2015

Provider Manual

Molina Healthcare of Wisconsin

Published Date: January 2015

Scion Dental, Inc.
W92 W14612 Anthony Avenue
Menomonee Falls WI 53051
www.sciondental.com

Contents

Quick Reference Guide

Provider Web Portal

Everything You Need • When You Need It • 24/7/365

Our user friendly Provider Web Portal features a full complement of resources.

Access the Provider Web Portal by clicking this link:

www.sciondental.com

Contacts

For information about...	Contact...
Provider Web Portal	www.sciondental.com
Customer Service	855-326-5059 providerservices@sciondental.com
Web Portal Team	855-434-9239
Molina Member Services	888-999-2404
Credentialing	855-812-9211 https://credentialingportal.sciondental.com
Fraud & Abuse Hotline	877-378-5292
Authorization Address	Molina Healthcare of Wisconsin Authorizations PO Box 2154 Milwaukee WI 53201
Claim Address	Molina Healthcare of Wisconsin Claims PO Box 2136 Milwaukee WI 53201
Enrollment & Contracting Portal	www.sciondental.com (code WI)

Summary

Quick Reference Guide	
Member Eligibility	Providers may verify member eligibility through one of the following: • Log on to Provider Web Portal: **www.sciondental.com** • Call Interactive Voice Response (IVR) eligibility hotline: 855-326-5059 • Call Customer Service: 855-326-5059
Authorization Submission	Submit authorizations in one of the following formats: • Provider Web Portal: **www.sciondental.com** • Electronic submission via clearinghouse, **Payer ID** SCION • HIPAA-compliant 837D file • Paper authorization via current ADA Dental Claim Form, sent via postal mail: Molina Healthcare of Wisconsin Authorizations PO Box 2154 Milwaukee WI 53201
Claims Submission	The timely filing requirement is 90 calendar days. Submit claims in one of the following formats: • Provider Web Portal: **www.sciondental.com** • Electronic submission via clearinghouse, **Payer ID** SCION • HIPAA-compliant 837D file • Paper claim via current ADA Dental Claim Form, sent via postal mail: Molina Healthcare of Wisconsin Claims PO Box 2136 Milwaukee WI 53201
Complaints and Grievances	To make a complaint or grievance: • Call: Molina Healthcare of Wisconsin 888-999-2404 • Write to: Molina Healthcare of Wisconsin Complaints and Appeals PO Box 649 Milwaukee WI 53201 • Email: mwiappeals@molinahealthcare.com

Quick Reference Guide	
Provider Appeals - Authorizations	Authorization Appeals must be filed within 60 days following the date the denial letter was mailed. Scion Dental issues a decision within 45 days if. To request reconsideration of a denied authorization, a provider may: • Call: 855-326-5059 • Write to: Molina Healthcare of Wisconsin Complaints and Appeals PO Box 649 Milwaukee WI 53201
Provider Appeals - Claims	Claim Appeals must be filed within 60 days following the date the denial letter was mailed. Scion Dental issues a decision within 45 days. To request a reconsideration of a claims denial, a provider may: • Call: 855-326-5059 • Write to: Molina Healthcare of Wisconsin Complaints and Appeals PO Box 649 Milwaukee WI 53201
Member Appeals	• Submit written appeals to: Molina Healthcare of Wisconsin Appeals & Grievances Department 2400 South 102nd Street West Allis WI 53227 • Email: mwiappeals@molinahealthcare.com
Molina Network Acute Care Facilities	For an up-to-date list of Molina Healthcare of Wisconsin facilities, call Main Member Services: 888-999-2404
Additional Provider Resources	For information about additional provider resources: • Call Customer Service: 855-326-5059 • Call Web Portal Team: 855-434-9239 • Access the Provider Web Portal: **www.sciondental.com** • Send email to: **providerservices@sciondental.com**

Welcome

Welcome to the Molina Healthcare of Wisconsin provider network! At Molina Healthcare of Wisconsin, we are committed to providing our members the best possible care, keeping them healthy, stable, and independent – it's our reason for being here. We are pleased to welcome you to our team.

We have partnered with Scion Dental, Inc., a nationwide leader in managed benefits administration, to administer the dental benefit for our members in the BadgerCare Plus and SSI Medicaid Programs.

Throughout your ongoing relationship with Molina Healthcare of Wisconsin and Scion Dental, refer to this provider manual for quick answers and useful information, including how to contact us, how to submit claims and authorizations, and what benefits are offered to members.

When you need help, log on to www.sciondental.com for quick answers, send an email message to **providerservices@sciondental.com**, or call Customer Service at 855-326-5059.

Molina Healthcare of Wisconsin and Scion Dental, Inc retain the right to add to, delete from, and otherwise modify this provider manual. Contracted providers must acknowledge this provider manual and any other written materials provided by Molina Healthcare of Wisconsin/Scion Dental as proprietary and confidential.

This manual describes Scion Dental policies and procedures that govern our administration of dental benefits for Molina Healthcare of Wisconsin programs. Scion Dental makes every effort to maintain accurate information in this manual, however we will not be held liable for any damages due to unintentional errors. If you discover an error, please report it to Customer Service: 855-326-5059 (providerservices@sciondental.com). If information in this manual differs from your Participating Agreement, the Participating Agreement takes precedence and shall control.

Member Rights & Responsibilities

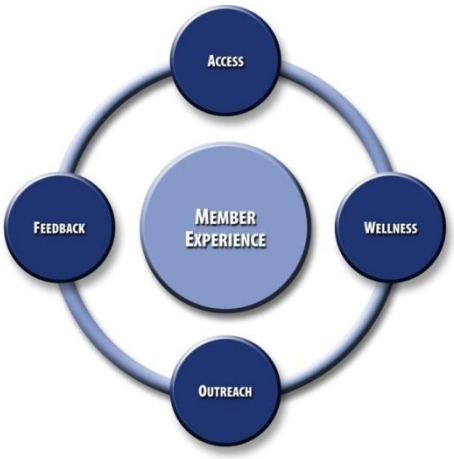
Molina of Healthcare of Wisconsin is committed to the following core concepts to member care:

Access to providers and services.

Wellness programs, which include member education and disease management initiatives.

Outreach programs to educate members and give them the tools they need to make informed decisions about their dental care.

Feedback measuring provider and member satisfaction.



Members have the right to:

- Privacy, respectful treatment and recognition of their dignity when receiving dental care.
- Fully participate with caregivers in decision-making process surrounding their health care.
- Be fully informed about the appropriate or medically necessary treatment options for any condition, regardless of the coverage or cost for the care discussed.
- Voice a grievance against Molina Healthcare of Wisconsin, or any of its participating dental offices, or any of the care provided by these groups or people, when their performance has not met the member's expectations.
- Appeal any decisions related to patient care and treatment.
- Make recommendations regarding Molina Healthcare of Wisconsin member rights and responsibilities policies.
- Receive relevant written and up-to-date information about Molina Healthcare of Wisconsin, the services we provide, the participating dentists and dental offices; as well as member rights and responsibilities.

Members are responsible for:

- Providing their dental care providers, to the best of their knowledge, accurate and complete information about current complaints, past illnesses, hospitalizations, medications, and other matters related to their health.
- Reporting unexpected changes in their health to their dental care providers.
- Reporting to their dental care providers whether they comprehend a contemplated course of action and understand what is expected of them.
- Following the treatment plan recommended by their dental care providers.
- Keeping appointments and, when unable to do so for any reason, for notifying the dental care provider or dental care facility.

Provider Rights & Responsibilities

Scion Dental has established the following core concepts in our approach to a positive provider experience:

Access to flexible participation options in provider networks.

Outreach programs that lower provider participation costs.

Technology tools that increase efficiency and lower administrative costs.

Feedback that measures provider and member satisfaction.

Provider Rights

Enrolled participating providers have the right to:

- Communicate with patients, including members, regarding dental treatment options.
- Recommend a course of treatment to a member, even if the course of treatment is not a covered benefit or approved by Molina Healthcare of Wisconsin/Scion Dental.
- File an appeal or grievance pursuant to the procedures of Molina Healthcare of Wisconsin/Scion Dental.
- Supply accurate, relevant, and factual information to a member in conjunction with an appeal, complaint, or grievance filed by the member.
- Object to policies, procedures, or decisions made by Molina Healthcare of Wisconsin/Scion Dental.
- Be informed of the status of their credentialing or re-credentialing application, upon request.

Provider Responsibilities

Participating providers have the following responsibilities:

- If a recommended treatment plan is not covered (not approved by Molina Healthcare of Wisconsin/Scion Dental), the participating dentist, if intending to charge the member for the non-covered services, must notify and obtain agreement from the member in advance. (See **Payment for Non-covered Services** on **page 21**.)
- A provider wishing to terminate participation with the Molina Healthcare of Wisconsin Network must follow the termination guidelines stipulated in the Molina Healthcare of Wisconsin provider contract.
- A provider may not bill both medical codes and dental codes for the same procedure.

Provider Bill of Rights

- To be treated with respect
- To be paid accurately
- To be paid on time

Provider Experience

Committed dentists are critical to the success of every government-sponsored dental program. At Molina Healthcare of Wisconsin/Scion Dental, we have structured our provider networks to give dentists the flexibility they need to participate in dental programs on their own terms.

We consider ourselves allies of dental associations while maintaining flexibility within the changing political climate surrounding government-sponsored dental programs. We recognize the significant link between good dental care and overall patient health, and advocate increasing provider funding while improving member education and outreach. We partner with providers to deliver high-quality care to all members of government-sponsored dental programs.

Access to Flexible Participation Options

Molina Healthcare of Wisconsin/Scion Dental invites all licensed dentists, regardless of their past commitment to government-sponsored dental programs, to participate in its provider network. Providers can choose their own level of participation for each of their practice locations. Providers can choose to:

- Be listed in a directory and accept appointments for all new patients.
- Be excluded from directories and accept appointments for only new patients directed to their office from Molina Healthcare of Wisconsin/Scion Dental.
- Treat only emergencies or special needs cases on an individual basis.
- Access web-based applications and credentialing.

To make it easy to apply and be accepted into the program, we use our web portals and electronic documents to streamline the provider/clinic contracting and credentialing process.

Consistent, Transparent Authorization Determination Logic

Trained paraprofessionals and dental consultants use clinical algorithms to ensure a consistent approach for determining authorizations submitted to Scion Dental. These algorithms are available from the Scion Dental Provider Web Portal so providers can follow the decision matrix and understand the logic behind authorization decisions. These requirements are also outlined in **Clinical Criteria**, beginning on **page 36**. It is our goal to foster a sense of partnership by encouraging providers to offer feedback about the algorithms. A consistent, well-understood approach to authorization determinations promotes clarity and transparency for providers, which in

turn reduces provider administrative costs.

Outreach Programs

Lowering costs and ensuring a positive experience are the focus points for Scion Dental Provider Outreach Programs. Visit **www.sciondental.com** for Outreach Programs available in your area.

Provider Web Portal

Our Provider Web Portal gives providers quick access to easy-to-use self-service tools for managing daily benefits administration tasks. The Provider Web Portal offers providers many benefits including:

- Lower administrative and participation costs.
- Faster payment through streamlined claim and authorization submission processes.
- Immediate information about member eligibility.
- Ability to review member information, claim and authorization history, and payment records at any time, 24 hours a day, 7 days a week.

A web browser, Internet connection, and a valid user ID and password are required for online access. From the Provider Web Portal, providers and authorized office staff can log in for secure access anytime from anywhere and handle a variety of day-to-day tasks, including:

- Verify member eligibility and review patient treatment history.
- Set up office appointment schedules that automatically verify eligibility and pre-populate claim forms for online submission.
- Submit claims and authorizations using pre-populated electronic forms and data entry shortcuts.
- Step through clinical guidelines as part of submitting authorizations for a quick indication of whether a service request is likely to be approved.
- Attach and securely send supporting documents, such as digital X-rays, EOBs, and treatment plans, for no extra charge.
- Generate a quick pricing estimate before submitting a claim.
- Check the status of in-process claims and authorizations and review historical payment records.
- Review provider clinical profiling data relative to your peers.
- Download and print provider manuals, Remittance Reports, and more.

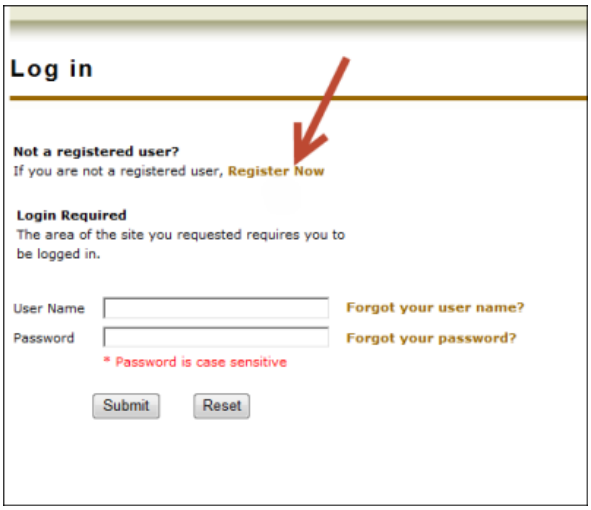
Online help and how-to videos are available from every page of the Provider Web Portal, offering quick answers and step-by-step instructions.

Get Started! For help getting started with the Provider Web Portal, contact the Web Portal Team: 855-434-9239.

