Code	Description	PA	Pre-	Required Documents	Age Min		Max Count	Period	Period	ADDITIONAL NOTES
		Required	Payment					Length	Туре	
				Meridian Medicare-Me	T		7			
D0120	Periodic Oral Evaluation - Established Patient	No	No		21	999	1	6	Month	Not allowed within 6 months of D0150.
D0140	Limited Oral Evaluation - Problem	No	No		21	999	1	1	Day	Only one of (D0140 or D9110) per day per provider
	Focused									group. For emergency exam only. Not payable if
										performed in conjunction with either D0120, D0150, or
										D0180.
D0150	Comprehensive Oral Evaluation - New Or Established Patient	No	No		21	999	1	1	Lifetime	Only one D0150 per lifetime per provider group.
D0210	Intraoral - Complete Series of	No	No		21	999	1	36	Month	Only one of (D0210, D0277, or D0330) per 36 months
	Radiographic Images	_	_							per member.
D0220	Intraoral - Periapical First Radiographic	No	No		21	999	1	1	Day	Only one D0220 per day per per provider or location.
	Image									Maximum reimbursement of a single date of service
										for radiographs limited to fee for complete Series
D0230	Intraoral - Periapical Each Additional	No	No		21	999				(D0210). Maximum reimbursement is up to the fee of D0210.
D0230	Image	NO	NO		21	555				
D0270	Bitewing - Single Radiographic Image	No	No		21	999	1	12	Month	One D0270 per 12 months per provider group.
										Maximum reimbursement of a single date of service
										for radiographs limited to fee for complete series (D0210).
D0272	Bitewings - Two Radiographic Images	No	No		21	999	1	12	Month	One (D0272 or D0274) per 12 month per provider or
										location. Maximum reimbursement of a single date of
										service for radiographs limited to fee for complete
										series (D0210).
D0274	Bitewings - Four Radiographic Images	No	No		21	999	1	12	Month	One (D0272 or D0274) per 12 month per provider or
										location. Maximum reimbursement of a single date of service for radiographs limited to fee for complete
										series (D0210).
D0277	Vertical Bitewings - 7 To 8 Radiographic	No	No		21	999	1	36	Month	Only one of (D0210, D0277, or D0330) per 36 months
	Images									per member. Maximum reimbursement of a single
										date of service for radiographs limited to fee for
D0220	Deneverie Dedieavenhie Image	No	No		24	000	4	26	N.A. a. a. b.la	complete series (D0210).
D0330	Panoramic Radiographic Image	NO	INO		21	999	1	36	Month	Only one of (D0210, D0277, or D0330) per 36 months per member. Maximum reimbursement of a single
										date of service for radiographs limited to fee for
										complete series (D0210).
D0999	Unspecified Diagnostic Procedures, By						1	1	Day	For FQHC Encounter billing. D0999 must be on first line
	Report									of claim
D 1110					24	000				with additional service listed.
D1110 D1354	Prophylaxis - Adult Interim Caries Arresting Medicament	No No	No No		21 21	<u>999</u> 999	1 6	6 1	Month Lifetime	2 applications per tooth per year. Lifetime maximum of
D1554	Application - Per Tooth	NO	NU		21	555	0	1	Lifetime	six applications per tooth. Providers may treat a
										maximum of 4 teeth per day, providing participant has
										no history of any prior or same day billing of CDT
										category D2000 (Restorative codes) or CDT category
										D3000 (Endodontic codes) on the same tooth.
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Code	Description	PA	Pre-	Required Documents	Age Min		Max Count	Period	Period	ADDITIONAL NOTES
couc		Required	Payment	nequireu bocuments	Age Milli	ABC MUX	max count	Length	Type	
D2140	Amalgam - One Surface, Primary Or	No	No		21	999	1	12		Only one (D2140, D2150, D2160, D2161, D2330,
	Permanent									D2331, D2332, D2335, D2391, D2392, D2393, D2394)
										per 12 months per surface. Teeth Covered: 1-32, A-T
D2150	Amalgam - Two Surfaces, Primary Or	No	No		21	999	1	12	Month	Only one (D2140, D2150, D2160, D2161, D2330,
	Permanent									D2331, D2332, D2335, D2391, D2392, D2393, D2394)
										per 12 months per surface. Teeth Covered: 1-32, A-T
D2160	Amalgam - Three Surfaces, Primary Or	No	No		21	999	1	12	Month	Only one (D2140, D2150, D2160, D2161, D2330,
02100	Permanent	NO	NO		21	555	1	12		D2331, D2332, D2335, D2391, D2392, D2393, D2394)
	i cimanent									per 12 months per surface. Teeth Covered: 1-32, A-T
D2161	Amalgam - Four Or More Surfaces,	No	No		21	999	1	12	Month	One of (D2161, D2335, D2394) per 12 months per
	Primary Or Permanent									tooth. Teeth Covered: 1-32, A-T
D2330	Resin-Based Composite - One Surface,	No	No		21	999	1	12		Only one (D2140, D2150, D2160, D2161, D2330,
	Anterior									D2331, D2332, D2335, D2391, D2392, D2393, D2394)
										per 12 months per surface. Teeth Covered: 6-11, 22-
D2221	Resin-Based Composite - Two Surfaces,	No	No		21	999	1	10	Manth	27. C-H. M-R Only one (D2140, D2150, D2160, D2161, D2330,
D2331	Anterior	NO	INO		21	999	1	12		D2331, D2332, D2335, D2391, D2392, D2393, D2394)
	Antenoi									per 12 months per surface. Teeth Covered: 6-11, 22-
										27. C-H. M-R
D2332	Resin-Based Composite - Three Surfaces,	No	No		21	999	1	12	Month	Only one (D2140, D2150, D2160, D2161, D2330,
	Anterior	_	_				_			D2331, D2332, D2335, D2391, D2392, D2393, D2394)
										per 12 months per surface. Teeth Covered: 6-11, 22-
										27. С-Н. М-R
D2335	Resin-Based Composite - Four Or More	No	No		21	999	1	12	Month	One of (D2161, D2335, D2394) per 12 months per
	Surfaces Or Involving Incisal Angle									tooth. Teeth Covered: 6-11, 22-27, C-H, M-R
D2391	Resin-Based Composite - One Surface,	No	No		21	999	1	12	Month	Only one (D2140, D2150, D2160, D2161, D2330,
02331	Posterior	NO	NO		21	555	1	12		D2331, D2332, D2335, D2391, D2392, D2393, D2394)
										per 12 months per surface. May not be used for PRR.
										Teeth Covered: 1-5, 12-21, 28-32, A, B, I-L, S, T
D2392	Resin-Based Composite - Two Surfaces,	No	No		21	999	1	12		Only one (D2140, D2150, D2160, D2161, D2330,
	Posterior									D2331, D2332, D2335, D2391, D2392, D2393, D2394)
										per 12 months per surface. Teeth Covered: 1-5, 12-21,
D2202	Resin-Based Composite - Three Surfaces,	No	No		21	000	1	10		28-32. A. B. I-L. S. T Only one (D2140, D2150, D2160, D2161, D2330,
D2393	•	No	No		21	999	1	12		D2331, D2332, D2335, D2391, D2392, D2393, D2394)
	Posterior									per 12 months per surface. Teeth Covered: 1-5, 12-21,
										28-32. A. B. I-I. S. T
D2394	Resin-Based Composite - Four Or More	No	No		21	999	1	12		One of (D2161, D2335, D2394) per 12 months per
	Surfaces, Posterior						_			tooth. Teeth Covered: 1-5, 12-21, 28-32, A, B, I-L, S, T
D2542	Onlay - Metallic - Two Surfaces	Yes	No	Pre-operative periapical x-rays and	21	999	1	60		Only one of (D2542, D2543, D2544, D2642, D2643,
				optional photos						D2644, D2740, D2750, D2751, D2752,D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth
	L									Covered: 1-32

Cada	Description	PA	Pre-	Required Desuments	Age Min		May Court	Doried	Deried	
Code	Description	Required	Pre- Payment	Required Documents	Age Min	Age Max	Max Count	Period Length	Period Type	ADDITIONAL NOTES
D2543	Onlay - Metallic - Three Surfaces	Yes	No	Pre-operative periapical x-rays and	21	999	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643,
				optional photos						D2644, D2740, D2750, D2751, D2752,D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth
										Covered: 1-32
D2544	Onlay - Metallic - Four Or More Surfaces	Yes	No	Pre-operative periapical x-rays and	21	999	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643,
				optional photos						D2644, D2740, D2750, D2751, D2752,D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth
D2C42	Outro Develais (Comming Two Soufrage	Mara	N.		24	000		60	N.A. a. a. b.la	Covered: 1-32
D2642	Onlay - Porcelain/Ceramic - Two Surfaces	Yes	No	Pre-operative periapical x-rays and	21	999	1	60		Only one of (D2542, D2543, D2544, D2642, D2643,
				optional photos						D2644, D2740, D2750, D2751, D2752, D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth Covered: 1-32
D2643	Onlay - Porcelain/Ceramic - Three	Yes	No	Pre-operative periapical x-rays and	21	999	1	60	Month	Covered: 1-32 Only one of (D2542, D2543, D2544, D2642, D2643,
02045	Surfaces	105	NO	optional photos	21	555	-	00		D2644, D2740, D2750, D2751, D2752, D2753, D2790,
	Surraces									D2791, D2792, D2931) per 60 months per tooth. Teeth
										Covered: 1-32
D2644	Onlay - Porcelain/Ceramic - Four Or More	Yes	No	Pre-operative periapical x-rays and	21	999	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643,
	Surfaces			optional photos						D2644, D2740, D2750, D2751, D2752,D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth
										Covered: 1-32
D2740	Crown - Porcelain/Ceramic	No	Yes	Pre-operative periapical x-rays and	21	999	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643,
				optional photos.						D2644, D2740, D2750, D2751, D2752,D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth
										Covered: 1-32
D2750	Crown - Porcelain Fused To High Noble	No	Yes	Pre-operative periapical x-rays and	21	999	1	60		Only one of (D2542, D2543, D2544, D2642, D2643,
	Metal			optional photos.						D2644, D2740, D2750, D2751, D2752,D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth
D2754	Crown Dereslein Fuend Te	No	Vee		24	000		60	N.A. a. a. b.la	Covered: 1-32 Only one of (D2542, D2543, D2544, D2642, D2643,
D2751	Crown - Porcelain Fused To	NO	Yes	Pre-operative periapical x-rays and	21	999	1	60	Month	
	Predominantly Base Metal			optional photos.						D2644, D2740, D2750, D2751, D2752, D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth Covered: 1-32
D2752	Crown - Porcelain Fused To Noble Metal	No	Yes	Pre-operative periapical x-rays and	21	999	1	60	Month	Covered: 1-32 Only one of (D2542, D2543, D2544, D2642, D2643,
02/52	crown - roreclain rased to hobic metal	NO	105	optional photos.	21	555	-	00		D2644, D2740, D2750, D2751, D2752, D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth
										Covered: 1-32
D2753	Crown - Porcelain Fused to Titanium and	No	Yes	Pre-operative periapical x-rays and	21	999	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643,
	Titanium Alloys			optional photos.						D2644, D2740, D2750, D2751, D2752, D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth
										Covered: 1-32
D2790	Crown - Full Cast High Noble Metal	No	Yes	Pre-operative periapical x-rays and	21	999	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643,
				optional photos.						D2644, D2740, D2750, D2751, D2752,D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth
										Covered: 1-32
D2791	Crown - Full Cast Predominantly Base	No	Yes	Pre-operative periapical x-rays and	21	999	1	60		Only one of (D2542, D2543, D2544, D2642, D2643,
	Metal			optional photos.						D2644, D2740, D2750, D2751, D2752,D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth
				l						Covered: 1-32

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Code	Description	PA Required	Pre- Payment	Required Documents	Age Min	Age Max	Max Count	Period Length	Period Type	ADDITIONAL NOTES
D2792	Crown - Full Cast Noble Metal	No	Yes	Pre-operative periapical x-rays and optional photos.	21	999	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752,D2753, D2790, D2791, D2792, D2931) per 60 months per tooth. Teeth Covered: 1-32
D2910	Recement Inlay, Onlay, Or Partial Coverage Restoration	No	No		21	999	1	6	Month	One per tooth per 6 months. Teeth Covered: 1-32
D2915	Recement Cast Or Prefabricated Post And Core	No	No		21	999	1	6	Month	Not allowed within 6 months of D2954 by the same provider or provider group. One per tooth per 6 months. Teeth Covered: 1-32
D2920	Recement Crown	No	No		21	999	1	6	Month	Re-cement within 6 months of initial placement by same provider or provider group will be considered a duplicate service and will not be paid. One per tooth per 6 months. Teeth Covered: 1-32, A-T
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth	No	Yes	Pre-operative periapical x-rays and optional photos	21	999	1	60		Only one of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 months per tooth. Authorization required for three or more crowns. Teeth Covered: 1-32
D2932	Prefabricated Resin Crown	No	Yes	Pre-operative periapical x-rays and optional photos	21	999	1	1	Lifetime	Only one of (D2930, D2932, D2933, D2934) per lifetime per tooth. Authorization required for three or more crowns. Teeth Covered: 6-11, 22-27, C-H, M-R
D2940	Protective Restoration	No	No		21	999	1	6	Month	Not allowed with pulpotomy, pulpectomy, or root canal therapy. Not allowed on the same date of service as a restoration. One per tooth per 6 months. Teeth Covered: 1-32. A-T
D2950	Core Buildup, Including Any Pins When Required	No	No		21	999	1	60	Month	Only one of (D2950 or D2954) per tooth per 60 months. Teeth Covered: 1-32
D2951	Pin Retention - Per Tooth, In Addition To Restoration	No	No		21	999	4	1	Day	Not allowed with (D2950, D2954) on same DOS. Teeth Covered: 1-32
D2954	Prefabricated Post And Core In Addition To Crown	No	Yes	Final RCT fill periapical x-ray	21	999	1	60	Month	Only one of (D2950 or D2954) per tooth per 60 months. Teeth Covered: 1-32
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)	No	No		21	999	1	1	Lifetime	One per lifetime per tooth. Teeth Covered: 6-11, 22-27
D4210	Gingivectomy Or Gingivoplasty - Four Or More Contiguous Teeth	No	Yes	Pre-operative x-rays, perio charting, narrative of medical necessity, photos optional	21	999	1	24	Month	Only one of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 months per quadrant per provider group. Minimum of four (4) affected teeth in the quadrant. For removing hyperplastic tissue to reduce pocket denth.
D4211	Gingivectomy Or Gingivoplasty - One To Three Contiguous Teeth	No	Yes	Pre-operative x-rays, perio charting, narrative of medical necessity, photos optional	21	999	1	24	Month	Only one of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 months per quadrant per provider group. One to three teeth affected in quadrant. For removing hyperplastic tissue to reduce pocket depth.
D4240	Gingival Flap Procedure, Including Root Planing - Four Or More Contiguous Teeth	No	Yes	Pre-operative x-rays, perio charting, narrative of medical necessity, photos optional	21	999	1	24	Month	Only one of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 months per quadrant per provider group. Minimum of four (4) affected teeth in the guadrant.

Code	Description	PA	Pre-	Required Documents	Age Min	Age Max	Max Count	Period	Period	ADDITIONAL NOTES
Code	Description	Required	Payment	Required Documents	Age IVIIII	Age Wax		Length	Type	ADDITIONAL NOTES
D4241	Gingival Flap Procedure, Including Root	No	Yes	Pre-operative x-rays, perio	21	999	1	24	Month	Only one of (D4210, D4211, D4240, D4241, D4260,
	Planing - One To Three Contiguous Teeth			charting, narrative of medical						D4261) per 24 months per quadrant per provider
				necessity, photos optional						group. One to three teeth affected in quadrant.
				,,,,,,,,,,,,,,,,,,,,,						0 · · · · · · · · · · · · · · · · · · ·
D4249	Clinical Crown Lengthening - Hard Tissue	No	Yes	Pre-operative x-ray(s), perio	21	999	1	1	Lifetime	One per lifetime per tooth. Not allowed in same
				charting, narrative of medical						quadrant as D4260 or D4261 within a 24 month period.
				necessity						1
D4260	Osseous Surgery (Including Flap Entry	No	Yes	Pre-operative x-rays, perio	21	999	1	24	Month	Only one of (D4210, D4211, D4240, D4241, D4260,
	And Closure) - Four Or More Teeth			charting, narrative of medical						D4261) per 24 months per quadrant per provider
				necessity, photos optional						group. Minimum of four (4) affected teeth in the
										guadrant.
D4261	Osseous Surgery (Including Flap Entry	No	Yes	Pre-operative x-rays, perio	21	999	1	24	Month	Only one of (D4210, D4211, D4240, D4241, D4260,
	And Closure) - One To Three Teeth			charting, narrative of medical			_			D4261) per 24 months per quadrant per provider
				necessity, photos optional						group. One to three teeth affected in quadrant.
				necessity, photos optional						
D4263	Bone Replacement Graft - First Site In	No	Yes	Pre-operative x-rays, perio	21	999	1	24	Month	One per quadrant per 24 months. Tooth number
	Quadrant			charting, narrative of medical						required on claim form. Teeth Covered: 1-32
				necessity, photos optional						
D4264	Bone Replacement Graft - Each	No	Yes	Pre-operative x-rays, perio	21	999	3	24	Month	Three per quadrant per 24 months. Tooth number
	Additional Site In Quadrant			charting, narrative of medical			-			required on claim form. Teeth Covered: 1-32
				necessity, photos optional						
D4270	Pedicle Soft Tissue Graft Procedure	No	Yes	Pre-operative x-rays, perio	21	999	1	24	Month	One per tooth per lifetime Teeth Covered: 1-32
				charting, narrative of medical			_			
				necessity, photos optional						
D4273	Subepithelial Connective Tissue Graft	No	Yes	Pre-operative x-rays, perio	21	999	1	24	Month	One per quadrant per 24 months. Tooth number
5.270	Procedures, Per Tooth			charting, narrative of medical		000	-			required on claim form. Teeth Covered: 1-32
				necessity, photos optional						
D4274	Distal Or Proximal Wedge Procedure	No	Yes	Pre-operative x-rays, perio	21	999	1	24	Month	One per quadrant per 24 months.Tooth number
5.271				charting, narrative of medical		000	-			required on claim form. Teeth Covered: 1-32
				necessity, photos optional						
D4277	Free Soft Tissue Graft Procedure	No	Yes	Pre-operative x-rays, perio	21	999	1	24	Month	One per quadrant per 24 months. Tooth number
01277	(Including Donor Site Surgery) First Tooth			charting, narrative of medical		555	-	2.	Wienen	required on claim form. Teeth Covered: 1-32, 51-82
				necessity, photos optional						
D4278	Free Soft Tissue Graft Procedure	No	Yes	Pre-operative x-rays, perio	21	999	1	24	Month	Three per quadrant per 24 months. Tooth number
2.270	(Including Donor Site Surgery) Additional			charting, narrative of medical		000	-			required on claim form. Teeth Covered: 1-32, 51-82
	Tooth			necessity, photos optional						
D4320	Provisional Splinting - Intracoronal	No	Yes	Pre-operative x-rays, perio	21	999	1	24	Month	Per arch (LA, UA) - one (D4320 or D4321) per arch per
01020				charting, narrative of medical		555	-	2.	Wienen	24 months.
				necessity, photos optional						24 months.
D4321	Provisional Splinting - Extracoronal	No	Yes	Pre-operative x-rays, perio	21	999	1	24	Month	Per arch (LA, UA) - one (D4320 or D4321) per arch per
DISEI				charting, narrative of medical		555	-	2.	Wienen	24 months.
				necessity, photos optional						24 months.
D4341	Periodontal Scaling And Root Planing -	No	Yes	Pre-operative x-rays (bitewings	21	999	1	24	Month	Only one of (D4341 or D4342) per 24 months per
04041	Four Or More Teeth Per Quadrant	110	105	and/or panoramic radiograph) and	21	555	-	27	WORth	quadrant. One full mouth service is covered every 24
				periodontal charting						months.
D4342	Periodontal Scaling And Root Planing -	No	Yes	Pre-operative x-rays (bitewings	21	999	1	24	Month	Only one of (D4341 or D4342) per 24 months per
5-342	One To Three Teeth Per Quadrant	110	103	and/or panoramic radiograph) and	~ 1	555		27	wonth	guadrant. One full mouth service is covered every 24
										, , ,
				periodontal charting		1				months.

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Code	Description	Required	Pre- Payment	Required Documents	Age Min	Age Max	Max Count	Period Length	Period Type	ADDITIONAL NOTES
D4355	Full Mouth Debridement	No	No		21	999	1	12		Only one of (D1110 or D4355) per 6 months. Not billable with D4341 or D4342. Not eligible for payment if performed on the same date or within 12 months of a D0120 or D0150. Not allowed for twelve months following D1120 or any D4000 series code.
D4910	Periodontal Maintenance	No	No		21	999	1	6	Month	Requires history of D4210, D4211, D4240, D4241, D4260, D4261, D4341, D4342, or valid 4910. One (D1110 or D4910) per 6 months.
D5110	Complete Denture - Maxillary	Yes	No	Full mouth x-rays or panorex, prior date of placement	21	999	1	60	Month	Only one of (D5110, D5130, or D5221) per 60 months
D5120	Complete Denture - Mandibular	Yes	No	Full mouth x-rays or panorex, prior date of placement	21	999	1	60	Month	Only one of (D5120, D5140, or D5222) per 60 months.
D5130	Immediate Denture - Maxillary	Yes	No	Full mouth x-rays or panorex, prior date of placement	21	999	1	1	Lifetime	
D5140	Immediate Denture - Mandibular	Yes	No	Full mouth x-rays or panorex, prior date of placement	21	999	1	1	Lifetime	
D5221	Immediate Maxillary Partial Denture - Resin Base	Yes	No	Full mouth x-rays or panorex, prior date of placement	21	999	1	60	Month	Only one of (D5110, D5130, or D5221) per 60 months
D5222	Immediate Mandibular Partial Denture - Resin Base	Yes	No	Full mouth x-rays or panorex, prior date of placement	21	999	1	60	Month	Only one of (D5120, D5140, or D5222) per 60 months.
D5511	Repair Broken Complete Denture Base, Mandibular	No	No		21	999	2	12	Month	Not covered within 6 months of insertion.
D5512	Repair Broken Complete Denture Base, Maxillary	No	No		21	999	2	12	Month	Not covered within 6 months of insertion.
D5520	Replace Missing Or Broken Teeth - Complete Denture (Each Tooth)	No	No		21	999	1	12	Month	One per tooth per 12 months. Teeth Covered: 1-32
D5611	Repair Resin Partial Denture Base, Mandibular	No	No		21	999	2	12	Month	Not covered within 6 months of insertion.
D5612	Repair Resin Partial Denture Base, Maxillary	No	No		21	999	2	12	Month	Not covered within 6 months of insertion.
D5621	Repair Cast Partial Framework, Mandibular	No	No		21	999	2	12	Month	Not covered within 6 months of insertion.
D5622	Repair Cast Partial Framework, Maxillary	No	No		21	999	2	12	Month	Not covered within 6 months of insertion.
D5630	Repair Or Replace Broken Retentive/Clasping Materials - per tooth	No	No		21	999	1	21	Month	One per tooth per 12 months. Teeth Covered: 1-32
D5640	Replace Broken Teeth - Per Tooth	No	No		21	999	1	12	Month	One per tooth per 12 months. Teeth Covered: 1-32
D5650	Add Tooth To Existing Partial Denture	No	No		21	999	1	12	Month	One per tooth per 12 months. Teeth Covered: 1-32
D5730	Reline Complete Maxillary Denture (direct)	No	Yes	Date of denture placement	21	999	1	24	Month	Only one of (D5730 or D5750) per 24 months. Not covered within 6 months of placement.
D5731	Reline Complete Mandibular Denture (direct)	No	Yes	Date of denture placement	21	999	1	24	Month	Only one of (D5731 or D5751) per 24 months. Not covered within 6 months of placement.
D5740	Reline Maxillary Partial Denture (direct)	No	Yes	Date of denture placement	21	999	1	24	Month	Only one of (D5740 or D5760) per 24 months. Not covered within 6 months of placement.
D5741	Reline Mandibular Partial Denture (direct)	No	Yes	Date of denture placement	21	999	1	24	Month	Only one of (D5741 or D5761) per 24 months. Not covered within 6 months of placement.

