Dental Provider Appendix

Molina Healthcare of Wisconsin, Inc. (Molina Healthcare or Molina)

Medicaid
2024

Capitalized words or phrases used in this Provider Manual shall have the meaning set forth in your Agreement with Molina Healthcare. “Molina Healthcare” or “Molina” have the same meaning as “health plan” in your Agreement. The Provider Manual is customarily updated annually but may be updated more frequently as needed. Providers can access the most current Provider Manual at MolinaHealthcare.com.

Last Updated: 01/2024

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Welcome and introduction

Thank you for your participation in the delivery of quality health care services to Molina plan members. We look forward to working with you.

This Provider Manual shall serve as a supplement as referenced thereto and incorporated therein, to the Molina Healthcare of Wisconsin, Inc. Services Agreement. For additional information, please see the Molina Healthcare of Wisconsin Provider Manual.

The information contained within this manual is proprietary. The information is not to be copied in whole or in part; nor is the information to be distributed without the express written consent of Molina.

The Provider Manual is a reference tool that contains eligibility, benefits, contact information and policies/procedures for services that the Molina Healthcare of Wisconsin specifically provides and administers on behalf of Molina members.

Contact information

Provider Services department

The Provider Services department handles telephone and written inquiries from providers regarding address and Tax-ID changes, contracting and training. The department has provider services representatives who serve all of Molina's provider network. Eligibility verifications can be conducted at your convenience via the SKYGEN provider web portal.

Molina Healthcare of Wisconsin
PO Box 242480
Milwaukee, WI 53224

SKYGEN provider web portal

SKYGEN provider phone: (855) 326-5059 (8a.m. to 5 p.m. CT, Monday through Friday)
Fax: (855) 297-3304
TTY: 711
IVR: (888) 999-2404

Members Services department

The Members Services department handles all telephone and written inquiries regarding members claim, benefits, eligibility/identification, pharmacy inquiries, selecting or changing primary care providers (general dentist) and members complaints. Members Services representatives are available 8 a.m. to 5 p.m. Monday through Friday, excluding state holidays. Eligibility verifications can be conducted at your convenience via the SKYGEN provider web portal.

Members Services phone: (888) 999-2404
TTY: 711

Claims department

Molina strongly encourages participating providers to submit claims electronically (via a clearinghouse or the SKYGEN provider web portal) whenever possible.

- SKYGEN provider web portal
- SKYGEN provider web EDI payer ID SKYGN

To verify the status of your claim, please use the SKYGEN provider web portal. Claim questions can be submitted through the chat feature on the SKYGEN provider web portal or by contacting Provider Services.

Claim recovery department

The claim recovery department manages recovery for overpayment and incorrect payment of claims.

Claim recovery correspondence mailing address:

Molina Healthcare of Wisconsin, Inc.
Claim recovery department
PO Box 641
Milwaukee, WI 53201

Phone: (855) 326-5059

Compliance and Fraud Alertline

If you suspect cases of fraud, waste, or abuse, you must report it to Molina. You may do so by contacting the Molina Alertline or submit an electronic complaint using the website listed below. For more information about fraud, waste, and abuse, please see the "Compliance" section of this Provider Manual.

Confidential
Compliance Official
Molina Healthcare, Inc.
200 Oceangate
Suite 100
Long Beach, CA 90802

Phone: (866) 606-3889
Online: MolinaHealthcare.Alertline.com

Credentialing department

The credentialing department verifies all information on the provider application prior to contracting and re-verifies this information every three years, or sooner, depending on Molina's credentialing criteria. The information is then presented to the professional review committee to evaluate a provider's qualifications to participate in the Molina network. Molina offers

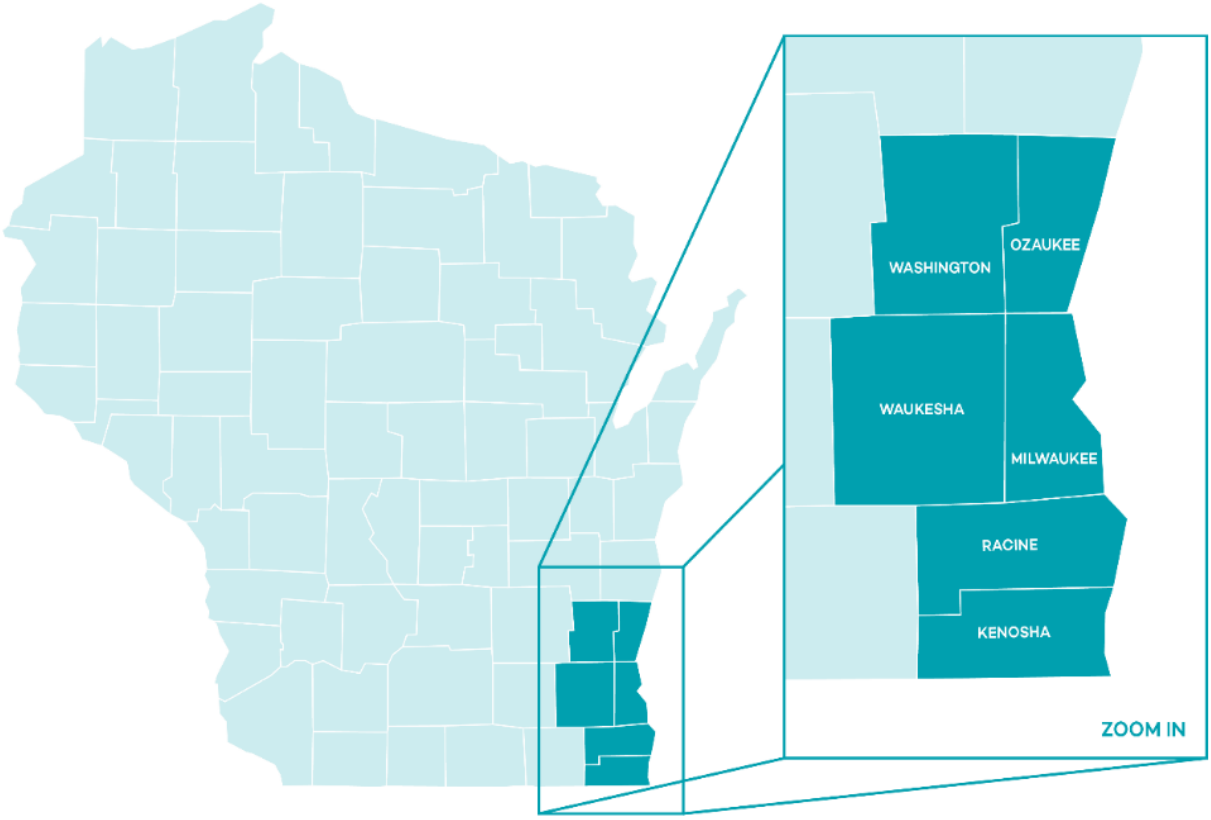
electronic credentialing through SKYGEN's credentialing portal. Register for the credentialing portal at:

providercap.skygenusasystems.com/CAP or CAQH at:
proview.caqh.org/Login/Index?ReturnUrl=%2for

To submit your paper credentialing application/CAQH and required documents, you may send an email with attachments to: MDVSPIM@MolinaHealthcare.com

Phone: (855) 326-5059
Fax: (877) 556-5863

Wisconsin service area



Delegation

For information regarding delegation, please see the Molina Healthcare of Wisconsin Provider Manual.

Provider responsibilities

Electronic claim submission requirement

Molina strongly encourages participating providers to submit claim electronically whenever possible. Electronic claim submission provides significant benefits to the provider such as:

- Promoting HIPAA compliance.
- Helping to reduce operational costs associated with paper claim (printing, postage, etc.).
- Increasing accuracy of data and efficient information delivery.
- Reducing claim processing delays as errors can be corrected and resubmitted electronically.
- Eliminating mailing time and enabling claim to reach Molina faster.

Molina offers the following electronic claim submission options:

- Submit claim directly to Molina via the SKYGEN provider web portal.
- Submit claim to Molina through your EDI clearinghouse using Payer ID SKYGN, refer to our website MolinaHealthcare.com for additional information.

While both options are embraced by Molina, submitting claim via the SKYGEN provider web portal (available to all providers at no cost) offers a number of additional claim processing benefits beyond the possible cost savings achieved from the reduction of high-cost paper claim.

