTULA CLOSURE

[BEGIN UNDERLINE]1. Radiographs for payment –submit a current, diagnostic preoperative radiograph. [END UNDERLINE]

[BEGIN STRIKEOUT]~~1.~~ [END STRIKEOUT] [BEGIN UNDERLINE]2. [END UNDERLINE]Written documentation or operative report for payment – shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.

[BEGIN STRIKEOUT]~~2.~~ [END STRIKEOUT] [BEGIN UNDERLINE]3. [END UNDERLINE] Requires a quadrant code.

[BEGIN STRIKEOUT]~~3.~~ [END STRIKEOUT] [BEGIN UNDERLINE]4. [END UNDERLINE] A benefit for the excision of a fistulous tract between the maxillary sinus and oral cavity.

[BEGIN STRIKEOUT]~~4.~~ [END STRIKEOUT] [BEGIN UNDERLINE]5. [END UNDERLINE] Not a benefit in conjunction with extraction procedures (D7111 – D7250).

PROCEDURE D7261
PRIMARY CLOSURE OF A SINUS PERFORATION

[BEGIN UNDERLINE]1. Radiographs for payment –submit a current, diagnostic preoperative radiograph. [END UNDERLINE]

[BEGIN STRIKEOUT]~~1.~~ [END STRIKEOUT] [BEGIN UNDERLINE]2. [END UNDERLINE]Written documentation or operative report for payment – shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.

[BEGIN STRIKEOUT]~~2.~~ [END STRIKEOUT] [BEGIN UNDERLINE]3. [END UNDERLINE] Requires a tooth code.

[BEGIN STRIKEOUT]~~3~~[END STRIKEOUT] [BEGIN UNDERLINE]~~.~~4. [END UNDERLINE] A benefit in the absence of a fistulous tract requiring the repair or immediate closure of the oroantral or oralnasal communication, subsequent to the removal of a tooth.

PROCEDURE D7270
TOOTH REIMPLANTATION AND/OR STABILIZATION OF ACCIDENTALLY EVULSED OR DISPLACED TOOTH

1. Radiographs for payment –submit a preoperative periapical radiograph.
2. Written documentation for payment – shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the tooth/teeth reimplanted.
3. Requires an arch code.
4. A benefit:
   a. once per arch regardless of the number of teeth involved, and
   b. for permanent anterior teeth only.
5. The fee for this procedure includes splinting and/or stabilization, postoperative care and the removal of the splint or stabilization, by the same provider.

PROCEDURE D7272
TOOTH TRANSPLANTATION (INCLUDES REIMPLANTATION FROM ONE SITE TO ANOTHER AND SPLINTING AND/OR STABILIZATION)

This procedure is not a benefit.

PROCEDURE D7280
SURGICAL ACCESS OF AN UNERUPTED TOOTH

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a pre-operative radiograph depicting the impacted tooth.
3. Written documentation for prior authorization –shall describe the specific conditions addressed by the procedure and the rationale demonstrating the medical necessity.
4. Requires a tooth code.
5. Not a benefit:
   a. for patients age 21 or older.
   b. for 3rd molars.

PROCEDURE D7282
MOBILIZATION OF ERUPTED OR MALPOSITIONED TOOTH TO AID ERUPTION

This procedure is not a benefit.

PROCEDURE D7283
PLACEMENT OF DEVICE TO FACILITATE ERUPTION OF IMPACTED TOOTH

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a pre-operative radiograph depicting the impacted tooth.
3. Written documentation for prior authorization – shall indicate that the patient is under active orthodontic treatment.
4. Requires a tooth code.
5. A benefit only for patients in active orthodontic treatment.
6. Not a benefit:
   a. for patients age 21 years or older.
   b. for 3rd molars unless the 3rd molar occupies the 1st or 2nd molar position.

PROCEDURE D7285
BIOPSY OF ORAL TISSUE – HARD (BONE, TOOTH)

1. Radiographs for payment –submit a pre-operative radiograph.
2. A pathology report from a certified pathology laboratory is required for payment.
3. Requires an arch code.
4. A benefit:
   a. for the removal of the specimen only.
   b. once per arch, per date of service regardless of the areas involved.
5. Not a benefit with an apicoectomy/periradicular surgery (D3410-D3426), an extraction (D7111-D7250) and an excision of any soft tissues or intraosseous lesions (D7410-D7461) in the same area or region on the same date of service.

PROCEDURE D7286
BIOPSY OF ORAL TISSUE – SOFT

1. Written documentation for payment – shall include the area or region and individual areas biopsied.
2. A pathology report from a certified pathology laboratory is required for payment.
3. A benefit:
   a. for the removal of the specimen only.
   b. up to a maximum of three per date of service.
4. Not a benefit with an apicoectomy/periradicular surgery (D3410-D3426), an extraction (D7111-D7250) and an excision of any soft tissues or intraosseous lesions (D7410-D7461) in the same area or region on the same date of service.

PROCEDURE D7287
EXFOLIATIVE CYTOLOGICAL SAMPLE COLLECTION

This procedure is not a benefit.

PROCEDURE D7288
BRUSH BIOPSY- TRANSEPITHELIAL SAMPLE COLLECTION

This procedure is not a benefit.

PROCEDURE D7290
SURGICAL REPOSITIONING OF TEETH

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a pre-operative radiograph.
3. Written documentation for prior authorization – shall indicate that the patient is under active orthodontic treatment.
4. Requires an arch code.
5. A benefit:
   a. for permanent teeth only.
   b. once per arch.
   c. only for patients in active orthodontic treatment.
6. Not a benefit:
   a. for patients age 21 years or older.
   b. for 3rd molars unless the 3rd molar occupies the 1st or 2nd molar position.

PROCEDURE D7291
TRANSSEPTAL FIBEROTOMY/SUPRA CRESTAL FIBEROTOMY, BY REPORT

1. Written documentation for payment – shall indicate that the patient is under active orthodontic treatment.
2. Requires an arch code.
3. A benefit:
   a. once per arch.
   b. only for patients in active orthodontic treatment.
4. Not a benefit for patients age 21 or older.

PROCEDURE D7292
SURGICAL PLACEMENT: TEMPORARY ANCHORAGE DEVICE [SCREW RETAINED PLATE] REQUIRING SURGICAL FLAP

This procedure is not a benefit.

PROCEDURE D7293
SURGICAL PLACEMENT: TEMPORARY ANCHORAGE DEVICE REQUIRING SURGICAL FLAP

This procedure is not a benefit.

PROCEDURE D7294
SURGICAL PLACEMENT: TEMPORARY ANCHORAGE DEVICE WITHOUT SURGICAL FLAP

This procedure is not a benefit.

PROCEDURE D7295
HARVEST OF BONE FOR USE IN AUTOGENOUS GRAFTING PROCEDURE

This procedure is not a benefit.

PROCEDURE D7310
ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS – FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT

1. Radiographs for payment –submit radiographs of the involved areas.
2. Requires a quadrant code.

3. A benefit on the same date of service with two or more extractions (D7140-D7250) in the same quadrant.
4. Not a benefit when only one tooth is extracted in the same quadrant on the same date of service.

PROCEDURE D7311
ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS – ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT

This procedure can only be billed as alveoloplasty in conjunction with extractions- four or more teeth or tooth spaces, per quadrant (D7310).

PROCEDURE D7320
ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS –FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT

1. Radiographs for payment- submit radiographs of the involved areas if photographs do not demonstrate the medical necessity.
2. Photographs for payment- submit photographs of the involved areas.
3. Requires a quadrant code.
4. A benefit regardless of the number of teeth or tooth spaces.
5. Not a benefit within six months following extractions (D7140-D7250) in the same quadrant, for the same provider.

PROCEDURE D7321
ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS – ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT

This procedure can only be billed as alveoloplasty not in conjunction with extractions- four or more teeth or tooth spaces, per quadrant (D7320).

PROCEDURE D7340
VESTIBULOPLASTY-RIDGE EXTENSION (SECONDARY EPITHELIALIZATION)

1. Prior authorization is required.
2. Radiographs for prior authorization –submit radiographs.
3. Photographs for prior authorization –submit photographs.

