

# VIP Dental Provider Supplement

AmeriHealth Caritas VIP Care — a Medicare Advantage dual-eligible special needs plan (D-SNP) — offers its members an allowance for preventive and comprehensive dental services. AmeriHealth Caritas VIP Care covers these members' traditional Medicare medical benefits, and Delaware Medicaid covers eligible Medicaid benefits.

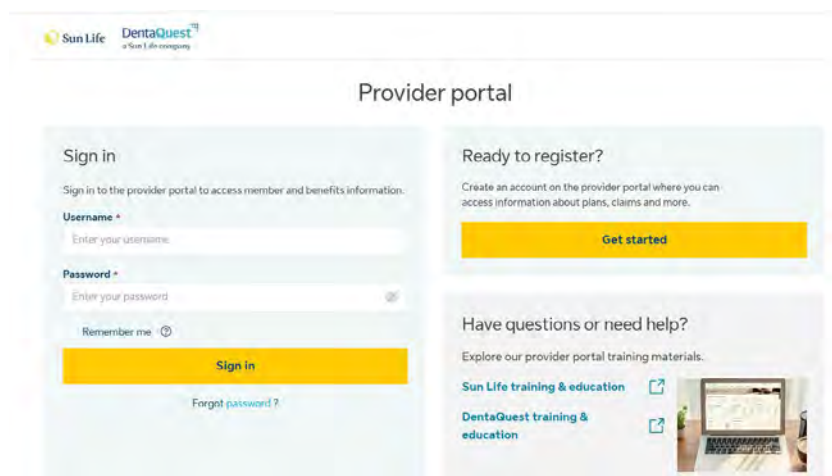
This dental provider reference guide provides an overview of the benefits available to members of AmeriHealth Caritas VIP Care.

## Member eligibility

Providers must verify member eligibility at the time of service and determine if members have other health insurance.

We provide eligibility information to participating providers through the following options:

- Access available 24/7:
  - DentaQuest's Interactive Voice Response (IVR) system by calling 1-855-343-7401
  - The Provider Portal at <https://www.dentaquest.com/en/providers/delaware>. With this option, the provider may also submit claims, authorization requests, and access other features.
- If you are unable to verify member eligibility via the DentaQuest provider portal or the IVR system, please contact AmeriHealth Caritas VIP Care at 1-833-433-2177.





## Claim filing guidelines

Each provider must complete and submit a standard American Dental Association (ADA) form or file an electronic claim each time a AmeriHealth Caritas VIP Care member receives dental services from them. Completing the 2024 ADA form or electronic claim is important because:

- It provides a mechanism for reimbursement of dental services.
- It allows AmeriHealth Caritas VIP Care to gather statistical information regarding the dental services provided to members, which better supports our statutory reporting requirements.
- It allows AmeriHealth Caritas VIP Care to identify the severity of our members' illnesses.

AmeriHealth Caritas VIP Care dental providers will submit claims to:

### **AmeriHealth Caritas VIP Care**

**c/o DentaQuest - Claims**

**P.O. Box 2906**

**Milwaukee, WI 53201-2906**

AmeriHealth Caritas VIP Care encourages all providers to submit claims electronically through the dental portal at [www.dentaquest.com/en/providers/delaware](http://www.dentaquest.com/en/providers/delaware).

## Payer ID = CX014

We encourage all providers to submit claims within 30 days of the visit. However, original invoices must be submitted to AmeriHealth Caritas VIP Care within **365 calendar days** from the date services were rendered or date when compensable items were provided.

Corrected previously denied claims and requests for adjustments must be submitted within **180 calendar days** from the date the initial claim was rejected.

## More information about AmeriHealth Caritas VIP Care

AmeriHealth Caritas VIP Care is a member of the AmeriHealth Caritas Family of Companies, a leader in managing medically complex members. By offering AmeriHealth Caritas VIP Care, a Medicare Advantage D-SNP, AmeriHealth Caritas is building and growing its vision and mission to provide health care services to the underserved.

