KANSAS MEDICAL ASSISTANCE PROGRAM

Provider Manual

Dental

Updated 01.2015

Kansas Medical Assistance Program
Contact Information

Customer Service can be reached at the following telephone numbers:
8:00 a.m. to 5:00 p.m., Monday through Friday
In-State Toll-Free Line: 1-800-933-6593 Local Line: 785-274-5990 (Topeka)

Callers should have their provider number and all pertinent information available at the time the call is placed**.** Business calls may be monitored or recorded at any time for the purpose of ensuring the accuracy and quality of information provided.

AVRS (Automatic Voice Response System)
24 hours a day, 7 days a week,
Except 1:00 to 2:00 a.m., Monday through Saturday, and 1:00 to 5:00 a.m. on Sunday
In-State Toll-Free Line: 1-800-933-6593 Local Line: 785-274-5990 (Topeka)

KMAP website 24 hours a day, 7 days per week

EDI (Electronic Data Interchange) **Help Desk**
8:00 a.m. to 5:00 p.m., Monday through Friday
E-Mail: loc-ksxix-edikmap@external.groups.hp.com
Phone Number: 1-800-933-6593 Fax Number: 785-267-7689

Written Inquiries
Mail written inquiries to the following address:
Office of the Fiscal Agent
P.O. Box 3571
Topeka, KS 66601-3571

Appeals/Fair Hearing
Mail written requests to the following address:
Office of Administrative Hearings
1020 South Kansas Avenue
Topeka, KS 66612-1327

A copy of the CDT (Current Dental Terminology) manual can be purchased from the American Dental Association at the following address:
American Dental Association
211 East Chicago Avenue
Chicago, IL 60611
1-800-947-4746

DISCLAIMER: For provider resources available through the KanCare managed care organizations, reference the KanCare website. Contact the specific health plan for managed care assistance.

Beneficiary Rights and Responsibilities

The mission of Kansas Medical Assistance Program (KMAP) is to expand the beneficiary's access to high-quality, compassionate healthcare services within the allocated resources. KMAP is committed to ensuring that all beneficiaries are treated in a manner that respects their rights and acknowledges its expectations of the beneficiary's responsibilities.

The following is a statement of the beneficiary's rights and responsibilities.

- All beneficiaries have a right to receive pertinent written and up-to-date information about KMAP, the participating providers and dental offices, and the beneficiary's rights and responsibilities.
- All beneficiaries have a right to privacy and to be treated with dignity when receiving dental care, which is a private and personal service.
- All beneficiaries have the right to fully participate with caregivers in the decision-making process surrounding their healthcare.
- All beneficiaries have the right to be fully informed about the appropriate or medically necessary treatment options for any condition, regardless of the coverage or cost for the care discussed.
- All beneficiaries have the right to voice a grievance against KMAP or any of its participating dental offices, or any of the care provided by these groups or people when their performance has not met the beneficiary's expectations.
- All beneficiaries have the right to appeal any decisions related to patient care and treatment. Beneficiaries may also request an external review or second opinion.
- All beneficiaries have the responsibility to provide, to the best of their abilities, accurate information that KMAP and its participating dentists need to provide the highest quality of healthcare services.
- All beneficiaries have a responsibility to follow closely the treatment plans and home care instructions for the care they have agreed upon with their healthcare practitioners.

Provider Rights and Responsibilities

Providers shall have the right to:

- Communicate with beneficiaries regarding dental treatment options
- Recommend a course of treatment to a beneficiary, even if the course of treatment is not a covered benefit or approved by KMAP
- File an appeal or grievance pursuant to KMAP procedures
- Supply accurate, relevant, factual information to a beneficiary in connection with an appeal or grievance filed by the beneficiaries
- Object to policies, procedures, or decisions made by KMAP

Note: If a recommended course of treatment is not covered (not approved by KMAP), the participating provider must notify the beneficiary in writing and obtain a signature of waiver if the provider intends to charge the beneficiary for such a noncompensable service.

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

Table of Contents

FORMS All forms pertaining to this provider manual can be found on the public and secure websites.

I. Introduction to the Kansas Medical Assistance Program

The Kansas Medical Assistance Program (KMAP) is designed to assist eligible individuals in obtaining medical care. KMAP is funded by a combination of state and federal monies.

A. Oversight

The Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF) is responsible for the administration of KMAP. All programs must operate according to the laws and regulations of the State of Kansas. Because KMAP receives federal monies, it must also abide by the regulations of the Department of Health and Human Services.

B. Provider Participation

The following provider types are allowed to submit claims for dental services subject to applicable laws and regulations:

- Dentist (including all dental specialists)
- Indian Health Clinic (IHC)
- Local Health Department (LHD)
- Federally Qualified Health Center (FQHC)
- Head Start

KMAP provider applications, ancillary documentation, and provider update forms are available on the KMAP website.

Each provider performing services, including those within a group practice, must be individually enrolled in KMAP. Therefore, as group practices enroll or as new providers join a group, each individual must enroll separately. If individual providers within a given group fail to enroll, payment to the group may be denied or recovered. Refer to Kansas Administrative Regulations (K.A.R.) 30-5-59 for specific regulation requirements. Notify KMAP as soon as possible with changes to your participation status. Contact the Provider Enrollment department at 1-800-933-6593 for assistance. Not having accurate enrollment information on file may cause delays to the payment of your dental claims.

IHC and FQHC provider types **do not** have to obtain a separate dental provider number to provide dental services through KMAP.

LHD and Head Start providers **must obtain** a separate dental provider number to provide dental services through KMAP.

1. Extended Care Permit Hygienist Services

Dental services are reimbursable to a participating dental provider when performed by an Extended Care Permit (ECP) hygienist in community settings for certain populations as defined in the Kansas Dental Practice Act (KDPA). Reference Kansas Statue Section 65-1456. This act includes services provided by an ECP I, ECP II, or ECP III.

As outlined in the KDPA, the sponsoring dentist must give oral or written instruction for the ECP to provide these services. If the permission is given by the sponsoring dentist and the procedure(s) are consistent with the KDPA, it will be considered for payment based on the benefits and limitations of the current dental program covered codes. An ECP may be an employee of or contracted by a participating dental provider and must comply with all regulations of the current KDPA. An ECP's sponsoring dentist or facility, FQHC, Head Start, or LHD must be a participating provider.

In addition to the services outlined in the KDPA, a registered dental hygienist with an ECP can bill KMAP for D9999 – clinical and caries risk assessment, toothbrush prophylaxis of a child 0-3 years of age and counseling to parents/primary caregivers. Maximum allowable amount is $20.30.

C. Payments to Providers

Payments to all providers are subject to the KMAP's limitations. This provider manual is intended to assist providers by outlining these limitations. Please refer to K.A.R. 30-5-67 and K.A.R. 30-5-70 for specific regulations. Should funds budgeted for the fiscal year prove inadequate to meet all costs on the basis of fees and charges, payments to providers will be pended, and a payment plan as determined by KDHE-DHCF will be developed within federal guidelines.

IHC and FQHC provider types are paid their encounter rate for dental services. All other dental providers are paid fee-for-service for dental services.

D. HIPAA Compliance

As a KMAP participant, providers are required to comply with compliance reviews and complaint investigations conducted by the Secretary of the Department of Health and Human Services as part of the Health Insurance Portability and Accountability Act (HIPAA) in accordance with section 45 of the code of regulations parts 160 and 164. Providers are required to furnish the Department of Health and Human Services all information required by the Department during its review and investigation.

The provider is required to provide the same forms of access to records to the Medicaid Fraud and Abuse Division of the Kansas Attorney General's Office upon request from such office as required by K.S.A. 21-3853 and amendments thereto.

A provider who receives such a request for access to or inspection of documents and records must promptly and reasonably comply with access to the records and facility at reasonable times and places. A provider must not obstruct any audit, review, or investigation, including the relevant questioning of the provider's employees. The provider shall not charge a fee for retrieving and copying documents and records related to compliance reviews and complaint investigations.

E. National Provider Identifier

The national provider identifier (NPI) is the standard provider identifier throughout the national healthcare industry as of May 23, 2007. All healthcare providers who are HIPAA-covered entities must have an NPI to be able to file standard electronic transactions via the KMAP website or using Provider Electronic Solutions software. The 10-digit number can either be Type 1 (individual) or Type 2 (businesses or group practices).

There are three ways to apply for your NPI:

- Call the National Plan and Provider Enumeration System (NPPES) at 1-800-465-3203 to request an application.
- Download the application from the Centers for Medicare & Medicaid Services website.
- Electronically file for an NPI through the NPPES website.

KMAP encourages you to include all of your provider numbers (including KMAP), the carrier name, and the state on your NPI application.

II. Border City/Out-of-State Providers

A. Border Cities

When a provider is located in a state other than Kansas, and services are rendered in that state, the provider must be licensed and otherwise certified by the proper agencies in his or her state of residence as qualified to render the services for which the charge is made. Certain cities, within 50 miles of the Kansas border, may be closer for Kansas residents than major cities in Kansas, and therefore these cities are considered border cities (see list below). This list is not all-inclusive. All others are considered out-of-state and require prior authorization.

Arkansas
Bentonville
Gateway
Gravette
Rogers

Colorado
Arapahoe
Burlington
Campo
Cheyenne
Wells
Eads
Eckley
Idalic
Joes
Kirk
Lamar
Lycan
Springfield
Stonington
Stratton
Vilas
Vona
Walsh
Wiley
Wray
Yuma

Missouri
Anderson
Appleton City
Asbury
Belton
Blue Springs
Burlington
Junction
Butler
Carthage
Claycomo
Craig
El Dorado Springs
Excelsior Springs
Gladstone
Golden
Gower
Grandview
Harrisonville
Independence
Jasper
Joplin
Kansas City Metro
King City
Lamar
Lee's Summit
Liberty
Maryville
Monett
Mound City
Mt. Vernon
Nevada
Noel
North Kansas City
Oregon
Parkville
Platte City
Plattewoods
Pleasanton
Raytown
Rich Hill
Rockport
St. Joseph
Sarcoxie
Savannah
Seligman
Seneca
Sheldon
Smithville
Stanberry
Tarkio
Urich
Warrensburg
Webb City

Nebraska
Alma
Araphoe
Auburn
Axtell
Ayr
Beatrice
Beaver City
Benkelman
Bertrand
Blue Hill
Cambridge
Chester
Clay Center
Cortland
Curtis
Deshler
Elwood
Fairbury
Falls City
Franklin
Geneva
Hastings
Hayes Center
Hebron
Holdrege
Humboldt
Indianola
Kearney
Maywood
McCook
Minden
Nelson
Oxford
Pawnee City
Red Cloud
Sterling
Stockville
Superior
Sutton
Table Rock
Tecumseh
Wilsonville
Wymore

Oklahoma
Afton
Alva
Bartlesville
Beaver
Blackwell
Boise City
Buffalo
Cherokee
Cleveland
Collinsville
Commerce
Dewey
Enid
Grainola
Grove
Guymon
Hooker
Laverne
Medford
Miami
Nowata
Pawnee
Ponca City
Vinita
Wakita
Waynoka
Woodward

Eligibility Verification Options

AVRS

1-800-933-6593

KMAP website

B. Out-of-State Providers

All nonemergent medical services provided out-of-state (except those within 50 miles of a Kansas border) require prior authorization (PA) be obtained before the services are rendered for KMAP to consider the claim for payment regardless of other insurance coverage. The in-state referring provider or the out-of-state provider can start the PA process.

When a beneficiary is referred for services outside the state of Kansas, it is the referring provider's responsibility to provide the following information:

- A copy of the patient's history and examination completed within the past year
- A statement from the referring provider documenting the medical necessity of the service being requested, including reasons why the service cannot be provided within the state, where the recommended service will be provided, and the expected outcome of the referral
- Name, address, and phone number of the out-of-state provider who will be providing the service for the patient

III. Benefits

A. Plan Eligibility

Any person who is enrolled in KMAP may be eligible for benefits under the KMAP dental program.

There are two plans of eligibility: Title 19 and Title 21.

Title 19 Children	**Ages 0-20**
Title 19 Adults	**Ages 21 and over**
Title 21 Children	**Ages 0-18**

Effective with dates of service on and after January 1, 2013, all Title 21 and most Title 19 beneficiaries will be assigned to a managed care organization (MCO) through KanCare.

Refer to the exhibits at the end of this manual for a complete list of covered codes for each benefit plan and age group.

For beneficiaries **not assigned to an MCO**, required documentation, medical review, and PA requirements are listed in this manual.

For beneficiaries **assigned to an MCO**, refer to the individual dental manual of the appropriate MCO for a list of documentation, PA requirements, and limitations for each covered dental code.

B. Title 21 Children Ages 0-18 and Title 19 Children Ages 0-20

KMAP covers periodic teeth cleaning, fluoride treatment, sealants, tooth restorations, radiographs, extractions, and other dental services as outlined in Exhibit A for children who qualify for the program.

C. ICF/IID Beneficiaries Ages 21 and Over

ICF/IID beneficiaries are eligible for selected dental services. Refer to Appendix B for specific procedure codes.

KMAP dental beneficiaries under age 21 residing in an ICF/IID are not restricted to the services specified in Exhibit B (ICF/IID Ages 21 and Over). They are allowed a full scope of dental services. Refer to Exhibit A (Title 21 Children Ages 0-18 and Title 19 Children Ages 0-20) for a list of covered codes as well as medical review and PA requirements for children in an ICF/IID.

D. Title 19 Ages 21 and Over (not ICF/IID)

Extractions are covered for Title 19 adults **only when considered medically necessary**. Exam and x-rays are reimbursable only when performed in conjunction with covered services or to make a diagnosis for such a situation. Extractions may be considered medically necessary for:

- Acute or chronic infection or abscesses
- Traumatic injury where the teeth are beyond salvage
- Prophylaxis (preventive) extractions under the following circumstances:
    - Organ transplant workup
    - Intraoral radiation workup
    - Heart valve replacement
    - Immunodeficient states for which prophylactic extractions are medically justified
- Potential life-threatening condition

Refer to the *General Benefits Fee-for-Service Provider Manual* on the Providers Manual page of the KMAP website for specific benefit plan information.

To obtain a paper copy of the provider manuals, please call Customer Service at 1-800-933-6593.

E. HCBS Adult Ages 21 and Over (not ICF/IID)

Home and Community Based Services (HCBS) adult beneficiaries covered under the waiver programs listed below are no longer eligible for selected dental services.

- Intellectual or Developmental Disabilities (I/DD)
- Traumatic Brain Injury (TBI), formerly known as Head Injury (HI)
- Physical Disability (PD)

Note: Dental coverage for these beneficiaries is provided under the Title 19 adult benefit plan (Exhibit C).

Refer to the *General Benefits Fee-for-Service Provider Manual* on the Providers Manual page of the KMAP website for specific benefit plan information.

To obtain a paper copy of the provider manuals, please call Customer Service at 1-800-933-6593.

F. HCBS Adult Ages 65 and Over (not ICF/IID)

HCBS adult beneficiaries covered under the Frail Elderly (FE) waiver program are no longer eligible for selected dental services. Although annual cost limits are not in place at this time, limitations have been imposed that require beneficiaries to receive crisis exception approval from the Kansas Department for Aging and Disability Services (KDADS). A notification of approval from the beneficiary's targeted case manager must be received noting a specified time frame for the services to be performed prior to any oral health services being provided.

Note: Primary dental coverage for these beneficiaries is provided under the Title 19 adult benefit plan (Exhibit C).

G. Money Follows the Person

Money Follows the Person (MFP) adult beneficiaries covered through the FE, PD, TBI (or HI) and I/DD waivers are eligible for dental coverage.

- Exhibit D outlines coverage for PD, TBI (or HI) and I/DD.
- Exhibit E outlines coverage for FE.

For specific information concerning MFP, reference the *Money Follows the Person Fee-for-Service Provider Manual*.

H. MediKan

Dental services are not covered for MediKan beneficiaries under KMAP.

I. Children and Family Services (CFS) Contractors

Medicaid reimbursable services are not paid by child welfare contractors. All services for children assigned to contractors, including behavior management and mental health, must be billed directly to KMAP and are reimbursed at the approved Medicaid rate. PA and other restrictions apply.

J. Medically Needy (Spenddown)

In some cases, the income of a family or individual exceeds the income standard to receive public assistance monies; however, their income is not sufficient to meet all medical expenses. The family or individual must then incur a specified amount of medical expense to be eligible for KMAP benefits. This process is referred to as spenddown.

KMAP does not make payment on the amount that is the beneficiary's responsibility. The KMAP website identifies those beneficiaries with a spenddown obligation.

Note: Do not reduce the claim charges or balance due by the spenddown amount. This reduction is made automatically during claim processing.

K. Emergency Services for Aliens (SOBRA)

In addition to inpatient hospital and emergency room hospital, emergency services performed in outpatient facilities and related physician, lab, and x-ray services are allowed for the following places of service: office, outpatient hospital, FQHC, state or local public health clinic, Rural Health Clinic, ambulance, and lab for SOBRA claims. Follow-up care is not allowed once the emergent condition has been stabilized.

L. Hospice Beneficiaries

Hospice provides an integrated program of appropriate hospital and home care for the terminally ill patient. It is a physician-directed, nurse-coordinated, interdisciplinary team approach to patient care which is available 24 hours a day, seven days a week.

Services normally covered under KMAP require PA when the beneficiary is a hospice beneficiary and the service does not relate to the terminal illness. For information on obtaining PA, refer to Section 4300 in the *General Special Requirement Fee-for-Service Provider Manual* on the Provider Manuals page of the KMAP website.

IV. Limitations

Dental offices are not allowed to charge the beneficiary for missed appointments.

Beneficiaries are to be allowed the same access to dental treatment as any other patient in the dental practice.

Private reimbursement arrangements may be made only for noncovered services.

A. Advanced Beneficiary Notice (ABN)

Before beneficiaries can be charged for any services, they must sign an Advanced Beneficiary Notice (ABN). A sign at the front desk of the provider's office or a verbal notice are **not** acceptable. A copy of the ABN must be kept in the beneficiary's chart. The beneficiary must sign and date the form. Each provider can create his or her own notice, but suggested wording is: "This constitutes advance notice to you, the beneficiary, that if all program requirements are met by (the provider) and payment is not made by KMAP, you may be held responsible for the charges if your services are not covered by KMAP."

B. Payment for Noncovered Services

Participating providers shall hold beneficiaries and KDHE-DHCF harmless for the payment of noncovered services except as provided in this paragraph. A provider may bill a beneficiary for noncovered services if the provider obtains a written waiver from the beneficiary prior to rendering such service that indicates:

- The services to be provided
- KMAP will not pay for or be liable for said services
- Beneficiary will be liable financially for such services

Beneficiaries may be billed only when program requirements have been met and the provider has informed the beneficiary in advance and in writing, per K.A.R. 30-5-59 (e)(4).

C. Copay

Copay is the beneficiary's share of the cost of his or her medical services. By federal guidelines, each state can set its own copay rates and policies.

Dental services require a $3 copay per date of service per claim.

Do **not** reduce charges or balance due by the copay amount. This reduction will be made automatically during claim processing.

Refer to the *General TPL Payment Fee-for-Service Provider Manual* on the Provider Manuals page of the KMAP website for additional copay information.

To obtain a paper copy of the provider manuals, please call Customer Service at 1-800-933-6593.

Copay applies to all beneficiaries and services unless one of the following **exceptions** is met:

- ICF/IID beneficiary
- Title 21 beneficiary
- Beneficiaries under 18 years of age
- Residents in adult care homes, swing bed nursing facilities, or participants in an HCBS waiver program
- Beneficiaries 18 years of age but under 22 years of age or 65 years of age or older, who are inpatients in a state psychiatric facility
- Beneficiaries eligible for KMAP due to a diagnosis of breast or cervical cancer
- Beneficiaries in out-of-home placement and in Kansas Department for Children and Families (DCF) or Kansas Department of Corrections (KDOC) custody who are at least 18 years of age, but under 21 years of age

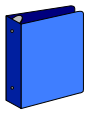
Services that are noncovered by KMAP do not have applicable copay amounts. In situations where the services are noncovered, a copay does not apply due to the fact that the beneficiary is responsible for the entire amount of the services.

Federal law mandates a provider cannot deny services to a beneficiary because he or she is unable to pay the current or prior copay. Providers may ask whether the beneficiary is able to pay the copay at the time of service. If the beneficiary states an inability to pay the copay, providers must accept this statement and may not collect the copay from the beneficiary at the time. Inability to pay the copay at the time the service is provided does not waive the beneficiary's responsibility to make payment at a future time. Providers may pursue incurred copay like any other debt owed them, including the use of payment plans and collection agencies.

D. Timely Filing

KMAP must receive claims within 12 months of the date of the service. Claims not received within 12 months are denied.

For specific billing information related to timely filing, see the Dental Billing Guide in Appendix B.



1. Retroactive Eligibility

For timely filing purposes, the provider may file a claim for services provided to a beneficiary whose application for benefits is delayed due to determination of eligibility. Enter the word **PENDING** in place of the beneficiary identification (ID) number on paper claims or all nines on electronic submission. The KMAP fiscal agent processes the claim and denies it with HIPAA Reason and Remark Code 140 on the remittance advice (RA). When the beneficiary's eligibility is approved, enter his or her ID number and resubmit the claim for processing. It is the beneficiary's responsibility to inform the provider of eligibility. If the provider believes eligibility has been determined but has not received this information from the beneficiary, the provider can check eligibility using the KMAP website or AVRS or by calling Customer Service.

2. Other Insurance Related Claims

Claims must be filed to other insurance within 12 months of the date of service. Once benefits have been determined by other insurance, KMAP must receive the claim within 12 months of the date of service or with proof of timely filing attached.

It is recommended that a claim filed with other insurance also be filed with KMAP within 12 months of the date of service to ensure timely filing criteria is met. However, the third party liability explanation of benefits (EOB) can be used for proof of timely filing if the date on that EOB falls within the 12-month timely filing period.

3. Claims Older Than 12 Months

Claims that were originally filed within 12 months of the date of service but were not resolved may be resubmitted to KMAP up to 24 months after the date of service.

Helpful Tips to Request Timely Filing Bypass

- Do not wait until 24 months to seek assistance.
- Use a cover letter and do not write on the face of the claim or use sticky notes.
- Be specific and clearly explain in a cover letter why timely filing should be bypassed.
- Include a contact name and phone number with the request. If the fiscal agent has questions or needs clarification, the contact person will be notified.
- If additional documentation is required, the provider has 10 business days after being contacted to forward documentation to KMAP. If it is not received within 10 business days, the request is closed and the claim will be denied.
- If the request is due to retroactive eligibility and the provider does not have the retroactive eligibility letter, the fiscal agent can access the letter, but the provider must indicate retroactive eligibility in the cover letter.
- The provider is responsible for all information on the face of the claim being correct and current.
- Proof of why timely filing should be bypassed must be attached along with the cover letter and claim. This proof should be similar to an RA or EOB rather than something from the provider's own computer program.

When resubmitting a claim, include the original internal control number (ICN) in the appropriate field as specified in the billing instructions.

When resubmitting a claim that was originally filed to KMAP within 12 months of the date of service, no attachment is necessary if the following data elements are **unchanged** from the original submission:

- Same beneficiary ID number
- Same provider number
- Same dates of service
- Same billed amount

Claims that meet these criteria can be refiled electronically with the original ICN in the appropriate field. When any of these data elements are changed, proof of timely filing must be attached to the claim.

When the claim was timely filed with other insurance, providers must submit a dated copy of proof of payment or denial from other insurance that proves the payer received the claim within 12 months of the service date. If the provider is unable to prove a claim was initially timely filed with any other carrier and the dates of service are more than 12 months old, KMAP cannot consider the claim for payment.

Claims not submitted within 12 months of the date of service cannot be billed to the beneficiary when a provider has knowledge of KMAP coverage. Claims that are timely filed and subsequently denied due to provider errors cannot be billed to the beneficiary if the provider fails to correct the errors and resubmit the claim for final adjudication within 24 months from the date of service.

Regardless of original timely filing or resubmissions, state regulations prohibit the fiscal agent from processing any claim received beyond 24 months from the date of service.

Third-party liability information can be obtained through:

AVRS

1-800-933-6593

or

KMAP website

E. Coordination of Benefits (COB)

KMAP is a secondary payer to all other insurance programs and should be billed only after payment or denial has been received from such carriers. The only exceptions to this policy are listed below:

- Services for Children with Special Health Care Needs (Special Health Service – SHS) Program
- DCF Vocational Rehabilitation Services
- Indian Health Services
- Crime Victim's Compensation Fund

When KMAP is the secondary insurance carrier, a copy of the primary carrier's EOB must be submitted with the claim. KMAP should be billed only after payment or denial has been received from these carriers.

For electronic claim submissions, the payment made by the primary carrier must be indicated in the appropriate EOB field. When a primary carrier's payment meets or exceeds the KMAP maximum allowable, KMAP considers the claim paid in full and no further payment is made on the claim.

If another insurance company does not respond to the provider or policyholder's claim submission and follow-up request and 30 days have lapsed, proceed as follows:

1. Submit a paper claim to KMAP within 12 months of the date of service.
2. Indicate in the other insurance field "No response from (name insurer) insurance company."
3. Attach a copy of the claim the provider submitted to the other insurance company.

F. Accident and Tort Liability

The State closely follows all accident claims to determine if another party may have liability. Information given on the claim form is of the utmost importance to assist the State of Kansas in researching these accident cases.

The following information is required when filing a claim for a beneficiary who has been involved in an accident:

- Date and time of accident
- Location
- Cause
- Possible other insurance resources

Fill out all blocks on the claim form concerning accident information when applicable. If an injury is self-inflicted, it should be stated clearly.

V. Documentation Requirements

All dental services performed must be recorded in the patient record, which must be available as required by your Provider Agreement.

A. The Patient Record

The patient record must have areas for documentation of the following information:

- Registration data including a complete health history
- Medical alert predominantly displayed
- Initial examination data
- Radiographs
- Periodontal and occlusal status
- Treatment plan or alternative treatment plan
- Progress notes to include diagnosis, preventive services, treatment rendered, and medical or dental consultations
- Miscellaneous items (correspondence, referrals, and clinical laboratory reports)

The design of the record must provide the capability of periodic update, without the loss of documentation of the previous status, of the following information:

- Health history
- Medical alert
- Examination or recall data
- Periodontal status
- Treatment plan

The design of the patient record must ensure that all permanent components of the record are attached or secured within the record. The record design also must ensure that all components are readily identified to the patient (such as patient name and identification number on each page). The organization of the record system must require that individual records are assigned to each patient. Waivers of information and authorization to bill for noncovered codes should also be maintained in the record.

Compliance

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

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

B. Dental Treatment Requiring Medical Review

Medical review is a utilization tool that requires participating providers to submit documentation associated with certain dental services for a beneficiary. Participating providers will not be paid if this documentation is not provided to KMAP.

KMAP uses specific dental utilization clinical criteria as well as a medical review process to manage usage of services. The clinical criteria are included in this manual.

Your submission of documentation should include:

- Radiographs, narrative, or other information where requested

  See exhibits at the end of this manual for specifics by procedure code.
- CDT codes on the fully completed claim form

  Send your submission on the most current ADA approved claim form.

The Benefit Tables (exhibits at the end of this manual) contain a column marked Medical Review. A "Yes" in this column indicates that the service listed requires medical review to be considered for reimbursement.

The dental consultant reviews the required documentation submitted with the claim. If the documentation is complete and aligns with the clinical criteria, the claim is considered medically necessary and is processed for payment.