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Code	Description	PA Required	Pre- Payment	Required Documents	Age Min	Age Max	Max Count	Period Length	Period Type	ADDITIONAL NOTES
D5750	Reline Complete Maxillary Denture	No	Yes	Date of denture placement	21	999	1	24	Month	Only one of (D5730 or D5750) per 24 months. Not
	(indirect)									covered within 6 months of placement.
D5751	Reline Complete Mandibular Denture	No	Yes	Date of denture placement	21	999	1	24	Month	Only one of (D5731 or D5751) per 24 months. Not
	(indirect)									covered within 6 months of placement.
D5760	Reline Maxillary Partial Denture (indirect)	No	Yes	Date of denture placement	21	999	1	24	Month	Only one of (D5740 or D5760) per 24 months. Not
										covered within 6 months of placement.
D5761	Reline Mandibular Partial Denture (indirect)	No	Yes	Date of denture placement	21	999	1	24	Month	Only one of (D5741 or D5761) per 24 months. Not covered within 6 months of placement.
D5999	Unspecified Maxillofacial Prosthesis, By	Yes	Yes	Description of procedure and	21	999	1	1	Day	One per day.
	Report			narrative of medical necessity					-	
D6930	Recement Fixed Partial Denture	No	No		21	999	1	6	Month	Same provider cannot bill within 6 months of
										placement. One per abutment per 6 months. Teeth
										Covered: 1-32
D6999	Unspecified Fixed Prosthodontic	Yes	No	Description of procedure and	21	999	1	1	Day	Teeth Covered: 1-32
	Procedure, By Report			narrative of medical necessity.					•	
				Preoperative periapical x-rays.						
				Photos optional.						
D7140	Extraction, Erupted Tooth Or Exposed	No	No		21	999	1	1	Lifetime	Includes incidental removal of a cyst or lesion attached
	Root									to the root(s). Teeth Covered: 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
D7210	Surgical Removal Of Erupted Tooth	No	No		21	999	1	1	Lifetime	Requires elevation of a mucoperiosteal flap and
										removal of bone and/or section of the tooth and
										closure. Includes incidental removal of a cyst or lesion
										attached to the root(s). Prophylactic removal of
										asymptomatic tooth or tooth free from pathology is
										not a covered benefit. Teeth Covered: 1-32, 51-82, A-
										T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS,
D7220	Removal Of Impacted Tooth - Soft Tissue	No	Yes	Pre-operative x-rays (excluding	21	999	1	1	Lifetime	Includes incidental removal of a cyst or lesion attached
				bitewings), Narrative of medical						to the root(s). Prophylactic removal of asymptomatic
				necessity						tooth or tooth free from pathology is not a covered
										benefit. Teeth Covered: 1-32, 51-82
D7230	Removal Of Impacted Tooth - Partially	No	Yes	Pre-operative x-rays (excluding	21	999	1	1	Lifetime	Includes incidental removal of a cyst or lesion attached
07230		NO	163	bitewings), Narrative of medical	21	555	-	1	Lifetime	to the root(s). Prophylactic removal of a symptomatic
	Bony									
				necessity						tooth or tooth free from pathology is not a covered
										benefit. Teeth Covered: 1-32, 51-82
D7240	Removal Of Impacted Tooth - Completely	No	Yes	Pre-operative x-rays (excluding	21	999	1	1	Lifetime	Includes incidental removal of a cyst or lesion attached
	Bony			bitewings), Narrative of medical						to the root(s). Prophylactic removal of asymptomatic
				necessity						tooth or tooth free from pathology is not a covered
										benefit. Teeth Covered: 1-32, 51-82
D7250	Surgical Removal Of Residual Tooth Roots	No	Yes	Pre-operative x-rays (excluding	21	999	1	1	Lifetime	Not payable to provider group who previously billed
	(Cutting Procedure)			bitewings)						extraction. Includes incidental removal of a cyst or
				<i></i>						lesion attached to the root(s). Teeth Covered: 1-32, 51-
										82, A-T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS,
										NS. OS. PS. OS. RS. SS. TS
					1		1			INS. US. P.S. US. RS. SS. 15

Code	Description	PA	Pre-	Required Documents	Age Min	Age Max	Max Count	Period	Period	ADDITIONAL NOTES
Coue	Description	Required	Payment	Required Documents	Age Milli	Age wax		Length		ADDITIONAL NOTES
D7270	Reimplantation And/Or Stabilization Of Accidentally Evulsed / Displaced Tooth	No	Yes	Pre-operative x-rays (excluding bitewings), Narrative of medical necessity. Photos optional	21	999	1	1		Once per lifetime per tooth. Teeth Covered: 1-32
D7310	Alveoloplasty In Conjunction With Extractions - Four Or More Teeth	No	Yes	Pre-operative x-rays (excluding bitewings).	21	999	1	1	Lifetime	Only one of (D7310 or D7311) per lifetime per quadrant. Minimum of four teeth extracted in quadrant.
D7311	Alveoloplasty In Conjunction With Extractions - One To Three Teeth	No	Yes	Pre-operative x-rays (excluding bitewings).	21	999	1	1	Lifetime	Only one of (D7310 or D7311) per lifetime per quadrant. One to three teeth extracted in quadrant.
D7320	Alveoloplasty Not In Conjunction With Extractions - Four Or More Teeth	No	Yes	Pre-operative x-rays. Narrative of medical necessity	21	999	1	1	Lifetime	Only one of (D7320 or D7321) per lifetime per quadrant. Minimum of four tooth spaces in quadrant.
D7321	Alveoloplasty Not In Conjunction With Extractions - One To Three Teeth	No	Yes	Pre-operative x-rays. Narrative of medical necessity	21	999	1	1	Lifetime	Only one of (D7320 or D7321) per lifetime per quadrant. One to three tooth spaces in quadrant.
D7450	Removal Of Benign Odontogenic Cyst Or Tumor - Dia Up To 1.25 Cm	No	Yes	Copy of pathology report and pre- operative x-ray.	21	999	1	1	Lifetime	Once per lifetime per tooth.
D7451	Removal Of Benign Odontogenic Cyst Or Tumor - Dia Greater Than 1.25 Cm	No	Yes	Copy of pathology report and pre- operative x-ray.	21	999	1	1	Lifetime	Once per lifetime per tooth.
D7460	Removal Of Benign Nonodontogenic Cyst Or Tumor - Dia Up To 1.25 Cm	No	Yes	Copy of pathology report and pre- operative x-ray.	21	999				
D7461	Removal Of Benign Nonodontogenic Cyst Or Tumor - Dia Greater Than 1.25 Cm	No	Yes	Copy of pathology report and pre- operative x-ray.	21	999				
D7510	Incision And Drainage Of Abscess - Intraoral Soft Tissue	No	Yes	Pre-operative x-rays, narrative of medical necessity, photos optional	21	999	1	1	Day	Only one of (D7510 or D7511) per day per tooth. Not payable same DOS as D7140-D7250. Teeth Covered: 1- 32, 51-82, A-T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, OS, RS, SS, TS
D7511	Incision And Drainage Of Abscess - Intraoral Soft Tissue - Complicated	No	Yes	Pre-operative x-rays, narrative of medical necessity, photos optional	21	999	1	1	Day	Only one of (D7510 or D7511) per day.
D7610	Maxilla - Open Reduction (Teeth Immobilized, If Present)	No	Yes	Pre-operative x-rays, narrative of medical necessity	21	999	1	1	Day	
D7620	Maxilla - Closed Reduction (Teeth Immobilized, If Present)	No	Yes	Pre-operative x-rays, narrative of medical necessity	21	999	1	1	Day	
D7630	Mandible - Open Reduction (Teeth Immobilized, If Present)	No	Yes	Pre-operative x-rays, narrative of medical necessity	21	999	1	1	Day	
D7640	Mandible - Closed Reduction (Teeth Immobilized, If Present)	No	Yes	Pre-operative x-rays, narrative of medical necessity	21	999	1	1	Day	
D7710	Maxilla - Open Reduction	No	Yes	Pre-operative x-rays, narrative of medical necessity	21	999	1	1	Day	
D7720	Maxilla - Closed Reduction	No	Yes	Pre-operative x-rays, narrative of medical necessity	21	999	1	1	Day	
D7730	Mandible - Open Reduction	No	Yes	Pre-operative x-rays, narrative of medical necessity	21	999	1	1	Day	
D7740	Mandible - Closed Reduction	No	Yes	Pre-operative x-rays, narrative of medical necessity	21	999	1	1	Day	
D7810	Open Reduction Of Dislocation	No	Yes	Pre-operative x-rays, narrative of medical necessity	21	999	1	1	Day	

Code	Description	PA	Pre-	Required Documents	Age Min	Age Max	Max Count		Period	ADDITIONAL NOTES
		Required	Payment					Length	Туре	
D7820	Closed Reduction Of Dislocation	No	Yes	Pre-operative x-rays, narrative of medical necessity	21	999	1	1	Day	
D7999	Unspecified Oral Surgery Procedure, By Report	Yes	No	Description of procedure, x-rays and narrative of medical necessity.	21	999	1	1	Day	
D9110	Palliative (Emergency) Treatment Of Dental Pain - Minor Procedure	No	No		21	999	4	12	Month	Only one of (D0140 or D9110) per day per provider group. For emergency care only.
D9222	Deep Sedation/General Anesthesia – First 15 Minutes	Yes	No	Clinical documentation supporting necessity	21	999	1	1	Day	Only one of (D9222 or D9239) per day. Permit B required. Not allowed same DOS as D9230, D9239, D9243. or D9248.
D9223	Deep Sedation/General Anesthesia - each subsequent 15 minute increment	No	No		21	999	5	1	Day	Five of (D9223 or D9243) per day. Permit B required. Not allowed on the same date of service with D9230, D9243, or D9248. Valid D9222 must be on file.
D9230	Inhalation Of Nitrous/Analgesia, Anxiolysis	No	No	Supporting documentation must be kept in patient record.	21	999	1	1	Day	Not allowed same DOS as D9222, D9223, D9239, D9243, or D9248
D9239	Intravenous Moderate (conscious) Sedation/Analgesia – First 15 Minutes	Yes	Yes	Clinical documentation supporting necessity	21	999	1	1	Day	Only one of (D9222 or D9239) per day. Permit B required. Not allowed same DOS as D9222, D9223, D9230. or D9248.
D9243	Intravenous Moderate (Conscious) Sedation/Analgesia - Subs 15 Min	No	No		21	999	5	1	Day	Five of (D9223 or D9243) per day. Permit B required. Not allowed same DOS as D9222, D9223, D9230, or D9248. Valid D9239 must be on file.
D9248	Non-Intravenous Moderate (Conscious) Sedation	No	Yes	Clinical documentation supporting necessity	21	999	1	1	Day	Limited to patients with a mental or physical handicap, extremely apprehensive, or extensive treatment is performed in one appointment. D9248 is not allowed on same date of service as D9222, D9223, D9230, D9239, or D9243. Permit A or B is required.
D9310	Consultation - Diagnostic Service Provided By Dentist Or Physician	No	No	Supporting documentation must be kept in patient record.	21	999	1	1	Day	One per day per provider group.
D9610	Therapeutic Parenteral Drug, Single Administration	No	Yes	Description of drugs and parenteral administration	21	999	1	1	Day	Name of drug and amount administered. One per day.
D9630	Other Drugs And/Or Medicaments, By Report	No	Yes	Description of drugs	21	999	1	1	Day	Name of drug and amount administered. One per day.
D9999	Unspecified Adjunctive Procedure, By Report	Yes	No	Description of procedure and narrative of medical necessity. For Outpatient facility usage, include completed health plan Outpatient Facility Authorization form, clinical documentation of necessity.	21	999	1	1	Day	
	•			Meridian Medicaid Pla	n – Adults	Age 21 and	d Older			
D0120					24					

D0120	Periodic Oral Evaluation - Established	No	No	21	999	1	6	Month	Not allowed within 6 months of D0150.
	Patient								
D0140	Limited Oral Evaluation - Problem	No	No	21	999	1	1	Day	Only one of (D0140 or D9110) per day per provider
	Focused								group. For emergency exam only. Not payable if
									performed in conjunction with either D0120, D0150, or
									D0180.
D0150	Comprehensive Oral Evaluation - New Or	No	No	21	999	1	1	Lifetime	Only one D0150 per lifetime per provider group.
	Established Patient								

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Code	Description	PA Required	Pre- Payment	Required Documents	Age Min	Age Max	Max Count	Period Length	Period Type	ADDITIONAL NOTES
D0210	Intraoral - Complete Series of Radiographic Images	No	No		21	999	1	36		Only one of (D0210, D0277, or D0330) per 36 months per member.
D0220	Intraoral - Periapical First Radiographic Image	No	No		21	999	1	1		Only one D0220 per day per per provider or location. Maximum reimbursement of a single date of service for radiographs limited to fee for complete Series (D0210).
D0230	Intraoral - Periapical Each Additional Image	No	No		21	999				Maximum reimbursement is up to the fee of D0210.
D0270	Bitewing - Single Radiographic Image	No	No		21	999	1	12		One D0270 per 12 months per provider group. Maximum reimbursement of a single date of service for radiographs limited to fee for complete series (D0210).
D0272	Bitewings - Two Radiographic Images	No	No		21	999	1	12		One (D0272 or D0274) per 12 month per provider or location. Maximum reimbursement of a single date of service for radiographs limited to fee for complete series (D0210).
	Bitewings - Four Radiographic Images	No	No		21	999	1	12		One (D0272 or D0274) per 12 month per provider or location. Maximum reimbursement of a single date of service for radiographs limited to fee for complete series (D0210).
D0277	Vertical Bitewings - 7 To 8 Radiographic Images	No	No		21	999	1	36		Only one of (D0210, D0277, or D0330) per 36 months per member. Maximum reimbursement of a single date of service for radiographs limited to fee for complete series (D0210).
D0330	Panoramic Radiographic Image	No	No		21	999	1	36		Only one of (D0210, D0277, or D0330) per 36 months per member. Maximum reimbursement of a single date of service for radiographs limited to fee for complete series (D0210).
D0999	Unspecified Diagnostic Procedures, By Report						1	1		For FQHC Encounter billing. D0999 must be on first line of claim with additional service listed.
D1110	Prophylaxis - Adult	No	No		21	999	1	6	Month	
	Interim Caries Arresting Medicament Application - Per Tooth	No	No		21	999	6	1	Lifetime	2 applications per tooth per year. Lifetime maximum of six applications per tooth. Providers may treat a maximum of 4 teeth per day, providing participant has no history of any prior or same day billing of CDT category D2000 (Restorative codes) or CDT category D3000 (Endodontic codes) on the same tooth.
D2140	Amalgam - One Surface, Primary Or Permanent	No	No		21	999	1	12		Only one (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 months per surface. Teeth Covered: 1-32, A-T
	Amalgam - Two Surfaces, Primary Or Permanent	No	No		21	999	1	12		Only one (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 months per surface. Teeth Covered: 1-32, A-T
D2160	Amalgam - Three Surfaces, Primary Or Permanent	No	No		21	999	1	12		Only one (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 months per surface. Teeth Covered: 1-32, A-T

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Code	Description	PA Required	Pre- Payment	Required Documents	Age Min	Age Max	Max Count	Period Length	Period Type	ADDITIONAL NOTES
D2161	Amalgam - Four Or More Surfaces,	No	No		21	999	1	12	Month	One of (D2161, D2335, D2394) per 12 months per
D2330	Primary Or Permanent Resin-Based Composite - One Surface,	No	No		21	999	1	12	Month	tooth. Teeth Covered: 1-32, A-T Only one (D2140, D2150, D2160, D2161, D2330,
02000	Anterior					555	-		Worten	D2331, D2332, D2335, D2391, D2392, D2393, D2394)
										per 12 months per surface. Teeth Covered: 6-11, 22-
										27. C-H. M-R
D2331	Resin-Based Composite - Two Surfaces,	No	No		21	999	1	12	Month	Only one (D2140, D2150, D2160, D2161, D2330,
	Anterior									D2331, D2332, D2335, D2391, D2392, D2393, D2394)
										per 12 months per surface. Teeth Covered: 6-11, 22-
D2332	Resin-Based Composite - Three Surfaces,	No	No		21	999	1	12	Month	27. C-H. M-R Only one (D2140, D2150, D2160, D2161, D2330,
02332	Anterior	NO	NO		21	555	-	12	Worten	D2331, D2332, D2335, D2391, D2392, D2393, D2394)
										per 12 months per surface. Teeth Covered: 6-11, 22-
										27. C-H. M-R
D2335	Resin-Based Composite - Four Or More	No	No		21	999	1	12	Month	One of (D2161, D2335, D2394) per 12 months per
	Surfaces Or Involving Incisal Angle									tooth. Teeth Covered: 6-11, 22-27, C-H, M-R
D2391	Resin-Based Composite - One Surface,	No	No		21	999	1	12	Month	Only one (D2140, D2150, D2160, D2161, D2330,
	Posterior		-							D2331, D2332, D2335, D2391, D2392, D2393, D2394)
										per 12 months per surface. May not be used for PRR.
										Teeth Covered: 1-5, 12-21, 28-32, A, B, I-L, S, T
D2392	Resin-Based Composite - Two Surfaces,	No	No		21	999	1	12	Month	Only one (D2140, D2150, D2160, D2161, D2330,
	Posterior									D2331, D2332, D2335, D2391, D2392, D2393, D2394)
										per 12 months per surface. Teeth Covered: 1-5, 12-21,
										28-32. A. B. I-L. S. T
D2393	Resin-Based Composite - Three Surfaces,	No	No		21	999	1	12	Month	Only one (D2140, D2150, D2160, D2161, D2330,
	Posterior									D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 months per surface. Teeth Covered: 1-5, 12-21,
										28-32. A. B. I-L. S. T
D2394	Resin-Based Composite - Four Or More	No	No		21	999	1	12	Month	One of (D2161, D2335, D2394) per 12 months per
	Surfaces, Posterior									tooth. Teeth Covered: 1-5, 12-21, 28-32, A, B, I-L, S, T
D2542	Onlay - Metallic - Two Surfaces	Yes	No	Pre-operative periapical x-rays and	21	999	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643,
				optional photos			_			D2644, D2740, D2750, D2751, D2752, D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth
										Covered: 1-32
D2543	Onlay - Metallic - Three Surfaces	Yes	No	Pre-operative periapical x-rays and	21	999	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643,
				optional photos						D2644, D2740, D2750, D2751, D2752,D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth Covered: 1-32
D2544	Onlay - Metallic - Four Or More Surfaces	Yes	No	Pre-operative periapical x-rays and	21	999	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643,
				optional photos						D2644, D2740, D2750, D2751, D2752,D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth
D2642		, v	- N		21	000				Covered: 1-32
D2642	Onlay - Porcelain/Ceramic - Two Surfaces	Yes	No	Pre-operative periapical x-rays and	21	999	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2752, D2750, D2751, D2752, D2752, D2750, D2751, D2752, D27
				optional photos						D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 months per tooth. Teeth
										Covered: 1-32
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Code	Description	Required	Payment	Required Documents	Age Min	Age Max	Max Count	Period Length	Period Type	ADDITIONAL NOTES
D2643	Onlay - Porcelain/Ceramic - Three	Yes	No	Pre-operative periapical x-rays and	21	999	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643,
	Surfaces			optional photos						D2644, D2740, D2750, D2751, D2752,D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth
										Covered: 1-32
D2644	Onlay - Porcelain/Ceramic - Four Or More	Yes	No	Pre-operative periapical x-rays and	21	999	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643,
	Surfaces			optional photos						D2644, D2740, D2750, D2751, D2752,D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth
										Covered: 1-32
D2740	Crown - Porcelain/Ceramic	No	Yes	Pre-operative periapical x-rays and	21	999	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643,
				optional photos.						D2644, D2740, D2750, D2751, D2752,D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth
										Covered: 1-32
D2750	Crown - Porcelain Fused To High Noble	No	Yes	Pre-operative periapical x-rays and	21	999	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643,
	Metal			optional photos.						D2644, D2740, D2750, D2751, D2752,D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth
										Covered: 1-32
D2751	Crown - Porcelain Fused To	No	Yes	Pre-operative periapical x-rays and	21	999	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643,
	Predominantly Base Metal			optional photos.						D2644, D2740, D2750, D2751, D2752,D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth
D2752	Crown Deveolein Ewood To Nickle Motel	Na	Vaa		21	000	1	<u> </u>	Manth	Covered: 1-32 Only one of (D2542, D2543, D2544, D2642, D2643,
D2752	Crown - Porcelain Fused To Noble Metal	No	Yes	Pre-operative periapical x-rays and	21	999	1	60	Month	
				optional photos.						D2644, D2740, D2750, D2751, D2752, D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth
D2752	Crown - Porcelain Fused to Titanium and	No	Yes	Pre-operative periapical x-rays and	21	999	1	60	Month	Covered: 1-32 Only one of (D2542, D2543, D2544, D2642, D2643,
D2755	Titanium Alloys	NO	163	optional photos.	21	333	1	00	wonth	D2644, D2740, D2750, D2751, D2752, D2753, D2790,
	Intanium Alloys			optional photos.						D2791, D2792, D2931) per 60 months per tooth. Teeth
										Covered: 1-32
D2790	Crown - Full Cast High Noble Metal	No	Yes	Pre-operative periapical x-rays and	21	999	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643,
02/00				optional photos.		555	-	00	Worten	D2644, D2740, D2750, D2751, D2752, D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth
										Covered: 1-32
D2791	Crown - Full Cast Predominantly Base	No	Yes	Pre-operative periapical x-rays and	21	999	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643,
	, Metal			optional photos.						D2644, D2740, D2750, D2751, D2752, D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth
										Covered: 1-32
D2792	Crown - Full Cast Noble Metal	No	Yes	Pre-operative periapical x-rays and	21	999	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643,
				optional photos.						D2644, D2740, D2750, D2751, D2752,D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth
										Covered: 1-32
D2910	Recement Inlay, Onlay, Or Partial	No	No		21	999	1	6	Month	One per tooth per 6 months. Teeth Covered: 1-32
	Coverage Restoration									
D2915	Recement Cast Or Prefabricated Post And	No	No		21	999	1	6	Month	Not allowed within 6 months of D2954 by the same
	Core									provider or provider group. One per tooth per 6
										months. Teeth Covered: 1-32
D2920	Recement Crown	No	No		21	999	1	6	Month	Re-cement within 6 months of initial placement by
										same provider or provider group will be considered a
										duplicate service and will not be paid. One per tooth
										per 6 months. Teeth Covered: 1-32, A-T
				1						

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Code	Description	PA Required	Pre- Payment	Required Documents	Age Min	Age Max	Max Count	Period Length	Period Type	ADDITIONAL NOTES
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth	No	Yes	Pre-operative periapical x-rays and optional photos	21	999	1	60		Only one of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 months per tooth. Authorization required for three or more crowns. Teeth Covered: 1-32
D2932	Prefabricated Resin Crown	No	Yes	Pre-operative periapical x-rays and optional photos	21	999	1	1	Lifetime	Only one of (D2930, D2932, D2933, D2934) per lifetime per tooth. Authorization required for three or more crowns. Teeth Covered: 6-11, 22-27, C-H, M-R
D2940	Protective Restoration	No	No		21	999	1	6	Month	Not allowed with pulpotomy, pulpectomy, or root canal therapy. Not allowed on the same date of service as a restoration. One per tooth per 6 months. Teeth Covered: 1-32. A-T
D2950	Core Buildup, Including Any Pins When Required	No	No		21	999	1	60	Month	Only one of (D2950 or D2954) per tooth per 60 months. Teeth Covered: 1-32
D2951	Pin Retention - Per Tooth, In Addition To Restoration	No	No		21	999	4	1	Day	Not allowed with (D2950, D2954) on same DOS. Teeth Covered: 1-32
D2954	Prefabricated Post And Core In Addition To Crown	No	Yes	Final RCT fill periapical x-ray	21	999	1	60	Month	Only one of (D2950 or D2954) per tooth per 60 months. Teeth Covered: 1-32
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)	No	No		21	999	1	1	Lifetime	One per lifetime per tooth. Teeth Covered: 6-11, 22-27
	Gingivectomy Or Gingivoplasty - Four Or More Contiguous Teeth	No	Yes	Pre-operative x-rays, perio charting, narrative of medical necessity, photos optional	21	999	1	24		Only one of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 months per quadrant per provider group. Minimum of four (4) affected teeth in the quadrant. For removing hyperplastic tissue to reduce pocket denth
	Gingivectomy Or Gingivoplasty - One To Three Contiguous Teeth	No	Yes	Pre-operative x-rays, perio charting, narrative of medical necessity, photos optional	21	999	1	24		Only one of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 months per quadrant per provider group. One to three teeth affected in quadrant. For removing hyperplastic tissue to reduce pocket depth.
	Gingival Flap Procedure, Including Root Planing - Four Or More Contiguous Teeth	No	Yes	Pre-operative x-rays, perio charting, narrative of medical necessity, photos optional	21	999	1	24		Only one of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 months per quadrant per provider group. Minimum of four (4) affected teeth in the quadrant.
	Gingival Flap Procedure, Including Root Planing - One To Three Contiguous Teeth	No	Yes	Pre-operative x-rays, perio charting, narrative of medical necessity, photos optional	21	999	1	24		Only one of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 months per quadrant per provider group. One to three teeth affected in quadrant.
D4249	Clinical Crown Lengthening - Hard Tissue	No	Yes	Pre-operative x-ray(s), perio charting, narrative of medical necessity	21	999	1	1	Lifetime	One per lifetime per tooth. Not allowed in same quadrant as D4260 or D4261 within a 24 month period.
	Osseous Surgery (Including Flap Entry And Closure) - Four Or More Teeth	No	Yes	Pre-operative x-rays, perio charting, narrative of medical necessity, photos optional	21	999	1	24		Only one of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 months per quadrant per provider group. Minimum of four (4) affected teeth in the quadrant.
	Osseous Surgery (Including Flap Entry And Closure) - One To Three Teeth	No	Yes	Pre-operative x-rays, perio charting, narrative of medical necessity, photos optional	21	999	1	24		Only one of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 months per quadrant per provider group. One to three teeth affected in quadrant.

