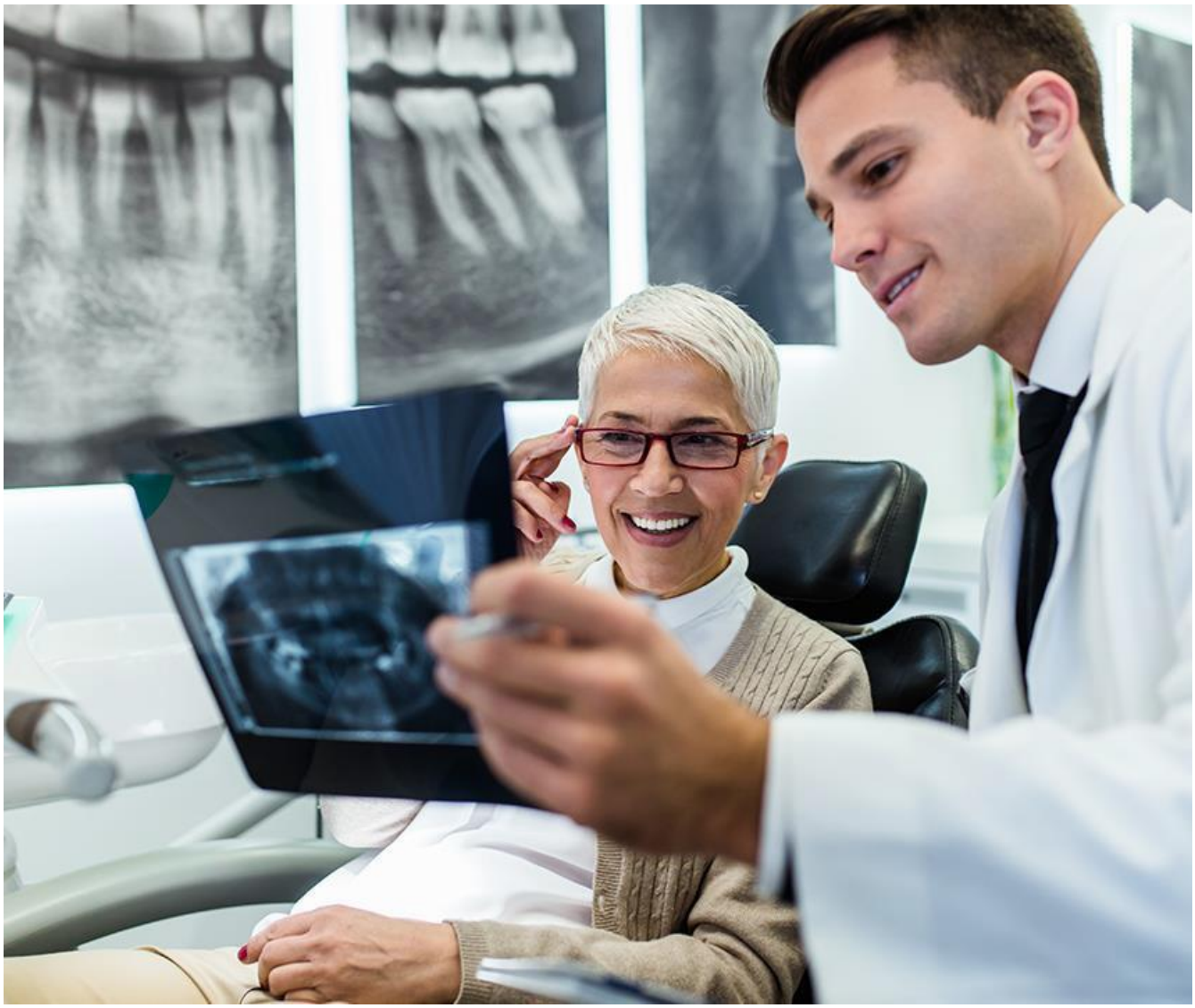
DentaQuest

DENTAL OFFICE REFERENCE MANUAL

CareSource

CareSource Health Insurance Marketplace Plans
PO Box 2906
Milwaukee, WI 53201-2906

www.dentaquest.com



DentaQuest makes every effort to maintain accurate information in this manual; however, will not be held liable for any damages directly or indirectly due to typographical errors. Please contact us should you discover an error.

DentaQuest, LLC

Statement of Members Rights and Responsibilities

The mission of DentaQuest is to expand access to high-quality, compassionate healthcare services within the allocated resources. DentaQuest is committed to ensuring that all Members are treated in a manner that respects their rights and acknowledges its expectations of Member's responsibilities. The following is a statement of Member's rights and responsibilities:

- All Members have a right to receive pertinent written and up-to-date information about DentaQuest, the managed care services DentaQuest provides, the Participating Providers and dental offices, as well as Member rights and responsibilities.
- All Members have a right to privacy, respect, and receive care that is culturally appropriate and respects their cultural and ethnic background and origins.
- All Members have the right to fully participate with caregivers in the decision-making process surrounding their health care.
- All Members have the right to be fully informed about the appropriate or medically necessary treatment options for any condition, regardless of the coverage or cost for the care discussed.
- All Members have the right to voice a complaint against DentaQuest, 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.
- All Members have the right to appeal any decisions related to patient care and treatment. Members may also request an external review or second opinion.
- All Members have the right to make recommendations regarding DentaQuest's/Plan's members' rights and responsibilities policies.

Likewise:

- All Members have the responsibility to provide, to the best of their abilities, accurate information that DentaQuest and its participating dentists need in order to provide the highest quality of health care services.
- All Members have a responsibility to closely follow the treatment plans and home care instructions for the care that they have agreed upon with their health care practitioners. All Members have the responsibility to participate in understanding their health problems and developing mutually agreed upon treatment goals to the degree possible.

DentaQuest, LLC

Statement of Provider Rights and Responsibilities

- Providers shall have the responsibilities and/or rights to: Identify and diagnose the member's oral health needs, maintaining open communication with a Member to discuss treatment needs (covered and noncovered plan benefit services) and recommended alternatives for medically necessary treatment, providing care directly or referring members to the best place for that care.

- If a recommended course of treatment is not covered, e.g., not approved by Plan (DentaQuest), the participating Provider must notify the Member in writing and obtain a signature of waiver if the Provider intends to charge the Member for a non-compensable service.

- Provide culturally competent and timely care.

- File an appeal or complaint pursuant to the procedures of CareSource.

- Supply accurate, relevant, factual information to a Member in connection with an appeal or complaint filed by the Member.

- Object to policies, procedures, or decisions made by Plan (DentaQuest).

- To be informed of the status of their credentialing or re-credentialing application, upon request.

- Comply with this Provider Office Reference Manual, policies and procedures, and the terms of the Provider Agreement.

* * *

DentaQuest, LLC
Address and Telephone Numbers

Provider Services:
PO Box 2906
Milwaukee, WI 53201-2906

North Carolina- 844-831-9098
Ohio-855.208.6575
All Others-855.398.8413

Fax numbers:
Claims/payment issues: 262.241.7379
Claims to be processed: 262.834.3589
All other: 262.834.3450

Claims Questions:
denclaims@dentaquest.com

Eligibility or Benefit Questions:
denelig.benefits@dentaquest.com

Member Services:
833-230-2099
TTY: 711

Fraud Hotline:
800.237.9139

Credentialing:
PO Box 2906
Milwaukee, WI 53201-2906
Credentialing Hotline: 800.233.1468

Authorizations should be sent to:
DENTAQUEST
PO Box 2906
Milwaukee, WI 53201-2906

Claims should be sent to:
DENTAQUEST
PO Box 2906
Milwaukee, WI 53201-2906

Electronic Claims should be sent:
Direct entry on the web
https://dentaquest.com/dentists/login/
Or:
Via Clearinghouse – Payer ID CX014
Include address on electronic claims –
DentaQuest, LLC
PO Box 2906
Milwaukee, WI 53201-2906

Table of Contents

SECTION 1 Contracting and Credentialing

Every plan requires that DentaQuest credential providers. DentaQuest's credentialing process adheres to National Committee for Quality Assurance (NCQA), Utilization Review Accreditation Commission (URAC), and Plan requirements.

DentaQuest, in conjunction with the Plan, has the right to determine which dentists (DDS or DMD); it shall accept and continue as Participating Providers. The purpose of DentaQuest's credentialing policies and procedures is to provide a general guide for the acceptance, discipline, and termination of Participating Providers. DentaQuest reviews each Participating Provider's practice history including, but not limited to, license actions, quality of care issues, and any history of criminal conduct, when making credentialing decisions.

Nothing in this Office Reference Manual or DentaQuest's credentialing policies and procedures limits DentaQuest's discretion to accept and discipline Participating Providers, including the right to restrict or suspend a Participating Provider's network participation.

Credentials Committee Denials (Policy PEC01)

If a provider's application to be a Participating Provider has been denied by DentaQuest's Credentials Committee, the provider must wait twelve (12) months from the date of his or her denial letter to reapply for participation in the network.

Recredentialing (Policy PEC01)

All actively participating providers must be reviewed every thirty-six (36) months from the date of their previous credentialing action.

Disciplinary Actions, Corrective Action Plans & Provider Appeals (Policy PEC05)

This policy includes actions which may be taken by DentaQuest in the event of quality-of-care issues, noncompliance with program requirements, or failure to adhere to DentaQuest's policies and procedures by Participating Providers.

Appeal of Credentials Committee Termination (Policy PEC05)

If the Credentials Committee terminates a Participating Provider from network participation, the Committee will offer the provider an opportunity to appeal the termination. The provider must request an appeal in writing and the request must be received by DentaQuest within thirty (30) days of the date the Committee gave notice of its decision to the provider. If the Credentials Committee decides to uphold a Participating Provider's termination on appeal, the Participating Provider must wait twelve (12) months from the date of his or her decision letter to reapply for participation in the network.

Note: The aforementioned policies are available upon request by emailing credentialscommittee@greatdentalplans.com

SECTION 2 Member Eligibility Verification Procedures

Plan Eligibility

Any person who is enrolled in a Plan's program is eligible for benefits under the Plan certificate subject to the below criteria:

- All pediatric members are eligible for pediatric benefits, regardless of Plan.
- Adult members in Georgia are always eligible for the Class V - Oral Surgical Services benefits.
- Adult members in all markets are only eligible for the Adult Dental Benefits if they are on a plan with the Adult Dental, Vision, & Fitness benefits.

Members are considered pediatric until the end of the month in which they turn the below age:

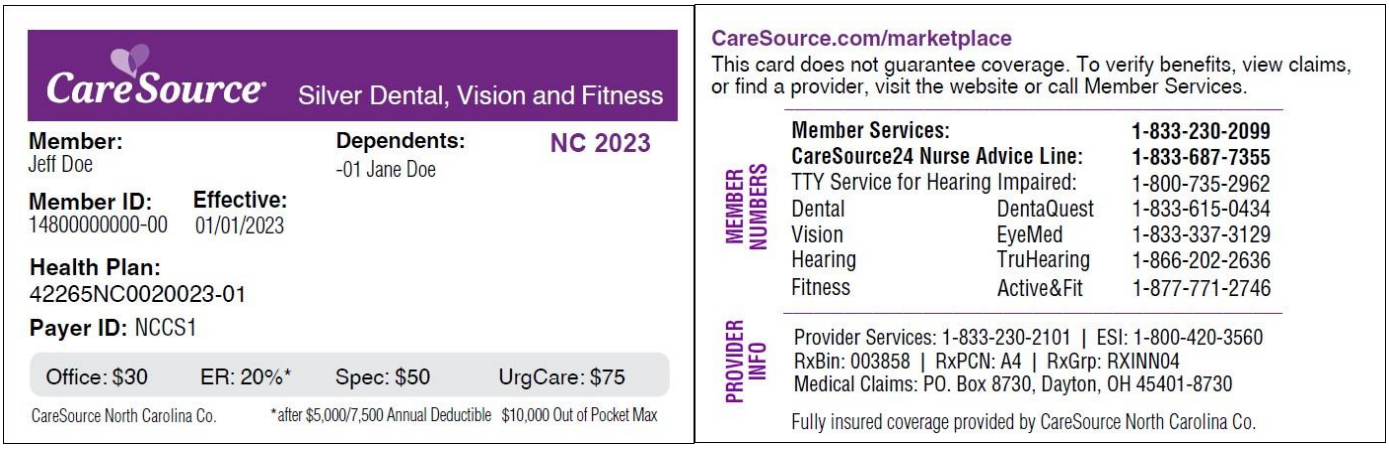
- KY-21 years old
- All other states-19 years old

Member Identification Card

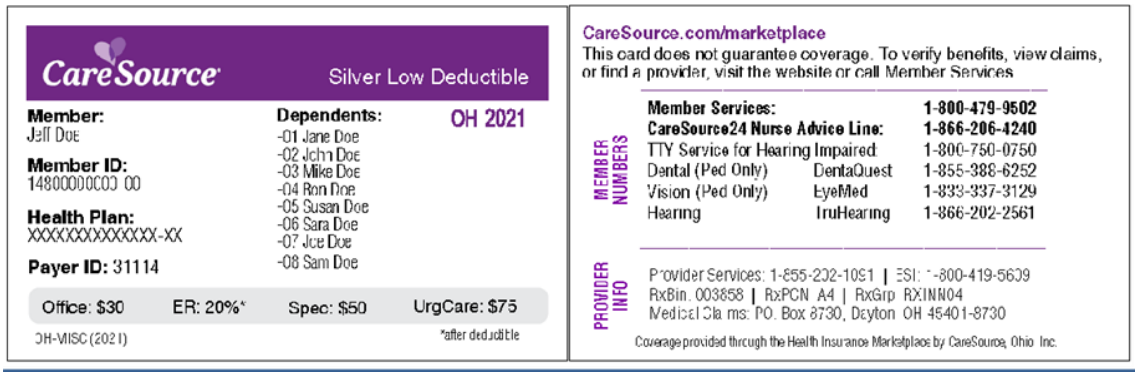
Participating Providers are responsible for verifying that Members are eligible at the time services are rendered and to determine if recipients have other health insurance. Please note that due to possible eligibility status changes, this information does not guarantee payment and is subject to change without notice. Members will receive a Health Plan ID Card. CareSource cards are similar but have separate branding. ID Cards are generally the same across different states. Plans with the Adult Dental, Vision, & Fitness benefits will have "Dental, Vision and Fitness" in the plan name. Plans without Adult Dental, Vision, and Fitness benefits will not show this in the plan name, and the back of the ID Card will note "Dental (Ped Only).

Please note: The Member's ID card will have their Medical Plan Payor ID (CareSource). Do not use this payor ID for Dental. Use the **DentaQuest Payor ID (CX014)**, as noted under the Electronic Claims Submission Section of this manual.

Marketplace ID Card-WITH Adult Dental, Vision and Fitness Benefits



Marketplace ID Card-WITHOUT Adult Dental, Vision and Fitness Benefits



DentaQuest recommends that each dental office make a photocopy of the Member's identification card each time treatment is provided. It is important to note that the Health Plan identification card is not dated, and it does not need to be returned to the Health Plan should a Member lose eligibility. Therefore, **an identification card in itself does not guarantee that a person is currently enrolled in the Health Plan.**

DentaQuest Eligibility Systems

Participating Providers may access Member eligibility information through DentaQuest's Interactive Voice Response (IVR) system or through the "Providers Only" section of DentaQuest's website at www.dentaquest.com. The eligibility information received from either system will be the same information you would receive by calling DentaQuest's Provider Services department; however, by utilizing either system you can get information 24 hours a day, 7 days a week without having to wait for an available Provider Services Representative.

Access to eligibility information via the Internet

DentaQuest's internet currently allows Providers to verify a Member's eligibility as well as submit claims directly to DentaQuest. You can verify the Member's eligibility on-line by entering the Member's date of birth, the expected date of service and the Member's identification number or last name and first initial. To access the eligibility information via DentaQuest's website, simply log on to the website at www.dentaquestgov.com. Once you have entered the website, click on "Dentist". From there choose your 'State" and press go. You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business's NPI or TIN, State and Zip Code. If you have not received instructions on how to complete the Provider Self Registration process, contact DentaQuest's Provider Services Department at 855.343.4260. Once logged in, select "eligibility look up" and enter the applicable information for each Member you are inquiring about. You are able to check on an unlimited number of patients and can print off the summary of eligibility given by the system for your records.

Directions for using DentaQuest's IVR to verify eligibility

Entering system with Tax and Location ID's

1. Call DentaQuest Provider Services.
2. After the greeting, stay on the line for English or Press 1 for Spanish.
3. When prompted, Press or Say 2 for Eligibility.
4. When prompted, Press or Say 1 if you know your NPI (National Provider Identification number) and Tax ID number.
5. If you do not have this information, Press or Say 2. When prompted, enter your User ID (previously referred to as Location ID) and the last 4 digits of your Tax ID number.

6. Does the Member's ID have **numbers and letters** in it? If so, Press or Say 1. When prompted, enter the Member ID.
7. Does the Member's ID have **only numbers** in it? If so, Press or Say 2. When prompted, enter the member ID.
8. Upon system verification of the Member's eligibility, you will be prompted to repeat the information given, verify the eligibility of another member, get benefit information, get limited claim history on this member, or get fax confirmation of this call.
9. If you choose to verify the eligibility of an additional Member(s), you will be asked to repeat step 5 above for each Member.

Please note that due to possible eligibility status changes, the information provided by either system does not guarantee payment.

If you are having difficulty accessing either the IVR or website, please contact DentaQuest's Provider Services Department. They will be able to assist you in utilizing either system.

SECTION 3 Member Cost Sharing Responsibilities

When members use their CareSource benefits, they may be responsible for making payments toward those services. The amount they may need to pay varies based on the service received and the product they are enrolled under. See the Benefits Cost Shares below for details on cost sharing for each Exchange product and the Definitions section for terms you may not be familiar with. See Appendix B for the services that are covered and how they map to the listed cost share categories.

Depending on the service, members may be expected to pay one or more of the following:

- Copayment
- Coinsurance
- Deductible

Members will be 100% responsible for services that are not covered as part of their Evidence of Coverage.

Deductible

If a member has satisfied their deductible, they should not be charged for the deductible where it is applicable. Note that for family plans the deductible is 2 times the individual deductible and an individual can satisfy their individual deductible prior to satisfaction of the family deductible. Providers should contact DentaQuest via Provider Services line or utilize the Provider Web Portal to verify member deductible balance.

Maximum Out of Pocket (MOOP)

Cost Shares for Pediatric Benefits as well as the Class V – Oral Surgical Services (GA Only) accumulate to the MOOP and therefore, if a member has met their MOOP for the year, they should not be charged cost shares. The Adult Dental benefits, outside of Class V – Oral Surgical Services (GA Only), will continue to require cost share application even after the member's MOOP is met. Providers should contact DentaQuest via Provider Services line or utilize the Provider Web Portal to verify member MOOP balance.

Native American/Alaskan Indian Cost Share Plans (CSP)

"Limited" and "Zero" plan variations for Native Americans are also available. These provide the same services as the non-CSR plans, but cost shares are impacted.
Limited plans - identified by "Limited" in the title such as "CareSource Marketplace Low Premium Limited Dental, Vision, and Fitness" - have the same cost shares as the non-CSR plan, however if services are delivered through an Indian Health Care provider, no cost share is applied.

Zero plans - identified by "Zero" in the plan name such as "CareSource Marketplace Low Premium Zero Dental, Vision, and Fitness" - do not have any member responsibility and the plan pays for 100% of the cost of covered services.

Benefits Cost Share Charts

Not all categories of services will be covered by the member's plan. Please refer to the Exhibits for covered services by CDT code, member type, and state as well as prior authorization and benefit limitations.

Catastrophic and Bronze Plans

	Cost-Sharing Provisions	2023 Catastrophic Core	2023 Bronze HSA Eligible	2023 Bronze	2023 Bronze First
	Market Availability	KY ONLY	GA, IN, KY, WV, NC	All Markets	All Markets
	Medical Deductible (Individual shown, Family = 2x)	$9,100	$6,000	$9,100	$8,000
	Medical Maximum Out-of-Pocket (Individual shown, Family = 2x)	$9,100	$7,000	$9,100	$9,100
Pediatric Benefits	Class I - Diagnostic/Preventive	0% Coins after deductible	60% Coins after deductible	No Charge	No Charge
	Class II - Minor Restorative	0% Coins after deductible	60% Coins after deductible	No Charge After Deductible	40% Coins after deductible
	Class III - Major/Comprehensive	0% Coins after deductible	60% Coins after deductible	No Charge After Deductible	50% Coins after deductible
	Class IV - Orthodontics	0% Coins after deductible	60% Coins after deductible	No Charge After Deductible	60% Coins after deductible
	Deductible and MOOP	Medical Deductible and MOOP	Medical Deductible and MOOP	Medical Deductible and MOOP	Medical Deductible and MOOP
Adult Rider Benefits	Class I - Diagnostic/Preventive	N/A	N/A	No Charge	No Charge
	Class II - Minor Restorative	N/A	N/A	40% Coins (Not subject to Deductible)	40% Coins (Not subject to Deductible)
	Class III - Major/Comprehensive	N/A	N/A	50% Coins (Not subject to Deductible)	50% Coins (Not subject to Deductible)
	Class IV - Orthodontics	N/A	N/A	Not Covered	Not Covered
	Overall Limit	N/A	N/A	$1,000 Annual Limit	$1,000 Annual Limit
	Deductible and MOOP	N/A	N/A	No Deductible or MOOP	No Deductible or MOOP
GA EHB Benefits - Adults	Class V - Oral Surgical Services	0% Coins after deductible	60% Coins after deductible	No Charge After Deductible	50% Coins after deductible
	Class V - Deductible and MOOP	Medical Deductible and MOOP	Medical Deductible and MOOP	Medical Deductible and MOOP	Medical Deductible and MOOP

Low Premium Silver Plans

	Cost-Sharing Provisions	2023 Low Premium Silver (70)	2023 Low Premium Silver 1 (73)	2023 Low Premium Silver 2 (87)	2023 Low Premium Silver 3 (94)
	Market Availability	All Markets	All Markets	All Markets	All Markets
	Medical Deductible (Individual shown, Family = 2x)	$6,500	$6,000	$1,000	$300
	Medical Maximum Out-of-Pocket (Individual shown, Family = 2x)	$9,100	$7,250	$2800	$800
Pediatric Benefits	Class I - Diagnostic/Preventive	No Charge	No Charge	No Charge	No Charge
	Class II - Minor Restorative	30% Coins after deductible	30% Coins after deductible	25% Coins after deductible	20% Coins after deductible
	Class III - Major/Comprehensive	50% Coins after deductible	50% Coins after deductible	45% Coins after deductible	40% Coins after deductible
	Class IV - Orthodontics	55% Coins after deductible	55% Coins after deductible	50% Coins after deductible	50% Coins after deductible
	Deductible and MOOP	Medical Deductible and MOOP	Medical Deductible and MOOP	Medical Deductible and MOOP	Medical Deductible and MOOP
Adult Rider Benefits	Class I - Diagnostic/Preventive	No Charge	No Charge	No Charge	No Charge
	Class II - Minor Restorative	30% Coins (Not subject to Deductible)	30% Coins (Not subject to Deductible)	25% Coins (Not subject to Deductible)	20% Coins (Not subject to Deductible)
	Class III - Major/Comprehensive	50% Coins (Not subject to Deductible)	50% Coins (Not subject to Deductible)	45% Coins (Not subject to Deductible)	40% Coins (Not subject to Deductible)
	Class IV - Orthodontics	Not Covered	Not Covered	Not Covered	Not Covered
	Overall Limit	$1,000 Annual Limit	$1,000 Annual Limit	$1,000 Annual Limit	$1,000 Annual Limit
	Deductible and MOOP	No Deductible or MOOP	No Deductible or MOOP	No Deductible or MOOP	No Deductible or MOOP
GA EHB Benefits-Adults	Class V - Oral Surgical Services	50% Coins after deductible	30% Coins after deductible	20% Coins after deductible	10% Coins after deductible
	Class V - Deductible and MOOP	Medical Deductible and MOOP	Medical Deductible and MOOP	Medical Deductible and MOOP	Medical Deductible and MOOP

Federal Standard Silver and Standard Silver Plans

	Cost-Sharing Provisions	2023 Federal Standard Silver (70)	2023 Standard Silver (70)	2023 Federal Standard Silver 1 (73)	2023 Standard Silver 1 (73)
	Market Availability	GA, IN, OH, WV, NC	GA & KY Only	GA, IN, OH, WV, NC	GA & KY Only
	Medical Deductible (Individual shown, Family = 2x)	$5,800	$5,800	$5,700	$5,700
	Medical Maximum Out-of-Pocket (Individual shown, Family = 2x)	$8,900	$8,900	$7,200	$7,200
Pediatric Benefits	Class I - Diagnostic/Preventive	No Charge	No Charge	No Charge	No Charge
	Class II - Minor Restorative	25% Coins after deductible	25% Coins after deductible	25% Coins after deductible	25% Coins after deductible
	Class III - Major/Comprehensive	45% Coins after deductible	45% Coins after deductible	45% Coins after deductible	45% Coins after deductible
	Class IV - Orthodontics	55% Coins after deductible	55% Coins after deductible	55% Coins after deductible	55% Coins after deductible
	Deductible and MOOP	Medical Deductible and MOOP	Medical Deductible and MOOP	Medical Deductible and MOOP	Medical Deductible and MOOP
Adult Rider Benefits	Class I - Diagnostic/Preventive	No Charge	No Charge	No Charge	No Charge
	Class II - Minor Restorative	25% Coins (Not subject to Deductible)	25% Coins (Not subject to Deductible)	25% Coins (Not subject to Deductible)	25% Coins (Not subject to Deductible)
	Class III - Major/Comprehensive	45% Coins (Not subject to Deductible)	45% Coins (Not subject to Deductible)	45% Coins (Not subject to Deductible)	45% Coins (Not subject to Deductible)
	Class IV - Orthodontics	Not Covered	Not Covered	Not Covered	Not Covered
	Overall Limit	$1,000 Annual Limit	$1,000 Annual Limit	$1,000 Annual Limit	$1,000 Annual Limit
	Deductible and MOOP	No Deductible or MOOP	No Deductible or MOOP	No Deductible or MOOP	No Deductible or MOOP
GA EHB Benefits - Adults	Class V - Oral Surgical Services	40% Coins after deductible	40% Coins after deductible	40% Coins after Deductible	40% Coins after deductible
	Class V - Deductible and MOOP	Medical Deductible and MOOP	Medical Deductible and MOOP	Medical Deductible and MOOP	Medical Deductible and MOOP

Federal Standard Silver and Standard Silver Plans, cont.

	Cost-Sharing Provisions	2023 Federal Standard Silver 2 (87)	2023 Standard Silver 2 (87)	2023 Federal Standard Silver 3 (94)	2023 Standard Silver 3 (94)
	Market Availability	GA, IN, OH, WV, NC, IA	GA & KY Only	GA, IN, OH, WV, NC, IA	GA & KY Only
	Medical Deductible (Individual shown, Family = 2x)	$800	$900	$0	$250
	Medical Maximum Out-of-Pocket (Individual shown, Family = 2x)	$3,000	$2,800	$1,700	$900
Pediatric Benefits	Class I - Diagnostic/Preventive	No Charge	No Charge	No Charge	No Charge
	Class II - Minor Restorative	20% Coins after deductible	20% Coins after deductible	15% Coins	15% Coins after deductible
	Class III - Major/Comprehensive	40% Coins after deductible	40% Coins after deductible	40% Coins	40% Coins after deductible
	Class IV - Orthodontics	50% Coins after deductible	50% Coins after deductible	45% Coins	45% Coins after deductible
	Deductible and MOOP	Medical Deductible and MOOP	Medical Deductible and MOOP	Medical Deductible and MOOP	Medical Deductible and MOOP
Adult Rider Benefits	Class I - Diagnostic/Preventive	No Charge	No Charge	No Charge	No Charge
	Class II - Minor Restorative	20% Coins (Not subject to Deductible)	20% Coins (Not subject to Deductible)	15% Coins (Not subject to Deductible)	15% Coins (Not subject to Deductible)
	Class III - Major/Comprehensive	40% Coins (Not subject to Deductible)	40% Coins (Not subject to Deductible)	40% Coins (Not subject to Deductible)	40% Coins (Not subject to Deductible)
	Class IV - Orthodontics	Not Covered	Not Covered	Not Covered	Not Covered
	Overall Limit	$1,000 Annual Limit	$1,000 Annual Limit	$1,000 Annual Limit	$1,000 Annual Limit
	Deductible and MOOP	No Deductible or MOOP	No Deductible or MOOP	No Deductible or MOOP	No Deductible or MOOP
GA EHB Benefits - Adults	Class V - Oral Surgical Services	30% Coins after deductible	20% Coins after deductible	25% Coins (Not subject to deductible)	15% Coins (Not subject to deductible)
	Class V - Deductible and MOOP	Medical Deductible and MOOP	Medical Deductible and MOOP	Medical Deductible and MOOP	Medical Deductible and MOOP

Low Deductible Silver Plans

	Cost-Sharing Provisions	2023 Low Deductible Silver (70)	2023 Low Deductible Silver 1 (73)	2023 Low Deductible Silver 2 (87)	2023 Low Deductible Silver 3 (94)
	Market Availability	WV, NC	WV, NC	WV, NC	WV, NC
	Medical Deductible (Individual shown, Family = 2x)	$4,000	$3,800	$650	$200
	Medical Maximum Out-of-Pocket (Individual shown, Family = 2x)	$8,250	$7,000	$2,800	$1,000
Pediatric Benefits	Class I - Diagnostic/Preventive	No Charge	No Charge	No Charge	No Charge
	Class II - Minor Restorative	20% Coins after deductible	20% Coins after deductible	15% Coins after deductible	10% Coins after deductible
	Class III - Major/Comprehensive	40% Coins after deductible	40% Coins after deductible	40% Coins after deductible	35% Coins after deductible
	Class IV - Orthodontics	50% Coins after deductible	50% Coins after deductible	45% Coins after deductible	35% Coins after deductible
	Deductible and MOOP	Medical Deductible and MOOP	Medical Deductible and MOOP	Medical Deductible and MOOP	Medical deductible and MOOP
Adult Rider Benefits	Class I - Diagnostic/Preventive	No Charge	No Charge	No Charge	No Charge
	Class II - Minor Restorative	20% Coins (Not subject to Deductible)	20% Coins (Not subject to Deductible)	15% Coins (Not subject to Deductible)	10% Coins (Not subject to Deductible)
	Class III - Major/Comprehensive	40% Coins (Not subject to Deductible)	40% Coins (Not subject to Deductible)	40% Coins (Not subject to Deductible)	35% Coins (Not subject to Deductible)
	Class IV - Orthodontics	Not Covered	Not Covered	Not Covered	Not Covered
	Overall Limit	$1,000 Annual Limit	$1,000 Annual Limit	$1,000 Annual limit	$1,000 Annual Limit
	Deductible and MOOP	No Deductible or MOOP	No Deductible or MOOP	No Deductible or MOOP	No Deductible or MOOP
GA EHB Benefits - Adults	Class V - Oral Surgical Services	40% Coins after deductible	40% Coins after deductible	20% Coins after deductible	15% Coins after deductible
	Class V - Deductible and MOOP	Medical Deductible and MOOP	Medical Deductible and MOOP	Medical Deductible and MOOP	Medical Deductible and MOOP

Essential Silver Plans

	Cost-Sharing Provisions	2023 Essential Silver (70)	2023 Essential Silver 1 (73)	2023 Essential Silver 2 (87)	2023 Essential Silver 3 (94)
	Market Availability	GA,IN,OH,NC	GA,IN,OH,NC	GA,IN,OH,NC	GA,IN,OH,NC
	Medical Deductible (Individual shown, Family = 2x)	$6,150	$5,000	$1,700	$600
	Medical Maximum Out-of-Pocket (Individual shown, Family = 2x)	$6,150	$5,000	$1,700	$600
Pediatric Benefits	Class I - Diagnostic/Preventive	No Charge	No Charge	No Charge	No Charge
	Class II - Minor Restorative	25% Coins after deductible (No Charge After Deductible)	25% Coins after deductible (No Charge After Deductible)	25% Coins after deductible (No Charge After Deductible)	25% Coins after deductible (No Charge After Deductible)
	Class III - Major/Comprehensive	45% Coins after deductible (No Charge After Deductible)	45% Coins after deductible (No Charge After Deductible)	45% Coins after deductible (No Charge After Deductible)	45% Coins after deductible (No Charge After Deductible)
	Class IV - Orthodontics	55% Coins after deductible (No Charge After Deductible)	55% Coins after deductible (No Charge After Deductible)	55% Coins after deductible (No Charge After Deductible)	55% Coins after deductible (No Charge After Deductible)
	Deductible and MOOP	Medical Deductible and MOOP	Medical Deductible and MOOP	Medical Deductible and MOOP	Medical Deductible and MOOP
Adult Rider Benefits	Class I - Diagnostic/Preventive	No Charge	No Charge	No Charge	No Charge
	Class II - Minor Restorative	25% Coins (Not subject to Deductible)	25% Coins (Not subject to Deductible)	25% Coins (Not subject to Deductible)	25% Coins (Not subject to Deductible)
	Class III - Major/Comprehensive	45% Coins (Not subject to Deductible)	45% Coins (Not subject to Deductible)	45% Coins (Not subject to Deductible)	45% Coins (Not subject to Deductible)
	Class IV - Orthodontics	Not Covered	Not Covered	Not Covered	Not Covered
	Overall Limit	$1,000 Annual Limit	$1,000 Annual Limit	$1,000 Annual Limit	$1,000 Annual Limit
	Deductible and MOOP	No Deductible or MOOP	No Deductible or MOOP	No Deductible or MOOP	No Deductible or MOOP
GA EHB Benefits - Adults	Class V - Oral Surgical Services	No Charge after Deductible	No Charge after Deductible	No Charge after Deductible	No Charge after Deductible
	Class V - Deductible and MOOP	Medical Deductible and MOOP	Medical Deductible and MOOP	Medical Deductible and MOOP	Medical Deductible and MOOP

.

Gold and Zero Cost Share Plans

	Cost-Sharing Provisions	2023 Federal Standard Gold	2023 Gold	2023 Zero Cost Share
	Market Availability	GA, IN, OH, WV, NC	GA & KY Only	All Markets
	Medical Deductible (Individual shown, Family = 2x)	$2,000	$2,000	$0
	Medical Maximum Out-of-Pocket (Individual shown, Family = 2x)	$8,700	$7,000	$0
Pediatric Benefits	Class I - Diagnostic/Preventive	No Charge	No Charge	No Charge
	Class II - Minor Restorative	15% Coins after deductible	15% Coins after deductible	No Charge
	Class III - Major/Comprehensive	40% Coins after deductible	40% Coins after deductible	No Charge
	Class IV - Orthodontics	40% Coins after deductible	40% Coins after deductible	No Charge
	Deductible and MOOP	Medical Deductible and MOOP	Medical Deductible and MOOP	Medical Deductible and MOOP
Adult Rider Benefits	Class I - Diagnostic/Preventive	No Charge	No Charge	No Charge
	Class II - Minor Restorative	15% Coins (Not subject to Deductible)	15% Coins (Not subject to Deductible)	No Charge
	Class III - Major/Comprehensive	40% Coins (Not subject to Deductible)	40% Coins (Not subject to Deductible)	No Charge
	Class IV - Orthodontics	Not Covered	Not Covered	Not Covered
	Overall Limit	$1,000 Annual Limit	$1,000 Annual Limit	$1,000 Annual Limit
	Deductible and MOOP	No Deductible or MOOP	No Deductible or MOOP	No Deductible or MOOP
GA EHB Benefits - Adults	Class V - Oral Surgical Services	25% Coins after Deductible	25% Coins after Deductible	No Charge
	Class V - Deductible and MOOP	Medical Deductible and MOOP	Medical Deductible and MOOP	Medical Deductible and MOOP

Cost Share Category

General Cost Share Categories. Not all categories of services will be covered by the member's plan. Please refer to the **Covered Benefits Exhibits in Appendix** for covered services by CDT code, member type, and state as well as prior authorization and benefit limitations.

Dental Product & Cost Share		
Code	**Coverage**	**Cost Share Category**
D0120	Pediatric & Adult	Class I
D0140	Pediatric & Adult	Class I
D0145	Pediatric Only	Class I
D0150	Pediatric & Adult	Class I
D0160	Pediatric Only	Class I
D0180	Pediatric & Adult	Class I
D0210	Pediatric & Adult	Class I
D0220	Pediatric & Adult	Class I
D0230	Pediatric & Adult	Class I
D0240	Pediatric & Adult	Class I
D0250	Pediatric Only	Class I
D0270	Pediatric & Adult	Class I
D0272	Pediatric & Adult	Class I
D0273	Pediatric & Adult	Class I
D0274	Pediatric & Adult	Class I
D0277	Pediatric & Adult	Class I
D0330	Pediatric & Adult	Class I
D0340	Pediatric Only	Class I
D0350	Pediatric Only	Class I
D0391	Pediatric & Adult	Class I
D0470	Pediatric & Adult	Class I
D1110	Pediatric & Adult	Class I
D1120	Pediatric Only	Class I
D1206	Pediatric Only	Class I
D1208	Pediatric Only	Class I
D1351	Pediatric Only	Class I
D1352	Pediatric Only	Class I
D1354	Pediatric Only	Class I
D1355	Pediatric Only	Class I
D1510	Pediatric Only	Class I
D1516	Pediatric Only	Class I
D1517	Pediatric Only	Class I
D1520	Pediatric Only	Class I
D1526	Pediatric Only	Class I
D1527	Pediatric Only	Class I
D1551	Pediatric Only	Class I
D1552	Pediatric Only	Class I
D1553	Pediatric Only	Class I
D1556	Pediatric Only	Class I

D1557	Pediatric Only	Class I
D1558	Pediatric Only	Class I
D9110	Pediatric & Adult	Class I
D2140	Pediatric & Adult	Class II
D2150	Pediatric & Adult	Class II
D2160	Pediatric & Adult	Class II
D2161	Pediatric & Adult	Class II
D2330	Pediatric & Adult	Class II
D2331	Pediatric & Adult	Class II
D2332	Pediatric & Adult	Class II
D2335	Pediatric & Adult	Class II
D2391	Pediatric & Adult	Class II
D2392	Pediatric & Adult	Class II
D2393	Pediatric & Adult	Class II
D2394	Pediatric & Adult	Class II
D2910	Pediatric & Adult	Class II
D2915	Pediatric & Adult	Class II
D2920	Pediatric & Adult	Class II
D2928	Pediatric Only	Class II
D2929	Pediatric Only	Class II
D2930	Pediatric Only	Class II
D2931	Pediatric Only	Class II
D2933	Pediatric Only	Class II
D2934	Pediatric Only	Class II
D2940	Pediatric & Adult	Class II
D2951	Pediatric & Adult	Class II
D4910	Pediatric & Adult	Class II
D5410	Pediatric & Adult	Class II
D5411	Pediatric & Adult	Class II
D5421	Pediatric & Adult	Class II
D5422	Pediatric & Adult	Class II
D5511	Pediatric & Adult	Class II
D5512	Pediatric & Adult	Class II
D5520	Pediatric & Adult	Class II
D5611	Pediatric & Adult	Class II
D5612	Pediatric & Adult	Class II
D5621	Pediatric & Adult	Class II
D5622	Pediatric & Adult	Class II
D5630	Pediatric & Adult	Class II
D5640	Pediatric & Adult	Class II
D5650	Pediatric & Adult	Class II
D5660	Pediatric & Adult	Class II
D5710	Pediatric & Adult	Class II
D5711	Pediatric & Adult	Class II
D5720	Pediatric & Adult	Class II
D5721	Pediatric & Adult	Class II
D5730	Pediatric & Adult	Class II

D5731	Pediatric & Adult	Class II
D5740	Pediatric & Adult	Class II
D5741	Pediatric & Adult	Class II
D5750	Pediatric & Adult	Class II
D5751	Pediatric & Adult	Class II
D5760	Pediatric & Adult	Class II
D5761	Pediatric & Adult	Class II
D5850	Pediatric & Adult	Class II
D5851	Pediatric & Adult	Class II
D7111	Pediatric Only	Class II
D7140	Pediatric & Adult	Class II
D9230	Pediatric Only	Class II
D9310	Pediatric & Adult	Class II
D9311	Pediatric & Adult	Class II
D2510	Pediatric & Adult	Class III
D2520	Pediatric & Adult	Class III
D2530	Pediatric & Adult	Class III
D2542	Pediatric & Adult	Class III
D2543	Pediatric & Adult	Class III
D2544	Pediatric & Adult	Class III
D2740	Pediatric & Adult	Class III
D2750	Pediatric & Adult	Class III
D2751	Pediatric & Adult	Class III
D2752	Pediatric & Adult	Class III
D2780	Pediatric & Adult	Class III
D2781	Pediatric & Adult	Class III
D2782	Pediatric & Adult	Class III
D2783	Pediatric & Adult	Class III
D2790	Pediatric & Adult	Class III
D2791	Pediatric & Adult	Class III
D2792	Pediatric & Adult	Class III
D2794	Pediatric & Adult	Class III
D2950	Pediatric & Adult	Class III
D2952	Pediatric & Adult	Class III
D2953	Pediatric & Adult	Class III
D2954	Pediatric & Adult	Class III
D2957	Pediatric & Adult	Class III
D2961	Pediatric Only	Class III
D2962	Pediatric Only	Class III
D2980	Pediatric & Adult	Class III
D2981	Pediatric & Adult	Class III
D2982	Pediatric & Adult	Class III
D2983	Pediatric & Adult	Class III
D2990	Pediatric Only	Class III
D3220	Pediatric & Adult	Class III
D3221	Adult Only	Class III
D3222	Pediatric & Adult	Class III

D3230	Pediatric Only	Class III
D3240	Pediatric Only	Class III
D3310	Pediatric & Adult	Class III
D3320	Pediatric & Adult	Class III
D3330	Pediatric & Adult	Class III
D3346	Pediatric & Adult	Class III
D3347	Pediatric & Adult	Class III
D3348	Pediatric & Adult	Class III
D3351	Pediatric & Adult	Class III
D3352	Pediatric & Adult	Class III
D3353	Pediatric & Adult	Class III
D3355	Pediatric & Adult	Class III
D3356	Pediatric & Adult	Class III
D3357	Pediatric & Adult	Class III
D3410	Pediatric & Adult	Class III
D3421	Pediatric & Adult	Class III
D3425	Pediatric & Adult	Class III
D3426	Pediatric & Adult	Class III
D3471	Pediatric & Adult	Class III
D3472	Pediatric & Adult	Class III
D3473	Pediatric & Adult	Class III
D3501	Pediatric & Adult	Class III
D3502	Pediatric & Adult	Class III
D3503	Pediatric & Adult	Class III
D3450	Pediatric & Adult	Class III
D3920	Pediatric & Adult	Class III
D4210	Pediatric & Adult	Class III
D4211	Pediatric & Adult	Class III
D4212	Pediatric & Adult	Class III
D4240	Pediatric & Adult	Class III
D4241	Pediatric & Adult	Class III
D4249	Pediatric & Adult	Class III
D4260	Pediatric & Adult	Class III
D4261	Pediatric & Adult	Class III
D4263	Pediatric Only	Class III
D4270	Pediatric & Adult	Class III
D4273	Pediatric & Adult	Class III
D4275	Pediatric Only	Class III
D4277	Pediatric & Adult	Class III
D4278	Pediatric & Adult	Class III
D4283	Pediatric Only	Class III
D4285	Pediatric Only	Class III
D4341	Pediatric & Adult	Class III
D4342	Pediatric & Adult	Class III
D4355	Pediatric & Adult	Class III
D5110	Pediatric & Adult	Class III
D5120	Pediatric & Adult	Class III

D5130	Pediatric & Adult	Class III
D5140	Pediatric & Adult	Class III
D5211	Pediatric & Adult	Class III
D5212	Pediatric & Adult	Class III
D5213	Pediatric & Adult	Class III
D5214	Pediatric & Adult	Class III
D5221	Pediatric & Adult	Class III
D5222	Pediatric & Adult	Class III
D5223	Pediatric & Adult	Class III
D5224	Pediatric & Adult	Class III
D5282	Pediatric & Adult	Class III
D5283	Pediatric & Adult	Class III
D6010	Pediatric Only	Class III
D6012	Pediatric Only	Class III
D6040	Pediatric Only	Class III
D6050	Pediatric Only	Class III
D6055	Pediatric Only	Class III
D6056	Pediatric Only	Class III
D6057	Pediatric Only	Class III
D6058	Pediatric Only	Class III
D6059	Pediatric Only	Class III
D6060	Pediatric Only	Class III
D6061	Pediatric Only	Class III
D6062	Pediatric Only	Class III
D6063	Pediatric Only	Class III
D6064	Pediatric Only	Class III
D6065	Pediatric Only	Class III
D6066	Pediatric Only	Class III
D6067	Pediatric Only	Class III
D6068	Pediatric Only	Class III
D6069	Pediatric Only	Class III
D6070	Pediatric Only	Class III
D6071	Pediatric Only	Class III
D6072	Pediatric Only	Class III
D6073	Pediatric Only	Class III
D6074	Pediatric Only	Class III
D6075	Pediatric Only	Class III
D6076	Pediatric Only	Class III
D6077	Pediatric Only	Class III
D6080	Pediatric Only	Class III
D6081	Pediatric Only	Class III
D6082	Pediatric Only	Class III
D6083	Pediatric Only	Class III
D6084	Pediatric Only	Class III
D6086	Pediatric Only	Class III
D6087	Pediatric Only	Class III
D6088	Pediatric Only	Class III

D6090	Pediatric Only	Class III
D6091	Pediatric Only	Class III
D6095	Pediatric Only	Class III
D6097	Pediatric Only	Class III
D6098	Pediatric Only	Class III
D6099	Pediatric Only	Class III
D6100	Pediatric Only	Class III
D6101	Pediatric Only	Class III
D6102	Pediatric Only	Class III
D6103	Pediatric Only	Class III
D6104	Pediatric Only	Class III
D6105	Pediatric Only	Class III
D6110	Pediatric Only	Class III
D6111	Pediatric Only	Class III
D6112	Pediatric Only	Class III
D6113	Pediatric Only	Class III
D6114	Pediatric Only	Class III
D6115	Pediatric Only	Class III
D6116	Pediatric Only	Class III
D6117	Pediatric Only	Class III
D6120	Pediatric Only	Class III
D6121	Pediatric Only	Class III
D6122	Pediatric Only	Class III
D6123	Pediatric Only	Class III
D6190	Pediatric Only	Class III
D6195	Pediatric Only	Class III
D6197	Pediatric Only	Class III
D6210	Pediatric & Adult	Class III
D6211	Pediatric & Adult	Class III
D6212	Pediatric & Adult	Class III
D6214	Pediatric & Adult	Class III
D6240	Pediatric & Adult	Class III
D6241	Pediatric & Adult	Class III
D6242	Pediatric & Adult	Class III
D6243	Pediatric & Adult	Class III
D6245	Pediatric & Adult	Class III
D6545	Pediatric & Adult	Class III
D6548	Pediatric & Adult	Class III
D6549	Pediatric & Adult	Class III
D6600	Pediatric & Adult	Class III
D6601	Pediatric & Adult	Class III
D6602	Pediatric & Adult	Class III
D6603	Pediatric & Adult	Class III
D6604	Pediatric & Adult	Class III
D6605	Pediatric & Adult	Class III
D6606	Pediatric & Adult	Class III
D6607	Pediatric & Adult	Class III

D6608	Pediatric & Adult	Class III
D6609	Pediatric & Adult	Class III
D6610	Pediatric & Adult	Class III
D6611	Pediatric & Adult	Class III
D6612	Pediatric & Adult	Class III
D6613	Pediatric & Adult	Class III
D6614	Pediatric & Adult	Class III
D6615	Pediatric & Adult	Class III
D6624	Pediatric & Adult	Class III
D6634	Pediatric & Adult	Class III
D6740	Pediatric & Adult	Class III
D6750	Pediatric & Adult	Class III
D6751	Pediatric & Adult	Class III
D6752	Pediatric & Adult	Class III
D6753	Pediatric & Adult	Class III
D6780	Pediatric & Adult	Class III
D6781	Pediatric & Adult	Class III
D6782	Pediatric & Adult	Class III
D6783	Pediatric & Adult	Class III
D6784	Pediatric & Adult	Class III
D6790	Pediatric & Adult	Class III
D6791	Pediatric & Adult	Class III
D6792	Pediatric & Adult	Class III
D6794	Pediatric & Adult	Class III
D6930	Pediatric & Adult	Class III
D6980	Pediatric & Adult	Class III
D7210	Pediatric & Adult	Class III
D7250	Pediatric & Adult	Class III
D7251	Pediatric & Adult	Class III
D7280	Pediatric & Adult	Class III
D7283	Pediatric & Adult	Class III
D7471	Pediatric & Adult	Class III
D7510	Pediatric & Adult	Class III
D7910	Pediatric & Adult	Class III
D7953	Pediatric Only	Class III
D7970	Pediatric Only	Class III
D7971	Pediatric & Adult	Class III
D9222	Pediatric & Adult	Class III
D9223	Pediatric & Adult	Class III
D9239	Pediatric & Adult	Class III
D9243	Pediatric & Adult	Class III
D9610	Pediatric & Adult	Class III
D9930	Pediatric & Adult	Class III
D9943	Pediatric Only	Class III
D9944	Pediatric & Adult	Class III
D9945	Pediatric Only	Class III
D9946	Pediatric Only	Class III

D9951	Pediatric Only	Class III
D9995	Pediatric & Adult	Class III
D9996	Pediatric & Adult	Class III
D7220	Pediatric & Adult	Class III - OH, IN, KY, WV, NC, IA Class III - GA (Ped.) Class V- GA (Adults)
D7230	Pediatric & Adult	Class III - OH, IN, KY, WV, NC, IA Class III - GA (Ped.) Class V- GA (Adults)
D7240	Pediatric & Adult	Class III - OH, IN, KY, WV, NC, IA Class III - GA (Ped.) Class V- GA (Adults)
D7241	Pediatric & Adult	Class III - OH, IN, KY, WV, NC, IA Class III - GA (Ped.) Class V- GA (Adults)
D7270	Pediatric & Adult	Class III - OH, IN, KY, WV, NC, IA Class III - GA (Ped.) Class V- GA (Adults)
D7310	Pediatric & Adult	Class III - OH, IN, KY, WV, NC, IA Class III - GA (Ped.) Class V- GA (Adults)
D7311	Pediatric & Adult	Class III - OH, IN, KY, WV, NC, IA Class III - GA (Ped.) Class V- GA (Adults)
D7320	Pediatric & Adult	Class III- OH, IN, KY, WV, NC, IA Class III - GA (Ped.) Class V- GA (Adults)
D7321	Pediatric & Adult	Class III - OH, IN, KY, WV, NC, IA Class III - GA (Ped.) Class V- GA (Adults)
D7520	Pediatric & Adult	Class III - OH, IN, KY, WV, NC, IA Class III - GA (Ped.) Class V- GA (Adults)
D7961	IN, KY, OH, WV, NC, IA: Ped Only GA: Pediatric & Adult	Class III - OH, IN, KY, WV, NC, IA Class III - GA (Ped.) Class V- GA (Adults)
D7962	IN, KY, OH, WV, NC, IA: Ped Only GA: Pediatric & Adult	Class III - OH, IN, KY, WV, NC, IA Class III - GA (Ped.) Class V- GA (Adults)
D8010	Pediatric Only	Class IV
D8020	Pediatric Only	Class IV
D8030	Pediatric Only	Class IV
D8040	Pediatric Only	Class IV
D8070	Pediatric Only	Class IV
D8080	Pediatric Only	Class IV

D8090	Pediatric Only	Class IV

D8210	Pediatric Only	Class IV
D8220	Pediatric Only	Class IV
D8660	Pediatric Only	Class IV
D8670	Pediatric Only	Class IV
D8680	Pediatric Only	Class IV
D8698	Pediatric Only	Class IV
D8699	Pediatric Only	Class IV

SECTION 4 Authorization of Treatment

Dental Treatment Requiring Authorization

Authorization is a utilization tool that requires Participating Providers to submit documentation associated with certain dental services for a Member. Participating Providers will not be paid if this documentation is not provided to DentaQuest. Participating Providers must hold the Member, DentaQuest, Plan and Agency harmless as set forth in the Provider Participation Agreement if coverage is denied for failure to obtain authorization (either before or after service is rendered).

DentaQuest utilizes specific dental utilization criteria as well as an authorization process to manage utilization of services. DentaQuest's operational focus is to assure compliance with its utilization criteria. The criteria are included in this manual. Please review these criteria as well as the benefits covered to understand the decision-making process used to determine payment for services rendered.

Authorization For Non-Emergency Treatment

Services that require authorization (non-emergency) should not be started prior to the determination of coverage (approval or denial of the authorization). Non-emergency 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, the Plan and/or DentaQuest.

Your submission of documentation must include:

- Radiographs, narrative, or other information where requested (See Exhibits for specifics by code)
- CDT codes on the claim form

Your submission should be sent on an ADA approved claim form. The tables of Covered Services (Exhibits A - E) contain a column marked Authorization Required. A "Yes" in this column indicates that the service listed requires authorization (documentation) to be considered for reimbursement.

After a DentaQuest dental director reviews the documentation, the submitting office shall be provided an authorization number, if approved. The authorization number will be provided within two business days from the date the documentation is received. The authorization number will be issued to the submitting office by mail and must be submitted with the other required claim information after the treatment is rendered.

Authorization for Emergency Treatments

If a patient presents with an emergency condition that requires immediate treatment or intervention, you should always take necessary clinical steps to mitigate pain, swelling, or other symptoms that might put the members overall health at risk and completely document your findings. After treatment, please complete the appropriate authorization request, and enter EMERGENCY/ URGENT in box 35, and the appropriate narrative or descriptor of the patient's conditions, including all supporting documentation. Please FAX this to 262-241-7150.

DentaQuest will process emergency authorization requests as expedited. After you receive the authorization number, then and only then should you submit the claim. Our system will link the authorization number and the claim, and payment should be processed.

Electronic Attachments

DentaQuest accepts dental radiographs electronically via **FastAttach™** for authorization requests. DentaQuest, in conjunction with National Electronic Attachment, Inc. (NEA), allows Participating

Providers the opportunity to submit all claims electronically, even those that require attachments.

This program allows transmissions via secure Internet lines for radiographs, periodontic charts, intraoral pictures, narratives, and EOBs.

FastAttach™ is inexpensive and easy to use, reduces administrative costs, eliminates lost or damaged attachments, and accelerates claims and prior authorization processing. It is compatible with most claims clearinghouse or practice management systems.

For more information or to sign up for FastAttach go to https://fastattachweb.nea-fast.com/ or call NEA at: 1-800-782-5150

Specialist Referral Process

A patient requiring a referral to a dental specialist can be referred directly to any specialist contracted with DentaQuest without authorization from DentaQuest. The dental specialist is responsible for obtaining prior authorization for services according to Appendix B of this manual. If you are unfamiliar with the DentaQuest contracted specialty network or need assistance locating a certain specialty, please contact DentaQuest's Provider Services Department.

Participating Hospitals

DentaQuest does not pay for hospital or Ambulatory Surgical Center (ASC) facility- related services. In the scenario of a dental service being performed in a hospital/ASC unit, these services should be directed to the Member's Medical Insurer for coverage/payment of facility- related services. Following the normal procedures and ORM requirements, DentaQuest will pay for the dental services conducted in this scenario but will not pay for the facility-related and medical services (e.g. anesthesia Operating Room facility charges, etc.).The Facility should submit precertification request to CareSource Medical Utilization Management (UM) by calling 1-888-488-0132 or visiting the CareSource Provider Portal at www.caresource.com. If you have any questions regarding the role of DentaQuest in hospitalization or utilization of a medical facility for dental services, and/or coordination of these services please contact the Provider Services number for your market.

SECTION 5 Claims Submission Procedures Claims

Submission Options

DentaQuest receives dental claims in four possible formats. These formats include:

- Electronic claims via DentaQuest's website (https://govservices.dentaquest.com)
- Electronic submission via clearinghouses
- HIPAA Compliant 837D File
- Paper claims

Electronic Claim Submission Utilizing DentaQuest's Internet Website

Participating Providers may submit claims directly to DentaQuest by utilizing the "Dentist" section of our website. Submitting claims via the website is very quick and easy. It is especially easy if you have already accessed the site to check a Member's eligibility prior to providing the service.

To submit claims via the website, simply log on to https://govservices.dentaquest.com. Once you have entered the website, click on the "Dentist" icon. From there choose your 'State" and press go. You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business's NPI or TIN, State and Zip Code. DentaQuest should have contacted your office regarding how to perform Provider Self Registration. You may also contact DentaQuest's Provider Services Department at 855-343-4260. Once logged in, select "Claims/Pre-Authorizations" and then "Dental Claim Entry". The Dentist Portal allows you to attach electronic files (such as x-rays in jpeg format, reports, and charts) to the claim.

If you have questions on submitting claims or accessing the website, please contact our Systems Operations Department at 800-417-7140 or via e-mail at: EDITeam@greatdentalplans.com

Electronic Authorization Submission Utilizing DentaQuest's Internet Website

Participating Providers may submit pre-authorizations directly to DentaQuest by utilizing the "Dentist" section of our website. Submitting pre-authorizations via the website is very quick and easy. It is especially easy if you have already accessed the site to check a Member's eligibility prior to providing the service.

To submit pre-authorizations via the website, simply log on to https://govservices.dentaquest.com. Once you have entered the website, click on the "Dentist" icon. From there choose your 'State" and press go. You will then be able to log in using your password and ID. First time users will have to register by utilizing the Business's NPI or TIN, State and Zip Code. If you have not received instruction on how to complete Provider Self Registration contact DentaQuest's Provider Services Department at 855-343-4260. Once logged in, select "Claims/Pre-Authorizations" and then "Dental Pre-Auth Entry".

The Dentist Portal also allows you to attach electronic files (such as x-rays in jpeg format, reports, and charts) to the pre-authorization.

Electronic Claim Submission via Clearinghouse

DentaQuest works directly with Emdeon (1-888-255-7293), Tesia (1-800-724-7240), EDI Health Group 1-800-576-6412, Secure EDI 1-877-466-9656, and Mercury Data Exchange 1-866-633-1090, for claim submissions to DentaQuest.

You can contact your software vendor and make certain that they have DentaQuest listed as the payer and claim mailing address on your electronic claim. Your software vendor will be able to provide you with any information you may need to ensure that submitted claims are forwarded to DentaQuest.

DentaQuest's Payor ID is CX014.

HIPAA Compliant 837D File

For Providers who are unable to submit electronically via the internet or a clearinghouse, DentaQuest will work directly with the Provider to receive their claims electronically via a HIPAA compliant 837D or 837P file from the Provider's practice management system. Please email EDITeam@greatdentalplans.com to inquire about this option for electronic claim submission.

Paper Claim Submission

- Claims must be submitted on ADA approved claim form or other forms approved in advance by DentaQuest.
- Member name, identification number, and date of birth must be listed on all claims submitted. If the Member Identification Number is missing or miscoded on the claim form, the patient cannot be identified. This could result in the claim being returned to the submitting Provider office, causing a delay in payment.
- The paper claim must contain an acceptable provider signature.
- The Provider and office location information must be clearly identified on the claim. Frequently, if only the dentist signature is used for identification, the dentist's name cannot be clearly identified. Please include either a typed dentist (practice) name or the DentaQuest Provider Identification Number.
- The paper claim form must contain a valid provider NPI (National Provider Identification) number. In the event of not having this box on the claim form, the NPI must still be included on the form. The ADA claim form only supplies two fields to enter NPI. On paper claims, the Type 2 NPI identifies the payee, and may be submitted in conjunction with a Type 1 NPI to identify the dentist who provided the treatment. For example, on a standard ADA Dental Claim Form, the treating dentist's NPI is entered in field 54 and the billing entity's NPI is entered in field 49.
- The date of service must be provided on the claim form for each service line submitted.
- Approved ADA dental codes as published in the current CDT book or as defined in this manual must be used to define all services. List all quadrants, tooth numbers and surfaces for dental codes that necessitate identification (extractions, root canals, amalgams, and resin fillings). Missing tooth and surface identification codes can result in the delay or denial of claim payment.
- Affix the proper postage when mailing bulk documentation. DentaQuest does not accept postage due mail. This mail will be returned to the sender and will result in delay of payment.

Paper Claims should be mailed to the following address:

DENTAQUEST, LLC-Claims
PO Box 2906
Milwaukee, WI 53201-2906

Submitting Authorization or Claims with X-Rays

Acceptable methods of submission:

- Electronic submission using the new web portal
- Electronic submission using National Electronic Attachment (NEA) is recommended. For more information, please visit www.nea-fast.com and click the "Learn More" button. To register, click the "Provider Registration" button in the middle of the home page.
- Submission of duplicate radiographs (which we will recycle and not return)

- Submission of original radiographs should be sent with a self-addressed stamped envelope (SASE) so that we may return the original radiographs. Note that determinations will be sent separately, and any radiographs received without a SASE will not be returned to the sender.

Please note we also require radiographs be mounted when there are five or more radiographs submitted at one time. If five or more radiographs are submitted and not mounted, they will be returned to you and your request for prior authorization and/or claims will not be processed. You will need to resubmit a copy of the 2006 or newer ADA form that was originally submitted, along with mounted radiographs so that we may process the claim correctly.

Acceptable methods of mounted radiographs are:

- Radiographs duplicated and displayed in proper order on a piece of duplicating film.
- Radiographs mounted in a radiograph holder or mount designed for this purpose.

Unacceptable methods of mounted radiographs are:

- Cut out radiographs taped or stapled together.
- Cut out radiographs placed in a coin envelope.
- Multiple radiographs placed in the same slot of a radiograph holder or mount.

All radiographs should include member's name, identification number and office name to ensure proper handling.

NPI Requirements for Submission of Electronic Claims

In accordance with the HIPAA guidelines, DentaQuest has adopted the following NPI standards in order to simplify the submission of claims from all of our providers, conform to industry required standards and increase the accuracy and efficiency of claims administered by DentaQuest.

- Providers must register for the appropriate NPI classification at the following website https://nppes.cms.hhs.gov/NPPES#/ and provide this information to DentaQuest in its entirety.
- All providers must register for an Individual NPI. You may also be required to register for a group NPI (or as part of a group) dependent upon your designation.
- When submitting claims to DentaQuest you must submit all forms of NPI properly and in their entirety for claims to be accepted and processed accurately. If you registered as part of a group, your claims must be submitted with both the Group and Individual NPIs. These numbers are not interchangeable and could cause your claims to be returned to you as non-compliant.
- If you are presently submitting claims to DentaQuest through a clearinghouse or through a direct integration you need to review your integration to assure that it is in compliance with the revised HIPAA compliant 837D format. This information can be found in the 837D Companion Guide located on the Provider Web Portal.

Coordination of Benefits (COB) (for all states except NC)

When DentaQuest 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 COB field. When a primary carrier's payment meets or exceeds a provider's contracted rate or fee schedule, DentaQuest will consider the claim paid in full and no further payment will be made on the claim.

Filing Limits

Each provider contract specifies a specific timeframe after the date of service for when a claim must be submitted to DentaQuest. Any claim submitted beyond the timely filing limit specified in the contract will be denied for "untimely filing." If a claim is denied for "untimely filing", the provider cannot bill the member. If DentaQuest is the secondary carrier (in all states except NC), the timely filing limit begins with the date of payment or denial from the primary carrier.

Direct Deposit

As a benefit to participating Providers, DentaQuest offers Direct Deposit for claims payments. This process improves payment turnaround times as funds are directly deposited into the Provider's banking account.

To receive claims payments through Direct Deposit, Providers must:

- Complete and sign the Direct Deposit Form found on the website.
- Attach a voided check to the form. *The authorization cannot be processed without a voided check.*
- Return the Direct Deposit Form and voided check to DentaQuest.

Via Fax – 262.241.4077
Via Mail – DentaQuest, LLC.
ATTN: PDA Department
PO Box 2906
Milwaukee, WI 53201-2906

The Direct Deposit Form must be legible to prevent delays in processing. Providers should allow up to six weeks for Direct Deposit to be implemented after the receipt of completed paperwork. Providers will receive a bank note one check cycle prior to the first Direct Deposit payment.

Providers enrolled in the Direct Deposit process must notify DentaQuest of any changes to bank accounts such as: changes in routing or account numbers, or a switch to a different bank. All changes must be submitted via the Direct Deposit Form. Changes to bank accounts or banking information typically take two to three weeks. DentaQuest is not responsible for delays in funding if Providers do not properly notify DentaQuest in writing of any banking changes.

Providers enrolled in Direct Deposit are required to access their remittance statements online and will no longer receive paper remittance statements. Electronic remittance statements are located on DentaQuest's Provider Web Portal (PWP). Providers may access their remittance statements by following these steps:

1. Login to the PWP at www.dentaquestgov.com
2. Once you have entered the website, click on the "Dentist" icon. From there choose your 'State' and press "Go".
3. Log in using your password and ID.
4. Once logged in, select "Claims/Pre-Authorizations" and then "Remittance Advice Search".
5. The remittance will display on the screen.

SECTION 6 Health Insurance Portability and Accountability Act (HIPAA)

As a health care provider, your office is required to comply with all aspects of the HIPAA regulations in effect as indicated in the final publications of the various rules covered by HIPAA. DentaQuest has implemented various operational policies and procedures to ensure that it is compliant with the Privacy, Administrative Simplification and Security Standards of HIPAA. One aspect of our compliance plan is working cooperatively with our providers to comply with the HIPAA regulations. In relation to the Privacy Standards, DentaQuest has previously modified its provider contracts to reflect the appropriate HIPAA compliance language. These contractual updates include the following in regard to record handling and HIPAA requirements:

- Maintenance of adequate dental/medical, financial, and administrative records related to covered dental services rendered by Provider in accordance with federal and state law.
- Safeguarding of all information about Members according to applicable state and federal laws and regulations. All material and information, in particular information relating to Members or potential Members, which is provided to or obtained by or through a Provider, whether verbal, written, tape, or otherwise, shall be reported as confidential information to the extent confidential treatment is provided under state and federal laws.
- Neither DentaQuest nor Provider shall share confidential information with a Member's employer absent the Member's consent for such disclosure.
- Provider agrees to comply with the requirements of the Health Insurance Portability and Accountability Act ("HIPAA") relating to the exchange of information and shall cooperate with DentaQuest in its efforts to ensure compliance with the privacy regulations promulgated under HIPAA and other related privacy laws.
- Provider and DentaQuest agree to conduct their respective activities in accordance with the applicable provisions of HIPAA and such implementing regulations.

In relation to the Administrative Simplification Standards, you will note that the benefit tables included in this ORM reflect the most current coding standards (CDT-4) recognized by the ADA. Effective the date of this manual, DentaQuest will require providers to submit all claims with the proper CDT-4 codes listed in this manual. In addition, all paper claims must be submitted on the current approved ADA claim form.

Note: Copies of DentaQuest's HIPAA policies are available upon request by contacting DentaQuest's Provider Services department at 855-343-4260 or via e-mail at denelig.benefits@dentaquest.com.

HIPAA Companion Guide

To view a copy of the most recent Companion Guide please visit our website at www.dentaquestgov.com. Once you have entered the website, click on the "Dentist" icon. From there choose your 'State' and press "Go". You will then be able to log in using your password and ID. Once you have logged in, click on the link named "Related Documents' (located under the picture on the right-hand side of the screen).

SECTION 7 Provider Appeals/Complaints/Grievances

<table>
<tr><td rowspan="3">Claim Appeal
(Due to Medical Necessity)
Submit to CareSource</td><td colspan="2">Claim Appeals are administrative appeals of an adverse decision regarding payment for a submitted claim or a denied claim for services rendered to a CareSource member. Examples include medical necessity not established, required authorization or documentation was not submitted or if you have additional, information that you believe may change the payment decision.
Submit with Claim Appeals
1. Supporting Documentation
2. Original Remittance Advice</td></tr>
<tr><td>Mail:
CareSource
Attn: Provider Claim Appeals
P.O. Box 2008
Dayton, OH 45401-2008</td><td>Fax:
Provider Claim Appeals
Coordinator Fax Number:
937-531-2398</td></tr>
<tr><td colspan="2">Note: All faxed documentation including Radiographs and photos must be clear and readable. Faxes must be in accordance with confidentiality guidelines and governed by the same authorization requirements as any other release of health care information.

