



# Dental Provider Manual

**UnitedHealthcare Dental  
Commercial PPO and Medicare**

Revised 12/10/2025



**United  
Healthcare®**

**Dental Benefit  
Providers®**

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# Section 1: Introduction

## Welcome to UnitedHealthcare®

### UnitedHealthcare welcomes you as a participating Dental Provider in providing dental services to our members.

UnitedHealthcare is committed to providing accessible, quality, comprehensive dental care in the most cost-effective and efficient manner possible. We realize that to do so, strong partnerships with our providers are critical, and we value you as an important part of our program.

UnitedHealthcare offers a portfolio of products to its members, your patients, as well as to its participating dental offices. Products include Preferred Provider Organization (PPO), Exclusive Provider Organization (EPO), In-Network Only (INO), Medicaid, Medicare, Dental Health Maintenance Organization (DHMO), Discount Programs, Direct Compensation (DC) and various discounted Fee for Service (FFS) plans.

The products offered and how our plans are branded vary by market, based on how the products are licensed and the associated contracting entity.

This Provider Manual is designed as a comprehensive reference guide focusing on the PPO, EPO, INO, Medicare, and Discount plans referenced above. Here you will find the tools and information needed to successfully administer UnitedHealthcare plans. As changes and new information arise, updates to the manual will be posted on the Provider Portal, along with the latest version of the manual. Sign in to [UHCdental.com](https://UHCdental.com) and select Manuals/Other Supporting Documents under Quick Links.

Our Medicaid, DHMO, and Direct Compensation Plans, are summarized separately. If you support one of these plans and need a manual, please log into [UHCdental.com](https://UHCdental.com) with your Optum ID or contact our Provider Services team at **1-800-822-5353**. For the Veterans Affairs Community Care Network (VA CCN) program Provider Manual, click [HERE](#).

This manual is being provided in accordance with your executed agreement. If you have any questions or concerns about the information contained within this Provider Manual, please contact the UnitedHealthcare provider services team at **1-800-822-5353**.

## Provider Online Academy

Provider Online Academy is a resource for 24/7, on-demand, interactive, and self-paced courses for providers that cover the following topics:

- Dental provider portal training guide and digital solutions
- Dental plans and products overview
- Up-to-date dental operational tools and processes
- State-specific training requirements

To access Provider Online Academy, visit [UHCdental.com/provideracademy](https://UHCdental.com/provideracademy).

## Required training

To remain compliant with the Centers for Medicare and Medicaid Services (CMS), all participating health care professionals who treat Medicare Advantage members are required to complete the Medicare Fraud and Abuse Training.

To complete the training click [HERE](#).

## Section 2: Resources and services

### 2.1. Quick reference guides – addresses and phone numbers

UnitedHealthcare is committed to providing your office with accurate and timely information about our programs, products and policies.

Refer to the table below for available resources based on type of inquiry.

You want to:	Provider Services Line – Dedicated Service Representatives Phone: 1-800-822-5353 Hours: 7 am–8 pm CST Monday–Friday	Online: UHCdental.com	Interactive Voice Response (IVR) System Phone: 1-800-822-5353 Hours: 24 / 7
Inquire about a claim	✓	✓	✓
Ask a benefit / plan question (including prior authorization requirements)	✓	✓	✓
Inquire about eligibility	✓	✓	✓
Request an EOB	✓	✓	
Request a Fee Schedule	✓	✓	
Request a copy of your contract	✓		
Ask a question about your contract	✓		
Inquire about the In-Network Practitioner Listing	✓	✓	✓
Nominate a provider for participation	✓	✓	
Changes to Practice Information (e.g., associate updates, address changes, adding or deleting addresses, Tax Identification Number change, specialty designation, demographic updates)	✓	✓	
Request participation status change	✓		
Request documents	✓	✓	
Request benefit information	✓	✓	

Need:	Address	Phone number	Payer I.D.	Submission guidelines	Form(s) required
<b>Claim Submission (initial)</b>	CLAIMS UnitedHealthcare P.O. Box 30567 Salt Lake City, UT 84130-0567	1-800-822-5353	52133 Claim Filing indicator: “CL”	Within 90 days of the date of service	ADA Claim Form, 2019 version or later
<b>Prior Authorization Requests*</b>	PTE/Preauthorizations UnitedHealthcare P.O. Box 30552 Salt Lake City, UT 84130-0567	1-800-822-5353	52133		ADA Claim Form – check the box titled: Request for Predetermination / Preauthorization section of the ADA Dental Claim Form
<b>Claim Adjustment Request or Requests for Reprocessing</b>	Adjustments/ Resubmissions UnitedHealthcare P.O. Box 30567 Salt Lake City, UT 84130-0567	1-800-822-5353	52133	Within 60 days from receipt of payment	ADA Claim Form Provider narrative Reason for requesting adjustment or resubmission
<b>Claim Disputes</b>	Provider Disputes UnitedHealthcare P.O. Box 30567 Salt Lake City, UT 84130-0567	1-800-822-5353	N/A	Within 60 days from receipt of payment	ADA Claim Form Written summary of appeal
<b>Coordination of Benefits</b>	Claims UnitedHealthcare P.O. Box 30567 Salt Lake City, UT 84130-0567	1-800-822-5353	52133	Within 90 days of the date of service	ADA Claim Form Primary Payer’s EOB showing the amount paid by the primary payer
<b>Member Complaints and Appeals</b>	UnitedHealthcare P.O. Box 30569 Salt Lake City, UT 84130-0567	1-800-822-5353	N/A	N/A	N/A

**Note:** For Medicare Advantage plans, refer to the [Medicare Advantage Quick Reference Guide](#) to find the appropriate claims mailing address based on member’s plan design.

**Note:** Refer to the Private label portfolio reference guide for a list of our Private Label clients, customer service number, claims address, and more. The guide can be found on the provider portal at [UHCdental.com/resources](https://UHCdental.com/resources). See Section A.1.d Private label clients for more information.

## 2.2.A Integrated Voice Response (IVR) system 1-800-822-5353

We have a toll-free Integrated Voice Response (IVR) system that allows you to access information 24 hours a day, seven days a week by responding to the system’s voice prompts.

Through this system, you can obtain immediate eligibility information, check the status of claims and receive an explanation of benefits. The system can also fax eligibility confirmation directly to the caller.

## 2.2.B Website [UHCdental.com](https://UHCdental.com)

The UnitedHealthcare website, [UHCdental.com](https://UHCdental.com), offers many time-saving features including eligibility verification, pre-authorization, claims submission and status, remittance, procedure level pricing, fee schedules, benefit information, provider search and much more 24 hours a day, seven days a week.

We also offer a self-service feature that allows your office to validate, change and attest to your office information online. Participating providers are expected to validate their demographic information every 90 days. To access this feature, click on Provider Self Service in the Quick Links section after you register and log in to [UHCdental.com](https://UHCdental.com).

For registration instructions and information on using our portal, please refer to the [User Guide](#) at [UHCdental.com](https://UHCdental.com). If you have any questions or need assistance with registration, contact Provider Services at **1-800-822-5353**.

### 2.3. Electronic Payments and Statements

The ePayment center is an online portal which will allow you to enroll in electronic delivery of payments and electronic remittance advice (ERA).

Through the ePayment Center, we will continue to offer a no-fee Automated Clearing House (ACH) delivery of claim payments with access to remittance files via download. Delivery of 835 files to clearinghouses is available directly through the ePayment Center enrollment portal.

#### **ePayment Center allows you to:**

- Improve cash flow with faster primary payments and speed up secondary filing/patient collections
- Access your electronic remittance advice (ERA) remotely and securely 24/7
- Streamline reconciliation with automated payment posting capabilities
- Download remittances in various formats (835, CSV, XLS, PDF)
- Search payments history up to 7 years

#### **To register:**

1. Visit [UHCdental.epayment.center/register](https://UHCdental.epayment.center/register)
2. Follow the instructions to obtain a registration code
3. Your registration will be reviewed by a customer service representative and a link will be sent to your email once confirmed
4. Follow the link to complete your registration and setup your account
5. Log into [UHCdental.epayment.center](https://UHCdental.epayment.center)
6. Enter your bank account information
7. Select remittance data delivery options
8. Review and accept ACH Agreement
9. Click “Submit”
10. Upon completion of the registration process, your bank account will undergo a prenotification process to validate the account prior to commencing the electronic fund transfer delivery. This process may take up to 6 business days to complete

Need additional help? Call **1-855-774-4392** or email [help@epayment.center](mailto:help@epayment.center).

In addition to a no-fee ACH option, other electronic payment methods are available through Zelis Payments.

#### **The Zelis Payments advantage:**

- Access all payers in the Zelis Payments network through one single portal
- Experience award winning customer service
- Receive funds weeks faster than mailed checks and improve the accuracy of your claim payments

- Streamline your operations and improve revenue stability with virtual card and ACH
- Protect your account with 24/7 Office of Foreign Assets Control (OFAC) fraud monitoring
- Reduce costs and boost efficiency by simplifying administrative work from processing payments
- Gain visibility and insights from your payment data with a secure provider portal. Download files (10 years of storage) in various formats (XLS, PDF, CSV or 835)

Each Zelis Payments product gives you multiple options to access data and customize notifications. You will have access to several features via the secure web portal.

All remittance information is available 24/7 via [provider.zelispayments.com](https://provider.zelispayments.com) and can be downloaded into a PDF, CSV, or standard 835 file format. For any additional information or questions, please contact Zelis Payments Client Service Department at **1-877-828-8770**.



## Section 3: Plan eligibility

### 3.1 Eligibility verification

Member eligibility must be verified prior to rendering services. Eligibility may be verified one of three ways:

1. At our website ([UHCdental.com](https://UHCdental.com))
2. Through our Interactive Voice Response (IVR) available through the Provider Services line
3. By speaking with a Provider Services Representative

Important note: A member's ID card is not proof of eligibility. Verification of eligibility is not a guarantee of payment. Payment can only be made after the claim has been received and reviewed in light of eligibility, dental necessity and other limitations and/or exclusions. Additional rules may apply to some benefit plans.

### 3.2 Member identification card

Members enrolled in benefits are issued an identification (ID) card. When members of a family enroll, separate cards may be issued to each family member. The ID cards are customized with the Plan logo and include the toll-free customer service number. For DHMO plans, the primary care dentist name and telephone number is also included. ID cards also include the member's group ID number.

The ID card has instructions for both members (how to access care) and providers (eligibility verification). ID cards should be presented by members when services are rendered.

Private label members seeking treatment may show a membership identification card that is different from the typical UnitedHealthcare identification card. Refer to Section A.1.d Private label clients for more information.

Presentation by a person with an ID card is not a guarantee of payment. It is the responsibility of the provider to verify eligibility at the time of service.

### 3.3 Specialty care referral guidelines

Participating dentists do not need authorization to refer members to a specialist. If specialty care is required, please refer members to a participating specialist whenever possible, as it will be more cost-effective for the member. Members with an 'in-network only' plan can only use their benefits when treated by a participating specialist.

You can find a list of participating specialists in your area on our website, [UHCdental.com](https://UHCdental.com), or by calling **1-800-822-5353** and using the Interactive Voice Response (IVR) system. If you cannot find a participating specialist in your area, contact a provider services representative at **1-800-822-5353** for assistance.

## Section 4: Member benefits/exclusions and limitations

### 4.1 Medicare Advantage

Information regarding Medicare Advantage member benefits, exclusions, and limitations is available in the [Medicare Advantage Quick Reference Guide](#). For the most current clinical policy criteria and documentation requirements, please refer to the [Medicare Clinical Guidelines](#).

### 4.2 Commercial

The most current clinical policy criteria and documentation requirements can be found at [Commercial Clinical Guidelines](#).

#### 4.2.A Diagnostic services guidelines

Code	Description	Age	Frequencies and limitations	Clinical review req
<b>Diagnostic</b>				
<b>D0120</b>	Periodic oral evaluation – established patient	0 - 99	Limited to 2 times per consecutive 12 months.	N
<b>D0140</b>	Limited oral evaluation – problem focused	0 - 99	Limited to 2 times per consecutive 12 months.	N
<b>D0145</b>	Oral evaluation for a patient under three years of age and counseling with primary caregiver	0 - 2	Limited to 2 times per consecutive 12 months. Not Covered if done in conjunction with other exams.	N
<b>D0150</b>	Comprehensive oral evaluation – new or established patient	0 - 99	Limited to 1 time per consecutive 36 months. Not Covered if done in conjunction with other exams.	N
<b>D0160</b>	Detailed and extensive oral evaluation – problem focused, by report	0 - 99	Limited to 2 times per consecutive 12 months. Only 1 exam is Covered per date of service.	N
<b>D0170</b>	Re-evaluation – limited, problem focused (established patient; not post-operative visit)	0 - 99	Limited to 2 times per consecutive 12 months. Only 1 exam is Covered per date of service.	N
<b>D0180</b>	Comprehensive periodontal evaluation – new or established patient	0 - 99	Limited to 2 times per consecutive 12 months. Only 1 exam is Covered per date of service.	N
<b>D0210</b>	Intraoral – comprehensive series of radiographic images	11 - 99	Limited to 2 times per consecutive 12 months. Only 1 exam is Covered per date of service.	N
<b>D0220</b>	Intraoral – periapical first radiographic image	0 - 99	Limited to 8 films per calendar year.	N
<b>D0230</b>	Intraoral – periapical each additional radiographic image	0 - 99	Limited to 8 films per calendar year.	N
<b>D0240</b>	Intraoral – occlusal radiographic image	0 - 99	Limited to 2 times per consecutive 6 months.	N

Code	Description	Age	Frequencies and limitations	Clinical review req
<b>Diagnostic</b>				
<b>D0250</b>	Extraoral – 2D projection radiographic image created using a stationary radiation source, and detector	0 - 99	Limited to 2 films per calendar year.	N
<b>D0251</b>	Extra-oral posterior dental radiographic image	0 - 99	Limited to 2 films per calendar year.	N
<b>D0270</b>	Bitewing – single radiographic image	3 - 99	Limited to 4 films per calendar year. Bitewings can not be billed in conjunction with a comprehensive series.	N
<b>D0272</b>	Bitewings – two radiographic image	3 - 99	Limited to 1 series of films per calendar year. Bitewings can not be billed in conjunction with a comprehensive series.	N
<b>D0273</b>	Bitewings – three radiographic image	3 - 99	Limited to 1 series of films per calendar year. Bitewings can not be billed in conjunction with a comprehensive series.	N
<b>D0274</b>	Bitewings – four radiographic image	3 - 99	Limited to 1 series of films per calendar year. Bitewings can not be billed in conjunction with a comprehensive series.	N
<b>D0277</b>	Vertical bitewings – 7 to 8 radiographic image	9 - 99	Limited to 1 time per consecutive 36 months. Vertical bitewings can not be billed in conjunction with a comprehensive series.	N
<b>D0320</b>	Temporomandibular joint arthrogram, including injection	0 - 99	TMJ plans only; not generally covered on core standard plans - Limited to 1 film per joint, total of 2 films per consecutive 12 months.	N
<b>D0321</b>	Other temporomandibular joint radiographic images, by report	0 - 99	TMJ plans only; not generally covered on core standard plans - Limited to 1 film per joint, total of 2 films per consecutive 12 months.	N
<b>D0322</b>	Tomographic survey	0 - 99	TMJ plans only; not generally covered on core standard plans - Limited to 1 film per joint, total of 2 films per consecutive 12 months.	N
<b>D0330</b>	Panoramic radiographic image	0 - 99	Limited to 1 time per consecutive 36 months.	N
<b>D0340</b>	2D cephalometric radiographic image – acquisition, measurement and analysis	0 - 18	Limited to 1 per consecutive 12 months. Can only be billed for orthodontics.	N
<b>D0350</b>	2D oral/facial photographic image obtained intra-orally or extra-orally	0 - 99	Limited to 1 time per consecutive 36 months.	N
<b>D0364</b>	Cone beam CT capture and interpretation with limited field of view – less than one whole jaw	0 - 99	Limited to 1 time per consecutive 60 months.	N
<b>D0365</b>	Cone beam CT capture and interpretation with field of view of one full dental arch – mandible	0 - 99	Limited to 1 time per consecutive 60 months.	N
<b>D0366</b>	Cone beam CT capture and interpretation with field of view of one full dental arch – maxilla, with or without cranium	0 - 99	Limited to 1 time per consecutive 60 months.	N