Code	Description	PA Required	Pre- Payment	Required Documents	Age Min		Max Count	Period Length	Period Type	ADDITIONAL NOTES
D4263	Bone Replacement Graft - First Site In Quadrant	No	Yes	Pre-operative x-rays, perio charting, narrative of medical necessity, photos optional	21	999	1	24	Month	One per quadrant per 24 months. Tooth number required on claim form. Teeth Covered: 1-32
D4264	Bone Replacement Graft - Each Additional Site In Quadrant	No	Yes	Pre-operative x-rays, perio charting, narrative of medical necessity, photos optional	21	999	3	24	Month	Three per quadrant per 24 months. Tooth number required on claim form. Teeth Covered: 1-32
D4270	Pedicle Soft Tissue Graft Procedure	No	Yes	Pre-operative x-rays, perio charting, narrative of medical necessity, photos optional	21	999	1	24	Month	One per tooth per lifetime Teeth Covered: 1-32
D4273	Subepithelial Connective Tissue Graft Procedures, Per Tooth	No	Yes	Pre-operative x-rays, perio charting, narrative of medical necessity, photos optional	21	999	1	24	Month	One per quadrant per 24 months. Tooth number required on claim form. Teeth Covered: 1-32
D4274	Distal Or Proximal Wedge Procedure	No	Yes	Pre-operative x-rays, perio charting, narrative of medical necessity, photos optional	21	999	1	24	Month	One per quadrant per 24 months.Tooth number required on claim form. Teeth Covered: 1-32
D4277	Free Soft Tissue Graft Procedure (Including Donor Site Surgery) First Tooth	No	Yes	Pre-operative x-rays, perio charting, narrative of medical necessity, photos optional	21	999	1	24	Month	One per quadrant per 24 months. Tooth number required on claim form. Teeth Covered: 1-32, 51-82
D4278	Free Soft Tissue Graft Procedure (Including Donor Site Surgery) Additional Tooth	No	Yes	Pre-operative x-rays, perio charting, narrative of medical necessity, photos optional	21	999	1	24	Month	Three per quadrant per 24 months. Tooth number required on claim form. Teeth Covered: 1-32, 51-82
D4320	Provisional Splinting - Intracoronal	No	Yes	Pre-operative x-rays, perio charting, narrative of medical necessity, photos optional	21	999	1	24	Month	Per arch (LA, UA) - one (D4320 or D4321) per arch per 24 months.
D4321	Provisional Splinting - Extracoronal	No	Yes	Pre-operative x-rays, perio charting, narrative of medical necessity, photos optional	21	999	1	24	Month	Per arch (LA, UA) - one (D4320 or D4321) per arch per 24 months.
D4341	Periodontal Scaling And Root Planing - Four Or More Teeth Per Quadrant	No	Yes	Pre-operative x-rays (bitewings and/or panoramic radiograph) and periodontal charting	21	999	1	24	Month	Only one of (D4341 or D4342) per 24 months per quadrant. One full mouth service is covered every 24 months.
D4342	Periodontal Scaling And Root Planing - One To Three Teeth Per Quadrant	No	Yes	Pre-operative x-rays (bitewings and/or panoramic radiograph) and periodontal charting	21	999	1	24	Month	Only one of (D4341 or D4342) per 24 months per quadrant. One full mouth service is covered every 24 months.
D4355	Full Mouth Debridement	No	No		21	999	1	12	Month	Only one of (D1110 or D4355) per 6 months. Not billable with D4341 or D4342. Not eligible for payment if performed on the same date or within 12 months of a D0120 or D0150. Not allowed for twelve months following D1120 or any D4000 series code.
D4910	Periodontal Maintenance	No	No		21	999	1	6	Month	Requires history of D4210, D4211, D4240, D4241, D4260, D4261, D4341, D4342, or valid 4910. One (D1110 or D4910) per 6 months.
D5110	Complete Denture - Maxillary	Yes	No	Full mouth x-rays or panorex, prior date of placement	21	999	1	60	Month	Only one of (D5110, D5130, or D5221) per 60 months
D5120	Complete Denture - Mandibular	Yes		Full mouth x-rays or panorex, prior date of placement	21	999	1	60		Only one of (D5120, D5140, or D5222) per 60 months.
D5130	Immediate Denture - Maxillary	Yes		Full mouth x-rays or panorex, prior date of placement	21	999	1	1	Lifetime	
D5140	Immediate Denture - Mandibular	Yes	No	Full mouth x-rays or panorex, prior date of placement	21	999	1	1	Lifetime	

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Code	Description	PA Required	Pre- Payment	Required Documents	Age Min	Age Max	Max Count	Period Length	Period Type	ADDITIONAL NOTES
D5221	Immediate Maxillary Partial Denture -	Yes	No	Full mouth x-rays or panorex, prior	21	999	1	60	Month	Only one of (D5110, D5130, or D5221) per 60 months
	Resin Base			date of placement						
D5222	Immediate Mandibular Partial Denture -	Yes	No	Full mouth x-rays or panorex, prior	21	999	1	60	Month	Only one of (D5120, D5140, or D5222) per 60 months.
	Resin Base			date of placement						
D5511	Repair Broken Complete Denture Base,	No	No		21	999	2	12	Month	Not covered within 6 months of insertion.
	Mandibular									
D5512	Repair Broken Complete Denture Base,	No	No		21	999	2	12	Month	Not covered within 6 months of insertion.
	Maxillary									
D5520	Replace Missing Or Broken Teeth -	No	No		21	999	1	12	Month	One per tooth per 12 months. Teeth Covered: 1-32
	Complete Denture (Each Tooth)									
D5611	Repair Resin Partial Denture Base,	No	No		21	999	2	12	Month	Not covered within 6 months of insertion.
	Mandibular									
D5612	Repair Resin Partial Denture Base,	No	No		21	999	2	12	Month	Not covered within 6 months of insertion.
	Maxillary									
D5621	Repair Cast Partial Framework,	No	No		21	999	2	12	Month	Not covered within 6 months of insertion.
	Mandibular									
D5622	Repair Cast Partial Framework, Maxillary	No	No		21	999	2	12	Month	Not covered within 6 months of insertion.
D5630	Repair Or Replace Broken	No	No		21	999	1	21	Month	One per tooth per 12 months. Teeth Covered: 1-32
20000	Retentive/Clasping Materials - per tooth					000	-			
	netentive/ clasping materials per tooth									
D5640	Replace Broken Teeth - Per Tooth	No	No		21	999	1	12	Month	One per tooth per 12 months. Teeth Covered: 1-32
20010						000	-			
D5650	Add Tooth To Existing Partial Denture	No	No		21	999	1	12	Month	One per tooth per 12 months. Teeth Covered: 1-32
20000						000	-			
D5730	Reline Complete Maxillary Denture	No	Yes	Date of denture placement	21	999	1	24	Month	Only one of (D5730 or D5750) per 24 months. Not
	(direct)	-		···· · · · · · · · · · · · · · · · · ·						covered within 6 months of placement.
D5731	Reline Complete Mandibular Denture	No	Yes	Date of denture placement	21	999	1	24	Month	Only one of (D5731 or D5751) per 24 months. Not
	(direct)									covered within 6 months of placement.
D5740	Reline Maxillary Partial Denture (direct)	No	Yes	Date of denture placement	21	999	1	24	Month	Only one of (D5740 or D5760) per 24 months. Not
										covered within 6 months of placement.
D5741	Reline Mandibular Partial Denture	No	Yes	Date of denture placement	21	999	1	24	Month	Only one of (D5741 or D5761) per 24 months. Not
	(direct)									covered within 6 months of placement.
D5750	Reline Complete Maxillary Denture	No	Yes	Date of denture placement	21	999	1	24	Month	Only one of (D5730 or D5750) per 24 months. Not
	(indirect)									covered within 6 months of placement.
D5751	Reline Complete Mandibular Denture	No	Yes	Date of denture placement	21	999	1	24	Month	Only one of (D5731 or D5751) per 24 months. Not
	(indirect)									covered within 6 months of placement.
D5760	Reline Maxillary Partial Denture (indirect)	No	Yes	Date of denture placement	21	999	1	24	Month	Only one of (D5740 or D5760) per 24 months. Not
										covered within 6 months of placement.
D5761	Reline Mandibular Partial Denture	No	Yes	Date of denture placement	21	999	1	24	Month	Only one of (D5741 or D5761) per 24 months. Not
	(indirect)									covered within 6 months of placement.
D5999	Unspecified Maxillofacial Prosthesis, By	Yes	Yes	Description of procedure and	21	999	1	1	Day	One per day.
	Report			narrative of medical necessity						
D6930	Recement Fixed Partial Denture	No	No		21	999	1	6	Month	Same provider cannot bill within 6 months of
										placement. One per abutment per 6 months. Teeth
										Covered: 1-32
D6999	Unspecified Fixed Prosthodontic	Yes	No	Description of procedure and	21	999	1	1	Day	Teeth Covered: 1-32
	Procedure, By Report			narrative of medical necessity.			1			
				Preoperative periapical x-rays.			1			
				Photos optional.						

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Code	Description	PA Required	Pre- Payment	Required Documents	Age Min	Age Max	Max Count	Period Length	Period Type	ADDITIONAL NOTES
D7140	Extraction, Erupted Tooth Or Exposed Root	No	No		21	999	1	1	Lifetime	Includes incidental removal of a cyst or lesion attached to the root(s). Teeth Covered: 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
D7210	Surgical Removal Of Erupted Tooth	No	No		21	999	1	1	Lifetime	Requires elevation of a mucoperiosteal flap and removal of bone and/or section of the tooth and closure. Includes incidental removal of a cyst or lesion attached to the root(s). Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit. Teeth Covered: 1-32, 51-82, A- T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS,
D7220	Removal Of Impacted Tooth - Soft Tissue	No	Yes	Pre-operative x-rays (excluding bitewings), Narrative of medical necessity	21	999	1	1	Lifetime	Includes incidental removal of a cyst or lesion attached to the root(s). Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit. Teeth Covered: 1-32, 51-82
D7230	Removal Of Impacted Tooth - Partially Bony	No	Yes	Pre-operative x-rays (excluding bitewings), Narrative of medical necessity	21	999	1	1	Lifetime	Includes incidental removal of a cyst or lesion attached to the root(s). Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit. Teeth Covered: 1-32, 51-82
D7240	Removal Of Impacted Tooth - Completely Bony	No	Yes	Pre-operative x-rays (excluding bitewings), Narrative of medical necessity	21	999	1	1		Includes incidental removal of a cyst or lesion attached to the root(s). Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit. Teeth Covered: 1-32, 51-82
D7250	Surgical Removal Of Residual Tooth Roots (Cutting Procedure)	No	Yes	Pre-operative x-rays (excluding bitewings)	21	999	1	1	Lifetime	Not payable to provider group who previously billed extraction. Includes incidental removal of a cyst or lesion attached to the root(s). Teeth Covered: 1-32, 51- 82, A-T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, OS, RS, SS, TS
D7270	Reimplantation And/Or Stabilization Of Accidentally Evulsed / Displaced Tooth	No	Yes	Pre-operative x-rays (excluding bitewings), Narrative of medical necessity. Photos optional	21	999	1	1	Lifetime	Once per lifetime per tooth. Teeth Covered: 1-32
D7310	Alveoloplasty In Conjunction With Extractions - Four Or More Teeth	No	Yes	Pre-operative x-rays (excluding bitewings).	21	999	1	1		Only one of (D7310 or D7311) per lifetime per quadrant. Minimum of four teeth extracted in quadrant.
D7311	Alveoloplasty In Conjunction With Extractions - One To Three Teeth	No	Yes	Pre-operative x-rays (excluding bitewings).	21	999	1	1	Lifetime	Only one of (D7310 or D7311) per lifetime per quadrant. One to three teeth extracted in quadrant.
D7320	Alveoloplasty Not In Conjunction With Extractions - Four Or More Teeth	No	Yes	Pre-operative x-rays. Narrative of medical necessity	21	999	1	1	Lifetime	Only one of (D7320 or D7321) per lifetime per quadrant. Minimum of four tooth spaces in quadrant.
D7321	Alveoloplasty Not In Conjunction With Extractions - One To Three Teeth	No	Yes	Pre-operative x-rays. Narrative of medical necessity	21	999	1	1	Lifetime	Only one of (D7320 or D7321) per lifetime per quadrant. One to three tooth spaces in quadrant.
D7450	Removal Of Benign Odontogenic Cyst Or Tumor - Dia Up To 1.25 Cm	No	Yes	Copy of pathology report and pre- operative x-ray.	21	999	1	1	Lifetime	Once per lifetime per tooth.

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Code	Description	PA Required	Pre- Payment	Required Documents	Age Min	Age Max	Max Count	Period Length	Period Type	ADDITIONAL NOTES
D7451	Removal Of Benign Odontogenic Cyst Or	No	Yes	Copy of pathology report and pre-	21	999	1	1	Lifetime	Once per lifetime per tooth.
	Tumor - Dia Greater Than 1.25 Cm			operative x-ray.						
D7460	Removal Of Benign Nonodontogenic Cyst	No	Yes	Copy of pathology report and pre-	21	999				
	Or Tumor - Dia Up To 1.25 Cm			operative x-ray.						
D7461	Removal Of Benign Nonodontogenic Cyst	No	Yes	Copy of pathology report and pre-	21	999				
	Or Tumor - Dia Greater Than 1.25 Cm			operative x-ray.						
D7510	Incision And Drainage Of Abscess -	No	Yes	Pre-operative x-rays, narrative of	21	999	1	1	Day	Only one of (D7510 or D7511) per day per tooth. Not
	Intraoral Soft Tissue			medical necessity, photos optional						payable same DOS as D7140-D7250. Teeth Covered: 1-
										32, 51-82, A-T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS,
										LS. MS. NS. OS. PS. OS. RS. SS. TS
D7511	Incision And Drainage Of Abscess -	No	Yes	Pre-operative x-rays, narrative of	21	999	1	1	Day	Only one of (D7510 or D7511) per day.
	Intraoral Soft Tissue - Complicated			medical necessity, photos optional						
07640					24					
D7610	Maxilla - Open Reduction (Teeth	No	Yes	Pre-operative x-rays, narrative of	21	999	1	1	Day	
D7C20	Immobilized, If Present)	Ne	Vaa	medical necessity	21	000	1	1	Devi	
D7620	Maxilla - Closed Reduction (Teeth Immobilized, If Present)	No	Yes	Pre-operative x-rays, narrative of medical necessity	21	999	1	1	Day	
D7630	Mandible - Open Reduction (Teeth	No	Yes	Pre-operative x-rays, narrative of	21	999	1	1	Day	
D7030	Immobilized, If Present)	NO	res	medical necessity	21	555	1	T	Day	
D7640	Mandible - Closed Reduction (Teeth	No	Yes	Pre-operative x-rays, narrative of	21	999	1	1	Day	
07040	Immobilized, If Present)	NO	103	medical necessity	21	555	1	1	Day	
D7710	Maxilla - Open Reduction	No	Yes	Pre-operative x-rays, narrative of	21	999	1	1	Day	
0//10				medical necessity		555	-	-	Duy	
D7720	Maxilla - Closed Reduction	No	Yes	Pre-operative x-rays, narrative of	21	999	1	1	Day	
_		-		medical necessity					- 1	
D7730	Mandible - Open Reduction	No	Yes	Pre-operative x-rays, narrative of	21	999	1	1	Day	
				medical necessity						
D7740	Mandible - Closed Reduction	No	Yes	Pre-operative x-rays, narrative of	21	999	1	1	Day	
				medical necessity						
D7810	Open Reduction Of Dislocation	No	Yes	Pre-operative x-rays, narrative of	21	999	1	1	Day	
				medical necessity						
D7820	Closed Reduction Of Dislocation	No	Yes	Pre-operative x-rays, narrative of	21	999	1	1	Day	
				medical necessity						
D7999	Unspecified Oral Surgery Procedure, By	Yes	No	Description of procedure, x-rays	21	999	1	1	Day	
	Report			and narrative of medical necessity.						
D9110	Palliative (Emergency) Treatment Of	No	No		21	999	4	12	Month	Only one of (D0140 or D9110) per day per provider
	Dental Pain - Minor Procedure	N.s.s			24				L	group. For emergency care only.
D9222	Deep Sedation/General Anesthesia – First	Yes	No	Clinical documentation supporting	21	999	1	1	Day	Only one of (D9222 or D9239) per day. Permit B
	15 Minutes			necessity						required. Not allowed same DOS as D9230, D9239,
D9223	Deep Sedation/General Anesthesia - each	No	No		21	999	5	1	Davi	D9243, or D9248. Five of (D9223 or D9243) per day. Permit B required.
09223		INO	INO		21	333	С	Т	Day	
	subsequent 15 minute increment									Not allowed on the same date of service with D9230,
										D9243, or D9248. Valid D9222 must be on file.
D9230	Inhalation Of Nitrous/Analgesia,	No	No	Supporting documentation must be	21	999	1	1	Day	Not allowed same DOS as D9222, D9223, D9239,
09230	Anxiolysis	NU	NU	kept in patient record.	21	555	Т	Т	Day	D9243, or D9248
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Code	Description	PA Required	Pre- Payment	Required Documents	Age Min	Age Max	Max Count	Period Length	Period Type	ADDITIONAL NOTES
	Intravenous Moderate (conscious) Sedation/Analgesia – First 15 Minutes	Yes	Yes	Clinical documentation supporting necessity	21	999	1	1		Only one of (D9222 or D9239) per day. Permit B required. Not allowed same DOS as D9222, D9223, D9230, or D9248.
	Intravenous Moderate (Conscious) Sedation/Analgesia - Subs 15 Min	No	No		21	999	5	1	Day	Five of (D9223 or D9243) per day. Permit B required. Not allowed same DOS as D9222, D9223, D9230, or D9248. Valid D9239 must be on file.
	Non-Intravenous Moderate (Conscious) Sedation	No	Yes	Clinical documentation supporting necessity	21	999	1	1	Day	Limited to patients with a mental or physical handicap, extremely apprehensive, or extensive treatment is performed in one appointment. D9248 is not allowed on same date of service as D9222, D9223, D9230, D9239, or D9243. Permit A or B is required.
D9310	Consultation - Diagnostic Service Provided By Dentist Or Physician	No	No	Supporting documentation must be kept in patient record.	21	999	1	1	Day	One per day per provider group.
D9610	Therapeutic Parenteral Drug, Single Administration	No	Yes	Description of drugs and parenteral administration	21	999	1	1	Day	Name of drug and amount administered. One per day.
D9630	Other Drugs And/Or Medicaments, By Report	No	Yes	Description of drugs	21	999	1	1	Day	Name of drug and amount administered. One per day.
D9999	Unspecified Adjunctive Procedure, By Report	Yes	No	Description of procedure and narrative of medical necessity. For Outpatient facility usage, include completed health plan Outpatient Facility Authorization form, clinical documentation of necessity.	21	999	1	1	Day	
L				Meridian Medicaid Pl	an – Childr	en Under A	Age 21			
D0120	Periodic Oral Evaluation - Established Patient	No	No		0	20	1	6	Month	One per 6 months per location. Not allowed within 6 months of D0150.
D0140	Limited Oral Evaluation - Problem Focused	No	No		0	20	1	1	Day	Only one of (D0140 or D9110) per day per provider group. For emergency exam only. Not payable if performed in conjunction with either D0120, D0150, or D0180.
D0150	Comprehensive Oral Evaluation - New Or Established Patient	No	No		0	20	1	1	Lifetime	One D0150 per provider or location per lifetime.
D0210	Intraoral - Complete Series of Radiographic Images	No	No		6	20	1	36	Month	Only one of (D0210, D0277, or D0330) per 36 months per member.
D0220	Intraoral - Periapical First Radiographic Image	No	No		0	20	1	1	Day	Only one D0220 per day per per provider or location. Maximum reimbursement of a single date of service for radiographs limited to fee for complete Series (D0210).
D0230	Intraoral - Periapical Each Additional Image	No	No		0	20				Maximum reimbursement is up to the fee of D0210.
D0270	Bitewing - Single Radiographic Image	No	No		0	20	1	12	Month	One D0270 per 12 months per provider group. Maximum reimbursement of a single date of service for radiographs limited to fee for complete series (D0210).
D0272	Bitewings - Two Radiographic Images	No	No		2	20	1	12	Month	One (D0272 or D0274) per 12 month per provider or location. Maximum reimbursement of a single date of service for radiographs limited to fee for complete series (D0210).

Code	Description	PA	Pre-	Required Documents	Age Min	Age Max	Max Count	Period	Period	ADDITIONAL NOTES
coue	Description	Required	Payment	nequirea Documents	Age Will	Age Max	Wax count	Length	Type	
D0274	Bitewings - Four Radiographic Images	No	No		10	20	1	12	Month	One (D0272 or D0274) per 12 month per provider or
										location. Maximum reimbursement of a single date of
										service for radiographs limited to fee for complete
										series (D0210).
D0277	Vertical Bitewings - 7 To 8 Radiographic	No	No		6	20	1	36	Month	Only one of (D0210, D0277, or D0330) per 36 months
	Images									per member. Maximum reimbursement of a single
										date of service for radiographs limited to fee for
										complete series (D0210).
D0330	Panoramic Radiographic Image	No	No		6	20	1	36	Month	Only one of (D0210, D0277, or D0330) per 36 months
										per member. Maximum reimbursement of a single
										date of service for radiographs limited to fee for
										complete series (D0210).
D0601	Caries Risk Assessment And	No	No		0	20	1	12	Month	Only when performed on same date of service as
	Documentation, With A Finding of Low									D0120, D0140, or D0150.
Dacaa	Risk				<u> </u>	20	1	42		
D0602	Caries Risk Assessment And	No	No		0	20	1	12	Month	Only when performed on same date of service as
	Documentation, With A Finding of									D0120, D0140, or D0150.
D0603	Moderate Risk Caries Risk Assessment And	No	No		0	20	1	12	Month	Only when performed on same date of service as
D0603		NO	INO		0	20	1	12	wonth	D0120, D0140, or D0150.
	Documentation, With A Finding of High									D0120, D0140, 01 D0130.
D0999	Risk Unspecified Diagnostic Procedures, By						1	1	Day	For FQHC Encounter billing. D0999 must be on first line
00333	Report						1	1	Day	of claim
	Report									with additional service listed.
D1120	Prophylaxis - Child	No	No		0	20	1	6	Month	Only one of (D1120 or D4355) per 6 months.
D1206	Topical Application Of Fluoride Varnish	No	No		0	20	1 or 3 (See	6 or 12		Age 0-2: 3 of (D1206 or D1208) per 12 Months in an
	The filter of the second se	-	-		_	-	Notes)	(See		office setting.
							,	Notes)		Age 3-20: 1 of (D1206 or D1208) per 6 months.
D1208	Topical Application of Fluoride	No	No		0	20	1 or 3 (See	6 or 12	Month	Age 0-2: 3 of (D1206 or D1208) per 12 Months in an
							Notes)	(See		office setting.
								Notes)		Age 3-20: 1 of (D1206 or D1208) per 6 months.
D1351	Sealant - Per Tooth	No	No		5	17	1	24	Month	One per 2 years per tooth regardless of place of
										service. Occlusal surfaces only. Teeth must be caries
										free. Sealant will not be covered when placed over
										restorations. Teeth Covered: 2, 3, 14, 15, 18, 19, 30, 31
D1354	Interim Caries Arresting Medicament	No	No		0	20	6	1	Lifetime	2 applications per tooth per year. Lifetime maximum of
	Application - Per Tooth									six applications per tooth. Providers may treat a
										maximum of 4 teeth per day, providing participant has
										no history of any prior or same day billing of CDT
										category D2000 (Restorative codes) or CDT category
										D3000 (Endodontic codes) on the same tooth.
D1510	Space Maintainer - Fixed - Unilateral	No	No		0	20	1	1	Lifetime	Only one of (D1510 or D1520) per quadrant per
51510		110			Ŭ	20	- -	-	Lincume	lifetime per provider group. (LL, LR, UL, UR)
D1516	Space Maintainer Fixed Bilateral	No	No		0	20	1	1	Lifetime	Only one of (D1516 or D1526) per lifetime per provider
2 20 20	Maxillary				, , , , , , , , , , , , , , , , , , ,		-	-		group.
D1517	Space Maintainer Fixed Bilateral	No	No		0	20	1	1	Lifetime	Only one of (D1517 or D1527) per lifetime per provider
	Mandibular				-					group.
D1520	Space Maintainer - Removable -	No	No		0	20	1	1	Lifetime	Only one of (D1510 or D1520) per quadrant per
	Unilateral									lifetime per provider group. (LL, LR, UL, UR)
	ormaterui	1		1						

Code	Description	PA	Pre-	Required Documents	Age Min	Age Max	Max Count	Period	Period	ADDITIONAL NOTES
couc		Required	Payment	nequirea bocaments		Age max	max count	Length	Type	
D1526	Space Maintainer Removable Bilateral	No	No		0	20	1	1		Only one of (D1516 or D1526) per lifetime per provider
	Maxillary									group.
D1527	Space Maintainer Removable Bilateral	No	No		0	20	1	1	Lifetime	Only one of (D1517 or D1527) per lifetime per provider
	Mandibular									group.
D1551	Re-Cement or Re-Bond Bilateral Space	No	No		0	20	1	6	Month	Not allowed within 6 months of placement.
	Maintainer - Maxillary									
D1552	Re-Cement or Re-Bond Bilateral Space	No	No		0	20	1	6	Month	Not allowed within 6 months of placement.
	Maintainer - Mandibular									
D1553	Re-Cement or Re-Bond Unilateral Space	No	No		0	20	1	6	Month	Not allowed within 6 months of placement.
	Maintainer - Per Quadrant									
D2140	Amalgam - One Surface, Primary Or	No	No		0	20	1	12		Only one (D2140, D2150, D2160, D2161, D2330,
	Permanent									D2331, D2332, D2335, D2391, D2392, D2393, D2394)
										per 12 months per surface. Teeth Covered: 1-32, A-T
D2150	Amalgam - Two Surfaces, Primary Or	No	No		0	20	1	12		Only one (D2140, D2150, D2160, D2161, D2330,
	Permanent									D2331, D2332, D2335, D2391, D2392, D2393, D2394)
										per 12 months per surface. Teeth Covered: 1-32, A-T
D2160	Amalgam - Three Surfaces, Primary Or	No	No		0	20	1	12	Month	Only one (D2140, D2150, D2160, D2161, D2330,
D2100	Permanent	NO	NO		0	20	T	12		D2331, D2332, D2335, D2391, D2392, D2393, D2394)
	rennanent									per 12 months per surface. Teeth Covered: 1-32, A-T
										per 12 months per surface. Teeth Covered. 1-32, A-1
D2161	Amalgam - Four Or More Surfaces,	No	No		0	20	1	12	Month	One of (D2161, D2335, D2394) per 12 months per
	Primary Or Permanent				-					tooth. Teeth Covered: 1-32, A-T
D2330	Resin-Based Composite - One Surface,	No	No		0	20	1	12	Month	Only one (D2140, D2150, D2160, D2161, D2330,
	Anterior				-	-				D2331, D2332, D2335, D2391, D2392, D2393, D2394)
										per 12 months per surface. Teeth Covered: 6-11, 22-
										27. C-H. M-R
D2331	Resin-Based Composite - Two Surfaces,	No	No		0	20	1	12	Month	Only one (D2140, D2150, D2160, D2161, D2330,
	Anterior									D2331, D2332, D2335, D2391, D2392, D2393, D2394)
										per 12 months per surface. Teeth Covered: 6-11, 22-
										27. C-H. M-R
D2332	Resin-Based Composite - Three Surfaces,	No	No		0	20	1	12	Month	Only one (D2140, D2150, D2160, D2161, D2330,
	Anterior									D2331, D2332, D2335, D2391, D2392, D2393, D2394)
										per 12 months per surface. Teeth Covered: 6-11, 22-
										27. С-Н. М-R
	Resin-Based Composite - Four Or More	No	No		0	20	1	12		One of (D2161, D2335, D2394) per 12 months per
	Surfaces Or Involving Incisal Angle									tooth. Teeth Covered: 6-11, 22-27, C-H, M-R
D2204	Desig Desed Composite One Surface	Ne	Ne	l	0	20	1	10	Manth	Only and (02140, 02150, 02160, 02161, 02220
D2391	Resin-Based Composite - One Surface,	No	No		0	20	1	12		Only one (D2140, D2150, D2160, D2161, D2330,
	Posterior									D2331, D2332, D2335, D2391, D2392, D2393, D2394)
										per 12 months per surface. May not be used for PRR.
										Teeth Covered: 1-5, 12-21, 28-32, A, B, I-L, S, T
D2392	Resin-Based Composite - Two Surfaces,	No	No		0	20	1	12	Month	Only one (D2140, D2150, D2160, D2161, D2330,
02352	Posterior				Ŭ	20	-	12		D2331, D2332, D2335, D2391, D2392, D2393, D2394)
										per 12 months per surface. Teeth Covered: 1-5, 12-21,
										28-32. A. B. I-L. S. T
L				1	1		1			20-32, A. D. I-L. S. I