Claim Appeals must be received within 365 calendar days from date of discharge or date of service for OH, GA, IN and WV; 90 calendar days from date of claim denial for KY, and within 2 years for NC.</td></tr>
<tr><td>Claim Disputes
Submit to CareSource</td><td colspan="2">If a service line on a claim was overpaid or underpaid—For example, if a claim is paid but Provider feels it was not paid at right amount then a claim dispute can be filed. Adjustments to any overpayments will be made on subsequent reimbursements to the Provider or the Provider can issue refund checks to CareSource for any overpayments.
Mail: CareSource
Attn: Provider Claim Appeals
P.O. Box 2008
Dayton OH 45401-2008</td></tr>
<tr><td></td><td colspan="2">Claim Disputes must be received within 90 calendar days from date of discharge or date of service for OH, GA, IN, and WV and 24 months from date of claim denial for KY. Please refer to Claim Appeal section for North Carolina.</td></tr>
<tr><td>Clinical Appeal Authorizations
Submit to CareSource</td><td colspan="2">There are multiple ways to respond to an adverse determination of an authorization review request.

1) Before submitting a request for a clinical appeal, the requesting provider may request a peer-to-peer (P2P) conversation with the DentaQuest Dentist Reviewer or Dental Director by contacting the DentaQuest Utilization Management department. This request must be made and occur within five business days of the determination. When requested, this conversation occurs within one business day of the request by the ordering provider.

2) A clinical appeal or reconsideration may be submitted by the member, their authorized representative or the provider on behalf of the member (with written authorization from the member). The clinical appeal must be submitted within 180 calendar days from the date of the adverse benefit determination.

CareSource responds to all standard clinical appeals in writing within 30 calendar days for GA, KY, OH and NC and within 20 business days for IN.

The following is applicable to WV:
• Standard prospective reviews must be decided within 30 calendar days of receipt.
• Retrospective reviews must be decided within 60 calendar days of receipt.
• Standard reviews not involving an adverse determination must be decided within 20 business days of receipt.</td></tr>
</table>

	CareSource responds to all expedited appeal requests within 72 hours of receipt for all markets, except Ohio which is 48 hrs.	
	Mail: CareSource Attn: Dental Provider Clinical Appeals P.O. Box 1947 Dayton, OH 45402	**Fax:** 937-531-2398

Provider Complaints and Member Grievances Rights	Providers are permitted to submit a complaint to CareSource regarding DentaQuest's policies, procedures, or any aspect of DentaQuest's administrative functions. A provider complaint is a written expression by a provider, which indicates dissatisfaction or dispute with DentaQuest's policies, procedures, or any aspect of DentaQuest's administrative functions. A Member also has the right to file a Grievance at any time. Examples include: • Member cannot get a timely appointment with a provider. • Member thinks the provider's office staff did not treat them fairly. • Member is not satisfied with the quality of care they received. These types of grievances do not involve benefits or denial of benefits. For additional information or assistance contact CareSource at **1-833-230-2101**, Monday through Friday, 7 a.m. to 7 p.m. Eastern Time (ET).	
	Mail: CareSource Attn: Dental Provider G & A P.O. Box 2008 Dayton, OH 45401-2008	**Fax:** 937-531-2398

Additional information on Member Grievances and Appeals procedures can be found in the Marketplace Evidence of Coverage.

Note: Copies of DentaQuest policies and procedures can be requested by contacting DentaQuest Provider Services at:

North Carolina - 844-831-9098
Ohio – 855-208-6575
All Others – 855-398-8413

SECTION 8 Fraud and Abuse

DentaQuest is committed to detecting, reporting, and preventing potential fraud and abuse. Fraud, waste/error, and abuse in dentistry occurs when a provider/office or a member knowingly submits or helps someone else submit false information on a dental claim form. Defined as:

- **Fraud**: includes any instances of waste or abuse if committed with intentional deception or misrepresentation.
- **Waste/Error**: includes over-utilization of services or practices that result in unnecessary costs to the healthcare system
- **Abuse**: provider practices are inconsistent with sound fiscal business resulting in unnecessary costs or reimbursement for services that are not dentally necessary, fail to meet professionally recognized standards of care, involve non-compliance with licensure standards, misuse of billing privileges, or any other behavior that results in unnecessary costs to the healthcare system.

As a result of a complaint or through comprehensive data analysis DentaQuest's Fraud Prevention and Recovery Unit (FPRU) undertakes reviews of potential aberrant utilization and billing patterns; and may conduct a record review of a dental provider/offices to assess any potential fraud, waste/error, or abuse. Similarly, the FPRU reviews post payment records to evaluate the dental necessity of the procedures performed and billed, as well as the administrative requirements that support the procedure billed for payment. While fraud, waste/error, and abuse can take many forms, the following issues and trends have been identified by DentaQuest's Fraud Prevention and Recovery Investigators during chart audits:

FRAUD

- Filing a claim for a service not provided
- Falsifying information on a claim form in attempt to gain benefits, including false information related to:
  - Procedure performed
  - Treating dentist
  - Tooth, quadrant, surface treated
  - Date of service
  - Location of service
- Altering a claim, diagnosis and/or other records
- Resubmitting a claim with a modified/altered date of service to maximize benefits and/or circumvent a time limitation
- Billing non-covered services as covered services
- Billing for a four or more surface anterior composite restoration when documentation supports an indirect composite veneer was performed
- Using someone else's identification card

WASTE/ERROR

- Incomplete or improper anesthesia documentation resulting in excessive reimbursement.
- Improper onlay documentation demonstrating overtreatment of decay.
- Administering periapical radiographs at routine hygiene visits without a specific focused problem.

- Provider inadvertently bills for the same restoration on two separate claim forms.

ABUSE

- Upcoding - billing for a more costly service than was actually performed
- Upcoding
- Billing for a completely bony extraction when documentation indicates a partially bony extraction was performed
- Billing for a composite restoration when documentation indicates that a preventative restoration was performed.
- Unbundling - billing each stage of a procedure separately
- Billing each tooth surface involved in a restoration as a separate line item
- Billing for oral evaluations without documentation to support the services were rendered by a licensed dentist
- Absence of dental necessity
- Direct or Indirect restorations performed without evidence of decay or fractured tooth structure
- Billing for services using the identification of a contracted provider because the treating provider is not contracted with DentaQuest

These examples above are indicators of waste/error and abuse, however, these examples can result in investigation and prosecution as fraud when knowing willful intent is apparent. Fraudulent intent can be inferred when a pattern of activity has been identified.

A provider bills appropriately when the service they performed were covered services per the plan design; dentally necessary, meaning the work was needed and there is a long-term prognosis, and that the services performed were conducted withing the expected standard of care; were coded at the correct level pursuant to the CDT, and were documented appropriately according to the Office Reference Manual (ORM), and consistent with relevant ADA guidelines and state regulations. DentaQuest may initiate remedial steps to correct identified instances of fraud, waste/error, or abuse, including but not limited to provider education, recovery of identified overpayments, a corrective action plan with formal monitoring and re-auditing, contract termination, and/or a referral to the appropriate government agency for their independent investigation, and potential criminal and civil penalties.

Pretreatment estimates issued by DentaQuest are not a guarantee of payment. DentaQuest reserves the right to recover dollars for procedures that no longer qualify for the pre-approved estimate of payment; reasons may include lack of dental necessity, do not meet the standards of good dental practice and/or are unsupported in the member's treatment record.

To report fraud, waste/error, or abuse call DentaQuest Fraud Hotline: 800-237-9139 or you may complete the "Report Fraud Form" found at https://www.dentaquest.com/report-fraud.

SECTION 9 Quality Improvement Program

DentaQuest currently administers a Quality Improvement Program modeled after National Committee for Quality Assurance (NCQA) standards. The NCQA standards are adhered to, as the standards apply to dental managed care. The Quality Improvement Program includes, but is not limited to:

- Provider credentialing and recredentialing;
- Member satisfaction surveys;
- Provider satisfaction surveys;
- Random Chart Audits;
- Complaint Monitoring and Trending;
- Peer Review Process;
- Utilization Management and practice patterns; and
- Quarterly Quality Indicator tracking (i.e. complaint rate, appointment waiting time, access to care, etc.)
- Quality Measures monitoring from stewards such as NCQA, the Dental Quality Alliance (American Dental Association) and any Plan metrics

A copy of DentaQuest's Quality Improvement Program is available upon request by contacting DentaQuest's Provider Services Department at 855-343-4260 or via e-mail at: denelig.benefits@dentaquest.com.

Access and Availability

As a quality standard, our goal is to ensure timely access and availability of care **for members.**

- DentaQuest Dentists are expected to meet minimum standards with regards to appointment availability.
- Routine and follow-up appointments must be scheduled within regulatory guidelines, with best standards not to exceed 30 days for routine appointments.
- Emergency care must be available within 24 hours.
- Urgent care must be available within 48 hours.

All Providers must have back-up (on call) coverage afterhours or during the Provider's absence or unavailability. CareSource requires Providers to maintain a twenty-four (24) hour phone service, seven (7) days a week for emergency needs. This access may be through an answering service or a recorded message after office hours. If a recorded message is used, it must provide an option to direct the Member to a live person for emergency dental communications. Language assistance services is available through the plan (DentaQuest).

SECTION 10 Records Management, Radiograph, and Periodicity Guidelines

The Patient Record

Organization

1. The record must have areas for documentation of the following information:
   a. Registration data including a complete health history.
   b. Medical alert predominantly displayed in paper or electronic record
   c. Initial examination data.
   d. Radiographs.
   e. Periodontal and Occlusal status.
   f. Treatment plan/Alternative treatment plan.
   g. Progress notes to include diagnosis, preventive services, treatment rendered, and medical/dental consultations.
   h. Miscellaneous items (correspondence, referrals, and clinical laboratory reports).

2. The design of the record must provide the capability or periodic update, without the loss of documentation of the previous status, of the following information.
   a. Health history.
   b. Medical alert.
   c. Examination/Recall data.
   d. Periodontal status.
   e. Treatment plan.

3. The design of the record must ensure that all permanent components of the record are attached or secured within the record.

4. The design of the record must ensure that all components must be readily identified to the patient, (i.e., patient name, and identification number on each page).

5. The organization of the record system must require that individual records be assigned to each patient.

Content-The patient record must contain the following:

1. Adequate documentation of registration information which requires entry of these items:
   a. Patient's first and last name
   b. Date of birth
   c. Sex
   d. Address
   e. Telephone number
   f. Name and telephone number of the person to contact in case of emergency.

2. An adequate health history that requires documentation of these items:
   a. Current medical treatment
   b. Significant past illnesses
   c. Current medications
   d. Drug allergies
   e. Hematologic disorders
   f. Cardiovascular disorders

g. Respiratory disorders
h. Endocrine disorders
i. Communicable diseases
j. Neurologic disorders
k. Signature and date by patient
l. Signature and date by reviewing dentist
m. History of alcohol and/or tobacco usage including smokeless tobacco

3. An adequate update of health history at subsequent recall examinations which requires documentation of these items:

a. Significant changes in health status
b. Current medical treatment
c. Current medications
d. Dental problems/concerns
e. Signature and date by reviewing dentist

4. A prominent and readily identifiable medical alert inside the chart jacket that documents highly significant terms from health history. These items are:

a. Health problems which contraindicate certain types of dental treatment
b. Health problems that require precautions or pre-medication prior to dental treatment
c. Current medications that may contraindicate the use of certain types of drugs or dental treatment
d. Drug sensitivities
e. Infectious diseases that may endanger personnel or other patients

5. Adequate documentation of the initial clinical examination which is dated and requires descriptions of findings in these items:

a. Blood pressure (Recommended)
b. Head/neck examination
c. Soft tissue examination
d. Periodontal assessment
e. Occlusal classification
f. Dentition charting

6. Adequate documentation of the patient's status at subsequent Periodic/Recall examinations which is dated and requires descriptions of changes/new findings in these items:

a. Blood pressure (Recommended)
b. Head/neck examination
c. Soft tissue examination
d. Periodontal assessment
e. Dentition charting

7. Radiographs which are:

a. Identified by patient name
b. Dated
c. Designated by patient's left and right side
d. Mounted (if intraoral films)

8. An indication of the patient's clinical problems/diagnosis.

9. Adequate documentation of the treatment plan (including any alternate treatment options) that specifically describes all the services planned for the patient by entry of these items:

    a. Procedure
    b. Localization (area of mouth, tooth number, surface)

10. An adequate documentation of the periodontal status, if necessary, which is dated and requires charting of the location and severity of these items:

    a. Periodontal pocket depth
    b. Furcation involvement
    c. Mobility
    d. Recession
    e. Adequacy of attached gingiva
    f. Missing teeth

11. An adequate documentation of the patient's oral hygiene status and preventive efforts which requires entry of these items:

    a. Gingival status
    b. Amount of plaque
    c. Amount of calculus
    d. Education provided to the patient
    e. Patient receptiveness/compliance
    f. Recall interval
    g. Date

12. An adequate documentation of medical and dental consultations within and outside the practice which requires entry of these items:

    a. Provider to whom consultation is directed
    b. Information/services requested
    c. Consultant's response

13. Adequate documentation of treatment rendered which requires entry of these items:

    a. Date of service/procedure
    b. Description of service, procedure, and observation. Documentation in treatment record must contain documentation to support the level of American Dental Association Current Dental Terminology code billed as detailed in the nomenclature and descriptors. Documentation must be written on a tooth-by-tooth basis for a per tooth code, on a quadrant basis for a quadrant code and on a per arch basis for an arch code.
    c. Type and dosage of anesthetics and medications given or prescribed.
    d. Localization of procedure/observation. (tooth #, quadrant etc.)
    e. Signature of the Provider who rendered the service.

14. Adequate documentation of the specialty care performed by another dentist that includes:

    a. Patient examination
    b. Treatment plan
    c. Treatment status

Compliance

1. The patient record has one explicitly defined format that is currently in use.
2. There is consistent use of each component of the patient record by all staff.

3. The components of the record that are required for complete documentation of each patient's status and care are present.
4. Entries in the records are legible.
5. Entries of symbols and abbreviations in the records are uniform, easily interpreted and are commonly understood in the practice

Radiology Requirement

Note: Please refer to benefit tables for Radiograph benefit limitations

DentaQuest utilizes the guidelines published by the Department of Health and Human Services, Center for Devices and Radiological Health. These guidelines were developed in conjunction with the Food and Drug Administration.

A. Radiographic Examination of the New Patient

1. Child – Primary Dentition

   The Panel recommends posterior bitewing radiographs for a new patient, with a primary dentition and closed proximal contacts.

2. Child – Transitional Dentition

   The Panel recommends an individualized periapical/occlusal examination with posterior bitewings OR a panoramic radiograph and posterior bitewings, for a new patient with a transitional dentition.

3. Adolescent – Permanent Dentition Prior to the eruption of the third molars

   The Panel recommends an individualized radiographic examination consisting of selected periapicals with posterior bitewings for a new adolescent patient.

4. Adult – Dentulous

   The Panel recommends an individualized radiographic examination consisting of selected periapicals with posterior bitewings for a new dentulous adult patient.

5. Adult – Edentulous

   The Panel recommends a full-mouth intraoral radiographic survey OR a panoramic radiograph for the new edentulous adult patient.

B. Radiographic Examination of the Recall Patient

1. Patients with clinical caries or other high – risk factors for caries

   a. Child – Primary and Transitional Dentition

      The Panel recommends that posterior bitewings be performed at a 6–12-month interval for those children with clinical caries or who are at increased risk for the development of caries in either the primary or transitional dentition.

   b. Adolescent

      The Panel recommends that posterior bitewings be performed at a 6–12-month interval for adolescents with clinical caries or who are at increased risk for the development of caries.

   c. Adult – Dentulous

      The Panel recommends that posterior bitewings be performed at a 6–12-month interval for adults with clinical caries or who are at increased risk for the development of caries.

   d. Adult – Edentulous

      The Panel found that an examination for occult disease in this group cannot be justified on the basis of prevalence, morbidity, mortality, radiation dose and cost. Therefore, the Panel

recommends that no radiographs be performed for edentulous recall patients without clinical signs or symptoms.

2. Patients with no clinical caries and no other high-risk factors for caries

a. Child – Primary Dentition

The Panel recommends that posterior bitewings be performed at an interval of 12-24 months for children with a primary dentition with closed posterior contacts that show no clinical caries and are not at increased risk for the development of caries.

b. Adolescent

The Panel recommends that posterior bitewings be performed at intervals of 12-24 months for patients with a transitional dentition who show no clinical caries and are not at an increased risk for the development of caries.

c. Adult – Dentulous

The Panel recommends that posterior bitewings be performed at intervals of 24-36 months for dentulous adult patients who show no clinical caries and are not at an increased risk for the development of caries.

3. Patients with periodontal disease, or a history of periodontal treatment for Child – primary and transitional dentition, Adolescent and Dentulous Adult

The Panel recommends an individualized radiographic survey consisting of selected periapicals and/or bitewing radiographs of areas with clinical evidence or a history of periodontal disease, (except nonspecific gingivitis).

4. Growth and Development Assessment

a. Child – Primary Dentition

The panel recommends that prior to the eruption of the first permanent tooth, no radiographs be performed to assess growth and development at recall visits in the absence of clinical signs or symptoms.

b. Child – Transitional Dentition

The Panel recommends an individualized periapical/occlusal series OR a panoramic radiograph to assess growth and development at the first recall visit for a child after the eruption of the first permanent tooth.

c. Adolescent

The Panel recommends that for the adolescent (age 16-19 years of age) recall patient, a single set of periapicals of the wisdom teeth OR a panoramic radiograph.

d. Adult

The Panel recommends that no radiographs be performed on adults to assess growth and development in the absence of clinical signs or symptoms.

Periodicity Guidelines Ages 0-18 Years

NOTE: Please refer to benefit tables for benefits and limitations.

Recommended Dental Periodicity Schedule for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling

Since each child is unique, these recommendations are designed for the care of children who have no contributing medical conditions and are developing normally. These recommendations will need to be modified for children with special health care needs or if disease or trauma manifests variations from normal. The American Academy of Pediatric Dentistry emphasizes the importance of very early professional intervention and the continuity of care based on the individualized needs of the child. Refer to the text of this best practice for supporting information and references. Refer to the text in the Recommendations on the Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance, and Oral Treatment for Infants, Children, and Adolescents (*www.aapd.org/policies/*) for supporting information and references.

	AGE				
	6 TO 12 MONTHS	12 TO 24 MONTHS	2 TO 6 YEARS	6 TO 12 YEARS	12 YEARS AND OLDER
Clinical oral examination [1]	•	•	•	•	•
Assess oral growth and development [2]	•	•	•	•	•
Caries-risk assessment [3]	•	•	•	•	•
Radiographic assessment [4]	•	•	•	•	•
Prophylaxis and topical fluoride [3,4]	•	•	•	•	•
Fluoride supplementation [5]	•	•	•	•	•
Anticipatory guidance/counseling [6]	•	•	•	•	•
Oral hygiene counseling [3,7]	Parent	Parent	Patient /parent	Patient /parent	Patient
Dietary counseling [3,8]	•	•	•	•	•
Counseling for nonnutritive habits [9]	•	•	•	•	•
Injury prevention and safety counseling [10]	•	•	•	•	•
Assess speech/language development [11]	•	•	•		
Assess developing occlusion [12]			•	•	•
Assessment for pit and fissure sealants [13]			•	•	•
Periodontal risk assessment [3,14]			•	•	•
Counseling for tobacco, vaping, and substance misuse				•	•
Counseling for human papilloma virus/vaccine				•	•
ounseling for intraoral/perioral piercing				•	•
Assess third molars					•
Transition to adult dental care					•

1 First examination at the eruption of the first tooth and no later than 12 months. Repeat every 6 months or as indicated by the child's risk status/susceptibility to disease. Includes assessment of pathology and injuries.

2 By clinical examination.

3 Must be repeated regularly and frequently to maximize effectiveness.

4 Timing, type, and frequency determined by child's history, clinical findings, and susceptibility to oral disease.

5 Consider when systemic fluoride exposure is suboptimal. Up to at least 16 years.

6 Appropriate discussion and counseling should be an integral part of each visit for care.

SECTION 11 Clinical Criteria

The criteria outlined in DentaQuest's Provider Office Reference Manual are based around procedure codes as defined in the American Dental Association's Code Manuals. Documentation requests for information regarding treatment using these codes are determined by generally accepted dental standards for authorization, such as radiographs, periodontal charting, treatment plans, or descriptive narratives. In some instances, the State legislature will define the requirements for dental procedures.

These criteria were formulated from information gathered from practicing dentists, dental schools, ADA clinical articles and guidelines, insurance companies, as well as other dental related organizations. These criteria and policies must meet and satisfy specific State and Health Plan requirements as well. They are designed as *guidelines* for authorization and payment decisions and *are not intended to be all-inclusive or absolute*. Additional narrative information is appreciated when there may be a special situation.

We hope that the enclosed criteria will provide a better understanding of the decision-making process for reviews. We also recognize that "local community standards of care" may vary from region to region and will continue our goal of incorporating generally accepted criteria that will be consistent with both the concept of local community standards and the current ADA concept of national community standards. Your feedback and input regarding the constant evolution of these criteria is both essential and welcome. DentaQuest shares your commitment and belief to provide quality care to Members and we appreciate your participation in the program.

Please remember these are generalized criteria. Services described may not be covered in your particular program. In addition, there may be additional program specific criteria regarding treatment. Therefore, it is essential you review the Benefits Covered Section before providing any treatment.

These clinical criteria will be used for making medical necessity determinations for prior authorizations, post payment review and retrospective review (prepayment review). Failure to submit the required documentation may result in a disallowed request and/or a denied payment of a claim related to that request. Some services require prior authorization, and some services require pre-payment review; this is detailed in the Benefits Covered Section(s) in the "Review Required" column.

For all procedures, every Provider in the DentaQuest program is subject to random chart audits. Providers are required to comply with any request for records. These audits may occur in the Provider's office as well as in the office of DentaQuest. The Provider will be notified in writing of the results and findings of the audit.

DentaQuest providers are required to maintain comprehensive treatment records that meet professional standards for risk management. Please refer to the "Patient Record" section for additional detail.

Documentation in the treatment record must justify the need for the procedure performed due to medical necessity, for all procedures rendered. Appropriate diagnostic pre-operative radiographs clearly showing the adjacent and opposing teeth and substantiating any pathology or caries present are required. Post-operative radiographs are required for endodontic procedures and permanent crown placement to confirm quality of care. In the event that radiographs are not available or cannot be obtained, diagnostic quality intraoral photographs must substantiate the need for procedures rendered.

Multistage procedures are reported and may be reimbursed upon completion. The completion date is the date of insertion for removable prosthetic appliances. The completion date for immediate dentures is the date that the remaining teeth are removed, and the denture is inserted. The completion date for fixed partial dentures and crowns, onlays, and inlays is the cementation date regardless of the type of cement utilized. The completion date for endodontic treatment is the date the canals are permanently filled.

Failure to provide the required documentation, adverse audit findings, or the failure to maintain acceptable practice standards may result in sanctions including, but not limited to, recoupment of benefits on paid claims, follow-up audits, or removal of the Provider from the DentaQuest Provider Panel.

Criteria for Cast Crowns

Documentation needed for authorization of procedure:

- Appropriate radiographs showing clearly the adjacent and opposing teeth should be submitted for authorization review: bitewings, periapicals or panorex.
- Treatment rendered without necessary authorization will still require that sufficient and appropriate radiographs showing clearly the adjacent and opposing teeth be submitted with the claim for review for payment.

Criteria

- In general, criteria for crowns will be met only for permanent teeth needing multi-surface restorations where other restorative materials have a poor prognosis.
- Permanent molar teeth must have pathologic destruction to the tooth by caries or trauma and should involve four or more surfaces and two or more cusps.
- Permanent bicuspid teeth must have pathologic destruction to the tooth by caries or trauma and should involve three or more surfaces and at least one cusp.
- Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma and must involve four or more surfaces and at least 50% of the incisal edge.
- A request for a crown following root canal therapy must meet the following criteria
- Request should include a dated post-endodontic radiograph.
- Tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the ability to fill the canal to the apex.
- The filling must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.

To meet criteria, a crown must be opposed by a tooth or denture in the opposite arch or be an abutment for a partial denture.

- The patient must be free from active and advanced periodontal disease.
- The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent teeth.
- Cast Crowns on permanent teeth are expected to last, at a minimum, five years.

Authorizations for Crowns will not meet criteria if:

- A lesser means of restoration is possible.
- Tooth has subosseous and/or furcation caries.
- Tooth has advanced periodontal disease.
- Tooth is a primary tooth.

- Crowns are being planned to alter vertical dimension.

Criteria for Stainless Steel Crowns

In most cases, authorization is not required. Where authorization is required for primary or permanent teeth, the following criteria apply:

Documentation needed for authorization of procedure:

- Appropriate radiographs showing clearly the adjacent and opposing teeth should be submitted for authorization review: bitewings, periapicals or panorex.
- Treatment rendered under emergency conditions, when authorization is not possible, will still require that appropriate radiographs showing clearly the adjacent and opposing teeth be submitted with the claim for review for payment.
- Narrative demonstrating medical necessity if radiographs are not available.

Criteria

- In general, criteria for stainless steel crowns will be met only for teeth needing multi-surface restorations where amalgams and other materials have a poor prognosis.
- Permanent molar teeth must have pathologic destruction to the tooth by caries or trauma and should involve four or more surfaces and two or more cusps.
- Permanent bicuspid teeth must have pathologic destruction to the tooth by caries or trauma and should involve three or more surfaces and at least one cusp.
- Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma and should involve four or more surfaces and at least 50% of the incisal edge.
- Primary molars must have pathologic destruction to the tooth by caries or trauma and should involve two or more surfaces or substantial occlusal decay resulting in an enamel shell.

An authorization for a crown on a permanent tooth following root canal therapy must meet the following criteria:

- Request should include a dated post-endodontic radiograph.
- Tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the dentist's ability to fill the canal to the apex.
- The filling must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.
- To meet criteria, a crown must be opposed by a tooth or denture in the opposite arch or be an abutment for a partial denture.
- The patient must be free from active and advanced periodontal disease.
- The permanent tooth must be at least 50% supported in bone.
- Stainless Steel Crowns on permanent teeth are expected to last five years.

Authorization and treatment using Stainless Steel Crowns will not meet criteria if:

- A lesser means of restoration is possible.
- Tooth has subosseous and/or furcation caries.
- Tooth has advanced periodontal disease.
- Tooth is a primary tooth with exfoliation imminent.
- Crowns are being planned to alter vertical dimension.

Criteria for Endodontics

Not all procedures require authorization. Documentation needed for authorization of procedure:

- Sufficient and appropriate radiographs showing clearly the adjacent and opposing teeth and a pre- operative radiograph of the tooth to be treated; bitewings, periapicals or panorex. A dated post- operative radiograph must be submitted for review for payment.
- Treatment rendered under emergency conditions, when authorization is not possible, will still require that appropriate radiographs showing clearly the adjacent and opposing teeth, pre-operative radiograph and dated post-operative radiograph of the tooth treated with the claim for retrospective review for payment. In cases where pathology is not apparent, a written narrative justifying treatment is required.

Criteria

Root canal therapy is performed in order to maintain teeth that have been damaged through trauma or carious exposure.

Root canal therapy must meet the following criteria:

- Fill should be sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the dentist's ability to fill the canal to the apex.
- Fill must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.

Authorizations for Root Canal therapy will not meet criteria if:

- Gross periapical or periodontal pathosis is demonstrated radiographically (caries subcrestal or to the furcation, deeming the tooth non-restorable).
- The general oral condition does not justify root canal therapy due to loss of arch integrity.
- Root canal therapy is for third molars, unless they are an abutment for a partial denture.
- Tooth does not demonstrate 50% bone support.
- Root canal therapy is in anticipation of placement of an overdenture.
- A filling material not accepted by the Federal Food and Drug Administration (e.g. Sargenti filling material) is used.

Other Considerations

- Root canal therapy for permanent teeth includes diagnosis, extirpation of the pulp, shaping and enlarging the canals, temporary fillings, filling and obliteration of root canal(s), and progress radiographs, including a root canal fill radiograph.
- In cases where the root canal filling does not meet DentaQuest's treatment standards, DentaQuest can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after DentaQuest reviews the circumstances.

Criteria for Periodontal Treatment

Documentation needed for authorization of procedure:

- Radiographs – periapicals or bitewings preferred.
- Complete periodontal charting with AAP Case Type.
- Treatment plan.

Periodontal scaling and root planing, per quadrant involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. It is indicated for patients with periodontal disease and is therapeutic, not prophylactic in nature. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and as a part of pre-surgical procedures in others.

It is anticipated that this procedure would be requested in cases of severe periodontal conditions (i.e. late Type II, III, IV periodontitis) where definitive comprehensive root planing requiring local/regional block anesthesia and several appointments would be indicated.

From the American Academy of Periodontology (AAP) Policy on Scaling and Root Planing:

"Periodontal scaling is a treatment procedure involving instrumentation of the crown and root surfaces of the teeth to remove plaque, calculus, and stains from these surfaces. It is performed on patients with periodontal disease and is therapeutic, not prophylactic, in nature. Periodontal scaling may precede root planing, which is the definitive, meticulous treatment procedure to remove cementum and/or dentin that is rough and may be permeated by calculus or contaminated with toxins or microorganisms. Periodontal scaling and root planing are arduous and time consuming. They may need to be repeated and may require local anesthetic."

Criteria

- A minimum of (4) teeth for D4341 and (1 to 3) teeth for D4342, must be affected in the quadrant.
- Periodontal charting indicating abnormal pocket depths in multiple sites.
- Additionally, at least one of the following must be present:
  1) Radiographic evidence of root surface calculus.
  2) Radiographic evidence of noticeable loss of bone support.

Criteria for Removable Prosthodontics

Documentation needed for authorization of procedure:

- Treatment plan.
- Appropriate radiographs showing clearly the adjacent and opposing teeth must be submitted for authorization review: bitewings, periapicals or panorex.
- Treatment rendered without necessary authorization will still require appropriate radiographs showing clearly the adjacent and opposing teeth be submitted with the claim for review for payment.
- Fabrication of a removable prosthetic includes multiple steps (appointments) these multiple steps (impressions, try-in appointments, delivery etc.) are inclusive in the fee for the removable prosthetic and as such not eligible for additional compensation.

Criteria

Prosthetic services are intended to restore oral form and function due to premature loss of permanent teeth that would result in significant occlusal dysfunction. Please review the benefit limitations in the Exhibits in the back of this Office Reference Manual in the D5000's series of codes.

- A denture is determined to be an initial placement if the patient has never worn a prosthesis. This does not refer to just the time a patient has been receiving treatment from a certain Provider.
- Partial dentures are covered only for recipients with good oral health and hygiene, good periodontal health (AAP Type I or II), and a favorable prognosis where continuous deterioration is not expected.
- Radiographs must show no untreated cavities or active periodontal disease in the abutment teeth, and abutments must be at least 50% supported in bone.
- As part of any removable prosthetic service, dentists are expected to instruct the patient in the proper care of the prosthesis.
- The replacement teeth should be anatomically full-sized teeth.
- Lost, stolen, or damaged and un-repairable appliance will be replaced only if replacement is needed due to circumstances beyond the recipient's control.

Authorizations for Removable prosthesis will not meet criteria:

- If the member has already received a prosthesis within the benefit limitation period noted in the Exhibits in the back of this Office Reference Manual.
- If good oral health and hygiene, good periodontal health, and a favorable prognosis are not present.
- If there are untreated cavities or active periodontal disease in the abutment teeth.
- If abutment teeth are less than 50% supported in bone.
- If the recipient cannot accommodate and properly maintain the prosthesis (i.e. Gag reflex, potential for swallowing the prosthesis, severely handicapped).
- If the recipient has a history or an inability to wear a prosthesis due to psychological or physiological reasons.
- If extensive repairs are performed on marginally functional partial dentures, or when a new partial denture would be better for the health of the recipient. However, adding teeth and/or a clasp to a partial denture is a covered benefit if the addition makes the denture functional.

Criteria

- If there is a pre-existing prosthesis, please review the benefit limitations in the Exhibits in the back of this ORM to determine if the member is eligible for a replacement.
- Payment for prosthesis includes all necessary adjustments, repairs, and relines within the first 6 months after insertion of prosthesis. Please review Exhibits of this ORM for any benefit limitations on subsequent adjustments, repairs and relines.
- Relines will be reimbursed per the benefit limitations in the Exhibits in the back of this ORM.
- The use of Preformed Dentures with teeth already mounted (that is, teeth set in acrylic before the initial impression) cannot be used for the fabrication of a new denture.
- All prosthetic appliances shall be inserted in the mouth and adjusted before a claim is submitted for payment.
- When billing for partial and complete dentures, dentists must list the date that the dentures or partials were inserted as the date of service. Recipients must be eligible on that date in order for the denture service to be covered.

Criteria for Fixed Prosthodontics

Documentation needed for authorization of procedure:

- Appropriate radiographs clearly showing the adjacent and opposing teeth should be submitted for authorization review: periapicals or panorex
- Treatment rendered without necessary authorization will still require that sufficient and appropriate radiographs clearly showing the adjacent and opposing teeth be submitted with the claim f or review for payment.

The placement of a fixed prosthetic appliance will only be considered for a 3-unit bridge when only one anterior tooth is missing with no other missing teeth in the arch.

Fixed Partial dentures are covered only for recipients with good oral health and hygiene, good periodontal health (AAP Type I or II), and a favorable prognosis where continuous deterioration is not expected.

As part of any fixed prosthetic service, dentists are expected to instruct the patient in the proper care of the prosthesis. When billing for fixed partial dentures, dentists must list the date of insertion as the date of service. Recipients must be eligible on that date f or the denture service to be covered.

Authorizations for prosthesis do not meet criteria:

- If good oral health and hygiene, good periodontal health, and a favorable prognosis are not present.
- If abutment teeth are less than 50% supported in bone.
- If there are untreated cavities or active periodontal disease in the abutment teeth.
- If abutment teeth have furcation involvement
- If abutment teeth have subcrestal decay
- If an existing bridge is present with an open margin without decay

- If an existing bridge is present with chipped or fractured porcelain without decay
- Tooth is endodontically treated and obturation is not sufficiently close to the radiologic apex to ensure an apical seal is achieved

Criteria for Dental Extractions

Not all procedures require authorization.

Documentation needed for authorization procedure:

- Appropriate radiographs showing clearly the adjacent and opposing teeth should be submitted for authorization review: bitewings, periapicals or panorex.
- Treatment rendered under emergency conditions, when authorization is not possible, will still require that appropriate radiographs showing clearly the adjacent and opposing teeth be submitted with the claim for review for payment.
- Narrative demonstrating medical necessity.

Criteria

The prophylactic removal of asymptomatic teeth (i.e. third molars) or teeth exhibiting no overt clinical pathology (for orthodontics) may be covered subject to consultant review.

- The removal of primary teeth whose exfoliation is imminent does not meet criteria.
- Alveoloplasty (code D7310) in conjunction with four or more extractions in the same quadrant will be covered subject to consultant review.

Criteria for the Excision of Bone Tissue

To ensure the proper seating of a removable prosthetic (partial or full denture) some treatment plans may require the removal of excess bone tissue prior to the fabrication of the prosthesis. Clinical guidelines have been formulated for the dental consultant to ensure that the removal of tori (mandibular and palatal) is an appropriate course of treatment prior to prosthetic treatment.

Code D7471 (CDT–4) is related to the removal of the lateral exostosis. This code is subject to authorization and may be reimbursed for when submitted in conjunction with a treatment plan that includes removable prosthetics. These determinations will be made by the appropriate dental specialist/consultant.

Documentation needed for authorization of procedure:

- Appropriate radiographs and/or intraoral photographs/bone scans which clearly identify the lateral exostosis must be submitted for authorization review; bitewings, periapicals or panorex.
- Treatment plan – includes prosthetic plan.
- Narrative of medical necessity, if appropriate.
- Study model or photo clearly identifying the lateral exostosis (es) to be removed.

Criteria for the Determination of a Non-Restorable Tooth

In the application of clinical criteria for benefit determination, dental consultants must consider the overall

dental health. A tooth that is determined to be non-restorable may be subject to an alternative treatment plan.

A tooth may be deemed non-restorable if one or more of the following criteria are present:

- The tooth presents with greater than a 75% loss of the clinical crown.
- The tooth has less than 50% bone support.
- The tooth has subosseous and/or furcation caries.
- The tooth is a primary tooth with exfoliation imminent.
- The tooth apex is surrounded by severe pathologic destruction of the bone.
- The overall dental condition (i.e. periodontal) of the patient is such that an alternative treatment plan would be better suited to meet the patient's needs.

Criteria for General Anesthesia and Intravenous (IV) Sedation

Documentation needed for authorization of procedure:

- Treatment plan (authorized if necessary).
- Narrative describing medical necessity for General Anesthesia or IV Sedation.
- Treatment rendered under emergency conditions, when authorization is not possible, will still require submission of treatment plan and narrative of medical necessity with the claim for review for payment.

Criteria

Requests for general anesthesia or IV sedation will be authorized (for procedures Covered by Health Plan) if any of the following criteria are met:

Extensive or complex oral surgical procedures such as:

- Impacted wisdom teeth.
- Surgical root recovery from maxillary antrum.
- Surgical exposure of impacted or unerupted cuspids.
- Radical excision of lesions in excess of 1.25 cm.

And/or one of the following medical conditions:

- Medical condition(s) which require monitoring (e.g. cardiac problems, severe hypertension).
- Underlying hazardous medical condition (cerebral palsy, epilepsy, mental retardation, including Down's syndrome) which would render patient non-compliant.
- Documented failed sedation or a condition where severe periapical infection would render local anesthesia ineffective.
- Patients 3 years old and younger with extensive procedures to be accomplished.

Criteria for Orthodontic Treatment

The determination whether or not a participant will be approved for orthodontic services shall be initially screened using the Handicapping Labio-Lingual Deviation (HLD) Index. The HLD Index (located in the appendix of this ORM), must be fully completed. Comprehensive orthodontic treatment is considered medically necessary when adequate corrective treatment is not achievable with less extensive means, and one of the following criteria is met:

- Dentition affected by significant cleft palate, craniofacial or other congenital or developmental disorder
- Significant skeletal disharmony requiring combination of orthodontic treatment and orthognathic surgery for correction
- Overjet greater than 9mm or reverse overjet greater than 3.5mm
- Anterior open bite greater than 4mm

Or one of the following criteria is met and demonstrated functional impairment is present:

- Impeded eruption of teeth (with the exception of third molars) due to crowding, displacement, the presence of supernumerary teeth, retained deciduous teeth or other pathological cause, where conservative removal of the ectopic tooth would create a significant functional deficit in biting or chewing
- Severe crowding of greater than 7mm in either the maxillary or mandibular arch
- Extensive hypodontia requiring pre-restorative orthodontics or orthodontic space closure to obviate the need for prosthetic treatment
- Significant posterior open bite (not involving partially erupted teeth or teeth slightly out of occlusion;
- Anterior crossbite involving permanent incisors or canines creating a functional interference and a resulting functional shift, or gingival stripping
- Posterior transverse discrepancies causing buccal or lingual crossbite involving permanent molar teeth and creating a functional interference and a resulting functional shift;
- Deep anterior overbite of multiple incisors resulting in soft tissue impingement or trauma Overjet greater than 6mm or reverse overjet greater than 1mm
- Other conditions as deemed medically necessary

Criteria for Implants

Implants will only be considered when a single tooth is missing in an arch (excluding third molars) or as support for an implant supported full denture (maximum allowance is 4 implants on the maxillary arch and 2 implants on the mandibular arch)

Dentulous arch:

- Replaces a single missing tooth in an arch, with no other missing teeth (excluding 3rd molars)
- Greater than 50% bone support in remaining arch
- Adequate space to accommodate implant and an anatomically correct restorative crown

- Restorative services have been completed on remainder of arch
- Absence of active periodontal disease

Edentulous arch:

- Only allowed in completely edentulous arches
- Implant placement is limited to 4 in the maxillary arch and 2 in the mandibular arch
- Patient should have a history of failed attempt at retaining a full denture in same arch
- Evidence of inadequate bone to support a traditional prosthesis

APPENDIX A - Definitions

General Definitions

The following definitions apply to this Office Reference Manual:

A. *(Note: as per state requirements) "DHMH" means the Department of Health and Mental Hygiene.*

B. "Contract" means the document specifying the services provided by DentaQuest to:

- an employer, directly or on behalf of the State of Maryland, as agreed upon between an employer or Plan and DentaQuest (a "Commercial Contract");
- a Medicare beneficiary, directly or on behalf of a Plan, as agreed upon between the Center for Medicaid and Medicare Services ("CMS") or Plan and DentaQuest (a "Medicare Contract").

C. "Covered Services" is a dental service or supply that satisfies all of the following criteria:

- provided or arranged by a Participating Provider to a Member; authorized by DentaQuest in accordance with the Plan Certificate; and
- submitted to DentaQuest according to DentaQuest 's filing requirements.

D. "Medically necessary services or supplies" means those covered services or supplies that are:

- Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease.
- Except as allowed under G.S. 58-3-255 for NC, not for experimental, investigational, or cosmetic purposes.
- Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms.
- Within generally accepted standards of medical care in the community.
- Not solely for the convenience of the insured, the insured's family, or the provider.

For medically necessary services, nothing in this subdivision precludes an insurer from comparing the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered.

E. "Member" means any individual who is eligible to receive Covered Services pursuant to a Contract and the eligible dependents of such individuals. A Member enrolled pursuant to a Commercial Contract is referred to as a "Commercial Member." A Member enrolled pursuant to a Medicaid Contract is referred to as a "Medicaid Member." A Member enrolled pursuant to a Medicare Contract is referred to as a "Medicare Member."

F. "Participating Provider" is a dental professional or facility or other entity, including a Provider, that has entered into a written agreement with DentaQuest, directly or through another entity, to provide dental services to selected groups of Members

G. "Plan" is an insurer, health maintenance organization or any other entity that is an organized system which combines the delivery and financing of health care, and which provides basic health services to enrolled Members for a fixed prepaid fee.

H. "Plan Certificate" means the document that outlines the benefits available to Members.

I. "Provider" means the undersigned health professional or any other entity that has entered into a written agreement with DentaQuest to provide certain health services to Members. Each Provider shall have its own distinct tax identification number.

J. “Provider Dentist” is a Doctor of dentistry, duly licensed and qualified under the applicable laws, who practices as a shareholder, partner, or employee of Provider, and who has executed a Provider Dentist Participation Addendum.

APPENDIX B – Additional Resources/Forms

Welcome to the DentaQuest provider forms and attachment resource page. The link below provides methods to access and acquire both electronic and printable forms addressed within this document. To view copies please visit our website at www.dentaquestgov.com. Once you have entered the website, click on the "Dentist" icon. From there choose your 'State" and press "Go". You will then be able to log in using your password and User ID. Once logged in, select the link "Related Documents" to access the following resources:

Orthodontic Services HLD Scoring Index

Sample Recall Exam Form

Sample Authorization For Dental Treatment Form

Sample Medical and Dental History

Non-Covered Services Disclosure Form

Request for Transfer of Records

Continuation of Care Submission Form

Sample ADA Claim Form

ACH Electronic Funds Transfer Form

Provider Change Form

CareSource Appointment of Representative Form

Prior Authorization/Retrospective Review Guidance

If you do not have internet access, to have a copy mailed, you may also contact DentaQuest Provider Services at 855-343-4260.

You can also find the forms within this manual - Appendix B.

Orthodontic Services - HLD Index
Comprehensive Orthodontics

Coverage of comprehensive orthodontics is limited to the most severe handicapping orthodontic conditions. Coverage is further limited to children under age 21 in Kentucky and children under 19 in all other states. Only one course of orthodontic treatment per recipient, per lifetime is covered.

Prior authorization is required for all comprehensive orthodontic treatment. The following must be included with the prior authorization request:

1) A completed 2012 or newer ADA claim form
2) Lateral and frontal photographs of the patient with lips together (D0471)
3) Cephalometric film with lips together, including a tracing (D0340)
4) A complete series of radiographs or a panoramic radiograph (D0210 or D0330)
5) Diagnostic models (D0470)
6) Treatment Plan, including projected length and cost of treatment

First Review ___
Second Review ___

Models ___
Orthocad ___
Ceph ___
X-Rays ___
Photos ___
Narrative ___

DENTAQUEST
ORTHODONTIC CRITERIA INDEX FORM – COMPREHENSIVE D8080

Patient Name:_____ **DOB:**_____

ABBREVIATIONS	CRITERIA	YES	NO
DO	Deep impinging overbite that shows palatal impingement of the majority of lower incisors – tissue destruction of the palate must be clearly visible in the mouth.		
AO	True anterior openbite. (Not including one or two teeth slightly out of occlusion or where the incisors have not fully erupted).		
OJ	Overjet in excess of 9 mm.		
NO	Negative Overjet greater than 3.5mm.		
LL	Cleft Lip/Palate deformities and other significant craniofacial anomalies.		
FAS	Malocclusions requiring a combination orthodontic and orthognathic surgery for correction.		
TRA	Severe Traumatic Deviations: Traumatic deviations include loss of a premaxilla segment by burns or by accident, the result of osteomyelitis or other gross pathology. Include a written report and photographs. Indicate with an "X" on the score sheet and do not score any further. This condition is considered to be a handicapping malocclusion.		

APPROVED: ☐ **DENIED:** ☐

Sample Recall Exam Form

RECALL EXAMINATION

PATIENT'S NAME _____

CHANGES IN HEALTH STATUS/MEDICAL HISTORY_____

	OK		OK	
LYMPH NODES		TMJ		CLINICAL FINDINGS/COMMENTS
PHARYNX		TONGUE		
TONSILS		VESTIBULES		
SOFT PALATE		BUCCAL MUCOSA		
HARD PALATE		GINGIVA		
FLOOR OF MOUTH		PROSTHESIS		
LIPS		PERIO EXAM		
SKIN		ORAL HYGIENE		
RADIOGRAPHS		B/P		RDH/DDS

R WORK NECESSARY L

TOOTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
SERVICE																
TOOTH	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
SERVICE																

COMMENTS:

NOTE: The above form is intended to be a sample. DentaQuest is not mandating the use of this form. Please refer to State statutes for specific State requirements and guidelines.

Sample Authorization for Dental Treatment Form

I hereby authorize Dr. _____and his/her associates to provide dental services, prescribe, dispense and/or administer any drugs, medicaments, antibiotics, and local anesthetics that he/she or his/her associates deem, in their professional judgment, necessary or appropriate in my care.

I am informed and fully understand that there are inherent risks involved in the administration of any drug, medicament, antibiotic, or local anesthetic. I am informed and fully understand that there are inherent risks involved in any dental treatment and extractions (tooth removal). The most common risks can include, but are not limited to:

Bleeding, swelling, bruising, discomfort, stiff jaws, infection, aspiration, paresthesia, nerve disturbance or damage either temporary or permanent, adverse drug response, allergic reaction, cardiac arrest.

I realize that it is mandatory that I follow any instructions given by the dentist and/or his/her associates and take any medication as directed.

Alternative treatment options, including no treatment, have been discussed and understood. No guarantees have been made as to the results of treatment. A full explanation of all complications is available to me upon request from the dentist.

Procedure(s): _____

Tooth Number(s): _____

Date: _____

Dentist: _____

Patient Name: _____

Legal Guardian/
Patient Signature: _____

Witness: _____

Note: The above form is intended to be a sample. DentaQuest is not mandating the use of this form. Please refer to State statutes for specific State requirements and guidelines.

Sample Medical and Dental History

Patient Name: _____ Date of Birth: _____

Address: _____

Why are you here today? _____

Are you having pain or discomfort at this time? □ Yes □ No

If yes, what type and where? _____

Have you been exposed to anyone who has tested positive or diagnosed with COVID-19 in the past 72 hours? □ Yes □ No

Have you tested positive for COVID-19 or experienced any symptoms of COVID-19 in the past 72 hours (i.e. coughing, fever, loss of smell, taste, runny nose)? □ Yes □ No

Have you been under the care of a medical doctor during the past two years? □ Yes □ No

Medical Doctor's Name: _____

Address: _____

Telephone: _____

Have you taken any medication or drugs during the past two years? □ Yes □ No

Are you now taking any medication, drugs, or pills? □ Yes □ No

If yes, please list medications: _____

Are you aware of being allergic to or have you ever reacted badly to any medication or substance? □ Yes □ No

If yes, please list: _____

When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? □ Yes □ No

Do your ankles swell during the day? □ Yes □ No

Do you use more than two pillows to sleep? □ Yes □ No

Have you lost or gained more than 10 pounds in the past year? □ Yes □ No

Do you ever wake up from sleep and feel short of breath? □ Yes □ No

Are you on a special diet? □ Yes □ No

Has your medical doctor ever said you have cancer or a tumor? □ Yes □ No

If yes, where? _____

Do you use tobacco products (smoke or chew tobacco)? □ Yes □ No

If yes, how often and how much? _____

Do you drink alcoholic beverages (beer, wine, whiskey, etc.)? □ Yes □ No

Do you have or have you had any disease, or condition not listed? □ Yes □ No

If yes, please list:

Indicate which of the following you have had or have at present. Check "Yes" or "No" for each item.

Heart Disease or Attack	□ Yes	□ No	Stroke	□ Yes	□ No	Hepatitis C	□ Yes	□ No
Heart Failure	□ Yes	□ No	Kidney Trouble	□ Yes	□ No	Arteriosclerosis (hardening of arteries)	□ Yes	□ No
Angina Pectoris	□ Yes	□ No	High Blood Pressure	□ Yes	□ No	Ulcers	□ Yes	□ No
Congenital Heart Disease	□ Yes	□ No	Venereal Disease	□ Yes	□ No	AIDS	□ Yes	□ No
Diabetes	□ Yes	□ No	Heart Murmur	□ Yes	□ No	Blood Transfusion	□ Yes	□ No
HIV Positive	□ Yes	□ No	Glaucoma	□ Yes	□ No	Cold sores/Fever blisters/ Herpes	□ Yes	□ No
High Blood Pressure	□ Yes	□ No	Cortisone Medication	□ Yes	□ No	Artificial Heart Valve	□ Yes	□ No
Mitral Valve Prolapse	□ Yes	□ No	Cosmetic Surgery	□ Yes	□ No	Heart Pacemaker	□ Yes	□ No
Emphysema	□ Yes	□ No	Anemia	□ Yes	□ No	Sickle Cell Disease	□ Yes	□ No
Chronic Cough	□ Yes	□ No	Heart Surgery	□ Yes	□ No	Asthma	□ Yes	□ No
Tuberculosis	□ Yes	□ No	Bruise Easily	□ Yes	□ No	Yellow Jaundice	□ Yes	□ No
Liver Disease	□ Yes	□ No	Rheumatic fever	□ Yes	□ No	Rheumatism	□ Yes	□ No
Arthritis	□ Yes	□ No	Epilepsy or Seizures	□ Yes	□ No	Fainting or Dizzy Spells	□ Yes	□ No
Allergies or Hives	□ Yes	□ No	Nervousness	□ Yes	□ No	Chemotherapy	□ Yes	□ No
Sinus Trouble	□ Yes	□ No	Radiation Therapy	□ Yes	□ No	Drug Addiction	□ Yes	□ No
Pain in Jaw Joints	□ Yes	□ No	Thyroid Problems	□ Yes	□ No	Psychiatric Treatment	□ Yes	□ No
Hay Fever	□ Yes	□ No	Hepatitis A (infectious)	□ Yes	□ No			
Artificial Joints (Hip, Knee, etc.)	□ Yes	□ No	Hepatitis B (serum)	□ Yes	□ No			

For Women Only:

Are you pregnant? □ Yes □ No

If yes, what month? _____

Are you nursing? □ Yes □ No

Are you taking birth control pills? □ Yes □ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully.

Patient Signature: _____ Date: _____

Dentist's Signature: _____ Date: _____

REVIEW DATE	**Changes in Health Status**	**Patient's Signature**	**Dentist's Signature**

Note: The above form is intended to be a sample. DentaQuest is not mandating the use of this form. Please refer to State statutes for specific State requirements and guidelines.

CareSource

CARESOURCE NON-COVERED SERVICES DISCLOSURE AND TREATMENT CONSENT FORM ("CONSENT FORM")

This Consent Form must be presented to the member **before** any non-covered services are rendered, kept as part of the member's medical record, and be made available to CareSource upon request.

Dental Provider Information

Marketplace Provider ID	Provider Address	Provider Phone
Provider Name	Date Consent Form Presented	

I, the undersigned Provider, understand and acknowledge, in accordance with the terms of my contract with DentaQuest on behalf of CareSource, I am only permitted to bill CareSource members for non-covered services when such members have, in writing, prior to the time services are rendered, agreed to assume full financial responsibility for the non-covered services. I confirm and attest I have reviewed the below health care services with the undersigned CareSource member or parent/guardian and that such services are not covered by CareSource Marketplace Plans and have not been denied by DentaQuest on the basis of lack of medical necessity or my failure to comply with the terms and conditions of my contract or any applicable DentaQuest provider manuals or policies ("Non-Covered Services"). I attest I have offered the below Non-Covered Services, in good faith, to the undersigned CareSource member or parent/guardian based on my assessment of the undersigned member's needs and I have discussed the relevant health care services that CareSource does cover that can safely and effectively treat the undersigned member's health condition, if any, with the undersigned member or parent/guardian.

Non-Covered Services

CDT/CPT Code	Procedure(s)	Cost ($)

I, the undersigned, do hereby affirm that all statements made by me on this Consent Form are true, accurate, and correct to the best of my knowledge and belief.

Provider Signature	Date

Member Information		
Marketplace Member ID	Name	DOB
Phone Number	Address	Parent/Guardian Name

I understand AND agree to what was presented. Answer YES or NO to each statement below and enter your initials.	**YES**	**NO**	**Initial**
I have been advised that the Non-Covered Services I am electing or that have been recommended are not covered health care services through CareSource Marketplace Plans, but I am electing to have these Non-Covered Services anyway and understand I am assuming full financial responsibility for the Non-Covered Services listed on this Consent Form.			
I understand by assuming full financial responsibility for the Non-Covered Services that DentaQuest on behalf of CareSource, will not be responsible for providing any payment to my doctor for the Non-Covered Services.			
I understand that CareSource may cover other health care services that can safely and effectively treat my heath condition and I may call DentaQuest, at any time, to determine what other health care services CareSource does cover to treat my health condition, if any.			
I, the undersigned, understand the acceptance of the Non-Covered Service(s) listed on this Consent Form is voluntary and that I may refuse the Non-Covered Service(s). I acknowledge I have been informed in advance of receiving the Non-Covered Services as to what my financial responsibility is and agree to make financial arrangements with my doctor to pay for the Non-Covered Services.			
Member Name (Print)			
If applicable, Authorized Representative Name (Print) and relationship to member:			
Member Signature (leave blank if member has an Authorized Representative):			Date
If applicable, Authorized Representative Signature:			Date

Members: If you feel you have not been offered alternative health care services that are within the benefits that CareSource does cover or feel uncomfortable signing this agreement, please contact DentaQuest Member Services at **1-833-230-2099**.

Records Request

Request for Transfer of Records

I, _____, hereby request and give my permission to Dr. _____ to provide Dr._____any and all information regarding past dental care for _____.

Such records may include medical care and treatment, illness or injury, dental history, medical history, consultation, prescriptions, radiographs, models and copies of all dental records and medical records.

Please have these records sent to:

_____

_____

_____

Signed: _____ Date: _____
(Patient)

Signed: _____ Date: _____

(Parent, Legal Guardian, or Custodian of the Patient, if Patient is a Minor)

Address: _____
Address: _____Phone: _____

DentaQuest

Continuation of Care Submission Form

Date:_____

Patient Information

Name (First & Last):	Date of Birth:	SS or ID #:
Address:	City, State, Zip:	Area Code & Phone number:
Group Name:	Plan Type:	

Provider Information

Dentist Name:	Provider NPI #:	Location ID #:
Address:	City, State, Zip:	Area Code & Phone number:

Name of Previous Vendor that issued original approval:

Banding Date:

Case Rate Approved By Previous Vendor:

Amount Paid for Dates of Service That Occurred Prior to DentaQuest:

Amount Owed for Dates of Service That Occurred Prior to DentaQuest:

Balance Expected for Future Dates of Service:

Remaining services and quantities to be paid from prior approval:

Additional information required:

If approved through a private or commercial plan, also include:

- **A copy of the original study models or a complete set of diagnostic photographs prior to the patient being banded**
- **Panorex film**

ADA 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

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 ☐U | 8. Policyholder/Subscriber ID (Assigned by Plan)

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 (Assigned by Plan 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 ☐U | 15. Policyholder/Subscriber ID (Assigned by Plan)

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 ☐U | 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-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ B _____ C _____ 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

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 posted on the ADA's web site (https://www.ADA.org/en/publications/cdt/ada-dental-claim-form).

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 instructions posted on the ADA's web site (ADA.org).

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.

F. GENDER Codes (Items 7, 14 and 22) – M = Male; F = Female; U = Unknown

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).

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 (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:
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/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:
http://www.wpc-edi.com/reference/codelists/healthcare/health-care-provider-taxonomy-code-set/

Authorization to Honor Direct Automated Clearing House (ACH) Credits Disbursed by DentaQuest, LLC.

DentaQuest

AUTHORIZATION TO HONOR DIRECT AUTOMATED CLEARING HOUSE (ACH) CREDITS DISBURSED BY DENTAQUEST, LLC

***Indicates Required Field. Please print legibly.**

Provider Information			
*Provider Name – Complete legal name of corporate entity, practice or individual provider		Doing Business As (DBA)	
Provider Address			
*Street		*City	
*State/Province		*ZIP Code /Postal Code	

Provider Identifiers Information			
*Provider Federal Tax ID (TIN) or Employer Identification Number (EIN) Numeric 9 Digits		*National Provider Identifier (NPI) Numeric 10 Digits	

Provider Contact Information			
*Provider Contact Name- (Name of contact in provider office authorized to handle EFT issues		Title	
*Telephone Number		*Email Address	

Financial Institution Information			
*Financial Institution Name			
Financial Institution Address			
*Street		*City	
*State/Province		*Zip Code/Postal Code	
*ZIP Code/Postal Code		Financial Institution Telephone Number	
*Financial Institution Routing Number (Numeric 9 Digits)		*Type of Account at Financial Institution (e.g., Checking, Saving)	
*Provider's Account Number with Financial Institution		*Account Number Linkage to Provider Identifier – Select One	Provider TIN ☐ Provider NPI ☐

Submission Information			
***Reason for Submission** Select One	**New Enrollment** ☐	**Change Enrollment** ☐	**Cancel Enrollment** ☐
Include with Enrollment Submission	Voided Check A voided check is attached to provide confirmation of Identification/Account Numbers		

2/2020

DentaQuest

As a convenience to me, for payment of services or goods due to me, I hereby request and authorize **DentaQuest, LLC** to credit my bank account via Direct Deposit for the agreed upon dollar amounts and dates. I also agree to accept my remittance statements online and understand paper remittance statements will no longer be processed.

This authorization will remain in effect until revoked by me in writing. I agree **DentaQuest, LLC** shall be fully protected in honoring any such credit entry.

I understand in endorsing or depositing this check that payment will be from Federal and State funds and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws.

I agree that **DentaQuest, LLC's** treatment of each such credit entry, and the rights in respect to it, shall be the same as if it were signed by me. I fully agree that if any such credit entry be dishonored, whether with or without cause, **DentaQuest, LLC** shall be under no liability whatsoever.

Submission Date

Authorized Signature

Requested EFT Start/Change/Cancel Date

Printed Name of Person Submitting Enrollment

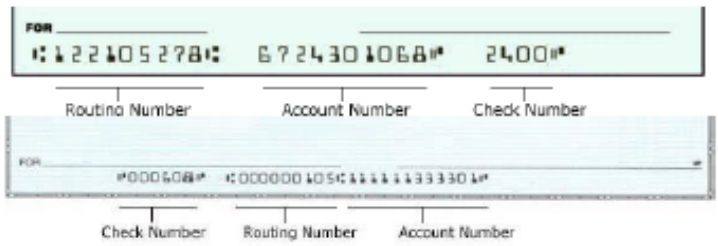
Printed Title of Person Submitting Enrollment

APPENDIX
Additional Information to assist with completion of this EFT/ACH Enrollment Form and the EFT/ACH banking process.

Please note the following *IMPORTANT* information:

- We are required to inform you that you MUST contact your financial institution to arrange for the delivery of the CORE-required Minimum CCD+ data elements needed for reassociation of the payment and the ERA.
- **You MUST attach a voided check from your account.**

ACCOUNT HOLDER INFORMATION:



Personal Checking Example

Business Checking Example

Questions?
You may send your completed form, as well as any questions regarding the status of your EFT enrollment, to the fax number or email address provided below:

Fax: (262)241-4077
Email: StandardUpdates@dentaquest.com

2/2020

Provider Change Form

DentaQuest

Provider Update Form - Provider Operations

You may send this form by e-mail to Standardupdates@dentaquest.com or by fax to 262-241-4077

Section 1: Current Information - *Complete for ALL Requests - Asterisk denotes required fields*

Change Effective Date *(Required)* :

*Provider Last Name | *Provider First Name

*Individual National Provider Identifier (NPI) #

Date of Birth | Social Security # | Gender

*Specialty | *Personal E-Mail

Requestor Information

*Requestor Name | *Title

*Requestor Contact Information *(Phone or E-mail)*

Section 2: Type of Update - Check all that Apply - *Complete for ALL Requests* - For Questions contact your Provider Engagement Representative or Customer Service

- ☐ Business (Tax ID) - Add/ Term/ Update - **Complete Sections 1, 7 and 8**
- ☐ Credentialing Correspondence Change/Update - **Complete Sections 1 and 5**
- ☐ EFT/ Payment - **Complete Sections 1 and 8**
- ☐ License Change - **Complete Sections 1 and 4**
- ☐ Name Change - **Complete Sections 1 and 3**
- ☐ Location - Add/ Term/ Update - **Complete Sections 1 and 6**
- ☐ Termination Request - **Complete Sections 1 and 9**

Section 3: Name Change - *Attach supporting legal documentation*

New Last Name | New First Name

New Middle Name | New Suffix

Please Note: Before DentaQuest can change your name in our system, your license must reflect the name change.

Section 4: License Change

New Dental License Number | State

New DEA License Number | State

New State Drug License Number | State

New Medicaid License Number | State

Other License Name

Other License Number | State

Section 5: Credentialing Correspondence Change

Credentialing Contact Name

Correspondence Address

City | State | Zip Code

Telephone | Fax

Credentialing E-Mail

Appointment of Representative

Name of person you are appointing as an Authorized Representative: _____

Relationship to covered person: ☐ Relative ☐ Healthcare Provider ☐ Attorney ☐ Other _____

Contact information of authorized representative

Mailing Address:

Daytime Phone:

Email Address: Fax:

Covered Person Information

Name: ID Number:

Mailing Address:

Phone:

Email Address: Fax:

Appointment of Authorized Representative (Purpose: To grant permission for another individual or company to act on your behalf in filing a Grievance or Appeal). You may revoke this authorization at any time.

I, _____(Member Name), appoint _____(Name of Authorized Representative), to act on my behalf in connection with any claim for coverage or benefits identified in this case, including receipt of any approval(s) or authorization(s) that are required before medical service(s). I authorize my representative to receive any and all information related to this case that is provided to me and to provide any information to the health plan in relation to the disputed claims, approvals, or authorizations. This information may include, a diagnosis (name of illness or condition), claims, doctors and other health care providers and financial information (like billing and banking). I also understand that I may revoke (or cancel) this approval at any time. I understand that I cannot cancel this approval when this form has already been used to disclose information.

Expiration: This consent is valid for one year from the date of this signed form unless you withdraw in writing sooner than one year.

I have read the contents of this form. I understand, agree, and allow CareSource to the use and release of my information as I have stated above. I also understand that signing this form is of my own free will. I understand that CareSource does not require that I sign this form in order for me to receive treatment or payment, or for enrollment or being eligible for benefits.

I have the right to withdraw this approval at any time by giving written notice of my withdrawal to CareSource.

I understand that my withdrawing of this approval will not affect any action taken before I do so. I also understand that information that's released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this form.

Signatures:

Signature of Covered Person (or legal representative*) Date
*Parent, Guardian, Conservator, Other—*please specify*

I _____(Name of Authorized Representative),

hereby accept the above appointment. I am a/an _____(Relationship to Member).

Signature of Authorized Representative _____Date _____

Designated Legal Representative/Guardian:

If this form is signed by someone other than the member or parent, such as a personal representative, legal representative, or guardian on behalf of the member, please submit the following:

☐ A copy of a health care, general or Durable Power of Attorney.

OR

☐ A court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the member's behalf.

SEND THIS FORM AND A COPY OF YOUR NOTICE OF ADVERSE BENEFIT DETERMINATION TO ONE OF THE FOLLOWING:

Fax Number: 937-531-2398

Mailing Address:
CareSource
Attn: Member Appeals
P.O. Box 1947
Dayton, OH 45401-1947

If you need help with this form, you may call the Member Services department for your state, Monday through Friday, 7 a.m. to 7 p.m. Eastern Time (ET):

Georgia Marketplace Members: 1-833-230-2030

Kentucky Marketplace Members: 1-888-815-6446

North Carolina Marketplace Members: 1-833-615-0434

Ohio Marketplace Members: 1-800-479-9502

West Virginia Marketplace Members: 1-855-202-0622

Prior Authorization/Retrospective Review Guidance

IMPORTANT

For procedures where "Authorization Required" fields indicate "**Prior Authorization or Retrospective Review**". Please review the information below on when to submit documentation to DentaQuest. The information refers to the "Documentation Required" field in the Benefits Covered section (Exhibits). In this section, documentation may be requested to be sent prior to beginning treatment or "with claim" after completion of treatment when documentation is requested. i.e. 03330 Preoperative Radiographs of adjacent and opposing teeth.

"Authorization Required" Field	"Documentation Required" Field	Treatment Condition	When to Submit Documentation
Prior Authorization	Documentation Requested	Non-emergency (routine)	Send documentation prior to beginning treatment
Retrospective Review	Documentation Requested	Emergency	Send documentation with claim after treatment

- Prior Authorization Required means that authorization must be submitted and determined prior to the service being performed.
  - If prior authorization was not received and approved prior to the date of service, claims will deny stating "Service requires prior authorization. No prior authorization is on file".
  - If prior authorization was approved, the system will process the claim accordingly.

- Pre-Payment Review or Retrospective Review can occur either Pre-Service (via prior authorization) or Post-Service (via claim review).
  - If a provider chooses to submit for pre-payment review pre-service (prior authorization), DentaQuest will review and render a determination. The provider will receive Prior Authorization determination notice. The provider should also leave date of service blank on ADA form.
  - If a provider chooses not to submit pre-service, but instead submits a post-service claim, DentaQuest will process the claim rendering a determination. This differs from "Prior Authorization Required" in that it allows the provider the flexibility of rendering treatment first without receiving prior authorization approval. The claim is reviewed prior to payment being made.
  - Providers often submit for pre-service service (prior authorization) to ensure services will be approved and paid prior to rendering services. This allows the provider/member to come to a financial agreement if necessary.

- No Prior Authorization or Pre-Payment Review or Retrospective Required
  - Services that do not require either Prior Authorization or Pre-Payment/Retrospective Review are not clinically reviewed on either an authorization or claim.
  - If submitted for prior authorization, the system applies language on the letter that states, "Prior Authorization is not required for this service".
  - If submitted on a date of service, the system adjudicates the claim.

APPENDIX C Covered Benefits (Exhibits A - H)

This section identifies covered benefits, provides specific criteria for coverage, and defines individual age and benefit limitations. The use of “Pediatric” implies members under age 19 in Georgia, Indiana, Ohio, and West Virginia, North Carolina, and under the age of 21 in Kentucky. The month following a member reaching 19 or 21, they will be considered “Adult”. Providers with benefit questions should contact DentaQuest’s Provider Services department directly.

Dental offices are not allowed to charge Members for missed appointments. Plan Members are to be allowed the same access to dental treatment, as any other patient in the dental practice. Private reimbursement arrangements may be made only for non-covered services.