SKYGEN provider web portal claim submission includes the ability to:

- Add attachments to claims
- Submit corrected claims
- Easily and quickly void claims
- Check claim status
- Receive timely notification of a change in status for a particular claim
- Ability to save incomplete/un-submitted claims
- Create/manage claim templates

For more information on EDI claim submission, see the “Claim and compensation” section of this Provider Manual.

Electronic Payment (EFT/ERA) requirement

Participating providers are required to enroll in Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). Providers enrolled in EFT payments will automatically receive ERAs as well. EFT/ERA services give providers the ability to reduce paperwork, utilize searchable ERAs and receive payment and ERA access faster than the paper check and remittance advice (RA) processes. There is no cost to the provider for EFT enrollment, and providers are not required

to be in-network to enroll. Molina uses a vendor to facilitate the HIPAA compliant EFT payment and ERA delivery processes.

Additional instructions on how to register are available under the EDI/ERA/EFT tab on Molina's website at pwp.skygenusasystems.com/PWP/Landing.

SKYGEN provider web portal

Providers and third-party billers can use the no-cost SKYGEN provider web portal to perform many functions online without the need to call or fax Molina. Registration can be performed online and once completed the easy-to-use tool offers the following features:

- Verify members eligibility, covered services and view HEDIS® needed services (gaps).
- Claim
  - Submit dental claims with attached files.
  - Correct/void claims.
  - Add attachments to previously submitted claims.
  - Check claim status.
  - View Electronic Remittance Advice (ERA) and Explanation of Payment (EOP).
  - Create and manage claim templates.
  - Create and submit a claim appeal with attached files.
- Prior authorizations/service requests.
  - Create and submit prior authorization/service requests.
  - Check status of authorization/service requests.
- Download forms and documents.
- Send/receive secure messages to/from Molina.

Members eligibility verification

Possession of a Molina ID card does not guarantee members eligibility or coverage. Providers should verify eligibility of Molina members prior to rendering services. Payment for services rendered is based on enrollment and benefit eligibility. The contractual agreement between providers and Molina places the responsibility for eligibility verification on the provider of services.

Providers who contract with Molina may verify a members' eligibility by checking the following:

- SKYGEN provider web portal
- Molina provider services automated IVR system at (855) 326-5059.

For additional information please refer to the "Eligibility, Enrollment, Disenrollment and Grace Period" section of this Provider Manual.

For additional information regarding provider responsibilities, please see the Molina Healthcare of Wisconsin Provider Manual.

Credentialing and re-credentialing

Credentialing

High-quality dental providers are essential to the success of the Molina Healthcare of Wisconsin's dental network, and even more importantly, essential to the health of members enrolled in its Medicaid benefit plans.

Molina offers electronic credentialing through SKYGEN's credentialing portal. First register on the credentialing portal to complete the electronic credentialing process.

Register at: Providercap.skygenusasystems.com/CAP.
CAQH registration link: Proview.caqh.org/PR/Registration.

(Indicate "global" authorization to allow access to your data profile to all health care organizations)

To submit your paper credentialing application/CAQH and required documents, you may send an email with attachments to: MDVSPIM@MolinaHealthcare.com.

- Copy of the provider's active dental license
- Copy of the provider's DEA or DEA completed waiver
- Certificate of professional/liability/malpractice insurance

Re-credentialing

- Re-credentialing occurs every 36 months
- Providers will receive notification 6 months in advance
- Molina Healthcare follows NCQA guidelines for re-credentialing

All re-credentialing applications must be completely approved before the lapse date to avoid any claim or payment impact.

For additional information, please email MDVSPIM@MolinaHealthcare.com.

For additional information regarding credentialing and re-credentialing, please see the Molina Healthcare of Wisconsin Provider Manual.

Cultural competency and linguistic services

For information regarding cultural competency and linguistic services, please see the Molina Healthcare of Wisconsin Provider Manual.

Compliance

For information on compliance, please see the Molina Healthcare of Wisconsin Provider Manual.

Health Care Services (HCS)

Prior authorizations

Participating providers are encouraged to use the provider portal for prior authorization submissions whenever possible. Instructions for how to submit a prior authorization request are available on the SKYGEN provider web portal. The benefits of submitting your prior authorization request through the SKYGEN provider web portal are:

- Create and submit prior authorization requests.
- Check status of authorization requests.
- Receive notification of change in status of authorization requests.
- Attach medical documentation required for timely medical review and decision making.

For additional information on health care services, please see the Molina Healthcare of Wisconsin Provider Manual.

Quality

Appointment access

All providers who oversee the member's health care are responsible for providing the following appointments to Molina members in the timeframes noted:

Dental appointment

Appointment types	Standard
Emergency/urgent	24 hours/7 days a week
Routine	90 days

Additional information on appointment access standards is available from your local Molina Quality department.

For additional information on quality, please see the Molina Healthcare of Wisconsin Provider Manual.

Members rights & responsibilities

For information regarding members rights and responsibilities, please see the Molina Healthcare of Wisconsin Provider Manual.

Eligibility, enrollment, disenrollment

Eligibility listing for Medicaid programs

Providers who contract with Molina may verify a member's eligibility by checking the following:

- SKYGEN provider web portal
- Molina: (855) 326-5059
- Molina Interactive Voice Response System (IVR): (888) 999-2404

Possession of a Medicaid ID Card does not mean a recipient is eligible for Medicaid services. A provider should verify a recipient's eligibility each time the recipient receives services. The verification sources can be used to verify a recipient's enrollment in a managed care plan.

For additional information on eligibility, enrollment and disenrollment, please see the Molina Healthcare of Wisconsin Provider Manual.

Claims and compensation

Payer ID	**SKYGN**
SKYGEN provider web portal	**SKYGEN provider web portal**
Clean claim timely filling	**90 days from date of service**

Electronic claim submission

Molina requires participating providers to submit claim electronically, including secondary claim. Electronic claim submission provides significant benefits to the provider including:

- Helps to reduce operation costs associated with paper claim (printing, postage, etc.).
- Increases accuracy of data and efficient information delivery.
- Reduces claim delays since errors can be corrected and resubmitted electronically.
- Eliminates mailing time and claim reach Molina faster.

Molina offers the following electronic claim submission options:

- Submit claim directly to Molina via the SKYGEN provider web portal.
- Submit claim to Molina via your regular EDI clearinghouse using payer ID SKYGN.

SKYGEN provider web portal

The SKYGEN provider SKYGEN provider web portal is a no-cost online platform that offers a number of claim processing features:

- Submit 2019 ADA dental claim with attached files.
- Correct/void claims.
- Add attachments to previously submitted claims.
- Check claim status.
- View Electronic Remittance Advice (ERA) and Explanation of Payment (EOP).
- Create and manage claim templates.
- Create and submit a claim appeal with attached files.

Clearinghouse

Molina uses Change Healthcare as its gateway clearinghouse. Change Healthcare has relationships with hundreds of other clearinghouses. Typically, providers can continue to submit claim to their usual clearinghouse.

If you do not have a clearinghouse, Molina offers additional electronic claim submissions options as shown by logging on to the SKYGEN provider web portal.

Molina accepts EDI transactions through our gateway clearinghouse for claim via the 837D. It is important to track your electronic transmissions using your acknowledgement reports. The reports assure claim are received for processing in a timely manner.

When your claim are filed via a clearinghouse:

- You should receive a 999 acknowledgement from your clearinghouse.
- You should also receive 277CA response file with initial status of the claim from your clearinghouse.
- You should refer to the Molina Companion Guide for information on the response format and messages.
- You should contact your local clearinghouse representative if you experience any problems with your transmission.

Paper claim submissions

Participating providers should submit claim electronically. If electronic claim submission is not possible, please submit paper claim to the following address:

Molina Dental Services Claim
PO Box 2136
Milwaukee, WI 53201

When submitting paper claims:

- Paper claim submissions are not considered to be “accepted” until received at the appropriate claim PO Box; claims received outside of the designated PO Box will be returned for appropriate submission.
- Paper claims are required to be submitted on original 2019 ADA Dental Claim Forms.
- Paper claim not submitted on the required forms will be rejected. This includes black and white forms, copied forms, and any altering to include claim with handwriting.
- Claim must be typed with either 10- or 12-point Times New Roman font, using black ink.

Corrected claim process

Providers may correct any necessary field of the 2019 ADA Dental Claim Forms.

Molina strongly encourages participating Providers to submit Corrected Claim electronically via EDI or the SKYGEN provider web portal.

