UnitedHealthcare Community Plan of Ohio Medicaid Dental Quick Reference Guide

Effective: Dec. 1, 2026

UHCdental.com/medicaid

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

Provider services

Phone: **1-855-642-5483**
8 a.m. – 6 p.m. ET Monday–Friday (IVR: 24/7)

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

Prior authorization

UnitedHealthcare Dental Authorizations
P.O. Box 2126
Milwaukee, WI 53201

Appeals for service denials

UnitedHealthcare Community Plan
Attn: Appeals Department
P.O. Box 31364
Salt Lake City, UT 84131-0364

Toll-free: **1-800-895-2017 (TTY 711)**

Claims

UnitedHealthcare OH Dental Claims
P.O. Box 2139
Milwaukee, WI 53201

EDI Payer ID

OHMD3

Claim disputes or adjustments

UnitedHealthcare OH Dental Claim Appeals
P.O. Box 1455
Milwaukee, WI 53201

Corrected claims

UnitedHealthcare OH Dental Corrected Claims
P.O. Box 481
Milwaukee, WI 53201

Claims may be submitted electronically through your clearinghouse, online via the Dental Hub, or by mail using the addresses listed 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



Benefit coverage, limitations, and requirements

The following Benefit Grid 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 limits	Frequency limits	Auth required	Required documentation
D0120	Periodic Oral Exam	0-999	1 per 180 day(s) per member	N	
D0140	Limited Oral Evaluation - Problem Focused	0-999		N	
D0150	Comprehensive Oral Evaluation - New Or Established Patient	0-999	1 per 5 year(s) per member/ per provider or location	N	
D0180	Comprehensive periodontal evaluation	0-999	1 per 365 day(s) per member	N	
D0210	Intraoral - Comprehensive Series of Radiographic Images	0-999	1 per 5 year(s) per member	N	
D0220	Intraoral - Periapical First Radiographic Image	0-999		N	
D0230	Intraoral - Periapical Each Additional Image	0-999		N	
D0240	Intraoral - Occlusal Radiographic Image	0-999		N	
D0250	Extraoral - 2D Projection Radiographic image	0-999		N	
D0270	Bitewing - Single Radiographic Image	0-999	1 per 6 month(s) per member	N	
D0272	Bitewings - Two Radiographic Images	0-999	1 per 6 month(s) per member	N	
D0273	Bitewings - Three Radiographic Images	0-999	1 per 6 month(s) per member	N	
D0274	Bitewings - Four Radiographic Images	0-999	1 per 6 month(s) per member	N	
D0321	Other Temporomandibular Joint Radiographic Images, By Report	0-999		N	
D0330	Panoramic Radiographic Image	0-5	1 per 60 month(s) per member	Y	Narrative of Medical Necessity
D0330	Panoramic Radiographic Image	6-999	1 per 60 month(s) per member	N	
D0340	2D Cephalometric Radiographic Image	0-999		N	
D0350	Oral/Facial Photographic Images	0-999		N	
D0367	Cone Beam - Both Jaws	0-999	1 per 5 year(s) per member	Y	Narrative of Medical Necessity

Code	Description	Age limits	Frequency limits	Auth required	Required documentation
D0372	intraoral tomosynthesis - comprehensive series of radiographic images	0-999		Y	Narrative of Medical Necessity, Supporting Medical Records
D0373	intraoral tomosynthesis - bitewing radiographic image	0-999		Y	Narrative of Medical Necessity, Supporting Medical Records
D0374	intraoral tomosynthesis - periapical radiographic image	0-999		Y	Narrative of Medical Necessity, Supporting Medical Records
D0387	intraoral tomosynthesis - comprehensive series of radiographic images - image ca	0-999		Y	Narrative of Medical Necessity, Supporting Medical Records
D0388	intraoral tomosynthesis - bitewing radiographic image - image capture only	0-999		Y	Narrative of Medical Necessity, Supporting Medical Records
D0389	intraoral tomosynthesis - periapical radiographic image - image capture only	0-999		Y	Narrative of Medical Necessity, Supporting Medical Records
D0396	3D Printing of a 3D Dental Surface Scan	0-999			
D0470	Diagnostic Casts	0-999		N	
D0604	antigen testing for a public health related pathogen, including coronavirus	0-999		N	
D0605	antibody testing for a public health related pathogen, including coronavirus	0-999		N	
D0606	Molecular testing for a public health related pathogen, including coronavirus	0-999		N	
D0801	3D dental surface scan - direct	0-999		Y	Narrative of Medical Necessity, Supporting Medical Records
D0802	3D dental surface scan - indirect A surface scan of a diagnostic cast	0-999		Y	Narrative of Medical Necessity, Supporting Medical Records
D0803	3D facial surface scan - direct	0-999		Y	Narrative of Medical Necessity, Supporting Medical Records
D0804	3D facial surface scan - indirect A surface scan of constructed facial feature	0-999		Y	Narrative of Medical Necessity, Supporting Medical Records
D1110	Prophylaxis - Adult	14-999	1 per 180 day(s) per member	N	
D1120	Prophylaxis - Child	0-13	1 per 180 day(s) per member	N	
D1206	Topical Application Of Fluoride Varnish	0-20	1 per 180 day(s) per member	N	
D1208	Topical Application of Fluoride	0-20	1 per 180 day(s) per member	N	
D1301	Immunication Counseling	0-999			
D1320	Tobacco Counseling For The Control And Prevention Of Oral Disease	0-999	2 per 365 day(s) per member	N	
D1321	counseling for the control and prevention of adverse oral, behavioral, and system	0-999	2 per 365 day(s) per member	N	
D1351	Sealant - Per Tooth	0-20	1 per year per tooth of permanent first and second molars	N	
D1354	Interim Caries Arresting Medicament Application - per tooth	0-999	3 per 1 year per patient per tooth	N	
D1510	Space Maintainer - Fixed - Unilateral - per quadrant	0-20		N	
D1516	Space Maintainer - Fixed - Bilateral, maxillary	0-20		N	
D1517	Space Maintainer - Fixed - Bilateral, mandibular	0-20		N	
D1520	Space Maintainer - Removable - Unilateral - per quadrant	0-20		N	