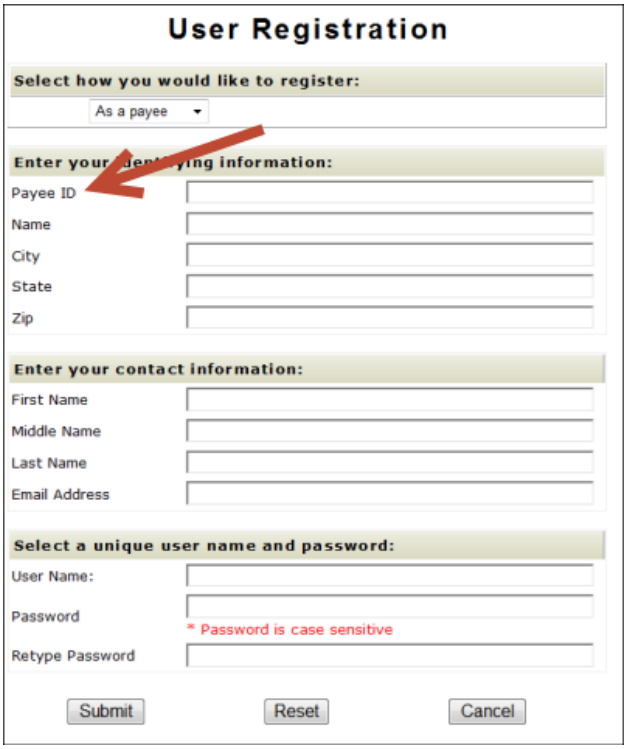
Provider Web Portal Registration

The Provider Web Portal allows us to meet our commitment of helping you keep office costs low, access information efficiently, submit claims and authorizations electronically, and get paid faster.

To register for our Provider Web Portal, visit www.sciondental.com and click the provider login link. On the login page, click **Register Now**.



Register as a **Payee** so you will have the option to view remittances and be paid electronically. Call the Web Portal Team at 855-434-9239 to obtain your Payee ID.



As soon as you register, you can log in and start using the portal. Online help and how-to videos are available on every page of the Provider Web Portal.

If you don't find answers to your questions, or want personalized help or training for yourself or your office staff, call the Scion Dental Web Portal Team for assistance: 855-434-9239.

Electronic Payments

Electronic Funds Transfer (EFT)

Scion Dental offers all providers the option of Electronic Funds Transfer (EFT) for claims payments. Providers are paid faster and more efficiently, because funds are deposited directly into payee bank accounts, eliminating the steps of printing and mailing paper checks.

To receive claims payments through the EFT Program:

1. Complete and sign the EFT Authorization Form. The form is available from the Provider Web Portal: www.sciondental.com.
2. Attach a voided check to the EFT Authorization Form. *The authorization cannot be processed without a voided check.*
3. Send the EFT Authorization Form and voided check to Scion Dental:
    - Fax: 262-721-0722
    - Email: **providerservices@sciondental.com**

Allow up to six weeks for the EFT Program to be implemented after we receive your completed paperwork. Once you are enrolled in the EFT Program, you will no longer receive paper remittance statements through postal mail. Instead, your Remittance statements will be posted online and made available from the Provider Web Portal as soon as your claims are paid. (Navigate to the Provider Web Portal from www.sciondental.com.)

Once you are enrolled in the EFT Program, notify Scion Dental of any changes to bank accounts, including changes in Routing Number or Account Number, or switching to a different bank. Submit all changes via the EFT Authorization Form. Allow up to three weeks for changes to be implemented after we receive your change request. Scion Dental is not responsible for delays in payment if providers do not properly notify Scion Dental in writing of banking changes.

Electronic Remittance Reports

If you enroll in the Scion Dental EFT Program, your Remittance statements will be made available automatically from the Provider Web Portal. For help registering for the portal or accessing your Remittance statements, call the Scion Dental Web Portal Team: 855-434-9239.

If you prefer to receive paper checks rather than electronic funds transfers, you can still eliminate paper Remittance statements and access your payment reports online. To have quick, easy access to Remittance statements as soon as your claims are paid, send an email message to Scion Dental Customer Service to request electronic remittances: **providerservices@sciondental.com**. As soon as the Customer Service team processes your request, paper Remittance statements will no longer be mailed to you. Your Remittance statements will be available online through the Provider Web Portal. For help or more information about electronic Remittance statements, call the Scion Dental Web Portal Team: 855-434-9239.

Health Insurance Portability and Accountability Act (HIPAA)

As a health care provider, if you transmit any health information electronically, your office is required to comply with all aspects of the Health Insurance Portability and Accountability Act (HIPAA) regulations that have gone/will go into effect as indicated in the final publications of the various rules covered by HIPAA.

Molina Healthcare of Wisconsin/Scion Dental have implemented numerous operational policies and procedures to ensure we comply with all HIPAA Privacy Standards, and we intend to comply with all Administrative Simplification and Security Standards by their compliance dates. We also expect all providers in our networks to work cooperatively with us to ensure compliance with all HIPAA regulations.

The provider and Molina Healthcare of Wisconsin/Scion Dental agree to conduct their respective activities in accordance with the applicable provisions of HIPAA and such implementing regulations.

When contacting Customer Service, providers will be asked to supply their Tax ID or NPI number. When calling regarding member inquiries, providers will be asked to supply specific member identification such as member ID or Social Security Number, date of birth, name, and/or address.

As regulated by the Administrative Simplification Standards, you will note the benefit tables included in this provider manual reflect the most current coding standards (CDT-2014) recognized by the American Dental Association (ADA). Effective as of the date of this manual, Molina Healthcare of Wisconsin/Scion Dental require providers to submit all claims with the proper CDT codes listed in this manual. In addition, all paper claims must be submitted on the current ADA claim form.

To request copies of Molina Healthcare of Wisconsin/Scion Dental HIPAA policies, call Customer Service at 855-326-5059 or send an email to **providerservices@sciondental.com**.

To report a potential security issue, call our Hotline: 877-378-5292.

National Provider Identifier (NPI)

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 required the adoption of a standard unique provider identifier for health care providers. An NPI number is required for all claims submitted to Scion Dental for payment. You must use your individual and billing NPI numbers.

To apply for an NPI, do one of the following:

- Complete the application online at **https://nppes.cms.hhs.gov**.
- Download and complete a paper copy from **https://nppes.cms.hhs.gov**.
- Call **800-465-3203** to request an application.

Utilization Management

Community Practice Patterns

To ensure fair and appropriate reimbursement, Scion Dental has developed a philosophy of Utilization Management which recognizes the fact there exists, as in all health care services, a relationship between the dentist's treatment planning, treatment costs, and outcomes. The dynamics of these relationships, in any region, are reflected by community practice patterns of local dentists and their peers. With this in mind, Scion Dental Utilization Management is designed to ensure the fair and appropriate distribution of health care dollars as defined by the regionally based community practice patterns of local dentists and their peers.

All Utilization Management analysis, evaluations, and outcomes are related to these patterns. Scion Dental Utilization Management recognizes individual dentist variance within these patterns among a community of dentists and accounts for such variance. Specialty dentists are evaluated as a separate group and not with general dentists, since the types and nature of treatment may differ.

Evaluation

Scion Dental Utilization Management evaluates claims submissions in such areas as:

- Diagnostic and preventive treatment
- Patient treatment planning and sequencing
- Types of treatment
- Treatment outcomes
- Treatment cost effectiveness

Results

With the objective of ensuring fair and appropriate reimbursement to providers, Scion Dental Utilization Management helps identify providers whose treatment patterns show significant deviation from the normal practice patterns of the community of their peers (typically less than five percent of all dentists). Scion Dental is contractually obligated to report suspected fraud, waste, abuse, or misuse by members and participating dental providers to Molina Healthcare of Wisconsin.

Non-Incentivization Policy

It is Scion Dental practice to ensure our contracted providers make treatment decisions based upon medical necessity for individual members. Providers are never offered, nor will they ever accept, any kind of financial incentives or any other encouragement to influence their treatment decisions.

Scion Dental Utilization Management Department bases their decisions on only appropriateness of care, service, and existence of coverage. Scion Dental does not specifically reward practitioners or other individuals for issuing denials of coverage or care. If financial incentives exist for Utilization Management decision makers, they do not include or encourage decisions which result in underutilization.

Fraud, Waste, and Abuse

Molina Healthcare of Wisconsin/Scion Dental conduct our business operations in compliance with ethical standards, contractual obligations, and all applicable federal and state statutes, regulations, and rules. We are committed to detecting, reporting, and preventing potential fraud, waste, and abuse, and we look to our providers to assist us. We expect our dental partners to share this same commitment, conduct their businesses similarly, and report suspected noncompliance, fraud, waste or abuse.

Definitions

Fraud, waste, and abuse are defined as:

Fraud. Fraud is intentional deception or misrepresentation made by a person with knowledge the deception could result in some unauthorized benefit to themselves or some other person or entity. It includes any act which constitutes fraud under federal or state law.

Waste. Waste is the unintentional, thoughtless, or careless expenditures, consumption, mismanagement, use, or squandering of federal or state resources. Waste also includes incurring unnecessary costs as a result of inefficient or ineffective practices, systems, or controls.

Abuse. Abuse is defined as practices that are inconsistent with sound fiscal, business, or medical practices, and that result in the unnecessary cost to the government healthcare program or in reimbursement for services medically unnecessary or that fail to meet professionally recognized standards for health care. Abuse includes intentional infliction of physical harm, injury caused by negligent acts, or omissions, unreasonable confinement, sexual abuse, or sexual assault. Abuse also includes beneficiary practices that result in unnecessary costs to the healthcare program.

Provider Fraud. Provider fraud is any deception or misrepresentation committed intentionally, or through willful ignorance or reckless disregard, by a person or entity in order to receive benefits or funds to which they are not entitled. This may include deception by improper coding or other false statements by providers seeking reimbursement or false representations or other violations of federal health care program requirements, its associates, or contractors.

Reporting suspected fraud, waste, or abuse

To report a suspected case of noncompliance, fraud, waste, or abuse, call the Scion Dental Fraud and Abuse hotline: 877-378-5292 or write to:

Scion Dental

Attention: Fraud and Abuse

10201 N Port Washington Rd

Mequon WI 53092

Deficit Reduction Act: The False Claims Act

Section 6034 of the Deficit Reduction Act of 2005 signed into law in 2006 established the Medicaid Integrity Program in section 1936 of the Social Security Act. The legislation directed the Secretary of the United States Department of Health and Human Services (HHS) to establish a comprehensive plan to combat provider fraud, waste, and abuse in the Medicaid program, beginning in 2006. The Comprehensive Medicaid Integrity Plan is issued for successive five-year periods.

Under the False Claims Act, those who knowingly submit or cause another person to submit false claims for payment of government funds are liable for up to three times the government's damages plus civil penalties of $5,500 to $11,000 for each false claim.

The False Claims Act allows private persons to bring a civil action against those who knowingly submit false claims. If there is a recovery in the case brought under the False Claims Act, the person bringing the suit may receive a percentage of the recovered funds.

For the party found responsible for the false claim, the government may exclude them from future participation in Federal health care programs or impose additional obligations against the individual.

The False Claims Act is the most effective tool U.S. taxpayers have to recover the billions of dollars stolen through fraud every year. Billions of dollars in health care fraud have been exposed, largely through the efforts of whistleblowers acting under federal and state false claims acts.

For more information about the False Claims Act visit **www.TAF.org**.

Whistleblower Protection

The False Claims Act (FCA) provides protection to qui tam relators who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the FCA. 31 U.S.C. § 3730(h). Remedies include reinstatement with comparable seniority as the qui tam relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

Fraud and Abuse Hotlines

Scion Dental Fraud and Abuse Hotline: 877-378-5292

Agency for Health Care Administration: 888-419-3456

Eligibility & Member Services

Any person who is enrolled in a Molina Healthcare of Wisconsin program is eligible for benefits under the Plan Certificate.

Member Identification Card

Members receive identification cards from Molina Healthcare of Wisconsin. Participating providers are responsible for verifying that members are eligible when services are rendered and for determining whether recipients have other health insurance. Because it is possible for a member's eligibility status to change at any time without notice, presenting a Member Identification Card does not guarantee a member's eligibility, nor does it guarantee provider payment.

Molina Healthcare of Wisconsin/Scion Dental recommend each dental office make a photocopy of the member's identification card each time treatment is provided. Please be aware that the Molina Healthcare of Wisconsin identification card is not dated and does not need to be returned to Molina Healthcare of Wisconsin should a member lose eligibility.

NOTE Presenting a Member ID Card does not guarantee that a person is currently enrolled in a Molina Healthcare of Wisconsin program.

For more information about member identification cards, call Customer Service: **888-999-2404.**

For health plan information, call Molina Healthcare of Wisconsin Customer Service: 888-999-2404.

Sample ID Card: Molina Healthcare of Wisconsin

Eligibility Verification

To quickly verify member eligibility, do one of the following:

- Log on to Provider Web Portal: www.sciondental.com
- Call Interactive Voice Response (IVR) system eligibility line: 855-326-5059

Eligibility information received from these sources is the same information you would receive by calling Customer Services. However, the Provider Web Portal and IVR system are both available 24 hours a day, 7 days a week – giving you quick access to information without requiring you to wait for an available Customer Services representative during business hours.

NOTE Because a member's eligibility can change at any time without prior notice, verifying eligibility does not guarantee payment.

For help using the Provider Web Portal or the IVR system, call Customer Service: 855-326-5059.

