PROVIDER MANUAL
UTAH GOVERNMENT PROGRAMS

This Manual and the information contained within are confidential and to be used only by Premier Access contracted oral health professionals. Any use, dissemination, distribution or copying of the information contained herein for any non-intended purpose without prior written authorization from Premier Access is prohibited.

Premier Access©
Post Office Box 659010
Sacramento, California 95865-9010
www.premierlife.com

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GENERAL INFORMATION

INTRODUCTION

Thank you for your participation in the Premier Access programs. This Provider Manual applies to operations for applicable programs and products underwritten by Premier Access Insurance Company. For the purpose of describing the Provider Manual, Premier Access Insurance Company shall be referred to as **"Premier Access."**

This Provider Manual is a compilation of all the information necessary to successfully manage the treatment and administration for members of Premier Access' Utah Government Programs.

Any changes to the guidelines in this Manual will be communicated 30 days prior to implementation by Premier Access.

It is important to Premier Access that we build strong relationships with our contracted dental care professionals. It is also important to Premier Access that our contracted dental care professionals build solid doctor-patient relationships with our Members. This manual provides you with many of the tools that will help you accomplish both goals.

We are here to support you in both your doctor-patient relations and your administrative needs. If you have questions, concerns or suggestions, please contact us.

Forms and this manual can also be found on our website at: www.premierlife.com

CONTACT INFORMATION

Name of Contact	Toll-Free	Website/Email
24-Hour Emergency	(800) 870-4290	
Dental Consultant **(Dentist use)**	(888) 634-6074 Ext. 6011	DentalConsultant@premierlife.com
Emergency Fax Referral	(877) 648-7741	
Forms (to order)	(888) 620-2447	Info@premierlife.com
Grievances	(800) 448-4733	Grievance@premierlife.com
Provider Services	(888) 620-2447	ProviderServices@premierlife.com
Referrals/Claims	(877) 541-5415	

CUSTOMER SERVICE

Utah Children's Health Insurance Program (CHIP)	(877) 854-4242
Utah Medicaid	(877) 541-5415

Monday through Friday from 8:00 am to 5:00 pm (Mountain Time)
Website: www.premierlife.com
Email: MemberServices@premierlife.com

For patient eligibility, patient benefit schedules, patient evidence of coverage and additional forms, such as: Grievance, Encounter, and Referral forms, please visit our website at: **www.premierlife.com**

CONTACT ADDRESSES

TO WRITE REGARDING:	ADDRESS:
GRIEVANCES	PREMIER ACCESS GRIEVANCE DEPARTMENT P.O. BOX 255039 SACRAMENTO CA 95865-5039
REFERRALS	PREMIER ACCESS CLAIMS DEPT/ REFERRAL DEPT P.O. BOX 659032 SACRAMENTO CA 95865-9032
CLAIMS	PREMIER ACCESS CLAIMS DEPARTMENT P.O. BOX 659010 SACRAMENTO CA 95865-9010

DENTAL HOME

As defined by the American Academy of Pediatric Dentistry (AAPD):

The Dental home is an ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. Establishment of a dental home begins no later than one year of age and includes referral to dental specialists when appropriate.

The AAPD recommends that by the age of one year, parents or caregivers establish a dental home that would provide a complete oral examination, risk assessment, prevention services and comprehensive care appropriate to the needs of the child.

Children who have a dental home are more likely to receive appropriate preventive and routine oral health care. Referral by the primary care physician or health provider has been recommended, based on risk assessment, as early as 6 months of age, 6 months after the first tooth erupts, and no later than 12 months of age. Furthermore, subsequent periodicity of reappointment is based upon risk assessment. This provides time-critical opportunities to implement preventive health practices and reduce the child's risk of preventable dental/oral disease.

Premier Access supports the AAPD in its efforts and recommends that providers follow the AAPD guidelines.

AAPD Policies and guidelines can be found online at:

http://www.aapd.org/media/Policies_Guidelines/P_DentalHome.pdf

HEALTH INSURANCE PORTABILITY ACCOUNTABILITY AND AVAILABILITY ACT (HIPAA)

The Health Insurance Portability Accountability and Availability Act, is a Federal Law designed to provide privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other health care providers. Developed by the Department of Health and Human Services, these standards provide Patients with access to their medical records and more control over how their personal health information is used and disclosed. They represent a uniform, federal floor of privacy protections for consumers across the country.

We are committed to complying with the requirements and standards of the Health Insurance Portability Accountability and Availability Act (HIPAA).

Premier Access has a Privacy Officer to develop, implement, maintain and provide oversight of our HIPAA Compliance Program as well as assist with the education and training of our employees on the requirements and implications of HIPAA.

Should you have any questions regarding HIPAA and/or Premier Access compliance, please contact the Privacy Officer via email at: PrivacyOfficer@premierlife.com or via telephone at 916-920-2500.

ANTI-FRAUD PROGRAM

Premier Access provides information to all employees, contractors, subcontractors and agents about the federal and State False Claims Acts; remedies available under these acts; and how employees and others can use them; and about whistleblower protections for individuals who report suspected false claims.
Possible False Claims Act violations should be reported to the Premier Access Fraud Officer for further investigation. The Fraud Officer can be contacted by phone at (916) 920-2500 or by mail at the following address: Anti-Fraud Officer, Premier Access, P.O. Box 659010, Sacramento, CA 95865-9010.

You may report possible violations directly to the Federal Department of Health and Human Services (DHHS). The Office of the Inspector General also maintains a hotline, which offers a confidential means for reporting vital information. The Hotline can be contacted:

Phone: 1-800-HHS-TIPS Fax: 1-800-223-2164
Email: HHSTips@oig.hhs.gov
Mail: Office of the Inspector General HHS TIPS Hotline
P.O. Box 23489 Washington, DC 20026

MEMBER'S RIGHTS AND RESPONSIBILITIES

To build a strong doctor-patient relationship, there are responsibilities that must be met by both doctor and patient; and a member has certain rights that must also be recognized.

A Member has the right to …

- Be treated with respect and dignity
- Have access to, and where legally appropriate, receive copies of, amend or correct their dental record
- Have dental records kept confidential
- Obtain access to care within a reasonable amount of time
- Choose a Primary Care Dentist from the applicable program Provider Directory
- Get services from any available provider, include non-network providers, in an emergency.
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand
- Participate in candid discussions and decisions about dental care needs, including appropriate or dentally necessary treatment options for the condition(s) regardless of cost or regardless of whether the treatment is covered by Premier Access
- Receive member materials translated into a preferred language or alternative formats
- Request an interpreter at no cost
- Use interpreters who are not family members or friends
- File grievances through Premier Access and obtain assistance from Premier Access in filing such grievances
- Be free of any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Have access to Premier's health education programs and outreach services in order to improve dental health
- Request a state fair hearing, including information on the circumstances under which an expedited fair hearing is possible
- Freedom to exercise these rights without adversely affecting how members are treated by Premier Access, providers or the program

A Member has the responsibility to …

- Treat Dentists and their office staff with respect and courtesy
- Present their plan-specific identification card at each appointment
- Notify the Dentist at least 24 hours in advance if they cannot keep an appointment
- Understand how the Premier Access Plan operates and what benefits are available to them
- Cooperate with the Dentist and follow the prescribed course of treatment
- Ask questions about any dental condition and make certain that the explanations and instructions are understandable
- Make correct co-payments as determined by the Plan benefits

PROVIDER'S RESPONSIBILITIES

A Primary Care Dentist must…

- Provide or coordinate all dental care for the enrollee in accordance with generally accepted dental practices and standards prevailing in the professional community at the time of treatment
- Provide 24-hour emergency service, seven days a week with information to obtain urgent or emergency care after regular business hours (Arrange for coverage by another Provider when necessary (vacation, illness, etc.)
- Reschedule any appointments promptly in a manner that is appropriate for the Enrollee's health care needs, ensuring continuity of care consistent with good professional practice
- Not differentiate by days or time of day when professional services are rendered to Members
- Obtain prior authorization, when required
- Comply with accessibility parameters as set by the Plan
- Ensure that dental records are protected and confidential in accordance with all Federal and State laws
- Complete and return quarterly Provider Survey within 10 days of mailing
- Maintain dental records for five years from the date of service and make dental records available during regular business hours
- Provide documentation within 5 days of receiving an acknowledgment letter from the Plan regarding a Patient complaint
- Provide a complete copy of dental records including x-rays upon Member and/or Plan request
- Provide updated re-credential information upon request by the Plan
- Provide monthly encounter information for all covered services, if applicable
- Participate in Quality Management Program and cooperate with all QMP activities, recommendations and corrective actions and adhering to all applicable program requirements
- Not use aggressive sales techniques to sell optional (non-covered) services or inadequately document the consent of the Member for accepting optional services
- Inform the Members of availability of free language assistance services for any linguistic need by referring them to the Plan's Member Services Department at the number listed in the Contact Information section of this manual, and on the member's Premier Access Identification Card.

These are a few of the responsibilities of a Premier Access contracted Dentist. There may be more information you need to meet your responsibilities included in this Manual. If you have any questions, please contact Provider Services at (888) 620-2447.

SPECIALIST'S RESPONSIBILITIES

A Dental Care Specialist must…

- Provide specialty care in a timely manner to Members when the applicable prior authorization has been obtained
- Work closely with Primary Care Dentists (PCDs) to enhance continuity of Patient care
- Send a notification to the PCD upon completion of treatment
- Submit a narrative of findings to the Plan
- Participate in Quality Management Program and cooperate with all QMP activities, recommendations and corrective actions and adhering to all applicable program requirements
- Maintain dental records for five years from the date of service and make dental records available during regular business hours
- Ensure that dental records are protected and confidential in accordance with all Federal and State laws
- Inform the Members of availability of free language assistance services for any linguistic need by referring them to Premier's Member Services Department at the number listed in the Contact Information section of this manual, and also listed in the member's Premier Access Identification Card.
- Provide documentation within 5 days of receiving an acknowledgement letter from Premier Access regarding a Patient complaint
- Provide a complete copy of dental records including x-rays upon request from the Member or from Premier Access
- Provide 24-hour emergency service, seven days a week
- Reschedule any appointments promptly in a manner that is appropriate for the Enrollee's health care needs, ensuring continuity of care consistent with good professional practice
- Not differentiate by days or time of day when professional services are rendered to Members

These are a few of the responsibilities of a Premier Access contracted Specialist. There may be more information you need to meet your responsibilities included in this Manual. If you have any questions, please contact Provider Services at (888) 620-2447.

QUALITY MANAGEMENT PROGRAM

The Quality Management Program (QMP) is designed to ensure that Premier Access provides the highest quality dental care to all Members, with an emphasis on dental disease prevention and the provision of exceptional customer service to Members.

Premier Access maintains an extensive Quality Management Program. The QMP provides specific policies relating to Member and Provider grievances/appeals, monitoring of Provider offices/patients and monitoring of dental care and services provided to our Members.

Premier Access' contracted Dental Providers are expected to participate in the quality management process by cooperating with all QMP activities, recommendations and corrective actions. In addition, dental Providers are encouraged to be actively involved with establishing dental policies, standards, practice guidelines and review criteria.

Quality Management Committee

The Board of Directors has ultimate oversight responsibility for monitoring and ensuring the delivery of the highest quality, cost effective dental care and services to our members. The Board of Directors has delegated day to day QMP operational responsibilities to the Dental Director, with oversight responsibilities delegated to the Quality Management Committee (QMC). The Dental Director, under the direction of the Premier Access Chief Executive Officer (CEO), chairs the committee.

The QMC has the responsibility to…

- Make recommendations for dental policies standards, practice guidelines and review criteria;
- Manage dental care functions to ensure high quality, cost effective dental care;
- Review individual cases and aggregate data to assess the level of quality care provided to Members;
- Peer Review is a Subcommittee that makes recommendations for corrective actions when needed;
- Conduct follow-up monitoring to ensure effectiveness of corrective actions.

Provider participation is an integral component of the QMC and its subcommittees. Providers are the primary decision-makers on quality issues relating to the delivery of dental care. The Dental Director, with QMC approval, selects Providers for participation on committees.

ON-SITE QUALITY MANAGEMENT (QM) AUDITS

Premier Access performs site visits to panel dental offices regularly. In most instances, the Dental Director and/or Dental Consultant (Auditor) visit the Provider offices according to established utilization thresholds. The frequency of the site visits may be higher for certain programs. Premier Access views the site visits of the Provider offices as a way to assist Providers in complying with regulations related to the operations of dental offices.

Premier Access believes that Provider offices benefit from the consulting services of our Auditors. These services are provided in a non-adversarial, professional manner, at no charge to the dental office, with respect for the Provider's privacy and patient schedule.

ONLINE ADMINISTRATIVE SUPPORT

The Premier Access website provides you with the support you need to effectively and efficiently manage your Premier Access patient base. You can verify Member eligibility, check on claims, view benefits and much more.

To register:

- Go to the Provider's page at **www.Premierlife.com**
- Click on the "Register Here" button.
- Once you have registered with a login and password, you will be able to directly access the information for your Premier Access patients.

PRACTICE PROTOCOLS

MEMBER ELIGIBILITY VERIFICATION

You are able to verify a member's eligibility online at www.premierlife.com. You may also call the Customer Service number found on the Member's ID Card or Contact Page in this Manual.

For additional information specific to the CHIP and Medicaid programs, please refer to the additional information under the Utah Government Dental Programs section in this Manual.

Each Member will have a Premier Access Identification Card but the card alone does not confirm current eligibility and authorization to be seen in your office. Check with the Plan by contacting Member Services.

Medicaid members also receive a monthly state-issued Medicaid card in addition to the Premier Access card. The state-issued Medicaid card will list a dental plan if the member is enrolled with a dental plan. If the member's state-issued card does not have a dental plan listed, the member is eligible under Medicaid Fee-For-Service. Services provided in that month should be billed to Medicaid Fee-For-Service, not to a dental plan.

There are three benefits plans under CHIP. The **CHIP Identification Card** will reflect the member's benefit plan, which is determined by Utah Department of Health. Details of the benefit plans are described under the section titled "Utah Children's Health Insurance Program & Processing Guidelines.

Sample Card

Front

Premier Access
<Plan or Program Name>

Member: ID:
Plan Effective:

For benefits, eligibility, or to find a dentist,
visit **www.premierlife.com** or call **(XXX) XXX-XXXX**.

Back

To receive dental services, please contact your assigned Primary Care Dentist. This card does not guarantee eligibility. To verify eligibility, to locate a provider or if you have a dental emergency in or out of the service area during your regular provider office hours, call Member Services' toll-free number on the front of the card. Emergency services are those performed for the direct relief of pain, as defined in your Evidence of Coverage. If you Primary Care Dentist is unavailable, any provider may treat your emergency and will be reimbursed without prior authorization.
DHMO Benefits for Emergency Care, not provided by the Primary Care Dentist, are limited to a maximum of $100 per incident, less the applicable Co-Payment.
The member identified on this card may not be balanced billed for covered services. All claim, prior authorization, and referral forms should be sent to:
Premier Access
P.O. Box XXXXXX
Sacramento, CA 95865-
XXXX

APPOINTMENT SCHEDULING AND WAIT TIMES

Participating dentists are required to provide covered services to Members during normal working hours, and during such other hours as may be necessary to keep patient appointment schedules on a current basis.

- Appointments for routine, non-urgent care must be available to members within 21 days.
- Appointments for urgent care that can be treated in a provider's office must be available within the same day.
- Emergency care shall be available to Members 24 hours a day, seven days a week.

When it is necessary for a Provider or an enrollee to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the enrollee's health care needs, and ensures continuity of care consistent with good professional practice.

Waiting time for a scheduled appointment ***must not exceed thirty (30) minutes***.
(Provider offices must maintain records indicating when a Member arrives for an appointment and when the Provider sees the Member.)

Note from Premier Access: You will receive an Accessibility Survey on a regular basis to obtain information on appointment availability, waiting time, acceptance of new Members and staffing changes. Please complete each survey and return it in a timely manner.

EMERGENCY SERVICES

An emergency dental service is the treatment of an unforeseen, sudden, and acute onset of symptoms or injuries requiring immediate treatment, where delay in treatment would jeopardize or cause permanent damage to a person's dental or medical health. Emergency services do not require a prior authorization.

Emergency services provided in the dental office are covered under the CHIP and Medicaid programs. Premier Access is not responsible for emergency services performed in a hospital or urgent care facility.

BUSINESS HOURS AND AFTER HOURS AVAILABILITY

The hours of operation and appointment availability you have for your patients enrolled in the CHIP or Medicaid programs must be the same as the hours of operation and appointment availability you provide for to all other patients.

Your after-hours response system must enable Members to reach an on-call Dentist, 24 hours a day, seven days a week.

An answering service or a telephone answering machine is required during non-business hours, which must provide instructions on how Members may obtain urgent or emergency care. This includes, when applicable, how to contact another Provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care.

INITIAL DENTAL ASSESSMENT

Initial dental care assessments must include a dental history, clinical examination and radiographs as needed, in the judgment of the PCD. PCDs shall additionally discuss general disease prevention and follow-up treatments as necessary with Members.

Primary Care Dentists are required to perform an initial dental assessment unless the Member has been treated within the last twelve months by his/her Primary Care Dentist.

Providers are able to advise or advocate for the following, within the lawful scope of his or her practice, on behalf of a Member who is his or her patient:

- The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
- Any information the Member needs in order to decide among all relevant treatment options.
- The risks, benefits, and consequences of treatment or non-treatment.
- The Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

DENTAL PERIODICITY SCHEDULE FOR CHILDREN

Premier Access supports the periodicity schedule recommended by the American Academy of Pediatric Dentistry. We believe this approach to treating children will aid in providing preventive dental services based on reasonable guidelines in accordance with a standard dental periodicity schedule.

LANGUAGE ASSISTANCE PROGRAM

Premier Access maintains a Language Assistance Program to assist Members with limited English language proficiency so that they may better communicate and participate more fully in their dental health care.

Premier Access will work with our Providers and Members to provide any vital documents in the member's preferred language, as well as telephone or face-to-face interpreting services. These services are available to Premier Members free of charge and can be arranged through the Premier Access Customer Service Department.

Free language assistance services are available 24 hours a day, 7 days a week. You may access the interpreting services by calling the Plan's Medicaid Member Service Department at (877) 541-5415.

Friends or family members must not be asked to serve as interpreters on dental matters. Instead, we encourage Members to use the qualified interpreters provided through this service.

If interpreting services are needed, contact Premier Access to obtain information regarding the Member's language preference.

If you have bilingual providers or office staff available to speak to Members, they may do so only to the extent necessary to facilitate administrative customer service functions. (Provide updated bilingual language capabilities by staff with Premier Access on a quarterly basis.) Compliance with the Language Assistance Program policies will be confirmed during quality assurance audits.

MEMBERS WITH SPECIAL HEALTH CARE NEEDS

If you identify a member with a Special Health Care Need and are not able to provide the required care for the member, contact Premier Access. We will coordinate the required care for the member.

CASE MANAGEMENT

All complex and special needs cases are to be referred to the Premier Access Case Management Coordinator. Case management provides valuable services to Members and Providers with complex cases.

Complex cases are those cases where the dental condition is compromised by a medical condition, and care needs to be coordinated between medical and dental providers. Special needs cases are those members with physical

and/or mental disabilities who are in need of dental care from Providers who have experience working with these patients.

SECOND OPINIONS

If the Utah Department of Health requests a second opinion for a member, Premier Access will arrange for one from a participating network provider, or outside of the network if a qualified provider is not available inside the network.

PRIOR AUTHORIZATION

Prior authorization requirements are specific to each program. Please refer to the Processing Guidelines section of this manual for program-specific requirements.

CLAIMS

Claims must be submitted within 12 months of the date of service. Premier Access will verify and acknowledge the receipt of each claim, whether complete or not and disclose the recorded date of receipt via the Premier Access website at www.premierlife.com.

