										•
			Prior Auth							
Proc Code	Description Codes	Covered	required (Y/N)	Limitations	Tooth # required	Quadrant required	Surface required	Films required	Adult Non- emergency	Adult Emergency
							337-5518-64	15446	20100180-007	Time Genry
	Periodic Oral			Limited to 2 times per						
L	Examination,			service year. 1 time per year						
D0120	established patient	Covered	N	for adult emergency Relating to a dental	N	N	N	N	У	N
-		1		emergency, requires						
1				documentation of findings,						
				diagnosis and treatment						
				pain, may not be used while						
Į	152101			patient undergoing						
	Limited Oral Evaluation-problem			comprehensive care, may						
D0140	focused	Covered	N	not be used more than once per day	Y	Υ	Y	Y	Y	Y
			,,,	iper day	'			Т		7
	intraoral-complete			Limit one set per 3 service						
D0040	series (including			years, includes not less than						
D0210	bitewings)	Covered	N	14 images	N	N	N	N N	N	N
1	Intraoral-periapical,			1 per day, exclusive of						
D0220	First Film Image	Covered	N	D0210	N	N	N	N	Y	Y
D0230	Intraoral-periapical each additional film	Carrana	.,	Not to exceed 4 per day,			1			
00230	Intraoral-occlusal	Covered	N	exclusive of D0210	N	N	N	N	Y	Y
D0240	film	Covered	N	Not to exceed 1 per day	N	N	N	N	N	N
				Limited to two times per			1			, , , , , , , , , , , , , , , , , , ,
D0270	Bitewing-single film	Covered	N	service year, 1 per day	N	N	N	N	ΥΥ	N
D0272	Bitewing-two films	Covered	N	Limited to two times per						
502.72	Ditewing-two mins	Covered	N	service year Limited to two times per	N	N	N	N	Y	N
D0274	Bitewing-four films	Covered	N	service year. 1 per day	N	N	N	N	Y	N
	Posterior-anterior									
	or lateral skull and					I		ı	į	
D0290	facial bone survey film	Covered	N	1 per day	N	N	N	.,		1
D0310	Sialography	Covered	N N	1 per day	N	N	N	N N	N N	N N
										''
				Limited to one film every two	ı		İ			
1				service years, not used with				1	Į.	
D0330	Panoramic Film	Covered	N	D0210	N	N	N	N	N	Y
D0340	Cephalometric film	Covered	N	Requires medical review	N	N	N	N	N	N
				1 ()4						
				Limited to two times per service year. Limited to ages						
		1		15 through 20, adult		-		l		
D1110	Prophylaxis - adult	Covered		emergency, one per one year	N	N	N	N	Υ	N
				Limited to two times per						
				service year. Limited to birth					l	
D1120	Prophylaxis - child	Covered	N	through age 14	N	N	N	N	N	N
	Topical application		l,	limited to hun times				ĺ	-	-
	of fluoride	Ì		Limited to two times per service year. Limited to birth			1	į	İ	
	(prophylaxis not	-	- 5	through age 14, including the	ĺ	1	1	-		
D1203	included)-child	Covered		use of fluoride varnish	N	N	N	N	N	N
	Topical application				Ī					
	of fluoride			Limited to two times per						1
D1204	(prophylaxis not included)-adult	Countral	1	service year. Limited to ages	.	_, [.	, 1		
D 1504	menudeuj-addit	Covered	N	15 through 20	N	N I	N	N	N	N

Proc Code	Description Codes	Covered	Prior Auth required (Y/N)	Limitations	Tooth # required	Quadrant required	Surface required	Films required	Adult Non- emergency	Adult Emergency
				Covered for 1st and 2nd permanent molars. A tooth may be re-sealed once every five service years if necessary. Not covered on teeth previously restored D21XX. Not covered when performed on the same day as a D21XX on the same						
D1351	Sealant – per tooth	Covered	N	tooth.	Y	N	N	N	N	N
D1510	Space maintainer - fixed lateral	Covered	N	4 per 2 years	N	N	N	N	N	N
D1515	Space maintainer - fixed bilateral	Covered	N	4 per 2 years	N	N	N	N	N	N
D1550	Recementation of space maintainer	Covered	N	1/year	N	N	N	N	N	N
D2140	Amalgam – 1 surface, Primary or permanent		N	Coding per restoration is on a per tooth basis. Separate, multiple restorations per tooth are not covered. 1 per tooth, per year	Y	N	Y	N.	Y	N.