Code	Description	Age	Frequencies and limitations	Clinical review req
<b>Diagnostic</b>				
<b>D0367</b>	Cone beam CT capture and interpretation with field of view of both jaws; with or without cranium	0 - 99	Limited to 1 time per consecutive 60 months.	N
<b>D0372</b>	Intraoral tomosynthesis - comprehensive series of radiographic images	11 - 99	Limited to 1 time per consecutive 36 months.	N
<b>D0373</b>	Intraoral tomosynthesis - bitewing radiographic image	3 - 99	Limited to 1 series of films per calendar year.	N
<b>D0374</b>	Intraoral tomosynthesis - periapical radiographic image	0 - 99	Limited to 8 films per calendar year.	N
<b>D0387</b>	Intraoral tomosynthesis - comprehensive series of radiographic images - image capture only	11 - 99	Limited to 1 time per consecutive 36 months.	N
<b>D0388</b>	Intraoral tomosynthesis - bitewing radiographic image - image capture only	3 - 99	Limited to 1 series of films per calendar year.	N
<b>D0389</b>	Intraoral tomosynthesis - periapical radiographic image - image capture only	0 - 99	Limited to 8 films per calendar year.	N
<b>D0414</b>	Lab processing of microbial specimen to include culture and sensitivity studies, preparation and transmission of written report	0 - 99		N
<b>D0701</b>	Panoramic radiographic image - image capture only	0 - 99	Limited to 1 time per consecutive 36 months.	N
<b>D0702</b>	2-D cephalometric radiographic image - image capture only	0 - 99	Limited to 1 time per consecutive 36 months.	N
<b>D0703</b>	2-D oral/facial photographic image obtained intra-orally or extra-orally - image capture only	0 - 99	Limited to 1 time per consecutive 36 months.	N
<b>D0705</b>	Extraoral posterior dental radiographic image - image capture only	0 - 99	Limited to 2 films per calendar year.	N
<b>D0706</b>	Intraoral - occlusal radiographic image - image capture only	0 - 99	Limited to 2 times per consecutive 6 months.	N
<b>D0707</b>	Intraoral - periapical radiographic image - image capture only	0 - 99	Limited to 8 films per calendar year.	N
<b>D0708</b>	Intraoral - bitewing radiographic image - image capture only	3 - 99	Limited to 4 films per calendar year.	N
<b>D0709</b>	Intraoral - comprehensive series of radiographic images - image capture only	11 - 99	Limited to 1 time per consecutive 36 months.	N

## 4.2.B Preventive services guidelines

Code	Description	Age	Frequencies and limitations	Clinical review req
<b>Preventive</b>				
<b>D1110</b>	Prophylaxis – adult	13 - 99	Limited to 2 times per consecutive 12 months.	N
<b>D1120</b>	Prophylaxis – child	0 - 12	Limited to 2 times per consecutive 12 months.	N
<b>D1206</b>	Topical application of fluoride varnish	0 - 15	Limited to Covered Persons under the age of 16 years, and limited to 2 times per consecutive 12 months.	N
<b>D1208</b>	Topical application of fluoride – excluding varnish	0 - 15	Limited to Covered Persons under the age of 16 years, and limited to 2 times per consecutive 12 months.	N
<b>D1351</b>	Sealant – per tooth	0 - 15	Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.	N
<b>D1352</b>	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth	0 - 15	Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.	N
<b>D1353</b>	Sealant repair – per tooth	0 - 15	Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.	N
<b>D1355</b>	Caries preventive medicament application – per tooth	0 - 99	Limited to 2 times per consecutive 12 months.	N
<b>D1510</b>	Space maintainer – fixed, unilateral – per quadrant	0 - 15	Limited to Covered Persons under the age of 16 years, once per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.	N
<b>D1516</b>	Space maintainer – fixed – bilateral, maxillary	0 - 15	Limited to Covered Persons under the age of 16 years, once per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.	N
<b>D1517</b>	Space maintainer – fixed – bilateral, mandibular	0 - 15	Limited to Covered Persons under the age of 16 years, once per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.	N
<b>D1520</b>	Space maintainer – removable, unilateral – per quadrant	0 - 15	Limited to Covered Persons under the age of 16 years, once per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.	N
<b>D1526</b>	Space maintainer – removable – bilateral, maxillary	0 - 15	Limited to Covered Persons under the age of 16 years, once per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.	N
<b>D1527</b>	Space maintainer – removable – bilateral, mandibular	0 - 15	Limited to Covered Persons under the age of 16 years, once per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.	N

Code	Description	Age	Frequencies and limitations	Clinical review req
<b>Preventive</b>				
<b>D1551</b>	Re-cement or re-bond bilateral space maintainer - maxillary	0 - 15	Limited to 1 per consecutive 6 months after initial insertion.	N
<b>D1552</b>	Re-cement or re-bond bilateral space maintainer - mandibular	0 - 15	Limited to 1 per consecutive 6 months after initial insertion.	N
<b>D1553</b>	Re-cement or re-bond unilateral space maintainer - per quadrant	0 - 15	Limited to 1 per consecutive 6 months after initial insertion.	N
<b>D1556</b>	Removal of fixed unilateral space maintainer - per quadrant	0 - 15	Limited to 1 time per quadrant per lifetime.	N
<b>D1557</b>	Removal of fixed bilateral space maintainer - maxillary	0 - 15	Limited to 1 time per arch per lifetime.	N
<b>D1558</b>	Removal of fixed bilateral space maintainer - mandibular	0 - 15	Limited to 1 time per arch per lifetime.	N
<b>D1575</b>	Distal shoe space maintainer - fixed, unilateral - per quadrant	0 - 15	Limited to Covered Persons under the age of 16 years, once per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.	N

## 4.2.C Restorative services guidelines

Code	Description	Age	Frequencies and limitations	Clinical review req
<b>Restorative</b> • Amalgam restorations include polishing • Inlay/onlay restorations: – Porcelain/ceramic inlays/onlays include all indirect ceramic and porcelain type inlays/onlays – Resin-based composite inlays/onlays must utilize indirect technique				
<b>D2140</b>	Amalgam – one surface, primary or permanent	0 - 99	Multiple restorations on one surface will be treated as a single filling.	N
<b>D2150</b>	Amalgam – two surfaces, primary or permanent	0 - 99	Multiple restorations on one surface will be treated as a single filling.	N
<b>D2160</b>	Amalgam – three surfaces, primary or permanent	0 - 99	Multiple restorations on one surface will be treated as a single filling.	N
<b>D2161</b>	Amalgam – four or more surfaces, primary or permanent	0 - 99	Multiple restorations on one surface will be treated as a single filling.	N
<b>D2330</b>	Resin-based composite – one surface, anterior	0 - 99	Multiple restorations on one surface will be treated as a single filling.	N
<b>D2331</b>	Resin-based composite – two surfaces, anterior	0 - 99	Multiple restorations on one surface will be treated as a single filling.	N
<b>D2332</b>	Resin-based composite – three surfaces, anterior	0 - 99	Multiple restorations on one surface will be treated as a single filling.	N
<b>D2335</b>	Resin-based composite – four or more surfaces (anterior)	0 - 99	Multiple restorations on one surface will be treated as a single filling.	N
<b>D2390</b>	Resin-based composite crown, anterior	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D2391</b>	Resin-based composite – one surface, posterior	0 - 99	Alternate benefit.Enhanced Plans Only - Multiple restorations on one surface will be treated as a single filling.	N
<b>D2392</b>	Resin-based composite – two surfaces, posterior	0 - 99	Alternate benefit.Enhanced Plans Only - Multiple restorations on one surface will be treated as a single filling.	N
<b>D2393</b>	Resin-based composite – three surfaces, posterior	0 - 99	Alternate benefit.Enhanced Plans Only - Multiple restorations on one surface will be treated as a single filling.	N
<b>D2394</b>	Resin-based composite – four or more surfaces, posterior	0 - 99	Alternate benefit.Enhanced Plans Only - Multiple restorations on one surface will be treated as a single filling.	N
<b>D2410</b>	Gold foil – one surface	0 - 99	Gold Foil Restorations - Multiple restorations on one surface will be treated as a single filling.	N
<b>D2420</b>	Gold foil – two surfaces	0 - 99	Gold Foil Restorations - Multiple restorations on one surface will be treated as a single filling.	N
<b>D2430</b>	Gold foil – three surfaces	0 - 99	Gold Foil Restorations - Multiple restorations on one surface will be treated as a single filling.	N



Code	Description	Age	Frequencies and limitations	Clinical review req
<b>Restorative</b> <ul style="list-style-type: none"> <li>• Amalgam restorations include polishing</li> <li>• Inlay/onlay restorations:               <ul style="list-style-type: none"> <li>– Porcelain/ceramic inlays/onlays include all indirect ceramic and porcelain type inlays/onlays</li> <li>– Resin-based composite inlays/onlays must utilize indirect technique</li> </ul> </li> </ul>				
<b>D2510</b>	Inlay – metallic – one surface	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	N
<b>D2520</b>	Inlay – metallic – two surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	N
<b>D2530</b>	Inlay – metallic – three or more surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	N
<b>D2542</b>	Onlay – metallic – two surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D2543</b>	Onlay – metallic – three surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D2544</b>	Onlay – metallic – four or more surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D2610</b>	Inlay – porcelain/ceramic – one surface	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	N
<b>D2620</b>	Inlay – porcelain/ceramic – two surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	N
<b>D2630</b>	Inlay – porcelain/ceramic – three or more surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	N



Code	Description	Age	Frequencies and limitations	Clinical review req
<b>Restorative</b> <ul style="list-style-type: none"> <li>• Amalgam restorations include polishing</li> <li>• Inlay/onlay restorations:               <ul style="list-style-type: none"> <li>– Porcelain/ceramic inlays/onlays include all indirect ceramic and porcelain type inlays/onlays</li> <li>– Resin-based composite inlays/onlays must utilize indirect technique</li> </ul> </li> </ul>				
D2642	Onlay – porcelain/ceramic – two surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D2643	Onlay – porcelain/ceramic – three surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D2644	Onlay – porcelain/ceramic – four or more surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D2650	Inlay – resin-based composite – one surface	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	N
D2651	Inlay – resin-based composite – two surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	N
D2652	Inlay – resin-based composite – three or more surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	N
D2662	Onlay – resin-based composite – two surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D2663	Onlay – resin-based composite – three surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
D2664	Onlay – resin-based composite – four or more surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y

Code	Description	Age	Frequencies and limitations	Clinical review req
<b>Restorative</b> <ul style="list-style-type: none"> <li>• Amalgam restorations include polishing</li> <li>• Inlay/onlay restorations:               <ul style="list-style-type: none"> <li>– Porcelain/ceramic inlays/onlays include all indirect ceramic and porcelain type inlays/onlays</li> <li>– Resin-based composite inlays/onlays must utilize indirect technique</li> </ul> </li> </ul>				
<b>D2710</b>	Crown – resin-based composite (indirect)	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D2712</b>	Crown – 3/4 resin-based composite (indirect)	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D2720</b>	Crown – resin with high noble metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D2721</b>	Crown – resin with predominantly base metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D2722</b>	Crown – resin with noble metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D2740</b>	Crown – porcelain/ceramic	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D2750</b>	Crown – porcelain fused to high noble metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D2751</b>	Crown – porcelain fused to predominantly base metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D2752</b>	Crown – porcelain fused to noble metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y

Code	Description	Age	Frequencies and limitations	Clinical review req
<b>Restorative</b> <ul style="list-style-type: none"> <li>• Amalgam restorations include polishing</li> <li>• Inlay/onlay restorations:               <ul style="list-style-type: none"> <li>– Porcelain/ceramic inlays/onlays include all indirect ceramic and porcelain type inlays/onlays</li> <li>– Resin-based composite inlays/onlays must utilize indirect technique</li> </ul> </li> </ul>				
<b>D2753</b>	Crown - porcelain fused to titanium and titanium alloys	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D2780</b>	Crown - 3/4 cast high noble metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D2781</b>	Crown - 3/4 cast predominantly base metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D2782</b>	Crown - 3/4 cast noble metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D2783</b>	Crown - 3/4 porcelain/ceramic	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D2790</b>	Crown - full cast high noble metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D2791</b>	Crown - full cast predominantly base metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D2792</b>	Crown - full cast noble metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D2794</b>	Crown - titanium and titanium alloys	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y

Code	Description	Age	Frequencies and limitations	Clinical review req
<b>Restorative</b> • Amalgam restorations include polishing • Inlay/onlay restorations: – Porcelain/ceramic inlays/onlays include all indirect ceramic and porcelain type inlays/onlays – Resin-based composite inlays/onlays must utilize indirect technique				
<b>D2799</b>	Interim crown– further treatment or completion of diagnosis necessary prior to final impression	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D2910</b>	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	0 - 99	Re-Cement Inlays/Onlays, Crowns, Bridges and Post and Core - Limited to those performed more than 12 months after the initial insertion. Limited to 1 time per consecutive 12 months.	N
<b>D2915</b>	Re-cement or re-bond indirectly fabricated or prefabricated post and core	0 - 99	Re-Cement Inlays/Onlays, Crowns, Bridges and Post and Core - Limited to those performed more than 12 months after the initial insertion. Limited to 1 time per consecutive 12 months.	N
<b>D2920</b>	Re-cement or re-bond crown	0 - 99	Re-Cement Inlays/Onlays, Crowns, Bridges and Post and Core - Limited to those performed more than 12 months after the initial insertion. Limited to 1 time per consecutive 12 months.	N
<b>D2921</b>	Reattachment of tooth fragment, incisal edge or cusp	0 - 99	Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns - Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	N
<b>D2930</b>	Prefabricated stainless steel crown – primary tooth	0 - 15	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.	N
<b>D2931</b>	Prefabricated stainless steel crown – permanent tooth	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.	N
<b>D2932</b>	Prefabricated resin crown	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Prefabricated resin crown, are limited to primary anterior teeth.	N
<b>D2933</b>	Prefabricated stainless steel crown with resin window	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Prefabricated stainless steel crown with resin window, are limited to primary anterior teeth.	N
<b>D2934</b>	Prefabricated esthetic coated stainless steel crown – primary tooth	0 - 15	Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Prefabricated esthetic coated stainless steel crown – primary tooth, are limited to primary anterior teeth.	N