TREATMENT AT SURGERY CENTERS

Prior authorization is not required to provide treatment at a surgery center. If the procedure(s) being performed requires prior authorization, authorization for the procedure must be obtained prior to treatment. The provider must coordinate with the medical carrier for facility charges. Facility charges are not covered under the dental plan.

BILLING GUIDELINES

Members may not be billed for any amounts other than applicable deductibles, copays or amounts described in the following sections “Non-Covered Services” and “Broken Appointments”.

Members cannot be held liable for the debt of a provider who becomes insolvent or bankrupt, or for amounts owed to the provider by Premier Access.

NON-COVERED SERVICES

A Member may be billed for a non-Covered Service when all of the following conditions are met:

(1) The provider has an established policy for billing all patients for non-covered services. The policy must apply to all patients, not just government program members.

(2) The Provider has informed the Member of its policy for billing patients for non-covered services;

(3) The Provider has advised the Member prior to rendering the non-covered service that the Enrollee shall be responsible for making payment; and

(4) An agreement, in writing, is made between the Provider and the Member that details the service and the amount to be paid by the Enrollee.

BROKEN APPOINTMENTS

A member may be billed for a missed appointment charge if all of the following conditions are met:

- The office has a policy that states what an acceptable cancellation is.
  (For example, the member must notify the office at least 24 hours before appointment.)
- The member agreed in writing to pay the charge if he or she misses an appointment.
- The missed appointment policy is the same for all patients.

GRIEVANCES & APPEALS

The main objective of the grievance/appeal process is to ensure an effective system for addressing and resolving issues in a timely manner.

A **grievance** is dissatisfaction about any matter other than an Action. Members or their designee can file grievances for any incident or action that is the subject of the Member's dissatisfaction. A grievance can be submitted verbally or in writing, and must be submitted within **90 days** of the date of the event. A Grievance Form is included in the Member Handbook provided to all new Members and in the Provider Manual. Grievance Forms are also available on the Premier Access website at: www.premierlife.com.

An **appeal** is a request for review of an Action by the plan. An Action is one of the following:

- the denial or limited authorization of a requested service, including the type or level of service;
- the reduction, suspension, or termination of a previously authorized service;
- the denial, in whole or in part, of payment for a service and the denial could result in the Member liable for payment;
- the provider's failure to provide services in a timely manner, as defined as failure to meet performance standards for appointment waiting times; or
- the failure of the plan to act within the time frames established for resolution and notification of Grievances and Appeals.

An appeal can be filed by a Member or his or her legally authorized representative. A provider, acting on behalf of a Member, may file an appeal with the Member's written consent.

A "Notice of Action" is the written notification to a Member, or written or verbal notification to a Provider when applicable, of an Action that will be taken by the Contractor. An appeal must be filed within **30 days** of the date of the Notice of Action. An appeal can be submitted verbally, however, it must be confirmed in writing within five working days from the oral appeal.

If a Member or Provider is not satisfied with the final resolution of an appeal, a State Fair Hearing may be requested. Premier's appeal resolution letter includes information about how to request a State Fair Hearing.

If requested, the Member is able to receive the disputed service during the appeal or State Fair Hearing process.

A grievance or appeal can be submitted by contacting Premier:

Phone: 1-877-541-5415 (Medicaid)
1-877-854-4242 (CHIP)
Fax: 1-916-646-9000
E-mail: GrievanceDept@PremierLife.com

Mail: Premier Access
Attn: Grievances/Appeals
P.O. Box 255039
Sacramento, CA 95865-5039

ADVERSE DETERMINATIONS & APPEALS

All Premier Access network providers may appeal an adverse determination which results in termination of a Provider Contract arrangement relating to quality of care issues. If a Provider wishes to appeal an adverse decision, the appeal must include an identification of the grounds for an appeal and a clear and concise statement of the facts and issues in support of the appeal.

Appeals must be requested in writing and submitted to:

By Mail: Premier Access Attn: Dental Director
P. O. Box 255039
Sacramento, CA 95865-5039

By Email: Grievance@premierlife.com

UTAH GOVERNMENT PROGRAMS

MEDICAID PROGRAM

The plan provides coverage to Members for all dental health care services available under the dental provisions of the Utah Medicaid Programs. This section of the Provider Manual contains a current list of procedure codes and descriptions for Utah Medicaid. It also contains information on prior authorization, payment policies, benefits, and exclusions.

Medicaid members receive their covered dental services from their Primary Care Dentist (PCD) without payment of any copayments. Collection of any amount from Medicaid Members towards a dental service that is a covered benefit is strictly prohibited under the provisions of your Provider Agreement. Maximum calendar year benefit is not applicable for beneficiaries on this program.

Dental services are available to Members who are pregnant women or who are individuals eligible under Early Periodic Screening, Diagnosis, and Treatment (EPSDT) also known in Utah as Child Health Evaluation and Care (CHEC).

CHEC Services

Medicaid Providers must provide CHEC Enrollees preventative screening and other necessary dental care, diagnostic services, treatment, and other measures necessary to correct or ameliorate defects and conditions discovered by the screening services, whether or not such services are covered under the State Medicaid Plan.

The Coverage and Reimbursement Lookup Tool

The Coverage and Reimbursement Lookup Tool found on the Medicaid website at http://health.utah.gov/medicaid contains the exhaustive list of covered services that Premier Access provides and the criteria that must be met for each service.

Restriction Program

The State of Utah will determine if a Member needs to be placed into the Restriction Program. This Program safeguards against inappropriate and excessive use of Medicaid services. Members selected for enrollment are informed of the reasons for the issuance of a Restriction Program card, and restricted to one Primary Care Provider and one pharmacy. For Members in the Restriction Program, Medicaid will only pay claims for services rendered by the providers listed on the card and by providers to who the Member has been appropriately referred. However, emergency services are not restricted to these providers.

For more information, contact the State of Utah Department of Health at 1-801-538-9045 or email: medicaidrestriction@utah.gov.

Provider Contract Types and Member Assignments

Providers are contracted on a fee-for-service or capitated basis.

- Under a **fee-for-service** arrangement, members are not assigned to the provider facility.
- Under a **capitated** arrangement, members are assigned to the specific provider facility. A roster of assigned members is sent to the facility each month. If an assigned member needs treatment from a provider outside the assigned facility, the Primary Care Dentist must submit a referral request to Premier Access.

Referrals

For providers under a capitated arrangement, prior authorization is required for referrals. Please refer to the Referral Guidelines and Form in the Administrative Forms section at the end of this Manual. For providers under a fee-for-service arrangement, prior authorization is not required for referral to another provider.
Note: A referral is not required for an orthodontic consultation. The consultation must be performed by a contracted orthodontist.

Dental Spend-Ups

Medicaid clients in the dental program may choose to upgrade a covered service to a non-covered service if they assume the responsibility for the difference in the fees for the covered and non-covered services. The only dental procedures which a Medicaid client may choose to upgrade are as follows:

1. Covered amalgam fillings to non-covered composite resin fillings.
2. Covered stainless steel crowns to non-covered porcelain or cast gold crowns
3. Covered anterior stainless steel crowns (deciduous) to non-covered anterior stainless steel crowns with facings (composite facings added or commercial or lab prepared facings)
4. Other covered dental procedures when authorized by the dental plan or through a hearing process

When the member chooses to have a spend-up procedure, the member can only be filled if all five of the following conditions are met:

1. The Provider has an established policy for billing all its patients for services not covered by a third party,
2. The member is advised prior to receiving the spend-up procedure that the Premier will not pay for the service.
3. The member agrees to be personally responsible for the payment,
4. The member and Provider enter into an agreement, in writing, prior to the service being rendered which details the service to be performed and the amount to be paid by the member, and
5. The member is only billed the difference between the Provider's usual and customary charge for the non-covered service and the usual and customary charge for the Covered Service the member is upgrading from.

The patient makes the choice. The Provider CANNOT mandate nor insist the covered procedure be upgraded.

Unless all five conditions are met, the Provider may not bill the patient for the non-covered service, even if the Provider chooses not to bill Premier Access. Further, the patient's Medicaid ID card may not be held by the Provider as guarantee of payment by the patient, nor may any other restrictions be placed upon the patient.

Medicaid Exclusions

Medicaid does NOT cover the following:

1. Cast crowns (porcelain fused to metal) on posterior permanent teeth or on primary teeth
2. Pulpotomies or pulpectomies on permanent teeth, except in the case of an open apex
3. Fixed bridges or pontics
4. Dental implants, including but not limited to endosteal implants, eposteal implants, transosteal implants, subperisteal implants
5. Tooth transplantation
6. Ridge augmentation
7. Osteotomies
8. Vestibuloplasty
9. Alveoloplasty
10. Occlusal appliances, habit control appliances or interceptive orthodontic treatment
11. Treatment of temporomandibular joint syndrome or its prevention, sequel, subluxation, therapy, arthostomy, meniscectomy or condylectomy
12. House calls
13. Consultations and second opinions not requested by Medicaid
14. Processing claim forms
15. Charges for lab tests or pathology reports (the lab or pathologist must bill the charges directly to Medicaid)
16. General anesthesia for removal of an erupted tooth, unless medically necessary
17. Services which require pre authorization and are provided before the prior authorization is given. However, this exclusion does not apply to an emergency service
18. Oral sedation and behavior management fees
19. Temporary dentures or temporary stayplate partial dentures
20. Limited orthodontic treatment, including removable appliance therapies
21. Removable appliances in conjunction with fixed banded treatment
22. Habit control appliances
23. Incomplete root canal

Procedure Guidelines for Utah Medicaid

The table below provides the guideline for each procedure covered by Medicaid.

Code	Procedure Name	Preauth Required?*	X-rays Required?*	Procedure Guideline
D0120	PERIODIC ORAL EVALUATION-ESTABLISHED PATIENT	No	No	Limited to 4 per calendar year for members age 20 and under. Limited to 2 per calendar year for members age 21 and over. A comprehensive oral evaluation (D0150) applies to the frequency limit.
D0140	LIMITED ORAL EVALUATION - PROBLEM FOCUSED	No	No	
D0150	COMPREHENSIVE ORAL EVALUATION-NEW OR ESTABLISHED PATIENT	No	No	One time only per provider. This code applies to the frequency limit for D0120. If a member has four periodic oral evaluations (D0120) in the same calendar year, this code is no longer covered for the calendar year.
D0210	INTRAORAL-COMPLETE SERIES (INCLUDING BITEWINGS)	No	No	1) Limited to once every two years. 2) Limited to age 6 and older. 3) More than 12 periapicals (D0220, D0230) and more than two bitewing (D0270, D0272, D0274) radiographs taken on the same date of service is considered a complete series (D0210). 4) Panoramic x-ray (D0330) with more than two or four bitewing and two periapical radiographs is considered a complete series (D0210). 5) No additional periapical or bitewing radiographs will be reimbursed with a complete series (D0210).
D0220	INTRAORAL-PERIAPICAL-FIRST FILM	No	No	1) More than 12 periapicals taken during a single visit will be considered a full mouth series. 2) Any periapical x-rays billed additionally with D0210 will be rebundled and considered part of the full mouth series. 3) X-rays billed as part of a root canal procedure will be rebundled as part of the global root canal fee.
D0230	INTRAORAL-PERIAPICAL-EACH ADDITIONAL FILM	No	No	
D0270	BITEWING-SINGLE FILM	No	No	Allowed two times per calendar year.
D0272	BITEWINGS-TWO FILMS	No	No	Allowed two times per calendar year.
D0274	BITEWINGS-FOUR FILMS	No	No	Allowed two times per calendar year.
D0330	PANORAMIC FILM	No	No	1) May be billed with bitewings. 2) A panoramic x-ray with more than bitewings, 2 or 4 films, plus 2 periapicals will rebundle to D0210. 3) Panoramic x-rays and full series x-rays shall not be taken more often than one every two years unless there is specific dental diagnostic need documented in the patient's records.
D0470	DIAGNOSTIC CASTS	No	No	
D1110	PROPHYLAXIS - ADULT	No	No	Two per calendar year. Limited to ages 16-20.
D1120	PROPHYLAXIS - CHILD	No	No	Four per calendar year, with or without fluoride varnish. Limited to ages 0-15.
D1206	TOPICAL APPLICATION OF FLUORIDE VARNISH	No	No	Limited to four per calendar year. Limited to ages 0 through 18. No age limit exception due to pregnancy.
D1351	SEALANT - PER TOOTH	No	No	1st and 2nd permanent molars or premolars (bicuspids), caries free, without restoration. Once every 2 years per tooth. Ages 0-20 only. No age limit exception due to pregnancy.
D1510	SPACE MAINTAINER-FIXED UNILATERAL	No	No	Ages 0-20 only. No age limit exception due to pregnancy. Limited to once every three years.
D1515	SPACE MAINTAINER-FIXED BILATERAL	No	No	Ages 0-20 only. No age limit exception due to pregnancy. Limited to once every three years.
D1520	SPACE MAINTAINER-REMOVABLE UNILATERAL	No	No	Ages 0-20 only. No age limit exception due to pregnancy. Limited to once every three years.
D1525	SPACE MAINTAINER-REMOVABLE BILATERAL	No	No	Ages 0-20 only. No age limit exception due to pregnancy. Limited to once every three years.
D1550	RECEMENTATION OF SPACE MAINTAINER	No	No	Ages 0-20 only. No age limit exception due to pregnancy. Limited to once every six months. The treating provider will be responsible for re-cement necessary within 6 months of applying space maintainer.
D2140	AMALGAM-ONE SURFACE, PRIMARY OR PERMANENT	No	No	Limited to once every two years, per tooth, per surface. If more than one filling is applied on the same tooth/same date of service, use the appropriate restorative code for 2, 3, or 4 or more surfaces.
D2150	AMALGAM-TWO SURFACES, PRIMARY OR PERMANENT	No	No	
D2160	AMALGAM-THREE SURFACES, PRIMARY OR PERMANENT	No	No	
D2161	AMALGAM-FOUR OR MORE SURFACES,PRIMARY OR PERMANENT	No	No	

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Procedure Guidelines for Utah Medicaid

Code	Procedure Name	Preauth Required?*	X-rays Required?*	Procedure Guideline
D2330	RESIN - ONE SURFACE, ANTERIOR	No	No	Limited to once every two years, per tooth, per surface. If more than one filling is applied on the same tooth/same date of service, use the appropriate restorative code for 2, 3, or 4 or more surfaces.
D2331	RESIN - TWO SURFACES, ANTERIOR	No	No	
D2332	RESIN - THREE SURFACES, ANTERIOR	No	No	
D2335	RESIN-4 OR MORE SURFACE/INVOLV INCISAL ANGLE,ANTER	No	No	
D2391	RESIN-BASED COMPOSITE,ONE SURFACE,POSTERIOR	No	No	*Resin-based composites on posterior teeth are **NOT covered** under the Medicaid program. Please refer to the "Dental Spend Ups" section of this Provider Manual. If the Spend Up provisions are followed, these procedures may be submitted to Premier and an allowance will be made for the amount of the corresponding amalgam restoration.*
D2392	RESIN-BASED COMPOSITE, TWO SURFACE,POSTERIOR	No	No	
D2393	RESIN-BASED COMPOSITE,THREE SURFACE,POSTERIOR	No	No	
D2394	RESIN-BASED COMPOSITE,FOUR OR MORE SURFACE,POSTERIOR	No	No	
D2751	CROWN-PORCELAIN FUSED TO PREDOMINATELY BASE METAL	Yes	Yes	Provider must send periapical x-rays. Permanent anterior teeth only. It is not allowable to bill for a core and build-up with pins, D2950, except in the exceptional instance where extensive build-up is needed. Ages 0-20 only. No age limit exception due to pregnancy. Limited to once every five years per tooth.
D2920	RECEMENT CROWN	No	No	Limited to once every six months. Treating provider will be responsible for re-cement necessary within six months of crown placement.
D2930	PREFABRICATED STAINLESS STEEL CROWN-PRIMARY TOOTH	No	No	Limited to once every two years, per tooth. Primary stainless steel crown, D2930, and alloy or composite fillings for the same tooth, same date of service. Bill for one or the other but not both procedures. It is not allowable to bill for a core and build-up with pins, D2950, and a stainless steel crown on a primary tooth. Not a benefit for primary teeth near exfoliation. Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. D2950 is not permitted on a primary tooth. The treating provider will be responsible for any replacements necessary within 24 month period following placement. EPSDT ONLY
D2931	PREFABRICAT STAINLESS STEEL CROWN-PERMANENT TOOTH	No	No	Limited to once every two years, per tooth. Valid for teeth numbers 2 – 15 and 18 – 31. Medicaid will not reimburse for a permanent stainless steel crown, D2931, and alloy or composite fillings for the same tooth, same date of service. It is allowable to bill for a core and build-up with pins, D2950, and a stainless steel crown – permanent. Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. D2950 and D2954 may be billed in conjunction with a permanent tooth when dentally necessary. The treating provider will be responsible for any replacements necessary within a 24 month period following placement.
D2950	CORE BUILD-UP, INCLUDING ANY PINS	No	Yes	Valid for teeth numbers 2 – 15 and 18 - 31. Fee is included in the fee for the crown, except in the exceptional instance where extensive build-up is needed. If extensive build-up is required, provide documentation explaining the need. Amalgam or plastic build up including pins. Permitted on permanent teeth, as dentally necessary. Include with preauthorization request for crown.
D2951	PIN RETENTION-PER TOOTH, IN ADDITION TO RESTORATION	No	No	Valid for teeth numbers 2 – 25 and 18 - 31. This is included in the cost of the prefabricated or laboratory crown and cannot be billed separately. A benefit for permanent teeth only when billed with an amalgam or composite restoration on the same date of service. Once per tooth regardless of the number of pins. Covered for a posterior restoration when the destruction involves three or more connected surfaces and at least one cusp, or for an anterior restoration when extensive coronal destruction involves the incisal angle.
D2954	PREFABRICATED POST AND CORE IN ADDITION TO CROWN	No	Yes	Valid for teeth numbers 2 – 15 and 18 - 31. Covered with prefabricated or laboratory processed crowns when medically necessary for retention of the crown on root canal treated permanent teeth. Include with preauthorization request for crown. Preauthorization is not required on stainless steel crowns.
D2980	CROWN REPAIR, BY REPORT	No	No	
D3220	THERAPEUTIC PULPOTOMY,(EXCLUDING FINAL RESTORATION) APPLICATION OF MEDICAMENT	No	No	Primary teeth only. This procedure does not require preauthorization. Submission of x-rays, photographs or written documentation demonstrating medical necessity is not required for payment. Requires a tooth code. A benefit for primary teeth only, limited to once per tooth. Not a benefit for a tooth near exfoliation, a tooth with a necrotic pulp or a periapical lesion, or for a tooth that is non restorable. This procedure is for the surgical removal of the entire portion of the pulp coronal to the dentinocemental junction with the aim of maintaining the vitality of the remaining radicular portion by means of an adequate dressing.
D3310	ROOT CANAL THERAPY, ANTERIOR (EXCLUDING FINAL RESTORATION)	No	Yes	Permanent teeth. Requires a tooth code. A benefit once per tooth for initial root canal therapy. The fee for this procedure includes all treatment and post treatment x-rays, any temporary restoration and/or occlusal seal. Post-operative x-rays required with claim. **EPSDT Only**