Code	Description	Age limits	Frequency limits	Auth required	Required documentation
D1526	Space Maintainer - Removable - Bilateral, maxillary	0-20		N	
D1527	Space Maintainer - Removable - Bilateral, mandibular	0-20		N	
D2140	Amalgam - One Surface, Primary Or Permanent	0-999	1 per 365 days per tooth	N	
D2150	Amalgam - Two Surfaces, Primary Or Permanent	0-999	1 per 365 days per tooth	N	
D2160	Amalgam - Three Surfaces, Primary Or Permanent	0-999	1 per 365 days per tooth	N	
D2161	Amalgam - Four Or More Surfaces, Primary Or Permanent	0-999	1 per 365 days per tooth	N	
D2330	Resin-Based Composite - One Surface, Anterior	0-999	1 per 365 days per tooth	N	
D2331	Resin-Based Composite - Two Surfaces, Anterior	0-999	1 per 365 days per tooth	N	
D2332	Resin-Based Composite - Three Surfaces, Anterior	0-999	1 per 365 days per tooth	N	
D2335	Resin-Based Composite - Four or More Surfaces, Anterior	0-999	1 per 365 days per tooth	N	
D2390	Resin-Based Composite Crown, Anterior	0-999	1 per 365 days per tooth	N	
D2391	Resin-Based Composite - One Surface, Posterior	0-999	1 per 365 days per tooth	N	
D2392	Resin-Based Composite - Two Surfaces, Posterior	0-999	1 per 365 days per tooth	N	
D2393	Resin-Based Composite - Three Surfaces, Posterior	0-999	1 per 365 days per tooth	N	
D2394	Resin-Based Composite - Four Or More Surfaces, Posterior	0-999	1 per 365 days per tooth	N	
D2740	Crown - Porcelain/Ceramic	0-999	1 per 5 years per tooth	Y	Current periapical x-ray(s); Narrative of medical necessity if decay not evident on films
D2751	Crown - Porcelain Fused To Predominantly Base Metal	0-999	1 per 5 years per tooth	Y	Current periapical x-ray(s); Narrative of medical necessity if decay not evident on films
D2752	Crown - Porcelain Fused To Noble Metal	0-999	1 per 5 years per tooth	Y	Current periapical x-ray(s); Narrative of medical necessity if decay not evident on films
D2790	Crown – full cast high noble metal	0-999	1 per 5 years per tooth	Y	Current periapical x-ray(s); Narrative of medical necessity if decay not evident on films
D2791	Crown – full cast predominantly base metal	0-999	1 per 5 years per tooth	Y	Current periapical x-ray(s); Narrative of medical necessity if decay not evident on films
D2792	Crown – full cast noble metal	0-999	1 per 5 years per tooth	Y	Current periapical x-ray(s); Narrative of medical necessity if decay not evident on films
D2920	Re-Cement or Re-Bond Crown	0-999	1 per 12 months per tooth	N	
D2928	Prefabricated Porcelain / Ceramic Crown - Permanent Tooth	0-999	1 every 36 months per anterior	N	
D2929	Prefabricated Porcelain / Ceramic Crown - Primary Tooth	0-999	1 every 36 months per anterior	N	
D2930	Prefabricated Stainless Steel Crown - Primary Tooth	0-999	1 every 36 months	N	
D2931	Prefabricated stainless steel crown – Permanent tooth	0-999	1 every 36 months	N	
D2933	Prefabricated Stainless Steel Crown With Resin Window	0-999	1 every 36 months per anterior	N	
D2934	Prefabricated Esthetic Coated Stainless Steel Crown - Primary Tooth	0-999	1 every 36 months per tooth	N	