Eligibility Verification via Provider Web Portal

Our Provider Web Portal allows quick, accurate verification of member's eligibility. Log in using your ID and password at **www.sciondental.com**. First-time users need to self-register by entering their Payee ID, office name, and office address. For help registering or using the Provider Web Portal, call the Scion Dental Web Portal Team: 855-434-9239.

Once logged in, verify the member's eligibility by entering the member's date of birth, the expected date of service, and either the member's Identification Number or their last name and first initial. You can verify eligibility for an unlimited number of patients, and you can print the online eligibility summary report for your records.

Eligibility Verification via IVR

Use the Scion Dental Interactive Voice Response (IVR) system to verify eligibility for an unlimited number of patients.

Call 855-326-5059**.** Follow the prompts to identify yourself and the patient whose eligibility you are verifying. Our system analyzes the information entered and verifies the patient's eligibility. If the system cannot verify the member information, you will be transferred to a Customer Service Representative. You also have the option of transferring to a Customer Service Representative after completing eligibility checks, if you have additional questions.

Specialist Referrals

A patient who requires a referral to a dental specialist can be referred directly to any specialist contracted with Molina Healthcare of Wisconsin without authorization from Scion Dental. The dental specialist is responsible for obtaining prior authorization for services, as defined in the **Benefit Plan**

Details and Authorization Requirements section of this provider manual, beginning on **page 47**. If you are unfamiliar with the Molina Healthcare of Wisconsin contracted specialty network or need help locating a specialist provider, call Scion Dental Customer Service: 855-326-5059.

Acute Care Facilities

To find a healthcare provider, facility, or pharmacy associated with the Molina Healthcare of Wisconsin Network, call Molina Healthcare of Wisconsin Main Member Services: 888-999-2404.

Appointment Availability Standards

Molina Healthcare of Wisconsin/Scion Dental has established appointment time requirements for all situations to ensure members receive dental services in a time period appropriate to their health condition. We expect our dental providers to meet these appointment standards to help ensure needed services are accessible to members, maintain member satisfaction, and reduce unnecessary use of alternative services such as emergency room visits.

Molina Healthcare of Wisconsin/Scion Dental dentists are expected to meet the following minimum standards for appointment availability:

- Routine dental care must be scheduled within 30 calendar days for non-urgent symptomatic care and within 60 calendar days for non-symptomatic care.
- Urgent care must be available within 48 hours.
- Emergent care must be scheduled immediately.

Molina Healthcare of Wisconsin/Scion Dental will educate providers about appointment standards, monitor the adequacy of the process, and take corrective action if required.

Missed Appointments

Enrolled participating providers are not allowed to charge members for missed appointments.

If your office mails letters to members who miss appointments, the following language may be helpful to include:

- *"We missed you when you did not come for your dental appointment on Month/Date. Regular checkups are needed to keep your teeth healthy."*
- *"Please call to reschedule another appointment. Call us in advance if you cannot keep the appointment. Missed appointments are very costly to us. Thank you for your help."*

Molina Healthcare of Wisconsin recommends contacting the member by phone or postcard prior to the appointment to remind the individual of the time and place of the appointment.

The Centers for Medicare & Medicaid Services (CMS) interpret federal law to prohibit a provider from billing any Molina Healthcare of Wisconsin Plan member for a missed appointment. In addition, your missed appointment policy for Molina Healthcare of Wisconsin Plan enrolled patients cannot be stricter than your private or commercial patients.

If a Molina Healthcare of Wisconsin Plan member exceeds your office policy for missed appointments and you choose to discontinue seeing the patient, ask them contact Molina Healthcare of Wisconsin for a referral to a new dentist.

Payment for Non-covered Services

Enrolled participating providers shall hold members, Molina Healthcare of Wisconsin and its Plans, and Scion Dental harmless for the payment of non-covered services except as provided in this paragraph.

A provider may bill a member for non-covered services if the provider obtains an agreement from the member prior to rendering such service which indicates:

- The services to be provided.
- Molina Healthcare of Wisconsin, its Plans, or Scion Dental, Inc. will not pay for or be liable for these services.
- Member will be financially liable for such services.

> Providers must inform members in advance and in writing when the member is responsible for non-covered services.

Prior Authorization & Documentation Requirements

Prior Authorization for Treatment

Scion Dental has specific utilization criteria, as well as a prior authorization review process, to manage the utilization of services. Whether prior authorization is required for a particular service, and whether supporting documentation is also required, is defined in this provider manual in **Benefit Plan Details and Authorization Requirements** beginning on **page 47**.

Services requiring prior authorization should not be started prior to the determination of coverage (approval or denial of the prior authorization) for nonemergency services. Nonemergency treatment started prior to the determination of coverage will be performed at the financial risk of the dental office. If coverage is denied, the treating dentist will be financially responsible and may not balance bill the member, Molina Healthcare of Wisconsin, its Plans, or Scion Dental

Requests for prior authorization should be entered online through the Provider Web Portal (**www.sciondental.com**), submitted electronically in a HIPAA-compliant data file, or sent with the appropriate documentation on a current ADA Dental Claim Form. (See **Authorization Submission Procedures** beginning on **page 23**.) Any claims or authorizations submitted without the required documentation will be denied and must be resubmitted to obtain reimbursement.

Scion Dental must make a decision on a request for prior authorization within 14 calendar days from the date request is received, provided all information is complete. If you indicate or we determine following this time frame could seriously jeopardize the member's life or health, or the ability to attain, maintain or regain maximum function, we will make an expedited authorization decision and provide notice of our decision within 72 hours. Prior authorizations will be honored for 180 days from the date they are issued. **An authorization does not guarantee payment**. The member must be eligible at the time the services are provided.

Scion Dental dental reviewers and licensed dental consultants approve or deny authorization requests based on whether the item or service is medically necessary, whether a less expensive service would adequately meet the member's needs, and whether the proposed item or service conforms to commonly accepted standards in the dental community. If you have questions about a prior authorization decision or wish to speak to the dental reviewer, call 855-326-5059.

If Scion Dental denies approval for some or all of the services requested, the member will receive written notice of the reasons for each denial and will be informed that he or she may appeal the decision. The requesting provider will also receive notice of the decision. To appeal an authorization decision, submit the appeal in writing along with any necessary documentation within 30 days of the original determination date to:

Molina Healthcare of Wisconsin Appeals & Grievances Department
2400 South 102nd Street
West Allis WI 53227

Authorization Submission Procedures

Scion Dental receives authorizations submitted in any of the following formats:

- Provider Web Portal, www.sciondental.com
- Electronic submission via clearinghouse, Payer ID: SCION
- HIPAA-compliant 837D file
- Paper authorization via current ADA Dental Claim Form, available from American Dental Association

Authorization Submission via Provider Web Portal

Providers may submit authorizations directly to Scion Dental through our Provider Web Portal: www.sciondental.com.

Submitting authorizations via the web portal has several significant advantages:

- The online dental form has built-in features that automatically verify member eligibility and make data entry quick and easy.
- The online authorization process steps you through any required clinical guidelines, giving you a quick indication of how your authorization request will be evaluated and whether it's likely to be approved. (Successfully completing a clinical guideline does not guarantee payment.)
- The online authorization process indicates whether supporting documentation is required and allows you to attach and send documents as part of the authorization request.
- Dental reviewers and consultants receive your authorization requests and supporting documentation faster, which means you receive decisions faster.

If you have questions about submitting authorizations online, attaching electronic documents, or accessing the Provider Web Portal, call the Scion Dental Web Portal Team: 855-434-9239.

Authorization Submission via Clearinghouse

Providers may submit electronic claims and authorizations to Scion Dental directly via either the Emdeon or DentalXChange clearinghouses. If you use a different clearinghouse, your software vendor can provide you with information you may need to ensure electronic files are forwarded to Scion Dental.

Scion Dental Payer ID is SCION. By using this unique Payer ID with electronic files, Emdeon and DentalXChange can ensure that claims and authorizations are submitted successfully to Scion Dental.

For more information about Emdeon and DentalXChange, visit their websites www.emdeon.com/ and www.dentalxchange.com.

Authorization Submission via HIPAA-Compliant 837D File

For those providers who cannot submit claims and authorizations electronically through the Provider Web Portal or clearinghouse, Scion Dental will work with these providers individually to receive electronic files submitted using the HIPAA Compliant 837D transaction set format. To inquire about this option, call Scion Dental Customer Service at 855-326-5059.

Electronic Attachments

In addition to accepting electronic documents submitted through the Provider Web Portal, Scion Dental also accepts dental radiographs and other documents electronically via Fast Attach™ for authorization requests. For more information, visit **www.nea-fast.com** or call NEA (National Electronic Attachment, Inc.): **800-782-5150**.

Paper Authorization Submission

To ensure timely processing of submitted authorizations, the following information must be included on the current ADA Dental Claim Form:

- Member Name
- Member Medicaid ID Number
- Member Date of Birth
- Provider Name
- Provider Location
- Billing Location
- Provider NPI
- Payee Tax Identification Number (TIN)

Use approved ADA dental codes, as published in the current CDT book or as defined in this manual, to identify all services. Include on the form all quadrants, tooth numbers, and surfaces for dental codes which necessitate identification (extractions, root canals, amalgams, and resin fillings).

Scion Dental recognizes tooth letters A through T for primary teeth and tooth numbers 1 to 32 for permanent teeth. Supernumerary teeth should be designated by using codes AS through TS or 51 through 82. Designation of the tooth can be determined by using the nearest erupted tooth. If the tooth closest to the supernumerary tooth is #1, then the supernumerary tooth should be charted as #51. Likewise, if the nearest tooth is A, the supernumerary tooth should be charted as AS.

Missing, incorrect, or illegible information could result in the authorization being returned to the submitting provider's office, causing a delay in determination. Use the proper postage when mailing bulk documentation. Mail with postage due will be returned. Mail paper authorizations to:

Molina Healthcare of Wisconsin Authorizations
PO Box 2154
Milwaukee WI 53201

ADA Approved Dental Claim Form

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT / Title XIX
2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F | 8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐ M ☐ F | 15. Policyholder/Subscriber ID (SSN or ID#)
16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Reserved For Future Use
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐ M ☐ F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17
34. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B; ICD-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ C _____ B _____ D _____
31a. Other Fee(s)
32. Total Fee
35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.
X _____ Patient/Guardian Signature _____ Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.
X _____ Subscriber Signature _____ Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
49. NPI | 50. License Number | 51. SSN or TIN
52. Phone Number ( ) - | 52a. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ____ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) ☐
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment | 43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) | 44. Date of Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident
46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.
X _____ Signed (Treating Dentist) _____ Date
54. NPI | 55. License Number
56. Address, City, State, Zip Code | 56a. Provider Specialty Code
57. Phone Number ( ) - | 58. Additional Provider ID

©2012 American Dental Association
J430D (Same as ADA Dental Claim Form – J430, J431, J432, J433, J434)
To reorder call 800.947.4746 or go online at adacatalog.org

SAMPLE

ADA American Dental Association®

America's leading advocate for oral health

The following information highlights certain form completion instructions. Comprehensive ADA Dental Claim Form completion instructions are printed in the CDT manual. Any updates to these instructions will be posted on the ADA's web site (ADA.org).

GENERAL INSTRUCTIONS

A. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard #9 window envelope (window to the left). Please fold the form using the 'tick-marks' printed in the margin.

B. Complete all items unless noted otherwise on the form or in the CDT manual's instructions.

C. Enter the full name of an individual or a full business name, address and zip code when a name and address field is required.

D. All dates must include the four-digit year.

E. If the number of procedures reported exceeds the number of lines available on one claim form, list the remaining procedures on a separate, fully completed claim form.

COORDINATION OF BENEFITS (COB)

When a claim is being submitted to the secondary payer, complete the entire form and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may also note the primary carrier paid amount in the "Remarks" field (Item 35). There are additional detailed completion instructions in the CDT manual.

DIAGNOSIS CODING

The form supports reporting up to four diagnosis codes per dental procedure. This information is required when the diagnosis may affect claim adjudication when specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions. Diagnosis codes are linked to procedures using the following fields:

Item 29a – Diagnosis Code Pointer ("A" through "D" as applicable from Item 34a)

Item 34 – Diagnosis Code List Qualifier (B for ICD-9-CM; AB for ICD-10-CM)

Item 34a – Diagnosis Code(s) / A, B, C, D (up to four, with the primary adjacent to the letter "A")

PLACE OF TREATMENT

Enter the 2-digit Place of Service Code for Professional Claims, a HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are:

11 = Office; 12 = Home; 21 = Inpatient Hospital; 22 = Outpatient Hospital; 31 = Skilled Nursing Facility; 32 = Nursing Facility

The full list is available online at "www.cms.gov/PhysicianFeeSched/Downloads/Website_POS_database.pdf"

PROVIDER SPECIALTY

This code is entered in Item 56a and indicates the type of dental professional who delivered the treatment. The general code listed as "Dentist" may be used instead of any of the other codes.

Category / Description Code	Code
Dentist A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license.	122300000X
General Practice	1223G0001X
Dental Specialty (see following list)	Various
Dental Public Health	1223D0001X
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223D0008X
Oral & Maxillofacial Surgery	1223S0112X

Provider taxonomy codes listed above are a subset of the full code set that is posted at "www.wpc-edi.com/codes/taxonomy"

Claim Submission Procedures

Scion Dental receives claims submitted in any of the following formats:

- Provider Web Portal, **www.sciondental.com**
- Electronic submission via clearinghouse, Payer ID: SCION
- HIPAA-compliant 837D file
- Paper claim via current ADA Dental Claim Form, available from American Dental Association

Claim Submission via Provider Web Portal

Providers may submit claims directly to Scion Dental through our Provider Web Portal: **www.sciondental.com**.