Procedure Guidelines for Utah Medicaid

Code	Procedure Name	Preauth Required?*	X-rays Required?*	Procedure Guideline
D3320	ROOT CANAL THERAPY, BICUSPID (EXCLUDING FINAL RESTORATION)	No	Yes	Permanent teeth. Requires a tooth code. A benefit once per tooth for initial root canal therapy. The fee for this procedure includes all treatment and post treatment x-rays, any temporary restoration and/or occlusal seal. Post-operative x-rays required with claim. **EPSDT Only**
D3330	ROOT CANAL THERAPY, MOLAR (EXCLUDING FINAL RESTORATION)	No	Yes	Root canal therapy is a covered benefit excluding third molars. X-rays billed as part of a root canal procedure will be rebundled as part of the global root canal fee. Requires a tooth code. A benefit once per tooth for initial root canal therapy. Not a benefit for 3rd molars unless the 3rd molar is in the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests. The fee for this procedure includes all treatment and post treatment x-rays, any temporary restoration and/or occlusal seal. Post-operative x-rays required with claim. EPSDT ONLY
D3410	APICOECTOMY / PERIRADICULAR SURGERY - ANTERIOR	No	Yes	Requires a tooth code. A benefit for permanent anterior teeth only. Not a benefit to the original provider within 90 days of root canal therapy, or to the original provider within 24 months of a prior apicoectomy/ periradicular surgery. The fee for this procedure includes the placement of retrograde filling material, all treatment and post treatment x-rays. EPSDT ONLY
D3421	APICOECTOMY/PERIRADICULAR SURG-BICUSPID (1ST ROOT)	No	Yes	Requires a tooth code. A benefit for permanent bicuspid teeth only. Not a benefit to the original provider within 90 days of root canal therapy, or to the original provider within 24 months of a prior apicoectomy/ periradicular surgery. The fee for this procedure includes the placement of retrograde filling material, all treatment and post treatment x-rays. If more than one root is treated, use apicoectomy/periradicular surgery - each additional root (D3426). EPSDT ONLY
D3425	APICOECTOMY/PERIRADICULAR SURGERY-MOLAR (1ST ROOT)	No	Yes	Requires a tooth code. A benefit for permanent molar teeth only. Not a benefit to the original provider within 90 days of root canal therapy, or to the original provider within 24 months of a prior apicoectomy/ periradicular surgery. The fee for this procedure includes the placement of retrograde filling material, all treatment and post treatment x-rays. If more than one root is treated, use apicoectomy/periradicular surgery - each additional root (D3426).
D3426	APICOECTOMY/PERIRADICULAR SURGERY (EACH ADDITIONAL ROOT)	No	Yes	Requires a tooth code. A benefit for permanent 1st and 2nd molar teeth only. Not a benefit to the original provider within 90 days of root canal therapy, or to the original provider within 24 months of a prior apicoectomy/ periradicular surgery. Not a benefit for 3rd molars, unless the 3rd molar is in the 1st or 2nd molar position or is an abutment for an existing fixed partial denture/removable partial denture with cast clasps or rests. The fee for this procedure includes the placement of retrograde filling material, all treatment and post treatment x-rays. If more than one root is treated, use apicoectomy/periradicular surgery - each additional root (D3426).
D3430	RETROGRADE FILLING-PER ROOT	No	Yes	Excludes permanent third molars.
D4210	GINGIVECTOMY OR GINGIVOPLASTY - FOUR OR MORE CONTIGUOUS TEETH OR BOUNDED TEETH SPACES PER QUADRANT	Yes	No	For drug-induced gingival hyperplasia only (such as Dilantin and Cyclosporin). Preauthorization is required. Photographs of the involved area required. Shall include a definitive periodontal diagnosis. A current and complete periodontal evaluation chart is required for preauthorization except in cases of pseudopockets as a result of gingival hyperplasia, which is demonstrated on a photograph. Requires a quadrant code (4 or more teeth).
D4341	PERIODONTAL SCALING/ROOT PLANING-4 OR MORE CONTINGUOUS TEETH, PER QUADRANT	Yes	Yes	Preauthorization is required. Preoperative x-rays are required. Shall include a definitive periodontal diagnosis and a minimum of one 4mm+ pocket on each diseased tooth. A current and complete periodontal evaluation chart is required for preauthorization. Requires a quadrant code (4 or more teeth). May be done once a year per quadrant.
D4355	FULL MOUTH DEBRIDE COMPREHENSIVE EVAL & DIAGNOSIS	No	No	Must have subgingival calculus present. Oral debridement may be done once per year and may be done in conjunction with a prophylaxis in cases requiring subgingival scaling. Preoperative x-rays are required. Shall include a definitive periodontal diagnosis and a minimum of one 4mm+ pocket on each diseased tooth. A current and complete periodontal evaluation chart is required for preauthorization. Requires a quadrant code (4 or more teeth). EPSDT ONLY
D5110	COMPLETE UPPER DENTURES (INCLUD POSTDELIVERY CARE)	Yes	Yes	Preauthorization is required. X-rays for all opposing natural teeth required. A benefit once in a 5 year period (D5110, D5130, D5860). All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
D5120	COMPLETE LOWER DENTURES(INCLUD POSTDELIVERY CARE)	Yes	Yes	Preauthorization is required. X-rays for all opposing natural teeth required. A benefit once in a 5 year period (D5120, D5140, D5860). All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
D5130	IMMEDIATE UPPER DENTURES(INCLUD POSTDELIVERY CARE)	Yes	Yes	Preauthorization is required. X-rays for all remaining natural teeth required. Limited to once per lifetime per patient. Not a benefit as a temporary denture. Subsequent complete dentures are not a benefit within a five year period of an immediate denture. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
D5140	IMMEDIATE LOWER DENTURES(INCLUD POSTDELIVERY CARE)	Yes	Yes	Prior authorization must be obtained before removing teeth in preparation for the immediate denture. X-rays for all remaining natural teeth required. Limited to once per lifetime per patient. Not a benefit as a temporary denture. Subsequent complete dentures are not a benefit within a five year period of an immediate denture. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

Procedure Guidelines for Utah Medicaid

Code	Procedure Name	Preauth Required?*	X-rays Required?*	Procedure Guideline
D5211	UPPER PARTIAL-RESIN BASE(INCL CLASP,RESTS & TEETH)	Yes	Yes	Limited to ages 6 through 20. Limited to once every five years. **Non-Emergency:** 1) Prior authorization must be obtained before fabricating the partial denture. 2) There must be an anterior tooth missing or the partial denture must restore mastication ability. 3) If mastication ability is present on one side, approval will not be given for a partial denture. Medicaid considers an individual to have mastication ability if he or she has two maxillary and two mandibular posterior teeth on the same side in occlusion. 4) There must be at least one posterior tooth or canine present with adequate bone support on each side of the arch. 5) Medicaid will cover a partial denture if it is opposed by a complete denture and if the patient does not have at least two posterior teeth in occlusion on both sides of the dental arch. 6) Provider must send the following: A. Mounted periapical x-rays or Panorex; B. List of teeth to be replaced. **Emergency:** Anterior #6 – 11 only Same criteria as D5211, Non-Emergency, PLUS one of the following: 1) Tooth is fractured or avulsed, or 2) Abscess requires immediate removal of tooth. Telephone authorization to be followed by submittal of x-rays with the claim.
D5212	LOWER PARTIAL-RESIN BASE(INCL CLASPS,RESTS,TEETH)	Yes	Yes	Limited to ages 6 through 20. Limited to once every five years. **Non-Emergency:** 1) Prior authorization must be obtained before fabricating the partial denture. 2) There must be an anterior tooth missing or the partial denture must restore mastication ability. 3) If mastication ability is present on one side, approval will not be given for a partial denture. Medicaid considers an individual to have mastication ability if he or she has two maxillary and two mandibular posterior teeth on the same side in occlusion. 4) There must be at least one posterior tooth or canine present with adequate bone support on each side of the arch. 5) Medicaid will cover a partial denture if it is opposed by a complete denture and if the patient does not have at least two posterior teeth in occlusion on both sides of the dental arch. 6) Provider must send the following: A. Mounted periapical x-rays or Panorex; B. List of teeth to be replaced. **Emergency:** Anterior #22 - 27 only. Same criteria as D5212, Non-Emergency, PLUS one of the following: 1) Tooth is fractured or avulsed, or 2) Abscess requires immediate removal of tooth. Telephone authorization to be followed by submittal of x-rays with the claim.
D5213	UPPER PARTIAL-CAST METAL FRAME W RESIN DENTURE BASES	Yes	Yes	Limited to ages 6 through 20. Limited to once every five years. 1) Prior authorization must be obtained before fabricating the partial denture. 2) There must be an anterior tooth missing or the partial denture must restore mastication ability. 3) If mastication ability is present on one side, approval will not be given for a partial denture. Medicaid considers an individual to have mastication ability if he or she has two maxillary and two mandibular posterior teeth on the same side in occlusion. 4) There must be at least one posterior tooth or canine present with adequate bone support on each side of the arch. 5) A partial denture will be covered if it is opposed by a complete denture and if the patient does not have at least two posterior teeth in occlusion on both sides of the dental arch. 6) Provider must send the following: A. Mounted periapical x-rays or Panorex; B. List of teeth to be replaced.
D5214	LOWER PARTIAL-CAST METAL FRAME W RESIN DENTURE BASES	Yes	Yes	
D5410	ADJUST COMPLETE DENTURE-UPPER	No	No	Payable to dentist who did not originally provide the denture. May be payable to originating dentist six months post delivery. Not a benefit on the same date of service or within 6 months of denture, reline or repair. EPSDT ONLY All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure. EPSDT ONLY
D5411	ADJUST COMPLETE DENTURE-LOWER	No	No	
D5421	ADJUST PARTIAL DENTURE-UPPER	No	No	
D5422	ADJUST PARTIAL DENTURE - LOWER	No	No	
D5510	REPAIR BROKEN COMPLETE DENTURE BASE	No	No	All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure. EPSDT ONLY
D5520	REPLACE MISSING OR BROKEN TEETH-COMPLETE DENTURE	No	No	
D5610	REPAIR RESIN DENTURE BASE - PARTIAL DENTURE	No	No	
D5630	REPAIR OR REPLACE BROKEN CLASP	No	No	
D5640	REPLACE BROKEN TEETH - PER TOOTH	No	No	
D5650	ADD TOOTH TO EXISTING PARTIAL DENTURE	No	No	
D5660	ADD CLASP TO EXISTING PARTIAL DENTURE	No	No	Billable if a tooth having a clasp has been extracted.

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Procedure Guidelines for Utah Medicaid

Code	Procedure Name	Preauth Required?*	X-rays Required?*	Procedure Guideline
D5750	RELINE COMPLETE UPPER DENTURE (LABORATORY)	No	No	Valid only for hard relines completed by a laboratory. It is difficult to establish a time for a reline following an immediate denture, but typically, hard relines must be delayed until bone resorption has stabilized following the extractions which would be 6 to 12 months following the extractions. Limited to two relines per year per arch. All adjustments made for six months after the date of reline, by the same provider and same arch, are included in the fee for this procedure. EPSDT ONLY
D5751	RELINE COMPLETE LOWER DENTURE (LABORATORY)	No	No	
D5760	RELINE UPPER PARTIAL DENTURE (LABORATORY)	No	No	
D5761	RELINE LOWER PARTIAL DENTURE (LABORATORY)	No	No	
D5931	OBTURATOR PROSTHESIS, SURGICAL	No	No	EPSDT ONLY
D5932	OBTURATOR PROSTHESIS, DEFINITIVE	No	No	
D5954	PALATAL AUGMENTATION PROSTHESIS	Yes	No	
D5955	PALATAL LIFT PROSTHESIS	Yes	No	EPSDT ONLY
D7111	EXTRACTION,CORONAL REMNANTS-DECIDUOUS TOOTH	No	No	X-rays are not required. Requires a tooth code. Not a benefit for asymptomatic teeth. EPSDT ONLY
D7140	EXTRACTION,ERUPTED TOOTH OR EXPOSED ROOT	No	No	X-rays are not required. Requires a tooth code. Not a benefit for asymptomatic teeth. Ortho-only extractions are covered.
D7210	SURG REMOVAL ERUPTED TOOTH REQ ELEV FLAP,BONE RMVL	No	Yes	Preoperative x-rays should be submitted with the claim. A benefit when the removal of any erupted tooth requires the elevation of mucoperiosteal flap and the removal of substantial alveolar one or sectioning of the tooth. Ortho-only extractions are covered.
D7220	REMOVAL OF IMPACTED TOOTH--SOFT TISSUE	No	Yes	Preoperative x-rays should be submitted with the claim. A benefit when the removal of any erupted tooth requires the elevation of mucoperiosteal flap and the removal of substantial alveolar one or sectioning of the tooth. The surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists. Ortho-only extractions are covered. EPSDT ONLY
D7230	REMOVAL OF IMPACTED TOOTH--PARTIALLY BONY	No	Yes	
D7240	REMOVAL OF IMPACTED TOOTH--COMPLETELY BONY	No	Yes	
D7241	REMOVAL OF IMPACTED TOOTH – COMPLETELY BONY, WITH UNUSUAL SURGICAL COMPLICATIONS	No	Yes	Covered only when performed by an Oral Surgeon.
D7260	ORAL ANTRAL FISTULA CLOSURE	No	No	Covered only when performed by an Oral Surgeon. Ages 0-20 only. No age limit exception due to pregnancy.
D7270	TOOTH REIMPLANT/STABILIZ ACCIDENT EVULSE/DISPLACED	No	Yes	Preoperative x-rays should be submitted with the claim. Requires a tooth code. EPSDT ONLY
D7280	SURGICAL ACCESS OF AN UNERUPTED TOOTH	No	Yes	All except primary teeth and third molars. Preoperative x-rays should be submitted with the claim. Preauthorization is recommended but not required. The procedure is limited to patients in active orthodontic treatment and the fee includes any orthodontic attachments. EPSDT ONLY
D7283	PLACEMENT OF DEV FACILITATE ERUPTION IMPACTD TOOTH	Yes	Yes	Clients approved for orthodontia treatment and are currently receiving orthodontia services under a PA from Utah Medicaid, will be approved for a Prior Authorization of D7283. Ages 0-20 only. No age limit exception due to pregnancy.
D7285	BIOPSY OF ORAL TISSUE - HARD (BONE, TOOTH)	No	No	Covered only when performed by an Oral Surgeon.
D7286	BIOPSY OF ORAL TISSUE - SOFT	No	No	Pathology report should be submitted with the claim. Treatment includes the fee for the resection of tumors and the resection of cysts.
D7410	EXCISION OF BENIGN LESION UP TO 1.25 CM	No	Yes	Operative and pathology reports should be submitted with the claim. Pre-op and Post operative x-rays must be submitted with the claim.
D7411	EXCISION OF BENIGN LESION GREATER THAN 1.25 CM	No	Yes	Operative and pathology reports should be submitted with the claim. EPSDT ONLY
D7412	EXCISION OF BENIGN LESION,COMPLICATED	No	Yes	EPSDT ONLY
D7413	EXCISION OF MALIGNANT LESION UP TO 1.25 CM	No	Yes	EPSDT ONLY
D7414	EXCISION OF MALIGNANT LESION GREATER THAN 1.25 CM	No	Yes	EPSDT ONLY
D7450	REMOVAL ODONTOGENIC CYST/TUMOR-LESION TO 1.25 CM	No	No	Covered only when performed by an Oral Surgeon.
D7451	REMOVAL ODONTOGENIC CYST/TUMOR-LESION > 1.25 CM	No	No	Covered only when performed by an Oral Surgeon.
D7460	REMOVAL NONODONTOGENIC CYST/TUMOR-LESION TO 1.25 CM	No	No	Covered only when performed by an Oral Surgeon.
D7461	REMOVAL NONODONTOGENIC CYST/TUMOR-LESION > 1.25 CM	No	No	Covered only when performed by an Oral Surgeon.
D7465	DESTRUCT LESION(S) PHYS/CHEMICAL METHOD,BY REPORT	No	No	Covered only when performed by an Oral Surgeon.
D7471	REMOVAL OF LATERAL EXOSTOSIS (MAXILLA OR MANDIBLE)	Yes	Yes	Must be done in conjunction with a new denture or partial denture fabrication. Preoperative x-rays must be submitted with claim. Please identify the quadrant treated by abbreviation in the area for the oral cavity.
D7510	INCISION & DRAINAGE OF ABCESS-INTRAORAL SOFT TISS	No	No	Written documentation required. Requires a quadrant code. Limited to once per quadrant per date of service. Not covered as a separate charge if any other definitive treatment is performed on the same date of service. Fee includes incision, placement and removal of a surgical draining device.

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Code	Procedure Name	Preauth Required?*	X-rays Required?*	Procedure Guideline
D7520	INCISION & DRAINAGE OF ABCESS-EXTRAORAL SOFT TISSUE	No	No	Covered only when performed by an Oral Surgeon.
D7530	REMOVAL FOREIGN BODY,SKIN,SUBCUT ALVEOLAR TISSUE	No	No	Covered only when performed by an Oral Surgeon.
D7540	REMOVAL REACTION-PRODUCING FOREIGN BODIES-MSCLSKELET	No	No	Covered only when performed by an Oral Surgeon.
D7550	PART OSTECTOMY/SEQUESTRECTOMY REMOV NON-VITAL BONE	No	No	Covered only when performed by an Oral Surgeon.
D7560	MAXILLARY SINUSOTOMY-REMOVE TOOTH FRAGMENT/FOREIGN	No	No	Covered only when performed by an Oral Surgeon.
D7610	MAXILLA-OPEN REDUCTION(TEETH IMMOBILIZE IF PRESNT)	No	No	Covered only when performed by an Oral Surgeon.
D7620	MAXILLA-CLOSED REDUCTION(TEETH IMMOBILIZE IF PRESNT)	No	No	Covered only when performed by an Oral Surgeon.
D7630	MANDIBLE-OPEN REDUCTION(TEETH IMMOBILIZE IF PRESENT)	No	No	Covered only when performed by an Oral Surgeon.
D7640	MANDIBLE-CLOSED REDUCTION(TEETH IMMOBILIZE IF PRESNT)	No	No	Covered only when performed by an Oral Surgeon.
D7670	ALVEOLUS-CLOSE REDUC,MAY INCLUDE STABILIZ OF TEETH	No	No	
D7710	MAXILLA – OPEN REDUCTION	No	No	Covered only when performed by an Oral Surgeon.
D7720	MAXILLA – CLOSED REDUCTION	No	No	Covered only when performed by an Oral Surgeon.
D7730	MANDIBLE – OPEN REDUCTION	No	No	Covered only when performed by an Oral Surgeon.
D7740	MANDIBLE – CLOSED REDUCTION	No	No	Covered only when performed by an Oral Surgeon.
D7910	SUTURE OF RECENT SMALL WOUNDS UP TO 5 CM	No	No	
D7911	COMPLICATED SUTURE – UP TO 5CM	No	No	Covered only when performed by an Oral Surgeon.
D7912	COMPLICATED SUTURE – GREATER THAN 5CM	No	No	Covered only when performed by an Oral Surgeon.
D7920	SKIN GRAFTS (IDENTIFY DEFECT COVERED, LOCATION, TYPE)	No	No	Covered only when performed by an Oral Surgeon.
D7950	OSSEOUS, OSTEOPERIOSTEAL OR CARTILAGE GRAFT OF THE MANDIBLE OR MAXILA-AUTOGENOUS OR NON-AUTOGENOUS, BY REPORT.	No	No	Covered only when performed by an Oral Surgeon.
D7955	REPAIR OF MAXILLOFACIAL SOFT/HARD TISSUE DEFECTS	No	No	Covered only when performed by an Oral Surgeon.
D7960	FRENULECTOMY - SEPARATE PROCEDURE	Yes	Yes	Written documentation including rationale demonstrating medical necessity and the specific treatment area.
D7980	SIALOLITHOTOMY	No	No	Covered only when performed by an Oral Surgeon.
D7981	EXCISION OF SALIVARY GLAND, BY REPORT	No	No	Covered only when performed by an Oral Surgeon.
D7982	SIALODOCHOPLASTY	No	No	Covered only when performed by an Oral Surgeon.
D7983	CLOSURE OF SALIVARY FISTULA	No	No	Covered only when performed by an Oral Surgeon.
D7999	UNSPECIFIED ORAL PROCEDURE, BY REPORT	Yes	No	
D8080	COMPRHENSIVE ORTHODONTIC TREAT,ADOLESCENT DENTITION	Yes	Yes	Prior authorization required. Ortho benefits are only covered if the client scores 30 or greater on the Salzmann Index. When assessing the handicap malocclusion, a tooth must have a 30-degree or greater rotation to be scored on the Salzmann Index. Orthodontic treatment is limited to one per lifetime. Re-banding and multistage orthodontic treatment are not covered.
D8680	ORTHODONTIC RETENTION	Yes	No	Prior authorization required at the completion of orthodontic treatment.
D8690	ORTHODONTIC TREATMENT (ALTERNATIVE BILLING)	Yes	No	EPSDT ONLY
D8692	REPLACEMENT OF LOST OR BROKEN RETAINER	No	No	This service is limited to one per lifetime for those who are receiving orthodontic treatment paid by Utah Medicaid. EPSDT ONLY
D8999	UNSPECIFIED ORTHODONTIC PROCEDURE,BY REPORT	Yes	No	
D9110	PALLIATIVE(EMER)TRTMNT DENTL PAIN-MINOR PROCEDURE	No	No	Limited to once per date of service when no other treatment is performed.