Code	Description	Age limits	Frequency limits	Auth required	Required documentation
D2940	Protective Restoration	0-999	1 per 180 days per tooth; Max 5 per lifetime	N	
D2950	Core Buildup, Including Any Pins When Required	0-999	1 per 60 months per tooth	N	
D2951	Pin Retention - Per Tooth, In Addition To Restoration	0-999	Pin retention is reimbursed per tooth, up to a maximum of 3 pins per tooth	N	
D2952	Post And Core In Addition To Crown, Indirectly Fabricated	0-999	1 per 60 months per tooth, permanent anterior teeth	Y	Current pre-op x-rays; For any tooth with endodontic procedure planned or performed, a periapical x-ray of the final endodontic procedure is required
D2954	Prefabricated Post And Core In Addition To Crown	0-999	1 per 60 months per tooth, permanent anterior teeth	Y	Current pre-op x-rays; For any tooth with endodontic procedure planned or performed, a periapical x-ray of the final endodontic procedure is required
D2956	Removal of an Indirect Restoration on a Natural Tooth	0-999		Y	Current pre-op x-rays
D2976	Band Stabilization - per tooth	0-999	1 per lifetime		
D2989	Evacation of a Tooth Resulting in the Determination of Non-restorability	0-999			
D2991	Application of Hydroxyapatite Regeneration Medicament - per tooth	0-999	2 times per tooth per year		
D3220	Therapeutic Pulpotomy	0-999	1 per code per tooth every lifetime	N	
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)	0-999	1 per code per tooth every lifetime	N	
D3320	Endodontic Therapy Premolar Tooth (Excluding Final Restoration)	0-999	1 per code per tooth every lifetime	N	
D3330	Endodontic Therapy, Molar tooth (Excluding Final Restoration)	0-999	1 per code per tooth every lifetime	N	
D3351	Apexification / Recalcification - Initial Visit	0-999		N	
D3352	Apexification / Recalcification - Interim	0-999		N	
D3353	Apexification / Recalcification - Final Visit	0-999		N	
D3410	Apicoectomy - Anterior	0-999	1 per tooth per lifetime, permanent teeth	N	
D4210	Gingivectomy Or Gingivoplasty - Four Or More Contiguous Teeth	0-999	1 per code per quadrant every 12 months	Y	Current pre-op x-rays; Complete current 6 point periodontal charting; Narrative of medical necessity
D4211	Gingivectomy Or Gingivoplasty - One To Three Contiguous Teeth	0-999	1 per every 12 months per patiend per quad	Y	Current pre-op x-rays; Complete current 6 point periodontal charting; Narrative of medical necessity
D4286	removal of non-resorbable barrier	0-999		Y	Narrative of medical necessity
D4341	Periodontal Scaling And Root Planing - Four Or More Teeth Per Quadrant	0-999	1 per 24 month(s) per member	Y	Panoramic x-ray or full series Complete, current 6 point periodontal; charting
D4342	Periodontal Scaling And Root Planing - One To Three Teeth Per Quadrant	0-999	1 per 24 month(s) per member	Y	Panoramic x-ray or full series Complete, current 6 point periodontal; charting

Code	Description	Age limits	Frequency limits	Auth required	Required documentation
D4910	Periodontal Maintenance	0-999	1 per 12 month(s) per member	N	Perio history - Date of previous periodontal surgical or scaling and root planing with claim
D5110	Complete Denture - Maxillary	0-999	1 per 8 year(s) per member	Y	Panoramic x-ray or full mouth series
D5120	Complete Denture - Mandibular	0-999	1 per 8 year(s) per member	Y	Panoramic x-ray or full mouth series
D5130	Immediate Denture - Maxillary	0-999	1 per 8 year(s) per member	Y	Panoramic x-ray or full mouth series
D5140	Immediate Denture - Mandibular	0-999	1 per 8 year(s) per member	Y	Panoramic x-ray or full mouth series
D5211	Maxillary Partial Denture - Resin Base	0-999	1 per 8 year(s) per member	Y	Panoramic x-ray or full mouth series
D5212	Mandibular Partial Denture - Resin Base	0-999	1 per 8 year(s) per member	Y	Panoramic x-ray or full mouth series
D5213	Maxillary Partial Denture - Cast Metal Framework with Resin Denture Bases	0-999	1 per 8 year(s) per member	Y	Panoramic x-ray or full mouth series
D5214	Mandibular Partial Denture - Cast Metal Framework with Resin Denture Bases	0-999	1 per 8 year(s) per member	Y	Panoramic x-ray or full mouth series
D5225	Maxillary Partial Denture - Flexible Base (Including Retentive/ Clasping Materials, Rests, and Teeth)	0-999	1 per 8 year(s) per member	Y	Panoramic x-ray or full mouth series
D5226	Mandibular Partial Denture - Flexible Base (Including Retentive/ Clasping Materials, Rests, and Teeth)	0-999	1 per 8 year(s) per member	y	Panoramic x-ray or full mouth series
D5511	Repair Broken Complete Denture Base - Mandibular	0-999	1 per 12 months per member	N	
D5512	Repair Broken Complete Denture Base - Maxillary	0-999	1 per 12 months per member	N	
D5520	Replace Missing Or Broken Teeth - Complete Denture (Each Tooth)	0-999	1 per tooth every 12 months	N	
D5611	Repair Resin Partial Denture Base - Mandibular	0-999	1 per 12 months per member	N	
D5612	Repair Resin Partial Denture Base - Maxillary	0-999	1 per 12 months per member	N	
D5621	Repair Cast Partial Framework - Mandibular	0-999	1 per 12 months per member	N	
D5622	Repair Cast Partial Framework - Maxillary	0-999	1 per 12 months per member	N	
D5630	Repair Or Replace Broken Retentive / Clasping Materials - Per Tooth	0-999	1 per tooth every 12 months	N	
D5640	Replace Broken Teeth - Per Tooth	0-999	1 per tooth every 12 months	N	
D5650	Add Tooth To Existing Partial Denture	0-999	1 per tooth every 12 months	N	
D5660	Add Clasp To Existing Partial Denture - Per Tooth	0-999	1 per tooth every 12 months	N	
D5750	Reline Complete Maxillary Denture (Indirect)	0-999	1 per 3 year(s) per member	N	
D5751	Reline Complete Mandibular Denture (Indirect)	0-999	1 per 3 year(s) per member	N	
D5760	Reline Maxillary Partial Denture (Indirect)	0-999	1 per 3 year(s) per member	N	
D5761	Reline Mandibular Partial Denture (Indirect)	0-999	1 per 3 year(s) per member	N	