DentaQuest recognizes tooth letters “A” through “T” for primary teeth and tooth numbers “1” to “32” for permanent teeth. Supernumerary teeth should be designated by “AS through TS” for primary teeth and tooth numbers “51” to “82” for permanent teeth. These codes must be referenced in the patient’s file for record retention and review. All dental services performed must be recorded in the patient record, which must be available as required by your Participating Provider Agreement.

For reimbursement, DentaQuest Providers should bill only per unique surface regardless of location. For example, when a dentist places separate filling in both occlusal pits on an upper permanent first molar, the billing should state a one surface occlusal amalgam ADA code D2140. Furthermore, DentaQuest will reimburse for the total number of surfaces restored per tooth, per day; (i.e., a separate occlusal and buccal restoration on tooth 30 will be reimbursed as 1 (OB) two surface restoration).

The DentaQuest claim system can only recognize dental services described using the current American Dental Association CDT code list or those as defined as a Covered Benefit. All other service codes not contained in the following tables will be rejected when submitted for payment. A complete, copy of the CDT book can be purchased from the American Dental Association at the following address:

American Dental Association
211 East Chicago Avenue
Chicago, IL 60611

800-947-4746

Furthermore, DentaQuest subscribes to the definition of services performed as described in the Certified Dental Technicians (CDT) manual.

The benefit tables (Exhibits) are all inclusive for covered services. Each category of service is contained in a separate table and lists:

1. the ADA approved service code to submit when billing,
2. brief description of the covered service,
3. any age limits imposed on coverage,
4. a description of documentation, in addition to a completed ADA claim form, that must be submitted when a claim or request for prior authorization is submitted,
5. an indicator of whether or not the service is subject to prior authorization, any other applicable benefit limitations.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0120	periodic oral evaluation - established patient	19 and older		No	No	Two of (D0120, D0140, D0150, D0180) per 1 Calendar year(s) Per patient. D0120 periodic oral evaluation may not occur in combination with D0150 on same date of service and not until 180 days after the D0150 comprehensive oral evaluation.	
D0140	limited oral evaluation-problem focused	19 and older		No	No	Two of (D0120, D0140, D0150, D0180) per 1 Calendar year(s) Per patient. Note- This procedure code is used for emergency examinations during regularly scheduled office hours. Evaluations solely for the purpose of adjustments or in conjunction with multi-visit procedures are not covered (i.e. endodontics and orthodontia). May not be used in conjunction with D0120, D0150, D9440, and D0180	
D0150	comprehensive oral evaluation - new or established patient	19 and older		No	No	Two of (D0120, D0140, D0150, D0180) per 1 Calendar year(s) Per patient. One of (D0150) per 24 Month(s) Per Provider OR Location. D0150 used when evaluating a patient comprehensively. D0150 or the periodic exam D0120 may not occur in conjunction with a limited oral evaluation (examination during office hours- D0140 or after office hours- D9440)	

Exhibit A Benefits Covered for CareSource Marketplace Adult (GA)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0180	comprehensive periodontal evaluation - new or established patient	19 and older		No	No	Two of (D0120, D0140, D0150, D0180) per 1 Calendar year(s) Per patient. One of (D0180) per 24 Month(s) Per Provider OR Location. D0180 requires a complete and detailed periodontal evaluation, including full-mouth probing and detailed charting. Reimbursement disallowed for D0180 performed in conjunction with D0150, D0120, or D1110.	
D0210	intraoral - comprehensive series of radiographic images	19 and older		No	No	One of (D0210, D0330) per 60 Month(s) Per patient. Indicated for the permanent dentition or Adult dentate. A full-mouth series consist of a minimum of fourteen (14) films, including all periapical and posterior bitewing films intended to display the crowns and roots of all teeth, periapical areas and alveolar bone necessary for examination and diagnosis. PA required if done more frequently than 60 months	

Exhibit A Benefits Covered for CareSource Marketplace Adult (GA)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0220	intraoral - periapical first radiographic image	19 and older		No	No	One of (D0220) per 1 Day(s) Per patient. Any additional periapical films (D0230 should be used) If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series. Periapical radiographs are used diagnostically and are not reimbursable when used intraoperatively (i.e. during RCT or other procedural x-rays.	

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0230	intraoral - periapical each additional radiographic image	19 and older		No	No	A total of four horizontal bitewing films in any combination of (D0270, D0272, D0273 or D0274) per 6 Month(s) “Or” One set of vertical bitewings (D0277) per 6 Month(s) See fee limitations for all radiographs. If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series.	

Exhibit A Benefits Covered for CareSource Marketplace Adult (GA)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0240	intraoral - occlusal radiographic image	19 and older		No	No	A total of four horizontal bitewing films in any combination of (D0270, D0272, D0273 or D0274) per 6 Month(s) “Or” One set of vertical bitewings (D0277) per 6 Month(s) See fee limitations for all radiographs. If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series.	

Exhibit A Benefits Covered for CareSource Marketplace Adult (GA)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0270	bitewing - single radiographic image	19 and older		No	No	A total of four horizontal bitewing films in any combination of (D0270, D0272, D0273 or D0274) per 6 Month(s) “Or” One set of vertical bitewings (D0277) per 6 Month(s) See fee limitations for all radiographs. If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series.	

Exhibit A Benefits Covered for CareSource Marketplace Adult (GA)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0272	bitewings - two radiographic images	19 and older		No	No	A total of four horizontal bitewing films in any combination of (D0270, D0272, D0273 or D0274) per 6 Month(s) “Or” One set of vertical bitewings (D0277) per 6 Month(s) See fee limitations for all radiographs. If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series.	

Exhibit A Benefits Covered for CareSource Marketplace Adult (GA)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0273	bitewings - three radiographic images	19 and older		No	No	A total of four horizontal bitewing films in any combination of (D0270, D0272, D0273 or D0274) per 6 Month(s) “Or” One set of vertical bitewings (D0277) per 6 Month(s) See fee limitations for all radiographs. If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series.	

Exhibit A Benefits Covered for CareSource Marketplace Adult (GA)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0274	bitewings - four radiographic images	19 and older		No	No	One of (D0274, D0277) per 6 Month(s) Per patient. A total of four horizontal bitewing films in any combination of (D0270, D0272, D0273 or D0274) per 6 Month(s) “Or” One set of vertical bitewings (D0277) per 6 Month(s) See fee limitations for all radiographs. If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series.	

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0277	vertical bitewings - 7 to 8 films	19 and older		No	No	One of (D0274, D0277) per 6 Month(s) Per patient. A total of four horizontal bitewing films in any combination of (D0270, D0272, D0273 or D0274) per 6 Month(s) “Or” One set of vertical bitewings (D0277) per 6 Month(s) See fee limitations for all radiographs. If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series.	
D0330	panoramic radiographic image	19 and older		No	No	One of (D0210, D0330) per 60 Month(s) Per patient. All periapical or occlusal films taken same date of service needed to render the necessary radiographic diagnosis are included in the fee for panoramic radiograph. If bitewing radiographs D0270, D0272 or D0274 are indicated for additional diagnosis, the amount reimbursed will not exceed the reimbursable amount for D0210 Full Mouth Series. PA required if done more frequently than 60 months.	

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0372	intraoral tomosynthesis – comprehensive series of radiographic images	19 and older		No	No	One of (D0210, D0277, D0330, D0372, D0387, D0701, D0709) per 1 Calendar year(s) Per patient.	
D0373	intraoral tomosynthesis – bitewing radiographic image	19 and older		No	No	One of (D0270, D0272, D0273, D0274, D0277, D0373, D0388, D0708) per 1 Calendar year(s) Per patient.	
D0374	intraoral tomosynthesis – periapical radiographic image	19 and older		No	No	One of (D0220, D0230, D0374, D0389, D0707) per 1 Calendar year(s) Per patient.	
D0387	intraoral tomosynthesis – comprehensive series of radiographic images – image capture only	19 and older		No	No	One of (D0210, D0277, D0330, D0372, D0387, D0701, D0709) per 1 Calendar year(s) Per patient.	
D0388	intraoral tomosynthesis – bitewing radiographic image – image capture only	19 and older		No	No	One of (D0220, D0230, D0374, D0389, D0707) per 1 Calendar year(s) Per patient.	
D0389	intraoral tomosynthesis – periapical radiographic image – image capture only	19 and older		No	No	One of (D0220, D0230, D0374, D0389, D0707) per 1 Calendar year(s) Per patient.	
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report	19 and older		No	No	One of (D0391) per 1 Day(s) Per Provider OR Location. Interpretation of diagnostic image and report by a Practitioner not associated with Image Capture. Report should be kept in patient record for post payment review as applicable.	

Exhibit A Benefits Covered for CareSource Marketplace Adult (GA)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0470	diagnostic casts	19 and older		No	No	One of (D0470) per 1 Day(s) Per Provider OR Location. One per case. Diagnostic models or study models used as a guide in the application of corrective or restorative dentistry. Payable as a diagnostic service intended for the documentation and subsequent analysis of occlusion.	

Exhibit A Benefits Covered for CareSource Marketplace Adult (GA)

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D1110	prophylaxis - adult	19 and older		No	No	Two of (D1110) per 1 Calendar year(s) Per patient. This service code used for permanent dentition.	

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2140	Amalgam - one surface, primary or permanent	19 and older	Teeth 1 - 32	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	
D2150	Amalgam - two surfaces, primary or permanent	19 and older	Teeth 1 - 32	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	

Exhibit A Benefits Covered for CareSource Marketplace Adult (GA)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2160	amalgam - three surfaces, primary or permanent	19 and older	Teeth 1 - 32	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	
D2161	amalgam - four or more surfaces, primary or permanent	19 and older	Teeth 1 - 32	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2330	resin-based composite - one surface, anterior	19 and older	Teeth 6 - 11, 22 - 27	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. The fee for resin-based composite restorations will include any necessary acid etching and bonding agents. Non-contiguous restorations, such as a separate Distal Facial (DF) and Mesial Facial (MF) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	
D2331	resin-based composite - two surfaces, anterior	19 and older	Teeth 6 - 11, 22 - 27	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. The fee for resin-based composite restorations will include any necessary acid etching and bonding agents. Non-contiguous restorations, such as a separate Distal Facial (DF) and Mesial Facial (MF) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2332	resin-based composite - three surfaces, anterior	19 and older	Teeth 6 - 11, 22 - 27	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. The fee for resin-based composite restorations will include any necessary acid etching and bonding agents. Non-contiguous restorations, such as a separate Distal Facial (DF) and Mesial Facial (MF) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	19 and older	Teeth 6 - 11, 22 - 27	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. The fee for resin-based composite restorations will include any necessary acid etching and bonding agents. Non-contiguous restorations, such as a separate Distal Facial (DF) and Mesial Facial (MF) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2391	resin-based composite - one surface, posterior	19 and older	Teeth 1 - 5, 12 - 21, 28 - 32	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. CareSource will reimburse based on Amalgam for posterior teeth.D2391 Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	
D2392	resin-based composite - two surfaces, posterior	19 and older	Teeth 1 - 5, 12 - 21, 28 - 32	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. CareSource will reimburse based on Amalgam for posterior teeth.D2391 Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2393	resin-based composite - three surfaces, posterior	19 and older	Teeth 1 - 5, 12 - 21, 28 - 32	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. CareSource will reimburse based on Amalgam for posterior teeth.D2391 Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	
D2394	resin-based composite - four or more surfaces, posterior	19 and older	Teeth 1 - 5, 12 - 21, 28 - 32	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. CareSource will reimburse based on Amalgam for posterior teeth.D2391 Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	

Exhibit A Benefits Covered for CareSource Marketplace Adult (GA)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2510	inlay - metallic -1 surface	19 and older	Teeth 1 - 32	No	No	One of (D2510) per 60 Month(s) Per patient per tooth. Covered only when a direct restoration (ie. amalgam, composite) will not adequately restore the tooth.	
D2520	inlay-metallic-2 surfaces	19 and older	Teeth 1 - 32	No	No	One of (D2520) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	
D2530	inlay-metallic-3+ surfaces	19 and older	Teeth 1 - 32	No	No	One of (D2530) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	
D2542	onlay - metallic - two surfaces	19 and older	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2543	onlay-metallic-3 surfaces	19 and older	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2544	onlay-metallic-4+ surfaces	19 and older	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2740	crown - porcelain/ceramic	19 and older	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2750	crown - porcelain fused to high noble metal	19 and older	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2751	crown - porcelain fused to predominantly base metal	19 and older	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs

Exhibit A Benefits Covered for CareSource Marketplace Adult (GA)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2752	crown - porcelain fused to noble metal	19 and older	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2780	crown - ¾ cast high noble metal	19 and older	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2781	crown - ¾ cast predominantly base metal	19 and older	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2782	crown - ¾ cast noble metal	19 and older	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs

Exhibit A Benefits Covered for CareSource Marketplace Adult (GA)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2783	crown - ¾ porcelain/ceramic	19 and older	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2790	crown - full cast high noble metal	19 and older	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2791	crown - full cast predominantly base metal	19 and older	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2792	crown - full cast noble metal	19 and older	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2794	Crown- Titanium and Titanium Alloys	19 and older	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	19 and older	Teeth 1 - 32	No	No	Not covered within 6 months of initial placement.	
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core	19 and older	Teeth 1 - 32	No	No	Not covered within 6 months of initial placement.	
D2920	re-cement or re-bond crown	19 and older	Teeth 1 - 32, A - T	No	No	Not covered within 6 months of initial placement.	
D2940	protective restoration	19 and older	Teeth 1 - 32	No	No	One of (D2940) per 1 Calendar year(s) Per patient per tooth. Restorative material to protect tooth and/or tissue form. Used to relieve pain, promote healing, and prevent further deterioration. Not reimbursable when used as endodontic access closure, or as a base or liner under restoration.	
D2950	core buildup, including any pins when required	19 and older	Teeth 1 - 32	Yes	No	One of (D2950) per 60 Month(s) Per patient per tooth.	pre-operative radiographs
D2951	pin retention - per tooth, in addition to restoration	19 and older	Teeth 1 - 32	No	No	Three of (D2951) per 1 Lifetime Per patient per tooth.	
D2952	cast post and core in addition to crown	19 and older	Teeth 1 - 32	Yes	No	One of (D2952, D2954) per 60 Month(s) Per patient per tooth.	pre-operative radiographs
D2953	each additional cast post - same tooth	19 and older	Teeth 1 - 32	Yes	No	One of (D2953) per 60 Month(s) Per patient per tooth.	pre-operative radiographs
D2954	prefabricated post and core in addition to crown	19 and older	Teeth 1 - 32	Yes	No	One of (D2952, D2954) per 60 Month(s) Per patient per tooth.	pre-operative radiographs

Exhibit A Benefits Covered for CareSource Marketplace Adult (GA)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2957	each additional prefabricated post - same tooth	19 and older	Teeth 1 - 32	Yes	No	One of (D2957) per 60 Month(s) Per patient per tooth.	pre-operative radiographs
D2980	crown repair, by report	19 and older	Teeth 1 - 32	Yes	No	One of (D2980) per 60 Month(s) Per patient per tooth.	Narr / Oper Rpt
D2981	Inlay repair necessitated by restorative material failure	19 and older	Teeth 1 - 32, 51 - 82	Yes	No	One of (D2981) per 60 Month(s) Per patient per tooth.	Narr / Oper Rpt
D2982	Onlay repair necessitated by restorative material failure	19 and older	Teeth 1 - 32, 51 - 82	Yes	No	One of (D2982) per 60 Month(s) Per patient per tooth.	Narr / Oper Rpt
D2983	Veneer repair necessitated by restorative material failure	19 and older	Teeth 1 - 32, 51 - 82	Yes	No	One of (D2983) per 60 Month(s) Per patient per tooth.	Narr / Oper Rpt

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Endodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	19 and older	Teeth 1 - 32, A - T	No	No	One of (D3220) per 1 Lifetime Per patient per tooth. If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.	
D3221	pulpal debridement, primary and permanent teeth	19 and older	Teeth 1 - 32, A - T	No	No	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.	
D3222	partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	19 and older	Teeth 1 - 32	No	No	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.	
D3310	endodontic therapy, anterior tooth (excluding final restoration)	19 and older	Teeth 6 - 11, 22 - 27	No	No	One of (D3310) per 1 Lifetime Per patient per tooth. 1)Once per tooth per lifetime except for exception cases of appropriate medical necessity.2)The date the RCT is completed should be the date of service.3)Reimbursement for a root canal includes opening and drainage, treatment planning, clinical procedures, follow-up care, radiographs during treatment, and post-operative radiographs. 4)D3310,D3320,D3330 are subject to Post Review Third molar wisdom teeth will only be considered for coverage when tooth is functional.	

Endodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D3320	endodontic therapy, premolar tooth (excluding final restoration)	19 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	No	One of (D3320) per 1 Lifetime Per patient per tooth. 1)Once per tooth per lifetime except for exception cases of appropriate medical necessity.2)The date the RCT is completed should be the date of service.3)Reimbursement for a root canal includes opening and drainage, treatment planning, clinical procedures, follow-up care, radiographs during treatment, and post-operative radiographs. 4)D3310,D3320,D3330 are subject to Post Review Third molar wisdom teeth will only be considered for coverage when tooth is functional.	
D3330	endodontic therapy, molar tooth (excluding final restoration)	19 and older	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	No	One of (D3330) per 1 Lifetime Per patient per tooth. 1)Once per tooth per lifetime except for exception cases of appropriate medical necessity.2)The date the RCT is completed should be the date of service.3)Reimbursement for a root canal includes opening and drainage, treatment planning, clinical procedures, follow-up care, radiographs during treatment, and post-operative radiographs. 4)D3310,D3320,D3330 are subject to Post Review Third molar wisdom teeth will only be considered for coverage when tooth is functional.	

Endodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D3346	retreatment of previous root canal therapy-anterior	19 and older	Teeth 6 - 11, 22 - 27	No	No	One of (D3346) per 1 Lifetime Per patient per tooth. 1)Dental provider who performed the original root canal should not be reimbursed for the retreatment for the first 12 months 2)D3346, D3347, D3348 are subject to Post Review	
D3347	retreatment of previous root canal therapy - premolar	19 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	No	One of (D3347) per 1 Lifetime Per patient per tooth. 1)Dental provider who performed the original root canal should not be reimbursed for the retreatment for the first 12 months 2)D3346, D3347, D3348 are subject to Post Review	
D3348	retreatment of previous root canal therapy-molar	19 and older	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	No	One of (D3348) per 1 Lifetime Per patient per tooth. 1)Dental provider who performed the original root canal should not be reimbursed for the retreatment for the first 12 months 2)D3346, D3347, D3348 are subject to Post Review	
D3351	apexification/recalcification - initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	19 and older	Teeth 2 - 16, 18 - 31	Yes	No	One of (D3351) per 1 Lifetime Per patient per tooth. Initial opening, preparation and first placement of medication and necessary radiographs	pre-operative radiographs
D3352	apexification/recalcification - interim medication replacement	19 and older	Teeth 2 - 16, 18 - 31	Yes	No	One of (D3352) per 1 Lifetime Per patient per tooth. For visits in which the intra-canal medication is replaced with new medication, includes any necessary radiographs	pre-operative radiographs

Endodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D3353	apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	19 and older	Teeth 1 - 32	Yes	No	One of (D3353) per 1 Lifetime Per patient per tooth. Includes removal of intra-canal medication and procedures necessary to place final root canal filling material, includes necessary radiographs.	pre-operative radiographs
D3355	Pulpal regeneration - initial visit	19 and older	Teeth 1 - 32	No	No	One of (D3355) per 1 Lifetime Per patient per tooth.	
D3356	Pulpal regeneration - interim medication replacement	19 and older	Teeth 1 - 32	No	No	One of (D3356) per 1 Lifetime Per patient per tooth.	
D3357	Pulpal regeneration - completion of treatment	19 and older	Teeth 1 - 32	No	No	One of (D3357) per 1 Lifetime Per patient per tooth. Subject to Post Review	
D3410	apicoectomy - anterior	19 and older	Teeth 6 - 11, 22 - 27	Yes	No	One of (D3410) per 1 Lifetime Per patient per tooth.	pre-operative radiographs
D3421	apicoectomy - premolar (first root)	19 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	No	One of (D3421) per 1 Lifetime Per patient per tooth.	pre-operative radiographs
D3425	apicoectomy - molar (first root)	19 and older	Teeth 2, 3, 14 - 19, 30, 31	Yes	No	One of (D3425) per 1 Lifetime Per patient per tooth.	pre-operative radiographs
D3426	apicoectomy (each additional root)	19 and older	Teeth 2 - 5, 12 - 15, 18 - 21, 28 - 31	Yes	No	One of (D3426) per 1 Lifetime Per patient per tooth.	pre-operative radiographs
D3450	root amputation - per root	19 and older	Teeth 2 - 16, 18 - 31	Yes	No		pre-operative radiographs
D3471	surgical repair of root resorption - anterior	19 and older	Teeth 6 - 11, 22 - 27	No	No	One of (D3471) per 1 Lifetime Per patient per tooth.	
D3472	surgical repair of root resorption – premolar	19 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	No	One of (D3472) per 1 Lifetime Per patient per tooth.	
D3473	surgical repair of root resorption – molar	19 and older	Teeth 1 - 3, 14 - 19, 30 - 32	No	No	One of (D3473) per 1 Lifetime Per patient per tooth.	
D3501	surgical exposure of root surface without apicoectomy or repair of root resorption – anterior	19 and older	Teeth 6 - 11, 22 - 27	No	No	One of (D3501) per 1 Lifetime Per patient per tooth.	

Exhibit A Benefits Covered for CareSource Marketplace Adult (GA)

Endodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D3502	surgical exposure of root surface without apicoectomy or repair of root resorption – premolar	19 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	No	One of (D3502) per 1 Lifetime Per patient per tooth.	
D3503	surgical exposure of root surface without apicoectomy or repair of root resorption – molar	19 and older	Teeth 1 - 3, 14 - 19, 30 - 32	No	No	One of (D3503) per 1 Lifetime Per patient per tooth.	
D3920	hemisection (including any root removal), not incl root canal therapy	19 and older	Teeth 2, 3, 14, 15, 18, 19, 30, 31	Yes	No		pre-operative radiographs

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Periodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	19 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4210, D4211) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	19 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4210, D4211) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	19 and older	Teeth 1 - 32, 51 - 82	Yes	No	One of (D4212) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4240	gingival flap procedure, including root planing – four or more contiguous teeth or tooth bound spaces per quadrant	19 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4240, D4241) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4241	gingival flap procedure, including root planing – one to three contiguous teeth or tooth bound spaces per quadrant	19 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4240, D4241) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4249	clinical crown lengthening - hard tissue	19 and older	Teeth 1 - 32	Yes	No	One of (D4249) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4260	osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	19 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4260, D4261) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4261	osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	19 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4260, D4261) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting

Exhibit A Benefits Covered for CareSource Marketplace Adult (GA)

Periodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D4270	pedicle soft tissue graft procedure	19 and older	Teeth 1 - 32	Yes	No	One of (D4270) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4273	subepithelial connective tissue graft procedure	19 and older	Teeth 1 - 32	Yes	No	One of (D4273) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	19 and older	Teeth 1 - 32, 51 - 82	Yes	No		pre-op x-ray(s), perio charting
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	19 and older	Teeth 1 - 32, 51 - 82	Yes	No	One of (D4278) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4341	periodontal scaling and root planing - four or more teeth per quadrant	19 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. A minimum of four affected teeth in the quadrant.	pre-op x-ray(s), perio charting
D4342	periodontal scaling and root planing - one to three teeth per quadrant	19 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. One to three affected teeth in the quadrant.	pre-op x-ray(s), perio charting
D4355	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	19 and older		No	No	One of (D4355) per 1 Lifetime Per patient.	
D4910	periodontal maintenance procedures	19 and older		No	No	Four of (D1110, D4910) per 12 Month(s) Per patient. D4341 or D4342 must be on file for claims or documentation from patient record history of periodontal therapy within the last 6 months.	

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D5110	complete denture - maxillary	19 and older		Yes	No	One of (D5110, D5130) per 60 Month(s) Per patient.	Photos, Narrative/treatment plan
D5120	complete denture - mandibular	19 and older		Yes	No	One of (D5120, D5140) per 60 Month(s) Per patient.	Photos, Narrative/treatment plan
D5130	immediate denture - maxillary	19 and older		Yes	No	One of (D5110, D5130) per 60 Month(s) Per patient. Reimbursement made upon delivery (completion) of immediate maxillary or mandibular denture. D5130, D5140 reimbursed on the same date of service as the extraction of all remaining teeth.Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5140	immediate denture - mandibular	19 and older		Yes	No	One of (D5120, D5140) per 60 Month(s) Per patient. Reimbursement made upon delivery (completion) of immediate maxillary or mandibular denture. D5130, D5140 reimbursed on the same date of service as the extraction of all remaining teeth.Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5211	maxillary partial denture, resin base (including retentive/clasping materials, rests, and teeth)	19 and older		Yes	No	One of (D5211, D5213, D5221, D5223) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5212	mandibular partial denture, resin base (including retentive/clasping materials, rests, and teeth)	19 and older		Yes	No	One of (D5212, D5214, D5222, D5224) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D5213	maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	19 and older		Yes	No	One of (D5211, D5213, D5221, D5223) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5214	mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	19 and older		Yes	No	One of (D5212, D5214, D5222, D5224) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5221	immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	19 and older		Yes	No	One of (D5211, D5213, D5221, D5223) per 60 Month(s) Per patient. Reimbursement made upon delivery (completion) of immediate maxillary or mandibular partial denture. Reimbursed on the same date of service as the extraction of all remaining teeth.Includes adjustments within 6 months of initial placement	pre-operative x-ray(s)
D5222	immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	19 and older		Yes	No	One of (D5212, D5214, D5222, D5224) per 60 Month(s) Per patient. Reimbursement made upon delivery (completion) of immediate maxillary or mandibular partial denture. Reimbursed on the same date of service as the extraction of all remaining teeth.Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D5223	immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	19 and older		Yes	No	One of (D5211, D5213, D5221, D5223) per 60 Month(s) Per patient. Reimbursement made upon delivery (completion) of immediate maxillary or mandibular partial denture. Reimbursed on the same date of service as the extraction of all remaining teeth.Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5224	immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	19 and older		Yes	No	One of (D5212, D5214, D5222, D5224) per 60 Month(s) Per patient. Reimbursement made upon delivery (completion) of immediate maxillary or mandibular partial denture. Reimbursed on the same date of service as the extraction of all remaining teeth.Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5282	Removable unilateral partial denture--one piececast metal (including clasps and teeth), maxillary	19 and older		Yes	No	One of (D5282) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5283	Removable unilateral partial denture--one piececast metal (including clasps and teeth), mandibular	19 and older		Yes	No	One of (D5283) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5410	adjust complete denture - maxillary	19 and older		No	No	Not covered within 6 months of initial placement.	
D5411	adjust complete denture - mandibular	19 and older		No	No	Not covered within 6 months of initial placement.	
D5421	adjust partial denture-maxillary	19 and older		No	No	Not covered within 6 months of initial placement.	
D5422	adjust partial denture - mandibular	19 and older		No	No	Not covered within 6 months of initial placement.	

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D5511	repair broken complete denture base, mandibular	19 and older		No	No	Limited to repairs or adjustments performed more than 12 months after the initial insertion.	
D5512	repair broken complete denture base, maxillary	19 and older		No	No	Limited to repairs or adjustments performed more than 12 months after the initial insertion.	
D5520	replace missing or broken teeth - complete denture (each tooth)	19 and older	Teeth 1 - 32	No	No	Not covered within 6 months of initial placement.	
D5611	repair resin partial denture base, mandibular	19 and older		No	No	Limited to repairs or adjustments performed more than 12 months after the initial insertion.	
D5612	repair resin partial denture base, maxillary	19 and older		No	No	Limited to repairs or adjustments performed more than 12 months after the initial insertion.	
D5621	repair cast partial framework, mandibular	19 and older		No	No	Limited to repairs or adjustments performed more than 12 months after the initial insertion.	
D5622	repair cast partial framework, maxillary	19 and older		No	No	Limited to repairs or adjustments performed more than 12 months after the initial insertion.	
D5630	repair or replace broken retentive/clasping materials per tooth	19 and older	Teeth 1 - 32	No	No	Not covered within 6 months of initial placement.	
D5640	replace broken teeth-per tooth	19 and older	Teeth 1 - 32	No	No	Not covered within 6 months of initial placement.	
D5650	add tooth to existing partial denture	19 and older	Teeth 1 - 32	No	No		
D5660	add clasp to existing partial denture	19 and older	Teeth 1 - 32	No	No		

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D5710	rebase complete maxillary denture	19 and older		No	No	One of (D5710) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5711	rebase complete mandibular denture	19 and older		No	No	One of (D5711) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5720	rebase maxillary partial denture	19 and older		No	No	One of (D5720) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5721	rebase mandibular partial denture	19 and older		No	No	One of (D5721) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5730	reline complete maxillary denture (chairside)	19 and older		No	No	One of (D5730) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5731	reline complete mandibular denture (chairside)	19 and older		No	No	One of (D5731) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5740	reline maxillary partial denture (chairside)	19 and older		No	No	One of (D5740) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5741	reline mandibular partial denture (chairside)	19 and older		No	No	One of (D5741) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5750	reline complete maxillary denture (laboratory)	19 and older		No	No	One of (D5750) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D5751	reline complete mandibular denture (laboratory)	19 and older		No	No	One of (D5751) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5760	reline maxillary partial denture (laboratory)	19 and older		No	No	One of (D5760) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5761	reline mandibular partial denture (laboratory)	19 and older		No	No	One of (D5761) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5850	tissue conditioning, maxillary	19 and older		No	No		
D5851	tissue conditioning,mandibular	19 and older		No	No		

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6210	pontic - cast high noble metal	19 and older	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6211	pontic-cast base metal	19 and older	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6212	pontic - cast noble metal	19 and older	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6214	Pontic - titanium and titanium alloys	19 and older	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6240	pontic-porcelain fused-high noble	19 and older	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6241	pontic-porcelain fused to base metal	19 and older	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6242	pontic-porcelain fused-noble metal	19 and older	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6243	Pontic - Porcelain fused to titanium and titanium alloys	19 and older	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6245	prosthodontics fixed, pontic - porcelain/ceramic	19 and older	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6545	retainer - cast metal fixed	19 and older	Teeth 1 - 32	Yes	No	One of (D6545, D6548, D6549) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6548	prosthodontics fixed, retainer - porcelain/ceramic for resin bonded fixed prosthodontic	19 and older	Teeth 1 - 32	Yes	No	One of (D6545, D6548, D6549) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6549	Resin retainer-For resin bonded fixed prosthesis	19 and older	Teeth 1 - 32	Yes	No	One of (D6545, D6548, D6549) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6600	inlay - porcelain/ceramic, two surfaces	19 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6601	inlay - porcelain/ceramic, three or more surfaces	19 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6602	inlay - cast high noble metal, two surfaces	19 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6603	inlay - cast high noble metal, three or more surfaces	19 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6604	inlay - cast predominantly base metal, two surfaces	19 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6605	inlay - cast predominantly base metal, three or more surfaces	19 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6606	inlay - cast noble metal, two surfaces	19 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6607	inlay - cast noble metal, three or more surfaces	19 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6608	onlay - porcelain/ceramic, two surfaces	19 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6609	onlay - porcelain/ceramic, three or more surfaces	19 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6610	onlay - cast high noble metal, two surfaces	19 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6611	onlay - cast high noble metal, three or more surfaces	19 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6612	onlay - cast predominantly base metal, two surfaces	19 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6613	onlay - cast predominantly base metal, three or more surfaces	19 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6614	onlay - cast noble metal, two surfaces	19 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6615	onlay - cast noble metal, three or more surfaces	19 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6624	inlay - titanium	19 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6634	onlay - titanium	19 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6740	retainer crown, porcelain/ceramic	19 and older	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6750	crown-porcelain fused high noble	19 and older	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6751	crown-porcelain fused to base metal	19 and older	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6752	crown-porcelain fused noble metal	19 and older	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6753	Retainer Crown- Porcelain fused to titanium and titanium alloys	19 and older	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6780	crown-3/4 cst high noble metal	19 and older	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6781	prosthodontics fixed, crown ¾ cast predominantly based metal	19 and older	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6782	prosthodontics fixed, crown ¾ cast noble metal	19 and older	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6783	prosthodontics fixed, crown ¾ porcelain/ceramic	19 and older	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6784	Retainer Crown 3/4-Titanium and Titanium Alloys	19 and older	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6790	crown-full cast high noble	19 and older	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6791	crown - full cast base metal	19 and older	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6792	crown - full cast noble metal	19 and older	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6794	Retainer crown - titanium and titanium alloys	19 and older	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6930	re-cement or re-bond fixed partial denture	19 and older		Yes	No	Not covered within 6 months of placement.	pre-operative radiographs and narrative
D6980	fixed partial denture repair	19 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No		pre-operative radiographs and narrative

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Oral and Maxillofacial Surgery							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	19 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No		
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	19 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No	Includes cutting of gingiva and bone, removal of tooth structure and closure. Subject to Post Review.	
D7220	removal of impacted tooth-soft tissue	19 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	No	The prophylactic removal of an asymptomatic tooth or teeth exhibiting no overt clinical pathology is covered only when at least one tooth is asymptomatic.	pre-operative radiographs
D7230	removal of impacted tooth-partially bony	19 and older	Teeth 1 - 32, 51 - 82	Yes	No	Includes splinting.	pre-operative radiographs
D7240	removal of impacted tooth-completely bony	19 and older	Teeth 1 - 32, 51 - 82	Yes	No	The prophylactic removal of an asymptomatic tooth or teeth exhibiting no overt clinical pathology is covered only when at least one tooth is asymptomatic.	pre-operative radiographs
D7241	removal of impacted tooth-completely bony, with unusual surgical complications	19 and older	Teeth 1 - 32, 51 - 82	Yes	No	The prophylactic removal of an asymptomatic tooth or teeth exhibiting no overt clinical pathology is covered only when at least one tooth is asymptomatic.	pre-operative radiographs
D7250	surgical removal of residual tooth roots (cutting procedure)	19 and older	Teeth 1 - 32, 51 - 82	Yes	No	The prophylactic removal of an asymptomatic tooth or teeth exhibiting no overt clinical pathology is covered only when at least one tooth is asymptomatic.	pre-operative radiographs

Exhibit A Benefits Covered for CareSource Marketplace Adult (GA)

Oral and Maxillofacial Surgery							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D7251	Coronectomy – intentional partial tooth removal, impacted teeth only	19 and older	Teeth 1 - 32, 51 - 82	Yes	No		pre-operative radiographs
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	19 and older	Teeth 2 - 16, 18 - 31	Yes	No	Retrospective Post Review allowed for Emergency	pre-operative radiographs
D7280	Surgical access of an unerupted tooth	19 and older	Teeth 2 - 16, 18 - 31	Yes	No		pre-operative radiographs
D7283	placement of device to facilitate eruption of impacted tooth	19 and older	Teeth 1 - 32	No	No	One of (D7283) per 1 Lifetime Per patient per tooth. Has to be submitted in combination with D7280; Report the surgical exposure separately using D7280	
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	19 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D7310) per 1 Lifetime Per patient per quadrant. Minimum of four extractions in the affected quadrant. Covered only in conjunction with the construction of a prosthodontic appliance.	pre-operative radiographs
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	19 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D7311) per 1 Lifetime Per patient per quadrant. Minimum of four extractions in the affected quadrant. Covered only in conjunction with the construction of a prosthodontic appliance.	pre-operative radiographs
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	19 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D7320) per 1 Lifetime Per patient per quadrant. Minimum of four extractions in the affected quadrant. Covered only in conjunction with the construction of a prosthodontic appliance.	pre-operative radiographs

Oral and Maxillofacial Surgery							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	19 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D7321) per 1 Lifetime Per patient per quadrant. Minimum of four extractions in the affected quadrant. Covered only in conjunction with the construction of a prosthodontic appliance.	pre-operative radiographs
D7471	removal of exostosis - per site	19 and older	Per Arch (01, 02, LA, UA)	Yes	No		narr. of med. necessity, post-op x-ray(s)
D7510	incision and drainage of abscess - intraoral soft tissue	19 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No		
D7520	incision and drainage of abscess - extraoral soft tissue	19 and older		No	No		
D7910	suture small wounds up to 5 cm	19 and older		No	No		
D7961	buccal / labial frenectomy (frenulectomy)	19 and older		Yes	No		narr. of med. necessity, pre-op x-ray(s)
D7962	lingual frenectomy (frenulectomy)	19 and older		Yes	No		narr. of med. necessity, pre-op x-ray(s)
D7971	excision of pericoronal gingiva	19 and older	Teeth 1 - 32	Yes	No		narr. of med. necessity, post-op x-ray(s)

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Adjunctive General Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D9110	palliative treatment of dental pain - per visit	19 and older		No	No	One of (D9110) per 1 Day(s) Per patient.	
D9222	deep sedation/general anesthesia first 15 minutes	19 and older		Yes	No	One of (D9222) per 1 Day(s) Per patient. Ten of (D9222, D9223) per 1 Calendar year(s) Per patient. This procedure code is not reimbursable on same date as D9239, D9243. Sedation approvals are limited to surgical and extensive cases	narr. of med. necessity, pre-op x-ray(s)
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	19 and older		Yes	No	Four of (D9223) per 1 Day(s) Per patient. Ten of (D9222, D9223) per 1 Calendar year(s) Per patient. This procedure code is not reimbursable on same date as D9239, D9243. Sedation approvals are limited to surgical and extensive cases	narr. of med. necessity, pre-op x-ray(s)
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	19 and older		Yes	No	One of (D9239) per 1 Day(s) Per patient. Ten of (D9239, D9243) per 1 Calendar year(s) Per patient. This procedure code is not reimbursable on same date as D9222, D9223. Sedation approvals are limited to surgical and extensive cases	narr. of med. necessity, pre-op x-ray(s)
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	19 and older		Yes	No	Four of (D9243) per 1 Day(s) Per patient. Ten of (D9239, D9243) per 1 Calendar year(s) Per patient. This procedure code is not reimbursable on same date as D9222, D9223. Sedation approvals are limited to surgical and extensive cases	narr. of med. necessity, pre-op x-ray(s)

Adjunctive General Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	19 and older		No	No	One of (D9310) per 1 Day(s) Per patient. Includes consultation with medical professional (D9310 used in lieu of D9311)	
D9311	consultation with medical health care professional	19 and older		No	No	One of (D9311) per 1 Day(s) Per patient. This should be used only for extensive consultation with medical professional regarding patient's medical issues.	
D9610	therapeutic drug injection, by report	19 and older		Yes	No	One of (D9610) per 1 Day(s) Per patient. Description and dosage of drug.	narrative of medical necessity
D9930	treatment of complications (post-surgical) - unusual circumstances, by report	19 and older		Yes	No		narrative of medical necessity
D9944	occlusal guard--hard appliance, full arch	19 and older	Per Arch (01, 02, LA, UA)	Yes	No	One of (D9944) per 12 Month(s) Per patient.	narrative of medical necessity
D9995	teledentistry – synchronous; real-time encounter	19 and older		No	No	Four of (D9995) per 1 Calendar year(s) Per patient. The appropriate teledentistry code (D9995 or D9996) should be reported as descriptor codes to identify services (D0140, D0145) provided via teledentistry by the dentist who provided the oversight of the teledentistry encounter as allowed and in accordance with any applicable state laws and/or: regulations, licensure, state dental practice acts. A teledentistry event is subject to applicable state law, regulation or licensure. D9995 & D9996 do not have separate distinct benefit limits, however, any benefit limits applicable to the underlying services rendered would continue to apply.	

Exhibit A Benefits Covered for CareSource Marketplace Adult (GA)

Adjunctive General Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D9996	teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	19 and older		No	No	Four of (D9996) per 1 Calendar year(s) Per patient. The appropriate teledentistry code (D9995 or D9996) should be reported as descriptor codes to identify services (D0140, D0145) provided via teledentistry by the dentist who provided the oversight of the teledentistry encounter as allowed and in accordance with any applicable state laws and/or: regulations, licensure, state dental practice acts. A teledentistry event is subject to applicable state law, regulation or licensure. D9995 & D9996 do not have separate distinct benefit limits, however, any benefit limits applicable to the underlying services rendered would continue to apply.	

Exhibit B Benefits Covered for CareSource Marketplace Child (GA)

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0120	periodic oral evaluation - established patient	0-18		No	No	Two of (D0120, D0140, D0145, D0150, D0180) per 1 Calendar year(s) Per patient. D0120 periodic oral evaluation may not occur in combination with D0150 on same date of service and not until 180 days after the D0150 comprehensive oral evaluation.	
D0140	limited oral evaluation-problem focused	0-18		No	No	Two of (D0120, D0140, D0145, D0150, D0180) per 1 Calendar year(s) Per patient. Note- This procedure code is used for emergency examinations during regularly scheduled office hours. Evaluations solely for the purpose of adjustments or in conjunction with multi-visit procedures are not covered (i.e. endodontics and orthodontia). May not be used in conjunction with D0120, D0150, D9440, and D0180	
D0145	oral evaluation for a patient under three years of age and counseling with primary caregiver	0-3		No	No	Two of (D0120, D0140, D0145, D0150, D0180) per 1 Calendar year(s) Per patient. Should be used only for first time visit for Children under three years who have not seen a dentist. Subsequent recall visit D0120 should be billed.	

Exhibit B Benefits Covered for CareSource Marketplace Child (GA)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0150	comprehensive oral evaluation - new or established patient	0-18		No	No	Two of (D0120, D0140, D0145, D0150, D0180) per 1 Calendar year(s) Per patient. One of (D0150) per 24 Month(s) Per Provider OR Location. D0150 used when evaluating a patient comprehensively. D0150 or the periodic exam D0120 may not occur in conjunction with a limited oral evaluation (examination during office hours- D0140 or after office hours- D9440)	
D0160	detailed and extensive oral eval-problem focused, by report	0-18		No	No	Two of (D0120, D0140, D0145, D0150, D0160, D0180) per 1 Calendar year(s) Per patient. A detailed & extensive problem focused eval entails extensive diagnostic and cognitive modalities based on the findings of a comprehensive oral evaluation. Integration of more extensive diagnostic modalities to develop a treatment plan for a specific problem is required. The cond requiring this type of eval should be described and documented. Examples of conditions requiring this type of eval may include dentofacial anomalies, complicated perio-prosthetic conditions, complex temporomandibular dysfunction, facial pain of unknown origin, conditions requiring multidisciplinary consult, etc.	

Exhibit B Benefits Covered for CareSource Marketplace Child (GA)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0180	comprehensive periodontal evaluation - new or established patient	0-18		No	No	Two of (D0120, D0140, D0145, D0150, D0160, D0180) per 1 Calendar year(s) Per patient. D0180 requires a complete and detailed periodontal evaluation, including full-mouth probing and detailed charting. Reimbursement disallowed for D0180 performed in conjunction with D0150, D0120, or D1110.	
D0210	intraoral - comprehensive series of radiographic images	0-18		No	No	One of (D0210, D0330) per 60 Month(s) Per patient. Indicated for the permanent dentition or Adult dentate. A full-mouth series consist of a minimum of fourteen (14) films, including all periapical and posterior bitewing films intended to display the crowns and roots of all teeth, periapical areas and alveolar bone necessary for examination and diagnosis. PA required if done more frequently than 60 months	

Exhibit B Benefits Covered for CareSource Marketplace Child (GA)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0220	intraoral - periapical first radiographic image	0-18		No	No	One of (D0220) per 1 Day(s) Per patient. Any additional periapical films (D0230 should be used) If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series. Periapical radiographs are used diagnostically and are not reimbursable when used intraoperatively (i.e. during RCT or other procedural x-rays.	

Exhibit B Benefits Covered for CareSource Marketplace Child (GA)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0230	intraoral - periapical each additional radiographic image	0-18		No	No	Any additional periapical films (D0230 should be used) If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series. Periapical radiographs are used diagnostically and are not reimbursable when used intraoperatively (i.e. during RCT or other procedural x-rays.	

Exhibit B Benefits Covered for CareSource Marketplace Child (GA)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0240	intraoral - occlusal radiographic image	0-18		No	No	Any additional periapical films (D0230 should be used) If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series. Periapical radiographs are used diagnostically and are not reimbursable when used intraoperatively (i.e. during RCT or other procedural x-rays.	
D0250	extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	0-18		No	No	One of (D0250) per 1 Benefit period(s) Per patient.	

Exhibit B Benefits Covered for CareSource Marketplace Child (GA)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0270	bitewing - single radiographic image	0-18		No	No	A total of four horizontal bitewing films in any combination of (D0270, D0272, D0273 or D0274) per 6 Month(s) “Or” One set of vertical bitewings (D0277) per 6 Month(s) See fee limitations for all radiographs. If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series.	

Exhibit B Benefits Covered for CareSource Marketplace Child (GA)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0272	bitewings - two radiographic images	0-18		No	No	A total of four horizontal bitewing films in any combination of (D0270, D0272, D0273 or D0274) per 6 Month(s) “Or” One set of vertical bitewings (D0277) per 6 Month(s) See fee limitations for all radiographs. If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series.	

Exhibit B Benefits Covered for CareSource Marketplace Child (GA)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0273	bitewings - three radiographic images	0-18		No	No	A total of four horizontal bitewing films in any combination of (D0270, D0272, D0273 or D0274) per 6 Month(s) “Or” One set of vertical bitewings (D0277) per 6 Month(s) See fee limitations for all radiographs. If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series.	

Exhibit B Benefits Covered for CareSource Marketplace Child (GA)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0274	bitewings - four radiographic images	0-18		No	No	One of (D0274, D0277) per 6 Month(s) Per patient. A total of four horizontal bitewing films in any combination of (D0270, D0272, D0273 or D0274) per 6 Month(s) “Or” One set of vertical bitewings (D0277) per 6 Month(s) See fee limitations for all radiographs. If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series.	

Exhibit B Benefits Covered for CareSource Marketplace Child (GA)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0277	vertical bitewings - 7 to 8 films	0-18		No	No	One of (D0274, D0277) per 6 Month(s) Per patient. A total of four horizontal bitewing films in any combination of (D0270, D0272, D0273 or D0274) per 6 Month(s) “Or” One set of vertical bitewings (D0277) per 6 Month(s) See fee limitations for all radiographs. If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series.	
D0330	panoramic radiographic image	0-18		No	No	One of (D0210, D0330) per 60 Month(s) Per patient. All periapical or occlusal films taken same date of service needed to render the necessary radiographic diagnosis are included in the fee for panoramic radiograph. If bitewing radiographs D0270, D0272 or D0274 are indicated for additional diagnosis, the amount reimbursed will not exceed the reimbursable amount for D0210 Full Mouth Series. PA required if done more frequently than 60 months.	

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0340	cephalometric radiographic image	0-18		No	No	One of (D0340) per 1 Day(s) Per Provider OR Location. Not included in single date of service maximum radiography reimbursable amount.	
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	0-18		No	No	One of (D0350) per 1 Day(s) Per Provider OR Location. Covered one per Orthodontist or Location as part of an Orthodontic case.	
D0372	intraoral tomosynthesis – comprehensive series of radiographic images	0-18		No	No	One of (D0210, D0277, D0330, D0372, D0387) per 1 Calendar year(s) Per patient.	
D0373	intraoral tomosynthesis – bitewing radiographic image	0-18		No	No	One of (D0270, D0272, D0273, D0274, D0277, D0373, D0388) per 1 Calendar year(s) Per patient.	
D0374	intraoral tomosynthesis – periapical radiographic image	0-18		No	No	One of (D0220, D0230, D0374, D0389) per 1 Calendar year(s) Per patient.	
D0387	intraoral tomosynthesis – comprehensive series of radiographic images – image capture only	0-18		No	No	One of (D0210, D0277, D0330, D0372, D0387) per 1 Calendar year(s) Per patient.	
D0388	intraoral tomosynthesis – bitewing radiographic image – image capture only	0-18		No	No	One of (D0270, D0272, D0273, D0274, D0277, D0373, D0388) per 1 Calendar year(s) Per patient.	
D0389	intraoral tomosynthesis – periapical radiographic image – image capture only	0-18		No	No	One of (D0220, D0230, D0374, D0389) per 1 Calendar year(s) Per patient.	
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report	0-18		No	No	One of (D0391) per 1 Day(s) Per Provider OR Location. Interpretation of diagnostic image and report by a Practitioner not associated with Image Capture. Report should be kept in patient record for post payment review as applicable.	

Exhibit B Benefits Covered for CareSource Marketplace Child (GA)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0470	diagnostic casts	0-18		No	No	One of (D0470) per 1 Day(s) Per Provider OR Location. One per case. Diagnostic models or study models used as a guide in the application of corrective or restorative dentistry. Payable as a diagnostic service intended for the documentation and subsequent analysis of occlusion.	

Exhibit B Benefits Covered for CareSource Marketplace Child (GA)

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D1110	prophylaxis - adult	13 - 18		No	No	Two of (D1110, D1120) per 1 Calendar year(s) Per patient. This service code used for permanent dentition.	
D1120	prophylaxis - child	0-12		No	No	Two of (D1110, D1120) per 1 Calendar year(s) Per patient. This service code used for primary dentition	
D1206	topical application of fluoride varnish	0-18		No	No	Two of (D1206, D1208) per 1 Calendar year(s) Per patient. Treatment that incorporates fluoride with the polishing compound is considered part of the prophylaxis procedure and not a separate topical fluoride treatment. The following treatments are not covered with use of D1206 or D1208: • Topical application of fluoride to the prepared portion of a tooth prior to restoration • The use of self or home fluoride application procedures	
D1208	topical application of fluoride - excluding varnish	0-18		No	No	Two of (D1206, D1208) per 1 Calendar year(s) Per patient. Treatment that incorporates fluoride with the polishing compound is considered part of the prophylaxis procedure and not a separate topical fluoride treatment. The following treatments are not covered with use of D1206 or D1208: • Topical application of fluoride to the prepared portion of a tooth prior to restoration • The use of self or home fluoride application procedures	

Exhibit B Benefits Covered for CareSource Marketplace Child (GA)

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D1351	sealant - per tooth	0-18	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	No	One of (D1351) per 36 Month(s) Per patient per tooth. Mechanically and/or chemically prepared enamel surface sealed to prevent decay. Sealants are reimbursable for unrestored pit and fissure surfaces (first and second molars only)	
D1352	Preventive resin restoration is a mod. to high caries risk patient perm tooth conservative rest of an active cavitated lesion in a pit or fissure that doesn't extend into dentin: includes placmt of a sealant in radiating non-carious fissure or pits.	0-18	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No	One of (D1352) per 36 Month(s) Per patient per tooth. Conservative restoration of an active cavitated lesion in a pit or fissure that does not extend into dentin; includes placement of a sealant in any radiating noncarious fissures or pits. • Must be a conservative restoration using a bur that extends into enamel only and includes all the deep grooves of the tooth. • Must be placed on a non-restored permanent tooth that has not had a sealant placed within 1 year	
D1354	application of caries arresting medicament- per tooth	0-18	Teeth 2 - 15, 18 - 31, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No	One of (D1354, D1355) per 36 Month(s) Per patient per tooth. Ten of (D1354, D1355) per 1 Day(s) Per patient. Conservative treatment of an active, non-symptomatic carious lesion by topical application of a caries arresting or inhibiting medicament and without mechanical removal of sound tooth structure.	

Exhibit B Benefits Covered for CareSource Marketplace Child (GA)

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D1355	caries preventive medicament application – per tooth	0-18	Teeth 2 - 15, 18 - 31, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No	One of (D1354, D1355) per 36 Month(s) Per patient per tooth. Ten of (D1354, D1355) per 1 Day(s) Per patient. Conservative treatment by topical application of a caries preventive or inhibiting medicament for primary prevention or remineralization and without mechanical removal of sound tooth structure.	
D1510	space maintainer-fixed, unilateral- per quadrant	0-13	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of (D1510) per 60 Month(s) Per patient per quadrant. Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	

Exhibit B Benefits Covered for CareSource Marketplace Child (GA)

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D1516	space maintainer --fixed--bilateral, maxillary	0-13		No	No	One of (D1516) per 60 Month(s) Per patient per tooth. Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	
D1517	space maintainer --fixed--bilateral, mandibular	0-13		No	No	One of (D1517) per 60 Month(s) Per patient per tooth. Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	

Exhibit B Benefits Covered for CareSource Marketplace Child (GA)

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D1520	space maintainer-removable-unilateral	0-13	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of (D1520) per 60 Month(s) Per patient per tooth. Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	
D1526	space maintainer --removable--bilateral, maxillary	0-13		No	No	One of (D1526) per 60 Month(s) Per patient per tooth. Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	

Exhibit B Benefits Covered for CareSource Marketplace Child (GA)

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D1527	space maintainer --removable--bilateral, mandibular	0-13		No	No	One of (D1527) per 60 Month(s) Per patient per tooth. Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	
D1551	re-cement or re-bond bilateral space maintainer-Maxillary	0-13		No	No	Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	

Exhibit B Benefits Covered for CareSource Marketplace Child (GA)

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D1552	re-cement or re-bond bilateral space maintainer-Mandibular	0-13		No	No	Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	
D1553	re-cement or re-bond unilateral space maintainer-Per Quadrant	0-13	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	

Exhibit B Benefits Covered for CareSource Marketplace Child (GA)

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D1556	Removal of fixed unilateral space maintainer- Per Quadrant	0-13	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	
D1557	Removal of fixed bilateral space maintainer- Maxillary	0-13		No	No	Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	

Exhibit B Benefits Covered for CareSource Marketplace Child (GA)

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D1558	Removal of fixed bilateral space maintainer-Mandibular	0-13		No	No	Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2140	Amalgam - one surface, primary or permanent	0-18	Teeth 1 - 32, A - T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	
D2150	Amalgam - two surfaces, primary or permanent	0-18	Teeth 1 - 32, A - T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	

Exhibit B Benefits Covered for CareSource Marketplace Child (GA)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2160	amalgam - three surfaces, primary or permanent	0-18	Teeth 1 - 32, A - T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	
D2161	amalgam - four or more surfaces, primary or permanent	0-18	Teeth 1 - 32, A - T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2330	resin-based composite - one surface, anterior	0-18	Teeth 6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. The fee for resin-based composite restorations will include any necessary acid etching and bonding agents. Non-contiguous restorations, such as a separate Distal Facial (DF) and Mesial Facial (MF) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	
D2331	resin-based composite - two surfaces, anterior	0-18	Teeth 6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. The fee for resin-based composite restorations will include any necessary acid etching and bonding agents. Non-contiguous restorations, such as a separate Distal Facial (DF) and Mesial Facial (MF) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2332	resin-based composite - three surfaces, anterior	0-18	Teeth 6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. The fee for resin-based composite restorations will include any necessary acid etching and bonding agents. Non-contiguous restorations, such as a separate Distal Facial (DF) and Mesial Facial (MF) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	0-18	Teeth 6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. The fee for resin-based composite restorations will include any necessary acid etching and bonding agents. Non-contiguous restorations, such as a separate Distal Facial (DF) and Mesial Facial (MF) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	

Exhibit B Benefits Covered for CareSource Marketplace Child (GA)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2391	resin-based composite - one surface, posterior	0-18	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. CareSource will reimburse based on Amalgam for posterior teeth.D2391 Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	
D2392	resin-based composite - two surfaces, posterior	0-18	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. CareSource will reimburse based on Amalgam for posterior teeth.D2391 Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2393	resin-based composite - three surfaces, posterior	0-18	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. CareSource will reimburse based on Amalgam for posterior teeth.D2391 Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	
D2394	resin-based composite - four or more surfaces, posterior	0-18	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. CareSource will reimburse based on Amalgam for posterior teeth.D2391 Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	

Exhibit B Benefits Covered for CareSource Marketplace Child (GA)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2510	inlay - metallic -1 surface	0-18	Teeth 1 - 32	No	No	One of (D2510) per 60 Month(s) Per patient per tooth. Covered only when a direct restoration (ie. amalgam, composite) will not adequately restore the tooth.	
D2520	inlay-metallic-2 surfaces	0-18	Teeth 1 - 32	No	No	One of (D2520) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	
D2530	inlay-metallic-3+ surfaces	0-18	Teeth 1 - 32	No	No	One of (D2530) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	
D2542	onlay - metallic - two surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2543	onlay-metallic-3 surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs

Exhibit B Benefits Covered for CareSource Marketplace Child (GA)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2544	onlay-metallic-4+ surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2740	crown - porcelain/ceramic	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2750	crown - porcelain fused to high noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2751	crown - porcelain fused to predominantly base metal	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs

Exhibit B Benefits Covered for CareSource Marketplace Child (GA)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2752	crown - porcelain fused to noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2780	crown - ¾ cast high noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2781	crown - ¾ cast predominantly base metal	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2782	crown - ¾ cast noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs

Exhibit B Benefits Covered for CareSource Marketplace Child (GA)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2783	crown - ¾ porcelain/ceramic	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2790	crown - full cast high noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2791	crown - full cast predominantly base metal	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2792	crown - full cast noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs

Exhibit B Benefits Covered for CareSource Marketplace Child (GA)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2794	Crown- Titanium and Titanium Alloys	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	0-18	Teeth 1 - 32	No	No	Not reimbursable within 6 months of initial placement.	
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core	0-18	Teeth 1 - 32	No	No	Not covered within 6 months of initial placement.	
D2920	re-cement or re-bond crown	0-18	Teeth 1 - 32, A - T	No	No	Not allowed within 6 months of delivery.	
D2928	prefabricated porcelain/ceramic crown – permanent tooth	0-18	Teeth 1 - 32	No	No	One of (D2928, D2929, D2930, D2931, D2933, D2934) per 60 Month(s) Per patient per tooth. Greater than 6 units of (D2928, D2929, D2930, D2931, D2933, and D2934) per date of service may be subject to post review.	pre-operative radiographs
D2929	Prefabricated porcelain/ceramic crown – primary tooth	0-14	Teeth A - T	No	No	One of (D2928, D2929, D2930, D2931, D2933, D2934) per 60 Month(s) Per patient per tooth. Greater than 6 units of (D2928, D2929, D2930, D2931, D2933, and D2934) per date of service may be subject to post review.	

Exhibit B Benefits Covered for CareSource Marketplace Child (GA)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2930	prefabricated stainless steel crown - primary tooth	0-14	Teeth A - T	No	No	One of (D2928, D2929, D2930, D2931, D2933, D2934) per 60 Month(s) Per patient per tooth. Greater than 6 units of (D2928, D2929, D2930, D2931, D2933, and D2934) per date of service may be subject to post review.	
D2931	prefabricated stainless steel crown-permanent tooth	0-14	Teeth 1 - 32	No	No	One of (D2928, D2929, D2930, D2931, D2933, D2934) per 60 Month(s) Per patient per tooth. Greater than 6 units of (D2928, D2929, D2930, D2931, D2933, and D2934) per date of service may be subject to post review.	
D2933	prefabricated stainless steel crown with resin window	0-14	Teeth 1 - 32, A - T	No	No	One of (D2928, D2929, D2930, D2931, D2933, D2934) per 60 Month(s) Per patient per tooth. Greater than 6 units of (D2928, D2929, D2930, D2931, D2933, and D2934) per date of service may be subject to post review.	
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	0-14	Teeth A - T	No	No	One of (D2928, D2929, D2930, D2931, D2933, D2934) per 60 Month(s) Per patient per tooth. Greater than 6 units of (D2928, D2929, D2930, D2931, D2933, and D2934) per date of service may be subject to post review.	
D2940	protective restoration	0-18	Teeth 1 - 32	No	No	One of (D2940) per 1 Calendar year(s) Per patient per tooth. Restorative material to protect tooth and/or tissue form. Used to relieve pain, promote healing, and prevent further deterioration. Not reimbursable when used as endodontic access closure, or as a base or liner under restoration.	

Exhibit B Benefits Covered for CareSource Marketplace Child (GA)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2950	core buildup, including any pins when required	0-18	Teeth 1 - 32	Yes	No	One of (D2950) per 60 Month(s) Per patient per tooth.	pre-operative radiographs
D2951	pin retention - per tooth, in addition to restoration	0-18	Teeth 1 - 32	No	No	Three of (D2951) per 1 Lifetime Per patient per tooth.	
D2952	cast post and core in addition to crown	0-18	Teeth 1 - 32	Yes	No	One of (D2952, D2954) per 60 Month(s) Per patient per tooth.	pre-operative radiographs
D2953	each additional cast post - same tooth	0-18	Teeth 1 - 32	Yes	No	One of (D2953) per 60 Month(s) Per patient per tooth.	pre-operative radiographs
D2954	prefabricated post and core in addition to crown	0-18	Teeth 1 - 32	Yes	No	One of (D2952, D2954) per 60 Month(s) Per patient per tooth.	pre-operative radiographs
D2957	each additional prefabricated post - same tooth	0-18	Teeth 1 - 32	Yes	No	One of (D2957) per 60 Month(s) Per patient per tooth.	pre-operative radiographs
D2961	labial veneer (resin laminate) - laboratory	0-18	Teeth 1 - 32	Yes	No	One of (D2961, D2962) per 60 Month(s) Per patient per tooth. D2961, D2962 may be covered in lieu of crowns when clinically indicated for anterior teeth that are severely fractured or carious, that cannot be adequately repaired with a direct restoration (i.e., CDT codes D2330–D2335) Not reimbursable when performed solely for cosmetic/aesthetic reasons.	Pre-operative radiographs and operative report
D2962	labial veneer (porc laminate) - laboratory	0-18	Teeth 1 - 32	Yes	No	One of (D2961, D2962) per 60 Month(s) Per patient per tooth. D2961, D2962 may be covered in lieu of crowns when clinically indicated for anterior teeth that are severely fractured or carious, that cannot be adequately repaired with a direct restoration (i.e., CDT codes D2330–D2335) Not reimbursable when performed solely for cosmetic/aesthetic reasons.	Pre-operative radiographs and operative report

Exhibit B Benefits Covered for CareSource Marketplace Child (GA)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2980	crown repair, by report	0-18	Teeth 1 - 32	Yes	No	One of (D2980) per 60 Month(s) Per patient per tooth.	Narr / Oper Rpt
D2981	Inlay repair necessitated by restorative material failure	0-18	Teeth 1 - 32, 51 - 82	Yes	No	One of (D2981) per 60 Month(s) Per patient per tooth.	Narr / Oper Rpt
D2982	Onlay repair necessitated by restorative material failure	0-18	Teeth 1 - 32, 51 - 82	Yes	No	One of (D2982) per 60 Month(s) Per patient per tooth.	Narr / Oper Rpt
D2983	Veneer repair necessitated by restorative material failure	0-18	Teeth 1 - 32, 51 - 82	Yes	No	One of (D2983) per 60 Month(s) Per patient per tooth.	Narr / Oper Rpt
D2990	Resin infiltration of incipient smooth surface lesions	0-18	Teeth 1 - 32, A - T	No	No	One of (D2990) per 60 Month(s) Per patient per tooth.	

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Endodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	0-18	Teeth 1 - 32, A - T	No	No	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.	
D3222	partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	0-18	Teeth 1 - 32	No	No	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.	
D3230	pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	0-11	Teeth C, H, M, R	No	No	One of (D3230) per 1 Lifetime Per patient per tooth.	
D3230	pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	0-6	Teeth D - G, N - Q	No	No	One of (D3230) per 1 Lifetime Per patient per tooth.	
D3240	pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	0-11	Teeth A, B, I - L, S, T	No	No	One of (D3240) per 1 Lifetime Per patient per tooth.	

Endodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D3310	endodontic therapy, anterior tooth (excluding final restoration)	0-18	Teeth 6 - 11, 22 - 27	No	No	One of (D3310) per 1 Lifetime Per patient per tooth. 1)Once per tooth per lifetime except for exception cases of appropriate medical necessity.2)The date the RCT is completed should be the date of service.3)Reimbursement for a root canal includes opening and drainage, treatment planning, clinical procedures, follow-up care, radiographs during treatment, and post-operative radiographs. 4)D3310,D3320,D3330 are subject to Post Review Third molar wisdom teeth will only be considered for coverage when tooth is functional.	
D3320	endodontic therapy, premolar tooth (excluding final restoration)	0-18	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	No	One of (D3320) per 1 Lifetime Per patient per tooth. 1)Once per tooth per lifetime except for exception cases of appropriate medical necessity.2)The date the RCT is completed should be the date of service.3)Reimbursement for a root canal includes opening and drainage, treatment planning, clinical procedures, follow-up care, radiographs during treatment, and post-operative radiographs. 4)D3310,D3320,D3330 are subject to Post Review Third molar wisdom teeth will only be considered for coverage when tooth is functional.	

Exhibit B Benefits Covered for CareSource Marketplace Child (GA)

Endodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D3330	endodontic therapy, molar tooth (excluding final restoration)	0-18	Teeth 1 - 3, 14 - 19, 30 - 32	No	No	One of (D3330) per 1 Lifetime Per patient per tooth. 1)Once per tooth per lifetime except for exception cases of appropriate medical necessity.2)The date the RCT is completed should be the date of service.3)Reimbursement for a root canal includes opening and drainage, treatment planning, clinical procedures, follow-up care, radiographs during treatment, and post-operative radiographs. 4)D3310,D3320,D3330 are subject to Post Review Third molar wisdom teeth will only be considered for coverage when tooth is functional.	
D3346	retreatment of previous root canal therapy-anterior	0-18	Teeth 6 - 11, 22 - 27	No	No	One of (D3346) per 1 Lifetime Per patient per tooth. 1)Dental provider who performed the original root canal should not be reimbursed for the retreatment for the first 12 months 2)D3346, D3347, D3348 are subject to Post Review	
D3347	retreatment of previous root canal therapy - premolar	0-18	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	No	One of (D3347) per 1 Lifetime Per patient per tooth. 1)Dental provider who performed the original root canal should not be reimbursed for the retreatment for the first 12 months 2)D3346, D3347, D3348 are subject to Post Review	

Endodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D3348	retreatment of previous root canal therapy-molar	0-18	Teeth 1 - 3, 14 - 19, 30 - 32	No	No	One of (D3348) per 1 Lifetime Per patient per tooth. 1)Dental provider who performed the original root canal should not be reimbursed for the retreatment for the first 12 months 2)D3346, D3347, D3348 are subject to Post Review	
D3351	apexification/recalcification - initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	0-18	Teeth 1 - 32	Yes	No	One of (D3351) per 1 Lifetime Per patient per tooth. Initial opening, preparation and first placement of medication and necessary radiographs	pre-operative radiographs
D3352	apexification/recalcification - interim medication replacement	0-18	Teeth 1 - 32	Yes	No	One of (D3352) per 1 Lifetime Per patient per tooth. For visits in which the intra-canal medication is replaced with new medication, includes any necessary radiographs	pre-operative radiographs
D3353	apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	0-18	Teeth 1 - 32	Yes	No	One of (D3353) per 1 Lifetime Per patient per tooth. Includes removal of intra-canal medication and procedures necessary to place final root canal filling material, includes necessary radiographs.	pre-operative radiographs
D3355	Pulpal regeneration - initial visit	0-18	Teeth 1 - 32	No	No	One of (D3355) per 1 Lifetime Per patient per tooth. Subject to Post Review	
D3356	Pulpal regeneration - interim medication replacement	0-18	Teeth 1 - 32	No	No	One of (D3356) per 1 Lifetime Per patient per tooth. Subject to Post Review	
D3357	Pulpal regeneration - completion of treatment	0-18	Teeth 1 - 32	No	No	One of (D3357) per 1 Lifetime Per patient per tooth. Subject to Post Review	
D3410	apicoectomy - anterior	0-18	Teeth 6 - 11, 22 - 27	Yes	No	One of (D3410) per 1 Lifetime Per patient per tooth.	pre-operative radiographs
D3421	apicoectomy - premolar (first root)	0-18	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	No	One of (D3421) per 1 Lifetime Per patient per tooth.	pre-operative radiographs

Exhibit B Benefits Covered for CareSource Marketplace Child (GA)

Endodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D3425	apicoectomy - molar (first root)	0-18	Teeth 1 - 3, 14 - 19, 30 - 32	Yes	No	One of (D3425) per 1 Lifetime Per patient per tooth.	pre-operative radiographs
D3426	apicoectomy (each additional root)	0-18	Teeth 1 - 5, 12 - 21, 28 - 32	Yes	No	One of (D3426) per 1 Lifetime Per patient per tooth.	pre-operative radiographs
D3450	root amputation - per root	0-18	Teeth 1 - 32	Yes	No		pre-operative radiographs
D3471	surgical repair of root resorption - anterior	0-18	Teeth 6 - 11, 22 - 27	No	No	One of (D3471) per 1 Lifetime Per patient per tooth.	
D3472	surgical repair of root resorption – premolar	0-18	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	No	One of (D3472) per 1 Lifetime Per patient per tooth.	
D3473	surgical repair of root resorption – molar	0-18	Teeth 1 - 3, 14 - 19, 30 - 32	No	No	One of (D3473) per 1 Lifetime Per patient per tooth.	
D3501	surgical exposure of root surface without apicoectomy or repair of root resorption – anterior	0-18	Teeth 6 - 11, 22 - 27	No	No	One of (D3501) per 1 Lifetime Per patient per tooth.	
D3502	surgical exposure of root surface without apicoectomy or repair of root resorption – premolar	0-18	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	No	One of (D3502) per 1 Lifetime Per patient per tooth.	
D3503	surgical exposure of root surface without apicoectomy or repair of root resorption – molar	0-18	Teeth 1 - 3, 14 - 19, 30 - 32	No	No	One of (D3503) per 1 Lifetime Per patient per tooth.	
D3920	hemisection (including any root removal), not incl root canal therapy	0-18	Teeth 1 - 3, 14 - 19, 30 - 32	Yes	No		pre-operative radiographs

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Periodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4210, D4211) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4210, D4211) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	0-18	Teeth 1 - 32, 51 - 82	Yes	No	One of (D4212) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4240	gingival flap procedure, including root planing – four or more contiguous teeth or tooth bound spaces per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4240, D4241) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4241	gingival flap procedure, including root planing – one to three contiguous teeth or tooth bound spaces per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4240, D4241) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4249	clinical crown lengthening - hard tissue	0-18	Teeth 1 - 32	Yes	No	One of (D4249) per 36 Month(s) Per patient per tooth.	Pre-op xrays, narr of med necessity, lab bill docs
D4260	osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4260, D4261) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4261	osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4260, D4261) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting

Periodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D4263	bone replacement graft - first site in quadrant	0-18	Teeth 1 - 32	Yes	No	One of (D4263) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4270	pedicle soft tissue graft procedure	0-18	Teeth 1 - 32	Yes	No	One of (D4270) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4273	subepithelial connective tissue graft procedure	0-18	Teeth 1 - 32	Yes	No	One of (D4273) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4275	soft tissue allograft	0-18	Teeth 1 - 32	Yes	No	One of (D4275) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	0-18	Teeth 1 - 32, 51 - 82	Yes	No		pre-op x-ray(s), perio charting
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	0-18	Teeth 1 - 32, 51 - 82	Yes	No	One of (D4278) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4283	autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	0-18	Teeth 1 - 32	Yes	No	One of (D4283) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4285	non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	0-18	Teeth 1 - 32	Yes	No	One of (D4285) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4341	periodontal scaling and root planing - four or more teeth per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. A minimum of four affected teeth in the quadrant.	pre-op x-ray(s), perio charting

Exhibit B Benefits Covered for CareSource Marketplace Child (GA)

Periodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D4342	periodontal scaling and root planing - one to three teeth per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. One to three affected teeth in the quadrant.	pre-op x-ray(s), perio charting
D4355	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	0-18		No	No	One of (D4355) per 1 Lifetime Per patient. Subject to Post Review.	
D4910	periodontal maintenance procedures	0-18		No	No	Four of (D1110, D4910) per 12 Month(s) Per patient. D4341 or D4342 must be on file for claims or documentation from patient record history of periodontal therapy within the last 6 months.	

