UnitedHealthcare Community Plan of Nebraska Medicaid Dental Quick Reference Guide

Effective: January 1, 2025

UHCdental.com/medicaid

The Dental Hub may be used to check eligibility, submit prior authorization, claims, and access useful information regarding plan coverage.

To register for the Hub, you will need information on a prior paid claim or a Registration code. To receive your Registration code and for other Dental Hub assistance, call Provider Services.

Provider services

Phone: **1-866-519-5961**
8 a.m. – 6 p.m. EST Monday–Friday (IVR: 24/7)

Member eligibility, benefits, claims, authorizations, network participation and contract questions

Prior authorization

UnitedHealthcare NE Authorizations
P.O. Box 2053
Milwaukee, WI 53201

Appeals for service denials

UnitedHealthcare NE Appeals
Attn: Appeals Department
P.O. Box 361
Milwaukee, WI 53201

Toll-free: **1-866-519-5961**

Claims

UnitedHealthcare NE Claims
P.O. Box 2176
Milwaukee, WI 53201

EDI Payer ID

GP133

Claim disputes or adjustments

UnitedHealthcare NE Appeals
P.O. Box 361
Milwaukee, WI 53201

Corrected claims

UnitedHealthcare NE
Claims Reprocessing and Overpaymnts
P.O. Box 481
Milwaukee, WI 53201

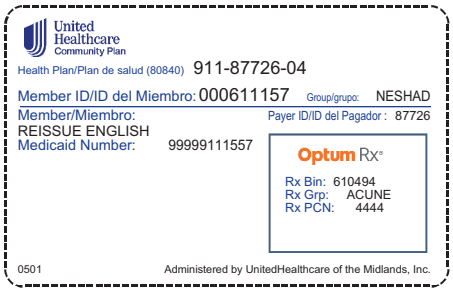
Claims may be submitted electronically via your clearinghouse, online via the provider portal or via the mailing addresses here.

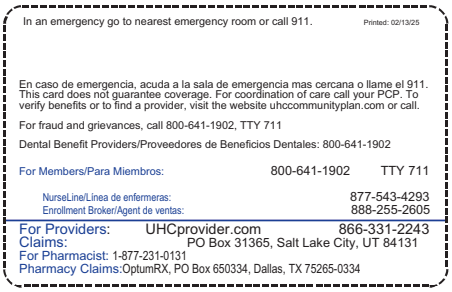
Important notes

This guide is intended to be used for quick reference and may not contain all of the necessary information; it is subject to change without notice. For current detailed benefit information, please visit the Dental Hub or contact our Provider Services toll free number.

Sample member ID card

Please note: The address for submitting dental claims is UHC NE Claims P.O. Box 2176 Milwaukee, WI 53201.





Benefit coverage, limitations, and requirements

Member benefits are listed in the following Benefit Grid, which contains all covered dental procedures and is intended to align to all State and Federal regulatory requirements; therefore, this Grid is subject to change. For the most updated member benefits, exclusions, and limitations please visit our website at **UHCdental.com/medicaid**.

Code	Description	Age limit	Limits	Prior auth required	Required documentation
D0120	PERIODIC ORAL EXAMINATION	0 - 999	1 per 180 days	N	
D0140	LIMITED ORAL EVALUATION - PROBLEM FOCUSED	0 - 999	2 per 12 months	N	
D0145	ORAL EVALUATION FOR A PATIENT UNDER THREE YEARS OF AGE AND COUNSELING WITH PRIMARY CAREGIVER	0 - 3	1 per 175 days	N	
D0150	COMPREHENSIVE ORAL EVALUATION - NEW OR ESTABLISHED PATIENT	0 - 999	1 per 3 years	N	
D0160	DETAILED AND EXTENSIVE ORAL EVALUATION - PROBLEM FOCUSED, BY REPORT	0 - 999	1 per 3 years	N	
D0170	RE-EVALUATION-LIMITED, PROBLEM FOCUSED (ESTAB. PATIENT; NOT POST-OP. VISIT)	0 - 999	1 per 12 months	N	
D0171	RE-EVALUATION - POST OPERATIVE OFFICE VISIT	0-999	1 per year	N	
D0180	COMPREHENSIVE PERIODONTAL EVALUATION - NEW OR ESTABLISHED PATIENT	0 - 999	1 per 3 years	N	
D0190	SCREENING OF A PATIENT	0 - 999	1 per 6 months	N	

Code	Description	Age limit	Limits	Prior auth required	Required documentation
D0191	ASSESSMENT OF A PATIENT	0 - 999	1 per 6 months	N	
D0210	INTRAORAL-COMPLETE SERIES (INCLUDING BITEWINGS)	0 - 999	1 per code every 3 years	N	
D0220	INTRAORAL - PERIAPICAL-FIRST FILM	0 - 999	1 per 1 day	N	
D0230	INTRAORAL - PERIAPICAL EACH ADDITIONAL FILM	0 - 999	no limit but must recode to full mouth as needed per 1 day	N	
D0240	INTRAORAL-OCCLUSAL FILM	0 - 999	2 per code per patient per every 6 months	N	
D0270	BITEWING-EACH FILM	0 - 999	4 per 1 day	N	
D0272	BITEWING-TWO FILMS	0 - 999	2 per 1 day	N	
D0273	BITEWINGS - THREE FILMS	0 - 999	2 per 1 day	N	
D0274	BITEWING-FOUR FILMS	0 - 999	1 per 1 day	N	
D0330	PANORAMIC FILM	0 - 999	1 per 3 years	N	
D0340	CEPHALOMETRIC FILM	0 - 20	1 per 1 lifetime	N	
D0470	DIAGNOSTIC CASTS	1 - 20	1 per 1 lifetime	N	
D1110	PROPHYLAXIS-ADULT (AGE 14 AND OLDER)	14 - 999	1 per 180 days	N	
D1120	PROPHYLAXIS-CHILD (AGE 13 AND YOUNGER)	0 - 13	1 per 180 days	N	
D1206	TOPICAL FLUORIDE VARNISH; THERAPEUTIC APPLICATION FOR MODERATE TO HIGH CARIES RISK PATIENTS	0 - 999	4 per 1 year	N	
D1208	TOPICAL APPLICATION OF FLUORIDE-EXCLUDING VARNISH	0 - 999	4 per 1 year	N	
D1351	SEALANT - PER TOOTH	0 - 20	1 per 24 months; per tooth	N	
D1354	INTERIM CARIES ARRESTING MEDICAMENT APPLICATION PER TOOTH	0 - 999	3 per 1 year; per tooth	Y	Narrative of medical necessity; prior authorization required after third application
D1355	CARIES PREVENTITIVE MEDICAMENT APPLICATION PER TOOTH	0 - 999	3 per 1 year; per tooth	Y	Narrative of medical necessity; prior authorization required after third application

Code	Description	Age limit	Limits	Prior auth required	Required documentation
D1510	SPACE MAINTAINER - FIXED UNILATERAL	0 - 20	1 per 1 year	N	
D1516	SPACE MAINTAINER FIXED BILATERAL MAXILLARY	0 - 20	1 per tooth or range per 1 year	N	
D1517	SPACE MAINTAINER FIXED BILATERAL MANDIBULAR	0 - 20	1 per tooth or range per 1 year	N	
D1551	RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER-MAXILLARY	0 - 20	1 per 1 year	N	
D1552	RE-CEMENT OR RE-BOND BILATERAL SPACE MAINTAINER-MANDIBULAR	0 - 20	1 per 1 year	N	
D1553	RE-CEMENT OR RE-BOND UNILATERAL SPACE MAINTAINER-PER QUADRANT	0 - 20	1 per 1 year	N	
D1556	REMOVAL OF FIXED UNILATERAL SPACE MAINTAINER-PER QUADRANT	0 - 20	1 per 1 year	N	
D1557	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER-MAXILLARY	0 - 20	1 per 1 year	N	
D1558	REMOVAL OF FIXED BILATERAL SPACE MAINTAINER-MANDIBULAR	0 - 20	1 per 1 year	N	
D1575	DISTAL SHOE SPACE MAINTAINER - FIXED - UNILATERAL	0 - 20	1 per 1 year	N	
D2140	AMALGAM - ONE SURFACE, PRIMARY OR PERMANENT	0 - 999	1 per 1 year	N	All restorative services are subject to medical necessity review. 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 (2) or more actual tooth surfaces are involved, whether they are connected or not.
D2150	AMALGAM - TWO SURFACES, PRIMARY OR PERMANENT	0 - 999	1 per 1 year	N	All restorative services are subject to medical necessity review. 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 (2) or more actual tooth surfaces are involved, whether they are connected or not.