If all required documentation is **not** submitted with the claim or the submitted documentation does not support medical necessity and/or the clinical criteria, the claim is denied.

The KMAP dental program does not require providers to submit medical review narrative or documentation when **other insurance is primary and makes payment** on the services provided. Payment from the primary insurance must be reported on the claim.

1. Outpatient Hospital, Inpatient Hospital, Ambulatory Surgery Center Facilities

KMAP reimburses providers for covered dental services (CDT codes) provided in a hospital setting. Dental services that require medical review as noted in this manual should be submitted as directed in the Benefit Tables (refer to exhibits at the end of this manual).

Medical (*CPT*®) codes must be submitted to the beneficiary's medical health plan for authorization and reimbursement.

a. Participating Hospitals

The dentist is required to administer services at a KMAP hospital.

The hospital or outpatient surgery center may be required to obtain a PA for some dental services. The facility should verify these requirements with the medical managed care organization or KMAP.

The dental provider needs to provide treatment and diagnostic information necessary to the facility for completion of the authorization forms prior to the date of service.

C. Prior Authorization

1. Orthodontic Services

Orthodontic services require PA and are only covered for eligible children with cases of severe orthodontic abnormality caused by genetic deformity (such as cleft lip or cleft palate) or traumatic facial injury resulting in serious health impairment to the beneficiary at the present time.

Refer to Appendix A for the Orthodontic Agreement.

2. Out-of-State Services

All nonemergent medical services provided out-of-state (except those within 50 miles of a Kansas border) require PA be obtained before the services are rendered for KMAP to consider the claim for payment regardless of other insurance coverage. The in-state referring provider or the out-of-state provider can start the PA process.

VI. Appeals

A. Appeals Process

If a provider disagrees with the action KDHE-DHCF has taken on a claim, the provider has the right to request an administrative fair hearing under the Kansas Administrative Procedures Act, K.S.A. 77-501, et seq. and K.A.R. 30-7-64 et seq.

To request an appeal on a timely basis, the provider must send a written request for such an appeal to:

Office of Administrative Hearings
1020 South Kansas Avenue
Topeka, KS 66612-1327

The request must be received by that office within 30 days of the date of the provider's notification letter. Because KDHE-DHCF mails such notices to the provider, three days will be added to the 30-day appeal period. The provider does not need to use a special form to request a fair hearing. The provider may simply put the request in writing and send it to the Office of Administrative Hearings. The request must specifically request a fair hearing and describe the decision appealed and specific reasons for the appeal.

VII. Fraud and Abuse

A. State's Right to Terminate Relationship with Providers

A provider of services to beneficiaries must comply with all laws of Kansas, the regulations and policies of KDHE-DHCF, and the standards or ethics of his or her business or profession to qualify as a participant in the program. K.A.R. 30-5-60 states in part that the agency may terminate a provider's participation in KMAP for one or more of the following reasons:

- Pattern of submitting inaccurate billings
- Pattern of unnecessary usage
- Civil or criminal fraud against KMAP, Kansas' social service programs, or any other state's Medicaid or social service programs
- Suspension from participation in the program by the Secretary of Health and Human Services
- Direct or indirect ownership or controlling interest of more than five percent in a provider institution, agency, or organization by a person who has been found guilty of fraud against the Medicaid or Medicare program
  Note: This also extends to those persons employed by such institution, agency, or organization.
- Other good cause

B. Reporting of Abuse, Neglect, or Exploitation of Children or Residents in Adult Care Homes

Any person in the capacity of dentist, administrator, or hygienist having reasonable cause to suspect or believe that a child or long-term care facility resident is being or has been abused, neglected, or exploited, or is in need of protective services is required to report such information to the local DCF office. The complainant should be given the toll-free hot line number of DCF, **1-800-922-5330**.
Complaints received in writing shall be forwarded to:

DCF
Prevention and Protection Services
Docking State Office Building
915 SW Harrison
Topeka, KS 66612

No person who makes such a report or who testifies in any administrative or judicial proceeding arising from such a report shall be subject to any civil liability on account of such report or testimony, unless the person acted in bad faith or with malicious purpose. No employer shall terminate the employment of; prevent or impair the practice or occupation of; or impose any other sanctions on any employee solely for the reason that such employee made or caused to be made such report.

VIII. Preventive Pediatric Dental Care Recommendations

The American Academy of Pediatrics recommends that a child first visit a dentist as soon as their first tooth comes in (usually around six months). It is then recommended that the child visit the dentist every six months thereafter.

American Academy of Pediatric Dentistry
Reference the *Guidelines on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Treatment for Infants, Children, and Adolescents* for recommendations on preventive pediatric dental care.

IX. Radiology Requirements

Note: Please refer to the exhibits at the end of this manual for radiograph benefit limitations.

KMAP uses the guidelines published by the Department of Health and Human Services (DHHS) and the Center for Devices and Radiological Health (CDRH). These guidelines were developed in conjunction with the Food and Drug Administration (FDA).

In the following subsections, the Panel refers to representatives from the DHHS and CDRH that serve together to oversee these radiological requirements with the FDA.

A. Radiographic Examination of the New Patient

1. Child – Primary Dentition

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

2. Child – Transitional Dentition

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

3. Adolescent – Permanent Dentition (prior to the eruption of third molars)

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

4. Adult – Dentulous

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

5. Adult – Edentulous

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

B. Radiographic Examination of the Recall Patient

Patients with clinical caries or other high-risk factors for caries

1. Child – Primary and Transitional Dentition

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

2. Adolescent

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

3. Adult – Dentulous

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

4. Adult – Edentulous

The Panel found that an examination for occult disease in this group cannot be justified on the basis of prevalence, morbidity, mortality, radiation dose, and cost. Therefore, the Panel recommends that no radiographs be performed for edentulous recall patients without clinical signs or symptoms.

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

1. Child – Primary Dentition

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

2. Adolescent

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

3. Adult – Dentulous

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

Patients with periodontal disease or a history of periodontal treatment for child – primary and transitional dentition, adolescent and dentulous adult

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

Growth and Development Assessment

1. Child – Primary Dentition

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

2. Child – Transitional Dentition

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

3. Adolescent

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

4. Adult

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

X. Clinical Criteria

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

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

The criteria described in this section provide a better understanding of the decision-making process for reviews. KMAP shares your commitment and belief to provide quality care to KMAP beneficiaries and appreciates your participation in the program.

Please remember these are generalized criteria. Services described may not be covered in a particular program. In addition, there may be additional program specific criteria regarding treatment. Therefore it is essential that the provider review the Covered Benefits section (exhibits at the end of this manual) before providing any treatment.

A. Criteria for Dental Extractions

Not all procedures require medical review.

Documentation needed for medical review:

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

Criteria

- The prophylactic removal of asymptomatic teeth (i.e. third molars) or teeth exhibiting no overt clinical pathology (for orthodontics) may be covered subject to consultant review.
- The removal of primary teeth whose exfoliation is imminent does not meet criteria.

B. Criteria for Cast Crowns

Documentation needed for medical review of procedure:

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

Criteria

- In general, criteria for crowns will be met only for permanent teeth needing multisurface restorations where other restorative materials have a poor prognosis.
- Permanent molar teeth must have pathologic destruction to the tooth by caries or trauma and should involve four or more surfaces and two or more cusps.
- Permanent bicuspid teeth must have pathologic destruction to the tooth by caries or trauma and should involve three or more surfaces and at least one cusp.
- Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma and must involve four or more surfaces and at least 50 percent of the incisal edge.

A request for a crown following root canal therapy must meet the following criteria:

- Request should include a dated post-endodontic radiograph.
- Tooth should be filled sufficiently close to the radiological apex to ensure that an apical seal is achieved, unless there is a curvature or calcification of the canal that limits the ability to fill the canal to the apex.
- The filling must be properly condensed/obturated. Filling material does not extend excessively beyond the apex.

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

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

Medical review for crowns will not meet criteria if:

- A lesser means of restoration is possible.

- Tooth has subosseous and/or furcation caries.
- Tooth has advanced periodontal disease.
- Tooth is a primary tooth.
- Crowns are being planned to alter vertical dimension.

C. Criteria for Endodontics

Not all procedures require medical review**.**

Documentation needed for medical review of procedure:

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

Criteria

Root canal therapy is performed in order to maintain teeth that have been damaged through trauma or carious exposure. Root canal therapy must meet the following criteria:

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

Medical review for root canal therapy will not meet criteria if:

- Gross periapical or periodontal pathosis is demonstrated radiographically (caries subcrestal or to the furcation, deeming the tooth nonrestorable).
- The general oral condition does not justify root canal therapy due to loss of arch integrity.
- Root canal therapy is for third molars, unless they are an abutment for a partial denture.
- Tooth does not demonstrate 50 percent bone support.

- Root canal therapy is in anticipation of placement of an overdenture.
- A filling material not accepted by the Federal Food and Drug Administration (e.g. Sargenti filling material) is used.

Other Considerations

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

D. Criteria for Stainless Steel Crowns

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

Documentation needed for medical review of procedure:

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

Criteria

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

- Primary molars must have pathologic destruction to the tooth by caries or trauma, and should involve two or more surfaces or substantial occlusal decay resulting in an enamel shell.

A medical review for a crown on a permanent tooth following root canal therapy must meet the following criteria:

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

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

- The patient must be free from active and advanced periodontal disease.
- The permanent tooth must be at least 50 percent supported in bone.
- Stainless steel crowns on permanent teeth are expected to last five years.

Medical review and treatment using stainless steel crowns will not meet criteria if:

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

E. Criteria for Removable Prosthodontics (Full and Partial Dentures)

Documentation needed for medical review of procedure:

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

Criteria

- Prosthetic services are intended to restore oral form and function due to premature loss of permanent teeth that would result in significant occlusal dysfunction.
- A denture is determined to be an initial placement if the patient has never worn prosthesis. This does not refer to just the time a patient has been receiving treatment from a certain provider.
- Partial dentures are covered only for recipients with good oral health and hygiene, good periodontal health (AAP Type I or II), and a favorable prognosis where continuous deterioration is not expected.
- Radiographs must show no untreated cavities or active periodontal disease in the abutment teeth, and abutments must be at least 50 percent supported in bone.
- As part of any removable prosthetic service, dentists are expected to instruct the patient in the proper care of the prosthesis.
- In general, if there is a pre-existing removable prosthesis (includes partial and full dentures), it must be at least five years old and unserviceable to qualify for replacement.
- In general, a partial denture will be approved for benefits if it replaces one or more anterior teeth, or replaces two or more posterior teeth unilaterally or replaces three or more posterior teeth bilaterally, excluding third molars, and it can be demonstrated that masticatory function has been severely impaired. The replacement teeth should be anatomically full-sized teeth.

Medical reviews for removable prosthesis will not meet criteria:

- If there is a pre-existing prosthesis which is not at least five years old and unserviceable
- If good oral health and hygiene, good periodontal health, and a favorable prognosis are not present
- If there are untreated cavities or active periodontal disease in the abutment teeth
- If abutment teeth are less than 50 percent supported in bone
- If the recipient cannot accommodate and properly maintain the prosthesis (i.e. Gag reflex, potential for swallowing the prosthesis, severely handicapped)
- If the recipient has a history or an inability to wear a prosthesis due to psychological or physiological reasons
- If a partial denture, less than five years old, is converted to a temporary or permanent complete denture
- If extensive repairs are performed on marginally functional partial dentures or when a new partial denture would be better for the health of the recipient ***Note:*** However, adding teeth and/or a clasp to a partial denture is a covered benefit if the addition makes the denture functional.

Criteria

- If there is a pre-existing prosthesis, it must be at least five years old and unserviceable to qualify for replacement.
- Adjustments, repairs and relines are included with the denture fee within the first six months after insertion. After that time has elapsed:
    - Adjustments will be reimbursed at one per calendar year per denture.
    - Repairs will be reimbursed at two repairs per denture per year, with five total denture repairs per five years.
    - Relines will be reimbursed once per denture every 24 months.
    - A new prosthesis will not be reimbursed for within 24 months of reline or repair of the existing prosthesis unless adequate documentation has been presented that all procedures to render the denture serviceable have been exhausted.
    - Replacement of lost, stolen, or broken dentures less than five years of age usually will not meet criteria for premedical review of a new denture.
- The use of preformed dentures with teeth already mounted (that is, teeth set in acrylic before the initial impression) cannot be used for the fabrication of a new denture.
- All prosthetic appliances shall be inserted in the mouth and adjusted before a claim is submitted for payment.
- When billing for partial and complete dentures, dentists must list the date that the dentures or partials were inserted as the date of service. Beneficiaries must be eligible on that date in order for the denture service to be covered.

F. Criteria for the Excision of Bone Tissue

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

Codes D7471, D7472 and D7473 are related to the removal of exostoses.

These codes are subject to medical review and may be reimbursed when submitted in conjunction with a treatment plan that includes removable prosthetics. These determinations will be made by the appropriate dental specialist/consultant.

Documentation needed for medical review of procedure:

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

G. Criteria for the Determination of a Nonrestorable Tooth

In the application of clinical criteria for benefit determination, dental consultants must consider the overall dental health. A tooth that is determined to be nonrestorable may be subject to an alternative treatment plan.

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

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

H. Criteria for General Anesthesia and Intravenous Sedation

Not all procedures require medical review.

Documentation needed for medical review of procedure:

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

Criteria

Requests for general anesthesia or IV sedation will meet medical review criteria (for procedures covered by KMAP) if any of the following criteria are met:

Extensive or complex oral surgical procedures such as:

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

And/or one of the following medical conditions:

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

I. Criteria for Periodontal Treatment

Not all procedures require medical review.

Documentation needed for medical review of procedure:

- Radiographs – periapicals or bitewings preferred
- Complete periodontal charting with American Academy of Periodontology (AAP) Case Type
- Treatment plan

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

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

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

Criteria

- A minimum of three teeth affected in the quadrant
- Periodontal charting indicating abnormal pocket depths in multiple sites
- Additionally at least one of the following must be present:
    - Radiographic evidence of root surface calculus
    - Radiographic evidence of noticeable loss of bone support

Appendix A
Orthodontic Agreement

Orthodontic services require prior authorization (PA) and are only covered for eligible children with cases of severe orthodontic abnormality caused by genetic deformity (such as cleft lip or cleft palate) or traumatic facial injury resulting in serious health impairment to the beneficiary at the present time. The following procedure codes may be covered:

- D8010 Limited orthodontic treatment of the primary dentition
- D8020 Limited orthodontic treatment of the transitioned dentition
- D8050 Interceptive orthodontic treatment of the primary dentition
- D8060 Interceptive orthodontic treatment of the transitional dentition
- D8070 Comprehensive orthodontic treatment of the transitional dentition
- D8080 Comprehensive orthodontic treatment of the adolescent dentition
- D8210 Removable appliance therapy
- D8220 Fixed appliance therapy
- D8999 Orthodontic exam and treatment (includes study models, full mouth radiographs, case history, complete treatment plan)

I Basic Requirements

- The plan for orthodontic treatment must have received prior approval before any service is performed.
- The beneficiary must be eligible for KMAP benefits on the date of the submission of the PA request.
- This agreement must be signed by the dental provider and KMAP's orthodontic consultant. The signatures must be dated prior to orthodontic treatment.

II Responsibility of KMAP

- All orthodontic treatment plans submitted in accordance with this process will be reviewed within 30 days.
- All treatment plans will receive equal consideration with approval or denial based upon criteria established by KDHE-DHCF.
- All documentation material will be returned immediately following review of the case.
- Reimbursement will be made for the orthodontic study if the PA request for treatment is denied.

- Upon approval and receipt of a properly completed form for a beneficiary who meets the requirements for orthodontic treatment, the entire amount, up to a maximum of $1,728, will be reimbursed to the provider, whether the beneficiary becomes ineligible after orthodontic treatment is started.
- At least once each year, KMAP may request a status report on the progress of the beneficiary.
- At the conclusion of treatment, or in 24 months, the case will be reviewed. At the 24-month review, no more documentation will be required and records will be finalized.

III Responsibility of Orthodontic Provider

- Submit documentation for PA review.
- Sign Orthodontic Certification and submit it with request for PA.
- Submit all claims for payment in compliance with rules and regulations in effect at the time of submission.
- Providers will be notified when reports are due and will be responsible for providing the information. If the reports are not received within 30 days, the case will be terminated and a recoupment will be initiated. Reports are to contain the following:
    - Brief description of services provided since initiation or last requested report
    - Estimate of time required to complete the treatment
    - Documentation of any unusual situations which have either hampered or facilitated the progress of the case
- Accept payment as payment in full.
- Continue treatment to conclusion, even if the beneficiary becomes ineligible.
- Notify KMAP immediately if the beneficiary or provider terminates treatment or transfers.
- Submit traced cephalometric radiograph and full mouth radiograph or panoramic view within 30 days of conclusion of treatment, or at the end of 24 months, whichever is less.
- If the orthodontic consultant determines from interim records that the treatment was not satisfactory, the case will be terminated and a recoupment will be initiated.
- Refund all payment if either interim or final records document that the treatment is/was satisfactory as determined by KMAP orthodontic consultant.

IV Authorization Process for Orthodontia

- A statement of medical necessity must be received from the dentist, orthodontist, or provider (or a collaboration of disciplines) and will be reviewed by KMAP's dental consultant prior to any services being performed. Medical necessity documentation must be sent to:

  Kansas Medical Assistance Program
  P.O. Box 3571
  Topeka, KS 66601-3571

- If the documentation submitted is inadequate to describe the nature of the deformity or injury, additional information may be requested.
- A determination letter authorizing orthodontic workup (D8999) will be sent to the orthodontic provider.
- Once the orthodontic workup has been completed, the provider must submit the following information for authorization of orthodontic treatment:
  - Traced cephalometric radiograph
  - Mounted full mouth radiograph (14 films) or panoramic view
  - External face photographs (lateral and frontal)
  - Intraoral photographs or slides (upper and lower occlusal views: right, left, and anterior centric occlusion views)
  - Diagnosis for which treatment is requested
  - Treatment plan including type of treatment, type of retention, and estimate of treatment time
  - Provider's usual and customary fee (must be a flat fee)
- A case may be submitted only twice; once as an original submission and once as a resubmission for consideration of a denial.

V Reimbursement for Orthodontia

Reimbursement is made for Orthodontic Exam and Treatment Plan (D8999) when PA has been denied for orthodontic treatment. If treatment is approved, the entire amount, up to a maximum of $1,728, will be reimbursed to the provider. The study charge is included in the reimbursement for full orthodontic treatment. Only one initial orthodontic study is reimbursed every 18 months. A total of three studies are covered per member per lifetime.

Orthodontic appliances (D8010, D8020, D8210, and D8220) are limited to one replacement.

The following dental procedure codes are content of service of an orthodontic workup (D8999) when performed on the same date of service by the same provider:

D0120	D0230	D0272	D0321
D0140	D0240	D0273	D0322
D0170	D0250	D0274	D0330
D0210	D0260	D0277	D0340
D0220	D0270	D0290	

Appendix B
Dental Staff Billing Guide

1. Claim Submission Billing Instructions

The KMAP claim system can only recognize dental services described using the current American Dental Association CDT code list or those defined as a covered benefit. All other service codes not contained in Exhibits A, B, C, D, and E at the end of this manual will be denied when submitted for payment.

KMAP is able to receive dental claims in the following formats:

- Electronic claims through the KMAP website
- Electronic submission through clearinghouses
- HIPAA Compliant 837D File
- Provider Electronic Solutions (PES)
- Paper claims

To use the website effectively, the following list of requirements must be met:

- **Internet Explorer 7.0 (or higher)**
  If a provider does not have Internet Explorer, it can be downloaded from the KMAP website.
- **Modem**
- **Phone line, DSL, or cable connection**
- **Internet service provider (ISP)**

Services provided on the KMAP website are free of charge.

A. KMAP Website

1. General Requirements/Information

There are two main areas of the website: public and secure.

Public website – Provides KMAP information and enrollment applications to the general public. The public website includes:

- Provider manuals
- Provider bulletins
- Enrollment forms

- KAN Be Healthy (KBH) information
- EDI and PES information
- Beneficiary benefits booklet

Secure website – Provides a secure means for the MMIS and authorized users to access and exchange data. The secure website includes:

- Claim submission
- Claim inquiry
- Payment inquiry
- Beneficiary eligibility
- Provider eligibility
- Provider secure correspondence
- Pricing inquiry

The secure website requires you to log on using a confidential user name and password. All Internet transactions meet HIPAA compliance. All you need to do is protect your logon information and manage the staff's logon capabilities.

On the public or unsecure website, you can access KMAP publications, enrollment forms, and other pertinent information, as well as the secure website. You can click on the Provider avatar to access the Provider home page or use the tabs at the top of the page (General, Beneficiary, Provider, and so forth).

The Publications tab is where the most current provider manuals and recently released provider bulletins are available.

To log on to the secure area from the public KMAP website:

- Click **Provider**.
- On the Provider home page, click **Provider login** under the *Interactive Tools* heading.

If you have never logged on or have forgotten your password, you need to contact KMAP Customer Service to obtain your user name and password. You can then enter this information in the Already a Member section and click **Log On**. This information is case sensitive and must be entered exactly as it was created.

A new provider will receive a letter with a personal identification number (PIN). This PIN will expire 90 days after the letter is generated. You must call KMAP Customer Service if the PIN has expired.

Your account will be locked out if you do not log on in 90 days or if you mistype your password three times in a row. To reactivate the account, the contact person associated with the user name must call KMAP Customer Service.

The system will prompt you to change the password every 30 days for security purposes.

2. Account Maintenance

After logging on for the first time, the **Account Maintenance window** displays. One staff person in your facility should act as your account administrator and control your staff's security to the secure site. The account administrator can add or remove clerks or third-party billing agents as your business needs dictate. This person should enter all the required information on the window along with creating a new password. This password must be eight characters long, start with an alpha character, and contain two numbers.

If there are additional staff at the facility that will also need access to the secure area of the KMAP website, the account administrator can create a clerk for each staff member.

To add a clerk, the administrator or super user must log on to the site and navigate to the Account Maintenance window. Click **Create New Clerk**. Type the new user name and initial password and click **Create Clerk**. You only create one new clerk profile one time.

After creating the user name, you must assign permissions to the user. To do this, type the user name in the User Name field and click **Grant Access To**. After this is complete, you must click **Save** to save the information.

To revoke permissions, click on the user name in the box to the left of the User Name field to highlight it and then click **Revoke Permissions** followed by **Save.**

Note: Because this is an Internet site, it is very important to revoke permissions from clerks who are no longer employed to protect beneficiary information and provider data. It is suggested that providers include a step in their staff exit procedures to disable access to the KMAP website.

3. Global Messages

After logging on, any global messages will automatically appear. After reading each message, click on the check box under the **Read** column. This action moves the message to the mailbox for future reference until it expires.

Most all global messages are posted as remittance advice (RA) banner messages as well. Global messages can be posted at any time. It is important to log on often to read them.

After reading all messages, click **Next.**

4. Provider Main Page

The main Provider menu appears after you log on and view your global messages. From here, you can click any of the links on the window to access the corresponding pages.

The first option, **Switch Provider Number**, only appears if your clerk ID is associated with more than one provider number. This option gives you the ability to switch between provider numbers. If you use more than one provider number, it is very important to validate which provider ID you are working with when submitting claims. Submitting claims with the wrong provider ID could result in denied claims.

5. Eligibility Verification

1. After logging on to the secure website, click **Eligibility Verification**.
2. Enter any one of the following options:
   - Beneficiary's ID number in the **Beneficiary ID** field
   - Beneficiary's Social Security number in the **SSN** field and the date of birth in the **Date of Birth** field
   - Beneficiary's last name in the **Last** field, first name in the **First** field, and date of birth in the **Date of Birth** field
3. Enter a date in the **From Date of Service** field, or click on the arrow button to display a calendar and click on the appropriate date.
4. Enter a date in the **To Date of Service** field, or click on the arrow button to display a calendar and click on the appropriate date.

   Note: The **From Date of Service** and **To Date of Service** must be in the same calendar month.

5. Click **Search**.

   The eligibility information is returned. Notice the **Status** refers to successfully completing the electronic transaction and not the eligibility of the beneficiary. The dates of eligibility and benefit programs determine the beneficiary's overall coverage.

   All Title 21 and most Title 19 beneficiaries are assigned to a managed care organization (MCO) through KanCare. Refer to the *KanCare Managed Care Assignment* box located directly below the *Eligibility* box. This will be the company from whom you will receive payment.

   The **TPL Carrier Name** field is a hyperlink that transfers the user to the TPL Carrier window where the carrier name, carrier code, and carrier address are available.

6. After the eligibility search has been completed, the Dental Services Profile button becomes functional. Click this button and a comprehensive list of paid dental services for the past five years will be displayed in a separate box for this beneficiary.

   Services on and after January 1, 2013, that were paid by a MCO, will not be reflected on this profile.

   - **Date of Service** – The date the service was provided in a CCYYMMDD format
   - **Procedure Code** – The CDT code indicating the service rendered
   - **Procedure Description** – A short description of the service rendered
   - **Tooth Number** – The tooth number associated with the service, if applicable
   - **Surface 1-5** – The surface associated with the tooth indicated, if applicable

6. Claim Submission

Click **Claim Submission** to access the Dental Claim form.

Dental Claim Fields

Header Information

Remember to TAB from field to field on the KMAP website claim form.

- **Previous ICN:** Do not use.
- **Timely Filing Override ICN**: Enter the internal control number (ICN) of the original claim to document timely filing for claims 12 months past the date of service. This field is not required. However, if this field is not completed, it could result in claims with a date of service older than 12 months to deny for timely filing. When entering a timely filing ICN, the ICN on the previously submitted claim must match on billing provider ID, beneficiary ID, and date of service; otherwise the claim will deny for timely filing. Enter the correct timely filing override ICN accordingly.
- **Provider ID:** This field will auto-populate based on the user. This provider number will be considered the billing provider number.
- **NPI:** This field will auto-populate based on the user. This national provider identifier (NPI) number will be considered the billing provider NPI number.
- **Beneficiary ID:** Enter the KMAP beneficiary ID number. This field auto-populates the name and date of birth.
- **Last Name:** This field auto-populates based on the beneficiary ID you enter.
- **First Name:** This field auto-populates based on the beneficiary ID you enter.
- **Date of Birth:** This field auto-populates based on the beneficiary ID you enter.
- **Patient Account #:** Optional – Enter the beneficiary's account number with your facility.

- **Signature on File:** Enter Yes if the provider's signature is on file.
- **Emergency:** Defaults to No. Choose Yes from the drop-down box if appropriate.
- **Accident:** If service is due to accident, choose appropriate selection from the drop-down box.
- **Place of Service:** Choose appropriate place of service from the drop-down box. FQHC providers should select Other-99.
- **Comments:** Free form text can be entered in this field. When taking multiple D0230, state "radiographs are not duplicate" for example. The text will only be reviewed if the claim suspends and must be processed manually.
- **Total Charges:** Not an entry field. This field auto-populates with the total charges entered in the detail section.
- **Total Amount Paid:** This field populates after the claim is submitted and processed by KMAP.
- **TPL Amount**: Enter the amount paid by the beneficiary's other insurance if applicable.
- **Insurance Denied:** If another insurance was billed and it denied, select Yes from the drop-down box. Otherwise, leave as No.
- **From DOS:** Enter the date of service.

Rendering Provider Information

- **Rendering Provider:** Enter the performing provider's KMAP provider number. This field is not required for individual providers. It auto-populates with your billing provider number if left blank when you click **Submit**.
- **NPI:** Enter the performing provider's NPI number.
- **Taxonomy Code:** Not required.
- **Last Name/Org Name:** Not required.
- **First Name:** Not required.
- **MI:** Not required.