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D5110	complete denture - maxillary	0-18		Yes	No	One of (D5110, D5130) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5120	complete denture - mandibular	0-18		Yes	No	One of (D5120, D5140) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5130	immediate denture - maxillary	0-18		Yes	No	One of (D5110, D5130) per 60 Month(s) Per patient. Reimbursement made upon delivery (completion) of immediate maxillary or mandibular denture. D5130, D5140 reimbursed on the same date of service as the extraction of all remaining teeth.Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5140	immediate denture - mandibular	0-18		Yes	No	One of (D5120, D5140) per 60 Month(s) Per patient. Reimbursement made upon delivery (completion) of immediate maxillary or mandibular denture. D5130, D5140 reimbursed on the same date of service as the extraction of all remaining teeth.Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5211	maxillary partial denture, resin base (including retentive/clasping materials, rests, and teeth)	0-18		Yes	No	One of (D5211, D5213, D5221, D5223) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan

Exhibit B Benefits Covered for CareSource Marketplace Child (GA)

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D5212	mandibular partial denture, resin base (including retentive/clasping materials, rests, and teeth)	0-18		Yes	No	One of (D5212, D5214, D5222, D5224) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5213	maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	0-18		Yes	No	One of (D5211, D5213, D5221, D5223) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5214	mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	0-18		Yes	No	One of (D5212, D5214, D5222, D5224) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5221	immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	0-18		Yes	No	One of (D5211, D5213, D5221, D5223) per 60 Month(s) Per patient. Reimbursement made upon delivery (completion) of immediate maxillary or mandibular partial denture. Reimbursed on the same date of service as the extraction of all remaining teeth.Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5222	immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	0-18		Yes	No	One of (D5212, D5214, D5222, D5224) per 60 Month(s) Per patient. Reimbursement made upon delivery (completion) of immediate maxillary or mandibular partial denture. Reimbursed on the same date of service as the extraction of all remaining teeth.Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D5223	immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	0-18		Yes	No	One of (D5211, D5213, D5221, D5223) per 60 Month(s) Per patient. Reimbursement made upon delivery (completion) of immediate maxillary or mandibular partial denture. Reimbursed on the same date of service as the extraction of all remaining teeth.Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5224	immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	0-18		Yes	No	One of (D5212, D5214, D5222, D5224) per 60 Month(s) Per patient. Reimbursement made upon delivery (completion) of immediate maxillary or mandibular partial denture. Reimbursed on the same date of service as the extraction of all remaining teeth.Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5282	Removable unilateral partial denture--one piececast metal (including clasps and teeth), maxillary	16 - 18		Yes	No	One of (D5282) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5283	Removable unilateral partial denture--one piececast metal (including clasps and teeth), mandibular	16 - 18		Yes	No	One of (D5283) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5410	adjust complete denture - maxillary	0-18		No	No	Not covered within 6 months of initial placement.	
D5411	adjust complete denture - mandibular	0-18		No	No	Not covered within 6 months of initial placement.	
D5421	adjust partial denture-maxillary	0-18		No	No	Not covered within 6 months of initial placement.	
D5422	adjust partial denture - mandibular	0-18		No	No	Not covered within 6 months of initial placement.	

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D5511	repair broken complete denture base, mandibular	0-18		No	No	Limited to repairs or adjustments performed more than 12 months after the initial insertion.	
D5512	repair broken complete denture base, maxillary	0-18		No	No	Limited to repairs or adjustments performed more than 12 months after the initial insertion.	
D5520	replace missing or broken teeth - complete denture (each tooth)	0-18	Teeth 1 - 32	No	No	Not covered within 6 months of initial placement.	
D5611	repair resin partial denture base, mandibular	0-18		No	No	Limited to repairs or adjustments performed more than 12 months after the initial insertion.	
D5612	repair resin partial denture base, maxillary	0-18		No	No	Limited to repairs or adjustments performed more than 12 months after the initial insertion.	
D5621	repair cast partial framework, mandibular	0-18		No	No	Limited to repairs or adjustments performed more than 12 months after the initial insertion.	
D5622	repair cast partial framework, maxillary	0-18		No	No	Limited to repairs or adjustments performed more than 12 months after the initial insertion.	
D5630	repair or replace broken retentive/clasping materials per tooth	0-18	Teeth 1 - 32	No	No	Not covered within 6 months of initial placement.	
D5640	replace broken teeth-per tooth	0-18	Teeth 1 - 32	No	No	Not covered within 6 months of initial placement.	
D5650	add tooth to existing partial denture	0-18	Teeth 1 - 32	No	No	Add clasp to existing partial denture	
D5660	add clasp to existing partial denture	0-18	Teeth 1 - 32	No	No	Add clasp to existing partial denture	

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D5710	rebase complete maxillary denture	0-18		No	No	One of (D5710) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5711	rebase complete mandibular denture	0-18		No	No	One of (D5711) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5720	rebase maxillary partial denture	0-18		No	No	One of (D5720) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5721	rebase mandibular partial denture	0-18		No	No	One of (D5721) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5730	reline complete maxillary denture (chairside)	0-18		No	No	One of (D5730) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5731	reline complete mandibular denture (chairside)	0-18		No	No	One of (D5731) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5740	reline maxillary partial denture (chairside)	0-18		No	No	One of (D5740) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5741	reline mandibular partial denture (chairside)	0-18		No	No	One of (D5741) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5750	reline complete maxillary denture (laboratory)	0-18		No	No	One of (D5750) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D5751	reline complete mandibular denture (laboratory)	0-18		No	No	One of (D5751) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5760	reline maxillary partial denture (laboratory)	0-18		No	No	One of (D5760) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5761	reline mandibular partial denture (laboratory)	0-18		No	No	One of (D5761) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5850	tissue conditioning, maxillary	0-18		No	No		
D5851	tissue conditioning,mandibular	0-18		No	No		

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Implant Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6010	surgical placement of implant body: endosteal implant	0-18	Teeth 1 - 32	Yes	No	One of (D6010) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6012	surgical placement of interim implant body-endosteal implant	0-18	Teeth 1 - 32	Yes	No	One of (D6012) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6040	surgical placement:eposteal implnt	0-18	Per Arch (01, 02, LA, UA)	Yes	No	One of (D6040) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6050	surgical placement-transosteal implant	0-18	Teeth 1 - 32	Yes	No	One of (D6050) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6055	connecting bar - implant supported or abutment supported	0-18	Teeth 1 - 32	Yes	No	One of (D6055) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6056	prefabricated abutment	0-18	Teeth 1 - 32	Yes	No	One of (D6056) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6057	custom abutment	0-18	Teeth 1 - 32	Yes	No	One of (D6057) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6058	abutment supported porcelain/ceramic crown	0-18	Teeth 1 - 32	Yes	No	One of (D6058) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6059	abutment supported porcelain fused to metal crown (high noble metal)	0-18	Teeth 1 - 32	Yes	No	One of (D6059) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6060	abutment supported porcelain fused to metal crown (predominantly base metal)	0-18	Teeth 1 - 32	Yes	No	One of (D6060) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6061	abutment supported porcelain fused to metal crown (noble metal)	0-18	Teeth 1 - 32	Yes	No	One of (D6061) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6062	abutment supported cast metal crown (high noble metal)	0-18	Teeth 1 - 32	Yes	No	One of (D6062) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Implant Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6063	abutment supported cast metal crown (predominantly base metal)	0-18	Teeth 1 - 32	Yes	No	One of (D6063) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6064	abutment supported cast metal crown (noble metal)	0-18	Teeth 1 - 32	Yes	No	One of (D6064) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6065	implant supported porcelain/ceramic crown	0-18	Teeth 1 - 32	Yes	No	One of (D6065) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6066	Implant Supported Crown-Porcelain Fused to High Noble Alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6066) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6067	Implant Supported Crown-High Noble Alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6067) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6068	abutment supported retainer for porcelain/ceramic FPD	0-18	Teeth 1 - 32	Yes	No	One of (D6068) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6069	abutment supported retainer for porcelain fused to metal FPD (high noble metal)	0-18	Teeth 1 - 32	Yes	No	One of (D6069) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6070	abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	0-18	Teeth 1 - 32	Yes	No	One of (D6070) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6071	abutment supported retainer for porcelain fused to metal FPD (noble metal)	0-18	Teeth 1 - 32	Yes	No	One of (D6071) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6072	abutment supported retainer for cast metal FPD (high noble metal)	0-18	Teeth 1 - 32	Yes	No	One of (D6072) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6073	abutment supported retainer for cast metal FPD (predominantly base metal)	0-18	Teeth 1 - 32	Yes	No	One of (D6073) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6074	abutment supported retainer for cast metal FPD (noble metal)	0-18	Teeth 1 - 32	Yes	No	One of (D6074) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6075	implant supported retainer for ceramic FPD	0-18	Teeth 1 - 32	Yes	No	One of (D6075) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Implant Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6076	Implant Supported Retainer for FPD-Porcelain Fused to High Noble Alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6076) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6077	Implant Supported Retainer for Metal FPD- High Noble Alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6078) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6080	implant maintenance procedure	0-18	Teeth 1 - 32	Yes	No	One of (D6080) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6081	scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	0-18	Teeth 1 - 32, 51 - 82	Yes	No	One of (D6081) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6082	Implant supported crown-porcelain fused to predominently base alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6082) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6083	Implant supported crown-porcelain fused to noble alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6083) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6084	Implant supported crown-porcelain fused to titanium and titanium alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6084) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6086	Implant supported crown-predominately base alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6086) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6087	Implant supported crown-noble alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6087) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6088	Implant supported crown-titanium and titanium alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6088) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6090	repair implant prosthesis	0-18	Teeth 1 - 32	Yes	No	One of (D6090) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6095	repair implant abutment	0-18	Teeth 1 - 32	Yes	No	One of (D6095) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6097	Abutment supported crown-porcelain fused to titanium and titanium alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6097) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Implant Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6098	Implant supported retainer-porcelain fused to predominately base alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6098) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6099	Implant supported retainer for FPD- porcelain fused to noble alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6099) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6100	surgical removal of implant body	0-18	Teeth 1 - 32	Yes	No	One of (D6100) per 60 Month(s) Per patient per tooth. Dental provider who performed the original implant will not be reimbursed for the removal of the implant	pre-operative radiographs and narrative
D6101	debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure	0-18	Teeth 1 - 32, 51 - 82	Yes	No	One of (D6101) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6102	debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure	0-18	Teeth 1 - 32, 51 - 82	Yes	No	One of (D6102) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6103	bone graft for repair of peri-implant defect - does not include flap entry and closure. Placement of a barrier membrane or biologic materials to aid in osseous regeneration are reported separately	0-18	Teeth 1 - 32, 51 - 82	Yes	No	One of (D6103) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6104	Bone graft at time of implant placement	0-18	Teeth 1 - 32, 51 - 82	Yes	No	One of (D6104) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6105	removal of implant body not requiring bone removal nor flap elevation	0-18	Teeth 1 - 32	Yes	Yes	One of (D6105) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Implant Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6110	Implant/abutment supported removable dentur for edentulous arch - maxillary	0-18	Per Arch (01, 02, LA, UA)	Yes	No	One of (D6110) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6111	Implant/abutment supported removable dentur for edentulous arch - mandibular	0-18	Per Arch (01, 02, LA, UA)	Yes	No	One of (D6111) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary	0-18	Per Arch (01, 02, LA, UA)	Yes	No	One of (D6112) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular	0-18	Per Arch (01, 02, LA, UA)	Yes	No	One of (D6113) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary	0-18	Teeth 1 - 32	Yes	No	One of (D6114) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6115	Implant/abutment supported fixed denture for edentulous arch - mandibular	0-18	Teeth 1 - 32	Yes	No	One of (D6115) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6116	Implant/abutment supported fixed denture for partially edentulous arch - maxillary	0-18	Teeth 1 - 32	Yes	No	One of (D6116) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6117	Implant/abutment supported fixed denture for partially edentulous arch - mandibular	0-18	Teeth 1 - 32	Yes	No	One of (D6117) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6120	Implant supported retainer-porcelain fused to titanium and titanium alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6120) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6121	Implant supported retainer for metal FPD-predominately base alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6121) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6122	Implant supported retainer for metal FPD- noble alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6122) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Exhibit B Benefits Covered for CareSource Marketplace Child (GA)

Implant Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6123	Implant supported retainer for metal FPD- titanium and titanium alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6123) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6190	radiographic/surgical implant index, by report	0-18	Teeth 1 - 32	Yes	No	One of (D6190) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6195	Abutment Supported Retainer- Porcelain fused to titanium and titanium alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6195) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6197	replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	0-18	Teeth 1 - 32	Yes	Yes	One of (D6197) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6210	pontic - cast high noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6211	pontic-cast base metal	0-18	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6212	pontic - cast noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6214	Pontic - titanium and titanium alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6240	pontic-porcelain fused-high noble	0-18	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6241	pontic-porcelain fused to base metal	0-18	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6242	pontic-porcelain fused-noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6243	Pontic - Porcelain fused to titanium and titanium alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6245	prosthodontics fixed, pontic - porcelain/ceramic	0-18	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6545	retainer - cast metal fixed	0-18	Teeth 1 - 32	Yes	No	One of (D6545, D6548, D6549) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6548	prosthodontics fixed, retainer - porcelain/ceramic for resin bonded fixed prosthodontic	0-18	Teeth 1 - 32	Yes	No	One of (D6545, D6548, D6549) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6549	Resin retainer-For resin bonded fixed prosthesis	0-18	Teeth 1 - 32	Yes	No	One of (D6545, D6548, D6549) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6600	inlay - porcelain/ceramic, two surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6601	inlay - porcelain/ceramic, three or more surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6602	inlay - cast high noble metal, two surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6603	inlay - cast high noble metal, three or more surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6604	inlay - cast predominantly base metal, two surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6605	inlay - cast predominantly base metal, three or more surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6606	inlay - cast noble metal, two surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6607	inlay - cast noble metal, three or more surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6608	onlay - porcelain/ceramic, two surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6609	onlay - porcelain/ceramic, three or more surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6610	onlay - cast high noble metal, two surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6611	onlay - cast high noble metal, three or more surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6612	onlay - cast predominantly base metal, two surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6613	onlay - cast predominantly base metal, three or more surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6614	onlay - cast noble metal, two surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6615	onlay - cast noble metal, three or more surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6624	inlay - titanium	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6634	onlay - titanium	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6740	retainer crown, porcelain/ceramic	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6750	crown-porcelain fused high noble	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6751	crown-porcelain fused to base metal	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6752	crown-porcelain fused noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6753	Retainer Crown- Porcelain fused to titanium and titanium alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6780	crown-3/4 cst high noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6781	prosthodontics fixed, crown ¾ cast predominantly based metal	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6782	prosthodontics fixed, crown ¾ cast noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6783	prosthodontics fixed, crown ¾ porcelain/ceramic	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6784	Retainer Crown 3/4-Titanium and Titanium Alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6790	crown-full cast high noble	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6791	crown - full cast base metal	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6792	crown - full cast noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6794	Retainer crown - titanium and titanium alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6930	re-cement or re-bond fixed partial denture	0-18		Yes	No	Not covered within 6 months of placement.	pre-operative radiographs and narrative
D6980	fixed partial denture repair	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No		pre-operative radiographs and narrative

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Oral and Maxillofacial Surgery							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D7111	extraction, coronal remnants - primary tooth	0-18	Teeth A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No		
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0-18	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No		
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	0-18	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No	Includes cutting of gingiva and bone, removal of tooth structure and closure. Subject to Post Review.	
D7220	removal of impacted tooth-soft tissue	0-18	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	No		pre-operative radiographs
D7230	removal of impacted tooth-partially bony	0-18	Teeth 1 - 32, 51 - 82	Yes	No		pre-operative radiographs
D7240	removal of impacted tooth-completely bony	0-18	Teeth 1 - 32, 51 - 82	Yes	No		pre-operative radiographs
D7241	removal of impacted tooth-completely bony, with unusual surgical complications	0-18	Teeth 1 - 32, 51 - 82	Yes	No		pre-operative radiographs
D7250	surgical removal of residual tooth roots (cutting procedure)	0-18	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	No		pre-operative radiographs
D7251	Coronectomy – intentional partial tooth removal, impacted teeth only	0-18	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	No		pre-operative radiographs

Exhibit B Benefits Covered for CareSource Marketplace Child (GA)

Oral and Maxillofacial Surgery							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	0-18	Teeth 1 - 32	Yes	No	Includes Splinting, Post Review allowed in emergency	pre-operative radiographs
D7280	Surgical access of an unerupted tooth	0-18	Teeth 1 - 32	Yes	No		pre-operative radiographs
D7283	placement of device to facilitate eruption of impacted tooth	0-18	Teeth 1 - 32	No	No	One of (D7283) per 1 Lifetime Per patient per tooth. Has to be submitted in combination with D7280; Report the surgical exposure separately using D7280	
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D7310) per 1 Lifetime Per patient per quadrant. Minimum of four extractions in the affected quadrant. Covered only in conjunction with the construction of a prosthodontic appliance.	pre-operative radiographs
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D7311) per 1 Lifetime Per patient per quadrant. Minimum of four extractions in the affected quadrant. Covered only in conjunction with the construction of a prosthodontic appliance.	pre-operative radiographs
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D7320) per 1 Lifetime Per patient per quadrant. Minimum of four extractions in the affected quadrant. Covered only in conjunction with the construction of a prosthodontic appliance.	pre-operative radiographs
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D7321) per 1 Lifetime Per patient per quadrant. Minimum of four extractions in the affected quadrant. Covered only in conjunction with the construction of a prosthodontic appliance.	pre-operative radiographs

Exhibit B Benefits Covered for CareSource Marketplace Child (GA)

Oral and Maxillofacial Surgery							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D7471	removal of exostosis - per site	0-18	Per Arch (01, 02, LA, UA)	Yes	No		pre-operative radiographs
D7510	incision and drainage of abscess - intraoral soft tissue	0-18	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No	Subject to Post Review.	
D7520	incision and drainage of abscess - extraoral soft tissue	0-18		No	No	Subject to Post Review.	
D7910	suture small wounds up to 5 cm	0-18		No	No	Subject to Post Review.	
D7953	bone replacement graft for ridge preservation - per site	0-18	Teeth 1 - 32	Yes	No	One of (D7953) per 1 Lifetime Per patient.	Narrative of medical necessity and photos
D7961	buccal / labial frenectomy (frenulectomy)	0-18		Yes	No		Narrative of medical necessity and photos
D7962	lingual frenectomy (frenulectomy)	0-18		Yes	No		Narrative of medical necessity and photos
D7970	excision of hyperplastic tissue - per arch	0-18	Per Arch (01, 02, LA, UA)	Yes	No	One of (D7970) per 1 Lifetime Per patient.	Narrative of medical necessity and photos
D7971	excision of pericoronal gingiva	0-18	Teeth 1 - 32	Yes	No		Narrative of medical necessity and photos

Exhibit B Benefits Covered for CareSource Marketplace Child (GA)

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Orthodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D8030	limited orthodontic treatment of the adolescent dentition	0-18		Yes	No	One of (D8030, D8040, D8080, D8090) per 1 Lifetime Per patient.	Study model or OrthoCad, x-rays
D8040	limited orthodontic treatment of the adult dentition	0-18		Yes	No	One of (D8030, D8040, D8080, D8090) per 1 Lifetime Per patient.	Study model or OrthoCad, x-rays
D8080	comprehensive orthodontic treatment of the adolescent dentition	0-18		Yes	No	One of (D8030, D8040, D8080, D8090) per 1 Lifetime Per patient.	Study model or OrthoCad, x-rays
D8090	comprehensive orthodontic treatment of the adult dentition	0-18		Yes	No	One of (D8030, D8040, D8080, D8090) per 1 Lifetime Per patient.	Study model or OrthoCad, x-rays
D8660	pre-orthodontic treatment examination to monitor growth and development	0-18		No	No	One of (D8660) per 1 Lifetime Per patient. Used for records (i.e. models, photos and pre-orthodontic work –up). Reimbursed even if orthodontic case is not approved Prior Authorization not required when submitted with requests for (D8010-D8220)	
D8670	periodic orthodontic treatment visit	0-18		Yes	No	One of (D8670) per 1 Lifetime Per patient. D8670 reimbursed in combination with active therapy and as part of complete ortho contract per case.	Study model or OrthoCad, x-rays
D8680	orthodontic retention (removal of appliances)	0-18		Yes	No	One of (D8680) per 1 Lifetime Per patient.	photos, xrays, treatment plan
D8698	Recement or rebond fixed retainer - maxillary	0-18		No	No	One of (D8698) per 1 Lifetime Per patient. Subject to Post Review.	
D8699	Recement or rebond fixed retainer - mandibular	0-18		No	No	One of (D8699) per 1 Lifetime Per patient. Subject to Post Review.	

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Adjunctive General Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D9110	palliative treatment of dental pain - per visit	0-18		No	No	One of (D9110) per 1 Day(s) Per patient.	
D9222	deep sedation/general anesthesia first 15 minutes	0-18		Yes	No	One of (D9222) per 1 Day(s) Per patient. Ten of (D9222, D9223) per 1 Calendar year(s) Per patient. This procedure code is not reimbursable on same date as D9239, D9243. Sedation approvals are limited to surgical and extensive cases	narr. of med. necessity, pre-op x-ray(s)
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	0-18		Yes	No	Four of (D9223) per 1 Day(s) Per patient. Ten of (D9222, D9223) per 1 Calendar year(s) Per patient. This procedure code is not reimbursable on same date as D9239, D9243. Sedation approvals are limited to surgical and extensive cases	narr. of med. necessity, pre-op x-ray(s)
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	0-18		Yes	No	One of (D9239) per 1 Day(s) Per patient. Ten of (D9239, D9243) per 1 Calendar year(s) Per patient. This procedure code is not reimbursable on same date as D9222, D9223. Sedation approvals are limited to surgical and extensive cases	narr. of med. necessity, pre-op x-ray(s)
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	0-18		Yes	No	Four of (D9243) per 1 Day(s) Per patient. Ten of (D9239, D9243) per 1 Calendar year(s) Per patient. This procedure code is not reimbursable on same date as D9222, D9223. Sedation approvals are limited to surgical and extensive cases	narr. of med. necessity, pre-op x-ray(s)

Exhibit B Benefits Covered for CareSource Marketplace Child (GA)

Adjunctive General Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	0-18		No	No	One of (D9310) per 1 Day(s) Per patient. Includes consultation with medical professional (D9310 used in lieu of D9311)	
D9311	consultation with medical health care professional	0-18		No	No	One of (D9311) per 1 Day(s) Per patient. This should be used only for extensive consultation with medical professional regarding patient's medical issues.	
D9610	therapeutic drug injection, by report	0-18		Yes	No	One of (D9610) per 1 Day(s) Per patient. Description and dosage of drug.	narrative of medical necessity
D9930	treatment of complications (post-surgical) - unusual circumstances, by report	0-18		Yes	No		narrative of medical necessity
D9943	occlusal guard adjustment	0-18		No	No	One of (D9943) per 24 Month(s) Per patient.	
D9944	occlusal guard--hard appliance, full arch	13 - 18	Per Arch (01, 02, LA, UA)	Yes	No	One of (D9944, D9945, D9946) per 12 Month(s) Per patient.	narrative of medical necessity
D9945	occlusal guard--soft appliance full arch	13 - 18	Per Arch (01, 02, LA, UA)	Yes	No	One of (D9944, D9945, D9946) per 12 Month(s) Per patient.	narrative of medical necessity
D9946	occlusal guard--hard appliance, partial arch	13 - 18	Per Arch (01, 02, LA, UA)	Yes	No	One of (D9944, D9945, D9946) per 12 Month(s) Per patient.	narrative of medical necessity
D9951	occlusal adjustment - limited	0-18		Yes	No	One of (D9951) per 36 Month(s) Per patient per quadrant. Only reimbursable when performed in conjunction with periodontal procedure. Claims history must show periodontal procedure within 6 months.	narrative of medical necessity

Exhibit B Benefits Covered for CareSource Marketplace Child (GA)

Adjunctive General Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D9995	teledentistry – synchronous; real-time encounter	0-18		No	No	Four of (D9995) per 1 Calendar year(s) Per patient. The appropriate teledentistry code (D9995 or D9996) should be reported as descriptor codes to identify services (D0140, D0145) provided via teledentistry by the dentist who provided the oversight of the teledentistry encounter as allowed and in accordance with any applicable state laws and/or: regulations, licensure, state dental practice acts. A teledentistry event is subject to applicable state law, regulation or licensure. D9995 & D9996 do not have separate distinct benefit limits, however, any benefit limits applicable to the underlying services rendered would continue to apply.	

Exhibit B Benefits Covered for CareSource Marketplace Child (GA)

Adjunctive General Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D9996	teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	0-18		No	No	Four of (D9996) per 1 Calendar year(s) Per patient. The appropriate teledentistry code (D9995 or D9996) should be reported as descriptor codes to identify services (D0140, D0145) provided via teledentistry by the dentist who provided the oversight of the teledentistry encounter as allowed and in accordance with any applicable state laws and/or: regulations, licensure, state dental practice acts. A teledentistry event is subject to applicable state law, regulation or licensure. D9995 & D9996 do not have separate distinct benefit limits, however, any benefit limits applicable to the underlying services rendered would continue to apply.	

Exhibit C Benefits Covered for CareSource Marketplace Adult (KY)

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0120	periodic oral evaluation - established patient	21 and older		No	No	Two of (D0120, D0140, D0150, D0180) per 1 Calendar year(s) Per patient. D0120 periodic oral evaluation may not occur in combination with D0150 on same date of service and not until 180 days after the D0150 comprehensive oral evaluation.	
D0140	limited oral evaluation-problem focused	21 and older		No	No	Two of (D0120, D0140, D0150, D0180) per 1 Calendar year(s) Per patient. Note- This procedure code is used for emergency examinations during regularly scheduled office hours. Evaluations solely for the purpose of adjustments or in conjunction with multi-visit procedures are not covered (i.e. endodontics and orthodontia). May not be used in conjunction with D0120, D0150, D9440, and D0180	
D0150	comprehensive oral evaluation - new or established patient	21 and older		No	No	Two of (D0120, D0140, D0150, D0180) per 1 Calendar year(s) Per patient. One of (D0150) per 24 Month(s) Per Provider OR Location. D0150 used when evaluating a patient comprehensively. D0150 or the periodic exam D0120 may not occur in conjunction with a limited oral evaluation (examination during office hours- D0140 or after office hours- D9440)	

Exhibit C Benefits Covered for CareSource Marketplace Adult (KY)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0180	comprehensive periodontal evaluation - new or established patient	21 and older		No	No	Two of (D0120, D0140, D0150, D0180) per 1 Calendar year(s) Per patient. One of (D0180) per 24 Month(s) Per Provider OR Location. Reimbursement disallowed for D0180 performed in conjunction with either a D0150 or D0120.	
D0210	intraoral - comprehensive series of radiographic images	21 and older		No	No	One of (D0210, D0330) per 60 Month(s) Per patient. Indicated for the permanent dentition or Adult dentate. A full-mouth series consist of a minimum of fourteen (14) films, including all periapical and posterior bitewing films intended to display the crowns and roots of all teeth, periapical areas and alveolar bone necessary for examination and diagnosis. PA required if done more frequently than 60 months	

Exhibit C Benefits Covered for CareSource Marketplace Adult (KY)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0220	intraoral - periapical first radiographic image	21 and older		No	No	One of (D0220) per 1 Day(s) Per patient. Any additional periapical films (D0230 should be used) If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series. Periapical radiographs are used diagnostically and are not reimbursable when used intraoperatively (i.e. during RCT or other procedural x-rays.	

Exhibit C Benefits Covered for CareSource Marketplace Adult (KY)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0230	intraoral - periapical each additional radiographic image	21 and older		No	No	Any additional periapical films (D0230 should be used) If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series. Periapical radiographs are used diagnostically and are not reimbursable when used intraoperatively (i.e. during RCT or other procedural x-rays.	

Exhibit C Benefits Covered for CareSource Marketplace Adult (KY)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0240	intraoral - occlusal radiographic image	21 and older		No	No	Any additional periapical films (D0230 should be used) If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series. Periapical radiographs are used diagnostically and are not reimbursable when used intraoperatively (i.e. during RCT or other procedural x-rays.	

Exhibit C Benefits Covered for CareSource Marketplace Adult (KY)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0270	bitewing - single radiographic image	21 and older		No	No	A total of four horizontal bitewing films in any combination of (D0270, D0272, D0273 or D0274) per 6 Month(s) “Or” One set of vertical bitewings (D0277) per 6 Month(s) See fee limitations for all radiographs. If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series.	

Exhibit C Benefits Covered for CareSource Marketplace Adult (KY)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0272	bitewings - two radiographic images	21 and older		No	No	A total of four horizontal bitewing films in any combination of (D0270, D0272, D0273 or D0274) per 6 Month(s) “Or” One set of vertical bitewings (D0277) per 6 Month(s) See fee limitations for all radiographs. If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series.	

Exhibit C Benefits Covered for CareSource Marketplace Adult (KY)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0273	bitewings - three radiographic images	21 and older		No	No	A total of four horizontal bitewing films in any combination of (D0270, D0272, D0273 or D0274) per 6 Month(s) “Or” One set of vertical bitewings (D0277) per 6 Month(s) See fee limitations for all radiographs. If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series.	

Exhibit C Benefits Covered for CareSource Marketplace Adult (KY)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0274	bitewings - four radiographic images	21 and older		No	No	One of (D0274, D0277) per 6 Month(s) Per patient. A total of four horizontal bitewing films in any combination of (D0270, D0272, D0273 or D0274) per 6 Month(s) “Or” One set of vertical bitewings (D0277) per 6 Month(s) See fee limitations for all radiographs. If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series.	

Exhibit C Benefits Covered for CareSource Marketplace Adult (KY)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0277	vertical bitewings - 7 to 8 films	21 and older		No	No	One of (D0274, D0277) per 6 Month(s) Per patient. A total of four horizontal bitewing films in any combination of (D0270, D0272, D0273 or D0274) per 6 Month(s) “Or” One set of vertical bitewings (D0277) per 6 Month(s) See fee limitations for all radiographs. If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series.	
D0330	panoramic radiographic image	21 and older		No	No	One of (D0210, D0330) per 60 Month(s) Per patient. All periapical or occlusal films taken same date of service needed to render the necessary radiographic diagnosis are included in the fee for panoramic radiograph. If bitewing radiographs D0270, D0272 or D0274 are indicated for additional diagnosis, the amount reimbursed will not exceed the reimbursable amount for D0210 Full Mouth Series. PA required if done more frequently than 60 months.	

Exhibit C Benefits Covered for CareSource Marketplace Adult (KY)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0372	intraoral tomosynthesis – comprehensive series of radiographic images	21 and older		No	No	One of (D0210, D0277, D0330, D0372, D0387, D0701, D0709) per 1 Calendar year(s) Per patient.	
D0373	intraoral tomosynthesis – bitewing radiographic image	21 and older		No	No	One of (D0270, D0272, D0273, D0274, D0277, D0373, D0388, D0708) per 1 Calendar year(s) Per patient.	
D0374	intraoral tomosynthesis – periapical radiographic image	21 and older		No	No	One of (D0220, D0230, D0374, D0389, D0707) per 1 Calendar year(s) Per patient.	
D0387	intraoral tomosynthesis – comprehensive series of radiographic images – image capture only	21 and older		No	No	One of (D0210, D0277, D0330, D0372, D0387, D0701, D0709) per 1 Calendar year(s) Per patient.	
D0388	intraoral tomosynthesis – bitewing radiographic image – image capture only	21 and older		No	No	One of (D0220, D0230, D0374, D0389, D0707) per 1 Calendar year(s) Per patient.	
D0389	intraoral tomosynthesis – periapical radiographic image – image capture only	21 and older		No	No	One of (D0220, D0230, D0374, D0389, D0707) per 1 Calendar year(s) Per patient.	
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report	21 and older		No	No	One of (D0391) per 1 Day(s) Per Provider OR Location. Interpretation of diagnostic image and report by a Practitioner not associated with Image Capture. Report should be kept in patient record for post payment review as applicable.	

Exhibit C Benefits Covered for CareSource Marketplace Adult (KY)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0470	diagnostic casts	21 and older		No	No	One of (D0470) per 1 Day(s) Per Provider OR Location. One per case. Diagnostic models or study models used as a guide in the application of corrective or restorative dentistry. Payable as a diagnostic service intended for the documentation and subsequent analysis of occlusion.	

Exhibit C Benefits Covered for CareSource Marketplace Adult (KY)

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D1110	prophylaxis - adult	21 and older		No	No	Two of (D1110) per 1 Calendar year(s) Per patient. This service code used for permanent dentition. One (1) additional for Covered Persons under the care of a medical professional during pregnancy	

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2140	Amalgam - one surface, primary or permanent	21 and older	Teeth 1 - 32	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	
D2150	Amalgam - two surfaces, primary or permanent	21 and older	Teeth 1 - 32	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	

Exhibit C Benefits Covered for CareSource Marketplace Adult (KY)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2160	amalgam - three surfaces, primary or permanent	21 and older	Teeth 1 - 32	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	
D2161	amalgam - four or more surfaces, primary or permanent	21 and older	Teeth 1 - 32	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	

Exhibit C Benefits Covered for CareSource Marketplace Adult (KY)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2330	resin-based composite - one surface, anterior	21 and older	Teeth 6 - 11, 22 - 27	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. The fee for resin-based composite restorations will include any necessary acid etching and bonding agents. Non-contiguous restorations, such as a separate Distal Facial (DF) and Mesial Facial (MF) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	
D2331	resin-based composite - two surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. The fee for resin-based composite restorations will include any necessary acid etching and bonding agents. Non-contiguous restorations, such as a separate Distal Facial (DF) and Mesial Facial (MF) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2332	resin-based composite - three surfaces, anterior	21 and older	Teeth 6 - 11, 22 - 27	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. The fee for resin-based composite restorations will include any necessary acid etching and bonding agents. Non-contiguous restorations, such as a separate Distal Facial (DF) and Mesial Facial (MF) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	21 and older	Teeth 6 - 11, 22 - 27	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. The fee for resin-based composite restorations will include any necessary acid etching and bonding agents. Non-contiguous restorations, such as a separate Distal Facial (DF) and Mesial Facial (MF) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	

Exhibit C Benefits Covered for CareSource Marketplace Adult (KY)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2391	resin-based composite - one surface, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. CareSource will reimburse based on Amalgam for posterior teeth.D2391 Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	
D2392	resin-based composite - two surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. CareSource will reimburse based on Amalgam for posterior teeth.D2391 Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	

Exhibit C Benefits Covered for CareSource Marketplace Adult (KY)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2393	resin-based composite - three surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. CareSource will reimburse based on Amalgam for posterior teeth.D2391 Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	
D2394	resin-based composite - four or more surfaces, posterior	21 and older	Teeth 1 - 5, 12 - 21, 28 - 32	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. CareSource will reimburse based on Amalgam for posterior teeth.D2391 Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	

Exhibit C Benefits Covered for CareSource Marketplace Adult (KY)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2510	inlay - metallic -1 surface	21 and older	Teeth 1 - 32	No	No	One of (D2510) per 60 Month(s) Per patient per tooth. Covered only when a direct restoration (ie. amalgam, composite) will not adequately restore the tooth.	
D2520	inlay-metallic-2 surfaces	21 and older	Teeth 1 - 32	No	No	One of (D2520) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors. Covered only when a direct restoration (ie. amalgam, composite) will not adequately restore the tooth.	
D2530	inlay-metallic-3+ surfaces	21 and older	Teeth 1 - 32	No	No	One of (D2530) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors. Covered only when a direct restoration (ie. amalgam, composite) will not adequately restore the tooth.	
D2542	onlay - metallic - two surfaces	21 and older	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs

Exhibit C Benefits Covered for CareSource Marketplace Adult (KY)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2543	onlay-metallic-3 surfaces	21 and older	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2544	onlay-metallic-4+ surfaces	21 and older	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2740	crown - porcelain/ceramic	21 and older	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2750	crown - porcelain fused to high noble metal	21 and older	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs

Exhibit C Benefits Covered for CareSource Marketplace Adult (KY)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2751	crown - porcelain fused to predominantly base metal	21 and older	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2752	crown - porcelain fused to noble metal	21 and older	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2780	crown - ¾ cast high noble metal	21 and older	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2781	crown - ¾ cast predominantly base metal	21 and older	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs

Exhibit C Benefits Covered for CareSource Marketplace Adult (KY)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2782	crown - ¾ cast noble metal	21 and older	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2783	crown - ¾ porcelain/ceramic	21 and older	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2790	crown - full cast high noble metal	21 and older	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2791	crown - full cast predominantly base metal	21 and older	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs

Exhibit C Benefits Covered for CareSource Marketplace Adult (KY)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2792	crown - full cast noble metal	21 and older	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2794	Crown- Titanium and Titanium Alloys	21 and older	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	21 and older	Teeth 1 - 32	No	No	Not covered within 6 months of initial placement.	
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core	21 and older	Teeth 1 - 32	No	No	Not covered within 6 months of initial placement.	
D2920	re-cement or re-bond crown	21 and older	Teeth 1 - 32, A - T	No	No	Not covered within 6 months of initial placement.	
D2940	protective restoration	21 and older	Teeth 1 - 32	No	No	One of (D2940) per 1 Calendar year(s) Per patient per tooth. Restorative material to protect tooth and/or tissue form. Used to relieve pain, promote healing, and prevent further deterioration. Not reimbursable when used as endodontic access closure, or as a base or liner under restoration.	
D2950	core buildup, including any pins when required	21 and older	Teeth 1 - 32	Yes	No	One of (D2950) per 60 Month(s) Per patient per tooth.	pre-operative radiographs

Exhibit C Benefits Covered for CareSource Marketplace Adult (KY)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2951	pin retention - per tooth, in addition to restoration	21 and older	Teeth 1 - 32	No	No	Three of (D2951) per 1 Lifetime Per patient per tooth.	
D2952	cast post and core in addition to crown	21 and older	Teeth 1 - 32	Yes	No	One of (D2952, D2954) per 60 Month(s) Per patient per tooth.	pre-operative radiographs
D2953	each additional cast post - same tooth	21 and older	Teeth 1 - 32	Yes	No	One of (D2953) per 60 Month(s) Per patient per tooth.	pre-operative radiographs
D2954	prefabricated post and core in addition to crown	21 and older	Teeth 1 - 32	Yes	No	One of (D2952, D2954) per 60 Month(s) Per patient per tooth.	pre-operative radiographs
D2957	each additional prefabricated post - same tooth	21 and older	Teeth 1 - 32	Yes	No	One of (D2957) per 60 Month(s) Per patient per tooth.	pre-operative radiographs
D2980	crown repair, by report	21 and older	Teeth 1 - 32	Yes	No	One of (D2980) per 60 Month(s) Per patient per tooth.	Narr / Oper Rpt
D2981	Inlay repair necessitated by restorative material failure	21 and older	Teeth 1 - 32, 51 - 82	Yes	No	One of (D2981) per 60 Month(s) Per patient per tooth.	Narr / Oper Rpt
D2982	Onlay repair necessitated by restorative material failure	21 and older	Teeth 1 - 32, 51 - 82	Yes	No	One of (D2982) per 60 Month(s) Per patient per tooth.	Narr / Oper Rpt
D2983	Veneer repair necessitated by restorative material failure	21 and older	Teeth 1 - 32, 51 - 82	Yes	No	One of (D2983) per 60 Month(s) Per patient per tooth.	Narr / Oper Rpt

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Endodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	21 and older	Teeth 1 - 32, A - T	No	No	One of (D3220) per 1 Lifetime Per patient per tooth. If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately. (only when there is no successor)	
D3221	pulpal debridement, primary and permanent teeth	21 and older	Teeth 1 - 32, A - T	No	No	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately. (only when there is no successor)	
D3222	partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	21 and older	Teeth 1 - 32	No	No	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.	

Endodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D3310	endodontic therapy, anterior tooth (excluding final restoration)	21 and older	Teeth 6 - 11, 22 - 27	No	No	One of (D3310) per 1 Lifetime Per patient per tooth. 1)Once per tooth per lifetime except for exception cases of appropriate medical necessity.2)The date the RCT is completed should be the date of service.3)Reimbursement for a root canal includes opening and drainage, treatment planning, clinical procedures, follow-up care, radiographs during treatment, and post-operative radiographs. 4)D3310,D3320,D3330 are subject to Post Review Third molar wisdom teeth will only be considered for coverage when tooth is functional.	
D3320	endodontic therapy, premolar tooth (excluding final restoration)	21 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	No	One of (D3320) per 1 Lifetime Per patient per tooth. 1)Once per tooth per lifetime except for exception cases of appropriate medical necessity.2)The date the RCT is completed should be the date of service.3)Reimbursement for a root canal includes opening and drainage, treatment planning, clinical procedures, follow-up care, radiographs during treatment, and post-operative radiographs. 4)D3310,D3320,D3330 are subject to Post Review Third molar wisdom teeth will only be considered for coverage when tooth is functional.	

Exhibit C Benefits Covered for CareSource Marketplace Adult (KY)

Endodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D3330	endodontic therapy, molar tooth (excluding final restoration)	21 and older	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	No	One of (D3330) per 1 Lifetime Per patient per tooth. 1)Once per tooth per lifetime except for exception cases of appropriate medical necessity.2)The date the RCT is completed should be the date of service.3)Reimbursement for a root canal includes opening and drainage, treatment planning, clinical procedures, follow-up care, radiographs during treatment, and post-operative radiographs. 4)D3310,D3320,D3330 are subject to Post Review Third molar wisdom teeth will only be considered for coverage when tooth is functional.	
D3346	retreatment of previous root canal therapy-anterior	21 and older	Teeth 6 - 11, 22 - 27	No	No	One of (D3346) per 1 Lifetime Per patient per tooth. 1)Dental provider who performed the original root canal should not be reimbursed for the retreatment for the first 12 months 2)D3346, D3347, D3348 are subject to Post Review	
D3347	retreatment of previous root canal therapy - premolar	21 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	No	One of (D3347) per 1 Lifetime Per patient per tooth. 1)Dental provider who performed the original root canal should not be reimbursed for the retreatment for the first 12 months 2)D3346, D3347, D3348 are subject to Post Review	

Endodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D3348	retreatment of previous root canal therapy-molar	21 and older	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	No	One of (D3348) per 1 Lifetime Per patient per tooth. 1)Dental provider who performed the original root canal should not be reimbursed for the retreatment for the first 12 months 2)D3346, D3347, D3348 are subject to Post Review	
D3351	apexification/recalcification - initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	21 and older	Teeth 2 - 16, 18 - 31	Yes	No	One of (D3351) per 1 Lifetime Per patient per tooth. Initial opening, preparation and first placement of medication and necessary radiographs	pre-operative radiographs
D3352	apexification/recalcification - interim medication replacement	21 and older	Teeth 2 - 16, 18 - 31	Yes	No	One of (D3352) per 1 Lifetime Per patient per tooth. For visits in which the intra-canal medication is replaced with new medication, includes any necessary radiographs	pre-operative radiographs
D3353	apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	21 and older	Teeth 1 - 32	Yes	No	One of (D3353) per 1 Lifetime Per patient per tooth. Includes removal of intra-canal medication and procedures necessary to place final root canal filling material, includes necessary radiographs.	pre-operative radiographs
D3355	Pulpal regeneration - initial visit	21 and older	Teeth 1 - 32	No	No	One of (D3355) per 1 Lifetime Per patient per tooth.	
D3356	Pulpal regeneration - interim medication replacement	21 and older	Teeth 1 - 32	No	No	One of (D3356) per 1 Lifetime Per patient per tooth.	
D3357	Pulpal regeneration - completion of treatment	21 and older	Teeth 1 - 32	No	No	One of (D3357) per 1 Lifetime Per patient per tooth. Subject to Post Review	
D3410	apicoectomy - anterior	21 and older	Teeth 6 - 11, 22 - 27	Yes	No	One of (D3410) per 1 Lifetime Per patient per tooth.	pre-operative radiographs
D3421	apicoectomy - premolar (first root)	21 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	No	One of (D3421) per 1 Lifetime Per patient per tooth.	pre-operative radiographs

Exhibit C Benefits Covered for CareSource Marketplace Adult (KY)

Endodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D3425	apicoectomy - molar (first root)	21 and older	Teeth 2, 3, 14 - 19, 30, 31	Yes	No	One of (D3425) per 1 Lifetime Per patient per tooth.	pre-operative radiographs
D3426	apicoectomy (each additional root)	21 and older	Teeth 2 - 5, 12 - 15, 18 - 21, 28 - 31	Yes	No	One of (D3426) per 1 Lifetime Per patient per tooth.	pre-operative radiographs
D3450	root amputation - per root	21 and older	Teeth 2 - 16, 18 - 31	Yes	No		pre-operative radiographs
D3471	surgical repair of root resorption - anterior	21 and older	Teeth 6 - 11, 22 - 27	Yes	No	One of (D3471) per 1 Lifetime Per patient per tooth.	
D3472	surgical repair of root resorption – premolar	21 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	No	One of (D3472) per 1 Lifetime Per patient per tooth.	
D3473	surgical repair of root resorption – molar	21 and older	Teeth 1 - 3, 14 - 19, 30 - 32	Yes	No	One of (D3473) per 1 Lifetime Per patient per tooth.	
D3501	surgical exposure of root surface without apicoectomy or repair of root resorption – anterior	21 and older	Teeth 6 - 11, 22 - 27	Yes	No	One of (D3501) per 1 Lifetime Per patient per tooth.	
D3502	surgical exposure of root surface without apicoectomy or repair of root resorption – premolar	21 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	No	One of (D3502) per 1 Lifetime Per patient per tooth.	
D3503	surgical exposure of root surface without apicoectomy or repair of root resorption – molar	21 and older	Teeth 1 - 3, 14 - 19, 30 - 32	Yes	No	One of (D3503) per 1 Lifetime Per patient per tooth.	
D3920	hemisection (including any root removal), not incl root canal therapy	21 and older	Teeth 2, 3, 14, 15, 18, 19, 30, 31	Yes	No		pre-operative radiographs

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Periodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4210, D4211) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4210, D4211) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	21 and older	Teeth 1 - 32, 51 - 82	Yes	No	One of (D4212) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4240	gingival flap procedure, including root planing – four or more contiguous teeth or tooth bound spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4240, D4241) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4241	gingival flap procedure, including root planing – one to three contiguous teeth or tooth bound spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4240, D4241) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4249	clinical crown lengthening - hard tissue	21 and older	Teeth 1 - 32	Yes	No	One of (D4249) per 36 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D4260	osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4260, D4261) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4261	osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4260, D4261) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting

Exhibit C Benefits Covered for CareSource Marketplace Adult (KY)

Periodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D4270	pedicle soft tissue graft procedure	21 and older	Teeth 1 - 32	Yes	No	One of (D4270) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4273	subepithelial connective tissue graft procedure	21 and older	Teeth 1 - 32	Yes	No	One of (D4273) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	21 and older	Teeth 1 - 32, 51 - 82	Yes	No		pre-op x-ray(s), perio charting
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	21 and older	Teeth 1 - 32, 51 - 82	Yes	No	One of (D4278) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4341	periodontal scaling and root planing - four or more teeth per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. A minimum of four affected teeth in the quadrant.	pre-op x-ray(s), perio charting
D4342	periodontal scaling and root planing - one to three teeth per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. One to three affected teeth in the quadrant.	pre-op x-ray(s), perio charting
D4355	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	21 and older		No	No	One of (D4355) per 1 Lifetime Per patient. Subject to Post Review	
D4910	periodontal maintenance procedures	21 and older		No	No	Four of (D1110, D4910) per 12 Month(s) Per patient. D4341 or D4342 must be on file for claims or documentation from patient record history of periodontal therapy within the last 6 months.	

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D5110	complete denture - maxillary	21 and older		Yes	No	One of (D5110, D5130) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5120	complete denture - mandibular	21 and older		Yes	No	One of (D5120, D5140) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5130	immediate denture - maxillary	21 and older		Yes	No	One of (D5110, D5130) per 60 Month(s) Per patient. Reimbursement made upon delivery (completion) of immediate maxillary or mandibular denture. D5130, D5140 reimbursed on the same date of service as the extraction of all remaining teeth.Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5140	immediate denture - mandibular	21 and older		Yes	No	One of (D5120, D5140) per 60 Month(s) Per patient. Reimbursement made upon delivery (completion) of immediate maxillary or mandibular denture. D5130, D5140 reimbursed on the same date of service as the extraction of all remaining teeth.Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5211	maxillary partial denture, resin base (including retentive/clasping materials, rests, and teeth)	21 and older		Yes	No	One of (D5211, D5213, D5221, D5223) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan

Exhibit C Benefits Covered for CareSource Marketplace Adult (KY)

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D5212	mandibular partial denture, resin base (including retentive/clasping materials, rests, and teeth)	21 and older		Yes	No	One of (D5212, D5214, D5222, D5224) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5213	maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	21 and older		Yes	No	One of (D5211, D5213, D5221, D5223) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5214	mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	21 and older		Yes	No	One of (D5212, D5214, D5222, D5224) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5221	immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	21 and older		Yes	No	One of (D5211, D5213, D5221, D5223) per 60 Month(s) Per patient. Reimbursement made upon delivery (completion) of immediate maxillary or mandibular partial denture. Reimbursed on the same date of service as the extraction of all remaining teeth.Includes adjustments within 6 months of initial placement	pre-operative x-ray(s)
D5222	immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	21 and older		Yes	No	One of (D5212, D5214, D5222, D5224) per 60 Month(s) Per patient. Reimbursement made upon delivery (completion) of immediate maxillary or mandibular partial denture. Reimbursed on the same date of service as the extraction of all remaining teeth.Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D5223	immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	21 and older		Yes	No	One of (D5211, D5213, D5221, D5223) per 60 Month(s) Per patient. Reimbursement made upon delivery (completion) of immediate maxillary or mandibular partial denture. Reimbursed on the same date of service as the extraction of all remaining teeth.Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5224	immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	21 and older		Yes	No	One of (D5212, D5214, D5222, D5224) per 60 Month(s) Per patient. Reimbursement made upon delivery (completion) of immediate maxillary or mandibular partial denture. Reimbursed on the same date of service as the extraction of all remaining teeth.Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5282	Removable unilateral partial denture--one piececast metal (including clasps and teeth), maxillary	21 and older		Yes	No	One of (D5282) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5283	Removable unilateral partial denture--one piececast metal (including clasps and teeth), mandibular	21 and older		Yes	No	One of (D5283) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5410	adjust complete denture - maxillary	21 and older		No	No	Not covered within 6 months of initial placement.	
D5411	adjust complete denture - mandibular	21 and older		No	No	Not covered within 6 months of initial placement.	
D5421	adjust partial denture-maxillary	21 and older		No	No	Not covered within 6 months of initial placement.	
D5422	adjust partial denture - mandibular	21 and older		No	No	Not covered within 6 months of initial placement.	

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D5511	repair broken complete denture base, mandibular	21 and older		No	No	Limited to repairs or adjustments performed more than 12 months after the initial insertion.	
D5512	repair broken complete denture base, maxillary	21 and older		No	No	Limited to repairs or adjustments performed more than 12 months after the initial insertion.	
D5520	replace missing or broken teeth - complete denture (each tooth)	21 and older	Teeth 1 - 32	No	No	Not covered within 6 months of initial placement.	
D5611	repair resin partial denture base, mandibular	21 and older		No	No	Limited to repairs or adjustments performed more than 12 months after the initial insertion.	
D5612	repair resin partial denture base, maxillary	21 and older		No	No	Limited to repairs or adjustments performed more than 12 months after the initial insertion.	
D5621	repair cast partial framework, mandibular	21 and older		No	No	Limited to repairs or adjustments performed more than 12 months after the initial insertion.	
D5622	repair cast partial framework, maxillary	21 and older		No	No	Limited to repairs or adjustments performed more than 12 months after the initial insertion.	
D5630	repair or replace broken retentive/clasping materials per tooth	21 and older	Teeth 1 - 32	No	No	Not covered within 6 months of initial placement.	
D5640	replace broken teeth-per tooth	21 and older	Teeth 1 - 32	No	No	Not covered within 6 months of initial placement.	
D5650	add tooth to existing partial denture	21 and older	Teeth 1 - 32	No	No		
D5660	add clasp to existing partial denture	21 and older	Teeth 1 - 32	No	No		

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D5710	rebase complete maxillary denture	21 and older		No	No	One of (D5710) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5711	rebase complete mandibular denture	21 and older		No	No	One of (D5711) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5720	rebase maxillary partial denture	21 and older		No	No	One of (D5720) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5721	rebase mandibular partial denture	21 and older		No	No	One of (D5721) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5730	reline complete maxillary denture (chairside)	21 and older		No	No	One of (D5730) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5731	reline complete mandibular denture (chairside)	21 and older		No	No	One of (D5731) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5740	reline maxillary partial denture (chairside)	21 and older		No	No	One of (D5740) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5741	reline mandibular partial denture (chairside)	21 and older		No	No	One of (D5741) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5750	reline complete maxillary denture (laboratory)	21 and older		No	No	One of (D5750) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D5751	reline complete mandibular denture (laboratory)	21 and older		No	No	One of (D5751) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5760	reline maxillary partial denture (laboratory)	21 and older		No	No	One of (D5760) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5761	reline mandibular partial denture (laboratory)	21 and older		No	No	One of (D5761) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5850	tissue conditioning, maxillary	21 and older		No	No		
D5851	tissue conditioning,mandibular	21 and older		No	No		

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6210	pontic - cast high noble metal	21 and older	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6211	pontic-cast base metal	21 and older	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6212	pontic - cast noble metal	21 and older	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6214	Pontic - titanium and titanium alloys	21 and older	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6240	pontic-porcelain fused-high noble	21 and older	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6241	pontic-porcelain fused to base metal	21 and older	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6242	pontic-porcelain fused-noble metal	21 and older	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6243	Pontic - Porcelain fused to titanium and titanium alloys	21 and older	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6245	prosthodontics fixed, pontic - porcelain/ceramic	21 and older	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6545	retainer - cast metal fixed	21 and older	Teeth 1 - 32	Yes	No	One of (D6545, D6548, D6549) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6548	prosthodontics fixed, retainer - porcelain/ceramic for resin bonded fixed prosthodontic	21 and older	Teeth 1 - 32	Yes	No	One of (D6545, D6548, D6549) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6549	Resin retainer-For resin bonded fixed prosthesis	21 and older	Teeth 1 - 32	Yes	No	One of (D6545, D6548, D6549) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6600	inlay - porcelain/ceramic, two surfaces	21 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6601	inlay - porcelain/ceramic, three or more surfaces	21 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6602	inlay - cast high noble metal, two surfaces	21 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6603	inlay - cast high noble metal, three or more surfaces	21 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6604	inlay - cast predominantly base metal, two surfaces	21 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6605	inlay - cast predominantly base metal, three or more surfaces	21 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6606	inlay - cast noble metal, two surfaces	21 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6607	inlay - cast noble metal, three or more surfaces	21 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6608	onlay - porcelain/ceramic, two surfaces	21 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6609	onlay - porcelain/ceramic, three or more surfaces	21 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6610	onlay - cast high noble metal, two surfaces	21 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6611	onlay - cast high noble metal, three or more surfaces	21 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6612	onlay - cast predominantly base metal, two surfaces	21 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6613	onlay - cast predominantly base metal, three or more surfaces	21 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6614	onlay - cast noble metal, two surfaces	21 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6615	onlay - cast noble metal, three or more surfaces	21 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6624	inlay - titanium	21 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6634	onlay - titanium	21 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6740	retainer crown, porcelain/ceramic	21 and older	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6750	crown-porcelain fused high noble	21 and older	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6751	crown-porcelain fused to base metal	21 and older	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6752	crown-porcelain fused noble metal	21 and older	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6753	Retainer Crown- Porcelain fused to titanium and titanium alloys	21 and older	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6780	crown-3/4 cst high noble metal	21 and older	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6781	prosthodontics fixed, crown ¾ cast predominantly based metal	21 and older	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6782	prosthodontics fixed, crown ¾ cast noble metal	21 and older	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Exhibit C Benefits Covered for CareSource Marketplace Adult (KY)

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6783	prosthodontics fixed, crown ¾ porcelain/ceramic	21 and older	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6784	Retainer Crown 3/4- Titanium and Titanium Alloys	21 and older	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6790	crown-full cast high noble	21 and older	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6791	crown - full cast base metal	21 and older	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6792	crown - full cast noble metal	21 and older	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6794	Retainer crown - titanium and titanium alloys	21 and older	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Exhibit C Benefits Covered for CareSource Marketplace Adult (KY)

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6930	re-cement or re-bond fixed partial denture	21 and older		Yes	No	Not covered within 6 months of placement.	pre-operative radiographs and narrative
D6980	fixed partial denture repair	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No		pre-operative radiographs and narrative

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Oral and Maxillofacial Surgery							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No		
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No	Includes cutting of gingiva and bone, removal of tooth structure and closure. Subject to Post Review.	
D7220	removal of impacted tooth-soft tissue	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	No		pre-operative radiographs
D7230	removal of impacted tooth-partially bony	21 and older	Teeth 1 - 32, 51 - 82	Yes	No	Includes splinting.	pre-operative radiographs
D7240	removal of impacted tooth-completely bony	21 and older	Teeth 1 - 32, 51 - 82	Yes	No		pre-operative radiographs
D7241	removal of impacted tooth-completely bony, with unusual surgical complications	21 and older	Teeth 1 - 32, 51 - 82	Yes	No		pre-operative radiographs
D7250	surgical removal of residual tooth roots (cutting procedure)	21 and older	Teeth 1 - 32, 51 - 82	Yes	No		pre-operative radiographs
D7251	Coronectomy – intentional partial tooth removal, impacted teeth only	21 and older	Teeth 1 - 32, 51 - 82	Yes	No		pre-operative radiographs
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	21 and older	Teeth 2 - 16, 18 - 31	Yes	No	Subject to post review as indicative of an emergency procedure	pre-operative radiographs
D7280	Surgical access of an unerupted tooth	21 and older	Teeth 2 - 16, 18 - 31	Yes	No		pre-operative radiographs

Oral and Maxillofacial Surgery							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D7283	placement of device to facilitate eruption of impacted tooth	21 and older	Teeth 1 - 32	No	No	One of (D7283) per 1 Lifetime Per patient per tooth.	
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D7310) per 1 Lifetime Per patient per quadrant. Minimum of four extractions in the affected quadrant. Covered only in conjunction with the construction of a prosthodontic appliance.	pre-operative radiographs
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D7311) per 1 Lifetime Per patient per quadrant. Minimum of four extractions in the affected quadrant. Covered only in conjunction with the construction of a prosthodontic appliance.	pre-operative radiographs
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D7320) per 1 Lifetime Per patient per quadrant. Minimum of four extractions in the affected quadrant. Covered only in conjunction with the construction of a prosthodontic appliance.	pre-operative radiographs
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D7321) per 1 Lifetime Per patient per quadrant. Minimum of four extractions in the affected quadrant. Covered only in conjunction with the construction of a prosthodontic appliance.	pre-operative radiographs
D7471	removal of exostosis - per site	21 and older	Per Arch (01, 02, LA, UA)	Yes	No		pre-operative radiographs and narrative
D7510	incision and drainage of abscess - intraoral soft tissue	21 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No	Subject to Post Review	

Exhibit C Benefits Covered for CareSource Marketplace Adult (KY)

Oral and Maxillofacial Surgery							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D7520	incision and drainage of abscess - extraoral soft tissue	21 and older		No	No	Subject to Post Review	
D7910	suture small wounds up to 5 cm	21 and older		No	No	Subject to Post Review	
D7971	excision of pericoronal gingiva	21 and older	Teeth 1 - 32	Yes	No		narr. of med. necessity, pre-op x-ray(s)

Exhibit C Benefits Covered for CareSource Marketplace Adult (KY)

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Adjunctive General Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D9110	palliative treatment of dental pain - per visit	21 and older		No	No	One of (D9110) per 1 Day(s) Per patient.	
D9222	deep sedation/general anesthesia first 15 minutes	21 and older		Yes	No	One of (D9222) per 1 Day(s) Per patient. Ten of (D9222, D9223) per 1 Calendar year(s) Per patient. This procedure code is not reimbursable on same date as D9239, D9243. Sedation approvals are limited to surgical and extensive cases	narr. of med. necessity, pre-op x-ray(s)
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	21 and older		Yes	No	Four of (D9223) per 1 Day(s) Per patient. Ten of (D9222, D9223) per 1 Calendar year(s) Per patient. This procedure code is not reimbursable on same date as D9239, D9243. Sedation approvals are limited to surgical and extensive cases	narr. of med. necessity, pre-op x-ray(s)
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	21 and older		Yes	No	One of (D9239) per 1 Day(s) Per patient. Ten of (D9239, D9243) per 1 Calendar year(s) Per patient. This procedure code is not reimbursable on same date as D9222, D9223. Sedation approvals are limited to surgical and extensive cases	narr. of med. necessity, pre-op x-ray(s)
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	21 and older		Yes	No	Four of (D9243) per 1 Day(s) Per patient. Ten of (D9239, D9243) per 1 Calendar year(s) Per patient. This procedure code is not reimbursable on same date as D9222, D9223. Sedation approvals are limited to surgical and extensive cases	narr. of med. necessity, pre-op x-ray(s)

Exhibit C Benefits Covered for CareSource Marketplace Adult (KY)

Adjunctive General Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	21 and older		Yes	No	One of (D9310) per 1 Day(s) Per patient. Includes consultation with medical professional (D9310 used in lieu of D9311)	narrative of medical necessity
D9311	consultation with medical health care professional	21 and older		No	No	One of (D9311) per 1 Day(s) Per patient. This should be used only for extensive consultation with medical professional regarding patient's medical issues.	
D9610	therapeutic drug injection, by report	21 and older		Yes	No	One of (D9610) per 1 Day(s) Per patient. Description and dosage of drug.	narrative of medical necessity
D9930	treatment of complications (post-surgical) - unusual circumstances, by report	21 and older		Yes	No		narrative of medical necessity
D9944	occlusal guard--hard appliance, full arch	21 and older	Per Arch (01, 02, LA, UA)	Yes	No	One of (D9944) per 12 Month(s) Per patient.	narrative of medical necessity
D9995	teledentistry – synchronous; real-time encounter	21 and older		No	No	Four of (D9995) per 1 Calendar year(s) Per patient. The appropriate teledentistry code (D9995 or D9996) should be reported as descriptor codes to identify services (D0140, D0145) provided via teledentistry by the dentist who provided the oversight of the teledentistry encounter as allowed and in accordance with any applicable state laws and/or: regulations, licensure, state dental practice acts. A teledentistry event is subject to applicable state law, regulation or licensure. D9995 & D9996 do not have separate distinct benefit limits, however, any benefit limits applicable to the underlying services rendered would continue to apply.	

Exhibit C Benefits Covered for CareSource Marketplace Adult (KY)

Adjunctive General Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D9996	teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	21 and older		No	No	Four of (D9996) per 1 Calendar year(s) Per patient. The appropriate teledentistry code (D9995 or D9996) should be reported as descriptor codes to identify services (D0140, D0145) provided via teledentistry by the dentist who provided the oversight of the teledentistry encounter as allowed and in accordance with any applicable state laws and/or: regulations, licensure, state dental practice acts. A teledentistry event is subject to applicable state law, regulation or licensure. D9995 & D9996 do not have separate distinct benefit limits, however, any benefit limits applicable to the underlying services rendered would continue to apply.	

Exhibit D Benefits Covered for CareSource Marketplace Child (KY)

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0120	periodic oral evaluation - established patient	0-20		No	No	Two of (D0120, D0140, D0145, D0150, D0180) per 1 Calendar year(s) Per patient. D0120 periodic oral evaluation may not occur in combination with D0150 on same date of service and not until 180 days after the D0150 comprehensive oral evaluation.	
D0140	limited oral evaluation-problem focused	0-20		No	No	Two of (D0120, D0140, D0145, D0150, D0180) per 1 Calendar year(s) Per patient. Note- This procedure code is used for emergency examinations during regularly scheduled office hours. Evaluations solely for the purpose of adjustments or in conjunction with multi-visit procedures are not covered (i.e. endodontics and orthodontia). May not be used in conjunction with D0120, D0150, D9440, and D0180	
D0145	oral evaluation for a patient under three years of age and counseling with primary caregiver	0-3		No	No	Two of (D0120, D0140, D0145, D0150, D0180) per 1 Calendar year(s) Per patient. Should be used only for first time visit for Children under three years who have not seen a dentist. Subsequent recall visit D0120 should be billed.	