Procedure Guidelines for Utah Medicaid

Code	Procedure Name	Preauth Required?*	X-rays Required?*	Procedure Guideline
D9223	GENERAL ANESTHESIA, EACH 15 MINUTES	No	No	**Age 5 years and older diagnosed WITH a physical or mental disability** - Document the disability which justifies use of general anesthesia. **Age 5 years and older WITHOUT a diagnosed physical or mental disability**-Document the condition which justifies use of a general anesthesia. Example, failure and inability to treat when using a pre-medication. Documentation of medical necessity is not required for age 9 and older if the procedure is in conjunction with the extraction of a partial or full boney impacted third molar.
D9243	IV SEDATION, EACH 15 MINUTES	No	No	Document the physical or mental disability or other condition which necessitates use of I.V. sedation. Anxiety does not qualify as a medical condition which necessitates use of I.V. sedation.
D9248	NON-INTRAVENOUS CONSCIOUS SEDATION	No	No	The code is covered for intramuscular and non-intravenous conscious sedation only and includes the sedative drug. EPSDT Only
D9310	CONSULTATION (DIAG SRVC BY DENTIST O/T TREAT PRACT)	No	No	Specialist Only - separate fee only if patient is not treated by the consulting specialist. This code is not payable for orthodontic assessments (i.e., completion of the Salzmann form)
D9420	HOSPITAL CALL	No	No	Submit name and address of the hospital or surgical center on the claim.
D9440	OFFICE VISIT-AFTER REGULARLY SCHEDULED HOURS	No	No	For use only in a situation where the dentist is called away from home to return to the office in the evening, night or early morning, or a non-business day, when staff is not present to treat an emergency condition which cannot be scheduled. Document time in patient's record.
D9930	TREATMENT OF COMPLICATIONS (POST SURGICAL, UNUSUAL CIRCUMSTANCES, BY REPORT	No	No	Covered only when performed by an Oral Surgeon.
D9951	OCCLUSAL ADJUSTMENT – LIMITED	Yes	No	Covered only when performed by an Oral Surgeon. Ages 0-20 only. No age limit exception due to pregnancy. Requires a quadrant code. Not a benefit within 30 days of any definitive treatment in same or opposing quadrant.

CHILDRENS HEALTH INSURANCE PROGRAM (CHIP)

This table lists the coverage for Childrens Health Insurance Program (CHIP) members. The member's ID card will specify the applicable plan.

BENEFITS	MEMBER CO-PAY [1]	
	PLAN B	PLAN C
Deductibles – Per Plan Year	None	$50 per member $150 per family
Preventive Services: • Routine exams • Cleanings • Topical fluoride • X-rays • Space maintainers	$0	$0
Basic Services: • Sealants • Fillings • Oral surgery • General Anesthesia • IV Sedation • Endodontics • Periodontics • Stainless Steel Crowns • Denture Repairs • Emergency	5% of covered charges	20% of covered charges, after deductible
Major Services: • Crowns • Bridges • Dentures • Inlays • Onlays	5% of covered charges	50% of covered charges, after deductible
Maximum Dental Benefit [2]: • Preventive, basic, and major services per person per plan year • Orthodontic services are not included in the Maximum Dental Benefit	$1,000 per plan year	$1,000 per plan year
Orthodontics [2]: • Only covered if medically necessary • Needs prior approval • Lifetime Maximum: $1,000	5% of covered charges to Lifetime Maximum	50% of covered charges to Lifetime Maximum
Specialists: Endodontists, Oral Surgeons, Periodontists, Prosthodontists	5% of covered charges	Member pays the costs between the plan costs and the specialist contracted fee for the covered service.
Maximum Out-of-Pocket Expenses	5% of family's annual gross income (dental and medical expenses)	5% of family's annual gross income (dental and medical expenses)

[1] American Indian/Alaska Natives will not be charged co-pays, premiums, or a deductible.

[2] The Maximum Dental Benefit and Orthodontic Lifetime Maximum applies for all members, including American Indian/Alaska Natives.

For Pregnant Members:

Pregnant members can get added services each plan year.

- One added oral exam and either one added routine cleaning or one added periodontal scaling and root planing per quadrant.

  The member must give the dentist written evidence that she is pregnant. This is sent in with the claim.

Dental Exclusions

1. Services and supplies not listed in the scope of coverage, not recognized as essential for the treatment of the condition according to accepted standards of practice or considered experimental.
2. Charges for cosmetic procedures and procedures performed primarily for cosmetic reasons.
3. Charges for services related to, performed in conjunction with, or resulting from a non-covered service.
4. Charges for services that are applied toward the satisfaction of deductible, if any.
5. Charges for implants, myofunctional therapy, athletic mouth guards, precision or semi-precision attachments, treatment of fractures, cysts, tumors, or lesions; maxillofacial prosthesis, orthognathic surgery or TMJ dysfunction.
6. Services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia, fluorosis and anodontia..
7. Charges for lab fees for higher metals or porcelain crowns, bridges, inlays or onlays.
8. Charges for treatment to restore tooth structure lost from wear, erosion or abrasion; treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion; or treatment to stabilize the teeth. Examples include but are not limited to: equilibration, periodontal splinting or occlusal adjustment.
9. Charges for extraoral grafts.
10. Charges for treatment performed by someone other than a dentist or a person who by law may work under a dentist's direct supervision.
11. Charges for services or supplies covered by any other health plan, medical expense, auto or no-fault plan.
12. Charges for treatment performed by a person who ordinarily resides in the enrollee's household or who is related to the enrollee by blood, marriage or legal adoption.
13. Charges for anesthesia, other than general anesthesia and IV sedation in connection with covered oral surgery or select endodontic and periodontal surgical procedures.
14. Charges for local anesthesia. These charges are included within the cost of the procedures performed and cannot be charged separately.
15. Charges for oral sedation and nitrous oxide.

General Exclusions

1. Charges in excess of the contracted fee-for service schedule or the Reasonable and Customary Rate, whichever applies.
2. Charges for any treatment program which began prior to the date the insured is covered by CHIP and Premier Access.
3. Treatment of condition, injury or illness covered under any Workers' Compensation Act or similar law.
4. Charges resulting from changing from one provider to another while receiving treatment, or from receiving treatment from more than one provider for one dental procedure to the extent that the total charges billed exceed the amount incurred if one provider had performed all services.
5. Charges by any hospital or other surgical or treatment facility and any additional fees charged for treatment in any such facility.
6. Charges for drugs or the dispensing of drugs.
7. Charges for oral hygiene instruction, plaque control, acid etch, prescription or take home fluoride, dietary instruction, x-ray duplications, cancer screening, broken appointments, completion of a claim form, OSHA/ sterilization fees (Occupational Safety & Health Agency), or diagnostic photographs (except for orthodontic purposes).
8. Services incurred during travel or activity outside of the United States, except for covered emergency services.

Procedure Guidelines for Utah CHIP

CODE	DESCRIPTION	PROCEDURE CATEGORY	PREAUTH REQUIRED	X-RAYS REQUIRED	PROCEDURE GUIDELINE
D0120	Periodic Exam	Preventive	No	No	Benefits are limited to two oral exams per plan year. This includes any combination of D0120, D0140,D145, D0150, D0160, D0170, D0180.
D0140	Limited Oral Evaluation – Problem Focused	Preventive	No	No	Benefits are limited to two oral exams per plan year. This includes any combination of D0120, D0140, D145,D0150, D0160, D0170, D0180.
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	Preventive	No	No	Benefits are limited to two oral exams per plan year. This includes any combination of D0120, D0140,D145, D0150, D0160, D0170, D0180. Benefits are limited to members through age 3.
D0150	Comprehensive Oral Exam – New or Established Patient	Preventive	No	No	Benefits are limited to two oral exams per plan year. This includes any combination of D0120, D0140, D145,D0150, D0160, D0170, D0180.
D0160	Detailed and Extensive Oral Evaluation – Problem Focused, by Report	Preventive	No	No	Benefits are limited to two oral exams per plan year. This includes any combination of D0120, D0140, D145,D0150, D0160, D0170, D0180.
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit).	Preventive	No	No	Benefits are limited to two oral exams per plan year. This includes any combination of D0120, D0140, D145,D0150, D0160, D0170, D0180.
D0180	Comprehensive Periodontal Evaluation – New or Established Patient	Preventive	No	No	Benefits are limited to two oral exams per plan year. This includes any combination of D0120, D0140, D145,D0150, D0160, D0170, D0180.
D0190	Screening of a patient	Preventive	No	No	Screening to identify the need for referral to a dentist for a full diagnosis and treatment plan. Limited to once per lifetime and counts toward oral exam frequency limitation.
D0191	Assessment of a patient	Preventive	No	No	Screening to identify the need for referral to a dentist for a full diagnosis and treatment plan. Limited to once per lifetime and counts toward oral exam frequency limitation.
D0210	Intraoral-Complete Series	Preventive	No	No	***Benefits are limited to once every five year period.*** Preauthorization is not required for examinations, x-rays or photographs. A complete series shall be at least 10 periapicals (D0230) and bitewings (D0272, D0274) or 8 periapicals (D0230), 2 occlusals (D0240) and bitewings (D0272, D0274) OR a panoramic film (D0330) plus bitewings (D0272, D0274) and a minimum of two periapicals (D0230). When multiple x-rays are taken on the same date of service or if an intraoral complete series including bitewings (D0210) has been paid in the last five years, the maximum payment shall not exceed the total fee allowed for an intraoral complete series.
D0220	Intraoral-Periapical - First Film	Preventive	No	No	This procedure is payable once per provider per date of service. All additional periapicals shall be billed as D0230. Any periapicals billed with D0210 will be rebundled and considered part of the full mouth series.
D0230	Intraoral-Periapical - Each Additional Film	Preventive	No	No	Any periapicals billed with D0210 will be rebundled and considered part of the full mouth series.
D0240	Intraoral-Occlusal View, Maxillary or Mandibular, Each	Preventive	No	No	This procedure is payable once per arch per provider per date of service.
D0250	Extraoral – First Film	Preventive	No	No	This procedure is payable once per provider per date of service. Additional extraoral shall be billed as D0260. Any extraorals billed with D0210 will be rebundled and considered part of the full mouth series.
D0260	Extraoral – Each Additional Film	Preventive	No	No	This procedure is payable once per provider per date of service. Any extraorals billed with D0210 will be rebundled and considered part of the full mouth series.
D0270	Bitewings, One Film	Preventive	No	No	Benefits are limited to one series of four films 2 times per plan year; Isolated bitewing or periapical films are allowed on an emergency or episodic basis.
D0272	Bitewings, Two Films	Preventive	No	No	Benefits are limited to one series of four films 2 times per plan year; Isolated bitewing or periapical films are allowed on an emergency or episodic basis.
D0273	Bitewings, Three Films	Preventive	No	No	Benefits are limited to one series of four films 2 times per plan year; Isolated bitewing or periapical films are allowed on an emergency or episodic basis.
D0274	Bitewings, Four Films	Preventive	No	No	Benefits are limited to one series of four films 2 times per plan year; Isolated bitewing or periapical films are allowed on an emergency or episodic basis.
D0277	Vertical Bitewings 7-8 Films	Preventive	No	No	Benefits are limited to 2 times per plan year. Applies to the frequency limitation for bitewings.
D0290	Posterior-anterior or lateral skull and facial bone survey film	Preventive	No	No	Considered a benefit for trauma survey or pathology. Limited to a maximum of three films per date of service.
D0330	Panoramic Film	Preventive	No	No	A benefit once in a 5 year period except when documented as essential for a follow up/post operative exam (e.g., after oral surgery).
D0340	Cephalometric film	Preventive	No	No	Considered to be a benefit for orthodontic treatment. Limited to once in a 24 month period.
D0350	Oral/facial photographic images	Preventive	No	No	Considered to be a benefit for orthodontic treatment.
D0460	Pulp vitality tests	Preventive	No	No	Considered to be part of, and included in the fee for, oral evaluations and/or other definitive services on the same day. Considered for payment per visit for the purpose of diagnosing an emergency condition with supporting documentation.
D0470	Diagnostic casts	Preventive	No	No	Considered to be a benefit for orthodontic treatment. Limited to once per enrollee.

Procedure Guidelines for Utah CHIP

CODE	DESCRIPTION	PROCEDURE CATEGORY	PREAUTH REQUIRED	X-RAYS REQUIRED	PROCEDURE GUIDELINE
D0472	Accession of tissue, gross examination, preparation and transmission of written report	Preventive	No	No	Requires submission of a laboratory report for payment.
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	Preventive	No	No	Requires submission of a laboratory report for payment.
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	Preventive	No	No	Requires submission of a laboratory report for payment.
D1110	Prophylaxis – Adult (age 13 and older) ***Benefits are limited to 2 per plan year.***	Preventive	No	No	Not a benefit when performed on the same date of service with: D4210, D4211, D4260, D4261, D4341 or D4342. Periodontal maintenance (D4910) applies toward frequency limit.
D1120	Prophylaxis - Child (age 12 and under) ***Benefits are limited to 2 per plan year.***	Preventive	No	No	Not a benefit when performed on the same date of service with: D4210, D4211, D4260, D4261, D4341 or D4342. Periodontal maintenance (D4910) applies toward frequency limit.
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients	Preventive	No	No	Benefits are limited to 2 per plan year for children under the age of 6. Shall be considered for payment for children age 6 or over with supporting documentation.
D1208	Topical application of fluoride	Preventive	No	No	Limited to 2 times per plan year.
D1351	Sealants	Basic	No	No	Benefits are limited to permanent molars, caries-free, without restorations and with the occlusal surface intact. Limited to enrollees through age 15. Requires a tooth code. Once per tooth every 24 months per provider regardless of surfaces placed. The original provider is responsible for any repair or replacement during the 24 month period.
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	Basic	No	No	Benefits are limited to permanent molars without restorations. Limited to enrollees through age 15. Requires a tooth code. Once per tooth every 24 months per provider regardless of surfaces placed. The original provider is responsible for any repair or replacement during the 24 month period.
D1510	Space Maintainer - Fixed-Unilateral Band Type	Preventive	No	Yes	Benefit only up to the age of 14. Limited to initial appliance only. This procedure does not require preauthorization. X-rays for payment - submit a diagnostic periapical or bitewing radiograph to document the presence of the erupting permanent tooth and to verify there is enough space to allow the eruption of the permanent tooth. Written documentation for payment - shall include the identification of the missing primary molar. Requires a quadrant code. A benefit once per quadrant per patient. Not a benefit when the permanent tooth is near eruption or is missing, for upper and lower anterior teeth, for orthodontic appliances, tooth guidance appliances, minor tooth movement or activating wires. Replacement space maintainers shall be considered for payment when documentation identifies an unusual circumstance (e.g., lost or non-repairable). The fee for space maintainers includes the band and loop.
D1515	Space Maintainer – Fixed-Lingual or Palatal Bar Type	Preventive	No	Yes	Benefit only up to the age of 14. Limited to initial appliance only. This procedure does not require preauthorization. X-rays for payment - submit a diagnostic periapical or bitewing radiograph to document the presence of the erupting permanent tooth and to verify there is enough space to allow the eruption of the permanent tooth. Requires a quadrant code. A benefit once per quadrant per patient. Not a benefit when the permanent tooth is near eruption or is missing, for upper and lower anterior teeth, for orthodontic appliances, tooth guidance appliances, minor tooth movement or activating wires. Replacement space maintainers shall be considered for payment when documentation identifies an unusual circumstance (e.g., lost or non-repairable).
D1520	Space Maintainer – Removable – Unilateral	Preventive	No	Yes	Benefit only up to the age of 14. Limited to initial appliance only. This procedure does not require preauthorization. X-rays for payment - submit a diagnostic periapical or bitewing radiograph to document the presence of the erupting permanent tooth and to verify there is enough space to allow the eruption of the permanent tooth. Written documentation for payment - shall include the identification of the missing primary molar. Requires a quadrant code. A benefit once per quadrant per patient. Not a benefit when the permanent tooth is near eruption or is missing, for upper and lower anterior teeth, for orthodontic appliances, tooth guidance appliances, minor tooth movement or activating wires. Replacement space maintainers shall be considered for payment when documentation identifies an unusual circumstance (e.g., lost or non-repairable). All clasps, rests and adjustments are included in the fee for this procedure.
D1525	Space Maintainer – Removable – Bilateral	Preventive	No	Yes	Benefit only up to the age of 14. Limited to initial appliance only. This procedure does not require preauthorization. X-rays for payment - submit a diagnostic periapical or bitewing radiograph to document the presence of the erupting permanent tooth and to verify there is enough space to allow the eruption of the permanent tooth. Requires an arch code. A benefit once per arch when there is a missing primary molar in both quadrants or when there are two missing primary molars in the same quadrant. Not a benefit when the permanent tooth is near eruption or is missing, for upper and lower anterior teeth, for orthodontic appliances, tooth guidance appliances, minor tooth movement or activating wires. Replacement space maintainers shall be considered for payment when documentation identifies an unusual circumstance (e.g., lost or non-repairable). All clasps, rests and adjustments are included in the fee for this procedure.