Code	Description	PA	Pre-	Required Documents	Age Min		Max Count	Period	Period	ADDITIONAL NOTES
coue		Required	Payment		Age min	ABC MUX		Length	Type	
	Resin-Based Composite - Three Surfaces, Posterior	No	No		0	20	1	12	Month	Only one (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 months per surface. Teeth Covered: 1-5, 12-21, 28-32, A. B. I-L. S. T
D2394	Resin-Based Composite - Four Or More Surfaces, Posterior	No	No		0	20	1	12	Month	One of (D2161, D2335, D2394) per 12 months per tooth. Teeth Covered: 1-5, 12-21, 28-32, A, B, I-L, S, T
D2542	Onlay - Metallic - Two Surfaces	Yes	No	Pre-operative periapical x-rays and optional photos	0	20	1	60		Only one of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752,D2753, D2790, D2791, D2792, D2931) per 60 months per tooth. Teeth Covered: 1-32
D2543	Onlay - Metallic - Three Surfaces	Yes	No	Pre-operative periapical x-rays and optional photos	0	20	1	60		Only one of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 months per tooth. Teeth Covered: 1-32
D2544	Onlay - Metallic - Four Or More Surfaces	Yes	No	Pre-operative periapical x-rays and optional photos	0	20	1	60		Only one of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752,D2753, D2790, D2791, D2792, D2931) per 60 months per tooth. Teeth Covered: 1-32
D2642	Onlay - Porcelain/Ceramic - Two Surfaces	Yes	No	Pre-operative periapical x-rays and optional photos	0	20	1	60		Only one of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752,D2753, D2790, D2791, D2792, D2931) per 60 months per tooth. Teeth Covered: 1-32
D2643	Onlay - Porcelain/Ceramic - Three Surfaces	Yes	No	Pre-operative periapical x-rays and optional photos	0	20	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 months per tooth. Teeth Covered: 1-32
D2644	Onlay - Porcelain/Ceramic - Four Or More Surfaces	Yes	No	Pre-operative periapical x-rays and optional photos	0	20	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 months per tooth. Teeth Covered: 1-32
D2740	Crown - Porcelain/Ceramic	No	Yes	Pre-operative periapical x-rays and optional photos	0	20	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 months per tooth. Teeth Covered: 1-32
D2750	Crown - Porcelain Fused To High Noble Metal	No	Yes	Pre-operative periapical x-rays and optional photos	0	20	1	60		Only one of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752,D2753, D2790, D2791, D2792, D2931) per 60 months per tooth. Teeth Covered: 1-32
D2751	Crown - Porcelain Fused To Predominantly Base Metal	No	Yes	Pre-operative periapical x-rays and optional photos	0	20	1	60		Only one of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752,D2753, D2790, D2791, D2792, D2931) per 60 months per tooth. Teeth Covered: 1-32
D2752	Crown - Porcelain Fused To Noble Metal	No	Yes	Pre-operative periapical x-rays and optional photos	0	20	1	60		Only one of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752,D2753, D2790, D2791, D2792, D2931) per 60 months per tooth. Teeth Covered: 1-32
D2753	Crown - Porcelain Fused to Titanium and Titanium Alloys	No	Yes	Pre-operative periapical x-rays and optional photos	0	20	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752,D2753, D2790, D2791, D2792, D2931) per 60 months per tooth. Teeth Covered: 1-32

Code	Description	PA	Pre-	Required Documents	Age Min		Max Count	Period	Period	ADDITIONAL NOTES
Code	Description	Required	Payment	Required Documents	Age IVIIII	Age Max		Length	Type	ADDITIONAL NOTES
D2790	Crown - Full Cast High Noble Metal	No	Yes	Pre-operative periapical x-rays and	0	20	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643,
				optional photos						D2644, D2740, D2750, D2751, D2752,D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth
D2701	Crawn Full Cast Dradaminanth, Dasa	Nia	Vee		0	20	1	60	Manth	Covered: 1-32 Only one of (D2542, D2543, D2544, D2642, D2643,
D2791	Crown - Full Cast Predominantly Base Metal	No	Yes	Pre-operative periapical x-rays and optional photos	0	20	T	60	Month	D2644, D2740, D2750, D2751, D2752,D2753, D2790,
	ivietai									D2791, D2792, D2931) per 60 months per tooth. Teeth
										Covered: 1-32
D2792	Crown - Full Cast Noble Metal	No	Yes	Pre-operative periapical x-rays and	0	20	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643,
				optional photos						D2644, D2740, D2750, D2751, D2752,D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth
D2040	Deserves to be a contract	NI-	N			20	4	6	Manth	Covered: 1-32
D2910	Recement Inlay, Onlay, Or Partial	No	No		0	20	1	6	Month	One per tooth per 6 months. Teeth Covered: 1-32
D2915	Coverage Restoration Recement Cast Or Prefabricated Post And	No	No		0	20	1	6	Month	Not allowed within 6 months of D2954 by the same
02013	Core				Ŭ	20	-	Ũ	Wienen	provider or provider group. One per tooth per 6
										months. Teeth Covered: 1-32
D2920	Recement Crown	No	No		0	20	1	6	Month	Re-cement within 6 months of initial placement by
										same provider or provider group will be considered a
										duplicate service and will not be paid. One per tooth
										per 6 months. Teeth Covered: 1-32, A-T
D2930	Prefabricated stainless steel crown -	No	No		0	20	1	1	Lifetime	Only one of (D2930, D2932, D2933, D2934) per lifetime
	primary tooth									per tooth. Teeth Covered: A-T
D2931	Prefabricated Stainless Steel Crown -	No	Yes	Pre-operative periapical x-rays and	0	20	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643,
	Permanent Tooth			optional photos						D2644, D2740, D2750, D2751, D2752,D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth.
										Authorization required for three or more crowns.
D2932	Prefabricated Resin Crown	No	Yes	Pre-operative periapical x-rays and	0	20	1	1	Lifetime	Teeth Covered: 1-32 Only one of (D2930, D2932, D2933, D2934) per lifetime
		-		optional photos	-	-				per tooth. Authorization required for three or more
										crowns. Teeth Covered: 6-11, 22-27, C-H, M-R
62022	Design to the state of the stat	NI-	N1 -		0	20		4	1:6-1:	0
D2933	Prefabricated Stainless Steel Crown With Resin Window	No	No		0	20	1	1	Lifetime	Only one of (D2930, D2932, D2933, D2934) per lifetime
D2934	Prefabricated Esthetic Coated Stainless	No	No		0	20	1	1	Lifetime	per tooth. Teeth Covered: C-H, M-R Only one of (D2930, D2932, D2933, D2934) per lifetime
02334	Steel Crown - Primary Tooth	NO	NO		0	20	1	1	Lifetifie	per tooth. Teeth Covered: A-T
D2940	Protective Restoration	No	No		0	20	1	6	Month	Not allowed with pulpotomy, pulpectomy, or root
										canal therapy. Not allowed on the same date of service
										as a restoration. One per tooth per 6 months. Teeth
D2050	Core Buildup, Including Any Pins When	No	No		0	20	1	60	Month	Covered: 1-32. A-T Only one of (D2950 or D2954) per tooth per 60
02930	Required	UVI	NO		U	20	Т	00	wonun	months. Teeth Covered: 1-32
D2951	Pin Retention - Per Tooth, In Addition To	No	No		0	20	4	1	Day	Not allowed with (D2950, D2954) on same DOS. Teeth
	Restoration								, í	Covered: 1-32
D2954	Prefabricated Post And Core In Addition	No	Yes	Final RCT fill periapical x-ray	0	20	1	60	Month	Only one of (D2950 or D2954) per tooth per 60
	To Crown									months. Teeth Covered: 1-32
D3220	Therapeutic Pulpotomy	No	No		0	20	1	1	Lifetime	Only one of (D3220 or D3230) per tooth per lifetime.
										Not reimbursable with root canal therapy. Teeth
										Covered: A-T

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Code	Description	PA Required	Pre-	Required Documents	Age Min	Age Max	Max Count		Period	ADDITIONAL NOTES
		-	Payment					Length	Туре	
D3222	Partial Pulpotomy For Apexogenesis -	No	Yes	Pre-operative periapical x-ray,	0	20	1	1	Lifetime	Only one of (D3222, D3351, D3352, D3353) per
	Permanent Tooth			narrative of medical necessity						lifetime per tooth. D3222 covered for trauma cases
										only. Teeth Covered: 6-11, 22-27
D3230	Pulpal Therapy (Resorbable Filling) -	No	No		0	20	1	1	Lifetime	Only one of (D3220 or D3230) per tooth per lifetime.
	Anterior, Primary Tooth									Teeth Covered: C-H, M-R
D3310	Endodontic Therapy, Anterior Tooth	No	No		0	20	1	1	Lifetime	One per lifetime per tooth. Teeth Covered: 6-11, 22-27
	(Excluding Final Restoration)									
D3320	Endodontic Therapy, Premolar Tooth	No	No		0	20	1	1	Lifetime	Only one of (D3310, D3320, D3330, D3351, D3352,
	(Excluding Final Restoration)									D3353) per lifetime per tooth. Teeth Covered: 4, 5,
										12, 13, 20, 21, 28, 29
D3330	Endodontic Therapy, Molar Tooth	No	No		0	20	1	1	Lifetime	Only one of (D3310, D3320, D3330, D3351, D3352,
	(Excluding Final Restoration)									D3353) per lifetime per tooth. Teeth Covered: 1-3, 14-
										19, 30-32
D3351	Apexification / Recalcification - Initial	No	Yes	Pre-operative periapical x-ray,	0	20	1	1	Lifetime	Only one of (D3310, D3320, D3330, D3351, D3352,
	Visit			narrative of medical necessity						D3353) per lifetime per tooth. Teeth Covered: 1-32
D3352	Apexification / Recalcification - Interim	No	Yes	Pre-operative periapical x-ray, date	0	20	1	1	Lifetime	Only one of (D3310, D3320, D3330, D3351, D3352,
				of initial visit						D3353) per lifetime per tooth. Teeth Covered: 1-32
D3353	Apexification / Recalcification - Final Visit	No	Yes	Pre-operative periapical x-ray, date	0	20	1	1	Lifetime	Only one of (D3310, D3320, D3330, D3351, D3352,
				of initial visit, post-operative x-ray						D3353) per lifetime per tooth. Teeth Covered: 1-32
D3410	Apicoectomy - Anterior	No	Yes	Pre-operative periapical x-ray	0	20	1	1	Lifetime	One per lifetime per tooth. Not payable concurrent
										with root canal treatment. Teeth Covered: 6-11, 22-27
										,
D4210	Gingivectomy Or Gingivoplasty - Four Or	No	Yes	Pre-operative x-rays, perio	0	20	1	24	Month	Only one of (D4210, D4211, D4240, D4241, D4260,
	More Contiguous Teeth			charting, narrative of medical						D4261) per 24 months per quadrant per provider
				necessity, photos optional						group. Minimum of four (4) affected teeth in the
										quadrant. For removing hyperplastic tissue to reduce
										pocket denth.
D4211	Gingivectomy Or Gingivoplasty - One To	No	Yes	Pre-operative x-rays, perio	0	20	1	24	Month	Only one of (D4210, D4211, D4240, D4241, D4260,
	Three Contiguous Teeth	_		charting, narrative of medical	-		_			D4261) per 24 months per quadrant per provider
				necessity, photos optional						group. One to three teeth affected in quadrant. For
				necessity, photos optional						removing hyperplastic tissue to reduce pocket depth.
										removing hyperplastic tissue to reduce pocket depth.
D4240	Gingival Flap Procedure, Including Root	No	Yes	Pre-operative x-rays, perio	0	20	1	24	Month	Only one of (D4210, D4211, D4240, D4241, D4260,
	Planing - Four Or More Contiguous Teeth			charting, narrative of medical	-		_			D4261) per 24 months per quadrant per provider
				necessity, photos optional						group. Minimum of four (4) affected teeth in the
										guadrant.
D4241	Gingival Flap Procedure, Including Root	No	Yes	Pre-operative x-rays, perio	0	20	1	24	Month	Only one of (D4210, D4211, D4240, D4241, D4260,
	Planing - One To Three Contiguous Teeth			charting, narrative of medical	, , , , , , , , , , , , , , , , , , ,		-			D4261) per 24 months per quadrant per provider
				necessity, photos optional						group. One to three teeth affected in quadrant.
D4249	Clinical Crown Lengthening - Hard Tissue	Yes	No	Pre-operative x-ray(s), perio	0	20	1	1	Lifetime	One per lifetime per tooth. Not allowed in same
5				charting, narrative of medical	Ŭ	_~	-			guadrant as D4260 or D4261 within a 24 month period.
				necessity						quadrant as D+200 or D+201 within a 24 month period.
D4260	Osseous Surgery (Including Flap Entry	No	Yes	Pre-operative x-rays, perio	0	20	1	24	Month	Only one of (D4210, D4211, D4240, D4241, D4260,
04200	And Closure) - Four Or More Teeth	110	103	charting, narrative of medical	U	20		24	wonth	D4261) per 24 months per quadrant per provider
				_						group. Minimum of four (4) affected teeth in the
				necessity, photos optional						
										quadrant.

Code	Description	PA	Pre-	Required Documents	Age Min		Max Count	Period	Period	ADDITIONAL NOTES
coue	Description	Required	Payment	Required Documents	Age Will	Age Max		Length	Type	
D4261	Osseous Surgery (Including Flap Entry	No	Yes	Pre-operative x-ray(s), perio	0	20	1	24	Month	Only one of (D4210, D4211, D4240, D4241, D4260,
	And Closure) - One To Three Teeth			charting, narrative of medical						D4261) per 24 months per quadrant per provider
				necessity. Photos optional.						group. One to three teeth affected in quadrant.
D4263	Bone Replacement Graft - First Site In	No	Yes	Pre-operative x-rays, perio	0	20	1	24	Month	One per quadrant per 24 months. Tooth number
	Quadrant			charting, narrative of medical						required on claim form. Teeth Covered: 1-32
D 4264	Dana Danlagament Craft Fach	Ne	Vee	necessity, photos optional		20		24	Manth	Three new surdraut new 24 meanths. Teath surshes
D4264	Bone Replacement Graft - Each	No	Yes	Pre-operative x-rays, perio	0	20	3	24	Month	Three per quadrant per 24 months. Tooth number
	Additional Site In Quadrant			charting, narrative of medical						required on claim form. Teeth Covered: 1-32
D4270	Pedicle Soft Tissue Graft Procedure	No	Yes	necessity, photos optional Pre-operative x-rays, perio	0	20	1	1	Lifetime	One per tooth per lifetime Teeth Covered: 1-32
D4270		NO	103	charting, narrative of medical	0	20	-	1	Litetime	one per tooth per metime reeth covered. 1-52
				necessity, photos optional						
D4273	Subepithelial Connective Tissue Graft	No	Yes	Pre-operative x-rays, perio	0	20	1	24	Month	One per quadrant per 24 months. Tooth number
	Procedures, Per Tooth			charting, narrative of medical	Ũ	20	-	- ·		required on claim form. Teeth Covered: 1-32
				necessity, photos optional						
D4274	Distal Or Proximal Wedge Procedure	No	Yes	Pre-operative x-rays, perio	0	20	1	24	Month	One per quadrant per 24 months.Tooth number
				charting, narrative of medical						required on claim form. Teeth Covered: 1-32
				necessity, photos optional						
D4277	Free Soft Tissue Graft Procedure	No	Yes	Pre-operative x-rays, perio	0	20	1	24	Month	One per quadrant per 24 months. Tooth number
	(Including Donor Site Surgery) First Tooth			charting, narrative of medical						required on claim form. Teeth Covered: 1-32, 51-82
				necessity, photos optional						
D4278	Free Soft Tissue Graft Procedure	No	Yes	Pre-operative x-rays, perio	0	20	3	24	Month	Three per quadrant per 24 months. Tooth number
	(Including Donor Site Surgery) Additional			charting, narrative of medical						required on claim form. Teeth Covered: 1-32, 51-82
	Tooth			necessity, photos optional						
D4320	Provisional Splinting - Intracoronal	No	Yes	Pre-operative x-rays, perio	0	20	1	24	Month	Per arch (LA, UA) - one (D4320 or D4321) per arch per
				charting, narrative of medical						24 months.
D 4224	Dura distance California - Extension and	N.	N	necessity, photos optional		20	1	24	Manth	
D4321	Provisional Splinting - Extracoronal	No	Yes	Pre-operative x-rays, perio	0	20	1	24	Month	Per arch (LA, UA) - one (D4320 or D4321) per arch per
				charting, narrative of medical						24 months.
D4341	Periodontal Scaling And Root Planing -	No	Yes	necessity, photos optional Pre-operative x-rays (bitewings	0	20	1	24	Month	Only one of (D4341 or D4342) per 24 months per
04341	Four Or More Teeth Per Quadrant	NO	103	and/or panoramic radiograph) and	0	20	-	24	WORth	quadrant. One full mouth service is covered every 24
				periodontal charting						months.
D4342	Periodontal Scaling And Root Planing -	No	Yes	Pre-operative x-rays (bitewings	0	20	1	24	Month	Only one of (D4341 or D4342) per 24 months per
	One To Three Teeth Per Quadrant			and/or panoramic radiograph) and	-		_			quadrant. One full mouth service is covered every 24
				periodontal charting						months.
D4355	Full Mouth Debridement	No	No		0	20	1	6	Month	Only one of (D1110 or D4355) per 6 months. Not
										billable with D4341 or D4342. Not eligible for payment
										if performed on the same date or within 12 months of
										a D0120 or D0150. Not allowed for twelve months
										following D1120 or any D4000 series code.
DAGAG	Deviadental Mainton	N! -	N1 -			20	4	6	N / a + l.	
04910	Periodontal Maintenance	No	No		0	20	1	6	Month	Requires history of D4210, D4211, D4240, D4241,
										D4260, D4261, D4341, D4342, or valid 4910. One
D5110	Complete Denture - Maxillary	Yes	No	Full mouth x-rays or panorex, prior	0	20	1	60	Month	(D1110 or D4910) per 6 months. Only one of (D5110, D5130, D5211, D5213, D5221,
01150	Complete Deliture - Maxillary	res	NO	date of placement	U	20	1	00	worth	D5223) per 60 months
D5120	Complete Denture - Mandibular	Yes	No	Full mouth x-rays or panorex, prior	0	20	1	60	Month	Only one of (D5120, D5140, D5212, D5214, D5222,
03120		103	110	date of placement	5	20		00	wonth	D5224) per 60 months.
							I			

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Code	Description	PA Required	Pre- Payment	Required Documents	Age Min	Age Max	Max Count	Period Length	Period Type	ADDITIONAL NOTES
D5130	Immediate Denture - Maxillary	Yes	No	Full mouth x-rays or panorex, prior	0	20	1	1	Lifetime	
				date of placement						
D5140	Immediate Denture - Mandibular	Yes	No	Full mouth x-rays or panorex, prior	0	20	1	1	Lifetime	
				date of placement						
D5211	Maxillary Partial Denture - Resin Base	Yes	No	Full mouth x-rays or panorex, prior	0	20	1	60	Month	Only one of (D5110, D5130, D5211, D5213, D5221,
				date of placement						D5223) per 60 months
D5212	Mandibular Partial Denture - Resin Base	Yes	No	Full mouth x-rays or panorex, prior	0	20	1	60	Month	Only one of (D5120, D5140, D5212, D5214, D5222,
				date of placement						D5224) per 60 months.
D5213	Maxillary Partial Denture - Cast Metal	Yes	No	Full mouth x-rays or panorex, prior	0	20	1	60	Month	Only one of (D5110, D5130, D5211, D5213, D5221,
	Framework With Resin Denture Bases			date of placement						D5223) per 60 months
D5214	Mandibular Partial Denture - Cast Metal	Yes	No	Full mouth x-rays or panorex, prior	0	20	1	60	Month	Only one of (D5120, D5140, D5212, D5214, D5222,
	Framework With Resin Denture Bases			date of placement	-		_			D5224) per 60 months.
	Tunework with tesh benture buses									
D5221	Immediate Maxillary Partial Denture -	Yes	No	Full mouth x-rays or panorex, prior	0	20	1	60	Month	Only one of (D5110, D5130, D5211, D5213, D5221,
	Resin Base	. 20		date of placement	-		-			D5223) per 60 months
D5222	Immediate Mandibular Partial Denture -	Yes	No	Full mouth x-rays or panorex, prior	0	20	1	60	Month	Only one of (D5120, D5140, D5212, D5214, D5222,
	Resin Base		_	date of placement	-		_			D5224) per 60 months.
D5223	immediate maxillary partial denture - cast	Yes	No	Full mouth x-rays or panorex, prior	0	20	1	60	Month	Only one of (D5110, D5130, D5211, D5213, D5221,
	metal framework with resin denture ba		_	date of placement	-	-				D5223) per 60 months
D5224	Immediate mandibular partial denture	Yes	No	Full mouth x-rays or panorex, prior	0	20	1	60	Month	Only one of (D5120, D5140, D5212, D5214, D5222,
				date of placement	-		_			D5224) per 60 months.
D5511	Repair Broken Complete Denture Base,	No	No		0	20	2	12	Month	Not covered within 6 months of insertion.
	Mandibular									
D5512	Repair Broken Complete Denture Base,	No	No		0	20	2	12	Month	Not covered within 6 months of insertion.
	Maxillary									
D5520	Replace Missing Or Broken Teeth -	No	No		0	20	1	12	Month	One per tooth per 12 months. Teeth Covered: 1-32
	Complete Denture (Each Tooth)									
D5611	Repair Resin Partial Denture Base,	No	No		0	20	2	12	Month	Not covered within 6 months of insertion.
	Mandibular									
D5612	Repair Resin Partial Denture Base,	No	No		0	20	2	12	Month	Not covered within 6 months of insertion.
	Maxillary									
D5621	Repair Cast Partial Framework,	No	No		0	20	2	12	Month	Not covered within 6 months of insertion.
	Mandibular									
D5622	Repair Cast Partial Framework, Maxillary	No	No		0	20	2	12	Month	Not covered within 6 months of insertion.
D5630	Repair Or Replace Broken	No	No		0	20	1	12	Month	One per tooth per 12 months. Teeth Covered: 1-32
	Retentive/Clasping Materials - per tooth									
D5640	Replace Broken Teeth - Per Tooth	No	No		0	20	1	12	Month	One per tooth per 12 months. Teeth Covered: 1-32
D5650	Add Tooth To Existing Partial Denture	No	No		0	20	1	12	Month	One per tooth per 12 months. Teeth Covered: 1-32
DE 730	Polino Complete Mavillany Denture	No	Vac	Data of donturo placement	0	20	1	24	Month	Only and of (DE720 or DE7E0) por 24 months. Not
D5730	Reline Complete Maxillary Denture	No	Yes	Date of denture placement	U	20	1	24	Month	Only one of (D5730 or D5750) per 24 months. Not
D5731	(direct) Reline Complete Mandibular Denture	No	Voc	Date of denture placement	0	20	1	24	Month	covered within 6 months of placement. Only one of (D5731 or D5751) per 24 months. Not
12/21	-	No	Yes	Date of denture placement	U	20	1	24	wonth	
DE740	(direct) Reline Maxillary Partial Denture (direct)	No	Vac	Data of donturo placement	0	20	1	24	Month	covered within 6 months of placement. Only one of (D5740 or D5760) per 24 months. Not
D5740	Renne Maxinary Partial Denture (difect)	No	Yes	Date of denture placement	0	20	1	24	Month	
				1					I	covered within 6 months of placement.