Code	Description	Age limits	Frequency limits	Auth required	Required documentation
D5899	Unspecified Removable Prosthodontic Procedure, By Report	0-999		Y	Panoramic x-ray or full mouth series; Narrative of medical
D5913	Nasal Prosthesis	0-999		Y	Current radiographs or images demonstrating the condition; Narrative of medical necessity; Surgical history; Associated Diagnosis
D5915	Orbital Prosthesis	0-999		Y	Current radiographs or images demonstrating the condition; Narrative of medical necessity; Surgical history; Associated Diagnosis
D5916	Ocular Prosthesis	0-999		Y	Current radiographs or images demonstrating the condition; Narrative of medical necessity; Surgical history; Associated Diagnosis
D5931	Obturator Prosthesis, Surgical	0-999		Y	Current radiographs or images demonstrating the condition; Narrative of medical necessity; Surgical history; Associated Diagnosis
D5932	Obturator Prosthesis, Definitive	0-999		Y	Current radiographs or images demonstrating the condition; Narrative of medical necessity; Surgical history; Associated Diagnosis
D5934	Mandibular Resection Prosthesis With Guide Flange	0-999		Y	Current radiographs or images demonstrating the condition; Narrative of medical necessity; Surgical history; Associated Diagnosis
D5935	Mandibular Resection Prosthesis Without Guide Flange 0-999	0-999		Y	Current radiographs or images demonstrating the condition; Narrative of medical necessity; Surgical history; Associated Diagnosis
D5955	Palatal Lift Prosthesis, Definitive	0-999		Y	Current radiographs or images demonstrating the condition; Narrative of medical necessity; Surgical history; Associated Diagnosis
D5999	Unspecified Maxillofacial Prosthesis, By Report	0-999		Y	Pre-op x-rays; Narrative of medical necessity
D6089	Accessing and Retorquing Loose Implant Screw - per screw	0-999			
D6096	Remove Broken Implant Retaining Screw	0-999		Y	Narrative of medical necessity
D6105	Removal of implant body not requiring bone removal or flap elevation	0-999		Y	Narrative of medical necessity
D6106	Guided tissue regeneration - resorbable barrier, per implant	0-999		Y	Narrative of medical necessity
D6107	guided tissue regeneration - non-resorbable barrier, per implant	0-999		Y	Narrative of medical necessity
D6180	Implant Maintenance Procedure	0-999	1 per every year	Y	Panoramic x-ray , Narrative of medical necessity
D6193	Replacement of an Implant Screw	0-999		Y	Current radiographs or images demonstrating the condition; Narrative of medical necessity
D6197	Replacement of restorative material use to close an access opening of a screw-retained implant supported prosthesis	0-999		Y	Narrative of medical necessity
D7140	Extraction, Erupted Tooth Or Exposed Root	0-999	1 per tooth per life per member	N	
D7210	Extraction, Erupted Tooth	0-999	1 per 1 lifetime per member	N	
D7220	Removal Of Impacted Tooth - Soft Tissue	0-999	1 per 1 lifetime per member	N	Tooth #1, #16, #17, and #32 do not require prior authorization for this code.
D7220	Removal Of Impacted Tooth - Soft Tissue	0-999	1 per 1 lifetime per member	Y	Teeth 2-15, 18-31; Current pre-op panoramic x-ray; Narrative of medical necessity
D7230	Removal Of Impacted Tooth - Partially Bony	0-999	1 per 1 lifetime per member	N	
D7240	Removal Of Impacted Tooth - Completely Bony	0-999	1 per 1 lifetime per member	Y	Current pre-op panoramic x-ray; Narrative of medical necessity