AmeriHealth Caritas VIP Care's coordinated care approach, leading technology solutions, and innovative community outreach programs enable its members with debilitating conditions to lead more comfortable lives. Working with dedicated health care providers, AmeriHealth Caritas VIP Care offers programs that achieve better outcomes for its members

For more information on AmeriHealth Caritas VIP Care, please visit [www.amerhealthcaritasvipcare.com](http://www.amerhealthcaritasvipcare.com).



## Covered benefits

AmeriHealth Caritas VIP Care recognizes the importance of good dental health. Members are eligible to receive the following benefits.



**Preventive Services** – Members have unlimited coverage every year. Preventive Services include the following services with zero dollar copay:

- Oral evaluations
- Cleanings
- Fluoride treatments
- Dental x-rays

**Comprehensive Services** – The comprehensive dental benefits include the following services up to a \$3,600 combined limit per calendar year:

- Minor restorations (fillings)
- Simple extractions

- Dentures, limited to one per arch every five years. Must provide documentation that the previous denture cannot be made serviceable (narrative, photo(s), records)
- Denture repair and relines
- Surgical extractions
- Limited oral surgery
- Periodontics
- Endodontics
- Crowns
- Mini-implants (lower arch only)—limited to one per every five years
- Implant supported denture (lower arch only) — limited to, one per every five years. Must provide documentation that the previous denture cannot be made serviceable (narrative, photo(s), records)

 <b>AmeriHealth Caritas</b> VIP Care	<b>AmeriHealth Caritas VIP Care</b> (HMO-SNP)
Member Name <b>&lt;Member Name&gt;</b>	PCP <b>&lt;PCP Name&gt;</b>
Member ID# <b>&lt;123456789&gt;</b>	PCP Phone <b>&lt;PCP Number&gt;</b>
Health Plan <b>(80840) 7427051066</b>	Prescription Drug Info: RX BIN <b>019587</b> RX PCN <b>PRX01815</b>
<b>MEMBER CANNOT BE CHARGED</b> Cost sharing/copays: \$0 for doctor visits and hospital stays	 Prescription Drug Coverage
<a href="#">H0738_001</a>	



## Specific procedure codes covered by AmeriHealth Caritas VIP Care under the supplemental benefit

Prior authorization is required for all crowns, dentures, endodontics, oral surgery, periodontics, mini-implants, and implant supported dentures. Codes indicated with shading require prior authorization. Authorization requests can be submitted via:

- DentaQuest provider portal at [www.dentaquest.com/en/providers/delaware](http://www.dentaquest.com/en/providers/delaware)
- Electronic submission via clearinghouse.
- Paper (2024 ADA claim form):

Mail to:

AmeriHealth Caritas VIP Care  
c/o DentaQuest - Authorizations  
P.O. Box 2906  
Milwaukee, WI 53201-2906

Fax: 1-262-834-3589

Prior authorization decisions are made within **14 calendar days** for standard requests and 72 hours for expedited requests from the date AmeriHealth Caritas VIP Care receives the request, provided all information is complete.

Prior authorizations will be honored for **180 calendar days** from the date they are determined.

### Dental Services Requiring Prior Authorization

Code	Description
D2710	Crown - resin
D2721	Crown - resin cast base metal
D2740	Crown - porcelain/ceramic
D2751	Crown - porcelain fused to metal
D2752	Crown - porcelain fused to noble metal
D2791	Crown - full cast base metal
D2952	Cast post and core in addition to crown
D2954	Prefabricated post and core in addition to crown
D3310	Endodontic therapy, anterior (excluding final restoration)
D3320	Endodontic therapy, premolar (excluding final restoration)
D3330	Endodontic therapy, molar (excluding final restoration)
D4210	Gingivectomy or gingivoplasty – 4 or more contiguous teeth/quad
D4341	Perio scaling & root planing - 4 or more teeth/quad
D4342	Perio scaling and root planing 1-3 teeth/quad
D5110	Complete denture - maxillary
D5120	Complete denture - mandibular
D5130	Immediate denture - maxillary