Code	Description	Age	Frequencies and limitations	Clinical review req
<b>Restorative</b> • Amalgam restorations include polishing • Inlay/onlay restorations: – Porcelain/ceramic inlays/onlays include all indirect ceramic and porcelain type inlays/onlays – Resin-based composite inlays/onlays must utilize indirect technique				
D2940	Placement of interim direct restoration	0 - 99	Sedative Filling - Covered as a separate benefit only if no other service, other than x-rays and exam, were performed on the same tooth during the visit. Limited to 1 time per tooth per consecutive 6 months.	N
D2941	Interim therapeutic restoration - primary dentition	0 - 99	Sedative Filling - Covered as a separate benefit only if no other service, other than x-rays and exam, were performed on the same tooth during the visit. Limited to 1 time per tooth per consecutive 6 months.	N
D2949	Restorative foundation for an indirect restoration	0 - 99	Limited to 1 time per tooth per consecutive 60 months.	Y
D2950	Core buildup, including any pins when required	0 - 99	Limited to 1 time per tooth per consecutive 60 months.	Y
D2951	Pin retention - per tooth, in addition to restoration	0 - 99	Pin Retention - Limited to 1 time per tooth per consecutive 60 months; not covered in addition to cast restoration.	N
D2952	Post and core in addition to crown, indirectly fabricated	0 - 99	Covered only for teeth that have had root canal therapy. Limited to 1 time per tooth per consecutive 60 months.	Y
D2953	Each additional indirectly fabricated post - same tooth	0 - 99	Covered only for teeth that have had root canal therapy. Limited to 1 time per tooth per consecutive 60 months.	Y
D2954	Prefabricated post and core in addition to crown	0 - 99	Covered only for teeth that have had root canal therapy. Limited to 1 time per tooth per consecutive 60 months.	Y
D2957	Each additional prefabricated post - same tooth	0 - 99	Covered only for teeth that have had root canal therapy. Limited to 1 time per tooth per consecutive 60 months.	Y
D2960	Labial veneer (resin laminate) - direct	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered for cosmetic/aesthetic reasons.	Y
D2961	Labial veneer (resin laminate) - indirect	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered for cosmetic/aesthetic reasons.	Y
D2962	Labial veneer (porcelain laminate) - indirect	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered for cosmetic/aesthetic reasons.	Y
D2975	Coping	0 - 99	Limited to 1 per tooth per consecutive 60 months. Not covered if done at the same time as a crown on same tooth.	Y
D2980	Crown repair necessitated by restorative material failure	0 - 99	Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns - Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	N

Code	Description	Age	Frequencies and limitations	Clinical review req
<b>Restorative</b> <ul style="list-style-type: none"> <li>• Amalgam restorations include polishing</li> <li>• Inlay/onlay restorations:               <ul style="list-style-type: none"> <li>– Porcelain/ceramic inlays/onlays include all indirect ceramic and porcelain type inlays/onlays</li> <li>– Resin-based composite inlays/onlays must utilize indirect technique</li> </ul> </li> </ul>				
<b>D2981</b>	Inlay repair necessitated by restorative material failure	0 - 99	Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns - Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	N
<b>D2982</b>	Onlay repair necessitated by restorative material failure	0 - 99	Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns - Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	N
<b>D2989</b>	Excavation of a tooth resulting in the determination of non-restorability	0 - 99	Limited to 1 time per tooth per lifetime.	N

## 4.2.D Endodontic services guidelines

Code	Description	Age	Frequencies and limitations	Clinical review req
<b>Endodontics</b> – Endodontic therapy includes treatment plan, clinical procedures and follow up care				
<b>D3110</b>	Pulp cap – direct (excluding final restoration)	0 - 99	Not Covered if utilized solely as a liner or base underneath a restoration.	N
<b>D3120</b>	Pulp cap – indirect (excluding final restoration)	0 - 99	Not Covered if utilized solely as a liner or base underneath a restoration.	N
<b>D3220</b>	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	0 - 99	Limited to 1 time per primary or secondary tooth per lifetime.	N
<b>D3221</b>	Pulpal debridement, primary and permanent teeth	0 - 99	Limited to 1 time per tooth per lifetime. This procedure is not to be used when endodontic services are done on same date of service..	N
<b>D3222</b>	Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development	0 - 99	Limited to 1 time per tooth per lifetime.	N
<b>D3230</b>	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	0 - 15	Limited to 1 time per tooth per lifetime. Covered for anterior teeth only.	N
<b>D3240</b>	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	0 - 15	Limited to 1 time per tooth per lifetime. Covered for posterior teeth only.	N
<b>D3310</b>	Endodontic therapy, anterior tooth (excluding final restoration)	0 - 99	Limited to 1 time per tooth per lifetime. Dentist who performed the original root canal should not be reimbursed for the retreatment for the first 12 months.	N
<b>D3320</b>	Endodontic therapy, premolar tooth (excluding final restoration)	0 - 99	Limited to 1 time per tooth per lifetime. Dentist who performed the original root canal should not be reimbursed for the retreatment for the first 12 months.	N
<b>D3330</b>	Endodontic therapy, molar (excluding final restoration)	0 - 99	Limited to 1 time per tooth per lifetime. Dentist who performed the original root canal should not be reimbursed for the retreatment for the first 12 months.	N
<b>D3331</b>	Treatment of root canal obstruction; non-surgical access	0 - 99	Limited to 1 time per tooth per lifetime.	N
<b>D3332</b>	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	0 - 99	Limited to 1 time per tooth per lifetime.	N
<b>D3333</b>	Internal root repair of perforation defects	0 - 99	Limited to 1 time per tooth per lifetime.	N
<b>D3346</b>	Retreatment of previous root canal therapy – anterior	0 - 99	Limited to 1 time per tooth per lifetime. Dentist who performed the original root canal should not be reimbursed for the retreatment for the first 12 months.	Y



Code	Description	Age	Frequencies and limitations	Clinical review req
<b>Endodontics</b> – Endodontic therapy includes treatment plan, clinical procedures and follow up care				
<b>D3347</b>	Retreatment of previous root canal therapy – premolar	0 - 99	Limited to 1 time per tooth per lifetime. Dentist who performed the original root canal should not be reimbursed for the retreatment for the first 12 months.	Y
<b>D3348</b>	Retreatment of previous root canal therapy – molar	0 - 99	Limited to 1 time per tooth per lifetime. Dentist who performed the original root canal should not be reimbursed for the retreatment for the first 12 months.	Y
<b>D3351</b>	Apexification/recalcification – initial visit (apical closure/ calcific repair of perforations, root resorption, etc.)	0 - 99	Limited to 1 time per tooth per lifetime.	N
<b>D3352</b>	Apexification/recalcification – interim medication replacement	0 - 99	Limited to 1 time per tooth per lifetime.	N
<b>D3353</b>	Apexification/recalcification – final visit (includes completed root canal therapy – apical closure/ calcific repair of perforations, root resorption, etc.)	0 - 99	Limited to 1 time per tooth per lifetime.	N
<b>D3355</b>	Pulpal regeneration – initial visit	0 - 99	Limited to 1 time per tooth per lifetime.	N
<b>D3356</b>	Pulpal regeneration – interim medicament replacement	0 - 99	Limited to 1 time per tooth per lifetime.	N
<b>D3357</b>	Pulpal regeneration – completion of treatment	0 - 99	Limited to 1 time per tooth per lifetime.	N
<b>D3410</b>	Apicoectomy – anterior	0 - 99	Limited to 1 time per tooth per lifetime.	N
<b>D3421</b>	Apicoectomy – premolar (first root)	0 - 99	Limited to 1 time per tooth per lifetime.	N
<b>D3425</b>	Apicoectomy – molar (first root)	0 - 99	Limited to 1 time per tooth per lifetime.	N
<b>D3426</b>	Apicoectomy (each additional root)	0 - 99	Limited to 2 times per tooth per lifetime.	N
<b>D3430</b>	Retrograde filling – per root	0 - 99	Limited to 1 time per tooth per lifetime.	N
<b>D3450</b>	Root amputation – per root	0 - 99	Limited to 1 time per tooth per lifetime.	Y
<b>D3470</b>	Intentional re-implantation (including necessary splinting)	0 - 99	Limited to 1 time per tooth per lifetime.	N
<b>D3471</b>	Surgical repair of root resorption – anterior	0 - 99	Limited to 1 time per tooth per lifetime.	N
<b>D3472</b>	Surgical repair of root resorption – premolar	0 - 99	Limited to 1 time per tooth per lifetime.	N
<b>D3473</b>	Surgical repair of root resorption – molar	0 - 99	Limited to 1 time per tooth per lifetime.	N
<b>D3501</b>	Surgical exposure of root surface without apicoectomy or repair of root resorption – anterior	0 - 99	Limited to 2 times per tooth per lifetime.	N
<b>D3502</b>	Surgical exposure of root surface without apicoectomy or repair of root resorption – premolar	0 - 99	Limited to 2 times per tooth per lifetime.	N



Code	Description	Age	Frequencies and limitations	Clinical review req
<b>Endodontics</b> – Endodontic therapy includes treatment plan, clinical procedures and follow up care				
<b>D3503</b>	Surgical exposure of root surface without apicoectomy or repair of root resorption – molar	0 - 99	Limited to 2 times per tooth per lifetime.	N
<b>D3911</b>	Intraorifice barrier	0 - 99	Limited to 1 time per tooth per consecutive 6 months.	N
<b>D3920</b>	Hemisection (including any root removal), not including root canal therapy	0 - 99	Limited to 1 time per tooth per lifetime.	Y

## 4.2.E Periodontal services guidelines

Code	Description	Age	Frequencies and limitations	Clinical review req
<b>Periodontics – Surgical services include usual post-operative care</b>				
<b>D4210</b>	Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant	0 - 99	Limited to 1 per quadrant per consecutive 36 months.	N
<b>D4211</b>	Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant	0 - 99	Limited to 1 per quadrant per consecutive 36 months.	N
<b>D4230</b>	Anatomical crown exposure – four or more contiguous teeth or tooth bounded spaces per quadrant	0 - 99	Limited to 1 per quadrant per consecutive 36 months.	N
<b>D4231</b>	Anatomical crown exposure – one to three teeth or tooth bounded spaces per quadrant	0 - 99	Limited to 1 per quadrant per consecutive 36 months.	N
<b>D4240</b>	Gingival flap procedure, including root planing – four or more contiguous teeth or tooth bounded spaces per quadrant	0 - 99	Limited to 1 per quadrant per consecutive 36 months.	N
<b>D4241</b>	Gingival flap procedure, including root planing – one to three contiguous teeth or tooth bounded spaces per quadrant	0 - 99	Limited to 1 per quadrant per consecutive 36 months.	N
<b>D4245</b>	Apically positioned flap	0 - 99	Limited to 1 per quadrant per consecutive 36 months.	N
<b>D4249</b>	Clinical crown lengthening – hard tissue	0 - 99	Limited to 1 per tooth per consecutive 36 months.	Y
<b>D4260</b>	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	0 - 99	Limited to 1 per quadrant per consecutive 36 months.	Y
<b>D4261</b>	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	0 - 99	Limited to 1 per quadrant per consecutive 36 months.	Y
<b>D4263</b>	Bone replacement graft – retained natural tooth – first site in quadrant	0 - 99	Limited to 1 per site per consecutive 36 months.	Y
<b>D4264</b>	Bone replacement graft – retained natural tooth – each additional site in quadrant	0 - 99	Limited to 1 per site per consecutive 36 months.	Y
<b>D4265</b>	Biologic materials to aid in soft and osseous tissue regeneration; per site	0 - 99	Limited to 1 per site per consecutive 36 months.	Y
<b>D4266</b>	Guided tissue regeneration, natural teeth – resorbable barrier, per site	0 - 99	Limited to 1 per site per consecutive 36 months.	Y
<b>D4267</b>	Guided tissue regeneration, natural teeth – non-resorbable barrier, per site	0 - 99	Limited to 1 per site per consecutive 36 months.	Y
<b>D4268</b>	Surgical revision procedure, per tooth	0 - 99	Limited to 1 per tooth per consecutive 36 months.	Y
<b>D4270</b>	Pedicle soft tissue graft procedure	0 - 99	Limited to 1 per site per consecutive 36 months.	Y

Code	Description	Age	Frequencies and limitations	Clinical review req
<b>Periodontics – Surgical services include usual post-operative care</b>				
<b>D4273</b>	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant or edentulous tooth position in graft	0 - 99	Limited to 1 per site per consecutive 36 months.	Y
<b>D4274</b>	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	0 - 99	Limited to 1 per site per consecutive 36 months.	Y
<b>D4275</b>	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	0 - 99	Limited to 1 per site per consecutive 36 months.	Y
<b>D4276</b>	Combined connective tissue and double pedicle graft, per tooth	0 - 99	Limited to 1 per tooth per consecutive 36 months.	Y
<b>D4277</b>	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	0 - 99	Limited to 1 per site per consecutive 36 months.	Y
<b>D4278</b>	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site	0 - 99	Limited to 1 per site per consecutive 36 months.	Y
<b>D4283</b>	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	0 - 99	Limited to 1 per site per consecutive 36 months.	Y
<b>D4285</b>	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	0 - 99	Limited to 1 per site per consecutive 36 months.	Y
<b>D4286</b>	Removal of non-resorbable barrier	0 - 99	Limited to 1 per site per consecutive 36 months.	N
<b>D4322</b>	Splint – intra-coronal; natural teeth or prosthetic crowns	0 - 99	Cannot be used to restore vertical dimension or as part of full mouth rehabilitation, should not include use of laboratory based crowns and/or fixed partial dentures (bridges). Exclusion of laboratory based crowns or bridges for the purposes of provisional. Limited to 1 per site per consecutive 36 months.	N

Code	Description	Age	Frequencies and limitations	Clinical review req
<b>Periodontics – Surgical services include usual post-operative care</b>				
<b>D4323</b>	Splint – extra-coronal; natural teeth or prosthetic crowns	0 - 99	Cannot be used to restore vertical dimension or as part of full mouth rehabilitation, should not include use of laboratory based crowns and/or fixed partial dentures (bridges). Exclusion of laboratory based crowns or bridges for the purposes of provisional. Limited to 1 per site per consecutive 36 months.	N
<b>D4341</b>	Periodontal scaling and root planing – four or more teeth per quadrant	0 - 99	Limited to 1 time per quadrant per consecutive 24 months.	N
<b>D4342</b>	Periodontal scaling and root planing – one to three teeth per quadrant	0 - 99	Limited to 1 time per quadrant per consecutive 24 months.	N
<b>D4346</b>	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	0 - 99	Limited to 2 times per consecutive 12 months.	N
<b>D4355</b>	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis on a subsequent visit	0 - 99	Limited to once per consecutive 36 months.	N
<b>D4381</b>	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	0 - 99	Limited to 12 sites total per lifetime, for refractory pockets, or in conjunction with scaling or root planing.	Y
<b>D4910</b>	Periodontal maintenance	0 - 99	Limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement.	N
<b>D4920</b>	Unscheduled dressing change (by someone other than treating dentist or their staff)	0 - 99		N