4. Written documentation for prior authorization- shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed prosthodontic treatment.
5. Requires an arch code.
6. A benefit once in a five year period per arch.
7. Not a benefit:
   a. on the same date of service with a vestibuloplasty – ridge extension (D7350) same arch.
   b. on the same date of service with extractions (D7111-D7250) same arch.

PROCEDURE D7350
VESTIBULOPLASTY – RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT AND MANAGEMENT OF HYPERTROPHIED AND HYPERPLASTIC TISSUE)

1. Prior authorization is required.
2. Radiographs for prior authorization –submit radiographs.
3. Photographs for prior authorization –submit photographs.
4. Written documentation for prior authorization- shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed prosthodontic treatment.
5. Requires an arch code.
6. A benefit once per arch.
7. Not a benefit:
   a. on the same date of service with a vestibuloplasty – ridge extension (D7340) same arch.
   b. on the same date of service with extractions (D7111-D7250) same arch.

PROCEDURE D7410
EXCISION OF BENIGN LESION UP TO 1.25 CM

1. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
2. A pathology report from a certified pathology laboratory is required for payment.

PROCEDURE D7411
EXCISION OF BENIGN LESION GREATER THAN 1.25 CM

1. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
2. A pathology report from a certified pathology laboratory is required for payment.

PROCEDURE D7412
EXCISION OF BENIGN LESION, COMPLICATED

1. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
2. A pathology report from a certified pathology laboratory is required for payment.
3. A benefit when there is extensive undermining with advancement or rotational flap closure.

PROCEDURE D7413
EXCISION OF MALIGNANT LESION UP TO 1.25 CM

1. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
2. A pathology report from a certified pathology laboratory is required for payment.

PROCEDURE D7414
EXCISION OF MALIGNANT LESION GREATER THAN 1.25 CM

1. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
2. A pathology report from a certified pathology laboratory is required for payment.

PROCEDURE D7415
EXCISION OF MALIGNANT LESION, COMPLICATED

1. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.

2. A pathology report from a certified pathology laboratory is required for payment.
3. A benefit when there is extensive undermining with advancement or rotational flap closure.

PROCEDURE D7440
EXCISION OF MALIGNANT TUMOR – LESION DIAMETER UP TO 1.25 CM

1. Radiographs for payment- submit a radiograph of the tumor.
2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. A pathology report from a certified pathology laboratory is required for payment.

PROCEDURE D7441
EXCISION OF MALIGNANT TUMOR – LESION DIAMETER GREATER THAN 1.25 CM

1. Radiographs for payment- submit a radiograph of the tumor.
2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. A pathology report from a certified pathology laboratory is required for payment.

PROCEDURE D7450
REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR – LESION DIAMETER UP TO 1.25 CM

1. Radiographs for payment- submit a radiograph of the cyst or tumor.
2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. A pathology report from a certified pathology laboratory is required for payment.

PROCEDURE D7451
REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR – LESION DIAMETER GREATER THAN 1.25 CM

1. Radiographs for payment- submit a radiograph of the cyst or tumor.

2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. A pathology report from a certified pathology laboratory is required for payment.

PROCEDURE D7460
REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR – LESION DIAMETER UP TO 1.25 CM

1. Radiographs for payment- submit a radiograph of the cyst or tumor.
2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. A pathology report from a certified pathology laboratory is required for payment.

PROCEDURE D7461
REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR – LESION DIAMETER GREATER THAN 1.25 CM

1. Radiographs for payment- submit a radiograph of the cyst or tumor.
2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. A pathology report from a certified pathology laboratory is required for payment.

PROCEDURE D7465
DESTRUCTION OF LESION(S) BY PHYSICAL OR CHEMICAL METHOD, BY REPORT

1. Photographs for payment –submit a pre-operative photograph.
2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. Examples include using cryo, laser or electro surgery.

PROCEDURE D7471
REMOVAL OF LATERAL EXOSTOSIS (MAXILLA OR MANDIBLE)

1. Photographs for payment –submit pre-operative photographs.

2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed prosthodontic treatment.
3. Requires a quadrant code.
4. A benefit:
   a. once per quadrant.
   b. for the removal of buccal or facial exostosis only.

PROCEDURE D7472
REMOVAL OF TORUS PALATINUS

1. Photographs for payment –submit pre-operative photographs.
2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed prosthodontic treatment.
3. A benefit once in the patient's lifetime.

PROCEDURE D7473
REMOVAL OF TORUS MANDIBULARIS

1. Photographs for payment –submit pre-operative photographs.
2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed prosthodontic treatment.
3. Requires a quadrant code.
4. A benefit once per quadrant.

PROCEDURE D7485
SURGICAL REDUCTION OF OSSEOUS TUBEROSITY

1. Radiographs for payment –submit preoperative radiographs.
2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed prosthodontic treatment.
3. Requires a quadrant code.
4. A benefit once per quadrant.

PROCEDURE D7490
RADICAL RESECTION OF MAXILLA OR MANDIBLE

1. Radiographs for payment –submit radiographs.
2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed or actual treatment.

PROCEDURE D7510
INCISION AND DRAINAGE OF ABSCESS – INTRAORAL SOFT TISSUE

1. Written documentation for payment- shall include the tooth involved, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
2. Requires a quadrant code.
3. A benefit once per quadrant, same date of service.
4. Not a benefit when any other definitive treatment is performed in the same quadrant on the same date of service, except necessary radiographs and/or photographs.
5. The fee for this procedure includes the incision, placement and removal of a surgical draining device.

PROCEDURE D7511
INCISION AND DRAINAGE OF ABSCESS – INTRAORAL SOFT TISSUE-COMPLICATED (INCLUDES DRAINAGE OF MULTIPLE FASCIAL SPACES)

1. Written documentation for payment- shall include the tooth involved, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
2. Requires a quadrant code.
3. A benefit once per quadrant, same date of service.
4. Not a benefit when any other definitive treatment is performed in the same quadrant on the same date of service, except necessary radiographs and/or photographs.
5. The fee for this procedure includes the incision, placement and removal of a surgical draining device.

PROCEDURE D7520
INCISION AND DRAINAGE OF ABSCESS – EXTRAORAL SOFT TISSUE

1. Written documentation for payment shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
2. The fee for this procedure includes the incision, placement and removal of a surgical draining device.

PROCEDURE D7521
INCISION AND DRAINAGE OF ABSCESS – EXTRAORAL SOFT TISSUE-COMPLICATED (INCLUDES DRAINAGE OF MULTIPLE FASCIAL SPACES)

1. Written documentation for payment- shall include the tooth involved, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
2. The fee for this procedure includes the incision, placement and removal of a surgical draining device.

PROCEDURE D7530
REMOVAL OF FOREIGN BODY FROM MUCOSA, SKIN, OR SUBCUTANEOUS ALVEOLAR TISSUE

1. Radiographs for payment –submit a pre-operative radiograph.
2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. A benefit once per date of service.
4. Not a benefit when associated with the removal of a tumor, cyst (D7440-D7461) or tooth (D7111-D7250).

PROCEDURE D7540
REMOVAL OF REACTION PRODUCING FOREIGN BODIES, MUSCULOSKELETAL SYSTEM

1. Radiographs for payment –submit a pre-operative radiograph.
2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. A benefit once per date of service.
4. Not a benefit when associated with the removal of a tumor, cyst (D7440-D7461) or tooth (D7111-D7250).

PROCEDURE D7550
PARTIAL OSTECTOMY/SEQUESTREC-TOMY FOR REMOVAL OF NON-VITAL BONE

1. Radiographs for payment –submit a pre-operative radiograph.
2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. Requires a quadrant code.
4. A benefit:
   a. once per quadrant per date of service.
   b. only for the removal of loose or sloughed off dead bone caused by infection or reduced blood supply.
5. Not a benefit within 30 days of an associated extraction (D7111-D7250).

PROCEDURE D7560
MAXILLARY SINUSOTOMY FOR REMOVAL OF TOOTH FRAGMENT OR FOREIGN BODY

1. Radiographs for payment –submit a pre-operative radiograph.
2. Written documentation for payment- shall include the area or region, describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. Not a benefit when a tooth fragment or foreign body is retrieved from the tooth socket.