Code	Description	Age limits	Frequency limits	Auth required	Required documentation
D7241	Removal Of Impacted Tooth - Completely Bony, Unusual Surgical Complications	0-999	1 per 1 lifetime per member	Y	Current pre-op panoramic x-ray; Narrative of medical necessity
D7250	Removal Of Residual Tooth (Cutting Procedure)	0-999	1 per 1 lifetime per member	Y	Current Pre-op x-ray; Narrative of medical necessity
D7259	Nerve Dissection	0-999		Y	Narrative of medical necessity
D7260	Oroantral Fistula Closure	0-999	1 per 1 lifetime per member	N	
D7270	Reimplantation And/Or Stabilization Of Accidentally Evulsed / Displaced Tooth	0-999		N	
D7280	Exposure of an Unerupted Tooth	0-999	1 per 1 lifetime per member	Y	Current pre-op panoramic x-ray or PA of entire tooth; Narrative of medical necessity
D7283	Placement Of Device To Facilitate Eruption Of Impacted Tooth	0-999	1 per 1 lifetime per member	Y	Current Pre-op x-ray; Narrative of medical necessity
D7284	Excisional Biopsy of Minor Salivary Glands	0-999		Y	Narrative of medical necessity
D7285	Incisional Biopsy Of Oral Tissue - Hard (Bone, Tooth)	0-999		N	
D7286	Incisional Biopsy Of Oral Tissue - Soft	0-999		Y	Narrative of Medical Necessity
D7296	Corticotomy - One To Three Teeth Or Tooth Spaces, Per Quadrant	0-999		Y	Narrative of Medical Necessity
D7297	Corticotomy - Four Or More Teeth Or Tooth Spaces, Per Quadrant	0-999		Y	Narrative of Medical Necessity
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	0-999	1 per 1 lifetime per member	N	
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	0-999	1 per 1 lifetime per member	N	
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	0-999	1 per 1 lifetime per member	N	
D7450	Removal Of Benign Odontogenic Cyst Or Tumor - Lesion Diameter Up To 1.25 Cm	0-999		N	
D7451	Removal Of Benign Odontogenic Cyst Or Tumor - Lesion Diameter Greater Than 1.25 Cm	0-999		N	
D7460	Removal Of Benign Nonodontogenic Cyst Or Tumor - Lesion Diameter Up To 1.25 Cm	0-999		N	
D7461	Removal Of Benign Nonodontogenic Cyst Or Tumor - Lesion Diameter Greater Than 1.25 Cm	0-999		N	
D7471	Removal Of Lateral Exostosis (Maxilla Or Mandible)	0-999	1 per lifetime per arch	N	
D7472	Removal Of Torus Palatinus	0-999	1 per lifetime	N	
D7473	Removal Of Torus Mandibularis	0-999	1 per lifetime	N	
D7509	Marsupialization of Odontogenic Cyst	0-999		Y	Narrative of Medical Necessity
D7510	Incision And Drainage Of Abscess - Intraoral Soft Tissue	0-999		N	
D7520	Incision And Drainage Of Abscess - Extraoral Soft Tissue	0-999		N	
D7670	Alveolus - Closed Reduction, May Include Stabilization Of Teeth	0-999		N	
D7671	Alveolus - Open Reduction, May Include Stabilization Of Teeth	0-999		Y	Current panoramic x-ray; Narrative of medical necessity
D7899	Unspecified TMD Therapy, By Report	0-999		Y	Narrative of medical necessity; TMJ radiographs
D7956	Guided Tissue Regeneration, Edentulous Area - Resorbable Barrier, Per Site	0-999		Y	Narrative of Medical Necessity
D7957	Guided Tissue Regeneration, Edentulous Area - Non-resorbable Barrier, Per Site	0-999		Y	Narrative of Medical Necessity

Code	Description	Age limits	Frequency limits	Auth required	Required documentation
D7961	Buccal / Labial Frenectomy (Frenulectomy)	0-18 months	1 per lifetime	Y	Narrative of medical necessity accompanied by corroborating physician note
D7961	Buccal / Labial Frenectomy (Frenulectomy)	19 months -999	1 per lifetime	N	
D7962	Lingual Frenectomy (Frenulectomy)	0-18 months	1 per lifetime	Y	Narrative of medical necessity accompanied by corroborating physician note
D7962	Lingual Frenectomy (Frenulectomy)	19 months -999	1 per lifetime	N	
D7970	Excision Of Hyperplastic Tissue - Per Arch	0-999	1 per lifetime per arch	N	
D7979	Non-Surgical Sialolithotomy	0-999		Y	Narrative of Medical Necessity
D8080	Comprehensive Orthodontic Treatment Of The Adolescent Dentition	0-20	1 per 1 lifetime per member	Y	ODM 03630 form; Extra/Intraoral photos; Ceph; Diag model images; Treatment plan
D8210	Removable Appliance Therapy	0-999		N	
D8220	Fixed Appliance Therapy	0-999		Y	Narrative of medical necessity
D8670	Periodic Orthodontic Treatment Visit	0-999	7 per 1 lifetime per member	Y	Approved D8080 case
D8680	Orthodontic Retention (removal of appliances, construction and placement of retainer(s)	0-999	2 per 1 lifetime per member	Y	Diagnostic quality photos submitted with prior authorization or with claim submission
D8695	Removal Of Fixed Orthodontic Appliances	0-999		Y	Narrative of Medical Necessity
D9130	Temporomandibular Joint Dysfunction - Non-invasive Physical Therapies	0-999		Y	Narrative of Medical Necessity
D9222	Deep Sedation/General Anesthesia - First 15 Minutes	0-999	1 per 1 day per member	N	
D9223	Deep Sedation / General Anesthesia - Each subsequent 15 Minute Increment	0-999	4 per 1 day per member	N	
D9230	Inhalation Of Nitrous/Analgesia, Anxiolysis	0-20		N	
D9230	Inhalation Of Nitrous/Analgesia, Anxiolysis	21-999		Y	Narrative of medical necessity
D9239	Intravenous Moderate (Conscious) Sedation/Analgesia - First 15 Minutes	0-999	1 per 1 day per member	N	
D9243	Intravenous Moderate (Conscious) Sedation/Analgesia - Each Subsequent 15 Minute	0-999	4 per 1 day per member	N	
D9610	Therapeutic Parenteral Drug, Single Administration	0-999	1 per 1 day per member	N	
D9612	Therapeutic Parenteral Drugs, Two Or More Administrations	0-999	1 per 1 day per member	N	
D9613	Infiltration of sustained release therapeutic drug, per quadrant	0-999		Y	Narrative of Medical Necessity
D9920	Behavior Management, By Report	0-999		Y	Narrative of Medical Necessity
D9944	Occlusal Guard-hard appliance, full arch	0-999	1 per 3 years per member	N	
D9945	Occlusal Guard-soft appliance, full arch	0-999	1 per 3 years per member	N	
D9946	Occlusal Guard-hard appliance, partial arch	0-999	1 per 3 years per member	N	
D9947	Custom sleep apnea appliance fabrication and placement	0-999		Y	Narrative of Medical Necessity
D9948	Adjustment of custom sleep apnea appliance	0-999		Y	Narrative of Medical Necessity
D9949	Repair of custom sleep apnea appliance	0-999		Y	Narrative of Medical Necessity
D9953	Reline Custom Sleep Apnea Appliance (Indirect)	0-999		Y	Narrative of Medical Necessity