Exhibit D Benefits Covered for CareSource Marketplace Child (KY)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0150	comprehensive oral evaluation - new or established patient	0-20		No	No	Two of (D0120, D0140, D0145, D0150, D0180) per 1 Calendar year(s) Per patient. One of (D0150) per 24 Month(s) Per Provider OR Location. D0150 used when evaluating a patient comprehensively. D0150 or the periodic exam D0120 may not occur in conjunction with a limited oral evaluation (examination during office hours- D0140 or after office hours- D9440)	
D0180	comprehensive periodontal evaluation - new or established patient	0-20		No	No	Two of (D0120, D0140, D0145, D0150, D0180) per 1 Calendar year(s) Per patient. Reimbursement disallowed for D0180 performed in conjunction with either a D0150 or D0120.	
D0210	intraoral - comprehensive series of radiographic images	0-20		No	No	One of (D0210, D0330) per 12 Month(s) Per patient. Indicated for the permanent dentition or Adult dentate. A full-mouth series consist of a minimum of fourteen (14) films intended to display the crowns and roots of all teeth, periapical areas and alveolar bone necessary for examination and diagnosis.	

Exhibit D Benefits Covered for CareSource Marketplace Child (KY)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0220	intraoral - periapical first radiographic image	0-20		No	No	One of (D0220) per 1 Day(s) Per patient. If the total allowed amount for services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for D0210 (Complete Series of Radiographic Images), the submitted radiographs will be consolidated and max fee reimbursement will be limited to the allowed amount of the D0210 series. Periapical radiographs are used diagnostically and are not reimbursable when used intraoperatively (i.e. during RCT or other procedural x-rays).	
D0230	intraoral - periapical each additional radiographic image	0-20		No	No	Two of (D0230) per 12 Month(s) Per patient. If the total allowed amount for services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for D0210 (Complete Series of Radiographic Images), the submitted radiographs will be consolidated and max fee reimbursement will be limited to the allowed amount of the D0210 series. Periapical radiographs are used diagnostically and are not reimbursable when used intraoperatively (i.e. during RCT or other procedural x-rays).	

Exhibit D Benefits Covered for CareSource Marketplace Child (KY)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0240	intraoral - occlusal radiographic image	0-20		No	No	Two of (D0240) per 12 Month(s) Per patient. If the total allowed amount for services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for D0210 (Complete Series of Radiographic Images), the submitted radiographs will be consolidated and max fee reimbursement will be limited to the allowed amount of the D0210 series. Periapical radiographs are used diagnostically and are not reimbursable when used intraoperatively (i.e. during RCT or other procedural x-rays).	
D0250	extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	0-20		No	No	One of (D0250) per 1 Benefit period(s) Per patient. These images include but are not limited to lateral skull, Posterior- Anterior Skull, Submentovertex, Waters, Reverse Tomes, Oblique Mandibular Body , Lateral Ramus. Periapical radiographs are used diagnostically and are not reimbursable when used intraoperatively (i.e. during RCT or other procedural x-rays) These images include but are not limited to lateral skull, Posterior- Anterior Skull, Submentovertex, Waters, Reverse Tomes, Oblique Mandibular Body , Lateral Ramus.	

Exhibit D Benefits Covered for CareSource Marketplace Child (KY)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0270	bitewing - single radiographic image	0-20		No	No	A total of four horizontal bitewing films in any combination of (D0270, D0272, D0273 or D0274) per 6 Month(s) “Or” One set of vertical bitewings (D0277) per 12 Month(s) See fee limitations for all radiographs. If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series.	

Exhibit D Benefits Covered for CareSource Marketplace Child (KY)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0272	bitewings - two radiographic images	0-20		No	No	A total of four horizontal bitewing films in any combination of (D0270, D0272, D0273 or D0274) per 6 Month(s) “Or” One set of vertical bitewings (D0277) per 12 Month(s) See fee limitations for all radiographs. If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series.	

Exhibit D Benefits Covered for CareSource Marketplace Child (KY)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0273	bitewings - three radiographic images	0-20		No	No	A total of four horizontal bitewing films in any combination of (D0270, D0272, D0273 or D0274) per 6 Month(s) “Or” One set of vertical bitewings (D0277) per 12 Month(s) See fee limitations for all radiographs. If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series.	

Exhibit D Benefits Covered for CareSource Marketplace Child (KY)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0274	bitewings - four radiographic images	0-20		No	No	One of (D0274, D0277) per 12 Month(s) Per patient. A total of four horizontal bitewing films in any combination of (D0270, D0272, D0273 or D0274) per 6 Month(s) “Or” One set of vertical bitewings (D0277) per 12 Month(s) See fee limitations for all radiographs. If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series.	

Exhibit D Benefits Covered for CareSource Marketplace Child (KY)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0277	vertical bitewings - 7 to 8 films	0-20		No	No	One of (D0274, D0277) per 12 Month(s) Per patient. A total of four horizontal bitewing films in any combination of (D0270, D0272, D0273 or D0274) per 6 Month(s) “Or” One set of vertical bitewings (D0277) per 12 Month(s) See fee limitations for all radiographs. If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series.	
D0330	panoramic radiographic image	0-20		No	No	One of (D0210, D0330) per 12 Month(s) Per patient. All periapical or occlusal films taken same date of service needed to render the necessary radiographic diagnosis are included in the fee for panoramic radiograph. If bitewing radiographs D0270, D0272 or D0274 are indicated for additional diagnosis, the amount reimbursed will not exceed the reimbursable amount for D0210 Full Mouth Series. PA required if done more frequently than 60 months.	

Exhibit D Benefits Covered for CareSource Marketplace Child (KY)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0340	cephalometric radiographic image	0-20		No	No	One of (D0340) per 1 Day(s) Per Provider OR Location. Not included in single date of service maximum radiography reimbursable amount.	
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	0-20		No	No	One of (D0350) per 1 Day(s) Per Provider OR Location. Covered one per Orthodontist or Location as part of an Orthodontic case.	
D0372	intraoral tomosynthesis – comprehensive series of radiographic images	0-20		No	No	One of (D0210, D0277, D0330, D0372, D0387) per 1 Calendar year(s) Per patient.	
D0373	intraoral tomosynthesis – bitewing radiographic image	0-20		No	No	One of (D0270, D0272, D0273, D0274, D0277, D0373, D0388) per 1 Calendar year(s) Per patient.	
D0374	intraoral tomosynthesis – periapical radiographic image	0-20		No	No	One of (D0220, D0230, D0374, D0389) per 1 Calendar year(s) Per patient.	
D0387	intraoral tomosynthesis – comprehensive series of radiographic images – image capture only	0-20		No	No	One of (D0210, D0277, D0330, D0372, D0387) per 1 Calendar year(s) Per patient.	
D0388	intraoral tomosynthesis – bitewing radiographic image – image capture only	0-20		No	No	One of (D0270, D0272, D0273, D0274, D0277, D0373, D0388) per 1 Calendar year(s) Per patient.	
D0389	intraoral tomosynthesis – periapical radiographic image – image capture only	0-20		No	No	One of (D0220, D0230, D0374, D0389) per 1 Calendar year(s) Per patient.	
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report	0-20		No	No	One of (D0391) per 1 Day(s) Per Provider OR Location. Interpretation of diagnostic image and report by a Practitioner not associated with Image Capture. Report should be kept in patient record for post payment review as applicable.	

Exhibit D Benefits Covered for CareSource Marketplace Child (KY)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0470	diagnostic casts	0-20		No	No	One of (D0470) per 1 Day(s) Per Provider OR Location. One per case. Diagnostic models or study models used as a guide in the application of corrective or restorative dentistry. Payable as a diagnostic service intended for the documentation and subsequent analysis of occlusion.	

Exhibit D Benefits Covered for CareSource Marketplace Child (KY)

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D1110	prophylaxis - adult	13 - 20		No	No	Two of (D1110, D1120) per 1 Calendar year(s) Per patient. This service code used for permanent dentition.	
D1120	prophylaxis - child	0-12		No	No	Two of (D1110, D1120) per 1 Calendar year(s) Per patient. This service code used for primary dentition	
D1206	topical application of fluoride varnish	0-20		No	No	Two of (D1206, D1208) per 1 Calendar year(s) Per patient. Treatment that incorporates fluoride with the polishing compound is considered part of the prophylaxis procedure and not a separate topical fluoride treatment. The following treatments are not covered with use of D1206 or D1208: • Topical application of fluoride to the prepared portion of a tooth prior to restoration • The use of self or home fluoride application procedures	
D1208	topical application of fluoride - excluding varnish	0-20		No	No	Two of (D1206, D1208) per 1 Calendar year(s) Per patient. Treatment that incorporates fluoride with the polishing compound is considered part of the prophylaxis procedure and not a separate topical fluoride treatment. The following treatments are not covered with use of D1206 or D1208: • Topical application of fluoride to the prepared portion of a tooth prior to restoration • The use of self or home fluoride application procedures	

Exhibit D Benefits Covered for CareSource Marketplace Child (KY)

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D1351	sealant - per tooth	0-20	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	No	One of (D1351) per 36 Month(s) Per patient per tooth. Mechanically and/or chemically prepared enamel surface sealed to prevent decay. Sealants are reimbursable for unrestored pit and fissure surfaces (first and second molars only)	
D1352	Preventive resin restoration is a mod. to high caries risk patient perm tooth conservative rest of an active cavitated lesion in a pit or fissure that doesn't extend into dentin: includes placmt of a sealant in radiating non-carious fissure or pits.	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No	One of (D1352) per 36 Month(s) Per patient per tooth. Conservative restoration of an active cavitated lesion in a pit or fissure that does not extend into dentin; includes placement of a sealant in any radiating noncarious fissures or pits. • Must be a conservative restoration using a bur that extends into enamel only and includes all the deep grooves of the tooth. • Must be placed on a non-restored permanent tooth that has not had a sealant placed within 1 year	
D1354	application of caries arresting medicament- per tooth	0-20	Teeth 2 - 15, 18 - 31, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No	One of (D1354, D1355) per 36 Month(s) Per patient per tooth. Ten of (D1354, D1355) per 1 Day(s) Per patient. Conservative treatment of an active, non-symptomatic carious lesion by topical application of a caries arresting or inhibiting medicament and without mechanical removal of sound tooth structure.	

Exhibit D Benefits Covered for CareSource Marketplace Child (KY)

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D1355	caries preventive medicament application – per tooth	0-20	Teeth 2 - 15, 18 - 31, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No	One of (D1354, D1355) per 36 Month(s) Per patient per tooth. Ten of (D1354, D1355) per 1 Day(s) Per patient. Conservative treatment by topical application of a caries preventive or inhibiting medicament for primary prevention or remineralization and without mechanical removal of sound tooth structure.	
D1510	space maintainer-fixed, unilateral- per quadrant	0-13	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	Two of (D1510) per 12 Month(s) Per patient per quadrant. Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	

Exhibit D Benefits Covered for CareSource Marketplace Child (KY)

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D1516	space maintainer --fixed--bilateral, maxillary	0-13		No	No	Two of (D1516) per 12 Month(s) Per patient per tooth. Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	
D1517	space maintainer --fixed--bilateral, mandibular	0-13		No	No	Two of (D1517) per 12 Month(s) Per patient per tooth. Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	

Exhibit D Benefits Covered for CareSource Marketplace Child (KY)

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D1520	space maintainer-removable-unilateral	0-13	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	Two of (D1520) per 12 Month(s) Per patient per tooth. Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	
D1526	space maintainer --removable--bilateral, maxillary	0-13		No	No	Two of (D1526) per 12 Month(s) Per patient per tooth. Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	

Exhibit D Benefits Covered for CareSource Marketplace Child (KY)

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D1527	space maintainer --removable--bilateral, mandibular	0-13		No	No	Two of (D1527) per 12 Month(s) Per patient per tooth. Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	
D1551	re-cement or re-bond bilateral space maintainer-Maxillary	0-13		No	No	Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	

Exhibit D Benefits Covered for CareSource Marketplace Child (KY)

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D1552	re-cement or re-bond bilateral space maintainer- Mandibular	0-13		No	No	Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	
D1553	re-cement or re-bond unilateral space maintainer- Per Quadrant	0-13	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	
D1556	Removal of fixed unilateral space maintainer- Per Quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	Not reimbursable to dentist or practice that originally placed the appliance	
D1557	Removal of fixed bilateral space maintainer- Maxillary	0-20		No	No	Not reimbursable to dentist or practice that originally placed the appliance	

Exhibit D Benefits Covered for CareSource Marketplace Child (KY)

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D1558	Removal of fixed bilateral space maintainer-Mandibular	0-20		No	No	Not reimbursable to dentist or practice that originally placed the appliance	

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2140	Amalgam - one surface, primary or permanent	0-20	Teeth 1 - 32, A - T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	
D2150	Amalgam - two surfaces, primary or permanent	0-20	Teeth 1 - 32, A - T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	

Exhibit D Benefits Covered for CareSource Marketplace Child (KY)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2160	amalgam - three surfaces, primary or permanent	0-20	Teeth 1 - 32, A - T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	
D2161	amalgam - four or more surfaces, primary or permanent	0-20	Teeth 1 - 32, A - T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	

Exhibit D Benefits Covered for CareSource Marketplace Child (KY)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2330	resin-based composite - one surface, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. The fee for resin-based composite restorations will include any necessary acid etching and bonding agents. Non-contiguous restorations, such as a separate Distal Facial (DF) and Mesial Facial (MF) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	
D2331	resin-based composite - two surfaces, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. The fee for resin-based composite restorations will include any necessary acid etching and bonding agents. Non-contiguous restorations, such as a separate Distal Facial (DF) and Mesial Facial (MF) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2332	resin-based composite - three surfaces, anterior	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. The fee for resin-based composite restorations will include any necessary acid etching and bonding agents. Non-contiguous restorations, such as a separate Distal Facial (DF) and Mesial Facial (MF) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	0-20	Teeth 6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. The fee for resin-based composite restorations will include any necessary acid etching and bonding agents. Non-contiguous restorations, such as a separate Distal Facial (DF) and Mesial Facial (MF) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	

Exhibit D Benefits Covered for CareSource Marketplace Child (KY)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2391	resin-based composite - one surface, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. CareSource will reimburse based on Amalgam for posterior teeth.D2391 Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	
D2392	resin-based composite - two surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. CareSource will reimburse based on Amalgam for posterior teeth.D2391 Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	

Exhibit D Benefits Covered for CareSource Marketplace Child (KY)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2393	resin-based composite - three surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. CareSource will reimburse based on Amalgam for posterior teeth.D2391 Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	
D2394	resin-based composite - four or more surfaces, posterior	0-20	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. CareSource will reimburse based on Amalgam for posterior teeth.D2391 Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	

Exhibit D Benefits Covered for CareSource Marketplace Child (KY)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2510	inlay - metallic -1 surface	0-20	Teeth 1 - 32	No	No	One of (D2510) per 60 Month(s) Per patient per tooth. Covered only when a direct restoration (ie. amalgam, composite) will not adequately restore the tooth.	
D2520	inlay-metallic-2 surfaces	0-20	Teeth 1 - 32	No	No	One of (D2520) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	
D2530	inlay-metallic-3+ surfaces	0-20	Teeth 1 - 32	No	No	One of (D2530) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	
D2542	onlay - metallic - two surfaces	0-20	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2543	onlay-metallic-3 surfaces	0-20	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs

Exhibit D Benefits Covered for CareSource Marketplace Child (KY)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2544	onlay-metallic-4+ surfaces	0-20	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2740	crown - porcelain/ceramic	0-20	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2750	crown - porcelain fused to high noble metal	0-20	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2751	crown - porcelain fused to predominantly base metal	0-20	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs

Exhibit D Benefits Covered for CareSource Marketplace Child (KY)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2752	crown - porcelain fused to noble metal	0-20	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2780	crown - ¾ cast high noble metal	0-20	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2781	crown - ¾ cast predominantly base metal	0-20	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2782	crown - ¾ cast noble metal	0-20	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs

Exhibit D Benefits Covered for CareSource Marketplace Child (KY)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2783	crown - ¾ porcelain/ceramic	0-20	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2790	crown - full cast high noble metal	0-20	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2791	crown - full cast predominantly base metal	0-20	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2792	crown - full cast noble metal	0-20	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs

Exhibit D Benefits Covered for CareSource Marketplace Child (KY)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2794	Crown- Titanium and Titanium Alloys	0-20	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	0-20	Teeth 1 - 32	No	No	Not reimbursable within 6 months of initial placement.	
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core	0-20	Teeth 1 - 32	No	No	Not covered within 6 months of initial placement.	
D2920	re-cement or re-bond crown	0-20	Teeth 1 - 32, A - T	No	No	Not reimbursable within 6 months of initial placement.	
D2928	prefabricated porcelain/ceramic crown – permanent tooth	0-20	Teeth 1 - 32	No	No	One of (D2928, D2929, D2930, D2931, D2933, D2934) per 60 Month(s) Per patient per tooth. Greater than 6 units of (D2928, D2929, D2930, D2931, D2933, and D2934) per date of service may be subject to post review.	
D2929	Prefabricated porcelain/ceramic crown – primary tooth	0-14	Teeth A - T	No	No	One of (D2928, D2929, D2930, D2931, D2933, D2934) per 60 Month(s) Per patient per tooth. Greater than 6 units of (D2928, D2929, D2930, D2931, D2933, and D2934) per date of service may be subject to post review.	

Exhibit D Benefits Covered for CareSource Marketplace Child (KY)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2930	prefabricated stainless steel crown - primary tooth	0-14	Teeth A - T	No	No	One of (D2928, D2929, D2930, D2931, D2933, D2934) per 60 Month(s) Per patient per tooth. Greater than 6 units of (D2928, D2929, D2930, D2931, D2933, and D2934) per date of service may be subject to post review.	
D2931	prefabricated stainless steel crown-permanent tooth	0-14	Teeth 1 - 32	No	No	One of (D2928, D2929, D2930, D2931, D2933, D2934) per 60 Month(s) Per patient per tooth. Greater than 6 units of (D2928, D2929, D2930, D2931, D2933, and D2934) per date of service may be subject to post review.	
D2933	prefabricated stainless steel crown with resin window	0-14	Teeth 1 - 32, A - T	No	No	One of (D2928, D2929, D2930, D2931, D2933, D2934) per 60 Month(s) Per patient per tooth. Greater than 6 units of (D2928, D2929, D2930, D2931, D2933, and D2934) per date of service may be subject to post review.	
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	0-14	Teeth A - T	No	No	One of (D2928, D2929, D2930, D2931, D2933, D2934) per 60 Month(s) Per patient per tooth. Greater than 6 units of (D2928, D2929, D2930, D2931, D2933, and D2934) per date of service may be subject to post review.	
D2940	protective restoration	0-20	Teeth 1 - 32	No	No	One of (D2940) per 1 Calendar year(s) Per patient per tooth. Restorative material to protect tooth and/or tissue form. Used to relieve pain, promote healing, and prevent further deterioration. Not reimbursable when used as endodontic access closure, or as a base or liner under restoration.	

Exhibit D Benefits Covered for CareSource Marketplace Child (KY)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2950	core buildup, including any pins when required	0-20	Teeth 1 - 32	Yes	No	One of (D2950) per 60 Month(s) Per patient per tooth.	pre-operative radiographs
D2951	pin retention - per tooth, in addition to restoration	0-20	Teeth 1 - 32	No	No	Three of (D2951) per 1 Lifetime Per patient per tooth.	
D2952	cast post and core in addition to crown	0-20	Teeth 1 - 32	Yes	No	One of (D2952, D2954) per 60 Month(s) Per patient per tooth.	pre-operative radiographs
D2953	each additional cast post - same tooth	0-20	Teeth 1 - 32	Yes	No	One of (D2953) per 60 Month(s) Per patient per tooth.	pre-operative radiographs
D2954	prefabricated post and core in addition to crown	0-20	Teeth 1 - 32	Yes	No	One of (D2952, D2954) per 60 Month(s) Per patient per tooth.	pre-operative radiographs
D2957	each additional prefabricated post - same tooth	0-20	Teeth 1 - 32	Yes	No	One of (D2957) per 60 Month(s) Per patient per tooth.	pre-operative radiographs
D2961	labial veneer (resin laminate) - laboratory	0-20	Teeth 1 - 32	Yes	No	One of (D2961, D2962) per 60 Month(s) Per patient per tooth. D2961, D2962 may be covered in lieu of crowns when clinically indicated for anterior teeth that are severely fractured or carious, that cannot be adequately repaired with a direct restoration (i.e., CDT codes D2330–D2335) Not reimbursable when performed solely for cosmetic/aesthetic reasons.	Pre-operative radiographs and operative report
D2962	labial veneer (porc laminate) - laboratory	0-20	Teeth 1 - 32	Yes	No	One of (D2961, D2962) per 60 Month(s) Per patient per tooth. D2961, D2962 may be covered in lieu of crowns when clinically indicated for anterior teeth that are severely fractured or carious, that cannot be adequately repaired with a direct restoration (i.e., CDT codes D2330–D2335) Not reimbursable when performed solely for cosmetic/aesthetic reasons.	Pre-operative radiographs and operative report

Exhibit D Benefits Covered for CareSource Marketplace Child (KY)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2980	crown repair, by report	0-20	Teeth 1 - 32	Yes	No	One of (D2980) per 60 Month(s) Per patient per tooth.	Narr / Oper Rpt
D2981	Inlay repair necessitated by restorative material failure	0-20	Teeth 1 - 32, 51 - 82	Yes	No	One of (D2981) per 60 Month(s) Per patient per tooth.	Narr / Oper Rpt
D2982	Onlay repair necessitated by restorative material failure	0-20	Teeth 1 - 32, 51 - 82	Yes	No	One of (D2982) per 60 Month(s) Per patient per tooth.	Narr / Oper Rpt
D2983	Veneer repair necessitated by restorative material failure	0-20	Teeth 1 - 32, 51 - 82	Yes	No	One of (D2983) per 60 Month(s) Per patient per tooth.	Narr / Oper Rpt
D2990	Resin infiltration of incipient smooth surface lesions	0-20	Teeth 1 - 32, A - T	No	No	One of (D2990) per 60 Month(s) Per patient per tooth.	
D2999	unspecified restorative procedure, by report	0-20	Teeth 1 - 32, A - T	No	No		

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Endodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	0-20	Teeth 1 - 32, A - T	No	No	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.	
D3222	partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	0-20	Teeth 1 - 32	No	No	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.	
D3230	pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	0-11	Teeth C, H, M, R	No	No	One of (D3230) per 1 Lifetime Per patient per tooth.	
D3230	pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	0-6	Teeth D - G, N - Q	No	No	One of (D3230) per 1 Lifetime Per patient per tooth.	
D3240	pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	0-11	Teeth A, B, I - L, S, T	No	No	One of (D3240) per 1 Lifetime Per patient per tooth.	

Exhibit D Benefits Covered for CareSource Marketplace Child (KY)

Endodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D3310	endodontic therapy, anterior tooth (excluding final restoration)	0-20	Teeth 6 - 11, 22 - 27	No	No	One of (D3310) per 1 Lifetime Per patient per tooth. 1)Once per tooth per lifetime except for exception cases of appropriate medical necessity.2)The date the RCT is completed should be the date of service.3)Reimbursement for a root canal includes opening and drainage, treatment planning, clinical procedures, follow-up care, radiographs during treatment, and post-operative radiographs. 4)D3310,D3320,D3330 are subject to Post Review Third molar wisdom teeth will only be considered for coverage when tooth is functional.	
D3320	endodontic therapy, premolar tooth (excluding final restoration)	0-20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	No	One of (D3320) per 1 Lifetime Per patient per tooth. 1)Once per tooth per lifetime except for exception cases of appropriate medical necessity.2)The date the RCT is completed should be the date of service.3)Reimbursement for a root canal includes opening and drainage, treatment planning, clinical procedures, follow-up care, radiographs during treatment, and post-operative radiographs. 4)D3310,D3320,D3330 are subject to Post Review Third molar wisdom teeth will only be considered for coverage when tooth is functional.	

Exhibit D Benefits Covered for CareSource Marketplace Child (KY)

Endodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D3330	endodontic therapy, molar tooth (excluding final restoration)	0-20	Teeth 1 - 3, 14 - 19, 30 - 32	No	No	One of (D3330) per 1 Lifetime Per patient per tooth. 1)Once per tooth per lifetime except for exception cases of appropriate medical necessity.2)The date the RCT is completed should be the date of service.3)Reimbursement for a root canal includes opening and drainage, treatment planning, clinical procedures, follow-up care, radiographs during treatment, and post-operative radiographs. 4)D3310,D3320,D3330 are subject to Post Review Third molar wisdom teeth will only be considered for coverage when tooth is functional.	
D3346	retreatment of previous root canal therapy-anterior	0-20	Teeth 6 - 11, 22 - 27	No	No	One of (D3346) per 1 Lifetime Per patient per tooth. 1)Dental provider who performed the original root canal should not be reimbursed for the retreatment for the first 12 months 2)D3346, D3347, D3348 are subject to Post Review	
D3347	retreatment of previous root canal therapy - premolar	0-20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	No	One of (D3347) per 1 Lifetime Per patient per tooth. 1)Dental provider who performed the original root canal should not be reimbursed for the retreatment for the first 12 months 2)D3346, D3347, D3348 are subject to Post Review	

Endodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D3348	retreatment of previous root canal therapy-molar	0-20	Teeth 1 - 3, 14 - 19, 30 - 32	No	No	One of (D3348) per 1 Lifetime Per patient per tooth. 1)Dental provider who performed the original root canal should not be reimbursed for the retreatment for the first 12 months 2)D3346, D3347, D3348 are subject to Post Review	
D3351	apexification/recalcification - initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	0-20	Teeth 1 - 32	Yes	No	One of (D3351) per 1 Lifetime Per patient per tooth. Initial opening, preparation and first placement of medication and necessary radiographs	pre-operative radiographs
D3352	apexification/recalcification - interim medication replacement	0-20	Teeth 1 - 32	Yes	No	One of (D3352) per 1 Lifetime Per patient per tooth. For visits in which the intra-canal medication is replaced with new medication, includes any necessary radiographs	pre-operative radiographs
D3353	apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	0-20	Teeth 1 - 32	Yes	No	One of (D3353) per 1 Lifetime Per patient per tooth. Includes removal of intra-canal medication and procedures necessary to place final root canal filling material, includes necessary radiographs.	pre-operative radiographs
D3355	Pulpal regeneration - initial visit	0-20	Teeth 1 - 32	No	No	One of (D3355) per 1 Lifetime Per patient per tooth. Subject to Post Review	
D3356	Pulpal regeneration - interim medication replacement	0-20	Teeth 1 - 32	No	No	One of (D3356) per 1 Lifetime Per patient per tooth. Subject to Post Review	
D3357	Pulpal regeneration - completion of treatment	0-20	Teeth 1 - 32	No	No	One of (D3357) per 1 Lifetime Per patient per tooth. Subject to Post Review	
D3410	apicoectomy - anterior	0-20	Teeth 6 - 11, 22 - 27	Yes	No	One of (D3410) per 1 Lifetime Per patient per tooth.	pre-operative radiographs
D3421	apicoectomy - premolar (first root)	0-20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	No	One of (D3421) per 1 Lifetime Per patient per tooth.	pre-operative radiographs

Exhibit D Benefits Covered for CareSource Marketplace Child (KY)

Endodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D3425	apicoectomy - molar (first root)	0-20	Teeth 1 - 3, 14 - 19, 30 - 32	Yes	No	One of (D3425) per 1 Lifetime Per patient per tooth.	pre-operative radiographs
D3426	apicoectomy (each additional root)	0-20	Teeth 1 - 5, 12 - 21, 28 - 32	Yes	No	One of (D3426) per 1 Lifetime Per patient per tooth.	pre-operative radiographs
D3450	root amputation - per root	0-20	Teeth 1 - 32	Yes	No		pre-operative radiographs
D3471	surgical repair of root resorption - anterior	0-20	Teeth 6 - 11, 22 - 27	No	No	One of (D3471) per 1 Lifetime Per patient per tooth.	
D3472	surgical repair of root resorption – premolar	0-20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	No	One of (D3472) per 1 Lifetime Per patient per tooth.	
D3473	surgical repair of root resorption – molar	0-20	Teeth 1 - 3, 14 - 19, 30 - 32	No	No	One of (D3473) per 1 Lifetime Per patient per tooth.	
D3501	surgical exposure of root surface without apicoectomy or repair of root resorption – anterior	0-20	Teeth 6 - 11, 22 - 27	No	No	One of (D3501) per 1 Lifetime Per patient per tooth.	
D3502	surgical exposure of root surface without apicoectomy or repair of root resorption – premolar	0-20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	No	One of (D3502) per 1 Lifetime Per patient per tooth.	
D3503	surgical exposure of root surface without apicoectomy or repair of root resorption – molar	0-20	Teeth 1 - 3, 14 - 19, 30 - 32	No	No	One of (D3503) per 1 Lifetime Per patient per tooth.	
D3920	hemisection (including any root removal), not incl root canal therapy	0-20	Teeth 1 - 3, 14 - 19, 30 - 32	Yes	No		pre-operative radiographs

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Periodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4210, D4211) per 12 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4210, D4211) per 12 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	0-20	Teeth 1 - 32, 51 - 82	Yes	No	One of (D4212) per 12 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4240	gingival flap procedure, including root planing – four or more contiguous teeth or tooth bound spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4240, D4241) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4241	gingival flap procedure, including root planing – one to three contiguous teeth or tooth bound spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4240, D4241) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4249	clinical crown lengthening - hard tissue	0-20	Teeth 1 - 32	Yes	No	One of (D4249) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4260	osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4260, D4261) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4261	osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4260, D4261) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting

Periodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D4263	bone replacement graft - first site in quadrant	0-20	Teeth 1 - 32	Yes	No	One of (D4263) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4270	pedicle soft tissue graft procedure	0-20	Teeth 1 - 32	Yes	No	One of (D4270) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4273	subepithelial connective tissue graft procedure	0-20	Teeth 1 - 32	Yes	No	One of (D4273) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4275	soft tissue allograft	0-20	Teeth 1 - 32	Yes	No	One of (D4275) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	0-20	Teeth 1 - 32, 51 - 82	Yes	No		pre-op x-ray(s), perio charting
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	0-20	Teeth 1 - 32, 51 - 82	Yes	No	One of (D4278) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4283	autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	0-20	Teeth 1 - 32	Yes	No	One of (D4283) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4285	non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	0-20	Teeth 1 - 32	Yes	No	One of (D4285) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4341	periodontal scaling and root planing - four or more teeth per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4341, D4342) per 12 Month(s) Per patient per quadrant. A minimum of four affected teeth in the quadrant.	Perio Charting, pre-op radiographs and narr of med necessity

Exhibit D Benefits Covered for CareSource Marketplace Child (KY)

Periodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D4342	periodontal scaling and root planing - one to three teeth per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4341, D4342) per 12 Month(s) Per patient per quadrant. One to three affected teeth in the quadrant.	Perio Charting, pre-op radiographs and narr of med necessity
D4355	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	0-20		No	No	One of (D4355) per 1 Lifetime Per patient. Subject to Post Review.	
D4910	periodontal maintenance procedures	0-20		No	No	Two of (D4210, D4211, D4240, D4241, D4249, D4260, D4261, D4341, D4342, D4346, D4355, D4910, D4999) per 12 Month(s) Per patient. After the completion of active periodontal therapy. Subject to post review, D4341 or D4342 must be on file for claims or documentation from patient record history of periodontal therapy within last 24 months.	

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D5110	complete denture - maxillary	0-20		Yes	No	One of (D5110, D5130) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5120	complete denture - mandibular	0-20		Yes	No	One of (D5120, D5140) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5130	immediate denture - maxillary	0-20		Yes	No	One of (D5110, D5130) per 60 Month(s) Per patient. Reimbursement made upon delivery (completion) of immediate maxillary or mandibular denture. D5130, D5140 reimbursed on the same date of service as the extraction of all remaining teeth.Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5140	immediate denture - mandibular	0-20		Yes	No	One of (D5120, D5140) per 60 Month(s) Per patient. Reimbursement made upon delivery (completion) of immediate maxillary or mandibular denture. D5130, D5140 reimbursed on the same date of service as the extraction of all remaining teeth.Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5211	maxillary partial denture, resin base (including retentive/clasping materials, rests, and teeth)	0-20		Yes	No	One of (D5211, D5213, D5221, D5223) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan

Exhibit D Benefits Covered for CareSource Marketplace Child (KY)

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D5212	mandibular partial denture, resin base (including retentive/clasping materials, rests, and teeth)	0-20		Yes	No	One of (D5212, D5214, D5222, D5224) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5213	maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	0-20		Yes	No	One of (D5211, D5213, D5221, D5223) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5214	mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	0-20		Yes	No	One of (D5212, D5214, D5222, D5224) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5221	immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	0-20		Yes	No	One of (D5211, D5213, D5221, D5223) per 60 Month(s) Per patient. Reimbursement made upon delivery (completion) of immediate maxillary or mandibular partial denture. Reimbursed on the same date of service as the extraction of all remaining teeth.Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5222	immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	0-20		Yes	No	One of (D5212, D5214, D5222, D5224) per 60 Month(s) Per patient. Reimbursement made upon delivery (completion) of immediate maxillary or mandibular partial denture. Reimbursed on the same date of service as the extraction of all remaining teeth.Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D5223	immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	0-20		Yes	No	One of (D5211, D5213, D5221, D5223) per 60 Month(s) Per patient. Reimbursement made upon delivery (completion) of immediate maxillary or mandibular partial denture. Reimbursed on the same date of service as the extraction of all remaining teeth.Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5224	immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	0-20		Yes	No	One of (D5212, D5214, D5222, D5224) per 60 Month(s) Per patient. Reimbursement made upon delivery (completion) of immediate maxillary or mandibular partial denture. Reimbursed on the same date of service as the extraction of all remaining teeth.Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5282	Removable unilateral partial denture--one piececast metal (including clasps and teeth), maxillary	16 - 20		Yes	No	One of (D5282) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5283	Removable unilateral partial denture--one piececast metal (including clasps and teeth), mandibular	16 - 20		Yes	No	One of (D5283) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5410	adjust complete denture - maxillary	0-20		No	No	Not covered within 6 months of initial placement.	
D5411	adjust complete denture - mandibular	0-20		No	No	Not covered within 6 months of initial placement.	
D5421	adjust partial denture-maxillary	0-20		No	No	Not covered within 6 months of initial placement.	
D5422	adjust partial denture - mandibular	0-20		No	No	Not covered within 6 months of initial placement.	

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D5511	repair broken complete denture base, mandibular	0-20		No	No	One of (D5511) per 6 Month(s) Per patient. Limited to repairs or adjustments performed more than 12 months after the initial insertion.	
D5512	repair broken complete denture base, maxillary	0-20		No	No	One of (D5512) per 6 Month(s) Per patient. Limited to repairs or adjustments performed more than 12 months after the initial insertion.	
D5520	replace missing or broken teeth - complete denture (each tooth)	0-20	Teeth 1 - 32	No	No	Not covered within 6 months of initial placement.	
D5611	repair resin partial denture base, mandibular	0-20		No	No	One of (D5611) per 6 Month(s) Per patient. Limited to repairs or adjustments performed more than 12 months after the initial insertion.	
D5612	repair resin partial denture base, maxillary	0-20		No	No	One of (D5612) per 6 Month(s) Per patient. Limited to repairs or adjustments performed more than 12 months after the initial insertion.	
D5621	repair cast partial framework, mandibular	0-20		No	No	One of (D5621) per 6 Month(s) Per patient. Limited to repairs or adjustments performed more than 12 months after the initial insertion.	
D5622	repair cast partial framework, maxillary	0-20		No	No	One of (D5622) per 6 Month(s) Per patient. Limited to repairs or adjustments performed more than 12 months after the initial insertion.	
D5630	repair or replace broken retentive/clasping materials per tooth	0-20	Teeth 1 - 32	No	No	Not covered within 6 months of initial placement.	
D5640	replace broken teeth-per tooth	0-20	Teeth 1 - 32	No	No	Not covered within 6 months of initial placement.	

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D5650	add tooth to existing partial denture	0-20	Teeth 1 - 32	No	No		
D5660	add clasp to existing partial denture	0-20	Teeth 1 - 32	No	No		
D5710	rebase complete maxillary denture	0-20		No	No	One of (D5710) per 12 Month(s) Per patient. 6 months after initial installation	
D5711	rebase complete mandibular denture	0-20		No	No	One of (D5711) per 12 Month(s) Per patient. 6 months after initial installation	
D5720	rebase maxillary partial denture	0-20		No	No	One of (D5720) per 12 Month(s) Per patient. 6 months after initial installation	
D5721	rebase mandibular partial denture	0-20		No	No	One of (D5721) per 12 Month(s) Per patient. 6 months after initial installation	
D5730	reline complete maxillary denture (chairside)	0-20		No	No	One of (D5730) per 12 Month(s) Per patient. 6 months after initial installation	
D5731	reline complete mandibular denture (chairside)	0-20		No	No	One of (D5731) per 12 Month(s) Per patient. 6 months after initial installation	
D5740	reline maxillary partial denture (chairside)	0-20		No	No	One of (D5740) per 12 Month(s) Per patient. 6 months after initial installation	
D5741	reline mandibular partial denture (chairside)	0-20		No	No	One of (D5741) per 12 Month(s) Per patient. 6 months after initial installation	
D5750	reline complete maxillary denture (laboratory)	0-20		No	No	One of (D5750) per 12 Month(s) Per patient. 6 months after initial installation	
D5751	reline complete mandibular denture (laboratory)	0-20		No	No	One of (D5751) per 12 Month(s) Per patient. 6 months after initial installation	
D5760	reline maxillary partial denture (laboratory)	0-20		No	No	One of (D5760) per 12 Month(s) Per patient. 6 months after initial installation	

Exhibit D Benefits Covered for CareSource Marketplace Child (KY)

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D5761	reline mandibular partial denture (laboratory)	0-20		No	No	One of (D5761) per 12 Month(s) Per patient. 6 months after initial installation	
D5850	tissue conditioning, maxillary	0-20		No	No		
D5851	tissue conditioning,mandibular	0-20		No	No		

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Implant Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6010	surgical placement of implant body: endosteal implant	0-20	Teeth 1 - 32	Yes	No	One of (D6010) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6012	surgical placement of interim implant body-endosteal implant	0-20	Teeth 1 - 32	Yes	No	One of (D6012) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6040	surgical placement:eposteal implnt	0-20	Teeth 1 - 32	Yes	No	One of (D6040, D6050) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6050	surgical placement-transosteal implant	0-20	Teeth 1 - 32	Yes	No	One of (D6040, D6050) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6055	connecting bar - implant supported or abutment supported	0-20	Teeth 1 - 32	Yes	No	One of (D6055) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6056	prefabricated abutment	0-20	Teeth 1 - 32	Yes	No	One of (D6056) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6057	custom abutment	0-20	Teeth 1 - 32	Yes	No	One of (D6057) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6058	abutment supported porcelain/ceramic crown	0-20	Teeth 1 - 32	Yes	No	One of (D6058) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6059	abutment supported porcelain fused to metal crown (high noble metal)	0-20	Teeth 1 - 32	Yes	No	One of (D6059) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6060	abutment supported porcelain fused to metal crown (predominantly base metal)	0-20	Teeth 1 - 32	Yes	No	One of (D6060) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6061	abutment supported porcelain fused to metal crown (noble metal)	0-20	Teeth 1 - 32	Yes	No	One of (D6061) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6062	abutment supported cast metal crown (high noble metal)	0-20	Teeth 1 - 32	Yes	No	One of (D6062) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Implant Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6063	abutment supported cast metal crown (predominantly base metal)	0-20	Teeth 1 - 32	Yes	No	One of (D6063) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6064	abutment supported cast metal crown (noble metal)	0-20	Teeth 1 - 32	Yes	No	One of (D6064) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6065	implant supported porcelain/ceramic crown	0-20	Teeth 1 - 32	Yes	No	One of (D6065) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6066	Implant Supported Crown-Porcelain Fused to High Noble Alloys	0-20	Teeth 1 - 32	Yes	No	One of (D6066) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6067	Implant Supported Crown-High Noble Alloys	0-20	Teeth 1 - 32	Yes	No	One of (D6067) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6068	abutment supported retainer for porcelain/ceramic FPD	0-20	Teeth 1 - 32	Yes	No	One of (D6068) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6069	abutment supported retainer for porcelain fused to metal FPD (high noble metal)	0-20	Teeth 1 - 32	Yes	No	One of (D6069) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6070	abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	0-20	Teeth 1 - 32	Yes	No	One of (D6070) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6071	abutment supported retainer for porcelain fused to metal FPD (noble metal)	0-20	Teeth 1 - 32	Yes	No	One of (D6071) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6072	abutment supported retainer for cast metal FPD (high noble metal)	0-20	Teeth 1 - 32	Yes	No	One of (D6072) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6073	abutment supported retainer for cast metal FPD (predominantly base metal)	0-20	Teeth 1 - 32	Yes	No	One of (D6073) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6074	abutment supported retainer for cast metal FPD (noble metal)	0-20	Teeth 1 - 32	Yes	No	One of (D6074) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6075	implant supported retainer for ceramic FPD	0-20	Teeth 1 - 32	Yes	No	One of (D6075) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Implant Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6076	Implant Supported Retainer for FPD-Porcelain Fused to High Noble Alloys	0-20	Teeth 1 - 32	Yes	No	One of (D6076) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6077	Implant Supported Retainer for Metal FPD- High Noble Alloys	0-20	Teeth 1 - 32	Yes	No	One of (D6078) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6080	implant maintenance procedure	0-20	Teeth 1 - 32	Yes	No	One of (D6080) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6081	scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	0-20	Teeth 1 - 32, 51 - 82	Yes	No	One of (D6081) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6082	Implant supported crown-porcelain fused to predominently base alloys	0-20	Teeth 1 - 32	Yes	No	One of (D6082) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6083	Implant supported crown-porcelain fused to noble alloys	0-20	Teeth 1 - 32	Yes	No	One of (D6083) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6084	Implant supported crown-porcelain fused to titanium and titanium alloys	0-20	Teeth 1 - 32	Yes	No	One of (D6084) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6086	Implant supported crown-predominately base alloys	0-20	Teeth 1 - 32	Yes	No	One of (D6086) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6087	Implant supported crown-noble alloys	0-20	Teeth 1 - 32	Yes	No	One of (D6087) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6088	Implant supported crown-titanium and titanium alloys	0-20	Teeth 1 - 32	Yes	No	One of (D6088) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6090	repair implant prosthesis	0-20	Teeth 1 - 32	Yes	No	One of (D6090) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6095	repair implant abutment	0-20	Teeth 1 - 32	Yes	No	One of (D6095) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6097	Abutment supported crown-porcelain fused to titanium and titanium alloys	0-20	Teeth 1 - 32	Yes	No	One of (D6097) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Implant Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6098	Implant supported retainer-porcelain fused to predominately base alloys	0-20	Teeth 1 - 32	Yes	No	One of (D6098) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6099	Implant supported retainer for FPD- porcelain fused to noble alloys	0-20	Teeth 1 - 32	Yes	No	One of (D6099) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6100	surgical removal of implant body	0-20	Teeth 1 - 32	Yes	No	One of (D6100) per 60 Month(s) Per patient per tooth. Dental provider who performed the original implant will not be reimbursed for the removal of the implant	pre-operative radiographs and narrative
D6101	debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure	0-20	Teeth 1 - 32, 51 - 82	Yes	No	One of (D6101) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6102	debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure	0-20	Teeth 1 - 32, 51 - 82	Yes	No	One of (D6102) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6103	bone graft for repair of peri-implant defect - does not include flap entry and closure. Placement of a barrier membrane or biologic materials to aid in osseous regeneration are reported separately	0-20	Teeth 1 - 32, 51 - 82	Yes	No	One of (D6103) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6104	Bone graft at time of implant placement	0-20	Teeth 1 - 32, 51 - 82	Yes	No	One of (D6104) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6105	removal of implant body not requiring bone removal nor flap elevation	0-20	Teeth 1 - 32	Yes	Yes	One of (D6105) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Exhibit D Benefits Covered for CareSource Marketplace Child (KY)

Implant Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6110	Implant/abutment supported removable dentur for edentulous arch - maxillary	0-20	Per Arch (01, 02, LA, UA)	Yes	No	One of (D6110) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6111	Implant/abutment supported removable dentur for edentulous arch - mandibular	0-20	Per Arch (01, 02, LA, UA)	Yes	No	One of (D6111) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary	0-20	Per Arch (01, 02, LA, UA)	Yes	No	One of (D6112) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular	0-20	Per Arch (01, 02, LA, UA)	Yes	No	One of (D6113) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary	0-20	Teeth 1 - 32	Yes	No	One of (D6114) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6115	Implant/abutment supported fixed denture for edentulous arch - mandibular	0-20	Teeth 1 - 32	Yes	No	One of (D6115) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6116	Implant/abutment supported fixed denture for partially edentulous arch - maxillary	0-20	Teeth 1 - 32	Yes	No	One of (D6116) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6117	Implant/abutment supported fixed denture for partially edentulous arch - mandibular	0-20	Teeth 1 - 32	Yes	No	One of (D6117) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6120	Implant supported retainer-porcelain fused to titanium and titanium alloys	0-20	Teeth 1 - 32	Yes	No	One of (D6120) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6121	Implant supported retainer for metal FPD-predominately base alloys	0-20	Teeth 1 - 32	Yes	No	One of (D6121) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6122	Implant supported retainer for metal FPD- noble alloys	0-20	Teeth 1 - 32	Yes	No	One of (D6122) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Exhibit D Benefits Covered for CareSource Marketplace Child (KY)

Implant Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6123	Implant supported retainer for metal FPD- titanium and titanium alloys	0-20	Teeth 1 - 32	Yes	No	One of (D6123) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6190	radiographic/surgical implant index, by report	0-20	Teeth 1 - 32	Yes	No	One of (D6190) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6195	Abutment Supported Retainer- Porcelain fused to titanium and titanium alloys	0-20	Teeth 1 - 32	Yes	No	One of (D6195) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6197	replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	0-20	Teeth 1 - 32	Yes	Yes	One of (D6197) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6210	pontic - cast high noble metal	0-20	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6211	pontic-cast base metal	0-20	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6212	pontic - cast noble metal	0-20	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6214	Pontic - titanium and titanium alloys	0-20	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6240	pontic-porcelain fused-high noble	0-20	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6241	pontic-porcelain fused to base metal	0-20	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6242	pontic-porcelain fused-noble metal	0-20	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6243	Pontic - Porcelain fused to titanium and titanium alloys	0-20	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6245	prosthodontics fixed, pontic - porcelain/ceramic	0-20	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6545	retainer - cast metal fixed	0-20	Teeth 1 - 32	Yes	No	One of (D6545, D6548, D6549) per 60 Month(s) Per patient per tooth.	photos, xrays, treatment plan
D6548	prosthodontics fixed, retainer - porcelain/ceramic for resin bonded fixed prosthodontic	0-20	Teeth 1 - 32	Yes	No	One of (D6545, D6548, D6549) per 60 Month(s) Per patient per tooth.	photos, xrays, treatment plan
D6549	Resin retainer-For resin bonded fixed prosthesis	0-20	Teeth 1 - 32	Yes	No	One of (D6545, D6548, D6549) per 60 Month(s) Per patient per tooth.	photos, xrays, treatment plan
D6600	inlay - porcelain/ceramic, two surfaces	0-20	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	photos, xrays, treatment plan
D6601	inlay - porcelain/ceramic, three or more surfaces	0-20	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	photos, xrays, treatment plan

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6602	inlay - cast high noble metal, two surfaces	0-20	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	photos, xrays, treatment plan
D6603	inlay - cast high noble metal, three or more surfaces	0-20	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	photos, xrays, treatment plan
D6604	inlay - cast predominantly base metal, two surfaces	0-20	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6605	inlay - cast predominantly base metal, three or more surfaces	0-20	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6606	inlay - cast noble metal, two surfaces	0-20	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6607	inlay - cast noble metal, three or more surfaces	0-20	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6608	onlay - porcelain/ceramic, two surfaces	0-20	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6609	onlay - porcelain/ceramic, three or more surfaces	0-20	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6610	onlay - cast high noble metal, two surfaces	0-20	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6611	onlay - cast high noble metal, three or more surfaces	0-20	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6612	onlay - cast predominantly base metal, two surfaces	0-20	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6613	onlay - cast predominantly base metal, three or more surfaces	0-20	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6614	onlay - cast noble metal, two surfaces	0-20	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6615	onlay - cast noble metal, three or more surfaces	0-20	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6624	inlay - titanium	0-20	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6634	onlay - titanium	0-20	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6740	retainer crown, porcelain/ceramic	0-20	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6750	crown-porcelain fused high noble	0-20	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6751	crown-porcelain fused to base metal	0-20	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6752	crown-porcelain fused noble metal	0-20	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6753	Retainer Crown- Porcelain fused to titanium and titanium alloys	0-20	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6780	crown-3/4 cst high noble metal	0-20	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6781	prosthodontics fixed, crown ¾ cast predominantly based metal	0-20	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6782	prosthodontics fixed, crown ¾ cast noble metal	0-20	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6783	prosthodontics fixed, crown ¾ porcelain/ceramic	0-20	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6784	Retainer Crown 3/4- Titanium and Titanium Alloys	0-20	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6790	crown-full cast high noble	0-20	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6791	crown - full cast base metal	0-20	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6792	crown - full cast noble metal	0-20	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6794	Retainer crown - titanium and titanium alloys	0-20	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Exhibit D Benefits Covered for CareSource Marketplace Child (KY)

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6930	re-cement or re-bond fixed partial denture	0-20		Yes	No	Not covered within 6 months of placement.	pre-operative radiographs and narrative
D6980	fixed partial denture repair	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No		pre-operative radiographs and narrative

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Oral and Maxillofacial Surgery							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D7111	extraction, coronal remnants - primary tooth	0-20	Teeth A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No		
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No		
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No	Includes cutting of gingiva and bone, removal of tooth structure and closure. Subject to Post Review.	
D7220	removal of impacted tooth-soft tissue	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	No		Pre-operative radiographs and operative report
D7230	removal of impacted tooth-partially bony	0-20	Teeth 1 - 32, 51 - 82	Yes	No		Pre-operative radiographs and operative report
D7240	removal of impacted tooth-completely bony	0-20	Teeth 1 - 32, 51 - 82	Yes	No		Pre-operative radiographs and operative report
D7241	removal of impacted tooth-completely bony, with unusual surgical complications	0-20	Teeth 1 - 32, 51 - 82	Yes	No		Pre-operative radiographs and operative report
D7250	surgical removal of residual tooth roots (cutting procedure)	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	No		Pre-operative radiographs and operative report
D7251	Coronectomy – intentional partial tooth removal, impacted teeth only	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	No		Pre-operative radiographs and operative report

Exhibit D Benefits Covered for CareSource Marketplace Child (KY)

Oral and Maxillofacial Surgery							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	0-20	Teeth 1 - 32	Yes	No	Includes splinting and/or stabilization.	Pre-operative radiographs and operative report
D7280	Surgical access of an unerupted tooth	0-20	Teeth 1 - 32	Yes	No		Pre-operative radiographs and operative report
D7283	placement of device to facilitate eruption of impacted tooth	0-20	Teeth 1 - 32	No	No	One of (D7283) per 1 Lifetime Per patient per tooth. Has to be submitted in combination with D7280; Report the surgical exposure separately using D7280	
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D7310) per 1 Lifetime Per patient per quadrant. Minimum of four extractions in the affected quadrant. Covered only in conjunction with the construction of a prosthodontic appliance.	Pre-operative radiographs and operative report
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D7311) per 1 Lifetime Per patient per quadrant. Minimum of four extractions in the affected quadrant. Covered only in conjunction with the construction of a prosthodontic appliance.	Pre-operative radiographs and operative report
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D7320) per 1 Lifetime Per patient per quadrant. Minimum of four extractions in the affected quadrant. Covered only in conjunction with the construction of a prosthodontic appliance.	Pre-operative radiographs and operative report
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D7321) per 1 Lifetime Per patient per quadrant. Minimum of four extractions in the affected quadrant. Covered only in conjunction with the construction of a prosthodontic appliance.	pre-operative radiographs

Exhibit D Benefits Covered for CareSource Marketplace Child (KY)

Oral and Maxillofacial Surgery							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D7471	removal of exostosis - per site	0-20	Per Arch (01, 02, LA, UA)	Yes	No		pre-operative radiographs
D7510	incision and drainage of abscess - intraoral soft tissue	0-20	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No	Subject to Post Review.	
D7520	incision and drainage of abscess - extraoral soft tissue	0-20		No	No	Subject to Post Review.	
D7910	suture small wounds up to 5 cm	0-20		No	No	Subject to Post Review.	
D7953	bone replacement graft for ridge preservation - per site	0-20	Teeth 1 - 32	Yes	No	One of (D7953) per 1 Lifetime Per patient.	Narrative of medical necessity and photos
D7961	buccal / labial frenectomy (frenulectomy)	0-20		Yes	No		Narrative of medical necessity and photos
D7962	lingual frenectomy (frenulectomy)	0-20		Yes	No		Narrative of medical necessity and photos
D7970	excision of hyperplastic tissue - per arch	0-20	Per Arch (01, 02, LA, UA)	Yes	No	One of (D7970) per 1 Lifetime Per patient.	Narrative of medical necessity and photos
D7971	excision of pericoronal gingiva	0-20	Teeth 1 - 32	Yes	No		Narrative of medical necessity and photos

Exhibit D Benefits Covered for CareSource Marketplace Child (KY)

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Orthodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D8010	limited orthodontic treatment of the primary dentition	0-20		Yes	No	One of (D8010, D8020, D8030, D8040, D8070, D8080, D8090) per 1 Lifetime Per patient.	Study model or OrthoCad, x-rays
D8020	limited orthodontic treatment of the transitional dentition	0-20		Yes	No	One of (D8010, D8020, D8030, D8040, D8070, D8080, D8090) per 1 Lifetime Per patient.	Study model or OrthoCad, x-rays
D8030	limited orthodontic treatment of the adolescent dentition	0-20		Yes	No	One of (D8010, D8020, D8030, D8040, D8070, D8080, D8090) per 1 Lifetime Per patient.	Study model or OrthoCad, x-rays
D8040	limited orthodontic treatment of the adult dentition	0-20		Yes	No	One of (D8010, D8020, D8030, D8040, D8070, D8080, D8090) per 1 Lifetime Per patient.	Study model or OrthoCad, x-rays
D8070	comprehensive orthodontic treatment of the transitional dentition	0-20		Yes	No	One of (D8010, D8020, D8030, D8040, D8070, D8080, D8090) per 1 Lifetime Per patient.	Study model or OrthoCad, x-rays
D8080	comprehensive orthodontic treatment of the adolescent dentition	0-20		Yes	No	One of (D8010, D8020, D8030, D8040, D8070, D8080, D8090) per 1 Lifetime Per patient.	Study model or OrthoCad, x-rays
D8090	comprehensive orthodontic treatment of the adult dentition	0-20		Yes	No	One of (D8010, D8020, D8030, D8040, D8070, D8080, D8090) per 1 Lifetime Per patient.	Study model or OrthoCad, x-rays
D8210	removable appliance therapy (includes appliances for thumb sucking and tongue thrusting)	0-20		Yes	No	One of (D8210, D8220) per 1 Lifetime Per patient. Includes appliances for thumb sucking and tongue thrusting	Study model or OrthoCad, x-rays
D8220	fixed appliance therapy (includes appliances for thumb sucking and tongue thrusting)	0-20		Yes	No	One of (D8210, D8220) per 1 Lifetime Per patient. Includes appliances for thumb sucking and tongue thrusting	Study model or OrthoCad, x-rays

Exhibit D Benefits Covered for CareSource Marketplace Child (KY)

Orthodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D8660	pre-orthodontic treatment examination to monitor growth and development	0-20		No	No	One of (D8660) per 1 Lifetime Per patient. Used for records (i.e. models, photos and pre-orthodontic work –up). Reimbursed even if orthodontic case is not approved Prior Authorization not required when submitted with requests for (D8010-D8220)	
D8670	periodic orthodontic treatment visit	0-20		Yes	No	One of (D8670) per 1 Lifetime Per patient. D8670 reimbursed in combination with active therapy and as part of complete ortho contract per case.	Study model or OrthoCad, x-rays
D8680	orthodontic retention (removal of appliances)	0-20		Yes	No	One of (D8680) per 1 Lifetime Per patient.	photos, xrays, treatment plan
D8698	Recement or rebond fixed retainer - maxillary	0-20		No	No	One of (D8698) per 1 Lifetime Per patient. Subject to Post Review.	
D8699	Recement or rebond fixed retainer - mandibular	0-20		No	No	One of (D8699) per 1 Lifetime Per patient. Subject to Post Review.	

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Adjunctive General Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D9110	palliative treatment of dental pain - per visit	0-20		No	No	One of (D9110) per 1 Day(s) Per patient.	
D9222	deep sedation/general anesthesia first 15 minutes	0-20		Yes	No	One of (D9222) per 1 Day(s) Per patient. Ten of (D9222, D9223) per 1 Calendar year(s) Per patient. Not allowed on same date as D9222, D9223, and D9230.Sedation approvals are limited to surgical and extensive cases	narr. of med. necessity, pre-op x-ray(s)
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	0-20		Yes	No	Four of (D9223) per 1 Day(s) Per patient. Ten of (D9222, D9223) per 1 Calendar year(s) Per patient. Not allowed on same date as D9239, D9243, and D9230. Sedation approvals are limited to surgical and extensive cases	narr. of med. necessity, pre-op x-ray(s)
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	0-7		No	No	One of (D9230) per 1 Day(s) Per patient. Three of (D9230) per 1 Calendar year(s) Per patient. Subject to Post Review.	
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	0-20		Yes	No	One of (D9239) per 1 Day(s) Per patient. Ten of (D9239, D9243) per 1 Calendar year(s) Per patient. Not allowed on same date as D9222, D9223, and D9230. Sedation approvals are limited to surgical and extensive cases	narr. of med. necessity, pre-op x-ray(s)
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	0-20		Yes	No	Four of (D9243) per 1 Day(s) Per patient. Ten of (D9239, D9243) per 1 Calendar year(s) Per patient. Not allowed on same date as D9222, D9223, and D9230. Sedation approvals are limited to surgical and extensive cases	narr. of med. necessity, pre-op x-ray(s)

Exhibit D Benefits Covered for CareSource Marketplace Child (KY)

Adjunctive General Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	0-20		No	No	One of (D9310) per 1 Day(s) Per patient. Includes consultation with medical professional (D9310 used in lieu of D9311)	
D9311	consultation with medical health care professional	0-20		No	No	One of (D9311) per 1 Day(s) Per patient. This should be used only for extensive consultation with medical professional regarding patient's medical issues.	
D9610	therapeutic drug injection, by report	0-20		Yes	No	One of (D9610) per 1 Day(s) Per patient. Description and dosage of drug.	narrative of medical necessity
D9930	treatment of complications (post-surgical) - unusual circumstances, by report	0-20		Yes	No		narrative of medical necessity
D9943	occlusal guard adjustment	0-20		No	No	One of (D9943) per 24 Month(s) Per patient.	
D9944	occlusal guard--hard appliance, full arch	13-19	Per Arch (01, 02, LA, UA)	Yes	No	One of (D9944, D9945, D9946) per 12 Month(s) Per patient.	narrative of medical necessity
D9945	occlusal guard--soft appliance full arch	13-19	Per Arch (01, 02, LA, UA)	Yes	No	One of (D9944, D9945, D9946) per 12 Month(s) Per patient.	narrative of medical necessity
D9946	occlusal guard--hard appliance, partial arch	13-19	Per Arch (01, 02, LA, UA)	Yes	No	One of (D9944, D9945, D9946) per 12 Month(s) Per patient.	narrative of medical necessity

Exhibit D Benefits Covered for CareSource Marketplace Child (KY)

Adjunctive General Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D9995	teledentistry – synchronous; real-time encounter	0-20		No	No	Four of (D9995) per 1 Calendar year(s) Per patient. The appropriate teledentistry code (D9995 or D9996) should be reported as descriptor codes to identify services (D0140, D0145) provided via teledentistry by the dentist who provided the oversight of the teledentistry encounter as allowed and in accordance with any applicable state laws and/or: regulations, licensure, state dental practice acts. A teledentistry event is subject to applicable state law, regulation or licensure. D9995 & D9996 do not have separate distinct benefit limits, however, any benefit limits applicable to the underlying services rendered would continue to apply.	

Exhibit D Benefits Covered for CareSource Marketplace Child (KY)

Adjunctive General Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D9996	teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	0-20		No	No	Four of (D9996) per 1 Calendar year(s) Per patient. The appropriate teledentistry code (D9995 or D9996) should be reported as descriptor codes to identify services (D0140, D0145) provided via teledentistry by the dentist who provided the oversight of the teledentistry encounter as allowed and in accordance with any applicable state laws and/or: regulations, licensure, state dental practice acts. A teledentistry event is subject to applicable state law, regulation or licensure. D9995 & D9996 do not have separate distinct benefit limits, however, any benefit limits applicable to the underlying services rendered would continue to apply.	

Exhibit E Benefits Covered for CareSource Marketplace IN, NC, OH, WV Adult

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0120	periodic oral evaluation - established patient	19 and older		No	No	Two of (D0120, D0140, D0150, D0180) per 1 Calendar year(s) Per patient. D0120 periodic oral evaluation may not occur in combination with D0150 on same date of service and not until 180 days after the D0150 comprehensive oral evaluation.	
D0140	limited oral evaluation-problem focused	19 and older		No	No	Two of (D0120, D0140, D0150, D0180) per 1 Calendar year(s) Per patient. Note- This procedure code is used for emergency examinations during regularly scheduled office hours. Evaluations solely for the purpose of adjustments or in conjunction with multi-visit procedures are not covered (i.e. endodontics and orthodontia). May not be used in conjunction with D0120, D0150, D9440, and D0180	
D0150	comprehensive oral evaluation - new or established patient	19 and older		No	No	Two of (D0120, D0140, D0150, D0180) per 1 Calendar year(s) Per patient. One of (D0150) per 24 Month(s) Per Provider OR Location. D0150 used when evaluating a patient comprehensively. D0150 or the periodic exam D0120 may not occur in conjunction with a limited oral evaluation (examination during office hours- D0140 or after office hours- D9440)	

Exhibit E Benefits Covered for
CareSource Marketplace IN, NC, OH, WV Adult

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0180	comprehensive periodontal evaluation - new or established patient	19 and older		No	No	Two of (D0120, D0140, D0150, D0180) per 1 Calendar year(s) Per patient. One of (D0180) per 24 Month(s) Per Provider OR Location. Reimbursement disallowed for D0180 performed in conjunction with either a D0150 or D0120.	
D0210	intraoral - comprehensive series of radiographic images	19 and older		No	No	One of (D0210, D0330) per 60 Month(s) Per patient. Indicated for the permanent dentition or Adult dentate. A full-mouth series consist of a minimum of fourteen (14) films, including all periapical and posterior bitewing films intended to display the crowns and roots of all teeth, periapical areas and alveolar bone necessary for examination and diagnosis. PA required if done more frequently than 60 months	

Exhibit E Benefits Covered for CareSource Marketplace IN, NC, OH, WV Adult

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0220	intraoral - periapical first radiographic image	19 and older		No	No	One of (D0220) per 1 Day(s) Per patient. Any additional periapical films (D0230 should be used) If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series. Periapical radiographs are used diagnostically and are not reimbursable when used intraoperatively (i.e. during RCT or other procedural x-rays.	

Exhibit E Benefits Covered for
CareSource Marketplace IN, NC, OH, WV Adult

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0230	intraoral - periapical each additional radiographic image	19 and older		No	No	Any additional periapical films (D0230 should be used) If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series. Periapical radiographs are used diagnostically and are not reimbursable when used intraoperatively (i.e. during RCT or other procedural x-rays.	

Exhibit E Benefits Covered for CareSource Marketplace IN, NC, OH, WV Adult

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0240	intraoral - occlusal radiographic image	19 and older		No	No	Any additional periapical films (D0230 should be used) If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series. Periapical radiographs are used diagnostically and are not reimbursable when used intraoperatively (i.e. during RCT or other procedural x-rays.	
D0250	extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	19 and older		No	No		

Exhibit E Benefits Covered for CareSource Marketplace IN, NC, OH, WV Adult

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0270	bitewing - single radiographic image	19 and older		No	No	A total of four horizontal bitewing films in any combination of (D0270, D0272, D0273 or D0274) per 6 Month(s) “Or” One set of vertical bitewings (D0277) per 6 Month(s) See fee limitations for all radiographs. If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series.	

Exhibit E Benefits Covered for CareSource Marketplace IN, NC, OH, WV Adult

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0272	bitewings - two radiographic images	19 and older		No	No	A total of four horizontal bitewing films in any combination of (D0270, D0272, D0273 or D0274) per 6 Month(s) “Or” One set of vertical bitewings (D0277) per 6 Month(s) See fee limitations for all radiographs. If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series.	

Exhibit E Benefits Covered for CareSource Marketplace IN, NC, OH, WV Adult

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0273	bitewings - three radiographic images	19 and older		No	No	A total of four horizontal bitewing films in any combination of (D0270, D0272, D0273 or D0274) per 6 Month(s) “Or” One set of vertical bitewings (D0277) per 6 Month(s) See fee limitations for all radiographs. If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series.	

Exhibit E Benefits Covered for
CareSource Marketplace IN, NC, OH, WV Adult

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0274	bitewings - four radiographic images	19 and older		No	No	One of (D0274, D0277) per 6 Month(s) Per patient. A total of four horizontal bitewing films in any combination of (D0270, D0272, D0273 or D0274) per 6 Month(s) “Or” One set of vertical bitewings (D0277) per 6 Month(s) See fee limitations for all radiographs. If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series.	

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0277	vertical bitewings - 7 to 8 films	19 and older		No	No	One of (D0274, D0277) per 6 Month(s) Per patient. A total of four horizontal bitewing films in any combination of (D0270, D0272, D0273 or D0274) per 6 Month(s) “Or” One set of vertical bitewings (D0277) per 6 Month(s) See fee limitations for all radiographs. If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series.	
D0330	panoramic radiographic image	19 and older		No	No	One of (D0210, D0330) per 60 Month(s) Per patient. All periapical or occlusal films taken same date of service needed to render the necessary radiographic diagnosis are included in the fee for panoramic radiograph. If bitewing radiographs D0270, D0272 or D0274 are indicated for additional diagnosis, the amount reimbursed will not exceed the reimbursable amount for D0210 Full Mouth Series. PA required if done more frequently than 60 months.	

Exhibit E Benefits Covered for CareSource Marketplace IN, NC, OH, WV Adult

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0372	intraoral tomosynthesis – comprehensive series of radiographic images	19 and older		No	No	One of (D0210, D0277, D0330, D0372, D0387, D0701, D0709) per 1 Calendar year(s) Per patient.	
D0373	intraoral tomosynthesis – bitewing radiographic image	19 and older		No	No	One of (D0270, D0272, D0273, D0274, D0277, D0373, D0388, D0708) per 1 Calendar year(s) Per patient.	
D0374	intraoral tomosynthesis – periapical radiographic image	19 and older		No	No	One of (D0220, D0230, D0374, D0389, D0707) per 1 Calendar year(s) Per patient.	
D0387	intraoral tomosynthesis – comprehensive series of radiographic images – image capture only	19 and older		No	No	One of (D0210, D0277, D0330, D0372, D0387, D0701, D0709) per 1 Calendar year(s) Per patient.	
D0388	intraoral tomosynthesis – bitewing radiographic image – image capture only	19 and older		No	No	One of (D0220, D0230, D0374, D0389, D0707) per 1 Calendar year(s) Per patient.	
D0389	intraoral tomosynthesis – periapical radiographic image – image capture only	19 and older		No	No	One of (D0220, D0230, D0374, D0389, D0707) per 1 Calendar year(s) Per patient.	
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report	19 and older		No	No	One of (D0391) per 1 Day(s) Per Provider OR Location. Interpretation of diagnostic image and report by a Practitioner not associated with Image Capture. Report should be kept in patient record for post payment review as applicable.	

Exhibit E Benefits Covered for CareSource Marketplace IN, NC, OH, WV Adult

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0470	diagnostic casts	19 and older		No	No	One of (D0470) per 1 Day(s) Per Provider OR Location. One per case. Diagnostic models or study models used as a guide in the application of corrective or restorative dentistry. Payable as a diagnostic service intended for the documentation and subsequent analysis of occlusion.	