PROCEDURE D7610
MAXILLA – OPEN REDUCTION (TEETH IMMOBILIZED, IF PRESENT)

1. Radiographs for payment –submit a [BEGIN STRIKEOUT]~~pre-operative~~ [END STRIKEOUT] [BEGIN UNDERLINE]postoperative[END UNDERLINE] radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.

4. Anesthesia procedures (D9220-D9248) are a separate benefit when necessary for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7620
MAXILLA – CLOSED REDUCTION (TEETH IMMOBILIZED, IF PRESENT)

1. Radiographs for payment –submit a [BEGIN STRIKEOUT]~~pre-operative~~ [END STRIKEOUT] [BEGIN UNDERLINE]postoperative [END UNDERLINE] radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9220-D9248) are a separate benefit when necessary for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7630
MANDIBLE – OPEN REDUCTION (TEETH IMMOBILIZED, IF PRESENT)

1. Radiographs for payment –submit a [BEGIN STRIKEOUT]~~pre-operative~~ [END STRIKEOUT] [BEGIN UNDERLINE]postoperative[END UNDERLINE] radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7640
MANDIBLE – CLOSED REDUCTION (TEETH IMMOBILIZED, IF PRESENT)

1. Radiographs for payment –submit a [BEGIN STRIKEOUT]~~pre-operative~~[END STRIKEOUT] [BEGIN UNDERLINE]~~-~~postoperative[END UNDERLINE] radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.

4. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7650
MALAR AND/OR ZYGOMATIC ARCH – OPEN REDUCTION

1. Radiographs for payment –submit a [BEGIN UNDERLINE]postoperative[END UNDERLINE] radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7660
MALAR AND/OR ZYGOMATIC ARCH – CLOSED REDUCTION

1. Radiographs for payment –submit a[BEGIN UNDERLINE] postoperative[END UNDERLINE] radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7670
ALVEOLUS – CLOSED REDUCTION, MAY INCLUDE STABILIZATION OF TEETH

1. Radiographs for payment –submit a[BEGIN UNDERLINE] postoperative[END UNDERLINE] radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.

3. Requires an arch code.
4. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
5. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7671
ALVEOLUS – OPEN REDUCTION, MAY INCLUDE STABILIZATION OF TEETH

1. Radiographs for payment –submit a[BEGIN UNDERLINE] postoperative[END UNDERLINE] radiograph.
2. Operative report for payment – shall include a copy of the operative report which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. Requires an arch code.
4. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
5. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7680
FACIAL BONES – COMPLICATED REDUCTION WITH FIXATION AND MULTIPLE SURGICAL APPROACHES

1. Radiographs for payment –submit a[BEGIN UNDERLINE] postoperative [END UNDERLINE] radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
3. A benefit for the treatment of simple fractures.
4. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
5. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7710
MAXILLA – OPEN REDUCTION

1. Radiographs for payment –submit a[BEGIN UNDERLINE] postoperative[END UNDERLINE] radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7720
MAXILLA – CLOSED REDUCTION

1. Radiographs for payment –submit a[BEGIN UNDERLINE] postoperative[END UNDERLINE] radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7730
MANDIBLE – OPEN REDUCTION

1. Radiographs for payment –submit a[BEGIN UNDERLINE] postoperative[END UNDERLINE] radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7740
MANDIBLE – CLOSED REDUCTION

1. Radiographs for payment –submit a[BEGIN UNDERLINE] postoperative [END UNDERLINE] radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7750
MALAR AND/OR ZYGOMATIC ARCH – OPEN REDUCTION

1. Radiographs for payment –submit a[BEGIN UNDERLINE] postoperative[END UNDERLINE] radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7760
MALAR AND/OR ZYGOMATIC ARCH – CLOSED REDUCTION

1. Radiographs for payment –submit a[BEGIN UNDERLINE] postoperative[END UNDERLINE] radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.

4. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7770
ALVEOLUS – OPEN REDUCTION STABILIZATION OF TEETH

1. Radiographs for payment –submit a radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7771
ALVEOLUS – CLOSED REDUCTION STABILIZATION OF TEETH

1. Radiographs for payment –submit a radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
3. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
4. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7780
FACIAL BONES – COMPLICATED REDUCTION WITH FIXATION AND MULTIPLE SURGICAL APPROACHES

1. Radiographs for payment –submit a radiograph.
2. Operative report for payment – shall include a copy of the operative report, which describes the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
3. A benefit for the treatment of compound fractures.

4. The fee for this procedure includes the placement and removal of wires, bands, splints and arch bars.
5. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7810
OPEN REDUCTION OF DISLOCATION

Written documentation or operative report for payment – shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.

PROCEDURE D7820
CLOSED REDUCTION OF DISLOCATION

Written documentation or operative report for payment – shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.

PROCEDURE D7830
MANIPULATION UNDER ANESTHESIA

1. Written documentation or operative report for payment – shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
2. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary.

PROCEDURE D7840
CONDYLECTOMY

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization – shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.

PROCEDURE D7850
SURGICAL DISCECTOMY, WITH/WITHOUT IMPLANT

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.

3. Written documentation for prior authorization – shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
4. An operative report shall be submitted for payment.

PROCEDURE D7852
DISC REPAIR

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization – shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
4. An operative report shall be submitted for payment.

PROCEDURE D7854
SYNOVECTOMY

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization – shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
4. An operative report shall be submitted for payment.

PROCEDURE D7856
MYOTOMY

Written documentation or operative report for payment – shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.

PROCEDURE D7858
JOINT RECONSTRUCTION

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.

3. Written documentation for prior authorization – shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
4. An operative report shall be submitted for payment.

PROCEDURE D7860
ARTHROTOMY

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization – shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
4. An operative report shall be submitted for payment.

PROCEDURE D7865
ARTHROPLASTY

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization – shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
4. An operative report shall be submitted for payment.

PROCEDURE D7870
ARTHROCENTESIS

Written documentation or operative report for payment – shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.

PROCEDURE D7871
NON-ARTHROSCOPIC LYSIS AND LAVAGE

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

PROCEDURE D7872
ARTHROSCOPY – DIAGNOSIS, WITH OR WITHOUT BIOPSY

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization– shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
4. An operative report shall be submitted for payment.
5. This procedure includes the fee for any biopsies performed.

PROCEDURE D7873
ARTHROSCOPY – SURGICAL: LAVAGE AND LYSIS OF ADHESIONS

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization– shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
4. An operative report shall be submitted for payment.

PROCEDURE D7874
ARTHROSCOPY – SURGICAL: DISC REPOSITIONING AND STABILIZATION

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization– shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
4. An operative report shall be submitted for payment.

PROCEDURE D7875
ARTHROSCOPY – SURGICAL: SYNOVECTOMY

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization– shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
4. An operative report shall be submitted for payment.

PROCEDURE D7876
ARTHROSCOPY – SURGICAL: DISCECTOMY

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization– shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
4. An operative report shall be submitted for payment.

PROCEDURE D7877
ARTHROSCOPY – SURGICAL: DEBRIDEMENT

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization– shall describe the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, the location (left or right) and any pertinent history.
4. An operative report shall be submitted for payment.

PROCEDURE D7880
OCCLUSAL ORTHOTIC DEVICE, BY REPORT

1. Prior authorization is required.
2. Radiographs for prior authorization –submit tomograms or a radiological report.
3. Written documentation for prior authorization – shall include the specific TMJ conditions to be addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
4. A benefit for diagnosed TMJ dysfunction.
5. Not a benefit for the treatment of bruxism.

PROCEDURE D7899
UNSPECIFIED TMD THERAPY, BY REPORT

1. Prior authorization is required for non-emergency procedures.
2. Radiographs for prior authorization – submit radiographs and/or tomograms, if applicable, for the type of procedure.

3. Written documentation for prior authorization – shall include the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
4. Not a benefit for procedures such as acupuncture, acupressure, biofeedback and hypnosis.