Code	Description	Age limits	Frequency limits	Auth required	Required documentation
D9954	Fabrication and Delivery of Oral Appliance Therapy (OAT) Morning Repositioning Device	0-999			
D9955	Oral Appliance Therapy (OAT) Titration Visit	0-999			
D9961	Duplicate / Copy Patient's Records	0-999		Y	Narrative of Medical Necessity
D9990	Translation Services	0-999		Y	Narrative of Medical Necessity
D9995	Teledentistry - Synchronous; Real-Time Encounter	0-999		N	
D9996	Teledentistry - Asynchronous; Information Stored And Forwarded To Dentist	0-999		Y	Narrative of Medical Necessity
D9997	Dental case management	0-999		Y	Narrative of Medical Necessity
D9999	Unspecified Adjunctive Procedure, By Report	0-999		Y	Description of procedure and narrative of medical necessity

*See page 11 for additional information regarding Orthodontic treatment.

Orthodontic Treatment

Orthodontic treatment is considered to be medically necessary in the presence of a handicapping malocclusion. The ODM 03630 Evaluation for Comprehensive Orthodontic Treatment is used to determine the presence of a handicapping malocclusion. Orthodontic treatment is considered to be medically necessary when one of the following criteria has been met:

- An automatically qualifying condition as reported in Section A of the ODM 03630 form, including:
  - Overjet greater than 9.0 mm
  - Reverse overjet greater than 3.5 mm
  - Anterior crossbite of two or more teeth with evidence of gingival recession
  - Impinging overbite with tissue laceration and/or clinical attachment loss
  - Anterior impactions where eruption is impeded but extraction is not indicated (excluding third molars)
  - Jaws and/or dentition profoundly affected by a congenital or developmental disorder (craniofacial anomalies), trauma, or pathology
  - Crowding greater than 8.0 mm in the maxillary arch only
- A total score of 22 or more on Section B of the ODM 03630 form, reporting elements of malocclusion related to:
  - Overjet
  - Overbite
  - Mandibular protrusion (reverse overjet/underbite)
  - Anterior open bite
  - Ectopic teeth
  - Congenitally missing posterior teeth
  - Anterior crowding of the maxilla
  - Anterior crowding of the mandible
  - Labio-lingual spread
  - Posterior crossbite
  - Posterior impactions
  - Psychosocial or speech impairment diagnosed by a qualified specialist
- The presence of other medical, psychosocial, or speech conditions that are exacerbated by a handicapping malocclusion, as documented in Section C of the ODM 03630 form, including but not limited to:
  - Clinically significant distress or impaired psychosocial functioning (with supporting documentation from a psychologist or psychiatrist)
  - Significant speech impairment (with supporting documentation from a speech therapist)
  - Other provider-documented reasons as noted in the provider notes section

Removal of fixed orthodontics appliances for reasons other than completion of treatment

Removal of fixed orthodontic appliances for reasons other than completion of treatment is a decision to be made by the treating provider based on an individual patient basis. Reasons include, but are not limited to:

- Patient non-compliance (AAOMS)
- Military deployment (Department of the Army)
- Prior to radiation therapy to the head or neck if the appliances will be in the radiation field (NIH, AAPD)
- Prior to highly stomatotic chemotherapy (NIH, AAPD)
- Complications related to IV bisphosphonates and other medical conditions (AAOMS)

Orthodontic continuity of care

Providers may submit Continuity of Care (COC) requests using three (3) methods of submission:

1. Online via the provider web portal (Dental Hub) at **UHCdental.com/medicaid**
2. Electronic submission via payer ID OHMD3
3. By mail to:
   UnitedHealthcare Community Plan of Ohio
   P.O. Box 2126
   Milwaukee, WI 53201

All COC requests must be submitted on the ADA form and must include the following contents:

- Code D8999 to recognize COC case
- Code D8670 identifying the number of adjustments remaining/requested
- Copy of EOB/remit showing paid banding
- Copy of original approval from prior Medicaid vendor or private insurer
- Payment history from prior insurer(s)

Periodic treatment visits

Reimbursement for code D8670 (periodic orthodontic treatment visit) will be switching from monthly to quarterly payments, in alignment with the new policy. This change ensures that periodic visits are reimbursed on a quarterly basis, supporting consistent and adequate orthodontic care for members.

ODM 03630 Evaluation for Comprehensive Orthodontic Treatment Form (page 1)

Ohio Department of Medicaid

EVALUATION FOR COMPREHENSIVE ORTHODONTIC TREATMENT

Last Name	First Name	Medicaid ID Number	Date of Birth

Cases must be considered, reviewed, and approved on a case-by-case basis. Generally, comprehensive orthodontic care (D8080) will require management of all permanent teeth except 3rd molars and as a guideline can begin for females at age 10 years and males at 12 years or if all permanent teeth except 2nd molars are at least partially present unless missing or impacted. This will allow for adequate treatment time for growth modification, if necessary, and control of all permanent teeth.

PROCEDURE *(use this score sheet and a Boley Gauge or disposable ruler):*

- **Indicate by checkmark next to A, B, or C, which criteria you are submitting for review**
- Position the patient's teeth in centric occlusion for photos and cephalometric radiographs with the lips relaxed for both
- Record all measurements in the order given and round off to the nearest millimeter (mm)
- ENTER SCORE "0" IF CONDITION IS ABSENT IN SECTION B

A. ☐ CONDITIONS 1 – 7 ARE AUTOMATIC QUALIFIERS *(place "X" if present)*		Provider	Plan Only
1.	Overjet: greater than 9.0 mm	☐	☐
2.	Reverse overjet: greater than 3.5 mm	☐	☐
3.	Anterior crossbite of 2 or more teeth with evidence of gingival recession	☐	☐
4.	Impinging overbite – tissue laceration and/or clinical attachment loss must be present	☐	☐
5.	Anterior impactions where eruption is impeded but extraction is not indicated	☐	☐
6.	Jaws and/or dentition which are profoundly affected by a congenital or developmental disorder (craniofacial anomalies), trauma, or pathology	☐	☐
7.	Crowding greater than 8.0 mm in maxillary arch only	☐	☐

CONTINUE TO SECTION BELOW AND SCORE ALL PRESENT CONDITIONS

B. ☐ CONDITIONS 8 – 19 MUST SCORE 22 POINTS OR MORE TO QUALIFY			Provider	Plan Only
8.	**Overjet** (measurement must be greater than 2 mm – see instructions on page 2)	mm____ x 1=		
9.	**Overbite** (measurement must be greater than 2 mm – see instructions on page 2)	mm____ x 1=		
10.	**Mandibular protrusion** (reverse overjet, **"underbite"** – see instructions on page 2)	mm____ x 5=		
11.	**Anterior open bite** (do not count ectopic teeth – see instructions on page 2)	mm____ x 4=		
12.	**Ectopic teeth** (excludes 3rd molars) # teeth (score 0 if crowding is claimed)	#_____ x 3=		
13.	**Congenitally missing posterior teeth** (excluding third molars)	#_____ x 3=		
14.	**Anterior crowding of maxilla** (greater than 3.5 mm) if present score as 5	x 5=		
15.	**Anterior crowding of mandible** (greater than 3.5 mm) if present score as 5	x 5=		
16.	**Labio-lingual spread** (either measure a displaced tooth from the normal arch form, the labial-lingual distance between adjacent anterior teeth, or the anterior mesio-distal spacing between adjacent anterior teeth – see rules on page 2)	mm____ x 1=		
17.	**Posterior crossbite** (2 or more teeth – 1 must be a molar), score only once as 4	4=		
18.	**Posterior impactions** (see scoring rules on page 2, excludes 3rd molars)	#_____ x 3=		
19.	**Psychiatrist/psychologist/speech therapist-diagnosed condition** (instructions on page 2)	x 10=		
	TOTAL SCORE *(must score **22** points or more to qualify)*			

C. ☐ Other reason to consider orthodontic case *(see provider notes)*

Provider Signature *(Provider attests to the accuracy stated above)*			Date
First Name	Last Name	NPI Number	Phone Number

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Other Conditions and Provider Notes

Plan Only Notes

INSTRUCTIONS FOR COMPLETING ODM 03630 SCORING INSTRUCTIONS

The provider is encouraged to score the case and exclude any case that obviously would *not* qualify for treatment.
Upon completion of the Form 03630 score sheet, review all measurements and calculations for accuracy.