Code	Description
D5140	Immediate denture - mandibular
D5211	Maxillary partial denture – resin base
D5212	Mandibular partial denture – resin base
D5213	Maxillary partial denture - cast metal framework
D5214	Mandibular partial denture – cast metal framework
D6013	Surgical placement of mini implant
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular
D7250	Surgical removal of residual roots
D7320	Alveoloplasty without extractions
D7962	Lingual frenectomy
D7970	Excision of hyperplastic tissue

## AmeriHealth Caritas VIP Care Clinical Criteria For Authorization Of Routine And Emergency Treatment

A number of procedures require prior authorization before initiating treatment. When prior authorizing these procedures, please note the documentation requirements when sending in the information to the Plan. The criteria used by dental reviewers for determinations of authorizations requests are listed below. Treatment may be provided if a procedure needs to be initiated under an emergency condition to relieve a patient's pain and suffering. However, to receive reimbursement for the treatment, the Plan will require the same documentation be provided (with the Claim for payment) and the same criteria to be met in order to receive payment for the treatment.

### **Crowns (D2710, D2721, D2740, D2751, D2752, D2791)**

Required documentation – Periapical radiograph showing the root and crown of the natural tooth. Non-abutment teeth: Current periapical x-rays of the tooth/teeth to be crowned. Abutment teeth: Current periapical x-rays of the tooth/teeth and panoramic or full mouth are needed for evaluation.

All criteria below must be met:

- Tooth to be crowned must have an opposing tooth in occlusion or be an abutment tooth for a partial denture
- Minimum 50% bone support
- The patient must be free of active / advanced periodontal disease
- No subosseous and / or furcation carious involvement
- No periodontal furcation lesion or a furcation involvement
- Clinically acceptable RCT if present and all the criteria below must be met:
  - The tooth is filled within two millimeters of the radiographic apex
  - The root canal is not filled beyond the radiographic apex
  - The root canal filling is adequately condensed and/or filled
  - Healthy periapical tissue (healing PARL or no PARL)
- And one of the criteria below must be met:
  - Anterior teeth must have pathological destruction to the tooth by caries or trauma, and involve four (4) or more surfaces and at least 50% of the incisal edge



- Premolar teeth must have pathological destruction to the tooth by caries or trauma, and must involve three (3) or more surfaces and at least one (1) cusp
- Molar teeth must have pathological destruction to the tooth by caries or trauma, and must involve four (4) or more surfaces and two (2) or more cusps

### Posts and cores (D2952, D2954)

Required documentation – Periapical radiograph showing the root and crown of the natural tooth.

All criteria below must be met:

- Minimum 50% bone support
- The patient must be free of active / advanced periodontal disease
- No subosseous and / or furcation carious involvement
- No periodontal furcation lesion or a furcation involvement
- Clinically acceptable RCT if present and all the criteria below must be met:
  - The tooth is filled within two millimeters of the radiographic apex
  - The root canal is not filled beyond the radiographic apex
  - The root canal filling is adequately condensed and/or filled
  - Healthy periapical tissue (healing PARL or no PARL)

### Root canal therapy (D3310, D3320, D3330)

Required documentation – Pre-operative periapical radiograph showing the crown and entire root of the tooth.

All criteria below must be met:

- Minimum 50% bone support
- The patient must be free of active / advanced periodontal disease
- No subosseous and / or furcation carious involvement

- No periodontal furcation lesion and / or a furcation involvement
- Closed apex
- Tooth must be crucial to arch/occlusion
- And 1 of the criteria below must be met if absence of decay or large restoration on the radiograph:
  - Evidence of apical pathology/fistula
  - Narrative describing symptoms of irreversible pulpitis

### Gingivectomy or Gingivoplasty (D4210)

Required documentation – pre-operative radiographs, periodontal charting, narrative of medical necessity, photo (optional)

1 of the criteria below must be met:

- Hyperplasia or hypertrophy from drug therapy, hormonal disturbances or congenital defects
- Generalized 5 mm or more pocketing indicated on the periodontal charting

### Periodontal scaling and root planing (D4341 and D4342)

Required documentation – periodontal charting and current diagnostic radiographs of the quadrant(s) to be treated.