Code	Description	Age limit	Limits	Prior auth required	Required documentation
D2160	AMALGAM - THREE SURFACES, PRIMARY OR PERMANENT	0 - 999	1 per 1 year	N	All restorative services are subject to medical necessity review. 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 (2) or more actual tooth surfaces are involved, whether they are connected or not.
D2161	AMALGAM - FOUR OR MORE SURFACES, PRIMARY OR PERMANENT	0 - 999	1 per 1 year	N	All restorative services are subject to medical necessity review. 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 (2) or more actual tooth surfaces are involved, whether they are connected or not.
D2330	RESIN-BASED COMPOSITE - ONE SURFACE, ANTERIOR	0 - 999	1 per 1 year	N	All restorative services are subject to medical necessity review. 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 (2) or more actual tooth surfaces are involved, whether they are connected or not.
D2331	RESIN-BASED COMPOSITE - TWO SURFACES, ANTERIOR	0 - 999	1 per 1 year	N	All restorative services are subject to medical necessity review. 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 (2) or more actual tooth surfaces are involved, whether they are connected or not.
D2332	RESIN-BASED COMPOSITE - THREE SURFACES, ANTERIOR	0 - 999	1 per 1 year	N	All restorative services are subject to medical necessity review. 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 (2) or more actual tooth surfaces are involved, whether they are connected or not.
D2335	RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES OR INVOLVING INCISAL ANGLE (ANTERIOR)	0 - 999	1 per 1 year	N	All restorative services are subject to medical necessity review. 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 (2) or more actual tooth surfaces are involved, whether they are connected or not.
D2390	RESIN-BASED COMPOSITE CROWN, ANTERIOR	0 - 999	1 per 1 year	N	All restorative services are subject to medical necessity review. 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 (2) or more actual tooth surfaces are involved, whether they are connected or not.
D2391	RESIN-BASED COMPOSITE - ONE SURFACE, POSTERIOR	0 - 999	1 per 1 year	N	All restorative services are subject to medical necessity review. 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 (2) or more actual tooth surfaces are involved, whether they are connected or not.

Code	Description	Age limit	Limits	Prior auth required	Required documentation
D2392	RESIN-BASED COMPOSITE - TWO SURFACES, POSTERIOR	0 - 999	1 per 1 year	N	All restorative services are subject to medical necessity review. 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 (2) or more actual tooth surfaces are involved, whether they are connected or not.
D2393	RESIN-BASED COMPOSITE - THREE SURFACES, POSTERIOR	0 - 999	1 per 1 year	N	All restorative services are subject to medical necessity review. 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 (2) or more actual tooth surfaces are involved, whether they are connected or not.
D2394	RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES, POSTERIOR	0 - 999	1 per 1 year	N	All restorative services are subject to medical necessity review. 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 (2) or more actual tooth surfaces are involved, whether they are connected or not.
D2710	CROWN - RESIN BASED COMPOSITE (INDIRECT)	0 - 999	1 per 5 years	Y	Crown services require radiographic images that depict the pre-condition. The documentation supporting the need for crown services must be available for review by UnitedHealthcare upon request.
D2720	CROWN-RESIN WITH HIGH NOBLE METAL	0 - 999	1 per 5 years	Y	Crown services require radiographic images that depict the pre-condition. The documentation supporting the need for crown services must be available for review by UnitedHealthcare upon request.
D2721	CROWN-RESIN WITH PREDOMINANTLY BASE METAL	0 - 999	1 per 5 years	Y	Crown services require radiographic images that depict the pre-condition. The documentation supporting the need for crown services must be available for review by UnitedHealthcare upon request.
D2722	CROWN-RESIN WITH NOBLE METAL	0 - 999	1 per 5 years	Y	Crown services require radiographic images that depict the pre-condition. The documentation supporting the need for crown services must be available for review by UnitedHealthcare upon request.
D2740	CROWN-PORCELAIN/ CERAMIC SUBSTRATE	0 - 999	1 per 5 years	Y	Crown services require radiographic images that depict the pre-condition. The documentation supporting the need for crown services must be available for review by UnitedHealthcare upon request.
D2750	CROWN-PORCELAIN FUSED TO HIGH NOBLE METAL	0 - 999	1 per 5 years	Y	Crown services require radiographic images that depict the pre-condition. The documentation supporting the need for crown services must be available for review by UnitedHealthcare upon request.
D2751	CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	0 - 999	1 per 5 years	Y	Crown services require radiographic images that depict the pre-condition. The documentation supporting the need for crown services must be available for review by UnitedHealthcare upon request.
D2752	CROWN-PORCELAIN FUSED TO NOBLE METAL	0 - 999	1 per 5 years	Y	Crown services require radiographic images that depict the pre-condition. The documentation supporting the need for crown services must be available for review by UnitedHealthcare upon request.
D2790	CROWN-FULL CAST HIGH NOBLE METAL	0 - 999	1 per 5 years	Y	Crown services require radiographic images that depict the pre-condition. The documentation supporting the need for crown services must be available for review by UnitedHealthcare upon request.
D2791	CROWN-FULL CAST PREDOMINANTLY BASE METAL	0 - 999	1 per 5 years	Y	Crown services require radiographic images that depict the pre-condition. The documentation supporting the need for crown services must be available for review by UnitedHealthcare upon request.

Code	Description	Age limit	Limits	Prior auth required	Required documentation
D2792	CROWN-FULL CAST NOBLE METAL	0 - 999	1 per 5 years	Y	Crown services require radiographic images that depict the pre-condition. The documentation supporting the need for crown services must be available for review by UnitedHealthcare upon request.
D2910	RE-CEMENT OR RE-BOND INLAY, ONLAY, VENEER OR PARTIAL COVERAGE RESTORATION	0 - 999	1 per 6 months	N	
D2915	RE-CEMENT OR RE-BOND INDIRECTLY FABRICATED OR PREFABRICATED POST AND CORE	0 - 999	1 per 6 months	N	
D2920	RE-CEMENT OR RE-BOND CROWN	0 - 999	1 per 6 months	N	
D2929	PRE FABRICATED PORCELAIN/CERAMIC CROWN PRIMARY TOOTH	0 - 999	1 per code per tooth every 2 years	N	
D2930	PREFABRICATED STAINLESS STEEL CROWN - PRIMARY TOOTH	0 - 999	1 per code per tooth every 2 years	N	
D2931	PREFABRICATED STAINLESS STEEL CROWN - PERMANENT TOOTH	0 - 999	1 per code per tooth every 2 years	N	
D2932	PREFABRICATED RESIN CROWN	0 - 999	1 per code per tooth every 2 years	N	
D2933	PREF. STAINLESS STEEL CROWN WITH RESIN WINDOW.	0 - 999	1 per code per tooth every 2 years	N	
D2934	PREFABRICATED ESTHETIC COATED STAINLESS STEEL CROWN - PRIMARY TOOTH	0 - 999	1 per code per tooth every 2 years	N	
D2940	PROTECTIVE RESTORATION	0 - 999	1 per 365 days	N	
D2950	CORE BUILDUP, INCLUDING ANY PINS	0 - 999	1 per code per tooth per 5 years	N	
D2951	PIN RETENTION - PER TOOTH, IN ADDITION TO RESTORATION	0 - 999	1 per code per tooth per year	N	
D2954	PREFABRICATED POST AND CORE IN ADDITION TO CROWN	0 - 999	1 per code per tooth per 5 years	N	
D2980	CROWN REPAIR- BY REPORT	0 - 999	1 per 1 lifetime	N	
D2999	UNSPECIFIED RESTORATIVE PROCEDURE, BY REPORT	0-999	None	N	

Code	Description	Age limit	Limits	Prior auth required	Required documentation
D3220	THERAPEUTIC PULPOTOMY (EXCLUDING FINAL RESTORATION)(PRIMARY TEETH ONLY)	0 - 999	1 per 1 lifetime	N	
D3230	PULPAL THERAPY (RESORBABLE FILLING) - ANTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION)	0 - 999	1 per 1 lifetime	N	
D3240	PULPAL THERAPY (RESORBABLE FILLING) - POSTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION)	0 - 999	1 per 1 lifetime	N	
D3310	ANTERIOR (EXCLUDING FINAL RESTORATION)	0 - 999	1 per 1 lifetime	N	
D3320	ENDODONTIC THERAPY, BICUSPID TOOTH (EXCLUDING FINAL RESTORATION)	0 - 999	1 per 1 lifetime	N	
D3330	ENDODONTIC THERAPY, MOLAR (EXCLUDING FINAL RESTORATION)	0 - 999	1 per 1 lifetime	N	
D3346	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - ANTERIOR	0 - 999	1 per code per tooth for lifetime	N	Minimum 365 days post D3310
D3347	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - BICUSPID	0 - 999	1 per code per tooth for lifetime	N	Minimum 365 days post D3320
D3348	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - MOLAR	0 - 999	1 per code per tooth for lifetime	N	Minimum 365 days post D3330
D3351	APEXIFICATION/ RECALCIFICATION-INITIAL VISIT (APICAL CLOSURE/ CALCIFIC REPAIR OF PERFORATIONS,ROOT RESORPTION, ETC.)	0 - 999	1 per 1 lifetime	N	
D3410	APICOECTOMY/ PERIRADICULAR SURGERY-ANTERIOR	0 - 999	1 per 1 lifetime	N	
D3999	EMERGENCY TREATMENT TO RELIEVE ENDODONTIC PAIN	0 - 999	2 per code per tooth every 12 months	N	No other definitive treatment on same tooth on for same DOS