D2150	Amalgam – 2 surfaces, primary, permanent	Covered	N	Coding per restoration is on a per tooth basis. Separate, multiple restorations per tooth are not covered. 1 per tooth, per year	Y	N	Y	N	Y	N
D2160	Amalgam – 3 surfaces, primary, permanent	Covered	N	Coding per restoration is on a per tooth basis. Separate, multiple restorations per tooth are not covered. 1 per tooth, per year	Y	N	Y	N	Y	N
D2161	Amalgam - 4 or more surfaces, primary, permanent	Covered		Coding per restoration is on a per tooth basis. Separate, multiple restorations per tooth are not covered. 1 per tooth, per year	Y	N	Y	N	Y	N
D2330	Resin-based composite-one surface, anterior	Covered	N	Coding per restoration is on a per tooth basis. Separate, multiple restorations per tooth are not covered. 1 per tooth, per year. 6 thru 11, 22- 27, C thru H, M thru R	Y	N	Y	N	¥	N
D2331	Resin-based composite-two surfaces, anterior	Covered		Coding per restoration is on a per tooth basis. Separate, multiple restorations per tooth are not covered. 1 per tooth, per year. 6 thru 11, 22-27, C thru H, M thru R	Y	N	Y	N	Y	N
D2332	Resin-based composite-three surfaces, anterior Resin-based	Covered		Coding per restoration is on a per tooth basis. Separate, multiple restorations per tooth are not covered. 6 thru 11, 22-27, C thru H, M thru R	Y	N	· ·	N	Y	N
D2335	composite-four or more surfaces or involving incisal angle, anterior	Covered		1 per tooth, per year 6 thru 11, 22-27, C thru H, M thru R	Y	N	Y	N	Y	N
	Crown-porcelain fused to noble metal	Covered		Limited to cases involving endodontic treatment or loss of at least one major cusp. One per five years.	Y	N	N	N	N	N

	1									
			Prior Auth						100000	
Proc Code	Description Codes	Covered	required (Y/N)	Limitations	Tooth# required	Quadrant required	Surface required	Films required	Adult Non- emergency	Adult Emergency
	Crown-full cast			Limited to cases involving endodontic treatment or loss						
D2792	noble metal	Covered	Y	of at least one major cusp.	γ	N	N	N	N	N
	Recement Inlay, onlay or partial									
D2910	coverage restoration	Covered	N	1 to oth/dy	Y	N .	N	N	, Li	N
02510	restoration	Covered	111	1 tooth/dy		N	N .	PN .	N	N
D2920	Recement Crown	Covered	N	1 tooth/dy	Y	N	N	N	N	N
	Prefabricated stainless steel									
	crown-primary									
D2930	tooth Stainless Steel	Covered	N	1 tooth/dy, teeth a thru t	Y	N	N	N	N	N
	Crown/ Prefabricated			-						
	stainless steel									
D2931	crown-permanent tooth	Covered	N	1 tooth/dy,	Y	N	N	N	Y	N
				Limited to cases involving						
	Prefabricated resin			endodontic treatment or loss of at least one major cusp. 1						
D2932	crown Core buildup -	Covered	Y	tooth/dy	Y	N	N	N	N	N
D2950	including any pins	Covered	N	1tooth/d	Y	N	N	N	N	N
D2951	Pin retention-per tooth, in addition	Covered	N	1tooth/d	Y	N	N	N	N	N
	Post and core in									
	addition to crown,	_								
D2952	indirectly fabricated Prefabricated post	Covered	N	1tooth/d	Y	N	N	N N	N	2
D2954	and core in addition to crown	Covered	N	1tooth/d	Υ	N	N	N	N	N
				Limited to cases involving endodontic treatment or loss	······································			.,		
	Temporary Crown			of at least one major cusp. 1						
D2970	(fractured tooth) Unspecified	Covered FQHC Use	Y	tooth/dy	Y	N	N	N	N	N
	restorative procedure, by	Only								
D2999	report									
	Therapeutic pulpotomy									
D3220	(excluding final restoration)	Covered	N	1 tooth/dy per lifetime	Υ	N	N	N	N	N
				Limited to permanent teeth.						