All criteria below must be met:

- 5 mm or more pocketing on two or more teeth indicated on the involved teeth
- Presence of root surface calculus and/or noticeable loss of bone support on x-rays

### Complete dentures (D5110, D5120)

Required documentation – Complete series of radiograph images (D0210) or panoramic radiographic image (D0330)

Criteria below must be met:

- Remaining teeth do not have adequate bone support or are not restorable. If a current denture exists that was not reimbursed by the Plan, it must be non-serviceable for reasons other than tooth loss.



**Immediate dentures (D5130, D5140)**

Required documentation – Complete series of radiograph images (D0210) or panoramic radiographic image (D0330)

Criteria below must be met:

- Remaining teeth do not have adequate bone support or are not restorable

**Removable partial dentures (D5211, D5212, D5213, D5214)**

Required documentation – Complete series of radiograph images (D0210) or panoramic radiographic image (D0330)

All criteria below must be met:

- Remaining teeth have greater than 50% bone support and are restorable. If a current denture exists that was not reimbursed by the plan, it must be non-serviceable for reasons other than tooth loss.

In addition 1 of the criteria below must be met

- Replacing one or more anterior teeth
- Replacing three or more posterior teeth (excluding 3rd molars)

**Surgical Placement of Mini-Implant (D6013)**

All criteria below must be met:

- History of mandibular complete removable denture (D5120) or approved treatment plan for mandibular complete removable denture
- History of inability to retain mandibular complete removable denture or radiographic evidence of ridge resorption to the extent that retention of mandibular complete removable denture is not possible

**Implant/Abutment Supported removable denture for Edentulous Arch- Mandibular (D6111)**

Existing denture greater than 5 years old and not serviceable per narrative

All criteria below must be met:

- Presence of mandibular implants or approval of mandibular implants
- Implants must have favorable long-term prognosis

**Surgical removal of residual tooth roots (D7250)**

Documentation required – Pre-operative radiographs (excluding bitewings) and narrative of medical necessity  
All criteria below must be met:

- Tooth root is completely covered by bony tissue on x-ray
- Documentation describes pain, swelling, etc. around tooth (must be symptomatic)

**Alveoloplasty without extractions (D7320)**

Documentation required – Pre-operative radiographs (excluding bitewings) and narrative of medical necessity

Criteria below must be met:

- Documentation supports medical necessity for fabrication of a prosthesis

**Lingual Frenectomy (D7962)**

Documentation required – Narrative of medical necessity, x-rays or photos

Criteria below must be met:

- Documentation describes tongue tied, diastema or tissue pull condition

**Excision of hyperplastic tissue (D7970)**

Documentation required – Pre-operative radiographs, narrative of medical necessity, photos

Criteria below must be met:

- Documentation describes medical necessity due to ill-fitting denture



## Dental Benefit Grid

### Procedure Codes and Eligibility Criteria

Note: Services not listed below are not benefits of this plan

Code	Code Description	Authorization Requirements				Benefit Details					
		Auth Reqd	Age Min	Age Max	Req Docs	Reporting Requirements	Age Min	Age Max	Max Count	Period Length	Period Type
D0120	Periodic oral Evaluation-established patient	No				N	0	999	1	180	Days Per patient
D0140	Limited oral evaluation-problem focused	No				N	0	999	1	1	Days Per patient
D0150	Comprehensive oral evaluation- new or established patient	No				N	0	999	1	1	Lifetime Per patient per dentist/dental group
D0180	Comprehensive periodontal evaluation – new or established patient	no				n	0	999	1	180	days per patient
D0210	Intraoral – comprehensive series of radiographic images	No				N	0	999	1	5	Year per patient
D0220	Intraoral- periapical first radiographic image	No				N	0	999	1	1	Day per patient
D0230	Intraoral – periapical each additional radiographic image	No				N	0	999	10	1	Day per patient
D0240	Intraoral -occlusal radiohgraphic image	No				N	0	999	2	1	Day per patient
D0270	Bitewing - single radiographic image	No				N	0	999	1	1	Day per patient
D0272	Bitewings -two radiographic images	No				N	0	999	1	1	Day per patient
D0274	Bitewings – four radiographic images	No				N	0	999	1	1	Day per patient
D0330	Panoramic radiographic image	No				N	0	999	1	5	Year per patient
D0340	2-D cephalometric radiographic image – acquisition, measurement and analysis	No				N	0	999	1	1	Day per patient