		PA	Pre-	ENVOLVE DENTAL - ILLIN			<u>· · ·</u>	Daniad	Dawlad	ADDITIONAL NOTES
Code De	escription	Required	Payment	Required Documents	Age Min	Age Max	Max Count	Period Length	Period Type	ADDITIONAL NOTES
05741 Re	eline Mandibular Partial Denture	No	Yes	Date of denture placement	0	20	1	24	Month	Only one of (D5741 or D5761) per 24 months. Not
	direct)									covered within 6 months of placement.
05750 Re	eline Complete Maxillary Denture	No	Yes	Date of denture placement	0	20	1	24	Month	Only one of (D5730 or D5750) per 24 months. Not
	ndirect)									covered within 6 months of placement.
	eline Complete Mandibular Denture	No	Yes	Date of denture placement	0	20	1	24	Month	Only one of (D5731 or D5751) per 24 months. Not
	ndirect)				-					covered within 6 months of placement.
05760 Re	eline Maxillary Partial Denture (indirect)	No	Yes	Date of denture placement	0	20	1	24	Month	Only one of (D5740 or D5760) per 24 months. Not
05761 Re	eline Mandibular Partial Denture	No	Yes	Date of denture placement	0	20	1	24	Month	covered within 6 months of placement. Only one of (D5741 or D5761) per 24 months. Not
	ndirect)	NO	163	Date of dentare placement	0	20	1	24	WORLD	covered within 6 months of placement.
	nspecified Maxillofacial Prosthesis, By	Yes	No	Narrative of medical necessity	0	20	1	1	Day	One per day.
	eport			, , , , , , , , , , , , , , , , , , , ,	°,	20	-	-	2017	
	ontic - Cast High Noble Metal	No	Yes	Pre-operative x-rays, date of prior	0	20	1	60	Month	Only one of (D6210, D6211, D6212, D6240, D6241,
	-			placement if applicable						D6242, D6251) per 60 months per tooth. Teeth
										Covered: 6-11, 22-27
06211 Po	ontic - Cast Predominantly Base Metal	No	Yes	Pre-operative x-rays, date of prior	0	20	1	60	Month	Only one of (D6210, D6211, D6212, D6240, D6241,
				placement if applicable						D6242, D6251) per 60 months per tooth. Teeth
										Covered: 6-11, 22-27
06212 Po	ontic - Cast Noble Metal	No	Yes	Pre-operative x-rays, date of prior	0	20	1	60	Month	Only one of (D6210, D6211, D6212, D6240, D6241,
				placement if applicable						D6242, D6251) per 60 months per tooth. Teeth
06240 Po	ontic - Porcelain Fused To High Noble	No	Yes	Pre-operative x-rays, date of prior	0	20	1	60	Month	Covered: 6-11, 22-27 Only one of (D6210, D6211, D6212, D6240, D6241,
	letal	NO	163	placement if applicable	0	20	1	00	WORLD	D6242, D6251) per 60 months per tooth. Teeth
IVI.										Covered: 6-11, 22-27
06241 Po	ontic - Porcelain Fused To	No	Yes	Pre-operative x-rays, date of prior	0	20	1	60	Month	Only one of (D6210, D6211, D6212, D6240, D6241,
Pro	redominantly Base Metal			placement if applicable						D6242, D6251) per 60 months per tooth. Teeth
	-									Covered: 6-11, 22-27
06242 Po	ontic - Porcelain Fused To Noble Metal	No	Yes	Pre-operative x-rays, date of prior	0	20	1	60	Month	Only one of (D6210, D6211, D6212, D6240, D6241,
				placement if applicable						D6242, D6251) per 60 months per tooth. Teeth
										Covered: 6-11, 22-27
	ontic - Resin With Predominantly Base	No	Yes	Pre-operative x-rays, date of prior	0	20	1	60	Month	Only one of (D6210, D6211, D6212, D6240, D6241,
Me	1etal			placement if applicable						D6242, D6251) per 60 months per tooth. Teeth
06721 Re	etainer Crown - Resin With	No	Yes	Pre-operative x-rays, date of prior	0	20	1	60	Month	Covered: 6-11, 22-27 Only one of (D6721, D6750, D6751, D6752, D6753,
-	redominantly Base Metal	NO	163	placement if applicable	0	20	1	00	WORLD	D6790, D6791, D6792) per 60 months per tooth. Teeth
	edominantiy base wetar									Covered: 5-12, 21-28
06750 Re	etainer Crown - Porcelain Fused To High	No	Yes	Pre-operative x-rays, date of prior	0	20	1	60	Month	Only one of (D6721, D6750, D6751, D6752, D6753,
	oble Metal			placement if applicable	-	-				D6790, D6791, D6792) per 60 months per tooth. Teeth
										Covered: 5-12, 21-28
06751 Re	etainer Crown - Porcelain Fused To	No	Yes	Pre-operative x-rays, date of prior	0	20	1	60	Month	Only one of (D6721, D6750, D6751, D6752, D6753,
Pro	redominantly Base Metal			placement if applicable						D6790, D6791, D6792) per 60 months per tooth. Teeth
$ \longrightarrow $										Covered: 5-12, 21-28
		No	Yes		0	20	1	60	Month	Only one of (D6721, D6750, D6751, D6752, D6753,
No	oble Metal			placement if applicable						D6790, D6791, D6792) per 60 months per tooth. Teeth
16752 Po	etainer Crown - Porcelain Eused to	No	Voc	Pre-operative x-rays, date of prior	0	20	1	60	Month	
		INU	162		U	20	T	00	worth	D6790, D6791, D6792) per 60 months per tooth. Teeth
	namuni anu mamuni Alloys									
06790 Re	etainer Crown - Full Cast High Noble	No	Yes	Pre-operative x-rays, date of prior	0	20	1	60	Month	Only one of (D6721, D6750, D6751, D6752, D6753,
					ı ~		-			
	letal			placement if applicable						D6790, D6791, D6792) per 60 months per tooth. Teeth
06751 Re Pre 06752 Re No 06753 Re Tit	etainer Crown - Porcelain Fused To			Pre-operative x-rays, date of prior	0 0 0 0	20 20 20 20 20	1 1 1 1 1	60 60 60 60	Month Month Month	Only one of (D6721, D6750, D6751, D6790, D6791, D6792) per 60 mont <u>Covered: 5-12, 21-28</u> Only one of (D6721, D6750, D6751, D6790, D6791, D6792) per 60 mont <u>Covered: 5-12, 21-28</u> Only one of (D6721, D6750, D6751, D6790, D6791, D6792) per 60 mont <u>Covered: 5-12, 21-28</u> Only one of (D6721, D6750, D6751, D6790, D6791, D6792) per 60 mont <u>Covered: 5-12, 21-28</u>

Carle	Description	PA	Pre-	ENVOLVE DENTAL - ILLIN				Devial	Derind	
Code	Description	PA Required	Pre- Payment	Required Documents	Age Min	Age Max	Max Count	Period Length	Period Type	ADDITIONAL NOTES
	Retainer Crown - Full Cast Predominantly Base Metal	No	Yes	Pre-operative x-rays, date of prior placement if applicable	0	20	1	60		Only one of (D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792) per 60 months per tooth. Teeth Covered: 5-12, 21-28
D6792	Retainer Crown - Full Cast Noble Metal	No	Yes	Pre-operative x-rays, date of prior placement if applicable	0	20	1	60	Month	Only one of (D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792) per 60 months per tooth. Teeth Covered: 5-12, 21-28
D6930	Recement Fixed Partial Denture	No	No		0	20	1	6	Month	Same provider cannot bill within 6 months of placement. One per abutment per 6 months. Teeth Covered: 1-32
	Unspecified Fixed Prosthodontic Procedure, By Report	Yes	No	Description of procedure and narrative of medical necessity. Preoperative periapical x-rays. Photos optional.	0	20	1	1	Day	Teeth Covered: 1-32
D7140	Extraction, Erupted Tooth Or Exposed Root	No	No		0	20	1	1	Lifetime	Includes incidental removal of a cyst or lesion attached to the root(s). Teeth Covered: 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
D7210	Surgical Removal Of Erupted Tooth	No	No		0	20	1	1	Lifetime	Requires elevation of a mucoperiosteal flap and removal of bone and/or section of the tooth and closure. Includes incidental removal of a cyst or lesion attached to the root(s). Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit. Teeth Covered: 1-32, 51-82, A- T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, DS, OS, PS, SS, TS
D7220	Removal Of Impacted Tooth - Soft Tissue	No	Yes	Pre-operative x-rays (excluding bitewings), Narrative of medical necessity	0	20	1	1	Lifetime	Includes incidental removal of a cyst or lesion attached to the root(s). Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit. Teeth Covered: 1-32, 51-82
	Removal Of Impacted Tooth - Partially Bony	No	Yes	Pre-operative x-rays (excluding bitewings), Narrative of medical necessity	0	20	1	1	Lifetime	Includes incidental removal of a cyst or lesion attached to the root(s). Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit. Teeth Covered: 1-32, 51-82
	Removal Of Impacted Tooth - Completely Bony	No	Yes	Pre-operative x-rays (excluding bitewings), Narrative of medical necessity	0	20	1	1	Lifetime	Includes incidental removal of a cyst or lesion attached to the root(s). Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit. Teeth Covered: 1-32, 51-82
	Surgical Removal Of Residual Tooth Roots (Cutting Procedure)	No	Yes	Pre-operative x-rays (excluding bitewings)	0	20	1	1		Not payable to provider group who previously billed extraction. Includes incidental removal of a cyst or lesion attached to the root(s). Teeth Covered: 1-32, 51- 82, A-T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, OS, RS, SS, TS
	Reimplantation And/Or Stabilization Of Accidentally Evulsed / Displaced Tooth	No	Yes	Pre-operative x-rays (excluding bitewings), Narrative of medical necessity. Photos optional	0	20	1	1	Lifetime	Once per lifetime per tooth. Teeth Covered: 1-32

Cada	Description	PA	Pre-	ENVOLVE DENTAL - ILLIN			<u>· · ·</u>	Daniad	Daniad	ADDITIONAL NOTES
Code	Description	Required	Payment	Required Documents	Age Min	Age Max	Max Count	Period Length	Period Type	ADDITIONAL NOTES
D7280	Surgical Access Of An Unerupted Tooth	No	Yes	Pre-operative x-rays. Narrative of	0	20	1	1		Only payable if Medicaid orthodontic treatment is
				medical necessity	-		_	_		approved. Once per lifetime per tooth. Teeth Covered:
				,						1-32
D7283	Placement Of Device To Facilitate	No	Yes	Pre-operative x-rays. Narrative of	0	20	1	1	Lifetime	Only payable if Medicaid orthodontic treatment is
	Eruption Of Impacted Tooth			medical necessity						approved. Once per lifetime per tooth. Teeth Covered:
				,						1-32
D7310	Alveoloplasty In Conjunction With	No	Yes	Pre-operative x-ray(s) (excluding	0	20	1	1	Lifetime	Only one of (D7310 or D7311) per lifetime per
	Extractions - Four Or More Teeth			bitewings).						quadrant. Minimum of four teeth extracted in
										guadrant.
D7311	Alveoloplasty In Conjunction With	No	Yes	Pre-operative x-ray(s) (excluding	0	20	1	1	Lifetime	Only one of (D7310 or D7311) per lifetime per
	Extractions - One To Three Teeth			bitewings).						quadrant. One to three teeth extracted in quadrant.
D7320	Alveoloplasty Not In Conjunction With	No	Yes	Pre-operative x-rays. Narrative of	0	20	1	1	Lifetime	Only one of (D7320 or D7321) per lifetime per
	Extractions - Four Or More Teeth			medical necessity						quadrant. Minimum of four tooth spaces in quadrant.
D7321	Alveoloplasty Not In Conjunction With	No	Yes	Pre-operative x-rays. Narrative of	0	20	1	1	Lifetime	Only one of (D7320 or D7321) per lifetime per
	Extractions - One To Three Teeth			medical necessity						quadrant. One to three tooth spaces in quadrant.
D7450	Removal Of Benign Odontogenic Cyst Or	No	Yes	Copy of pathology report and pre-	0	20	1	1	Lifetime	Once per lifetime per tooth.
	Tumor - Dia Up To 1.25 Cm			operative x-ray.						
D7451	Removal Of Benign Odontogenic Cyst Or	No	Yes	Copy of pathology report and pre-	0	20	1	1	Lifetime	Once per lifetime per tooth.
	Tumor - Dia Greater Than 1.25 Cm			operative x-ray.						
	Removal Of Benign Nonodontogenic Cyst	No	Yes	Copy of pathology report and pre-	0	20				
	Or Tumor - Dia Up To 1.25 Cm			operative x-ray.		20				
D7461	Removal Of Benign Nonodontogenic Cyst	No	Yes	Copy of pathology report and pre-	0	20				
	Or Tumor - Dia Greater Than 1.25 Cm			operative x-ray.						
D7510	Incision And Drainage Of Abscess -	No	Yes	Pre-operative x-rays, narrative of	0	20	1	1	Day	Only one of (D7510 or D7511) per day per tooth. Not
D7510	Intraoral Soft Tissue	NO	res		0	20	1	1	Day	payable same DOS as D7140-D7250. Teeth Covered: 1-
				medical necessity, photos optional						32, 51-82, A-T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS,
										SZ, S1-82, A-1, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS. MS. NS. OS. PS. OS. RS. SS. TS
D7511	Incision And Drainage Of Abscess -	No	Yes	Pre-operative x-rays, narrative of	0	20	1	1	Day	Only one of (D7510 or D7511) per day.
	Intraoral Soft Tissue - Complicated	110	105	medical necessity, photos optional	Ũ	20	-	-	Duy	
				medical necessity, photos optional						
D7610	Maxilla - Open Reduction (Teeth	No	Yes	Pre-operative x-rays, narrative of	0	20	1	1	Day	
	Immobilized, If Present)			medical necessity					,	
D7620	Maxilla - Closed Reduction (Teeth	No	Yes	Pre-operative x-rays, narrative of	0	20	1	1	Day	
	Immobilized, If Present)			medical necessity						
D7630	Mandible - Open Reduction (Teeth	No	Yes	Pre-operative x-rays, narrative of	0	20	1	1	Day	
	Immobilized, If Present)			medical necessity						
D7640	Mandible - Closed Reduction (Teeth	No	Yes	Pre-operative x-rays, narrative of	0	20	1	1	Day	
	Immobilized, If Present)			medical necessity						
D7710	Maxilla - Open Reduction	No	Yes	Pre-operative x-rays, narrative of	0	20	1	1	Day	
				medical necessity						
D7720	Maxilla - Closed Reduction	No	Yes	Pre-operative x-rays, narrative of	0	20	1	1	Day	
				medical necessity						
D7730	Mandible - Open Reduction	No	Yes	Pre-operative x-rays, narrative of	0	20	1	1	Day	
				medical necessity						
D7740	Mandible - Closed Reduction	No	Yes	Pre-operative x-rays, narrative of	0	20	1	1	Day	
	1			medical necessity						<u> </u>

Code D	escription	PA	Pre-	ENVOLVE DENTAL - ILLIN Required Documents	Age Min		Max Count	Period	Period	ADDITIONAL NOTES
		Required	Payment	·····				Length	Туре	
D7810 O	pen Reduction Of Dislocation	No	Yes	Pre-operative x-rays, narrative of	0	20	1	1	Day	
				medical necessity						
D7820 Cl	losed Reduction Of Dislocation	No	Yes	Pre-operative x-rays, narrative of	0	20	1	1	Day	
D7961 B	uccal/Labial Frenectomy (Frenulectomy)	No	Yes	medical necessity Narrative of medical necessity and	0	20	6	1	Lifetime	
D1901 D		NO	165	photos	0	20	0	1	Litetime	
D7962 Li	ngual Frenectomy (Frenulectomy)	No	Yes	Narrative of medical necessity and	0	20	1	1	Lifetime	
	c <i>i i i</i>			photos						
D7963 Fr	renuloplasty	No	Yes	Narrative of medical necessity.	0	20	1	1	Lifetime	Only 1 D7963 per arch per lifetime. Indicate arch on
				Photos optional.						claim form.
	nspecified Oral Surgery Procedure, By	Yes	No	Description of procedure, x-rays	0	20	1	1	Day	
R	eport			and narrative of medical necessity.						
D8080 C	omprehensive Orthodontic Treatment	Yes	No	Cephalometric X-rays with	0	20	1	1	Lifetime	
0	f The Adolescent Dentition			interpretation, Panoramic						
				radiograph, intra-oral and facial						
				photographs, completed						
				Handicapping Labio-Lingual						
				Deviation Index (HLD), Treatment						
D8660 Pi	re-Orthodontic Treatment Visit	Yes	No	Plan	0	20	1	1	Lifetime	Billed only for approved orthodontic cases. For cases
20000 11		105	110		Ŭ	20	-	-	Linctinic	when D8080 is not approved, bill D8999 for the pre-
										orthodontic treatment visit.
D8670 Pe	eriodic Orthodontic Treatment Visit (As	No	No		0	20	11	1	Lifetime	Only one D8670 per 45 days. Approved Medicaid
	art Of Contract)									orthodontic case must be on file.
	rthodontic Retention (Removal Of	No	Yes	Photos of finished orthodontic case	0	20	1	1	Lifetime	
	ppliances, Place Retainers) nspecified Orthodontic Procedure, By	No	Yes	Narrative of necessity,	0	20	1	1	Lifetime	Only one D8999 per lifetime per member. Covered
	eport	NO	103	documentation of case denial	U	20	-	-	Linctinic	only when D8080 is denied.
	alliative (Emergency) Treatment Of	No	No		0	20	4	12	Month	Only one of (D0140 or D9110) per day per provider
	ental Pain - Minor Procedure									group. For emergency care only.
	eep Sedation/General Anesthesia – First	Yes	No	Clinical documentation supporting	0	20	1	1	Day	Only one of (D9222 or D9239) per day. Permit B
1	5 Minutes			necessity						required. Not allowed same DOS as D9230, D9239,
D9223 D	eep Sedation/General Anesthesia - each	No	No		0	20	5	1	Day	D9243, or D9248. Five of (D9223 or D9243) per day. Permit B required.
	ubsequent 15 minute increment	NO	NO		0	20	5	1	Day	Not allowed on the same date of service with D9230,
										D9243, or D9248. Valid D9222 must be on file.
	halation Of Nitrous/Analgesia,	No	No	Supporting documentation must be	0	20	1	1	Day	Not allowed same DOS as D9222, D9223, D9239,
	nxiolysis Itravenous Moderate (conscious)	Yes	No	kept in patient record. Clinical documentation supporting	0	20	1	1	Dav	D9243, or D9248 Only one of (D9222 or D9239) per day. Permit B
	edation/Analgesia – First 15 Minutes	162	INU	necessity	U	20	1	T	Day	required. Not allowed same DOS as D9222, D9223,
36				necessity						D9230. or D9248.
D9243 In	travenous Moderate (Conscious)	No	No		0	20	5	1	Day	Five of (D9223 or D9243) per day. Permit B required.
Se	edation/Analgesia - Subs 15 Min									Not allowed same DOS as D9222, D9223, D9230, or
										D9248. Valid D9239 must be on file.
										, , ,

		_	_	ENVOLVE DENTAL - ILLIN	-		<u> </u>			
Code	Description	PA Required	Pre- Payment	Required Documents	Age Min	Age Max	Max Count	Period Length	Period Type	ADDITIONAL NOTES
D9248	Non-Intravenous Moderate (Conscious) Sedation	No	Yes	Clinical documentation supporting necessity	0	20	1	1	Day	Limited to patients with a mental or physical handicap, extremely apprehensive, or extensive treatment is performed in one appointment. D9248 is not allowed on same date of service as D9222, D9223, D9230, D9239, or D9243. Permit A or B is required.
D9310	Consultation - Diagnostic Service Provided By Dentist Or Physician	No	No	Supporting documentation must be kept in patient record.	0	20	1	1	Day	One per day per provider group.
D9610	Therapeutic Parenteral Drug, Single Administration	No	Yes	Description of drug and parenteral administration	0	20	1	1	Day	Name of drug and amount administered. One per day.
D9630	Other Drugs And/Or Medicaments, By Report	No	Yes	Description of drugs	0	20	1	1	Day	Name of drug and amount administered. One per day.
D9999	Unspecified Adjunctive Procedure, By Report	Yes	No	Description of procedure and narrative of medical necessity. For Outpatient facility usage, include completed health plan Outpatient Facility Authorization form, clinical documentation of necessity.	0	20	1	1	Day	
		•		Meridian Hea	Ith Pregnar	it Women	•			
D0120	Periodic Oral Evaluation - Established Patient	No	No		21	999	1	6	Month	Not allowed within 6 months of D0150.
D0140	Limited Oral Evaluation - Problem Focused	No	No		21	999	1	1	Day	Only one of (D0140 or D9110) per day per provider group. For emergency exam only. Not payable if performed in conjunction with either D0120, D0150, or D0180.
D0150	Comprehensive Oral Evaluation - New Or Established Patient	No	No		21	999	1	1	Lifetime	Only one D0150 per lifetime per provider group.
D0210	Intraoral - Complete Series of Radiographic Images	No	No		21	999	1	36	Month	Only one of (D0210, D0277, or D0330) per 36 months per member.
D0220	Intraoral - Periapical First Radiographic Image	No	No		21	999	1	1	Day	Only one D0220 per day per per provider or location. Maximum reimbursement of a single date of service for radiographs limited to fee for complete Series (D0210).
D0230	Intraoral - Periapical Each Additional Image	No	No		21	999				Maximum reimbursement is up to the fee of D0210.
D0270	Bitewing - Single Radiographic Image	No	No		21	999	1	12	Month	One D0270 per 12 months per provider group. Maximum reimbursement of a single date of service for radiographs limited to fee for complete series (D0210).
D0272	Bitewings - Two Radiographic Images	No	No		21	999	1	12		One (D0272 or D0274) per 12 month per provider or location. Maximum reimbursement of a single date of service for radiographs limited to fee for complete series (D0210).
D0274	Bitewings - Four Radiographic Images	No	No		21	999	1	12	Month	One (D0272 or D0274) per 12 month per provider or location. Maximum reimbursement of a single date of service for radiographs limited to fee for complete series (D0210).

Code	Description	PA	Pre-	Required Documents	Age Min	Age Max	Max Count	Period	Period	ADDITIONAL NOTES
		Required	Payment					Length	Туре	
D0277	Vertical Bitewings - 7 To 8 Radiographic	No	No		21	999	1	36	Month	Only one of (D0210, D0277, or D0330) per 36 months
	Images									per member. Maximum reimbursement of a single
										date of service for radiographs limited to fee for
D0330	Panoramic Radiographic Image	No	No		21	999	1	36	Month	complete series (D0210). Only one of (D0210, D0277, or D0330) per 36 months
00330		NO	NO		21	999	1	50	Month	per member. Maximum reimbursement of a single
										date of service for radiographs limited to fee for
										complete series (D0210).
D0999	Unspecified Diagnostic Procedures, By						1	1	Day	For FQHC Encounter billing. D0999 must be on first line
	Report								-	of claim
										with additional service listed.
D1110	Prophylaxis - Adult	No	No		21	999	1	6	Month	
D1354	Interim Caries Arresting Medicament	No	No		21	999	6	1	Lifetime	2 applications per tooth per year. Lifetime maximum of
	Application - Per Tooth									six applications per tooth. Providers may treat a
										maximum of 4 teeth per day, providing participant has
										no history of any prior or same day billing of CDT
										category D2000 (Restorative codes) or CDT category
										D3000 (Endodontic codes) on the same tooth.
D2140	Amalgam - One Surface, Primary Or	No	No		21	999	1	12	Month	Only one (D2140, D2150, D2160, D2161, D2330,
	Permanent									D2331, D2332, D2335, D2391, D2392, D2393, D2394)
										per 12 months per surface. Teeth Covered: 1-32, A-T
D2150	Amalgam - Two Surfaces, Primary Or	No	No		21	999	1	12	Month	Only one (D2140, D2150, D2160, D2161, D2330,
	Permanent									D2331, D2332, D2335, D2391, D2392, D2393, D2394)
										per 12 months per surface. Teeth Covered: 1-32, A-T
D2160	Amalgam - Three Surfaces, Primary Or	No	No		21	999	1	12	Month	Only one (D2140, D2150, D2160, D2161, D2330,
02100	Permanent	NO	NO		21	555	-	12	Worten	D2331, D2332, D2335, D2391, D2392, D2393, D2394)
										per 12 months per surface. Teeth Covered: 1-32, A-T
										p =
D2161	Amalgam - Four Or More Surfaces,	No	No		21	999	1	12	Month	One of (D2161, D2335, D2394) per 12 months per
	Primary Or Permanent									tooth. Teeth Covered: 1-32, A-T
D2330	Resin-Based Composite - One Surface,	No	No		21	999	1	12	Month	Only one (D2140, D2150, D2160, D2161, D2330,
	Anterior									D2331, D2332, D2335, D2391, D2392, D2393, D2394)
										per 12 months per surface. Teeth Covered: 6-11, 22-
D2331	Resin-Based Composite - Two Surfaces,	No	No		21	999	1	12	Month	27. C-H. M-R Only one (D2140, D2150, D2160, D2161, D2330,
D2551	Anterior	NO	NO		21	333	1	12	WOITT	D2331, D2332, D2335, D2391, D2392, D2393, D2394)
	Anterior									per 12 months per surface. Teeth Covered: 6-11, 22-
										27. C-H. M-R
D2332	Resin-Based Composite - Three Surfaces,	No	No		21	999	1	12	Month	Only one (D2140, D2150, D2160, D2161, D2330,
	Anterior									D2331, D2332, D2335, D2391, D2392, D2393, D2394)
										per 12 months per surface. Teeth Covered: 6-11, 22-
										27. C-H. M-R
D2335	Resin-Based Composite - Four Or More	No	No		21	999	1	12	Month	One of (D2161, D2335, D2394) per 12 months per
	Surfaces Or Involving Incisal Angle									tooth. Teeth Covered: 6-11, 22-27, C-H, M-R