TPL Information

If the beneficiary is assigned to one of the MCOs through KanCare, the claim can ~~must~~ be submitted on paper through the front-end billing process, electronically through the individual MCO's website, or on the KMAP website ~~if applicable~~.

The third party liability (TPL) section must be completed if you indicated TPL has initiated a payment or denial for the same service. To access the TPL section, click on the two arrows pointing downward on the far right side of the blue bar containing the word TPL. This will expand the TPL section and allow you to enter the fields. You will enter data in the fields beginning with Insured's Last Name. To enter additional lines, click **Add**. To remove a line previously entered, click on the line and click **Remove**.

- **Insured's Last Name:** Enter the last name of the policy holder.

- **First:** Enter the first name of the policy holder.
- **MI:** Enter the middle initial of the policy holder.
- **Suffix:** Enter the suffix (if any) of the policy holder (such as Jr., Sr.).
- **Policy #:** Enter the policy number of the other insurance.
- **Plan Name:** Enter the name of the plan under which the policy holder has coverage.
- **Date Adjudicated:** Enter the appropriate date from the other insurance carrier's RA.
- **Policyholder Relationship to Patient:** Select the relationship from the drop-down menu.
- **Insurance Type:** Select the type of insurance from the drop-down menu.
- **Release of Information:** Select the release of information from the drop-down menu.

Detail Information

KMAP will reimburse for the total number of surfaces restored per tooth, per day (a separate occlusal and buccal restoration on tooth 30 will be reimbursed as one [OB] two surface restoration).

- **Item**: Auto-populates.
- **From DOS**: Enter the from date of service.
- **Procedure**: Enter the appropriate procedure code.
- **Supporting Documentation**: This box will be activated when certain CDT codes have been entered in the procedure code box. For example, when D9241 is entered, the drop-down box will give medical reasons for the anesthesia services. Select one of these or if you choose "Other," you can then enter text giving the medical reason for the anesthesia in the Comments Box at the header level.
- **Quadrant/Arch**: Select the appropriate quadrant/arch from the drop-down box only if applicable.
- **Tooth Number**: Enter tooth number if applicable.
- **Surface:** Enter the tooth surface if applicable. Enter only one surface per box. If more than one surface, enter each surface in separate boxes. A scroll bar will appear.
- **Units**: Auto-populates with quantity of 1. For services where multiple quantities of the same CDT code are performed on the same day, enter the correct number of units. For example, D9221 30 minutes = 2 units.
- **Charges**: Enter the charge amount corresponding to the service you are billing for this particular detail line.
- **Status**: Not an entry field; used for internal purpose after processing the claim.
- **Allowed Amount**: Not an entry field; used for internal purpose after processing the claim. Auto-populates the allowed amount for the line item after the claim is submitted for processing.
- **Warrant Amount:** Not an entry field; used for internal purpose after processing the claim. Auto-populates the warrant amount for the line item after the claim is submitted for processing.
- **Add/Remove Buttons**: These buttons allow you to add or remove detail lines as needed. Do not add detail lines unless you have additional lines to bill.

Hard Copy Attachment Option

To enter a hard copy paper attachment, you need to assign it a control number (CN) that you choose. This number must be unique every time you submit an attachment and cannot contain any personal health information (PHI).

1. Enter the number you have selected in the **Control Number** field.
2. Select the **Transmission Code** from the drop-down box.
3. Enter your comments or a description of the paper attachment cover sheet in the **Description** field.
4. Select the option that best describes the paper attachment cover sheet from the **Report Type** drop-down box.

Before you click **Submit** at the bottom of the claim, write the CN, provider number, and beneficiary number on the Hard Copy Attachment Cover Sheet, available on the KMAP website. The cover sheet must be sent with your paper attachments. When the paper documents are received by the fiscal agent, the CN, provider number, and beneficiary number will be used to link the paper documents to the electronic website claim form. These elements must be an exact match.

After you have completed the cover sheet, click **Submit** to process the claim. The claim will suspend. If your attachment is not received within 30 days, payment for your claim will be denied.

Do not send an attachment unless the services listed on the claim require supporting documentation.

Mail or fax your attachment to:

Office of the Fiscal Agent
P.O. Box 3571
Topeka, KS 66601
Fax: 785-274-4296

Helpful Hint:

For more concise results use:

Beneficiary ID#

and

From Thru Dates of Service

as your search criteria.

Reminder: Do not forget to click **Submit** once you complete the claim.

After clicking Submit, **"**Processing Claim**"** appears in the lower left corner of your screen. Your computer screen will appear to flicker a few times indicating your claim is processing. After your claim is finished processing, your newly processed claim information will appear. The newly assigned ICN, status of the claim (paid, denied, or suspended), and all the explanation of benefits (EOB) reasons and remarks will display.

If the beneficiary is assigned to one of the MCOs through KanCare, the electronic claim will be sent to the appropriate MCO for processing.

7. Claim Inquiry

Services on and after January 1, 2013, that were paid by a MCO, will not be reflected on this profile.

1. Click **Claim Inquiry**.
2. If known, enter the beneficiary ID number in the **Beneficiary ID** field.
3. Select the appropriate **Claim Status** from the drop-down box: Any Status, Denied, Paid, or Suspended.
4. If the patient account number is known, enter it in the **Patient Acct. #** field.
5. Click the appropriate **Date Type** button: Date of Service or Warrant Date.
6. If known, enter the ICN in the **ICN** field.
7. Enter the from date of service in the **From Date** field and enter the through date of service in the **Thru Date** field.
8. Click **Search**.

To open the Internet claim, click on the ICN. A new window will open with claim details.

8. Claim Functions

Resubmit Claim – Denied Claims Only

Access the denied claims from the **Claim Inquiry** window using the Claim Status field.

Once you identify the denied claim to correct, open the claim by clicking on the corresponding ICN link. The claim will display and allow you to change the information as needed. Once you have entered the correct information, use the TAB key to exit the corrected field and click **Re-Submit.**

Adjust Claim – Paid Claims Only

Access the paid claims from the **Claim Inquiry** window using the Claim Status field.

Once you identify the paid claim to adjust, open the claim by clicking on the corresponding ICN link.

Helpful Hint:

You cannot adjust a previously adjusted claim.

You cannot adjust a claim that is over 24 months old.

Make any corrections, use the TAB key to exit the corrected field, and click **Adjust.**

Void Claim – Paid Claims Only

Access the paid claims from the **Claim Inquiry** window using the Claim Status field.

Once you identify the paid claim to void, open the claim by clicking on the corresponding ICN link. The corresponding claim will display.

Scroll to the bottom of the claim and click **Void**.

Copy Claim – Paid Claims Only

Access the paid claims from the **Claim Inquiry** window using the Claim Status field.

Once you identify the paid claim to copy, open the claim by clicking on the corresponding ICN link. The corresponding claim will display.

Scroll to the bottom of the claim and click **Copy Claim**. A new window will appear with an exact copy of the previously paid claim's data.

Make any changes to the copied version of the claim and click **Re-Submit**.

Note: It is important to verify whether you are adjusting an existing claim or copying a previously paid claim to submit as a new claim. Adjusting previously paid claims may result in KMAP taking back money.

9. Prior Authorization

Orthodontic Services

Orthodontic services require PA and are only covered for eligible children with cases of severe orthodontic abnormality caused by genetic deformity (such as cleft lip or cleft palate) or traumatic facial injury resulting in serious health impairment to the beneficiary at the present time.

See Appendix A for the Orthodontic Agreement.

Out-of-State Services

All nonemergent medical services provided out of state (except those within 50 miles of a Kansas border) require PA be obtained before the services are rendered for KMAP to consider the claim for payment regardless of other insurance coverage. **The in-state referring provider or the out-of-state provider can start the PA process.**

10. Provider Secure Correspondence

Provider Secure Correspondence allows you to send a secure message to the fiscal agent. The fiscal agent researches the inquiry and sends a secure message back to you. It can be accessed from the main provider secure page under Provider Secure Correspondence.

You can submit inquiries related to the following topics:

- Paid, denied, suspended, and recouped claims
- EOB codes
- Adjustments

The inquiry must include basic information and give a detailed description of the specific inquiry. In order to view responses, you must open the tool and click View Messages. There will be detailed help cards available within the tool to assist providers.

Once an inquiry is responded to, the item is considered closed. If additional related inquiries arise, you need to submit a new inquiry and provide the reference number from the original message.

Note: For users with clerk level access, the super user for the provider's web account must add this responsibility to the clerk before he or she can access the new feature. For help with adding this role for a user with clerk level access, go to the Account Maintenance page and click the Help feature for detailed help cards.

11. Payment Inquiry

Search your most recent payment or a date range of payments. Click the button next to the search criteria you want and click **Search**.

B. Electronic Submission Through a Clearinghouse

Providers and billing agents may use a clearinghouse to submit claims to KMAP. Clearinghouses must be authorized by the fiscal agent. An EDI application and an authorization test are required from the clearinghouse, but not the provider or billing agent. Submitters using a clearinghouse should complete an EDI application if an 835 electronic remittance advice is needed. Instructions for maintaining and routing 835s are provided in the *835 Maintenance Guide*.

EDI Help Desk Contact Information

Phone Number: 1-800-933-6593

Email: LOC-KSXIX-EDIKMAP@external.groups.hp.com

Fax Number: 785-267-7689

C. Billing Electronically Using 837D Through the KMAP Website

Providers and billing agents have the option to use their own software. They are required to complete testing with the fiscal agent to ensure claims received by KMAP are HIPAA compliant. Use of third-party software requires an EDI application and an authorization test.

After testing has been completed, the 837D may be transmitted to the fiscal agent through the KMAP website by completing the following steps:

1. From the toolbar on the KMAP website, select the **Trade Files** tab.
2. Select one of the two options on the **Trade Files** tab – **Upload** or **Download**.

   Upload an 837D Batch File

   - To submit a batch file, select the Upload tab or select the Upload New Files link.
   - In the Select File to Upload field, click Browse.
   - Browse to the identified file that you want to upload.
   - Change the filename in the Save As filename field.
   - Select the applicable transaction type from the Transaction Type drop-down box.
   - Click Upload to submit the file. If the file uploaded successfully, a message displays that indicates the upload was successful and lists the transaction ID assignment.

   Download an 835 File

   - Select the **Download** tab or the Download Available Files menu item.

D. Provider Electronic Solutions

Provider Electronic Solutions (PES) is proprietary Windows-based software that enables providers to submit claims electronically, receive claim status, and verify member eligibility in a batch mode. PES has an easy-to-use online help tool that can be activated at the individual field level or from a list of topics. Features, such as reference lists, archiving, and searches, save valuable provider time by providing access to commonly used data. This process eliminates re-entry of certain data. With built-in data validation and editing, it helps to eliminate common data entry errors. Providers can also retrieve, resubmit, and print claims stored locally. The results are improved percentages of claims paid on the first submission.

System Requirements (minimum):

- Pentium II with CD-ROM
- Windows 98/2000/XP

- MS Internet Explorer 5.5 or greater
- 64 Megabytes RAM
- 800 X 600 Resolution
- 100 MB Hard Drive space available
- 28.8 Kbps Modem (or faster)

PES can be installed on a hard disk or a network drive and on as many personal computers (PCs) as necessary. PES can also be installed for use by multiple computers in a network environment. The network administrator should be contacted to set up a shared database location for network installations.

You can get your copy of PES by contacting the EDI help desk by email or by telephone at 1-800-933-6593. You can also download a copy from the KMAP website. Select the EDI tab at the top of the page.

E. Automated Voice Response System

The Automated Voice Response System (AVRS) allows you to:

- Check eligibility
- Inquire about claim status
- Check National Drug Code (NDC) coverage
- Inquire about a PA request
- Hear recent payments
- Hear suspended claims
- Change PIN (AVRS and KMAP website)
- Contact EDI help desk
- Contact KMAP Customer Service

To access AVRS, simply have your PIN number ready.

Dial **1-800-933-6593** and follow the prompts.

Note: Make sure you press the # key after each option. AVRS does not recognize the selection you are making without the # key.

Option 1# – Log on to AVRS

This option requires you to enter your provider number, location code, and PIN.

- Enter your nine-digit provider number along with the location code and select # (for example, 999999999 *99#).

For your location code, enter an alpha character. Press the * key followed by a two-digit number and the # key. The two-digit number is based on the letter of the location code. The first digit represents what key the letter is on. The second digit represents what placement the letter is on the key. For example, the letter A appears on the 2 key, and it is the first letter on that key. So, for the letter A, you would enter *21#. The exceptions to this rule are Q and Z.

Following is a list of characters and how to enter them.

A=*21#	B=*22#	C=*23#	D=*31#	E=*32#	F=*33#	G=*41#	H=*42#	I=*43#
J=*51#	K=*52#	L=*53#	M=*61#	N=*62#	O=*63#	P=*71#	Q=*11#	R=*72#
S=*73#	T=*81#	U=*82#	V=*83#	W=*91#	X=*92#	Y=*93#	Z=*12#	

- Enter your four-digit PIN and press # (for example, 1234#).

Option 2# – Reset a PIN

This option requires you to reset your PIN for AVRS or the KMAP website.

1. Reset your AVRS PIN.
2. Reset your KMAP website PIN.

After you log on to the AVRS, you will be presented with the following menu options:

Option 1 – Check Eligibility

All Title 21 and most Title 19 beneficiaries are assigned to a MCO through KanCare.

Enter beneficiary information.

- **Press 1#** to enter a KMAP beneficiary ID number.
- **Press 2#** to enter a Social Security number and date of birth.

Enter the dates of service.

- Enter the **From Date of Service** in MMDDCCYY format followed by the # key, or just press # for today's date.
- Enter the **To Date of Service** in MMDDCCYY format followed by the # key, or just press # to enter the same as the From Date of Service.

Get results.

- **Press 1#** to have the eligibility information faxed to you. You will be prompted to enter your fax number followed by the # key. Once the call is terminated, the fax is transmitted to the number you entered.
- **Press 2#** to hear the eligibility information read back to you. If you choose to hear the eligibility information, you will also be able to hear information about TPL, KBH, eye exams, therapeutic reserve days, and psychological limits.

Hear verification number.

It is recommended that you write down your verification number for tracking purposes.

Option 2 – Perform a Claim Inquiry

Enter search information.

- **Press 1#** to enter a specific ICN.
- **Press 2#** to enter a KMAP beneficiary ID number followed by the # key, dates of service in MMDDCCYY format followed by the # key, and billed amount followed by the # key.
- Hear claim status information read back over the phone.

Option 3 – NDC Inquiry

Enter the NDC number, followed by the # key.

- Enter the date of service in MMDDCCYY format followed by the # key.
- Hear NDC coverage information.

Option 4 – Prior Authorization Inquiry

Enter search criteria.

- **Press 1#** to enter the PA reference number followed by the # key.
- **Press 2#** to enter the KMAP beneficiary ID number followed by the # key and an optional start date of the PA in MMDDYYYY format followed by the # key.

Receive information.

- **Press 1#** to have the PA information faxed to you. You will be prompted to enter your fax number followed by the # key. Once the call is terminated, the fax is transmitted to the number you entered.
- **Press 2#** to hear the information you requested read back to you over the phone.

Option 5 – Payment Inquiry

Enter search criteria.

- **Press 1#** to hear recent RA payments.
- **Press 2#** to hear suspended claims.

Option 6 – Change PIN

Enter new PIN.

- Enter a new PIN followed by the # key.
- Confirm the new PIN followed by the # key.

AVRS hours of operation:

24 hours a day, 7 days a week
except 1 to 2 a.m., Monday through Saturday
and 1 to 5 a.m. on Sunday

Common menu options:

Press **# to repeat the last prompt.

Press *# to repeat the last response.

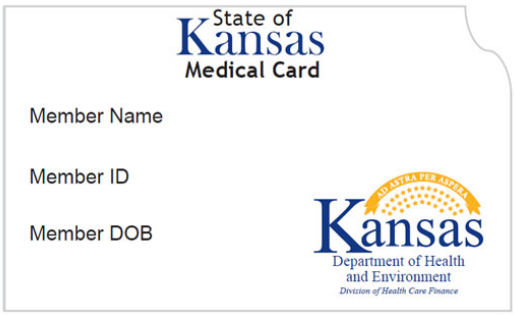
Press *99# to return to the main menu.

Press ** to void incorrect information entered.

Your PIN expires every 180 days.

F. Medical Card/Forms

1. State of Kansas Medical Card



Providers are always responsible for verifying eligibility and coverage before providing services.

Above is an example of the plastic State of Kansas Medical Card. Below is an explanation of the information included on the front and back.

- Beneficiary information is simple and easy to read.
  - The front of the card contains the member name, member ID number, and member date of birth (DOB).
  - The back of the card contains a magnetic stripe, as well as important information for both the beneficiary and the provider.

- Providers can still use existing verification processes.
  - Providers do not have to process beneficiary eligibility information through the card reader.
  - AVRS and secure website inquiries continue to be offered at no cost to providers.
  - The KMAP website is available nearly 24 hours a day, seven days a week with only limited downtime in the early morning hours (approximately 1:00 a.m.) for maintenance.
  - Customer Service is still available to assist providers with beneficiary inquiries Monday through Friday, 8:00 a.m. to 5:00 p.m.
  - PES software will still be available to conduct eligibility verifications through batch files. Response files are available within one to two hours of submission.
  - Providers can submit 270/271 transactions using their business practice management software.

2. Dental Claim Form ADA 2006

ADA Form Requirement
Dental claims must be submitted on an ADA claim form with a version date of 2006 or newer. Paper claims submitted on older versions will be returned to providers. Claims forms containing a tooth chart or diagnosis code are outdated.

3. Individual Adjustment Form

Underpayment Adjustments – If a provider feels a detail was underpaid, an adjustment may be submitted. To be considered for additional payment, an adjustment must be submitted within two years from the date of service on the claim. Underpayment adjustments received for dates of service more than two years old cannot be processed by the fiscal agent and will be returned by the provider, unless a provider submits to timely filing first and the timely filing bypass stamp is on the claim.

Overpayment Adjustments – When a claim has been paid incorrectly resulting in overpayment, the overpayment amount is subject to recoupment, regardless of when the claim paid or how old the dates of service. Once an overpayment is identified, a recoupment letter is sent to the provider.

Individual Adjustment Form
Helpful Tips

To speed processing and ensure your adjustment is processed correctly, verify that the following fields are completed before submitting an Individual Adjustment Form to the fiscal agent:

Complete only what needs to be changed on the claim.

- Internal Control Number – can be found in column four of the RA.
- Beneficiary ID Number – can be found in column two of the RA.
- Provider Number.
- Beneficiary Name.
- Qty/Units on RA and corrected Quantity/Units – if applicable.
- NDC/Procedure Code on RA and Corrected NDC/Procedure Code – if applicable.
- Drug Name – if applicable.
- Billed Amount on RA and Corrected Billed Amount – if applicable.
- Other/Remarks – enter the specific reason for the adjustment request.
- Signature and Date – signature of the provider or the authorized party and date.

In addition to the above information, please attach a copy of your claim and the RA to facilitate processing.

If an overpayment is discovered on the RA, complete the Individual Adjustment Form reporting the overpayment. Personal or company checks will be accepted only when the fiscal agent or KDHE-DHCF specifically requests the repayment to be made by check. Checks that are received but are not requested will be returned to the provider.

Once an adjustment is processed, the results are reported on a subsequent RA. The original claim will appear with negative dollar amounts. The adjusted claim will appear directly above the original claim. The adjusted claim will have an ICN that begins with number 5.

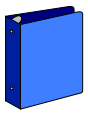
Note: You cannot adjust a claim that has been previously adjusted. If you need to adjust a claim that has previously been adjusted, indicate the *adjusted* claim's ICN on the Individual Adjustment Form.

4. Prior Authorization

- Orthodontic Services

  Orthodontic services require PA and are only covered for eligible children with cases of severe orthodontic abnormality caused by genetic deformity (such as cleft lip or cleft palate) or traumatic facial injury resulting in serious health impairment to the beneficiary at the present time.

The Orthodontic Agreement, Requirements, Responsibilities,and Acceptance Agreement are listed in the Appendix A of this manual.



- Out-of-State Services

  All nonemergent medical services provided out of state (except those within 50 miles of a Kansas border) require PA be obtained before the services are rendered for KMAP to consider the claim for payment regardless of other insurance coverage. **The in-state referring provider or the out-of-state provider can start the PA process.**

5. Criteria for Medical Review Narrative

Specific KMAP dental services require a medical review after the service is rendered. The Benefit Tables (Exhibits A, B, and C at the end of this manual) contain a column marked Medical Review. A "Yes" in this column indicates that the service listed requires medical review narrative to be considered for reimbursement.

KMAP does not require a specific form for this narrative. Each provider can formulate his or her own form to submit to KMAP with the other documentation required.

To fully understand the decision-making process used to determine payment for services rendered, please see the following:

Section IX. Radiology Requirements

Section X. Clinical Criteria

Benefit Tables A, B, and C

The medical review narrative must contain the following information:

- Beneficiary name
- KMAP ID number
- Date of service
- Procedure code
- Procedure code description
- Clinical evaluation/remarks
- Provider name
- Provider KMAP ID number
- Provider signature and date

The dental consultant reviews the documentation submitted with the claim. If the documentation is complete and aligns with the clinical criteria, the claim is processed.

If all required documentation is **not** submitted with the claim or the submitted documentation does not support the clinical criteria the claim is denied.

KMAP does not require providers to submit the medical review narrative and/or documentation when other insurance is primary and makes payment on the service provided. However, providers must attach proof of the other insurance payment to the claim for it to process without additional documentation.

When payment is not made by the beneficiary's primary insurance carrier, medical review narrative and/or documentation is required before payment will be made.

6. TPL Update Form

The TPL Update form is used to report a change in a beneficiary's other insurance coverage. This form can be found on the Forms page of the KMAP website.

7. Remittance Advice

You will receive an RA for each claim received and adjudicated for payment. This RA includes sections for the total amount of payment, payment by provider, claims payment by beneficiary, and adjusted claims.

ICN Regions

ICN – Internal Control Number
Example of an ICN**: 10 05 300 123456**

10	two-digit ICN region
05	two-digit year indicator
300	three-digit Julian date
123456	six-digit sequence number

This is the 123,456 paper claim with no attachments (ICN region 10) received on Julian date 300 (October 27) of year 2005.

Claim ICN Regions

10 Paper claims with no attachments
11 Paper claims with attachments
20 Electronic claims with no attachments
21 Electronic claims
25 Point of service claims
30 Crossover
31 Crossover SNF
40 Claims converted from old MMIS
45 Adjustments converted from old MMIS
47 Credit or void (converted)
49 Beneficiary linking claims
50 Adjustments – noncheck related
51 Adjustments – check related
52 Mass adjustments – noncheck related
53 Mass adjustments – check related
54 Mass adjustments – void transactions
55 Mass adjustments – provider rates
56 Adjustments – void noncheck related
57 Adjustments – void check related
58 Adjustments processed by the fiscal agent
59 POS reversal and Internet adjustments
60 Web claims
65 Web claim resubmission by the fiscal agent
70 Encounters
76 Beneficiary billed spenddown claims
77 Adjustments – encounters
80 Claims reprocessed by the fiscal agent
90 Special projects
91 Batches requiring manual review
92 HMO copays

Exhibit A	**Covered Benefit Table**	**Title 19 and Title 21 Children**

Title 21 Children (ages 0-18) *AND* Title 19 Children (ages 0-20)

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

Diagnostic Clinical Oral Evaluations

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D0120	Periodic oral evaluation-Established patient		No	No	Only one exam every 6 months per provider or provider billing group. Only one exam (D0120, D0140, D0145, D0150, D0170) per date of service, per consumer, per provider or provider billing group.	
D0140	Limited oral evaluation - Problem focused		No	No	Only one exam (D0120, D0140, D0145, D0150, D0170) per date of service, per consumer, per provider or provider billing group. Limited oral evaluation is only covered when performed in conjunction with treatment to address an emergency situation. An emergency is defined as treatment medically necessary to treat pain, infection, swelling, uncontrolled bleeding, or traumatic injury.	
D0145	Oral Evaluation for a beneficiary under three years of age and counseling with primary caregiver		No	No	Only one exam every 6 months per provider or provider billing group. Only one exam (D0120, D0140, D0145, D0150, D0170) per date of service, per consumer, per provider or provider billing group.	
D0150	Comprehensive oral evaluation - New or established patient		No	No	One comprehensive exam per consumer, per provider or provider billing group per lifetime. Only one exam (D0120, D0145, or D0150) every six months per consumer, per provider or provider billing group.	
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)		No	No	One per 12 months. Established consumer to assess the status of a previously existing condition (not post-operative visit). Not covered with any other procedure other than radiographs.	

Title 21 Children (ages 0-18) *AND* Title 19 Children (ages 0-20)

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

Radiographs must be of diagnostic quality, dated, and identified with the consumer's name.

Radiographs not of diagnostic quality will not be reimbursed, or if already paid, will be recouped.

An intraoral complete series (D0210) for a child should consist of 10 films, including 2 bitewings and 4 upper and 4 lower views.

An intraoral complete series (D0210) for an adult complete series should consist of at least 16 films to include 2 bitewings.

Bitewing radiographs (D0270, D0272, D0273, D0274, D0277) and intraoral radiographs (D0220, D0230) require documentation of medical necessity when performed on the same day as an intraoral complete series (D0210).

Without medical necessity, the maximum reimbursement for a single date of service for radiographs shall be limited to the fee for a complete series.

Narrative of medical necessity shall be maintained in consumer's record.

Diagnostic Radiographs/Diagnostic Imaging

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D0210	Intraoral - Complete Series of radiographic images		No	No	One per 36 months. The following are also considered an Intraoral Complete Series (D0210) D0330 and D0272 D0330 and D0273 D0330 and D0274 D0330 and D0277	
D0220	Intraoral - Periapical first radiographic image		No	No	One per day. Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and will not be reimbursed.	
D0230	Intraoral - Periapical each additional radiographic image		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and will not be reimbursed.	If more than one unit is taken on the same date of service, note on claim "not duplicate." Paper claim: Put in remarks sections. Website claim: Put in comments box at header level.

Exhibit A	**Covered Benefit Table**	**Title 19 and Title 21 Children**

Title 21 Children (ages 0-18) *AND* Title 19 Children (ages 0-20)

Diagnostic Radiographs/Diagnostic Imaging

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D0240	Intraoral - Occlusal radiographic image		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.	If more than one unit is taken on the same date of service, note on claim "not duplicate." Paper claim: Put in remarks sections. Website claim: Put in comments box at header level.
D0250	Extraoral - First radiographic image		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.	
D0260	Extraoral - Each additional radiographic image		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.	If more than one unit is taken on the same date of service, note on claim "not duplicate." Paper claim: Put in remarks sections. Website claim: Put in comments box at header level.
D0270	Bitewing - Single radiographic image		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per consumer, per provider or provider billing group.	
D0272	Bitewings - Two radiographic images		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.	

Exhibit A	**Covered Benefit Table**	**Title 19 and Title 21 Children**

Title 21 Children (ages 0-18) *AND* Title 19 Children (ages 0-20)

Diagnostic Radiographs/Diagnostic Imaging

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D0273	Bitewing - Three radiographic images		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.	
D0274	Bitewings - Four radiographic images		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.	
D0277	Vertical bitewings - 7 to 8 radiographic images		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.	
D0290	Posterior - Anterior or lateral skull and facial bone survey radiographic image		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.	