All corrected claims:
- Must be free of handwritten or stamped verbiage (paper claim)
- Must be submitted on a standard 2019 ADA Dental Claim Forms

Corrected claims must be received within the contractual claim submission timely filing limit.

Corrected claim submission options:
- Submit corrected claim directly to Molina via the SKYGEN provider web portal.
- Submit corrected claim to Molina via your regular EDI clearing house.

For additional information on claim and compensation, please see the Molina Healthcare of Wisconsin Provider Manual.

Benefits and covered services

This section provides an overview of the medical benefits and covered services for Molina Medicaid members. Some benefits may have limitations. If there are questions as to whether a service is covered or requires prior authorization, please reference the prior authorization tools located on the Molina website and the SKYGEN provider web provider portal. You may also contact Molina at (855) 326-5059, 8 a.m. to 5 p.m. Monday through Friday, excluding state holidays.

Dental service covered by Molina

Molina covers the services described in the Summary of Benefits documentation. If there are questions as to whether a service is covered or requires prior authorization, please reference the prior authorization tools located on the Molina website and SKYGEN provider web provider portal. You may also contact Molina at (855) 326-5059, 8 a.m. to 5 p.m. Monday through Friday, excluding state holidays.

Code	Description	PA required	Limitation
D0120	Periodic oral evaluation — established patient	No	One per six-month period, per members, per provider. (Also billable for teledentistry.)
D0140	Limited oral evaluation — problem focused	No	One per six months, per members, per provider. (Also billable for teledentistry.)
D0150	Comprehensive oral evaluation — new or established patient	No	One per three years, per members, per provider.
D0160	Detailed and extensive oral evaluation — problem focused, by report	No	One per three years, per members, per provider.
D0170	Re-evaluation — limited, problem focused (established patient; not post-operative visit)	No	Allowed provide Allowable in office or hospital POS (place of service) billable for teledentistry, once per year, per members

Code	Description	PA required	Limitation
D0191	Assessment of a patient	No	One per six months, per members, per provider. Code billable only by dental hygienists. (Also billable for teledentistry.)
D0210	Intraoral — complete series of radiographic image	No	One per three years, per members, per provider. Not billable within six months of other X- rays including D0220, D0230, D0240, D0270, D0272, D0274, and D0330 except in an emergency. Panorex plus bitewings may be billed under D0210.
D0220	Intraoral — periapical first radiographic image	No	One per day. Not payable with D0210 on same DOS or up to six months after.

Code	Description	PA required	Limitation
D0230	Intraoral — periapical each additional radiographic image	No	Up to three per day. Must be billed with D0220. Not payable with D0210 on same DOS or up to six months after.
D0240	Intraoral — occlusal radiographic image	No	Up to two per day. Not payable with D0210 on same DOS.
D0250	Extra-oral — 2D projection radiographic image created using a stationary radiation source, detector	No	Emergency only, one per day.
D0251	Extra-oral posterior dental radiographic image	No	Not payable with D0210, D0270, D0272, D0273, or D0274 on same DOS or up to six months after.
D0270	Bitewing — single radiographic image	No	One per day, up to two per six-month period, per members, per provider. Not payable with D0210, D0272, D0273, or D0274 on same DOS or up to six months after.
D0272	Bitewings — two radiographic images	No	One set of bitewings per six-month period, per members, per provider. Not payable with D0210, D0270, D0273, or D0274 on same DOS or up to six months after.
D0273	Bitewings — three radiographic images	No	One set of bitewings per six-month period, per members, per provider. Not payable with D0210, D0270, D0272, or D0274 on same DOS or up to six months after.
D0274	Bitewings — four radiographic images	No	One set of bitewings per six-month period, per members, per provider. Not payable with D0210, D0270, D0272, or D0273 on same DOS or up to six months after.
D0277	Vertical bitewings — 7 to 8 radiographic images	No	Only for adults aged 21 and older once per 12 months. Not payable with any other bitewings on the same DOS.
D0330	Panoramic radiographic image	No	One per day when another radiograph is insufficient for proper diagnosis. Not payable with D0210, D0270, D0272, D0273, or D0274.
D0340	2D cephalometric radiographic image — acquisition, measurement, and analysis	No	Orthodontia diagnosis only. Allowable for members up to age 20.
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	No	Allowable for members up to age 20. Allowable for orthodontia or oral surgery.
D0372	Intraoral tomosynthesis — comprehensive series of radiographic images	No	One per three years, per members, per provider.
D0373	Intraoral tomosynthesis — bitewing radiographic image	No	One per three years, per members, per provider.
D0374	Intraoral tomosynthesis — periapical radiographic image	No	One per three years, per members, per provider.

Code	Description	PA required	Limitation
D0387	Intraoral tomosynthesis — comprehensive series of radiographic images — image capture only	No	One per day when another radiograph is insufficient for proper diagnosis.
D0388	Intraoral tomosynthesis — bitewing radiographic image — image capture only	No	One per day when another radiograph is insufficient for proper diagnosis.
D0389	Intraoral tomosynthesis — periapical radiographic image — image capture only	No	One per day when another radiograph is insufficient for proper diagnosis.
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report	No	The number of images interpreted should be billed as units.
D0470	Diagnostic casts	No	Orthodontia diagnosis only. Allowed with PA (prior authorization) for members ages 21 and over, at BadgerCare Plus's request (for example, for dentures).
D0486	Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report	No	
D0701	Panoramic radiographic image — image capture only	No	One per day when another radiograph is insufficient for proper diagnosis. Not payable with D0708 or D0709.
D0702	2–D cephalometric radiographic image — image capture only	No	Orthodontia or oral surgery diagnosis only.
D0703	2–D oral/facial photographic image obtained intra orally or extra orally — image capture only	No	Allowable for all dental procedures and all dental specialties, including general dentists.
D0705	Extra-oral posterior dental radiographic image — image capture only	No	Not payable with D0708 or D0709 on same DOS or up to six months after.
D0706	Intraoral — occlusal radiographic image — image capture only	No	Up to two per day. Not payable with D0709 on same DOS.
D0707	Intraoral — perapical radiographic image — image capture only	No	Up to four per DOS. Not payable with D0709 on same DOS or up to six months after.
D0708	Intraoral — bitewing radiographic image — image capture only	No	One set of bitewings per six-month period, per members, per provider. Not payable with D0709 on same DOS or up to six months after.
D0709	Intraoral — complete series of radiographic images — image capture only	No	One per three years, per members, per provider. Not billable within six months of other X-rays including D0701, D0706, D0707, and D0708, except in an emergency. Panorex plus bitewings image capture only may be billed under D0709.
D0999	Unspecified diagnostic procedure, by report	Yes	HealthCheck "Other Services." Use this code for up to two additional oral exams per year with a HealthCheck referral. Allowable for members ages 13–20.

Code	Description	PA required	Limitation
D1110	Prophylaxis — adult	No	One per 12-month period, per members, per provider, for ages 21 and older. One per six-month period, per members, per provider, for ages 13–20. Allowable for members ages 13 or older. Not payable with periodontal scaling and root
D1120	Prophylaxis — child	No	One per six-month period, per members, per provider. Allowable for members up to age 12. Special Circumstances: Up to four per 12-month period, per members, per provider, for permanently disabled members. Retain documentation of disability that impairs ability to maintain oral hygiene. Allowable for Medicaid-enrolled dental hygienists.

Code	Description	PA required	Limitation
D1206	Topical application of fluoride varnish	No	Up to two times per 12-month period for members between 0–20 years of age. Once per 12-month period for members 21 years of age and older. Up to four times per 12-month period for a member who has an oral hygiene-impairing disability. Retain documentation of disability that impairs ability to maintain oral hygiene. Up to four times per 12-month period for a member with a high caries risk. Retain documentation of member's high caries risk. Per CDT, not used for desensitization. Not payable with periodontal scaling and root planning. Allowable for Medicaid-enrolled dental hygienists.
D1208	Topical application of fluoride — excluding varnish	No	Up to two times per 12-month period for members between 0–20 years of age. Once per 12-month period for members 21 years of age and older. Up to four times per 12-month period for a member who has an oral hygiene-impairing

Code	Description	PA required	Limitation
D1351	Sealant — per tooth (20 years of age or younger)	No	Sealants are covered for tooth numbers/letters 2, 3, 4, 5, 12, 13, 14, 15, 18, 19, 20, 21, 28, 29, 30, 31, A, B, I, J, K, L, S, and T. Covered once every 3 years per tooth, per members, per provider. Refer to the Sealants Online Handbook topic for limitations and requirements.
D1351	Sealant — per tooth (21 years of age and older)	No	Sealants are covered for tooth numbers: 2, 3, 14, 15, 18, 19, 30, and 31. Covered once every 3 years per tooth, per members, per provider. Refer to the Sealants Online Handbook topic for limitations and requirements.