Code	Description	PA	Pre-	Required Documents	Age Min	Age Max	Max Count	Period	Period	ADDITIONAL NOTES
		Required	Payment					Length	Type	
D2391	Resin-Based Composite - One Surface,	No	No		21	999	1	12	Month	Only one (D2140, D2150, D2160, D2161, D2330,
	Posterior									D2331, D2332, D2335, D2391, D2392, D2393, D2394)
										per 12 months per surface. May not be used for PRR.
										Teeth Covered: 1-5, 12-21, 28-32, A, B, I-L, S, T
D2392	Resin-Based Composite - Two Surfaces,	No	No		21	999	1	12	Month	Only one (D2140, D2150, D2160, D2161, D2330,
	Posterior									D2331, D2332, D2335, D2391, D2392, D2393, D2394)
										per 12 months per surface. Teeth Covered: 1-5, 12-21,
										28-32. A. B. I-L. S. T
D2393	Resin-Based Composite - Three Surfaces,	No	No		21	999	1	12	Month	Only one (D2140, D2150, D2160, D2161, D2330,
	Posterior									D2331, D2332, D2335, D2391, D2392, D2393, D2394)
										per 12 months per surface. Teeth Covered: 1-5, 12-21,
										28-32. A. B. I-L. S. T
D2394	Resin-Based Composite - Four Or More	No	No		21	999	1	12	Month	One of (D2161, D2335, D2394) per 12 months per
	Surfaces, Posterior									tooth. Teeth Covered: 1-5, 12-21, 28-32, A, B, I-L, S, T
D2542	Onlay - Metallic - Two Surfaces	Yes	No	Pre-operative periapical x-rays and	21	999	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643,
				optional photos						D2644, D2740, D2750, D2751, D2752,D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth
										Covered: 1-32
D2543	Onlay - Metallic - Three Surfaces	Yes	No	Pre-operative periapical x-rays and	21	999	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643,
				optional photos						D2644, D2740, D2750, D2751, D2752, D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth
D2544		N	NL-		24	000		60	Manth	Covered: 1-32 Only one of (D2542, D2543, D2544, D2642, D2643,
D2544	Onlay - Metallic - Four Or More Surfaces	Yes	No	Pre-operative periapical x-rays and	21	999	1	60	Month	
				optional photos						D2644, D2740, D2750, D2751, D2752, D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth
D2642	Onlay - Porcelain/Ceramic - Two Surfaces	Yes	No	Pre-operative periapical x-rays and	21	999	1	60	Month	Covered: 1-32 Only one of (D2542, D2543, D2544, D2642, D2643,
D2042	Onlay - Forcelain/Cerainic - Two Surfaces	163	NO	optional photos	21	333	1	00	wonth	D2644, D2740, D2750, D2751, D2752, D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth
										Covered: 1-32
D2643	Onlay - Porcelain/Ceramic - Three	Yes	No	Pre-operative periapical x-rays and	21	999	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643,
02013	Surfaces	105	110	optional photos		555	-	00	Wienen	D2644, D2740, D2750, D2751, D2752, D2753, D2790,
	Surfaces									D2791, D2792, D2931) per 60 months per tooth. Teeth
										Covered: 1-32
D2644	Onlay - Porcelain/Ceramic - Four Or More	Yes	No	Pre-operative periapical x-rays and	21	999	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643,
_	Surfaces		-	optional photos						D2644, D2740, D2750, D2751, D2752, D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth
										Covered: 1-32
D2740	Crown - Porcelain/Ceramic	No	Yes	Pre-operative periapical x-rays and	21	999	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643,
				optional photos.						D2644, D2740, D2750, D2751, D2752,D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth
										Covered: 1-32
D2750	Crown - Porcelain Fused To High Noble	No	Yes	Pre-operative periapical x-rays and	21	999	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643,
	Metal			optional photos.						D2644, D2740, D2750, D2751, D2752,D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth
										Covered: 1-32

Carla	Description	PA	Pre-	ENVOLVE DENTAL - ILLIN			<u> </u>	Doriad	Doried	
	Description	PA Required	Pre- Payment	Required Documents	Age Min	Age Max	Max Count	Period Length	Period Type	ADDITIONAL NOTES
D2751	Crown - Porcelain Fused To	No	Yes	Pre-operative periapical x-rays and	21	999	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643,
	Predominantly Base Metal			optional photos.						D2644, D2740, D2750, D2751, D2752,D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth
										Covered: 1-32
D2752	Crown - Porcelain Fused To Noble Metal	No	Yes	Pre-operative periapical x-rays and	21	999	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643,
				optional photos.						D2644, D2740, D2750, D2751, D2752,D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth
										Covered: 1-32
D2753	Crown - Porcelain Fused to Titanium and	No	Yes	Pre-operative periapical x-rays and	21	999	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643,
	Titanium Alloys			optional photos.						D2644, D2740, D2750, D2751, D2752,D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth
										Covered: 1-32
D2790	Crown - Full Cast High Noble Metal	No	Yes	Pre-operative periapical x-rays and	21	999	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643,
				optional photos.						D2644, D2740, D2750, D2751, D2752,D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth
										Covered: 1-32
D2791	Crown - Full Cast Predominantly Base	No	Yes	Pre-operative periapical x-rays and	21	999	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643,
	Metal			optional photos.						D2644, D2740, D2750, D2751, D2752,D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth
										Covered: 1-32
D2792	Crown - Full Cast Noble Metal	No	Yes	Pre-operative periapical x-rays and	21	999	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643,
				optional photos.						D2644, D2740, D2750, D2751, D2752,D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth
										Covered: 1-32
D2910	Recement Inlay, Onlay, Or Partial	No	No		21	999	1	6	Month	One per tooth per 6 months. Teeth Covered: 1-32
	Coverage Restoration									
D2915	Recement Cast Or Prefabricated Post And	No	No		21	999	1	6	Month	Not allowed within 6 months of D2954 by the same
	Core									provider or provider group. One per tooth per 6
D 2020	De come ant Comme	NI-	N		24	000		6	N.4 a vehic	months. Teeth Covered: 1-32
D2920	Recement Crown	No	No		21	999	1	6	Month	Re-cement within 6 months of initial placement by
										same provider or provider group will be considered a
										duplicate service and will not be paid. One per tooth
										per 6 months. Teeth Covered: 1-32, A-T
D2931	Prefabricated Stainless Steel Crown -	No	Yes	Pre-operative periapical x-rays and	21	999	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643,
D2931	Permanent Tooth	NO	res	optional photos	21	999	1	60	wonth	D2644, D2740, D2750, D2751, D2752, D2753, D2790,
				optional priotos						D2791, D2792, D2931) per 60 months per tooth.
										Authorization required for three or more crowns.
D2932	Prefabricated Resin Crown	No	Yes	Pre-operative periapical x-rays and	21	999	1	1	Lifetime	Teeth Covered: 1-32 Only one of (D2930, D2932, D2933, D2934) per lifetime
02332	r refubricated Resili crown	NO	105	optional photos	21	555	-	-	Lifetime	per tooth. Authorization required for three or more
				optional photos						crowns. Teeth Covered: 6-11, 22-27, C-H, M-R
										crowns. reeth covered. 0-11, 22-27, C-H, M-K
D2940	Protective Restoration	No	No		21	999	1	6	Month	Not allowed with pulpotomy, pulpectomy, or root
2_010							-	J		canal therapy. Not allowed on the same date of service
										as a restoration. One per tooth per 6 months. Teeth
										Covered: 1-32. A-T
D2950	Core Buildup, Including Any Pins When	No	No		21	999	1	60	Month	Only one of (D2950 or D2954) per tooth per 60
000	Required	-					-			months. Teeth Covered: 1-32
D2951	Pin Retention - Per Tooth, In Addition To	No	No		21	999	4	1	Day	Not allowed with (D2950, D2954) on same DOS. Teeth
	Restoration	-						_	-,	Covered: 1-32
										0010.001 I 0E

Code	Description	PA	Pre-	Required Documents	Age Min	Age Max	Max Count	Period	Period	ADDITIONAL NOTES
		Required	Payment					Length	Туре	
D2954	Prefabricated Post And Core In Addition	No	Yes	Final RCT fill periapical x-ray	21	999	1	60	Month	Only one of (D2950 or D2954) per tooth per 60
	To Crown									months. Teeth Covered: 1-32
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)	No	No		21	999	1	1	Lifetime	One per lifetime per tooth. Teeth Covered: 6-11, 22-27
D4210	Gingivectomy Or Gingivoplasty - Four Or	No	Yes	Pre-operative x-rays, perio	21	999	1	24	Month	Only one of (D4210, D4211, D4240, D4241, D4260,
	More Contiguous Teeth			charting, narrative of medical						D4261) per 24 months per quadrant per provider
				necessity, photos optional						group. Minimum of four (4) affected teeth in the
										quadrant. For removing hyperplastic tissue to reduce pocket depth.
D4211	Gingivectomy Or Gingivoplasty - One To	No	Yes	Pre-operative x-rays, perio	21	999	1	24	Month	Only one of (D4210, D4211, D4240, D4241, D4260,
	Three Contiguous Teeth			charting, narrative of medical						D4261) per 24 months per quadrant per provider
				necessity, photos optional						group. One to three teeth affected in quadrant. For
										removing hyperplastic tissue to reduce pocket depth.
D4240	Gingival Flap Procedure, Including Root	No	Yes	Pre-operative x-rays, perio	21	999	1	24	Month	Only one of (D4210, D4211, D4240, D4241, D4260,
	Planing - Four Or More Contiguous Teeth			charting, narrative of medical						D4261) per 24 months per quadrant per provider
				necessity, photos optional						group. Minimum of four (4) affected teeth in the quadrant.
	Gingival Flap Procedure, Including Root	No	Yes	Pre-operative x-rays, perio	21	999	1	24	Month	Only one of (D4210, D4211, D4240, D4241, D4260,
	Planing - One To Three Contiguous Teeth			charting, narrative of medical						D4261) per 24 months per quadrant per provider
				necessity, photos optional						group. One to three teeth affected in quadrant.
D4249	Clinical Crown Lengthening - Hard Tissue	No	Yes	Pre-operative x-ray(s), perio	21	999	1	1	Lifetime	
				charting, narrative of medical						quadrant as D4260 or D4261 within a 24 month period.
D4200	Ossessus Surgery (Including Flore France	Ne	Vee	necessity	21	999	1	24	Manth	Only one of (D4210, D4211, D4240, D4241, D4260,
D4260	Osseous Surgery (Including Flap Entry And Closure) - Four Or More Teeth	No	Yes	Pre-operative x-rays, perio charting, narrative of medical	21	999	1	24	Month	Diffy one of $(D4210, D4211, D4240, D4241, D4260, D4261)$ per 24 months per quadrant per provider
	And closure) - Four or more reeth			necessity, photos optional						group. Minimum of four (4) affected teeth in the
										group: Minimum of four (4) anected teeth in the
D4261	Osseous Surgery (Including Flap Entry	No	Yes	Pre-operative x-rays, perio	21	999	1	24	Month	Only one of (D4210, D4211, D4240, D4241, D4260,
	And Closure) - One To Three Teeth			charting, narrative of medical						D4261) per 24 months per quadrant per provider
				necessity, photos optional						group. One to three teeth affected in quadrant.
D4263	Bone Replacement Graft - First Site In	No	Yes	Pre-operative x-rays, perio	21	999	1	24	Month	One per quadrant per 24 months. Tooth number
	Quadrant			charting, narrative of medical						required on claim form. Teeth Covered: 1-32
				necessity, photos optional						
D4264	Bone Replacement Graft - Each	No	Yes	Pre-operative x-rays, perio	21	999	3	24	Month	Three per quadrant per 24 months. Tooth number
	Additional Site In Quadrant			charting, narrative of medical						required on claim form. Teeth Covered: 1-32
D4270	Pedicle Soft Tissue Graft Procedure	No	Yes	necessity, photos optional Pre-operative x-rays, perio	21	999	1	24	Month	One per tooth per lifetime Teeth Covered: 1-32
012/0		110	105	charting, narrative of medical		555	-	21	Wienen	
				necessity, photos optional						
D4273	Subepithelial Connective Tissue Graft	No	Yes	Pre-operative x-rays, perio	21	999	1	24	Month	One per quadrant per 24 months. Tooth number
	Procedures, Per Tooth			charting, narrative of medical						required on claim form. Teeth Covered: 1-32
				necessity, photos optional			ļ			
D4274	Distal Or Proximal Wedge Procedure	No	Yes	Pre-operative x-rays, perio	21	999	1	24	Month	One per quadrant per 24 months.Tooth number
				charting, narrative of medical						required on claim form. Teeth Covered: 1-32
D4277	Free Soft Tissue Graft Procedure	No	Yes	necessity, photos optional Pre-operative x-rays, perio	21	999	1	24	Month	One per quadrant per 24 months. Tooth number
04277	(Including Donor Site Surgery) First Tooth	NU	103	charting, narrative of medical	21	555		24	wonth	required on claim form. Teeth Covered: 1-32, 51-82
				necessity, photos optional						

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Code	Description	PA Required	Pre- Payment	Required Documents	Age Min	Age Max	Max Count	Period Length	Period Type	ADDITIONAL NOTES
D4278	Free Soft Tissue Graft Procedure	No	Yes	Pre-operative x-rays, perio	21	999	1	24	Month	Three per quadrant per 24 months. Tooth number
	(Including Donor Site Surgery) Additional			charting, narrative of medical						required on claim form. Teeth Covered: 1-32, 51-82
	Tooth			necessity, photos optional						
D4320	Provisional Splinting - Intracoronal	No	Yes	Pre-operative x-rays, perio	21	999	1	24	Month	Per arch (LA, UA) - one (D4320 or D4321) per arch per
	1 0			charting, narrative of medical						24 months.
				necessity, photos optional						
D4321	Provisional Splinting - Extracoronal	No	Yes	Pre-operative x-rays, perio	21	999	1	24	Month	Per arch (LA, UA) - one (D4320 or D4321) per arch per
DISEI				charting, narrative of medical		555	-	2.	wonen	24 months.
				necessity, photos optional						24 months.
D4341	Periodontal Scaling And Root Planing -	No	Yes	Pre-operative x-rays (bitewings	21	999	1	24	Month	Only one of (D4341 or D4342) per 24 months per
04341	Four Or More Teeth Per Quadrant	NO	103	and/or panoramic radiograph) and	21	555	1	24	WORth	quadrant. One full mouth service is covered every 24
	Four Or More reeth Per Quadrant									
04242	Periodontal Scaling And Root Planing -	No	Yes	periodontal charting Pre-operative x-rays (bitewings	21	999	1	24	Month	months. Only one of (D4341 or D4342) per 24 months per
D4342		No	res		21	999	1	24	wonth	
	One To Three Teeth Per Quadrant			and/or panoramic radiograph) and						quadrant. One full mouth service is covered every 24
				periodontal charting						months.
D4355	Full Mouth Debridement	No	No		21	999	1	12	Month	Only one of (D1110 or D4355) per 6 months. Not
										billable with D4341 or D4342. Not eligible for payment
										if performed on the same date or within 12 months of
										a D0120 or D0150. Not allowed for twelve months
										following D1120 or any D4000 series code.
D4910	Periodontal Maintenance	No	No		21	999	1	6	Month	Requires history of D4210, D4211, D4240, D4241,
										D4260, D4261, D4341, D4342, or valid 4910. One
										(D1110 or D4910) per 6 months.
D5110	Complete Denture - Maxillary	Yes	No	Full mouth x-rays or panorex, prior	21	999	1	60	Month	Only one of (D5110, D5130, or D5221) per 60 months
				date of placement						
D5120	Complete Denture - Mandibular	Yes	No	Full mouth x-rays or panorex, prior	21	999	1	60	Month	Only one of (D5120, D5140, or D5222) per 60 months.
				date of placement						
D5130	Immediate Denture - Maxillary	Yes	No	Full mouth x-rays or panorex, prior	21	999	1	1	Lifetime	
20100				date of placement		555	-	-		
D5140	Immediate Denture - Mandibular	Yes	No	Full mouth x-rays or panorex, prior	21	999	1	1	Lifetime	
05140		105	NO	date of placement	21	555	-	-	Lifetime	
D5221	Immediate Maxillary Partial Denture -	Yes	No	Full mouth x-rays or panorex, prior	21	999	1	60	Month	Only one of (D5110, D5130, or D5221) per 60 months
DJZZI	Resin Base	163	NO	date of placement	21	555	1	00	wonth	
D5222	Immediate Mandibular Partial Denture -	Yes	No	Full mouth x-rays or panorex, prior	21	999	1	60	Month	Only one of (D5120, D5140, or D5222) per 60 months.
DSZZZ		res	INO		21	999	1	60	wonth	
05544	Resin Base	N -	N -	date of placement	24		2	42		Not covered within 6 months of insertion.
D5511	Repair Broken Complete Denture Base,	No	No		21	999	2	12	Month	Not covered within 6 months of insertion.
05540	Mandibular				24		2	42		
D5512	Repair Broken Complete Denture Base,	No	No		21	999	2	12	Month	Not covered within 6 months of insertion.
	Maxillary	<u> </u>								
D5520	Replace Missing Or Broken Teeth -	No	No		21	999	1	12	Month	One per tooth per 12 months. Teeth Covered: 1-32
	Complete Denture (Each Tooth)									
D5611	Repair Resin Partial Denture Base,	No	No		21	999	2	12	Month	Not covered within 6 months of insertion.
	Mandibular									
D5612	Repair Resin Partial Denture Base,	No	No		21	999	2	12	Month	Not covered within 6 months of insertion.
	Maxillary									
D5621	Repair Cast Partial Framework,	No	No		21	999	2	12	Month	Not covered within 6 months of insertion.
	Mandibular									
D5622	Repair Cast Partial Framework, Maxillary	No	No		21	999	2	12	Month	Not covered within 6 months of insertion.

Code	Description	PA	Pre-	Required Documents	Age Min	Age Max	Max Count	Period	Period	ADDITIONAL NOTES
		Required	Payment			-		Length	Туре	
D5630	Repair Or Replace Broken	No	No		21	999	1	21	Month	One per tooth per 12 months. Teeth Covered: 1-32
	Retentive/Clasping Materials - per tooth									
D5640	Replace Broken Teeth - Per Tooth	No	No		21	999	1	12	Month	One per tooth per 12 months. Teeth Covered: 1-32
D5650	Add Tooth To Existing Partial Denture	No	No		21	999	1	12	Month	One per tooth per 12 months. Teeth Covered: 1-32
D5730	Reline Complete Maxillary Denture (direct)	No	Yes	Date of denture placement	21	999	1	24	Month	Only one of (D5730 or D5750) per 24 months. Not covered within 6 months of placement.
D5731	Reline Complete Mandibular Denture (direct)	No	Yes	Date of denture placement	21	999	1	24	Month	Only one of (D5731 or D5751) per 24 months. Not covered within 6 months of placement.
D5740	Reline Maxillary Partial Denture (direct)	No	Yes	Date of denture placement	21	999	1	24	Month	Only one of (D5740 or D5760) per 24 months. Not covered within 6 months of placement.
D5741	Reline Mandibular Partial Denture (direct)	No	Yes	Date of denture placement	21	999	1	24	Month	Only one of (D5741 or D5761) per 24 months. Not covered within 6 months of placement.
D5750	Reline Complete Maxillary Denture (indirect)	No	Yes	Date of denture placement	21	999	1	24	Month	Only one of (D5730 or D5750) per 24 months. Not covered within 6 months of placement.
D5751	Reline Complete Mandibular Denture (indirect)	No	Yes	Date of denture placement	21	999	1	24	Month	Only one of (D5731 or D5751) per 24 months. Not covered within 6 months of placement.
D5760	Reline Maxillary Partial Denture (indirect)	No	Yes	Date of denture placement	21	999	1	24	Month	Only one of (D5740 or D5760) per 24 months. Not covered within 6 months of placement.
D5761	Reline Mandibular Partial Denture (indirect)	No	Yes	Date of denture placement	21	999	1	24	Month	Only one of (D5741 or D5761) per 24 months. Not covered within 6 months of placement.
D5999	Unspecified Maxillofacial Prosthesis, By Report	Yes	Yes	Description of procedure and narrative of medical necessity	21	999	1	1	Day	One per day.
D6930	Recement Fixed Partial Denture	No	No		21	999	1	6	Month	Same provider cannot bill within 6 months of placement. One per abutment per 6 months. Teeth Covered: 1-32
D6999	Unspecified Fixed Prosthodontic Procedure, By Report	Yes	No	Description of procedure and narrative of medical necessity. Preoperative periapical x-rays. Photos optional.	21	999	1	1	Day	Teeth Covered: 1-32
D7140	Extraction, Erupted Tooth Or Exposed Root	No	No		21	999	1	1	Lifetime	Includes incidental removal of a cyst or lesion attached to the root(s). Teeth Covered: 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
D7210	Surgical Removal Of Erupted Tooth	No	No		21	999	1	1	Lifetime	Requires elevation of a mucoperiosteal flap and removal of bone and/or section of the tooth and closure. Includes incidental removal of a cyst or lesion attached to the root(s). Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit. Teeth Covered: 1-32, 51-82, A- T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, DS, OS, PS, SS, TS,
D7220	Removal Of Impacted Tooth - Soft Tissue	No	Yes	Pre-operative x-rays (excluding bitewings), Narrative of medical necessity	21	999	1	1	Lifetime	Includes incidental removal of a cyst or lesion attached to the root(s). Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit. Teeth Covered: 1-32, 51-82

			-	ENVOLVE DENTAL - ILLIN						
Code	Description	PA Required	Pre- Payment	Required Documents	Age Min	Age Max	Max Count	Period Length	Period Type	ADDITIONAL NOTES
	Removal Of Impacted Tooth - Partially Bony	No	Yes	Pre-operative x-rays (excluding bitewings), Narrative of medical necessity	21	999	1	1	Lifetime	Includes incidental removal of a cyst or lesion attached to the root(s). Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit. Teeth Covered: 1-32, 51-82
	Removal Of Impacted Tooth - Completely Bony	No	Yes	Pre-operative x-rays (excluding bitewings), Narrative of medical necessity	21	999	1	1	Lifetime	Includes incidental removal of a cyst or lesion attached to the root(s). Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit. Teeth Covered: 1-32, 51-82
	Surgical Removal Of Residual Tooth Roots (Cutting Procedure)	No	Yes	Pre-operative x-rays (excluding bitewings)	21	999	1	1	Lifetime	Not payable to provider group who previously billed extraction. Includes incidental removal of a cyst or lesion attached to the root(s). Teeth Covered: 1-32, 51- 82, A-T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, OS, RS, SS, TS
	Reimplantation And/Or Stabilization Of Accidentally Evulsed / Displaced Tooth	No	Yes	Pre-operative x-rays (excluding bitewings), Narrative of medical necessity. Photos optional	21	999	1	1	Lifetime	Once per lifetime per tooth. Teeth Covered: 1-32
	Alveoloplasty In Conjunction With Extractions - Four Or More Teeth	No	Yes	Pre-operative x-rays (excluding bitewings).	21	999	1	1	Lifetime	Only one of (D7310 or D7311) per lifetime per quadrant. Minimum of four teeth extracted in quadrant.
	Alveoloplasty In Conjunction With Extractions - One To Three Teeth	No	Yes	Pre-operative x-rays (excluding bitewings).	21	999	1	1	Lifetime	Only one of (D7310 or D7311) per lifetime per quadrant. One to three teeth extracted in quadrant.
	Alveoloplasty Not In Conjunction With Extractions - Four Or More Teeth	No	Yes	Pre-operative x-rays. Narrative of medical necessity	21	999	1	1	Lifetime	Only one of (D7320 or D7321) per lifetime per quadrant. Minimum of four tooth spaces in quadrant.
D7321	Alveoloplasty Not In Conjunction With Extractions - One To Three Teeth	No	Yes	Pre-operative x-rays. Narrative of medical necessity	21	999	1	1	Lifetime	Only one of (D7320 or D7321) per lifetime per quadrant. One to three tooth spaces in quadrant.
D7450	Removal Of Benign Odontogenic Cyst Or Tumor - Dia Up To 1.25 Cm	No	Yes	Copy of pathology report and pre- operative x-ray.	21	999	1	1	Lifetime	Once per lifetime per tooth.
D7451	Removal Of Benign Odontogenic Cyst Or Tumor - Dia Greater Than 1.25 Cm	No	Yes	Copy of pathology report and pre- operative x-ray.	21	999	1	1	Lifetime	Once per lifetime per tooth.
	Removal Of Benign Nonodontogenic Cyst Or Tumor - Dia Up To 1.25 Cm	No	Yes	Copy of pathology report and pre- operative x-ray.	21	999				
	Removal Of Benign Nonodontogenic Cyst Or Tumor - Dia Greater Than 1.25 Cm	No	Yes	Copy of pathology report and pre- operative x-ray.	21	999				
	Incision And Drainage Of Abscess - Intraoral Soft Tissue	No	Yes	Pre-operative x-rays, narrative of medical necessity, photos optional	21	999	1	1		Only one of (D7510 or D7511) per day per tooth. Not payable same DOS as D7140-D7250. Teeth Covered: 1- 32, 51-82, A-T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS. MS. NS. OS. PS. OS. RS. SS. TS
	Incision And Drainage Of Abscess - Intraoral Soft Tissue - Complicated	No	Yes	Pre-operative x-rays, narrative of medical necessity, photos optional	21	999	1	1	Day	Only one of (D7510 or D7511) per day.
D7610	Maxilla - Open Reduction (Teeth Immobilized, If Present)	No	Yes	Pre-operative x-rays, narrative of medical necessity	21	999	1	1	Day	

	1			ENVOLVE DENTAL - ILLIN			<u> </u>			
Code	Description	PA Required	Pre- Payment	Required Documents	Age Min	Age Max	Max Count	Period Length	Period Type	ADDITIONAL NOTES
	Maxilla - Closed Reduction (Teeth Immobilized, If Present)	No	Yes	Pre-operative x-rays, narrative of medical necessity	21	999	1	1	Day	
	Mandible - Open Reduction (Teeth Immobilized, If Present)	No	Yes	Pre-operative x-rays, narrative of medical necessity	21	999	1	1	Day	
	Mandible - Closed Reduction (Teeth Immobilized, If Present)	No	Yes	Pre-operative x-rays, narrative of medical necessity	21	999	1	1	Day	
	Maxilla - Open Reduction	No	Yes	Pre-operative x-rays, narrative of medical necessity	21	999	1	1	Day	
D7720	Maxilla - Closed Reduction	No	Yes	Pre-operative x-rays, narrative of medical necessity	21	999	1	1	Day	
D7730	Mandible - Open Reduction	No	Yes	Pre-operative x-rays, narrative of medical necessity	21	999	1	1	Day	
D7740	Mandible - Closed Reduction	No	Yes	Pre-operative x-rays, narrative of medical necessity	21	999	1	1	Day	
D7810	Open Reduction Of Dislocation	No	Yes	Pre-operative x-rays, narrative of medical necessity	21	999	1	1	Day	
D7820	Closed Reduction Of Dislocation	No	Yes	Pre-operative x-rays, narrative of medical necessity	21	999	1	1	Day	
	Unspecified Oral Surgery Procedure, By Report	Yes	No	Description of procedure, x-rays and narrative of medical necessity.	21	999	1	1	Day	
	Palliative (Emergency) Treatment Of Dental Pain - Minor Procedure	No	No		21	999	4	12	Month	Only one of (D0140 or D9110) per day per provider group. For emergency care only.
D9222	Deep Sedation/General Anesthesia – First 15 Minutes	Yes	No	Clinical documentation supporting necessity	21	999	1	1	Day	Only one of (D9222 or D9239) per day. Permit B required. Not allowed same DOS as D9230, D9239, D9243, or D9248.
D9223	Deep Sedation/General Anesthesia - each subsequent 15 minute increment	No	No		21	999	5	1	Day	Five of (D9223 or D9243) per day. Permit B required. Not allowed on the same date of service with D9230, D9243, or D9248. Valid D9222 must be on file.
D9230	Inhalation Of Nitrous/Analgesia, Anxiolysis	No	No	Supporting documentation must be kept in patient record.	21	999	1	1	Day	Not allowed same DOS as D9222, D9223, D9239, D9243, or D9248
	Intravenous Moderate (conscious) Sedation/Analgesia – First 15 Minutes	Yes	Yes	Clinical documentation supporting necessity	21	999	1	1	Day	Only one of (D9222 or D9239) per day. Permit B required. Not allowed same DOS as D9222, D9223, D9230. or D9248.
	Intravenous Moderate (Conscious) Sedation/Analgesia - Subs 15 Min	No	No		21	999	5	1	Day	Five of (D9223 or D9243) per day. Permit B required. Not allowed same DOS as D9222, D9223, D9230, or D9248. Valid D9239 must be on file.
	Non-Intravenous Moderate (Conscious) Sedation	No	Yes	Clinical documentation supporting necessity	21	999	1	1	Day	Limited to patients with a mental or physical handicap, extremely apprehensive, or extensive treatment is performed in one appointment. D9248 is not allowed on same date of service as D9222, D9223, D9230, D9239, or D9243. Permit A or B is required.
	Consultation - Diagnostic Service Provided By Dentist Or Physician	No	No	Supporting documentation must be kept in patient record.	21	999	1	1	Day	One per day per provider group.
	Therapeutic Parenteral Drug, Single Administration	No	Yes	Description of drugs and parenteral administration	21	999	1	1	Day	Name of drug and amount administered. One per day.
	Other Drugs And/Or Medicaments, By Report	No	Yes	Description of drugs	21	999	1	1	Day	Name of drug and amount administered. One per day.