Procedure Guidelines for Utah CHIP

CODE	DESCRIPTION	PROCEDURE CATEGORY	PREAUTH REQUIRED	X-RAYS REQUIRED	PROCEDURE GUIDELINE
D1550	Recementation Space Maintainer	Preventive	No	No	This procedure does not require preauthorization. Submission of x-rays, photographs or written documentation demonstrating medical necessity is not required for payment. Requires a quadrant code or arch code, as applicable. A benefit once per provider, per applicable quadrant or arch for patients under the age of 18. Additional requests beyond this frequency limitations shall be considered for payment when the medical necessity is documented and identifies unusual condition (such as displacement due to a sticky food item).
D1555	Removal of fixed space maintainer	Preventive	No	No	This procedure does not require preauthorization. Benefit only up to the age of 14. Requires a quadrant code.
D2140	Amalgam Restoration - One Surface Primary	Basic	No	No	This procedure does not require preauthorization. Requires a tooth code and surface code. A benefit once in a 24 month period. X-rays are not required with claim submission, but may be requested for claims review. Each unique tooth surface is only payable once per tooth per date of service.
D2140	Amalgam - One Surface Permanent	Basic	No	No	
D2150	Amalgam Restoration - Two Surfaces Primary	Basic	No	No	This procedure does not require preauthorization. Requires a tooth code and surface code. A benefit once in a 24 month period. X-rays are not required with claim submission, but may be requested for claims review. Each unique tooth surface is only payable once per tooth per date of service.
D2150	Amalgam Restoration - Two Surfaces Permanent	Basic	No	No	
D2160	Amalgam Restoration - Three Surfaces Primary	Basic	No	No	This procedure does not require preauthorization. Requires a tooth code and surface code. A benefit once in a 24 month period. X-rays are not required with claim submission, but may be requested for claims review. Each unique tooth surface is only payable once per tooth per date of service.
D2160	Amalgam Restoration - Three Surfaces Permanent	Basic	No	No	
D2161	Amalgam Restoration - Four or More Surfaces Primary	Basic	No	No	This procedure does not require preauthorization. Requires a tooth code and surface code. A benefit once in a 24 month period. X-rays are not required with claim submission, but may be requested for claims review. Each unique tooth surface is only payable once per tooth per date of service.
D2161	Amalgam Restoration - Four or More Surfaces Permanent	Basic	No	No	
D2330	Anterior Resin Restoration - One Surface	Basic	No	No	Primary and Permanent teeth: This procedure does not require preauthorization. Requires a tooth code and surface code. A benefit once in a 24 month period. X-rays are not required with claim submission, but may be requested for claims review. Each unique tooth surface is only payable once per tooth per date of service.
D2331	Anterior Resin Restoration - Two Surfaces	Basic	No	No	Primary and Permanent teeth: This procedure does not require preauthorization. Requires a tooth code and surface code. A benefit once in a 24 month period. X-rays are not required with claim submission, but may be requested for claims review. Each unique tooth surface is only payable once per tooth per date of service.
D2332	Anterior Resin Restoration - Three Surfaces	Basic	No	No	Primary and Permanent teeth: This procedure does not require preauthorization. Requires a tooth code and surface code. A benefit once in a 24 month period. X-rays are not required with claim submission, but may be requested for claims review. Each unique tooth surface is only payable once per tooth per date of service.
D2335	Anterior Resin Restoration - Four or More Surfaces or Incisal Angle	Basic	No	No	Primary and Permanent teeth: This procedure does not require preauthorization. Requires a tooth code and surface code. A benefit once in a 24 month period. X-rays are not required with claim submission, but may be requested for claims review. Each unique tooth surface is only payable once per tooth per date of service.
D2390	Resin-Based Composite Crown, Anterior	Basic	No	No	Primary and Permanent teeth: This procedure does not require preauthorization. Requires a tooth code and surface code. A benefit once in a 24 month period. X-rays are not required with claim submission, but may be requested for claims review. At least 4 unique tooth surfaces must be involved.
D2391	Resin-Based Composite - One Surface, Posterior - Primary	Basic	No	No	**Benefits are limited to the corresponding amalgam benefit for primary and permanent teeth. Differences in fees between the two codes may be billed to the member as noncovered expense.** This procedure does not require preauthorization. Requires a tooth code and surface code. A benefit once in a 24 month period. X-rays are not required with claim submission, but may be requested for claims review. Each unique tooth surface is only payable once per tooth per date of service.
D2391	Resin-Based Composite - One Surface, Posterior - Permanent				
D2392	Resin-Based Composite - Two Surfaces, Posterior - Primary	Basic	No	No	**Benefits are limited to the corresponding amalgam benefit for primary and permanent teeth. Differences in fees between the two codes may be billed to the member as noncovered expense.** This procedure does not require preauthorization. Requires a tooth code and surface code. A benefit once in a 24 month period. X-rays are not required with claim submission, but may be requested for claims review. Each unique tooth surface is only payable once per tooth per date of service.
D2392	Resin-Based Composite - Two Surfaces, Posterior - Permanent				
D2393	Resin-Based Composite - Three Surfaces, Posterior - Primary	Basic	No	No	**Benefits are limited to the corresponding amalgam benefit for primary and permanent teeth. Differences in fees between the two codes may be billed to the member as noncovered expense.** This procedure does not require preauthorization. Requires a tooth code and surface code. A benefit once in a 24 month period. X-rays are not required with claim submission, but may be requested for claims review. Each unique tooth surface is only payable once per tooth per date of service.
D2393	Resin-Based Composite - Three Surfaces, Posterior - Permanent				
D2394	Resin-Based Composite – Four or More Surfaces, Posterior - Primary	Basic	No	No	**Benefits are limited to the corresponding amalgam benefit for primary and permanent teeth. Differences in fees between the two codes may be billed to the member as noncovered expense.** This procedure does not require preauthorization. Requires a tooth code and surface code. A benefit once in a 24 month period. X-rays are not required with claim submission, but may be requested for claims review. Each unique tooth surface is only payable once per tooth per date of service.
D2394	Resin-Based Composite – Four or More Surfaces, Posterior - Permanent				

Procedure Guidelines for Utah CHIP

CODE	DESCRIPTION	PROCEDURE CATEGORY	PREAUTH REQUIRED	X-RAYS REQUIRED	PROCEDURE GUIDELINE
D2510	Inlay - metallic - one surface	Major	Yes	Yes	Permanent teeth only. Preauthorization is required. Preoperative x-rays required. Requires a tooth code. A benefit once in a five-year period. Not a benefit for patients under the age of 13 or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.
D2520	Inlay - metallic - two surfaces	Major	Yes	Yes	Permanent teeth only. Preauthorization is required. Preoperative x-rays required. Requires a tooth code. A benefit once in a five-year period. Not a benefit for patients under the age of 13 or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.
D2530	Inlay - metallic - three or more surfaces	Major	Yes	Yes	Permanent teeth only. Preauthorization is required. Preoperative x-rays required. Requires a tooth code. A benefit once in a five-year period. Not a benefit for patients under the age of 13 or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.
D2542	Onlay - metallic - two surfaces	Major	Yes	Yes	Permanent teeth only. Preauthorization is required. Preoperative x-rays required. Requires a tooth code. A benefit once in a five-year period. Not a benefit for patients under the age of 13 or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.
D2543	Onlay - metallic - three surfaces	Major	Yes	Yes	Permanent teeth only. Preauthorization is required. Preoperative x-rays required. Requires a tooth code. A benefit once in a five-year period. Not a benefit for patients under the age of 13 or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.
D2544	Onlay - metallic - four or more surfaces	Major	Yes	Yes	Permanent teeth only. Preauthorization is required. Preoperative x-rays required. Requires a tooth code. A benefit once in a five-year period. Not a benefit for patients under the age of 13 or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.
D2710	Crown - resin-based composite (indirect)	Major	Yes	Yes	Permanent teeth only. Preauthorization is required. Preoperative x-rays required. Requires a tooth code. A benefit once in a five-year period. Not a benefit for patients under the age of 13 or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.
D2712	Crown - 3/4 resin-based composite (indirect)	Major	Yes	Yes	Permanent teeth only. Preauthorization is required. Preoperative x-rays required. Requires a tooth code. A benefit once in a five-year period. Not a benefit for patients under the age of 13 or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.
D2720	Crown - resin with high noble metal	Major	Yes	Yes	Permanent teeth only. Preauthorization is required. Preoperative x-rays required. Requires a tooth code. A benefit once in a five-year period. Not a benefit for patients under the age of 13 or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.
D2721	Crown - resin with predominantly base metal	Major	Yes	Yes	Permanent teeth only. Preauthorization is required. Preoperative x-rays required. Requires a tooth code. A benefit once in a five-year period. Not a benefit for patients under the age of 13 or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.
D2722	Crown - resin with noble metal	Major	Yes	Yes	Permanent teeth only. Preauthorization is required. Preoperative x-rays required. Requires a tooth code. A benefit once in a five-year period. Not a benefit for patients under the age of 13 or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.
D2740	Crown - porcelain/ceramic substrate ***Benefits limited to D2751. The difference in contracted fees for the procedure codes may be charged to the member as a noncovered expense.***	Major	Yes	Yes	Permanent teeth only. Preauthorization is required. Preoperative x-rays required. Requires a tooth code. A benefit once in a five-year period. Not a benefit for patients under the age of 13 or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.
D2750	Crown - porcelain fused to high noble metal ***Benefits are limited to D2751. The difference in contracted fees for the procedure codes may be charged to the member as a noncovered expense.***	Major	Yes	Yes	Permanent teeth only. Preauthorization is required. Preoperative x-rays required. Requires a tooth code. A benefit once in a five-year period. Not a benefit for patients under the age of 13 or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.
D2751	Porcelain/Predominantly Base Metal Crown	Major	Yes	Yes	Permanent teeth only. Preauthorization is required. Preoperative x-rays required. Requires a tooth code. A benefit once in a five-year period. Not a benefit for patients under the age of 13 or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.
D2752	Porcelain/Noble Metal Crown ***Benefit limited to D2751. The difference in contracted fees for the procedure codes may be charged to the member as a noncovered expense.***	Major	Yes	Yes	Permanent teeth only. Preauthorization is required. Preoperative x-rays required. Requires a tooth code. A benefit once in a five-year period. Not a benefit for patients under the age of 13 or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.
D2780	Crown - 3/4 cast high noble metal ***Benefits are limited to D2781. The difference in contracted fees for the procedure codes may be charged to the member as a noncovered expense.***	Major	Yes	Yes	Permanent teeth only. Preauthorization is required. Preoperative x-rays required. Requires a tooth code. A benefit once in a five-year period. Not a benefit for patients under the age of 13 or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.
D2781	Crown - 3/4 cast predominantly base metal	Major	Yes	Yes	Permanent teeth only. Preauthorization is required. Preoperative x-rays required. Requires a tooth code. Not a benefit for patients under the age of 13 or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.
D2782	Crown - 3/4 cast noble metal ***Benefit limited to D2781. The difference in contracted fees for the procedure codes may be charged to the member as a noncovered expense.***	Major	Yes	Yes	Permanent teeth only. Preauthorization is required. Preoperative x-rays required. Requires a tooth code. A benefit once in a five-year period. Not a benefit for patients under the age of 13 or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.

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CODE	DESCRIPTION	PROCEDURE CATEGORY	PREAUTH REQUIRED	X-RAYS REQUIRED	PROCEDURE GUIDELINE
D2783	Crown - 3/4 porcelain/ceramic ***Benefit limited to D2781. The difference in contracted fees for the procedure codes may be charged to the member as a noncovered expense.***	Major	Yes	Yes	Permanent teeth only. Preauthorization is required. Preoperative x-rays required. Requires a tooth code. A benefit once in a five-year period. Not a benefit for patients under the age of 13 or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.
D2790	Crown - full cast high noble metal ***Benefit limited to D2791. The difference in contracted fees for the procedure codes may be charged to the member as a noncovered expense.***	Major	Yes	Yes	Permanent teeth only. Preauthorization is required. Preoperative x-rays required. Requires a tooth code. A benefit once in a five-year period. Not a benefit for patients under the age of 13 or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.
D2791	Crown - full cast predominantly base metal	Major	Yes	Yes	Permanent teeth only. Preauthorization is required. Preoperative x-rays required. Requires a tooth code. A benefit once in a five-year period. Not a benefit for patients under the age of 13 or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.
D2792	Crown - full cast noble metal ***Benefit limited to D2791. The difference in contracted fees for the procedure codes may be charged to the member as a noncovered expense.***	Major	Yes	Yes	Permanent teeth only. Preauthorization is required. Preoperative x-rays required. Requires a tooth code. A benefit once in a five-year period. Not a benefit for patients under the age of 13 or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.
D2794	Crown - titanium	Major	Yes	Yes	Permanent teeth only. Preauthorization is required. Preoperative x-rays required. Requires a tooth code. A benefit once in a five-year period. Not a benefit for patients under the age of 13 or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.
D2910	Recement inlay, onlay or partial coverage restoration	Major	No	No	Requires a tooth code. The original provider is responsible for all recementations within the first 12 months following the initial placement of prefabricated or laboratory processed crowns. Not a benefit within 12 months of recementation by the same provider.
D2915	Recement cast or prefabricated post and core	Major	No	No	Requires a tooth code. A benefit once in a 12 month period, per provider.
D2920	Crown (Recementation)	Major	No	No	Requires a tooth code. The original provider is responsible for all recementations within the first 12 months following the initial placement of prefabricated or laboratory processed crowns. Not a benefit within 12 months of recementation by the same provider.
D2929	Prefabricated porcelain/ceramic crown - primary tooth	Basic	No	No	Not a benefit for primary teeth near exfoliation. Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. D2950 is not permitted on a primary tooth. The treating provider will be responsible for any replacements necessary within 24 month period following placement.
D2930	Stainless Steel Crown (Primary) Prefabricated	Basic	No	No	Not a benefit for primary teeth near exfoliation. Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. D2950 is not permitted on a primary tooth. The treating provider will be responsible for any replacements necessary within 24 month period following placement.
D2931	Stainless Steel Crown (Permanent) Prefabricated	Major	No	No	Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. D2950 and D2954 may be billed in conjunction with a permanent tooth when dentally necessary. The treating provider will be responsible for any replacements necessary within 24 month period following placement.
D2932	Prefabricated resin crown	Major	No	Yes	Primary teeth: This procedure does not require preauthorization. Requires a tooth code. Permanent teeth only: When a resin crown is used as a termporay restoration while the final restoration is being fabricated it is considered to be included in the fee for the completed restoration.
D2933	Stainless Steel Crown With Resin Window Prefabricated	Basic	No	No	Not a benefit for primary teeth near exfoliation. Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. D2950 and D2954 may be billed in conjunction with a permanent tooth when dentally necessary. The treating provider will be responsible for any replacements necessary within 24 months.
D2934	Pre-fabricated esthetic coated stainless steel crown primary	Basic	No	No	Not a benefit for primary teeth near exfoliation. Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. D2950 and D2954 may be billed in conjunction with a permanent tooth when dentally necessary. The treating provider will be responsible for any replacements necessary within 24 month period following placement.
D2940	Protective restoration	Basic	No	No	This procedure cannot be prior authorized. Written documentation for payment shall include the rationale for the placement of the sedative filling and why a permanent restoration could not be placed. Requires a tooth code. A benefit once per tooth in a six month period, per provider. Not a benefit when performed on the same of service with a permanent restoration or crown for the same tooth. This procedure is for a temporary restoration intended to relieve pain and is not to be used as a base or liner under a restoration.
D2950	Core buildup, involving and including any pins.	Major	Yes	Yes	Fee is included under crowns except in the exceptional instance where extensive build-up is needed (by written report and substantiating radiographic support). Amalgam or plastic build-up including pins. Permitted on permanent teeth, as dentally necessary. Include with preauthorization request for crown. Preauthorization is not required on stainless steel crowns.

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D2951	Pin retention - per tooth, in addition to restoration ***(Pin retention per tooth, when necessary & final restore is amalgam, plastic or resin). Fee should be for pin retention only. Restoration should be listed separately.)***	Basic	No	No	This is included in the cost of the prefabricated or laboratory crown and cannot be billed separately. This procedure does not require preauthorization. Requires a tooth code. A benefit for permanent teeth only when billed with an amalgam or composite restoration on the same date of service. Once per tooth regardless of the number of pins. Covered for a posterior restoration when the destruction involves three or more connected surfaces and at least one cusp, or for an anterior restoration when extensive coronal destruction involves the incisal angle.
D2952	Post and core in addition to crown, indirectly fabricated	Major	Yes	Yes	Covered with prefabricated or laboratory processed crowns when medically necessary for retention of the crown on root canal treated permanent teeth. Include with preauthorization request for crown. Preauthorization is not required on stainless steel crowns.
D2953	Additional cast post - same tooth	Major	Yes	Yes	To be used with D2952.
D2954	Prefabricated Post and Core in Addition to Crown	Major	Yes	Yes	Covered with prefabricated or laboratory processed crowns when medically necessary for retention of the crown on root canal treated permanent teeth. Include with preauthorization request for crown. Preauthorization is not required on stainless steel crowns.
D2957	Additional cast post and core Prefabricated - same tooth	Major	Yes	Yes	To be used with D2954.
D2960	Labial veneer (resin laminate) - chairside	Major	Yes	Yes	Permanent Anterior teeth only. Preauthorization is required. Preoperative x-rays required. Requires a tooth code. A benefit once in a five-year period. Not a benefit for patients under the age of 13. Not a benefit for cosmetic purposes.
D2961	Labial veneer (resin laminate) - laboratory	Major	Yes	Yes	Permanent Anterior teeth only. Preauthorization is required. Preoperative x-rays required. Requires a tooth code. A benefit once in a five-year period. Not a benefit for patients under the age of 13. Not a benefit for cosmetic purposes.
D2962	Labial veneer (porcelain laminate) - laboratory	Major	Yes	Yes	Permanent Anterior teeth only. Preauthorization is required. Preoperative x-rays required. Requires a tooth code. A benefit once in a five-year period. Not a benefit for patients under the age of 13. Not a benefit for cosmetic purposes.
D2981	Inlay repair, material failure	Major	No	No	
D2982	Onlay repair, material failure	Major	No	No	
D2983	Veneer repair, material failure	Major	No	No	
D3220	Therapeutic Pulpotomy (in Addition to Restoration) Per Treatment	Basic	No	No	This procedure does not require preauthorization. Submission of x-rays, photographs or written documentation demonstrating medical necessity is not required for payment. Requires a tooth code. A benefit for primary teeth only, limited to once per tooth. Not a benefit for a tooth near exfoliation, a tooth with a necrotic pulp or a periapical lesion, or for a tooth that is non restorable. This procedure is for the surgical removal of the entire portion of the pulp coronal to the dentinocemental junction with the aim of maintaining the vitality of the remaining radicular portion by means of an adequate dressing.
D3221	Pulpal debridement, primary and permanent teeth	Basic	No	No	This procedure does not require preauthorization. Submission of x-rays, photographs or written documentation demonstrating medical necessity is not required for payment. Requires a tooth code. A benefit for permanent or for over retained primary teeth with no permanent successor. Limited to once per tooth. Not a benefit on the same date of service with any additional services, same tooth. This procedure is for the relief of acute pain prior to conventional root canal therapy and is not a benefit for root canal therapy visits. Procedure used in pulp exposure in permanent teeth with immature root development with healthy pulp in root canal. Performed in teeth with limited pathology and no apex formation.
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	Basic	No	No	This procedure does not require preauthorization. Submission of x-rays, photographs or written documentation demonstrating medical necessity is not required for payment. Requires a tooth code. A benefit for permanent or for over retained primary teeth with no permanent successor. once per tooth. Not a benefit on the same date of service with any additional services, same tooth. this procedure is for the relief of acute pain prior to conventional root canal therapy and is not a benefit for root canal therapy visits. Procedure used in pulp exposure in permanent teeth with immature root development with healthy pulp in root canal. Performed in teeth with limited pathology and no apex formation.
D3230	Pulpal Therapy – Anterior, Primary Tooth	Basic	No	No	This procedure does not require preauthorization. Submission of x-rays, photographs, or written documentation demonstrating medical necessity is not required for payment. Requires a tooth code. A benefit once per primary tooth. Not a benefit for primary tooth near exfoliation, with a therapeutic pulpotomy (excluding final restoration) (D3220), same date of service, same tooth, or with pulpal debridement, primary and permanent tooth (D3221), same date of service, same tooth.
D3240	Pulpal Therapy – Post, Primary Tooth	Basic	No	No	This procedure does not require preauthorization. Submission of x-rays, photographs, or written documentation demonstrating medical necessity is not required for payment. Requires a tooth code. A benefit once per primary tooth. Not a benefit for primary tooth near exfoliation, with a therapeutic pulpotomy (excluding final restoration) (D3220), same date of service, same tooth, or with pulpal debridement, primary and permanent tooth (D3221), same date of service, same tooth.