Exhibit E Benefits Covered for
CareSource Marketplace IN, NC, OH, WV Adult

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D1110	prophylaxis - adult	19 and older		No	No	Two of (D1110) per 1 Calendar year(s) Per patient. This service code used for permanent dentition. One (1) additional for Covered Persons under the care of a medical professional during pregnancy	

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2140	Amalgam - one surface, primary or permanent	19 and older	Teeth 1 - 32	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	
D2150	Amalgam - two surfaces, primary or permanent	19 and older	Teeth 1 - 32	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	

Exhibit E Benefits Covered for CareSource Marketplace IN, NC, OH, WV Adult

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2160	amalgam - three surfaces, primary or permanent	19 and older	Teeth 1 - 32	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	
D2161	amalgam - four or more surfaces, primary or permanent	19 and older	Teeth 1 - 32	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	

Exhibit E Benefits Covered for CareSource Marketplace IN, NC, OH, WV Adult

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2330	resin-based composite - one surface, anterior	19 and older	Teeth 6 - 11, 22 - 27	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. The fee for resin-based composite restorations will include any necessary acid etching and bonding agents. Non-contiguous restorations, such as a separate Distal Facial (DF) and Mesial Facial (MF) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	
D2331	resin-based composite - two surfaces, anterior	19 and older	Teeth 6 - 11, 22 - 27	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. The fee for resin-based composite restorations will include any necessary acid etching and bonding agents. Non-contiguous restorations, such as a separate Distal Facial (DF) and Mesial Facial (MF) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	

Exhibit E Benefits Covered for CareSource Marketplace IN, NC, OH, WV Adult

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2332	resin-based composite - three surfaces, anterior	19 and older	Teeth 6 - 11, 22 - 27	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. The fee for resin-based composite restorations will include any necessary acid etching and bonding agents. Non-contiguous restorations, such as a separate Distal Facial (DF) and Mesial Facial (MF) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	19 and older	Teeth 6 - 11, 22 - 27	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. The fee for resin-based composite restorations will include any necessary acid etching and bonding agents. Non-contiguous restorations, such as a separate Distal Facial (DF) and Mesial Facial (MF) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	

Exhibit E Benefits Covered for
CareSource Marketplace IN, NC, OH, WV Adult

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2391	resin-based composite - one surface, posterior	19 and older	Teeth 1 - 5, 12 - 21, 28 - 32	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. CareSource will reimburse based on Amalgam for posterior teeth.D2391 Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	
D2392	resin-based composite - two surfaces, posterior	19 and older	Teeth 1 - 5, 12 - 21, 28 - 32	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. CareSource will reimburse based on Amalgam for posterior teeth.D2391 Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2393	resin-based composite - three surfaces, posterior	19 and older	Teeth 1 - 5, 12 - 21, 28 - 32	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. CareSource will reimburse based on Amalgam for posterior teeth.D2391 Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	
D2394	resin-based composite - four or more surfaces, posterior	19 and older	Teeth 1 - 5, 12 - 21, 28 - 32	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. CareSource will reimburse based on Amalgam for posterior teeth.D2391 Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	

Exhibit E Benefits Covered for CareSource Marketplace IN, NC, OH, WV Adult

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2510	inlay - metallic -1 surface	19 and older	Teeth 1 - 32	No	No	One of (D2510) per 60 Month(s) Per patient per tooth. Covered only when a direct restoration (ie. amalgam, composite) will not adequately restore the tooth.	
D2520	inlay-metallic-2 surfaces	19 and older	Teeth 1 - 32	No	No	One of (D2520) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors. Covered only when a direct restoration (ie. amalgam, composite) will not adequately restore the tooth.	
D2530	inlay-metallic-3+ surfaces	19 and older	Teeth 1 - 32	No	No	One of (D2530) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors. Covered only when a direct restoration (ie. amalgam, composite) will not adequately restore the tooth.	
D2542	onlay - metallic - two surfaces	19 and older	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs

Exhibit E Benefits Covered for
CareSource Marketplace IN, NC, OH, WV Adult

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2543	onlay-metallic-3 surfaces	19 and older	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2544	onlay-metallic-4+ surfaces	19 and older	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2740	crown - porcelain/ceramic	19 and older	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2750	crown - porcelain fused to high noble metal	19 and older	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs

Exhibit E Benefits Covered for
CareSource Marketplace IN, NC, OH, WV Adult

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2751	crown - porcelain fused to predominantly base metal	19 and older	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2752	crown - porcelain fused to noble metal	19 and older	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2780	crown - ¾ cast high noble metal	19 and older	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2781	crown - ¾ cast predominantly base metal	19 and older	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs

Exhibit E Benefits Covered for CareSource Marketplace IN, NC, OH, WV Adult

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2782	crown - ¾ cast noble metal	19 and older	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2783	crown - ¾ porcelain/ceramic	19 and older	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2790	crown - full cast high noble metal	19 and older	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2791	crown - full cast predominantly base metal	19 and older	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2792	crown - full cast noble metal	19 and older	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2794	Crown- Titanium and Titanium Alloys	19 and older	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	19 and older	Teeth 1 - 32	No	No	Not covered within 6 months of initial placement.	
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core	19 and older	Teeth 1 - 32	No	No	Not covered within 6 months of initial placement.	
D2920	re-cement or re-bond crown	19 and older	Teeth 1 - 32, A - T	No	No	Not covered within 6 months of initial placement.	
D2940	protective restoration	19 and older	Teeth 1 - 32	No	No	One of (D2940) per 1 Calendar year(s) Per patient per tooth. Restorative material to protect tooth and/or tissue form. Used to relieve pain, promote healing, and prevent further deterioration. Not reimbursable when used as endodontic access closure, or as a base or liner under restoration.	
D2950	core buildup, including any pins when required	19 and older	Teeth 1 - 32	Yes	No	One of (D2950) per 60 Month(s) Per patient per tooth.	pre-operative radiographs

Exhibit E Benefits Covered for CareSource Marketplace IN, NC, OH, WV Adult

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2951	pin retention - per tooth, in addition to restoration	19 and older	Teeth 1 - 32	No	No	Three of (D2951) per 1 Lifetime Per patient per tooth.	
D2952	cast post and core in addition to crown	19 and older	Teeth 1 - 32	Yes	No	One of (D2952, D2954) per 60 Month(s) Per patient per tooth.	pre-operative radiographs
D2953	each additional cast post - same tooth	19 and older	Teeth 1 - 32	Yes	No	One of (D2953) per 60 Month(s) Per patient per tooth.	pre-operative radiographs
D2954	prefabricated post and core in addition to crown	19 and older	Teeth 1 - 32	Yes	No	One of (D2952, D2954) per 60 Month(s) Per patient per tooth.	pre-operative radiographs
D2957	each additional prefabricated post - same tooth	19 and older	Teeth 1 - 32	Yes	No	One of (D2957) per 60 Month(s) Per patient per tooth.	pre-operative radiographs
D2980	crown repair, by report	19 and older	Teeth 1 - 32	Yes	No	One of (D2980) per 60 Month(s) Per patient per tooth.	Narr / Oper Rpt
D2981	Inlay repair necessitated by restorative material failure	19 and older	Teeth 1 - 32, 51 - 82	Yes	No	One of (D2981) per 60 Month(s) Per patient per tooth.	Narr / Oper Rpt
D2982	Onlay repair necessitated by restorative material failure	19 and older	Teeth 1 - 32, 51 - 82	Yes	No	One of (D2982) per 60 Month(s) Per patient per tooth.	Narr / Oper Rpt
D2983	Veneer repair necessitated by restorative material failure	19 and older	Teeth 1 - 32, 51 - 82	Yes	No	One of (D2983) per 60 Month(s) Per patient per tooth.	Narr / Oper Rpt

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Endodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	19 and older	Teeth 1 - 32, A - T	No	No	One of (D3220) per 1 Lifetime Per patient per tooth. If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately. (only when there is no successor)	
D3221	pulpal debridement, primary and permanent teeth	19 and older	Teeth 1 - 32, A - T	No	No	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately. (only when there is no successor)	
D3222	partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	19 and older	Teeth 1 - 32	No	No	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.	

Endodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D3310	endodontic therapy, anterior tooth (excluding final restoration)	19 and older	Teeth 6 - 11, 22 - 27	No	No	One of (D3310) per 1 Lifetime Per patient per tooth. 1)Once per tooth per lifetime except for exception cases of appropriate medical necessity.2)The date the RCT is completed should be the date of service.3)Reimbursement for a root canal includes opening and drainage, treatment planning, clinical procedures, follow-up care, radiographs during treatment, and post-operative radiographs. 4)D3310,D3320,D3330 are subject to Post Review Third molar wisdom teeth will only be considered for coverage when tooth is functional.	
D3320	endodontic therapy, premolar tooth (excluding final restoration)	19 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	No	One of (D3320) per 1 Lifetime Per patient per tooth. 1)Once per tooth per lifetime except for exception cases of appropriate medical necessity.2)The date the RCT is completed should be the date of service.3)Reimbursement for a root canal includes opening and drainage, treatment planning, clinical procedures, follow-up care, radiographs during treatment, and post-operative radiographs. 4)D3310,D3320,D3330 are subject to Post Review Third molar wisdom teeth will only be considered for coverage when tooth is functional.	

Exhibit E Benefits Covered for CareSource Marketplace IN, NC, OH, WV Adult

Endodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D3330	endodontic therapy, molar tooth (excluding final restoration)	19 and older	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	No	One of (D3330) per 1 Lifetime Per patient per tooth. 1)Once per tooth per lifetime except for exception cases of appropriate medical necessity.2)The date the RCT is completed should be the date of service.3)Reimbursement for a root canal includes opening and drainage, treatment planning, clinical procedures, follow-up care, radiographs during treatment, and post-operative radiographs. 4)D3310,D3320,D3330 are subject to Post Review Third molar wisdom teeth will only be considered for coverage when tooth is functional.	
D3346	retreatment of previous root canal therapy-anterior	19 and older	Teeth 6 - 11, 22 - 27	No	No	One of (D3346) per 1 Lifetime Per patient per tooth. 1)Dental provider who performed the original root canal should not be reimbursed for the retreatment for the first 12 months 2)D3346, D3347, D3348 are subject to Post Review	
D3347	retreatment of previous root canal therapy - premolar	19 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	No	One of (D3347) per 1 Lifetime Per patient per tooth. 1)Dental provider who performed the original root canal should not be reimbursed for the retreatment for the first 12 months 2)D3346, D3347, D3348 are subject to Post Review	

Endodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D3348	retreatment of previous root canal therapy-molar	19 and older	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	No	One of (D3348) per 1 Lifetime Per patient per tooth. 1)Dental provider who performed the original root canal should not be reimbursed for the retreatment for the first 12 months 2)D3346, D3347, D3348 are subject to Post Review	
D3351	apexification/recalcification - initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	19 and older	Teeth 2 - 16, 18 - 31	Yes	No	One of (D3351) per 1 Lifetime Per patient per tooth. Initial opening, preparation and first placement of medication and necessary radiographs	pre-operative radiographs
D3352	apexification/recalcification - interim medication replacement	19 and older	Teeth 2 - 16, 18 - 31	Yes	No	One of (D3352) per 1 Lifetime Per patient per tooth. For visits in which the intra-canal medication is replaced with new medication, includes any necessary radiographs	pre-operative radiographs
D3353	apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	19 and older	Teeth 1 - 32	Yes	No	One of (D3353) per 1 Lifetime Per patient per tooth. Includes removal of intra-canal medication and procedures necessary to place final root canal filling material, includes necessary radiographs.	pre-operative radiographs
D3355	Pulpal regeneration - initial visit	19 and older	Teeth 1 - 32	No	No	One of (D3355) per 1 Lifetime Per patient per tooth.	
D3356	Pulpal regeneration - interim medication replacement	19 and older	Teeth 1 - 32	No	No	One of (D3356) per 1 Lifetime Per patient per tooth.	
D3357	Pulpal regeneration - completion of treatment	19 and older	Teeth 1 - 32	No	No	One of (D3357) per 1 Lifetime Per patient per tooth. Subject to Post Review	
D3410	apicoectomy - anterior	19 and older	Teeth 6 - 11, 22 - 27	Yes	No	One of (D3410) per 1 Lifetime Per patient per tooth.	pre-operative radiographs
D3421	apicoectomy - premolar (first root)	19 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	No	One of (D3421) per 1 Lifetime Per patient per tooth.	pre-operative radiographs

Exhibit E Benefits Covered for CareSource Marketplace IN, NC, OH, WV Adult

Endodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D3425	apicoectomy - molar (first root)	19 and older	Teeth 2, 3, 14 - 19, 30, 31	Yes	No	One of (D3425) per 1 Lifetime Per patient per tooth.	pre-operative radiographs
D3426	apicoectomy (each additional root)	19 and older	Teeth 2 - 5, 12 - 15, 18 - 21, 28 - 31	Yes	No	One of (D3426) per 1 Lifetime Per patient per tooth.	pre-operative radiographs
D3450	root amputation - per root	19 and older	Teeth 2 - 16, 18 - 31	Yes	No		pre-operative radiographs
D3471	surgical repair of root resorption - anterior	19 and older	Teeth 6 - 11, 22 - 27	Yes	No	One of (D3471) per 1 Lifetime Per patient per tooth.	
D3472	surgical repair of root resorption – premolar	19 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	No	One of (D3472) per 1 Lifetime Per patient per tooth.	
D3473	surgical repair of root resorption – molar	19 and older	Teeth 1 - 3, 14 - 19, 30 - 32	Yes	No	One of (D3473) per 1 Lifetime Per patient per tooth.	
D3501	surgical exposure of root surface without apicoectomy or repair of root resorption – anterior	19 and older	Teeth 6 - 11, 22 - 27	Yes	No	One of (D3501) per 1 Lifetime Per patient per tooth.	
D3502	surgical exposure of root surface without apicoectomy or repair of root resorption – premolar	19 and older	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	No	One of (D3502) per 1 Lifetime Per patient per tooth.	
D3503	surgical exposure of root surface without apicoectomy or repair of root resorption – molar	19 and older	Teeth 1 - 3, 14 - 19, 30 - 32	Yes	No	One of (D3503) per 1 Lifetime Per patient per tooth.	
D3920	hemisection (including any root removal), not incl root canal therapy	19 and older	Teeth 2, 3, 14, 15, 18, 19, 30, 31	Yes	No		pre-operative radiographs

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Periodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	19 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4210, D4211) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	19 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4210, D4211) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	19 and older	Teeth 1 - 32, 51 - 82	Yes	No	One of (D4212) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4240	gingival flap procedure, including root planing – four or more contiguous teeth or tooth bound spaces per quadrant	19 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4240, D4241) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4241	gingival flap procedure, including root planing – one to three contiguous teeth or tooth bound spaces per quadrant	19 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4240, D4241) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4249	clinical crown lengthening - hard tissue	19 and older	Teeth 1 - 32	Yes	No	One of (D4249) per 36 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D4260	osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	19 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4260, D4261) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4261	osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	19 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4260, D4261) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting

Exhibit E Benefits Covered for
CareSource Marketplace IN, NC, OH, WV Adult

Periodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D4270	pedicle soft tissue graft procedure	19 and older	Teeth 1 - 32	Yes	No	One of (D4270) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4273	subepithelial connective tissue graft procedure	19 and older	Teeth 1 - 32	Yes	No	One of (D4273) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	19 and older	Teeth 1 - 32, 51 - 82	Yes	No		pre-op x-ray(s), perio charting
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	19 and older	Teeth 1 - 32, 51 - 82	Yes	No	One of (D4278) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4341	periodontal scaling and root planing - four or more teeth per quadrant	19 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. A minimum of four affected teeth in the quadrant.	pre-op x-ray(s), perio charting
D4342	periodontal scaling and root planing - one to three teeth per quadrant	19 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. One to three affected teeth in the quadrant.	pre-op x-ray(s), perio charting
D4355	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	19 and older		No	No	One of (D4355) per 1 Lifetime Per patient. Subject to Post Review	
D4910	periodontal maintenance procedures	19 and older		No	No	Four of (D1110, D4910) per 12 Month(s) Per patient. D4341 or D4342 must be on file for claims or documentation from patient record history of periodontal therapy within the last 6 months.	

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D5110	complete denture - maxillary	19 and older		Yes	No	One of (D5110, D5130) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5120	complete denture - mandibular	19 and older		Yes	No	One of (D5120, D5140) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5130	immediate denture - maxillary	19 and older		Yes	No	One of (D5110, D5130) per 60 Month(s) Per patient. Reimbursement made upon delivery (completion) of immediate maxillary or mandibular denture. D5130, D5140 reimbursed on the same date of service as the extraction of all remaining teeth.Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5140	immediate denture - mandibular	19 and older		Yes	No	One of (D5120, D5140) per 60 Month(s) Per patient. Reimbursement made upon delivery (completion) of immediate maxillary or mandibular denture. D5130, D5140 reimbursed on the same date of service as the extraction of all remaining teeth.Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5211	maxillary partial denture, resin base (including retentive/clasping materials, rests, and teeth)	19 and older		Yes	No	One of (D5211, D5213, D5221, D5223) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D5212	mandibular partial denture, resin base (including retentive/clasping materials, rests, and teeth)	19 and older		Yes	No	One of (D5212, D5214, D5222, D5224) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5213	maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	19 and older		Yes	No	One of (D5211, D5213, D5221, D5223) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5214	mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	19 and older		Yes	No	One of (D5212, D5214, D5222, D5224) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5221	immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	19 and older		Yes	No	One of (D5211, D5213, D5221, D5223) per 60 Month(s) Per patient. Reimbursement made upon delivery (completion) of immediate maxillary or mandibular partial denture. Reimbursed on the same date of service as the extraction of all remaining teeth.Includes adjustments within 6 months of initial placement	pre-operative x-ray(s)
D5222	immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	19 and older		Yes	No	One of (D5212, D5214, D5222, D5224) per 60 Month(s) Per patient. Reimbursement made upon delivery (completion) of immediate maxillary or mandibular partial denture. Reimbursed on the same date of service as the extraction of all remaining teeth.Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D5223	immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	19 and older		Yes	No	One of (D5211, D5213, D5221, D5223) per 60 Month(s) Per patient. Reimbursement made upon delivery (completion) of immediate maxillary or mandibular partial denture. Reimbursed on the same date of service as the extraction of all remaining teeth.Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5224	immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	19 and older		Yes	No	One of (D5212, D5214, D5222, D5224) per 60 Month(s) Per patient. Reimbursement made upon delivery (completion) of immediate maxillary or mandibular partial denture. Reimbursed on the same date of service as the extraction of all remaining teeth.Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5282	Removable unilateral partial denture--one piececast metal (including clasps and teeth), maxillary	19 and older		Yes	No	One of (D5282) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5283	Removable unilateral partial denture--one piececast metal (including clasps and teeth), mandibular	19 and older		Yes	No	One of (D5283) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5410	adjust complete denture - maxillary	19 and older		No	No	Not covered within 6 months of initial placement.	
D5411	adjust complete denture - mandibular	19 and older		No	No	Not covered within 6 months of initial placement.	
D5421	adjust partial denture-maxillary	19 and older		No	No	Not covered within 6 months of initial placement.	
D5422	adjust partial denture - mandibular	19 and older		No	No	Not covered within 6 months of initial placement.	

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D5511	repair broken complete denture base, mandibular	19 and older		No	No	Limited to repairs or adjustments performed more than 12 months after the initial insertion.	
D5512	repair broken complete denture base, maxillary	19 and older		No	No	Limited to repairs or adjustments performed more than 12 months after the initial insertion.	
D5520	replace missing or broken teeth - complete denture (each tooth)	19 and older	Teeth 1 - 32	No	No	Not covered within 6 months of initial placement.	
D5611	repair resin partial denture base, mandibular	19 and older		No	No	Limited to repairs or adjustments performed more than 12 months after the initial insertion.	
D5612	repair resin partial denture base, maxillary	19 and older		No	No	Limited to repairs or adjustments performed more than 12 months after the initial insertion.	
D5621	repair cast partial framework, mandibular	19 and older		No	No	Limited to repairs or adjustments performed more than 12 months after the initial insertion.	
D5622	repair cast partial framework, maxillary	19 and older		No	No	Limited to repairs or adjustments performed more than 12 months after the initial insertion.	
D5630	repair or replace broken retentive/clasping materials per tooth	19 and older	Teeth 1 - 32	No	No	Not covered within 6 months of initial placement.	
D5640	replace broken teeth-per tooth	19 and older	Teeth 1 - 32	No	No	Not covered within 6 months of initial placement.	
D5650	add tooth to existing partial denture	19 and older	Teeth 1 - 32	No	No		
D5660	add clasp to existing partial denture	19 and older	Teeth 1 - 32	No	No		

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D5710	rebase complete maxillary denture	19 and older		No	No	One of (D5710) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5711	rebase complete mandibular denture	19 and older		No	No	One of (D5711) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5720	rebase maxillary partial denture	19 and older		No	No	One of (D5720) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5721	rebase mandibular partial denture	19 and older		No	No	One of (D5721) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5730	reline complete maxillary denture (chairside)	19 and older		No	No	One of (D5730) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5731	reline complete mandibular denture (chairside)	19 and older		No	No	One of (D5731) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5740	reline maxillary partial denture (chairside)	19 and older		No	No	One of (D5740) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5741	reline mandibular partial denture (chairside)	19 and older		No	No	One of (D5741) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5750	reline complete maxillary denture (laboratory)	19 and older		No	No	One of (D5750) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D5751	reline complete mandibular denture (laboratory)	19 and older		No	No	One of (D5751) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5760	reline maxillary partial denture (laboratory)	19 and older		No	No	One of (D5760) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5761	reline mandibular partial denture (laboratory)	19 and older		No	No	One of (D5761) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5850	tissue conditioning, maxillary	19 and older		No	No		
D5851	tissue conditioning,mandibular	19 and older		No	No		

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6210	pontic - cast high noble metal	19 and older	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6211	pontic-cast base metal	19 and older	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6212	pontic - cast noble metal	19 and older	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6214	Pontic - titanium and titanium alloys	19 and older	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6240	pontic-porcelain fused-high noble	19 and older	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6241	pontic-porcelain fused to base metal	19 and older	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6242	pontic-porcelain fused-noble metal	19 and older	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6243	Pontic - Porcelain fused to titanium and titanium alloys	19 and older	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6245	prosthodontics fixed, pontic - porcelain/ceramic	19 and older	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6545	retainer - cast metal fixed	19 and older	Teeth 1 - 32	Yes	No	One of (D6545, D6548, D6549) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6548	prosthodontics fixed, retainer - porcelain/ceramic for resin bonded fixed prosthodontic	19 and older	Teeth 1 - 32	Yes	No	One of (D6545, D6548, D6549) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6549	Resin retainer-For resin bonded fixed prosthesis	19 and older	Teeth 1 - 32	Yes	No	One of (D6545, D6548, D6549) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6600	inlay - porcelain/ceramic, two surfaces	19 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6601	inlay - porcelain/ceramic, three or more surfaces	19 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6602	inlay - cast high noble metal, two surfaces	19 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6603	inlay - cast high noble metal, three or more surfaces	19 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6604	inlay - cast predominantly base metal, two surfaces	19 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6605	inlay - cast predominantly base metal, three or more surfaces	19 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6606	inlay - cast noble metal, two surfaces	19 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6607	inlay - cast noble metal, three or more surfaces	19 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6608	onlay - porcelain/ceramic, two surfaces	19 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6609	onlay - porcelain/ceramic, three or more surfaces	19 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6610	onlay - cast high noble metal, two surfaces	19 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6611	onlay - cast high noble metal, three or more surfaces	19 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6612	onlay - cast predominantly base metal, two surfaces	19 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6613	onlay - cast predominantly base metal, three or more surfaces	19 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6614	onlay - cast noble metal, two surfaces	19 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6615	onlay - cast noble metal, three or more surfaces	19 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6624	inlay - titanium	19 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6634	onlay - titanium	19 and older	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6740	retainer crown, porcelain/ceramic	19 and older	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6750	crown-porcelain fused high noble	19 and older	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6751	crown-porcelain fused to base metal	19 and older	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6752	crown-porcelain fused noble metal	19 and older	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6753	Retainer Crown- Porcelain fused to titanium and titanium alloys	19 and older	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6780	crown-3/4 cst high noble metal	19 and older	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6781	prosthodontics fixed, crown ¾ cast predominantly based metal	19 and older	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6782	prosthodontics fixed, crown ¾ cast noble metal	19 and older	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6783	prosthodontics fixed, crown ¾ porcelain/ceramic	19 and older	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6784	Retainer Crown 3/4-Titanium and Titanium Alloys	19 and older	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6790	crown-full cast high noble	19 and older	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6791	crown - full cast base metal	19 and older	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6792	crown - full cast noble metal	19 and older	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6794	Retainer crown - titanium and titanium alloys	19 and older	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Exhibit E Benefits Covered for CareSource Marketplace IN, NC, OH, WV Adult

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6930	re-cement or re-bond fixed partial denture	19 and older		Yes	No	Not covered within 6 months of placement.	pre-operative radiographs and narrative
D6980	fixed partial denture repair	19 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No		pre-operative radiographs and narrative

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Oral and Maxillofacial Surgery							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	19 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No		
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	19 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No	Includes cutting of gingiva and bone, removal of tooth structure and closure. Subject to Post Review.	
D7220	removal of impacted tooth-soft tissue	19 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	No		pre-operative radiographs
D7230	removal of impacted tooth-partially bony	19 and older	Teeth 1 - 32, 51 - 82	Yes	No	Includes splinting.	pre-operative radiographs
D7240	removal of impacted tooth-completely bony	19 and older	Teeth 1 - 32, 51 - 82	Yes	No		pre-operative radiographs
D7241	removal of impacted tooth-completely bony, with unusual surgical complications	19 and older	Teeth 1 - 32, 51 - 82	Yes	No		pre-operative radiographs
D7250	surgical removal of residual tooth roots (cutting procedure)	19 and older	Teeth 1 - 32, 51 - 82	Yes	No		pre-operative radiographs
D7251	Coronectomy – intentional partial tooth removal, impacted teeth only	19 and older	Teeth 1 - 32, 51 - 82	Yes	No		pre-operative radiographs
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	19 and older	Teeth 2 - 16, 18 - 31	Yes	No	Subject to post review as indicative of an emergency procedure	pre-operative radiographs
D7280	Surgical access of an unerupted tooth	19 and older	Teeth 2 - 16, 18 - 31	Yes	No		pre-operative radiographs

Oral and Maxillofacial Surgery							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D7283	placement of device to facilitate eruption of impacted tooth	19 and older	Teeth 1 - 32	No	No	One of (D7283) per 1 Lifetime Per patient per tooth.	
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	19 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D7310) per 1 Lifetime Per patient per quadrant. Minimum of four extractions in the affected quadrant. Covered only in conjunction with the construction of a prosthodontic appliance.	pre-operative radiographs
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	19 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D7311) per 1 Lifetime Per patient per quadrant. Minimum of four extractions in the affected quadrant. Covered only in conjunction with the construction of a prosthodontic appliance.	pre-operative radiographs
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	19 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D7320) per 1 Lifetime Per patient per quadrant. Minimum of four extractions in the affected quadrant. Covered only in conjunction with the construction of a prosthodontic appliance.	pre-operative radiographs
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	19 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D7321) per 1 Lifetime Per patient per quadrant. Minimum of four extractions in the affected quadrant. Covered only in conjunction with the construction of a prosthodontic appliance.	pre-operative radiographs
D7471	removal of exostosis - per site	19 and older	Per Arch (01, 02, LA, UA)	Yes	No		pre-operative radiographs and narrative
D7510	incision and drainage of abscess - intraoral soft tissue	19 and older	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No	Subject to Post Review	

Exhibit E Benefits Covered for CareSource Marketplace IN, NC, OH, WV Adult

Oral and Maxillofacial Surgery							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D7520	incision and drainage of abscess - extraoral soft tissue	19 and older		No	No	Subject to Post Review	
D7910	suture small wounds up to 5 cm	19 and older		No	No	Subject to Post Review	
D7971	excision of pericoronal gingiva	19 and older	Teeth 1 - 32	Yes	No		narr. of med. necessity, pre-op x-ray(s)

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Adjunctive General Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D9110	palliative treatment of dental pain - per visit	19 and older		No	No	One of (D9110) per 1 Day(s) Per patient.	
D9222	deep sedation/general anesthesia first 15 minutes	19 and older		Yes	No	One of (D9222) per 1 Day(s) Per patient. Ten of (D9222, D9223) per 1 Calendar year(s) Per patient. This procedure code is not reimbursable on same date as D9239, D9243. Sedation approvals are limited to surgical and extensive cases	narr. of med. necessity, pre-op x-ray(s)
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	19 and older		Yes	No	Four of (D9223) per 1 Day(s) Per patient. Ten of (D9222, D9223) per 1 Calendar year(s) Per patient. This procedure code is not reimbursable on same date as D9239, D9243. Sedation approvals are limited to surgical and extensive cases	narr. of med. necessity, pre-op x-ray(s)
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	19 and older		Yes	No	One of (D9239) per 1 Day(s) Per patient. Ten of (D9239, D9243) per 1 Calendar year(s) Per patient. This procedure code is not reimbursable on same date as D9222, D9223. Sedation approvals are limited to surgical and extensive cases	narr. of med. necessity, pre-op x-ray(s)
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	19 and older		Yes	No	Four of (D9243) per 1 Day(s) Per patient. Ten of (D9239, D9243) per 1 Calendar year(s) Per patient. This procedure code is not reimbursable on same date as D9222, D9223. Sedation approvals are limited to surgical and extensive cases	narr. of med. necessity, pre-op x-ray(s)

Adjunctive General Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	19 and older		Yes	No	One of (D9310) per 1 Day(s) Per patient. Includes consultation with medical professional (D9310 used in lieu of D9311)	narrative of medical necessity
D9311	consultation with medical health care professional	19 and older		No	No	One of (D9311) per 1 Day(s) Per patient. This should be used only for extensive consultation with medical professional regarding patient's medical issues.	
D9610	therapeutic drug injection, by report	19 and older		Yes	No	One of (D9610) per 1 Day(s) Per patient. Description and dosage of drug.	narrative of medical necessity
D9930	treatment of complications (post-surgical) - unusual circumstances, by report	19 and older		Yes	No		narrative of medical necessity
D9944	occlusal guard--hard appliance, full arch	19 and older	Per Arch (01, 02, LA, UA)	Yes	No	One of (D9944) per 12 Month(s) Per patient.	narrative of medical necessity
D9995	teledentistry – synchronous; real-time encounter	19 and older		No	No	Four of (D9995) per 1 Calendar year(s) Per patient. The appropriate teledentistry code (D9995) should be reported as descriptor codes to identify services (D0140, D0145) provided via teledentistry by the dentist who provided the oversight of the teledentistry encounter as allowed and in accordance with any applicable state laws and/or: regulations, licensure, state dental practice acts. A teledentistry event is subject to applicable state law, regulation or licensure. D9995 does not have separate distinct benefit limits, however, any benefit limits applicable to the underlying services rendered would continue to apply.	

Exhibit F Benefits Covered for CareSource Marketplace IN, NC Child

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0120	periodic oral evaluation - established patient	0-18		No	No	Two of (D0120, D0140, D0145, D0150, D0180) per 1 Calendar year(s) Per patient. D0120 periodic oral evaluation may not occur in combination with D0150 on same date of service and not until 180 days after the D0150 comprehensive oral evaluation.	
D0140	limited oral evaluation-problem focused	0-18		No	No	Two of (D0120, D0140, D0145, D0150, D0180) per 1 Calendar year(s) Per patient. Note- This procedure code is used for emergency examinations during regularly scheduled office hours. Evaluations solely for the purpose of adjustments or in conjunction with multi-visit procedures are not covered (i.e. endodontics and orthodontia). May not be used in conjunction with D0120, D0150, D9440, and D0180	
D0145	oral evaluation for a patient under three years of age and counseling with primary caregiver	0-3		No	No	Two of (D0120, D0140, D0145, D0150, D0180) per 1 Calendar year(s) Per patient. Should be used only for first time visit for Children under three years who have not seen a dentist. Subsequent recall visit D0120 should be billed.	

Exhibit F Benefits Covered for CareSource Marketplace IN, NC Child

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0150	comprehensive oral evaluation - new or established patient	0-18		No	No	Two of (D0120, D0140, D0145, D0150, D0160, D0180) per 1 Calendar year(s) Per patient. One of (D0150) per 24 Month(s) Per Provider OR Location. D0150 used when evaluating a patient comprehensively. D0150 or the periodic exam D0120 may not occur in conjunction with a limited oral evaluation (examination during office hours- D0140 or after office hours- D9440)	
D0160	detailed and extensive oral eval-problem focused, by report	0-18		No	No	Two of (D0120, D0140, D0145, D0150, D0160, D0180) per 1 Calendar year(s) Per patient per tooth. A detailed & extensive problem focused eval entails extensive diagnostic and cognitive modalities based on the findings of a comprehensive oral evaluation. Integration of more extensive diagnostic modalities to develop a treatment plan for a specific problem is required. The cond requiring this type of eval should be described and documented. Examples of conditions requiring this type of eval may include dentofacial anomalies, complicated perio-prosthetic conditions, complex temporomandibular dysfunction, facial pain of unknown origin, conditions requiring multidisciplinary consult, etc.	

Exhibit F Benefits Covered for CareSource Marketplace IN, NC Child

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0180	comprehensive periodontal evaluation - new or established patient	0-18		No	No	Two of (D0120, D0140, D0145, D0150, D0180) per 1 Calendar year(s) Per patient. One of (D0180) per 24 Month(s) Per Provider OR Location. Reimbursement disallowed for D0180 performed in conjunction with either a D0150 or D0120.	
D0210	intraoral - comprehensive series of radiographic images	0-18		No	No	One of (D0210, D0330) per 60 Month(s) Per patient. Indicated for the permanent dentition or Adult dentate. A full-mouth series consist of a minimum of fourteen (14) films, including all periapical and posterior bitewing films intended to display the crowns and roots of all teeth, periapical areas and alveolar bone necessary for examination and diagnosis. PA required if done more frequently than 60 months	

Exhibit F Benefits Covered for CareSource Marketplace IN, NC Child

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0220	intraoral - periapical first radiographic image	0-18		No	No	One of (D0220) per 1 Day(s) Per patient. Any additional periapical films (D0230 should be used) If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series. Periapical radiographs are used diagnostically and are not reimbursable when used intraoperatively (i.e. during RCT or other procedural x-rays.	

Exhibit F Benefits Covered for CareSource Marketplace IN, NC Child

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0230	intraoral - periapical each additional radiographic image	0-18		No	No	Any additional periapical films (D0230 should be used) If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series. Periapical radiographs are used diagnostically and are not reimbursable when used intraoperatively (i.e. during RCT or other procedural x-rays.	

Exhibit F Benefits Covered for CareSource Marketplace IN, NC Child

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0240	intraoral - occlusal radiographic image	0-18		No	No	Any additional periapical films (D0230 should be used) If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series. Periapical radiographs are used diagnostically and are not reimbursable when used intraoperatively (i.e. during RCT or other procedural x-rays.	
D0250	extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	0-18		No	No	One of (D0250) per 1 Calendar year(s) Per patient.	

Exhibit F Benefits Covered for CareSource Marketplace IN, NC Child

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0270	bitewing - single radiographic image	0-18		No	No	A total of four horizontal bitewing films in any combination of (D0270, D0272, D0273 or D0274) per 6 Month(s) “Or” One set of vertical bitewings (D0277) per 6 Month(s) See fee limitations for all radiographs. If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series.	

Exhibit F Benefits Covered for CareSource Marketplace IN, NC Child

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0272	bitewings - two radiographic images	0-18		No	No	A total of four horizontal bitewing films in any combination of (D0270, D0272, D0273 or D0274) per 6 Month(s) “Or” One set of vertical bitewings (D0277) per 6 Month(s) See fee limitations for all radiographs. If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series.	

Exhibit F Benefits Covered for CareSource Marketplace IN, NC Child

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0273	bitewings - three radiographic images	0-18		No	No	A total of four horizontal bitewing films in any combination of (D0270, D0272, D0273 or D0274) per 6 Month(s) “Or” One set of vertical bitewings (D0277) per 6 Month(s) See fee limitations for all radiographs. If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series.	

Exhibit F Benefits Covered for CareSource Marketplace IN, NC Child

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0274	bitewings - four radiographic images	0-18		No	No	One of (D0274, D0277) per 6 Month(s) Per patient. A total of four horizontal bitewing films in any combination of (D0270, D0272, D0273 or D0274) per 6 Month(s) “Or” One set of vertical bitewings (D0277) per 6 Month(s) See fee limitations for all radiographs. If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series.	

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0277	vertical bitewings - 7 to 8 films	0-18		No	No	One of (D0274, D0277) per 6 Month(s) Per patient. A total of four horizontal bitewing films in any combination of (D0270, D0272, D0273 or D0274) per 6 Month(s) “Or” One set of vertical bitewings (D0277) per 6 Month(s) See fee limitations for all radiographs. If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series.	
D0330	panoramic radiographic image	0-18		No	No	One of (D0210, D0330) per 60 Month(s) Per patient. All periapical or occlusal films taken same date of service needed to render the necessary radiographic diagnosis are included in the fee for panoramic radiograph. If bitewing radiographs D0270, D0272 or D0274 are indicated for additional diagnosis, the amount reimbursed will not exceed the reimbursable amount for D0210 Full Mouth Series. PA required if done more frequently than 60 months.	

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0340	cephalometric radiographic image	0-18		No	No	One of (D0340) per 1 Day(s) Per Provider OR Location. Not included in single date of service maximum radiography reimbursable amount.	
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	0-18		No	No	One of (D0350) per 1 Day(s) Per Provider OR Location. Covered one per Orthodontist or Location as part of an Orthodontic case.	
D0372	intraoral tomosynthesis – comprehensive series of radiographic images	0-18		No	No	One of (D0210, D0277, D0330, D0372, D0387) per 1 Calendar year(s) Per patient.	
D0373	intraoral tomosynthesis – bitewing radiographic image	0-18		No	No	One of (D0270, D0272, D0273, D0274, D0277, D0373, D0388) per 1 Calendar year(s) Per patient.	
D0374	intraoral tomosynthesis – periapical radiographic image	0-18		No	No	One of (D0220, D0230, D0374, D0389) per 1 Calendar year(s) Per patient.	
D0387	intraoral tomosynthesis – comprehensive series of radiographic images – image capture only	0-18		No	No	One of (D0210, D0277, D0330, D0372, D0387) per 1 Calendar year(s) Per patient.	
D0388	intraoral tomosynthesis – bitewing radiographic image – image capture only	0-18		No	No	One of (D0270, D0272, D0273, D0274, D0277, D0373, D0388) per 1 Calendar year(s) Per patient.	
D0389	intraoral tomosynthesis – periapical radiographic image – image capture only	0-18		No	No	One of (D0220, D0230, D0374, D0389) per 1 Calendar year(s) Per patient.	
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report	0-18		No	No	One of (D0391) per 1 Day(s) Per Provider OR Location. Interpretation of diagnostic image and report by a Practitioner not associated with Image Capture. Report should be kept in patient record for post payment review as applicable.	

Exhibit F Benefits Covered for CareSource Marketplace IN, NC Child

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0470	diagnostic casts	0-18		No	No	One of (D0470) per 1 Day(s) Per Provider OR Location. One per case. Diagnostic models or study models used as a guide in the application of corrective or restorative dentistry. Payable as a diagnostic service intended for the documentation and subsequent analysis of occlusion.	

Exhibit F Benefits Covered for CareSource Marketplace IN, NC Child

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D1110	prophylaxis - adult	13 - 18		No	No	Two of (D1110, D1120) per 1 Calendar year(s) Per patient. This service code used for permanent dentition.	
D1120	prophylaxis - child	0-12		No	No	Two of (D1110, D1120) per 1 Calendar year(s) Per patient. This service code used for primary dentition	
D1206	topical application of fluoride varnish	0-18		No	No	Two of (D1206, D1208) per 1 Calendar year(s) Per patient. Treatment that incorporates fluoride with the polishing compound is considered part of the prophylaxis procedure and not a separate topical fluoride treatment. The following treatments are not covered with use of D1206 or D1208: • Topical application of fluoride to the prepared portion of a tooth prior to restoration • The use of self or home fluoride application procedures	
D1208	topical application of fluoride - excluding varnish	0-18		No	No	Two of (D1206, D1208) per 1 Calendar year(s) Per patient. Treatment that incorporates fluoride with the polishing compound is considered part of the prophylaxis procedure and not a separate topical fluoride treatment. The following treatments are not covered with use of D1206 or D1208: • Topical application of fluoride to the prepared portion of a tooth prior to restoration • The use of self or home fluoride application procedures	

Exhibit F Benefits Covered for CareSource Marketplace IN, NC Child

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D1351	sealant - per tooth	0-18	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	No	One of (D1351) per 36 Month(s) Per patient per tooth. Mechanically and/or chemically prepared enamel surface sealed to prevent decay. Sealants are reimbursable for unrestored pit and fissure surfaces (first and second molars only)	
D1352	Preventive resin restoration is a mod. to high caries risk patient perm tooth conservative rest of an active cavitated lesion in a pit or fissure that doesn't extend into dentin: includes placmt of a sealant in radiating non-carious fissure or pits.	0-18	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	No	One of (D1352) per 36 Month(s) Per patient per tooth. Conservative restoration of an active cavitated lesion in a pit or fissure that does not extend into dentin; includes placement of a sealant in any radiating noncarious fissures or pits. • Must be a conservative restoration using a bur that extends into enamel only and includes all the deep grooves of the tooth. • Must be placed on a non-restored permanent tooth that has not had a sealant placed within 1 year	
D1354	application of caries arresting medicament- per tooth	0-18	Teeth 2 - 15, 18 - 31, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No	One of (D1354, D1355) per 36 Month(s) Per patient per tooth. Ten of (D1354, D1355) per 1 Calendar year(s) Per patient. Conservative treatment of an active, non-symptomatic carious lesion by topical application of a caries arresting or inhibiting medicament and without mechanical removal of sound tooth structure.	

Exhibit F Benefits Covered for CareSource Marketplace IN, NC Child

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D1355	caries preventive medicament application – per tooth	0-18	Teeth 2 - 15, 18 - 31, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No	One of (D1354, D1355) per 36 Month(s) Per patient per tooth. Ten of (D1354, D1355) per 1 Calendar year(s) Per patient. Conservative treatment by topical application of a caries preventive or inhibiting medicament for primary prevention or remineralization and without mechanical removal of sound tooth structure.	
D1510	space maintainer-fixed, unilateral- per quadrant	0-13	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of (D1510) per 60 Month(s) Per patient per quadrant. Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	

Exhibit F Benefits Covered for CareSource Marketplace IN, NC Child

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D1516	space maintainer --fixed--bilateral, maxillary	0-13		No	No	One of (D1516) per 60 Month(s) Per patient per tooth. Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	
D1517	space maintainer --fixed--bilateral, mandibular	0-13		No	No	One of (D1517) per 60 Month(s) Per patient per tooth. Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D1520	space maintainer-removable-unilateral	0-13	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of (D1520) per 60 Month(s) Per patient per quadrant. Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	
D1526	space maintainer --removable--bilateral, maxillary	0-13		No	No	One of (D1526) per 60 Month(s) Per patient per tooth. Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	

Exhibit F Benefits Covered for CareSource Marketplace IN, NC Child

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D1527	space maintainer --removable--bilateral, mandibular	0-13		No	No	One of (D1527) per 60 Month(s) Per patient per tooth. Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	
D1551	re-cement or re-bond bilateral space maintainer-Maxillary	0-18		No	No	Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	

Exhibit F Benefits Covered for CareSource Marketplace IN, NC Child

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D1552	re-cement or re-bond bilateral space maintainer-Mandibular	0-18		No	No	Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	
D1553	re-cement or re-bond unilateral space maintainer-Per Quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	

Exhibit F Benefits Covered for CareSource Marketplace IN, NC Child

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D1556	Removal of fixed unilateral space maintainer- Per Quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	
D1557	Removal of fixed bilateral space maintainer- Maxillary	0-18		No	No	Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	

Exhibit F Benefits Covered for CareSource Marketplace IN, NC Child

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D1558	Removal of fixed bilateral space maintainer-Mandibular	0-18		No	No	Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2140	Amalgam - one surface, primary or permanent	0-18	Teeth 1 - 32, A - T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	
D2150	Amalgam - two surfaces, primary or permanent	0-18	Teeth 1 - 32, A - T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	

Exhibit F Benefits Covered for CareSource Marketplace IN, NC Child

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2160	amalgam - three surfaces, primary or permanent	0-18	Teeth 1 - 32, A - T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	
D2161	amalgam - four or more surfaces, primary or permanent	0-18	Teeth 1 - 32, A - T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2330	resin-based composite - one surface, anterior	0-18	Teeth 6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. The fee for resin-based composite restorations will include any necessary acid etching and bonding agents. Non-contiguous restorations, such as a separate Distal Facial (DF) and Mesial Facial (MF) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	
D2331	resin-based composite - two surfaces, anterior	0-18	Teeth 6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. The fee for resin-based composite restorations will include any necessary acid etching and bonding agents. Non-contiguous restorations, such as a separate Distal Facial (DF) and Mesial Facial (MF) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2332	resin-based composite - three surfaces, anterior	0-18	Teeth 6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. The fee for resin-based composite restorations will include any necessary acid etching and bonding agents. Non-contiguous restorations, such as a separate Distal Facial (DF) and Mesial Facial (MF) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	0-18	Teeth 6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. The fee for resin-based composite restorations will include any necessary acid etching and bonding agents. Non-contiguous restorations, such as a separate Distal Facial (DF) and Mesial Facial (MF) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	

Exhibit F Benefits Covered for CareSource Marketplace IN, NC Child

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2391	resin-based composite - one surface, posterior	0-18	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. CareSource will reimburse based on Amalgam for posterior teeth.D2391 Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	
D2392	resin-based composite - two surfaces, posterior	0-18	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. CareSource will reimburse based on Amalgam for posterior teeth.D2391 Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2393	resin-based composite - three surfaces, posterior	0-18	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. CareSource will reimburse based on Amalgam for posterior teeth.D2391 Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	
D2394	resin-based composite - four or more surfaces, posterior	0-18	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. CareSource will reimburse based on Amalgam for posterior teeth.D2391 Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	

Exhibit F Benefits Covered for CareSource Marketplace IN, NC Child

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2510	inlay - metallic -1 surface	0-18	Teeth 1 - 32	No	No	One of (D2510) per 60 Month(s) Per patient per tooth. Covered only when a direct restoration (ie. amalgam, composite) will not adequately restore the tooth.	
D2520	inlay-metallic-2 surfaces	0-18	Teeth 1 - 32	No	No	One of (D2520) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	
D2530	inlay-metallic-3+ surfaces	0-18	Teeth 1 - 32	No	No	One of (D2530) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	
D2542	onlay - metallic - two surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2543	onlay-metallic-3 surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	Pre-operative radiographs and operative report

Exhibit F Benefits Covered for CareSource Marketplace IN, NC Child

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2544	onlay-metallic-4+ surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2750	crown - porcelain fused to high noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2751	crown - porcelain fused to predominantly base metal	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2752	crown - porcelain fused to noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs

Exhibit F Benefits Covered for CareSource Marketplace IN, NC Child

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2780	crown - ¾ cast high noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2781	crown - ¾ cast predominantly base metal	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2782	crown - ¾ cast noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2783	crown - ¾ porcelain/ceramic	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs

Exhibit F Benefits Covered for CareSource Marketplace IN, NC Child

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2790	crown - full cast high noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2791	crown - full cast predominantly base metal	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2792	crown - full cast noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2794	Crown- Titanium and Titanium Alloys	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	0-18	Teeth 1 - 32	No	No	Not allowed within 6 months of delivery.	

Exhibit F Benefits Covered for CareSource Marketplace IN, NC Child

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core	0-18	Teeth 1 - 32	No	No	Not covered within 6 months of initial placement.	
D2920	re-cement or re-bond crown	0-18	Teeth 1 - 32, A - T	No	No	Not allowed within 6 months of delivery.	
D2928	prefabricated porcelain/ceramic crown – permanent tooth	0-18	Teeth 1 - 32	No	No	One of (D2928, D2929, D2930, D2931, D2933, D2934) per 60 Month(s) Per patient per tooth.	
D2929	Prefabricated porcelain/ceramic crown – primary tooth	0-14	Teeth A - T	No	No	One of (D2928, D2929, D2930, D2931, D2933, D2934) per 60 Month(s) Per patient per tooth. Greater than 6 units of (D2928, D2929, D2930, D2931, D2933, and D2934) per date of service may be subject to post review.	
D2930	prefabricated stainless steel crown - primary tooth	0-14	Teeth A - T	No	No	One of (D2928, D2929, D2930, D2931, D2933, D2934) per 60 Month(s) Per patient per tooth. Greater than 6 units of (D2928, D2929, D2930, D2931, D2933, and D2934) per date of service may be subject to post review.	
D2931	prefabricated stainless steel crown-permanent tooth	0-14	Teeth 1 - 32	No	No	One of (D2928, D2929, D2930, D2931, D2933, D2934) per 60 Month(s) Per patient per tooth. Greater than 6 units of (D2928, D2929, D2930, D2931, D2933, and D2934) per date of service may be subject to post review.	
D2933	prefabricated stainless steel crown with resin window	0-14	Teeth 1 - 32, A - T	No	No	One of (D2928, D2929, D2930, D2931, D2933, D2934) per 60 Month(s) Per patient per tooth. Greater than 6 units of (D2928, D2929, D2930, D2931, D2933, and D2934) per date of service may be subject to post review.	

Exhibit F Benefits Covered for CareSource Marketplace IN, NC Child

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	0-14	Teeth A - T	No	No	One of (D2928, D2929, D2930, D2931, D2933, D2934) per 60 Month(s) Per patient per tooth. Greater than 6 units of (D2928, D2929, D2930, D2931, D2933, and D2934) per date of service may be subject to post review.	
D2940	protective restoration	0-18	Teeth 1 - 32	No	No	One of (D2940) per 1 Calendar year(s) Per patient per tooth. Restorative material to protect tooth and/or tissue form. Used to relieve pain, promote healing, and prevent further deterioration. Not reimbursable when used as endodontic access closure, or as a base or liner under restoration.	
D2950	core buildup, including any pins when required	0-18	Teeth 1 - 32	Yes	No	One of (D2950) per 60 Month(s) Per patient per tooth.	pre-operative radiographs
D2951	pin retention - per tooth, in addition to restoration	0-18	Teeth 1 - 32	No	No	Three of (D2951) per 1 Lifetime Per patient per tooth.	
D2952	cast post and core in addition to crown	0-18	Teeth 1 - 32	Yes	No	One of (D2952, D2954) per 60 Month(s) Per patient per tooth.	pre-operative radiographs
D2953	each additional cast post - same tooth	0-18	Teeth 1 - 32	Yes	No	One of (D2953) per 60 Month(s) Per patient per tooth.	pre-operative radiographs
D2954	prefabricated post and core in addition to crown	0-18	Teeth 1 - 32	Yes	No	One of (D2952, D2954) per 60 Month(s) Per patient per tooth.	pre-operative radiographs
D2957	each additional prefabricated post - same tooth	0-18	Teeth 1 - 32	Yes	No	One of (D2957) per 60 Month(s) Per patient per tooth.	pre-operative radiographs

Exhibit F Benefits Covered for CareSource Marketplace IN, NC Child

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2961	labial veneer (resin laminate) - laboratory	0-18	Teeth 1 - 32	Yes	No	One of (D2961, D2962) per 60 Month(s) Per patient per tooth. D2961, D2962 may be covered in lieu of crowns when clinically indicated for anterior teeth that are severely fractured or carious, that cannot be adequately repaired with a direct restoration (i.e., CDT codes D2330–D2335) Not reimbursable when performed solely for cosmetic/aesthetic reasons.	Pre-operative radiographs and operative report
D2962	labial veneer (porc laminate) - laboratory	0-18	Teeth 1 - 32	Yes	No	One of (D2961, D2962) per 60 Month(s) Per patient per tooth. D2961, D2962 may be covered in lieu of crowns when clinically indicated for anterior teeth that are severely fractured or carious, that cannot be adequately repaired with a direct restoration (i.e., CDT codes D2330–D2335) Not reimbursable when performed solely for cosmetic/aesthetic reasons.	Pre-operative radiographs and operative report
D2980	crown repair, by report	0-18	Teeth 1 - 32	Yes	No	One of (D2980) per 60 Month(s) Per patient per tooth.	Narr / Oper Rpt
D2981	Inlay repair necessitated by restorative material failure	0-18	Teeth 1 - 32, 51 - 82	Yes	No	One of (D2981) per 60 Month(s) Per patient per tooth.	Narr / Oper Rpt
D2982	Onlay repair necessitated by restorative material failure	0-18	Teeth 1 - 32, 51 - 82	Yes	No	One of (D2982) per 60 Month(s) Per patient per tooth.	Narr / Oper Rpt
D2983	Veneer repair necessitated by restorative material failure	0-18	Teeth 1 - 32, 51 - 82	Yes	No	One of (D2983) per 60 Month(s) Per patient per tooth.	Narr / Oper Rpt
D2990	Resin infiltration of incipient smooth surface lesions	0-18	Teeth 1 - 32, A - T	No	No	One of (D2990) per 60 Month(s) Per patient per tooth.	

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Endodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	0-18	Teeth 1 - 32, A - T	No	No	One of (D3220) per 1 Lifetime Per patient per tooth. If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.	
D3222	partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	0-18	Teeth 1 - 32	No	No	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.	
D3230	pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	0-11	Teeth C, H, M, R	No	No	One of (D3230) per 1 Lifetime Per patient per tooth.	
D3230	pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	0-6	Teeth D - G, N - Q	No	No	One of (D3230) per 1 Lifetime Per patient per tooth.	
D3240	pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	0-11	Teeth A, B, I - L, S, T	No	No	One of (D3240) per 1 Lifetime Per patient per tooth.	

Exhibit F Benefits Covered for CareSource Marketplace IN, NC Child

Endodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D3310	endodontic therapy, anterior tooth (excluding final restoration)	0-18	Teeth 6 - 11, 22 - 27	No	No	One of (D3310) per 1 Lifetime Per patient per tooth. 1)Once per tooth per lifetime except for exception cases of appropriate medical necessity.2)The date the RCT is completed should be the date of service.3)Reimbursement for a root canal includes opening and drainage, treatment planning, clinical procedures, follow-up care, radiographs during treatment, and post-operative radiographs. 4)D3310,D3320,D3330 are subject to Post Review Third molar wisdom teeth will only be considered for coverage when tooth is functional.	
D3320	endodontic therapy, premolar tooth (excluding final restoration)	0-18	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	No	One of (D3320) per 1 Lifetime Per patient per tooth. 1)Once per tooth per lifetime except for exception cases of appropriate medical necessity.2)The date the RCT is completed should be the date of service.3)Reimbursement for a root canal includes opening and drainage, treatment planning, clinical procedures, follow-up care, radiographs during treatment, and post-operative radiographs. 4)D3310,D3320,D3330 are subject to Post Review Third molar wisdom teeth will only be considered for coverage when tooth is functional.	

Exhibit F Benefits Covered for CareSource Marketplace IN, NC Child

Endodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D3330	endodontic therapy, molar tooth (excluding final restoration)	0-18	Teeth 1 - 3, 14 - 19, 30 - 32	No	No	One of (D3330) per 1 Lifetime Per patient per tooth. 1)Once per tooth per lifetime except for exception cases of appropriate medical necessity.2)The date the RCT is completed should be the date of service.3)Reimbursement for a root canal includes opening and drainage, treatment planning, clinical procedures, follow-up care, radiographs during treatment, and post-operative radiographs. 4)D3310,D3320,D3330 are subject to Post Review Third molar wisdom teeth will only be considered for coverage when tooth is functional.	
D3346	retreatment of previous root canal therapy-anterior	0-18	Teeth 6 - 11, 22 - 27	No	No	One of (D3346) per 1 Lifetime Per patient per tooth. 1)Dental provider who performed the original root canal should not be reimbursed for the retreatment for the first 12 months 2)D3346, D3347, D3348 are subject to Post Review	
D3347	retreatment of previous root canal therapy - premolar	0-18	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	No	One of (D3347) per 1 Lifetime Per patient per tooth. 1)Dental provider who performed the original root canal should not be reimbursed for the retreatment for the first 12 months 2)D3346, D3347, D3348 are subject to Post Review	

Endodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D3348	retreatment of previous root canal therapy-molar	0-18	Teeth 1 - 3, 14 - 19, 30 - 32	No	No	One of (D3348) per 1 Lifetime Per patient per tooth. 1)Dental provider who performed the original root canal should not be reimbursed for the retreatment for the first 12 months 2)D3346, D3347, D3348 are subject to Post Review	
D3351	apexification/recalcification - initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	0-18	Teeth 1 - 32	Yes	No	One of (D3351) per 1 Lifetime Per patient per tooth. Initial opening, preparation and first placement of medication and necessary radiographs	pre-operative radiographs
D3352	apexification/recalcification - interim medication replacement	0-18	Teeth 1 - 32	Yes	No	One of (D3352) per 1 Lifetime Per patient per tooth. Subject to Post Review	pre-operative radiographs
D3353	apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	0-18	Teeth 1 - 32	Yes	No	One of (D3353) per 1 Lifetime Per patient per tooth. Subject to Post Review	pre-operative radiographs
D3355	Pulpal regeneration - initial visit	0-18	Teeth 1 - 32	No	No	One of (D3355) per 1 Lifetime Per patient per tooth. Subject to Post Review	
D3356	Pulpal regeneration - interim medication replacement	0-18	Teeth 1 - 32	No	No	One of (D3356) per 1 Lifetime Per patient per tooth. Subject to Post Review	
D3357	Pulpal regeneration - completion of treatment	0-18	Teeth 1 - 32	No	No	One of (D3357) per 1 Lifetime Per patient per tooth. Subject to Post Review	
D3410	apicoectomy - anterior	0-18	Teeth 6 - 11, 22 - 27	Yes	No	One of (D3410) per 1 Lifetime Per patient per tooth.	pre-operative radiographs
D3421	apicoectomy - premolar (first root)	0-18	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	No	One of (D3421) per 1 Lifetime Per patient per tooth.	pre-operative radiographs
D3425	apicoectomy - molar (first root)	0-18	Teeth 1 - 3, 14 - 19, 30 - 32	Yes	No	One of (D3425) per 1 Lifetime Per patient per tooth.	pre-operative radiographs

Endodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D3426	apicoectomy (each additional root)	0-18	Teeth 1 - 5, 12 - 21, 28 - 32	Yes	No	One of (D3426) per 1 Lifetime Per patient per tooth.	pre-operative radiographs
D3450	root amputation - per root	0-18	Teeth 1 - 32	Yes	No		pre-operative radiographs
D3471	surgical repair of root resorption - anterior	0-18	Teeth 6 - 11, 22 - 27	No	No	One of (D3471) per 1 Lifetime Per patient per tooth.	
D3472	surgical repair of root resorption – premolar	0-18	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	No	One of (D3472) per 1 Lifetime Per patient per tooth.	
D3473	surgical repair of root resorption – molar	0-18	Teeth 1 - 3, 14 - 19, 30 - 32	No	No	One of (D3473) per 1 Lifetime Per patient per tooth.	
D3501	surgical exposure of root surface without apicoectomy or repair of root resorption – anterior	0-18	Teeth 6 - 11, 22 - 27	No	No	One of (D3501) per 1 Lifetime Per patient per tooth.	
D3502	surgical exposure of root surface without apicoectomy or repair of root resorption – premolar	0-18	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	No	One of (D3502) per 1 Lifetime Per patient per tooth.	
D3503	surgical exposure of root surface without apicoectomy or repair of root resorption – molar	0-18	Teeth 1 - 3, 14 - 19, 30 - 32	No	No	One of (D3503) per 1 Lifetime Per patient per tooth.	
D3920	hemisection (including any root removal), not incl root canal therapy	0-18	Teeth 1 - 3, 14 - 19, 30 - 32	Yes	No		pre-operative radiographs

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Periodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4210, D4211) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4210, D4211) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	0-18	Teeth 1 - 32, 51 - 82	Yes	No	One of (D4212) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4240	gingival flap procedure, including root planing – four or more contiguous teeth or tooth bound spaces per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4240, D4241) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4241	gingival flap procedure, including root planing – one to three contiguous teeth or tooth bound spaces per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4240, D4241) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4249	clinical crown lengthening - hard tissue	0-18	Teeth 1 - 32	Yes	No	One of (D4249) per 36 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D4260	osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4260, D4261) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4261	osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4260, D4261) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting

Periodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D4263	bone replacement graft - first site in quadrant	0-18	Teeth 1 - 32	Yes	No	One of (D4263) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4270	pedicle soft tissue graft procedure	0-18	Teeth 1 - 32	Yes	No	One of (D4270) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4273	subepithelial connective tissue graft procedure	0-18	Teeth 1 - 32	Yes	No	One of (D4273) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4275	soft tissue allograft	0-18	Teeth 1 - 32	Yes	No	One of (D4275) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	0-18	Teeth 1 - 32, 51 - 82	Yes	No		pre-op x-ray(s), perio charting
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	0-18	Teeth 1 - 32, 51 - 82	Yes	No	One of (D4278) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4283	autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	0-18	Teeth 1 - 32	Yes	No	One of (D4283) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4285	non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	0-18	Teeth 1 - 32	Yes	No	One of (D4285) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4341	periodontal scaling and root planing - four or more teeth per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. A minimum of four affected teeth in the quadrant.	pre-op x-ray(s), perio charting

Exhibit F Benefits Covered for CareSource Marketplace IN, NC Child

Periodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D4342	periodontal scaling and root planing - one to three teeth per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. One to three affected teeth in the quadrant.	pre-op x-ray(s), perio charting
D4355	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	0-18		No	No	One of (D4355) per 1 Lifetime Per patient. Subject to Post Review.	
D4910	periodontal maintenance procedures	0-18		No	No	Four of (D1110, D4910) per 12 Month(s) Per patient. D4341 or D4342 must be on file for claims or documentation from patient record history of periodontal therapy within the last 6 months.	

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D5110	complete denture - maxillary	0-18		Yes	No	One of (D5110, D5130) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5120	complete denture - mandibular	0-18		Yes	No	One of (D5120, D5140) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5130	immediate denture - maxillary	0-18		Yes	No	One of (D5110, D5130) per 60 Month(s) Per patient. Reimbursement made upon delivery (completion) of immediate maxillary or mandibular denture. D5130, D5140 reimbursed on the same date of service as the extraction of all remaining teeth.Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5140	immediate denture - mandibular	0-18		Yes	No	One of (D5120, D5140) per 60 Month(s) Per patient. Reimbursement made upon delivery (completion) of immediate maxillary or mandibular denture. D5130, D5140 reimbursed on the same date of service as the extraction of all remaining teeth.Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5211	maxillary partial denture, resin base (including retentive/clasping materials, rests, and teeth)	0-18		Yes	No	One of (D5211, D5213, D5221, D5223) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan

Exhibit F Benefits Covered for CareSource Marketplace IN, NC Child

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D5212	mandibular partial denture, resin base (including retentive/clasping materials, rests, and teeth)	0-18		Yes	No	One of (D5212, D5214, D5222, D5224) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5213	maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	0-18		Yes	No	One of (D5211, D5213, D5221, D5223) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5214	mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	0-18		Yes	No	One of (D5212, D5214, D5222, D5224) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5221	immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	0-18		Yes	No	One of (D5211, D5213, D5221, D5223) per 60 Month(s) Per patient. Reimbursement made upon delivery (completion) of immediate maxillary or mandibular partial denture. Reimbursed on the same date of service as the extraction of all remaining teeth.Includes adjustments within 6 months of initial placement	pre-operative x-ray(s)
D5222	immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	0-18		Yes	No	One of (D5212, D5214, D5222, D5224) per 60 Month(s) Per patient. Reimbursement made upon delivery (completion) of immediate maxillary or mandibular partial denture. Reimbursed on the same date of service as the extraction of all remaining teeth.Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D5223	immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	0-18		Yes	No	One of (D5211, D5213, D5221, D5223) per 60 Month(s) Per patient. Reimbursement made upon delivery (completion) of immediate maxillary or mandibular partial denture. Reimbursed on the same date of service as the extraction of all remaining teeth.Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5224	immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	0-18		Yes	No	One of (D5212, D5214, D5222, D5224) per 60 Month(s) Per patient. Reimbursement made upon delivery (completion) of immediate maxillary or mandibular partial denture. Reimbursed on the same date of service as the extraction of all remaining teeth.Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5282	Removable unilateral partial denture--one piececast metal (including clasps and teeth), maxillary	16 - 18		Yes	No	One of (D5282) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5283	Removable unilateral partial denture--one piececast metal (including clasps and teeth), mandibular	16 - 18		Yes	No	One of (D5283) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5410	adjust complete denture - maxillary	0-18		No	No	Not covered within 6 months of initial placement.	
D5411	adjust complete denture - mandibular	0-18		No	No	Not covered within 6 months of initial placement.	
D5421	adjust partial denture-maxillary	0-18		No	No	Not covered within 6 months of initial placement.	
D5422	adjust partial denture - mandibular	0-18		No	No	Not covered within 6 months of initial placement.	