## 4.2.F Removable prosthodontic services guidelines

Code	Description	Age	Frequencies and limitations	Clinical review req
<b>Removable prosthodontics</b> – Complete and partial dentures include routine post delivery care				
<b>D5110</b>	Complete denture – maxillary	0 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
<b>D5120</b>	Complete denture – mandibular	0 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
<b>D5130</b>	Immediate denture – maxillary	0 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
<b>D5140</b>	Immediate denture – mandibular	0 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
<b>D5211</b>	Maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth)	0 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
<b>D5212</b>	Mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth)	0 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
<b>D5213</b>	Maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	0 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
<b>D5214</b>	Mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	0 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
<b>D5221</b>	Immediate maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth)	0 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
<b>D5222</b>	Immediate mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth)	0 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
<b>D5223</b>	Immediate maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	0 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
<b>D5224</b>	Immediate mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	0 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
<b>D5225</b>	Maxillary partial denture – flexible base (including retentive/clasping materials, rests and teeth)	0 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N

Code	Description	Age	Frequencies and limitations	Clinical review req
<b>Removable prosthodontics – Complete and partial dentures include routine post delivery care</b>				
<b>D5226</b>	Mandibular partial denture – flexible base (including retentive/clasping materials, rests and teeth)	0 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
<b>D5227</b>	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	0 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
<b>D5228</b>	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	0 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
<b>D5282</b>	Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests and teeth), maxillary	0 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
<b>D5283</b>	Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests and teeth), mandibular	0 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
<b>D5284</b>	Removable unilateral partial denture – one piece flexible base (including retentive/clasping materials, rests, and teeth) – per quadrant	0 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
<b>D5286</b>	Removable unilateral partial denture – one piece resin (including retentive/clasping materials, rests, and teeth) – per quadrant	0 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
<b>D5410</b>	Adjust complete denture – maxillary	0 - 99	Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	N
<b>D5411</b>	Adjust complete denture – mandibular	0 - 99	Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	N
<b>D5421</b>	Adjust partial denture – maxillary	0 - 99	Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	N
<b>D5422</b>	Adjust partial denture – mandibular	0 - 99	Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	N
<b>D5511</b>	Repair broken complete denture base, mandibular	0 - 99	Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	N
<b>D5512</b>	Repair broken complete denture base, maxillary	0 - 99	Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	N

Code	Description	Age	Frequencies and limitations	Clinical review req
<b>Removable prosthodontics – Complete and partial dentures include routine post delivery care</b>				
<b>D5520</b>	Replace missing or broken teeth – complete denture – per tooth	0 - 99	Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns - Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	N
<b>D5611</b>	Repair resin partial denture base, mandibular	0 - 99	Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	N
<b>D5612</b>	Repair resin partial denture base, maxillary	0 - 99	Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	N
<b>D5621</b>	Repair cast partial framework, mandibular	0 - 99	Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	N
<b>D5622</b>	Repair cast partial framework, maxillary	0 - 99	Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	N
<b>D5630</b>	Repair or replace broken retentive/clasping materials – per tooth	0 - 99	Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns - Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	N
<b>D5640</b>	Replace missing or broken teeth – partial denture – per tooth	0 - 99	Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns - Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	N
<b>D5650</b>	Add tooth to existing partial denture – per tooth	0 - 99	Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns - Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	N
<b>D5660</b>	Add clasp to existing partial denture – per tooth	0 - 99	Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns - Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	N
<b>D5670</b>	Replace all teeth and acrylic on cast metal framework (maxillary)	0 - 99	Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns - Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	N
<b>D5671</b>	Replace all teeth and acrylic on cast metal framework (mandibular)	0 - 99	Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns - Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	N



Code	Description	Age	Frequencies and limitations	Clinical review req
<b>Removable prosthodontics – Complete and partial dentures include routine post delivery care</b>				
<b>D5710</b>	Rebase complete maxillary denture	0 - 99	Limited to rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	N
<b>D5711</b>	Rebase complete mandibular denture	0 - 99	Limited to rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	N
<b>D5720</b>	Rebase maxillary partial denture	0 - 99	Limited to rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	N
<b>D5721</b>	Rebase mandibular partial denture	0 - 99	Limited to rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	N
<b>D5725</b>	Rebase hybrid prosthesis	0 - 99	Limited to rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	N
<b>D5730</b>	Reline complete maxillary denture (direct)	0 - 99	Limited to relining performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	N
<b>D5731</b>	Reline complete mandibular denture (direct)	0 - 99	Limited to relining performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	N
<b>D5740</b>	Reline maxillary partial denture (direct)	0 - 99	Limited to relining performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	N
<b>D5741</b>	Reline mandibular partial denture (direct)	0 - 99	Limited to relining performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	N
<b>D5750</b>	Reline complete maxillary denture (indirect)	0 - 99	Limited to relining performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	N
<b>D5751</b>	Reline complete mandibular denture (indirect)	0 - 99	Limited to relining performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	N
<b>D5760</b>	Reline maxillary partial denture (indirect)	0 - 99	Limited to relining performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	N
<b>D5761</b>	Reline mandibular partial denture (indirect)	0 - 99	Limited to relining performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	N
<b>D5765</b>	Soft liner for complete or partial removable denture - indirect	0 - 99	Limited to 1 time per consecutive 12 months.	N
<b>D5810</b>	Interim complete denture (maxillary)	0 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
<b>D5811</b>	Interim complete denture (mandibular)	0 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N



Code	Description	Age	Frequencies and limitations	Clinical review req
<b>Removable prosthodontics – Complete and partial dentures include routine post delivery care</b>				
<b>D5820</b>	Interim partial denture (including retentive/clasping materials, rests, and teeth), (maxillary)	0 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
<b>D5821</b>	Interim partial denture (including retentive/clasping materials, rests, and teeth), (mandibular)	0 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
<b>D5850</b>	Tissue conditioning, maxillary	0 - 99	Limited to 1 time per consecutive 12 months.	N
<b>D5851</b>	Tissue conditioning, mandibular	0 - 99	Limited to 1 time per consecutive 12 months.	N
<b>D5863</b>	Overdenture - complete maxillary	0 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
<b>D5864</b>	Overdenture - partial mandibular	0 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
<b>D5865</b>	Overdenture - complete maxillary	0 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
<b>D5866</b>	Overdenture - partial mandibular	0 - 99	Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	N
<b>D5876</b>	Add metal substructure to acrylic full denture (per arch)	0 - 99	Limited to 1 time per consecutive 12 months.	N

## 4.2.G Implant and fixed prosthetic services guidelines

Code	Description	Age	Frequencies and limitations	Clinical review req
<b>Implants and fixed prosthodontics</b>				
<b>D6010</b>	Surgical placement of implant body: endosteal implant	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6012</b>	Surgical placement of interim implant body for transitional prosthesis: endosteal implant	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6013</b>	Surgical placement of a mini-implant	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6040</b>	Surgical placement: eposteal implant	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6050</b>	Surgical placement: transosteal implant	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6051</b>	Placement of interim implant abutment	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6055</b>	Connecting bar - implant supported or abutment supported	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6056</b>	Prefabricated abutment - includes modification and placement	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6057</b>	Custom fabricated abutment - includes placement	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6058</b>	Abutment supported porcelain/ceramic crown	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6059</b>	Abutment supported porcelain fused to metal crown (high noble metal)	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6060</b>	Abutment supported porcelain fused to metal crown (predominantly base metal)	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6061</b>	Abutment supported porcelain fused to metal crown (noble metal)	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6062</b>	Abutment supported cast metal crown (high noble metal)	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6063</b>	Abutment supported cast metal crown (predominantly base metal)	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6064</b>	Abutment supported cast metal crown (noble metal)	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6065</b>	Implant supported porcelain/ceramic crown	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6066</b>	Implant supported crown - porcelain fused to high noble alloys	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6067</b>	Implant supported crown - high noble alloys	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y

Code	Description	Age	Frequencies and limitations	Clinical review req
<b>Implants and fixed prosthodontics</b>				
<b>D6068</b>	Abutment supported retainer for porcelain/ceramic FPD	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6069</b>	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6070</b>	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6071</b>	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6072</b>	Abutment supported retainer for cast metal FPD (high noble metal)	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6073</b>	Abutment supported retainer for cast metal FPD (predominantly base metal)	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6074</b>	Abutment supported retainer for cast metal FPD (noble metal)	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6075</b>	Implant supported retainer for ceramic FPD	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6076</b>	Implant supported retainer for FPD - porcelain fused to high noble alloys	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6077</b>	Implant supported retainer for metal FPD - high noble alloys	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6080</b>	Implant maintenance procedures when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 12 months.	N
<b>D6081</b>	Scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths; includes cleaning of the implant surfaces, without flap entry and closure	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 36 months.	Y
<b>D6082</b>	Implant supported crown - porcelain fused to predominantly base alloys	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6083</b>	Implant supported crown - porcelain fused to noble alloys	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6084</b>	Implant supported crown - porcelain fused to titanium and titanium alloys	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6085</b>	Interim implant crown	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y

Code	Description	Age	Frequencies and limitations	Clinical review req
<b>Implants and fixed prosthodontics</b>				
<b>D6086</b>	Implant supported crown - predominantly base alloys	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6087</b>	Implant supported crown - noble alloys	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6088</b>	Implant supported crown - titanium and titanium alloys	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6089</b>	Accessing and retorquing loose implant screw - per screw	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 12 months.	N
<b>D6090</b>	Repair of implant/abutment supported prosthesis	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 6 months.	N
<b>D6091</b>	Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6092</b>	Re-cement or re-bond implant/abutment supported crown	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 6 months.	N
<b>D6093</b>	Re-cement or re-bond implant/abutment supported fixed partial denture	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 6 months.	N
<b>D6094</b>	Abutment supported crown - titanium and titanium alloys	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6095</b>	Repair implant abutment, by report	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to repairs or adjustments performed more than 12 months after initial insertion. Limited to 1 per consecutive 6 months.	Y
<b>D6096</b>	Remove broken implant retaining screw	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to repairs or adjustments performed more than 12 months after initial insertion. Limited to 1 per consecutive 6 months.	Y
<b>D6097</b>	Abutment supported crown - porcelain fused to titanium and titanium alloys	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6098</b>	Implant supported retainer - porcelain fused to predominantly base alloys	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6099</b>	Implant supported retainer for FPD - porcelain fused to noble alloys	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6100</b>	Surgical removal of implant body	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	N
<b>D6101</b>	Debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 36 months.	N

Code	Description	Age	Frequencies and limitations	Clinical review req
<b>Implants and fixed prosthodontics</b>				
<b>D6102</b>	Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 36 months.	Y
<b>D6103</b>	Bone graft for repair of peri-implant defect - does not include flap entry and closure	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 36 months.	N
<b>D6104</b>	Bone graft at time of implant placement	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 36 months.	Y
<b>D6105</b>	Removal of implant body not requiring bone removal or flap elevation	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	N
<b>D6106</b>	Guided tissue regeneration - resorbable barrier, per implant	0 - 99	Limited to 1 per site per consecutive 36 months.	Y
<b>D6107</b>	Guided tissue regeneration - non-resorbable barrier, per implant	0 - 99	Limited to 1 per site per consecutive 36 months.	Y
<b>D6110</b>	Implant /abutment supported removable denture for edentulous arch - maxillary	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6111</b>	Implant /abutment supported removable denture for edentulous arch - mandibular	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6112</b>	Implant /abutment supported removable denture for partially edentulous arch - maxillary	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6113</b>	Implant /abutment supported removable denture for partially edentulous arch - mandibular	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6114</b>	Implant /abutment supported fixed denture for edentulous arch - maxillary	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6115</b>	Implant /abutment supported fixed denture for edentulous arch - mandibular	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6116</b>	Implant /abutment supported fixed denture for partially edentulous arch - maxillary	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6117</b>	Implant /abutment supported fixed denture for partially edentulous arch - mandibular	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6118</b>	Implant /abutment supported interim fixed denture for edentulous arch - mandibular	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y

Code	Description	Age	Frequencies and limitations	Clinical review req
<b>Implants and fixed prosthodontics</b>				
<b>D6119</b>	Implant/abutment supported interim fixed denture for edentulous arch – maxillary	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6120</b>	Implant supported retainer – porcelain fused to titanium and titanium alloys	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6121</b>	Implant supported retainer for metal FPD – predominantly base alloys	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6122</b>	Implant supported retainer for metal FPD – noble alloys	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6123</b>	Implant supported retainer for metal FPD – titanium and titanium alloys	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6180</b>	Implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 12 months.	N
<b>D6190</b>	Radiographic/surgical implant index, by report	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6191</b>	Semi-precision abutment – placement	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6192</b>	Semi-precision attachment – placement	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6193</b>	Replacement of an implant screw	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to repairs or adjustments performed more than 6 months after initial insertion. Limited to 1 per consecutive 12 months	N
<b>D6194</b>	Abutment supported retainer crown for FPD – titanium and titanium alloys	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6195</b>	Abutment supported retainer – porcelain fused to titanium and titanium alloys	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6197</b>	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 6 months.	N
<b>D6199</b>	Unspecified implant procedure, by report	0 - 99	Buy-Up Only - Enhanced Plans Only: Limited to 1 time per consecutive 60 months.	Y
<b>D6205</b>	Pontic – indirect resin based composite	0 - 99	Limited to 1 time per tooth per consecutive 60 months.	Y
<b>D6210</b>	Pontic – cast high noble metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months.	Y



Code	Description	Age	Frequencies and limitations	Clinical review req
<b>Implants and fixed prosthodontics</b>				
<b>D6211</b>	Pontic – cast predominantly base metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months..	Y
<b>D6212</b>	Pontic – cast noble metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months.	Y
<b>D6214</b>	pontic - titanium and titanium alloys	0 - 99	Limited to 1 time per tooth per consecutive 60 months.	Y
<b>D6240</b>	Pontic – porcelain fused to high noble metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months.	Y
<b>D6241</b>	Pontic – porcelain fused to predominantly base metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months.	Y
<b>D6242</b>	Pontic – porcelain fused to noble metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months.	Y
<b>D6243</b>	Pontic - porcelain fused to titanium and titanium alloys	0 - 99	Limited to 1 time per tooth per consecutive 60 months.	Y
<b>D6245</b>	Pontic – porcelain/ceramic	0 - 99	Limited to 1 time per tooth per consecutive 60 months.	Y
<b>D6250</b>	Pontic – resin with high noble metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months.	Y
<b>D6251</b>	Pontic – resin with predominantly base metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months.	Y
<b>D6252</b>	Pontic – resin with noble metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months.	Y
<b>D6253</b>	Interim pontic - further treatment or completion of diagnosis necessary prior to final impression	0 - 99	Limited to 1 time per tooth per consecutive 60 months.	Y
<b>D6545</b>	Retainer – cast metal for resin bonded fixed prosthesis	0 - 99	Limited to 1 time per tooth per consecutive 60 months.	Y
<b>D6548</b>	Retainer – porcelain/ceramic for resin bonded fixed prosthesis	0 - 99	Limited to 1 time per tooth per consecutive 60 months.	Y
<b>D6549</b>	Retainer – resin bonded fixed prosthesis	0 - 99	Limited to 1 time per tooth per consecutive 60 months.	Y
<b>D6600</b>	Retainer inlay - porcelain/ceramic, two surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D6601</b>	Retainer inlay – porcelain/ceramic, three or more surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D6602</b>	Retainer inlay – cast high noble metal, two surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y