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CODE	DESCRIPTION	PROCEDURE CATEGORY	PREAUTH REQUIRED	X-RAYS REQUIRED	PROCEDURE GUIDELINE
D3310	Root Canal Anterior	Basic	Yes	Yes	Preauthorization is required. X-rays for preauthorization - submit arch and periapical x-rays. Requires a tooth code. A benefit once per tooth for initial root canal therapy. For root canal therapy retreatment use D3346. The fee for this procedure includes all treatment and post treatment x-rays, any temporary restoration and/or occlusal seal. Post-operative x-rays required with claim.
D3320	Root Canal - Bicuspid	Basic	Yes	Yes	Preauthorization is required. X-rays for preauthorization - submit arch and periapical x-rays. Requires a tooth code. A benefit once per tooth for initial root canal therapy. For root canal therapy retreatment use D3347. The fee for this procedure includes all treatment and post treatment x-rays, any temporary restoration and/or occlusal seal. Post-operative x-rays required with claim.
D3330	Root Canal - Molar (Three Canals)	Basic	Yes	Yes	Preauthorization is required. X-rays for preauthorization - submit arch and periapical x-rays. Requires a tooth code. A benefit once per tooth for initial root canal therapy. For root canal therapy retreatment use D3348. Not a benefit for 3rd molars unless the 3rd molar is in the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests. The fee for this procedure includes all treatment and post treatment x-rays, any temporary restoration and/or occlusal seal. Post-operative x-rays required with claim.
D3333	Internal root repair of perforation defects	Basic	Yes	Yes	Preauthorization is required. Preoperative x-rays required.
D3346	Retreatment of previous root canal therapy – anterior ***Retreatment of root canals is a covered benefit only if clinical or radiographic signs of abscess formation are present and/or the patient is experiencing symptoms. Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology, is not a covered benefit.***	Basic	Yes	Yes	Retreatment of root canals is a covered benefit only if clinical or radiographic signs of abscess formation are present and/or the patient is experiencing symptoms. Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology, is not a covered benefit Preauthorization is required. X-rays for preauthorization - submit arch and periapical radiographs. Written documentation should include the rationale for retreatment if not evident from radiographs. Requires a tooth code. Not a benefit to the original provider within 12 months of initial treatment or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed or partial denture or removable partial denture with cast clasps or rests. The fee for this procedure includes all treatment and post treatment radiographs, any temporary restoration and/or occlusal seal. Post-operative x-rays required with claim.
D3347	Retreatment of previous root canal therapy – bicuspid	Basic	Yes	Yes	***Retreatment of root canals is a covered benefit only if clinical or radiographic signs of abscess formation are present and/or the patient is experiencing symptoms. Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology, is not a covered benefit.*** Preauthorization is required. X-rays for preauthorization - submit arch and periapical x-rays. Written documentation should include the rationale for retreatment if not evident from x-rays. Requires a tooth code. Not a benefit to the original provider within 12 months of initial treatment or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed or partial denture or removable partial denture with cast clasps or rests. The fee for this procedure includes all treatment and post treatment x-rays, any temporary restoration and/or occlusal seal. Post-operative x-rays required with claim.
D3348	Retreatment of previous root canal therapy – molar	Basic	Yes	Yes	***Retreatment of root canals is a covered benefit only if clinical or radiographic signs of abscess formation are present and/or the patient is experiencing symptoms. Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology, is not a covered benefit.*** Preauthorization is required. X-rays for preauthorization - submit arch and periapical x-rays. Written documentation should include the rationale for retreatment if not evident from x-rays. Requires a tooth code. Not a benefit to the original provider within 12 months of initial treatment or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed or partial denture or removable partial denture with cast clasps or rests. The fee for this procedure includes all treatment and post treatment x-rays, any temporary restoration and/or occlusal seal. Post-operative x-rays required with claim.
D3351	Apexification/recalcification/pulpal regeneration - initial visit (apical closure/calcific repair of perforations, root resportion, pulp space disinfection, etc.)	Basic	Yes	Yes	Preauthorization is required. X-rays for preauthorization.
D3352	Apexification/recalcification/pulpal regeneration - interim medication replacement (apical closure/calcific repair of perforations, root resportion, pulp space disinfection, etc.)	Basic	Yes	Yes	Preauthorization is required. X-rays for preauthorization.
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resportion, etc.)	Basic	Yes	Yes	Preauthorization is required. X-rays for preauthorization.

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CODE	DESCRIPTION	PROCEDURE CATEGORY	PREAUTH REQUIRED	X-RAYS REQUIRED	PROCEDURE GUIDELINE
D3410	Apicoectomy/periradicular surgery – anterior	Basic	Yes	Yes	Preauthorization is required. X-rays for preauthorization - submit arch and periapical x-rays demonstrating the medical necessity. Written documentation for preauthorization if the medical necessity is not evident from x-rays, documentation shall include the rationale for treatment. Requires a tooth code. A benefit for permanent anterior teeth only. Not a benefit to the original provider within 90 days of root canal therapy. or to the original provider within 24 months of a prior apicoectomy/ periradicular surgery. The fee for this procedure includes the placement of retrograde filling material, all treatment and post treatment x-rays.
D3421	Apicoectomy/periradicular surgery – bicuspid (first root)	Basic	Yes	Yes	Preauthorization is required. X-rays for preauthorization - submit arch and periapical x-rays demonstrating the medical necessity. Written documentation for preauthorization if the medical necessity is not evident from x-rays, documentation shall include the rationale for treatment. Requires a tooth code. A benefit for permanent bicuspid teeth only. Not a benefit to the original provider within 90 days of root canal therapy. or to the original provider within 24 months of a prior apicoectomy/ periradicular surgery. The fee for this procedure includes the placement of retrograde filling material, all treatment and post treatment x-rays. If more than one root is treated, use apicoectomy/periradicular surgery - each additional root (D3426).
D3425	Apicoectomy/periradicular surgery – molar (first root)	Basic	Yes	Yes	Preauthorization is required. X-rays for preauthorization - submit arch and periapical x-rays demonstrating the medical necessity. Written documentation for preauthorization if the medical necessity is not evident from x-rays, documentation shall include the rationale for treatment. Requires a tooth code. A benefit for permanent 1st and 2nd molar teeth only. Not a benefit to the original provider within 90 days of root canal therapy, or to the original provider within 24 months of a prior apicoectomy/ periradicular surgery. Not a benefit for 3rd molars, unless the 3rd molar is in the 1st or 2nd molar position or is an abutment for an existing fixed partial denture/removable partial denture with cast clasps or rests. The fee for this procedure includes the placement of retrograde filling material, all treatment and post treatment x-rays. If more than one root is treated, use apicoectomy/periradicular surgery - each additional root (D3426).
D3426	Apicoectomy/periradicular surgery (each additional root)	Basic	Yes	Yes	Preauthorization is required. X-rays for preauthorization - submit arch and periapical x-rays demonstrating the medical necessity. Written documentation for preauthorization if the medical necessity is not evident from x-rays, documentation shall include the rationale for treatment. Requires a tooth code. A benefit for permanent teeth only. Not a benefit to the original provider within 90 days of root canal therapy, or to the original provider within 24 months of a prior apicoectomy/ periradicular surgery. Not a benefit for 3rd molars, unless the 3rd molar is in the 1st or 2nd molar position or is an abutment for an existing fixed partial denture/removable partial denture with cast clasps or rests. Only payable the same date of service as procedures D3421 or D3425. The fee for this procedure includes the placement of retrograde filling material, all treatment and post treatment x-rays.
D3430	Retrograde filling - per root	Basic	Yes	Yes	Preauthorization is required. X-rays required.
D3450	Root amputation - per root	Basic	Yes	Yes	Preauthorization is required. Pre-op and Post op X-rays required.
D3460	Endodontic endosseous implant	Basic	Yes	Yes	Preauthorization is required. X-rays required.
D3920	Hemisection (including any root removal), not including root canal therapy	Basic	Yes	Yes	Preauthorization is required. X-rays required.
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	Basic	Yes	No	Preauthorization is required. Photographs of the involved area required. Shall include a definitive periodontal diagnosis. A current and complete periodontal evaluation chart is required for preauthorization except in cases of pseudopockets as a result of gingival hyperplasia, which is demonstrated on a photograph. Requires a quadrant code (4 or more teeth).
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	Basic	Yes	No	Preauthorization is required. Photographs of the involved area required. Shall include a definitive periodontal diagnosis. A current and complete periodontal evaluation chart is required for preauthorization except in cases of pseudopockets as a result of gingival hyperplasia, which is demonstrated on a photograph. Requires a quadrant code (1 to 3 teeth).
D4212	Gingevectomy or gingivoplasty - access for restorative procedures - per tooth	Basic	Yes	Yes	Preauthorization is required. Photographs of the involved area required.
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	Basic	Yes	No	Preauthorization is required. Photographs of the involved area required. Shall include a definitive periodontal diagnosis. A current and complete periodontal evaluation chart is required for preauthorization. Requires a quadrant code (4 or more teeth).
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces per quadrant	Basic	Yes	No	Preauthorization is required. Photographs of the involved area required. Shall include a definitive periodontal diagnosis. A current and complete periodontal evaluation chart is required for preauthorization. Requires a quadrant code (1 to 3 teeth).
D4245	Apically positioned flap	Basic	Yes	Yes	Preauthorization is required. X-rays required.
D4249	Clinical crown lengthening - hard tissue	Basic	Yes	Yes	Preauthorization is required, including applicable preoperative x-rays.
D4260	Osseous surgery (including flap entry and closure) – four or more contiguous teeth or bounded teeth spaces per quadrant	Basic	Yes	Yes	Preauthorization is required. Preoperative x-rays are required. Shall include a definitive periodontal diagnosis. A current and complete periodontal evaluation chart is required for preauthorization. Requires a quadrant code (4 or more teeth).

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CODE	DESCRIPTION	PROCEDURE CATEGORY	PREAUTH REQUIRED	X-RAYS REQUIRED	PROCEDURE GUIDELINE
D4261	Osseous surgery (including flap entry and closure) – one to three contiguous teeth or bounded teeth spaces per quadrant	Basic	Yes	Yes	Preauthorization is required. Preoperative x-rays are required. Shall include a definitive periodontal diagnosis. A current and complete periodontal evaluation chart is required for preauthorization. Requires a quadrant code (1 to 3 teeth).
D4263	Bone replacement graft - first site in quadrant	Basic	Yes	Yes	Preauthorization is required, including applicable preoperative x-rays.
D4264	Bone replacement graft - each additional site in quadrant	Basic	Yes	Yes	Preauthorization is required, including applicable preoperative x-rays.
D4266	Guided tissue regeneration - resorbable barrier, per site	Basic	Yes	Yes	Preauthorization is required, including applicable preoperative x-rays.
D4267	Guided tissue regeneration - resorbable barrier, per site (includes membrane removal)	Basic	Yes	Yes	Preauthorization is required, including applicable preoperative x-rays.
D4270	Pedicle soft tissue graft procedure	Basic	Yes	Yes	Preauthorization is required, including applicable preoperative x-rays.
D4273	Subepithelial connective tissue graft procedures, per tooth	Basic	Yes	Yes	Preauthorization is required, including applicable preoperative x-rays.
D4277	Free soft tissue graft procedure (including donor site surgery) - first tooth or edentulous tooth site in graft	Basic	Yes	Yes	Preauthorization is required, including applicable preoperative x-rays.
D4278	Free soft tissue graft procedure (including donor site surgery) - each add'l contiguous tooth position in same graft site	Basic	Yes	Yes	Preauthorization is required, including applicable preoperative x-rays.
D4321	Provisional splinting - extracoronal	Basic	Yes	Yes	Preauthorization is required, including applicable preoperative x-rays.
D4341	Periodontal Root Planing, Per Quadrant ***Benefits are limited to four quadrant treatments in any 24 consecutive months.***	Basic	Yes	Yes	Preauthorization is required. Preoperative x-rays are required. Shall include a definitive periodontal diagnosis and a minimum of one 4mm+ pocket on each diseased tooth. A current and complete periodontal evaluation chart is required for preauthorization. Requires a quadrant code (4 or more teeth).
D4342	Periodontal Scaling, One to Three Teeth, Per Quadrant ***Benefits are limited to four quadrant treatments in any 24 consecutive months.***	Basic	Yes	Yes	Preauthorization is required. Preoperative x-rays are required. Shall include a definitive periodontal diagnosis and a minimum of one 4mm+ pocket on each diseased tooth. A current and complete periodontal evaluation chart is required for preauthorization. Requires a quadrant code.
D4355	Full Mouth Debridement	Basic	Yes	No	Preauthorization is required. Subgingival calculus must be present. May be done in conjunction with prophy.
D4910	Periodontal Recall *(Periodontal Prophylaxis) Following Active Periodontal Therapy Maintenance Procedures after Active Therapy After Three Months (Includes Any Examination Evaluation, Curettage, Root Planning and/or Polishing As May Be Necessary)*	Basic	No	No	Following active periodontal therapy. Maintenance procedures after three months (includes any examination, evaluation, currettage, root planing, and/or polishing as may be necessary). Benefits are limited to 2 per plan year following active periodontal therapy. Prophylaxis (D1110/D1120) applies toward frequency limitation.
D5110	Complete denture - maxillary ***Additional fees may be charged to the member for actual lab fees.***	Major	Yes	Yes	Preauthorization is required. X-rays for all opposing natural teeth required. A benefit once in a 5 year period (D5110, D5130, D5860). All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
D5120	Complete denture - mandibular ***Additional fees may be charged to the member for actual lab fees.***	Major	Yes	Yes	Preauthorization is required. X-rays for all opposing natural teeth required. A benefit once in a 5 year period (D5120, D5140, D5860). All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
D5130	Immediate denture – maxillary ***Additional fees may be charged to the member for actual lab fees.***	Major	Yes	Yes	Preauthorization is required. X-rays for all remaining natural teeth required. Limited to once per lifetime per patient. Not a benefit as a temporary denture. Subsequent complete dentures are not a benefit within a five year period of an immediate denture. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
D5140	Immediate denture – mandibular ***Additional fees may be charged to the member for actual lab fees.***	Major	Yes	Yes	Preauthorization is required. X-rays for all remaining natural teeth required. Limited to once per lifetime per patient. Not a benefit as a temporary denture. Subsequent complete dentures are not a benefit within a five year period of an immediate denture. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) ***Additional fees may be charged to the member for actual lab fees.***	Major	Yes	Yes	Preauthorization is required. X-rays for all remaining natural teeth and abutment teeth required. A benefit once in a 5 year period. A benefit when replacing a permanent anterior tooth/ teeth and/ or the arch lacks posterior balanced occlusion. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) ***Additional fees may be charged to the member for actual lab fees.***	Major	Yes	Yes	Preauthorization is required. X-rays for all remaining natural teeth and abutment teeth required. A benefit once in a 5 year period. A benefit when replacing a permanent anterior tooth/ teeth and/ or the arch lacks posterior balanced occlusion. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

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D5213	Maxillary partial denture - cast metal framework with resin denture bases (including. any conventional clasps, rests and teeth) ***Additional fees may be charged to the member for actual lab fees.***	Major	Yes	Yes	Preauthorization is required. X-rays for all remaining natural teeth and abutment teeth required. A benefit once in a 5 year period. A benefit when opposing full denture and the arch lacks posterior balanced occlusion. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) ***Additional fees may be charged to the member for actual lab fees.***	Major	Yes	Yes	Preauthorization is required. X-rays for all remaining natural teeth and abutment teeth required. A benefit once in a 5 year period. A benefit when opposing full denture and the arch lacks posterior balanced occlusion. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	Major	Yes	Yes	Preauthorization is required. X-rays for all remaining natural teeth and abutment teeth required. A benefit once in a 5 year period. A benefit when opposing full denture and the arch lacks posterior balanced occlusion. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	Major	Yes	Yes	Preauthorization is required. X-rays for all remaining natural teeth and abutment teeth required. A benefit once in a 5 year period. A benefit when opposing full denture and the arch lacks posterior balanced occlusion. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
D5281	Removable Unilateral Partial Denture – One Piece Cast Metal	Major	Yes	Yes	Preauthorization is required. X-rays for all remaining natural teeth and abutment teeth required. A benefit once in a 5 year period. A benefit when opposing full denture and the arch lacks posterior balanced occlusion. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
D5410	Adjust complete denture - maxillary	Major	No	No	Not a benefit on the same date of service or within 6 months of denture, reline or repair.
D5411	Adjust complete denture - mandibular	Major	No	No	Not a benefit on the same date of service or within 6 months of denture, reline or repair.
D5421	Adjust partial denture - maxillary	Major	No	No	Not a benefit on the same date of service or within 6 months of denture, reline or repair.
D5422	Adjust partial denture - mandibular	Major	No	No	Not a benefit on the same date of service or within 6 months of denture, reline or repair.
D5510	Repair broken complete denture base ***Additional fees may be charged to the member for actual lab fees.***	Basic	No	No	All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.
D5520	Replace missing or broken teeth- complete denture (each tooth) ***Additional fees may be charged to the member for actual lab fees.***	Major	No	No	All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.
D5610	Repair resin denture base ***Additional fees may be charged to the member for actual lab fees.***	Basic	No	No	All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.
D5630	Repair or replace broken clasp ***Additional fees may be charged to the member for actual lab fees.***	Basic	No	No	All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.
D5640	Replace broken teeth - per tooth ***Additional fees may be charged to the member for actual lab fees.***	Major	No	No	All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.
D5650	Add tooth to existing partial denture ***Additional fees may be charged to the member for actual lab fees.***	Major	No	No	All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.
D5660	Add clasp to existing partial denture ***Additional fees may be charged to the member for actual lab fees.***	Major	No	No	All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.
D5710	Rebase complete maxillary denture ***Additional fees may be charged to the member for actual lab fees.***	Major	No	No	Limited to once per 12 month period. All adjustments made for six months after the date of reline, by the same provider and same arch, are included in the fee for this procedure.
D5711	Rebase complete mandibular denture ***Additional fees may be charged to the member for actual lab fees.***	Major	No	No	Limited to once per 12 month period. All adjustments made for six months after the date of reline, by the same provider and same arch, are included in the fee for this procedure.
D5720	Rebase maxillary partial denture ***Additional fees may be charged to the member for actual lab fees.***	Major	No	No	Limited to once per 12 month period. All adjustments made for six months after the date of reline, by the same provider and same arch, are included in the fee for this procedure.