Code	Description	Age limit	Limits	Prior auth required	Required documentation
D4210	GINGIVECTOMY OR GINGIVOPLASTY, 4 OR MORE CONTIGUOUS TEETH OR TOOTH BONDED SPACES PER QUADRANT	0 - 999	1 per code per quadrant per year	N	
D4211	GINGIVECTOMY OR GINGIVOPLASTY, 1 TO 3 CONTIGUOUS TEETH OR TOOTH BONDED SPACES PER QUADRANT	0 - 999	1 per code per quadrant per year	N	
D4323	SPLINT EXTRA-CORONAL NATURAL TEETH OT PROSTHETIC CROWNS	0 - 999	1 per code per arch for lifetime	N	
D4341	PERIODONTAL SCALING AND ROOT PLANING - FOUR OR MORE TEETH PER QUADRANT	0 - 999	1 per code per quadrant every 12 months; max 2 quads per day unless reported in hospital	Y	A minimum of four (4) affected teeth in the quadrant. Periapical x-rays must show subgingival calculus and/or loss of crestal bone. When requiring local anesthesia only one (1) half of the mouth per day is a benefit unless completed as a hospital case. D4341 will be denied if provided within 21 days of D4355. Denied when submitted for the same date of service as other D4000 series codes. When an exam is performed on the same date of service as this procedure, the exam must be performed after completion. Requires pre-authorization with x-rays, periodontal charting including current probing, rationale, a treatment plan that demonstrates that curettage, scaling, or root planing is required in addition to a routine prophylaxis and indication of quadrant (10,20,30,40)
D4342	PERIODONTAL SCALING AND ROOT PLANING - ONE TO THREE TEETH, PER QUADRANT	0 - 999	1 per 12 months	Y	
D4355	FULL MOUTH DEBRIDEMENT TO ENABLE COMPREHENSIVE EVALUATION AND DIAGNOSIS	0 - 999	1 per 12 months	N	
D4910	PERIODONTAL MAINTENANCE PROCEDURES (FOLLOWING SCALING & ROOT PLANING)	0 - 999	1 per 90 days	Y	Include date of previous periodontal surgical or SRP Perio charting for authorization.

Code	Description	Age limit	Limits	Prior auth required	Required documentation
D5110	COMPLETE DENTURE - MAXILLARY	0 - 999	1 per 5 years	Y	The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. The provider must inform the member that no reline is covered within six (6) months of the delivery date of the denture or partial denture. A complete prosthetic appliance case includes all materials, fittings and placement of the prosthesis, and all necessary adjustments for a period of 180 days following placement of the prosthesis. Prosthetic appliances are covered once every five (5) years when: • The member's dental history does not show that previous prosthetic appliances have been unsatisfactory to the member. • The member does not have a history of lost prosthetic appliances. • A repair, reline or rebase will not make the existing prosthetic functional. Materials used for codes D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5820 and D5821 must be of a quality that with normal wear the prosthetic appliance will last a minimum of five (5) years. Medicaid covers a one-time replacement within the five-year coverage limit for broken/lost/stolen appliances. This one time replacement is available once within each member's lifetime, and a prior authorization request must be submitted and marked as a one-time replacement request.
D5120	COMPLETE DENTURE - MANDIBLE	0 - 999	1 per 5 years	Y	The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. The provider must inform the member that no reline is covered within six (6) months of the delivery date of the denture or partial denture. A complete prosthetic appliance case includes all materials, fittings and placement of the prosthesis, and all necessary adjustments for a period of 180 days following placement of the prosthesis. Prosthetic appliances are covered once every five (5) years when: • The member's dental history does not show that previous prosthetic appliances have been unsatisfactory to the member. • The member does not have a history of lost prosthetic appliances. • A repair, reline or rebase will not make the existing prosthetic functional. Materials used for codes D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5820 and D5821 must be of a quality that with normal wear the prosthetic appliance will last a minimum of five (5) years. Medicaid covers a one-time replacement within the five-year coverage limit for broken/lost/stolen appliances. This one time replacement is available once within each member's lifetime, and a prior authorization request must be submitted and marked as a one-time replacement request.

Code	Description	Age limit	Limits	Prior auth required	Required documentation
D5130	IMMEDIATE DENTURE - MAXILLARY	0 - 999	1 per 5 years	Y	The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. The provider must inform the member that no reline is covered within six (6) months of the delivery date of the denture or partial denture. A complete prosthetic appliance case includes all materials, fittings and placement of the prosthesis, and all necessary adjustments for a period of 180 days following placement of the prosthesis. Prosthetic appliances are covered once every five (5) years when: • The member's dental history does not show that previous prosthetic appliances have been unsatisfactory to the member. • The member does not have a history of lost prosthetic appliances. • A repair, reline or rebase will not make the existing prosthetic functional. Materials used for codes D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5820 and D5821 must be of a quality that with normal wear the prosthetic appliance will last a minimum of five (5) years. Medicaid covers a one-time replacement within the five-year coverage limit for broken/lost/stolen appliances. This one time replacement is available once within each member's lifetime, and a prior authorization request must be submitted and marked as a one-time replacement request.
D5140	IMMEDIATE DENTURE - MANDIBULAR	0 - 999	1 per 5 years	Y	The time period for eligibility for a new prosthesis for the same arch begins on the delivery date of original prosthesis. The provider must inform the member that no reline is covered within six (6) months of the delivery date of the denture or partial denture. A complete prosthetic appliance case includes all materials, fittings and placement of the prosthesis, and all necessary adjustments for a period of 180 days following placement of the prosthesis. Prosthetic appliances are covered once every five (5) years when: • The member's dental history does not show that previous prosthetic appliances have been unsatisfactory to the member. • The member does not have a history of lost prosthetic appliances. • A repair, reline or rebase will not make the existing prosthetic functional. Materials used for codes D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5820 and D5821 must be of a quality that with normal wear the prosthetic appliance will last a minimum of five (5) years. Medicaid covers a one-time replacement within the five-year coverage limit for broken/lost/stolen appliances. This one time replacement is available once within each member's lifetime, and a prior authorization request must be submitted and marked as a one-time replacement request.

Code	Description	Age limit	Limits	Prior auth required	Required documentation
D5211	UPPER PARTIAL DENTURE-RESIN BASE (INC. ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	0 - 999	1 per 5 years	Y	The following codes require pre-authorization, x-rays, and rationale. Medicaid may provide a partial denture (D5211, D5212, D5213, or D5214) in cases where the recipient has matured beyond the mixed dentition stage in the following cases: • Missing three (3) or more maxillary anterior teeth, or • Missing two (2) or more mandibular anterior teeth, or • Missing at least three (3) adjacent posterior permanent teeth in a single quadrant when the prosthesis would restore masticatory function (third molars not considered for replacement), or • Missing at least two (2) adjacent posterior permanent teeth in both quadrants of the same arch when the prosthesis would restore masticatory function in at least one (1) quadrant (third molars not considered for replacement) or, • Missing a combination of two (2) or more anterior and at least one (1) posterior tooth (excluding wisdom teeth and the second molar) in the same arch. Replacement prosthetic appliances are covered when: • The member's dental history does not show that previous prosthetic appliances have been unsatisfactory to the member; and • The member does not have a history of lost prosthetic appliances; and • A repair will not make the existing denture or partial wearable; or • A reline will not make the existing denture or partial wearable; or • A rebase will not make the existing denture or partial wearable Medicaid covers a one-time replacement within the five-year coverage limit for broken/lost/stolen appliances. This one time replacement is available once within each member's lifetime, and a prior authorization request must be submitted and marked as a one-time replacement request..