Code	Description	PA required	Limitation
D1354	Application of caries arresting medicament application — per tooth	No	Allowable for treatment of asymptomatic and active dental caries only. Allowable once per tooth, per six-month period for a maximum of five teeth per DOS. Allowable a maximum of four applications per tooth, per lifetime, per members. Allowable for all ages. Not allowable on the same DOS as the restoration of that tooth. Reimbursable when rendered by dentists, dental hygienists, and HealthCheck providers only. Frequency limitation may be exceeded for up to four times per tooth per 12-month period for members with high caries risk. Providers are required to retain documentation demonstrating medical necessity. Additional coverage information is available.
D1510	Space maintainer — fixed, unilateral — per quadrant	No	First and second primary molar only (tooth letters A, B, I, J, K, L, S, and T only). Limited to four per DOS; once per year, per tooth. Narrative required to exceed frequency limitation. Allowable for members up to age 20. Requires the appropriate area of the oral cavity code for each requested quadrant. Each quadrant must be indicated on a

Code	Description	PA required	Limitation
			separate detail.
D1516	Space maintainer — fixed — bilateral, maxillary	No	Once per year. Narrative required to exceed frequency limitation. Allowable for members up to age 20.
D1517	Space maintainer — fixed — bilateral, mandibular	No	Once per year. Narrative required to exceed frequency limitation. Allowable for members up to age 20.
D1551	Re-cement or re-bond bilateral space maintainer — maxillary	No	Allowable for members up to age 20.
D1552	Re-cement or re-bond bilateral space maintainer — mandibular	No	Allowable for members up to age 20.
D1553	Re-cement or re-bond unilateral space maintainer — per quadrant	No	Allowable for members up to age 20. Requires the appropriate area of the oral cavity code for each requested quadrant. Each quadrant must be indicated on a separate detail.
D1556	Removal of fixed unilateral space maintainer — per quadrant	No	Requires the appropriate area of the oral cavity code for each requested quadrant. Each quadrant must be indicated on a separate detail.
D1557	Removal of fixed bilateral space maintainer — maxillary	No	
D1558	Removal of fixed bilateral space maintainer — mandibular	No	
D1575	Distal shoe space maintainer — fixed, unilateral — per quadrant	No	Second primary molar only (tooth letters A, J, K, and T only). Limited to four per DOS; once per year, per tooth. Narrative required to exceed frequency limitation. Allowable for members up to age 20.
D2140	Amalgam — one surface, primary or permanent	No	Primary teeth: Once per tooth, per year, per members, per provider1 (tooth letters A–T and AS–TS only). Permanent teeth: Once per tooth, per three years, per provider1 (tooth numbers 1–32 and 51–82 only).
D2150	Amalgam — two surfaces, primary or permanent	No	Primary teeth: Once per tooth, per year, per members, per provider1 (tooth letters A–T and AS–TS only). Permanent teeth: Once per tooth, per three years, per members, per provider1 (tooth numbers 1–32 and 51–82 only).

Code	Description	PA required	Limitation
D2160	Amalgam — three surfaces, primary or permanent	No	Primary teeth: Once per tooth, per year, per provider1 (tooth letters A–T and AS–TS only). Permanent teeth: Once per tooth, per three years, per members, per provider (tooth numbers 1–32 and 51–82 only).
D2161	Amalgam — four or more surfaces, primary or permanent	No	Primary teeth: Once per tooth, per year, per members, per provider1 (tooth letters A–T and AS–TS only). Permanent teeth: Once per tooth, per three years, per members, per provider1 (tooth numbers 1–32 and 51–82 only).
D2330	Resin-based composite — one surface, anterior	No	Primary teeth: Once per tooth, per year, per members, per provider.1 Permanent teeth: Once per tooth, per three years, per members, per provider. Allowed for Class I and Class V only (tooth
D2331	Resin-based composite — two surfaces, anterior	No	Primary teeth: Once per tooth, per year, per members, per provider.1 Permanent teeth: Once per tooth, per three years, per members, per provider. Allowed for Class III only (tooth numbers 6–11, 22–27, C–H, M–R, 56–61, 72–77, CS–HS, and MS–RS only).
D2335	Resin-based composite — four or more surfaces or involving incisal angle (anterior)	No	Primary teeth: Once per tooth, per year, per members, per provider.1 Permanent teeth: Once per tooth, per three years, per members, per provider. Allowed for Class IV only (tooth numbers 6–11, 22–27, C–H, M–R, 56–61, 72–77, CS–HS, and MS–RS only). Must include incisal angle. Four surface resins may be billed under D2332, unless an incisal angle is included.
D2390	Resin-based composite	No	Primary teeth: Once per year, per tooth (tooth letters D–G, DS–GS only). Permanent teeth: Once per five years, per tooth (tooth numbers 6–11, 22–27, 56–61, 72–77 only.) Limitation can be exceeded with narrative for children, and with PA for adults greater than age 20.
D2391	Resin-based composite — one surface, posterior	No	Primary teeth: Once per year, per members, per provider, per tooth1 (tooth letters A, B, I, J, K, L, S, T, AS, BS, IS, JS, KS, LS, SS, and TS only). Permanent teeth: Once per three years, per members, per provider, per tooth1 (tooth numbers 1–5, 12–21, 28–32, 51–55, 62–71, and 78–82 only).

Code	Description	PA required	Limitation
D2392	Resin-based composite — two surfaces, posterior	No	Primary teeth: Once per year, per members, per provider, per tooth (tooth letters A, B, I, J, K, L, S, T, AS, BS, IS, JS, KS, LS, SS, and TS only). Permanent teeth: Once per three years, per members, per provider, per tooth (tooth numbers 1–5, 12–21, 28–32, 51–55, 62–71, and 78–82 only).
D2393	Resin-based composite — three surfaces, posterior	No	Primary teeth: Once per year, per members, per provider, per tooth1 (tooth letters A, B, I, J, K, L, S, T, AS, BS, IS, JS, KS, LS, SS, and TS only). Permanent teeth: Once per three years, per members, per provider, per tooth1 (tooth numbers 1–5, 12–21, 28–32, 51–55, 62–71, and 78–82 only).
D2394	Resin-based composite — four or more surfaces, posterior	No	Primary teeth: Once per year, per members, per provider, per tooth1 (tooth letters A, B, I, J, K, L, S, T, AS, BS, IS, JS, KS, LS, SS, and TS only). Permanent teeth: Once per three years, per members, per provider, per tooth1 (tooth numbers 1–5, 12–21, 28–32, 51–55, 62–71, and 78–82 only).

Code	Description	PA required	Limitation
D2791	Crown — full cast predominantly base metal	No	Once per year, per primary tooth; once per five years, per permanent tooth2 (tooth numbers 1–32, A–T, 51–82, and AS–TS.) Reimbursement is limited to the rate of code D2933. Upgraded crown. No dentist is obligated to complete this type of crown.
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	No	Tooth numbers 1–32, 51–82 only.
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	No	Tooth numbers 1–32, A–T, 51–82, AS–TS.
D2920	Re-cement or re-bond crown	No	Tooth numbers 1–32, A–T, 51–82, AS–TS.
D2928	Prefabricated porcelain/ceramic crown — permanent tooth	No	Once per five years, per tooth (tooth numbers 1–32 and 51–82 only).
D2929	Prefabricated porcelain/ceramic crown — primary tooth	No	Once per year, per tooth (tooth letters A– and AS–TS only).2
D2930	Prefabricated stainless steel crown — primary tooth	No	Once per year, per tooth (tooth letters A–T and AS–TS only).
D2931	Prefabricated stainless steel crown — permanent tooth	No	Once per five years, per tooth (tooth numbers 1–32 and 51–82 only).