Exhibit A	**Covered Benefit Table**	**Title 19 and Title 21 Children**

Title 21 Children (ages 0-18) *AND* Title 19 Children (ages 0-20)

Diagnostic Radiographs/Diagnostic Imaging

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D0321	Other- Temporomandibular joint arthrogram radiographic images - by report		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.	
D0322	Tomographic survey		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.	
D0330	Panoramic radiographic image		No	No	One per 36 months. The following are also considered an Intraoral Complete Series (D0210) D0330 and D0272 D0330 and D0273 D0330 and D0274 D0330 and D0277	
Diagnostic Tests and Examinations						
D0460	Pulp vitality tests	1 - 32 51 - 82 (SN) A - T AS - TS (SN)	No	No	Maximum of three teeth per visit.	

Preventive Dental Prophylaxis

D1110	Prophylaxis - Adult		No	No	One per 6 months. Title 21 Children Ages 13-18 Title 19 Children Ages 13-20 Includes scaling and polishing procedures to remove coronal plaque, calculus, and stains.	
D1120	Prophylaxis - Child		No	No	One per 6 months. Title 21 Children Ages 0-12 Title 19 Children Ages 0-12 Includes scaling and polishing procedures to remove coronal plaque, calculus, and stains.	

Title 21 Children (ages 0-18) *AND* Title 19 Children (ages 0-20)

Preventive Topical Fluoride Treatment (Office Procedure)

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D1206	Topical application of fluoride varnish		No	No	3 times per 12 months. Title 21 Children Ages 0-18 Title 19 Children Ages 0-20	
D1208	Topical application of fluoride - excluding varnish		No	No	3 times per 12 months. Title 21 Children Ages 0-18 Title 19 Children Ages 0-20	

Sealants are reimbursable when placed on the occlusal or occlusal-buccal surfaces of lower 1st and 2nd permanent molars or upper 1st and 2nd permanent molars as well as permanent upper and lower bicuspids.

Preventive Other Preventive Services

D1351	Sealant - per tooth		No	No	Once per 12 months. Occlusal surfaces only. Teeth must be caries free. Sealant is not covered when placed over restorations.	

Space maintainers are a covered service when medically indicated due to the premature loss of a posterior primary tooth.

A lower lingual holding arch placed where there is not premature loss of the primary molar is considered a transitional orthodontic appliance and is <u>not</u> covered by this plan.

Preventive Space Maintenance (Passive Appliances)

D1510	Space maintainer - Fixed - Unilateral	Per quadrant 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	No	One per 12 months per quadrant.	
D1515	Space maintainer - Fixed - Bilateral	01 (UA) 02 (LA)	No	No	One per 12 months per arch.	
D1525	Space maintainer - Removable - bilateral	01 (UA) 02 (LA)	No	No	One per 12 months per arch.	
D1550	Re-cement or re-bond space maintainer	01 (UA) 02 (LA) 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	No	Not covered within 6 months of initial placement.	

Title 21 Children (ages 0-18) *AND* Title 19 Children (ages 0-20)

Reimbursement for Restorative Services includes local anesthesia.

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

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

Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day.

A restoration is considered a two or more surface restoration only when two or more actual tooth surfaces are involved, whether or not they are connected.

Arches, Quadrants, Primary, Permanent, Supernumerary Teeth, and Surfaces should be billed as defined in the current CDT manual.

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
Restorative	Amalgam Restorations (Including Polishing)					
D2140	Amalgam - one surface, primary or permanent	1 - 32 51 - 82 (SN) A - T AS - TS (SN)	No	No		
D2150	Amalgam - two surfaces, primary or permanent	1 - 32 51 - 82 (SN) A - T AS - TS (SN)	No	No		
D2160	Amalgam - three surfaces, primary or permanent	1 - 32 51 - 82 (SN) A - T AS - TS (SN)	No	No		
D2161	Amalgam - four or more surfaces, primary or permanent	1 - 32 51 - 82 (SN) A - T AS - TS (SN)	No	No		
Restorative	Resin-Based Composite Restorations - Direct					
D2330	Resin-based composite - one surface, anterior	6 - 11, 22 - 27 56 - 61 (SN) 72 - 77 (SN) C - H, M - R CS - HS (SN) MS - RS (SN)	No	No		
D2331	Resin-based composite - two surfaces, anterior	6 - 11, 22 - 27 56 - 61 (SN) 72 - 77 (SN) C - H, M - R CS - HS (SN) MS - RS (SN)	No	No		

Title 21 Children (ages 0-18) *AND* Title 19 Children (ages 0-20)

Restorative Resin-Based Composite Restorations - Direct

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D2332	Resin-based composite - three surfaces, anterior	6 - 11, 22 - 27 56 - 61 (SN) 72 - 77 (SN) C - H, M - R CS - HS (SN) MS - RS (SN)	No	No		
D2335	Resin-based composite - four or more surfaces, or involving the incisal angle anterior	6 - 11, 22 - 27 56 - 61 (SN) 72 - 77 (SN) C - H, M - R CS - HS (SN) MS - RS (SN)	No	No		
D2390	Resin-based composite crown - anterior	6 - 11, 22 - 27 56 - 61 (SN) 72 - 77 (SN) C - H, M - R CS - HS (SN) MS - RS (SN)	No	No		
D2391	Resin-based composite - one surface, posterior	1 - 5, 12 - 21, 28 - 32 51 - 55 (SN) 62 - 71 (SN) 78 - 82 (SN) A, B, I - L, S, T, AS (SN), BS (SN) IS - LS (SN), SS (SN), TS (SN)	No	No		
D2392	Resin-based composite - two surfaces posterior	1 - 5, 12 - 21, 28 - 32 51 - 55 (SN) 62 - 71 (SN) 78 - 82 (SN) A, B, I - L, S, T, AS (SN), BS (SN) IS - LS (SN), SS (SN), TS (SN)	No	No		
D2393	Resin-based composite - three surfaces, posterior	1 - 5, 12 - 21, 28 - 32 51 - 55 (SN) 62 - 71 (SN) 78 - 82 (SN) A, B, I - L, S, T, AS (SN), BS (SN) IS - LS (SN), SS (SN), TS (SN)	No	No		

Exhibit A	**Covered Benefit Table**	**Title 19 and Title 21 Children**

Title 21 Children (ages 0-18) *AND* Title 19 Children (ages 0-20)

Restorative Resin-Based Composite Restorations - Direct

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D2394	Resin-based composite - four or more surfaces, posterior	1 - 5, 12 - 21, 28 - 32 51 - 55 (SN) 62 - 71 (SN) 78 - 82 (SN) A, B, I - L, S, T, AS (SN), BS (SN) IS - LS (SN), SS (SN), TS (SN)	No	No		

Restorative Crowns - Single Restorations only

D2710	Crown - resin-based composite (indirect)	6 - 11 22 - 27 56 - 61 (SN) 72 - 77 (SN)	Yes	No	Once per 60 months.	Preoperative radiographs of adjacent and opposing teeth. If a tooth has had RCT, a postendodontic radiograph is also required showing the entire tooth.
D2740	Crown - porcelain/ceramic substrate	1 - 32 51 - 82 (SN)	Yes	No	Once per 60 months.	Preoperative radiographs of adjacent and opposing teeth. If a tooth has had RCT, a postendodontic radiograph is also required showing the entire tooth.
D2751	Crown - porcelain fused to predominantly base metal	1 - 32 51 - 82 (SN)	Yes	No	Once per 60 months.	Preoperative radiographs of adjacent and opposing teeth. If a tooth has had RCT, a postendodontic radiograph is also required showing the entire tooth.
D2752	Crown - porcelain fused to noble metal	1 - 32 51 - 82 (SN)	Yes	No	Once per 60 months.	Preoperative radiographs of adjacent and opposing teeth. If a tooth has had RCT, a postendodontic radiograph is also required showing the entire tooth.
D2783	Crown - 3/4 porcelain/ceramic	1 - 32 51 - 82 (SN)	Yes	No	Once per 60 months.	Preoperative radiographs of adjacent and opposing teeth. If a tooth has had RCT, a postendodontic radiograph is also required showing the entire tooth.

Title 21 Children (ages 0-18) *AND* Title 19 Children (ages 0-20)

Restorative Crowns - Single Restorations only

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D2791	Crown - full cast predominantly base metal	1 - 32 51 - 82 (SN)	Yes	No	Once per 60 months.	Preoperative radiographs of adjacent and opposing teeth. If a tooth has had RCT, a postendodontic radiograph is also required showing the entire tooth.
D2792	Crown - full cast noble metal	1 - 32 51 - 82 (SN)	Yes	No	Once per 60 months.	Preoperative radiographs of adjacent and opposing teeth. If a tooth has had RCT, a postendodontic radiograph is also required showing the entire tooth.
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	1 - 32 51 - 82 (SN)	No	No		
D2920	Re-cement or re-bond crown	1 - 32 51 - 82 (SN)	No	No		
D2921	Reattachment of tooth fragment, incisal edge or cusp	1 - 32 51 - 82 (SN)	No	No	Not allowed same tooth, same surface(s), same DOS as D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394	Pre- and post-operative radiographic images shall be maintained in beneficiary records.
D2930	Prefabricated stainless steel crown - primary tooth	A - T AS - TS (SN)	No	No	Once per 24 months. D2930 and D2934 cannot be placed on the same tooth during a 24-month period.	
D2931	Prefabricated stainless steel crown - permanent tooth	1 - 32 51 - 82 (SN)	No	No	Once per 24 months.	
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	C - H, M - R CS - HS (SN) MS - RS (SN)	No	No	Once per 24 months. D2930 and D2934 cannot be placed on the same tooth during a 24-month period.	
D2940	Protective restoration	1 - 32 51 - 82 (SN)	No	No	Temporary restoration intended to relieve pain. Not to be used as a base or liner under a restoration.	
D2951	Pin retention - per tooth, in addition to restoration	1 - 32 51 - 82 (SN)	No	No		
D2954	Prefabricated post and core in addition to crown	1 - 32 51 - 82 (SN)	Yes	No	Once per 60 months.	Endodontic fill radiograph and narrative of medical necessity submitted with claim.
D2957	Each additional prefabricated post - same tooth	1 - 3 14 - 19 30 - 32 51- 53 (SN) 64 - 69 (SN) 80 - 82 (SN)	Yes	No	Once per 60 months.	Endodontic fill radiograph and narrative of medical necessity submitted with claim.

Title 21 Children (ages 0-18) *AND* Title 19 Children (ages 0-20)

Reimbursement for Endodontic Services includes local anesthesia.

In cases where a root canal filing does not meet the general clinical criteria standards (Section IX. Clinical Criteria in this manual), KMAP can require the procedure be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after the dental consultant reviews the circumstances.

A pulpotomy or palliative treatment is not to be billed in conjunction with a root canal treatment on the same date.

Filling material not accepted by the Federal Food and Drug Administration is not covered.

Complete root canal therapy includes pulpectomy, all appointments necessary to complete the treatment, temporary filling, filling and obturation of canals, intraoperative, and fill radiographs.

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
Endodontics Pulp Capping						
D3110	Pulp cap - direct (excluding final restoration)	1 - 32 51 - 82(SN)	No	No		
Endodontics Pulpotomy						
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	1 - 32 51 - 82(SN) A - T AS - TS	No	No	One per tooth, per lifetime. Not covered within 30 days of D3310 - D3331 on same tooth.	
D3221	Pulpal debridement - primary and permanent teeth	1 - 32 51 - 82(SN) A - T AS - TS(SN)	No	No	One per tooth, per lifetime. Not covered within 30 days of D3310 - D3331 on same tooth.	
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	1 - 32 51 - 82(SN)	Yes	No	One per tooth, per lifetime. Should only be performed as preparation for endodontic treatment.	Preoperative periapical radiograph of tooth submitted with claim.
Endodontics Endodontic Therapy (including treatment plan, clinical procedures, and follow-up care).						
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	6 - 11 22 - 27 56 - 61(SN) 72 - 77(SN)	No	No	One per tooth, per lifetime.	
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	4, 5, 12, 13, 20, 21, 28, 29, 54(SN), 55(SN), 62(SN), 63(SN), 70(SN), 71(SN), 78(SN), 79(SN)	No	No	One per tooth, per lifetime.	
D3330	Endodontic therapy, molar tooth (excluding final restoration)	1 - 3, 14 - 19 30 - 32 51 - 53(SN) 64 - 69(SN) 80 - 82(SN)	No	No	One per tooth, per lifetime.	

Title 21 Children (ages 0-18) *AND* Title 19 Children (ages 0-20)

Endodontics Endodontic Therapy (including treatment plan, clinical procedures, and follow-up care).

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D3331	Treatment of root canal obstruction; non-surgical access	1 - 32 51 - 82(SN)	Yes	No		Preoperative, fill radiograph, and narrative of medical necessity submitted with claim.
Endodontics	Apexification/recalcification procedures					
D3351	Apexification/recalcification - initial visit (apical closure/ calcific repair of perforations, root resorption, etc.)	1 - 32 51 - 82(SN)	No	No		Pre- and post-operative radiographs shall be maintained in beneficiary records.
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	1 - 32 51 - 82(SN)	No	No		Pre- and post-operative radiographs shall be maintained in beneficiary records.
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/clacific repair of perforations, root receptions, etc.)	1 - 32 51 - 82(SN)	No	No		Pre- and post-operative radiographs shall be maintained in beneficiary records.
Endodontics	Apicoectomy/Periradicular Services					
D3410	Apicoectomy - anterior	6 - 11 22 - 27 56 - 61(SN) 72 - 77(SN)	No	No		Pre- and post-operative radiographs shall be maintained in beneficiary records.
D3421	Apicoectomy - bicuspid (first root)	4, 5, 12, 13, 20, 21, 28, 29, 54(SN), 55(SN), 62(SN), 63(SN), 70(SN), 71(SN), 78(SN), 79(SN)	No	No		
D3425	Apicoectomy - molar (first root)	1 - 3, 14 - 19 30 - 32 51 - 53 (SN) 64-69 (SN) 80 - 82 (SN)	No	No		
D3426	Apicoectomy (each additional root)	1 - 5, 12 - 21 28 - 32 51 - 55 (SN) 62 - 71 (SN) 78 - 82 (SN)	No	No		
D3427	Periradicular surgery without apicoectomy	1 - 32, 51 - 82 (SN)	No	No	Not allowed same tooth, same DOS as D3410, D3421, D3425, D3426	Pre- and post-operative radiographs shall be maintained in beneficiary records.
D3430	Retrograde filling - per root	1 - 32 51 - 82(SN)	No	No		Pre- and post-operative radiographs shall be maintained in beneficiary records.

Title 21 Children (ages 0-18) *AND* Title 19 Children (ages 0-20)

Reimbursement for Periodontic Services includes local anesthesia.

Arches, Quadrants, Primary, Permanent, Supernumerary Teeth, and Surfaces should be billed as defined in the current CDT manual.

Periodontics Surgical Services (including usual post-operative care)						
Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D4210	Gingivectomy or gingivolplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	No	A minimum of four affected teeth in the quadrant.	Periodontal charting, preoperative radiographs, and treatment plan submitted with claim.
D4211	Gingivectomy or gingivolplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	No	One to three affected teeth in the quadrant.	Periodontal charting, preoperative radiographs, and treatment plan submitted with claim.
D4230	Anatomical crown exposure - four or more contiguous teeth per quadrant	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	No	Must be billed same date same tooth in conjunction with the restorative codes (D2140 - D2957).	Periodontal charting for affected area preoperative radiographs and narrative of medical necessity submitted with claim and a photo of the area if available.
D4231	Anatomical crown exposure - one to three teeth per quadrant	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	No	Same date and same tooth in conjunction with the restorative code.	Periodontal charting for affected area preoperative radiographs and narrative of medical necessity submitted with claim and a photo of the area if available.
D4268	Surgical revision procedure, per tooth	1 - 32 51 - 82(SN)	Yes	No	Only covered after D4210.	Narrative of medical necessity submitted with claim.
Periodontics Non-Surgical Services						
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	No	Four per 12 months. A minimum of four affected teeth in the quadrant.	Periodontal charting, preoperative radiographs, and treatment plan submitted with claim. There must be radiographic evidence of root calculus or noticeable loss of bone support.
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	No	Four per 12 months. One to three affected teeth in the quadrant.	Periodontal charting, preoperative radiographs, and treatment plan submitted with claim. There must be radiographic evidence of root calculus or noticeable loss of bone support.
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis		No	No	One per 12 months.	Documentation of medical necessity shall be maintained in beneficiary records.

Title 21 Children (ages 0-18) *AND* Title 19 Children (ages 0-20)

Medically necessary partial or full mouth dentures and related services may be covered when they are determined to be the primary treatment of choice or an essential part of the overall treatment plan to treat the beneficiary's oral health.

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

Extractions for asymptomatic teeth are not covered services unless removal constitutes the most cost-effective dental procedure for the provision of dentures. Provision for dentures for cosmetic purposes is not a covered service.

Arches, Quadrants, Primary, Permanent, Supernumerary Teeth, and Surfaces should be billed as defined in the current CDT manual.

Prosthodontics (Removable)	Complete Dentures (Including routine post-delivery care)					
Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D5110	Complete denture - maxillary		Yes	No	One per 60 months.	Preoperative radiographs and treatment plan submitted with claim.
D5120	Complete denture - mandibular		Yes	No	One per 60 months.	Preoperative radiographs and treatment plan submitted with claim.
Prosthodontics (Removable)	Partial Dentures (Including routine post-delivery care)					
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)		Yes	No	One per 60 months.	Preoperative radiographs of adjacent and opposing teeth and treatment plan submitted with claim.
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)		Yes	No	One per 60 months.	Preoperative radiographs of adjacent and opposing teeth and treatment plan submitted with claim.
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)		Yes	No	One per 60 months.	Preoperative radiographs of adjacent and opposing teeth and treatment plan submitted with claim.
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)		Yes	No	One per 60 months.	Preoperative radiographs of adjacent and opposing teeth and treatment plan submitted with claim.
D5225	Maxillary partial denture - flexible base (including any conventional clasps, rests and teeth)		Yes	No	One per 60 months.	Preoperative radiographs of adjacent and opposing teeth and treatment plan submitted with claim.
D5226	Mandibular partial denture - flexible base (including any conventional clasps, rests and teeth)		Yes	No	One per 60 months.	Preoperative radiographs of adjacent and opposing teeth and treatment plan submitted with claim.

Exhibit A	Covered Benefit Table	Title 19 and Title 21 Children

Title 21 Children (ages 0-18) *AND* Title 19 Children (ages 0-20)

Prosthodontics (Removable) Partial Dentures (Including routine post-delivery care)

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	No	One per 60 months.	Preoperative radiographs of adjacent and opposing teeth and treatment plan submitted with claim.
Prosthodontics Adjustments to Dentures						
D5410	Adjust complete denture - maxillary		No	No	Not covered within 6 months of placement.	
D5411	Adjust complete denture - mandibular		No	No	Not covered within 6 months of placement.	
D5421	Adjust partial denture - maxillary		No	No	Not covered within 6 months of placement.	
D5422	Adjust partial denture - mandibular		No	No	Not covered within 6 months of placement.	
Prosthodontics Repairs to Complete Dentures						
D5510	Repair broken complete denture base	01 (UA) 02 (LA)	No	No		
D5520	Replace missing or broken teeth - complete denture (each tooth)	1 - 32	No	No		
Prosthodontics Repairs to Partial Dentures						
D5610	Repair resin denture base	01 (UA) 02 (LA) 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	No		
D5620	Repair cast framework	01 (UA) 02 (LA) 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	No		
D5630	Repair or replace broken clasp	01 (UA) 02 (LA) 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	No		
D5640	Replace broken teeth - per tooth	1 - 32	No	No		
D5650	Add tooth to existing partial denture	1 - 32	No	No		
D5660	Add clasp to existing partial denture	01 (UA) 02 (LA) 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	No		

Exhibit A	Covered Benefit Table	Title 19 and Title 21 Children

Title 21 Children (ages 0-18) *AND* Title 19 Children (ages 0-20)

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
Prosthodontics Repairs to Partial Dentures						
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)		No	No		
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)		No	No		
Prosthodontics Denture Reline Procedures						
D5750	Reline complete maxillary denture (laboratory)		No	No	One per 24 months. Not covered within 24 months of placement.	
D5751	Reline complete mandibular denture (laboratory)		No	No	One per 24 months. Not covered within 24 months of placement.	
D5760	Reline maxillary partial denture (laboratory)		No	No	One per 24 months. Not covered within 24 months of placement.	
D5761	Reline mandibular partial denture (laboratory)		No	No	One per 24 months. Not covered within 24 months of placement.	
Prosthodontics Other removable prosthetic services						
D5850	Tissue conditioning, maxillary		No	No		
D5851	Tissue conditioning, mandibular		No	No		
Implant Services Other Implant services						
D6100	Implant removal - by report	1-32 51-82 (SN)	Yes	No		Pre- and postoperative radiographs along with narrative of medical necessity submitted with claim.
Prostodontics Fixed Other fixed partial denture services						
D6930	Re-cement or re-bond fixed partial denture	01 (UA) 02 (LA) 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	No		

Title 21 Children (ages 0-18) *AND* Title 19 Children (ages 0-20)

Reimbursement for Oral and Maxillofacial Surgery Services includes local anesthesia, sutures, and routine postoperative care.

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

Removal of impacted teeth (such as third molars) are reviewed by the dental consultant. If these impacted teeth are asymptomatic, the root of the tooth should be adequately developed to determine that the impacted tooth is so positioned that it cannot fully erupt into function and could also contribute to pathology with dental and medical consequences.

The radiographs and/or narrative submitted with the claim must support the CDT code submitted. Please consult the current CDT manual for complete code descriptions.

Preoperative radiographs must be available for the following procedures: D7140, D7210, D7220, D7230, D7240, D7241, D7250, and D7280.

Only CDT (dental) codes should be submitted for processing.

Only one extraction per tooth, per lifetime, is allowed for the beneficiary.

Arches, Quadrants, Primary, Permanent, Supernumerary Teeth, and Surfaces should be billed as defined in the CDT manual.

Oral and Maxillofacial Surgery Extractions (Includes local anesthesia, suturing, if needed, and routine postoperative care).						
Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	1 - 32 51- 82 (SN) A - T AS - TS (SN)	No	No		
Oral and Maxillofacial Surgery Surgical Extractions (Includes local anesthesia, suturing, and routine postoperative care).						
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	1 - 32 51- 82 (SN) A - T AS - TS (SN)	No	No	Includes cutting of gingiva and bone, removal of tooth structure, and closure.	
D7220	Removal of impacted tooth - soft tissue	1 - 32 51- 82 (SN)	Yes	No	Includes cutting of gingiva and bone, removal of tooth structure, and closure.	Preoperative radiographs and narrative of medical necessity submitted with claim.
D7230	Removal of impacted tooth - partially bone	1 - 32 51- 82 (SN)	Yes	No	Includes cutting of gingiva and bone, removal of tooth structure, and closure.	Preoperative radiographs and narrative of medical necessity submitted with claim.
D7240	Removal of impacted tooth - completely bony	1 - 32 51- 82 (SN)	Yes	No	Includes cutting of gingiva and bone, removal of tooth structure, and closure.	Preoperative radiographs and narrative of medical necessity submitted with claim.

Exhibit A	**Covered Benefit Table**	**Title 19 and Title 21 Children**

Title 21 Children (ages 0-18) *AND* Title 19 Children (ages 0-20)

Oral and Maxillofacial Surgery Surgical Extractions (Includes local anesthesia, suturing, and routine postoperative care).

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	1 - 32 51- 82 (SN)	Yes	No	Includes cutting of gingiva and bone, removal of tooth structure, and closure. *Unusual complications such as nerve dissection, separate closure of the maxillary sinus, or aberrant tooth position*	Preoperative radiographs and narrative of medical necessity submitted with claim.
D7250	Surgical removal of residual roots (cutting procedure)	1 - 32 51- 82 (SN) A - T AS - TS (SN)	No	No	Includes cutting of gingiva and bone, removal of tooth structure, and closure. Will not be paid to the providers or group that originally removed the tooth	
Oral and Maxillofacial Surgery Other surgical procedures						
D7260	Oroantral fistula closure		Yes	No		Pre- and postoperative radiographs and narrative of medical necessity submitted with claim
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	1 - 32 51- 82 (SN) A - T AS - TS (SN)	No	No	Includes splinting and/or stabilization.	
D7280	Surgical access of unerupted tooth	1 - 32 51- 82 (SN)	Yes	No	Will not be payable unless the orthodontic treatment has been authorized as a covered benefit.	Preoperative radiographs and narrative of medical necessity submitted with claim.
D7285	Incisional biopsy of oral tissue - hard (bone, tooth)		No	No		Pathology report should be kept in beneficiary record.
D7286	Incisional biopsy of oral tissue - soft		No	No		Pathology report should be kept in beneficiary record.
Oral and Maxillofacial Surgery Alveoloplasty Surgical preparation of ridge for dentures						
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	No	No extractions performed in an edentulous area.	Preoperative radiographs and narrative of medical necessity submitted with claim.
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment, and management of hypertrophied and hyper plastic tissue).	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	No		Preoperative radiographs and narrative of medical necessity submitted with claim.

Pathology report should be kept in beneficiary record.

Title 21 Children (ages 0-18) *AND* Title 19 Children (ages 0-20)

Oral and Maxillofacial Surgery Surgical excision of soft tissue lesions

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D7410	Excision of benign lesion up to 1.25 cm		No	No		
D7411	Excision of benign lesion greater than 1.25 cm		No	No		
D7412	Excision of benign lesion - complicated		No	No		
D7413	Excision of malignant lesion up to 1.25 cm		No	No		
D7414	Excision of malignant lesion greater than 1.25 cm		No	No		
D7415	Excision of malignant lesion - complicated		No	No		
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm		No	No		
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm		No	No		
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm		No	No		
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm		No	No		
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm		No	No		
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm		No	No		
D7471	Removal of lateral exostosis - (maxilla or mandible)	01 (UA) 02 (LA)	Yes	No	Once per lifetime.	Preoperative radiographs and narrative of medical necessity submitted with claim.
D7472	Removal of torus palatinus		Yes	No	Once per lifetime.	Preoperative radiographs and narrative of medical necessity submitted with claim.
D7473	Removal of torus mandibularis		Yes	No	Once per lifetime.	Preoperative radiographs and narrative of medical necessity submitted with claim.
D7490	Radical resection of maxilla or mandible	01 (UA) 02 (LA)	Yes	No		Preoperative radiographs and narrative of medical necessity submitted with claim.