Code	Description	Age limit	Limits	Prior auth required	Required documentation
D5212	LOWER PARTIAL DENTURE-RESIN BASE(INC. ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	0 - 999	1 per 5 years	Y	The following codes require pre-authorization, x-rays, and rationale. Medicaid may provide a partial denture (D5211, D5212, D5213, or D5214) in cases where the recipient has matured beyond the mixed dentition stage in the following cases: • Missing three (3) or more maxillary anterior teeth, or • Missing two (2) or more mandibular anterior teeth, or • Missing at least three (3) adjacent posterior permanent teeth in a single quadrant when the prosthesis would restore masticatory function (third molars not considered for replacement), or • Missing at least two (2) adjacent posterior permanent teeth in both quadrants of the same arch when the prosthesis would restore masticatory function in at least one (1) quadrant (third molars not considered for replacement) or, • Missing a combination of two (2) or more anterior and at least one (1) posterior tooth (excluding wisdom teeth and the second molar) in the same arch. Replacement prosthetic appliances are covered when: • The member's dental history does not show that previous prosthetic appliances have been unsatisfactory to the member; and • The member does not have a history of lost prosthetic appliances; and • A repair will not make the existing denture or partial wearable; or • A reline will not make the existing denture or partial wearable; or • A rebase will not make the existing denture or partial wearable Medicaid covers a one-time replacement within the five-year coverage limit for broken/lost/stolen appliances. This one time replacement is available once within each member's lifetime, and a prior authorization request must be submitted and marked as a one-time replacement request..

Code	Description	Age limit	Limits	Prior auth required	Required documentation
D5213	MAXILLARY PARTIAL DENTURE-CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	0 - 999	1 per 5 years	Y	The following codes require pre-authorization, x-rays, and rationale. Medicaid may provide a partial denture (D5211, D5212, D5213, or D5214) in cases where the recipient has matured beyond the mixed dentition stage in the following cases: • Missing three (3) or more maxillary anterior teeth, or • Missing two (2) or more mandibular anterior teeth, or • Missing at least three (3) adjacent posterior permanent teeth in a single quadrant when the prosthesis would restore masticatory function (third molars not considered for replacement), or • Missing at least two (2) adjacent posterior permanent teeth in both quadrants of the same arch when the prosthesis would restore masticatory function in at least one (1) quadrant (third molars not considered for replacement) or, • Missing a combination of two (2) or more anterior and at least one (1) posterior tooth (excluding wisdom teeth and the second molar) in the same arch. Replacement prosthetic appliances are covered when: • The member's dental history does not show that previous prosthetic appliances have been unsatisfactory to the member; and • The member does not have a history of lost prosthetic appliances; and • A repair will not make the existing denture or partial wearable; or • A reline will not make the existing denture or partial wearable; or • A rebase will not make the existing denture or partial wearable Medicaid covers a one-time replacement within the five-year coverage limit for broken/lost/stolen appliances. This one time replacement is available once within each member's lifetime, and a prior authorization request must be submitted and marked as a one-time replacement request.

Code	Description	Age limit	Limits	Prior auth required	Required documentation
D5214	MANDIBULAR PARTIAL DENTURE-CASE METAL FRAMEWORK WITH RESIN DENTUR BASES (INCLUDING ANY CONVENTIONAL CLASPS, REST & TEETH)	0 - 999	1 per 5 years	Y	The following codes require pre-authorization, x-rays, and rationale. Medicaid may provide a partial denture (D5211, D5212, D5213, or D5214) in cases where the recipient has matured beyond the mixed dentition stage in the following cases: • Missing three (3) or more maxillary anterior teeth, or • Missing two (2) or more mandibular anterior teeth, or • Missing at least three (3) adjacent posterior permanent teeth in a single quadrant when the prosthesis would restore masticatory function (third molars not considered for replacement), or • Missing at least two (2) adjacent posterior permanent teeth in both quadrants of the same arch when the prosthesis would restore masticatory function in at least one (1) quadrant (third molars not considered for replacement) or, • Missing a combination of two (2) or more anterior and at least one (1) posterior tooth (excluding wisdom teeth and the second molar) in the same arch. Replacement prosthetic appliances are covered when: • The member's dental history does not show that previous prosthetic appliances have been unsatisfactory to the member; and • The member does not have a history of lost prosthetic appliances; and • A repair will not make the existing denture or partial wearable; or • A reline will not make the existing denture or partial wearable; or • A rebase will not make the existing denture or partial wearable Medicaid covers a one-time replacement within the five-year coverage limit for broken/lost/stolen appliances. This one time replacement is available once within each member's lifetime, and a prior authorization request must be submitted and marked as a one-time replacement request..
D5410	ADJUST COMPLETE DENTURE - MAXILLARY	0 - 999	None	N	
D5411	ADJUST COMPLETE DENTURE - MANDIBULAR	0 - 999	None	N	
D5421	ADJUST PARTIAL DENTURE - MAXILLARY	0 - 999	None	N	
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	0 - 999	None	N	
D5511	REPAIR BROKEN COMPLETE DENTURE BASE, MANDIBULAR	0 - 999	2 per 12 months	N	
D5512	REPAIR BROKEN COMPLETE DENTURE BASE, MAXILLARY	0 - 999	2 per 12 months	N	
D5520	REPLACE MISSING OR BROKEN TEETH - COMPLETE DENTURE (EACH TOOTH)	0 - 999	2 per 12 months	N	
D5611	REPAIR RESIN PARTIAL DENTURE BASE, MANDIBULAR	0 - 999	2 per 12 months	N	

Code	Description	Age limit	Limits	Prior auth required	Required documentation
D5612	REPAIR RESIN PARTIAL DENTURE BASE, MAXILLARY	0 - 999	2 per 12 months	N	
D5621	REPAIR CAST PARTIAL FRAMEWORK, MANDIBULAR	0 - 999	2 per 12 months	N	
D5622	REPAIR CAST PARTIAL FRAMEWORK, MAXILLARY	0 - 999	2 per 12 months	N	
D5630	REPAIR OR REPLACE BROKEN CLASP - PARTIAL PER TOOTH	0 - 999	2 per 12 months	N	
D5640	REPLACE BROKEN TEETH - PER TOOTH	0 - 999	2 per 12 months	N	
D5650	ADD TOOTH TO EXISTING PARTIAL DENTURE	0 - 999	2 per 12 months	N	
D5660	ADD CLASP TO EXISTING PARTIAL DENTURE PER TOOTH	0 - 999	2 per 12 months	N	
D5710	REBASE COMPLETE MAXILLARY DENTURE	0 - 999	1 per 365 days	N	
D5711	REBASE COMPLETE MANDIBULAR DENTURE	0 - 999	1 per 365 days	N	
D5720	REBASE MAXILLARY PARTIAL DENTURE	0 - 999	1 per 365 days	N	
D5721	REBASE MANDIBULAR PARTIAL DENTURE	0 - 999	1 per 365 days	N	
D5730	RELINE COMPLETE MAXILLARY DENTURE (CHAIRSIDE)	0 - 999	1 per 12 months	N	
D5731	RELINE COMPLETE MANDIBULAR DENTURE (CHAIRSIDE)	0 - 999	1 per 12 months	N	
D5740	RELINE MAXILLARY PARTIAL DENTURE (CHAIRSIDE)	0 - 999	1 per 12 months	N	
D5741	RELINE MANDIBULAR PARTIAL DENTURE (CHAIRSIDE)	0 - 999	1 per 12 months	N	
D5750	RELINE COMPLETE MAXILLARY DENTURE (LABORATORY)	0 - 999	1 per 12 months	N	
D5751	RELINE COMPLETE MANDIBULAR DENTURE (LABORATORY)	0 - 999	1 per 12 months	N	
D5760	RELINE MAXILLARY PARTIAL DENTURE (LABORATORY)	0 - 999	1 per 12 months	N	