Code	Description	PA required	Limitation
D2932	Prefabricated resin crown	No	Primary teeth: Once per year, per tooth (tooth letters D–G and DS–GS only). Permanent teeth: Once per five years, per tooth (tooth numbers 6–11, 22–27, 56–61, and 72–77 only.) Limitation can be exceeded with narrative for children,1 and with PA for adults older than age 20.
D2933	Prefabricated stainless steel crown with resin window	No	Primary teeth: Once per year, per tooth (tooth letters D–G, DS–GS only). Permanent teeth: Once per five years, per tooth (tooth numbers 6–11 and 56–61 only.) Limitation can be exceeded with narrative for children,1 and with PA for adults older than age 20.
D2934	Prefabricated esthetic coated stainless steel crown — primary tooth	No	Once per year, per tooth. Allowable for members up to age 20. Tooth letters D–G and DS–GS only.
D2940	Protective restoration	No	Not allowed with pulpotomies, permanent restorations, or endodontic procedures (tooth numbers 1–32, A–T, 51–82, and AS–TS).
D2951	Pin retention — per tooth, in addition to restoration	No	Once per three years, per tooth (tooth numbers 1–32 and 51–82 only).
D2952	Post and core in addition to crown, indirectly fabricated	No	Once per tooth, per lifetime, per members, per provider. Tooth numbers 2–15, 18–31, 52–65, and 68–81 only. Cannot be billed with D2954.
D2954	Prefabricated post and core in addition to crown	No	Once per tooth, per lifetime, per members, per provider. Tooth numbers 2–15, 18–31, 52–65, and 68–81 only.
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework	No	Tooth numbers 2–15 and 18–31 only.
D2999	Unspecified restorative	Yes	HealthCheck "Other Services." Use this code for single-unit crown. Allowable for members up to age 20.
D3220	Therapeutic pulpotomy (excluding final restoration) — removal of pulp coronal to the dentinocemental junction and application of medicament	No	Once per tooth, per lifetime. Primary teeth only (tooth letters A–T and AS–TS only).
D3221	Pulpal debridement, primary and permanent teeth	No	Allowable for tooth numbers 2–15, 18–31, 52–65, and 68–81 only. For primary teeth, use D3220. Not to be used by provider completing endodontic treatment.
D3222	Partial pulpotomy for apexogenesis — permanent tooth with incomplete root development	No	Allowable for members through age 12.
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	No (see limitations)	Normally for permanent anterior teeth. May be used to bill a single canal on a bicuspid or molar (tooth numbers 2–15, 18–31, 52–65,

Code	Description	PA required	Limitation
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	No (see limitations)	Normally for permanent premolar teeth. May be used to bill two canals on a premolar or molar (tooth numbers 2–5, 12–15, 18–21, 28–31, 52–55, 62–65, 68–71, and 78–81 only, once per tooth, per lifetime). Not allowed with sedative filling. Root canal therapy on four or more teeth requires PA.
D3330	Endodontic therapy, molar tooth (excluding final restoration)	Yes, if age >20	Not covered for third molars. Permanent teeth only (tooth numbers 2, 3, 14, 15, 18, 19, 30, 31, 53, 53, 64, 65, 68, 69, 80, and 81 only, once per tooth, per lifetime). Not allowed with sedative filling. Root canal therapy on four or more teeth requires PA.
D3351	Apexification/recalcification — initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	No	Permanent teeth only (tooth numbers 2–15, 18–31 only). Not allowable with root canal therapy. Allowable for members up to age 20.1
D3352	Apexification/recalcification — interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	No	Limited to one unit per day with a two-unit maximum per lifetime, per tooth. Permanent teeth only (tooth numbers 2–15, 18–31 only). Not allowable with root canal therapy. Allowable for members up to age 20.1
D3353	Apexification/recalcification — final visit (includes completed root canal therapy — apical closure/calcific repair of perforations, root resorption, etc.)	No	Limited to one unit per day with a one-unit maximum per
D3410	Apicoectomy — anterior	No	Permanent anterior teeth only (tooth numbers 6–11, 22–27, 56–61, and 72–77 only). Not payable with root canal therapy on the same DOS. Code does not include retrograde filling (D3430), which may be billed separately.
D3430	Retrograde filling — per root	No	Permanent anterior teeth only (tooth numbers 6–11, 22–27, 56–61, and 72–77 only). Not payable with root canal therapy on the same DOS.
D4210	Gingivectomy or	No	Allowable area of oral cavity codes: 10 (upper right), 20 (upper left), 30 (lower left), and 40 (lower right).
D4211	Gingivectomy or	No	Allowable area of oral cavity codes: 10 (upper right), 20 (upper left), 30 (lower left), and 40 (lower right).
D4341	Periodontal scaling and	No	Allowable area of oral cavity codes: 10 (upper
D4342	Periodontal scaling and	No	Allowable area of oral cavity codes: 10 (upper
D4346	Scaling in presence of	No	Full mouth code.

Code	Description	PA required	Limitation
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	No	Full mouth code. Excess calculus must be evident on an X-ray. One per three years, per members, per provider. Billed on completion date only. May be completed in one long appointment. No other periodontal treatment (D4341, D4342, or D4910) can be authorized immediately after this procedure. Includes tooth polishing. Not payable with prophylaxis. Allowable for members ages 13 and older. Allowable with PA for members ages 0-12. D4355 and D4346 cannot be reported on same day.
D4910	Periodontal maintenance	No	PA may be granted up to three years. Not payable with prophylaxis. Once per year in most cases. Allowable for members ages 13 and older.
D4999	Unspecified periodontal	Yes	HealthCheck "Other Services." Use this code for unspecified surgical procedure with a HealthCheck referral. Allowable for members up to age 20.
D5110	Complete denture—maxillary	Yes	Allowed once per five years.
D5120	Complete denture—mandibular	Yes	Allowed once per five years.
D5211	Maxillary (upper) partial denture; resin base (including any conventional clasps, rests, and teeth)	Yes	Allowed once per five years.
D5212	Mandibular (lower) partial denture; resin base (including any conventional clasps, rests, and teeth)	Yes	Allowed once per five years.
D5213	Maxillary partial denture; cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)	Yes	Allowed once per five years. Reimbursement is limited to reimbursement for D5211. Upgraded partial denture. No dentist is obligated to complete this type of partial.
D5214	Mandibular partial denture; cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)	Yes	Allowed once per five years. Reimbursement is limited to reimbursement for D5212. Upgraded partial denture. No dentist is obligated to complete this type of partial.
D5225	Maxillary partial denture— flexible base (including any clasps, rests, and teeth)	Yes	Allowed once per five years.
D5226	Mandibular partial denture— flexible base (including any clasps, rests, and teeth)	Yes	Allowed once per five years.
D5511	Repair broken complete denture base, mandibular	No	Combined maximum reimbursement limit per six months for repairs.
D5512	Repair broken complete denture base, maxillary	No	Combined maximum reimbursement limit per six months for repairs.
D5520	Replace missing or broken teeth —complete denture (each tooth)	No	Combined maximum reimbursement limit per six months for repairs.
D5611	Repair resin partial denture base, mandibular	No	Combined maximum reimbursement limit per six months for repairs.

Code	Description	PA required	Limitation
D5612	Repair resin partial denture base, maxillary	No	Combined maximum reimbursement limit per six months for repairs.
D5621	Repair cast partial framework, mandibular	No	Combined maximum reimbursement limit per six months for repairs.
D5622	Repair cast partial framework, maxillary	No	Combined maximum reimbursement limit per six months for repairs.
D5630	Repair or replace broken clasp— per tooth	No	Combined maximum reimbursement limit per six months for repairs. Requires an area of oral cavity code (01=Maxillary or 02=Mandibular) in the appropriate element of the claim form. Requires tooth numbers on claim submission.
D5640	Replace broken teeth—per tooth	No	Combined maximum reimbursement limit per six months for repairs. Requires an area of oral cavity code (01=Maxillary or 02=Mandibular) in the appropriate element of the claim form.
D5650	Add tooth to existing partial denture	No	Combined maximum reimbursement limit per six months for repairs. Requires an area of oral cavity code (01=Maxillary or 02=Mandibular) in the appropriate element of the claim form.