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D5721	Rebase mandibular partial denture ***Additional fees may be charged to the member for actual lab fees.***	Major	No	No	Limited to once per 12 month period. All adjustments made for six months after the date of reline, by the same provider and same arch, are included in the fee for this procedure.
D5730	Reline complete maxillary denture (chairside)	Major	No	No	Limited to once per 12 month period. All adjustments made for six months after the date of reline, by the same provider and same arch, are included in the fee for this procedure.
D5731	Reline complete mandibular denture (chairside)	Major	No	No	Limited to once per 12 month period. All adjustments made for six months after the date of reline, by the same provider and same arch, are included in the fee for this procedure.
D5740	Reline maxillary partial denture (chairside)	Major	No	No	Limited to once per 12 month period. All adjustments made for six months after the date of reline, by the same provider and same arch, are included in the fee for this procedure.
D5741	Reline mandibular partial denture (chairside)	Major	No	No	Limited to once per 12 month period. All adjustments made for six months after the date of reline, by the same provider and same arch, are included in the fee for this procedure.
D5750	Reline complete maxillary denture (laboratory) ***Additional fees may be charged to the member for actual lab fees.***	Major	No	No	Limited to once per 12 month period. All adjustments made for six months after the date of reline, by the same provider and same arch, are included in the fee for this procedure.
D5751	Reline complete mandibular denture (laboratory) ***Additional fees may be charged to the member for actual lab fees.***	Major	No	No	Limited to once per 12 month period. All adjustments made for six months after the date of reline, by the same provider and same arch, are included in the fee for this procedure.
D5760	Reline maxillary partial denture (laboratory) ***Additional fees may be charged to the member for actual lab fees.***	Major	No	No	Limited to once per 12 month period. All adjustments made for six months after the date of reline, by the same provider and same arch, are included in the fee for this procedure.
D5761	Reline mandibular partial denture (laboratory) ***Additional fees may be charged to the member for actual lab fees.***	Major	No	No	Limited to once per 12 month period. All adjustments made for six months after the date of reline, by the same provider and same arch, are included in the fee for this procedure.
D5820	Interim partial denture (maxillary)	Major	Yes	No	A stayplate or other temporization service is a benefit only to replace extracted permanent anterior teeth during the healing period and includes all teeth and claps. Replacement of a stayplate or other temporiztion services is not a benefit.
D5821	Interim partial denture (mandibular)	Major	Yes	No	A stayplate or other temporization service is a benefit only to replace extracted permanent anterior teeth during the healing period and includes all teeth and claps. Replacement of a stayplate or other temporiztion services is not a benefit.
D5850	Tissue conditioning, maxillary	Major	No	No	Limited to two per denture.
D5851	Tissue conditioning, mandibular	Major	No	No	Limited to two per denture.
D6210	Pontic - cast high noble metal	Major	Yes	Yes	**Benefits are limited to D6211. The difference in contracted fees for the procedure codes may be charged to the member as a noncovered expense.** Preauthorization is required. X-rays required. Not a benefit under the age of 16. A benefit once in a five-year period.
D6211	Pontic - cast predominantly base metal	Major	Yes	Yes	Preauthorization is required. X-rays required. Not a benefit under the age of 16. A benefit once in a five-year period.
D6212	Pontic - cast noble metal	Major	Yes	Yes	**Benefits are limited to D6211. The difference in contracted fees for the procedure codes may be charged to the member as a noncovered expense.** Preauthorization is required. X-rays required. Not a benefit under the age of 16. A benefit once in a five-year period.
D6214	Pontic - titanium	Major	Yes	Yes	Preauthorization is required. X-rays required. Not a benefit under the age of 16. A benefit once in a five-year period.
D6240	Pontic - porcelain fused to high noble metal	Major	Yes	Yes	**Benefits are limited to D6241. The difference in contracted fees for the procedure codes may be charged to the member as a noncovered expense.** Preauthorization is required. X-rays required. Not a benefit under the age of 16. A benefit once in a five-year period.
D6241	Pontic - Porcelain Predominantly Base Metal	Major	Yes	Yes	Preauthorization is required. X-rays required. Not a benefit under the age of 16. A benefit once in a five-year period.
D6242	Pontic - Porcelain Noble Metal	Major	Yes	Yes	**Benefits are limited to D6241. The difference in contracted fees for the procedure codes may be charged to the member as a noncovered expense.** Preauthorization is required. X-rays required. Not a benefit under the age of 16. A benefit once in a five-year period.
D6250	Pontic - resin with high noble metal	Major	Yes	Yes	**Benefits are limited to D6251. The difference in contracted fees for the procedure codes may be charged to the member as a noncovered expense.** Preauthorization is required. X-rays required. Not a benefit under the age of 16. A benefit once in a five-year period.
D6251	Pontic - resin with predominately base metal	Major	Yes	Yes	Preauthorization is required. X-rays required. Not a benefit under the age of 16. A benefit once in a five-year period.
D6252	Pontic - resin with nobel metal	Major	Yes	Yes	Preauthorization is required. X-rays required. Not a benefit under the age of 16. A benefit once in a five-year period.

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CODE	DESCRIPTION	PROCEDURE CATEGORY	PREAUTH REQUIRED	X-RAYS REQUIRED	PROCEDURE GUIDELINE
D6545	Retainer - cast metal for resin bonded fixed prosthesis	Major	Yes	Yes	Preauthorization is required. X-rays required. Not a benefit under the age of 16. A benefit once in a five-year period.
D6549	Resin retainer - for resin bonded fixed prosthesis	Major	Yes	Yes	Preauthorization is required. X-rays required. Not a benefit under the age of 16. A benefit once in a five-year period.
D6602	Inlay - cast high noble metal, two surfaces	Major	Yes	Yes	Preauthorization is required. X-rays required. Not a benefit under the age of 16. A benefit once in a five-year period.
D6603	Inlay - cast high noble metal, three or more surfaces	Major	Yes	Yes	Preauthorization is required. X-rays required. Not a benefit under the age of 16. A benefit once in a five-year period.
D6604	Inlay - predominantly base metal, two surfaces	Major	Yes	Yes	Preauthorization is required. X-rays required. Not a benefit under the age of 16. A benefit once in a five-year period.
D6605	Inlay - predominantly base metal, three or more surfaces	Major	Yes	Yes	Preauthorization is required. X-rays required. Not a benefit under the age of 16. A benefit once in a five-year period.
D6606	Inlay - cast high noble metal, two surfaces	Major	Yes	Yes	Preauthorization is required. X-rays required. Not a benefit under the age of 16. A benefit once in a five-year period.
D6607	Inlay - cast noble metal, three or more surfaces	Major	Yes	Yes	Preauthorization is required. X-rays required. Not a benefit under the age of 16. A benefit once in a five-year period.
D6610	Onlay - cast high noble metal, two surfaces	Major	Yes	Yes	**Benefits are limited to D6612. The difference in contracted fees for the procedure codes may be charged to the member as a noncovered expense.** Preauthorization is required. X-rays required. Not a benefit under the age of 16. A benefit once in a five-year period.
D6611	Onlay - cast high noble metal, three or more surfaces	Major	Yes	Yes	**Benefits are limited to D6613. The difference in contracted fees for the procedure codes may be charged to the member as a noncovered expense.** Preauthorization is required. X-rays required. Not a benefit under the age of 16. A benefit once in a five-year period.
D6612	Onlay - cast predominantly base metal, two surfaces	Major	Yes	Yes	Preauthorization is required. X-rays required. Not a benefit under the age of 16. A benefit once in a five-year period.
D6613	Onlay - cast predominantly base metal, three or more surfaces	Major	Yes	Yes	Preauthorization is required. X-rays required. Not a benefit under the age of 16. A benefit once in a five-year period.
D6614	Onlay - cast noble metal, two surfaces	Major	Yes	Yes	Preauthorization is required. X-rays required. Not a benefit under the age of 16. A benefit once in a five-year period.
D6615	Onlay - cast noble metal, three or more surfaces	Major	Yes	Yes	Preauthorization is required. X-rays required. Not a benefit under the age of 16. A benefit once in a five-year period.
D6624	Inlay - titanium	Major	Yes	Yes	Preauthorization is required. X-rays required. Not a benefit under the age of 16. A benefit once in a five-year period.
D6634	Onlay - titanium	Major	Yes	Yes	Preauthorization is required. X-rays required. Not a benefit under the age of 16. A benefit once in a five-year period.
D6720	Crown - resin with high noble metal	Major	Yes	Yes	**Benefits are limited to D6721. The difference in contracted fees for the procedure codes may be charged to the member as a noncovered expense.** Preauthorization is required. X-rays required. Not a benefit under the age of 16. A benefit once every five-year period from date of last placement except when the crown is no longer functional as determined by the Plan.
D6721	Crown - resin with predominantly base metal	Major	Yes	Yes	Preauthorization is required. X-rays required. Not a benefit under the age of 16. A benefit once every five-year period from date of last placement except when the crown is no longer functional as determined by the Plan.
D6722	Crown - resin with noble metal	Major	Yes	Yes	**Benefits are limited to D6721. The difference in contracted fees for the procedure codes may be charged to the member as a noncovered expense.** Preauthorization is required. X-rays required. Not a benefit under the age of 16. A benefit once every five-year period from date of last placement except when the crown is no longer functional as determined by the Plan.
D6750	Crown - porcelain fused to high noble metal	Major	Yes	Yes	**Benefits are limited to D6751. The difference in contracted fees for the procedure codes may be charged to the member as a noncovered expense.** Preauthorization is required. X-rays required. Not a benefit under the age of 16. A benefit once every five-year period from date of last placement except when the crown is no longer functional as determined by the Plan.
D6751	Crown – Porcelain Predom Base Metal	Major	Yes	Yes	Preauthorization is required. X-rays required. Not a benefit under the age of 16. A benefit once every five-year period from date of last placement except when the crown is no longer functional as determined by the Plan.
D6752	Crown – Porcelain Noble Metal	Major	Yes	Yes	**Benefits are limited to D6751. The difference in contracted fees for the procedure codes may be charged to the member as a noncovered expense.** Preauthorization is required. X-rays required. Not a benefit under the age of 16. A benefit once every five-year period from date of last placement except when the crown is no longer functional as determined by the Plan.
D6780	Crown - 3/4 cast high noble metal	Major	Yes	Yes	**Benefits are limited to D6781. The difference in contracted fees for the procedure codes may be charged to the member as a noncovered expense.** Preauthorization is required. X-rays required. Not a benefit under the age of 16. A benefit once every five-year period from date of last placement except when the crown is no longer functional as determined by the Plan.

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D6781	Crown - 3/4 cast predominantly base metal	Major	Yes	Yes	Preauthorization is required. X-rays required. Not a benefit under the age of 16. A benefit once every five-year period from date of last placement except when the crown is no longer functional as determined by the Plan.
D6782	Crown - 3/4 cast noble metal	Major	Yes	Yes	**Benefits are limited to D6781. The difference in contracted fees for the procedure codes may be charged to the member as a noncovered expense.** Preauthorization is required. X-rays required. Not a benefit under the age of 16. A benefit once every five-year period from the date of last placement except when the crown is no longer functional as determined by the Plan.
D6790	Crown - full cast high noble metal	Major	Yes	Yes	**Benefits are limited to D6791. The difference in contracted fees for the procedure codes may be charged to the member as a noncovered expense.** Preauthorization is required. X-rays required. Not a benefit under the age of 16. A benefit once every five-year period from the date of last placement except when the crown is no longer functional as determined by the Plan.
D6791	Crown - full cast predominantly base metal	Major	Yes	Yes	Preauthorization is required. X-rays required. Not a benefit under the age of 16. A benefit once every five-year period from the date of last placement except when the crown is no longer functional as determined by the Plan.
D6792	Crown - full cast noble metal	Major	Yes	Yes	**Benefits are limited to D6791. The difference in contracted fees for the procedure codes may be charged to the member as a noncovered expense.** Preauthorization is required. X-rays required. Not a benefit under the age of 16. A benefit once every five-year period from the date of last placement except when the crown is no longer functional as determined by the Plan.
D6794	Crown - titanium	Major	Yes	Yes	Preauthorization is required. X-rays required. Not a benefit under the age of 16. A benefit once in a five-year period.
D6930	Recement fixed partial denture	Major	Yes	Yes	Preauthorization is required. X-rays required. Not a benefit under the age of 16.
D6940	Stress breaker	Major	Yes	No	Coverage for simple stress breaker such as a keyway. Covered only in connection with fixed prosthodontics. More complex or precision attachments are considered optional.
D7111	Coronal Remnants - Deciduous Tooth	Basic	No	No	X-rays are not required. Requires a tooth code. Not a benefit for asymptomatic teeth.
D7140	Extraction, Erupted Tooth or Exposed Root	Basic	No	No	X-rays are not required. Requires a tooth code. Not a benefit for asymptomatic teeth. Ortho-only extractions are covered.
D7210	Surgical Removal of an Erupted Tooth	Basic	No	Yes	Preoperative x-rays should be submitted with the claim. A benefit when the removal of any erupted tooth requires the elevation of mucoperiosteal flap and the removal of substantial alveolar one or sectioning of the tooth. The surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists. Ortho-only extractions are covered.
D7220	Removal of Impacted Tooth (Soft Tissue)	Basic	No	Yes	**The surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists.** Preoperative x-rays should be submitted with the claim. A benefit when the major or the entire occlusal surface is covered by mucogingival soft tissue. The surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists. Ortho-only extractions are covered.
D7230	Removal of Impacted Tooth (Partially Bony)	Basic	No	Yes	**The surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists.** Preoperative x-rays should be submitted with the claim. A benefit when the removal of any impacted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone. One of the proximal heights of contour of the crown shall be covered by bone. The surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists. Ortho-only extractions are covered.
D7240	Removal of Impacted Tooth (Complete Bony)	Basic	No	Yes	**The surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists.** Preoperative x-rays should be submitted with the claim. A benefit when the removal of any impacted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone covering most or all of the crown. The surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists. Ortho-only extractions are covered.
D7250	Removal of Residual Root Totally Covered by Bone	Basic	No	Yes	Preoperative x-rays should be submitted with the claim. A benefit when the root is completely covered by alveolar bone. Not a separate fee/benefit to the provider performing the initial tooth extraction.
D7260	Oroantral fistual closure	Basic	Yes	Yes	Preoperative x-rays should be submitted with the claim, along with additional written documentation (surgical report)
D7261	Primary closure of a sinus perforation	Basic	Yes	Yes	Preoperative x-rays should be submitted with the claim, along with additional written documentation (surgical report)
D7270	Reimplantation and/or Stabilization of Accidentally Evulsed/Displaced Teeth and/or Alveous	Basic	No	Yes	Preoperative x-rays should be submitted with the claim. Requires a tooth code.
D7280	Surgical access of an unerupted tooth	Basic	No	Yes	Preoperative x-rays should be submitted with the claim. Preauthorization is recommended but not required. The procedure is limited to patients in active orthodontic treatment and the fee includes any orthodontic attachments.

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D7283	Placement of device to facilitate eruption of impacted tooth	Basic	Yes	Yes	Preauthorization is required. X-rays required.
D7285	Biopsy of oral tissues - hard (bone, tooth)	Basic	No	Yes	Pathology report should be submitted with the claim. Treatment includes the fee for the resection of hard tissue.
D7286	Biopsy of oral tissues - soft	Basic	No	No	Pathology report should be submitted with the claim. Treatment includes the fee for the resection of tumors and the resection of cysts.
D7310	Alveoloplasty (in Addition to Removal of Teeth) Per Quadrant	Basic	No	Yes	Preoperative x-rays must be submitted with claim. Requires a quadrant code. Not a benefit on the same date of service with two or more surgical extractions.
D7311	Alveoloplasty in Conjunction with Extractions – One to Three Teeth	Basic	No	Yes	Preoperative x-rays must be submitted with claim. Not a benefit on the same date of service with two or more surgical extractions.
D7320	Alveoloplasty No Extraction - Per Quadrant	Basic	No	Yes	Preoperative x-rays must be submitted with claim if photographs do not demonstrate need. Requires a quadrant code. Not a benefit within 6 months following extractions in the same quadrant performed by the same provider.
D7321	Alveoloplasty not with Extractions – One to Three Teeth	Basic	No	Yes	Preoperative x-rays must be submitted with claim if photographs do not demonstrate need. Not a benefit within 6 months following extractions in the same quadrant performed by the same provider.
D7340	Vestibuloplasty - ridge extension (secondary epithelialization)	Basic	No	Yes	Operative report should be submitted with the claim.
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	Basic	No	Yes	Operative report should be submitted with the claim. Bone or other hard tissue or synthetic grafts used to augment the vestibuloplasty are not a benefit. A frenectomy can not be charged as a separate benefit.
D7410	Excision of benign lesion up to 125 cm	Basic	No	Yes	Operative and pathology reports should be submitted with the claim. Pre-op and Post operative x-rays must be submit with the claim.
D7411	Excision of benign lesion greater than 125 cm	Basic	No	Yes	Operative and pathology reports should be submitted with the claim.
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 125cm	Basic	No	Yes	Preoperative x-rays indicating the location of the cyst and a pathology report must be submitted with claim.
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 125cm	Basic	No	Yes	Preoperative x-rays indicating the location of the cyst and a pathology report must be submitted with claim.
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 125cm	Basic	No	Yes	Preoperative x-rays indicating the location of the cyst and a pathology report must be submitted with claim.
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 125cm	Basic	No	Yes	Preoperative x-rays indicating the location of the cyst and a pathology report must be submitted with claim.
D7471	Removal of lateral exostosis (maxilla or mandible)	Basic	No	Yes	Preoperative x-rays must be submitted with claim. Please identify the quadrant treated by abbreviation in the area for the oral cavity.
D7510	Intraoral incision and drainage of abscess (Soft Tissue)	Basic	No	No	Written documentation required. Requires a quadrant code. Limited to once per quadrant per date of service. Not covered as a separate charge if any other definitive treatment is performed on the same date of service. Fee includes incision, placement and removal of a surgical draining device.
D7520	Extraoral incision and drainage of abscess (soft tissue)	Basic	No	No	Operative report should be submitted with the claim.
D7530	Removal of foreign body from mucosa, skin or subcutaneous alveolar tissue	Basic	No	No	Identify the nature of the foreign body on the claim.
D7540	Removal of reaction-producing foreign bodies, musculoskeletal system	Basic	No	Yes	Preoperative x-rays must be submitted with claim. Identify the nature of the foreign body on the claim.
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	Basic	No	Yes	Preoperative x-rays must be submitted with claim. Should be submitted to the Medical Carrier prior to submitting to the dental carrier for payment.
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	Basic	No	Yes	Preoperative x-rays and an operative report must be submitted with claim. Should be submitted to the Medical Carrier prior to submitting to the dental carrier for payment.
D7960	Frenulectomy - separate procedure	Basic	No	Yes	Preoperative photographs required. Written documentation including rationale demonstrating medical necessity and the specific treatment area. Requires arch code and is limited to once per arch per date of service.
D7970	Excision of hyperplastic tissue - per arch	Basic	No	No	Arch is required to be submitted on the claim.
D7971	Excision of Pericoronal Gingiva	Basic	No	Yes	Preoperative x-rays required. Written documentation including rationale demonstrating medical necessity. This procedure is included within the fee for any other treatment performed to the same tooth on the same date of service and should not be billed separately.

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CODE	DESCRIPTION	PROCEDURE CATEGORY	PREAUTH REQUIRED	X-RAYS REQUIRED	PROCEDURE GUIDELINE
D8010	Limited orthodontic treatment of the primary dentition	Ortho	No	No	Payment based on initial banding and ongoing treatment costs (e.g. monthly, quarterly). **Orthodontic benefits are only covered if the client scores 30 or greater on the Salzmann Index.** **NOTE: Once the Ortho Lifetime Maximum is reached, the member is responsible for all remaining charges, up to the Contracted fee.**
D8020	Limited orthodontic treatment of the transitional dentition	Ortho	No	No	
D8030	Limited orthodontic treatment of the adolescent dentition	Ortho	No	No	
D8040	Limited orthodontic treatment of the adult dentition	Ortho	No	No	
D8050	Interceptive orthodontic treatment of the primary dentition	Ortho	No	No	
D8060	Interceptive orthodontic treatment of the transitional dentition	Ortho	No	No	
D8070	Comprehensive orthodontic treatment of the transitional dentition	Ortho	No	No	
D8080	Comprehensive orthodontic treatment of the adolescent dentition	Ortho	No	No	
D8090	Comprehensive orthodontic treatment of the adult dentition	Ortho	No	No	
D8210	Removable appliance therapy	Ortho	No	No	Benefit limited to once per lifetime.
D8220	Fixed appliance therapy	Ortho	No	No	Benefit limited to once per lifetime.
D8660	Pre-orthodontic treatment visit	Ortho	No	No	
D9110	Palliative (Emergency) Treatment of Dental Pain	Basic	No	No	Limited to once per date of service when no other treatment is performed.
D9220	Anesthesia, General, One Half Hour	Basic	No	No	**A benefit only in conjunction with covered oral surgery or select endodontic (D3425, D3426) and periodontal surgical procedure (D4260).** The difference in contracted fee may be billed to the member as a noncovered expense. Documentation of medical necessity is required.
D9221	Anesthesia, General, Each Additional 15 Minutes	Basic	No	No	**A benefit only in conjunction with covered oral surgery or select endodontic (D3425, D3426) and periodontal surgical procedure (D4260).** The difference in contracted fee may be billed to the member as a noncovered expense. Documentation of medical necessity is required.
D9241	Intravenous Conscious Sedation/Analgesia – First 30 Minutes	Basic	No	No	**A benefit only in conjunction with covered oral surgery or select endodontic (D3425, D3426) and periodontal surgical procedure (D4260).** The difference in contracted fee may be billed to the member as a noncovered expense. Documentation of medical necessity is required.
D9242	Intravenous Conscious Sedation/Analgesia – Each Additional 15 Minutes	Basic	No	No	**A benefit only in conjunction with covered oral surgery or select endodontic (D3425, D3426) and periodontal surgical procedure (D4260).** The difference in contracted fee may be billed to the member as a noncovered expense. Documentation of medical necessity is required.
D9310	Special Consultation (Specialist Only – Separate Fee Only if Patient Not Treated by Consultant)	Preventive	No	No	Specialist Only - separate fee only if patient is not treated by the consulting specialist.
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed	Basic	No	No	
D9440	Office Visit - After Regularly Scheduled Hours	Basic	No	No	
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	Basic	No	No	Documentation describing the complications is required for payment.
D9940	Occlusal Guard, by Report	Basic	No	No	Documentation describing dental necessity is required for payment.
D9951	Occlusal adjustment - limited	Basic	No	No	Requires a quadrant code. Limited to patients age 13 and over and natural teeth. Not a benefit within 30 days of any definitive treatment in same or opposing quadrant.
D9952	Occlusal adjustment - complete	Basic	No	No	Requires a quadrant code. Limited to patients age 13 and over and natural teeth. Not a benefit within 30 days of any definitive treatment in same or opposing quadrant.