PROCEDURE D7910
SUTURE OF RECENT SMALL WOUNDS UP TO 5 CM

1. Written documentation or operative report for payment – shall include the specific conditions addressed by the procedure and the length of the wound.
2. Not a benefit for the closure of surgical incisions.

PROCEDURE D7911
COMPLICATED SUTURE – UP TO 5 CM

1. Written documentation or operative report for payment – shall include the specific conditions addressed by the procedure and the length of the wound.
2. Not a benefit for the closure of surgical incisions.

PROCEDURE D7912
COMPLICATED SUTURE – GREATER THAN 5 CM

1. Written documentation or operative report for payment – shall include the specific conditions addressed by the procedure and the length of the wound.
2. Not a benefit for the closure of surgical incisions.

PROCEDURE D7920
SKIN GRAFT (IDENTIFY DEFECT COVERED, LOCATION AND TYPE OF GRAFT)

1. Written documentation or operative report for payment – shall include the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the actual treatment.
2. Not a benefit for periodontal grafting.

[BEGIN UNDERLINE]**PROCEDURE D7921**
COLLECTION AND APPLICATION OF AUTOLOGOUS BLOOD CONCENTRATE PRODUCT

This procedure is not a benefit. [END UNDERLINE]

PROCEDURE D7940
OSTEOPLASTY – FOR ORTHOGNATHIC DEFORMITIES

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization – shall include the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed treatment.
4. An operative report shall be submitted for payment.

PROCEDURE D7941
OSTEOTOMY – MANDIBULAR RAMI

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization – shall include the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
4. An operative report shall be submitted for payment.

PROCEDURE D7943
OSTEOTOMY – MANDIBULAR RAMI WITH BONE GRAFT; INCLUDES OBTAINING THE GRAFT

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization – shall include the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
4. An operative report shall be submitted for payment.

PROCEDURE D7944
OSTEOTOMY – SEGMENTED OR SUBAPICAL

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.

3. Written documentation for prior authorization – shall include the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
4. Requires a quadrant code.
5. An operative report shall be submitted for payment.

PROCEDURE D7945
OSTEOTOMY – BODY OF MANDIBLE

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization – shall include the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
4. An operative report shall be submitted for payment.

PROCEDURE D7946
LEFORT I (MAXILLA – TOTAL)

1. Radiographs for payment –submit a pre-operative radiograph.
2. An operative report shall be submitted for payment.

PROCEDURE D7947
LEFORT I (MAXILLA – SEGMENTED)

1. Radiographs for payment –submit a pre-operative radiograph.
2. An operative report shall be submitted for payment.
3. When reporting a surgically assisted palatal expansion without downfracture, use unspecified oral surgery procedure, by report (D7999).

PROCEDURE D7948
LEFORT II OR LEFORT III (OSTEOPLASTY OF FACIAL BONES FOR MIDFACE HYPOPLASIA OR RETRUSION) – WITHOUT BONE GRAFT

1. Radiographs for payment –submit a pre-operative radiograph.
2. An operative report shall be submitted for payment.

PROCEDURE D7949
LEFORT II OR LEFORT III – WITH BONE GRAFT

1. Radiographs for payment –submit a pre-operative radiograph.
2. An operative report shall be submitted for payment.

PROCEDURE D7950
OSSEOUS, OSTEOPERIOSTEAL, OR CARTILAGE GRAFT OF THE MANDIBLE OR FACIAL BONES – AUTOGENOUS OR NONAUTOGENOUS, BY REPORT

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization – shall include the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed treatment.
4. Not a benefit for periodontal grafting.
5. An operative report shall be submitted for payment.

PROCEDURE D7951
SINUS AUGMENTATION WITH BONE OR BONE SUBSTITUTES [BEGIN UNDERLINE]**VIA A LATERAL OPEN APPROACH**[END UNDERLINE]

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization – shall include the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
4. A benefit only for patients with authorized implant services.
5. An operative report shall be submitted for payment.

[BEGIN UNDERLINE]**PROCEDURE D7952**
SINUS AUGMENTATION WITH BONE OR BONE SUBSTITUTE VIA A VERTICAL APPROACH

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.

3. Written documentation for prior authorization – shall include the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
4. A benefit only for patients with authorized implant services.
5. An operative report shall be submitted for payment. [END UNDERLINE]

PROCEDURE D7953
BONE REPLACEMENT GRAFT FOR RIDGE PRESERVATION- PER SITE

This procedure is not a benefit.

PROCEDURE D7955
REPAIR OF MAXILLOFACIAL SOFT AND/OR HARD TISSUE DEFECT

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization – shall include the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed treatment.
4. Not a benefit for periodontal grafting.
5. An operative report shall be submitted for payment.

PROCEDURE D7960
FRENULECTOMY- ALSO KNOWN AS FRENECTOMY OR FRENOTOMY– SEPARATE PROCEDURE NOT INCIDENTAL TO ANOTHER

1. Photographs for payment –submit a pre-operative photograph.
2. Written documentation for payment – shall include the rationale demonstrating the medical necessity and the specific area the treatment was performed.
3. Requires an arch code.
4. A benefit:

   [BEGIN UNDERLINE]a. [END UNDERLINE] once per arch per date of service.

   [BEGIN UNDERLINE]b. only when the permanent incisors and cuspids have erupted. [END UNDERLINE]

PROCEDURE D7963
FRENULOPLASTY

1. Photographs for payment –submit a pre-operative photograph.
2. Written documentation for payment – shall include the rationale demonstrating the medical necessity and the specific area the treatment was performed.
3. Requires an arch code.
4. A benefit:

   [BEGIN UNDERLINE]a. [END UNDERLINE] once per arch per date of service.

   [BEGIN UNDERLINE]b. only when the permanent incisors and cuspids have erupted. [END UNDERLINE]

PROCEDURE D7970
EXCISION OF HYPERPLASTIC TISSUE – PER ARCH

1. Photographs for payment –submit a pre-operative photograph.
2. Written documentation for payment – shall include the rationale demonstrating the medical necessity and the specific area the treatment was performed.
3. Requires an arch code.
4. A benefit once per arch per date of service.
5. Not a benefit for drug induced hyperplasia or where removal of tissue requires extensive gingival recontouring.
6. This procedure is included in the fees for other surgical procedures that are performed in the same area on the same date of service.

PROCEDURE D7971
EXCISION OF PERICORONAL GINGIVA

1. Radiographs for payment- submit a pre-operative periapical radiograph.
2. Photographs for payment –submit a pre-operative photograph only when the radiograph does not adequately demonstrate the medical necessity.
3. Written documentation for payment – shall include the rationale demonstrating the medical necessity.
4. Requires a tooth code.
5. This procedure is included in the fee for other associated procedures that are performed on the same tooth on the same date of service.

PROCEDURE D7972
SURGICAL REDUCTION OF FIBROUS TUBEROSITY

1. Photographs for payment –submit a pre-operative photograph.
2. Written documentation for payment – shall include the rationale demonstrating the medical necessity and the actual or proposed prosthodontic treatment.
3. Requires a quadrant code.
4. A benefit once per quadrant per date of service.
5. This procedure is included in the fees for other surgical procedures that are performed in the same quadrant on the same date of service.

PROCEDURE D7980
SIALOLITHOTOMY

1. Radiographs for payment –submit a pre-operative radiograph.
2. Written documentation or operative report for payment – shall include the area or region the treatment was performed, the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.

PROCEDURE D7981
EXCISION OF SALIVARY GLAND, BY REPORT

Operative report for payment – shall include the area or region the treatment was performed, the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.

PROCEDURE D7982
SIALODOCHOPLASTY

Operative report for payment – shall include the area or region the treatment was performed, the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.

PROCEDURE D7983
CLOSURE OF SALIVARY FISTULA

Operative report for payment – shall include the area or region the treatment was performed, the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.

PROCEDURE D7990
EMERGENCY TRACHEOTOMY

Operative report for payment – shall include the specific conditions addressed by the procedure.

PROCEDURE D7991
CORONOIDECTOMY

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization – shall include the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
4. An operative report shall be submitted for payment.