Code	Description	Age limit	Limits	Prior auth required	Required documentation
D5761	RELINE MANDIBULAR PARTIAL DENTURE (LABORATORY)	0 - 999	1 per 12 months	N	
D5765	SOFT LINER FOR COMPLETE OR REMOVABLE DENTURE	0 - 999	1 per 365 days	N	
D5810	INTERIM COMPLETE DENTURE (MAXILLARY)	0 - 999	1 per 5 years	Y	Requires pre-authorization, date and list of teeth to be extracted, narrative of medical necessity, and x-rays. D5810 and D5811, interim complete dentures, can be replaced with a complete denture six (6) months after placement of the interim denture. One (1) to three (3) missing anterior teeth should be replaced with a flipper partial (D5820 and D5821), which is considered a permanent replacement. Flipper partials are not covered for temporary replacement of missing teeth. Relines, rebases and adjustments are not billable for 180 days after placement of the prosthesis. Interim complete and flipper partial dentures require pre-authorization, x-rays, and rationale.
D5811	INTERIM COMPLETE DENTURE (MANDIBULAR)	0 - 999	1 per 5 years	Y	Requires pre-authorization, date and list of teeth to be extracted, narrative of medical necessity, and x-rays. D5810 and D5811, interim complete dentures, can be replaced with a complete denture six (6) months after placement of the interim denture. One (1) to three (3) missing anterior teeth should be replaced with a flipper partial (D5820 and D5821), which is considered a permanent replacement. Flipper partials are not covered for temporary replacement of missing teeth. Relines, rebases and adjustments are not billable for 180 days after placement of the prosthesis. Interim complete and flipper partial dentures require pre-authorization, x-rays, and rationale.
D5820	FLIPPER PARTIAL DENTURE (MAXILLARY)	0 - 999	1 per 5 years	Y	Requires pre-authorization, date and list of teeth to be extracted, narrative of medical necessity, and x-rays. D5810 and D5811, interim complete dentures, can be replaced with a complete denture six (6) months after placement of the interim denture. One (1) to three (3) missing anterior teeth should be replaced with a flipper partial (D5820 and D5821), which is considered a permanent replacement. Flipper partials are not covered for temporary replacement of missing teeth. Relines, rebases and adjustments are not billable for 180 days after placement of the prosthesis. Interim complete and flipper partial dentures require pre-authorization, x-rays, and rationale.
D5821	FLIPPER PARTIAL DENTURE (MANDIBULAR)	0 - 999	1 per 5 years	Y	Requires pre-authorization, date and list of teeth to be extracted, narrative of medical necessity, and x-rays. D5810 and D5811, interim complete dentures, can be replaced with a complete denture six (6) months after placement of the interim denture. One (1) to three (3) missing anterior teeth should be replaced with a flipper partial (D5820 and D5821), which is considered a permanent replacement. Flipper partials are not covered for temporary replacement of missing teeth. Relines, rebases and adjustments are not billable for 180 days after placement of the prosthesis. Interim complete and flipper partial dentures require pre-authorization, x-rays, and rationale.
D5850	TISSUE CONDITIONING, MAXILLARY	0 - 999	2 per 12 months	N	
D5851	TISSUE CONDITIONING, MANDIBULAR	0 - 999	2 per 12 months	N	

Code	Description	Age limit	Limits	Prior auth required	Required documentation
D5899	UNSPECIFIED REMOVABLE PROSTHODONTIC PROCEDURE, BY REPORT	0 - 999	1 per 5 years	Y	Requires pre-authorization, narrative, and operative notes. Documentation must clearly indicate that denture treatment was interrupted and unable to be completed. the stage(s) of treatment completed must be identified. Coverage is allowed under the following circumstances: • Treatment was interrupted after final impressions were taken but before initial jaw relation • Treatment was interrupted after initial jaw relation but before processing.
D6930	RE-CEMENT OR RE-BOND FIXED PARTIAL DENTURE OR FIXED BRIDGE	0 - 999	2 per 12 months	N	
D7111	CORONAL REMNANTS - DECIDUOUS TOOTH	0 - 999	1 per code per tooth per 1 lifetime	N	
D7140	EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND/ OR FORCEPS REMOVAL)	0 - 999	1 per code per tooth per 1 lifetime	N	
D7210	SURGICAL REMOVAL OF ERUPTED TOOTH REQUIRING ELEVATION OF MUCOPERIOSTEAL FLAP AND REMOVAL OF BONE AND/OR SECTION OF TOOTH	0 - 999	1 per code per tooth per 1 lifetime	N	
D7220	REMOVAL OF IMPACTED TOOTH--SOFT TISSUE	0 - 999	1 per code per tooth per 1 lifetime	N	
D7230	REMOVAL OF IMPACTED TOOTH - PARTICALLY BONY	0 - 999	1 per code per tooth per 1 lifetime	N	
D7240	REMOVAL OF IMPACTED TOOTH - COMPLETELY BONY	0 - 999	1 per code per tooth per 1 lifetime	N	
D7241	REMOVAL OF IMPACTED TOOTH-COMPLETELY BONY, WITH UNUSUAL SURGICAL COMPLICATIONS	0 - 999	1 per code per tooth per 1 lifetime	N	
D7250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)	0 - 999	1 per code per tooth per 1 lifetime	N	Involves tissue incision and removal of bone to remove a permanent or primary tooth root left in the bone from a previous extraction, caries, or trauma. Usually some degree of soft or hard tissue healing has occurred. requires x-rays and rationale for all teeth: 1-32, A-T, 51-82, and AS-TS. Includes removal of the roots of a previously erupted tooth missing its clinical crown. If the member's treatment record does not clearly demonstrate the need for the cutting of gingiva and removal of bone and/or sectioning of tooth structure, all records may be reviewed and recoupment of payment for services will be initiated.

Code	Description	Age limit	Limits	Prior auth required	Required documentation
D7270	TOOTH REIMPLANTATION AND/ OR STABILIZATION OF ACCIDENTLY EVULSED OR DISPLACED TOOTH AND/OR ALVEOLUS	0 - 999	1 per code per tooth per 1 lifetime	N	
D7280	SURGICAL ACCESS OF AN UNERUPTED TOOTH	0 - 999	1 per code per tooth per 1 lifetime	N	
D7282	MOBILIZATION OF ERUPTED OR MALPOSITIONED TOOTH TO AID ERUPTION	0 - 999	1 per code per tooth per 1 lifetime	N	
D7283	PLACEMENT OF DEVICE TO FACILITATE ERUPTION OF IMPACTED TOOTH	0 - 20	1 per code per tooth per 1 lifetime	N	
D7285	INCISIONAL BIOPSY OF ORAL TISSUE - HARD (BONE, TOOTH)	0 - 999	1 per day per patient	N	
D7286	INCISIONAL BIOPSY OF ORAL TISSUE - SOFT	0 - 999	1 per day per patient	N	
D7310	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS - FOUR OR MORE TEETH OR TOOTH SPACES PER QUADRANT	0 - 999	1 per code per quadrant per 1 lifetime	N	
D7311	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS - ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT	0 - 999	1 per code per quadrant per 1 lifetime	N	
D7320	ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS - FOUR OR MORE TEETH OR TOOTH SPACES PER QUADRANT	0 - 999	1 per code per quadrant per 1 lifetime	N	
D7321	ALVEOLOPLASTY NOT IN CONJUCTION WITH EXTRACTIONS - ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT	0 - 999	1 per code per quadrant per 1 lifetime	N	
D7410	EXCISION OF BENIGN LESION UP TO 1.25 CM (1-3-03)	0-999	None	N	
D7411	Excision of benign lesion greater than 1.25 cm	0-999	None	N	
D7412	Excision of benign lesion, complicated	0-999	None	N	
D7413	Excision of malignant lesion up to 1.25 cm	0-999	None	N	

Code	Description	Age limit	Limits	Prior auth required	Required documentation
D7414	Excision of malignant lesion greater than 1.25 cm	0-999	None	N	
D7415	Excision of malignant lesion, complicated	0-999	None	N	
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm	0-999	None	N	
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm	0-999	None	N	
D7450	Removal of benign or odontogenic cyst or tumor-lesion diameter up to 1.25 cm (1-3-03)	0-999	None	N	
D7451	Removal of benign odontogenic cyst or tumor-lesion diameter greater than 1.25 cm (1-3-03)	0-999	None	N	
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm (1-3-03)	0-999	None	N	
D7461	Removal of benign nonodontogenic cyst or tumor-lesion diameter greater than 1.25 cm (1-3-03)	0-999	None	N	
D7465	Destruction of lesion(s) by physical or chemical method, by report	0-999	None	N	
D7471	Removal of lateral exostosis (maxilla or mandible)	0-999	None	N	
D7510	INCISION & DRAINAGE OF ABSCESS, INTRAORAL SOFT TISSUE	0 - 999	1 per patient per day	N	
D7880	OCCLUSAL ORTHOTIC DEVICE, BY REPORT	0 - 999	1 per code every 3 years	N	
D7961	BUCCAL LABIAL FRENECTOMY (FRENULECTOMY)	0 - 999	1 per 1 lifetime	N	
D7962	LINGUAL FRENECTOMY (FRENULECTOMY)	0 - 999	1 per 1 lifetime	N	
D8020	LIMITED ORTHODONTIC TREATMENT/TRANS. DENTITION	0 - 20	1 per 1 lifetime	Y	Requires pre-authorization and will be limited to 12 months. Must include panoramic radiographs of the teeth being moved or the space that is being maintained. Complete HDL form and rationale/treatment plan. Requires Color photos