Code	Code Description	Authorization Requirements				Benefit Details					
		Auth Reqd	Age Min	Age Max	Req Docs	Reporting Requirements	Age Min	Age Max	Max Count	Period Length	Period Type
D1110	Prophylaxis -adult	No				N	0	999	1	180	DAYS (per patient . Additional requires Benefit Limit Exception for individuals 21 years of age and older unless they reside in a NF or ICF
D1206	Topical application of Fluoride varnish	No				N	0	999	6	1	Year per patient- 1 per tooth every 3 years regardless of crown procedure code
D1208	Topical application of Fluoride – excluding varnish	No				N	0	999	1	180	Days per patient
D2140	Amalgam - one Surface primary or permanent	No				T	0	999	1	1	Day per patient
D2150	Amalgam – two surface primary or permanent	No				T	0	999	1	1	Day per patient
D2160	Amalgam – three surface primary or permanent	No				T	0	999	1	1	Day per patient
D2161	Amalgam – four surface primary or permanent	No				T	0	999	1	1	Day per patient
D2330	Resin-based composite - 1 surface, Anterior	No				T	0	999	1	1	Day per patient
D2331	Resin- based composite -2 surface, anterior	No				T	0	999	1	1	Day per patient
D2332	Resin- based composite 3	No				T	0	999	1	1	Day per patient
D2335	Resin- based composite 4+ surfaces or involving incisal angle (anterior)	No				T	0	999	1	1	Day per patient
D2390	Resin-based composite crown -anterior	No				T	0	999	1	1	Day per patient
D2391	Resin - based Composite - 1 surface, posterior	No				T	0	999	1	1	Day per patient



Code	Code Description	Authorization Requirements				Benefit Details					
		Auth Reqd	Age Min	Age Max	Req Docs	Reporting Requirements	Age Min	Age Max	Max Count	Period Length	Period Type
D2392	Resin - based Composite - 2 surface, posterior	No				T	0	999	1	1	Day per patient
D2393	Resin - based Composite - 3 surface. posterior	No				T	0	999	1	1	Day per patient
D2394	Resin - based composite-4+ surface, posterior	No				T	0	999	1	1	Day per patient
D2710	Crown - resin - based composite (indirect)	Yes	0	999	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity	T	0	999	1	3	Year per patient-1 per tooth every 3 years regardless of crown procedure code
D2721	Crown-resin with predominantly base metal	Yes	0	999	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity	T	0	999	1	5	Year per patient-1 per tooth every 5 years regardless of crown procedure code
D2740	Crown-porcelain/ceramic	Yes	0	999	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity	T	0	999	1	5	Year per patient-1 per tooth every 5 years regardless of crown procedure code
D2751	Crown-porcelain fused to predominantly base metal	Yes	0	999	Pre-operative x-rays (excluding bitewings), Narrative of medical necessity	T	0	999	1	5	Year per patient-1 per tooth every 5 years regardless of crown procedure code
D2752	Crown-porcelain fused to noble metal	Yes	0	999	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity	T	0	999	1	5	Year per patient-1 per tooth every 5 years regardless of crown procedure code
D2791	Crown - full cast predominantly base metal	Yes	0	999	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity	T	0	999	1	5	Year per patient-1 per tooth every 5 years regardless of crown procedure code
D2920	Re-cement or re-bond crown	No	0	999		N	0	999	1	1	day per patient