Title 21 Children (ages 0-18) *AND* Title 19 Children (ages 0-20)

Oral and Maxillofacial Surgery Surgical incision						
Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D7510	Incision and drainage of abscess - intraoral soft tissue		No	No	Not covered same date of service as D7511.	
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)		No	No		
D7520	Incision and drainage of abscess - extraoral soft tissue		No	No	Not covered same date of service as D7521.	
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)		No	No		
D7530	Removal of foreign body from mucosa, skin or subcutaneous alveolar tissue		No	No		
D7540	Removal of reaction producing foreign bodies, musculoskeletal system		No	No		
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone		No	No		
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body		Yes	No		Pre- and postoperative radiographs along with narrative of medical necessity must be submitted with claim.
Oral and Maxillofacial Surgery Treatment of Fractures Simple						
D7610	Maxilla - open reduction (teeth immobilized, if present)		No	No		
D7620	Maxilla - closed reduction (teeth immobilized, if present)		No	No		
D7630	Mandible - open reduction (teeth immobilized, if present)		No	No		
D7640	Mandible - closed reduction (teeth immobilized, if present)		No	No		
D7650	Malar and/or zygomatic arch - open reduction		No	No		
D7660	Malar and/or zygomatic arch - closed reduction		No	No		

Exhibit A	Covered Benefit Table	Title 19 and Title 21 Children

Title 21 Children (ages 0-18) *AND* Title 19 Children (ages 0-20)

Oral and Maxillofacial Surgery	Treatment of Fractures Simple					
Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D7670	Alveolus - closed reduction - may include stabilization of teeth	1- 32	No	No	May include stabilization.	
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches		Yes	No		Pre- and postoperative radiographs along with narrative of medical necessity must be submitted with claim.
Oral and Maxillofacial Surgery	Treatment of Fractures Compound					
D7710	Maxilla - open reduction		No	No		
D7720	Maxilla - closed reduction		No	No		
D7730	Mandible - open reduction		No	No		Postoperative radiographs must be available in the beneficiary records.
D7740	Mandible - closed reduction		No	No		
D7750	Malar and/or zygomatic arch - open reduction		No	No		
D7760	Malar and/or zygomatic arch - closed reduction		No	No		
D7770	Alveolus - open reduction stabilization of teeth		No	No		
D7780	Facial bones - complicated reduction with fixation and multiple surgical approaches		No	No		
D7820	Closed reduction of dislocation		No	No		
D7860	Arthrotomy		Yes	No		Preoperative radiographs, narrative of medical necessity, and treatment plan submitted with claim.
D7865	Arthroplasty		Yes	No		Preoperative, postoperative radiographs, and narrative of medical necessity submitted with claim.
Oral and Maxillofacial Surgery	Repair of traumatic wounds					
D7910	Suture of recent small wounds up to 5 cm		No	No	Not covered on same day as D7140, D7210, D7220, D7230, D7240, D7241, or D7250.	
Oral and Maxillofacial Surgery	Complicated suturing (reconstruction requiring delicate handling of tissues and wide undermining for meticulous closure)					
D7911	Complicated suture - up to 5 cm		No	No	Not covered on same day as D7140, D7210, D7220, D7230, D7240, D7241, or D7250.	
D7912	Complicated suture - greater than 5 cm		No	No	Not covered on same day as D7140, D7210, D7220, D7230, D7240, D7241, or D7250.	

Title 21 Children (ages 0-18) *AND* Title 19 Children (ages 0-20)

Oral and Maxillofacial Surgery Other repair procedures

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D7920	Skin graft (identify defect covered, location and type of graft)	01 (UA) 02 (LA) 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	No		Narrative of medical necessity submitted with claim.
D7955	Repair of maxillofacial soft and/or hard tissue defect		Yes	No		Pre- and postoperative radiographs and narrative of medical necessity submitted with claim
D7960	Frenulectomy also known as frenectomy or frenotomy-separate procedure not incidental to another procedure	01 (UA) 02 (LA)	No	No	Once per lifetime. Per location Lingual, Buccal or Labial. Not covered same date of service as D7963.The frenum may be excised when the tongue has limited mobility; for large diastemas between teeth, or when the frenum interferes with a prosthetic appliance; or when it is the etiology of periodontal tissue disease.	
D7963	Frenuloplasty		No	No	Excision of frenum with excision or repositioning of abervant muscle and z-plasty or other local flap closure	
D7971	Excision of pericoronal gingiva	1 - 32	No	No		
D7980	Sialolithotomy		No	No		
D7981	Excision of salivary gland, by report		No	No		
D7982	Sialodochoplasty		No	No		
D7983	Closure of salivary fistula		Yes	No		Pre- and postoperative radiographs along with narrative of medical necessity submitted with claim.
D7990	Emergency tracheotomy		No	No		

Title 21 Children (ages 0-18) *AND* Title 19 Children (ages 0-20)

Orthodontic services require prior authorization and are only covered for eligible children with cases of severe orthodontic abnormality caused by genetic deformity (such as cleft lip or cleft palate) or traumatic facial injury resulting in serious health impairment to the beneficiary at the present time.

Limited orthodontic treatment is treatment with a limited objective, not involving the entire dentition. It may be directed at the only existing problem or at only one aspect of a larger problem in which a decision is made to defer or forego more comprehensive therapy.

Limited orthodontic treatment requires prior authorization and is only covered for eligible children with documented medical necessity.

The following dental procedure codes are content of service of an orthodontic workup (D8999) when performed on the same date of service by the same provider: D0120, D0140, D0170, D0210, D0220, D0230, D0240, D0250, D0260, D0270, D0272, D0273, D0274, D0277, D0290, D0321, D0330, D0322, and D0340.

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
Orthodontics	Limited orthodontic treatment					
D8010	Limited orthodontic treatment of the primary dentition		No	Yes	Limited to one replacement. Limited orthodontic treatment requires prior authorization and is only covered for eligible children with documented medical necessity.	Study models. Panoramic or periapical radiographs. Narrative/treatment plan. *Cephalogram and/or photos optional.*
D8020	Limited orthodontic treatment of the transitional dentition		No	Yes	Limited to one replacement. Limited orthodontic treatment requires prior authorization and is only covered for eligible children with documented medical necessity.	Study models. Panoramic or periapical radiographs. Narrative/treatment plan. *Cephalogram and/or photos optional.*
Orthodontics	Interceptive orthodontic treatment					
D8050	Interceptive orthodontic treatment of the primary dentition		No	Yes	Interceptive orthodontic treatment requires prior authorization and is only covered for eligible children with documented medical necessity.	Study models. Panoramic or periapical radiographs. Narrative/treatment plan. *Cephalogram and/or photos optional.*
D8060	Interceptive orthodontic treatment of the transitional dentition		No	Yes	Interceptive orthodontic treatment requires prior authorization and is only covered for eligible children with documented medical necessity.	Study models. Panoramic or periapical radiographs. Narrative/treatment plan. *Cephalogram and/or photos optional.*
Orthodontics	Comprehensive orthodontic treatment					
D8070	Comprehensive orthodontic treatment of the transitional dentition		No	Yes	Comprehensive orthodontic treatment requires prior authorization and is only covered for eligible children with documented medical necessity.	Study models. Panoramic or periapical radiographs. Narrative/treatment plan. *Cephalogram and/or photos optional.*
D8080	Comprehensive orthodontic treatment of the adolescent dentition		No	Yes	Comprehensive orthodontic treatment requires prior authorization and is only covered for eligible children with documented medical necessity.	Study models. Panoramic or periapical radiographs. Narrative/treatment plan. *Cephalogram and/or photos optional.*

Title 21 Children (ages 0-18) *AND* Title 19 Children (ages 0-20)

Orthodontics Minor treatment to control harmful habits						
Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D8210	Removable appliance therapy		No	Yes	Limited to one replacement. Removable appliance therapy requires prior authorization and is only covered for eligible children with documented medical necessity.	Study models. Panoramic or periapical radiographs. Narrative/treatment plan. *Cephalogram and/or photos optional.*
D8220	Fixed appliance therapy		No	Yes	Limited to one replacement. Removable appliance therapy requires prior authorization and is only covered for eligible children with documented medical necessity.	Study models. Panoramic or periapical radiographs. Narrative/treatment plan. *Cephalogram and/or photos optional.*
Orthodontics Other orthodontic services						
D8999	Unspecified orthodontic procedure - by report		No	Yes	All orthodontic treatment requires prior authorization and is only covered for eligible children with documented medical necessity.	Study models. Panoramic or periapical radiographs. Narrative/treatment plan. *Cephalogram and/or photos optional*

Exhibit A	Covered Benefit Table	Title 19 and Title 21 Children

Title 21 Children (ages 0-18) *AND* Title 19 Children (ages 0-20)

D9220 and D9221 are only billable when dental services other than ONLY diagnostic are provided on the same date of service.

D9310 is billable when ONLY diagnostic services are provided on the same date of service.

Registered dental hygienists with an extended care permit can bill KMAP for D9999 - clinical and caries risk assessment, toothbrush prophylaxis of a child 0-3 years of age and counseling to parents/primary caregivers. Maximum allowable amount is $20.30.

More information regarding ECP services is under the **Provider Participation** secion in the main portion of this manual.

Adjunctive General Services	Anesthesia					
Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D9212	Trigeminal division block anesthesia		No	No		Narrative of medical necessity shall be maintained in beneficiary records.
D9219	Evaluation for deep sedation or general anesthesia		No	No	One time per beneficiary per provider or provider billing group per lifetime. One time per beneficiary per 12 months.	Narrative of the evaluaion for anesthesia shall be maintained in the beneficiary records.
D9220	Deep sedation/general anesthesia - first 30 minutes		Yes	No		Narrative of medical necessity/treatment plan must be submitted with claim.
D9221	Deep sedation/general anesthesia - each additional 15 minutes		Yes	No		Narrative of medical necessity/treatment plan must be submitted with claim.
D9230	Inhalation of nitrous oxide/ analgesia, anxiolysis		No	No	Not covered when billed with **only** diagnostic and/or preventative services (D0120 through D1208, D1515 through D1550, D9410, D9420).	Narrative of medical necessity shall be maintained in beneficiary records.
D9241	Intravenous moderate (conscious) sedation/ analgesia - first 30 minutes		Yes	No		Narrative of medical necessity/treatment plan must be submitted with claim.
D9242	Intravenous moderate (conscious) sedation/ analgesia - each additional 15 minutes		Yes	No		Narrative of medical necessity/treatment plan must be submitted with claim.
Professional Consultation						
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician		No	No	One per 12 months by same provider. One inpatient followup per beneficiary within a 10 day period by same provider. Not covered on same date of service as D0120 -D0170, D9410, D9420.	Narrative of the consultation for dental services shall be maintained in beneficiary records.
Professional Visits						
D9410	House/extended care facility call		No	No	Extended Care Facilities only.	Narrative of medical necessity shall be maintained in beneficiary records.
D9420	Hospital call		No	No	Hospital Facilities only	Narrative of medical necessity shall be maintained in beneficiary records.
Drugs						
D9610	Therapeutic drug injection, by report		No	No		Description and dosage of drug shall be maintained in beneficiary records.
Miscellaneous Services						
D9920	Behavior management - by report		Yes	No		Narrative of medical necessity shall be submitted with claim.
D9999	Unspecified adjunctive procedure, by report		Yes	No		Narrative of medical necessity shall be submitted with claim.

Exhibit B	Covered Benefit Table	Title 19 ICF/IID Adult

Title 19 ICF/IID Adult Ages 21 and Over

Dental services provided to ICF/IID beneficiaries **MUST BE BILLED TO KMAP BY THE DENTAL PROVIDER.**

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

Diagnostic Clinical Oral Evaluations

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D0120	Periodic oral evaluation-Established patient		No	No	Only one exam every six months per provider or provider billing group. Only one exam (D0120, D0140, D0145, D0150, D0170) per date of service, per beneficiary, per provider or provider billing group.	
D0140	Limited oral evaluation - Problem focused		No	No	Only one exam (D0120, D0140, D0145, D0150, D0170) per date of service, per beneficiary, per provider or provider billing group. Limited oral evaluation is only covered when performed in conjunction with treatment to address an emergency situation. An emergency is defined as treatment medically necessary to treat pain, infection, swelling, uncontrolled bleeding, or traumatic injury.	
D0150	Comprehensive oral evaluation - New or established patient		No	No	One comprehensive exam per beneficiary, per provider or provider billing group per lifetime. Only one exam (D0120, D0145, or D0150) every six months per beneficiary, per provider or provider billing group.	
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)		No	No	One per 12 months. Established beneficiary to assess the status of a previously existing condition (not post-operative visit). Not covered with any other procedure other than radiographs.	

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

Radiographs must be of diagnostic quality, dated, and identified with the beneficiary's name.

Radiographs not of diagnostic quality will not be reimbursed, or if already paid, will be recouped.

An intraoral complete series (D0210) for an adult complete series should consist of at least 16 films to include 2 bitewings.

Bitewing radiographs (D0270, D0272, D0273, D0274, D0277) and intraoral radiographs (D0220, D0230) require documentation of medical necessity when performed on the same day as an intraoral complete series (D0210).

Without medical necessity, the maximum reimbursement for a single date of service for radiographs shall be limited to the fee for a complete series.

Diagnostic Radiographs/Diagnostic Imaging

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D0210	Intraoral - Complete Series of radiographic images		No	No	One per 36 months. The following are also considered an Intraoral Complete Series (D0210) D0330 and D0272 D0330 and D0273 D0330 and D0274 D0330 and D0277.	
D0220	Intraoral - Periapical first radiographic image		No	No	One per day. Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.	
D0230	Intraoral - Periapical each additional radiographic image		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.	If more than one unit is taken on the same date of service note on claim "not duplicate." Paper claim: Put in remarks sections. Website claim: Put in comments box at header level.

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Diagnostic Radiographs/Diagnostic Imaging

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D0240	Intraoral - Occlusal radiographic image		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.	If more than one unit is taken on the same date of service note on claim "not duplicate." Paper claim: Put in remarks sections. Website claim: Put in comments box at header level.
D0250	Extraoral - First radiographic image		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.	
D0260	Extraoral - Each additional radiographic image		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.	If more than one unit is taken on the same date of service note on claim "not duplicate." Paper claim: Put in remarks sections. Website claim: Put in comments box at header level.
D0270	Bitewing - Single radiographic image		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.	
D0272	Bitewings - Two radiograph images		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.	

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Diagnostic Radiographs/Diagnostic Imaging

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D0273	Bitewing - Three radiographic images		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.	
D0274	Bitewings - Four radiographic images		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.	
D0277	Vertical bitewings - 7 to 8 radiographic images		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.	
D0290	Posterior - Anterior or lateral skull and facial bone survey radiographic image		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.	

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Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
Diagnostic Radiographs/Diagnostic Imaging						
D0321	Other- Temporomandibular joint arthrogram radiographic images - by report		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.	
D0330	Panoramic radiographic image		No	No	One per 36 months. The following are also considered an Intraoral Complete Series (D0210) D0330 and D0272 D0330 and D0273 D0330 and D0274 D0330 and D0277	
Diagnostic Tests and Examinations						
D0460	Pulp vitality tests	1 - 32 51 - 82 (SN) A - T AS - TS (SN)	No	No	Maximum of three teeth per visit.	
Preventive Dental Prophylaxis						
D1110	Prophylaxis - Adult		No	No	One per 6 months. Includes scaling and polishing procedures to remove coronal plaque, calculus, and stains.	

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Reimbursement for Restorative Services includes local anesthesia.

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

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

Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day.

A restoration is considered a two or more surface restoration only when two or more actual tooth surfaces are involved, whether or not they are connected.

Arches, Quadrants, Primary, Permanent, Supernumerary Teeth, and Surfaces should be billed as defined in the current CDT manual.

Restorative Amalgam Restorations (Including Polishing)						
Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D2140	Amalgam - one surface, primary or permanent	1 - 32 51 - 82 (SN) A - T AS - TS (SN)	No	No		
D2150	Amalgam - two surfaces, primary or permanent	1 - 32 51 - 82 (SN) A - T AS - TS (SN)	No	No		
D2160	Amalgam - three surfaces, primary or permanent	1 - 32 51 - 82 (SN) A - T AS - TS (SN)	No	No		
D2161	Amalgam - four or more surfaces, primary or permanent	1 - 32 51 - 82 (SN) A - T AS - TS (SN)	No	No		
Restorative Resin-Based Composite Restorations - Direct						
D2330	Resin-based composite - one surface, anterior	6 - 11, 22 - 27 56 - 61(SN) 72 - 77(SN) C - H, M - R CS - HS(SN) MS - RS(SN)	No	No		
D2331	Resin-based composite - two surfaces, anterior	6 - 11, 22 - 27 56 - 61(SN) 72 - 77(SN) C - H, M - R CS - HS(SN) MS - RS(SN)	No	No		

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Restorative Resin-Based Composite Restorations - Direct						
Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D2332	Resin-based composite - three surfaces, anterior	6 - 11, 22 - 27 56 - 61(SN) 72 - 77(SN) C - H, M - R CS - HS(SN) MS - RS(SN)	No	No		
D2335	Resin-based composite - four or more surfaces, or involving the incisal angle anterior	6 - 11, 22 - 27 56 - 61(SN) 72 - 77(SN) C - H, M - R CS - HS(SN) MS - RS(SN)	No	No		
D2390	Resin-based composite crown - anterior	6 - 11, 22 - 27 56 - 61(SN) 72 - 77(SN) C - H, M - R CS - HS(SN) MS - RS(SN)	No	No		
D2391	Resin-based composite - one surface, posterior	1 - 5, 12 - 21, 28 - 32 51 - 55 (SN) 62 - 71 (SN) 78 - 82 (SN) A, B, I - L, S, T, AS (SN), BS (SN) IS - LS (SN), SS (SN), TS (SN)	No	No		
D2392	Resin-based composite - two surfaces posterior	1 - 5, 12 - 21, 28 - 32 51 - 55 (SN) 62 - 71 (SN) 78 - 82 (SN) A, B, I - L, S, T, AS (SN), BS (SN) IS - LS (SN), SS (SN), TS (SN)	No	No		
D2393	Resin-based composite - three surfaces, posterior	1 - 5, 12 - 21, 28 - 32 51 - 55 (SN) 62 - 71 (SN) 78 - 82 (SN) A, B, I - L, S, T, AS (SN), BS (SN) IS - LS (SN), SS (SN), TS (SN)	No	No		

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Restorative Resin-Based Composite Restorations - Direct

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D2394	Resin-based composite - four or more surfaces, posterior	1 - 5, 12 - 21, 28 - 32 51 - 55 (SN) 62 - 71 (SN) 78 - 82 (SN) A, B, I - L, S, T, AS (SN), BS (SN) IS - LS (SN), SS (SN), TS (SN)	No	No		

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Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
Restorative Crowns - Single Restorations only						
D2710	Crown - resin-based composite (indirect)	6 - 11 22 - 27 56 - 61(SN) 72 - 77(SN)	No	No	Once per 60 months.	
D2740	Crown - porcelain/ceramic substrate	6 - 11 22 - 27 56 - 61(SN)	No	No	Once per 60 months.	
D2751	Crown - porcelain fused to predominantly base metal	1 - 32 51 - 82(SN)	No	No	Once per 60 months.	
D2752	Crown - porcelain fused to noble metal	1 - 32 51 - 82(SN)	No	No	Once per 60 months.	
D2783	Crown - 3/4 porcelain/ceramic	1 - 32 51 - 82(SN)	No	No	Once per 60 months.	
D2791	Crown - full cast predominantly base metal	1 - 32 51 - 82(SN)	No	No	Once per 60 months.	
D2792	Crown - full cast noble metal	1 - 32 51 - 82(SN)	No	No	Once per 60 months.	
Restorative Other Restorative Services						
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	1 - 32 51 - 82(SN)	No	No		
D2920	Re-cement or re-bond crown	1 - 32 51 - 82(SN)	No	No		
D2921	Reattachment of tooth fragment, incisal edge or cusp	1 - 32 51 - 82 (SN)	No	No	Not allowed same tooth, same surface(s), same DOS as D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394	Pre- and post-operative radiographic images shall be maintained in beneficiary records.
D2930	Prefabricated stainless steel crown - primary tooth	A - T AS - TS(SN)	No	No	Once per 24 months.	
D2931	Prefabricated stainless steel crown - permanent tooth	1 - 32 51 - 82(SN)	No	No	Once per 24 months.	
D2940	Protective restoration	1 - 32 51 - 82(SN)	No	No	Temporary restoration intended to relieve pain. Not to be used as a base or liner under a restoration.	
D2951	Pin retention - per tooth, in addition to restoration	1 - 32 51 - 82(SN)	No	No		
D2954	Prefabricated post and core in addition to crown	1 - 32 51 - 82(SN)	No	No	Once per 60 months.	
D2957	Each additional prefabricated post - same tooth	1 - 3 14 - 19 30 - 32 51- 53(SN) 64 - 69(SN) 80 - 82(SN)	No	No	Once per 60 months.	

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Reimbursement for Endodontic Services includes local anesthesia.

In cases where a root canal filing does not meet the general clinical criteria standards (Section IX. Clinical Criteria this manual), KMAP can require the procedure be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after the dental consultant reviews the circumstances.

A pulpotomy or palliative treatment is not to be billed in conjunction with a root canal treatment on the same date.

Filling material not accepted by the Federal Food and Drug Administration is not covered.

Complete root canal therapy includes pulpectomy, all appointments necessary to complete the treatment, temporary filling, filling, and obturation of canals, intraoperative, and fill radiographs.

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
Endodontics Pulp Capping						
D3110	Pulp cap - direct (excluding final restoration)	1 - 32 51 - 82(SN)	No	No		
Endodontics Pulpotomy						
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	1 - 32 51 - 82(SN) A - T AS - TS	No	No	One per tooth, per lifetime. Not covered within 30 days of D3310 - D3331 on same tooth.	
D3221	Pulpal debridement - primary and permanent teeth	1 - 32 51 - 82(SN) A - T AS - TS(SN)	No	No	One per tooth, per lifetime. Not covered within 30 days of D3310 - D3331 on same tooth.	
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	1 - 32 51 - 82(SN)	Yes	No	One per tooth, per lifetime. Should only be performed as preparation for endodontic treatment.	Preoperative periapical radiograph of tooth submitted with claim.
Endodontics Endodontic Therapy (including treatment plan, clinical procedures and follow-up care).						
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	6 - 11 22 - 27 56 - 61(SN) 72 - 77(SN)	No	No	One per tooth, per lifetime.	
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	4, 5, 12, 13, 20, 21, 28, 29, 54(SN), 55(SN), 62(SN), 63(SN), 70(SN), 71(SN), 78(SN), 79(SN)	No	No	One per tooth, per lifetime.	

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Endodontics Endodontic Therapy (including treatment plan, clinical procedures and follow-up care).

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D3330	Endodontic therapy, molar tooth (excluding final restoration)	1 - 3, 14 - 19 30 - 32 51 - 53(SN) 64 - 69(SN) 80 - 82(SN)	No	No	One per tooth, per lifetime.	
D3331	Treatment of root canal obstruction; non-surgical access	1 - 32 51 - 82(SN)	No	No		

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Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
Endodontics Apexification/recalcification procedures						
D3351	Apexification/recalcification - initial visit (apical closure/ calcific repair of perforations, root resorption, etc.)	1 - 32 51 - 82(SN)	No	No		Pre- and postoperative radiographs shall be maintained in beneficiary records.
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	1 - 32 51 - 82(SN)	No	No		Pre- and postoperative radiographs shall be maintained in beneficiary records.
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/clacific repair of perforations, root receptions, etc.)	1 - 32 51 - 82(SN)	No	No		Pre- and postoperative radiographs shall be maintained in beneficiary records.
Endodontics Apicoectomy/Periradicular Services						
D3410	Apicoectomy - anterior	6 - 11 22 - 27 56 - 61(SN) 72 - 77(SN)	No	No		Pre- and postoperative radiographs shall be maintained in beneficiary records.
D3421	Apicoectomy - bicuspid (first root)	4, 5, 12, 13, 20, 21, 28, 29, 54(SN), 55(SN), 62(SN), 63(SN), 70(SN), 71(SN), 78(SN), 79(SN)	No	No		
D3425	Apicoectomy - molar (first root)	1 - 3, 14 - 19 30 - 32 51 - 53(SN) 64 - 69(SN) 80 - 82(SN)	No	No		
D3426	Apicoectomy (each additional root)	1 - 5, 12 - 21 28 - 32 51 - 55(SN) 62 - 71(SN) 78 - 82(SN)	No	No		
D3427	Periradicular surgery without apicoectomy	1 - 32, 51 - 82 (SN)	No	No	Not allowed same tooth, same DOS as D3410, D3421, D3425, D3426	Pre- and post-operative radiographs shall be maintained in beneficiary records.

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Endodontics Apicoectomy/Periradicular Services

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D3430	Retrograde filling - per root	1 - 32 51 - 82(SN)	No	No		Pre- and postoperative radiographs shall be maintained in beneficiary records.

Reimbursement for Periodontic Services includes local anesthesia

Arches, Quadrants, Primary, Permanent, Supernumerary Teeth, and Surfaces should be billed as defined in the current CDT manual.

Periodontics Surgical Services (including usual postoperative care)

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D4210	Gingivectomy or gingivolplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	No	A minimum of four affected teeth in the quadrant.	
D4211	Gingivectomy or gingivolplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	No	One to three affected teeth in the quadrant.	
D4230	Anatomical crown exposure - four or more contiguous teeth per quadrant	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	No	Must be billed same date same tooth in conjunction with the restorative codes (D2140 - D2957).	
D4231	Anatomical crown exposure - one to three teeth per quadrant	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	No	Same date and same tooth in conjunction with the restorative code.	
D4268	Surgical revision procedure, per tooth	1 - 32 51 - 82(SN)	No	No	Only covered after D4210.	
Periodontics Nonsurgical Services						
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	No	Four per 12 months. A minimum of four affected teeth in the quadrant.	
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	No	Four per 12 months. One to three affected teeth in the quadrant.	
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis		No	No	One per 12 months.	

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Medically necessary partial or full mouth dentures and related services may be covered when they are determined to be the primary treatment of choice or an essential part of the overall treatment plan to treat the beneficiary's oral health.

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

Extractions for asymptomatic teeth are not covered services unless removal constitutes the most cost-effective dental procedure for the provision of dentures. Provision for dentures for cosmetic purposes is not a covered service.

Arches, Quadrants, Primary, Permanent, Supernumerary Teeth, and Surfaces should be billed as defined in the current CDT manual.

Prosthodontics (Removable)	Complete Dentures (Including routine postdelivery care)					
Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D5110	Complete denture - maxillary		No	No	Once per 60 months.	
D5120	Complete denture - mandibular		No	No	Once per 60 months.	
Prosthodontics (Removable)	Partial Dentures (Including routine postdelivery care)					
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)		No	No	Once per 60 months.	Preoperative radiographs of adjacent and opposing teeth along with narrative of medical necessity should be retained in beneficiary's chart.
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)		No	No	Once per 60 months.	
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)		No	No	Once per 60 months.	
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)		No	No	Once per 60 months.	
D5225	Maxillary partial denture - flexible base (including any conventional clasps, rests and teeth)		No	No	Once per 60 months.	
D5226	Mandibular partial denture - flexible base (including any conventional clasps, rests and teeth)		No	No	Once per 60 months.	
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	No	Once per 60 months.	

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Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
Prosthodontics Adjustments to Dentures						
D5410	Adjust complete denture - maxillary		No	No	Not covered within 6 months of placement.	
D5411	Adjust complete denture - mandibular		No	No	Not covered within 6 months of placement.	
D5421	Adjust partial denture - maxillary		No	No	Not covered within 6 months of placement.	
D5422	Adjust partial denture - mandibular		No	No	Not covered within 6 months of placement.	
Prosthodontics Repairs to Complete Dentures						
D5510	Repair broken complete denture base	01 (UA) 02 (LA)	No	No		
D5520	Replace missing or broken teeth - complete denture (each tooth)	1 - 32	No	No		
Prosthodontics Repairs to Partial Dentures						
D5610	Repair resin denture base	01 (UA) 02 (LA) 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	No		
D5620	Repair cast framework	01 (UA) 02 (LA) 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	No		
D5630	Repair or replace broken clasp	01 (UA) 02 (LA) 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	No		
D5640	Replace broken teeth - per tooth	1 - 32	No	No		
D5650	Add tooth to existing partial denture	1 - 32	No	No		
D5660	Add clasp to existing partial denture	01 (UA) 02 (LA) 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	No		
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)		No	No		
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)		No	No		

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Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
Prosthodontics Denture Reline Procedures						
D5750	Reline complete maxillary denture (laboratory)		No	No	One per 24 months. Not covered within 24 months of placement.	
D5751	Reline complete mandibular denture (laboratory)		No	No	One per 24 months. Not covered within 24 months of placement.	
D5760	Reline maxillary partial denture (laboratory)		No	No	One per 24 months. Not covered within 24 months of placement.	
D5761	Reline mandibular partial denture (laboratory)		No	No	One per 24 months. Not covered within 24 months of placement.	
Prosthodontics Other removable prosthetic services						
D5850	Tissue conditioning, maxillary		No	No		
D5851	Tissue conditioning, mandibular		No	No		
Implant Services Other Implant services						
D6100	Implant removal - by report	1-32 51-82 (SN)	Yes	No		Pre- and postoperative radiographs along with narrative of medical necessity submitted with claim.
Prosthodontics Fixed Other fixed partial denture services						
D6930	Re-cement or re-bond fixed partial denture	01 (UA) 02 (LA) 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	No		

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Reimbursement for Oral and Maxillofacial Surgery Services includes local anesthesia, sutures, and routine postoperative care.