Code	Description	Age limit	Limits	Prior auth required	Required documentation
D8080	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION	0-20	1 per lifetime	Y	Requires pre-authorization, rationale/treatment plan, a completed HDL form, complete set of diagnostic color photos (or OrthoCad equivalent), and panoramic x-ray. Cephalometric radiograph is required. Periapical radiographs are optional. When the individual has had a surgical correction (cleft lip or palate, or orthognathic correction), the monthly adjustment procedure is reimbursed at a higher fee. Following completed surgery, a surgical letter of documentation is required accompanying an additional prior authorization request for the added surgical fee. Most cases will be limited to twenty-four months of adjustments. Procedures covered under code D8090: Constructing and placing fixed maxillary appliance, active treatment $422.68 Constructing and placing fixed mandibular appliance, active treatment $422.68 Each one- month period of active treatment - maxillary arch $41.67 Each one-month period of active treatment - maxillary arch, unusual service (surgical correction case) $60.72 Each one-month period of active treatment - mandibular arch $41.67 Each one month period of active treatment - mandibular arch, unusual service (surgical correction case) $60.72 Retainer or retention appliance $113.12 Each one-month period of retention appliance adjustments, maxillary arch. Not to exceed four (4). $22.61 Each one-month period of retention appliance adjustments, mandibular arch. Not to exceed four (4). $22.61 Rapid palatal expander (RPE) or crossbite correcting (fixed) appliance $214.31 Herbst appliance $321.48 Protraction facemask $192.88 Slow expansion appliance $210.75 Headgear $192.88 Inclined plane (Hawley) appliance, bite plane, with clasps $185.76 Orthodontic appliance not listed Manually Priced Orthodontic procedure not listed Manually Priced Space maintainer - fixed - unilateral, part of comprehensive orthodontic treatment plan $130.96 Space maintainer - fixed - bilateral, part of comprehensive $226.22

Code	Description	Age limit	Limits	Prior auth required	Required documentation
D8090	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADULT DENTITION	0 - 20	1 per 1 lifetime	Y	Requires pre-authorization, rationale/treatment plan, a completed HDL form, complete set of diagnostic color photos (or OrthoCad equivalent), and panoramic x-ray. Cephalometric radiograph is required. Periapical radiographs are optional. When the individual has had a surgical correction (cleft lip or palate, or orthognathic correction), the monthly adjustment procedure is reimbursed at a higher fee. Following completed surgery, a surgical letter of documentation is required accompanying an additional prior authorization request for the added surgical fee. Most cases will be limited to twenty-four months of adjustments. Procedures covered under code D8090: Constructing and placing fixed maxillary appliance, active treatment $422.68 Constructing and placing fixed mandibular appliance, active treatment $422.68 Each one-month period of active treatment - maxillary arch $41.67 Each one-month period of active treatment - maxillary arch, unusual service (surgical correction case) $60.72 Each one-month period of active treatment - mandibular arch $41.67 Each one month period of active treatment - mandibular arch, unusual service (surgical correction case) $60.72 Retainer or retention appliance $113.12 Each one-month period of retention appliance adjustments, maxillary arch. Not to exceed four (4). $22.61 Each one-month period of retention appliance adjustments, mandibular arch. Not to exceed four (4). $22.61 Rapid palatal expander (RPE) or crossbite correcting (fixed) appliance $214.31 Herbst appliance $321.48 Protraction facemask $192.88 Slow expansion appliance $210.75 Headgear $192.88 Inclined plane (Hawley) appliance, bite plane, with clasps $185.76 Orthodontic appliance not listed Manually Priced Orthodontic procedure not listed Manually Priced Space maintainer - fixed - unilateral, part of comprehensive orthodontic treatment plan $130.96 Space maintainer - fixed - bilateral, part of comprehensive $226.22
D8210	REMOVABLE APPLIANCE THERAPY (THUMB-SUCKING & TONGUE THRUST)	0 - 20	1 per 1 lifetime	N	
D8220	FIXED APPLIANCE THERAPY (THUMB-SUCKING AND TONGUE THRUST)	0 - 20	1 per 1 lifetime	N	
D8696	REPAIR OF ORTHODONTIC APPLIANCE MAXILLARY	0 - 20	5 per 1 lifetime	N	
D8697	REPAIR OF ORTHODONTIC APPLIANCE-MANDIBULAR	0 - 20	5 per 1 lifetime	N	
D8698	RE-CEMENT OF RE-BOND FIXED RETAINER-MAXILLARY	0 - 20	5 per 1 lifetime	N	
D8699	RE-CEMENT OR RE-BOND FIXED RETAINER-MANDIBULAR	0 - 20	5 per 1 lifetime	N	

Code	Description	Age limit	Limits	Prior auth required	Required documentation
D8703	REPLACEMENT OF OF LOST OR BROKEN RETAINER-MAXILLARY	0 - 20	1 per 1 lifetime	N	
D8704	REPLACEMENT OF LOST OR BROKEN RETAINER-MANDIBULAR	0 - 20	1 per 1 lifetime	N	
D8999	UNSPECIFIED ORTHODONTIC PROCEDURE, BY REPORT.	0 - 20	None	Y	Used for transfer cases; additional surgical fees when surgery has been completed; additional requests for appliances for noncompliant patients; and other unspecified orthodontic procedures, by report. Requires pre authorization and narrative of medical necessity
D9110	PALLIATIVE (EMERGENCY) TREATMENT OF DENTAL PAIN-MINOR PROCEDURE (1-3-03)	0 - 999	1 per 12 months	N	Not covered if definitive treatment the same day of same tooth.
D9219	EVALUATION FOR MODERATE SEDATION, DEEP SEDATION, OR GENERAL ANESTHESIA	0-999	1 per code per day	N	
D9222	DEEP SEDATION/ GENERAL ANESTHESIA - FIRST 15 MIN	0 - 999	1 per code per 1 day	N	
D9223	DEEP SEDATION/ GENERAL ANESTHESIA -EACH 15 MIN. INCREMENT	0 - 999	7 per code per 1 day	N	
D9230	INHALATION OF NITROUS OXIDE/ ANXIOLYSIS, ANALGESIA	0 - 999	1 per code per 1 day	N	
D9239	INTRAVENOUS MODERATE (CONSIOUS) SEDATION/ANALGESIA-FIRST 15 MIN	0 - 999	1 per code per 1 day	N	
D9243	INTRAVENOUS MODERATE (CONSCIOUS) SEDATION/ ANALGESIA - EACH 15 MIN INCREMENT	0 - 999	3 per code per 1 day	N	
D9248	NON-INTRAVENOUS MODERATE (CONSCIOUS) SEDATION	0 - 999	2 per 12 months	N	
D9410	HOUSE CALL- NURSING FAC. OR PERSON'S HOME (1 PER DAY PER FAC. REGARDLESSNUMBER OF PERSON'S SEEN	0 - 999	1 per day per facility	N	
D9420	HOSPITAL CALL	0 - 999	1 per day per facility	N	
D9440	OFFICE VISIT-AFTER REGULAR HOURS	0 - 999	1 per code per 1 day	N	Requires rationale including time of patient arrival

Code	Description	Age limit	Limits	Prior auth required	Required documentation
D9944	OCCLUSAL GUARD HARD APPLIANCE FULL ARCH REMOVABLE DENTAL APPLIANCE	0 - 999	1 per code every 3 years	N	
D9945	OCCLUSAL GUARD SOFT APPLIANCE FULL ARCH REMOVABLE DENTAL APPLIANCE	0 - 999	1 per code every 3 years	N	
D9946	OCCLUSAL GUARD HARD APPLIANCE PARTIAL ARCH REMOVABLE DENTAL APPLIANCE	0 - 999	1 per code every 3 years	N	
D9997	DENTAL CASE MANAGEMENT - PATIENTS WITH SPECIAL HEALTH CARE NEEDS	0-999		N	A narrative indicating the member's special healthcare need(s)
T1013	SIGN LANGUAGE OR ORAL INTERPRETIVE SERVICES	0-999	8 per code per day (15 mins per code)	N	

B.1.b Benefit grid - special healthcare need(s)

Code	Description	Age limit	Limits	Prior auth required	Required documentation
D0120	PERIODIC ORAL EXAMINATION	0-999	1 per 90 days	N	
D1110	PROPHYLAXIS - ADULT	14-999	1 per 90 days	N	
D1120	PROPHYLAXIS - CHILD	0-13	1 per 90 days	N	
D9997	DENTAL CASE MANAGEMENT				No reimbursement for this code. Used to identify a member with special healthcare need(s). A narrative indicting the member's special healthcare need(s) should be included when this code is submitted on a claim.

Orthodontic forms

Handicapping Labiolingual Deviation (HLD) Index - NE (Mod):
The submitting dentist shall complete and submit the Handicapping Labiolingual Deviation (HLD) Index score sheet when submitting an orthodontic pre-treatment request. The attached score sheet may be photocopied by the dental office for completion and submission.