				Submit post-procedure x-ray						
D3310	Anterior (excluding final restoration)	Covered	N	with claim. Limited to one per tooth per lifetime.	Υ	N	N	Υ	N	N
				Limited to permanent teeth.	1					
	Bicuspid (excluding			Submit post-procedure x-ray with claim. Limited to one						
D3320	final restoration)	Covered	N	per tooth per lifetime.	Y	N	N	Y	N	N
				Limited to permanent teeth.						
	Molar (excluding		Y - 1, 16,	Submit post-procedure x-ray with claim. Limited to one						
	final restoration)	Covered	17, 32	per tooth per lifetime. Limited to permanent teeth.	Y	N	N	Y	N	N
				Submit pre- and post-						
	Apexification/recalc			procedure x-ray with claim. Limited to one per tooth per				İ		
	ification-initial visit	Covered	N	lifetime.	Υ	N	N	Υ	N	N

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Proc			Prior Auth required		Tooth#	Quadrant	Surface	Films	Adult Non-	Adult
Code	Description Codes	Covered	(Y/N)	Limitations	required	required	required	required	emergency	Emergency
	Apexification/recald			Limited to permanent teeth.						
	ification-interim	1		Submit pre- and post- procedure x-ray with claim,						1
	medication			Limited to one per tooth per						
D3352	preplacement	Covered	N	lifetime.	Y	N	N	Υ	N	N
				Limited to permanent teeth.						
				Submit pre- and post- procedure x-ray with claim.						
	Apexification/recald			Limited to one per tooth per						
D3353	ification-final visit	Covered	N	lifetime.	Y	N	N	Y	N	N
ŀ				21 or older, 1/d, require						
	Complete denture-			documentation of missing teeth, charting or x-rays, 1						
D5110	maxillary	Covered	Y	per 5 years	Y	N	N	N	Y	Ni Ni
			Ì	Under 21. 1/d require	<u>'</u>		,,,	14	1	IV.
Ì	_			documentation of missing						
DE140	Complete denture-			teeth, charting or x-rays, 1						
D5110	maxillary	Covered	Y	per 5 years 21 or older. 1/d require	Y	N	N	N	Y	N
		Ì		documentation of missing						
	Complete denture-			teeth, charting or x-rays, 1						
D5120	mandibular	Covered	Y	per 5 years	Υ	N	N	N	Y	N
				Under 21. 1/d require						
	Complete denture-			documentation of missing teeth, charting or x-rays, 1				İ		
D5120	mandibular	Covered	Υ	per 5 years	Y	N	N	N	γ	N
				21 or older. 1/d require						
				documentation of missing				I		
D5130	Immediate denture- maxillary			teeth, charting or x-rays, 1						
03130	тпахшагу	Covered	Y	per 5 years Under 21. 1/d require	Y	N N	N	N N	Y	N
				documentation of missing				Į		
	Immediate denture-			teeth, charting or x-rays, 1						
D5130	maxillary	Covered	Y	per 5 years	Υ	N	N	N	Υ	N
				21 or older. 1/d require		İ	l			
	Immediate denture-			documentation of missing teeth, charting or x-rays, 1						
D5140	mandibular	Covered	Y	per 5 years	Y	N	N	N	Υ	N
				Under 21. 1/d require						, , , , , , , , , , , , , , , , , , ,
				documentation of missing]	- 1		
D5140	Immediate denture- mandibular	Covered		teeth, charting or x-rays, 1 per 5 years	Y	N			, l	