1. Indicate by checkmark next to Section A, B, or C to indicate which criteria you are submitting for review.
2. Position the patient's teeth in centric occlusion for lateral and frontal intraoral photographic images.
3. Record all measurements in the order given and round off to the nearest millimeter (use a ruler to show measurements).
4. Enter the score of "0" for section elements in the B Section if using Section B to qualify and the condition is absent.

A. CONDITIONS 1 - 7 ARE AUTOMATIC QUALIFIERS (indicate with an "X" if condition is present)

B. CONDITIONS 8 - 19 MUST SCORE 22 POINTS OR MORE TO QUALIFY

8. **Overjet** --this is recorded with the patient's teeth in centric occlusion and is measured from the labial surface of the lower incisor to the incisal edge of upper incisor. Measure parallel to the occlusal plane. Only use central incisors. The measurement may apply to only one (1) tooth if it is severely protrusive. Do *not* record overjet and mandibular protrusion (reverse overjet) on the same patient. Enter measurement if greater than 2 mm and multiply by one (1).
9. **Overbite** --a pencil mark on the tooth indicating the extent of the overlap assists in making this measurement. Hold the pencil parallel to the occlusal plane when marking and use the incisal edge of one of the upper central incisors. Do *not* use the upper lateral incisors or cuspids. The measurement is done on the lower incisor from the incisal edge to the pencil mark. "Reverse" overbite may exist and should be measured on an upper central incisor - from the incisal edge to the pencil mark. Do *not* record overbite and open bite on the same patient. Enter measurement if greater than 2 mm and multiply by one (1).
10. **Mandibular (dental) protrusion or reverse overjet** --measured from the labial surface of the upper incisor to the incisal edge of the lower incisor. Measure parallel to the occlusal plane. Only use central incisors for this measurement. Do *not* record mandibular protrusion (reverse overjet) and overjet on the same patient. The measurement is entered on the score sheet and multiplied by five (5).
11. **Open bite** --measured from the incisal edge of an upper central incisor to the incisal edge of a lower incisor. Do *not* use the upper lateral incisors or cuspids for this measurement. Do *not* record overbite and open bite on the same patient. The measurement is entered on the score sheet and multiplied by four (4).
12. **Ectopic eruption*** -- Refers to an unusual pattern of eruption, such as a high canine. Count each tooth excluding third molars. Enter the number of teeth and multiply by three (3). If anterior crowding of either arch is claimed, ectopic eruption must be scored as "0."
13. **Congenitally missing posterior teeth** –, excluding third molars. Enter number of teeth and multiply by three (3).
14. **Anterior crowding of maxilla*** --anterior arch length insufficiency *must* exceed 3.5 mm. Score only fully erupted incisors and canines. Mild rotations that may react favorably to stripping or mild expansion procedures are *not* to be scored as crowded. Score one (1) point for a maxillary arch with anterior crowding and multiply by five (5).

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15. **Anterior crowding of mandible*** -- anterior arch length insufficiency *must* exceed 3.5 mm. Score only fully erupted incisors and canines. Mild rotations that may react favorably to stripping or mild expansion procedures are *not* to be scored as crowded. Score one (1) point for mandibular arch with anterior crowding and multiply by five (5).

16. **Labio-lingual spread** --use a measurement tool is used to determine the extent of deviation from a normal arch. Where there is only a protruded or lingually displaced anterior tooth, the measurement should be made from the incisal edge of that tooth to the normal arch line. Otherwise, the total distance between the most protruded tooth and the lingually displaced anterior tooth is measured. If multiple anterior crowding of teeth is observed, all deviations from the normal arch should be measured for labio-lingual spread, but only the most severe individual measurement should be entered on the index. Additionally, anterior spacing may be measured as the total score in mm of the spacing from the mesial of the canine to the mesial of the opposite canine, totaling both arches. Score only the greater score attained by either of these two methods, and multiply by one (1).

17. **Posterior crossbite** --this condition involves two (2) or more posterior teeth, one (1) of which *must* be a molar. The crossbite *must* be one in which the maxillary posterior teeth involved may be palatal to normal relationships or completely buccal to the mandibular posterior teeth. The presence of posterior crossbite is indicated by a score of four (4) on the score sheet.

18. **Posterior impactions** – where eruption is impeded but extraction is not indicated, excluding third molars. Enter number of teeth and multiply by three (3).

19. **A) Psychosocial Injury Cases**** – Patient experiences clinically significant distress or impaired psychosocial functioning substantially contributed to by the patient's malocclusion. This is supported by a diagnosis verified with documentation from a psychologist or psychiatrist following a screening examination or interview. Score as 10; or,
B) Speech Impairment Cases** – Patient experiences significant speech impairment which is diagnosed as a speech or language pathology caused by the patient's malocclusion. This is verified with documentation from a speech therapist following a screening evaluation or interview. Score as 10.
*** Either ectopic eruption or anterior crowding in the same arch may be counted, but not both.**
**** 19.A or 19.B (not both)** must be combined with scored conditions: **19A** with points from 8, 10, 11, 12, 14, and 16; **OR 19B** with points from 8, 10, 11, 16, and 17 for total scoring.

C. Other reason to consider orthodontic case – enter reason(s) in provider notes section.



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