Code	Description	PA required	Limitation
D5660	Add clasp to existing partial denture—per tooth	No	Combined maximum reimbursement limit per six months for repairs. Requires an area of oral cavity code (01=Maxillary or 02=Mandibular) in the appropriate element of the claim form. Requires tooth numbers on claim submission.
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	Yes	Combined maximum reimbursement limit per six months for repairs. Requires area of oral cavity code 01=Maxillary in the appropriate element of the claim form.
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	Yes	Combined maximum reimbursement limit per six months for repairs. Requires area of oral cavity code 02=Mandibular in the appropriate element of the claim form.
D5750	Reline complete maxillary denture (laboratory)	No	Allowed once per three years. Retain documentation of medical necessity.
D5751	Reline complete mandibular denture (laboratory)	No	Allowed once per three years. Retain documentation of medical necessity.
D5760	Reline maxillary partial denture (laboratory)	No	Allowed once per three years. Retain documentation of medical necessity.
D5761	Reline mandibular partial denture (laboratory)	No	Allowed once per three years. Retain documentation of medical necessity.
D5932	Obturator prosthesis,	No	Allowed once per six months. Retain documentation of medical necessity.

Code	Description	PA required	Limitation
D5955	Palatal lift prosthesis, definitive	No	Allowed once per six months. Retain documentation of medical necessity.
D5991	Topical medicament	No	
D5999	Unspecified	Yes	For medically necessary removable prosthodontic procedures. Use this code only if a service is provided that is not accurately described by other HCPCS (Healthcare Common Procedure Code
D6211	Pontic—cast predominantly base metal	Yes	Permanent teeth only (tooth numbers 1–32 and 51–82 only).
D6241	Pontic—porcelain fused to predominantly base metal	Yes	Permanent teeth only (tooth numbers 1–32 and 51–82 only).
D6545	Retainer: cast metal for resin bonded fixed prosthesis	Yes	Tooth numbers 1–32, 51–82 only.
D6751	Retainer crown—porcelain fused to predominantly base metal	Yes	Permanent teeth only (tooth numbers 1–32 and 51–82 only).
D6791	Retainer crown—full cast predominantly base metal	Yes	Permanent teeth only (tooth numbers 1–32 and 51–82 only).
D6930	Recement fixed partial denture	No	
D6940	Stress breaker	Yes	Copy of lab bill required.
D6980	Fixed partial denture repair, by report	Yes	Copy of lab bill required.
D6985	Pediatric partial denture, fixed	No	Allowable up to age 12. Retain documentation of medical necessity.

Code	Description	PA required	Limitation
D7111	Extraction, coronal remnants—primary tooth	No	Allowed primary and AS. Not payable same DOS (date of as D7250 for same tooth service)only once per tooth. Teeth only (tooth letters A–T–TS only).
D7140	Extraction, erupted tooth, or exposed root (elevation and/or forceps removal)	No	Allowed only once per tooth (tooth numbers 1–32, A–T, 51–82 and AS– TS). Not payable same DOS as D7250 for same tooth number.
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	No	Allowed only once per tooth. Covered when performing an emergency service or for orthodontia (tooth numbers 1–32, A–T, 51–82 and AS–TS).1
D7220	Removal of impacted tooth—soft tissue	No	Allowed only once per tooth. Covered when performing an emergency service or for orthodontia (tooth numbers 1–32, A–T, 51–82 and AS–TS). Not payable same DOS as D7250 for the same tooth number.
D7230	Removal of impacted tooth—partially bony	No	Allowed only once per tooth. Covered when performing an emergency service or for orthodontia (tooth numbers 1–32, A–T, 51–82 and AS–TS). Not payable same DOS as D7250 for the same tooth number.

Code	Description	PA required	Limitation
D7240	Removal of impacted tooth— completely bony	No	Allowed only once per tooth. Covered when performing an emergency service or for orthodontia (tooth numbers 1–32, A–T, 51–82 and AS–TS). Not payable same DOS as D7250 for the same tooth number.
D7241	Removal of impacted tooth— completely bony, with unusual surgical complications	No	Allowed only once per tooth. Covered when performing an emergency service or for orthodontia (tooth numbers 1–32, A–T, 51–82 and AS–TS). 1 not payable same DOS as D7250 for the same tooth number.
D7250	Removal of residual tooth roots (cutting procedure)	No	Emergency only (tooth numbers 1–32, A–T, 51–82 and AS–TS). Allowed only once per tooth. Not allowed on the same DOS as tooth extraction of same tooth number.
D7260	Oroantral fistula closure	No	Operative report required on claim submission.
D7261	Primary closure of a sinus perforation	No	Operative report required on claim submission.
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed	No	Emergency only (tooth numbers 1–32, C–H, M–R, 51–82, CS–HS, and

Code	Description	PA required	Limitation
D7280	Exposure of an unerupted tooth	No	Not allowed for primary or wisdom teeth (tooth numbers 2–15, 18–31, 52–65, and 68–81 only). Allowable for members ages 0–20. Covered for orthodontic reasons. Clinical notes and an operative report must be retained in the member's medical or dental record.
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	No	Not allowed for primary or wisdom teeth (tooth numbers 2–15, 18–31, 52–65, and 68–81 only). Allowable for members ages 0–20. Covered for orthodontic reasons. Clinical notes and an operative report must be retained in the member's medical or dental record.
D7283	Placement of device to facilitate eruption of impacted tooth	No	Not allowed for primary or wisdom teeth (tooth numbers 2–15, 18–31, 52–65, and 68–81 only). Allowable for members ages 0–20. Covered for orthodontic reasons. Clinical notes and an operative report must be retained in the member's medical or dental record.
D7285	Incisional biopsy of oral tissue— hard (bone, tooth)	No	Once per DOS. Operative report required on claim submission.

Code	Description	PA required	Limitation
D7286	Incisional biopsy of oral tissue—soft	No	Once per DOS. Operative report required on claim submission.
D7287	Exfoliative cytological sample collection	No	Once per DOS. Operative report required on claim submission.
D7288	Brush biopsy—transepithelial	No	Once per DOS. Operative report required on claim submission.
D7310	Alveoloplasty in conjunction with extractions—per quadrant	No	Allowable area of oral cavity codes: 10 (upper right), 20 (upper left), 30
D7311	Alveoloplasty in conjunction with extractions—one to three teeth or tooth spaces, per quadrant	No	Allowable area of oral cavity codes: 10 (upper right), 20 (upper left), 30 (lower left), 40 (lower right). X-ray, treatment notes and treatment plan required.
D7320	Alveoloplasty not in conjunction with extractions—per quadrant	No	Allowable area of oral cavity codes: 10 (upper right), 20 (upper left), 30 (lower left), 40 (lower right). X-ray, treatment notes and treatment plan required.
D7321	Alveoloplasty not in conjunction with extractions—one to three teeth or tooth spaces, per quadrant	No	Allowable area of oral cavity codes: 10 (upper right), 20 (upper left), 30 (lower left), 40 (lower right). X-ray, treatment notes and treatment plan required.
D7410	Excision of benign lesion up to 1.25 cm	No	Once per DOS. Pathology report required.
D7411	Excision of benign lesion greater than 1.25 cm	No	Once per DOS. Pathology report required.
D7412	Excision of benign lesion, complicated	No	Once per DOS. Pathology report required.
D7413	Excision of malignant lesion up to 1.25 cm	No	Once per DOS. Pathology report required.
D7414	Excision of malignant lesion greater than 1.25 cm	No	Once per DOS. Pathology report required.
D7415	Excision of malignant lesion, complicated	No	Once per DOS. Pathology report required.
D7440	Excision of malignant tumor—lesion diameter up to 1.25 cm	No	Once per DOS. Pathology report required.
D7441	Excision of malignant tumor—lesion diameter greater than 1.25 cm	No	Once per DOS. Pathology report required.
D7450	Removal of benign odontogenic cyst or tumor—lesion diameter up to 1.25 cm	No	Once per DOS. Pathology report required.
D7451	Removal of benign odontogenic cyst or tumor—lesion diameter greater than 1.25 cm	No	Once per DOS. Pathology report required.
D7460	Removal of benign nonodontogenic cyst or tumor—lesion diameter up to 1.25 cm	No	Once per DOS. Pathology report required.
D7461	Removal of benign nonodontogenic cyst or tumor—lesion diameter greater than 1.25 cm	No	Once per DOS. Pathology report required.
D7471	Removal of lateral exostosis (maxilla or mandible)	Yes	Oral photographic image or diagnostic cast of arch required for PA.
D7472	Removal of torus palatinus	Yes	Oral photographic image or diagnostic cast of arch required for PA.
D7473	Removal of torus mandibularis	Yes	Oral photographic image or diagnostic cast of arch required for PA.
D7485	Surgical reduction of osseous tuberosity	No	Operative report required on claim submission.