		Govered		21 or older, 1/d require	1		N	N	Y	N
				documentation of missing		İ		-		I
20011	Maxillary partial			teeth, charting or x-rays, 1				I		İ
D5211	denture-resin base	Covered		per 5 years Under 21, 1/d require	Y	N	N	N	Y	N
İ				documentation of missing	1	-			-	-
	Maxillary partial			teeth, charting or x-rays, 1	- 1			İ		ŀ
D5211	denture-resin base	Covered	Y	per 5 years	Υ	N	N	N	Υ	N
				21 or older. 1/d require						
	Mandibular partial	Ì		documentation of missing teeth, charting or x-rays, 1		1	1		·	- 1
D5212	denture-resin base	Covered		per 5 years	Y	N	N	N	Y	N
				Under 21. 1/d require						
			ŀ	documentation of missing		l		1		j
D5040	Mandibular partial			teeth, charting or x-rays, 1		İ				
D5212	denture-resin base	Covered	Y	per 5 years	Y	N	N	N	Y	N
	Mavillani nestini			na an aldan atd		ł		-	Ì	
	Maxillary partial denture-cast metal			21 or older. 1/d require documentation of missing			ļ	İ		
	framework with	-		eeth, charting or x-rays, 1	l	ļ	I		-	
D5213	resin denture bases	Covered	3	per 5 years	Y	N	N	N	Υ	N
	Maxillary partial		1	Jnder 21. 1/d require]		- 1
	denture-cast metal framework with			documentation of missing			-			I
	resin denture bases	Covered		eeth, charting or x-rays, 1 per 5 years	Y	N	N	N	Υ	N
				: - /~- -~				- ' -		IA

Proc Code	Description Codes	Covered	Prior Auth required (Y/N)	Limitations	Tooth#	Quadrant required	Surface required	Films required	Adult Non- emergency	Adult Emergency
D5214	Mandibular partial denture-cast metal framwork with resin denture bases		Y	21 or older. 1/d require documentation of missing teeth, charting or x-rays, 1 per 5 years	Y	N	N	N	Y	N
D5214	Mandibular partial denture-cast metal framwork with resin denture bases	Covered	Y	Under 21. 1/d require documentation of missing teeth, charting or x-rays, 1 per 5 years	Y	N	N	N	Y	N
D5410	Adjust complete denture - maxillary	Covered	N	1/d	N	N	N	N	N	N
D5411	Adjust complete denture - mandibular	Covered	N	1/d	N	N	N	N	N	N
D5421	Adjust partial denture - maxillary Adjust partial	Covered	N	1/d	N	N.	N	N	N	N
D5422	denture - mandibular Repair broken	Covered	N	1/d	N	N	N	N	N	N
D5510	complete denture base Replace missing or broken teeth-	Covered	N	1/d	N	N	N	N	N N	N
D5520	complete denture (each tooth) Repair resin	Covered	N	1/d	N	N	N	N	N	N
D5610	denture base Repair cast	Covered	N	1/d	N	N	N	N	N	N.
D5620	framework Repair or replace	Covered	N	1/d	N	N	N	N	N	N
D5630 D5640	broken clasp Replace broken	Covered	N	1/d	N	N I	N 	N	N	N
D5650	teeth-per tooth Add tooth to existing partial denture	Covered Covered	N N	1/d none	N N	N N	N N	N N	N N	N N
D5660	Add clasp to existing partial denture Rebase complete	Covered	N	none	N	N	N	N	N	N
D5710	maxillary denture	Covered	N	1/d	N	N	N	N	N	N
D5711	Rebase complete mandibular denture Rebase maxillary	Covered	N	1/d	N	N	N	N	N	N
D5720	partial denture	Covered	N	1/d	N	N	N	N	N	N N
D5721	Rebase mandibular partial denture Reline complete	Covered	Y for	1/d	N	N	N	N	N	N.