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ADMINISTRATIVE FORMS

Premier Access Insurance Company
8890 Cal Center Drive
Sacramento, CA 95826
FAX: 866.379.3247
WWW.PREMIERLIFE.COM

GRIEVANCE FORM

CHILDREN'S HEALTH INSURANCE PROGRAM
(Member Services: 1-877-854-4242)
❑ **CHIP**

UTAH MEDICAID
(Member Services 1-877-541-5415)
❑ **UT-MC**

Premier Access Insurance Company ("Premier") takes very seriously problems raised by its enrollees and endeavors to reach solutions acceptable to all concerned. To facilitate these efforts, please provide us with the following information. If you need assistance in completing this form, please contact Premier Member Services or any Plan provider representative.

Name: _____ Address:

City: _____ State: _____ Zip Code:_____ Telephone: (_____) _____-_____

NATURE OF COMPLAINT (BE AS SPECIFIC AS POSSIBLE & USE THE BACK OF THIS FORM IF MORE SPACE IS NEEDED):

DATE OF INCIDENT GIVING RISE TO THIS COMPLAINT: _____

NAMES OF PLAN PERSONNEL INVOLVED IN INCIDENT: _____

PLEASE MAIL or EMAILTHIS FORM TO:

Premier Access Insurance Company

Attention: Grievances/Appeals Department

P. O. Box 255039
Sacramento, CA 95865-5039

GreivanceDept@PremierLife.com

Please do not write below this line – for Plan use only.

Grievance Received By:	Date Received:	Time Received:	Grievance Log Completed By:
_____	_____	_____	_____

Premier Access Insurance Company
P.O. Box 659010
Sacramento, CA 95865-9010
WWW.PREMIERLIFE.COM

AUTHORIZATION TO USE & DISCLOSE HEALTH INFORMATION

Name of Member:_____ I.D. Number: _____

Address of Member: _____

I authorize **Premier Access Insurance Company** to use and disclose a copy of the specific health and dental information described below.

Information consisting of: *(Check all that apply.)*

❒ Eligibility ❒ Benefits ❒ Claims ❒ Prior Authorizations/Specialty Referrals

❒ Other (*Please specify*) _____

Name of the Person(s) or Organization(s) to whom you authorize us to use or disclose your information:

Please check all that apply, and list the name or organization:

❒ Spouse _____ ❒ Mother _____

❒ Employer _____ ❒ Father _____

❒ Child _____ ❒ Other _____

For the purpose of: *(Describe intended use or purpose of this disclosure)*

_____

_____

Expiration of Authorization: *(For how long do you wish this Authorization to last)*

❒ 1 year ❒ 3 years ❒ 5 years ❒ No expiration ❒ Other _____

If we are requesting this Authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

- We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
- You may inspect a copy of the protected health information to be used or disclosed;
- You may refuse to sign this Authorization; and
- We must provide you with a copy of the signed authorization.

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization.

Unless revoked earlier or otherwise indicated, this Authorization will expire one year from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

By:_____ Date: _____
Signature of Member (*or authorized representative, if Member is a minor*)

Printed Name of Authorized Representative _____

Relationship to Member _____

Please mail this form to the above-mentioned address to the attention of Customer Service. You may also FAX the form to 916.646.9000 to the Attention of Customer Service.

FOR INTERNAL USE ONLY		
Date Received	Entered into Member's Record By	Date original given to Privacy Officer

ORTHODONTIC SERVICE
SALZMANN EVALUATION INDEX

PATIENT'S NAME – LAST, FIRST, MIDDLE INITIAL	Member #	Date of Birth

REFERRING DENTIST

ORTHODONTIST'S NAME	Tax ID	DATE OF ASSESSMENT

HANDICAPPING MALOCCLUSION ASSESSMENT RECORD

A. Intra – Arch Deviation

SCORE TEETH AFFECTED ONLY		MISSING	CROWDED	ROTATED	SPACING		NO.	POINT VALUE	SCORE
					Open	Closed			
MAXILLA	ANT.							X2	
	POST.							X1	
MANDIBLE	ANT.							X1	
	POST.							X1	

ANT = Anterior Teeth (4 incisors)
POST = Posterior Teeth (Include canine, premolars and first molars)
NO. = Number of teeth affected

TOTAL SCORE

B. Inter – Arch Deviation

1. Anterior Segment

SCORE MAXILLARY TEETH AFFECTED ONLY EXCEPT OVERBITE*	OVERJET	OVERBITE	CROSSBITE	OPENBITE	NO.	POINT VALUE	SCORE
						X2	

*Score Maxillary or Mandibular Incisors
No. = Number of teeth affected

TOTAL SCORE

2. Posterior Segment

SCORE AFFECTED TEETH ONLY	RELATE MANDIBULAR TO MAXILLARY TEETH				SCORE AFFECTED MAXILLARY TEETH ONLY				NO.	POINT VALUE	SCORE
	DISTAL		MESIAL		CROSSBITE		OPENBITE				
	Right	Left	Right	Left	Right	Left	Right	Left			
CANINE										X1	
1ST PREMOLAR										X1	
2ND PREMOLAR										X1	
1ST MOLAR										X1	

TOTAL SCORE

When intra- and inter-arch maxillary incisor score is 6 or more to denote esthetic handicap, add 8 points.

GRAND TOTAL

A Salzmann Evaluation Index score of 30 points or more must be achieved to be eligible for orthodontic benefits under the Utah Children's Health Insurance Program (CHIP) and Utah Medicaid.

PLEASE COMPLETE THE FOLLOWING IN DETAIL:

DESCRIPTION OF PATIENT'S CONDITION AND DIAGNOSIS:

DIAGNOSTIC PROCEDURES:

TREATMENT PLAN:

REMARKS:

Detailed Instructions for Completing the Salzmann Index Evaluation

Introduction

This assessment record (not an examination) is intended to disclose whether a handicapping malocclusion is present and to assess its severity according to the criteria and weights (point values) assigned to them. The weights are based on tested clinical orthodontic values from the standpoint of the effect of the malocclusion on dental health, function, and esthetics. The assessment is not directed to ascertain the presence of occlusal deviations ordinarily included in epidemiological surveys of malocclusion. Etiology, diagnosis, planning, complexity of treatment, and prognosis are not factors in this assessment.

A. Intra-Arch Deviations

The casts are placed, teeth upward, in direct view. When the assessment is made directly in the mouth, a mouth mirror is used. The number of teeth affected is entered as indicated in the "Handicapping Malocclusion Assessment Record." The scoring can be entered later.

1. Anterior segment: A value of 2 points is scored for each tooth affected in the maxilla and 1 point in the mandible.
   - Missing teeth are assessed by actual count. A tooth with only the roots remaining is scored as missing.
   - Crowded refers to tooth irregularities that interrupt the continuity of the dental arch when the space is insufficient for alignment without moving other teeth in the arch. Crowded teeth may or may not also be rotated. A tooth scored as crowded is not scored also as rotated.
   - Rotated refers to tooth irregularities that interrupt the continuity of the dental arch but there is sufficient space for alignment. A tooth scored as rotated is not scored also as crowded or spaced.
   - Spacing:
     - Open spacing refers to tooth separation that exposes to view the interdental papillac on the alveolar crest. Score the number of papillae visible (not teeth).
     - Closed spacing refers to partial space closure that will not permit a tooth to complete its eruption without moving other teeth in the same arch. Score the number of teeth affected.

2. Posterior segment: A value of 1 point is scored of each tooth affected.
   - Missing teeth are assessed by actual count. A tooth with only the roots remaining is scored as missing.
   - Crowded refers to tooth irregularities that interrupt the continuity of the dental arch when the space is insufficient for alignment. Crowded teeth may or may not also be rotated. A tooth scored as crowded is not scored also as rotated.

Posterior segment continued…

- Rotated refers to tooth irregularities that interrupt the continuity of the dental arch and all or part of the lingual or buccal surface faces some part or all of the adjacent proximal tooth surfaces. There is sufficient space for alignment. A tooth scored as rotated is not scored also as crowded.
- Spacing:
  - Open spacing refers to interproximal tooth separation that exposes to view the mesial and distal papillae of a tooth. Score the number of teeth affected (Not the spaces).
  - Closed spacing refers to partial space closure that will not permit a tooth to erupt without moving other teeth in the same arch. Score the number of teeth affected.

B. Interarch Deviations

When casts are assessed for interarch deviations, they first are approximated in terminal occlusion. Each side assessed is held in direct view. When the assessment is made in the mouth, terminal occlusion is obtained by bending the head backward as far as possible while the mouth is held wide open. The tongue is bent upward and backward on the palate and the teeth are quickly brought to terminal occlusion before the head is again brought downward. A mouth mirror is used to obtain a more direct view in the mouth.

1. Anterior segment: A value of 2 points is scored for each affected maxillary tooth only.
   - Overjet refers to labial axial inclination of the maxillary incisors in relation to the mandibular incisor, permitting the latter to occlude on or over the palatal mucosa. If the maxillary incisors are not in labial axial inclination, the condition is scored as overbite only.
   - Overbite refers to the occlusion of the maxillary incisors on or over the labial gingival mucosa of the mandibular incisors, while the mandibular incisors themselves occlude on or over the palatal mucosa in back of the maxillary incisors. When the maxillary incisors are in labial axial inclination, the deviation is scored also as overjet.
   - Cross-bite refers to maxillary incisors that occlude lingual to their opponents in the opposing jaw, when the teeth are in terminal occlusion.
   - Open-bite refers to vertical interach dental separation between the upper and lower incisors when the posterior teeth are in terminal occlusion. Open-bite is scored in addition to overjet if the maxillary incisor teeth are above the incisal edges of the mandibular incisors when the posterior teeth are in terminal occlusion edge-to-edge occlusion in not assessed as open-bite.

2. Posterior segment: A value of 1 point is scored for each affected tooth.
   - Cross-bite refers to teeth in the buccal segment that are positioned lingually or buccally out of entire occlusal contact with the teeth in the opposing jaw when the dental arches are in terminal occlusion.
   - Open-bite refers to the vertical interdental separation between the upper and lower segments when the anterior teeth are in terminal occlusion. Cusp-to-cusp occlusion is not assessed as open-bite.
   - Anteroposterior deviation refers to the occlusion forward or rearward of the accepted normal of the mandibular canine, first and second premolars, and first molar in relation to the opposing maxillary teeth. The deviation is scored when it extends a full cusp or more in the molar and the premolars and canine occlude in the interproximal area mesial or distal to the accepted normal position.

REFERRAL GUIDELINES

Purpose:

To provide uniform guidelines of responsibility for General Dentists under the **Medicaid capitated program**, to ensure that the level of specialized care provided by general practitioners is appropriate. The General Dentist is responsible for providing routine emergency and after hours emergency care, diagnostic and treatment planning procedures, diagnostic therapy, and the coordination of multi-disciplined treatment as needed.

Policy:

Under the Medicaid capitated program, prior authorization is required for referral outside of the capitated facility. It is the policy of Premier Access that general dentists provide the complete range of dental treatments for which they are licensed. Patients are only referred to a provider outside the capitated facility for treatment of conditions that are beyond the capability of the general practitioner. The Referral Department will make decisions on authorizations based on the information provided by the referring provider. The accuracy of this information will be verified based on the written referral request submitted by the referring provider.

In cases where a referring dentist inappropriately refers a member to a provider outside of his/her facility, the referring dentist may be financially responsible for the dental care. The member will only be financially responsible for applicable co-payment (if any) and the treating provider shall receive payment of benefits for covered services. The referring dentist may be subject to a back charge to cover the costs the Plan incurred for the inappropriate referral. The referring dentist may appeal the determination in writing via letter, e-mail or facsimile and the Plan will process the appeal request in accordance with any regulatory requirements and existing policies and procedures.

An inappropriate referral is defined as:

- A referral when the member is not eligible for benefits;
- A referral for services that do not meet the conditions listed for referral guidelines below; or
- A referral to a non-contracted dentist providing specialty care without prior authorization of benefits from the Plan for non emergency services.

Endodontics

All routine endodontic procedures are the responsibility of the general Dentist. This includes initial treatment of root canal fillings for single and multi-canal teeth. The Dentist must also provide emergency pulpal, I & D, and bleaching treatment. Referrals may be made for complicated "tried and failed" cases, apicoectomies, and retro fillings.

Pedodontics

The general Dentist is responsible for the routine care of children of all ages. Routine care includes extractions, fillings, stainless steel crowns, pulpotomy, space maintainers, sealants, prophylaxis, and fluoride treatment. Young children with complicated management problems may constitute an appropriate referral to a specialist if at least two documented attempts with date of attempts, have been made by the Dentist in treating the patient. Some Patients with special health care needs may be considered as exceptions to this policy.

Periodontics

The general Dentist is responsible for the diagnosis and maintenance of his/her patient's periodontal care. The Dentist must be adept at surveying the patient's periodontal situation and home care motivation. The Dentist is responsible for all non-surgical treatment including, but not limited to, prophylaxis, subgingival curettage, root planning, oral hygiene instruction, and minor occlusal adjustment.

Referral procedures may include: gingival surgery, osseous surgery, complete occlusal equilibration and orthodontic appliances. All periodontal referrals must indicate that the following procedures have been performed by the general Dentist prior to the referral:

1. Complete exam
2. Full Mouth X-rays
3. Full periodontal examination
4. Full mouth root planning
5. Recall periodontic exam within 3-6 months from the date of the initial root planning.

Oral Surgery

The general Dentist is responsible for providing Oral Surgery for erupted and devastated dentition including surgical extractions, root sectioning and retrieval, soft tissue impaction, intra-oral I & D, and/or routine minor surgical procedures. THE PLAN will cover extractions of impacted teeth only with an existing pathology, immature, erupting third molars, which are currently impacted (usually on patients 18 years or younger) are not a covered benefit. Extraction of impacted, asymptomatic teeth with no pathology on adult patients is not a benefit of THE PLAN. Part and full bony symptomatic impactions, biopsies, and osseous re-contouring and patients requiring hospital dentistry and specialist involvement due to the medical problem, may be referred to an Oral Surgeon.

Anesthesia

The general Dentist is expected to be an expert in controlling pain through the use of relaxation techniques and local anesthesia.

Orthodontics

General Dentists are not expected to have extensive orthodontic training and are not required to provide this care.

Referral Form
Utah Medicaid

Mail: Premier Access Referral Dept.
P.O. Box 659010
Sacramento, CA 95865-9010
Telephone: 877-541-5415 Fax: 877-679-7197

PLEASE CHECK APPROPRIATE

O Routine Referral **O Emergency Referral**

PATIENT INFORMATION	PRIMARY CARE DENTIST INFORMATION
Patient Name:	Provider Name:
Parent's Name (if minor):	Provider Office Number:
CIN Number:	Provider Phone Number:
Phone: DOB:	Provider Fax Number:
Address:	Address:
City, State, Zip:	City, State, Zip:
Social Security Number (optional):	License Number:

REQUEST FOR REFERRAL: O Endodontist O Pedodontist O Orthodontist
O Oral surgeon O Periodontist

ATTACHMENTS: O X-rays included: O YES O NO If yes, how many?_____(PLEASE ATTACH FILMS TO THIS FORM)

PLEASE REFER TO THE PREMIER ACCESS REFERRAL GUIDELINES ON THE BACK OF THIS FORM FOR DETAILS REGARDING THE DOCUMENTATION REQUIRED TO PROCESS YOUR REFERRAL.

DESCRIBE THE PROCEDURE AND REASON FOR REFERRAL

PATIENT MUST BE ELIGIBLE FOR COVERAGE AT TIME OF SERVICE

REFERRED PROVIDER: PLEASE RETURN X-RAYS WHEN TREATMENT IS COMPLETED

IN MY PROFESSIONAL JUDGMENT THE TREATMENT LISTED REQUIRES : TREATMENT BY A PROVIDER OUTSIDE OF MY FACILITY O YES O NO

REFERRING DENTIST SIGNATURE: _____ **DATE:** _____

THIS AUTHORIZATION IS VALID FOR 90 DAYS FROM DATE OF APPROVAL

FOR ACCESS DENTAL/PREMIER ACCESS PLAN USE ONLY

PLEASE SEE ATTACHED RESPONSE TO REFERRAL REQUEST FOR THE FOLLOWING

O Approved	Date:	Initial:
O Modified	Date:	Initial:
O Insufficient Information	Date:	Initial:
O Denied	Date:	Initial:

PREMIER ACCESS

Transfer Request Form
Utah Medicaid Capitated Program

Date:_____

Dental Office Name:_____ Member Name:_____

Office Telephone #:_____ Member ID #:_____

Member Telephone #:_____

Reason for Request: All Provider Transfer Requests will be processed by the Plan within 30 days from the date of receipt. All approved transfers will be result in the deletion of the Member from the next month's roster. Providers will be notified by the Plan, in writing, of any denied requests.

- ❑ Member is repeatedly verbally abusive to the provider, auxiliary or administrative staff or other Plan members.
- ❑ Member physically assaulted the provider or staff person or another member or threatened another individual with a weapon on provider's premises. In this instance, the provider shall file a police report and file charges against the member.
- ❑ Member was disruptive to the provider's office operations.
- ❑ Member has allowed the fraudulent use of his/her coverage under the Plan, which includes his/her allowance of others to use his/her membership card to receive services from Providers.
- ❑ Member has failed to follow prescribed treatment (including failure to keep established appointments). This shall not, in and of itself, be good cause for a request for Member reassignment unless the provider can demonstrate that, as a result of the failure, the Provider is exposed to a substantially greater and unforeseeable risk than otherwise contemplated under the Plan and the rate-setting assumptions.

Additional comments for transfer:_____

_____

Please list the missed appointment dates: _____

Dentist's Signature:_____ **Date:**_____

PLEASE MAIL REQUEST TO: PREMIER ACCESS, P.O. BOX 659010, SACRAMENTO, CA 95865-9010
Attention: Provider Services Department

FOR PREMIER ACCESS OFFICE USE ONLY:

Person Receiving Complaint:_____ Date of Action:_____

Action Taken:_____

_____