If the diagnosed condition does not qualify in 1 through 6 listed on the Handicapping Labiolingual Deviation (HLD) Index the dental provider must complete items 7 through 14. The total score on 7 through 14 of the Handicapping Labiolingual Deviation (HLD)Index must be 28 or greater to qualify for Medicaid coverage of orthodontic treatment.

Nebraska Orthodontic Pre-Treatment Request Form(s):
Orthodontic (interceptive and comprehensive) pre-treatment request details must be submitted using the description of the treatment to be completed. The pretreatment request can be submitted on the Nebraska Interceptive Orthodontic Pre-Treatment Request form, the Comprehensive Orthodontic Pre-Treatment Request form, or listed on an American Dental Association (ADA) claim.

Orthodontic Case Tool:
The submitting dentist should complete and submit the orthodontic case tool when submitting an orthodontic pre-treatment request. The tool can be found on **UHCdental.com/medicaid** under State specific alerts and resources.

REV. DECEMBER 13, 2023 NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES MEDICAID SERVICES 471-000-406

NEBRASKA MEDICAID HANDICAPPING LABIO-LINGUAL DEVIATIONS FORM (HLD INDEX)

THIS FORM IS A QUANTITATIVE, OBJECTIVE METHOD FOR MEASURING MALOCCLUSION. THE HLD PROVIDES A SINGLE SCORE, BASED ON A SERIES OF MEASUREMENTS THAT REPRESENT THE DEGREE TO WHICH A CASE DEVIATES FROM NORMAL ALIGNMENT AND OCCLUSION.

PATIENT INFO

CLIENT NAME: _____CLIENT MEDICAID NUMBER_____

CLIENT ADDRESS:_____CLIENT DATE OF BIRTH ___/____/_____

PROVIDER INFO (must be 20 years old or under)

PROVIDER NAME:_____PROVIDER ID NUMBER:_____

CONDITIONS OBSERVED

PROCEDURE: SCORING STEPS 1 THROUGH 6. IF ONE OF THESE CONDITIONS EXIST, INDICATE WITH AN "X" AND SCORE NO FURTHER.

1. DEEP IMPINGING OVERBITE. SCORE "X"_____
2. CROSSBITE OF THREE OR MORE PERMANENT AND/OR DECIDUOUS POSTERIOR TEETH OR ANTERIOR CROSSBITE OF ONE TO TWO TEETH. SCORE "X"_____
3. CONGENITAL BIRTH DEFECT THAT AFFECTS SKELETAL RELATIONSHIP AND/OR DENTITION. SCORE "X"_____
4. IMPACTED CUSPIDS WITH MOST OF THE PERMANENT DENTITION PRESENT. SCORE "X"_____
5. OVERJET GREATER THAN 9 MM OR ANTERIOR CROSSBITE. SCORE "X"_____
6. MALOCCLUSION WITH OPEN BITE FROM CANINE TO CANINE. SCORE "X"_____

IF YOU HAVE MARKED AN "X" IN ANY OF THE ABOVE; **STOP**; AND PROCEED TO PRIOR AUTHORIZATION STEP 16.

PROCEDURE: COMPLETE 7 through 14 IF CASE DOES NOT QUALIFY IN 1 through 6 ABOVE. THE TOTAL SCORE WILL DETERMINE IF THE CASE QUALIFIES FOR ORTHODONTIC TREATMENT. COMPLETE INSTRUCTIONS ARE ON THE SECOND PAGE; "SCORING INSTRUCTIONS FOR HANIDAPPING MALOCCLUSION."

- POSITION THE PATIENT'S TEETH IN CENTRIC OCCLUSION. RECORD MEASUREMENTS N THE ORDER GIVEN AND ROUND TO THE NEAREST MILLIMETER (MM).
- ENTER SCORE "0" IF CONDITION IS ABSENT.
- NOTE: WHEN COMPLETEING 11 AND 12, IF BOTH ANTERIOR CROWDING AND ECTOPIC ERUPTION ARE PRESENT IN THE ANTERIOR PORTION OF THE MOUTH, SCORE ONLY THE MOST SEVER CONDITION. DO NOT SCORE BOTH CONDITIONS.

7. OVERJET IN MM. (1 - 8 MM) _____
8. OVERBITE IN MM. (ANTERIOR CROSSBITE) _____
9. MANDIBULAR IN PROTRUSION, IN MM. X5_____
10. OPEN BITE, IN MM. X4 _____
11. ECTOPIC ERUPTION: COUNT EACH TOOTH EXCLUDING 3RD MOLARS.
    LIST TEETH_____ # OF TEETH X3_____
12. ANTERIOR CROWDING OR SPACING: SCORE ONE POINT FOR MAXILLA, AND/OR ONE POINT FOR MANDIBLE; TWO POINT MAXIMUM. SCORE THE ONE OR TWO X5. # X5 _____
13. LABIOLINGUAL SPREAD IN MM. _____
14. POSTERIOR UNILATERAL CROSSBITE. (MUST INVOLVE TWO OR MORE ADJACENT TEETH, ONE OF WHICH MUST BE A MOLAR) IF PRESENT SCORE 4 _____

A TOTAL SCORE OF 28 OR GREATER CONSTITUTES A HANDICAPPING MALOCCLUSION: TOTAL OF 7 through 14 _____

IF 7 – 14 ABOVE SCORED 28 OR GREATER, PROCEED TO PRIOR AUTHORIZATION STEP 16.

15. IF TOTAL SCORE IS 27 OR UNDER**, STOP**, DO NOT PROCEED TO PRIOR AUTHORIZTION STEP 16. A SCORE OF 27 OR UNDER WILL NOT BE REVIEWED, CONSIDER THIS SCORE SHEET AS PROOF OF DENIAL FOR CONSIDERATION. DO NOT PROCEED TO COMPLETE AND BILL FOR CEPH FILM AND DIAGNOSTIC CASTS, THEY MAY NOT BE PAID WITHOUT AN ORTHODONTIC TREATMENT APPROVAL.
16. IF THE ABOVE CONDITIONS QUALIFY FOR A REVIEW (YOU MUST HAVE AN "X" AND/OR A SCORE OF 28 OR ABOVE) YOU MAY PROCEED TO SUBMIT FOR PRIOR AUTHORIZATION WITH REQUIRED DOCUMENTATION CHECKED OFF BELOW. IN ORDER FOR MEDICAID PATIENTS TO RECEIVE TIMELY TREATMENT, PLEASE CONSIDER YOUR REQUEST FOR APPROVAL AS YOUR ACCEPTANCE OF THE MEDICAID FEE AND A COMMITMENT TO COMPLETE CARE. ADA FORM ____ CEPH FILM ____ X-RAYS _____ PHOTOS _____ NARRATIVE _____

Handicapping Labiolingual Index (HLD) - (NE-Mod)
Scoring Instructions for Severe Malocclusions

The intent of the HLD Index is to measure the presence or absence, and the degree, of the handicap caused by the components of the index, and not to diagnose "malocclusion." All measurements are made with a Boley Gauge (or disposable ruler) scaled in millimeters. Absence of any condition must be recorded by entering "0" on 7 - 14. Measurements are rounded to the nearest millimeter.

1 – 6. Indicate an "X" on the score-sheet. These conditions are automatically considered a handicapping malocclusion and no further scoring is necessary.

7. Overjet in Millimeters: This is recorded with the patient's teeth in centric occlusion and measured from the labial portion of the lower incisors to the labial of the upper incisors. The measurement may apply to a protruding single tooth as well as to the whole arch. Enter the number of millimeters as the HLD score.

8. Overbite in Millimeters: A pencil mark on the tooth indicating the extent of overlap facilitates this measurement. Anterior crossbite may exist in certain conditions and should be measured and recorded. Enter the number of millimeters as the HLD score. (Vertical measurement.)

9. Mandibular Protrusion in Millimeters: Score exactly as measured from the labial of the lower incisor to the labial of the upper incisor. A anterior crossbite, if present, should be shown under "overbite". The measurement in millimeters is entered on the score-sheet and multiplied by five (5). Enter the multiplied total as the HLD score. (Horizontal measurement.)

10. Open Bite in Millimeters: This condition is defined as the absence of occlusal contact in the anterior region. It is measured from edge to edge, in millimeters. In cases of pronounced protrusion associated with open bite, measurement of the open bite should be estimated. The measurement is entered on the score-sheet and multiplied by four (4). Enter the multiplied total as the HLD score.