Code	Description	Age	Frequencies and limitations	Clinical review req
<b>Implants and fixed prosthodontics</b>				
<b>D6603</b>	Retainer inlay – cast high noble metal, three or more surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D6604</b>	Retainer inlay – cast predominantly base metal, two surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D6605</b>	Retainer inlay – cast predominantly base metal, three or more surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D6606</b>	Retainer inlay – cast noble metal, two surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D6607</b>	Retainer inlay – cast noble metal, three or more surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D6608</b>	Retainer onlay – porcelain/ceramic, two surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D6609</b>	Retainer onlay – porcelain/ceramic, three or more surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D6610</b>	Retainer onlay – cast high noble metal, two surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D6611</b>	Retainer onlay – cast high noble metal, three or more surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D6612</b>	Retainer onlay – cast predominantly base metal, two surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D6613</b>	Retainer onlay – cast predominantly base metal, three or more surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D6614</b>	Retainer onlay – cast noble metal, two surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y



Code	Description	Age	Frequencies and limitations	Clinical review req
<b>Implants and fixed prosthodontics</b>				
<b>D6615</b>	Retainer onlay - cast noble metal, three or more surfaces	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D6624</b>	Retainer inlay - titanium	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D6634</b>	Retainer onlay - titanium	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D6710</b>	Retainer crown - indirect resin based composite	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D6720</b>	Retainer crown - resin with high noble metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D6721</b>	Retainer crown - resin with predominantly base metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D6722</b>	Retainer crown - resin with noble metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D6740</b>	Retainer crown - porcelain/ceramic	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D6750</b>	Retainer crown - porcelain fused to high noble metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D6751</b>	Retainer crown - porcelain fused to predominantly base metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D6752</b>	Retainer crown - porcelain fused to noble metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D6753</b>	Retainer crown - porcelain fused to titanium and titanium alloys	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y

Code	Description	Age	Frequencies and limitations	Clinical review req
<b>Implants and fixed prosthodontics</b>				
<b>D6780</b>	Retainer crown – 3/4 cast high noble metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D6781</b>	Retainer crown – 3/4 cast predominantly base metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D6782</b>	Retainer crown – 3/4 cast noble metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D6783</b>	Retainer crown – 3/4 porcelain/ceramic	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D6784</b>	Retainer crown ¾ - titanium and titanium alloys	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D6790</b>	Retainer crown – full cast high noble metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D6791</b>	Retainer crown – full cast predominantly base metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D6792</b>	Retainer crown – full cast noble metal	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D6793</b>	Provisional retainer crown – further treatment of completion of diagnosis necessary prior to final impression	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D6794</b>	Retainer crown – titanium and titanium alloys	0 - 99	Limited to 1 time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	Y
<b>D6930</b>	Re-cement or re-bond fixed partial denture	0 - 99	Limited to those performed more than 12 months after the initial insertion. Limited to 1 time per consecutive 6 months.	N
<b>D6980</b>	Fixed partial denture repair necessitated by restorative material failure	0 - 99	Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	Y

## 4.2.H Oral and maxillofacial surgery services guidelines

Code	Description	Age	Frequencies and limitations	Clinical review req
<b>Oral and maxillofacial surgery</b>				
– Extractions include local anesthesia, suturing if needed, and routine post operative care				
<b>D7111</b>	Extraction, coronal remnants – primary tooth	0 - 99	Limited to 1 time per tooth per lifetime.	N
<b>D7140</b>	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0 - 99	Limited to 1 time per tooth per lifetime.	N
<b>D7210</b>	Extraction, erupted tooth requiring removal of bone and/ or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	0 - 99	Limited to 1 time per tooth per lifetime.	N
<b>D7220</b>	Removal of impacted tooth – soft tissue	0 - 99	Limited to 1 time per tooth per lifetime.	Y
<b>D7230</b>	Removal of impacted tooth – partially bony	0 - 99	Limited to 1 time per tooth per lifetime.	Y
<b>D7240</b>	Removal of impacted tooth – completely bony	0 - 99	Limited to 1 time per tooth per lifetime.	Y
<b>D7241</b>	Removal of impacted tooth – completely bony, with unusual surgical complications	0 - 99	Limited to 1 time per tooth per lifetime.	Y
<b>D7250</b>	Removal of residual tooth roots (cutting procedure)	0 - 99	Limited to 1 time per tooth per lifetime.	N
<b>D7251</b>	Coronectomy – intentional partial tooth removal, impacted teeth only	0 - 99	Limited to 1 time per tooth per lifetime.	Y
<b>D7260</b>	Oroantral fistula closure	0 - 99	Limited to 1 per site per lifetime.	N
<b>D7261</b>	Primary closure of a sinus perforation	0 - 99	Limited to 1 per lifetime.	Y
<b>D7270</b>	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	0 - 99	Limited to 1 per site per lifetime.	N
<b>D7272</b>	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)	0 - 99	Limited to 1 per site per lifetime.	N
<b>D7280</b>	Exposure of an unerupted tooth	0 - 99	Limited to 1 time per tooth per lifetime.	N
<b>D7282</b>	Mobilization of erupted or malpositioned tooth to aid eruption	0 - 99	Limited to 1 time per tooth per lifetime.	N
<b>D7283</b>	Placement of device to facilitate eruption of impacted tooth	0 - 99	Limited to 1 time per tooth per lifetime.	N
<b>D7285</b>	Incisional biopsy of oral tissue – hard (bone, tooth)	0 - 99	Limited to 1 biopsy per visit.	N
<b>D7286</b>	Incisional biopsy of oral tissue – soft	0 - 99	Limited to 1 biopsy per visit.	N
<b>D7287</b>	Exfoliative cytological sample collection	0 - 99	Limited to 1 biopsy per visit.	N
<b>D7288</b>	Brush biopsy – transepithelial sample collection	0 - 99	Limited to 1 biopsy per visit.	N
<b>D7291</b>	Transseptal fiberotomy/supra crestal fiberotomy, by report	0 - 99	Limited to 1 time per tooth per lifetime.	N
<b>D7310</b>	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	0 - 99	Limited to 1 time per quadrant per lifetime.	N

Code	Description	Age	Frequencies and limitations	Clinical review req
<b>Oral and maxillofacial surgery</b>				
– Extractions include local anesthesia, suturing if needed, and routine post operative care				
<b>D7311</b>	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	0 - 99	Limited to 1 time per quadrant per lifetime.	N
<b>D7320</b>	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	0 - 99	Limited to 1 time per quadrant per lifetime.	N
<b>D7321</b>	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	0 - 99	Limited to 1 time per quadrant per lifetime.	N
<b>D7340</b>	Vestibuloplasty – ridge extension (secondary epithelialization)	0 - 99	Limited to 1 time per arch per consecutive 60 months.	N
<b>D7350</b>	Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	0 - 99	Limited to 1 time per arch per consecutive 60 months.	N
<b>D7410</b>	Excision of benign lesion up to 1.25 cm	0 - 99	Limited to 1 per visit.	N
<b>D7411</b>	Excision of benign lesion greater than 1.25 cm	0 - 99	Limited to 1 per visit.	Y
<b>D7412</b>	Excision of benign lesion, complicated	0 - 99	Limited to 1 per visit.	Y
<b>D7450</b>	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	0 - 99	Limited to 1 per visit.	N
<b>D7451</b>	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	0 - 99	Limited to 1 per visit.	N
<b>D7460</b>	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	0 - 99	Limited to 1 per visit.	N
<b>D7461</b>	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	0 - 99	Limited to 1 per visit.	N
<b>D7472</b>	Removal of torus palatinus	0 - 99	Limited to 1 per visit.	N
<b>D7473</b>	Removal of torus mandibularis	0 - 99	Limited to 1 per arch per visit.	N
<b>D7509</b>	Marsupialization of odontogenic cyst	0 - 99	Limited to 1 per visit.	N
<b>D7510</b>	Incision and drainage of abscess – intraoral soft tissue	0 - 99	Limited to 1 per site per visit.	N
<b>D7511</b>	Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	0 - 99	Limited to 1 per site per visit.	N
<b>D7520</b>	Incision and drainage of abscess – extraoral soft tissue	0 - 99	Limited to 1 per visit.	N
<b>D7521</b>	Incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	0 - 99	Limited to 1 per visit.	N
<b>D7530</b>	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	0 - 99	Limited to 1 per visit.	N
<b>D7540</b>	Removal of reaction producing foreign bodies, musculoskeletal system	0 - 99	Limited to 1 per visit.	N

Code	Description	Age	Frequencies and limitations	Clinical review req
<b>Oral and maxillofacial surgery</b>				
– Extractions include local anesthesia, suturing if needed, and routine post operative care				
<b>D7550</b>	Partial ostectomy/sequestrectomy for removal of non-vital bone	0 - 99	Limited to 1 per visit.	N
<b>D7560</b>	Maxillary sinusotomy for removal of tooth fragment or foreign body	0 - 99	Limited to 1 per visit.	N
<b>D7810</b>	Open reduction of dislocation	0 - 99	TMJ plans only; not generally covered on core standard plans.	N
<b>D7820</b>	Closed reduction of dislocation	0 - 99	TMJ plans only; not generally covered on core standard plans.	N
<b>D7830</b>	Manipulation under anesthesia	0 - 99	TMJ plans only; not generally covered on core standard plans - Limited to 1 per visit.	N
<b>D7840</b>	Condylectomy	0 - 99	TMJ plans only; not generally covered on core standard plans - Limited to 2 times per lifetime.	N
<b>D7850</b>	Surgical discectomy, with/without implant	0 - 99	TMJ plans only; not generally covered on core standard plans - Limited to 2 times per lifetime.	N
<b>D7852</b>	Disc repair	0 - 99	TMJ plans only; not generally covered on core standard plans.	N
<b>D7854</b>	Synovectomy	0 - 99	TMJ plans only; not generally covered on core standard plans - Limited to 2 times per lifetime.	N
<b>D7856</b>	Myotomy	0 - 99	TMJ plans only; not generally covered on core standard plans - Limited to 2 times per lifetime.	N
<b>D7858</b>	Joint reconstruction	0 - 99	TMJ plans only; not generally covered on core standard plans - Limited to 2 times per lifetime.	N
<b>D7860</b>	Arthrotomy	0 - 99	TMJ plans only; not generally covered on core standard plans - Limited to 2 times per lifetime.	N
<b>D7865</b>	Arthroplasty	0 - 99	TMJ plans only; not generally covered on core standard plans - Limited to 2 times per lifetime.	N
<b>D7870</b>	Arthrocentesis	0 - 99	TMJ plans only; not generally covered on core standard plans - Limited to 2 times per lifetime.	N
<b>D7871</b>	Non-arthroscopic lysis and lavage	0 - 99	TMJ plans only; not generally covered on core standard plans - Limited to 2 times per lifetime.	N
<b>D7872</b>	Arthroscopy - diagnosis, with or without biopsy	0 - 99	TMJ plans only; not generally covered on core standard plans - Limited to 2 times per lifetime.	N
<b>D7873</b>	Arthroscopy: lavage and lysis of adhesions	0 - 99	TMJ plans only; not generally covered on core standard plans - Limited to 2 times per lifetime.	N

Code	Description	Age	Frequencies and limitations	Clinical review req
<b>Oral and maxillofacial surgery</b>				
– Extractions include local anesthesia, suturing if needed, and routine post operative care				
<b>D7874</b>	Arthroscopy: disc repositioning and stabilization	0 - 99	TMJ plans only; not generally covered on core standard plans - Limited to 2 times per lifetime.	N
<b>D7875</b>	Arthroscopy: synovectomy	0 - 99	TMJ plans only; not generally covered on core standard plans - Limited to 2 times per lifetime.	N
<b>D7876</b>	Arthroscopy: discectomy	0 - 99	TMJ plans only; not generally covered on core standard plans - Limited to 2 times per lifetime.	N
<b>D7877</b>	Arthroscopy: debridement	0 - 99	TMJ plans only; not generally covered on core standard plans - Limited to 2 times per lifetime.	N
<b>D7880</b>	Occlusal orthotic device, by report	0 - 99	TMJ plans only; not generally covered on core standard plans - Limited to 1 time every consecutive 24 months.	Y
<b>D7881</b>	Occlusal orthotic device adjustment	0 - 99	Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	N
<b>D7899</b>	Unspecified TMD therapy, by report	0 - 99	TMJ plans only; not generally covered on core standard plans - Limited to 1 per visit. Cannot be billed in conjunction with other TMD procedures.	Y
<b>D7953</b>	Bone replacement graft for ridge preservation - per site	0 - 99	Limited to 1 time per site per lifetime.	Y
<b>D7956</b>	Guided tissue regeneration, edentulous area - resorbable barrier, per site	0 - 99	Limited to 1 per site per consecutive 36 months.	Y
<b>D7957</b>	Guided tissue regeneration, edentulous area - non-resorbable barrier, per site	0 - 99	Limited to 1 per site per consecutive 36 months.	Y
<b>D7961</b>	Buccal / labial frenectomy (frenulectomy)	0 - 99	Limited to 1 per arch per consecutive 36 months.	Y
<b>D7962</b>	Lingual frenectomy (frenulectomy)	0 - 99	Limited to 1 per arch per consecutive 36 months.	Y
<b>D7963</b>	Frenuloplasty	0 - 99	Limited to 1 time per consecutive 36 months.	Y
<b>D7970</b>	Excision of hyperplastic tissue - per arch	0 - 99	Limited to 1 per arch per consecutive 36 months.	N
<b>D7971</b>	Excision of pericoronal gingiva	0 - 99	Limited to 1 per site per consecutive 36 months.	N
<b>D7972</b>	Surgical reduction of fibrous tuberosity	0 - 99	Limited to 1 time per consecutive 36 months.	Y
<b>D7997</b>	Appliance removal (not by dentist who placed appliance), includes removal of archbar	0 - 99	Limited to once per lifetime.	N