Submitting claims via the web portal has several significant advantages:

- The online dental form has built-in features that automatically verify member eligibility and make data entry quick and easy.
- The online process allows you to attach and send electronic documents as part of the submitting a claim.
- Before submitting a claim, you can generate an online payment estimate.
- Claims enter the Scion Dental benefits administration system faster, which means you receive payment faster.

If you have questions about submitting claims online, attaching electronic documents, or accessing the Provider Web Portal, call the Scion Dental Web Portal Team: 855-434-9239.

Claim Submission via Clearinghouse

Providers may submit electronic claims and authorizations to Scion Dental directly via either the Emdeon or DentalXChange clearinghouses. If you use a different clearinghouse, your software vendor can provide you with information you may need to ensure electronic files are forwarded to Scion Dental.

Scion Dental Payer ID is SCION. By using this unique Payer ID with electronic files, Emdeon and DentalXChange can ensure that claims and authorizations are submitted successfully to Scion Dental.

For more information about Emdeon and DentalXChange, visit their websites: www.emdeon.com/ and www.dentalxchange.com.

HIPAA-Compliant 837D File

For those providers who cannot submit claims and authorizations electronically through the Provider Web Portal or clearinghouse, Scion Dental will work with these providers individually to receive electronic files submitted using the HIPAA Compliant 837D transaction set format. To inquire about this option, call Scion Dental Customer Service at 855-326-5059.

Electronic Attachments

In addition to accepting electronic documents submitted through the Provider Web Portal, Scion Dental also accepts electronic documents submitted via FastAttach™.

Scion Dental, in conjunction with NEA (National Electronic Attachment, Inc.), allows enrolled providers to submit claims electronically via FastAttach™. This program allows secure transmissions via the Internet for radiographs, periodontics charts, intraoral pictures, narratives, and Explanation of Benefits (EOBs).

FastAttach™ is compatible with most claims clearinghouses and practice management systems. For more information, visit **http://www.nea-fast.com** or call NEA at **800-782-5150**.

Paper Claim Submission

To ensure timely processing of submitted claims, the following information must be included on the current ADA Dental Claim Form:

- Member Name
- Member Medicaid ID Number
- Member Date of Birth
- Provider Name
- Provider Location
- Billing Location
- Provider NPI
- Payee Tax Identification Number (TIN)
- Date of Service for each service line

Use approved ADA dental codes, as published in the current CDT book or as defined in this manual, to identify all services. Include on the form all quadrants, tooth numbers, and surfaces for dental codes which necessitate identification (extractions, root canals, amalgams and resin fillings).

Scion Dental recognizes tooth letters A through T for primary teeth and tooth numbers 1 to 32 for permanent teeth. Supernumerary teeth should be designated by using codes AS through TS or 51 through 82. Designation of the tooth can be determined by using the nearest erupted tooth. If the tooth closest to the supernumerary tooth is #1 then the supernumerary tooth should be charted as #51. Likewise, if the nearest tooth is A, the supernumerary tooth should be charted as AS.

Missing, incorrect, or illegible information could result in the claim being returned to the submitting provider's office, causing a delay in payment. Use the proper postage when mailing bulk documentation. Mail with postage due will be returned. Mail paper claims to:

Molina Healthcare of Wisconsin Claims
PO Box 2136
Milwaukee WI 53201

Coordination of Benefits (COB)

When Molina Healthcare of Wisconsin is the secondary insurance carrier, a copy of the primary carrier's Explanation of Benefits (EOB) must be submitted with the claim. For electronic claim submissions, the payment made by the primary carrier must be indicated in the appropriate Coordination of Benefits (COB) field. When a primary carrier's payment meets or exceeds a provider's contracted rate or fee schedule, Molina Healthcare of Wisconsin/Scion Dental will consider the claim paid in full and no further payment will be made on the claim.

Corrected Claim Process

If a claim or a service line is denied because information was missing from the submitted claim, or if you have additional information or documentation that you believe may change the payment decision, simply resubmit the claim and include the missing information. For example, resubmit a claim with additional information if a service was denied because of a missing tooth number or surface, or if a claim was denied because documentation showing medical necessity was not originally submitted.

However, if service lines on a claim were paid that should not have been paid—or if a claim was paid to the wrong payee or on behalf of the wrong member, then submit a new "Corrected" claim to reverse the incorrect payment and reprocess the claim with the corrected information. For example, if a claim is submitted and paid with the wrong provider NPI or clinic location, incorrect payee Tax ID, wrong member, incorrect procedure code, etc., then the paid claim must be corrected and reprocessed.

Resubmitting a denied claim

To resubmit a claim that has been denied with additional information, follow the standard **Claim Submission Procedures** beginning on **page 28** of this provider manual. Timely filing limitations apply when a claim is resubmitted for reprocessing.

Submitting a Corrected claim

To reverse and correct a payment that should not have been made, submit a Corrected claim on the current ADA Dental Claim Form through the Provider Web Portal or via postal mail.

- Identify the claim as CORRECTED in the REFERRAL # field on in the Provider Web Portal or write "CORRECTED" across the top of a paper claim form.
- Identify the original Claim/Encounter Number and itemize all corrections in the REMARKS tab in the Provider Web Portal or write in the REMARKS field (Box 35) on a paper ADA form.
- Attach supporting documentation in the Provider Web Portal or send documentation in the same package with the paper claim form.

Send paper forms and documents to:

Molina Healthcare of Wisconsin Corrected Claims
PO Box 649
Milwaukee WI 53201

Receipt and Audit of Claims

A Dental Reimbursement Analyst dedicated to Molina dental offices analyzes any claim conditions that would result in nonpayment. When potential problems are identified, your office may be contacted and asked to assist in resolving the problem. Each enrolled participating provider's office receives a remittance detailing claims processing decisions. Call Customer Service at 855-326-5059 with questions about claims submission or remittances.

Claims Adjudication and Payment

The Scion Dental benefits administration system imports claim and authorization data, evaluates and edits the data for completeness and correctness, analyzes the data for clinical appropriateness and coding correctness, audits against plan and benefit limits, calculates the appropriate payment amounts, and generates payments and remittance summaries. The system also evaluates and automatically matches claims and services that require prior authorizations and matches the claims and services to the appropriate member record for efficient and accurate claims processing.

As soon as the system prices and pays claims, checks and electronic payments are generated, and remittance summaries are posted and available for online review from the Provider Web Portal (**www.sciondental.com**).

To appeal a reimbursement decision, submit the appeal in writing along with any necessary documentation to:

Molina Healthcare of Wisconsin Complaints and Appeals
PO Box 649
Milwaukee WI 53201

Complaints, Grievances, Appeals

Molina Healthcare of Wisconsin and Scion Dental are committed to providing high-quality dental services to all members. As part of that commitment, we work to ensure all members have every opportunity to exercise their rights to a fair and expeditious resolution to any and all complaints, grievances, and appeals. Our procedures for handling and resolving complaints, grievances, and appeals are designed to meet these goals:

- To ensure members and providers receive a fair, just, and speedy resolution by working cooperatively with providers and supplying any documentation related to the member grievance and/or appeal, upon request.
- To treat providers and members with dignity and respect at all levels of the grievances and appeals resolution process.
- To inform providers of their full rights as they relate to grievance and appeal resolutions, including their rights of appeal at each step in the process.
- To resolve provider grievances and appeals in a satisfactory and acceptable manner within the Molina Healthcare of Wisconsin/Scion Dental protocol.
- To comply with all regulatory guidelines and policies with respect to member complaints, grievances, and appeals.
- To efficiently monitor the resolution of provider-related grievances, to allow for tracking and identifying unacceptable patterns of care over time.

Provider Complaints, Grievances, Appeals

Scion Dental provides services to providers who participate in the Molina Healthcare of Wisconsin network. Our primary purpose is to ensure provider access to information, services, and assistance on issues affecting network participation and member benefits. A designated Scion Dental complaint coordinator is dedicated to the expedient, satisfactory resolution of provider complaints, grievances, and appeals.

Differences sometimes develop between dental providers and insurers/benefit administrators regarding prior authorization determinations and payment decisions. Since many of these issues result from misunderstanding of service coverage, processing policy, or payment levels, we encourage providers to contact us for explanation and education. For assistance, call Scion Dental Customer Service: 855-326-505.

Participating providers who disagree with authorization decisions made by the Scion Dental reviewers or dental consultants may submit a written appeal within 60 days of the original authorization denial date. Submit complaints, grievances, or appeals to:

Molina Healthcare of Wisconsin Complaints and Appeals
PO Box 649
Milwaukee WI 53201

Member Appeals

A member may appeal any Molina Healthcare of Wisconsin/Scion Dental decision which denies or reduces services. Member appeals are reviewed under our administrative appeal procedure.

Appeals regarding authorization determinations must be filed within 30 days of the authorization denial date. Scion Dental will review the appeal and render a decision within 45 calendar days.

- Member appeals must be submitted in writing to:
  Molina Healthcare of Wisconsin Appeal & Grievance Dpartment
  2400 South 102nd Street
  West Allis WI 53227

- Email: mwiappeals@molinahealthcare.com

- Call Customer Service at 888-999-2404

Provider Enrollment & Contracting

To enroll in the Molina Healthcare of Wisconsin provider network, access enrollment information and documents, or add a clinic location, visit:

www.sciondental.com

Enter code WI, and then click **Enter**.

Credentialing

As required by law, any dentist (DDS or DMD) who is interested in participating with Molina Healthcare of Wisconsin is invited to apply and submit a credentialing application for review by our Credentialing Committee. Molina Healthcare of Wisconsin does not differentiate or discriminate in the treatment of providers seeking credentialing on the basis of race, ethnicity, gender, age, national origin, or religion. Molina Healthcare of Wisconsin has contracted with Scion Dental to perform credentialing activities.

Providers must be credentialed before participating in the Molina Healthcare of Wisconsin network. Providers accepted into the Molina Healthcare of Wisconsin network are re-credentialed at least every 36 months.

The Scion Dental credentialing process follows NCQA (National Committee for Quality Assurance) credentialing guidelines for dentistry. All credentialing applications must satisfy NCQA and/or URAC standards of credentialing as they apply to dental services. Molina Healthcare of Wisconsin has the sole right to determine which dentists it accepts and continues to allow as participating providers in its network.

In reviewing an application, the Credentialing Committee may request further information from the applicant. The Credentialing Committee may table an application pending the outcome of an investigation of the applicant by a hospital, licensing board, government agency, institution, or any other organization, or the Committee may recommend any other action it deems appropriate. Scion Dental notifies Molina Healthcare of Wisconsin of all disciplinary actions that involve participating providers.

Any acceptance of an applicant is conditioned upon the applicant's execution of a participation agreement with Molina Healthcare of Wisconsin.

Credentialing Portal

To make the credentialing process as easy and efficient as possible for providers, Scion Dental gathers credentialing information through an online credentialing portal. To begin the credentialing process, visit:

https://credentialingportal.sciondental.com

Once at the credentialing portal, click **First Time Users**. Complete the form, and then click **Register**.

Once registered, you can:

- Begin a credential application.
- Complete the step-by-step application process for each provider to be credentialed.
- Check an application status.
- Add and manage your locations.

Clinical Criteria

Medical Necessity

Molina Healthcare of Wisconsin defines medical necessity as accepted health care services and supplies provided by health care entities appropriate to the evaluation and treatment of a disease, condition, illness, or injury and consistent with the applicable standard of care.

Dental care is medically necessary to prevent and eliminate orofacial disease, infection, and pain, to restore form and function to the dentition, and to correct facial disfiguration or dysfunction. Medical necessity is the reason why a test, a procedure, or an instruction is performed.

Medical necessity is different from person to person and changes as the individual changes. The dental team must provide consistent methodical documentation of medical necessity for coding.

Clinical Criteria

Prior Authorization of 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 Scion Dental. The criteria Scion Dental reviewers will look for in order to approve the request is listed below. Should the procedure ned to be initiated under an emergency condition to relieve pain and suffering, you are to provide treatment to alleviate the patient's condition. However, to receive reimbursement for the treatment, Scion Dental will require the same criteria/documentation be provided (with the claim for payment) and the same criteria be met to receive payment for the treatment.

Emergency Treatment

Should a procedure need to be initiated to relieve pain and suffering in an emergency situation, you are to provide treatment to alleviate the patient's condition. To receive reimbursement for emergency treatment, submit all required documentation along with the claim for services rendered. Scion Dental uses the same clinical criteria (and requires the same supporting documentation) for claims submitted after emergency treatment as it would have used to determine prior authorizations for the same services.

Clinical Criteria Descriptions

Scion Dental clinical criteria for determining medical necessity were developed from information collected from American Dental Association's Code Manuals, clinical articles and guidelines, as well as dental schools, practicing dentists, insurance companies, other dental-related organizations, and local state or health plan requirements.

Scion Dental reviewers use the following clinical criteria to approve authorization requests.