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D5511	repair broken complete denture base, mandibular	0-18		No	No	Limited to repairs or adjustments performed more than 12 months after the initial insertion.	
D5512	repair broken complete denture base, maxillary	0-18		No	No	Limited to repairs or adjustments performed more than 12 months after the initial insertion.	
D5520	replace missing or broken teeth - complete denture (each tooth)	0-18	Teeth 1 - 32	No	No	Not covered within 6 months of initial placement.	
D5611	repair resin partial denture base, mandibular	0-18		No	No	Limited to repairs or adjustments performed more than 12 months after the initial insertion.	
D5612	repair resin partial denture base, maxillary	0-18		No	No	Limited to repairs or adjustments performed more than 12 months after the initial insertion.	
D5621	repair cast partial framework, mandibular	0-18		No	No	Limited to repairs or adjustments performed more than 12 months after the initial insertion.	
D5622	repair cast partial framework, maxillary	0-18		No	No	Limited to repairs or adjustments performed more than 12 months after the initial insertion.	
D5630	repair or replace broken retentive/clasping materials per tooth	0-18	Teeth 1 - 32	No	No	Not covered within 6 months of initial placement.	
D5640	replace broken teeth-per tooth	0-18	Teeth 1 - 32	No	No	Not covered within 6 months of initial placement.	
D5650	add tooth to existing partial denture	0-18	Teeth 1 - 32	No	No		
D5660	add clasp to existing partial denture	0-18	Teeth 1 - 32	No	No		

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D5710	rebase complete maxillary denture	0-18		No	No	One of (D5710) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5711	rebase complete mandibular denture	0-18		No	No	One of (D5711) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5720	rebase maxillary partial denture	0-18		No	No	One of (D5720) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5721	rebase mandibular partial denture	0-18		No	No	One of (D5721) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5730	reline complete maxillary denture (chairside)	0-18		No	No	One of (D5730) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5731	reline complete mandibular denture (chairside)	0-18		No	No	One of (D5731) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5740	reline maxillary partial denture (chairside)	0-18		No	No	One of (D5740) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5741	reline mandibular partial denture (chairside)	0-18		No	No	One of (D5741) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5750	reline complete maxillary denture (laboratory)	0-18		No	No	One of (D5750) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	

Exhibit F Benefits Covered for CareSource Marketplace IN, NC Child

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D5751	reline complete mandibular denture (laboratory)	0-18		No	No	One of (D5751) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5760	reline maxillary partial denture (laboratory)	0-18		No	No	One of (D5760) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5761	reline mandibular partial denture (laboratory)	0-18		No	No	One of (D5761) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5850	tissue conditioning, maxillary	0-18		No	No		
D5851	tissue conditioning,mandibular	0-18		No	No		

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Implant Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6010	surgical placement of implant body: endosteal implant	0-18	Teeth 1 - 32	Yes	No	One of (D6010) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6012	surgical placement of interim implant body-endosteal implant	0-18	Teeth 1 - 32	Yes	No	One of (D6012) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6040	surgical placement:eposteal implnt	0-18	Per Arch (01, 02, LA, UA)	Yes	No	One of (D6040) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6050	surgical placement-transosteal implant	0-18	Teeth 1 - 32	Yes	No	One of (D6050) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6055	connecting bar - implant supported or abutment supported	0-18	Teeth 1 - 32	Yes	No	One of (D6055) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6056	prefabricated abutment	0-18	Teeth 1 - 32	Yes	No	One of (D6056) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6057	custom abutment	0-18	Teeth 1 - 32	Yes	No	One of (D6057) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6058	abutment supported porcelain/ceramic crown	0-18	Teeth 1 - 32	Yes	No	One of (D6058) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6059	abutment supported porcelain fused to metal crown (high noble metal)	0-18	Teeth 1 - 32	Yes	No	One of (D6059) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6060	abutment supported porcelain fused to metal crown (predominantly base metal)	0-18	Teeth 1 - 32	Yes	No	One of (D6060) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6061	abutment supported porcelain fused to metal crown (noble metal)	0-18	Teeth 1 - 32	Yes	No	One of (D6061) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6062	abutment supported cast metal crown (high noble metal)	0-18	Teeth 1 - 32	Yes	No	One of (D6062) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Implant Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6063	abutment supported cast metal crown (predominantly base metal)	0-18	Teeth 1 - 32	Yes	No	One of (D6063) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6064	abutment supported cast metal crown (noble metal)	0-18	Teeth 1 - 32	Yes	No	One of (D6064) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6065	implant supported porcelain/ceramic crown	0-18	Teeth 1 - 32	Yes	No	One of (D6065) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6066	Implant Supported Crown-Porcelain Fused to High Noble Alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6066) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6067	Implant Supported Crown-High Noble Alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6067) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6068	abutment supported retainer for porcelain/ceramic FPD	0-18	Teeth 1 - 32	Yes	No	One of (D6068) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6069	abutment supported retainer for porcelain fused to metal FPD (high noble metal)	0-18	Teeth 1 - 32	Yes	No	One of (D6069) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6070	abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	0-18	Teeth 1 - 32	Yes	No	One of (D6070) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6071	abutment supported retainer for porcelain fused to metal FPD (noble metal)	0-18	Teeth 1 - 32	Yes	No	One of (D6071) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6072	abutment supported retainer for cast metal FPD (high noble metal)	0-18	Teeth 1 - 32	Yes	No	One of (D6072) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6073	abutment supported retainer for cast metal FPD (predominantly base metal)	0-18	Teeth 1 - 32	Yes	No	One of (D6073) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6074	abutment supported retainer for cast metal FPD (noble metal)	0-18	Teeth 1 - 32	Yes	No	One of (D6074) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6075	implant supported retainer for ceramic FPD	0-18	Teeth 1 - 32	Yes	No	One of (D6075) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Implant Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6076	Implant Supported Retainer for FPD-Porcelain Fused to High Noble Alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6076) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6077	Implant Supported Retainer for Metal FPD- High Noble Alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6078) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6080	implant maintenance procedure	0-18	Teeth 1 - 32	Yes	No	One of (D6080) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6081	scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	0-18	Teeth 1 - 32, 51 - 82	Yes	No	One of (D6081) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6082	Implant supported crown-porcelain fused to predominently base alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6082) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6083	Implant supported crown-porcelain fused to noble alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6083) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6084	Implant supported crown-porcelain fused to titanium and titanium alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6084) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6086	Implant supported crown-predominately base alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6086) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6087	Implant supported crown-noble alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6087) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6088	Implant supported crown-titanium and titanium alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6088) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6090	repair implant prosthesis	0-18	Teeth 1 - 32	Yes	No	One of (D6090) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6091	replacement of attachment-implant/abutment prosthesis	0-18		Yes	No	One of (D6091) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6095	repair implant abutment	0-18	Teeth 1 - 32	Yes	No	One of (D6095) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Implant Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6097	Abutment supported crown-porcelain fused to titanium and titanium alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6097) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6098	Implant supported retainer-porcelain fused to predominately base alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6098) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6099	Implant supported retainer for FPD- porcelain fused to noble alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6099) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6100	surgical removal of implant body	0-18	Teeth 1 - 32	Yes	No	One of (D6100) per 60 Month(s) Per patient per tooth. Dental provider who performed the original implant will not be reimbursed for the removal of the implant	pre-operative radiographs and narrative
D6101	debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure	0-18	Teeth 1 - 32, 51 - 82	Yes	No	One of (D6101) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6102	debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure	0-18	Teeth 1 - 32, 51 - 82	Yes	No	One of (D6102) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6103	bone graft for repair of peri-implant defect - does not include flap entry and closure. Placement of a barrier membrane or biologic materials to aid in osseous regeneration are reported separately	0-18	Teeth 1 - 32, 51 - 82	Yes	No	One of (D6103) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6104	Bone graft at time of implant placement	0-18	Teeth 1 - 32, 51 - 82	Yes	No	One of (D6104) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Implant Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6105	removal of implant body not requiring bone removal nor flap elevation	0-18	Teeth 1 - 32	Yes	Yes	One of (D6105) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6110	Implant/abutment supported removable dentur for edentulous arch - maxillary	0-18	Per Arch (01, 02, LA, UA)	Yes	No	One of (D6110) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6111	Implant/abutment supported removable dentur for edentulous arch - mandibular	0-18	Per Arch (01, 02, LA, UA)	Yes	No	One of (D6111) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary	0-18	Per Arch (01, 02, LA, UA)	Yes	No	One of (D6112) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular	0-18	Per Arch (01, 02, LA, UA)	Yes	No	One of (D6113) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary	0-18	Teeth 1 - 32	Yes	No	One of (D6114) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6115	Implant/abutment supported fixed denture for edentulous arch - mandibular	0-18	Teeth 1 - 32	Yes	No	One of (D6115) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6116	Implant/abutment supported fixed denture for partially edentulous arch - maxillary	0-18	Teeth 1 - 32	Yes	No	One of (D6116) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6117	Implant/abutment supported fixed denture for partially edentulous arch - mandibular	0-18	Teeth 1 - 32	Yes	No	One of (D6117) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6120	Implant supported retainer-porcelain fused to titanium and titanium alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6120) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6121	Implant supported retainer for metal FPD-predominately base alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6121) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Exhibit F Benefits Covered for CareSource Marketplace IN, NC Child

Implant Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6122	Implant supported retainer for metal FPD- noble alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6122) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6123	Implant supported retainer for metal FPD- titanium and titanium alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6123) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6190	radiographic/surgical implant index, by report	0-18	Teeth 1 - 32	Yes	No	One of (D6190) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6195	Abutment Supported Retainer- Porcelain fused to titanium and titanium alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6195) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6197	replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	0-18	Teeth 1 - 32	Yes	Yes	One of (D6197) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6210	pontic - cast high noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6211	pontic-cast base metal	0-18	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6212	pontic - cast noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6214	Pontic - titanium and titanium alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6240	pontic-porcelain fused-high noble	0-18	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6241	pontic-porcelain fused to base metal	0-18	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6242	pontic-porcelain fused-noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6243	Pontic - Porcelain fused to titanium and titanium alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6245	prosthodontics fixed, pontic - porcelain/ceramic	0-18	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6545	retainer - cast metal fixed	0-18	Teeth 1 - 32	Yes	No	One of (D6545, D6548, D6549) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6548	prosthodontics fixed, retainer - porcelain/ceramic for resin bonded fixed prosthodontic	0-18	Teeth 1 - 32	Yes	No	One of (D6545, D6548, D6549) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6549	Resin retainer-For resin bonded fixed prosthesis	0-18	Teeth 1 - 32	Yes	No	One of (D6545, D6548, D6549) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6600	inlay - porcelain/ceramic, two surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6601	inlay - porcelain/ceramic, three or more surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6602	inlay - cast high noble metal, two surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6603	inlay - cast high noble metal, three or more surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6604	inlay - cast predominantly base metal, two surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6605	inlay - cast predominantly base metal, three or more surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6606	inlay - cast noble metal, two surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6607	inlay - cast noble metal, three or more surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6608	onlay - porcelain/ceramic, two surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6609	onlay - porcelain/ceramic, three or more surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6610	onlay - cast high noble metal, two surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6611	onlay - cast high noble metal, three or more surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6612	onlay - cast predominantly base metal, two surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6613	onlay - cast predominantly base metal, three or more surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6614	onlay - cast noble metal, two surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6615	onlay - cast noble metal, three or more surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6624	inlay - titanium	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6634	onlay - titanium	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6740	retainer crown, porcelain/ceramic	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6750	crown-porcelain fused high noble	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6751	crown-porcelain fused to base metal	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6752	crown-porcelain fused noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6753	Retainer Crown- Porcelain fused to titanium and titanium alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6780	crown-3/4 cst high noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6781	prosthodontics fixed, crown ¾ cast predominantly based metal	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6782	prosthodontics fixed, crown ¾ cast noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6783	prosthodontics fixed, crown ¾ porcelain/ceramic	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6784	Retainer Crown 3/4-Titanium and Titanium Alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6790	crown-full cast high noble	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6791	crown - full cast base metal	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6792	crown - full cast noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6794	Retainer crown - titanium and titanium alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Exhibit F Benefits Covered for CareSource Marketplace IN, NC Child

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6930	re-cement or re-bond fixed partial denture	0-18		Yes	No	Not covered within 6 months of placement.	pre-operative radiographs and narrative
D6980	fixed partial denture repair	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No		pre-operative radiographs and narrative

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Oral and Maxillofacial Surgery							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D7111	extraction, coronal remnants - primary tooth	0-18	Teeth A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No		
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0-18	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No		
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	0-18	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No	Includes cutting of gingiva and bone, removal of tooth structure and closure. Subject to Post Review.	
D7220	removal of impacted tooth-soft tissue	0-18	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	No		pre-operative radiographs
D7230	removal of impacted tooth-partially bony	0-18	Teeth 1 - 32, 51 - 82	Yes	No		pre-operative radiographs
D7240	removal of impacted tooth-completely bony	0-18	Teeth 1 - 32, 51 - 82	Yes	No		pre-operative radiographs
D7241	removal of impacted tooth-completely bony, with unusual surgical complications	0-18	Teeth 1 - 32, 51 - 82	Yes	No		pre-operative radiographs
D7250	surgical removal of residual tooth roots (cutting procedure)	0-18	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	No		pre-operative radiographs
D7251	Coronectomy – intentional partial tooth removal, impacted teeth only	0-18	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	No		pre-operative radiographs

Oral and Maxillofacial Surgery							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	0-18	Teeth 1 - 32	Yes	No	Includes splinting and/or stabilization.	pre-operative radiographs
D7280	Surgical access of an unerupted tooth	0-18	Teeth 1 - 32	Yes	No		pre-operative radiographs
D7283	placement of device to facilitate eruption of impacted tooth	0-18	Teeth 1 - 32	No	No	One of (D7283) per 1 Lifetime Per patient per tooth. Has to be submitted in combination with D7280; Report the surgical exposure separately using D7280	
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D7310) per 1 Lifetime Per patient per quadrant. Minimum of four extractions in the affected quadrant. Covered only in conjunction with the construction of a prosthodontic appliance.	pre-operative radiographs
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D7311) per 1 Lifetime Per patient per quadrant. Minimum of four extractions in the affected quadrant. Covered only in conjunction with the construction of a prosthodontic appliance.	pre-operative radiographs
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D7320) per 1 Lifetime Per patient per quadrant. Minimum of four extractions in the affected quadrant. Covered only in conjunction with the construction of a prosthodontic appliance.	pre-operative radiographs
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D7321) per 1 Lifetime Per patient per quadrant. Minimum of four extractions in the affected quadrant. Covered only in conjunction with the construction of a prosthodontic appliance.	pre-operative radiographs

Exhibit F Benefits Covered for CareSource Marketplace IN, NC Child

Oral and Maxillofacial Surgery							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D7471	removal of exostosis - per site	0-18	Per Arch (01, 02, LA, UA)	Yes	No		pre-operative radiographs and narrative
D7510	incision and drainage of abscess - intraoral soft tissue	0-18	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No	Subject to Post Review.	
D7520	incision and drainage of abscess - extraoral soft tissue	0-18		No	No	Subject to Post Review.	
D7910	suture small wounds up to 5 cm	0-18		No	No	Subject to Post Review.	
D7953	bone replacement graft for ridge preservation - per site	0-18	Teeth 1 - 32	Yes	No	One of (D7953) per 1 Lifetime Per patient.	Narrative of medical necessity and photos
D7961	buccal / labial frenectomy (frenulectomy)	0-18		Yes	No		Narrative of medical necessity and photos
D7962	lingual frenectomy (frenulectomy)	0-18		Yes	No		Narrative of medical necessity and photos
D7970	excision of hyperplastic tissue - per arch	0-18	Per Arch (01, 02, LA, UA)	Yes	No	One of (D7970) per 1 Lifetime Per patient.	Narrative of medical necessity and photos
D7971	excision of pericoronal gingiva	0-18	Teeth 1 - 32	Yes	No		narr. of med. necessity, post-op x-ray(s)

Exhibit F Benefits Covered for CareSource Marketplace IN, NC Child

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Orthodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D8010	limited orthodontic treatment of the primary dentition	0-18		Yes	No	One of (D8010, D8020, D8030, D8040, D8070, D8080, D8090) per 1 Lifetime Per patient.	Study model or OrthoCad, x-rays
D8020	limited orthodontic treatment of the transitional dentition	0-18		Yes	No	One of (D8010, D8020, D8030, D8040, D8070, D8080, D8090) per 1 Lifetime Per patient.	Study model or OrthoCad, x-rays
D8030	limited orthodontic treatment of the adolescent dentition	0-18		Yes	No	One of (D8010, D8020, D8030, D8040, D8070, D8080, D8090) per 1 Lifetime Per patient.	Study model or OrthoCad, x-rays
D8040	limited orthodontic treatment of the adult dentition	0-18		Yes	No	One of (D8010, D8020, D8030, D8040, D8070, D8080, D8090) per 1 Lifetime Per patient.	Study model or OrthoCad, x-rays
D8070	comprehensive orthodontic treatment of the transitional dentition	0-18		Yes	No	One of (D8010, D8020, D8030, D8040, D8070, D8080, D8090) per 1 Lifetime Per patient.	Study model or OrthoCad, x-rays
D8080	comprehensive orthodontic treatment of the adolescent dentition	0-18		Yes	No	One of (D8010, D8020, D8030, D8040, D8070, D8080, D8090) per 1 Lifetime Per patient.	Study model or OrthoCad, x-rays
D8090	comprehensive orthodontic treatment of the adult dentition	0-18		Yes	No	One of (D8010, D8020, D8030, D8040, D8070, D8080, D8090) per 1 Lifetime Per patient.	Study model or OrthoCad, x-rays
D8210	removable appliance therapy (includes appliances for thumb sucking and tongue thrusting)	0-18		Yes	No	One of (D8210, D8220) per 1 Lifetime Per patient. Includes appliances for thumb sucking and tongue thrusting	Study model or OrthoCad, x-rays
D8220	fixed appliance therapy (includes appliances for thumb sucking and tongue thrusting)	0-18		Yes	No	One of (D8210, D8220) per 1 Lifetime Per patient. Includes appliances for thumb sucking and tongue thrusting	Study model or OrthoCad, x-rays

Exhibit F Benefits Covered for CareSource Marketplace IN, NC Child

Orthodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D8660	pre-orthodontic treatment examination to monitor growth and development	0-18		No	No	One of (D8660) per 1 Lifetime Per patient. Used for records (i.e. models, photos and pre-orthodontic work –up). Reimbursed even if orthodontic case is not approved Prior Authorization not required when submitted with requests for (D8010-D8220)	
D8670	periodic orthodontic treatment visit	0-18		Yes	No	One of (D8670) per 1 Lifetime Per patient. D8670 reimbursed in combination with active therapy and as part of complete ortho contract per case.	Study model or OrthoCad, x-rays
D8680	orthodontic retention (removal of appliances)	0-18		Yes	No	One of (D8680) per 1 Lifetime Per patient.	photos, xrays, treatment plan

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Adjunctive General Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D9110	palliative treatment of dental pain - per visit	0-18		No	No	One of (D9110) per 1 Day(s) Per patient.	
D9222	deep sedation/general anesthesia first 15 minutes	0-18		Yes	No	One of (D9222) per 1 Day(s) Per patient. Ten of (D9222, D9223) per 1 Calendar year(s) Per patient. This procedure code is not reimbursable on same date as D9239, D9243. Sedation approvals are limited to surgical and extensive cases	narr. of med. necessity, pre-op x-ray(s)
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	0-18		Yes	No	Four of (D9223) per 1 Day(s) Per patient. Ten of (D9222, D9223) per 1 Calendar year(s) Per patient. This procedure code is not reimbursable on same date as D9239, D9243. Sedation approvals are limited to surgical and extensive cases	narr. of med. necessity, pre-op x-ray(s)
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	0-18		Yes	No	One of (D9239) per 1 Day(s) Per patient. Ten of (D9239, D9243) per 1 Calendar year(s) Per patient. This procedure code is not reimbursable on same date as D9222, D9223. Sedation approvals are limited to surgical and extensive cases	narr. of med. necessity, pre-op x-ray(s)
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	0-18		Yes	No	Four of (D9243) per 1 Day(s) Per patient. Ten of (D9239, D9243) per 1 Calendar year(s) Per patient. This procedure code is not reimbursable on same date as D9222, D9223. Sedation approvals are limited to surgical and extensive cases	narr. of med. necessity, pre-op x-ray(s)

Exhibit F Benefits Covered for CareSource Marketplace IN, NC Child

Adjunctive General Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	0-18		No	No	One of (D9310) per 1 Day(s) Per patient. Includes consultation with medical professional (D9310 used in lieu of D9311)	
D9311	consultation with medical health care professional	0-18		No	No	One of (D9311) per 1 Day(s) Per patient. This should be used only for extensive consultation with medical professional regarding patient's medical issues.	
D9610	therapeutic drug injection, by report	0-18		Yes	No	One of (D9610) per 1 Day(s) Per patient. Description and dosage of drug.	narrative of medical necessity
D9930	treatment of complications (post-surgical) - unusual circumstances, by report	0-18		Yes	No		narrative of medical necessity
D9943	occlusal guard adjustment	0-18		No	No	One of (D9943) per 24 Month(s) Per patient.	
D9944	occlusal guard--hard appliance, full arch	13 - 18	Per Arch (01, 02, LA, UA)	Yes	No	One of (D9944, D9945, D9946) per 12 Month(s) Per patient.	narrative of medical necessity
D9945	occlusal guard--soft appliance full arch	13 - 18	Per Arch (01, 02, LA, UA)	Yes	No	One of (D9944, D9945, D9946) per 12 Month(s) Per patient.	narrative of medical necessity
D9946	occlusal guard--hard appliance, partial arch	13 - 18	Per Arch (01, 02, LA, UA)	Yes	No	One of (D9944, D9945, D9946) per 12 Month(s) Per patient.	narrative of medical necessity

Exhibit F Benefits Covered for CareSource Marketplace IN, NC Child

Adjunctive General Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D9995	teledentistry – synchronous; real-time encounter	0-18		No	No	Four of (D9995) per 1 Calendar year(s) Per patient. The appropriate teledentistry code (D9995) should be reported as descriptor codes to identify services (D0140, D0145) provided via teledentistry by the dentist who provided the oversight of the teledentistry encounter as allowed and in accordance with any applicable state laws and/or: regulations, licensure, state dental practice acts. A teledentistry event is subject to applicable state law, regulation or licensure. D9995 does not have separate distinct benefit limits, however, any benefit limits applicable to the underlying services rendered would continue to apply.	

Exhibit G Benefits Covered for CareSource Marketplace Child (OH)

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0120	periodic oral evaluation - established patient	0-18		No	No	Two of (D0120, D0140, D0145, D0150, D0180) per 1 Calendar year(s) Per patient. D0120 periodic oral evaluation may not occur in combination with D0150 on same date of service and not until 180 days after the D0150 comprehensive oral evaluation.	
D0140	limited oral evaluation-problem focused	0-18		No	No	Two of (D0120, D0140, D0145, D0150, D0180) per 1 Calendar year(s) Per patient. Note- This procedure code is used for emergency examinations during regularly scheduled office hours. Evaluations solely for the purpose of adjustments or in conjunction with multi-visit procedures are not covered (i.e. endodontics and orthodontia). May not be used in conjunction with D0120, D0150, D9440, and D0180	
D0145	oral evaluation for a patient under three years of age and counseling with primary caregiver	0-3		No	No	Two of (D0120, D0140, D0145, D0150, D0180) per 1 Calendar year(s) Per patient. Should be used only for first time visit for Children under three years who have not seen a dentist. Subsequent recall visit D0120 should be billed.	

Exhibit G Benefits Covered for CareSource Marketplace Child (OH)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0150	comprehensive oral evaluation - new or established patient	0-18		No	No	Two of (D0120, D0140, D0145, D0150, D0160, D0180) per 1 Calendar year(s) Per patient. One of (D0150) per 24 Month(s) Per Provider OR Location. D0150 used when evaluating a patient comprehensively. D0150 or the periodic exam D0120 may not occur in conjunction with a limited oral evaluation (examination during office hours- D0140 or after office hours- D9440)	
D0160	detailed and extensive oral eval-problem focused, by report	0-18		No	No	Two of (D0120, D0140, D0145, D0150, D0160, D0180) per 1 Calendar year(s) Per patient per tooth. A detailed & extensive problem focused eval entails extensive diagnostic and cognitive modalities based on the findings of a comprehensive oral evaluation. Integration of more extensive diagnostic modalities to develop a treatment plan for a specific problem is required. The cond requiring this type of eval should be described and documented. Examples of conditions requiring this type of eval may include dentofacial anomalies, complicated perio-prosthetic conditions, complex temporomandibular dysfunction, facial pain of unknown origin, conditions requiring multidisciplinary consult, etc.	

Exhibit G Benefits Covered for CareSource Marketplace Child (OH)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0180	comprehensive periodontal evaluation - new or established patient	0-18		No	No	Two of (D0120, D0140, D0145, D0150, D0180) per 1 Calendar year(s) Per patient. One of (D0180) per 24 Month(s) Per Provider OR Location. Reimbursement disallowed for D0180 performed in conjunction with either a D0150 or D0120.	
D0210	intraoral - comprehensive series of radiographic images	0-18		No	No	One of (D0210, D0330) per 60 Month(s) Per patient. Indicated for the permanent dentition or Adult dentate. A full-mouth series consist of a minimum of fourteen (14) films, including all periapical and posterior bitewing films intended to display the crowns and roots of all teeth, periapical areas and alveolar bone necessary for examination and diagnosis. PA required if done more frequently than 60 months	

Exhibit G Benefits Covered for CareSource Marketplace Child (OH)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0220	intraoral - periapical first radiographic image	0-18		No	No	One of (D0220) per 1 Day(s) Per patient. Any additional periapical films (D0230 should be used) If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series. Periapical radiographs are used diagnostically and are not reimbursable when used intraoperatively (i.e. during RCT or other procedural x-rays.	

Exhibit G Benefits Covered for CareSource Marketplace Child (OH)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0230	intraoral - periapical each additional radiographic image	0-18		No	No	Any additional periapical films (D0230 should be used) If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series. Periapical radiographs are used diagnostically and are not reimbursable when used intraoperatively (i.e. during RCT or other procedural x-rays.	

Exhibit G Benefits Covered for CareSource Marketplace Child (OH)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0240	intraoral - occlusal radiographic image	0-18		No	No	Any additional periapical films (D0230 should be used) If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series. Periapical radiographs are used diagnostically and are not reimbursable when used intraoperatively (i.e. during RCT or other procedural x-rays.	
D0250	extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	0-18		No	No	One of (D0250) per 1 Calendar year(s) Per patient.	

Exhibit G Benefits Covered for CareSource Marketplace Child (OH)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0270	bitewing - single radiographic image	0-18		No	No	A total of four horizontal bitewing films in any combination of (D0270, D0272, D0273 or D0274) per 6 Month(s) “Or” One set of vertical bitewings (D0277) per 6 Month(s) See fee limitations for all radiographs. If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series.	

Exhibit G Benefits Covered for CareSource Marketplace Child (OH)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0272	bitewings - two radiographic images	0-18		No	No	A total of four horizontal bitewing films in any combination of (D0270, D0272, D0273 or D0274) per 6 Month(s) “Or” One set of vertical bitewings (D0277) per 6 Month(s) See fee limitations for all radiographs. If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series.	

Exhibit G Benefits Covered for CareSource Marketplace Child (OH)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0273	bitewings - three radiographic images	0-18		No	No	A total of four horizontal bitewing films in any combination of (D0270, D0272, D0273 or D0274) per 6 Month(s) “Or” One set of vertical bitewings (D0277) per 6 Month(s) See fee limitations for all radiographs. If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series.	

Exhibit G Benefits Covered for CareSource Marketplace Child (OH)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0274	bitewings - four radiographic images	0-18		No	No	One of (D0274, D0277) per 6 Month(s) Per patient. A total of four horizontal bitewing films in any combination of (D0270, D0272, D0273 or D0274) per 6 Month(s) “Or” One set of vertical bitewings (D0277) per 6 Month(s) See fee limitations for all radiographs. If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series.	

Exhibit G Benefits Covered for CareSource Marketplace Child (OH)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0277	vertical bitewings - 7 to 8 films	0-18		No	No	One of (D0274, D0277) per 6 Month(s) Per patient. A total of four horizontal bitewing films in any combination of (D0270, D0272, D0273 or D0274) per 6 Month(s) “Or” One set of vertical bitewings (D0277) per 6 Month(s) See fee limitations for all radiographs. If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series.	
D0330	panoramic radiographic image	0-18		No	No	One of (D0210, D0330) per 60 Month(s) Per patient. All periapical or occlusal films taken same date of service needed to render the necessary radiographic diagnosis are included in the fee for panoramic radiograph. If bitewing radiographs D0270, D0272 or D0274 are indicated for additional diagnosis, the amount reimbursed will not exceed the reimbursable amount for D0210 Full Mouth Series. PA required if done more frequently than 60 months.	

Exhibit G Benefits Covered for CareSource Marketplace Child (OH)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0340	cephalometric radiographic image	0-18		No	No	One of (D0340) per 1 Day(s) Per Provider OR Location. Not included in single date of service maximum radiography reimbursable amount.	
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	0-18		No	No	One of (D0350) per 1 Day(s) Per Provider OR Location. Covered one per Orthodontist or Location as part of an Orthodontic case.	
D0372	intraoral tomosynthesis – comprehensive series of radiographic images	0-18		No	No	One of (D0210, D0277, D0330, D0372, D0387) per 1 Calendar year(s) Per patient.	
D0373	intraoral tomosynthesis – bitewing radiographic image	0-18		No	No	One of (D0270, D0272, D0273, D0274, D0277, D0373, D0388) per 1 Calendar year(s) Per patient.	
D0374	intraoral tomosynthesis – periapical radiographic image	0-18		No	No	One of (D0220, D0230, D0374, D0389) per 1 Calendar year(s) Per patient.	
D0387	intraoral tomosynthesis – comprehensive series of radiographic images – image capture only	0-18		No	No	One of (D0210, D0277, D0330, D0372, D0387) per 1 Calendar year(s) Per patient.	
D0388	intraoral tomosynthesis – bitewing radiographic image – image capture only	0-18		No	No	One of (D0270, D0272, D0273, D0274, D0277, D0373, D0388) per 1 Calendar year(s) Per patient.	
D0389	intraoral tomosynthesis – periapical radiographic image – image capture only	0-18		No	No	One of (D0220, D0230, D0374, D0389) per 1 Calendar year(s) Per patient.	
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report	0-18		No	No	One of (D0391) per 1 Day(s) Per Provider OR Location. Interpretation of diagnostic image and report by a Practitioner not associated with Image Capture. Report should be kept in patient record for post payment review as applicable.	

Exhibit G Benefits Covered for CareSource Marketplace Child (OH)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0470	diagnostic casts	0-18		No	No	One of (D0470) per 1 Day(s) Per Provider OR Location. One per case. Diagnostic models or study models used as a guide in the application of corrective or restorative dentistry. Payable as a diagnostic service intended for the documentation and subsequent analysis of occlusion.	

Exhibit G Benefits Covered for CareSource Marketplace Child (OH)

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D1110	prophylaxis - adult	13 - 18		No	No	Two of (D1110, D1120) per 1 Calendar year(s) Per patient. This service code used for permanent dentition.	
D1120	prophylaxis - child	0-12		No	No	Two of (D1110, D1120) per 1 Calendar year(s) Per patient. This service code used for primary dentition	
D1206	topical application of fluoride varnish	0-18		No	No	Two of (D1206, D1208) per 1 Calendar year(s) Per patient. Treatment that incorporates fluoride with the polishing compound is considered part of the prophylaxis procedure and not a separate topical fluoride treatment. The following treatments are not covered with use of D1206 or D1208: • Topical application of fluoride to the prepared portion of a tooth prior to restoration • The use of self or home fluoride application procedures	
D1208	topical application of fluoride - excluding varnish	0-18		No	No	Two of (D1206, D1208) per 1 Calendar year(s) Per patient. Treatment that incorporates fluoride with the polishing compound is considered part of the prophylaxis procedure and not a separate topical fluoride treatment. The following treatments are not covered with use of D1206 or D1208: • Topical application of fluoride to the prepared portion of a tooth prior to restoration • The use of self or home fluoride application procedures	

Exhibit G Benefits Covered for CareSource Marketplace Child (OH)

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D1351	sealant - per tooth	0-18	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	No	One of (D1351) per 36 Month(s) Per patient per tooth. Mechanically and/or chemically prepared enamel surface sealed to prevent decay. Sealants are reimbursable for unrestored pit and fissure surfaces (first and second molars only)	
D1352	Preventive resin restoration is a mod. to high caries risk patient perm tooth conservative rest of an active cavitated lesion in a pit or fissure that doesn't extend into dentin: includes placmt of a sealant in radiating non-carious fissure or pits.	0-18	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	No	One of (D1352) per 36 Month(s) Per patient per tooth. Conservative restoration of an active cavitated lesion in a pit or fissure that does not extend into dentin; includes placement of a sealant in any radiating noncarious fissures or pits. • Must be a conservative restoration using a bur that extends into enamel only and includes all the deep grooves of the tooth. • Must be placed on a non-restored permanent tooth that has not had a sealant placed within 1 year	
D1354	application of caries arresting medicament- per tooth	0-18	Teeth 2 - 15, 18 - 31, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No	One of (D1354, D1355) per 36 Month(s) Per patient per tooth. Ten of (D1354, D1355) per 1 Calendar year(s) Per patient. Conservative treatment of an active, non-symptomatic carious lesion by topical application of a caries arresting or inhibiting medicament and without mechanical removal of sound tooth structure.	

Exhibit G Benefits Covered for CareSource Marketplace Child (OH)

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D1355	caries preventive medicament application – per tooth	0-18	Teeth 2 - 15, 18 - 31, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No	One of (D1354, D1355) per 36 Month(s) Per patient per tooth. Ten of (D1354, D1355) per 1 Calendar year(s) Per patient. Conservative treatment by topical application of a caries preventive or inhibiting medicament for primary prevention or remineralization and without mechanical removal of sound tooth structure.	
D1510	space maintainer-fixed, unilateral- per quadrant	0-13	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of (D1510) per 60 Month(s) Per patient per quadrant. Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	

Exhibit G Benefits Covered for CareSource Marketplace Child (OH)

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D1516	space maintainer --fixed--bilateral, maxillary	0-13		No	No	One of (D1516) per 60 Month(s) Per patient per tooth. Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	
D1517	space maintainer --fixed--bilateral, mandibular	0-13		No	No	One of (D1517) per 60 Month(s) Per patient per tooth. Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	

Exhibit G Benefits Covered for CareSource Marketplace Child (OH)

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D1520	space maintainer-removable-unilateral	0-13	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of (D1520) per 60 Month(s) Per patient per quadrant. Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	
D1526	space maintainer --removable--bilateral, maxillary	0-13		No	No	One of (D1526) per 60 Month(s) Per patient per tooth. Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	

Exhibit G Benefits Covered for CareSource Marketplace Child (OH)

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D1527	space maintainer --removable--bilateral, mandibular	0-13		No	No	One of (D1527) per 60 Month(s) Per patient per tooth. Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	
D1551	re-cement or re-bond bilateral space maintainer-Maxillary	0-18		No	No	Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	

Exhibit G Benefits Covered for CareSource Marketplace Child (OH)

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D1552	re-cement or re-bond bilateral space maintainer-Mandibular	0-18		No	No	Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	
D1553	re-cement or re-bond unilateral space maintainer-Per Quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	

Exhibit G Benefits Covered for CareSource Marketplace Child (OH)

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D1556	Removal of fixed unilateral space maintainer- Per Quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	
D1557	Removal of fixed bilateral space maintainer- Maxillary	0-18		No	No	Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	

Exhibit G Benefits Covered for CareSource Marketplace Child (OH)

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D1558	Removal of fixed bilateral space maintainer-Mandibular	0-18		No	No	Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2140	Amalgam - one surface, primary or permanent	0-18	Teeth 1 - 32, A - T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	
D2150	Amalgam - two surfaces, primary or permanent	0-18	Teeth 1 - 32, A - T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	

Exhibit G Benefits Covered for CareSource Marketplace Child (OH)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2160	amalgam - three surfaces, primary or permanent	0-18	Teeth 1 - 32, A - T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	
D2161	amalgam - four or more surfaces, primary or permanent	0-18	Teeth 1 - 32, A - T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	

Exhibit G Benefits Covered for CareSource Marketplace Child (OH)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2330	resin-based composite - one surface, anterior	0-18	Teeth 6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. The fee for resin-based composite restorations will include any necessary acid etching and bonding agents. Non-contiguous restorations, such as a separate Distal Facial (DF) and Mesial Facial (MF) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	
D2331	resin-based composite - two surfaces, anterior	0-18	Teeth 6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. The fee for resin-based composite restorations will include any necessary acid etching and bonding agents. Non-contiguous restorations, such as a separate Distal Facial (DF) and Mesial Facial (MF) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2332	resin-based composite - three surfaces, anterior	0-18	Teeth 6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. The fee for resin-based composite restorations will include any necessary acid etching and bonding agents. Non-contiguous restorations, such as a separate Distal Facial (DF) and Mesial Facial (MF) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	0-18	Teeth 6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. The fee for resin-based composite restorations will include any necessary acid etching and bonding agents. Non-contiguous restorations, such as a separate Distal Facial (DF) and Mesial Facial (MF) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	

Exhibit G Benefits Covered for CareSource Marketplace Child (OH)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2391	resin-based composite - one surface, posterior	0-18	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. CareSource will reimburse based on Amalgam for posterior teeth.D2391 Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	
D2392	resin-based composite - two surfaces, posterior	0-18	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. CareSource will reimburse based on Amalgam for posterior teeth.D2391 Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	

Exhibit G Benefits Covered for CareSource Marketplace Child (OH)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2393	resin-based composite - three surfaces, posterior	0-18	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. CareSource will reimburse based on Amalgam for posterior teeth.D2391 Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	
D2394	resin-based composite - four or more surfaces, posterior	0-18	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. CareSource will reimburse based on Amalgam for posterior teeth.D2391 Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	

Exhibit G Benefits Covered for CareSource Marketplace Child (OH)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2510	inlay - metallic -1 surface	0-18	Teeth 1 - 32	No	No	One of (D2510) per 60 Month(s) Per patient per tooth. Covered only when a direct restoration (ie. amalgam, composite) will not adequately restore the tooth.	
D2520	inlay-metallic-2 surfaces	0-18	Teeth 1 - 32	No	No	One of (D2520) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	
D2530	inlay-metallic-3+ surfaces	0-18	Teeth 1 - 32	No	No	One of (D2530) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	
D2542	onlay - metallic - two surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2543	onlay-metallic-3 surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs

Exhibit G Benefits Covered for CareSource Marketplace Child (OH)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2544	onlay-metallic-4+ surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2750	crown - porcelain fused to high noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2751	crown - porcelain fused to predominantly base metal	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2752	crown - porcelain fused to noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs

Exhibit G Benefits Covered for CareSource Marketplace Child (OH)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2780	crown - ¾ cast high noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2781	crown - ¾ cast predominantly base metal	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2782	crown - ¾ cast noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2783	crown - ¾ porcelain/ceramic	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs

Exhibit G Benefits Covered for CareSource Marketplace Child (OH)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2791	crown - full cast predominantly base metal	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2792	crown - full cast noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2794	Crown- Titanium and Titanium Alloys	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	0-18	Teeth 1 - 32	No	No	Not reimbursable within 6 months of initial placement.	
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core	0-18	Teeth 1 - 32	No	No	Not reimbursable within 6 months of initial placement.	
D2920	re-cement or re-bond crown	0-18	Teeth 1 - 32, A - T	No	No	Not reimbursable within 6 months of initial placement.	

Exhibit G Benefits Covered for CareSource Marketplace Child (OH)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2928	prefabricated porcelain/ceramic crown – permanent tooth	0-18	Teeth 1 - 32	No	No	One of (D2928, D2929, D2930, D2931, D2933, D2934) per 60 Month(s) Per patient per tooth. Greater than 6 units of (D2928, D2929, D2930, D2931, D2933, and D2934) per date of service may be subject to post review.	
D2929	Prefabricated porcelain/ceramic crown – primary tooth	0-14	Teeth A - T	No	No	One of (D2928, D2929, D2930, D2931, D2933, D2934) per 60 Month(s) Per patient per tooth. Greater than 6 units of (D2928, D2929, D2930, D2931, D2933, and D2934) per date of service may be subject to post review.	
D2930	prefabricated stainless steel crown - primary tooth	0-14	Teeth A - T	No	No	One of (D2928, D2929, D2930, D2931, D2933, D2934) per 60 Month(s) Per patient per tooth. Greater than 6 units of (D2928, D2929, D2930, D2931, D2933, and D2934) per date of service may be subject to post review.	
D2931	prefabricated stainless steel crown-permanent tooth	0-14	Teeth 1 - 32	No	No	One of (D2928, D2929, D2930, D2931, D2933, D2934) per 60 Month(s) Per patient per tooth. Greater than 6 units of (D2928, D2929, D2930, D2931, D2933, and D2934) per date of service may be subject to post review.	
D2933	prefabricated stainless steel crown with resin window	0-14	Teeth 1 - 32, A - T	No	No	One of (D2928, D2929, D2930, D2931, D2933, D2934) per 60 Month(s) Per patient per tooth. Greater than 6 units of (D2928, D2929, D2930, D2931, D2933, and D2934) per date of service may be subject to post review.	

Exhibit G Benefits Covered for CareSource Marketplace Child (OH)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	0-14	Teeth A - T	No	No	One of (D2928, D2929, D2930, D2931, D2933, D2934) per 60 Month(s) Per patient per tooth. Greater than 6 units of (D2928, D2929, D2930, D2931, D2933, and D2934) per date of service may be subject to post review.	
D2940	protective restoration	0-18	Teeth 1 - 32	No	No	One of (D2940) per 1 Calendar year(s) Per patient per tooth. Restorative material to protect tooth and/or tissue form. Used to relieve pain, promote healing, and prevent further deterioration. Not reimbursable when used as endodontic access closure, or as a base or liner under restoration.	
D2950	core buildup, including any pins when required	0-18	Teeth 1 - 32	Yes	No	One of (D2950) per 60 Month(s) Per patient per tooth.	pre-operative radiographs
D2951	pin retention - per tooth, in addition to restoration	0-18	Teeth 1 - 32	No	No	Three of (D2951) per 1 Lifetime Per patient per tooth.	
D2952	cast post and core in addition to crown	0-18	Teeth 1 - 32	Yes	No	One of (D2952, D2954) per 60 Month(s) Per patient per tooth.	pre-operative radiographs
D2953	each additional cast post - same tooth	0-18	Teeth 1 - 32	Yes	No	One of (D2953) per 60 Month(s) Per patient per tooth.	pre-operative radiographs
D2954	prefabricated post and core in addition to crown	0-18	Teeth 1 - 32	Yes	No	One of (D2952, D2954) per 60 Month(s) Per patient per tooth.	pre-operative radiographs
D2957	each additional prefabricated post - same tooth	0-18	Teeth 1 - 32	Yes	No	One of (D2957) per 60 Month(s) Per patient per tooth.	pre-operative radiographs

Exhibit G Benefits Covered for CareSource Marketplace Child (OH)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2961	labial veneer (resin laminate) - laboratory	0-18	Teeth 1 - 32	Yes	No	One of (D2961, D2962) per 60 Month(s) Per patient per tooth. D2961, D2962 may be covered in lieu of crowns when clinically indicated for anterior teeth that are severely fractured or carious, that cannot be adequately repaired with a direct restoration (i.e., CDT codes D2330–D2335) Not reimbursable when performed solely for cosmetic/aesthetic reasons.	Pre-operative radiographs and operative report
D2962	labial veneer (porc laminate) - laboratory	0-18	Teeth 1 - 32	Yes	No	One of (D2961, D2962) per 60 Month(s) Per patient per tooth. D2961, D2962 may be covered in lieu of crowns when clinically indicated for anterior teeth that are severely fractured or carious, that cannot be adequately repaired with a direct restoration (i.e., CDT codes D2330–D2335) Not reimbursable when performed solely for cosmetic/aesthetic reasons.	Pre-operative radiographs and operative report
D2980	crown repair, by report	0-18	Teeth 1 - 32	Yes	No	One of (D2980) per 60 Month(s) Per patient per tooth.	Narr / Oper Rpt
D2981	Inlay repair necessitated by restorative material failure	0-18	Teeth 1 - 32, 51 - 82	Yes	No	One of (D2981) per 60 Month(s) Per patient per tooth.	Narr / Oper Rpt
D2982	Onlay repair necessitated by restorative material failure	0-18	Teeth 1 - 32, 51 - 82	Yes	No	One of (D2982) per 60 Month(s) Per patient per tooth.	Narr / Oper Rpt
D2983	Veneer repair necessitated by restorative material failure	0-18	Teeth 1 - 32, 51 - 82	Yes	No	One of (D2983) per 60 Month(s) Per patient per tooth.	Narr / Oper Rpt
D2990	Resin infiltration of incipient smooth surface lesions	0-18	Teeth 1 - 32, A - T	No	No	One of (D2990) per 60 Month(s) Per patient per tooth.	

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Endodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	0-18	Teeth 1 - 32, A - T	No	No	One of (D3220) per 1 Lifetime Per patient per tooth. If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.	
D3222	partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	0-18	Teeth 1 - 32	No	No	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.	
D3230	pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	0-11	Teeth C, H, M, R	No	No	One of (D3230) per 1 Lifetime Per patient per tooth.	
D3230	pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	0-6	Teeth D - G, N - Q	No	No	One of (D3230) per 1 Lifetime Per patient per tooth.	
D3240	pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	0-11	Teeth A, B, I - L, S, T	No	No	One of (D3240) per 1 Lifetime Per patient per tooth.	

Endodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D3310	endodontic therapy, anterior tooth (excluding final restoration)	0-18	Teeth 6 - 11, 22 - 27	No	No	One of (D3310) per 1 Lifetime Per patient per tooth. 1)Once per tooth per lifetime except for exception cases of appropriate medical necessity.2)The date the RCT is completed should be the date of service.3)Reimbursement for a root canal includes opening and drainage, treatment planning, clinical procedures, follow-up care, radiographs during treatment, and post-operative radiographs. 4)D3310,D3320,D3330 are subject to Post Review Third molar wisdom teeth will only be considered for coverage when tooth is functional.	
D3320	endodontic therapy, premolar tooth (excluding final restoration)	0-18	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	No	One of (D3320) per 1 Lifetime Per patient per tooth. 1)Once per tooth per lifetime except for exception cases of appropriate medical necessity.2)The date the RCT is completed should be the date of service.3)Reimbursement for a root canal includes opening and drainage, treatment planning, clinical procedures, follow-up care, radiographs during treatment, and post-operative radiographs. 4)D3310,D3320,D3330 are subject to Post Review Third molar wisdom teeth will only be considered for coverage when tooth is functional.	

Endodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D3330	endodontic therapy, molar tooth (excluding final restoration)	0-18	Teeth 1 - 3, 14 - 19, 30 - 32	No	No	One of (D3330) per 1 Lifetime Per patient per tooth. 1)Once per tooth per lifetime except for exception cases of appropriate medical necessity.2)The date the RCT is completed should be the date of service.3)Reimbursement for a root canal includes opening and drainage, treatment planning, clinical procedures, follow-up care, radiographs during treatment, and post-operative radiographs. 4)D3310,D3320,D3330 are subject to Post Review Third molar wisdom teeth will only be considered for coverage when tooth is functional.	
D3346	retreatment of previous root canal therapy-anterior	0-18	Teeth 6 - 11, 22 - 27	No	No	One of (D3346) per 1 Lifetime Per patient per tooth. 1)Dental provider who performed the original root canal should not be reimbursed for the retreatment for the first 12 months 2)D3346, D3347, D3348 are subject to Post Review	
D3347	retreatment of previous root canal therapy - premolar	0-18	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	No	One of (D3347) per 1 Lifetime Per patient per tooth. 1)Dental provider who performed the original root canal should not be reimbursed for the retreatment for the first 12 months 2)D3346, D3347, D3348 are subject to Post Review	

Endodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D3348	retreatment of previous root canal therapy-molar	0-18	Teeth 1 - 3, 14 - 19, 30 - 32	No	No	One of (D3348) per 1 Lifetime Per patient per tooth. 1)Dental provider who performed the original root canal should not be reimbursed for the retreatment for the first 12 months 2)D3346, D3347, D3348 are subject to Post Review	
D3351	apexification/recalcification - initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	0-18	Teeth 1 - 32	Yes	No	One of (D3351) per 1 Lifetime Per patient per tooth. Initial opening, preparation and first placement of medication and necessary radiographs	pre-operative radiographs
D3352	apexification/recalcification - interim medication replacement	0-18	Teeth 1 - 32	Yes	No	One of (D3352) per 1 Lifetime Per patient per tooth. For visits in which the intra-canal medication is replaced with new medication, includes any necessary radiographs	pre-operative radiographs
D3353	apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	0-18	Teeth 1 - 32	Yes	No	One of (D3353) per 1 Lifetime Per patient per tooth. Includes removal of intra-canal medication and procedures necessary to place final root canal filling material, includes necessary radiographs.	pre-operative radiographs
D3355	Pulpal regeneration - initial visit	0-18	Teeth 1 - 32	No	No	One of (D3355) per 1 Lifetime Per patient per tooth. Subject to Post Review	
D3356	Pulpal regeneration - interim medication replacement	0-18	Teeth 1 - 32	No	No	One of (D3356) per 1 Lifetime Per patient per tooth. Subject to Post Review	
D3357	Pulpal regeneration - completion of treatment	0-18	Teeth 1 - 32	No	No	One of (D3357) per 1 Lifetime Per patient per tooth. Subject to Post Review	
D3410	apicoectomy - anterior	0-18	Teeth 6 - 11, 22 - 27	Yes	No	One of (D3410) per 1 Lifetime Per patient per tooth.	pre-operative radiographs
D3421	apicoectomy - premolar (first root)	0-18	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	No	One of (D3421) per 1 Lifetime Per patient per tooth.	pre-operative radiographs

Exhibit G Benefits Covered for CareSource Marketplace Child (OH)

Endodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D3425	apicoectomy - molar (first root)	0-18	Teeth 1 - 3, 14 - 19, 30 - 32	Yes	No	One of (D3425) per 1 Lifetime Per patient per tooth.	pre-operative radiographs
D3426	apicoectomy (each additional root)	0-18	Teeth 1 - 5, 12 - 21, 28 - 32	Yes	No	One of (D3426) per 1 Lifetime Per patient per tooth.	pre-operative radiographs
D3450	root amputation - per root	0-18	Teeth 1 - 32	Yes	No		pre-operative radiographs
D3471	surgical repair of root resorption - anterior	0-18	Teeth 6 - 11, 22 - 27	No	No	One of (D3471) per 1 Lifetime Per patient per tooth.	
D3472	surgical repair of root resorption – premolar	0-18	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	No	One of (D3472) per 1 Lifetime Per patient per tooth.	
D3473	surgical repair of root resorption – molar	0-18	Teeth 1 - 3, 14 - 19, 30 - 32	No	No	One of (D3473) per 1 Lifetime Per patient per tooth.	
D3501	surgical exposure of root surface without apicoectomy or repair of root resorption – anterior	0-18	Teeth 6 - 11, 22 - 27	No	No	One of (D3501) per 1 Lifetime Per patient per tooth.	
D3502	surgical exposure of root surface without apicoectomy or repair of root resorption – premolar	0-18	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	No	One of (D3502) per 1 Lifetime Per patient per tooth.	
D3503	surgical exposure of root surface without apicoectomy or repair of root resorption – molar	0-18	Teeth 1 - 3, 14 - 19, 30 - 32	No	No	One of (D3503) per 1 Lifetime Per patient per tooth.	
D3920	hemisection (including any root removal), not incl root canal therapy	0-18	Teeth 1 - 3, 14 - 19, 30 - 32	Yes	No		pre-operative radiographs

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Periodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4210, D4211) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4210, D4211) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	0-18	Teeth 1 - 32, 51 - 82	Yes	No	One of (D4212) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4240	gingival flap procedure, including root planing – four or more contiguous teeth or tooth bound spaces per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4240, D4241) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4241	gingival flap procedure, including root planing – one to three contiguous teeth or tooth bound spaces per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4240, D4241) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4249	clinical crown lengthening - hard tissue	0-18	Teeth 1 - 32	Yes	No	One of (D4249) per 36 Month(s) Per patient per tooth.	Pre-op xrays, narr of med necessity, lab bill docs
D4260	osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4260, D4261) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4261	osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4260, D4261) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting

Periodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D4263	bone replacement graft - first site in quadrant	0-18	Teeth 1 - 32	Yes	No	One of (D4263) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4270	pedicle soft tissue graft procedure	0-18	Teeth 1 - 32	Yes	No	One of (D4270) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4273	subepithelial connective tissue graft procedure	0-18	Teeth 1 - 32	Yes	No	One of (D4273) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4275	soft tissue allograft	0-18	Teeth 1 - 32	Yes	No	One of (D4275) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	0-18	Teeth 1 - 32, 51 - 82	Yes	No		pre-op x-ray(s), perio charting
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	0-18	Teeth 1 - 32, 51 - 82	Yes	No	One of (D4278) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4283	autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	0-18	Teeth 1 - 32	Yes	No	One of (D4283) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4285	non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	0-18	Teeth 1 - 32	Yes	No	One of (D4285) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4341	periodontal scaling and root planing - four or more teeth per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. A minimum of four affected teeth in the quadrant.	pre-op x-ray(s), perio charting

Exhibit G Benefits Covered for CareSource Marketplace Child (OH)

Periodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D4342	periodontal scaling and root planing - one to three teeth per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. One to three affected teeth in the quadrant.	pre-op x-ray(s), perio charting
D4355	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	0-18		No	No	One of (D4355) per 1 Lifetime Per patient. Subject to Post Review.	
D4910	periodontal maintenance procedures	0-18		No	No	Four of (D1110, D4910) per 12 Month(s) Per patient. D4341 or D4342 must be on file for claims or documentation from patient record history of periodontal therapy within the last 6 months.	

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D5110	complete denture - maxillary	0-18		Yes	No	One of (D5110, D5130) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5120	complete denture - mandibular	0-18		Yes	No	One of (D5120, D5140) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5130	immediate denture - maxillary	0-18		Yes	No	One of (D5110, D5130) per 60 Month(s) Per patient. Reimbursement made upon delivery (completion) of immediate maxillary or mandibular denture. D5130, D5140 reimbursed on the same date of service as the extraction of all remaining teeth.Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5140	immediate denture - mandibular	0-18		Yes	No	One of (D5120, D5140) per 60 Month(s) Per patient. Reimbursement made upon delivery (completion) of immediate maxillary or mandibular denture. D5130, D5140 reimbursed on the same date of service as the extraction of all remaining teeth.Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5211	maxillary partial denture, resin base (including retentive/clasping materials, rests, and teeth)	0-18		Yes	No	One of (D5211, D5213, D5221, D5223) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan

Exhibit G Benefits Covered for CareSource Marketplace Child (OH)

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D5212	mandibular partial denture, resin base (including retentive/clasping materials, rests, and teeth)	0-18		Yes	No	One of (D5212, D5214, D5222, D5224) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5213	maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	0-18		Yes	No	One of (D5211, D5213, D5221, D5223) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5214	mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	0-18		Yes	No	One of (D5212, D5214, D5222, D5224) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5221	immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	0-18		Yes	No	One of (D5211, D5213, D5221, D5223) per 60 Month(s) Per patient. Reimbursement made upon delivery (completion) of immediate maxillary or mandibular partial denture. Reimbursed on the same date of service as the extraction of all remaining teeth.Includes adjustments within 6 months of initial placement	pre-operative x-ray(s)
D5222	immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	0-18		Yes	No	One of (D5212, D5214, D5222, D5224) per 60 Month(s) Per patient. Reimbursement made upon delivery (completion) of immediate maxillary or mandibular partial denture. Reimbursed on the same date of service as the extraction of all remaining teeth.Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D5223	immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	0-18		Yes	No	One of (D5211, D5213, D5221, D5223) per 60 Month(s) Per patient. Reimbursement made upon delivery (completion) of immediate maxillary or mandibular partial denture. Reimbursed on the same date of service as the extraction of all remaining teeth.Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5224	immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	0-18		Yes	No	One of (D5212, D5214, D5222, D5224) per 60 Month(s) Per patient. Reimbursement made upon delivery (completion) of immediate maxillary or mandibular partial denture. Reimbursed on the same date of service as the extraction of all remaining teeth.Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5282	Removable unilateral partial denture--one piececast metal (including clasps and teeth), maxillary	16 - 18		Yes	No	One of (D5282) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5283	Removable unilateral partial denture--one piececast metal (including clasps and teeth), mandibular	16 - 18		Yes	No	One of (D5283) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5410	adjust complete denture - maxillary	0-18		No	No	Not covered within 6 months of initial placement.	
D5411	adjust complete denture - mandibular	0-18		No	No	Not covered within 6 months of initial placement.	
D5421	adjust partial denture-maxillary	0-18		No	No	Not covered within 6 months of initial placement.	
D5422	adjust partial denture - mandibular	0-18		No	No	Not covered within 6 months of initial placement.	

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D5511	repair broken complete denture base, mandibular	0-18		No	No	Limited to repairs or adjustments performed more than 12 months after the initial insertion.	
D5512	repair broken complete denture base, maxillary	0-18		No	No	Limited to repairs or adjustments performed more than 12 months after the initial insertion.	
D5520	replace missing or broken teeth - complete denture (each tooth)	0-18	Teeth 1 - 32	No	No	Not covered within 6 months of initial placement.	
D5611	repair resin partial denture base, mandibular	0-18		No	No	Limited to repairs or adjustments performed more than 12 months after the initial insertion.	
D5612	repair resin partial denture base, maxillary	0-18		No	No	Limited to repairs or adjustments performed more than 12 months after the initial insertion.	
D5621	repair cast partial framework, mandibular	0-18		No	No	Limited to repairs or adjustments performed more than 12 months after the initial insertion.	
D5622	repair cast partial framework, maxillary	0-18		No	No	Limited to repairs or adjustments performed more than 12 months after the initial insertion.	
D5630	repair or replace broken retentive/clasping materials per tooth	0-18	Teeth 1 - 32	No	No	Not covered within 6 months of initial placement.	
D5640	replace broken teeth-per tooth	0-18	Teeth 1 - 32	No	No	Not covered within 6 months of initial placement.	
D5650	add tooth to existing partial denture	0-18	Teeth 1 - 32	No	No		
D5710	rebase complete maxillary denture	0-18		No	No	One of (D5710) per 36 Month(s) Per patient. 6 months after initial installation	

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D5711	rebase complete mandibular denture	0-18		No	No	One of (D5711) per 36 Month(s) Per patient. 6 months after initial installation	
D5720	rebase maxillary partial denture	0-18		No	No	One of (D5720) per 36 Month(s) Per patient. 6 months after initial installation	
D5721	rebase mandibular partial denture	0-18		No	No	One of (D5721) per 36 Month(s) Per patient. 6 months after initial installation	
D5730	reline complete maxillary denture (chairside)	0-18		No	No	One of (D5730) per 36 Month(s) Per patient. 6 months after initial installation	
D5731	reline complete mandibular denture (chairside)	0-18		No	No	One of (D5731) per 36 Month(s) Per patient. 6 months after initial installation	
D5740	reline maxillary partial denture (chairside)	0-18		No	No	One of (D5740) per 36 Month(s) Per patient. 6 months after initial installation	
D5741	reline mandibular partial denture (chairside)	0-18		No	No	One of (D5741) per 36 Month(s) Per patient. 6 months after initial installation	
D5750	reline complete maxillary denture (laboratory)	0-18		No	No	One of (D5750) per 36 Month(s) Per patient. 6 months after initial installation	
D5751	reline complete mandibular denture (laboratory)	0-18		No	No	One of (D5751) per 36 Month(s) Per patient. 6 months after initial installation	
D5760	reline maxillary partial denture (laboratory)	0-18		No	No	One of (D5760) per 36 Month(s) Per patient. 6 months after initial installation	
D5761	reline mandibular partial denture (laboratory)	0-18		No	No	One of (D5761) per 36 Month(s) Per patient. 6 months after initial installation	
D5850	tissue conditioning, maxillary	0-18		No	No		
D5851	tissue conditioning,mandibular	0-18		No	No		

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Implant Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6010	surgical placement of implant body: endosteal implant	0-18	Teeth 1 - 32	Yes	No	One of (D6010) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6012	surgical placement of interim implant body-endosteal implant	0-18	Teeth 1 - 32	Yes	No	One of (D6012) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6040	surgical placement:eposteal implnt	0-18	Per Arch (01, 02, LA, UA)	Yes	No	One of (D6040) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6050	surgical placement-transosteal implant	0-18	Teeth 1 - 32	Yes	No	One of (D6050) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6055	connecting bar - implant supported or abutment supported	0-18	Teeth 1 - 32	Yes	No	One of (D6055) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6056	prefabricated abutment	0-18	Teeth 1 - 32	Yes	No	One of (D6056) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6057	custom abutment	0-18	Teeth 1 - 32	Yes	No	One of (D6057) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6058	abutment supported porcelain/ceramic crown	0-18	Teeth 1 - 32	Yes	No	One of (D6058) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6059	abutment supported porcelain fused to metal crown (high noble metal)	0-18	Teeth 1 - 32	Yes	No	One of (D6059) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6060	abutment supported porcelain fused to metal crown (predominantly base metal)	0-18	Teeth 1 - 32	Yes	No	One of (D6060) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6061	abutment supported porcelain fused to metal crown (noble metal)	0-18	Teeth 1 - 32	Yes	No	One of (D6061) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6062	abutment supported cast metal crown (high noble metal)	0-18	Teeth 1 - 32	Yes	No	One of (D6062) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Implant Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6063	abutment supported cast metal crown (predominantly base metal)	0-18	Teeth 1 - 32	Yes	No	One of (D6063) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6064	abutment supported cast metal crown (noble metal)	0-18	Teeth 1 - 32	Yes	No	One of (D6064) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6065	implant supported porcelain/ceramic crown	0-18	Teeth 1 - 32	Yes	No	One of (D6065) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6066	Implant Supported Crown-Porcelain Fused to High Noble Alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6066) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6067	Implant Supported Crown-High Noble Alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6067) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6068	abutment supported retainer for porcelain/ceramic FPD	0-18	Teeth 1 - 32	Yes	No	One of (D6068) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6069	abutment supported retainer for porcelain fused to metal FPD (high noble metal)	0-18	Teeth 1 - 32	Yes	No	One of (D6069) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6070	abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	0-18	Teeth 1 - 32	Yes	No	One of (D6070) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6071	abutment supported retainer for porcelain fused to metal FPD (noble metal)	0-18	Teeth 1 - 32	Yes	No	One of (D6071) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6072	abutment supported retainer for cast metal FPD (high noble metal)	0-18	Teeth 1 - 32	Yes	No	One of (D6072) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6073	abutment supported retainer for cast metal FPD (predominantly base metal)	0-18	Teeth 1 - 32	Yes	No	One of (D6073) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6074	abutment supported retainer for cast metal FPD (noble metal)	0-18	Teeth 1 - 32	Yes	No	One of (D6074) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6075	implant supported retainer for ceramic FPD	0-18	Teeth 1 - 32	Yes	No	One of (D6075) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Implant Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6076	Implant Supported Retainer for FPD-Porcelain Fused to High Noble Alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6076) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6077	Implant Supported Retainer for Metal FPD- High Noble Alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6078) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6080	implant maintenance procedure	0-18	Teeth 1 - 32	Yes	No	One of (D6080) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6081	scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	0-18	Teeth 1 - 32, 51 - 82	Yes	No	One of (D6081) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6082	Implant supported crown-porcelain fused to predominently base alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6082) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6083	Implant supported crown-porcelain fused to noble alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6083) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6084	Implant supported crown-porcelain fused to titanium and titanium alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6084) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6086	Implant supported crown-predominately base alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6086) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6087	Implant supported crown-noble alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6087) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6088	Implant supported crown-titanium and titanium alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6088) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6090	repair implant prosthesis	0-18	Teeth 1 - 32	Yes	No	One of (D6090) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6091	replacement of attachment-implant/abutment prosthesis	0-18		Yes	No	One of (D6091) per 60 Month(s) Per patient per tooth.	Photos, Narrative/treatment plan
D6095	repair implant abutment	0-18	Teeth 1 - 32	Yes	No	One of (D6095) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Implant Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6097	Abutment supported crown-porcelain fused to titanium and titanium alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6097) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6098	Implant supported retainer-porcelain fused to predominately base alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6098) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6099	Implant supported retainer for FPD- porcelain fused to noble alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6099) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6100	surgical removal of implant body	0-18	Teeth 1 - 32	Yes	No	One of (D6100) per 60 Month(s) Per patient per tooth. Dental provider who performed the original implant will not be reimbursed for the removal of the implant	pre-operative radiographs and narrative
D6101	debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure	0-18	Teeth 1 - 32, 51 - 82	Yes	No	One of (D6101) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6102	debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure	0-18	Teeth 1 - 32, 51 - 82	Yes	No	One of (D6102) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6103	bone graft for repair of peri-implant defect - does not include flap entry and closure. Placement of a barrier membrane or biologic materials to aid in osseous regeneration are reported separately	0-18	Teeth 1 - 32, 51 - 82	Yes	No	One of (D6103) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6104	Bone graft at time of implant placement	0-18	Teeth 1 - 32, 51 - 82	Yes	No	One of (D6104) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Exhibit G Benefits Covered for CareSource Marketplace Child (OH)

Implant Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6105	removal of implant body not requiring bone removal nor flap elevation	0-18	Teeth 1 - 32	Yes	Yes	One of (D6105) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6110	Implant/abutment supported removable dentur for edentulous arch - maxillary	0-18	Per Arch (01, 02, LA, UA)	Yes	No	One of (D6110) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6111	Implant/abutment supported removable dentur for edentulous arch - mandibular	0-18	Per Arch (01, 02, LA, UA)	Yes	No	One of (D6111) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary	0-18	Per Arch (01, 02, LA, UA)	Yes	No	One of (D6112) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular	0-18	Per Arch (01, 02, LA, UA)	Yes	No	One of (D6113) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary	0-18	Teeth 1 - 32	Yes	No	One of (D6114) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6115	Implant/abutment supported fixed denture for edentulous arch - mandibular	0-18	Teeth 1 - 32	Yes	No	One of (D6115) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6116	Implant/abutment supported fixed denture for partially edentulous arch - maxillary	0-18	Teeth 1 - 32	Yes	No	One of (D6116) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6117	Implant/abutment supported fixed denture for partially edentulous arch - mandibular	0-18	Teeth 1 - 32	Yes	No	One of (D6117) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6120	Implant supported retainer-porcelain fused to titanium and titanium alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6120) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6121	Implant supported retainer for metal FPD-predominately base alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6121) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Exhibit G Benefits Covered for CareSource Marketplace Child (OH)

Implant Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6122	Implant supported retainer for metal FPD- noble alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6122) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6123	Implant supported retainer for metal FPD- titanium and titanium alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6123) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6190	radiographic/surgical implant index, by report	0-18	Teeth 1 - 32	Yes	No	One of (D6190) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6195	Abutment Supported Retainer- Porcelain fused to titanium and titanium alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6195) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6197	replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	0-18	Teeth 1 - 32	Yes	Yes	One of (D6197) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6210	pontic - cast high noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6211	pontic-cast base metal	0-18	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6212	pontic - cast noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6214	Pontic - titanium and titanium alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6240	pontic-porcelain fused-high noble	0-18	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6241	pontic-porcelain fused to base metal	0-18	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6242	pontic-porcelain fused-noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6243	Pontic - Porcelain fused to titanium and titanium alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6245	prosthodontics fixed, pontic - porcelain/ceramic	0-18	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6545	retainer - cast metal fixed	0-18	Teeth 1 - 32	Yes	No	One of (D6545, D6548, D6549) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6548	prosthodontics fixed, retainer - porcelain/ceramic for resin bonded fixed prosthodontic	0-18	Teeth 1 - 32	Yes	No	One of (D6545, D6548, D6549) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6549	Resin retainer-For resin bonded fixed prosthesis	0-18	Teeth 1 - 32	Yes	No	One of (D6545, D6548, D6549) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6600	inlay - porcelain/ceramic, two surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6601	inlay - porcelain/ceramic, three or more surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6602	inlay - cast high noble metal, two surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6603	inlay - cast high noble metal, three or more surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6604	inlay - cast predominantly base metal, two surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6605	inlay - cast predominantly base metal, three or more surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6606	inlay - cast noble metal, two surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6607	inlay - cast noble metal, three or more surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6608	onlay - porcelain/ceramic, two surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6609	onlay - porcelain/ceramic, three or more surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6610	onlay - cast high noble metal, two surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6611	onlay - cast high noble metal, three or more surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6612	onlay - cast predominantly base metal, two surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6613	onlay - cast predominantly base metal, three or more surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6614	onlay - cast noble metal, two surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6615	onlay - cast noble metal, three or more surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6624	inlay - titanium	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6634	onlay - titanium	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6740	retainer crown, porcelain/ceramic	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6750	crown-porcelain fused high noble	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6751	crown-porcelain fused to base metal	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6752	crown-porcelain fused noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6753	Retainer Crown- Porcelain fused to titanium and titanium alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6780	crown-3/4 cst high noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6781	prosthodontics fixed, crown ¾ cast predominantly based metal	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6782	prosthodontics fixed, crown ¾ cast noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6783	prosthodontics fixed, crown ¾ porcelain/ceramic	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6784	Retainer Crown 3/4-Titanium and Titanium Alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6790	crown-full cast high noble	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6791	crown - full cast base metal	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6792	crown - full cast noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6794	Retainer crown - titanium and titanium alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Exhibit G Benefits Covered for CareSource Marketplace Child (OH)

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6930	re-cement or re-bond fixed partial denture	0-18		Yes	No	Not covered within 6 months of placement.	pre-operative radiographs and narrative
D6980	fixed partial denture repair	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No		pre-operative radiographs and narrative

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Oral and Maxillofacial Surgery							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D7111	extraction, coronal remnants - primary tooth	0-18	Teeth A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No		
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0-18	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No		
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	0-18	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No	Includes cutting of gingiva and bone, removal of tooth structure and closure. Subject to Post Review.	
D7220	removal of impacted tooth-soft tissue	0-18	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	No		pre-operative radiographs
D7230	removal of impacted tooth-partially bony	0-18	Teeth 1 - 32, 51 - 82	Yes	No		pre-operative radiographs
D7240	removal of impacted tooth-completely bony	0-18	Teeth 1 - 32, 51 - 82	Yes	No		pre-operative radiographs
D7241	removal of impacted tooth-completely bony, with unusual surgical complications	0-18	Teeth 1 - 32, 51 - 82	Yes	No		pre-operative radiographs
D7250	surgical removal of residual tooth roots (cutting procedure)	0-18	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	No		pre-operative radiographs
D7251	Coronectomy – intentional partial tooth removal, impacted teeth only	0-18	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	No		pre-operative radiographs

Exhibit G Benefits Covered for CareSource Marketplace Child (OH)

Oral and Maxillofacial Surgery							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	0-18	Teeth 1 - 32	Yes	No	Includes splinting.	pre-operative radiographs
D7280	Surgical access of an unerupted tooth	0-18	Teeth 1 - 32	Yes	No		pre-operative radiographs
D7283	placement of device to facilitate eruption of impacted tooth	0-18	Teeth 1 - 32	No	No	One of (D7283) per 1 Lifetime Per patient per tooth. Has to be submitted in combination with D7280; Report the surgical exposure separately using D7280	
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D7310) per 1 Lifetime Per patient per quadrant. Minimum of four extractions in the affected quadrant. Covered only in conjunction with the construction of a prosthodontic appliance.	pre-operative radiographs
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D7311) per 1 Lifetime Per patient per quadrant. Minimum of four extractions in the affected quadrant. Covered only in conjunction with the construction of a prosthodontic appliance.	pre-operative radiographs
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D7320) per 1 Lifetime Per patient per quadrant. Minimum of four extractions in the affected quadrant. Covered only in conjunction with the construction of a prosthodontic appliance.	pre-operative radiographs
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D7321) per 1 Lifetime Per patient per quadrant. Minimum of four extractions in the affected quadrant. Covered only in conjunction with the construction of a prosthodontic appliance.	pre-operative radiographs

Exhibit G Benefits Covered for CareSource Marketplace Child (OH)

Oral and Maxillofacial Surgery							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D7471	removal of exostosis - per site	0-18	Per Arch (01, 02, LA, UA)	Yes	No		pre-operative radiographs and narrative
D7510	incision and drainage of abscess - intraoral soft tissue	0-18	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No	Subject to Post Review.	
D7520	incision and drainage of abscess - extraoral soft tissue	0-18		No	No	Subject to Post Review.	
D7910	suture small wounds up to 5 cm	0-18		No	No	Subject to Post Review.	
D7953	bone replacement graft for ridge preservation - per site	0-18	Teeth 1 - 32	Yes	No	One of (D7953) per 1 Lifetime Per patient.	Narrative of medical necessity and photos
D7961	buccal / labial frenectomy (frenulectomy)	0-18		Yes	No		Narrative of medical necessity and photos
D7962	lingual frenectomy (frenulectomy)	0-18		Yes	No		Narrative of medical necessity and photos
D7970	excision of hyperplastic tissue - per arch	0-18	Per Arch (01, 02, LA, UA)	Yes	No	One of (D7970) per 1 Lifetime Per patient.	Narrative of medical necessity and photos
D7971	excision of pericoronal gingiva	0-18	Teeth 1 - 32	Yes	No		Narrative of medical necessity and photos

Exhibit G Benefits Covered for CareSource Marketplace Child (OH)

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Orthodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D8010	limited orthodontic treatment of the primary dentition	0-18		Yes	No	One of (D8010, D8020, D8030, D8040, D8070, D8080, D8090) per 1 Lifetime Per patient.	Study model or OrthoCad, x-rays
D8020	limited orthodontic treatment of the transitional dentition	0-18		Yes	No	One of (D8010, D8020, D8030, D8040, D8070, D8080, D8090) per 1 Lifetime Per patient.	Study model or OrthoCad, x-rays
D8030	limited orthodontic treatment of the adolescent dentition	0-18		Yes	No	One of (D8010, D8020, D8030, D8040, D8070, D8080, D8090) per 1 Lifetime Per patient.	Study model or OrthoCad, x-rays
D8040	limited orthodontic treatment of the adult dentition	0-18		Yes	No	One of (D8010, D8020, D8030, D8040, D8070, D8080, D8090) per 1 Lifetime Per patient.	Study model or OrthoCad, x-rays
D8070	comprehensive orthodontic treatment of the transitional dentition	0-18		Yes	No	One of (D8010, D8020, D8030, D8040, D8070, D8080, D8090) per 1 Lifetime Per patient.	Study model or OrthoCad, x-rays
D8080	comprehensive orthodontic treatment of the adolescent dentition	0-18		Yes	No	One of (D8010, D8020, D8030, D8040, D8070, D8080, D8090) per 1 Lifetime Per patient.	Study model or OrthoCad, x-rays
D8090	comprehensive orthodontic treatment of the adult dentition	0-18		Yes	No	One of (D8010, D8020, D8030, D8040, D8070, D8080, D8090) per 1 Lifetime Per patient.	Study model or OrthoCad, x-rays
D8210	removable appliance therapy (includes appliances for thumb sucking and tongue thrusting)	0-18		Yes	No	One of (D8210, D8220) per 1 Lifetime Per patient. Includes appliances for thumb sucking and tongue thrusting	Study model or OrthoCad, x-rays
D8220	fixed appliance therapy (includes appliances for thumb sucking and tongue thrusting)	0-18		Yes	No	One of (D8210, D8220) per 1 Lifetime Per patient. Includes appliances for thumb sucking and tongue thrusting	Study model or OrthoCad, x-rays

Exhibit G Benefits Covered for CareSource Marketplace Child (OH)

Orthodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D8660	pre-orthodontic treatment examination to monitor growth and development	0-18		No	No	One of (D8660) per 1 Lifetime Per patient. Used for records (i.e. models, photos and pre-orthodontic work –up). Reimbursed even if orthodontic case is not approved Prior Authorization not required when submitted with requests for (D8010-D8220)	
D8670	periodic orthodontic treatment visit	0-18		Yes	No	One of (D8670) per 1 Lifetime Per patient. D8670 reimbursed in combination with active therapy and as part of complete ortho contract per case.	Study model or OrthoCad, x-rays
D8680	orthodontic retention (removal of appliances)	0-18		Yes	No	One of (D8680) per 1 Lifetime Per patient.	photos, xrays, treatment plan

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Adjunctive General Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D9110	palliative treatment of dental pain - per visit	0-18		No	No	One of (D9110) per 1 Day(s) Per patient.	
D9222	deep sedation/general anesthesia first 15 minutes	0-18		Yes	No	One of (D9222) per 1 Day(s) Per patient. Ten of (D9222, D9223) per 1 Calendar year(s) Per patient. This procedure code is not reimbursable on same date as D9239, D9243. Sedation approvals are limited to surgical and extensive cases	narr. of med. necessity, pre-op x-ray(s)
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	0-18		Yes	No	Four of (D9223) per 1 Day(s) Per patient. Ten of (D9222, D9223) per 1 Calendar year(s) Per patient. This procedure code is not reimbursable on same date as D9239, D9243. Sedation approvals are limited to surgical and extensive cases	narr. of med. necessity, pre-op x-ray(s)
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	0-18		Yes	No	One of (D9239) per 1 Day(s) Per patient. Ten of (D9239, D9243) per 1 Calendar year(s) Per patient. This procedure code is not reimbursable on same date as D9222, D9223. Sedation approvals are limited to surgical and extensive cases	narr. of med. necessity, pre-op x-ray(s)
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	0-18		Yes	No	Four of (D9243) per 1 Day(s) Per patient. Ten of (D9239, D9243) per 1 Calendar year(s) Per patient. This procedure code is not reimbursable on same date as D9222, D9223. Sedation approvals are limited to surgical and extensive cases	narr. of med. necessity, pre-op x-ray(s)

Exhibit G Benefits Covered for CareSource Marketplace Child (OH)

Adjunctive General Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	0-18		No	No	One of (D9310) per 1 Day(s) Per patient. Includes consultation with medical professional (D9310 used in lieu of D9311)	
D9311	consultation with medical health care professional	0-18		No	No	One of (D9311) per 1 Day(s) Per patient. This should be used only for extensive consultation with medical professional regarding patient's medical issues.	
D9610	therapeutic drug injection, by report	0-18		Yes	No	One of (D9610) per 1 Day(s) Per patient. Description and dosage of drug.	narrative of medical necessity
D9930	treatment of complications (post-surgical) - unusual circumstances, by report	0-18		Yes	No		narrative of medical necessity
D9943	occlusal guard adjustment	0-18		No	No	One of (D9943) per 24 Month(s) Per patient.	
D9944	occlusal guard--hard appliance, full arch	13 - 18	Per Arch (01, 02, LA, UA)	Yes	No	One of (D9944, D9945, D9946) per 12 Month(s) Per patient.	narrative of medical necessity
D9945	occlusal guard--soft appliance full arch	13 - 18	Per Arch (01, 02, LA, UA)	Yes	No	One of (D9944, D9945, D9946) per 12 Month(s) Per patient.	narrative of medical necessity
D9946	occlusal guard--hard appliance, partial arch	13 - 18	Per Arch (01, 02, LA, UA)	Yes	No	One of (D9944, D9945, D9946) per 12 Month(s) Per patient.	narrative of medical necessity

Exhibit G Benefits Covered for CareSource Marketplace Child (OH)

Adjunctive General Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D9995	teledentistry – synchronous; real-time encounter	0-18		No	No	Four of (D9995) per 1 Calendar year(s) Per patient. The appropriate teledentistry code (D9995) should be reported as descriptor codes to identify services (D0140, D0145) provided via teledentistry by the dentist who provided the oversight of the teledentistry encounter as allowed and in accordance with any applicable state laws and/or: regulations, licensure, state dental practice acts. A teledentistry event is subject to applicable state law, regulation or licensure. D9995 does not have separate distinct benefit limits, however, any benefit limits applicable to the underlying services rendered would continue to apply.	