D5750	maxillary denture (laboratory)	Covered		1/d	N	N	N	N	Y	N
D5751	Reline complete mandibular denture (laboratory) Reline maxillary	Covered	Y for adults only Y for	1/d	N	N	N	N	Y	N
	partial denture (laboratory) Reline mandibular	Covered	aduits	1/d	N	N	N	N	Y	N
D5761	parital denture (laboratory) Obturator	Covered	adults	1/d	N	N	N	N	Y	N
	prosthesis, modification	Covered	Y w/report	Submit report with claim.	N	N	N	N	N	N

			Prior Auth							
Proc Code	Description Codes	Covered	required (Y/N)	Limitations	Tooth#	Quadrant required	Surface required	Films required	Adult Non- emergency	Adult Emergency
	Mandibular					,,,,,,,,,,		regumen	ennergency	Citiciganica
	resection prosthesis with				-					
D5934	guide flange	Covered	Y w/repor	Submit report with claim.	N	N	N	N	N	N
	Mandibular									
	resection prosthesis without									
D5935	guide flange	Covered	Y w/repor	Submit report with claim.	N	N	N	N	N	N
	Obturator									
D5936	prosthesis, interim Trismus appliance	Covered	Y w/report	Submit report with claim.	N	N	N	N	N	N
DE027	(not for TMD									
D5937	treatment)	Covered	Y w/report	Submit report with claim.	N	N	N	N	N	N
D5951	Feeding aid Speech aid	Covered	Y w/report	Submit report with claim.	N	N	N	N	N	N
Droco	prosthesis,									
D5952	pediatric Speech aid	Covered	Y w/report	Submit report with claim.	N	N	N	N	N	N
D5953	prosthesis, adult Palatal	Covered	Y w/report	Submit report with claim.	N	N	N	N	N	N
	augmentation									
D5954	prosthesis Palatal lift	Covered	Y w/report	Submit report with claim.	N	N	N	N	N	N
D5955	prosthesis, definitive	Covered	V w/sonord	Cubmit ranget with alalm		٠,	.,		.,	
00000		Covered	T Witepoil	Submit report with claim.	N	N	N	N	N	N
D5958	Palatal lift prosthesis, interim	Covered	Y wireport	Submit report with claim.	N	N	N	N	N	N
	Palatal lift									,,,
D5959	prosthesis, modification	Covered	Y w/report	Submit report with claim.	N	N	N	N	N	N
	Speech aid prosthesis,									
D5960	modification	Covered	Y w/report	Submit report with claim.	N	N	N	N	N	N
D5982	Surgical stent	Covered	Y w/report	Submit report with claim.	N	N	N	N	N	N
D5983	Radiation carrier	Covered	V w/report	Submit report with claim.	N	N	N	N	N	N .
D5984	Radiation shield Radiation cone	Covered	Y W/report	Submit report with claim.	N	N	N	N	N	N N
D5985	locator	Covered	Y w/report	Submit report with claim.	N	N	N	N	N	N
D5986	Fluoride gel carrier	Covered	Y w/report	Submit report with claim.	N.	N	N	N	N	N
D5987	Commissure splint	Covered	Y w/report	Submit report with claim.	N	N	N	N	N	N
D5988	Surgical splint	Covered	Y w/report	Submit report with claim.	N	N	N	N	N	N
	Unspecified	OOVIICA	· wieport	COMMETCE OF WILL CRAIM.		14	IX		14	14
	maxillofacial prosthesis, by							i i		
	report Extraction, erupted	Covered	Y w/report	Submit report with claim.	N_	N	N	N	N	N
	tooth or exposed					į				
	root	Covered	N	1 /lifetime	Y	N	N	N	N	Y
1 1	Surgical removal of erupted tooth						ļ			