Crowns / onlays / coping

- Minimum 50% bone support
- No periodontal furcation
- No subcrestal caries
- Clinically acceptable RCT
- Anterior - 50% incisal edge / 4+ surfaces involved
- Bicuspid – 1 cusp / 3+ surfaces involved
- Molar – 2 cusps / 4+ surfaces involved

Additional procedures to construct new crown under existing partial

- Documentation supports procedure, missing teeth on at least one side of requested crown

Root canals

- Minimum 50% bone support
- No periodontal furcation
- No subcrestal caries
- Evidence of apical pathology/fistula
- Pain from percussion / temp
- Closed apex

Apexification/recalcification

- Deep caries
- Traumatic fracture with near pulpal exposure
- Pain from percussion, temperature
- History of trauma
- Presence of open root apex/apices
- Pain from percussion / temp

Apicoectomy / periradicular services

- Minimum 50% bone support
- No caries below bone level
- History of RCT

- Apical pathology

Retrograde filling

- History of apicoectomy

Gingivectomy or gingivoplasty

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

Gingival flap procedure (D4240)

- Perio classification of Type III or IV
- Lack of attached gingiva

Scaling and root planning

D4341

- Four or more teeth in the quadrant
- 5 mm or more pocketing on 2 or more teeth indicated on the perio charting
- Presence of root surface calculus and/or noticeable loss of bone support on x-rays

D4342

- One to three teeth in the quadrant
- 5 mm or more pocketing on 1 or more teeth indicated on the perio charting
- Presence of root surface calculus and/or noticeable loss of bone support on x-rays

Full mouth debridement

- No history of periodontal treatment in past 12 months
- Extensive coronal calculus on 50% of teeth

Periodontal maintenance

- Periodontal surgical or scaling and root planning procedure more than 90 days previous

Full dentures

- Existing denture greater than 5 years old (exception is when documentation is submitted showing a reasonable explanation for the loss or theft of the prosthesis including how, when and where the prosthesis was lost or damaged and such documentation is submitted as a prior authorization subject to review and approval or denial.)
- Remaining teeth do not have adequate bone support or are restorable

Partial dentures

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

- Existing partial denture greater than 5 years old (exception is when documentation is submitted showing a reasonable explanation for the loss or theft of the prosthesis including how, when and where the prosthesis was lost or damaged and such documentation is submitted as a prior authorization subject to review and approval or denial.)
- Remaining teeth have greater than 50% bone support and are restorable

Full/partial dentures-adjustments, repairs, replacement, add ons (teeth and clasps)

- Dentures greater than 6 months old
- Documentation describes medical necessity for replacement of all teeth on partial denture

Maxillofacial prosthetics

- Documentation describes accident, facial trauma, disease, facial reconstruction or other medical necessity need

Fixed partial denture pontics / retainers

- Minimum 50% bone support
- No periodontal furcation
- No subcrestal caries
- Clinically acceptable RCT
- Anterior- 50% incisal edge / 4+ surfaces involved
- Bicuspid- 1 cusp / 3+ surfaces involved
- Molar- 2 cusps / 4+ surfaces involved

Connector bar / stress breaker / precision attachment

- Attachment will significantly enhance function

Fixed partial denture repair, by report

- Documentation describes medical necessity

Pediatric partial denture

- Missing anterior teeth

Surgical removal of erupted tooth

- Greater than 50% bone support
- Periapical pathology or furcation involvement
- Gross carious lesion or large existing restoration
- Curved or dilacerated root
- Elevation of flap and/or removal of bone and/or sectioning of tooth

Impacted teeth – (asymptomatic impactions will not be approved)

- Documentation describes pain, swelling, etc. around tooth (must be symptomatic) and documentation noted in patient record

- Tooth impinges on the root of an adjacent tooth, is horizontal impacted, or shows a documented enlarged tooth follicle or potential cystic formation
- Documentation supports procedure for unusual surgical complications
- X-rays matches type of impaction code described

Surgical removal of residual tooth roots

- Tooth root is completely covered by tissue on x-ray
- Documentation describes pain, swelling, etc around tooth (must be symptomatic) and documentation noted in patient record

Oroantral fistula closure/sinus perforation

- Due to extraction, oral infection or sinus infection

Tooth reimplantation and / or stabilization

- Documentation describes accident and medical necessity

Surgical access of an unerupted tooth

- Documenation supports impacted/unerupted tooth
- Tooth is beyond one year of normal eruption pattern

Mobilization of erupted tooth

- Documentation supports procedure

Placement of device to facilitate eruption

- Documentation supports procedure

Biopsy / exfolliative cytological sample collection

- Copy of pathology report or test results

Alveoloplasty with extractions

- Appropriate number of teeth being extracted for code

Alveoloplasty without extractions

- Necessary for fabrication of a prothesis

Excision of lesion / tumor

- Copy of pathology report with claim

Excision of bone tissue

- Necessary for fabrication of a prosthesis

Radical resection of maxilla or mandible

- Documentation supports medical necessity need

Incision / drain abscess

- Documentation describes non-vital or foreign body for intraoral incision
- Documentation describes periapical or periodontal abscess for extraoral incision

Removal of foreign body/reaction producing foreign bodies

- Documentation describes presence or description of foreign body

Partial ostectomy

- Documentation describes presence or description of non-vital bone or foreign body

Maxillary sinusotomy

- Documentation describes presence or description of root fracture of foreign body in maxillary antrum

Fractures- simple / compound

- Documentation describes accident, operative report and medical necessity

Reduction and dislocation and management of TMJ dysfunctions

- Narrative, x-rays or photos support medical necessity for procedure

Suture repairs

- Documentation describes accident
- Not for tooth extraction or to close surgical incision

Osteoplasty

- Documentation describes and supports congenital defect condition

Other repair procedure (Oral & Maxillofacial Surgery)

- Narrative, x-rays or photos support medical necessity for procedure

Frenulectomy

- Documentation describes medical necessity due to ill fitting denture

Surgical reduction of fibrous tuberosity

- Documentation indicates medical necessity need for future denture placement

Sialolithotomy

- Documentation describes evidence of salivary blockage

General anesthesia / IV sedation (Dental Office Setting) 1 or more of the criteria below

- Extractions of impacted teeth or unerupted cuspids or wisdom teeth or surgical exposure of unerupted cuspids
- 2 or more extractions in 2 or more quadrants

- 4 or more extractions in 1 quadrant
- Excision of lesions greater than 1.25 cm
- Surgical recovery from the maxillary antrum
- Documentation that patient is less than 9 years old with extensive treatment (described)
- Documentation of failed local anesthesia and documentation noted in patient record
- Documentation of situational anxiety and documentation noted in patient record
- Documentation and narrative of medical necessity supported by submitted medical records (cardiac, cerebral palsy, epilepsy, or condition that would render patient noncompliant)

Inhalation of nitrous oxide / analgesia D9230

- Documentation (treatment history) supports indication of non-cooperative patient under age 9
- Documentation supports indication of patient with a medical condition (cardiac, cerebral palsy, epilepsy, or other condition that would render the patient non-compliant)
- Documentation describes extensive treatment for patient under age 9
- Documentation describes situational anxiety

Non-intravenous conscious sedation (Dental Office Setting) – 1 or more of the criteria below

- Extractions of impacted or unerupted cuspids or wisdom teeth or surgical exposure of unerupted cuspids
- 2 or more extractions in 2 or more quadrants
- 4 or more extractions in 1 quadrant
- Excision of lesions greater than 1.25 cm
- Surgical recovery from the maxillary antrum
- Documentation that patient is less than 9 years old with extensive treatment (described)
- Documentation of failed local anesthesia and documentation noted in patient record
- Documentation of situational anxiety and documentation noted in patient record
- Documentation and narrative of medical necessity supported by submitted medical records (cardiac, cerebral palsy, epilepsy or condition that would render patient noncompliant)

Hospital Call

- Documentation of time spent and reason for hospital call

Therapeutic drug injection

- Description of drugs (antibiotics, steroids, anti-inflammation or other therapeutic medication) and parental administration

Unspecified procedures, by report

- Procedure cannot be adequately described by an existing code

OR (Hospital Operating Room or Outpatient Facility) request – use D9999

- Patient under six (6) years of age with extensive treatment needed
- Documentation supports indication of patient with a medical condition (cardiac, cerebral palsy, epilepsy), or other condition that would render the patient non-compliant

Orthodontics

Fixed or removable appliance therapy

- Documentation of thumb sucking or tongue thrusting habit

Limited / interceptive treatment

- Partial treatment to correct crowding in one arch
- Minor tooth movement
- Uprighting teeth
- Rotating teeth
- Opening space(s)
- Closing space(s)
- Palatal expansion, skeletal disharmonies, space deficiency to lessen future effects of malformation dentition (primary / transitional dentition)

Comprehensive (WI)

Comprehensive orthodontic treatment

- Documentation shows a cleft lip or palate with missing teeth
- Documentation shows a greater than 6mm overjet in at least two of the upper front teeth, numbers 7 through 10
- Documentation shows a full tooth class II or III in all four back teeth on either side
- Documentation shows at least three of four canines are impacted or severely ectopic, blocked, closed, or crowded.
- Documentation supports Salzmann Criteria Index Form score of 34 or greater

Pre-orthodontic treatment visit

- Part of approved comprehensive orthodontic treatment

Orthodontic retention

- Documentation shows completed comprehensive orthodontic treatment

Orthodontic repair / replacement of lost or broken retainer . rebonding or recementation

- Narrative of active ortho case

Covered Benefits | BadgerCare Plus & SSI Medicaid

Diagnostic and Preventive Services

Diagnostic services include the oral examinations and selected radiographs needed to assess oral health, diagnose oral pathology, and develop an adequate treatment plan for the member's oral health.

Reimbursement for some or multiple x-rays of the same tooth or area may be denied if Scion Dental determines the number to be redundant, excessive, or not in keeping with the federal guidelines relating to radiation exposure. The maximum amount paid for individual radiographs taken on the same day will be limited to the allowance for a full mouth series.

Reimbursement for radiographs is limited to when required for proper treatment and/or diagnosis.

Scion Dental utilizes the guidelines published by the Department of Health and Human Services Center for Devices and Radiological Health. However, please consult the following benefit tables for benefit limitations.

All radiographs must be of diagnostic quality, properly mounted, dated, and identified with the member's name. Radiographs not of diagnostic quality will not be reimbursed for, or if already paid for, Scion Dental will recoup the funds previously paid.

Restorative Services

Reimbursement includes local anesthesia.

Generally, once a particular restoration is placed in a tooth, a similar restoration will not be covered for at least 12 months, unless there is recurrent decay or material failure.

Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day. A restoration is considered a two or more surface restoration only when two or more actual tooth surfaces are involved, whether they are connected or not.

Tooth preparation, all adhesives (including amalgam and resin bonding agents), acid etching, copalite, liners, bases and curing are included as part of the restoration.

When restorations involving multiple surfaces are requested or performed, that are outside the usual anatomical expectation, the allowance is limited to that of a one-surface restoration. Any fee charged in excess of the allowance for the one-surface restoration is DISALLOWED.

Endodontics Services

Reimbursement includes local anesthesia.

In cases where a root canal filling does not meet Scion Dental general criteria treatment standards, Scion Dental can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after the Scion Dental Consultant reviews the circumstances.

A pulpotomy, pulpectomy, or palliative treatment is not to be billed in conjunction with a root canal treatment on the same date. Filling material not accepted by the Federal Food and Drug Administration (FDA) (e.g., Sargenti filling material) is not covered.

Complete root canal therapy includes all appointments necessary to complete treatment, temporary fillings, filling and obturation of canals, intra-operative and fill radiographs.

Periodontics Services

Reimbursement includes local anesthesia.

Prosthodontics, Removable

Provisions for a removable prosthesis will be considered when there is evidence that masticatory function is impaired, a serious aesthetic condition is present, when the existing prosthesis is unserviceable, or when masticatory insufficiencies are likely to impair the general health of the member (medically necessary). It is generally considered that eight posterior teeth in occlusion constitutes adequate masticatory function. One missing maxillary anterior tooth or two missing mandibular anterior teeth may be considered a serious aesthetic problem.

Provisions for a fixed prosthesis may be considered when there is one missing maxillary anterior tooth or two missing adjacent mandibular anterior teeth and the member's overall status would justify consideration.

A fixed prosthesis may not be utilized to replace an existing prosthesis (either fixed or removable).

A preformed denture with teeth already mounted forming a denture module is not a covered service.

Oral and Maxillofacial Surgery

Reimbursement includes local anesthesia and routine post-operative care.

The extraction of asymptomatic impacted teeth is not a covered benefit. Symptomatic conditions would include pain and/or infection or demonstrated malocclusion causing a shifting of existing dentition.

Benefit Plan Details and Authorization Requirements

All of the following benefit plan details and related authorization requirements apply to the Molina Healthcare of Wisconsin BadgerCare Plus and SSI Medicaid. If Yes is indicated in the Auth Required column, then a service requires a prior authorization. If documentation is indicated in the Doc Required column, then supporting documentation is required before the authorization can be approved. When a prior authorization is required, submit it (along with any required documentation) to Scion Dental for approval before beginning non-emergency or routine treatment. If immediate treatment is required in an emergency situation, submit required documentation after treatment with the claim.

Diagnostic Services

Diagnostic Services						
Code	Description	Age Limitation	Teeth Covered	Auth Required	Benefit Limitations	Doc Required
D0120	periodic oral evaluation	0-999		No	One (D0120) per 6 months per provider.	
D0140	limited oral evaluation-problem focused	0-999		No	One (D0140) per 6 months per provider. Not allowed on same day as (D0120, D0150). Not allowed on same day as non-emergency treatment.	
D0150	comprehensive oral evaluation	0-999		No	One (D0150) per 36 months per provider.	
D0160	detailed and extensive oral eval-problem focused, by report	0-999		No	One (D0160) per 36 months per provider.	
D0170	re-evaluation, limited problem focused	0-999		No	One (D0170) per 12 months per provider.	
D0210	intraoral-complete series (including bitewings)	0-999		No	One (D0210) per 36 months per provider. One (D0210, D0270, D0272, D0273, D0274) per 6 months per provider.	
D0220	intraoral-periapical-1st film	0-999		No	One (D0220) per 1 days per patient. Not allowed for 6 months following D0210.	
D0230	intraoral-periapical-each additional film	0-999		No	Three (D0230) per 1 days per patient. Not allowed for 6 months following D0210.	