PROCEDURE D7995
SYNTHETIC GRAFT – MANDIBLE OR FACIAL BONES, BY REPORT

1. Prior authorization is required.
2. Radiographs for prior authorization –submit a radiograph.
3. Written documentation for prior authorization – shall include the specific conditions to be addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
4. Not a benefit for periodontal grafting.
5. An operative report shall be submitted for payment.

PROCEDURE D7996
IMPLANT – MANDIBLE FOR AUGMENTATION PURPOSES (EXCLUDING ALVEOLAR RIDGE), BY REPORT.

This procedure is not a benefit.

PROCEDURE D7997
APPLIANCE REMOVAL (NOT BY DENTIST WHO PLACED APPLIANCE), INCLUDES REMOVAL OF ARCH BAR

1. Radiographs for payment –submit a pre-operative radiograph.

2. Written documentation for payment – shall include the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity and any pertinent history.
3. Requires an arch code.
4. A benefit:
   a. once per arch per date of service.
   b. for the removal of appliances related to surgical procedures only.
5. Not a benefit for the removal of orthodontic appliances and space maintainers.

PROCEDURE D7998
INTRAORAL PLACEMENT OF A FIXATION DEVICE NOT IN CONJUNCTION WITH A FRACTURE

This procedure is not a benefit.

PROCEDURE D7999
UNSPECIFIED ORAL SURGERY PROCEDURE, BY REPORT

1. Radiographs for payment – submit radiographs if applicable for the type of procedure.
2. Photographs for payment – submit photographs if applicable for the type of procedure.
3. Written documentation or operative report– describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the actual treatment.
4. Procedure D7999 shall be used:
   a. for a procedure which is not adequately described by a CDT code, or
   b. for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the medical condition and the specific CDT code associated with the treatment.

Orthodontic General Policies (D8000-D8999)

Orthodontic Procedures (D8080, D8660, D8670 and D8680)

a) Orthodontic procedures shall only be performed by dentists who qualify as orthodontists under the California Code of Regulations, Title 22, Section 51223(c).

b) Orthodontic procedures are benefits for medically necessary handicapping malocclusion, cleft palate and facial growth management cases for patients under the age of 21 and shall be prior authorized.

c) Only those cases with permanent dentition shall be considered for medically necessary handicapping malocclusion, unless the patient is age 13 or older with primary teeth remaining. Cleft palate and craniofacial anomaly cases are a benefit for primary, mixed and permanent dentitions. Craniofacial anomalies are treated using facial growth management.

d) All necessary procedures that may affect orthodontic treatment shall be completed before orthodontic treatment is considered.

e) Orthodontic procedures are a benefit only when the diagnostic casts verify a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (06/09) or one of the six automatic qualifying conditions below exist or when there is written documentation of a craniofacial anomaly from a credentialed specialist on their professional letterhead.

f) The automatic qualifying conditions are:

   i) cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,

   ii) craniofacial anomaly. Written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,

   iii) a deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,

   iv) a crossbite of individual anterior teeth causing destruction of soft tissue,

   v) an overjet greater than 9 mm or reverse overjet greater than 3.5 mm,

   vi) a severe traumatic deviation (such as loss of a premaxilla segment by burns, accident or osteomyelitis or other gross pathology). Written documentation of the trauma or pathology shall be submitted with the prior authorization request.

g) When a patient transfers from one orthodontist to another orthodontist, a new TAR for prior authorization shall be submitted:

i) when the patient has already qualified under the Medi-Cal Dental Program and has been receiving treatment, the balance of the originally authorized treatment shall be authorized to the new orthodontist to complete the case. Diagnostic casts, Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (06/09), and photographs are not required for a transfer case that has already been approved, or

ii) when a patient has been receiving orthodontic treatment that has not been previously approved by the Medi-Cal Dental Program, pre-treatment diagnostic casts and current photographs are required. If pre-treatment diagnostic casts are not available then current diagnostic casts shall be submitted. Prior authorization for the balance of the orthodontic treatment shall be allowed or denied based on the Medi-Cal Dental Program's evaluation of the diagnostic casts and photographs.

h) When additional periodic orthodontic treatment visit(s) (D8670) are necessary beyond the maximum allowed to complete the case, prior authorization is required. Current photographs are required to justify the medical necessity.

i) If the patient's orthodontic treatment extends beyond the month of their 21st birthday or they become ineligible during treatment, then it is the patient's responsibility to pay for their continued treatment.

j) If the patient's orthodontic treatment is interrupted and orthodontic bands are prematurely removed, then the patient no longer qualifies for continued orthodontic treatment.

k) If the patient's orthodontic bands have to be temporarily removed and then replaced due to a medical necessity, a claim for comprehensive orthodontic treatment of the adolescent dentition (D8080) for rebanding shall be submitted along with a letter from the treating physician or radiologist, on their professional letterhead, stating the reason why the bands needed to be temporarily removed.

Orthodontic Procedures (D8000-D8999)

PROCEDURE D8010
LIMITED ORTHODONTIC TREATMENT OF THE PRIMARY DENTITION

This procedure is not a benefit.

PROCEDURE D8020
LIMITED ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION

This procedure is not a benefit.

PROCEDURE D8030
LIMITED ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION

This procedure is not a benefit.

PROCEDURE D8040
LIMITED ORTHODONTIC TREATMENT OF THE ADULT DENTITION

This procedure is not a benefit.

PROCEDURE D8050
INTERCEPTIVE ORTHODONTIC TREATMENT OF THE PRIMARY DENTITION

This procedure is not a benefit.

PROCEDURE D8060
INTERCEPTIVE ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION

This procedure is not a benefit.

PROCEDURE D8070
COMPREHENSIVE ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION

This procedure is not a benefit.

PROCEDURE D8080
COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION

1. Prior authorization is required. The following shall be submitted together for prior authorization:
   a. comprehensive orthodontic treatment of the adolescent dentition (D8080), and
   b. periodic orthodontic treatment visit(s) (D8670), and
   c. orthodontic retention (D8680), and
   d. the diagnostic casts (D0470), and
   e. a completed Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (06/09).
2. No treatment will be authorized and no payment will be allowed after the month of the patient's 21st birthday.
3. Written documentation for prior authorization for cleft palate and facial growth management cases shall be submitted:
   a. cleft palate cases require documentation from a credentialed specialist, on their professional letterhead, if the cleft palate is not visible on the diagnostic casts, or
   b. facial growth management cases require documentation from a credentialed specialist, on their professional letterhead, of the craniofacial anomaly.
4. A benefit:
   a. for handicapping malocclusion, cleft palate and facial growth management cases.
   b. for patients under the age of 21.
   c. for permanent dentition (unless the patient is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly).
   d. once per patient per phase of treatment.
5. All appliances (such as bands, arch wires, headgear and palatal expanders) are included in the fee for this procedure. No additional charge to the patient is permitted.
6. This procedure includes the replacement, repair and removal of brackets, bands and arch wires by the original provider.

PROCEDURE D8090
COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADULT DENTITION

This procedure is not a benefit.

PROCEDURE D8210
REMOVABLE APPLIANCE THERAPY

1. Prior authorization is required.
2. Radiographs for prior authorization –submit current periapical radiographs of the maxillary anterior teeth.
3. Written documentation for prior authorization –shall justify the medical necessity for the appliance and the presence of a harmful oral habit such as thumb sucking and/or tongue thrusting.
4. A benefit:
   a. for patients ages 6 through 12.
   b. once per patient.
5. Not a benefit:
   a. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.
   b. for space maintainers in the upper or lower anterior region.
6. This procedure includes all adjustments to the appliance.

PROCEDURE D8220
FIXED APPLIANCE THERAPY

1. Prior authorization is required.
2. Radiographs for prior authorization –submit current periapical radiographs of the maxillary anterior teeth.
3. Written documentation for prior authorization –shall justify the medical necessity for the appliance and the presence of a harmful oral habit such as thumb sucking and/or tongue thrusting.
4. A benefit:
   a. for patients ages 6 through 12.
   b. once per patient.

5. Not a benefit:
   a. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.
   b. for space maintainers in the upper or lower anterior region.
6. This procedure includes all adjustments to the appliance.