Code	Code Description	Authorization Requirements				Benefit Details					
		Auth Reqd	Age Min	Age Max	Req Docs	Reporting Requirements	Age Min	Age Max	Max Count	Period Length	Period Type
D2952	Post and core in addition to crown, indirectly fabricated	Yes	0	999	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity	T	0	999	1	1	Per day/per Tooth/per patient
D2954	Prefabricated post and core in addition to crown	Yes	0	999	Pre-operative x-rays of adjacent teeth and opposing teeth. Narrative of medical necessity\	T	0	999	1	1	Per day/per Tooth/per patient
D3310	Endodontic therapy, Anterior tooth (excluding final restoration)	Yes	0	999	Pre-operative x-rays (excluding bitewings), Narrative of medical necessity	T	0	999	1	1	Lifetime per tooth per patient
D3320	Endodontic therapy, Premolar tooth (excluding final restoration)	Yes	0	999	Pre-operative x-rays (excluding bitewings). Narrative of medical necessity	T	0	999	1	1	Lifetime per tooth per patient
D3330	Endodontic therapy, molar tooth (excluding final restoration))	Yes	0	999	Pre-operative x-rays (excluding bitewings), narrative of medical necessity	T	0	999	1	1	Lifetime per tooth per patient
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	Yes	0	999	Pre-op x-rays and periodontal charting. Narrative of medical necessity, Photo (optional)	Q	0	999	4 (different quadrants)	24	Months Per patient
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	Yes	0	999	Periodontal charting and pre-op x-rays. Narrative of medical necessity	Q	0	999	2 different quadrants	1	Day Per patient
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	Yes	0	999	Periodontal charting and pre-op x-rays. Narrative of medical necessity	Q	0	999	4 different quadrants	24	Months Per patient
D4342	Periodontal scaling and root planing one to three teeth per quadrant	Yes	0	999	Periodontal charting and pre-op x-rays. Narrative of medical necessity	Q	0	999	4 (different quadrants)	1	Day per patient
D4342	Periodontal scaling and root planing one to three teeth per quadrant	Yes	0	999	Periodontal charting and pre-op x-rays. Narrative o medical necessity	Q	0	999	4 (different quadrants)	24	Months per patient



Code	Code Description	Authorization Requirements				Benefit Details					
		Auth Reqd	Age Min	Age Max	Req Docs	Reporting Requirements	Age Min	Age Max	Max Count	Period Length	Period Type
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	No				N	0	999	1	1	Year per patient No history of prophylaxis or periodontal treatment in past 12 months.
D4910	Periodontal maintenance	No				N	0	999	1	90	days per patient with past history of therapeutic periodontal treatment or periodontal maintenance
D5110	Complete denture - maxillary	Yes	0	999	Full mouth or panorex x-rays. Narrative of medical necessity,	N	0	999	1	5	Years per arch per patient limited to one (full or partial denture) per arch, regardless of procedure (D5110, D5130, D5211, D5213) and one (full or partial denture) per lower arch, regardless of procedure code (D5120, D5140, D5212, D5214,) every 5 years
D5120	Complete denture - mandibular	Yes	0	999	Full mouth or panorex x-rays. Narrative of medical necessity,	N	0	999	1	5	Years per arch per patient limited to one (full or partial denture) per arch, regardless of procedure (D5110, D5130, D5211, D5213) and one (full or partial denture) per lower arch, regardless of procedure code (D5120, D5140, D5212, D5214, D6111) every 5 years



Code	Code Description	Authorization Requirements				Benefit Details					
		Auth Reqd	Age Min	Age Max	Req Docs	Reporting Requirements	Age Min	Age Max	Max Count	Period Length	Period Type
D5130	Immediate denture -maxillary	Yes	0	999	Full mouth or panorex x-rays. Narrative of medical necessity,	N	0	999	1	1	Lifetime appliance per arch per patient limited to one (full or partial denture) per arch, regardless of procedure (D5110, D5130, D5211, D5213) and one (full or partial denture) per lower arch, regardless of procedure code (D5120, D5140, D5212, D5214)
D5140	Immediate denture -mandibular	Yes	0	999	Full mouth or panorex x-rays. Narrative of medical necessity,	N	0	999	1	1	Lifetime appliance per arch per patient limited to one (full or partial denture) per arch, regardless of procedure (D5110, D5130, D5211, D5213) and one (full or partial denture) per lower arch, regardless of procedure code (D5120, D5140, D5212, D5214, D6111)
D5211	Maxillary partial denture – resin base (including retentive/ clasp materials, rests, and teeth)	Yes	6	999	Full mouth or panorex x-rays. Narrative of medical necessity,	N	6	999	1	5	Years per arch per patient limited to one (full or partial denture) per arch, regardless of procedure (D5110, D5130, D5211, D5213) and one (full or partial denture) per lower arch, regardless of procedure code (D5120, D5140, D5212, D5214) every 5 years