## 4.2.I Orthodontic services guidelines

Code	Description	Age	Frequencies and limitations	Clinical review req
<b>Orthodontics</b>				
<b>D8010</b>	Limited orthodontic treatment of the primary dentition	0 - 99	Plans with orthodontic benefits	N
<b>D8020</b>	Limited orthodontic treatment of the transitional dentition	0 - 99	Plans with orthodontic benefits	N
<b>D8030</b>	Limited orthodontic treatment of the adolescent dentition	0 - 99	Plans with orthodontic benefits	N
<b>D8040</b>	Limited orthodontic treatment of the adult dentition	0 - 99	Plans with orthodontic benefits	N
<b>D8070</b>	Comprehensive orthodontic treatment of the transitional dentition	0 - 99	Plans with orthodontic benefits	N
<b>D8080</b>	Comprehensive orthodontic treatment of the adolescent dentition	0 - 99	Plans with orthodontic benefits	N
<b>D8090</b>	Comprehensive orthodontic treatment of the adult dentition	0 - 99	Plans with orthodontic benefits	N
<b>D8091</b>	Comprehensive orthodontic treatment with orthognathic surgery	0 - 99	Plans with orthodontic benefits	N
<b>D8210</b>	Removable appliance therapy	0 - 99	Plans with orthodontic benefits. Limited to 1 time per consecutive 60 months.	N
<b>D8220</b>	Fixed appliance therapy	0 - 99	Plans with orthodontic benefits. Limited to 1 time per consecutive 60 months.	N
<b>D8660</b>	Pre-orthodontic treatment visit	0 - 99	Plans with orthodontic benefits	N
<b>D8670</b>	Periodic orthodontic treatment visit (as part of contract)	0 - 99	Plans with orthodontic benefits	N
<b>D8671</b>	Periodic orthodontic treatment visit associated with orthognathic surgery	0 - 99	Plans with orthodontic benefits	N
<b>D8680</b>	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	0 - 99	Plans with orthodontic benefits	N
<b>D8695</b>	Removal of fixed orthodontic appliances for reasons other than completion of treatment	0 - 99	Plans with orthodontic benefits	N
<b>D8696</b>	Repair of orthodontic appliance - maxillary	0 - 99	Plans with orthodontic benefits.	N
<b>D8697</b>	Repair of orthodontic appliance - mandibular	0 - 99	Plans with orthodontic benefits.	N
<b>D8698</b>	Re-cement or re-bond fixed retainer - maxillary	0 - 99	Plans with orthodontic benefits.	N
<b>D8699</b>	Re-cement or re-bond fixed retainer - mandibular	0 - 99	Plans with orthodontic benefits.	N



Code	Description	Age	Frequencies and limitations	Clinical review req
<b>Orthodontics</b>				
<b>D8701</b>	Repair of fixed retainer, includes reattachment – maxillary	0 - 99	Plans with orthodontic benefits.	N
<b>D8702</b>	Repair of fixed retainer, includes reattachment – mandibular	0 - 99	Plans with orthodontic benefits.	N

## 4.2.J Adjunctive services guidelines

Code	Description	Age	Frequencies and limitations	Clinical review req
<b>Adjunctive and general services</b>				
<b>D9110</b>	Palliative treatment of dental pain – per visit	0 - 99	Covered as a separate benefit only if no other services, other than radiographs, were done during the visit.	N
<b>D9120</b>	Fixed partial denture sectioning	0 - 99	Limited to one time per bridge.	N
<b>D9210</b>	Local anesthesia not in conjunction with operative or surgical procedures	0 - 99	Not Covered in conjunction with operative or surgical procedures.	N
<b>D9219</b>	Evaluation for moderate sedation, deep sedation or general anesthesia	0 - 99	Not covered if done with exams or professional visit. Limited to 4 times per consecutive 12 months.	N
<b>D9222</b>	Deep sedation/general anesthesia – first 15 minutes	0 - 99	Covered when Necessary in conjunction with Covered Dental Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is clinically necessary.	Y
<b>D9223</b>	Deep sedation/general anesthesia – each subsequent 15 minutes increment	0 - 99	Covered when Necessary in conjunction with Covered Dental Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is clinically necessary.	Y
<b>D9230</b>	Inhalation of nitrous oxide/analgesia, anxiolysis	0 - 99	Covered when Necessary in conjunction with Covered Dental Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is clinically necessary.	Y
<b>D9239</b>	Intravenous moderate (conscious) sedation/analgesia – first 15 minutes	0 - 99	Covered when Necessary in conjunction with Covered Dental Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is clinically necessary.	Y
<b>D9243</b>	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment	0 - 99	Covered when Necessary in conjunction with Covered Dental Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is clinically necessary.	Y
<b>D9248</b>	Non-intravenous conscious sedation	0 - 99	Covered when Necessary in conjunction with Covered Dental Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is clinically necessary.	Y

Code	Description	Age	Frequencies and limitations	Clinical review req
<b>Adjunctive and general services</b>				
<b>D9310</b>	Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	0 - 99	Consultation (diagnostic service provided by dentists or physician other than practitioner providing treatment). Not covered if done with exams or professional visit. Limited to 4 times per consecutive 12 months.	N
<b>D9610</b>	Therapeutic parenteral drug, single administration	0 - 99	Therapeutic Drug Injection, by report/Other Drugs and/or Medicaments, by report - Limited to 1 per visit.	Y
<b>D9612</b>	Therapeutic parenteral drugs, two or more administrations, different medications	0 - 99	Therapeutic Drug Injection, by report/Other Drugs and/or Medicaments, by report - Limited to 1 per visit.	Y
<b>D9630</b>	Drugs or medicaments dispensed in the office for home use	0 - 99	Therapeutic Drug Injection, by report/Other Drugs and/or Medicaments, by report - Limited to 1 per visit.	N
<b>D9910</b>	Application of desensitizing medicament	0 - 99	Desensitizing Medicament: Limited to 1 time per consecutive 6 months.	N
<b>D9911</b>	Application of desensitizing resin for cervical and/ or root surface, per tooth	0 - 99	Desensitizing Medicament: Limited to 1 time per tooth per consecutive 6 months.	N
<b>D9942</b>	Repair and/or reline of occlusal guard	0 - 99	Limited to relining and repair performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.	N
<b>D9943</b>	Occlusal guard adjustment	0 - 99	Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.	N
<b>D9944</b>	Occlusal guard – hard appliance, full arch	0 - 99	Limited to 1 guard every consecutive 36 months and only covered if prescribed to control habitual grinding.	Y
<b>D9945</b>	Occlusal guard – soft appliance, full arch	0 - 99	Limited to 1 guard every consecutive 36 months and only covered if prescribed to control habitual grinding.	Y
<b>D9946</b>	Occlusal guard – hard appliance, partial arch	0 - 99	Limited to 1 guard every consecutive 36 months and only covered if prescribed to control habitual grinding.	Y
<b>D9950</b>	Occlusion analysis – mounted case	0 - 99	Limited to 1 time per consecutive 60 months.	N
<b>D9951</b>	Occlusal adjustment – limited	0 - 99	Limited to 1 time per consecutive 12 months.	N
<b>D9952</b>	Occlusal adjustment – complete	0 - 99	Limited to 1 time per consecutive 60 months.	N
<b>D9995</b>	Teledentistry – synchronous; real-time encounter	0 - 99	Limited to 2 times per consecutive 12 months.	N
<b>D9996</b>	Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	0 - 99	Limited to 2 times per consecutive 12 months.	N

## 4.3 Exclusions & limitations

### Exclusions

Except as may be specifically provided in the Schedule of Covered Dental Services or through a Rider to the Policy, the following are not covered:

- Dental Services that are not necessary.
- Hospitalization or other facility charges.
- Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
- Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury or congenital anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
- Any Dental Procedure not directly associated with dental disease.
- Any Dental Procedure not performed in a dental setting.
- Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
- Any implant procedures performed which are not listed as Covered implant procedures in the Schedule of Covered Dental Services on plans that cover implants.
- Any placement of dental implants, implant supported crowns, abutments and prostheses on plans that do not cover implants.
- Drugs/medications, obtainable with or without a prescription.
- Services for injuries or conditions covered by Workers' Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
- Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
- Treatment of benign neoplasms, cysts or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
- Replacement of complete dentures, and fixed and removable partial dentures or crowns, and implants, implant crowns, implant prosthesis and implant supporting structures (such as connectors), if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
- Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment or treatment for the temporomandibular joint.
- Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
- Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled under the Policy.

- Fixed or removable prosthodontic restoration procedures or implant services for complete oral rehabilitation or reconstruction. Employer benefit contracts may vary. Please call **1-800-822-5353** or log on to **UHCdental.com** to verify benefits for a specific patient.
- Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
- Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
- Replacement of crowns, bridges, and fixed or removable prosthetic appliances, and implants, implant crowns, implant prosthesis and implant supporting structures (such as connectors) inserted prior to plan Coverage unless the patient has been Covered under the Policy for 12 continuous months. If loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this 12-month period, the plan is responsible only for the procedures associated with the addition.
- Replacement of missing natural teeth lost prior to the onset of plan Coverage until the patient has been Covered under the Policy for 12 continuous months.
- Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
- Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
- Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.
- Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.
- Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
- Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.
- In the event that a Non-Network Dentist routinely waives Copayments and/or the Deductible for a particular Dental Service, the Dental Service for which the Copayments and/or Deductible are waived is reduced by the amount waived by the Non-Network provider.
- Foreign Services are not Covered unless required as an Emergency.
- Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
- Any Dental Services or Procedures not listed in the Schedule of Covered Dental Services.

## **Limitations**

- Dental services are covered at the least costly, clinically accepted treatment.
- Oral examinations are covered with a limit of two times per 12 consecutive months.
- Complete series or panoramic radiographs are limited to one time per 36 consecutive months.
- Bitewing radiographs are limited to one series of films per plan year.
- Extraoral radiographs are limited to two films per plan year.
- Dental prophylaxes are limited to two times per 12 consecutive months.
- Diagnostic casts are limited to one per 24 consecutive months.
- Fluoride treatment is limited to covered persons under the age of 12 years, and limited to two times per 12 consecutive months. Treatment should be performed in conjunction with dental prophylaxis.

- Sealants are limited to covered persons under the age of 16 years, and once per first or second permanent molar every 36 consecutive months.
- Space maintainers are limited to covered persons under the age of 16 years, once per lifetime. Benefit includes all adjustments within six months of placement.
- Multiple restorations submitted for the same tooth with contiguous surfaces will be treated as a single multi-surface restoration.
- Pin retention is limited to two pins per tooth; not covered in addition to cast restorations.
- Inlays and onlays are limited to one time per 60 consecutive months. Covered only when a filling cannot restore the tooth.
- Crowns are limited to one time per 60 consecutive months. Covered only when a filling cannot restore the tooth.
- Post and cores are covered as a separate benefit only for teeth that have had root canal therapy.
- Sedative fillings are covered as a separate benefit only if no other service, other than X-rays and exam, were performed on the same tooth during the visit.
- Scaling and root planing is limited to one time per quadrant per 24 consecutive months.
- Periodontal maintenance is limited to two times per 12 consecutive months following active and adjunctive periodontal therapy within the prior 24 months, exclusive of gross debridement.
- For full dentures, there are no additional allowances for over-dentures or customized dentures.
- For partial fixed and removable dentures, there are no additional allowances for precision or semi-precision attachments.
- Relining or rebasing dentures is limited to relining performed more than six months after the initial insertion. Limited to one time every 12 consecutive months.
- Repairs and adjustments to full dentures or partial fixed or removable dentures are limited to those performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.
- Palliative treatment is covered as a separate benefit only if no other service, other than X-rays and exam, was performed on the same tooth during that visit.
- Occlusal guards are limited to one guard every 36 consecutive months.
- Full-mouth debridement is limited to once every 36 consecutive months.
- General anesthesia is covered only when medically necessary.

#### **4.4 Member appeals and inquiries (Commercial PPO)**

Members and providers acting on a member's behalf have the right to appeal how a claim was paid or how a utilization management decision was made.

Appeals regarding a denial of coverage based on dental necessity must be submitted within 180 days of the date of notification of an adverse decision unless otherwise prescribed by state regulations.

Appeals may be filed in writing or by fax and must include:

- Member name
- Claim ID
- Nature of the appeal including identification of the service
- Appropriate supporting documentation (such as X-rays or periodontal charting) and a narrative stating why the service should be covered.

Appeal reviews will be completed within state mandated time frames upon receipt of all necessary information. Providers and/or members will be notified of an appeal determination within the state law statute requirements.

**Expedited appeals:**

In time-sensitive circumstances in which the time frame for issuing determinations could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, an expedited appeal may be requested.

Expedited Appeals may be submitted by the member, the member's representative, or by the practitioner acting on behalf of the member. To arrange an expedited appeal, please call 1-800-445-9090.

Determinations will be completed within 72 hours of receiving the appeal request and any additional information or within the time frame required by state law, statute, or act.

Our Provider Services line is also available for any questions.



## Section 5: Radiographs

### 5.1 Radiographs

For some procedures, it is required that copies of radiographs are submitted prior to payment. Requirements for radiographs are found at the following links: [COMMERCIAL](#) and [MEDICARE](#). Providers should refer to the previously noted links for documentation guidelines before performing a procedure.

Guidelines for providing radiographs are as follows:

- Send a duplicate radiograph instead of the original
- Radiograph must be diagnostic for the condition or site and contain all critical anatomical landmarks
- Radiographs should be labeled with the practice name, member name and exposure date (not the duplication date)
- When a radiograph does not demonstrate a clinical condition well, an intra-oral photo and/or narrative are suggested as additional diagnostic aides

Electronic submission, rather than paper copies of digital x-rays is preferred. Film copies are only accepted if labeled, mounted and paper clipped to the authorization. Please do not utilize staples.

Orthodontic and other models are not accepted forms of supporting documentation and will not be reviewed. Orthodontic models will be returned to you along with a copy of the paperwork submitted.

Please note: Authorizations, including attachments, can be submitted online at no additional cost by logging into the provider portal at [UHCdental.com](https://UHCdental.com).

## Section 6: Claim submission procedures

### 6.1 Claim submission options

#### Electronic claims

Electronic Claims Submission refers to the ability to submit claims electronically versus paper. This expedites the claim adjudication process and can improve overall claim payment turnaround time (especially when combined with Electronic Funds Transfer, which is the ability to be paid electronically directly into your bank account).

UnitedHealthcare partners with electronic clearinghouses to support electronic claims submissions. While the payer ID may vary for some plans, the UnitedHealthcare number is 52133. Please refer to Section 2: Resources and services for additional information as needed.

If you wish to submit claims electronically, please contact your clearinghouse to initiate this process. If you do not currently work with a clearinghouse, you may sign up with one to initiate this process. The UnitedHealthcare website (UHCdental.com) also offers the feature to directly submit your claims online through the provider portal. Refer to section 2.4.B for more information on how to register as a participating user.

#### Paper claims

When submitting a paper claim, dentists are recommended to submit an American Dental Association (ADA) Dental Claim Form (2019 version or later). Refer to Section 2: Resources and services for the appropriate claims address information to ensure your claims are routed to the correct resource for payment.

All dental claims must be legible. Computer-generated forms are recommended. Additional documentation and radiographs should be attached when applicable. Such attachments are required for pre-treatment estimates and for the submission of claims for complex clinical procedures. Please refer to the Exclusions & Limitations section of this manual to find the recommendations for dental services.

#### HIPAA compliant 837D file

The 837D is a HIPAA compliant EDI transaction format for the submission of dental claims. This transaction set can be used to submit health care claim billing information, encounter information, or both, from providers of health care services to payers via established claims clearinghouses.

### 6.2 Claim submission required elements and best practices

#### Dental claim form required information

One claim form should be used for each member and the claim should reflect only one treating dentist for services rendered. The claims must also have all necessary fields populated as outlined below.

#### Header information

Indicate the type of transaction by checking the appropriate box: Statement of Actual Services or Request for Pre-Treatment Estimate.

**Subscriber information**

- Name (Last, First, and Middle Initial)
- Address, City, State, ZIP Code
- Date of Birth
- Gender
- Subscriber ID number

**Member information**

- Name (Last, First, and Middle Initial)
- Address, City, State, ZIP Code
- Date of Birth
- Gender
- Member ID number

**Primary payer information**

Record the name, address, city, state and ZIP code of the carrier.