PROCEDURE D8660
PRE-ORTHODONTIC TREATMENT VISIT

1. This procedure is for the observation of the patient's oral and/or facial growth for craniofacial anomalies prior to starting orthodontic treatment for facial growth management cases.
2. Prior authorization is required. The following shall be submitted together for authorization:
   a. comprehensive orthodontic treatment of the adolescent dentition (D8080), and
   b. pre-orthodontic treatment visit(s) (D8660) indicating the quantity of treatment visits required up to a maximum of six during the patient's lifetime, and
   c. periodic orthodontic treatment visit(s) (D8670), and
   d. orthodontic retention (D8680), and
   e. a completed Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (06/09).
3. Written documentation for prior authorization- shall include a letter from a credentialed specialist, on their professional letterhead, confirming a craniofacial anomaly.
4. A benefit:
   a. prior to comprehensive orthodontic treatment of the adolescent dentition (D8080) for the initial treatment phase for facial growth management cases regardless of how many dentition phases are required.
   b. once every three months.
   c. for patients under the age of 21.
   d. for a maximum of six.

PROCEDURE D8670
PERIODIC ORTHODONTIC TREATMENT VISIT (AS PART OF CONTRACT)

1. Prior authorization is required. Refer to Orthodontic General Policies for specific authorization requirements.

2. The start of payments for this procedure shall be the next calendar month following the date of service for comprehensive orthodontic treatment of the adolescent dentition (D8080).
3. A benefit:
   a. for patients under the age of 21.
   b. for permanent dentition (unless the patient is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly).
   c. once per calendar quarter.
4. The maximum quantity of monthly treatment visits for the following phases are:
   a. Malocclusion- up to a maximum of 8 quarterly visits. (4 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity), or
   b. Cleft Palate:
      i) Primary dentition – up to a maximum of 4 quarterly visits. (2 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
      ii) Mixed dentition - up to a maximum of 5 quarterly visits. (3 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
      iii) Permanent dentition- up to a maximum of 10 quarterly visits. (5 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity), or
   c. Facial Growth Management:
      i) Primary dentition- up to a maximum of 4 quarterly visits. (2 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
      ii) Mixed dentition- up to a maximum of 5 quarterly visits. (3 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
      iii) Permanent dentition- up to a maximum of 8 quarterly visits. (4 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).

PROCEDURE D8680
ORTHODONTIC RETENTION (REMOVAL OF APPLIANCES, CONSTRUCTION AND PLACEMENT OF RETAINER(S))

1. Prior authorization is required. Refer to Orthodontic General Policies for specific authorization requirements.
2. This procedure shall be paid only following the completion of periodic orthodontic treatment visit(s) (D8670) which is considered to be the active phase of orthodontic treatment.
3. Requires an arch code.
4. A benefit:
   a. for patients under the age of 21.
   b. for permanent dentition (unless the patient is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly).
   c. once per arch for each authorized phase of orthodontic treatment.
5. Not a benefit until the active phase of orthodontic treatment (D8670) is completed. If fewer than the authorized number of periodic orthodontic treatment visit(s) (D8670) are necessary because the active phase of treatment has been completed early, then this shall be documented on the claim for orthodontic retention (D8680).
6. The removal of appliances, construction and placement of retainers, all observations and necessary adjustments are included in the fee for this procedure.

PROCEDURE D8690
ORTHODONTIC TREATMENT (ALTERNATIVE BILLING TO A CONTRACT FEE)

This procedure is not a benefit.

PROCEDURE D8691
REPAIR OF ORTHODONTIC APPLIANCE

1. This procedure does not require prior authorization.
2. Written documentation for payment – indicate the type of orthodontic appliance and a description of the repair.
3. Requires an arch code.
4. A benefit:
   a. for patients under the age of 21.
   b. once per appliance.
5. Not a benefit to the original provider for the replacement and/or repair of brackets, bands, or arch wires.

PROCEDURE D8692
REPLACEMENT OF LOST OR BROKEN RETAINER

1. This procedure does not require prior authorization.
2. Written documentation for payment – indicate how the retainer was lost or why it is no longer serviceable.
3. Requires an arch code.
4. A benefit:
   a. for patients under the age of 21.
   b. once per arch.
   c. only within 24 months following the date of service of orthodontic retention (D8680).
5. This procedure is only payable when orthodontic retention (D8680) has been previously paid by the program.

PROCEDURE D8693
REBONDING OR RECEMENTING: AND/OR REPAIR, AS REQUIRED, OF FIXED RETAINERS

1. This procedure does not require prior authorization.
2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
3. Requires an arch code.
4. A benefit:
   a. for patients under the age of 21.

b. once per provider.

5. Additional requests beyond the stated frequency limitations shall be considered for payment when the medical necessity is documented and identifies an unusual condition (such as displacement due to a sticky food item).

PROCEDURE D8999
UNSPECIFIED ORTHODONTIC PROCEDURE, BY REPORT

1. Prior authorization is required for non-emergency procedures.
2. Radiographs for prior authorization or payment- submit radiographs if applicable for the type of procedure.
3. Photographs for prior authorization or payment- submit photographs if applicable for the type of procedure.

4. Written documentation for prior authorization or payment – describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed or actual treatment.
5. A benefit for patients under the age of 21.
6. Not a benefit to the original provider for the adjustment, repair, replacement or removal of brackets, bands or arch wires.
7. Procedure D8999 shall be used:
   a. for a procedure which is not adequately described by a CDT code, or
   b. for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the medical condition and the specific CDT code associated with the treatment.

Adjunctive General Policies (D9000-D9999)

Anesthesia (D9210-D9248)

a) General anesthesia (D9220 and D9221) is defined as a controlled state of unconsciousness, accompanied by a partial or complete loss of protective reflexes, including the loss of the ability to independently maintain an airway and respond purposefully to physical stimulation or verbal command, produced by a pharmacologic or non-pharmacologic method or combination thereof.

b) Intravenous sedation/analgesia (D9241 and D9242) is a medically controlled state of depressed consciousness while maintaining the patient's airway, protective reflexes and the ability to respond to stimulation or verbal commands. It includes intravenous (IV) administration of sedative and/or analgesic agent(s) and appropriate monitoring.

c) Non-intravenous conscious sedation (D9248) is a medically controlled state of depressed consciousness while maintaining the patient's airway, protective reflexes and the ability to respond to stimulation or verbal commands. It includes administration of sedative and/or analgesic agent(s) by a route other than IV (oral, patch, intramuscular or subcutaneous) and appropriate monitoring.

d) Deep sedation/general anesthesia (D9220 and D9221) and intravenous conscious sedation/analgesia (D9241 and D9242) shall be considered for payment when it is documented why local anesthesia is contraindicated. Such contraindications shall include the following:

   i) a severe mental or physical handicap,

   ii) extensive surgical procedures,

   iii) an uncooperative child,

   iv) an acute infection at an injection site,

   v) a failure of a local anesthetic to control pain.

e) The administration of deep sedation/general anesthesia (D9220 and D9221), nitrous oxide (D9230), intravenous conscious sedation/analgesia (D9241 and D9242) and therapeutic parenteral drug (D9610) is a benefit in conjunction with payable associated procedures. Prior authorization or payment shall be denied if all associated procedures by the same provider are denied.

[BEGIN UNDERLINE]f) Only one anesthesia procedure is payable per date of service regardless of the methods of administration or drugs used. When one or more anesthesia procedures are performed only the most profound procedure will be allowed. The following anesthesia procedures are listed in order from most profound to least profound:

i) Procedure D9220/D9221 (Deep Sedation/General Anesthesia),

ii) Procedure D9241/D9242 (Intravenous Conscious Sedation/Analgesia),

iii) Procedure D9248 (Non-Intravenous Conscious Sedation),

iv) Procedure D9230 (Inhalation Of Nitrous Oxide/Analgesia, Anxiolysis). [END UNDERLINE]

[BEGIN STRIKEOUT]~~f)~~ [END STRIKEOUT] [BEGIN UNDERLINE]g) [END UNDERLINE] Providers who administer general anesthesia (D9220 and D9221) and/or intravenous conscious sedation/analgesia (D9241 and D9242) shall have valid anesthesia permits with the California Dental Board.