Code	Description	PA required	Limitation
D7490	Radical resection of maxilla or mandible	No	Operative report required on claim.
D7509	Marsupialization of odontogenic cyst	No	
D7510	Incision and drainage of abscess—intraoral soft tissue	No	Operative report required on claim submission. Not to be used for periodontal abscess—use D9110.
D7511	Incision and drainage of abscess—intraoral soft tissue—complicated (includes drainage of multiple fascial spaces)	No	Operative report required on claim submission. Not to be used for periodontal abscess—use D9110.
D7520	Incision and drainage of abscess—extraoral soft tissue	No	Operative report required on claim submission.
D7521	Incision and drainage of abscess—extraoral soft tissue—complicated (includes drainage of multiple fascial spaces)	No	Operative report required on claim submission.
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	No	Not allowed for removal of root fragments and bone spicules. (Use D7250 instead.) Operative report required on claim submission.
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	No	Not allowed for removal of root fragments and bone spicules. (Use D7250 instead.) Operative report required on claim submission.
D7550	Partial ostectomy/sequestrectomy	No	Operative report required on claim submission.

Code	Description	PA required	Limitation
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	No	Operative report required on claim submission.
D7610	Maxilla—open reduction (teeth immobilized, if present)	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required on claim submission.
D7620	Maxilla—closed reduction (teeth immobilized, if present)	No	Operative report required on claim submission.
D7630	Mandible—open reduction (teeth immobilized, if present)	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required on claim submission.
D7640	Mandible—closed reduction (teeth immobilized, if present)	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required on claim submission.
D7650	Malar and/or zygomatic arch—open reduction	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required on claim submission.
D7660	Malar and/or zygomatic arch—closed reduction	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required on claim submission.
D7670	Alveolus—closed reduction, may include stabilization of teeth	No	Operative report required on claim submission.
D7671	Alveolus—open reduction, may include stabilization of teeth	No	Operative report required on claim submission.

Code	Description	PA required	Limitation
D7680	Facial bones—complicated	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required on claim submission.
D7710	Maxilla—open reduction	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required on claim submission.
D7720	Maxilla—closed reduction	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required on claim submission.
D7730	Mandible—open reduction	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required on claim submission.
D7740	Mandible—closed reduction	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required on claim submission.
D7750	Malar and/or zygomatic arch—open reduction	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required on claim submission.
D7760	Malar and/or zygomatic arch—closed reduction	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required on claim submission.
D7770	Alveolus—open reduction	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required on claim submission.
D7771	Alveolus—closed reduction	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required on claim submission.
D7780	Facial bones—complicated	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required on claim submission.
D7810	Open reduction of dislocation	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required on claim submission.
D7820	Closed reduction of dislocation	No	Once per DOS. Operative report required on claim submission.
D7830	Manipulation under anesthesia	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required on claim submission.
D7840	Condylectomy	Yes	Only allowable in hospital, office, or ambulatory surgical center POS. No operative report required on claim submission.
D7850	Surgical discectomy, with/without implant	Yes	Only allowable in hospital, office, or ambulatory surgical center POS. No operative report required on claim submission.
D7860	Arthrotomy	Yes	Only allowable in hospital, office, or ambulatory surgical center POS. No operative report required on claim submission.
D7871	Non-arthroscopic lysis and lavage	Yes	Allowable only once per side (right and left) per three years.
D7899	Unspecified TMJ therapy, by report	Yes	Use this code for billing TMJ (temporomandibular joint)

Code	Description	PA required	Limitation
D7910	Suture of recent small wounds up to 5 cm	No	Emergency only1—operative report required on claim submission. Once per DOS.3
D7911	Complicated suture—up to 5 cm	No	Covered for trauma (emergency) situations only.1 Once per DOS.3
D7912	Complicated suture—greater than 5 cm	No	Covered for trauma (emergency) situations only.1 Once per DOS.3 Operative report required on claim submission.
D7940	Osteoplasty—for orthognathic	Yes	Only allowable in hospital, office, or ambulatory surgical center POS. No operative report required on claim submission. Allowable age less than 21.
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or facial bones—autogeneous or nonautogeneous, by report	Yes	Only allowable in hospital, office, or ambulatory surgical center POS. No operative report required on claim submission.
D7951	Sinus augmentation with bone or bone substitutes	No	

Code	Description	PA required	Limitation
D7961	Buccal/labial frenectomy	No	Covered areas of the oral cavity are 01 and 02. The area of the oral cavity is required to be indicated on the claim. Up to two units of service per area of the oral cavity allowed per DOS. Total of four units per DOS. Note: An image of the obstructed frenum is not required to be submitted with claim but must be available in the medical or dental record. A dentist statement regarding the medical/dental need for the treatment is required to be available upon request. Refer to the Frenulectomy Procedures Online Handbook topic for limitations and requirements.
D7962	Lingual frenectomy (frenulectomy)	No	Covered areas of the oral cavity are 01 and 02. The area of the oral cavity is required to be indicated on the claim. Up to two units of service per area of the oral cavity allowed per DOS. Total of four units per DOS. Note: An image of the obstructed
D7970	Excision of hyperplastic tissue per arch	Yes	No operative report required on claim submission.
D7972	Surgical reduction of fibrous tuberosity	No	Operative report required on claim submission.
D7979	Non-surgical sialolithotomy	No	No operative report required on claim submission.

Code	Description	PA required	Limitation
D7980	Surgical sialolithotomy	No	Only allowable in hospital, office, or ambulatory surgical center POS. Operative report required on claim submission.
D7991	Coronoidectomy	Yes	Only allowable in hospital or ambulatory surgical center POS. No operative report required on claim submission.
D7997	Appliance removal (not by dentist who placed appliance), includes removal of arch bar	No	Operative report required on claim submission.
D7999	Unspecified oral surgery procedure, by report	Yes	For medically necessary unspecified oral surgery procedure, by report. Use this code only if a service is provided that is not accurately described by other HCPCS or CPT procedure codes. Note: For occlusal guard use procedure code D9440.
D8010	Limited orthodontic	Yes	Allowable age less than 21.
D8020	Limited orthodontic	Yes	Allowable age less than 21.
D8030	Limited orthodontic	Yes	Allowable age less than 21.
D8040	Limited orthodontic	Yes	Allowable age less than 21.
D8050	Interceptive orthodontic	Yes	Allowable age less than 21.
D8060	Interceptive orthodontic	Yes	Allowable age less than 21.
D8070	Comprehensive orthodontic	Yes	Allowable age less than 21.
D8080	Comprehensive orthodontic	Yes	Allowable age less than 21.
D8090	Comprehensive orthodontic	Yes	Allowable age less than 21.
D8210	Removable appliance	Yes	Allowable age less than 21.
D8220	Fixed appliance therapy	Yes	Allowable age less than 21.

Code	Description	PA required	Limitation
D8660	Pre-orthodontic treatment	No	Allowable age less than 21. Includes exam, diagnostic tests, and consult.
D8670	Periodic orthodontic	Yes	Allowable age less than 21. Used for monthly adjustments.
D8680	Orthodontic retention	Yes	Allowable age less than 21.
D8695	Removal of fixed orthodontic appliances for reasons other than completion of treatment	Yes	Covered for members ages 0 to 20 years. Allowable once per members per provider. Coverage is considered on a case-by-case basis with a review of the following requirements: Supporting documentation explaining the rationale for terminating existing treatment, including, but not limited to, clinical or members considerations. A signed statement showing the members, and/or member's authorized representative, approval of the service.
D8698	Re-cement or re-bond fixed retainer—maxillary	No	
D8699	Re-cement or re-bond fixed retainer—mandibular	No	
D8703	Replacement of lost or broken retainer—maxillary	No	Covered for members ages 0 to 20 years.
D8704	Replacement of lost or broken retainer—mandibular	No	Covered for members ages 0 to 20 years.