Code	Code Description	Authorization Requirements				Benefit Details					
		Auth Reqd	Age Min	Age Max	Req Docs	Reporting Requirements	Age Min	Age Max	Max Count	Period Length	Period Type
D5212	Mandibular partial denture – resin base (including retentive/ clasping materials, rests, and teeth)	Yes	6	999	Full mouth or panorex x-rays. Narrative of medical necessity	N	6	999	1	5	Years per arch per patient limited to one (full or partial denture) per arch, regardless of procedure (D5110, D5130, D5211, D5213) and one (full or partial denture) per lower arch, regardless of procedure code (D5120, D5140, D5212, D5214, D6111) every 5 years
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including retentive/ clasping materials, rests and teeth)	Yes	6	999	Full mouth or panorex x-rays. Narrative of medical necessity,	N	6	999	1	5	Years per arch per patient limited to one (full or partial denture) per arch, regardless of procedure (D5110, D5130, D5211, D5213) and one (full or partial denture) per lower arch, regardless of procedure code (D5120, D5140, D5212, D5214) every 5 years
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including retentive/ clasping materials, rests and teeth)	Yes	6	999	Full mouth or panorex x-rays. Narrative of medical necessity,	N	6	999	1	5	Years per arch per patient limited to one (full or partial denture) per arch, regardless of procedure (D5110, D5130, D5211, D5213) and one (full or partial denture) per lower arch, regardless of procedure code (D5120, D5140, D5212, D5214, D6111) every 5 years



Code	Code Description	Authorization Requirements				Benefit Details					
		Auth Reqd	Age Min	Age Max	Req Docs	Reporting Requirements	Age Min	Age Max	Max Count	Period Length	Period Type
D5410	Adjust complete denture – maxillary	No				N	0	999	1	1	Day per patient Adjustments are included in the fee for the denture; through 180 days post insertion.
D5411	Adjust complete denture – mandibular	No				N	0	999	1	1	Day per patient Adjustments are included in the fee for the denture; through 180 days post insertion.
D5421	Adjust partial denture – maxillary	No				N	0	999	1	1	Day per patient Adjustments are included in the fee for the denture; through 180 days post insertion.
D5422	Adjust partial denture – maxillary	No				N	0	999	1	1	Day per patient Adjustments are included in the fee for the denture; through 180 days post insertion.
D5511	Repair complete broken denture base mandibular	No				N	6	999	1	1	Day per patient
D5512	Repair complete broken denture base maxillary	No				N	6	999	1	1	Day per patient
D5520	Replace missing or broken teeth – complete denture (each tooth)	No				T	0	999	3	1	Day per patient
D5611	Repair resin partial denture base mandibular	No				N	0	999	1	1	Day per patient
D5612	Repair resin partial denture base maxillary	No				N	0	999	1	1	Day per patient
D5621	Repair cast partial framework - mandibular	No				N	0	999	1	1	Day per patient





Code	Code Description	Authorization Requirements				Benefit Details					
		Auth Reqd	Age Min	Age Max	Req Docs	Reporting Requirements	Age Min	Age Max	Max Count	Period Length	Period Type
D5622	Repair cast partial framework - maxillary	No				N	0	999	1	1	Day per patient
D5630	Repair or replace broken retentive/ clasping materials - per tooth	No				T	0	999	1 clasp per tooth	1	Day per patient
D5630	Repair or replace broken retentive/ clasping materials - per tooth	No				T	0	999	4 clasps	1	Year per patient
D5640	Replace broken teeth- per tooth	No				T	0	999	3 teeth	1	Day per patient
D5650	Add tooth to existing partial denture	No				T	0	999	2 teeth	1	Day per patient
D5660	Add clasp to existing partial denture per tooth	No				T	0	999	1 PER TOOTH	1	Lifetime per patient
D5730	Reline complete maxillary denture (direct)	No				N	0	999	1	2	Year relines are included in the fee for the denture through 180 days post placement/day (relines are included in the fee for the denture. Beginning 180 days post insertion. Same dentist/group dentist/group
D5731	Reline complete mandibular denture (direct)	No				N	0	999	1(per arch)	2	Year relines are included in the fee for the denture through 180 days post placement
D5740	Reline maxillary partial denture (direct)	NO				N	0	999	1(per arch)	2	Year relines are included in the fee for the denture through 180 days post placement
D5741	Reline mandibular partial denture (direct)	No				N	0	999	1(per arch)	2	Year relines are included in the fee for the denture through 180 days post placement