	requiring elevation									
	of mucoperiosteal flap and removal of		Y - 1, 16,							
D7210	bone	Covered		1 /lifetime	Y	N	N	Υ	N	Υ
: I	Removal of impacted tooth-soft			If 3rd Molar, requires prior						
D7220	tissue	Covered		authorization, 1 tooth/life	<u> </u>	N	N	Y	N	Y

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Proc			Prior Auth		Tooth#	Quadrant	Surface	Films	Adult Non-	Adult
Code	Description Codes	Covered	(Y/N)	Umitations If 3rd Molar, requires prior	required	required	required	required	emergency	Emergency
	Removal of			authorization/Prior Auth						
	impacted tooth-			(tooth numbers 1, 16, 17, 32),						
D7230	partially bony Removal of	Covered	Υ	1 tooth/life	Υ	N N	N	Υ	N	Υ
	impacted tooth-			If 3rd Molar, requires prior						
	completely bony			authorization/Prior Auth						
ŀ	with unusual surgical			required for 3rd molars (tooth numbers 1, 16, 17, 32),						
D7240	complications	Covered	Υ	1 tooth/life	Y	N	N	Υ	N	Υ
	Surgical removal of			Prior Auth required for 3rd						
D7241	impacted tooth- completely bony	Covered	Y	molars (tooth numbers 1, 16, 17, 32), 1 tooth/life	Y	N	N	Υ	N	Y
2.2						3N	111	T	IN .	1
	Surgical removal of residual tooth roots			Applicable to fistulas. Not applicable to latrogenic						
D7250	(cutting procedure)	Covered	N	sinus exposure.	N	Y	N	N	N	Y
	A			Requires pathologic OA						
D7260	Oroanthral fistula closure	Covered	N	fistula. Not applicable to liatrogenic defects.	N	N	N	N	N	Y
	Tooth					.,	- ',	19	74	
	reimplantation and/or stablization									ļ
ļ	of accidentally									- I
	evulsed or									
D7270	displaced tooth and/or alveolus	Covered	N	1 tooth / lifetime	Y	N	N	N	N	Y
	Surgical exposure of impacted or					- 1			ĺ	
	unerupted tooth for									
	orthodontic reasons (including						İ			
1	orthodontic									
D7280	attachments)	Covered	Y		Y	N	N	N	N	N
	Placement of device to facilitate			Limted to cases approved for						
	eruption of			orthodontic coverage, 2 thru						
D7283	impacted tooth. Biopsy of oral	Covered	Y	15, 18 thru 31	Y	N	N	N	N	N
	tissue-hard (bone,					[Ì
D7285	tooth)	Covered	N	By report	Y	N	N	N	N	Υ
				Requires the submission of a copy of the pathology report.				l	1	
				Not applicable to the routine		ĺ	-			1
	Biopsy of oral			removal of the peri-radicular inflammatory tissues, by						
D7286	tissue-soft	Covered	N	report	Y	N	N	N	N	Υ
	Alveoloplasty in conjunction with									
	extractions-four or			4/d when claimed together	l				ļ	
	more teeth or tooth			with D7210 or greater, then				***************************************		
D7310	spaces, per quadrant	Covered	N	considered included as a component of the procedure.	N	Y	N	N	N	γ
	Alveloloplasty in			and the product of the					,,	
	conjuntion with extractions- four or	1		4/d when claimed together	-		1	1	l	
	more teeth or tooth			with D7210 or greater, then	Ī	1				
D7311	spaces, per quadrant.	Covered		considered included as a	.,			.		