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

Pre-operative radiographs must be available for the following procedures: D7140, D7210, D7220, D7230, D7240, D7241, D7250, and D7280.

Only CDT (dental) codes should be submitted for processing.

Only one extraction per tooth, per lifetime, is allowed for the beneficiary.

Arches, Quadrants, Primary, Permanent, Supernumerary Teeth, and Surfaces should be billed as defined in the current CDT manual.

Oral and Maxillofacial Surgery Extractions (Includes local anesthesia, suturing, if needed, and routine postoperative care).						
Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	1 - 32 51- 82 (SN) A - T AS - TS (SN)	No	No		
Oral and Maxillofacial Surgery Surgical Extractions (Includes local anesthesia, suturing, and routine postoperative care).						
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	1 - 32 51- 82 (SN) A - T AS - TS (SN)	No	No	Includes cutting of gingiva and bone, removal of tooth structure, and closure.	
D7220	Removal of impacted tooth - soft tissue	1 - 32 51- 82 (SN)	No	No	Includes cutting of gingiva and bone, removal of tooth structure, and closure.	
D7230	Removal of impacted tooth - partially bone	1 - 32 51- 82 (SN)	No	No	Includes cutting of gingiva and bone, removal of tooth structure, and closure.	
D7240	Removal of impacted tooth - completely bony	1 - 32 51- 82 (SN)	No	No	Includes cutting of gingiva and bone, removal of tooth structure, and closure.	
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	1 - 32 51- 82 (SN)	No	No	Includes cutting of gingiva and bone, removal of tooth structure, and closure. *Unusual complications such as nerve dissection, separate closure of the maxillary sinus, or aberrant tooth position.*	
D7250	Surgical removal of residual roots (cutting procedure)	1 - 32 51- 82 (SN) A - T AS - TS (SN)	No	No	Includes cutting of gingiva and bone, removal of tooth structure, and closure. Will not be paid to the provider or provider billing group that originally removed the tooth.	

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Pathology reports should be kept in beneficiary record.

Oral and Maxillofacial Surgery Other surgical procedures						
Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D7260	Oroantral fistula closure		No	No		
D7270	Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth	1 - 32 51- 82 (SN) A - T AS - TS (SN)	No	No	Includes splinting and/or stabilization.	
D7280	Surgical access of unerupted tooth	1 - 32 51- 82 (SN) A - T AS - TS (SN)	No	No		
D7285	Incisional biopsy of oral tissue - hard (bone, tooth)		No	No		
D7286	Incisional biopsy of oral tissue - soft		No	No		
Oral and Maxillofacial Surgery Alveoloplasty Surgical preparation of ridge for dentures						
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	No	No extractions performed in an edentulous area. Not covered when performed on the same day as an extraction for the same tooth.	
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment, and management of hypertrophied and hyper plastic tissue)	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	No		

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Oral and Maxillofacial Surgery Surgical excision of soft tissue lesions

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D7410	Excision of benign lesion up to 1.25 cm		No	No		
D7411	Excision of benign lesion greater than 1.25 cm		No	No		
D7412	Excision of benign lesion - complicated		No	No		
D7413	Excision of malignant lesion up to 1.25 cm		No	No		
D7414	Excision of malignant lesion greater than 1.25 cm		No	No		
D7415	Excision of malignant lesion - complicated		No	No		
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm		No	No		
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm		No	No		
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm		No	No		
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm		No	No		
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm		No	No		
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm		No	No		
D7471	Removal of lateral exostosis - (maxilla or mandible)	01 (UA) 02 (LA)	No	No	Once per lifetime.	
D7472	Removal of torus palatinus		No	No	Once per lifetime.	
D7473	Removal of torus mandibularis		No	No	Once per lifetime.	
D7490	Radical resection of maxilla or mandible	01 (UA) 02 (LA)	No	No		

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Oral and Maxillofacial Surgery Surgical incision						
Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D7510	Incision and drainage of abscess - intraoral soft tissue		No	No	Not covered same date of service as D7511.	
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple facial spaces)		No	No		
D7520	Incision and drainage of abscess - extraoral soft tissue		No	No	Not covered same date of service as D7521.	
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple facial spaces)		No	No		
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue		No	No		
D7540	Removal of reaction producing foreign bodies, musculoskeletal system		No	No		
D7550	Partial ostectomy/ sequestrectomy for removal of non-vital bone		No	No		
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body		Yes	No		Pre- and post-operative radiographs along with narrative of medical necessity must be submitted with claim.
Oral and Maxillofacial Surgery Treatment of Fractures Simple						
D7610	Maxilla - open reduction (teeth immobilized, if present)		No	No		
D7620	Maxilla - closed reduction (teeth immobilized, if present)		No	No		
D7630	Mandible - open reduction (teeth immobilized, if present)		No	No		
D7640	Mandible - closed reduction (teeth immobilized, if present)		No	No		
D7650	Malar and/or zygomatic arch - open reduction		No	No		
D7660	Malar and/or zygomatic arch - closed reduction		No	No		

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Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
Oral and Maxillofacial Surgery	Treatment of Fractures Simple					
D7670	Alveolus - closed reduction - may include stabilization of teeth	1- 32	No	No	May include stabilization.	
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches		Yes	No		Pre- and post-operative radiographs along with narrative of medical necessity must be submitted with claim.
Oral and Maxillofacial Surgery	Treatment of Fractures Compound					
D7710	Maxilla - open reduction		No	No		
D7720	Maxilla - closed reduction		No	No		
D7730	Mandible - open reduction		No	No		
D7740	Mandible - closed reduction		No	No		
D7750	Malar and/or zygomatic arch - open reduction		No	No		
D7760	Malar and/or zygomatic arch - closed reduction		No	No		
D7770	Alveolus - open reduction stabilization of teeth		No	No		
D7780	Facial bones - complicated reduction with fixation and multiple surgical approaches		No	No		
D7820	Closed reduction of dislocation		No	No		
D7860	Arthrotomy		No	No		
D7865	Arthroplasty		Yes	No		Pre- and post-operative radiographs and narrative of medical necessity submitted with claim.
Oral and Maxillofacial Surgery	Repair of traumatic wounds					
D7910	Suture of recent small wounds up to 5 cm		No	No	Not covered on same day as D7140, D7210, D7220, D7230, D7240, D7241, or D7250.	
Oral and Maxillofacial Surgery	Complicated suturing (reconstruction requiring delicate handling of tissues and wide undermining for meticulous closure)					
D7911	Complicated suture - up to 5 cm		No	No	Not covered on same day as D7140, D7210, D7220, D7230, D7240, D7241, or D7250.	
D7912	Complicated suture - greater than 5 cm		No	No	Not covered on same day as D7140, D7210, D7220, D7230, D7240, D7241, or D7250.	

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Oral and Maxillofacial Surgery Other repair procedures

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D7920	Skin graft (identify defect covered, location, and type of graft)	01 (UA) 02 (LA) 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	No		Narrative of medical necessity submitted with claim.
D7955	Repair of maxillofacial soft and/or hard tissue defect		Yes	No		Pre- and post-operative radiographs and narrative of medical necessity submitted with claim.
D7960	Frenulectomy also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	01 (UA) 02 (LA)	No	No	Once per lifetime. Per location Lingual, Buccal or Labial. Not covered same date of service as D7963. The frenum may be excised when the tongue has limited mobility; for large diastemas between teeth, or when the frenum interferes with a prosthetic appliance; or when it is the etiology of periodontal tissue disease.	
D7963	Frenuloplasty		No	No	Excision of frenum with excision or repositioning of abervant muscle and z-plasty or other local flap closure.	
D7971	Excision of pericoronal gingiva	1 - 32	No	No		
D7980	Sialolithotomy		No	No		
D7981	Excision of salivary gland, by report		No	No		
D7982	Sialodochoplasty		No	No		
D7983	Closure of salivary fistula		Yes	No		Pre- and post-operative radiographs along with narrative of medical necessity submitted with claim.
D7990	Emergency tracheotomy		No	No		

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D9220 and D9221 are only billable when dental services other than ONLY diagnostic are provided on the same date of service.

D9310 is billable when ONLY diagnostic services are provided on the same date of service.

Adjunctive General Services	Anesthesia					
Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D9212	Trigeminal division block anesthesia		No	No		Narrative of medical necessity shall be maintained in beneficiary records.
D9219	Evaluation for deep sedation or general anesthesia		No	No	One time per beneficiary per provider or provider billing group per lifetime. One time per beneficiary per 12 months.	Narrative of the evaluation for anesthesia shall be maintained in the beneficiary records.
D9220	Deep sedation/general anesthesia - first 30 minutes		No	No		Narrative of medical necessity shall be maintained in beneficiary records.
D9221	Deep sedation/general anesthesia - each additional 15 minutes		No	No		Narrative of medical necessity shall be maintained in beneficiary records.
D9230	Inhalation of nitrous oxide/ analgesia, anxiolysis		No	No	Not covered when billed with only diagnostic and/or preventative services (D0120 through D1208, D1515 through D1550, D9410, D9420).	Narrative of medical necessity shall be maintained in beneficiary records.
D9241	Intravenous moderate (conscious) sedation/ analgesia - first 30 minutes		No	No		Narrative of medical necessity shall be maintained in beneficiary records.
D9242	Intravenous moderate (conscious) sedation/ analgesia - each additional 15 minutes		No	No		Narrative of medical necessity shall be maintained in beneficiary records.
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician		No	No	One per 12 months by same provider. One inpatient followup per beneficiary within a 10 day period by same provider. *Not covered on same date of service as D0120 -D0170, D9410, D9420.*	Narrative of the consultation for dental services shall be maintained in beneficiary records.
Professional Visits						
D9410	House/extended care facility call		No	No	Extended care facilities only.	Narrative of medical necessity shall be maintained in beneficiary records.
D9420	Hospital or ambulatory surgical center call		No		Hospital facilities only.	Narrative of medical necessity shall be maintained in beneficiary records.
Drugs						
D9610	Therapeutic parenteral drug, single administration		No	No		Description and dosage of drug shall be maintained in beneficiary records.

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Miscellaneous Services

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D9920	Behavior management - by report		Yes	No		Narrative of medical necessity shall be submitted with claim.
D9999	Unspecified adjunctive procedure, by report		Yes	No		Narrative of medical necessity shall be submitted with claim.

Exhibit C	Covered Benefit Table	Title 19 Adult

Title 19 Adult Ages 21 and Over

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

Exams and radiographs are payable only when done in conjunction with or to determine if extractions are medically necessary.

Diagnostic Clinical Oral Evaluations

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D0120	Periodic oral evaluation-Established patient		No	No	Only one exam every six months per provider or provider billing group. Only one exam (D0120, D0140, D0145, D0150, D0170) per date of service, per beneficiary, per provider or provider billing group.	
D0140	Limited oral evaluation - Problem focused		No	No	Only one exam (D0120, D0140, D0145, D0150, D0170) per date of service, per beneficiary, per provider or provider group. Limited oral evaluation is only covered when performed in conjunction with treatment to address an emergency situation. An emergency is defined as treatment medically necessary to treat pain, infection, swelling, uncontrolled bleeding, or traumatic injury.	
D0150	Comprehensive oral evaluation - New or established patient		No	No	One comprehensive exam per beneficiary, per provider or provider billing group per lifetime. Only one exam (D0120, D0145, or D0150) every six months per beneficiary, per provider or provider billing group.	
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)		No	No	One per 12 months Established beneficiary to assess the status of a previously existing condition (not post operative visit). Not covered with any other procedure other than radiographs.	

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

Radiographs must be of diagnostic quality, dated, and identified with the beneficiary's name.

Radiographs not of diagnostic quality will not be reimbursed, or if already paid, will be recouped.

An intraoral complete series (D0210) for an adult complete series should consist of at least 16 films to include 2 bitewings.

Bitewing radiographs (D0270, D0272, D0273, D0274, D0277) and intraoral radiographs (D0220, D0230) require documentation of medical necessity when performed on the same day as an intraoral complete series (D0210).

Without medical necessity, the maximum reimbursement for a single date of service for radiographs shall be limited to the fee for a complete series.

Exams and radiographs are payable only when done in conjunction with or to determine if extractions are medically necessary.

Diagnostic Radiographs/Diagnostic Imaging

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D0210	Intraoral - Complete Series of radiographic images		No	No	One per 36 months. The following are also considered an Intraoral Complete Series (D0210) D0330 and D0272 D0330 and D0273 D0330 and D0274 D0330 and D0277	
D0220	Intraoral - Periapical first radiographic image		No	No	One per day. Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and will not be reimbursed.	
D0230	Intraoral - Periapical each additional radiographic image		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and will not be reimbursed.	If more then one unit is taken on the same date of service, note on claim "not duplicate" Paper claim: Put in remarks sections. Website claim: Put in comments box at header level.

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Diagnostic Radiographs/Diagnostic Imaging

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D0240	Intraoral - Occlusal radiographic image		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and will not be reimbursed.	If more then one unit is taken on the same date of service, note on claim "not duplicate" Paper claim: Put in remarks sections. Website claim: Put in comments box at header level.
D0250	Extraoral - First radiographic image		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and will not be reimbursed.	
D0260	Extraoral - Each additional radiographic image		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and will not be reimbursed.	If more then one unit is taken on the same date of service, note on claim "not duplicate" Paper claim: Put in remarks sections. Website claim: Put in comments box at header level.
D0270	Bitewing - Single radiographic image		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and will not be reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.	
D0272	Bitewings - Two radiographic images		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and will not be reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.	

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Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
Diagnostic	Radiographs/Diagnostic Imaging					
D0273	Bitewing - Three radiographic images		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.	
D0274	Bitewings - Four radiographic images		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and will not be reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.	
D0330	Panoramic radiographic image		No	No	One per 36 months. The following are also considered an Intraoral Complete Series (D0210) D0330 and D0272 D0330 and D0273 D0330 and D0274 D0330 and D0277	
Implant Services	Other Implant services					
D6100	Implant removal - by report	1-32 51-82 (SN)	Yes	No		Pre- and postoperative radiographs along with narrative of medical necessity submitted with claim.

Title 19 Adult Ages 21 and Over

Reimbursement for Oral and Maxillofacial Surgery Services includes local anesthesia, sutures, and routine postoperative care.

Extractions are covered for Title 19 Adults only when considered medically necessary.
Please refer to Section III Benefits D Title 19 Adults 21 and Over in this manual for specifics.

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

The radiographs and/or narrative submitted with the claim must support the CDT code submitted. Please consult the current CDT manual for complete code descriptions.

Preoperative radiographs must be available for the following procedures: D7140, D7210, D7220, D7230, D7240, D7241, D7250, and D7280.

Only CDT (dental) codes should be submitted for processing.

Only one extraction per tooth, per lifetime, is allowed for the beneficiary.

Arches, Quadrants, Primary, Permanent, Supernumerary Teeth, and Surfaces should be billed as defined in the current CDT manual.

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
Oral and Maxillofacial Surgery Extractions (Includes local anesthesia, suturing, if needed, and routine postoperative care).						
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	1 - 32 51- 82 (SN) A - T AS - TS (SN)	No	No	Removal of asymptotic tooth not covered.	
Oral and Maxillofacial Surgery Surgical Extractions (Includes local anesthesia, suturing, and routine postoperative care).						
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	1 - 32 51- 82 (SN) A - T AS - TS (SN)	No	No	Removal of asymptotic tooth not covered. Includes cutting of gingiva and bone, removal of tooth structure, and closure.	
D7220	Removal of impacted tooth - soft tissue	1 - 32 51- 82 (SN)	Yes	No	Removal of asymptotic tooth not covered. Includes cutting of gingiva and bone, removal of tooth structure, and closure.	Preoperative radiographs and narrative of medical necessity submitted with claim.
D7230	Removal of impacted tooth - partially bone	1 - 32 51- 82 (SN)	Yes	No	Removal of asymptotic tooth not covered. Includes cutting of gingiva and bone, removal of tooth structure, and closure.	Preoperative radiographs and narrative of medical necessity submitted with claim.
D7240	Removal of impacted tooth - completely bony	1 - 32 51- 82 (SN)	Yes	No	Removal of asymptotic tooth not covered. Includes cutting of gingiva and bone, removal of tooth structure, and closure.	Preoperative radiographs and narrative of medical necessity submitted with claim.

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Pathology report should be kept in beneficiary record.

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
Oral and Maxillofacial Surgery Extractions (Includes local anesthesia, suturing, if needed, and routine postoperative care).						
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	1 - 32 51- 82 (SN)	Yes	No	Removal of asymptotic tooth not covered. Includes cutting of gingiva and bone, removal of tooth structure, and closure. *Unusual complications such as nerve dissection, separate closure of the maxillary sinus, or aberrant tooth position.*	Preoperative radiographs and narrative of medical necessity submitted with claim.
Oral and Maxillofacial Surgery Surgical Extractions (Includes local anesthesia, suturing, and routine postoperative care).						
D7250	Surgical removal of residual roots (cutting procedure)	1 - 32 51- 82 (SN) A - T AS - TS (SN)	No	No	Includes cutting of gingiva and bone, removal of tooth structure, and closure. Will not be paid to the providers or provider billing group that originally removed the tooth.	Preoperative radiographs and narrative of medical necessity shall be maintained in beneficiary records.
Oral and Maxillofacial Surgery Other surgical procedures						
D7260	Oroantral fistula closure		Yes	No		Pre- and post-operative radiographs and narrative of medical necessity submitted with claim.
D7285	Incisional biopsy of oral tissue - hard (bone, tooth)		No	No		
D7286	Incisional biopsy of oral tissue - soft		No	No		
Oral and Maxillofacial Surgery Surgical excision of soft tissue lesions						
D7410	Excision of benign lesion up to 1.25 cm		No	No		
D7411	Excision of benign lesion greater than 1.25 cm		No	No		
D7412	Excision of benign lesion - complicated		No	No		
D7413	Excision of malignant lesion up to 1.25 cm		No	No		
D7414	Excision of malignant lesion greater than 1.25 cm		No	No		
D7415	Excision of malignant lesion - complicated		No	No		
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm		No	No		
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm		No	No		
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm		No	No		

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Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
Oral and Maxillofacial Surgery	Surgical excision of soft tissue lesions					
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm		No	No		
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm		No	No		
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm		No	No		
D7471	Removal of lateral exostosis - (maxilla or mandible)	01 (UA) 02 (LA)	Yes	No	**Once per lifetime.**	Preoperative radiographs and narrative of medical necessity submitted with claim.
D7472	Removal of torus palatinus		Yes	No	**Once per lifetime.**	Preoperative radiographs and narrative of medical necessity submitted with claim.
D7473	Removal of torus mandibularis		Yes	No	**Once per lifetime.**	Preoperative radiographs and narrative of medical necessity submitted with claim.
D7490	Radical resection of maxilla or mandible	01 (UA) 02 (LA)	Yes	No		Preoperative radiographs and narrative of medical necessity with claim.
Oral and Maxillofacial Surgery	Surgical incision					
D7510	Incision and drainage of abscess - intraoral soft tissue		No	No	Not covered same date of service as D7511.	
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)		No	No		
D7520	Incision and drainage of abscess - extraoral soft tissue		No	No	Not covered same date of service as D7521.	
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)		No	No		
D7530	Removal of foreign body from mucosa, skin or subcutaneous alveolar tissue		No	No		
D7540	Removal of reaction producing foreign bodies, musculoskeletal system		No	No		

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Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
Oral and Maxillofacial Surgery	Surgical excision of soft tissue lesions					
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone		No	No		
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body		Yes	No		Pre- and postoperative radiographs along with narrative of medical necessity must be submitted with claim.
Oral and Maxillofacial Surgery	Treatment of Fractures Simple					
D7610	Maxilla - open reduction (teeth immobilized, if present)		No	No		
D7620	Maxilla - closed reduction (teeth immobilized, if present)		No	No		
D7630	Mandible - open reduction (teeth immobilized, if present)		No	No		Postoperative radiographs must be available in the beneficiary records.
D7640	Mandible - closed reduction (teeth immobilized, if present)		No	No		
D7650	Malar and/or zygomatic arch - open reduction		No	No		
D7660	Malar and/or zygomatic arch - closed reduction		No	No		
D7670	Alveolus - closed reduction - may include stabilization of teeth	1- 32	No	No	May include stabilization.	
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches		Yes	No		Pre- and postoperative radiographs along with narrative of medical necessity must be submitted with claim.
Oral and Maxillofacial Surgery	Treatment of Fractures Compound					
D7710	Maxilla - open reduction		No	No		
D7720	Maxilla - closed reduction		No	No		
D7730	Mandible - open reduction		No	No		Postoperative radiographs must be available in the beneficiary records.
D7740	Mandible - closed reduction		No	No		
D7750	Malar and/or zygomatic arch - open reduction		No	No		
D7760	Malar and/or zygomatic arch - closed reduction		No	No		
D7770	Alveolus - open reduction stabilization of teeth		No	No		

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Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
Oral and Maxillofacial Surgery	Treatment of Fractures Compound					
D7780	Facial bones - complicated reduction with fixation and multiple surgical approaches		No	No		
D7820	Closed reduction of dislocation		No	No		
D7860	Arthrotomy		Yes	No		Preoperative radiographs, narrative of medical necessity, and treatment plan submitted with claim
Oral and Maxillofacial Surgery	Repair of traumatic wounds					
D7910	Suture of recent small wounds up to 5 cm		No	No	Not covered on same day as D7140, D7210, D7220, D7230, D7240, D7241, or D7250.	
Oral and Maxillofacial Surgery	Complicated suturing (reconstruction requiring delicate handling of tissues and wide undermining for meticulous closure)					
D7911	Complicated suture - up to 5 cm		No	No	Not covered on same day as D7140, D7210, D7220, D7230, D7240, D7241, or D7250.	
D7912	Complicated suture - greater than 5 cm		No	No	Not covered on same day as D7140, D7210, D7220, D7230, D7240, D7241, or D7250.	
Oral and Maxillofacial Surgery	Other repair procedures					
D7920	Skin graft (identify defect covered, location and type of graft)	01 (UA) 02 (LA) 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	No		Narrative of medical necessity submitted with claim.
D7960	Frenulectomy also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	01 (UA) 02 (LA)	No	No	Once per lifetime. Per location Lingual, Buccal or Labial. Not covered same date of service as D7963. The frenum may be excised when the tongue has limited mobility; for large diastemas between teeth, or when the frenum interferes with a prosthetic appliance; or when it is the etiology of periodontal tissue disease.	
D7963	Frenuloplasty		No	No	Excision of frenum with excision or repositioning of abervant muscle and z-plasty or other local flap closure	
D7971	Excision of pericoronal gingiva	1 - 32	No	No		
D7980	Sialolithotomy		No	No		
D7981	Excision of salivary gland, by report		No	No		

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Oral and Maxillofacial Surgery Other repair procedures

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D7982	Sialodochoplasty		No	No		
D7983	Closure of salivary fistula		Yes	No		Pre- and postoperative radiographs along with narrative of medical necessity submitted with claim.
D7990	Emergency tracheotomy		No	No		

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D9220 and D9221 are only billable when dental services other than ONLY diagnostic are provided on the same date of service.

D9310 is billable when ONLY diagnostic services are provided on the same date of service.

Adjunctive General Services	Anesthesia					
Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D9212	Trigeminal division block anesthesia		Yes	No		Narrative of medical necessity submitted with claim.
D9219	Evaluation for deep sedation or general anesthesia		No	No	One time per beneficiary per provider or provider billing group per lifetime. One time per beneficiary per 12 months.	Narrative of the evaluation for anesthesia shall be maintained in the beneficiary records.
D9220	Deep sedation/general anesthesia - first 30 minutes		Yes	No		Narrative of medical necessity/treatment plan must be submitted with claim.
D9221	Deep sedation/general anesthesia - each additional 15 minutes		Yes	No		Narrative of medical necessity/treatment plan must be submitted with claim.
D9230	Inhalation of nitrous oxide/ analgesia, anxiolysis		No	No	Not covered when billed with **only** diagnostic and/or preventative services (D0120 through D1208, D1515 through D1550, D9410, D9420).	Narrative of medical necessity shall be maintained in beneficiary records.
D9241	Intravenous moderate (conscious) sedation/ analgesia - first 30 minutes		Yes	No		Narrative of medical necessity/treatment plan must be submitted with claim.
D9242	Intravenous moderate (conscious) sedation/ analgesia - each additional 15 minutes		Yes	No		Narrative of medical necessity/treatment plan must be submitted with claim.
Professional Consultation						
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician		No	No	One per 12 months by same provider. One inpatient followup per beneficiary within a 10 day period by same provider. *Not covered on same date of service as D0120 -D0170, D9410, D9420.*	Narrative of the consultation for dental services shall be maintained in beneficiary records.
Professional Visits						
D9410	House/extended care facility call		No			Narrative of medical necessity shall be maintained in beneficiary records.
D9420	Hospital or ambulatory surgical center call		No			Same as above code
Drugs						
D9610	Therapeutic parenteral drug, single administration		Yes	No		Narrative of medical necessity and description and dosage of drug submitted with claim.

Exhibit D	Covered Benefit Table	MFP Adult Ages 21 and Over

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HCBS beneficiaries covered under the waivers listed above will no longer have coverage for the dental services listed in this exhibit. Refer to Exhibit C for a list of covered benefits.

KMAP dental providers can bill the following services for Money Follows the Person (MFP) beneficiaries covered under the waivers listed above.

Providers should submit claims for these beneficiaries in the SAME MANNER as their other KMAP dental claims.

Primary dental coverage for these MFP beneficiaries is provided under the Title 19 adult benefit plan.

If the service is NOT covered under the Title 19 adult benefit plan (Exhibit C), refer to this appendix for additional coverage for MFP beneficiaries.

All claim questions should be directed to Customer Service at 785-274-5990 or 1-800-933-6593.

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

Diagnostic Clinical Oral Evaluations

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D0120	Periodic oral evaluation - Established patient		No	No	Only one exam every six months per provider or provider billing group. Only one exam (D0120, D0140, D0145, D0150, D0170) per date of service, per beneficiary, per provider or provider billing group.	
D0140	Limited oral evaluation - Problem focused		No	No	Only one exam (D0120, D0140, D0145, D0150, D0170) per date of service, per beneficiary, per provider or provider billing group. Limited oral evaluation is only covered when performed in conjunction with treatment to address an emergency situation. An emergency is defined as treatment medically necessary to treat pain, infection, swelling, uncontrolled bleeding, or traumatic injury.	