Code	Code Description	Authorization Requirements				Benefit Details					
		Auth Reqd	Age Min	Age Max	Req Docs	Reporting Requirements	Age Min	Age Max	Max Count	Period Length	Period Type
D5750	Reline complete maxillary denture (indirect)	No				N	0	999	1(per arch)	2	Year relines are included in the fee for the denture through 180 days post placement
D5751	Reline complete mandibular denture (indirect)	No				N	0	999	1(per arch)	2	Year relines are included in the fee for the denture through 180 days post placement
D5760	Reline maxillary partial denture (indirect)	No				N	0	999	1(per arch)	2	Year relines are included in the fee for the denture through 180 days post placement
D5761	Reline mandibular partial denture (indirect)	No				N	0	999	1(per arch)	2	Year relines are included in the fee for the denture through 180 days post placement
D6013	Surgical placement of mini implant	Yes	0	999		N	0	999	1	1	Lifetime per patient (not per tooth)
D6111	Implant supported removable denture for edentulous arch -mandibular	Yes	0	999	Full mouth or panorex x-rays. Narrative of medical necessity,	N	0	999	1	5	Years per arch per patient limited to one (full or partial denture) per arch, regardless of procedure (d5110, d5130, d5211, d5213) and one (full or partial denture) per lower arch, regardless of procedure code (d5120, d5140, d5212, d5214, d6111) every 5 years
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No			Full mouth or panorex x-rays. Narrative of medical necessity,	T	0	999	1 per tooth	1	Lifetime per patient



Code	Code Description	Authorization Requirements				Benefit Details					
		Auth Req'd	Age Min	Age Max	Req Docs	Reporting Requirements	Age Min	Age Max	Max Count	Period Length	Period Type
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	No				T	0	999	1 per tooth	1	Lifetime per patient
D7250	Removal of residual tooth roots (cutting procedure)	Yes	0	999	Pre-operative x-rays (excluding bitewings) and narrative of medical necessity	T	0	999	1 per tooth	1	Lifetime per patient
D7310	Alveoplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	No				Q	0	999	1 per quadrant	1	Day per patient
D7320	Alveoplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	Yes	0	999	Pre-operative x-rays (excluding bitewings) and narrative of medical necessity	Q	0	999	1 per quadrant	1	Day per patient
D7471	Removal of lateral exostosis – maxilla or mandible-	No				N	0	999	2	1	Day per patient
D7472	Removal of torus palatinus	No				N	0	999	2	1	Day per patient
D7473	Removal of torus mandibularis	No				N	0	999	2	1	Day per patient
D7485	Reduction of osseous tuberosity	No				N	0	999	2	1	Day per patient
D7961	Buccal/ labial frenectomy (frenulectomy)	No	0	999	Narrative of medical necessity, xrays or photos optional	N	0	999	2	1	Lifetime per patient
D7962	Lingual Frenectomy (frenulectomy)	Yes	0	999	Narrative of medical necessity, xrays or photos optional	N	0	999	1	1	Lifetime per patient
D7970	Excision of hyperplastic tissue - per arch	Yes	0	999	Pre-operative x-rays, narrative of medical necessity, photos optional	N	0	999	1 per arch	1	Day per patient

N = no reporting requirements

T = tooth reporting requirement

Q = quadrant reporting requirement

Services not appearing in the benefit grid are not benefits of the plan.

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