Exhibit H Benefits Covered for CareSource Marketplace Child (WV)

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0120	periodic oral evaluation - established patient	0-18		No	No	Two of (D0120, D0140, D0145, D0150, D0160, D0180) per 1 Calendar year(s) Per patient. D0120 periodic oral evaluation may not occur in combination with D0150 on same date of service and not until 180 days after the D0150 comprehensive oral evaluation.	
D0140	limited oral evaluation-problem focused	0-18		No	No	Two of (D0120, D0140, D0145, D0150, D0160, D0180) per 1 Calendar year(s) Per patient. Note- This procedure code is used for emergency examinations during regularly scheduled office hours. Evaluations solely for the purpose of adjustments or in conjunction with multi-visit procedures are not covered (i.e. endodontics and orthodontia). May not be used in conjunction with D0120, D0150, D9440, and D0180	
D0145	oral evaluation for a patient under three years of age and counseling with primary caregiver	0-3		No	No	Two of (D0120, D0140, D0145, D0150, D0160, D0180) per 1 Calendar year(s) Per patient. Should be used only for first time visit for Children under three years who have not seen a dentist. Subsequent recall visit D0120 should be billed.	

Exhibit H Benefits Covered for CareSource Marketplace Child (WV)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0150	comprehensive oral evaluation - new or established patient	0-18		No	No	Two of (D0120, D0140, D0145, D0150, D0160, D0180) per 1 Calendar year(s) Per patient. One of (D0150) per 24 Month(s) Per Provider OR Location. D0150 used when evaluating a patient comprehensively. D0150 or the periodic exam D0120 may not occur in conjunction with a limited oral evaluation (examination during office hours- D0140 or after office hours- D9440)	
D0160	detailed and extensive oral eval-problem focused, by report	0-18		No	No	Two of (D0120, D0140, D0145, D0150, D0160, D0180) per 1 Calendar year(s) Per patient. A detailed & extensive problem focused eval entails extensive diagnostic and cognitive modalities based on the findings of a comprehensive oral evaluation. Integration of more extensive diagnostic modalities to develop a treatment plan for a specific problem is required. The cond requiring this type of eval should be described and documented. Examples of conditions requiring this type of eval may include dentofacial anomalies, complicated perio-prosthetic conditions, complex temporomandibular dysfunction, facial pain of unknown origin, conditions requiring multidisciplinary consult, etc.	

Exhibit H Benefits Covered for CareSource Marketplace Child (WV)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0180	comprehensive periodontal evaluation - new or established patient	0-18		No	No	Two of (D0120, D0140, D0145, D0150, D0160, D0180) per 1 Calendar year(s) Per patient. Reimbursement disallowed for D0180 performed in conjunction with either a D0150 or D0120.	
D0210	intraoral - comprehensive series of radiographic images	0-18		No	No	One of (D0210, D0330) per 60 Month(s) Per patient. Indicated for the permanent dentition or Adult dentate. A full-mouth series consist of a minimum of fourteen (14) films, including all periapical and posterior bitewing films intended to display the crowns and roots of all teeth, periapical areas and alveolar bone necessary for examination and diagnosis. PA required if done more frequently than 60 months	

Exhibit H Benefits Covered for CareSource Marketplace Child (WV)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0220	intraoral - periapical first radiographic image	0-18		No	No	One of (D0220) per 1 Day(s) Per patient. Any additional periapical films (D0230 should be used) If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series. Periapical radiographs are used diagnostically and are not reimbursable when used intraoperatively (i.e. during RCT or other procedural x-rays.	

Exhibit H Benefits Covered for CareSource Marketplace Child (WV)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0230	intraoral - periapical each additional radiographic image	0-18		No	No	Two of (D0230) per 12 Month(s) Per patient. Any additional periapical films (D0230 should be used) If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series. Periapical radiographs are used diagnostically and are not reimbursable when used intraoperatively (i.e. during RCT or other procedural x-rays.	

Exhibit H Benefits Covered for CareSource Marketplace Child (WV)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0240	intraoral - occlusal radiographic image	0-18		No	No	Two of (D0240) per 12 Month(s) Per patient. Any additional periapical films (D0230 should be used) If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series. Periapical radiographs are used diagnostically and are not reimbursable when used intraoperatively (i.e. during RCT or other procedural x-rays.	
D0250	extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	0-18		No	No	One of (D0250) per 12 Month(s) Per patient.	

Exhibit H Benefits Covered for CareSource Marketplace Child (WV)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0270	bitewing - single radiographic image	0-18		No	No	A total of four horizontal bitewing films in any combination of (D0270, D0272, D0273 or D0274) per 6 Month(s) “Or” One set of vertical bitewings (D0277) per 6 Month(s) See fee limitations for all radiographs. If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series.	

Exhibit H Benefits Covered for CareSource Marketplace Child (WV)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0272	bitewings - two radiographic images	0-18		No	No	A total of four horizontal bitewing films in any combination of (D0270, D0272, D0273 or D0274) per 6 Month(s) “Or” One set of vertical bitewings (D0277) per 6 Month(s) See fee limitations for all radiographs. If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series.	

Exhibit H Benefits Covered for CareSource Marketplace Child (WV)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0273	bitewings - three radiographic images	0-18		No	No	A total of four horizontal bitewing films in any combination of (D0270, D0272, D0273 or D0274) per 6 Month(s) “Or” One set of vertical bitewings (D0277) per 6 Month(s) See fee limitations for all radiographs. If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series.	

Exhibit H Benefits Covered for CareSource Marketplace Child (WV)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0274	bitewings - four radiographic images	0-18		No	No	One of (D0274, D0277) per 6 Month(s) Per patient. A total of four horizontal bitewing films in any combination of (D0270, D0272, D0273 or D0274) per 6 Month(s) “Or” One set of vertical bitewings (D0277) per 6 Month(s) See fee limitations for all radiographs. If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series.	

Exhibit H Benefits Covered for CareSource Marketplace Child (WV)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0277	vertical bitewings - 7 to 8 films	0-18		No	No	One of (D0274, D0277) per 6 Month(s) Per patient. A total of four horizontal bitewing films in any combination of (D0270, D0272, D0273 or D0274) per 6 Month(s) “Or” One set of vertical bitewings (D0277) per 6 Month(s) See fee limitations for all radiographs. If the total allowed amount for radiography services (D0220 – D0240) and (D0270 - D0277) performed on a Member for a single date of service exceeds the allowed amount for procedure code D0210 (Complete Series of Radiographic Images), the submitted radiograph codes will be consolidated and maximum fee reimbursement will be limited to the allowed amount of the D0210 complete series.	
D0330	panoramic radiographic image	0-18		No	No	One of (D0210, D0330) per 60 Month(s) Per patient. All periapical or occlusal films taken same date of service needed to render the necessary radiographic diagnosis are included in the fee for panoramic radiograph. If bitewing radiographs D0270, D0272 or D0274 are indicated for additional diagnosis, the amount reimbursed will not exceed the reimbursable amount for D0210 Full Mouth Series. PA required if done more frequently than 60 months.	

Exhibit H Benefits Covered for CareSource Marketplace Child (WV)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0340	cephalometric radiographic image	0-18		No	No	One of (D0340) per 1 Day(s) Per Provider OR Location. Not included in single date of service maximum radiography reimbursable amount.	
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	0-18		No	No	One of (D0350) per 1 Day(s) Per Provider OR Location. Covered one per Orthodontist or Location as part of an Orthodontic case.	
D0372	intraoral tomosynthesis – comprehensive series of radiographic images	0-18		No	No	One of (D0210, D0277, D0330, D0372, D0387) per 1 Calendar year(s) Per patient.	
D0373	intraoral tomosynthesis – bitewing radiographic image	0-18		No	No	One of (D0270, D0272, D0273, D0274, D0277, D0373, D0388) per 1 Calendar year(s) Per patient.	
D0374	intraoral tomosynthesis – periapical radiographic image	0-18		No	No	One of (D0220, D0230, D0374, D0389) per 1 Calendar year(s) Per patient.	
D0387	intraoral tomosynthesis – comprehensive series of radiographic images – image capture only	0-18		No	No	One of (D0210, D0277, D0330, D0372, D0387) per 1 Calendar year(s) Per patient per tooth.	
D0388	intraoral tomosynthesis – bitewing radiographic image – image capture only	0-18		No	No	One of (D0270, D0272, D0273, D0274, D0277, D0373, D0388) per 1 Calendar year(s) Per patient.	
D0389	intraoral tomosynthesis – periapical radiographic image – image capture only	0-18		No	No	One of (D0220, D0230, D0374, D0389) per 1 Calendar year(s) Per patient.	
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report	0-18		No	No	One of (D0391) per 1 Day(s) Per Provider OR Location. Interpretation of diagnostic image and report by a Practitioner not associated with Image Capture. Report should be kept in patient record for post payment review as applicable.	

Exhibit H Benefits Covered for CareSource Marketplace Child (WV)

Diagnostic							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D0470	diagnostic casts	0-18		No	No	One of (D0470) per 1 Day(s) Per Provider OR Location. One per case. Diagnostic models or study models used as a guide in the application of corrective or restorative dentistry. Payable as a diagnostic service intended for the documentation and subsequent analysis of occlusion.	

Exhibit H Benefits Covered for CareSource Marketplace Child (WV)

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D1110	prophylaxis - adult	13 - 18		No	No	Two of (D1110, D1120) per 1 Calendar year(s) Per patient. This service code used for permanent dentition. Must allow an additional cleaning per benefit year for covered persons under the care of a medical professional during pregnancy.	
D1120	prophylaxis - child	0-12		No	No	Two of (D1110, D1120) per 1 Calendar year(s) Per patient. This service code used for primary dentition. Must allow an additional cleaning per benefit year for covered persons under the care of a medical professional during pregnancy.	
D1206	topical application of fluoride varnish	0-18		No	No	Two of (D1206, D1208) per 1 Calendar year(s) Per patient. Treatment that incorporates fluoride with the polishing compound is considered part of the prophylaxis procedure and not a separate topical fluoride treatment. The following treatments are not covered with use of D1206 or D1208: • Topical application of fluoride to the prepared portion of a tooth prior to restoration • The use of self or home fluoride application procedures	

Exhibit H Benefits Covered for CareSource Marketplace Child (WV)

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D1208	topical application of fluoride - excluding varnish	0-18		No	No	Two of (D1206, D1208) per 1 Calendar year(s) Per patient. Treatment that incorporates fluoride with the polishing compound is considered part of the prophylaxis procedure and not a separate topical fluoride treatment. The following treatments are not covered with use of D1206 or D1208: • Topical application of fluoride to the prepared portion of a tooth prior to restoration • The use of self or home fluoride application procedures	
D1351	sealant - per tooth	0-18	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	No	One of (D1351) per 36 Month(s) Per patient per tooth. Mechanically and/or chemically prepared enamel surface sealed to prevent decay. Sealants are reimbursable for unrestored pit and fissure surfaces (first and second molars only)	
D1352	Preventive resin restoration is a mod. to high caries risk patient perm tooth conservative rest of an active cavitated lesion in a pit or fissure that doesn't extend into dentin: includes placmt of a sealant in radiating non-carious fissure or pits.	0-18	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	No	One of (D1352) per 36 Month(s) Per patient per tooth. Conservative restoration of an active cavitated lesion in a pit or fissure that does not extend into dentin; includes placement of a sealant in any radiating noncarious fissures or pits. • Must be a conservative restoration using a bur that extends into enamel only and includes all the deep grooves of the tooth. • Must be placed on a non-restored permanent tooth that has not had a sealant placed within 1 year	

Exhibit H Benefits Covered for CareSource Marketplace Child (WV)

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D1354	application of caries arresting medicament- per tooth	0-18	Teeth 2 - 15, 18 - 31, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No	One of (D1354, D1355) per 36 Month(s) Per patient per tooth. Ten of (D1354, D1355) per 1 Day(s) Per patient. Conservative treatment of an active, non-symptomatic carious lesion by topical application of a caries arresting or inhibiting medicament and without mechanical removal of sound tooth structure.	
D1355	caries preventive medicament application – per tooth	0-18	Teeth 2 - 15, 18 - 31, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No	One of (D1354, D1355) per 36 Month(s) Per patient per tooth. Ten of (D1354, D1355) per 1 Day(s) Per patient. Conservative treatment by topical application of a caries preventive or inhibiting medicament for primary prevention or remineralization and without mechanical removal of sound tooth structure.	

Exhibit H Benefits Covered for CareSource Marketplace Child (WV)

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D1510	space maintainer-fixed, unilateral- per quadrant	0-13	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of (D1510) per 60 Month(s) Per patient per quadrant. Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	
D1516	space maintainer --fixed--bilateral, maxillary	0-13		No	No	One of (D1516) per 60 Month(s) Per patient per tooth. Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	

Exhibit H Benefits Covered for CareSource Marketplace Child (WV)

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D1517	space maintainer --fixed--bilateral, mandibular	0-13		No	No	One of (D1517) per 60 Month(s) Per patient per tooth. Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	
D1520	space maintainer-removable-unilateral	0-13	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	One of (D1520) per 60 Month(s) Per patient per tooth. Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	

Exhibit H Benefits Covered for CareSource Marketplace Child (WV)

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D1526	space maintainer --removable--bilateral, maxillary	0-13		No	No	One of (D1526) per 60 Month(s) Per patient per tooth. Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	
D1527	space maintainer --removable--bilateral, mandibular	0-13		No	No	One of (D1527) per 60 Month(s) Per patient per tooth. Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	

Exhibit H Benefits Covered for CareSource Marketplace Child (WV)

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D1551	re-cement or re-bond bilateral space maintainer-Maxillary	0-13		No	No	Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	
D1552	re-cement or re-bond bilateral space maintainer-Mandibular	0-13		No	No	Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	

Exhibit H Benefits Covered for CareSource Marketplace Child (WV)

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D1553	re-cement or re-bond unilateral space maintainer- Per Quadrant	0-13	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	
D1556	Removal of fixed unilateral space maintainer- Per Quadrant	0-13	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	

Exhibit H Benefits Covered for CareSource Marketplace Child (WV)

Preventative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D1557	Removal of fixed bilateral space maintainer- Maxillary	0-13		No	No	Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	
D1558	Removal of fixed bilateral space maintainer- Mandibular	0-13		No	No	Space Maintenance Therapy Covered when indicated due to premature loss of posterior primary teethAdjustments are included for 6 monthsAge maximum 13 Maintainers for primary anterior teeth or missing permanent teeth are not coveredAppropriate code for claim form UR-upper right =10 UL-upper left = 20 LL-lower left. = 30 LR-lower right = 40 Upper 01 Lower 02 Pre-operative and post op radiographs and chart notes should be available upon request for reviewNot covered by dentist or practice that originally placed the appliance	

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2140	Amalgam - one surface, primary or permanent	0-18	Teeth 1 - 32, A - T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	
D2150	Amalgam - two surfaces, primary or permanent	0-18	Teeth 1 - 32, A - T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	

Exhibit H Benefits Covered for CareSource Marketplace Child (WV)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2160	amalgam - three surfaces, primary or permanent	0-18	Teeth 1 - 32, A - T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	
D2161	amalgam - four or more surfaces, primary or permanent	0-18	Teeth 1 - 32, A - T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	

Exhibit H Benefits Covered for CareSource Marketplace Child (WV)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2330	resin-based composite - one surface, anterior	0-18	Teeth 6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. The fee for resin-based composite restorations will include any necessary acid etching and bonding agents. Non-contiguous restorations, such as a separate Distal Facial (DF) and Mesial Facial (MF) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	
D2331	resin-based composite - two surfaces, anterior	0-18	Teeth 6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. The fee for resin-based composite restorations will include any necessary acid etching and bonding agents. Non-contiguous restorations, such as a separate Distal Facial (DF) and Mesial Facial (MF) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	

Exhibit H Benefits Covered for CareSource Marketplace Child (WV)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2332	resin-based composite - three surfaces, anterior	0-18	Teeth 6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. The fee for resin-based composite restorations will include any necessary acid etching and bonding agents. Non-contiguous restorations, such as a separate Distal Facial (DF) and Mesial Facial (MF) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	0-18	Teeth 6 - 11, 22 - 27, C - H, M - R	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. The fee for resin-based composite restorations will include any necessary acid etching and bonding agents. Non-contiguous restorations, such as a separate Distal Facial (DF) and Mesial Facial (MF) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	

Exhibit H Benefits Covered for CareSource Marketplace Child (WV)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2391	resin-based composite - one surface, posterior	0-18	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. CareSource will reimburse based on Amalgam for posterior teeth.D2391 Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	
D2392	resin-based composite - two surfaces, posterior	0-18	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. CareSource will reimburse based on Amalgam for posterior teeth.D2391 Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	

Exhibit H Benefits Covered for CareSource Marketplace Child (WV)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2393	resin-based composite - three surfaces, posterior	0-18	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. CareSource will reimburse based on Amalgam for posterior teeth.D2391 Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	
D2394	resin-based composite - four or more surfaces, posterior	0-18	Teeth 1 - 5, 12 - 21, 28 - 32, A, B, I - L, S, T	No	No	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 Month(s) Per patient per tooth, per surface. CareSource will reimburse based on Amalgam for posterior teeth.D2391 Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure. Non-contiguous restorations, such as a separate Distal Occlusal (DO) and Mesial Occlusal (MO) on the same tooth, are billable as a three surface restoration. Each claim line for restorative services must relate to only one tooth number.	

Exhibit H Benefits Covered for CareSource Marketplace Child (WV)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2510	inlay - metallic -1 surface	0-18	Teeth 1 - 32	No	No	One of (D2510) per 60 Month(s) Per patient per tooth. Covered only when a direct restoration (ie. amalgam, composite) will not adequately restore the tooth.	
D2520	inlay-metallic-2 surfaces	0-18	Teeth 1 - 32	No	No	One of (D2520) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	
D2530	inlay-metallic-3+ surfaces	0-18	Teeth 1 - 32	No	No	One of (D2530) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	
D2542	onlay - metallic - two surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs
D2543	onlay-metallic-3 surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs

Exhibit H Benefits Covered for CareSource Marketplace Child (WV)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2544	onlay-metallic-4+ surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2750	crown - porcelain fused to high noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2751	crown - porcelain fused to predominantly base metal	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2752	crown - porcelain fused to noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs

Exhibit H Benefits Covered for CareSource Marketplace Child (WV)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2780	crown - ¾ cast high noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2781	crown - ¾ cast predominantly base metal	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2782	crown - ¾ cast noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2783	crown - ¾ porcelain/ceramic	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs

Exhibit H Benefits Covered for CareSource Marketplace Child (WV)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2790	crown - full cast high noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2791	crown - full cast predominantly base metal	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2792	crown - full cast noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2794	Crown- Titanium and Titanium Alloys	0-18	Teeth 1 - 32	Yes	No	One of (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) per 60 Month(s) Per patient per tooth. Limited to fully developed permanent teeth and primary teeth with no permanent successors.	pre-operative radiographs
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	0-18	Teeth 1 - 32	No	No	Not allowed within 6 months of delivery.	

Exhibit H Benefits Covered for CareSource Marketplace Child (WV)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core	0-18	Teeth 1 - 32	No	No	Not covered within 6 months of initial placement.	
D2920	re-cement or re-bond crown	0-18	Teeth 1 - 32, A - T	No	No	Not reimbursable within 6 months of initial placement.	
D2928	prefabricated porcelain/ceramic crown – permanent tooth	0-18	Teeth 1 - 32	No	No	One of (D2928, D2929, D2930, D2931, D2933, D2934) per 60 Month(s) Per patient per tooth. Greater than 6 units of (D2928, D2929, D2930, D2931, D2933, and D2934) per date of service may be subject to post review.	
D2929	Prefabricated porcelain/ceramic crown – primary tooth	0-14	Teeth A - T	No	No	One of (D2928, D2929, D2930, D2931, D2933, D2934) per 60 Month(s) Per patient per tooth. Greater than 6 units of (D2928, D2929, D2930, D2931, D2933, and D2934) per date of service may be subject to post review.	
D2930	prefabricated stainless steel crown - primary tooth	0-14	Teeth A - T	No	No	One of (D2928, D2929, D2930, D2931, D2933, D2934) per 60 Month(s) Per patient per tooth. Greater than 6 units of (D2928, D2929, D2930, D2931, D2933, and D2934) per date of service may be subject to post review.	
D2931	prefabricated stainless steel crown-permanent tooth	0-14	Teeth 1 - 32	No	No	One of (D2928, D2929, D2930, D2931, D2933, D2934) per 60 Month(s) Per patient per tooth. Greater than 6 units of (D2928, D2929, D2930, D2931, D2933, and D2934) per date of service may be subject to post review.	

Exhibit H Benefits Covered for CareSource Marketplace Child (WV)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2933	prefabricated stainless steel crown with resin window	0-14	Teeth 1 - 32, A - T	No	No	One of (D2928, D2929, D2930, D2931, D2933, D2934) per 60 Month(s) Per patient per tooth. Greater than 6 units of (D2928, D2929, D2930, D2931, D2933, and D2934) per date of service may be subject to post review.	
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	0-14	Teeth A - T	No	No	One of (D2928, D2929, D2930, D2931, D2933, D2934) per 60 Month(s) Per patient per tooth. Greater than 6 units of (D2928, D2929, D2930, D2931, D2933, and D2934) per date of service may be subject to post review.	
D2940	protective restoration	0-18	Teeth 1 - 32	No	No	One of (D2940) per 1 Calendar year(s) Per patient per tooth. Restorative material to protect tooth and/or tissue form. Used to relieve pain, promote healing, and prevent further deterioration. Not reimbursable when used as endodontic access closure, or as a base or liner under restoration.	
D2950	core buildup, including any pins when required	0-18	Teeth 1 - 32	Yes	No	One of (D2950) per 60 Month(s) Per patient per tooth.	pre-operative radiographs
D2951	pin retention - per tooth, in addition to restoration	0-18	Teeth 1 - 32	No	No	Three of (D2951) per 1 Lifetime Per patient per tooth.	
D2952	cast post and core in addition to crown	0-18	Teeth 1 - 32	Yes	No	One of (D2952, D2954) per 60 Month(s) Per patient per tooth.	pre-operative radiographs
D2953	each additional cast post - same tooth	0-18	Teeth 1 - 32	Yes	No	One of (D2953) per 60 Month(s) Per patient per tooth.	pre-operative radiographs
D2954	prefabricated post and core in addition to crown	0-18	Teeth 1 - 32	Yes	No	One of (D2952, D2954) per 60 Month(s) Per patient per tooth.	pre-operative radiographs
D2957	each additional prefabricated post - same tooth	0-18	Teeth 1 - 32	Yes	No	One of (D2957) per 60 Month(s) Per patient per tooth.	pre-operative radiographs

Exhibit H Benefits Covered for CareSource Marketplace Child (WV)

Restorative							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D2961	labial veneer (resin laminate) - laboratory	0-18	Teeth 1 - 32	Yes	No	One of (D2961, D2962) per 60 Month(s) Per patient per tooth. D2961, D2962 may be covered in lieu of crowns when clinically indicated for anterior teeth that are severely fractured or carious, that cannot be adequately repaired with a direct restoration (i.e., CDT codes D2330–D2335) Not reimbursable when performed solely for cosmetic/aesthetic reasons.	Pre-operative radiographs and operative report
D2962	labial veneer (porc laminate) - laboratory	0-18	Teeth 1 - 32	Yes	No	One of (D2961, D2962) per 60 Month(s) Per patient per tooth. D2961, D2962 may be covered in lieu of crowns when clinically indicated for anterior teeth that are severely fractured or carious, that cannot be adequately repaired with a direct restoration (i.e., CDT codes D2330–D2335) Not reimbursable when performed solely for cosmetic/aesthetic reasons.	Pre-operative radiographs and operative report
D2980	crown repair, by report	0-18	Teeth 1 - 32	Yes	No	One of (D2980) per 60 Month(s) Per patient per tooth.	Narr / Oper Rpt
D2981	Inlay repair necessitated by restorative material failure	0-18	Teeth 1 - 32, 51 - 82	Yes	No	One of (D2981) per 60 Month(s) Per patient per tooth.	Narr / Oper Rpt
D2982	Onlay repair necessitated by restorative material failure	0-18	Teeth 1 - 32, 51 - 82	Yes	No	One of (D2982) per 60 Month(s) Per patient per tooth.	Narr / Oper Rpt
D2983	Veneer repair necessitated by restorative material failure	0-18	Teeth 1 - 32, 51 - 82	Yes	No	One of (D2983) per 60 Month(s) Per patient per tooth.	Narr / Oper Rpt
D2990	Resin infiltration of incipient smooth surface lesions	0-18	Teeth 1 - 32, A - T	No	No	One of (D2990) per 60 Month(s) Per patient per tooth.	

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Endodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	0-18	Teeth 1 - 32, A - T	No	No	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.	
D3222	partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	0-18	Teeth 1 - 32	No	No	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.	
D3230	pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	0-11	Teeth C, H, M, R	No	No	One of (D3230) per 1 Lifetime Per patient per tooth.	
D3230	pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	0-6	Teeth D - G, N - Q	No	No	One of (D3230) per 1 Lifetime Per patient per tooth.	
D3240	pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	0-11	Teeth A, B, I - L, S, T	No	No	One of (D3240) per 1 Lifetime Per patient per tooth.	

Exhibit H Benefits Covered for CareSource Marketplace Child (WV)

Endodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D3310	endodontic therapy, anterior tooth (excluding final restoration)	0-18	Teeth 6 - 11, 22 - 27	No	No	One of (D3310) per 1 Lifetime Per patient per tooth. 1)Once per tooth per lifetime except for exception cases of appropriate medical necessity.2)The date the RCT is completed should be the date of service.3)Reimbursement for a root canal includes opening and drainage, treatment planning, clinical procedures, follow-up care, radiographs during treatment, and post-operative radiographs. 4)D3310,D3320,D3330 are subject to Post Review Third molar wisdom teeth will only be considered for coverage when tooth is functional.	
D3320	endodontic therapy, premolar tooth (excluding final restoration)	0-18	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	No	One of (D3320) per 1 Lifetime Per patient per tooth. 1)Once per tooth per lifetime except for exception cases of appropriate medical necessity.2)The date the RCT is completed should be the date of service.3)Reimbursement for a root canal includes opening and drainage, treatment planning, clinical procedures, follow-up care, radiographs during treatment, and post-operative radiographs. 4)D3310,D3320,D3330 are subject to Post Review Third molar wisdom teeth will only be considered for coverage when tooth is functional.	

Exhibit H Benefits Covered for CareSource Marketplace Child (WV)

Endodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D3330	endodontic therapy, molar tooth (excluding final restoration)	0-18	Teeth 1 - 3, 14 - 19, 30 - 32	No	No	One of (D3330) per 1 Lifetime Per patient per tooth. 1)Once per tooth per lifetime except for exception cases of appropriate medical necessity.2)The date the RCT is completed should be the date of service.3)Reimbursement for a root canal includes opening and drainage, treatment planning, clinical procedures, follow-up care, radiographs during treatment, and post-operative radiographs. 4)D3310,D3320,D3330 are subject to Post Review Third molar wisdom teeth will only be considered for coverage when tooth is functional.	
D3346	retreatment of previous root canal therapy-anterior	0-18	Teeth 6 - 11, 22 - 27	No	No	One of (D3346) per 1 Lifetime Per patient per tooth. 1)Dental provider who performed the original root canal should not be reimbursed for the retreatment for the first 12 months 2)D3346, D3347, D3348 are subject to Post Review	
D3347	retreatment of previous root canal therapy - premolar	0-18	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	No	One of (D3347) per 1 Lifetime Per patient per tooth. 1)Dental provider who performed the original root canal should not be reimbursed for the retreatment for the first 12 months 2)D3346, D3347, D3348 are subject to Post Review	

Endodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D3348	retreatment of previous root canal therapy-molar	0-18	Teeth 1 - 3, 14 - 19, 30 - 32	No	No	One of (D3348) per 1 Lifetime Per patient per tooth. 1)Dental provider who performed the original root canal should not be reimbursed for the retreatment for the first 12 months 2)D3346, D3347, D3348 are subject to Post Review	
D3351	apexification/recalcification - initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	0-18	Teeth 1 - 32	Yes	No	One of (D3351) per 1 Lifetime Per patient per tooth. Initial opening, preparation and first placement of medication and necessary radiographs	pre-operative radiographs
D3352	apexification/recalcification - interim medication replacement	0-18	Teeth 1 - 32	Yes	No	One of (D3352) per 1 Lifetime Per patient per tooth. For visits in which the intra-canal medication is replaced with new medication, includes any necessary radiographs	pre-operative radiographs
D3353	apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	0-18	Teeth 1 - 32	Yes	No	One of (D3353) per 1 Lifetime Per patient per tooth. Includes removal of intra-canal medication and procedures necessary to place final root canal filling material, includes necessary radiographs.	pre-operative radiographs
D3355	Pulpal regeneration - initial visit	0-18	Teeth 1 - 32	No	No	One of (D3355) per 1 Lifetime Per patient per tooth. Subject to Post Review	
D3356	Pulpal regeneration - interim medication replacement	0-18	Teeth 1 - 32	No	No	One of (D3356) per 1 Lifetime Per patient per tooth. Subject to Post Review	
D3357	Pulpal regeneration - completion of treatment	0-18	Teeth 1 - 32	No	No	One of (D3357) per 1 Lifetime Per patient per tooth. Subject to Post Review	
D3410	apicoectomy - anterior	0-18	Teeth 6 - 11, 22 - 27	Yes	No	One of (D3410) per 1 Lifetime Per patient per tooth.	pre-operative radiographs
D3421	apicoectomy - premolar (first root)	0-18	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	No	One of (D3421) per 1 Lifetime Per patient per tooth.	pre-operative radiographs

Exhibit H Benefits Covered for CareSource Marketplace Child (WV)

Endodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D3425	apicoectomy - molar (first root)	0-18	Teeth 1 - 3, 14 - 19, 30 - 32	Yes	No	One of (D3425) per 1 Lifetime Per patient per tooth.	pre-operative radiographs
D3426	apicoectomy (each additional root)	0-18	Teeth 1 - 5, 12 - 21, 28 - 32	Yes	No	One of (D3426) per 1 Lifetime Per patient per tooth.	pre-operative radiographs
D3450	root amputation - per root	0-18	Teeth 1 - 32	Yes	No		pre-operative radiographs
D3471	surgical repair of root resorption - anterior	0-18	Teeth 6 - 11, 22 - 27	No	No	One of (D3471) per 1 Lifetime Per patient per tooth.	
D3472	surgical repair of root resorption – premolar	0-18	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	No	One of (D3472) per 1 Lifetime Per patient per tooth.	
D3473	surgical repair of root resorption – molar	0-18	Teeth 1 - 3, 14 - 19, 30 - 32	No	No	One of (D3473) per 1 Lifetime Per patient per tooth.	
D3501	surgical exposure of root surface without apicoectomy or repair of root resorption – anterior	0-18	Teeth 6 - 11, 22 - 27	No	No	One of (D3501) per 1 Lifetime Per patient per tooth.	
D3502	surgical exposure of root surface without apicoectomy or repair of root resorption – premolar	0-18	Teeth 4, 5, 12, 13, 20, 21, 28, 29	No	No	One of (D3502) per 1 Lifetime Per patient per tooth.	
D3503	surgical exposure of root surface without apicoectomy or repair of root resorption – molar	0-18	Teeth 1 - 3, 14 - 19, 30 - 32	No	No	One of (D3503) per 1 Lifetime Per patient per tooth.	
D3920	hemisection (including any root removal), not incl root canal therapy	0-18	Teeth 1 - 3, 14 - 19, 30 - 32	Yes	No		pre-operative radiographs

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Periodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4210, D4211) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4210, D4211) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	0-18	Teeth 1 - 32, 51 - 82	Yes	No	One of (D4212) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4240	gingival flap procedure, including root planing – four or more contiguous teeth or tooth bound spaces per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4240, D4241) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4241	gingival flap procedure, including root planing – one to three contiguous teeth or tooth bound spaces per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4240, D4241) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4249	clinical crown lengthening - hard tissue	0-18	Teeth 1 - 32	Yes	No	One of (D4249) per 36 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D4260	osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4260, D4261) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting
D4261	osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4260, D4261) per 36 Month(s) Per patient per quadrant.	pre-op x-ray(s), perio charting

Periodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D4263	bone replacement graft - first site in quadrant	0-18	Teeth 1 - 32	Yes	No	One of (D4263) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4270	pedicle soft tissue graft procedure	0-18	Teeth 1 - 32	Yes	No	One of (D4270) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4273	subepithelial connective tissue graft procedure	0-18	Teeth 1 - 32	Yes	No	One of (D4273) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4275	soft tissue allograft	0-18	Teeth 1 - 32	Yes	No	One of (D4275) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	0-18	Teeth 1 - 32, 51 - 82	Yes	No		pre-op x-ray(s), perio charting
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	0-18	Teeth 1 - 32, 51 - 82	Yes	No	One of (D4278) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4283	autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	0-18	Teeth 1 - 32	Yes	No	One of (D4283) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4285	non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	0-18	Teeth 1 - 32	Yes	No	One of (D4285) per 36 Month(s) Per patient per tooth.	pre-op x-ray(s), perio charting
D4341	periodontal scaling and root planing - four or more teeth per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. A minimum of four affected teeth in the quadrant.	pre-op x-ray(s), perio charting

Exhibit H Benefits Covered for CareSource Marketplace Child (WV)

Periodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D4342	periodontal scaling and root planing - one to three teeth per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D4341, D4342) per 24 Month(s) Per patient per quadrant. One to three affected teeth in the quadrant.	pre-op x-ray(s), perio charting
D4355	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	0-18		No	No	One of (D4355) per 1 Lifetime Per patient. Subject to Post Review.	
D4910	periodontal maintenance procedures	0-18		No	No	Four of (D1110, D4910) per 12 Month(s) Per patient. D4341 or D4342 must be on file for claims or documentation from patient record history of periodontal therapy within the last 6 months.	

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D5110	complete denture - maxillary	0-18		Yes	No	One of (D5110, D5130) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5120	complete denture - mandibular	0-18		Yes	No	One of (D5120, D5140) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5130	immediate denture - maxillary	0-18		Yes	No	One of (D5110, D5130) per 60 Month(s) Per patient. Reimbursement made upon delivery (completion) of immediate maxillary or mandibular denture. D5130, D5140 reimbursed on the same date of service as the extraction of all remaining teeth.Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5140	immediate denture - mandibular	0-18		Yes	No	One of (D5120, D5140) per 60 Month(s) Per patient. Reimbursement made upon delivery (completion) of immediate maxillary or mandibular denture. D5130, D5140 reimbursed on the same date of service as the extraction of all remaining teeth.Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5211	maxillary partial denture, resin base (including retentive/clasping materials, rests, and teeth)	0-18		Yes	No	One of (D5211, D5213, D5221, D5223) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D5212	mandibular partial denture, resin base (including retentive/clasping materials, rests, and teeth)	0-18		Yes	No	One of (D5212, D5214, D5222, D5224) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5213	maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	0-18		Yes	No	One of (D5211, D5213, D5221, D5223) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5214	mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	0-18		Yes	No	One of (D5212, D5214, D5222, D5224) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5221	immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	0-18		Yes	No	One of (D5211, D5213, D5221, D5223) per 60 Month(s) Per patient. Reimbursement made upon delivery (completion) of immediate maxillary or mandibular partial denture. Reimbursed on the same date of service as the extraction of all remaining teeth.Includes adjustments within 6 months of initial placement	pre-operative x-ray(s)
D5222	immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	0-18		Yes	No	One of (D5212, D5214, D5222, D5224) per 60 Month(s) Per patient. Reimbursement made upon delivery (completion) of immediate maxillary or mandibular partial denture. Reimbursed on the same date of service as the extraction of all remaining teeth.Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D5223	immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	0-18		Yes	No	One of (D5211, D5213, D5221, D5223) per 60 Month(s) Per patient. Reimbursement made upon delivery (completion) of immediate maxillary or mandibular partial denture. Reimbursed on the same date of service as the extraction of all remaining teeth.Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5224	immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	0-18		Yes	No	One of (D5212, D5214, D5222, D5224) per 60 Month(s) Per patient. Reimbursement made upon delivery (completion) of immediate maxillary or mandibular partial denture. Reimbursed on the same date of service as the extraction of all remaining teeth.Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5282	Removable unilateral partial denture--one piececast metal (including clasps and teeth), maxillary	16 - 18		Yes	No	One of (D5282) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5283	Removable unilateral partial denture--one piececast metal (including clasps and teeth), mandibular	16 - 18		Yes	No	One of (D5283) per 60 Month(s) Per patient. Includes adjustments within 6 months of initial placement	Photos, Narrative/treatment plan
D5410	adjust complete denture - maxillary	0-18		No	No	Not covered within 6 months of initial placement.	
D5411	adjust complete denture - mandibular	0-18		No	No	Not covered within 6 months of initial placement.	
D5421	adjust partial denture-maxillary	0-18		No	No	Not covered within 6 months of initial placement.	
D5422	adjust partial denture - mandibular	0-18		No	No	Not covered within 6 months of initial placement.	

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D5511	repair broken complete denture base, mandibular	0-18		No	No	Limited to repairs or adjustments performed more than 12 months after the initial insertion.	
D5512	repair broken complete denture base, maxillary	0-18		No	No	Limited to repairs or adjustments performed more than 12 months after the initial insertion.	
D5520	replace missing or broken teeth - complete denture (each tooth)	0-18	Teeth 1 - 32	No	No	Not covered within 6 months of initial placement.	
D5611	repair resin partial denture base, mandibular	0-18		No	No	Limited to repairs or adjustments performed more than 12 months after the initial insertion.	
D5612	repair resin partial denture base, maxillary	0-18		No	No	Limited to repairs or adjustments performed more than 12 months after the initial insertion.	
D5621	repair cast partial framework, mandibular	0-18		No	No	Limited to repairs or adjustments performed more than 12 months after the initial insertion.	
D5622	repair cast partial framework, maxillary	0-18		No	No	Limited to repairs or adjustments performed more than 12 months after the initial insertion.	
D5630	repair or replace broken retentive/clasping materials per tooth	0-18	Teeth 1 - 32	No	No	Not covered within 6 months of initial placement.	
D5640	replace broken teeth-per tooth	0-18	Teeth 1 - 32	No	No	Not covered within 6 months of initial placement.	
D5650	add tooth to existing partial denture	0-18	Teeth 1 - 32	No	No		
D5660	add clasp to existing partial denture	0-18	Teeth 1 - 32	No	No		

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D5710	rebase complete maxillary denture	0-18		No	No	One of (D5710) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5711	rebase complete mandibular denture	0-18		No	No	One of (D5711) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5720	rebase maxillary partial denture	0-18		No	No	One of (D5720) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5721	rebase mandibular partial denture	0-18		No	No	One of (D5721) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5730	reline complete maxillary denture (chairside)	0-18		No	No	One of (D5730) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5731	reline complete mandibular denture (chairside)	0-18		No	No	One of (D5731) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5740	reline maxillary partial denture (chairside)	0-18		No	No	One of (D5740) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5741	reline mandibular partial denture (chairside)	0-18		No	No	One of (D5741) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5750	reline complete maxillary denture (laboratory)	0-18		No	No	One of (D5750) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	

Prosthodontics, removable							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D5751	reline complete mandibular denture (laboratory)	0-18		No	No	One of (D5751) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5760	reline maxillary partial denture (laboratory)	0-18		No	No	One of (D5760) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5761	reline mandibular partial denture (laboratory)	0-18		No	No	One of (D5761) per 36 Month(s) Per patient. Not covered within 6 months of initial placement.	
D5850	tissue conditioning, maxillary	0-18		No	No		
D5851	tissue conditioning,mandibular	0-18		No	No		

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Implant Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6010	surgical placement of implant body: endosteal implant	0-18	Teeth 1 - 32	Yes	No	One of (D6010) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6012	surgical placement of interim implant body-endosteal implant	0-18	Teeth 1 - 32	Yes	No	One of (D6012) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6040	surgical placement:eposteal implnt	0-18	Per Arch (01, 02, LA, UA)	Yes	No	One of (D6040, D6050) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6050	surgical placement-transosteal implant	0-18	Teeth 1 - 32	Yes	No	One of (D6040, D6050) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6055	connecting bar - implant supported or abutment supported	0-18	Teeth 1 - 32	Yes	No	One of (D6055) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6056	prefabricated abutment	0-18	Teeth 1 - 32	Yes	No	One of (D6056) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6057	custom abutment	0-18	Teeth 1 - 32	Yes	No	One of (D6057) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6058	abutment supported porcelain/ceramic crown	0-18	Teeth 1 - 32	Yes	No	One of (D6058) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6059	abutment supported porcelain fused to metal crown (high noble metal)	0-18	Teeth 1 - 32	Yes	No	One of (D6059) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6060	abutment supported porcelain fused to metal crown (predominantly base metal)	0-18	Teeth 1 - 32	Yes	No	One of (D6060) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6061	abutment supported porcelain fused to metal crown (noble metal)	0-18	Teeth 1 - 32	Yes	No	One of (D6061) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6062	abutment supported cast metal crown (high noble metal)	0-18	Teeth 1 - 32	Yes	No	One of (D6062) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Implant Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6063	abutment supported cast metal crown (predominantly base metal)	0-18	Teeth 1 - 32	Yes	No	One of (D6063) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6064	abutment supported cast metal crown (noble metal)	0-18	Teeth 1 - 32	Yes	No	One of (D6064) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6065	implant supported porcelain/ceramic crown	0-18	Teeth 1 - 32	Yes	No	One of (D6065) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6066	Implant Supported Crown-Porcelain Fused to High Noble Alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6066) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6067	Implant Supported Crown-High Noble Alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6067) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6068	abutment supported retainer for porcelain/ceramic FPD	0-18	Teeth 1 - 32	Yes	No	One of (D6068) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6069	abutment supported retainer for porcelain fused to metal FPD (high noble metal)	0-18	Teeth 1 - 32	Yes	No	One of (D6069) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6070	abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	0-18	Teeth 1 - 32	Yes	No	One of (D6070) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6071	abutment supported retainer for porcelain fused to metal FPD (noble metal)	0-18	Teeth 1 - 32	Yes	No	One of (D6071) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6072	abutment supported retainer for cast metal FPD (high noble metal)	0-18	Teeth 1 - 32	Yes	No	One of (D6072) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6073	abutment supported retainer for cast metal FPD (predominantly base metal)	0-18	Teeth 1 - 32	Yes	No	One of (D6073) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6074	abutment supported retainer for cast metal FPD (noble metal)	0-18	Teeth 1 - 32	Yes	No	One of (D6074) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6075	implant supported retainer for ceramic FPD	0-18	Teeth 1 - 32	Yes	No	One of (D6075) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Implant Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6076	Implant Supported Retainer for FPD-Porcelain Fused to High Noble Alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6076) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6077	Implant Supported Retainer for Metal FPD- High Noble Alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6078) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6080	implant maintenance procedure	0-18	Teeth 1 - 32	Yes	No	One of (D6080) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6081	scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	0-18	Teeth 1 - 32, 51 - 82	Yes	No	One of (D6081) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6082	Implant supported crown-porcelain fused to predominently base alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6082) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6083	Implant supported crown-porcelain fused to noble alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6083) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6084	Implant supported crown-porcelain fused to titanium and titanium alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6084) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6086	Implant supported crown-predominately base alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6086) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6087	Implant supported crown-noble alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6087) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6088	Implant supported crown-titanium and titanium alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6088) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6090	repair implant prosthesis	0-18	Teeth 1 - 32	Yes	No	One of (D6090) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6091	replacement of attachment-implant/abutment prosthesis	0-18		Yes	No	One of (D6091) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6095	repair implant abutment	0-18	Teeth 1 - 32	Yes	No	One of (D6095) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Exhibit H Benefits Covered for CareSource Marketplace Child (WV)

Implant Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6097	Abutment supported crown-porcelain fused to titanium and titanium alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6097) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6098	Implant supported retainer-porcelain fused to predominately base alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6098) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6099	Implant supported retainer for FPD- porcelain fused to noble alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6099) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6100	surgical removal of implant body	0-18	Teeth 1 - 32	Yes	No	One of (D6100) per 60 Month(s) Per patient per tooth. Dental provider who performed the original implant will not be reimbursed for the removal of the implant	pre-operative radiographs and narrative
D6101	debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure	0-18	Teeth 1 - 32, 51 - 82	Yes	No	One of (D6101) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6102	debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure	0-18	Teeth 1 - 32, 51 - 82	Yes	No	One of (D6102) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6103	bone graft for repair of peri-implant defect - does not include flap entry and closure. Placement of a barrier membrane or biologic materials to aid in osseous regeneration are reported separately	0-18	Teeth 1 - 32, 51 - 82	Yes	No	One of (D6103) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6104	Bone graft at time of implant placement	0-18	Teeth 1 - 32, 51 - 82	Yes	No	One of (D6104) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Implant Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6105	removal of implant body not requiring bone removal nor flap elevation	0-18	Teeth 1 - 32	Yes	Yes	One of (D6105) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6110	Implant/abutment supported removable dentur for edentulous arch - maxillary	0-18	Per Arch (01, 02, LA, UA)	Yes	No	One of (D6110) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6111	Implant/abutment supported removable dentur for edentulous arch - mandibular	0-18	Per Arch (01, 02, LA, UA)	Yes	No	One of (D6111) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary	0-18	Per Arch (01, 02, LA, UA)	Yes	No	One of (D6112) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular	0-18	Per Arch (01, 02, LA, UA)	Yes	No	One of (D6113) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary	0-18	Teeth 1 - 32	Yes	No	One of (D6114) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6115	Implant/abutment supported fixed denture for edentulous arch - mandibular	0-18	Teeth 1 - 32	Yes	No	One of (D6115) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6116	Implant/abutment supported fixed denture for partially edentulous arch - maxillary	0-18	Teeth 1 - 32	Yes	No	One of (D6116) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6117	Implant/abutment supported fixed denture for partially edentulous arch - mandibular	0-18	Teeth 1 - 32	Yes	No	One of (D6117) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6120	Implant supported retainer-porcelain fused to titanium and titanium alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6120) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6121	Implant supported retainer for metal FPD-predominately base alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6121) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Exhibit H Benefits Covered for CareSource Marketplace Child (WV)

Implant Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6122	Implant supported retainer for metal FPD- noble alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6122) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6123	Implant supported retainer for metal FPD- titanium and titanium alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6123) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6190	radiographic/surgical implant index, by report	0-18	Teeth 1 - 32	Yes	No	One of (D6190) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6195	Abutment Supported Retainer- Porcelain fused to titanium and titanium alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6195) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6197	replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	0-18	Teeth 1 - 32	Yes	Yes	One of (D6197) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6210	pontic - cast high noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6211	pontic-cast base metal	0-18	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6212	pontic - cast noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6214	Pontic - titanium and titanium alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6240	pontic-porcelain fused-high noble	0-18	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6241	pontic-porcelain fused to base metal	0-18	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6242	pontic-porcelain fused-noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6243	Pontic - Porcelain fused to titanium and titanium alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6245	prosthodontics fixed, pontic - porcelain/ceramic	0-18	Teeth 1 - 32	Yes	No	One of (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6545	retainer - cast metal fixed	0-18	Teeth 1 - 32	Yes	No	One of (D6545, D6548, D6549) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6548	prosthodontics fixed, retainer - porcelain/ceramic for resin bonded fixed prosthodontic	0-18	Teeth 1 - 32	Yes	No	One of (D6545, D6548, D6549) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6549	Resin retainer-For resin bonded fixed prosthesis	0-18	Teeth 1 - 32	Yes	No	One of (D6545, D6548, D6549) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6600	inlay - porcelain/ceramic, two surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6601	inlay - porcelain/ceramic, three or more surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6602	inlay - cast high noble metal, two surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6603	inlay - cast high noble metal, three or more surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6604	inlay - cast predominantly base metal, two surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6605	inlay - cast predominantly base metal, three or more surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6606	inlay - cast noble metal, two surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6607	inlay - cast noble metal, three or more surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6608	onlay - porcelain/ceramic, two surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6609	onlay - porcelain/ceramic, three or more surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6610	onlay - cast high noble metal, two surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6611	onlay - cast high noble metal, three or more surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6612	onlay - cast predominantly base metal, two surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6613	onlay - cast predominantly base metal, three or more surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6614	onlay - cast noble metal, two surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6615	onlay - cast noble metal, three or more surfaces	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6624	inlay - titanium	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6634	onlay - titanium	0-18	Teeth 1 - 32	Yes	No	One of (D6600, D6601, D6602, D6603, D6604, D6605, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6740	retainer crown, porcelain/ceramic	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6750	crown-porcelain fused high noble	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6751	crown-porcelain fused to base metal	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6752	crown-porcelain fused noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6753	Retainer Crown- Porcelain fused to titanium and titanium alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6780	crown-3/4 cst high noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6781	prosthodontics fixed, crown ¾ cast predominantly based metal	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6782	prosthodontics fixed, crown ¾ cast noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6783	prosthodontics fixed, crown ¾ porcelain/ceramic	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6784	Retainer Crown 3/4- Titanium and Titanium Alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6790	crown-full cast high noble	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6791	crown - full cast base metal	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6792	crown - full cast noble metal	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative
D6794	Retainer crown - titanium and titanium alloys	0-18	Teeth 1 - 32	Yes	No	One of (D6740, D6750, D6751, D6752, D6753, D6754, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) per 60 Month(s) Per patient per tooth.	pre-operative radiographs and narrative

Prosthodontics, fixed							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D6930	re-cement or re-bond fixed partial denture	0-18		Yes	No	Not covered within 6 months of placement.	pre-operative radiographs and narrative
D6980	fixed partial denture repair	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No		pre-operative radiographs and narrative

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Oral and Maxillofacial Surgery							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D7111	extraction, coronal remnants - primary tooth	0-18	Teeth A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No		
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0-18	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No		
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	0-18	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No	Includes cutting of gingiva and bone, removal of tooth structure and closure. Subject to Post Review.	
D7220	removal of impacted tooth-soft tissue	0-18	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	No		pre-operative radiographs
D7230	removal of impacted tooth-partially bony	0-18	Teeth 1 - 32, 51 - 82	Yes	No		pre-operative radiographs
D7240	removal of impacted tooth-completely bony	0-18	Teeth 1 - 32, 51 - 82	Yes	No		pre-operative radiographs
D7241	removal of impacted tooth-completely bony, with unusual surgical complications	0-18	Teeth 1 - 32, 51 - 82	Yes	No		pre-operative radiographs
D7250	surgical removal of residual tooth roots (cutting procedure)	0-18	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	No		pre-operative radiographs
D7251	Coronectomy – intentional partial tooth removal, impacted teeth only	0-18	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	No		pre-operative radiographs

Exhibit H Benefits Covered for CareSource Marketplace Child (WV)

Oral and Maxillofacial Surgery							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	0-18	Teeth 1 - 32	Yes	No	Includes splinting and/or stabilization.	pre-operative radiographs
D7280	Surgical access of an unerupted tooth	0-18	Teeth 1 - 32	Yes	No		pre-operative radiographs
D7283	placement of device to facilitate eruption of impacted tooth	0-18	Teeth 1 - 32	No	No	One of (D7283) per 1 Lifetime Per patient per tooth. Has to be submitted in combination with D7280; Report the surgical exposure separately using D7280	
D7310	alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D7310) per 1 Lifetime Per patient per quadrant. Minimum of four extractions in the affected quadrant. Covered only in conjunction with the construction of a prosthodontic appliance.	pre-operative radiographs
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D7311) per 1 Lifetime Per patient per quadrant. Minimum of four extractions in the affected quadrant. Covered only in conjunction with the construction of a prosthodontic appliance.	pre-operative radiographs
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D7320) per 1 Lifetime Per patient per quadrant. Minimum of four extractions in the affected quadrant. Covered only in conjunction with the construction of a prosthodontic appliance.	pre-operative radiographs
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	0-18	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One of (D7321) per 1 Lifetime Per patient per quadrant. Minimum of four extractions in the affected quadrant. Covered only in conjunction with the construction of a prosthodontic appliance.	pre-operative radiographs

Exhibit H Benefits Covered for CareSource Marketplace Child (WV)

Oral and Maxillofacial Surgery							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D7471	removal of exostosis - per site	0-18	Per Arch (01, 02, LA, UA)	Yes	No		pre-operative radiographs and narrative
D7510	incision and drainage of abscess - intraoral soft tissue	0-18	Teeth 1 - 32, 51 - 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No	Subject to Post Review.	
D7520	incision and drainage of abscess - extraoral soft tissue	0-18		No	No	Subject to Post Review.	
D7910	suture small wounds up to 5 cm	0-18		No	No	Subject to Post Review.	
D7953	bone replacement graft for ridge preservation - per site	0-18	Teeth 1 - 32	Yes	No	One of (D7953) per 1 Lifetime Per patient.	Narrative of medical necessity and photos
D7961	buccal / labial frenectomy (frenulectomy)	0-18		Yes	No		Narrative of medical necessity and photos
D7962	lingual frenectomy (frenulectomy)	0-18		Yes	No		Narrative of medical necessity and photos
D7970	excision of hyperplastic tissue - per arch	0-18	Per Arch (01, 02, LA, UA)	Yes	No	One of (D7970) per 1 Lifetime Per patient.	Narrative of medical necessity and photos
D7971	excision of pericoronal gingiva	0-18	Teeth 1 - 32	Yes	No		narr. of med. necessity, post-op x-ray(s)

Exhibit H Benefits Covered for CareSource Marketplace Child (WV)

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Orthodontics							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D8030	limited orthodontic treatment of the adolescent dentition	0-18		Yes	No	One of (D8030, D8040, D8080, D8090) per 1 Lifetime Per patient.	Study model or OrthoCad, x-rays
D8040	limited orthodontic treatment of the adult dentition	0-18		Yes	No	One of (D8030, D8040, D8080, D8090) per 1 Lifetime Per patient.	Study model or OrthoCad, x-rays
D8080	comprehensive orthodontic treatment of the adolescent dentition	0-18		Yes	No	One of (D8030, D8040, D8080, D8090) per 1 Lifetime Per patient.	Study model or OrthoCad, x-rays
D8090	comprehensive orthodontic treatment of the adult dentition	0-18		Yes	No	One of (D8030, D8040, D8080, D8090) per 1 Lifetime Per patient.	Study model or OrthoCad, x-rays
D8660	pre-orthodontic treatment examination to monitor growth and development	0-18		No	No	One of (D8660) per 1 Lifetime Per patient. Used for records (i.e. models, photos and pre-orthodontic work –up). Reimbursed even if orthodontic case is not approved Prior Authorization not required when submitted with requests for (D8010-D8220)	
D8670	periodic orthodontic treatment visit	0-18		Yes	No	One of (D8670) per 1 Lifetime Per patient. D8670 reimbursed in combination with active therapy and as part of complete ortho contract per case.	Study model or OrthoCad, x-rays
D8680	orthodontic retention (removal of appliances)	0-18		Yes	No	One of (D8680) per 1 Lifetime Per patient.	photos, xrays, treatment plan
D8698	Recement or rebond fixed retainer - maxillary	0-18		No	No	One of (D8698) per 1 Lifetime Per patient. Subject to Post Review.	
D8699	Recement or rebond fixed retainer - mandibular	0-18		No	No	One of (D8699) per 1 Lifetime Per patient. Subject to Post Review.	

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Adjunctive General Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D9110	palliative treatment of dental pain - per visit	0-18		No	No	One of (D9110) per 1 Day(s) Per patient.	
D9222	deep sedation/general anesthesia first 15 minutes	0-18		Yes	No	One of (D9222) per 1 Day(s) Per patient. Ten of (D9222, D9223) per 1 Calendar year(s) Per patient. Not allowed on same date as D9239, D9243, and D9230. Sedation approvals are limited to surgical and extensive cases	narr. of med. necessity, pre-op x-ray(s)
D9223	deep sedation/general anesthesia - each subsequent 15 minute increment	0-18		Yes	No	Four of (D9223) per 1 Day(s) Per patient. Ten of (D9222, D9223) per 1 Calendar year(s) Per patient. Not allowed on same date as D9239, D9243, and D9230. Sedation approvals are limited to surgical and extensive cases	narr. of med. necessity, pre-op x-ray(s)
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	0-7		Yes	No	One of (D9230) per 1 Day(s) Per patient. Three of (D9230) per 1 Calendar year(s) Per patient. Subject to Post Review.	narr. of med. necessity, pre-op x-ray(s)
D9239	intravenous moderate (conscious) sedation/analgesia- first 15 minutes	0-18		Yes	No	One of (D9239) per 1 Day(s) Per patient. Ten of (D9239, D9243) per 1 Calendar year(s) Per patient. Not allowed on same date as D9222, D9223, and D9230. Sedation approvals are limited to surgical and extensive cases	narr. of med. necessity, pre-op x-ray(s)
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	0-18		Yes	No	Four of (D9243) per 1 Day(s) Per patient. Ten of (D9239, D9243) per 1 Calendar year(s) Per patient. Not allowed on same date as D9222, D9223, and D9230. Sedation approvals are limited to surgical and extensive cases	narr. of med. necessity, pre-op x-ray(s)

Exhibit H Benefits Covered for CareSource Marketplace Child (WV)

Adjunctive General Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	0-18		No	No	One of (D9310) per 1 Day(s) Per patient. Includes consultation with medical professional (D9310 used in lieu of D9311)	
D9311	consultation with medical health care professional	0-18		No	No	One of (D9311) per 1 Day(s) Per patient. This should be used only for extensive consultation with medical professional regarding patient's medical issues.	
D9610	therapeutic drug injection, by report	0-18		Yes	No	One of (D9610) per 1 Day(s) Per patient. Description and dosage of drug.	narrative of medical necessity
D9930	treatment of complications (post-surgical) - unusual circumstances, by report	0-18		Yes	No		narrative of medical necessity
D9943	occlusal guard adjustment	0-18		No	No	One of (D9943) per 24 Month(s) Per patient.	
D9944	occlusal guard--hard appliance, full arch	13 - 18	Per Arch (01, 02, LA, UA)	Yes	No	One of (D9944, D9945, D9946) per 12 Month(s) Per patient.	narrative of medical necessity
D9945	occlusal guard--soft appliance full arch	13 - 18	Per Arch (01, 02, LA, UA)	Yes	No	One of (D9944, D9945, D9946) per 12 Month(s) Per patient.	narrative of medical necessity
D9946	occlusal guard--hard appliance, partial arch	13 - 18	Per Arch (01, 02, LA, UA)	Yes	No	One of (D9944, D9945, D9946) per 12 Month(s) Per patient.	narrative of medical necessity

Exhibit H Benefits Covered for CareSource Marketplace Child (WV)

Adjunctive General Services							
Code	**Description**	**Age Limitation**	**Teeth Covered**	**Prior Authorization Required**	**PrePayment (Retrospective) Review Required**	**Benefit Limitations**	**Documentation Required**
D9995	teledentistry – synchronous; real-time encounter	0-18		No	No	Four of (D9995) per 1 Calendar year(s) Per patient. The appropriate teledentistry code (D9995) should be reported as descriptor codes to identify services (D0140, D0145) provided via teledentistry by the dentist who provided the oversight of the teledentistry encounter as allowed and in accordance with any applicable state laws and/or: regulations, licensure, state dental practice acts. A teledentistry event is subject to applicable state law, regulation or licensure. D9995 does not have separate distinct benefit limits, however, any benefit limits applicable to the underlying services rendered would continue to apply.	