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Diagnostic Clinical Oral Evaluations

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D0150	Comprehensive oral evaluation - New or established patient		No	No	One comprehensive exam per beneficiary, per provider or provider billing group per lifetime. Only one exam (D0120, D0145, or D0150) every six months per beneficiary, per provider or provider billing group.	
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)		No	No	One per 12 months Established beneficiary to assess the status of a previously existing condition (not post-operative visit). Not covered with any other procedure other than radiographs.	

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

Radiographs must be of diagnostic quality, dated, and identified with the beneficiary's name.

Radiographs not of diagnostic quality will not be reimbursed, or if already paid, will be recouped.

An intraoral complete series (D0210) for an adult complete series should consist of at least 16 films to include 2 bitewings.

Bitewing radiographs (D0270, D0272, D0273, D0274, D0277) and intraoral radiographs (D0220, D0230) require documentation of medical necessity when performed on the same day as an intraoral complete series (D0210).

Without medical necessity, the maximum reimbursement for a single date of service for radiographs shall be limited to the fee for a complete series.

Diagnostic Radiographs/Diagnostic Imaging

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D0210	Intraoral - Complete Series of radiographic images		No	No	One per 36 months. The following are also considered an Intraoral Complete Series (D0210) D0330 and D0272 D0330 and D0273 D0330 and D0274 D0330 and D0277	
D0220	Intraoral - Periapical first radiographic image		No	No	One per day. Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.	
D0230	Intraoral - Periapical each additional radiographic image		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.	If more than one unit is taken on the same date of service note on claim "not duplicate". Paper claim: Put in remarks sections. Website claim: Put in comments box at header level.

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Diagnostic Radiographs/Diagnostic Imaging

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D0240	Intraoral - Occlusal radiographic image		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.	If more than one unit is taken on the same date of service note on claim "not duplicate". Paper claim: Put in remarks sections. Website claim: Put in comments box at header level.
D0250	Extraoral - First radiographic image		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.	
D0260	Extraoral - Each additional radiographic image		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.	If more than one unit is taken on the same date of service note on claim "not duplicate". Paper claim: Put in remarks sections. Website claim: Put in comments box at header level.
D0270	Bitewing - Single radiographic image		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.	
D0272	Bitewings - Two radiographic images		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.	

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Diagnostic Radiographs/Diagnostic Imaging

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D0273	Bitewing - Three radiographic images		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.	
D0274	Bitewings - Four radiographic images		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.	
D0277	Vertical bitewings - 7 to 8 radiographic images		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.	
D0290	Posterior - Anterior or lateral skull and facial bone survey radiographic image		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.	

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Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
Diagnostic Radiographs/Diagnostic Imaging						
D0321	Other- Temporomandibular joint arthrogram radiographic images - by report		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.	
D0330	Panoramic radiographic image		No	No	One per 36 months. The following are also considered an Intraoral Complete Series (D0210) D0330 and D0272 D0330 and D0273 D0330 and D0274 D0330 and D0277	
Diagnostic Tests and Examinations						
D0460	Pulp vitality tests	1 - 32 51 - 82 (SN) A - T AS - TS (SN)	No	No	Maximum of three teeth per visit.	
Preventive Dental Prophylaxis						
D1110	Prophylaxis - Adult		No	No	One per six months. Includes scaling and polishing procedures to remove coronal plaque, calculus, and stains.	

Reimbursement for Restorative Services includes local anesthesia.

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

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

Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day.

A restoration is considered a two or more surface restoration only when two or more actual tooth surfaces are involved, whether or not they are connected.

Arches, Quadrants, Primary, Permanent, Supernumerary Teeth, and Surfaces should be billed as defined in the current CDT manual.

Restorative Amalgam Restorations (Including Polishing)

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D2140	Amalgam - one surface, primary or permanent	1 - 32 51 - 82 (SN) A - T AS - TS (SN)	No	No		
D2150	Amalgam - two surfaces, primary or permanent	1 - 32 51 - 82 (SN) A - T AS - TS (SN)	No	No		
D2160	Amalgam - three surfaces, primary or permanent	1 - 32 51 - 82 (SN) A - T AS - TS (SN)	No	No		
D2161	Amalgam - four or more surfaces, primary or permanent	1 - 32 51 - 82 (SN) A - T AS - TS (SN)	No	No		

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Restorative Resin-Based Composite Restorations - Direct						
Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D2330	Resin-based composite - one surface, anterior	6 - 11, 22 - 27 56 - 61(SN) 72 - 77(SN) C - H, M - R CS - HS(SN) MS - RS(SN)	No	No		
D2331	Resin-based composite - two surfaces, anterior	6 - 11, 22 - 27 56 - 61(SN) 72 - 77(SN) C - H, M - R CS - HS(SN) MS - RS(SN)	No	No		
D2332	Resin-based composite - three surfaces, anterior	6 - 11, 22 - 27 56 - 61(SN) 72 - 77(SN) C - H, M - R CS - HS(SN) MS - RS(SN)	No	No		
D2335	Resin-based composite - four or more surfaces, or involving the incisal angle anterior	6 - 11, 22 - 27 56 - 61(SN) 72 - 77(SN) C - H, M - R CS - HS(SN) MS - RS(SN)	No	No		
D2390	Resin-based composite crown - anterior	6 - 11, 22 - 27 56 - 61(SN) 72 - 77(SN) C - H, M - R CS - HS(SN) MS - RS(SN)	No	No		
D2391	Resin-based composite - one surface, posterior	1 - 5, 12 - 21, 28 - 32 51 - 55 (SN) 62 - 71 (SN) 78 - 82 (SN) A, B, I - L, S, T, AS (SN), BS (SN) IS - LS (SN), SS (SN), TS (SN)	No	No		

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Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
Restorative Resin-Based Composite Restorations - Direct						
D2392	Resin-based composite - two surfaces posterior	1 - 5, 12 - 21, 28 - 32 51 - 55 (SN) 62 - 71 (SN) 78 - 82 (SN) A, B, I - L, S, T, AS (SN), BS (SN) IS - LS (SN), SS (SN), TS (SN)	No	No		
D2393	Resin-based composite - three surfaces, posterior	1 - 5, 12 - 21, 28 - 32 51 - 55 (SN) 62 - 71 (SN) 78 - 82 (SN) A, B, I - L, S, T, AS (SN), BS (SN) IS - LS (SN), SS (SN), TS (SN)	No	No		
D2394	Resin-based composite - four or more surfaces, posterior	1 - 5, 12 - 21, 28 - 32 51 - 55 (SN) 62 - 71 (SN) 78 - 82 (SN) A, B, I - L, S, T, AS (SN), BS (SN) IS - LS (SN), SS (SN), TS (SN)	No	No		
Restorative Crowns - Single Restorations only						
D2710	Crown - resin-based composite (indirect)	6 - 11 22 - 27 56 - 61 (SN) 72 - 77 (SN)	No	No	One per 60 months.	
D2740	Crown - porcelain/ceramic substrate	1 - 32 51 - 82 (SN)	No	No	One per 60 months.	
D2751	Crown - porcelain fused to predominantly base metal	1 - 32 51 - 82(SN)	No	No	One per 60 months.	
D2752	Crown - porcelain fused to noble metal	1 - 32 51 - 82(SN)	No	No	One per 60 months.	
D2783	Crown - 3/4 porcelain/ceramic	1 - 32 51 - 82(SN)	No	No	One per 60 months.	
D2791	Crown - full cast predominantly base metal	1 - 32 51 - 82(SN)	No	No	One per 60 months.	
D2792	Crown - full cast noble metal	1 - 32 51 - 82(SN)	No	No	One per 60 months.	

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Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
Restorative Other Restorative Services						
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	1 - 32 51 - 82(SN)	No	No		
D2920	Re-cement or re-bond crown	1 - 32 51 - 82(SN)	No	No		
D2921	Reattachment of tooth fragment, incisal edge or cusp	1 - 32 51 - 82 (SN)	No	No	Not allowed same tooth, same surface(s), same DOS as D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394	Pre- and post-operative radiographic images shall be maintained in beneficiary records.
D2930	Prefabricated stainless steel crown - primary tooth	A - T AS - TS(SN)	No	No	One per 24 months.	
Restorative Crowns - Single Restorations only						
D2931	Prefabricated stainless steel crown - permanent tooth	1 - 32 51 - 82(SN)	No	No	One per 24 months.	
Restorative Other Restorative Services						
D2940	Protective restoration	1 - 32 51 - 82(SN)	No	No	Temporary restoration intended to relieve pain. Not to be used as a base or liner under a restoration	
D2951	Pin retention - per tooth, in addition to restoration	1 - 32 51 - 82(SN)	No	No		
D2954	Prefabricated post and core in addition to crown	1 - 32 51 - 82(SN)	No	No	One per 60 months.	
D2957	Each additional prefabricated post - same tooth	1 - 3 14 - 19 30 - 32 51- 53(SN) 64 - 69(SN) 80 - 82(SN)	No	No	One per 60 months.	

Reimbursement for Endodontic Services includes local anesthesia.

In cases where a root canal filing does not meet the general clinical criteria standards (Section IX. Clinical Criteria this manual), KMAP can require the procedure be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after the dental consultant reviews the circumstances.

A pulpotomy or palliative treatment is not to be billed in conjunction with a root canal treatment on the same date.

Filling material not accepted by the Federal Food and Drug Administration is not covered.

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

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
Endodontics Pulp Capping						
D3110	Pulp cap - direct (excluding final restoration)	1 - 32 51 - 82(SN)	No	No		
Endodontics Pulpotomy						
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	1 - 32 51 - 82(SN) A - T AS - TS	No	No	One per tooth, per lifetime. Not covered within 30 days of D3310 - D3331 on same tooth.	
D3221	Pulpal debridement - primary and permanent teeth	1 - 32 51 - 82(SN), A - T AS - TS(SN)	No	No	One per tooth, per lifetime. Not covered within 30 days of D3310 - D3331 on same tooth.	
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	1 - 32 51 - 82(SN)	Yes	No	One per tooth, per lifetime. Should only be performed as preparation for endodontic treatment.	Preoperative periapical radiograph of tooth submitted with claim
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	6 - 11 22 - 27 56 - 61(SN) 72 - 77(SN)	No	No	One per tooth, per lifetime.	
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	4, 5, 12, 13, 20, 21, 28, 29, 54(SN), 55(SN), 62(SN), 63(SN), 70(SN), 71(SN), 78(SN), 79(SN)	No	No	One per tooth, per lifetime.	
D3330	Endodontic therapy, molar tooth (excluding final restoration)	1 - 3, 14 - 19 30 - 32 51 - 53(SN) 64 - 69(SN) 80 - 82(SN)	No	No	One per tooth, per lifetime.	

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Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
Endodontics Endodontic Therapy (including treatment plan, clinical procedures and follow-up care).						
D3331	Treatment of root canal obstruction; non-surgical access	1 - 32 51 - 82(SN)	No	No		
Endodontics Apexification/recalcification procedures						
D3351	Apexification/recalcification - initial visit (apical closure/ calcific repair of perforations, root resorption, etc.)	1 - 32 51 - 82(SN)	No	No		Pre- and postoperative radiographs shall be maintained in beneficiary records.
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	1 - 32 51 - 82(SN)	No	No		Pre- and postoperative radiographs shall be maintained in beneficiary records.
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/clacific repair of perforations, root receptions, etc.)	1 - 32 51 - 82(SN)	No	No		Pre- and postoperative radiographs shall be maintained in beneficiary records.

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Endodontics Apicoectomy/Periradicular Services

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D3410	Apicoectomy - anterior	6 - 11 22 - 27 56 - 61(SN) 72 - 77(SN)	No	No		Pre- and post-operative radiographs shall be maintained in beneficiary records.
D3421	Apicoectomy - bicuspid (first root)	4, 5, 12, 13, 20, 21, 28, 29, 54(SN), 55(SN), 62(SN), 63(SN), 70(SN), 71(SN), 78(SN), 79(SN)	No	No		
D3425	Apicoectomy - molar (first root)	1 - 3, 14 - 19 30 - 32 51 - 53(SN) 64 - 69(SN) 80 - 82(SN)	No	No		
D3426	Apicoectomy (each additional root)	1 - 5, 12 - 21 28 - 32 51 - 55(SN) 62 - 71(SN) 78 - 82(SN)	No	No		
D3427	Periradicular surgery without apicoectomy	1 - 32, 51 - 82 (SN)	No	No	Not allowed same tooth, same DOS as D3410, D3421, D3425, D3426	Pre- and post-operative radiographs shall be maintained in beneficiary records.
D3430	Retrograde filling - per root	1 - 32 51 - 82(SN)	No	No		Pre- and post-operative radiographs shall be maintained in beneficiary records.

Reimbursement for Periodontic Services includes local anesthesia.

Arches, Quadrants, Primary, Permanent, Supernumerary Teeth, and Surfaces should be billed as defined in the current CDT manual.

Periodontics Surgical Services (including usual post-operative care)						
Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D4210	Gingivectomy or gingivolplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	No	A minimum of four affected teeth in the quadrant.	
D4211	Gingivectomy or gingivolplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	No	One to three affected teeth in the quadrant.	
D4230	Anatomical crown exposure - four or more contiguous teeth per quadrant	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	No	Must be billed same date same tooth in conjunction with the restorative codes (D2140 - D2957).	
D4231	Anatomical crown exposure - one to three teeth per quadrant	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	No	Same date and same tooth in conjunction with the restorative code.	
D4268	Surgical revision procedure, per tooth	1 - 32 51 - 82(SN)	No	No	Only covered after D4210.	
Periodontics Non-Surgical Services						
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	No	Four per 12 months. A minimum of four affected teeth in the quadrant.	
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	No	Four per 12 months. One to three affected teeth in the quadrant.	
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis		No	No	One per 12 months.	

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Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
Implant Services	Other Implant services					
D6100	Implant removal - by report	1-32 51-82 (SN)	*** See Exhibit C**	No		
Prosthodontics Fixed	Other fixed partial denture services					
D6930	Re-cement or re-bond fixed partial denture	01 (UA) 02 (LA) 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	No		

*** See Exhibit C Requires the provider to follow all guidelines for Medical Review, PA, Benefit Limits and Documentation Required as stated in Exhibit C (Title 19 Adult Ages 21 and Over). Failure to follow these guidelines will result in loss of reimbursement.**

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Reimbursement for Oral and Maxillofacial Surgery includes local anesthesia and routine postoperative care. The extraction of asymptomatic impacted teeth is not a covered benefit. Symptomatic conditions would include pain and/or infection or demonstrated malocclusion causing a shifting of existing dentition.

Preoperative radiographs must be available for the following procedures: D7140, D7210, D7220, D7230, D7240, D7241, D7250, and D7280.

Only CDT (dental) codes should be submitted for processing.

Only one extraction per tooth, per lifetime, is allowed for the beneficiary.
Arches, Quadrants, Primary, Permanent, Supernumerary Teeth, and Surfaces should be billed as defined in the current CDT manual.

Oral and Maxillofacial Surgery Extractions (Includes local anesthesia, suturing, if needed, and routine postoperative care).						
Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	1 - 32 51- 82 (SN) A - T AS - TS (SN)	No	No		
Oral and Maxillofacial Surgery Surgical Extractions (Includes local anesthesia, suturing, and routine postoperative care).						
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	1 - 32 51- 82 (SN) A - T AS - TS (SN)	No	No	Includes cutting of gingiva and bone, removal of tooth structure, and closure.	
D7220	Removal of impacted tooth - soft tissue	1 - 32 51- 82 (SN)	*** See Exhibit C**		Includes cutting of gingiva and bone, removal of tooth structure, and closure.	
D7230	Removal of impacted tooth - partially bone	1 - 32 51- 82 (SN)	*** See Exhibit C**		Includes cutting of gingiva and bone, removal of tooth structure, and closure.	
D7240	Removal of impacted tooth - completely bony	1 - 32 51- 82 (SN)	*** See Exhibit C**		Includes cutting of gingiva and bone, removal of tooth structure, and closure.	
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	1 - 32 51- 82 (SN)	*** See Exhibit C**		Includes cutting of gingiva and bone, removal of tooth structure, and closure. *Unusual complications such as nerve dissection, separate closure of the maxillary sinus, or aberrant tooth position.*	
D7250	Surgical removal of residual roots (cutting procedure)	1 - 32 51- 82 (SN) A - T AS - TS (SN)	No	No	Includes cutting of gingiva and bone, removal of tooth structure, and closure. Will not be paid to the providers or provider billing group that originally removed the tooth.	

*** See Exhibit C Requires the provider to follow all guidelines for Medical Review, PA, Benefit Limits and Documentation Required as stated in Exhibit C (Title 19 Adult Ages 21 and over). Failure to follow these guidelines will result in loss of reimbursement.**

Pathology reports should be kept in beneficiary record.

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
Oral and Maxillofacial Surgery Other surgical procedures						
D7260	Oroantral fistula closure		*** See Exhibit C**			
D7270	Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth	1 - 32 51- 82 (SN) A - T AS - TS (SN)	No	No	Includes splinting and/or stabilization.	
D7280	Surgical access of unerupted tooth	1 - 32 51- 82 (SN) A - T AS - TS (SN)	No	No		
D7285	Incisional biopsy of oral tissue - hard (bone, tooth)		No	No		
D7286	Incisional biopsy of oral tissue - soft		No	No		
Oral and Maxillofacial Surgery Alveoloplasty Surgical preparation of ridge for dentures						
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	No	No extractions performed in an edentulous area. Not covered when performed on the same day as an extraction for the same tooth.	
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment, and management of hypertrophied and hyper plastic tissue)	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	No		

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MFP Adult Ages 21 and Over I/DD TBI(HI) PD Waivers

Oral and Maxillofacial Surgery Surgical excision of soft tissue lesions

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D7410	Excision of benign lesion up to 1.25 cm		No	No		
D7411	Excision of benign lesion greater than 1.25 cm		No	No		
D7412	Excision of benign lesion - complicated		No	No		
D7413	Excision of malignant lesion up to 1.25 cm		No	No		
D7414	Excision of malignant lesion greater than 1.25 cm		No	No		
D7415	Excision of malignant lesion - complicated		No	No		
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm		No	No		
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm		No	No		
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm		No	No		
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm		No	No		
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm		No	No		
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm		No	No		
D7471	Removal of lateral exostosis - (maxilla or mandible)	01 (UA) 02 (LA)	*** See Exhibit C**			
D7472	Removal of torus palatinus		*** See Exhibit C**			
D7473	Removal of torus mandibularis		*** See Exhibit C**			
D7490	Radical resection of maxilla or mandible	01 (UA) 02 (LA)	*** See Exhibit C**			

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MFP Adult Ages 21 and Over I/DD TBI(HI) PD Waivers

Oral and Maxillofacial Surgery Surgical incision						
Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D7510	Incision and drainage of abscess - intraoral soft tissue		No	No	Not covered same date of service as D7511.	
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple facial spaces)		No	No		
D7520	Incision and drainage of abscess - extraoral soft tissue		No	No	Not covered same date of service as D7521.	
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple facial spaces)		No	No		
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue		No	No		
D7540	Removal of reaction producing foreign bodies, musculoskeletal system		No	No		
D7550	Partial ostectomy/ sequestrectomy for removal of non-vital bone		No	No		
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body		No	No		Pre- and post-operative radiographs along with narrative of medical necessity must be submitted with claim.
Oral and Maxillofacial Surgery Treatment of Fractures Simple						
D7610	Maxilla - open reduction (teeth immobilized, if present)		No	No		
D7620	Maxilla - closed reduction (teeth immobilized, if present)		No	No		
D7630	Mandible - open reduction (teeth immobilized, if present)		No	No		
D7640	Mandible - closed reduction (teeth immobilized, if present)		No	No		
D7650	Malar and/or zygomatic arch - open reduction		No	No		
D7660	Malar and/or zygomatic arch - closed reduction		No	No		

MFP Adult Ages 21 and Over I/DD TBI(HI) PD Waivers

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
Oral and Maxillofacial Surgery	Treatment of Fractures Simple					
D7670	Alveolus - closed reduction - may include stabilization of teeth	1 - 32	No	No	May include stabilization.	
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches		*** See Exhibit C**			
Oral and Maxillofacial Surgery	Treatment of Fractures Compound					
D7710	Maxilla - open reduction		No	No		
D7720	Maxilla - closed reduction		No	No		
D7730	Mandible - open reduction		No	No		
D7740	Mandible - closed reduction		No	No		
D7750	Malar and/or zygomatic arch - open reduction		No	No		
D7760	Malar and/or zygomatic arch - closed reduction		No	No		
D7770	Alveolus - open reduction stabilization of teeth		No	No		
D7780	Facial bones - complicated reduction with fixation and multiple surgical approaches		No	No		
D7820	Closed reduction of dislocation		No	No		
D7860	Arthrotomy		*** See Exhibit C**			
D7865	Arthroplasty		Yes	No		Pre- and post-operative radiographs and narrative of medical necessity submitted with claim.
Oral and Maxillofacial Surgery	Repair of traumatic wounds					
D7910	Suture of recent small wounds up to 5.0 cm		No	No	Not covered on same day as D7140, D7210, D7220, D7230, D7240, D7241, or D7250.	
Oral and Maxillofacial Surgery	Complicated suturing (reconstruction requiring delicate handling of tissues and wide undermining for meticulous closure)					
D7911	Complicated suture - up to 5.0 cm		No	No	Not covered on same day as D7140, D7210, D7220, D7230, D7240, D7241, or D7250.	
D7912	Complicated suture - greater than 5.0 cm		No	No	Not covered on same day as D7140, D7210, D7220, D7230, D7240, D7241, or D7250.	

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MFP Adult Ages 21 and Over I/DD TBI(HI) PD Waivers

Oral and Maxillofacial Surgery Other repair procedures

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D7920	Skin graft (identify defect covered, location, and type of graft)	01 (UA) 02 (LA) 10 (UR) 20 (UL) 30 (LL) 40 (LR)	*** See Exhibit C**			
D7955	Repair of maxillofacial soft and/or hard tissue defect		No	No		Pre- and post-operative radiographs and narrative of medical necessity submitted with claim.
D7960	Frenulectomy also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	01 (UA) 02 (LA)	No	No	Once per lifetime. Per location Lingual, Buccal or Labial. Not covered same date of service as D7963. The frenum may be excised when the tongue has limited mobility; for large diastemas between teeth, or when the frenum interferes with a prosthetic appliance; or when it is the etiology of periodontal tissue disease.	
D7963	Frenuloplasty		No	No	Excision of frenum with excision or repositioning of abervant muscle and z-plasty or other local flap closure.	
D7971	Excision of pericoronal gingiva	1 - 32	No	No		
D7980	Sialolithotomy		No	No		
D7981	Excision of salivary gland, by report		No	No		
D7982	Sialodochoplasty		No	No		
D7983	Closure of salivary fistula		*** See Exhibit C**			
D7990	Emergency tracheotomy		No	No		

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MFP Adult Ages 21 and Over I/DD TBI(HI) PD Waivers

D9220 and D9221 are only billable when dental services other than ONLY diagnostic are provided on the same date of service.
D9310 is billable when ONLY diagnostic services are provided on the same date of service.

Adjunctive General Services Anesthesia						
Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D9212	Trigeminal division block anesthesia		*** See Exhibit C**			
D9219	Evaluation for deep sedation or general anesthesia		No	No	One time per beneficiary per provider or provider billing group per lifetime. One time per beneficiary per 12 months.	Narrative of the evaluation for anesthesia shall be maintained in the beneficiary records.
D9220	Deep sedation/general anesthesia - first 30 minutes		*** See Exhibit C**			
D9221	Deep sedation/general anesthesia - each additional 15 minutes		*** See Exhibit C**			
D9230	Inhalation of nitrous oxide/ analgesia, anxiolysis		No	No	Not covered when billed with only diagnostic and/or preventative services (D0120 through D1208, D1515 through D1550, D9410, D9420).	Narrative of medical necessity shall be maintained in beneficiary records.
D9241	Intravenous moderate (conscious) sedation/ analgesia - first 30 minutes		*** See Exhibit C**			
D9242	Intravenous moderate (conscious) sedation/ analgesia - each additional 15 minutes		*** See Exhibit C**			
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician		No	No	One per 12 months by same provider. One inpatient followup per beneficiary within a 10 day period by same provider. *Not covered on same date of service as D0120 -D0170, D9410, D9420.*	Narrative of the consultation for dental services shall be maintained in beneficiary records.
Professional Visits						
D9410	House/extended care facility call		No	No	Extended care facilities only.	Narrative of medical necessity shall be maintained in beneficiary records.
D9420	Hospital or ambulatory surgical center call		No		Hospital facilities only.	Narrative of medical necessity shall be maintained in beneficiary records.
Drugs						
D9610	Therapeutic parenteral drug, single administration		*** See Exhibit C**			
Miscellaneous Services						
D9920	Behavior management - by report		Yes	No		Narrative of medical necessity shall be submitted with claim.
D9999	Unspecified adjunctive procedure, by report		Yes	No		Narrative of medical necessity shall be submitted with claim.

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Title 19 HCBS and MFP Frail Elderly Ages 65 and Over

Although annual cost limits are not in place at this time, limitations have been imposed that require beneficiaries to receive crisis exception approval from the Kansas Department for Aging and Disability Services (KDADS).
A notification of approval from the beneficiary's targeted case manager must be received noting a specified time frame for the services to be performed prior to any oral health services being provided.

HCBS beneficiaries covered under the HCBS Frail Elderly (FE) waiver will no longer have additional coverage for the dental services listed in this exhibit. Refer to the Title 19 adult benefit plan, Exhibit C, for a list of covered benefits.

KMAP dental providers can bill the following services for Money Follows the Person (MFP) beneficiaries covered under the waiver listed above.

Providers must submit claims for these beneficiaries in the same manner as other KMAP dental claims.

Primary dental coverage for these MFP beneficiaries is provided under the Title 19 adult benefit plan.
If the service is NOT covered under the Title 19 adult benefit plan (Exhibit C), refer to this appendix for additional coverage for MFP beneficiaries.
Direct all claim questions to Customer Service at 785-274-5990 or 1-800-933-6593.

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

Diagnostic Clinical Oral Evaluations

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D0120	Periodic oral evaluation - Established patient		No	No	Only one exam (D0120 or D0150) every six months per provider or provider billing group. Only one exam (D0120, D0140, D0145, D0150, D0170) per date of service, per beneficiary, per provider or provider billing group.	Routine documentation shall be retained in beneficiary's chart.
D0140	Limited oral evaluation - Problem focused		No	No	Only one exam (D0120, D0140, D0145, D0150, D0170) per date of service, per beneficiary, per provider or provider billing group. Limited oral evaluation is only covered when performed in conjunction with treatment to address an emergency situation. An emergency is defined as treatment medically necessary to treat pain, infection, swelling, uncontrolled bleeding, or traumatic injury.	
D0150	Comprehensive oral evaluation - New or established patient		No	No	One comprehensive exam per beneficiary, per provider or provider billing group per lifetime. Only one exam (D0120, D0145, or D0150) every six months per beneficiary per provider or provider billing group.	

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Diagnostic Clinical Oral Evaluations

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D0170	Re-evaluation - limited, problem focused (established beneficiary; not post-operative visit)		No	No	One per 12 months Established beneficiary to assess the status of a previously existing condition (not post-operative visit). Not covered with any other procedure other than radiographs.	

Title 19 HCBS and MFP Frail Elderly Ages 65 and Over

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

Radiographs must be of diagnostic quality, dated, and identified with the beneficiary's name.

Radiographs not of diagnostic quality will not be reimbursed, or if already paid, will be recouped.

An intraoral complete series (D0210) for an adult complete series should consist of at least 16 films to include 2 bitewings.