0,317	Alveoloplasty not in	Covered		component of the procedure. 4/d when claimed together	N	<u> </u>	N	N	N	Y
	conjunction with	Ī	ľ	with D7210 or greater, then	l				İ	
D7320	extractions-per quadrant	Covered		considered included as a	N.	Υ	A.		.	, I
	Alveoloplasty not in	Covered	- 1	component of the procedure.	N	1	N	N	N	<u> </u>
	conjunction with		ļ	414		ĺ				
	extractions-one to three teeth or tooth			4/d when claimed together with D7210 or greater, then					I	
	spaces, per			considered included as a	j	1				
D7321	quadrant	Covered	N I	component of the procedure.	N	<u> </u>	N	N	N	Υ

			Prior Auth	Early Guideline by the Court						100
Proc			required		Tooth#	Quadrant		Films	Adult Non-	Adult
Code	Radical excision-	Covered	(YAN)	Limitations	required	required	required	required	emergency	Emergency
D7410	lesion diameter up to 1.25 cm		N				١.,			
D/**10	Incision and	Covered	I N		N	N	N	N	N	Y
	drainage of			Requires separate surgical						
D7510	abscess-intraoral soft tissue	Covered	N	procedure involving tissue incision and drain placement	Y	N	N	N	N	Y
	Incision and									
	drainage of									
	abscess-intraoral soft tissue-									
	complicated									
	(includes drainage of multiple fascial									
D7511	spaces)	Covered	N		N	N	N	N	N	Y
	Incision and						·			
İ	drainage of			Covered under medical						
D7520	abscess-extraoral soft tissue	Covered	N	benefit (QUEST plan or Medicaid)	Y	N	N	N	N	Y
	Frenulectomy						- 31			
	(frenectomy or frenotomy)									
57000	separate			W						
D7960	procedures Excision of	Covered	N	once per lifetime	N	N	N	N	N	N
D7070	hyperplastic tissue- per arch		.,		٠,					
D7970	Excision of	Covered	N		N	N	N	N	N	Y
D7971	pericornal gingiva	Covered	N		N	N	N	N	N	Υ
				Limited to repair of cleft lip						
				and palate or other severe					İ	
	Limited orthodontic			craniofacial defects or injury for which the function of						
D8010	treatment of the primary dentition	Covered	Y	speech, swallowing, or chewing shall be restored.	N	N	N	N	N	
20010	printery continuer	Oovered			- 14	IV	IN	N	N	N
			: :	Limited to repair of cleft lip and palate or other severe						
	Limited orthodontic			craniofacial defects or injury						
	treatment of the transitional			for which the function of speech, swallowing, or						
D8020	dentition	Covered	Y	chewing shall be restored.	N.	N	N	N	N	N
				Limited to repair of cleft lip		-	- 1			
	Limited orthodontic			and palate or other severe craniofacial defects or injury						
	treatment of the			for which the function of				Ì		İ
D8030	adolescent dentition	Covered	Y	speech, swallowing, or	N.	.	, I		١,	L3
20000	MINOH	Ouvered		chewing shall be restored.	N	N	N N	N I	N	N N
				Limited to repair of cleft lip and palate or other severe				-		į
	1.1		1	craniofacial defects or injury	İ			Î	l	
	Limited orthodontic treatment of the		1	for which the function of speech, swallowing, or	İ		***************************************		ĺ	
D8040	adult dentition	Covered		chewing shall be restored.	<u> N</u>	N	N	N	N	N N
				Limited to repair of cleft lip						
	Interceptive			and palate or other severe craniofacial defects or injury						
	orthodontic			for which the function of		l			ļ	
	treatment of the primary dentition	Covered		speech, swallowing, or	.	N	N	,		
20020	primary dentition [Coveted		chewing shall be restored.	N j	N	N	N	N	N

Proc			Prior Auth required		Tooth#	Quadrant	Surface	Films	Adult Non-	Adult
Code D8060	Interceptive orthodontic treatment of the transitional dentition	Covered	(YJN)	Limitations Limited to repair of cleft lip and palate or other severe craniofacial defects or injury for which the function of speech, swallowing, or chewing shall be restored.	required N	required	required	required	emergency	Emergency N
D8070	Comprehensive orthodontic treatment of the transitional dentition	Covered	Y	Limited to repair of cleft lip and palate or other severe craniofacial defects or injury for which the function of speech, swallowing, or chewing shall be restored.	N	N	N	N	N	N
D8080	Comprehensive orthodontic treatment of the adolescent dentition	Covered	¥	Limited to repair of cleft lip and palate or other severe craniofacial defects or injury for which the function of speech, swallowing, or chewing shall be restored.	N	N	N	N	N	N
D8090	Comprehensive orthodontic treatment of the adult dentition	Covered	Y	Limited to repair of cleft lip and palate or other severe craniofacial defects or injury for which the function of speech, swallowing, or chewing shall be restored.	N	N	N	8	N	N
D8210	Removable appliance therapy	Covered		Limited to repair of cleft lip and palate or other severe craniofacial defects or injury for which the function of speech, swallowing, or chewing shall be restored.	N	N	N	N	N	N
D8220	Fixed appliance therapy	Covered		Limited to repair of cleft lip and palate or other severe craniofacial defects or injury for which the function of speech, swallowing, or chewing shall be restored.	N	N	N	N	N	N .