			-	ENVOLVE DENTAL - ILLIN						
Code	Description	PA Required	Pre- Payment	Required Documents	Age Min	Age Max	Max Count			ADDITIONAL NOTES
D9999	Unspecified Adjunctive Procedure, By	Yes	No	Description of procedure and	21	999	1	Length 1	Type Day	
09999		163	NO		21	333	Ŧ	1	Day	
	Report			narrative of medical necessity. For						
				Outpatient facility usage, include						
				completed health plan Outpatient						
				Facility Authorization form, clinical						
				documentation of necessity.						
			Ŷ	outhCare & Meridian (Foster	Care and S	pecial Need	ds Children)		
D0120	Periodic Oral Evaluation - Established	No	No		0	999	1	6	Month	One per 6 months per location. Not allowed within 6
	Patient									months of D0150.
D0140	Limited Oral Evaluation - Problem	No	No		0	999	1	1	Day	Only one of (D0140 or D9110) per day per provider
	Focused								-	group. For emergency exam only. Not payable if
										performed in conjunction with either D0120, D0150, or
										D0180.
D0150	Comprehensive Oral Evaluation - New Or	No	No		0	999	1	1	Lifetime	One D0150 per provider or location per lifetime.
	Established Patient				-			_		
D0210	Intraoral - Complete Series of	No	No		6	999	1	36	Month	Only one of (D0210, D0277, or D0330) per 36 months
00210	Radiographic Images				Ŭ	555	-	50	Worth	per member.
D0220	Intraoral - Periapical First Radiographic	No	No		0	999	1	1	Day	Only one D0220 per day per per provider or location.
00220		NO	NO		0	333	1	1	-	
	Image									Maximum reimbursement of a single date of service
										for radiographs limited to fee for complete Series
D0330	later and Device ind Each Additional	NLa	NI -		0	000				(D0210).
D0230	Intraoral - Periapical Each Additional Image	No	No		0	999				Maximum reimbursement is up to the fee of D0210.
D0270	Bitewing - Single Radiographic Image	No	No		0	999	1	12	Month	One D0270 per 12 months per provider group.
										Maximum reimbursement of a single date of service
										for radiographs limited to fee for complete series
D0272	Bitewings - Two Radiographic Images	No	No		2	999	1	12	Month	One (D0272 or D0274) per 12 month per provider or
		-	-		_					location. Maximum reimbursement of a single date of
										service for radiographs limited to fee for complete
										series (D0210).
D0274	Bitewings - Four Radiographic Images	No	No		10	999	1	12	Month	One (D0272 or D0274) per 12 month per provider or
00274	bitewings - I our Nadiographie images	NO	NO		10	555	1	12		location. Maximum reimbursement of a single date of
										Ũ
										service for radiographs limited to fee for complete
00277	Vertical Diterrings 7 To 9 Dediagraphic	Na	Na		C	000	1	20	Manth	series (D0210).
D0277	Vertical Bitewings - 7 To 8 Radiographic	No	No		6	999	1	36		Only one of (D0210, D0277, or D0330) per 36 months
	Images									per member. Maximum reimbursement of a single
										date of service for radiographs limited to fee for
										complete series (D0210).
D0330	Panoramic Radiographic Image	No	No		6	999	1	36		Only one of (D0210, D0277, or D0330) per 36 months
										per member. Maximum reimbursement of a single
										date of service for radiographs limited to fee for
										complete series (D0210).
D0601	Caries Risk Assessment And	No	No		0	999	1	12	Month	Only when performed on same date of service as
	Documentation, With A Finding of Low									D0120, D0140, or D0150.
	Risk									
D0602	Caries Risk Assessment And	No	No		0	999	1	12	Month	Only when performed on same date of service as
	Documentation, With A Finding of									D0120, D0140, or D0150.
	Moderate Risk									

Carla	Description	PA	Pre-	ENVOLVE DENTAL - ILLIN				Deuted	Deuted	
Code	Description	Required	Payment	Required Documents	Age Min	Age Max	Max Count	Period Length	Period Type	ADDITIONAL NOTES
	Caries Risk Assessment And Documentation, With A Finding of High Risk	No	No		0	999	1	12	Month	Only when performed on same date of service as D0120, D0140, or D0150.
D0999	Unspecified Diagnostic Procedures, By Report	No	No		0	999	1	1	Day	For FQHC Encounter billing. D0999 must be on first line of claim with additional service listed.
D1110	Prophylaxis - Adult	No	No		21	999	1	6	Month	Only one of (D1110, D1120, D4355) per 6 months.
D1120	Prophylaxis - Child	No	No		0	20	1	6	Month	Only one of (D1110, D1120, D4355) per 6 months.
D1206	Topical Application Of Fluoride Varnish	No	No		0	20	1 or 3 (See Notes)	6 or 12 (See Notes)	Month	Age 0-2: 3 of (D1206 or D1208) per 12 Months in an office setting. Age 3-20: 1 of (D1206 or D1208) per 6 months.
D1208	Topical Application of Fluoride	No	No		0	20	1 or 3 (See Notes)	6 or 12 (See Notes)	Month	Age 0-2: 3 of (D1206 or D1208) per 12 Months in an office setting. Age 3-20: 1 of (D1206 or D1208) per 6 months.
D1351	Sealant - Per Tooth	No	No		5	17	1	24	Month	One per 2 years per tooth regardless of place of service. Occlusal surfaces only. Teeth must be caries free. Sealant will not be covered when placed over restorations. Teeth Covered: 2, 3, 14, 15, 18, 19, 30, 31
D1354	Interim Caries Arresting Medicament Application - Per Tooth	No	No		0	999	6	1	Lifetime	2 applications per tooth per year. Lifetime maximum of six applications per tooth. Providers may treat a maximum of 4 teeth per day, providing participant has no history of any prior or same day billing of CDT category D2000 (Restorative codes) or CDT category D3000 (Endodontic codes) on the same tooth.
D1510	Space Maintainer - Fixed - Unilateral	No	No		0	20	1	1	Lifetime	Only one of (D1510 or D1520) per quadrant per lifetime per provider group. (LL, LR, UL, UR)
D1516	Space Maintainer Fixed Bilateral Maxillary	No	No		0	20	1	1	Lifetime	Only one of (D1516 or D1526) per lifetime per provider group.
D1517	Space Maintainer Fixed Bilateral Mandibular	No	No		0	20	1	1	Lifetime	Only one of (D1517 or D1527) per lifetime per provider group.
D1520	Space Maintainer - Removable - Unilateral	No	No		0	20	1	1	Lifetime	Only one of (D1510 or D1520) per quadrant per lifetime per provider group. (LL, LR, UL, UR)
D1526	Space Maintainer Removable Bilateral Maxillary	No	No		0	20	1	1	Lifetime	Only one of (D1516 or D1526) per lifetime per provider group.
D1527	Space Maintainer Removable Bilateral Mandibular	No	No		0	20	1	1	Lifetime	Only one of (D1517 or D1527) per lifetime per provider group.
	Re-Cement or Re-Bond Bilateral Space Maintainer - Maxillary	No	No		0	20	1	6	Month	Not allowed within 6 months of placement.
	Re-Cement or Re-Bond Bilateral Space Maintainer - Mandibular	No	No		0	20	1	6	Month	Not allowed within 6 months of placement.
	Re-Cement or Re-Bond Unilateral Space Maintainer - Per Quadrant	No	No		0	20	1	6	Month	Not allowed within 6 months of placement.
D2140	Amalgam - One Surface, Primary Or Permanent	No	No		0	999	1	12	Month	Only one (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 12 months per surface. Teeth Covered: 1-32, A-T

Code	Description	PA	Pre-	Required Documents	Age Min		Max Count	Period	Period	ADDITIONAL NOTES
couc		Required	Payment	nequirea bocamento	Age Will	Age max	max count	Length	Type	
D2150	Amalgam - Two Surfaces, Primary Or	No	No		0	999	1	12		Only one (D2140, D2150, D2160, D2161, D2330,
02130	Permanent				ů	555	-		Wienen	D2331, D2332, D2335, D2391, D2392, D2393, D2394)
	i cimanent									per 12 months per surface. Teeth Covered: 1-32, A-T
										per 12 months per surface. Teeth covered. 1-52, A-1
D2160	Amalgam - Three Surfaces, Primary Or	No	No		0	999	1	12	Month	Only one (D2140, D2150, D2160, D2161, D2330,
	Permanent									D2331, D2332, D2335, D2391, D2392, D2393, D2394)
										per 12 months per surface. Teeth Covered: 1-32, A-T
										, , , ,
D2161	Amalgam - Four Or More Surfaces,	No	No		0	999	1	12	Month	One of (D2161, D2335, D2394) per 12 months per
	Primary Or Permanent									tooth. Teeth Covered: 1-32, A-T
D2330	Resin-Based Composite - One Surface,	No	No		0	999	1	12	Month	Only one (D2140, D2150, D2160, D2161, D2330,
	Anterior									D2331, D2332, D2335, D2391, D2392, D2393, D2394)
										per 12 months per surface. Teeth Covered: 6-11, 22-
										27. C-H. M-R
D2331	Resin-Based Composite - Two Surfaces,	No	No		0	999	1	12	Month	Only one (D2140, D2150, D2160, D2161, D2330,
	Anterior									D2331, D2332, D2335, D2391, D2392, D2393, D2394)
										per 12 months per surface. Teeth Covered: 6-11, 22-
										27. C-H. M-R
D2332	Resin-Based Composite - Three Surfaces,	No	No		0	999	1	12	Month	Only one (D2140, D2150, D2160, D2161, D2330,
	Anterior									D2331, D2332, D2335, D2391, D2392, D2393, D2394)
										per 12 months per surface. Teeth Covered: 6-11, 22-
										27. C-H. M-R
D2335	Resin-Based Composite - Four Or More	No	No		0	999	1	12	Month	One of (D2161, D2335, D2394) per 12 months per
	Surfaces Or Involving Incisal Angle									tooth. Teeth Covered: 6-11, 22-27, C-H, M-R
D2391	Resin-Based Composite - One Surface,	No	No		0	999	1	12	Month	Only one (D2140, D2150, D2160, D2161, D2330,
	Posterior									D2331, D2332, D2335, D2391, D2392, D2393, D2394)
										per 12 months per surface. May not be used for PRR.
										Teeth Covered: 1-5, 12-21, 28-32, A, B, I-L, S, T
D 2202	Design Description of the True Conference	N	NL		0	000	4	42	N. A. a. a. t. la	Ontrans (D2140, D2150, D2450, D2451, D2220
D2392	Resin-Based Composite - Two Surfaces,	No	No		0	999	1	12	Month	Only one (D2140, D2150, D2160, D2161, D2330,
	Posterior									D2331, D2332, D2335, D2391, D2392, D2393, D2394)
										per 12 months per surface. Teeth Covered: 1-5, 12-21,
D2202	Resin-Based Composite - Three Surfaces,	No	No		0	999	1	12	Manth	28-32. A. B. I-L. S. T Only one (D2140, D2150, D2160, D2161, D2330,
D2393		INO	NO		0	999	1	12	Month	
	Posterior									D2331, D2332, D2335, D2391, D2392, D2393, D2394)
										per 12 months per surface. Teeth Covered: 1-5, 12-21,
D2204	Resin-Based Composite - Four Or More	No	No		0	999	1	12	Month	28-32. A. B. I-L. S. T One of (D2161, D2335, D2394) per 12 months per
D2594	Surfaces, Posterior	NO	NU		0	999	1	12	wonth	tooth. Teeth Covered: 1-5, 12-21, 28-32, A, B, I-L, S, T
	Surfaces, Posterior									tooth. Teeth covered. 1-5, 12-21, 28-32, А, В, I-L, S, Т
D2542	Onlay - Metallic - Two Surfaces	Yes	No	Pre-operative periapical x-rays and	0	999	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643,
5 20 12	,			optional photos	, , , , , , , , , , , , , , , , , , ,		-			D2644, D2740, D2750, D2751, D2752, D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth
										Covered: 1-32
D2543	Onlay - Metallic - Three Surfaces	Yes	No	Pre-operative periapical x-rays and	0	999	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643,
	,		-	optional photos	-					D2644, D2740, D2750, D2751, D2752, D2753, D2790,
				, , , ,						D2791, D2792, D2931) per 60 months per tooth. Teeth
										Covered: 1-32
L										COVERED 1-32

Cada	Description	PA	Pre-	ENVOLVE DENTAL - ILLIN			<u>· ·</u>	Dawlad	Daniad	ADDITIONAL NOTES
Code	Description	Required	Pre- Payment	Required Documents	Age Min	Age Max	Max Count	Period Length	Period Type	ADDITIONAL NOTES
D2544	Onlay - Metallic - Four Or More Surfaces	Yes	No	Pre-operative periapical x-rays and	0	999	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643,
				optional photos						D2644, D2740, D2750, D2751, D2752,D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth
										Covered: 1-32
D2642	Onlay - Porcelain/Ceramic - Two Surfaces	Yes	No	Pre-operative periapical x-rays and	0	999	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643,
				optional photos						D2644, D2740, D2750, D2751, D2752,D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth
										Covered: 1-32
D2643	Onlay - Porcelain/Ceramic - Three	Yes	No	Pre-operative periapical x-rays and	0	999	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643,
	Surfaces			optional photos						D2644, D2740, D2750, D2751, D2752,D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth
										Covered: 1-32
D2644	Onlay - Porcelain/Ceramic - Four Or More	Yes	No	Pre-operative periapical x-rays and	0	999	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643,
	Surfaces			optional photos						D2644, D2740, D2750, D2751, D2752,D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth
										Covered: 1-32
D2740	Crown - Porcelain/Ceramic	No	Yes	Pre-operative periapical x-rays and	0	999	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643,
				optional photos						D2644, D2740, D2750, D2751, D2752,D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth
										Covered: 1-32
D2750	Crown - Porcelain Fused To High Noble	No	Yes	Pre-operative periapical x-rays and	0	999	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643,
	Metal			optional photos						D2644, D2740, D2750, D2751, D2752,D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth
										Covered: 1-32
D2751	Crown - Porcelain Fused To	No	Yes	Pre-operative periapical x-rays and	0	999	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643,
	Predominantly Base Metal			optional photos						D2644, D2740, D2750, D2751, D2752,D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth
										Covered: 1-32
D2752	Crown - Porcelain Fused To Noble Metal	No	Yes	Pre-operative periapical x-rays and	0	999	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643,
				optional photos						D2644, D2740, D2750, D2751, D2752,D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth
D 2752								60		Covered: 1-32
D2753	Crown - Porcelain Fused to Titanium and	No	Yes	Pre-operative periapical x-rays and	0	999	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643,
	Titanium Alloys			optional photos						D2644, D2740, D2750, D2751, D2752, D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth
D2700	Crewn Full Cest High Neble Metel	Nie	Vaa			000	1	60	Manth	Covered: 1-32 Only one of (D2542, D2543, D2544, D2642, D2643,
D2790	Crown - Full Cast High Noble Metal	No	Yes	Pre-operative periapical x-rays and	0	999	1	60	Month	
				optional photos						D2644, D2740, D2750, D2751, D2752, D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth
D2701	Crown - Full Cast Predominantly Base	No	Yes	Pre-operative periapical x-rays and	0	999	1	60	Month	Covered: 1-32 Only one of (D2542, D2543, D2544, D2642, D2643,
02791	,	NO	res		0	333	1	00	wonth	
	Metal			optional photos						D2644, D2740, D2750, D2751, D2752, D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth
D2702	Crown - Full Cast Noble Metal	No	Yes	Pre-operative periapical x-rays and	0	999	1	60	Month	Covered: 1-32 Only one of (D2542, D2543, D2544, D2642, D2643,
02/92		NU	162		0	555	1	00	wonun	
				optional photos						D2644, D2740, D2750, D2751, D2752, D2753, D2790,
										D2791, D2792, D2931) per 60 months per tooth. Teeth
D2910	Recement Inlay, Onlay, Or Partial	No	No		0	999	1	6	Month	Covered: 1-32 One per tooth per 6 months. Teeth Covered: 1-32
02910		NU	NU		0	555	1	0	wonun	one per tooth per o months. reeth covered. 1-32
	Coverage Restoration						1			

Code	Description	PA Required	Pre- Payment	Required Documents	Age Min	Age Max	Max Count	Period Length	Period Type	ADDITIONAL NOTES
D2915	Recement Cast Or Prefabricated Post And Core	No	No		0	999	1	6	Month	Not allowed within 6 months of D2954 by the same provider or provider group. One per tooth per 6 months. Teeth Covered: 1-32
D2920	Recement Crown	No	No		0	999	1	6	Month	Re-cement within 6 months of initial placement by same provider or provider group will be considered a duplicate service and will not be paid. One per tooth per 6 months. Teeth Covered: 1-32, A-T
D2930	Prefabricated stainless steel crown - primary tooth	No	No		0	20	1	1	Lifetime	Only one of (D2930, D2932, D2933, D2934) per lifetime per tooth. Teeth Covered: A-T
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth	No	Yes	Pre-operative periapical x-rays and optional photos	0	999	1	60	Month	Only one of (D2542, D2543, D2544, D2642, D2643, D2644, D2740, D2750, D2751, D2752, D2753, D2790, D2791, D2792, D2931) per 60 months per tooth. Authorization required for three or more crowns. Teeth Covered: 1-32
D2932	Prefabricated Resin Crown	No	Yes	Pre-operative periapical x-rays and optional photos	0	999	1	1	Lifetime	Only one of (D2930, D2932, D2933, D2934) per lifetime per tooth. Authorization required for three or more crowns. Teeth Covered: 6-11, 22-27, C-H, M-R
D2933	Prefabricated Stainless Steel Crown With Resin Window	No	No		0	20	1	1	Lifetime	Only one of (D2930, D2932, D2933, D2934) per lifetime per tooth. Teeth Covered: C-H, M-R
D2934	Prefabricated Esthetic Coated Stainless Steel Crown - Primary Tooth	No	No		0	20	1	1	Lifetime	Only one of (D2930, D2932, D2933, D2934) per lifetime per tooth. Teeth Covered: A-T
D2940	Protective Restoration	No	No		0	999	1	6	Month	Not allowed with pulpotomy, pulpectomy, or root canal therapy. Not allowed on the same date of service as a restoration. One per tooth per 6 months. Teeth Covered: 1-32. A-T
D2950	Core Buildup, Including Any Pins When Required	No	No		0	999	1	60	Month	Only one of (D2950 or D2954) per tooth per 60 months. Teeth Covered: 1-32
D2951	Pin Retention - Per Tooth, In Addition To Restoration	No	No		0	999	4	1	Day	Not allowed with (D2950, D2954) on same DOS. Teeth Covered: 1-32
D2954	Prefabricated Post And Core In Addition To Crown	No	Yes	Final RCT fill periapical x-ray	0	999	1	60	Month	Only one of (D2950 or D2954) per tooth per 60 months. Teeth Covered: 1-32
D3220	Therapeutic Pulpotomy	No	No		0	20	1	1	Lifetime	Only one of (D3220 or D3230) per tooth per lifetime. Not reimbursable with root canal therapy. Teeth Covered: A-T
D3222	Partial Pulpotomy For Apexogenesis - Permanent Tooth	No	Yes	Pre-operative periapical x-ray, narrative of medical necessity	0	20	1	1	Lifetime	Only one of (D3222, D3351, D3352, D3353) per lifetime per tooth. D3222 covered for trauma cases only. Teeth Covered: 6-11, 22-27
D3230	Pulpal Therapy (Resorbable Filling) - Anterior, Primary Tooth	No	No		0	20	1	1	Lifetime	Only one of (D3220 or D3230) per tooth per lifetime. Teeth Covered: C-H, M-R
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)	No	No		0	999	1	1	Lifetime	One per lifetime per tooth. Teeth Covered: 6-11, 22-27
D3320	Endodontic Therapy, Premolar Tooth (Excluding Final Restoration)	No	No		0	20	1	1		Only one of (D3310, D3320, D3330, D3351, D3352, D3353) per lifetime per tooth. Teeth Covered: 4, 5, 12, 13, 20, 21, 28, 29
D3330	Endodontic Therapy, Molar Tooth (Excluding Final Restoration)	No	No		0	20	1	1	Lifetime	Only one of (D3310, D3320, D3330, D3351, D3352, D3353) per lifetime per tooth. Teeth Covered: 1-3, 14- 19, 30-32

			D	ENVOLVE DENTAL - ILLIN			<u> </u>			
Code	Description	PA Required	Pre- Payment	Required Documents	Age Min	Age Max	Max Count	Period Length	Туре	ADDITIONAL NOTES
D3351	Apexification / Recalcification - Initial Visit	No	Yes	Pre-operative periapical x-ray, narrative of medical necessity	0	20	1	1	Lifetime	Only one of (D3310, D3320, D3330, D3351, D3352, D3353) per lifetime per tooth. Teeth Covered: 1-32
D3352	Apexification / Recalcification - Interim	No	Yes	Pre-operative periapical x-ray, date of initial visit	0	20	1	1	Lifetime	Only one of (D3310, D3320, D3330, D3351, D3352, D3353) per lifetime per tooth. Teeth Covered: 1-32
D3353	Apexification / Recalcification - Final Visit	No	Yes	Pre-operative periapical x-ray, date of initial visit, post-operative x-ray	0	20	1	1	Lifetime	Only one of (D3310, D3320, D3330, D3351, D3352, D3353) per lifetime per tooth. Teeth Covered: 1-32
D3410	Apicoectomy - Anterior	No	Yes	Pre-operative periapical x-ray	0	20	1	1	Lifetime	One per lifetime per tooth. Not payable concurrent with root canal treatment. Teeth Covered: 6-11, 22-27
D4210	Gingivectomy Or Gingivoplasty - Four Or More Contiguous Teeth	No	Yes	Pre-operative x-rays, perio charting, narrative of medical necessity, photos optional	0	999	1	24	Month	Only one of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 months per quadrant per provider group. Minimum of four (4) affected teeth in the quadrant. For removing hyperplastic tissue to reduce pocket depth.
D4211	Gingivectomy Or Gingivoplasty - One To Three Contiguous Teeth	No	Yes	Pre-operative x-rays, perio charting, narrative of medical necessity, photos optional	0	999	1	24	Month	Only one of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 months per quadrant per provider group. One to three teeth affected in quadrant. For removing hyperplastic tissue to reduce pocket depth.
D4240	Gingival Flap Procedure, Including Root Planing - Four Or More Contiguous Teeth	No	Yes	Pre-operative x-rays, perio charting, narrative of medical necessity, photos optional	0	999	1	24	Month	Only one of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 months per quadrant per provider group. Minimum of four (4) affected teeth in the guadrant.
D4241	Gingival Flap Procedure, Including Root Planing - One To Three Contiguous Teeth	No	Yes	Pre-operative x-rays, perio charting, narrative of medical necessity, photos optional	0	999	1	24	Month	Only one of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 months per quadrant per provider group. One to three teeth affected in quadrant.
D4249	Clinical Crown Lengthening - Hard Tissue	Yes	No	Pre-operative x-ray(s), perio charting, narrative of medical necessity	0	999	1	1	Lifetime	One per lifetime per tooth. Not allowed in same quadrant as D4260 or D4261 within a 24 month period.
D4260	Osseous Surgery (Including Flap Entry And Closure) - Four Or More Teeth	No	Yes	Pre-operative x-rays, perio charting, narrative of medical necessity, photos optional	0	999	1	24	Month	Only one of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 months per quadrant per provider group. Minimum of four (4) affected teeth in the quadrant.
D4261	Osseous Surgery (Including Flap Entry And Closure) - One To Three Teeth	No	Yes	Pre-operative x-ray(s), perio charting, narrative of medical necessity. Photos optional.	0	999	1	24	Month	Only one of (D4210, D4211, D4240, D4241, D4260, D4261) per 24 months per quadrant per provider group. One to three teeth affected in quadrant.
D4263	Bone Replacement Graft - First Site In Quadrant	No	Yes	Pre-operative x-rays, perio charting, narrative of medical necessity. photos optional	0	999	1	24	Month	One per quadrant per 24 months. Tooth number required on claim form. Teeth Covered: 1-32
D4264	Bone Replacement Graft - Each Additional Site In Quadrant	No	Yes	Pre-operative x-rays, perio charting, narrative of medical necessity, photos optional	0	999	3	24	Month	Three per quadrant per 24 months. Tooth number required on claim form. Teeth Covered: 1-32
D4270	Pedicle Soft Tissue Graft Procedure	No	Yes	Pre-operative x-rays, perio charting, narrative of medical necessity, photos optional	0	999	1	1	Lifetime	One per tooth per lifetime Teeth Covered: 1-32