Bitewing radiographs (D0270, D0272, D0274, D0277) and intraoral radiographs (D0220, D0230) require documentation of medical necessity when performed on the same day as an intraoral complete series (D0210).

Without medical necessity, the maximum reimbursement for a single date of service for radiographs shall be limited to the fee for a complete series.

Diagnostic Radiographs/Diagnostic Imaging

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D0210	Intraoral - Complete Series of radiographic images		No	No	One per 36 months. The following are also considered an Intraoral Complete Series (D0210) D0330 and D0272 D0330 and D0273 D0330 and D0274 D0330 and D0277	
D0220	Intraoral - Periapical first radiographic images		No	No	One per day. Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.	
D0230	Intraoral - Periapical each additional radiographic image		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.	If more than one unit is taken on the same date of service note on claim "not duplicate". Paper claim: put in remarks section. Website claim: put in comments box at header level.

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Diagnostic Radiographs/Diagnostic Imaging

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D0240	Intraoral - Occlusal radiographic image		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.	If more than one unit is taken on the same date of service note on claim "not duplicate". Paper claim: put in remarks section. Website claim: put in comments box at header level.
D0250	Extraoral - First radiographic image		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.	
D0260	Extraoral - Each additional radiographic image		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.	If more than one unit is taken on the same date of service note on claim "not duplicate". Paper claim: put in remarks section. Website claim: put in comments box at header level.
D0270	Bitewing - Single radiographic image		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.	
D0272	Bitewings - Two radiographic images		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.	

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Diagnostic Radiographs/Diagnostic Imaging

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D0273	Bitewing - Three radiographic images		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.	
D0274	Bitewings - Four radiographic images		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.	

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Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
Diagnostic	Radiographs/Diagnostic Imaging					
D0277	Vertical bitewings - 7 to 8 radiographic images		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.	
D0290	Posterior - Anterior or lateral skull and facial bone survey radiographic image		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.	
D0321	Other- Temporomandibular joint arthrogram radiographic images - by report		No	No	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.	
D0330	Panoramic radiographic image		No	No	One per 36 months. The following are also considered an Intraoral Complete Series (D0210) D0330 and D0272 D0330 and D0273 D0330 and D0274 D0330 and D0277	
Diagnostic	Tests and Examinations					
D0460	Pulp vitality tests	1 - 32 51 - 82 (SN) A - T AS - TS (SN)	No	No	Maximum of three teeth per visit.	
Preventive	Dental Prophylaxis					
D1110	Prophylaxis - Adult		No	No	One per 6 months. Includes scaling and polishing procedures to remove coronal plaque, calculus, and stains.	

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Reimbursement for Restorative Services includes local anesthesia.

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

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

Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day.

A restoration is considered a two or more surface restoration only when two or more actual tooth surfaces are involved, whether or not they are connected.

Arches, Quadrants, Primary, Permanent, Supernumerary Teeth, and Surfaces should be billed as defined in the current CDT manual.

Restorative Amalgam Restorations (Including Polishing)						
Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D2140	Amalgam - one surface, primary or permanent	1 - 32 51 - 82 (SN) A - T AS - TS (SN)	No	No		
D2150	Amalgam - two surfaces, primary or permanent	1 - 32 51 - 82 (SN) A - T AS - TS (SN)	No	No		
D2160	Amalgam - three surfaces, primary or permanent	1 - 32 51 - 82 (SN) A - T AS - TS (SN)	No	No		
D2161	Amalgam - four or more surfaces, primary or permanent	1 - 32 51 - 82 (SN) A - T AS - TS (SN)	No	No		
Restorative Resin-Based Composite Restorations - Direct						
D2330	Resin-based composite - one surface, anterior	6 - 11, 22 - 27 56 - 61(SN) 72 - 77(SN) C - H, M - R CS - HS(SN) MS - RS(SN)	No	No		
D2331	Resin-based composite - two surfaces, anterior	6 - 11, 22 - 27 56 - 61(SN) 72 - 77(SN) C - H, M - R CS - HS(SN) MS - RS(SN)	No	No		
D2332	Resin-based composite - three surfaces, anterior	6 - 11, 22 - 27 56 - 61(SN) 72 - 77(SN) C - H, M - R CS - HS(SN) MS - RS(SN)	No	No		

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Restorative Resin-Based Composite Restorations - Direct

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D2335	Resin-based composite - four or more surfaces, or involving the incisal angle anterior	6 - 11, 22 - 27 56 - 61(SN) 72 - 77(SN) C - H, M - R CS - HS(SN) MS - RS(SN)	No	No		
D2390	Resin-based composite crown - anterior	6 - 11, 22 - 27 56 - 61(SN) 72 - 77(SN) C - H, M - R CS - HS(SN) MS - RS(SN)	No	No		
D2391	Resin-based composite - one surface, posterior	1 - 5, 12 - 21 28 - 32 51 - 55 (SN) 62 - 71 (SN) 78 - 82 (SN) A, B, I - L, S, T, AS (SN), BS (SN), IS - LS (SN), SS (SN), TS (SN)	No	No		
D2392	Resin-based composite - two surfaces posterior	1 - 5, 12 - 21 28 - 32 51 - 55 (SN) 62 - 71 (SN) 78 - 82 (SN) A, B, I - L, S, T, AS (SN), BS (SN), IS - LS (SN), SS (SN), TS (SN)	No	No		
D2393	Resin-based composite - three surfaces, posterior	1 - 5, 12 - 21 28 - 32 51 - 55 (SN) 62 - 71 (SN) 78 - 82 (SN) A, B, I - L, S, T, AS (SN), BS (SN), IS - LS (SN), SS (SN), TS (SN)	No	No		
D2394	Resin-based composite - four or more surfaces, posterior	1 - 5, 12 - 21 28 - 32 51 - 55 (SN) 62 - 71 (SN) 78 - 82 (SN) A, B, I - L, S, T, AS (SN), BS (SN), IS - LS (SN), SS (SN), TS (SN)	No	No		

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Restorative Crowns - Single Restorations only						
Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D2710	Crown - resin-based composite (indirect)	6 - 11 22 - 27 56 - 61(SN) 72 - 77(SN)	No	No	Once per 60 months.	
D2740	Crown - porcelain/ceramic substrate	1 - 32 51 - 82 (SN)	No	No	Once per 60 months.	
D2751	Crown - porcelain fused to predominantly base metal	1 - 32 51 - 82(SN)	No	No	Once per 60 months.	
D2752	Crown - porcelain fused to noble metal	1 - 32 51 - 82(SN)	No	No	Once per 60 months.	
D2783	Crown - 3/4 porcelain/ceramic	1 - 32 51 - 82(SN)	No	No	Once per 60 months.	
D2791	Crown - full cast predominantly base metal	1 - 32 51 - 82(SN)	No	No	Once per 60 months.	
D2792	Crown - full cast noble metal	1 - 32 51 - 82(SN)	No	No	Once per 60 months.	
Restorative Other Restorative Services						
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	1 - 32 51 - 82(SN)	No	No		
D2920	Re-cement or re-bond crown	1 - 32 51 - 82(SN)	No	No		
D2921	Reattachment of tooth fragment, incisal edge or cusp	1 - 32 51 - 82 (SN)	No	No	Not allowed same tooth, same surface(s), same DOS as D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394	Pre- and post-operative radiographic images shall be maintained in beneficiary records.
D2930	Prefabricated stainless steel crown - primary tooth	A - T AS - TS(SN)	No	No	Once per 24 months.	
D2931	Prefabricated stainless steel crown - permanent tooth	1 - 32 51 - 82(SN)	No	No	Once per 24 months.	
D2940	Protective restoration	1 - 32 51 - 82(SN)	No	No	Temporary restoration intended to relieve pain. Not to be used as a base or liner under a restoration.	
D2951	Pin retention - per tooth, in addition to restoration	1 - 32 51 - 82(SN)	No	No		
D2954	Prefabricated post and core in addition to crown	1 - 32 51 - 82(SN)	No	No	Once per 60 months.	
D2957	Each additional prefabricated post - same tooth	1 - 3 14 - 19 30 - 32 51- 53(SN) 64 - 69(SN) 80 - 82(SN)	No	No	Once per 60 months.	

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Reimbursement for Endodontic Services includes local anesthesia.

In cases where a root canal filing does not meet the general clinical criteria standards (Section IX. Clinical Criteria this manual) KMAP can require the procedure be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after the dental consultant reviews the circumstances.

A pulpotomy or palliative treatment is not to be billed in conjunction with a root canal treatment on the same date.

Filling material not accepted by the Federal Food and Drug Administration is not covered.

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

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
Endodontics Pulp Capping						
D3110	Pulp cap - direct (excluding final restoration)	1 - 32 51 - 82(SN)	No	No		
Endodontics Pulpotomy						
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	1 - 32 51 - 82(SN) A - T AS - TS	No	No	One per tooth, per lifetime. Not covered within 30 days of D3310 - D3331 on same tooth.	
D3221	Pulpal debridement - primary and permanent teeth	1 - 32 51 - 82(SN) A - T AS - TS(SN)	No	No	One per tooth, per lifetime. Not covered within 30 days of D3310 - D3331 on same tooth.	
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	1 - 32 51 - 82(SN)	Yes	No	One per tooth, per lifetime. Should only be performed as preparation for endodontic treatment.	Preoperative periapical radiograph of tooth submitted with claim.
Endodontics Endodontic Therapy (including treatment plan, clinical procedures and follow-up care).						
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	6 - 11 22 - 27 56 - 61(SN) 72 - 77(SN)	No	No	One per tooth, per lifetime.	
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	4, 5, 12, 13, 20, 21, 28, 29, 54(SN), 55(SN), 62(SN), 63(SN), 70(SN), 71(SN), 78(SN), 79(SN)	No	No	One per tooth, per lifetime.	
D3330	Endodontic therapy, molar tooth (excluding final restoration)	1 - 3, 14 - 19 30 - 32 51 - 53(SN) 64 - 69(SN) 80 - 82(SN)	No	No	One per tooth, per lifetime.	
D3331	Treatment of root canal obstruction; non-surgical access	1 - 32 51 - 82(SN)	No	No		

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Endodontics Apexification/recalcification procedures						
Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D3351	Apexification/recalcification - initial visit (apical closure/ calcific repair of perforations, root resorption, etc.)	1 - 32 51 - 82(SN)	No	No		Pre- and post-operative radiographs shall be maintained in beneficiary records.
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	1 - 32 51 - 82(SN)	No	No		Pre- and post-operative radiographs shall be maintained in beneficiary records.
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/clacific repair of perforations, root receptions, etc.)	1 - 32 51 - 82(SN)	No	No		Pre- and post-operative radiographs shall be maintained in beneficiary records.
Endodontics Apicoectomy/Periradicular Services						
D3410	Apicoectomy - anterior	6 - 11 22 - 27 56 - 61(SN) 72 - 77(SN)	No	No		Pre- and post-operative radiographs shall be maintained in beneficiary records.
D3421	Apicoectomy - bicuspid (first root)	4, 5, 12, 13, 20, 21, 28, 29, 54(SN), 55(SN), 62(SN), 63(SN), 70(SN), 72(SN), 78(SN), 79(SN)	No	No		
D3425	Apicoectomy - molar (first root)	1 - 3, 14 - 19 30 - 32 51 - 53(SN) 64 - 69(SN) 80 - 82(SN)	No	No		
D3426	Apicoectomy (each additional root)	1 - 5, 12 - 21 28 - 32 51 - 55(SN) 62 - 71(SN) 78 - 82(SN)	No	No		
D3427	Periradicular surgery without apicoectomy	1 - 32, 51 - 82 (SN)	No	No	Not allowed same tooth, same DOS as D3410, D3421, D3425, D3426	Pre- and post-operative radiographs shall be maintained in beneficiary records.
D3430	Retrograde filling - per root	1 - 32 51 - 82(SN)	No	No		Pre- and post-operative radiographs shall be maintained in beneficiary records.

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Reimbursement for Periodontic Services includes local anesthesia

Arches, Quadrants, Primary, Permanent, Supernumerary Teeth, and Surfaces should be billed as defined in the current CDT manual.

Periodontics Surgical Services (including usual post-operative care)						
Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D4210	Gingivectomy or gingivolplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	No	A minimum of four affected teeth in the quadrant.	
D4211	Gingivectomy or gingivolplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	No	One to three affected teeth in the quadrant.	
D4230	Anatomical crown exposure - four or more contiguous teeth per quadrant	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	No	Must be billed same date same tooth in conjunction with the restorative codes (D2140 - D2957).	
D4231	Anatomical crown exposure - one to three teeth per quadrant	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	No	Must be billed same date same tooth in conjunction with the restorative codes (D2140 - D2957).	
D4268	Surgical revision procedure, per tooth	1 - 32 51 - 82(SN)	No	No	Only covered after D4210.	
Periodontics Non-Surgical Services						
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	No	Four per 12 months. A minimum of four affected teeth in the quadrant.	
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	No	Four per 12 months. One to three affected teeth in the quadrant.	
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis		No	No	One per 12 months.	

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Medically necessary partial or full mouth dentures and related services may be covered when they are determined to be the primary treatment of choice or an essential part of the overall treatment plan to treat the beneficiary's oral health.

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

Extractions for asymptomatic teeth are not covered services unless removal constitutes the most cost-effective dental procedure for the provision of dentures. Provision for dentures for cosmetic purposes is not a covered service.

Arches, Quadrants, Primary, Permanent, Supernumerary Teeth, and Surfaces should be billed as defined in the current CDT manual.

Prosthodontics (Removable)	Complete Dentures (Including routine post-delivery care)					
Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D5110	Complete denture - maxillary		No	No	Once per 60 months.	
D5120	Complete denture - mandibular		No	No	Once per 60 months.	
Prosthodontics (Removable)	Partial Dentures (Including routine post-delivery care)					
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)		No	No	Once per 60 months.	Preoperative radiographs of adjacent and opposing teeth along with narrative of medical necessity should be retained in beneficiary's chart.
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)		No	No	Once per 60 months.	
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)		No	No	Once per 60 months.	
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)		No	No	Once per 60 months.	
D5225	Maxillary partial denture - flexible base (including any conventional clasps, rests and teeth)		No	No	Once per 60 months.	
D5226	Mandibular partial denture - flexible base (including any conventional clasps, rests and teeth)		No	No	Once per 60 months.	
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	No	Once per 60 months.	

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Prosthodontics Adjustments to Dentures						
Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D5410	Adjust complete denture - maxillary		No	No	Not covered within 6 months of placement.	
D5411	Adjust complete denture - mandibular		No	No	Not covered within 6 months of placement.	
D5421	Adjust partial denture - maxillary		No	No	Not covered within 6 months of placement.	
D5422	Adjust partial denture - mandibular		No	No	Not covered within 6 months of placement.	
Prosthodontics Repairs to Complete Dentures						
D5510	Repair broken complete denture base	01 (UA) 02 (LA)	No	No		
D5520	Replace missing or broken teeth - complete denture (each tooth)	1 - 32	No	No		
Prosthodontics Repairs to Partial Dentures						
D5610	Repair resin denture base	01 (UA) 02 (LA) 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	No		
D5620	Repair cast framework	01 (UA) 02 (LA) 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	No		
D5630	Repair or replace broken clasp	01 (UA) 02 (LA) 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	No		
D5640	Replace broken teeth - per tooth	1 - 32	No	No		
D5650	Add tooth to existing partial denture	1 - 32	No	No		
D5660	Add clasp to existing partial denture	01 (UA) 02 (LA) 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	No		
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)		No	No		
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)		No	No		

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Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
Prosthodontics	Denture Reline Procedures					
D5730	Reline complete maxillary denture - chairside		No	No	One per 24 months. Not covered within 24 months of placement. Covered for Frail Elderly benefit plan only.	
D5731	Reline complete mandibular denture - chairside		No	No	One per 24 months. Not covered within 24 months of placement. Covered for Frail Elderly benefit plan only.	
D5750	Reline complete maxillary denture (laboratory)		No	No	One per 24 months. Not covered within 24 months of placement.	
D5751	Reline complete mandibular denture (laboratory)		No	No	One per 24 months. Not covered within 24 months of placement.	
D5760	Reline maxillary partial denture (laboratory)		No	No	One per 24 months. Not covered within 24 months of placement.	
D5761	Reline mandibular partial denture (laboratory)		No	No	One per 24 months. Not covered within 24 months of placement.	
Prosthodontics	Other removable prosthetic services					
D5850	Tissue conditioning, maxillary		No	No		
D5851	Tissue conditioning, mandibular		No	No		
Implant Services	Other Implant services					
D6100	Implant removal - by report	1 - 32 51 - 82 (SN)	Yes	No		Pre- and postoperative radiographs along with narrative of medical necessity submitted with claim.
Prosthodontics Fixed	Other fixed partial denture services					
D6930	Re-cement or re-bond fixed partial denture	01 (UA) 02 (LA) 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	No		

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Reimbursement for Oral and Maxillofacial Surgery includes local anesthesia and routine post-operative care.

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

Preoperative radiographs must be available for the following procedures: D7140, D7210, D7220, D7230, D7240, D7241, D7250, and D7280.

Only CDT (dental) codes should be submitted for processing.

Only one extraction per tooth, per lifetime, is allowed for the beneficiary.

Arches, Quadrants, Primary, Permanent, Supernumerary Teeth, and Surfaces should be billed as defined in the current CDT manual.

Oral and Maxillofacial Surgery Extractions (Includes local anesthesia, suturing, if needed, and routine postoperative care).						
Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	1 - 32 51- 82 (SN) A - T AS - TS (SN)	No	No		
Oral and Maxillofacial Surgery Surgical Extractions (Includes local anesthesia, suturing, and routine postoperative care)						
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	1 - 32 51- 82 (SN) A - T AS - TS (SN)	No	No	Includes cutting of gingiva and bone, removal of tooth structure and closure.	
D7220	Removal of impacted tooth - soft tissue	1 - 32 51- 82 (SN)	* See Exhibit C	* See Exhibit C	* See Exhibit C	* See Exhibit C
D7230	Removal of impacted tooth - partially bone	1 - 32 51- 82 (SN)	* See Exhibit C	* See Exhibit C	* See Exhibit C	* See Exhibit C
D7240	Removal of impacted tooth - completely bony	1 - 32 51- 82 (SN)	* See Exhibit C	* See Exhibit C	* See Exhibit C	* See Exhibit C
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	1 - 32 51- 82 (SN)	* See Exhibit C	* See Exhibit C	* See Exhibit C	* See Exhibit C
D7250	Surgical removal of residual roots (cutting procedure)	1 - 32 51- 82 (SN) A - T AS - TS (SN)	No	No	* See Exhibit C Will not be paid to the providers or provider billing group that originally removed the tooth.	

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Pathology reports should be kept in the beneficiary's record.

Oral and Maxillofacial Surgery Other surgical procedures						
Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D7260	Oroantral fistula closure		* See Exhibit C	* See Exhibit C	* See Exhibit C	* See Exhibit C
D7270	Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth	1 - 32 51- 82 (SN) A - T AS - TS (SN)	No	No	Includes splinting and/or stabilization.	
D7280	Surgical access of unerupted tooth	1 - 32 51- 82 (SN) A - T AS - TS (SN)	No	No		
D7285	Incisional biopsy of oral tissue - hard (bone, tooth)		No	No		
D7286	Incisional biopsy of oral tissue - soft		No	No		
Oral and Maxillofacial Surgery Alveoloplasty Surgical preparation of ridge for dentures						
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	No	Covered for MFP Frail Elderly benefit plan only.	
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces - per quadrant	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	No	No extractions performed in an edentulous area. Not covered when performed on the same day as an extraction for the same tooth.	
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment, and management of hypertrophied and hyper plastic tissue)	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	No		

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Oral and Maxillofacial Surgery Surgical excision of soft tissue lesions

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D7410	Excision of benign lesion up to 1.25 cm		No	No		
D7411	Excision of benign lesion greater than 1.25 cm		No	No		
D7412	Excision of benign lesion - complicated		No	No		
D7413	Excision of malignant lesion up to 1.25 cm		No	No		
D7414	Excision of malignant lesion greater than 1.25 cm		No	No		
D7415	Excision of malignant lesion - complicated		No	No		
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm		No	No		
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm		No	No		
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm		No	No		
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm		No	No		
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm		No	No		
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm		No	No		
D7471	Removal of lateral exostosis - (maxilla or mandible)	01 (UA) 02 (LA)	* See Exhibit C	* See Exhibit C	* See Exhibit C	* See Exhibit C
D7472	Removal of torus palatinus		* See Exhibit C	* See Exhibit C	* See Exhibit C	* See Exhibit C
D7473	Removal of torus mandibularis		* See Exhibit C	* See Exhibit C	* See Exhibit C	* See Exhibit C
D7490	Radical resection of maxilla or mandible	01 (UA) 02 (LA)	* See Exhibit C	* See Exhibit C	* See Exhibit C	* See Exhibit C

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Oral and Maxillofacial Surgery	Surgical incision					
Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D7510	Incision and drainage of abscess - intraoral soft tissue		No	No	Not covered same date of service as D7511.	
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple facial spaces)		No	No		
D7520	Incision and drainage of abscess - extraoral soft tissue		No	No	Not covered same date of service as D7521.	
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple facial spaces)		No	No		
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue		No	No		
D7540	Removal of reaction producing foreign bodies, musculoskeletal system		No	No		
D7550	Partial ostectomy/ sequestrectomy for removal of non-vital bone		No	No		
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body		Yes	No		Pre- and postoperative radiographs along with narrative of medical necessity must be submitted with claim.
Oral and Maxillofacial Surgery	Treatment of Fractures Simple					
D7610	Maxilla - open reduction (teeth immobilized, if present)		No	No		
D7620	Maxilla - closed reduction (teeth immobilized, if present)		No	No		
D7630	Mandible - open reduction (teeth immobilized, if present)		No	No		
D7640	Mandible - closed reduction (teeth immobilized, if present)		No	No		
D7650	Malar and/or zygomatic arch - open reduction		No	No		
D7660	Malar and/or zygomatic arch - closed reduction		No	No		

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Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
Oral and Maxillofacial Surgery	Treatment of Fractures Simple					
D7670	Alveolus - closed reduction - may include stabilization of teeth	1 - 32	No	No	May include stabilization.	
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches		* See Exhibit C	* See Exhibit C	* See Exhibit C	* See Exhibit C
Oral and Maxillofacial Surgery	Treatment of Fractures Compound					
D7710	Maxilla - open reduction		No	No		
D7720	Maxilla - closed reduction		No	No		
D7730	Mandible - open reduction		No	No		
D7740	Mandible - closed reduction		No	No		
D7750	Malar and/or zygomatic arch - open reduction		No	No		
D7760	Malar and/or zygomatic arch - closed reduction		No	No		
D7770	Alveolus - open reduction stabilization of teeth		No	No		
D7780	Facial bones - complicated reduction with fixation and multiple surgical approaches		No	No		
D7820	Closed reduction of dislocation		No	No		
D7860	Arthrotomy		* See Exhibit C	* See Exhibit C	* See Exhibit C	* See Exhibit C
D7865	Arthroplasty		Yes	No		Pre- and postoperative radiographs and narrative of medical necessity submitted with claim.
Oral and Maxillofacial Surgery	Repair of traumatic wounds					
D7910	Suture of recent small wounds up to 5 cm		No	No	Not covered on same day as D7140, D7210, D7220, D7230, D7240, D7241 or D7250.	
Oral and Maxillofacial Surgery	Complicated suturing (reconstruction requiring delicate handling of tissues and wide undermining for meticulous closure)					
D7911	Complicated suture - up to 5 cm		No	No	Not covered on same day as D7140, D7210, D7220, D7230, D7240, D7241 or D7250.	
D7912	Complicated suture - greater than 5 cm		No	No	Not covered on same day as D7140, D7210, D7220, D7230, D7240, D7241 or D7250.	

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Oral and Maxillofacial Surgery Other repair procedures

Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D7920	Skin graft (identify defect covered, location, and type of graft)	01 (UA) 02 (LA) 10 (UR) 20 (UL) 30 (LL) 40 (LR)	* See Exhibit C	* See Exhibit C	* See Exhibit C	* See Exhibit C
D7955	Repair of maxillofacial soft and/or hard tissue defect		No	No		Pre- and postoperative radiographs and narrative of medical necessity submitted with claim.
D7960	Frenulectomy also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	01 (UA) 02 (LA)	No	No	Once per lifetime. Per location Lingual, Buccal or Labial. Not covered same date of service as D7963. The frenum may be excised when the tongue has limited mobility; for large diastemas between teeth, or when the frenum interferes with a prosthetic appliance; or when it is the etiology of periodontal tissue disease.	
D7963	Frenuloplasty		No	No	Excision of frenum with excision or repositioning of abervant muscle and z-plasty or other local flap closure.	
D7971	Excision of pericoronal gingiva	1 - 32	No	No		
D7980	Sialolithotomy		No	No		
D7981	Excision of salivary gland, by report		No	No		
D7982	Sialodochoplasty		No	No		
D7983	Closure of salivary fistula		* See Exhibit C	* See Exhibit C	* See Exhibit C	* See Exhibit C
D7990	Emergency tracheotomy		No	No		

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D9220 and D9221 are only billable when dental services other than ONLY diagnostic are provided on the same date of service.

D9310 is billable when ONLY diagnostic services are provided on the same date of service.

Adjunctive General Services Anesthesia						
Code	Description	Teeth or Area Covered	Medical Review Required	PA Required	Benefit Limits	Documentation Required
D9212	Trigeminal division block anesthesia		* See Exhibit C	* See Exhibit C	* See Exhibit C	* See Exhibit C
D9219	Evaluation for deep sedation or general anesthesia		No	No	One time per beneficiary per provider or provider billing group per lifetime. One time per beneficiary per 12 months.	Narrative of the evaluation for anesthesia shall be maintained in the beneficiary records.
D9220	Deep sedation/general anesthesia - first 30 minutes		* See Exhibit C	* See Exhibit C	* See Exhibit C	* See Exhibit C
D9221	Deep sedation/general anesthesia - each additional 15 minutes		* See Exhibit C	* See Exhibit C	* See Exhibit C	* See Exhibit C
D9230	Inhalation of nitrous oxide/ analgesia, anxiolysis		No	No	Not covered when billed with diagnostic and/or preventive services (D0120 through D1208, D1515 through D1550, D9410, D9420).	Narrative of medical necessity shall be maintained in beneficiary records.
D9241	Intravenous moderate (conscious) sedation/ analgesia - first 30 minutes		* See Exhibit C	* See Exhibit C	* See Exhibit C	* See Exhibit C
D9242	Intravenous moderate (conscious) sedation/ analgesia - each additional 15 minutes		* See Exhibit C	* See Exhibit C	* See Exhibit C	* See Exhibit C
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician		No	No	One per 12 months by same provider. One inpatient followup per beneficiary within a 10 day period by same provider. *Not covered on same date of service as D0120 -D0170, D9410, D9420.*	Narrative of the consultation for dental services shall be maintained in beneficiary records.
Professional Visits						
D9410	House/extended care facility call		No	No	Extended Care Facilities only.	Narrative of medical necessity shall be maintained in beneficiary records.
D9420	Hospital or ambulatory surgical center call		No		Hospital Facilities only.	Narrative of medical necessity shall be maintained in beneficiary records.
Drugs						
D9610	Therapeutic parenteral drug, single administration		* See Exhibit C	* See Exhibit C	* See Exhibit C	* See Exhibit C
Miscellaneous Services						
D9920	Behavior management - by report		Yes	No		Narrative of medical necessity shall be submitted with claim.
D9999	Unspecified adjunctive procedure, by report		Yes	No		Narrative of medical necessity shall be submitted with claim.

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