11. Ectopic Eruption: Count each tooth. Teeth deemed to be ectopic must be more than 50% blocked out and clearly out of the dental arch. Mutually blocked teeth are counted one time and third molars are excluded. If condition #12, anterior crowding is also present with an ectopic eruption in the anterior portion of the mouth, score only the most severe condition. DO NOT SCORE BOTH CONDITIONS. Enter the number of teeth on the score-sheet and multiply by three (3). Enter the multiplied total as the HLD score.

12. Anterior Crowding or spacing: Arch length insufficiency or excess must exceed 3.5 mm. Mild rotations that may react favorably to stripping or mild expansion procedures are not to be scored as crowded. If condition #11, ectopic eruption, is also present in the anterior portion of the mouth, score the most severe condition. DO NOT SCORE BOTH CONDITIONS. Two point maximum multiplied by five (5) for a maximum score of 10. Enter the multiplied total as the HLD score.

13. Labiolingual Spread: A Boley Gauge (or a disposable ruler) is used to determine the extent of deviation from a normal arch line. Otherwise, the total distance between the most protruded tooth and the lingually displaced anterior tooth is measured. The labiolingual spread probably comes close to a measurement of overall deviation from what would have been a normal arch. If multiple anterior crowding of teeth is present only the most severe individual millimeter measurement should be entered on the index. Enter the number of millimeters as the HLD score.

14. Posterior Unilateral Crossbite: This condition involves two or more adjacent teeth, one of which must be a molar. The crossbite must be one in which the maxillary posterior teeth involved may be both palatal or both completely buccal in relation to the mandibular posterior teeth. If posterior unilateral crossbite is present enter four (4) as the HLD score.

Nebraska Medicaid Interceptive Orthodontic Pre-Treatment Request Form

Patient Name:	Patient's Medicaid #:
Birthdate:	Date of Request:
Provider Name:	Provider Medicaid #:
Provider Address: (Street, City, State, Zip)	Phone Number:

Treatment Request:	Maxillary Arch	Mandibular Arch	Fee	Administrative Use Only
Inclined plane (Hawley) appliance, bite plane, with clasps				
Cross-bite appliance, anterior, acrylic				
Cross-bite appliance, posterior, two bands plus attachments				
Adjustments of appliance (# each arch)				
Space maintainer – fixed – unilateral				
Space maintainer – fixed – bilateral				
Description appliance not listed:				
	Number Requested			
Chrome steel wire clasps – each .036 or minimum .030				
Attachment springs for appliance, each				

Diagnostic Narrative:

Nebraska Medicaid Interceptive Orthodontic Pre-Treatment Request Form

Patient Name: Enter the full name (first, middle initial, and last name) of the client.

Patient's Medicaid #: Enter the client's eleven-digit Medicaid identification number.

Birthdate: Enter the client's month, day and year of birth.

Date of Request: Enter the submission date for the request.

Provider Name: Enter the dentist name.

Provider Medicaid #: Enter the eleven-digit Medicaid provider number.

Provider Address: Enter the dentist office address (Street, City, State, and Zip).

Provider Phone Number: Enter the dentist office phone number.

Treatment Request:

- Appliances: Under the Maxillary Arch and Mandibular Arch column check the type of appliances being requested.
- Adjustments of pedodontic and interceptive appliances: Enter the number of adjustments for the Maxillary arch and Mandibular Arch in the appropriate column.
- Chrome steel wire clasps - enter the number of clasps requested.
- Attachment springs for appliance - enter the number of springs requested.
- Enter the dentist usual and customary fee for each treatment being requested.

Diagnostic Narrative: Provide information regarding the diagnosis and treatment requested.

Nebraska Medicaid Comprehensive Orthodontic Pre-Treatment Request Form

Patients Name: Patient's Medicaid #:

Birthdate: Date of Request: Surgical Correction: Yes No Surgical Diagnosis:

Provider Name: Provider Medicaid #:

Provider Address: (Street, City, State, Zip) Phone Number:

Treatment Request	**Maxillary Arch**	**Mandibular Arch**	**Fee**	**Administrative Use Only**
Construct & place fixed appliance, active trt.				
Number of monthly adjustments per arch				
Retainer or retention appliance				
Number of monthly retention visits, per arch				
Other Appliances:				
Rapid palatal expander (RPE)				
Crossbite correcting (fixed appliance)				
Herbst appliance				
Protraction facemask				
Slow expansion appliance				
Headgear				
Space maintainer – fixed - unilateral				
Space Maintainer – fixed – bilateral				
Description orthodontic appliance not listed:				

Diagnostic Narrative:

Nebraska Medicaid Comprehensive Orthodontic Pre-Treatment Request Form

Client Name: Enter the full name (first, middle initial, and last name) of the client.

Client's Medicaid: Enter the client's eleven-digit Medicaid identification number.

Birthdate: Enter the client's month, day and year of birth.

Date of Request: Enter the date the submission date for the request.

Provider Name: Enter the dentist name.

Provider Medicaid #: Enter the eleven-digit Medicaid provider number.

Provider Address: Enter the dentist office address (Street, City, State, and Zip).

Provider Phone Number: Enter the dentist office phone number.

Treatment Request:

- In the Maxillary Arch and Mandibular Arch column check the column for the treatment or type of appliance being requested for each arch.
- Number of months of arch adjustments – Enter the number of months of monthly adjustments being requested for each arch.
- Number of months of retention appliance treatment – Enter the number of months of retention visits.
- Fee Column: Enter the dentist usual and customary fee for the treatment requested.

Diagnostic Narrative: Provide information regarding the diagnosis and treatment requested.

Nebraska Ortho Case Tool Choose either one bundled treatment plan OR use the itemized plan calculator to request specific services. Indicate plan In Notes of authorization.

Member Name Tess Tester **Member ID** 12345678 **Plan** C4 *Use T99 for itemized treatment plan*

D8020 Limited Ortho Bundled Plans

Includes 12 monthly adjustments, retainer and 2 post-retainer visits

REGULAR		SURGICAL		Arches Treated	Rapid P E or x-bite	Herbst Appliance	Incline / Hawley
plan	fee	plan	fee				
L1	678.13	*SL1*	913.57	one			
L2	869.46	*SL2*	1104.90	one			x
L3	1009.25	*SL3*	1244.69	one		x	
L4	1200.58	*SL4*	1436.02	one		x	x
L5	898.87	*SL5*	1134.31	one	x		
L6	1090.20	*SL6*	1325.64	one	x		x
L7	1229.99	*SL7*	1465.43	one	x	x	
L8	1421.32	*SL8*	1656.76	one	x	x	x
L9	1239.75	*SL9*	1710.63	both			
L10	1431.08	*SL10*	1901.96	both			x
L11	1570.87	*SL11*	2041.75	both		x	
L12	1762.20	*SL12*	2233.08	both		x	x
L13	1460.49	*SL13*	1931.37	both	x		
L14	1651.82	*SL14*	2122.70	both	x		x
L15	1791.61	*SL15*	2262.49	both	x	x	
L16	1982.94	*SL16*	2453.82	both	x	x	x

D8090 Comprehensive Ortho Bundled Plans

Includes both-arch banding, 24 monthly adj, retainer and 4 post-retainer visits

REGULAR		SURGICAL		Rpd Pal Exp or crossbite	Unilaterl Space Mnt	Bilateral Space Mnt
plan	fee	plan	fee			
C1	3233.71	*SC1*	4175.47			
C2	3368.60	*SC2*	4310.36		x	
C3	3466.72	*SC3*	4408.48			x
C4	3454.45	*SC4*	4396.21	x		
C5	3589.34	*SC5*	4531.10	x	x	
C6	3687.46	*SC6*	4629.22	x		x

Itemized Treatment Plans for D8020 or D8090

Use only if treatment plan does not match any pre- bundled plan

Rate	Qty	Fee Total	Service
435.36		0.00	Appliance - Maxillary
435.36		0.00	Appliance - Mandibular
42.92		0.00	Monthly Adj - Regular - Maxillary
42.92		0.00	Monthly Adj - Regular - Mandibular
62.54		0.00	Monthly Adj - Surgical - Maxillary
62.54		0.00	Monthly Adj - Surgical - Mandibular
116.51		0.00	Retainer
23.29		0.00	Retention Appliance Adj - Maxillary
23.29		0.00	Retention Appliance Adj - Mandibular
220.74		0.00	Rapid Palatal Expander or Cross Bite
217.07		0.00	Slow Expansion Appliance
331.12		0.00	Herbst Appliance
198.67		0.00	Headgear
198.67		0.00	Protration Face Mask
134.89		0.00	Space Maintainer - Unilateral
233.01		0.00	Space Maintainer- Bilateral
191.33		0.00	Inclined Plane / Hawley Device
0.00		0.00	Other

plan	fee
T99	0.00

total for all itemized services selected

Dental Benefit Providers®