Code	Description	PA	Pre-	Required Documents	Age Min		Max Count	Period	Period	ADDITIONAL NOTES
couc		Required	Payment		Age min	ABC MUX		Length	Type	
D4273	Subepithelial Connective Tissue Graft	No	Yes	Pre-operative x-rays, perio	0	999	1	24	Month	One per quadrant per 24 months. Tooth number
	Procedures, Per Tooth			charting, narrative of medical						required on claim form. Teeth Covered: 1-32
				necessity, photos optional						
D4274	Distal Or Proximal Wedge Procedure	No	Yes	Pre-operative x-rays, perio	0	999	1	24	Month	One per quadrant per 24 months. Tooth number
				charting, narrative of medical						required on claim form. Teeth Covered: 1-32
				necessity, photos optional						
D4277	Free Soft Tissue Graft Procedure	No	Yes	Pre-operative x-rays, perio	0	999	1	24	Month	One per quadrant per 24 months. Tooth number
	(Including Donor Site Surgery) First Tooth			charting, narrative of medical						required on claim form. Teeth Covered: 1-32, 51-82
				necessity, photos optional						
D4278	Free Soft Tissue Graft Procedure	No	Yes	Pre-operative x-rays, perio	0	999	3	24	Month	Three per quadrant per 24 months. Tooth number
	(Including Donor Site Surgery) Additional			charting, narrative of medical						required on claim form. Teeth Covered: 1-32, 51-82
	Tooth			necessity, photos optional						
D4320	Provisional Splinting - Intracoronal	No	Yes	Pre-operative x-rays, perio	0	999	1	24	Month	Per arch (LA, UA) - one (D4320 or D4321) per arch per
				charting, narrative of medical						24 months.
				necessity, photos optional						
D4321	Provisional Splinting - Extracoronal	No	Yes	Pre-operative x-rays, perio	0	999	1	24	Month	Per arch (LA, UA) - one (D4320 or D4321) per arch per
				charting, narrative of medical						24 months.
				necessity, photos optional						
D4341	Periodontal Scaling And Root Planing -	No	Yes	Pre-operative x-rays (bitewings	0	999	1	24	Month	Only one of (D4341 or D4342) per 24 months per
	Four Or More Teeth Per Quadrant			and/or panoramic radiograph) and						quadrant. One full mouth service is covered every 24
				periodontal charting						months.
D4342	Periodontal Scaling And Root Planing -	No	Yes	Pre-operative x-rays (bitewings	0	999	1	24	Month	Only one of (D4341 or D4342) per 24 months per
	One To Three Teeth Per Quadrant			and/or panoramic radiograph) and						guadrant. One full mouth service is covered every 24
				periodontal charting						months.
D4355	Full Mouth Debridement	No	No		0	999	1	6	Month	Only one of (D1110 or D4355) per 6 months. Not
										billable with D4341 or D4342. Not eligible for payment
										if performed on the same date or within 12 months of
										a D0120 or D0150. Not allowed for twelve months
										following D1120 or any D4000 series code.
										Tonowing D1120 of any D4000 series code.
D4910	Periodontal Maintenance	No	No		0	999	1	6	Month	Requires history of D4210, D4211, D4240, D4241,
										D4260, D4261, D4341, D4342, or valid 4910. One
										(D1110 or D4910) per 6 months.
D5110	Complete Denture - Maxillary	Yes	No	Full mouth x-rays or panorex, prior	0	999	1	60	Month	Only one of (D5110, D5130, D5211, D5213, D5221,
				date of placement						D5223) per 60 months
D5120	Complete Denture - Mandibular	Yes	No	Full mouth x-rays or panorex, prior	0	999	1	60	Month	Only one of (D5120, D5140, D5212, D5214, D5222,
				date of placement						D5224) per 60 months.
D5130	Immediate Denture - Maxillary	Yes	No	Full mouth x-rays or panorex, prior	0	999	1	1	Lifetime	
				date of placement						
D5140	Immediate Denture - Mandibular	Yes	No	Full mouth x-rays or panorex, prior	0	999	1	1	Lifetime	
				date of placement						
D5211	Maxillary Partial Denture - Resin Base	Yes	No	Full mouth x-rays or panorex, prior	0	20	1	60	Month	Only one of (D5110, D5130, D5211, D5213, D5221,
	,			date of placement	-			-		D5223) per 60 months
D5212	Mandibular Partial Denture - Resin Base	Yes	No	Full mouth x-rays or panorex, prior	0	20	1	60	Month	Only one of (D5120, D5140, D5212, D5214, D5222,
			-	date of placement	-			-		D5224) per 60 months.
D5213	Maxillary Partial Denture - Cast Metal	Yes	No	Full mouth x-rays or panorex, prior	0	20	1	60	Month	Only one of (D5110, D5130, D5211, D5213, D5221,
	Framework With Resin Denture Bases		-	date of placement	-		_			D5223) per 60 months
D5214	Mandibular Partial Denture - Cast Metal	Yes	No	Full mouth x-rays or panorex, prior	0	20	1	60	Month	Only one of (D5120, D5140, D5212, D5214, D5222,
	Framework With Resin Denture Bases			date of placement	-		-			D5224) per 60 months.
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Code	Description	Required	Payment	Required Documents	Age Min	Age Max	Max Count	Period Length	Period Type	ADDITIONAL NOTES
D5221	Immediate Maxillary Partial Denture -	Yes	No	Full mouth x-rays or panorex, prior	0	20	1	60	Month	Only one of (D5110, D5130, D5211, D5213, D5221,
	Resin Base			date of placement						D5223) per 60 months
D5222	Immediate Mandibular Partial Denture -	Yes	No	Full mouth x-rays or panorex, prior	0	20	1	60	Month	Only one of (D5120, D5140, D5212, D5214, D5222,
	Resin Base			date of placement						D5224) per 60 months.
D5223	immediate maxillary partial denture - cast	Yes	No	Full mouth x-rays or panorex, prior	0	20	1	60	Month	Only one of (D5110, D5130, D5211, D5213, D5221,
	metal framework with resin denture ba			date of placement						D5223) per 60 months
D5224	Immediate mandibular partial denture	Yes	No	Full mouth x-rays or panorex, prior	0	20	1	60	Month	Only one of (D5120, D5140, D5212, D5214, D5222,
				date of placement						D5224) per 60 months.
D5511	Repair Broken Complete Denture Base,	No	No		0	999	2	12	Month	Not covered within 6 months of insertion.
	Mandibular									
D5512	Repair Broken Complete Denture Base,	No	No		0	999	2	12	Month	Not covered within 6 months of insertion.
	Maxillary									
D5520	Replace Missing Or Broken Teeth -	No	No		0	999	1	12	Month	One per tooth per 12 months. Teeth Covered: 1-32
	Complete Denture (Each Tooth)									
D5611	Repair Resin Partial Denture Base,	No	No		0	999	2	12	Month	Not covered within 6 months of insertion.
	Mandibular									
D5612	Repair Resin Partial Denture Base,	No	No		0	999	2	12	Month	Not covered within 6 months of insertion.
	Maxillary									
D5621	Repair Cast Partial Framework,	No	No		0	999	2	12	Month	Not covered within 6 months of insertion.
	Mandibular									
D5622	Repair Cast Partial Framework, Maxillary	No	No		0	999	2	12	Month	Not covered within 6 months of insertion.
D5630	Repair Or Replace Broken	No	No		0	999	1	12	Month	One per tooth per 12 months. Teeth Covered: 1-32
	Retentive/Clasping Materials - per tooth									
D5640	Replace Broken Teeth - Per Tooth	No	No		0	999	1	12	Month	One per tooth per 12 months. Teeth Covered: 1-32
D5650	Add Tooth To Existing Partial Denture	No	No		0	999	1	12	Month	One per tooth per 12 months. Teeth Covered: 1-32
D5730	Reline Complete Maxillary Denture	No	Yes	Date of denture placement	0	999	1	24	Month	Only one of (D5730 or D5750) per 24 months. Not
	(direct)									covered within 6 months of placement.
D5731	Reline Complete Mandibular Denture	No	Yes	Date of denture placement	0	999	1	24	Month	Only one of (D5731 or D5751) per 24 months. Not
	(direct)									covered within 6 months of placement.
D5740	Reline Maxillary Partial Denture (direct)	No	Yes	Date of denture placement	0	999	1	24	Month	Only one of (D5740 or D5760) per 24 months. Not
										covered within 6 months of placement.
D5741	Reline Mandibular Partial Denture	No	Yes	Date of denture placement	0	999	1	24	Month	Only one of (D5741 or D5761) per 24 months. Not
	(direct)						-			covered within 6 months of placement.
D5750	Reline Complete Maxillary Denture	No	Yes	Date of denture placement	0	999	1	24	Month	Only one of (D5730 or D5750) per 24 months. Not
	(indirect)						 			covered within 6 months of placement.
D5751	Reline Complete Mandibular Denture	No	Yes	Date of denture placement	0	999	1	24	Month	Only one of (D5731 or D5751) per 24 months. Not
	(indirect)		L				 			covered within 6 months of placement.
D5760	Reline Maxillary Partial Denture (indirect)	No	Yes	Date of denture placement	0	999	1	24	Month	Only one of (D5740 or D5760) per 24 months. Not
										covered within 6 months of placement.
D5761	Reline Mandibular Partial Denture	No	Yes	Date of denture placement	0	999	1	24	Month	Only one of (D5741 or D5761) per 24 months. Not
	(indirect)		L				 			covered within 6 months of placement.
D5999	Unspecified Maxillofacial Prosthesis, By	Yes	No	Narrative of medical necessity	0	999	1	1	Day	One per day.
	Report									
D6210	Pontic - Cast High Noble Metal	No	Yes	Pre-operative x-rays, date of prior	0	20	1	60	Month	Only one of (D6210, D6211, D6212, D6240, D6241,
				placement if applicable						D6242, D6251) per 60 months per tooth. Teeth
										Covered: 6-11. 22-27

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	Description	PA Required	Pre- Payment	Required Documents	Age Min	-	Max Count	Period Length	Period Type	ADDITIONAL NOTES
D6211	Pontic - Cast Predominantly Base Metal	No	Yes	Pre-operative x-rays, date of prior placement if applicable	0	20	1	60	Month	Only one of (D6210, D6211, D6212, D6240, D6241, D6242, D6251) per 60 months per tooth. Teeth Covered: 6-11, 22-27
D6212	Pontic - Cast Noble Metal	No	Yes	Pre-operative x-rays, date of prior placement if applicable	0	20	1	60	Month	Only one of (D6210, D6211, D6212, D6240, D6241, D6242, D6251) per 60 months per tooth. Teeth Covered: 6-11, 22-27
D6240	Pontic - Porcelain Fused To High Noble Metal	No	Yes	Pre-operative x-rays, date of prior placement if applicable	0	20	1	60	Month	Only one of (D6210, D6211, D6212, D6240, D6241, D6242, D6251) per 60 months per tooth. Teeth Covered: 6-11, 22-27
D6241	Pontic - Porcelain Fused To Predominantly Base Metal	No	Yes	Pre-operative x-rays, date of prior placement if applicable	0	20	1	60	Month	Only one of (D6210, D6211, D6212, D6240, D6241, D6242, D6251) per 60 months per tooth. Teeth Covered: 6-11, 22-27
D6242	Pontic - Porcelain Fused To Noble Metal	No	Yes	Pre-operative x-rays, date of prior placement if applicable	0	20	1	60	Month	Only one of (D6210, D6211, D6212, D6240, D6241, D6242, D6251) per 60 months per tooth. Teeth Covered: 6-11, 22-27
D6251	Pontic - Resin With Predominantly Base Metal	No	Yes	Pre-operative x-rays, date of prior placement if applicable	0	20	1	60	Month	Only one of (D6210, D6211, D6212, D6240, D6241, D6242, D6251) per 60 months per tooth. Teeth Covered: 6-11, 22-27
	Retainer Crown - Resin With Predominantly Base Metal	No	Yes	Pre-operative x-rays, date of prior placement if applicable	0	20	1	60	Month	Only one of (D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792) per 60 months per tooth. Teeth Covered: 5-12, 21-28
D6750	Retainer Crown - Porcelain Fused To High Noble Metal	No	Yes	Pre-operative x-rays, date of prior placement if applicable	0	20	1	60	Month	Only one of (D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792) per 60 months per tooth. Teeth Covered: 5-12, 21-28
D6751	Retainer Crown - Porcelain Fused To Predominantly Base Metal	No	Yes	Pre-operative x-rays, date of prior placement if applicable	0	20	1	60	Month	Only one of (D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792) per 60 months per tooth. Teeth Covered: 5-12. 21-28
D6752	Retainer Crown - Porcelain Fused To Noble Metal	No	Yes	Pre-operative x-rays, date of prior placement if applicable	0	20	1	60	Month	Only one of (D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792) per 60 months per tooth. Teeth Covered: 5-12, 21-28
	Retainer Crown - Porcelain Fused to Titanium and Titanium Alloys	No	Yes	Pre-operative x-rays, date of prior placement if applicable	0	20	1	60	Month	Only one of (D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792) per 60 months per tooth. Teeth Covered: 5-12, 21-28
D6790	Retainer Crown - Full Cast High Noble Metal	No	Yes	Pre-operative x-rays, date of prior placement if applicable	0	20	1	60	Month	Only one of (D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792) per 60 months per tooth. Teeth Covered: 5-12, 21-28
D6791	Retainer Crown - Full Cast Predominantly Base Metal	No	Yes	Pre-operative x-rays, date of prior placement if applicable	0	20	1	60	Month	Only one of (D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792) per 60 months per tooth. Teeth Covered: 5-12, 21-28
D6792	Retainer Crown - Full Cast Noble Metal	No	Yes	Pre-operative x-rays, date of prior placement if applicable	0	20	1	60	Month	Only one of (D6721, D6750, D6751, D6752, D6753, D6790, D6791, D6792) per 60 months per tooth. Teeth Covered: 5-12, 21-28
D6930	Recement Fixed Partial Denture	No	No		0	999	1	6	Month	Same provider cannot bill within 6 months of placement. One per abutment per 6 months. Teeth Covered: 1-32
	Unspecified Fixed Prosthodontic Procedure, By Report	Yes	No	Description of procedure and narrative of medical necessity. Preoperative periapical x-rays. Photos optional.	0	999	1	1	Day	Teeth Covered: 1-32

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	Description	PA Required	Pre- Payment	Required Documents	Age Min	Age Max	Max Count	Period Length	Period Type	ADDITIONAL NOTES
	Extraction, Erupted Tooth Or Exposed Root	No	No		0	999	1	1		Includes incidental removal of a cyst or lesion attached to the root(s). Teeth Covered: 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
D7210	Surgical Removal Of Erupted Tooth	No	No		0	999	1	1	Lifetime	Requires elevation of a mucoperiosteal flap and removal of bone and/or section of the tooth and closure. Includes incidental removal of a cyst or lesion attached to the root(s). Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit. Teeth Covered: 1-32, 51-82, A- T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, DS, OS, PS, SS, TS
D7220	Removal Of Impacted Tooth - Soft Tissue	No	Yes	Pre-operative x-rays (excluding bitewings), Narrative of medical necessity	0	999	1	1	Lifetime	Includes incidental removal of a cyst or lesion attached to the root(s). Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit. Teeth Covered: 1-32, 51-82
D7230	Removal Of Impacted Tooth - Partially Bony	No	Yes	Pre-operative x-rays (excluding bitewings), Narrative of medical necessity	0	999	1	1	Lifetime	Includes incidental removal of a cyst or lesion attached to the root(s). Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit. Teeth Covered: 1-32, 51-82
D7240	Removal Of Impacted Tooth - Completely Bony	No	Yes	Pre-operative x-rays (excluding bitewings), Narrative of medical necessity	0	999	1	1	Lifetime	Includes incidental removal of a cyst or lesion attached to the root(s). Prophylactic removal of asymptomatic tooth or tooth free from pathology is not a covered benefit. Teeth Covered: 1-32, 51-82
D7250	Surgical Removal Of Residual Tooth Roots (Cutting Procedure)	No	Yes	Pre-operative x-rays (excluding bitewings)	0	999	1	1	Lifetime	Not payable to provider group who previously billed extraction. Includes incidental removal of a cyst or lesion attached to the root(s). Teeth Covered: 1-32, 51- 82, A-T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, OS, RS, SS, TS
D7270	Reimplantation And/Or Stabilization Of Accidentally Evulsed / Displaced Tooth	No	Yes	Pre-operative x-rays (excluding bitewings), Narrative of medical necessity. Photos optional	0	999	1	1	Lifetime	Once per lifetime per tooth. Teeth Covered: 1-32
D7280	Surgical Access Of An Unerupted Tooth	No	Yes	Pre-operative x-rays. Narrative of medical necessity	0	20	1	1	Lifetime	Only payable if Medicaid orthodontic treatment is approved. Once per lifetime per tooth. Teeth Covered: 1-32
D7283	Placement Of Device To Facilitate Eruption Of Impacted Tooth	No	Yes	Pre-operative x-rays. Narrative of medical necessity	0	20	1	1		Only payable if Medicaid orthodontic treatment is approved. Once per lifetime per tooth. Teeth Covered: 1-32
D7310	Alveoloplasty In Conjunction With Extractions - Four Or More Teeth	No	Yes	Pre-operative x-ray(s) (excluding bitewings).	0	999	1	1	Lifetime	Only one of (D7310 or D7311) per lifetime per quadrant. Minimum of four teeth extracted in quadrant.
D7311	Alveoloplasty In Conjunction With Extractions - One To Three Teeth	No	Yes	Pre-operative x-ray(s) (excluding bitewings).	0	999	1	1	Lifetime	Only one of (D7310 or D7311) per lifetime per quadrant. One to three teeth extracted in quadrant.
D7320	Alveoloplasty Not In Conjunction With Extractions - Four Or More Teeth	No	Yes	Pre-operative x-rays. Narrative of medical necessity	0	999	1	1	Lifetime	Only one of (D7320 or D7321) per lifetime per quadrant. Minimum of four tooth spaces in quadrant.

	ENVOLVE DENTAL - ILLINOIS DENTAL GRID: 01/01/2022									
Code	Description	PA Required	Pre- Payment	Required Documents	Age Min	Age Max	Max Count	Period Length	Period Type	ADDITIONAL NOTES
D7321	Alveoloplasty Not In Conjunction With	No	Yes	Pre-operative x-rays. Narrative of	0	999	1	1	Lifetime	Only one of (D7320 or D7321) per lifetime per
	Extractions - One To Three Teeth			medical necessity						quadrant. One to three tooth spaces in quadrant.
D7450	Removal Of Benign Odontogenic Cyst Or Tumor - Dia Up To 1.25 Cm	No	Yes	Copy of pathology report and pre- operative x-ray.	0	999	1	1	Lifetime	Once per lifetime per tooth.
D7451	Removal Of Benign Odontogenic Cyst Or Tumor - Dia Greater Than 1.25 Cm	No	Yes	Copy of pathology report and pre- operative x-ray.	0	999	1	1	Lifetime	Once per lifetime per tooth.
D7460	Removal Of Benign Nonodontogenic Cyst Or Tumor - Dia Up To 1.25 Cm	No	Yes	Copy of pathology report and pre- operative x-ray.	0	999				
D7461	Removal Of Benign Nonodontogenic Cyst Or Tumor - Dia Greater Than 1.25 Cm	No	Yes	Copy of pathology report and pre- operative x-ray.	0	999				
D7510	Incision And Drainage Of Abscess - Intraoral Soft Tissue	No	Yes	Pre-operative x-rays, narrative of medical necessity, photos optional	0	999	1	1	Day	Only one of (D7510 or D7511) per day per tooth. Not payable same DOS as D7140-D7250. Teeth Covered: 1- 32, 51-82, A-T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS. MS. NS. OS. PS. OS. RS. SS. TS
D7511	Incision And Drainage Of Abscess - Intraoral Soft Tissue - Complicated	No	Yes	Pre-operative x-rays, narrative of medical necessity, photos optional	0	999	1	1	Day	Only one of (D7510 or D7511) per day.
D7610	Maxilla - Open Reduction (Teeth Immobilized, If Present)	No	Yes	Pre-operative x-rays, narrative of medical necessity	0	999	1	1	Day	
D7620	Maxilla - Closed Reduction (Teeth Immobilized, If Present)	No	Yes	Pre-operative x-rays, narrative of medical necessity	0	999	1	1	Day	
D7630	Mandible - Open Reduction (Teeth Immobilized, If Present)	No	Yes	Pre-operative x-rays, narrative of medical necessity	0	999	1	1	Day	
D7640	Mandible - Closed Reduction (Teeth Immobilized, If Present)	No	Yes	Pre-operative x-rays, narrative of medical necessity	0	999	1	1	Day	
D7710	Maxilla - Open Reduction	No	Yes	Pre-operative x-rays, narrative of medical necessity	0	999	1	1	Day	
D7720	Maxilla - Closed Reduction	No	Yes	Pre-operative x-rays, narrative of medical necessity	0	999	1	1	Day	
D7730	Mandible - Open Reduction	No	Yes	Pre-operative x-rays, narrative of medical necessity	0	999	1	1	Day	
D7740	Mandible - Closed Reduction	No	Yes	Pre-operative x-rays, narrative of medical necessity	0	999	1	1	Day	
D7810	Open Reduction Of Dislocation	No	Yes	Pre-operative x-rays, narrative of medical necessity	0	999	1	1	Day	
D7820	Closed Reduction Of Dislocation	No	Yes	Pre-operative x-rays, narrative of medical necessity	0	999	1	1	Day	
D7961	Buccal/Labial Frenectomy (Frenulectomy)	No	Yes	Narrative of medical necessity and photos	0	20	6	1	Lifetime	
D7962	Lingual Frenectomy (Frenulectomy)	No	Yes	Narrative of medical necessity and photos	0	20	1	1	Lifetime	
D7963	Frenuloplasty	No	Yes	Narrative of medical necessity. Photos optional.	0	20	1	1	Lifetime	Only 1 D7963 per arch per lifetime. Indicate arch on claim form.
D7999	Unspecified Oral Surgery Procedure, By Report	Yes	No	Description of procedure, x-rays and narrative of medical necessity.	0	999	1	1	Day	

Code	Description	PA	Pre-	ENVOLVE DENTAL - ILLIN Required Documents	Age Min		Max Count	Period	Period	ADDITIONAL NOTES
Coue	Description	Required	Payment	Required Documents	Age Will	Age Iviax		Length		ADDITIONAL NOTES
	Comprehensive Orthodontic Treatment Of The Adolescent Dentition	Yes	No	Cephalometric X-rays with interpretation, Panoramic radiograph, intra-oral and facial photographs, completed Handicapping Labio-Lingual	0	20	1	1	Lifetime	
D8660	Pre-Orthodontic Treatment Visit	Yes	No	Deviation Index (HLD), Treatment	0	20	1	1	Lifetime	Billed only for approved orthodontic cases. For cases when D8080 is not approved, bill D8999 for the pre-
D8670	Periodic Orthodontic Treatment Visit (As Part Of Contract)	No	No		0	20	11	1	Lifetime	orthodontic treatment visit. Only one D8670 per 45 days. Approved Medicaid orthodontic case must be on file.
D8680	Orthodontic Retention (Removal Of Appliances, Place Retainers)	No	Yes	Photos of finished orthodontic case	0	20	1	1	Lifetime	
D8999	Unspecified Orthodontic Procedure, By Report	No	Yes	Narrative of necessity, documentation of case denial	0	20	1	1	Lifetime	Only one D8999 per lifetime per member. Covered only when D8080 is denied.
	Palliative (Emergency) Treatment Of Dental Pain - Minor Procedure	No	No		0	999	4	12	Month	Only one of (D0140 or D9110) per day per provider group. For emergency care only.
	Deep Sedation/General Anesthesia – First 15 Minutes	Yes	No	Clinical documentation supporting necessity	0	999	1	1	Day	Only one of (D9222 or D9239) per day. Permit B required. Not allowed same DOS as D9230, D9239, D9243. or D9248.
D9223	Deep Sedation/General Anesthesia - each subsequent 15 minute increment	No	No		0	999	5	1	Day	Five of (D9223 or D9243) per day. Permit B required. Not allowed on the same date of service with D9230, D9243, or D9248. Valid D9222 must be on file.
D9230	Inhalation Of Nitrous/Analgesia, Anxiolysis	No	No	Supporting documentation must be kept in patient record.	0	999	1	1	Day	Not allowed same DOS as D9222, D9223, D9239, D9243. or D9248
	Intravenous Moderate (conscious) Sedation/Analgesia – First 15 Minutes	Yes	No	Clinical documentation supporting necessity	0	999	1	1	Day	Only one of (D9222 or D9239) per day. Permit B required. Not allowed same DOS as D9222, D9223, D9230. or D9248.
	Intravenous Moderate (Conscious) Sedation/Analgesia - Subs 15 Min	No	No		0	999	5	1	Day	Five of (D9223 or D9243) per day. Permit B required. Not allowed same DOS as D9222, D9223, D9230, or D9248. Valid D9239 must be on file.
D9248	Non-Intravenous Moderate (Conscious) Sedation	No	Yes	Clinical documentation supporting necessity	0	999	1	1	Day	Limited to patients with a mental or physical handicap, extremely apprehensive, or extensive treatment is performed in one appointment. D9248 is not allowed on same date of service as D9222, D9223, D9230, D9239, or D9243. Permit A or B is required.
	Consultation - Diagnostic Service Provided By Dentist Or Physician	No	No	Supporting documentation must be kept in patient record.	0	999	1	1	Day	One per day per provider group.
	Therapeutic Parenteral Drug, Single Administration	No	Yes	Description of drug and parenteral administration	0	999	1	1	Day	Name of drug and amount administered. One per day.
	Other Drugs And/Or Medicaments, By Report	No	Yes	Description of drugs	0	999	1	1	Day	Name of drug and amount administered. One per day.

Code	Description	PA		Required Documents	Age Min	Age Max	Max Count	Period	Period	ADDITIONAL NOTES
		Required	Payment					Length	Туре	
D9999	Unspecified Adjunctive Procedure, By	Yes	No	Description of procedure and	0	999	1	1	Day	
	Report			narrative of medical necessity. For						
				Outpatient facility usage, include						
				completed health plan Outpatient						
				Facility Authorization form, clinical						
				documentation of necessity.						