**Other coverage**

If the member has other insurance coverage, completing the “Other Coverage” section of the form with the name, address, city, state and ZIP code of the carrier is required. You will need to indicate if the “other insurance” is the primary insurance. You may need to provide documentation from the primary insurance carrier, including amounts paid for specific services.

**Other insured’s information (only if other coverage exists)**

If the member has other coverage, provide the following information:

- Name of subscriber / policy holder (Last, First, and Middle Initial)
- Date of Birth and Gender
- Subscriber Identification number
- Relationship to the Member

**Billing dentist or dental entity**

Indicate the provider or entity responsible for billing, including the following:

- Name/DBA
- Address, City, State, ZIP Code
- License number
- TIN
- Phone number

**Treating dentist and treatment location**

List the following information regarding the dentist that provided treatment:

- Certification – Signature of dentist and the date the form was signed
- Name (as it appears on dental license)
- NPI
- License number

- TIN
- Address, city, state, ZIP code
- Phone number

### Services provided

Most claim forms have 10 field rows for recording procedures. Each procedure must be listed separately and must include the following information if applicable. If the number of procedures exceeds the number of available lines, the remaining procedures must be listed on a separate, fully completed claim form.

- Procedure date
- Area of oral cavity
- Tooth number or letter and the tooth surface
- Procedure code
- Description of procedure
- Charges for dentist's fee/charges for the procedure.
- Total sum of all charges

### Missing teeth information

When submitting for periodontal or prosthodontic procedures, this area should be completed. An "X" can be placed on any missing tooth number or letter when missing.

### Remarks section

Some procedures require a narrative. If space allows, you may record your narrative in this field. Otherwise, a narrative attached to the claim form, preferably on practice letterhead with all pertinent member information, is acceptable.

### Subscriber / member authorization

Signature of subscriber or member authorizing payment of dental benefits is required. A claim form that indicates a signature is "on file" for a particular member will be accepted. The dentist must keep a copy of a signed claim in the member record.

### By report procedures

All "By Report" procedures require a narrative along with the submitted claim form. The narrative should explain the need for the procedure and any other pertinent information.

### Using current ADA codes

It is expected that providers use Current Dental Terminology (CDT). For the latest dental procedure codes and descriptions, you may order a current CDT book by calling the ADA or visiting the ADA store at [engage.ada.org](https://engage.ada.org).

### Tips on claim submission

The National Association of Dental Plans says dentists will be reimbursed more quickly if they include the information below on their dental claim forms.

- Treating dentist information should include dentist's name, address and tax identification number (TIN). If any of this information has changed from the last submission, or if the payer was not informed of the change, a delay can occur while verification of correct data is made.

- Patient information should include patient's full name, identification or member number and date of birth and relationship to the insured person (self, dependent or spouse).
- Date of service should be the day on which the service was performed.
- CDT codes of services performed – Dental claim logic systems are designed to read approved current CDT codes according to their definition. Internal codes, outdated codes or codes that are considered an integral part of another procedure can delay a claim while research is conducted.
- Tooth number or quadrant along with the surface, if appropriate, is required to identify where procedure was performed.
- Missing teeth information should be reported on claims for periodontal, prosthodontic (fixed and removable), or implant services procedures, if covered.
- Prior placement date for crowns, bridges – As many plans have frequency limitations on crowns and bridges, it is important to indicate whether this is an initial placement in the claim form box provided. If not an initial placement, the prior placement date should be indicated and an explanation included in the narrative. This is a particular problem when older versions of the ADA claim form are utilized.
- Narratives are essential to help the treating dentist explain why a certain procedure was recommended. Payers will not try to validate the course of treatment but will assign benefits according to the plan purchased for that particular patient. If it isn't part of their benefit design, then the dentist can charge the member accordingly.
- Coordination of benefits – If the patient is covered by more than one dental carrier, or if the procedure is also covered under the patient's health plan, include any explanation of benefits or remittance notice from the other payer. Payers are required by state law or regulation to coordinate benefits when more than one entity is involved – this is not a payer choice. The objective is to ensure the dentist is reimbursed appropriately by the proper payer first (primary) with any other payer coordinating the benefit on the balance.
- Remarks – The Remarks section of the claim form should only be used to provide additional explanation of the procedures performed. For most payers, information included in this section will remove a claim from auto-adjudication, thus delaying the processing.

### 6.3 Pre-Treatment Estimate (PTE)

A pre-treatment estimate is a summary estimating how planned treatment will be adjudicated according to the member's plan design and enrollment status at the time the PTE is reviewed. These estimates may be submitted on an ADA claim form and are not a guarantee of coverage or how the claim will be ultimately adjudicated.

Pre-treatment estimates are strongly encouraged to ensure that both the practice and the member fully understand how benefits will be applied, particularly for high-dollar procedures. Your office is encouraged to use features found on the UnitedHealthcare website ([UHCdental.com](https://www.uhcdental.com)) to do your own pre-treatment estimates. In addition, many practice management systems will perform this function (consult your office's practice management system support organization to determine the capabilities of your office's systems).

If a pre-treatment is older than 90 days, a new PTE must be attained prior to delivering clinical services.

### 6.4 Claims processing systems

UnitedHealthcare processes claims using a proprietary claims processing platform. Claims are edited and paid according to ADA Code and Dental Procedures. There are no modifiers associated with this code set. Claims are edited and paid according to the specific plan design for a member's employer group.

Any specific plan design questions that would assist you in determining how to administer claims for a particular member can be answered by our Provider Services line.

## 6.5 HIPAA compliant 835 file

An 835 is an electronic remittance detailing payments and/or adjustments including cancellations, recoveries, reversals, etc., made on claims submitted electronically via an 837D transaction file or via paper.

For practitioners participating in Electronic Payments and Statements (EPS), the 835 file can be accessed via EPS. You must be an EPS participant to access this information.

If you're not already participating with EPS and would like to take advantage of this cost-savings opportunity, simply visit [UHCdental.com](https://UHCdental.com). Section 2.3 Electronic payments and statements in this manual provides a detailed overview of this service and how to enroll.

For general questions, eligibility and/or claim status inquiries, please call **1-877-620-6194**. Additional tools and resources can also be found online at [UHCdental.com](https://UHCdental.com).

## 6.6 Coordination of Benefits (COB)

Coordination of Benefits (COB) is used when a member is covered by more than one dental insurance policy. By coordinating benefit payments, the member receives maximum benefits available under each plan. It is each provider's responsibility to assist in correct coordination of benefits by notifying all payers so that claims may be paid correctly.

If the patient is covered by more than one dental carrier, or if the procedure is also covered under the patient's health plan, include any explanation of benefits or remittance notice from the other payer. Payers are required by state law or regulation to coordinate benefits when more than one entity is involved – this is not a payer choice. The objective is to ensure that the dentist is reimbursed appropriately by the proper payer first (primary) with any other payer coordinating the benefit on the balance.

When a claim is being submitted to us as the secondary payer for Coordination of Benefits (COB), a fully completed claim form must be submitted along with the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer.

## 6.8 Dental claim filing limits and adjustments

All Dental Claims should be submitted within ninety (90) days from the date of service (30 days is preferred). Payment may be considered after the date of service for up to three hundred and sixty-five (365) days. This may vary for some plans.

All adjustments or requests for reprocessing must be made within sixty (60) days from receipt of payment. An adjustment can be requested telephonically by calling our Provider Servicing team at **1-800-822-5353**.

## 6.9 Claim adjudication and periodic overview

In accordance with UnitedHealthcare's standard practice, clean claims will be adjudicated and paid within five to ten days of receipt (this may vary by state and claim submission and/or payment method).

Quality Assurance (QA) audits are performed to ensure the accuracy and effectiveness of our claim adjudication procedures. Any identified discrepancies are resolved within established timelines. The QA process is based on an established methodology, but in general, on a daily basis, various samples of claims are selected for quality assurance reviews. QA samples include center-specific claims, adjustments, claims adjudicated by newly hired claims processors and high-dollar claims. In addition, management selects

other areas for review, including customer-specific and processor-specific audits. Management reviews the summarized results and correction is implemented, if necessary.

**Invalid or incomplete claims:**

- If claims are submitted with missing information or incomplete claim forms, the claim will be returned or rejected with a request for the missing required information to be sent.
- If the claim is missing a tooth number or surface, a letter will be generated to the provider requesting this information.
- If the procedure code is invalid or expired, a letter will be sent to the provider requesting the appropriate code.
- If there are inadequate provider details to process under the submitting provider, the claim will be returned with a letter requesting appropriate provider information.
- If the member is not found or ineligible, the claim will be returned.

## 6.10 Explanation of provider remittance advice

The Provider Remittance Advice is a claim detail of each member and each procedure considered for payment. Please use these as a guide to reconcile member payments. As a best practice it is recommended that Remittance Advices be kept for future reference and reconciliation.

Below is a list and description of each field:

**PROVIDER OR MBR NAME AND ID NO**

Treating dentist's name, NPI submitted with claim, Member's name and Subscriber's ID number. To conform to HIPAA regulations, the subscriber's alternate ID number is shown in place of the Social Security number.

**GROUP NO**

Group ID number assigned to the member's plan

**CLAIM NO**

Number assigned to the claim

**ADA CODE**

Procedure code submitted pertaining to the service

**DESCRIPTION**

Description of the procedure code

**DATE OF SERVICE**

Date when services were rendered

**TOOTH NO**

Tooth number or the quadrant pertaining to the procedure

**AMOUNT CLAIMED**

Amount submitted by provider

**AMOUNT ALLOWED**

Provider's contracted fee amount

**DEDUCT APPLIED**

Applicable plan deductible

**OTHER INS**

Member's primary insurance if applicable



**MEMBER RESP**

Member's copayment that pertains to the procedure

**AMOUNT PAID**

Claim paid amount

**EOB CODE**

Refers to the explanations provided within the EOB that explain how the procedure adjudicated

**6.11 Provider claim appeal and inquiry process**

Appeal rights vary by business and/or state. Refer to the appeals language on the back of the Provider Remittance Advice (PRA)/ Electronic Remittance Advice (ERA) for guidance with the appeals processes that are appropriate for each particular claim.

There are two types of provider appeals:

**Utilization Management (UM) Appeal:** Any appeal that is based on dental necessity and/or would require review by a dental clinician. UM appeals must include a narrative and any supporting documentation including X-rays.

**Administrative Appeal:** Appeals that are not based on dental necessity. This type of appeal would include but is not limited to appeals for timely filing of claims, member's eligibility, over/underpayment adjustment requests, etc. Administrative appeals must include a narrative.

Refer to the Quick Reference Guide section for appeal submission addresses.

## Section 7: Quality management

### 7.1 Quality Improvement Program (QIP) description

UnitedHealthcare has established and maintains an ongoing program of quality management and quality improvement to facilitate, enhance and improve member care and services while meeting or exceeding customer needs, expectations, accreditation and regulatory standards.

The objective of the QIP is to ensure that quality of care is being reviewed; that problems are being identified and that follow up is planned where indicated. The program is directed by all state, federal and client requirements. The program addresses various service elements including accessibility, availability and continuity of care. It also monitors the provisions and utilization of services to ensure they meet professionally recognized standards of care. The QIP Description is reviewed annually and updated as needed.

The QIP includes, but is not limited to, the following goals:

- To measure, monitor, trend and analyze the quality of patient care delivery against performance goals and/or recognized benchmarks.
- To foster continuous quality improvement in the delivery of patient care by identifying aberrant practice patterns and opportunities for improvement.
- When indicated, implement improvement plans and document actions taken to increase performance.
- To evaluate the effectiveness of implemented changes to the QIP.
- To reduce or minimize opportunity for adverse impact to members.
- To improve efficiency, value, and productivity in the delivery of oral health services.
- To promote effective communications, awareness and cooperation between members, participating providers and the plan.
- To ensure quality of care, dentists are vetted through a credentialing and recredentialing process.
- To comply with pertinent legal, professional and regulatory standards.
- To foster the provision of appropriate dental care according to professionally recognized standards.
- To ensure that written policies and procedures are established and maintained by the Plan to ensure that quality dental care is provided to the members.
- To communicate results of performance measurement to the committees and Board of Directors.

A complete copy of our QIP policy and procedure is available upon request by contacting our Provider Services line at **1-800-822-5353**.

### 7.2 Credentialing Overview

To join UnitedHealthcare's Dental network as a participating provider, you must complete the full credentialing process and receive approval from our Credentialing Committee. To maintain participation, all practitioners are required to undergo recredentialing – typically every three (3) years, unless otherwise mandated by state regulations.

#### Initial Credentialing

Before acceptance into the network, UnitedHealthcare conducts a thorough review of each applicant's credentials. We partner with SKYGEN Dental Hub to collect and verify the necessary data for both

credentialing and recredentialing. Timely responses to requests from SKYGEN or UnitedHealthcare are essential for an efficient process.

The credentialing review includes, but is not limited to:

- State license status
- Sanctions or disciplinary actions
- Malpractice insurance coverage
- Other relevant professional credentials

If any adverse findings are identified, we will request a written explanation detailing the incident, its resolution, and a corrective action plan. For certain plans or markets, state-specific regulations may require an initial facility site visit. Each location must pass this review before activation. Your Professional Networks Representative will inform you if a site visit is necessary.

The Credentialing Committee evaluates all submitted information against established criteria, which are reviewed and approved with input from practicing network providers to ensure alignment with industry standards. If discrepancies are found, UnitedHealthcare will request clarification or correction.

### **Provider Rights During Credentialing**

Applicants have the right to:

- Review the information submitted for their application (excluding peer review-protected materials and references).
- Correct erroneous information. If we identify substantial discrepancies, we will notify you in writing, by fax, or email. Corrections must be submitted within 30 days of notification.
- Request the status of your credentialing or recredentialing application by calling 1-800-822-5353.

### **Credentialing decisions are never based on:**

- Race or ethnic/national identity
- Gender
- Age
- Sexual orientation
- Specialties serving high-risk populations or costly conditions

If your state allows credentialing appeals, you may appeal a decision based on information reviewed during the process. Instructions for initiating an appeal will be included in your determination letter.

### **Recredentialing**

Recredentialing is required to maintain participation and is a condition of your provider agreement. Failure to comply may result in termination for cause. Requests are sent several months before the due date, directing you to SKYGEN Dental Hub to begin the process. If SKYGEN cannot obtain a complete packet, UnitedHealthcare will make additional outreach attempts. If there is no response, a termination letter will be issued.

In addition to the items verified in the initial credentialing process, UnitedHealthcare may also review provider performance measures such as, but not limited to:

- Utilization reports
- Current facility review scores
- Member chart review scores
- Grievance and appeals data

For more details, refer to the [Credentialing Guidelines](#) at [UHCdental.com/resources](https://UHCdental.com/resources). Questions regarding your credentialing status can be directed to our Provider Services line.

## 7.2.A Confidentiality

Our staff treats information obtained in the credentialing process as confidential. We and our delegates maintain mechanisms to properly limit review of confidential credentialing information. Our contracts require Delegated Entities to maintain the confidentiality of credentialing information.

Credentialing staff or representatives will not disclose confidential care provider credentialing information to any persons or entity except with the express written permission of the care provider or as otherwise permitted or required by law.