[BEGIN STRIKEOUT]~~g)~~ [END STRIKEOUT] [BEGIN UNDERLINE]h) [END UNDERLINE] The cost of analgesic and anesthetic agents and supplies are included in the fee for the analgesic/anesthetic procedure.

[BEGIN STRIKEOUT]~~h)~~ [END STRIKEOUT] [BEGIN UNDERLINE]i) [END UNDERLINE] Anesthesia time for general anesthesia and intravenous conscious sedation is defined as the period between the beginning of the administration of the anesthetic agent and the time that the anesthetist is no longer in personal attendance.

[BEGIN STRIKEOUT]~~i)~~ [END STRIKEOUT] [BEGIN UNDERLINE]j) [END UNDERLINE] Sedation is a benefit in conjunction with the surgical removal of wires, bands, splints and arch bars.

Adjunctive Service Procedures (D9000-D9999)

PROCEDURE D9110
PALLIATIVE (EMERGENCY) TREATMENT OF DENTAL PAIN – MINOR PROCEDURE

1. This procedure cannot be prior authorized.
2. Written documentation for payment –shall include the tooth/area, condition and specific treatment performed.
3. A benefit once per date of service per provider regardless of the number of teeth and/or areas treated.
4. Not a benefit when any other treatment is performed on the same date of service, except when radiographs/photographs are needed of the affected area to diagnose and document the emergency condition.

PROCEDURE D9120
FIXED PARTIAL DENTURE SECTIONING

1. This procedure does not require prior authorization.
2. Radiographs for payment- submit pre-operative radiographs.
3. Requires a tooth code for the retained tooth.
4. A benefit when at least one of the abutment teeth is to be retained.

PROCEDURE D9210
LOCAL ANESTHESIA NOT IN CONJUNCTION WITH OPERATIVE OR SURGICAL PROCEDURES

1. This procedure cannot be prior authorized.
2. Written documentation for payment –shall include the medical necessity for the local anesthetic injection.
3. A benefit:
   a. once per date of service per provider.
   b. only for use in order to perform a differential diagnosis or as a therapeutic injection to [BEGIN STRIKEOUT]~~relieve the patient from pain~~[END STRIKEOUT][BEGIN UNDERLINE]eliminate or control a disease or abnormal state[END UNDERLINE].

4. Not a benefit when any other treatment is performed on the same date of service, except when radiographs/photographs are needed of the affected area to diagnose and document the emergency condition.

PROCEDURE D9211
REGIONAL BLOCK ANESTHESIA

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

PROCEDURE D9212
TRIGEMINAL DIVISION BLOCK ANESTHESIA

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

PROCEDURE D9215
LOCAL ANESTHESIA IN CONJUNCTION WITH OPERATIVE OR SURGICAL PROCEDURES

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

PROCEDURE D9220
DEEP SEDATION/GENERAL ANESTHESIA – FIRST 30 MINUTES

1. This procedure does not require prior authorization.
2. Written documentation for payment –shall justify the medical necessity based on a mental or physical limitation or contraindication to a local anesthetic agent. [BEGIN UNDERLINE]The anesthetic induction agent shall also be documented. [END UNDERLINE]
3. An anesthesia record that indicates the anesthetic agent(s) and the anesthesia time shall be submitted for payment.
4. Not a benefit:
   a. on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide (D9230), intravenous conscious sedation/analgesia (D9241 and D9242) or non-intravenous conscious sedation (D9248).
   b. when all associated procedures on the same date of service by the same provider are denied.

PROCEDURE D9221
DEEP SEDATION/GENERAL ANESTHESIA – EACH ADDITIONAL 15 MINUTES

1. This procedure does not require prior authorization.
2. Written documentation for payment –shall justify the medical necessity based on a mental or physical limitation or contraindication to a local anesthetic agent. [BEGIN UNDERLINE]The anesthetic induction agent shall also be documented. [END UNDERLINE]
3. An anesthesia record that indicates the anesthetic agent(s) and the anesthesia time shall be submitted for payment.
4. The quantity, in 15-minute increments, that was necessary to complete the treatment shall be indicated on the claim.
5. Not a benefit:
   a. on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide (D9230), intravenous conscious sedation/analgesia (D9241 and D9242) or non-intravenous conscious sedation (D9248).
   b. when all associated procedures on the same date of service by the same provider are denied.

PROCEDURE D9230
INHALATION OF NITROUS OXIDE /ANALGESIA, ANXIOLYSIS

1. This procedure does not require prior authorization.
2. Written documentation for payment for patients age 13 or older- shall indicate the physical, behavioral, developmental or emotional condition that prohibits the patient from responding to the provider's attempts to perform treatment.
3. A benefit:
   a. for uncooperative patients under the age of 13, or
   b. for patients age 13 or older when documentation specifically identifies the physical, behavioral, developmental or emotional condition that prohibits the patient from responding to the provider's attempts to perform treatment.
4. Not a benefit:
   a. on the same date of service as deep sedation/general anesthesia (D9220 and D9221), intravenous conscious sedation/analgesia (D9241 and D9242) or non-intravenous conscious sedation (D9248).
   b. when all associated procedures on the same date of service by the same provider are denied.

PROCEDURE D9241
INTRAVENOUS CONSCIOUS SEDATION/ANALGESIA – FIRST 30 MINUTES

1. This procedure does not require prior authorization.
2. Written documentation for payment –shall justify the medical necessity based on a mental or physical limitation or contraindication to a local anesthetic agent.
3. An anesthesia record that indicates the anesthetic agent(s) and the anesthesia time shall be submitted for payment.
4. Not a benefit:
   a. on the same date of service as deep sedation/general anesthesia (D9220 and D9221), analgesia, anxiolysis, inhalation of nitrous oxide (D9230) or non-intravenous conscious sedation (D9248).
   b. when all associated procedures on the same date of service by the same provider are denied.

PROCEDURE D9242
INTRAVENOUS CONSCIOUS SEDATION/ANALGESIA – EACH ADDITIONAL 15 MINUTES

1. This procedure does not require prior authorization.
2. Written documentation for payment –shall justify the medical necessity based on a mental or physical limitation or contraindication to a local anesthetic agent.
3. An anesthesia record that indicates the anesthetic agent(s) and the anesthesia time shall be submitted for payment.
4. The quantity, in 15-minute increments, that was necessary to complete the treatment shall be indicated on the claim.
5. Not a benefit:
   a. on the same date of service as deep sedation/general anesthesia (D9220 and D9221), analgesia, anxiolysis, inhalation of nitrous oxide (D9230) or non-intravenous conscious sedation (D9248).
   b. when all associated procedures on the same date of service by the same provider are denied.

PROCEDURE D9248
NON-INTRAVENOUS CONSCIOUS SEDATION

1. This procedure does not require prior authorization.

2. Written documentation for payment for patients of all ages- shall indicate the specific anesthetic agent administered and the method of administration.
3. Written documentation for payment for patients age 13 or older- shall indicate the physical, behavioral, developmental or emotional condition that prohibits the patient from responding to the provider's attempts to perform treatment.
4. A benefit:
   a. for uncooperative patients under the age of 13, or
   b. for patients age 13 or older when documentation specifically identifies the physical, behavioral, developmental or emotional condition that prohibits the patient from responding to the provider's attempts to perform treatment.
   c. for oral, patch, intramuscular or subcutaneous routes of administration.
   d. once per date of service.
5. Not a benefit:
   a. on the same date of service as deep sedation/general anesthesia (D9220 and D9221), analgesia, anxiolysis, inhalation of nitrous oxide (D9230) or intravenous conscious sedation/analgesia (D9241 and D9242).
   b. when all associated procedures on the same date of service by the same provider are denied.

PROCEDURE D9310
CONSULTATION- DIAGNOSTIC SERVICE PROVIDED BY DENTIST OR PHYSICIAN OTHER THAN REQUESTING DENTIST OR PHYSICIAN

This procedure shall only be billed as diagnostic procedures D0120, D0140, D0150, or D0160.