D8660	Pre-orthodontic treatment visit	Covered		Limited to repair of cleft lip and palate or other severe craniofacial defects or injury for which the function of speech, swallowing, or chewing shall be restored.	· N	N	N	N	N	N
D8670	Periodic orthodontic treatment visit	Covered		Limited to repair of cleft lip and palate or other severe craniofacial defects or injury for which the function of speech, swallowing, or chewing shall be restored.	N	N	N	N	N	N
	Orthodontic retention (removal of appliances, construction and placement of retainers)	Covered		Limited to repair of cleft lip and palate or other severe craniofacial defects or injury for which the function of speech, swallowing, or chewing shall be restored.	N	N	N	N	N	N
	Orthodontic treatment (alternative billing to a contract fee)	Covered	i f	imited to repair of cleft lip and palate or other severe craniofacial defects or injury for which the function of speech, swallowing, or chewing shall be restored.	N	N	N	N	N	N

			Prior Auth							
Proc Code	Description Codes	Covered	required (Y/N)	Limitations	Tooth # required	Quadrant required	Surface required	Films required	Adult Non- emergency	Adult Emergency
				Limited to repair of cleft lip						
				and palate or other severe craniofacial defects or injury						
	Repair of orthodontic			for which the function of						
D8691	appliance	Covered	Y	speech, swallowing, or chewing shall be restored.	N	N	N	N	N	N
				Limited to repair of cleft lip						
				and palate or other severe craniofacial defects or injury						
				for which the function of						
D8692	Replacement of lost or broken retainer	Covered	Y	speech, swallowing, or chewing shall be restored.	N	N	N	N	N	N
	Rebonding or recementing:									
D8693	and/or repair, as required, of fixed	Cd			.,					
00093	required, or fixed	Covered	У		N	N	N	N	N	N
				Limited to repair of cleft lip						
	Unspecified			and palate or other severe craniofacial defects or injury						
	orthodontic procedures, by			for which the function of speech, swallowing, or						
D8999	report	Covered	Y	chewing shall be restored.	N	N	N	N	N	N
				Billable only once per visit						
	Palliative Treatment/Palliative			regardless of the number of teeth treated, not covered if						
	(emergency) treatment of dental			performed within 90 days						
	pain-minor			prior to completion date of D33XX. Requires a surgical						
D9110	procedure	Covered	N	intervention. Limited to under 13 y only	Y	N	N	N	N	Υ
				and in conjunction with a						
	Analgesia,			treatment service, requires training through a formal		ĺ				
	Anxiolysis, inhalation of			post-graduate (accredited clinical specialty, residency					:	
D9230	nitrous oxide	Covered		and fellowship programs).	N	N	N	N	N	N
	Intravenous sedation/analegesia							ĺ		
D9241	first 30 minutes Intravenous	Covered	N N		N	N	N	N	N	Y
	sedation/analegesia									
D9242	each additional 15 minutes	Covered	N		N	N	N	N	N	Y
	Consultation-			Dental specialist billing the						
	diagnostic service provided by dentist			consultation code may not provide treatment for which						
	or physician other than requesting	,	1	the consultation is obtained. Limited to formally trained						
	dentist or physician	Covered	N I	dental specialists. 1/ day	N	N	N	N	N	
D9420	Hospital Call	Covered	N	1/ d	N	N	N	N	N	Y
		***************************************		only billable in conjunction						
			<u> </u>	with an emergency service.						
			,	This code can only be used when the dentist is returning						
	Office visit after			to the office for an un- scheduled, emergency visit						İ
ı	regularly scheduled hours	Covered	į.	after the office has been	.			. 1		
U\$44U	HOUIS	Covered	N c	closed for the day.	N	N	N	N L	N	Y