Code	Description	PA required	Limitation
D9110	Palliative (emergency) treatment of dental pain — minor procedure	No	Not payable immediately before or after surgery. Emergency only. Limit of $62.50 reimbursement per DOS for all emergency procedures done on a
D9222	Deep sedation/general	Yes	PA not required in the following
D9223	Deep sedation/general	Yes	PA not required in the following
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis (20 years of age or younger)	Yes	Allowable for children (ages 0–20) without PA, when performed by an oral surgeon or pediatric dentist. All other providers require PA. Not payable with D9223, D9243, or D9248. Billable as one unit per DOS. Refer to the Inhalation of Nitrous Oxide Online Handbook topic for limitations and requirements.
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis (21 years of age and older)	Yes	Allowable for members 21 and older with PA when an emergency extraction is needed or the members has been diagnosed with a permanent physical, developmental, or intellectual disability, or has a documented medical condition that impairs their ability to maintain oral hygiene or anxiety disorder. Not payable with D9223, D9243, or D9248. Billable as one unit per DOS. Refer to the Inhalation of Nitrous Oxide
			Online Handbook topic for limitations and requirements.
D9239	Intravenous moderate	Yes	PA not required in the following
D9243	Intravenous moderate	Yes	PA not required in the following
D9248	Non-intravenous conscious	Yes	PA not required for children (ages 0–20), when performed by an oral surgeon or pediatric dentist. Not analgesia. Not payable with D9223, D9230, or D9243. Not inhalation of nitrous oxide.
D9410	House/extended care facility call	No	Reimbursed for professional visits to nursing homes and skilled nursing facilities. Only reimbursed for claim that indicate POS code 31 (skilled nursing facility) or 32 (nursing home). Service is limited to once every 333 days per members, per provider. Service must be performed by a Medicaid-enrolled dentist.

Code	Description	PA required	Limitation
D9420	Hospital or ambulatory surgical center call	No	Up to two visits per stay. Only allowable in hospital and ASC POS.
D9610	Therapeutic parenteral drug, single administration	No	
D9612	Therapeutic parenteral	No	
D9613	Infiltration of sustained release therapeutic drug — per quadrant	No	
D9910	Application of desensitizing medicament	No	Tooth numbers 1–32, A–T, 51–82, and AS– TS. Limit of $62.50 reimbursement per DOS for all emergency procedures done on a single DOS. Narrative required to override limitations. Not payable immediately before or after surgery, or periodontal procedures (D4210, D4211, D4341, D4342, D4355, D4910). Cannot be billed for routine fluoride
D9944	Occlusal guard — hard appliance, full arch (20 years of age or younger)	Yes	Allowable with PA for members 20 years of age and younger. Coverage is limited to one occlusal guard type per year. Refer to the Occlusal Guards Online Handbook topic for limitations and requirements.

Code	Description	PA required	Limitation
D9944	Occlusal guard — hard appliance, full arch (21 years of age and older)	Yes	Allowable with PA for members 21 years of age and older who have been medically diagnosed with a permanent physical, developmental, or intellectual disability, or have a documented medical condition that impairs their ability to maintain oral hygiene. Coverage is limited to one occlusal guard type per year. Refer to the Occlusal Guards Online Handbook topic for limitations and requirements.
D9945	Occlusal guard — soft appliance, full arch (20 years of age or younger)	Yes	Allowable with PA for members 20 years of age or younger. Coverage is limited to one occlusal guard type per year. Refer to the Occlusal Guards Online handbook topic for limitations and requirements.
D9945	Occlusal guard — soft appliance, full arch (21 years of age and older)	Yes	Allowable with PA for members 21 years of age and older who have been medically diagnosed with a permanent physical, developmental, or intellectual disability, or have a documented medical condition that impairs their ability to maintain oral hygiene. Coverage is limited to one occlusal guard type per year. Refer to the Occlusal Guards Online Handbook topic for

Code	Description	PA required	Limitation
			limitations and requirements.
D9946	Occlusal guard — hard appliance, partial arch (20 years of age or younger)	Yes	Allowable with PA for members 20 years of age or younger. Coverage is limited to one occlusal guard
D9946	Occlusal guard — hard appliance, partial arch (21 years of age and older)	Yes	Allowable with PA for members 21 years of age and older who have been medically diagnosed with a permanent physical, developmental, or intellectual disability or have a documented medical condition that impairs their ability to maintain oral hygiene. Coverage is limited to one occlusal guard type per year. Refer to the Occlusal Guards Online Handbook topic for limitations and requirements.

Code	Description	PA required	Limitation
D9995	Teledentistry synchronous;	No	Refer to the Teledentistry Policy topic for limitations and requirement.
D9999	Unspecified adjunctive	Yes	HealthCheck "Other Services." Use this code for unspecified non-surgical procedures with a HealthCheck referral.
E0486	Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, custom fabricated, includes fitting and adjustment	Yes	Allowable with PA for members 20 years of age or younger when criteria are met. Coverage limited to one oral device/appliance per year. HealthCheck screening within the last 365 days is required. Refer to the Oral Devices/Appliances Online Handbook topic for limitations and requirements.

For additional information on benefits and covered services, please see the Molina Healthcare of Wisconsin Provider Manual.

Grievance and appeals process

Provider appeals

Providers disputing a claim previously adjudicated must request such action within 90 calendar days of Molina's original remittance advice date. Regardless of type of denial/dispute (service denied, incorrect payment, administrative, etc.); all claim disputes must be submitted on the Molina Appeals Form found on the Molina provider website and the provider portal. *The form must be filled out completely to be processed*. Additionally, the item(s) being resubmitted should be clearly marked as an appeal and must include the following:

- Provider's name
- Date of service
- Date of billing
- Date of payment and/or nonpayment
- Member's name
- Claim number- services cannot be appealed without a claim on file
- BadgerCare Plus ID number
- The reason(s) the claim merits reconsideration. If the appeal relates to medical emergency, medical necessity and/or prior authorization, medical records or substantiating documentation must accompany your request for reconsideration which must include but is not limited to the following: Provider notes.
- The claim number clearly marked on all supporting documents

Appeals must be submitted via the provider portal (preferred method), secure email or USPS.

Note: Corrected claims are considered new claim and are not considered an appeal or dispute and will be rejected.

Provider appeals:

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

SKYGEN provider web portal

All BadgerCare Plus providers must first appeal to the HMO and then to the Department of Health Services (DHS) if they disagree with the HMO's payment or nonpayment of a claim. Appeals to the Department of Health Services (DHS) must be submitted through the provider appeals portal at wi-appeals.entellitrak.com/.

Providers are required to submit appeals with legible copies of all supporting documentation as outlined in the “Appeals to BadgerCare Plus HMOs and Medicaid SSI HMOs” (#384) and “Appeals to ForwardHealth” (#385) topics of the ForwardHealth Online Handbook.

The decision to overturn an HMO's denial must be clearly supported by the documentation the provider submits. Submitting incomplete or insufficient documentation may lead to ForwardHealth upholding the HMO’s denial. Appeals to DHS must be received within 60 calendar days of Molina’s final decision or in the case of no response, within 60 calendar days from the 45-calendar day timeline allotted to Molina to respond. DHS has 45 days from the date of receipt to inform you and Molina of the final decision.

BadgerCare Plus and Medicaid SSI
Managed Care Unit – Provider Appeal
PO Box 6470
Madison, WI 537I6-0470

Fax number: (608) 224-6318

Members appeals

Standard appeals may be received orally or in writing within 60 calendar days following the date of the notice of action. An appeal may be filed by a member, member's authorized representative or a provider. Oral appeals must be followed by a written request, except when a provider requests an expedited appeal.

The members or authorized representative must be a party to all appeals. If members are being represented in their appeal, members must provide their written, signed consent for someone to act on their behalf.

Written requests should be submitted to:

Members Appeals
Molina Healthcare of Wisconsin, Inc.
Attn: Grievance Coordinator
PO Box 242480
Milwaukee, WI 53224

Fax: (844) 251-1445
Email: WIMembersAppeals@MolinaHealthcare.com

Written acknowledgement of an appeal received is sent to the members or his/her authorized representative within 10 business days of receipt. A resolution letter is sent within 30 calendar days of initially receiving the appeal unless the members are notified in writing of the need for an
additional 14-day extension, along with the reason for the delay. The members are notified of his/her right to request a hearing at Molina Healthcare and that the members may attend or send representation for him/her to the hearing. The members are also notified that interpretation would be provided free of charge should he/she decide to exercise this option.

In the case of expedited appeals, a determination is made within 72 hours of appeal request and the members are notified within two business days.

If the appealing party is dissatisfied with the outcome of an appeal, A State Fair Hearing may be requested.

For additional information regarding grievance and appeals, please see the Molina Healthcare of Wisconsin Provider Manual.

Risk adjustment management program

For additional information on the risk adjustment management program, please see the Molina Healthcare of Wisconsin Provider Manual.