Diagnostic Services						
Code	Description	Age Limitation	Teeth Covered	Auth Required	Benefit Limitations	Doc Required
D0240	intraoral - occlusal film	0-999		No	Two (D0240) per 1 days per patient. Not allowed for 6 months following D0210.	
D0250	extra oral - first film	0-999		No	One (D0250) per 1 days per patient.	
D0260	extra oral-each additional film	0-999		No	Two (D0260) per 1 days per patient.	
D0270	bitewing - single film	0-999		No	One (D0270) per day, up to two (D0270) per 6 months per provider	
D0272	bitewings - two films	0-999		No	One (D0272, D0273, D0274) per 6 months per provider	
D0273	Bitewings – three films	0-999		No	One (D0272, D0273, D0274) per 6 months per provider	
D0274	bitewings - four films	0-999		No	One (D0272, D0273, D0274) per 6 months per provider	
D0330	panoramic film	0-999		No	One (D0330) per 1 days per patient.	
D0340	cephalometric film	0-20		**Yes**	Orthodontia diagnosis only.	narrative of medical necessity
D0350	oral/facial images	0-20		No	Orthodontia and oral surgery only.	
D0470	diagnostic casts	0-20		**Yes**	Orthodontia diagnosis only.	narrative of medical necessity
D0486	accession of exfoliative cytological smears, microscopic examination,	0-999		No		
D0999	unspecified diagnostic procedure, by report	13-20		**Yes**	HealthCheck "Other Service" referral form required. Use this code for up to two additional oral exams per year with a HealthCheck referral.	desc. of proc. & narrative of medical necessity

Preventive Services

Preventive Services						
Code	Description	Age Limitation	Teeth Covered	Auth Required	Benefit Limitations	Doc Required
D1110	prophylaxis – adult	13-20		No	One (D1110, D1120) per 6 months per provider. Up to four per 12 month period with documentation of permanent disability.	
D1110	prophylaxis – adult	21-999		No	One (D1110) per 12 months per provider. Up to four per 12 month period with documentation of permanent disability.	
D1120	prophylaxis - child	0-12			One (D1110, D1120) per 6 months per provider. Up to four per 12 month period with documentation of permanent disability.	
D1206	topical fluoride varnish	0-20		No	Two (D1206) per 12 months per patient. Not payable on same DOS as D4341, D4342, D4355.	
D1206	topical fluoride varnish	21-999		No	One (D1206) per 12 months per patient. Not payable on same DOS as D4341, D4342, D4355.	
D1208	Topical application of fluoride	0-20		No	Two (D1206) per 12 months per patient. Not payable on same DOS as D4341, D4342, D4355.	
D1208	Topical application of fluoride	21-999		No	One (D1206) per 12 months per patient. Not payable on same DOS as D4341, D4342, D4355.	
D1351	sealant - per tooth	0-20	Teeth 1 - 32, 51 - 82,A - T, AS - TS	No	One (D1351) per 36 months per patient per tooth. Narrative required in order to exceed once per three-year limitation.	
D1510	space maintainer-fixed-unilateral	0-20	Teeth A, B, I, J, K, L, S, T	No	One (D1510) per 12 months per patient per tooth. No more than four per 1 day.	
D1515	space maintainer - fixed - bilateral	0-20	per Arch (01, 02, LA, UA)	No	One (D1515) per 1 Calendar years per patient per arch.	
D1550	re-cementation of space maintainer	0-20		No	Two (D1550) per 1 days per patient. Not allowed within 6 months of initial placement.	
D1555	removal of fixed space maintainer	0-999		No		

Restorative Services

Restorative Services						
Code	Description	Age Limitation	Teeth Covered	Auth Required	Benefit Limitations	Doc Required
D2140	Amalgam - one surface, primary or permanent	0-999	Teeth A - T, AS - TS	No	One (D2140) per 12 months per tooth.	
D2140	Amalgam - one surface, primary or permanent	0-999	Teeth 1 - 32, 51 - 82	No	One (D2140) per 36 months per tooth.	
D2150	Amalgam - two surfaces, primary or permanent	0-999	Teeth A - T, AS - TS	No	One (D2150) per 12 months per tooth.	
D2150	Amalgam - two surfaces, primary or permanent	0-999	Teeth 1 - 32, 51 - 82	No	One (D2150) per 36 months per tooth.	
D2160	Amalgam - three surface, primary or permanent	0-999	Teeth A - T, AS - TS	No	One (D2160) per 12 months per tooth.	
D2160	Amalgam - three surface, primary or permanent	0-999	Teeth 1 - 32, 51 - 82	No	One (D2160) per 12 months per tooth.	
D2161	Amalgam - four surfaces, primary or permanent	0-999	Teeth A - T, AS - TS	No	One (D2161) per 12 months per tooth.	
D2161	Amalgam - four surfaces, primary or permanent	0-999	Teeth 1 - 32, 51 - 82	No	One (D2161) per 36 months per tooth.	
D2330	resin-1 surface, anterior	0-999	Teeth C - H, M - R, CS - HS, MS - RS	No	One (D2330) per 12 months per tooth.	
D2330	resin-1 surface, anterior	0-999	Teeth 6 - 11, 22 - 27, 56 - 61, 72-77	No	One (D2330) per 36 months per tooth.	
D2331	resin-2 surfaces, anterior	0-999	Teeth C - H, M - R, CS - HS, MS - RS	No	One (D2331) per 12 months per tooth.	
D2331	resin-2 surfaces, anterior	0-999	Teeth 6 - 11, 22 - 27, 56 - 61, 72-77	No	One (D2331) per 36 months per tooth.	

Restorative Services						
Code	Description	Age Limitation	Teeth Covered	Auth Required	Benefit Limitations	Doc Required
D2332	resin-3 surfaces, anterior	0-999	Teeth C - H, M - R, CS - HS, MS - RS	No	One (D2332) per 12 months per tooth.	
D2332	resin-3 surfaces, anterior	0-999	Teeth 6 - 11, 22 - 27, 56 - 61, 72-77	No	One (D2332) per 36 months per tooth.	
D2335	resin-4+ surfaces or involving incisal angle (anterior)	0-999	Teeth C - H, M - R, CS - HS, MS - RS	No	One (D2335) per 12 months per tooth.	
D2335	resin-4+ surfaces or involving incisal angle (anterior)	0-999	Teeth 6 - 11, 22 - 27, 56 - 61, 72-77	No	One (D2335) per 36 months per tooth.	
D2390	resin-based composite crown, anterior	0-999	Teeth A - T, AS - TS	No	One (D2390) per 12 months per tooth.	
D2390	resin-based composite crown, anterior	0-999	Teeth 1 - 32, 51 - 82	No	One (D2390) per 60 months per tooth.	
D2391	resin-based composite - 1 surface, posterior	0-999	Teeth A, B, I, J, K, L, S, T, AS, BS, IS, JS, KS, LS, SS, TS	No	One (D2391) per 12 months per tooth.	
D2391	resin-based composite - 1 surface, posterior	0-999	Teeth 1 - 5, 12 - 21, 28 - 32, 51 - 55, 62 - 71, 78 - 82	No	One (D2391) per 36 months per tooth.	
D2392	resin-based composite - 2 surfaces, posterior	0-999	Teeth A, B, I, J, K, L, S, T, AS, BS, IS, JS, KS, LS, SS, TS	No	One (D2392) per 12 months per tooth.	
D2392	resin-based composite - 2 surfaces, posterior	0-999	Teeth 1 - 5, 12 - 21, 28 - 32, 51 - 55, 62 - 71, 78 - 82	No	One (D2392) per 36 months per tooth.	

Restorative Services						
Code	Description	Age Limitation	Teeth Covered	Auth Required	Benefit Limitations	Doc Required
D2393	resin-based composite - 3 surfaces, posterior	0-999	Teeth A, B, I, J, K, L, S, T, AS, BS, IS, JS, KS, LS, SS, TS	No	One (D2393) per 12 months per tooth.	
D2393	resin-based composite - 3 surfaces, posterior	0-999	Teeth 1 - 5, 12 - 21, 28 - 32, 51 - 55, 62 - 71, 78 - 82	No	One (D2393) per 36 months per tooth.	
D2394	resin-based composite - 4 or more surfaces, posterior	0-999	Teeth A, B, I, J, K, L, S, T, AS, BS, IS, JS, KS, LS, SS, TS	No	One (D2394) per 12 months per tooth.	
D2394	resin-based composite - 4 or more surfaces, posterior	0-999	Teeth 1 - 5, 12 - 21, 28 - 32, 51 - 55, 62 - 71, 78 - 82	No	One (D2394) per 36 months per tooth.	
D2791	crown - full cast base metal	0-999	Teeth 1 - 32, 51 - 82, A - T, AS - TS	**Yes**	One (D2791) per 60 months per patient per tooth.	pre-op x-rays of adj and opposing teeth
D2910	recement inlay	0-999	Teeth 1 - 32, 51 - 82	No		
D2915	recement cast or prefabricated post and core	0-999	Teeth 1 - 32, 51 - 82, A - T, AS - TS	No		
D2920	recement crown	0-999	Teeth 1 - 32, 51 - 82, A - T, AS - TS	No		
D2921	reattachment of tooth fragment	0-999		No		
D2930	reattachment of tooth fragment	0-999	Teeth A - T, AS - TS	No	One (D2390) per 12 months per patient per tooth.	
D2931	prefabricated stainless	0-999	Teeth 1 - 32,	No	One of (D2931) per 60 Month(s) Per patient per tooth.	

Restorative Services						
Code	Description	Age Limitation	Teeth Covered	Auth Required	Benefit Limitations	Doc Required
	steel crown-permanent tooth		51 - 82			
D2932	prefabricated resin crown	0-999	Teeth D - G, DS - GS	No	One (D2392) per 12 months per patient per tooth.	
D2932	prefabricated resin crown	0-999	Teeth 6 - 11, 22 - 27, 56 - 61, 72-77	No	One (D2932) per 60 months per patient per tooth.	
D2933	prefabricated stainless steel crown with resin window	0-999	Teeth D - G, DS - GS	No	One (D2393) per 12 months per patient per tooth.	
D2933	prefabricated stainless steel crown with resin window	0-999	Teeth 6 - 11, 56 - 61	No	One (D2933) per 60 months per patient per tooth.	
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	0-20	Teeth D - G, DS - GS	No	One (D2394) per 12 months per patient per tooth.	
D2940	protective restoration	0-999	Teeth 1 - 32, 51 - 82, A - T, AS - TS	No	Not allowed with (D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2934, D3221, D3222, D3310, D3320, D3330) Same Tooth Same day.	
D2941	Temporary Filling	0-999	Teeth 1 - 32	No		
D2951	pin retention - per tooth in addition to restoration	0-999	Teeth 1 - 32, 51 - 82	No	One (D2951) per 36 months per patient per tooth.	
D2952	cast post and core in addition to crown	0-999	Teeth 2 - 15, 18 - 31, 52 - 65, 68-81	No	One (D2952, D2954) per 1 lifetime per provider per tooth.	
D2954	prefabricated post and core in addition to crown	0-999	Teeth 2 - 15, 18 - 31, 52 - 65, 68-81	No	One (D2952, D2954) per 1 lifetime per patient per tooth.	
D2971	additional procedures to construct new crown under partial denture framework	0-999	Teeth 2 - 15, 18 - 31	**Yes**		pre-op x-rays of adj and opposing teeth
D2999	Unspecified restorative procedure, by report	0-20		**Yes**	Health Check "Other Services". Use this code for single-unit crown.	desc. of proc. & narrative of medical necessity

Endodontics

Endodontics						
Code	Description	Age Limitation	Teeth Covered	Auth Required	Benefit Limitations	Doc Required
D3220	therapeutic pulpotomy (excluding final restoration)	0-20	Teeth A - T, AS - AT	No	One (D3220) per 1 lifetime per patient per tooth. Primary teeth only.	
D3221	gross pulpal debridement, primary and permanent teeth	0-999	Teeth 2 - 15, 18 - 31, 52 -65, 68-81	No		
D3222	partial pulpotomy for apexogenesis	0-12		No		
D3310	Endodontic therapy, anterior (exc final rest)	0-999	Teeth 6 - 11, 22 - 27	**Yes**	One (D3310) per 1 lifetime per patient per tooth.	pre-op x-rays (excluding bitewings)
D3320	Endodontic therapy, bicuspid (exc final restore)	0-999	Teeth 4, 5, 12, 13, 20, 21, 28, 29	**Yes**	One (D3320) per 1 lifetime per patient per tooth.	pre-op x-rays (excluding bitewings)
D3330	Endodontic therapy, molar(excluding final restore)	0-999	Teeth 2, 3, 14 - 19, 30, 31	**Yes**	One (D3330) per 1 lifetime per patient per tooth.	pre-op x-rays (excluding bitewings)
D3351	apexification/recalcification/pulpal regeneration - initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	0-20	Teeth 2 - 15, 18 - 31, 52 -65, 68-81	**Yes**		pre-op x-rays (excluding bitewings)
D3410	apicoectomy/periradicular surgery- anterior	0-999	Teeth 6 - 11, 22 - 27, 56 - 61, 72 - 77	**Yes**		pre-op x-rays of adj and opposing teeth
D3430	retrograde filling - per root	21 and older	Teeth 6 - 11, 22 - 27, 56 - 61, 72 - 77	**Yes**		pre-op x-rays of adj and opposing teeth