PROCEDURE D9410
HOUSE/EXTENDED CARE FACILITY CALL

1. Written documentation for payment – shall include the name, phone number, and address of the facility. When requesting treatment for a patient who cannot leave their private residence due to a medical condition, the patient's physician shall submit a letter on their professional letterhead with the following information documented:
   a. the patient's specific medical condition, and
   b. the reason why the patient cannot leave their private residence, and
   c. the length of time the patient will be homebound.

2. A benefit:
   a. once per patient per date of service.
   b. only in conjunction with procedures that are payable.
3. When this procedure is submitted for payment without associated procedures, the medical necessity for the visit shall be documented and justified.

PROCEDURE D9420
HOSPITAL OR AMBULATORY SURGICAL CENTER CALL

1. The operative report for payment – shall include the total time in the operating room or ambulatory surgical center.
2. A benefit for each hour or fraction thereof as documented on the operative report.
3. Not a benefit:
   a. for an assistant surgeon.
   b. for time spent compiling the patient history, writing reports or for post-operative or follow up visits.

PROCEDURE D9430
OFFICE VISIT FOR OBSERVATION (DURING REGULARLY SCHEDULED HOURS) – NO OTHER SERVICES PERFORMED

1. This procedure cannot be prior authorized.
2. Written documentation for payment – shall include the tooth/area, the chief complaint and the non-clinical treatment taken.
3. A benefit once per date of service per provider.
4. Not a benefit:
   a. when procedures other than necessary radiographs and/or photographs are provided on the same date of service.
   b. for visits to patients residing in a house/extended care facility.

PROCEDURE D9440
OFFICE VISIT – AFTER REGULARLY SCHEDULED HOURS

1. This procedure cannot be prior authorized.
2. Written documentation for payment – shall include justification of the emergency (chief complaint) and be specific to an area or tooth. The time and day of the week shall also be documented.

3. A benefit:

   [BEGIN UNDERLINE]a. [END UNDERLINE] once per date of service per provider.

   [BEGIN UNDERLINE]b. only with treatment that is a benefit. [END UNDERLINE]

4. This procedure is to compensate providers for travel time back to the office for emergencies outside of regular office hours.

PROCEDURE D9450
CASE PRESENTATION, DETAILED AND EXTENSIVE TREATMENT PLANNING

This procedure is not a benefit.

PROCEDURE D9610
THERAPEUTIC PARENTERAL DRUG, SINGLE ADMINISTRATION

1. Written documentation for payment – shall include the specific drug name and classification.
2. A benefit for up to a maximum of four injections per date of service.
3. Not a benefit:
   a. for the administration of an analgesic or sedative when used in conjunction with deep sedation/general anesthesia (D9220 and D9221), analgesia, anxiolysis, inhalation of nitrous oxide (D9230), intravenous conscious sedation/analgesia (D9241 and D9242) or non-intravenous conscious sedation (D9248).
   b. when all associated procedures on the same date of service by the same provider are denied.

PROCEDURE D9612
THERAPEUTIC PARENTERAL DRUG, TWO OR MORE ADMINISTRATIONS, DIFFERENT MEDICATIONS

This procedure can only be billed as therapeutic parenteral drug, single administration (D9610).

PROCEDURE D9630
OTHER DRUGS AND/OR MEDICAMENTS, BY REPORT

This procedure is not a benefit.

PROCEDURE D9910
APPLICATION OF DESENSITIZING MEDICAMENT

1. This procedure cannot be prior authorized.
2. Written documentation for payment –shall include the tooth/teeth and the specific treatment performed.
3. A benefit:
   a. once in a 12-month period per provider.
   b. for permanent teeth only.
4. Not a benefit:
   a. when used as a base, liner or adhesive under a restoration.
   b. the same date of service as fluoride ([BEGIN STRIKEOUT]~~D1203, D1204 and~~[END STRIKEOUT]-D1206 [BEGIN UNDERLINE]and D1208[END UNDERLINE]).

PROCEDURE D9911
APPLICATION OF DESENSITIZING RESIN FOR CERVICAL AND/OR ROOT SURFACE, PER TOOTH

This procedure is not a benefit.

PROCEDURE D9920
BEHAVIOR MANAGEMENT, BY REPORT

This procedure is not a benefit.

PROCEDURE D9930
TREATMENT OF COMPLICATIONS (POST-SURGICAL) – UNUSUAL CIRCUMSTANCES, BY REPORT

1. This procedure cannot be prior authorized.
2. Written documentation for payment – shall include the tooth, condition and specific treatment performed.
3. Requires a tooth code.
4. A benefit:
   a. once per date of service per provider.

b. for the treatment of a dry socket or excessive bleeding within 30 days of the date of service of an extraction.

c. for the removal of bony fragments within 30 days of the date of service of an extraction.

5. Not a benefit:

a. for the removal of bony fragments on the same date of service as an extraction.

b. for routine post-operative visits.

PROCEDURE D9940
OCCLUSAL GUARD, BY REPORT

This procedure is not a benefit.

PROCEDURE D9941
FABRICATION OF ATHLETIC MOUTHGUARD

This procedure is not a benefit.

PROCEDURE D9942
REPAIR AND/OR RELINE OF OCCLUSAL GUARD

This procedure is not a benefit.

PROCEDURE D9950
OCCLUSION ANALYSIS – MOUNTED CASE

1. Prior authorization is required.
2. Written documentation for prior authorization – shall describe the specific symptoms with a detailed history and diagnosis.
3 A benefit:

a. once in a 12-month period.

b. for patients age 13 or older.

c. for diagnosed TMJ dysfunction only.

d. for permanent dentition.

4. Not a benefit for bruxism only.
5. The fee for this procedure includes face bow, interocclusal record tracings, diagnostic wax up and diagnostic casts.

PROCEDURE D9951
OCCLUSAL ADJUSTMENT - LIMITED

1. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
2. Requires a quadrant code.
3. A benefit:
   a. once in a 12-month period per quadrant per provider.
   b. for patients age 13 or older.
   c. for natural teeth only.
4. Not a benefit within 30 days following definitive restorative, endodontic, removable and fixed prosthodontic treatment in the same or opposing quadrant.

PROCEDURE D9952
OCCLUSAL ADJUSTMENT - COMPLETE

1. Prior authorization is required.
2. Written documentation for prior authorization – submit interocclusal record tracings that demonstrate the medical necessity to eliminate destructive occlusal forces.
3. A benefit:
   a. once in a 12-month period following occlusion analysis- mounted case (D9950).
   b. for patients age 13 or older.
   c. for diagnosed TMJ dysfunction only.
   d. for permanent dentition.
4. Not a benefit in conjunction with an occlusal orthotic device (D7880).
5. Occlusion analysis-mounted case (D9950) must precede this procedure.

PROCEDURE D9970
ENAMEL MICROABRASION

This procedure is not a benefit.

PROCEDURE D9971
ODONTOPLASTY 1 – 2 TEETH; INCLUDES REMOVAL OF ENAMEL PROJECTIONS

This procedure is not a benefit.

PROCEDURE D9972
EXTERNAL BLEACHING – PER ARCH[BEGIN UNDERLINE]**- PERFORMED IN OFFICE** [END UNDERLINE]

This procedure is not a benefit.

PROCEDURE D9973
EXTERNAL BLEACHING – PER TOOTH

This procedure is not a benefit.

PROCEDURE D9974
INTERNAL BLEACHING – PER TOOTH

This procedure is not a benefit.

[BEGIN UNDERLINE]**PROCEDURE D9975**
EXTERNAL BLEACHING FOR HOME APPLICATION, PER ARCH; INCLUDES MATERIALS AND FABRICATION OF CUSTOM TRAYS

This procedure is not a benefit. [END UNDERLINE]

PROCEDURE D9999
UNSPECIFIED ADJUNCTIVE PROCEDURE, BY REPORT

1. Prior authorization is required for non-emergency procedures.
2. Radiographs for prior authorization or payment – submit radiographs if applicable for the type of procedure.
3. Photographs for prior authorization or payment – submit photographs if applicable for the type of procedure.
4. Written documentation for prior authorization or payment – shall include a full description of the proposed or actual treatment and the medical necessity.
5. Procedure D9999 shall be used:
   a. for a procedure which is not adequately described by a CDT code, or
   b. for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the medical condition and the specific CDT code associated with the treatment.