Periodontics

Periodontics						
Code	Description	Age Limitation	Teeth Covered	Auth Required	Benefit Limitations	Doc Required
D4210	gingivectomy or gingivoplasty - per quadrant	0-999	per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes		pre-op x-rays,perio chart,narr of med nec,photos optional
D4211	gingivectomy or gingivoplasty, per tooth	0-999	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes		pre-op x-rays,perio chart,narr of med nec,photos optional
D4341	periodontal scaling and root planing - four or more teeth per quadrant	13-999	per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One (D4341) per 36 months per patient per quadrant. Not allowed with D1110 or D1120.	periodontal charting and pre-op x-rays
D4342	periodontal scaling and root planing - 1-3 teeth, per quadrant	13-999	per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	One (D4342) per 36 months per patient per quadrant. Not allowed with D1110 or D1120.	periodontal charting and pre-op x-rays
D4355	full mouth debridement to enable comprehensive periodontal evaluation	0-999		Yes	One (D4355) per 36 months per patient. Not payable on same day as D1110 or D1120.	pre-op x-rays or photos
D4910	periodontal maintenance procedures	0-999		Yes	One (D4910) per 12 months per patient. Not payable on same day as D1110 or D1120.	date of previous perio surgical or S&C service
D4999	Unspecified periodontal procedure, by reoprt	0-20		Yes	Health Check "Other Services". Use this code for unspecified surgical procedure with Health Check referral.	desc of proc and narrative of med necessity

Prosthodontics, removable

Prosthodontics, removable						
Code	Description	Age Limitation	Teeth Covered	Auth Required	Benefit Limitations	Doc Required
D5110	complete denture - maxillary	0-999	Per Arch (01, UA)	**Yes**	One (D5110) per 60 months per patient.	full mouth x-rays or panorex, or administrator / member statement on loss / theft
D5120	complete denture - mandibular	0-999	Per Arch (02, LA)	**Yes**	One (D5120) per 60 months per patient.	full mouth x-rays or panorex, or administrator / member statement on loss / theft
D5211	maxillary partial denture-resin base	0-999		**Yes**	One (D5211) per 60 months per patient.	full mouth x-rays or panorex, or administrator / member statement on loss / theft
D5212	mandibular partial denture-resin base	0-999		**Yes**	One (D5212) per 60 months per patient.	full mouth x-rays or panorex, or administrator / member statement on loss / theft

Prosthodontics, removable						
Code	Description	Age Limitation	Teeth Covered	Auth Required	Benefit Limitations	Doc Required
D5213	maxillary part denture - cast metal framework with resin bases	0-999		Yes	One (D5213) per 60 months per patient.	full mouth x-rays or panorex, or administrator / member statement on loss / theft
D5214	mandibular partial denture - cast metal framework with resin bases	0-999		Yes	One (D5214) per 60 months per patient.	full mouth x-rays or panorex, or administrator / member statement on loss / theft
D5225	maxillary partial denture-flexible base	0-999		Yes	One (D5225) per 60 months per patient.	full mouth x-rays or panorex, or administrator / member statement on loss / theft
D5226	mandibular partial denture-flexible base	0-999		Yes	One (D5226) per 60 months per patient.	full mouth x-rays or panorex, or administrator / member statement on loss / theft
D5510	repair broken complete denture base	0-999	Per Arch (01, 02, LA, UA)	No		
D5520	replace missing or broken teeth - complete denture (each tooth)	0-999		No		
D5610	repair resin denture base	0-999	Per Arch (01, 02, LA, UA)	No	One (D5610) per 1 day	

Prosthodontics, removable						
Code	Description	Age Limitation	Teeth Covered	Auth Required	Benefit Limitations	Doc Required
D5620	repair cast framework	0-999	Per Arch (01, 02, LA, UA)	No		
D5630	repair or replace broken clasp	0-999		No		
D5640	replace broken teeth-per tooth	0-999		No		
D5650	add tooth to existing partial denture	0-999		No		
D5660	add clasp to existing partial denture	0-999		No		
D5670	replace all teeth and acrylic on cast metal framework (maxillary)	0-999		**Yes**		date of service
D5671	rebase complete mandibular denture	0-999		**Yes**		date of service
D5750	reline complete maxillary denture (laboratory)	0-999		No	One (D5750) per 36 months per patient.	
D5751	reline complete mandibular denture (laboratory)	0-999		No	One (D5751) per 36 months per patient.	
D5760	reline maxillary partial denture (laboratory)	0-999		No	One (D5760) per 36 months per patient.	
D5761	reline mandibular partial denture (laboratory)	0-999		No	One (D5761) per 36 months per patient.	
D5922	false nose	0-999		**Yes**		narrative of medical necessity
D5923	temporary false eye	0-999		**Yes**		narrative of medical necessity

Prosthodontics, removable						
Code	Description	Age Limitation	Teeth Covered	Auth Required	Benefit Limitations	Doc Required
D5925	head Implant	0-999		Yes		narrative of medical necessity
D5926	false nose replacement	0-999		Yes		narrative of medical necessity
D5927	false ear replacement	0-999		Yes		narrative of medical necessity
D5928	false eye replacement	0-999		Yes		narrative of medical necessity
D5929	replacement face part	0-999		Yes		narrative of medical necessity
D5932	obturator prosthesis, definitive	0-999		Yes	One (D5932) per 6 months per patient.	narrative of medical necessity
D5936	temporary upper jaw	0-999		Yes		narrative of medical necessity
D5955	palatal lift prosthesis, definitive	0-999		Yes	One (D5955) per 6 months per patient.	narrative of medical necessity
D5958	false roof of mouth part	0-999		Yes		narrative of medical necessity
D5960	speech aid	0-999		Yes		narrative of medical necessity

Prosthodontics, removable						
Code	Description	Age Limitation	Teeth Covered	Auth Required	Benefit Limitations	Doc Required
D5991	vesiculobullous disease medicament carrier	0-999		Yes		narrative of medical necessity
D5999	unspecified maxillofacial prosthesis, by report	0-999		Yes		desc of proc and narrative of med

Prosthodontics, fixed

Prosthodontics, fixed						
Code	Description	Age Limitation	Teeth Covered	Auth Required	Benefit Limitations	Doc Required
D6211	pontic-cast base metal	0-999	Teeth 6 - 11, 22 - 27	**Yes**	Teeth 1 - 32, 51 - 82	pre-op x-rays of adj and opposing teeth
D6241	pontic-porcelain fused metal	0-999	Teeth 6 - 11, 22 - 27	**Yes**	Teeth 1 - 32, 51 - 82	pre-op x-rays of adj and opposing teeth
D6545	retainer - cast metal fixed	0-999	Teeth 5 - 12, 21 - 28	**Yes**	Teeth 1 - 32, 51 - 82	pre-op x-rays of adj and opposing teeth
D6751	crown-porcelain fused to metal	0-999	Teeth 5 - 12, 21 - 28	**Yes**	Teeth 1 - 32, 51 - 82	pre-op x-rays of adj and opposing teeth
D6791	crown - full cast base metal	0-999	Teeth 5 - 12, 21 - 28	**Yes**	Teeth 1 - 32, 51 - 82	pre-op x-rays of adj and opposing teeth
D6930	recement fixed partial denture	0-999		No		
D6940	stress breaker	0-999		**Yes**		doc describing type of device and narr of med nec
D6980	fixed partial denture repair	0-999	per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	**Yes**		narrative of medical necessity
D6985	pediatric partial denture, fixed	0-12	per Arch (01, 02, LA, UA)	**Yes**		pre-op x-rays or diagnostic quality photos, narr of med nec

Oral and Maxillofacial Surgery

Oral and Maxillofacial Surgery						
Code	Description	Age Limitation	Teeth Covered	Auth Required	Benefit Limitations	Doc Required
D7111	extraction, coronal remnants - deciduous tooth	0-999	Teeth A - T, AS - TS	No	One (D7111) per 1 lifetime per patient per tooth.	
D7140	extraction - erupted or exposed root	0-999	Teeth 1 - 32, 51 - 82, A - T, AS - TS	No	One (D7140, D7210, D7220, D7230, D7240 per 1 lifetime per patient per tooth. Prophylactic removal of asymptomatic teeth free from pathology is not covered.	
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	0-999	Teeth 1 - 32, 51 - 82, A - T, AS - TS	**Yes**	One (D7140, D7210, D7220, D7230, D7240 per 1 lifetime per patient per tooth. Prophylactic removal of asymptomatic teeth free from pathology is not covered.	pre-op x-rays (excluding bitewings)
D7220	removal of impacted tooth-soft tissue	0-999	Teeth 1 - 32, 51 - 82, A - T, AS - TS	**Yes**	One (D7140, D7210, D7220, D7230, D7240 per 1 lifetime per patient per tooth. Prophylactic removal of asymptomatic teeth free from pathology is not covered.	pre-op x-rays (excluding bitewings) and narr of med nec
D7230	Removal of impacted tooth partial boney	0-999	Teeth 1 - 32, 51 - 82, A - T, AS - TS	**Yes**	One (D7140, D7210, D7220, D7230, D7240 per 1 lifetime per patient per tooth. Prophylactic removal of asymptomatic teeth free from pathology is not covered.	pre-op x-rays (excluding bitewings) and narr of med nec

Oral and Maxillofacial Surgery						
Code	Description	Age Limitation	Teeth Covered	Auth Required	Benefit Limitations	Doc Required
D7240	removal of impacted tooth-completely bony	0-999	Teeth 1 - 32, 51 - 82, A - T, AS - TS	**Yes**	One (D7140, D7210, D7220, D7230, D7240 per 1 lifetime per patient per tooth. Prophylactic removal of asymptomatic teeth free from pathology is not covered.	pre-op x-rays (excluding bitewings) and narr of med nec
D7250	surgical removal of residual tooth roots	0-999	Teeth 1 - 32, 51 - 82, A - T, AS - TS	**Yes**	Not payable on same DOS as D7140, D7210, D7220, D7230, D7240.	pre-op x-rays (excluding bitewings) and narr of med nec
D7260	oroantral fistula closure	0-999		**Yes**		narrative of medical necessity
D7261	primary closure of a sinus perforation	0-999		**Yes**		narrative of medical necessity
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	0-999	Teeth 1 - 32, C - H, M - R, CS - HS, MS - RS	**Yes**		narrative of medical necessity
D7280	Surgical access of an unerupted tooth	0-20	Teeth 2 - 15, 18 - 31, 52 -65, 68-81	**Yes**		pre-op x-rays and narrative of medical nec
D7282	mobilization of erupted or malpositioned tooth to aid eruption	0-20	Teeth 2 - 15, 18 - 31, 52 -65, 68-81	**Yes**		pre-op x-rays and narrative of medical nec
D7283	placement of device to facilitate eruption of impacted tooth	0-20	Teeth 2 - 15, 18 - 31, 52 -65, 68-81	**Yes**		pre-op x-rays and narrative of medical nec
D7285	biopsy of oral tissue - hard (bone, tooth)	0-999		**Yes**	One (D7285) per 1 day per patient.	copy of pathology report
D7286	biopsy of oral tissue - soft (all others)	0-999		**Yes**	One (D7286) per 1 day per patient.	copy of pathology report
D7287	cytology sample collection	0-999		**Yes**	One (D7287) per 1 day per patient.	copy of pathology report
D7288	brush biopsy - transepithelial sample collection	0-999		**Yes**	One (D7288) per 1 day per patient.	copy of pathology report
D7310	alveoloplasty in conjunction with extractions per quadrant	0-999	per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	**Yes**		pre-operative x-rays (excluding bitewings)

Oral and Maxillofacial Surgery						
Code	Description	Age Limitation	Teeth Covered	Auth Required	Benefit Limitations	Doc Required
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	0-999	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes		pre-operative x-rays (excluding bitewings)
D7320	alveoloplasty not in conjunction with extractions - per quadrant	0-999	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes		pre-operative x-rays (excluding bitewings) and narr of med nec
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	0-999	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes		pre-operative x-rays (excluding bitewings) and narr of med nec
D7410	radical excision - lesion diameter up to 1.25cm	0-999		Yes	One (D7410) per 1 day per patient.	Pathology report
D7411	excision of benign lesion greater than 1.25 cm	0-999		Yes	One (D7411) per 1 day per patient.	Pathology report
D7412	excision of benign lesion, complicated	0-999		Yes	One (D7412) per 1 day per patient.	Pathology report
D7413	excision of malignant lesion up to	0-999		Yes	One (D7413) per 1 day per patient.	Pathology report
D7414	excision of malignant lesion greater than 1.25 cm	0-999		Yes	One (D7414) per 1 day per patient.	Pathology report
D7415	excision of malignant lesion, complicated	0-999		Yes	One (D7415) per 1 day per patient.	Pathology report
D7440	excision of malignant tumor - lesion diameter up to 1.25cm	0-999		Yes	One (D7440) per 1 day per patient.	Pathology report
D7441	excision of malignant tumor - lesion diameter greater than 1.25cm	0-999		Yes	One (D7441) per 1 day per patient.	Pathology report
D7450	removal of odontogenic cyst or tumor - lesion diameter up to 1.25cm	0-999		Yes	One (D7450) per 1 day per patient.	Pathology report
D7451	removal of odontogenic cyst or tumor - lesion greater than 1.25cm	0-999		Yes	One (D7451) per 1 day per patient.	Pathology report

Oral and Maxillofacial Surgery						
Code	Description	Age Limitation	Teeth Covered	Auth Required	Benefit Limitations	Doc Required
D7460	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	0-999		Yes	One (D7460) per 1 day per patient.	Pathology report
D7461	removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25cm	0-999		Yes	One (D7461) per 1 day per patient.	Pathology report
D7471	removal of exostosis - per site	0-999	per Arch (01, 02, LA, UA)	Yes		narr of med nec ,x-rays or photos optional
D7472	removal of torus palatinus	0-999		Yes		narr of med nec,x-rays or photos optional
D7473	removal of torus mandibularis	0-999		Yes		narr of med nec,x-rays or photos optional
D7485	surgical reduction of osseous tuberosity	0-999		Yes		narr of med nec,x-rays or photos optional
D7490	radical resection of mandible with bone graft	0-999		Yes		narr of med nec,x-rays or photos optional
D7510	incision and drainage of abscess - intraoral soft tissue	0-999		Yes		narr of med nec,x-rays or photos optional
D7511	incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	0-999		Yes		narr of med nec,x-rays or photos optional
D7520	incision and drainage of abscess - extraoral soft tissue	0-999		Yes		narr of med nec,x-rays or photos optional
D7521	incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	0-999		Yes		narr of med nec,x-rays or photos optional
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	0-999		Yes		narr of med nec,x-rays or photos optional
D7540	removal of reaction-producing foreign bodies, musculoskeletal system	0-999		Yes		narr of med nec,x-rays or photos optional
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	0-999	per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes		narr of med nec,x-rays or photos optional

Oral and Maxillofacial Surgery						
Code	Description	Age Limitation	Teeth Covered	Auth Required	Benefit Limitations	Doc Required
D7560	maxillary sinusotomy for removal of tooth fragment or foreign body	0-999		Yes		narr of med nec,x-rays or photos optional
D7610	maxilla - open reduction	0-999		Yes		narr of med nec,x-rays or photos optional
D7620	maxilla - closed reduction	0-999		Yes		narr of med nec,x-rays or photos optional
D7630	mandible-open reduction	0-999		Yes		narr of med nec,x-rays or photos optional
D7640	mandible - closed reduction	0-999		Yes		narr of med nec,x-rays or photos optional
D7650	malar and/or zygomatic arch-open reduction	0-999		Yes		narr of med nec,x-rays or photos optional
D7660	malar and/or zygomatic arch-closed	0-999		Yes		narr of med nec,x-rays or photos optional
D7670	alveolus stabilization of teeth, closed reduction splinting	0-999		Yes		narr of med nec,x-rays or photos optional
D7671	alveolus - open reduction, may include stabilization of teeth	0-999		Yes		narr of med nec,x-rays or photos optional
D7680	facial bones - complicated reduction with fixation and multiple surgical approaches	0-999		Yes		narr of med nec,x-rays or photos optional
D7710	maxilla - open reduction	0-999		Yes		narr of med nec,x-rays or photos optional
D7720	maxilla - closed reduction	0-999		Yes		narr of med nec,x-rays or photos optional
D7730	mandible - open reduction	0-999		Yes		narr of med nec,x-rays or photos optional
D7740	mandible - closed reduction	0-999		Yes		narr of med nec,x-rays or photos optional
D7750	malar and/or zygomatic arch-open reduction	0-999		Yes		narr of med nec,x-rays or photos optional
D7760	malar and/or zygomatic arch-closed reduction	0-999		Yes		narr of med nec,x-rays or photos optional
D7770	alveolus-stabilization of teeth, open reduction splinting	0-999		Yes		narr of med nec,x-rays or photos optional
D7771	alveolus, closed reduction stabilization of teeth	0-999		Yes		narr of med nec,x-rays or photos optional
D7780	facial bones - complicated reduction with fixation and multiple surgical approaches	0-999		Yes		narr of med nec,x-rays or photos optional
D7810	open reduction of dislocation	0-999		Yes		narr of med nec,x-rays or photos optional

Oral and Maxillofacial Surgery						
Code	Description	Age Limitation	Teeth Covered	Auth Required	Benefit Limitations	Doc Required
D7820	closed reduction dislocation	0-999		Yes	One (D7820) per 1 day per patient.	narr of med nec,x-rays or photos optional
D7830	manipulation under anesthesia	0-999		Yes		narr of med nec,x-rays or photos optional
D7840	condylectomy	0-999		Yes		narr of med nec,x-rays or photos optional
D7850	surgical discectomy, with/without implant	0-999		Yes		narr of med nec,x-rays or photos optional
D7852	jaw joint surgery - disc repair	0-999		Yes		narr of med nec,x-rays or photos optional
D7854	jaw joint surgery - synovectomy	0-999		Yes		narr of med nec,x-rays or photos optional
D7856	jaw joint surgery - myotomy	0-999		Yes		narr of med nec,x-rays or photos optional
D7858	jaw joint surgery - joint reconstruction	0-999		Yes		narr of med nec,x-rays or photos optional
D7860	arthrotomy	0-999		Yes		narr of med nec,x-rays or photos optional
D7865	jaw joint surgery - arthroplasty	0-999		Yes		narr of med nec,x-rays or photos optional
D7871	non-arthroscopic lysis and lavage	0-999		Yes	One (D7871) per 36 months per patient per arch.	narr of med nec,x-rays or photos optional
D7872	jaw joint surgery - arthroscopy diagnosis with or without biopsy	0-999		Yes		narr of med nec,x-rays or photos optional
D7873	jaw joint surgery - arthroscopy surgical: lavage and lysis of adhesions	0-999		Yes		narr of med nec,x-rays or photos optional
D7874	jaw joint surgery - arthroscopy surgical: disc repositioning	0-999		Yes		narr of med nec,x-rays or photos optional
D7875	jaw joint surgery - arthroscopy surgical: synovectomy	0-999		Yes		narr of med nec,x-rays or photos optional
D7876	jaw joint surgery - arthroscopy surgical: discectomy	0-999		Yes		narr of med nec,x-rays or photos optional
D7877	jaw joint surgery - arthroscopy surgical: debridement	0-999		Yes		narr of med nec,x-rays or photos optional

Oral and Maxillofacial Surgery						
Code	Description	Age Limitation	Teeth Covered	Auth Required	Benefit Limitations	Doc Required
D7899	unspecified TMD therapy, by report	0-999		Yes		desc of proc and narrative of med necessity
D7910	suture small wounds up to 5 cm	0-999		Yes	One (D7910) per 1 day per patient.	narr of med nec,x-rays or photos optional
D7911	complicated suture-up to 5 cm	0-999		Yes	One (D7911) per 1 day per patient.	narr of med nec,x-rays or photos optional
D7912	complex suture - greater than 5cm	0-999		Yes	One (D7912) per 1 day per patient.	narr of med nec,x-rays or photos optional
D7940	osteoplasty- for orthognathic deformities	0-20		Yes	HealthCheck referral only.	narr of med nec,x-rays or photos optional
D7950	osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report	0-999		Yes		narr of med nec,x-rays or photos optional
D7951	sinus augmentation	0-999		Yes		narr of med nec,x-rays or photos optional
D7960	frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure	0-20		Yes		narr of med nec,x-rays or photos optional
D7970	excision of hyperplastic tissue - per arch	0-999	per Arch (01, 02, LA, UA)	Yes		pre-op x-rays,narr of medical nec,photos optional
D7972	surgical reduction of fibrous tuberosity	0-999		Yes		pre-op x-rays,narr of medical nec,photos optional
D7980	sialolithotomy	0-999		Yes		narr of med nec,x-rays or photos optional
D7991	coronoidectomy	0-999		Yes		narr of med nec,x-rays or photos optional
D7997	appliance removal (not by dentist who placed appliance), includes removal of archbar	0-999		Yes		narr of med nec,x-rays or photos optional
D7999	unspecified oral surgery procedure, by report	0-999		Yes		narr of med nec,x-rays or photos optional

Orthodontics

Orthodontics						
Code	Description	Age Limitation	Teeth Covered	Auth Required	Benefit Limitations	Doc Required
D8010	limited orthodontic treatment of the primary dentition	0-20		Yes	HealthCheck referral.	panoramic or full mouth x-rays, cephalometric x-ray, diagnostic quality photos, salzman scoresheet, narr of med necessity, Health Check referral form
D8020	limited orthodontic treatment of the transitional dentition	0-20		Yes	HealthCheck referral.	panoramic or full mouth x-rays, cephalometric x-ray, diagnostic quality photos, salzman scoresheet, narr of med necessity, Health Check referral form
D8030	limited orthodontic treatment of the adolescent dentition	0-20		Yes	HealthCheck referral.	panoramic or full mouth x-rays, cephalometric x-ray, diagnostic quality photos, salzman scoresheet, narr of med necessity, Health Check referral form
D8040	limited orthodontic treatment of the adult dentition	0-20		Yes	HealthCheck referral.	panoramic or full mouth x-rays, cephalometric x-ray, diagnostic quality photos, salzman scoresheet, narr of med necessity, Health Check referral form
D8050	interceptive orthodontic treatment of the primary dentition	0-20		Yes	HealthCheck referral.	panoramic or full mouth x-rays, cephalometric x-ray, diagnostic quality photos, salzman scoresheet, narr of med necessity, Health Check referral form
D8060	interceptive orthodontic treatment of the transitional dentition	0-20		Yes	HealthCheck referral.	panoramic or full mouth x-rays, cephalometric x-ray, diagnostic quality photos, salzman scoresheet, narr of med necessity, Health Check referral form
D8070	comprehensive orthodontic treatment of the transitional dentition	0-20		Yes	HealthCheck referral.	panoramic or full mouth x-rays, cephalometric x-ray, diagnostic quality photos, salzman scoresheet, narr of med necessity, Health Check referral form

Orthodontics						
Code	Description	Age Limitation	Teeth Covered	Auth Required	Benefit Limitations	Doc Required
D8080	comprehensive orthodontic treatment of the adolescent dentition	0-20		Yes	HealthCheck referral.	panoramic or full mouth x-rays, cephalometric x-ray, diagnostic quality photos, salzman scoresheet, narr of med necessity, Health Check referral form
D8090	comprehensive orthodontic treatment of the adult dentition	0-20		Yes	HealthCheck referral.	panoramic or full mouth x-rays, cephalometric x-ray, diagnostic quality photos, salzman scoresheet, narr of med necessity, Health Check referral form
D8210	removable appliance therapy (includes appliances for thumb sucking and tongue thrusting)	0-20		Yes	HealthCheck referral.	panoramic or full mouth x-rays, cephalometric x-ray, diagnostic quality photos, salzman scoresheet, narr of med necessity, Health Check referral form
D8220	fixed appliance therapy (includes appliances for thumb sucking and tongue thrusting)	0-20		Yes	HealthCheck referral.	panoramic or full mouth x-rays, cephalometric x-ray, diagnostic quality photos, salzman scoresheet, narr of med necessity, Health Check referral form
D8660	pre-orthodontic treatment visit	0-20		Yes	HealthCheck referral.	Health Check referral form
D8670	periodic orthodontic treatment visit (as part of contract)	0-20		No	Record of original banding required. 24 (D8670) per lifetime	
D8680	orthodontic retention (removal of appliances)	0-20		No	Record of original banding required.	
D8692	replacement of lost or broken retainer	0-20	per Arch (01, 02, LA, UA)	Yes	HealthCheck referral.	narr of active ortho case
D8693	rebonding or recementing of fixed retainers	0-999		No		

Adjunctive General Services

Adjunctive General Services						
Code	Description	Age Limitation	Teeth Covered	Auth Required	Benefit Limitations	Doc Required
D9110	palliative (emergency) treatment of dental pain - minor procedure	0-999		No		
D9220	deep sedation/general anesthesia	0-20		No	One (D9220, D9230, D9241, D9248) per patient per day.	
D9220	deep sedation/general anesthesia	21-999		Yes	One (D9220, D9230, D9241, D9248) per patient per day.	narrative of medical necessity
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	0-20		Yes	One (D9220, D9230, D9241, D9248) per patient per day.	narrative of medical necessity
D9241	intravenous conscious sedation/analgesia - first 30 minutes	0-20		No	One (D9220, D9230, D9241, D9248) per patient per day.	
D9241	intravenous conscious sedation/analgesia - first 30 minutes	21-999		Yes	One (D9220, D9230, D9241, D9248) per patient per day.	narrative of medical necessity
D9248	non-intravenous conscious sedation	0-20		No	One (D9220, D9230, D9241, D9248) per patient per day.	
D9248	non-intravenous conscious sedation	21-999		Yes	One (D9220, D9230, D9241, D9248) per patient per day.	narrative of medical necessity
D9420	hospital or ambulatory surgical center call	0-20		Yes	Two per stay.	narr of time spent and medical necessity
D9610	therapeutic drug injection, by report	0-20		Yes		desc of drugs and parental administration
D9612	therapeutic drug injection - 2 or more medications by report	0-20		Yes		desc of drugs and parental administration
D9910	application of desensitizing medicament	0-999		No		

Adjunctive General Services						
Code	Description	Age Limitation	Teeth Covered	Auth Required	Benefit Limitations	Doc Required
D9999	unspecified adjunctive procedure, by report	0-999		Yes		desc of proc and narrative of med necessity and if necessary name of hospital/outpatient facility