## 7.3 Site visits

With appropriate notice, provider locations may receive an in-office site visit as part of our quality management oversight processes. All surveyed offices are expected to perform quality dental work and maintain appropriate dental records.

The site visit focuses primarily on: dental recordkeeping, patient accessibility, infectious disease control, and emergency preparedness and radiation safety. Results of site reviews will be shared with the dental office. Any significant failures may result in a review by the Peer Review Committee, leading to a corrective action plan or possible termination. If terminated, the dentist can reapply for network participation once a second review has been completed and a passing score has been achieved.

## 7.4 Grievances

The member grievance process encompasses investigation, review and resolution of member issues related to the plan and/or contracted providers.

Issues are accepted via telephone, fax, email, letter, written grievance form, or through our Web portal. Grievance forms may be requested from our Customer Service Department, website or from a contracted dental provider office. UnitedHealthcare does not delegate grievance processing and resolution to any provider group.

All member benefit and quality of care grievances are received and reviewed in accordance with state and federal regulatory and client-specific requirements both in terms of the notifications sent and the time frames allowed.

Your office is required to cooperate with UnitedHealthcare's Policies and Procedures, Member Rights and Responsibilities (including grievances) and Dental Records.

UnitedHealthcare shall have access to office records for that purpose and such information obtained from the records shall be kept confidential. Your office is required to comply with UnitedHealthcare's request for patient records and films, etc., within five business days of receiving the request.

Failure to comply will result in the grievance resolution in favor of the member. Additionally, your right to appeal the decision will be considered waived.

UnitedHealthcare recognizes the importance of thoroughly reviewing all appropriate documentation to determine if there are any potentially systemic problems.

Periodic reports on member grievance activities are made to all appropriate committees and the Board of Directors.

UnitedHealthcare's Grievance policies are filed with the necessary regulatory agencies when required.

## New Mexico Commercial Networks: Provider grievance process

In accordance with New Mexico law, providers have the right to file a grievance about termination from the Network, credentialing and timely claims payment.

The online Grievance form is available through our provider portal. Access the form after you register and log in to [UHCdental.com](https://UHCdental.com).

## 7.5 Preventive health guideline

The UnitedHealthcare approach to preventive health is a multi-focused strategy which includes several integrated areas. Preventive health focuses primarily on the prevention, assessment for risk, and early treatment of caries and periodontal diseases, but also encompasses areas including prevention of malocclusion, oral cancer prevention and detection, injury prevention, avoidance of harmful habits and the impact of oral disease on overall health. We have a long history of working with customers on education and outreach programs focusing on wellness, oral health management and the relationship between oral disease and overall health.

We strive to ensure that all of our programs and review criteria are based on the most current clinical evidence. The UnitedHealthcare Dental Clinical Policy and Technology Committee (DCPTC) researches, develops and implements the clinical practice guidelines recommendations, based on principles of evidence-based dentistry. Our guidelines are consistent with the most current scientific literature, along with the American Dental Association's (ADA's) current CDT- codes and specialty guidelines as suggested by organizations such as the American Academy of Periodontology, American Academy of Pediatric Dentistry, American Association of Endodontists, American College of Prosthodontists and American Association of Oral and Maxillofacial Surgeons. We also refer to additional resources such as the Journal of Evidence Based Dental Practice, the online Library of Medicine, and evidence-based clearinghouses such as the Cochrane Oral Health Group and Centre for Evidence-Based Dentistry. Other sources of input are the respected public health benchmarks, such as the Surgeon General's Report on Oral Health in America, along with government organizations such as the National Institutes of Health and Center for Disease Control.

Preventive health recommendations for children are intended to be consistent with American Academy of Pediatric Dentistry periodicity recommendations.

**Caries management** – Begins with a complete evaluation including an assessment for risk.

- X-ray periodicity – X-ray examination should be tailored to the individual patient based on the patient's health history and risk assessment/vulnerability to oral disease and should follow current professionally accepted dental guidelines necessary for appropriate diagnosis and monitoring.
- Recall periodicity – Frequency of recall examination should also be tailored to the individual patient based on clinical assessment and risk assessment.
- Preventive interventions – Interventions to prevent caries should consider AAPD periodicity guidelines while remaining tailored to the needs of the individual patient based on age, health history, and risk assessment/vulnerability to oral disease. These preventative interventions include but are not limited to regular prophylaxis, fluoride application, placement of sealants, dietary counseling and adjunctive therapies where appropriate.
- Caries Classification and Risk Assessment Systems - methods of caries detection, classification, and risk assessment combined with prevention strategies, can help to reduce patient risk of developing advanced disease and may even arrest the disease process. Consideration should be given to these conservative nonsurgical approaches to early caries; or alternatively, where appropriate, to minimally invasive approaches, conserving tooth structure whenever possible.

**Periodontal management** – Screening, and as appropriate, complete evaluation for periodontal diseases should be performed on all adults, and children in late adolescence and younger, if that patient exhibits signs and symptoms or a history of periodontal disease.

- A periodontal evaluation should be conducted at the initial examination and periodically thereafter, as appropriate, based on American Academy of Periodontology guidelines.
- Periodontal evaluation and measures to maintain periodontal health after active periodontal treatment should be performed as appropriate.
- Special consideration should be given to those patients with periodontal disease, a previous history of periodontal disease and/or those at risk for future periodontal disease if they concurrently have systemic conditions reported to be linked to periodontal disease such as diabetes, cardiovascular disease and/or pregnancy complications.

**Oral cancer screening** – Should be performed for all adults and children in late adolescence or younger if there is a personal or family history, if the patient uses tobacco products, or if there are additional factors in the patient history, which in the judgment of the practitioner elevate their risk.

- Screening should be done at the initial evaluation and again at each recall.
- Screening should include, at a minimum, a manual/visual exam, but may include newer screening procedures, such as light contrast or brush biopsy, for the appropriate patient.

Additional areas for prevention evaluation and intervention – Include malocclusion, prevention of sports injuries and harmful habits (including, but not limited to, digit- and pacifier-sucking, tongue thrusting, mouth breathing, intraoral and perioral piercing, and the use of tobacco products). Other preventive concerns may include preservation of primary teeth, space maintenance and eruption of permanent dentition.

Multiple channels of communication will be used to share information with providers and members via manuals, websites, newsletters, training sessions, individual contact, health fairs, in-service programs and educational materials. It is the mission of UnitedHealthcare to educate providers and members on maintaining oral health, specifically in the areas of prevention, caries, periodontal disease and oral cancer screening.

## 7.6 Consumer account cards and qualified medical expenses

You may only charge our HRA or FSA consumer account cards for qualified medical expenses incurred by the cardholder, or the cardholder's spouse or dependent. "Qualified medical expenses" are expenses for medical care that provide diagnosis, cure, mitigation, treatment or prevention of any disease, or for affecting any structure or function of the body.

Examples of non-qualifying expenses include:

- Cosmetic surgery/procedures (i.e., procedures directed at improving a person's appearance that do not meaningfully promote the proper function of the body or prevent or treat illness or disease), such as:
- Teeth whitening and similar cosmetic dental procedures
- Advance expenses for future medical care
- Illegal operations or procedures
- An expense defined as a qualified medical expense but might not be covered under a member's benefit plan

For updated information regarding qualified medical expenses, go to: [irs.gov](https://www.irs.gov) or call the IRS at 1-800-TAX-FORM (1-800-829-3676).

## Section 8: Utilization Management program

### 8.1 Utilization Management

Through Utilization Management practices, UnitedHealthcare aims to provide members with cost-effective, quality dental care through participating providers. By integrating data from a variety of sources, including provider analytics, utilization review, prior authorization, claims data and audits, UnitedHealthcare can evaluate group and individual practice patterns and identify those patterns that demonstrate significant variation from norms.

By identifying and remediating providers who demonstrate unwarranted variation, we can reduce the overall impact of such variation on cost of care, and improve the quality of dental care delivered.

### 8.2 Community practice patterns

Utilization analysis is completed using data from a variety of sources. The process compares group performance across a variety of procedure categories and subcategories including diagnostic, preventive, minor restorative (fillings), major restorative (crowns), endodontics, periodontics, fixed prosthetics (bridges), removable prosthetics (dentures), oral surgery and adjunctive procedures. The quantity and distribution of procedures performed in each category are compared with benchmarks such as similarly designed UnitedHealthcare plans and peers to determine if utilization for each category and overall are within expected levels.

Significant variation might suggest either over-utilization or underutilization. Variables which might influence utilization, such as plan design and/or population demographics, are taken into account. Additional analysis can determine whether the results are common throughout the group or caused by outliers.

### 8.3 Evaluation of Utilization Management data

Once the initial Utilization Management data is analyzed, if a dentist is identified as having practice patterns demonstrating significant variation, his or her utilization may be reviewed further. For each specific dentist, a Peer Comparison Report may be generated and analysis may be performed that identifies all procedures performed on all patients for a specified time period. Potential causes of significant variation include upcoding, unbundling, miscoding, excessive treatment, under-treatment, duplicate billing, or duplicate payments. Providers demonstrating significant variation may be selected for counseling or other corrective actions.

### 8.4 Utilization Management analysis results

Utilization analysis findings may be shared with individual providers in order to present feedback about their performance relative to their peers.

Feedback and recommended follow-up may also be communicated to the provider network as a whole. This is done by using a variety of currently available communication tools including:

- Provider Manual/Standards of Care
- Provider Training
- Continuing Education
- Provider News Bulletins



## 8.5 Fraud and abuse

Every Network Provider and third party contractor of UnitedHealthcare is responsible for conducting business in an honest and ethical way. This entails fostering a climate of ethical behavior that does not tolerate fraud or abuse, remaining alert to instances of possible fraud and/or abuse and reporting such situations to the appropriate person(s).

We conduct programs and activities to deter, detect and address fraud and abuse in all aspects of our operations. We utilize a variety of resources to carry out these activities, including anti-fraud services from other affiliated entities, as well as outside consultants and experts when necessary.

If adverse practice patterns are found, interventions will be implemented on a variety of levels. The first is with the individual practitioners. The emphasis is heavily weighted toward education and corrective action. In some instances, corrective action, ranging from reimbursement of over payments to additional consideration by UnitedHealthcare's Peer Review Committee – or further action, including potential termination – may be imposed.

If mandated by the state in question, the appropriate state dental board will be notified. If the account is Medicaid or Medicare, the Office of the Inspector General or the State Attorney General's office will also be notified.

## 8.6 Utilization review

UnitedHealthcare shall perform utilization review on all submitted claims. Utilization review (UR) is a clinical analysis performed to confirm that the services in question are or were necessary dental services as defined in the member's certificate of coverage. UR may occur after the dental services have been rendered and a claim has been submitted (retrospective review).

Utilization review may also occur prior to dental services being rendered. This is known as prior authorization, pre-authorization, or a request for a pre-treatment estimate. UnitedHealthcare does not require prior authorization or pre-treatment estimates (although we encourage these before costly procedures are undertaken).

Retrospective reviews and prior authorization reviews are performed by licensed dentists.

Utilization review is completed based on the following:

- To ascertain that the procedure meets our clinical criteria for necessary dental services, which is approved by the Dental Clinical Policy and Technology Committee, and state regulatory agencies where required.
- To determine whether an alternate benefit should be provided.
- To determine whether the documentation supports the submitted procedure.
- To appropriately apply the benefits according to the member's specific plan design.

(See Section 4 for treatment codes that require clinical review and documentation requirements)

## Section 9: Evidence-Based Dentistry and the Clinical Policy & Technology Committee

### 9.1 Evidence-Based Dentistry and the Dental Clinical Policy and Technology Committee (DCPTC)

According to the American Dental Association (ADA), Evidence-Based Dentistry is defined as:

“An approach to oral health care that requires the judicious integration of systematic assessments of clinically relevant scientific evidence, relating to the patient’s oral and medical condition and history, with the dentist’s clinical expertise and the patient’s treatment needs and preferences.” Evidence-based dentistry is a methodology to help reduce variation and determine proven treatments and technologies. It can be used to support or refute treatment for the individual patient, practice, plan or population levels. At UnitedHealthcare, it ensures that our clinical programs and policies are grounded in science. This can result in new products or enhanced benefits for members. Recent examples include: our current medical-dental outreach program which focuses on identifying those with medical conditions thought to be impacted by dental health, early childhood caries programs, oral cancer screening benefit, implant benefit, enhanced benefits for periodontal maintenance and pregnant members, and delivery of locally placed antibiotics.

Evidence is gathered from published studies, typically from peer reviewed journals. However, not all evidence is created equal, and in the absence of high quality evidence, the “best available” evidence may be used. The hierarchy of evidence used at UnitedHealthcare is as follows:

- Systematic review and meta-analysis
- Randomized controlled trials (RCT)
- Retrospective studies
- Case series
- Case studies
- Anecdotal/expert opinion (including professional society statements, white papers and practice guidelines)

Evidence is found in a variety of sources including:

- Electronic database searches such as Medline®, PubMed®, and the Cochrane Library.
- Hand search of the scientific literature
- Recognized dental school textbooks

Evidence based dentistry can be used clinically to guide treatment decisions, and aid health plans in the development of benefits. At UnitedHealthcare, we use evidence as the foundation of our efforts, including:

- Practice guidelines, parameters and algorithms based on evidence and consensus.
- Comparing dentist quality and utilization data
- Conducting audits and site visits
- Development of dental policies and coverage guidelines

The Dental Clinical Policy and Technology Committee (DCPTC) is responsible for developing and evaluating the inclusion of evidence-based practice guidelines, new technology and the new

application of existing technology in the UnitedHealthcare dental policies, benefits, clinical programs, and business functions; to include, but not limited to dental procedures, pharmaceuticals as utilized in the practice of dentistry, equipment, and dental services. The DCPTC convenes bimonthly and no less frequently than four times per year. The DCPTC is comprised of Dental Policy Development and Implementation Staff Members, Non-Voting Members, and Voting Members. Voting Members are UnitedHealthcare Dentists with diverse dental experience and business background including but not limited to members from Utilization Management and Quality Management.

## Section 10: Patient access

### 10.1 Practice capacity and appointment scheduling standards

UnitedHealthcare is committed to ensuring that its providers are accessible and available to their members for the full range of services specified in the UnitedHealthcare Provider Agreement and Provider Manual.

Participating providers must comply with any state-mandated appointment scheduling requirements for emergency care as well as elective or routine care appointments.

In states where there are specified access and availability standards, UnitedHealthcare will monitor the access and availability of our participating providers through a variety of methods, including member feed-back/surveys, a review of appointment books, spot checks of waiting room activity, investigation of member complaints and random calls to provider offices. Any noted concerns are discussed with the participating provider(s), and corrective action may be taken.

#### Walk-in appointment standards

Dental offices that operate by “walk-in” or “first come, first served” appointments are monitored for access and waiting times, where applicable.

#### Missed appointments

Offices should inform patients of office policies relating to missed appointments and any fees that will be incurred.

- Appointment scheduling guidelines may vary by state. It is recommended that you confirm whether or not the state in which you’re providing services has any state-specific mandates.
- Emergency Care appointments would be needed if a patient is experiencing excessive bleeding, pain or trauma.
- Providers are encouraged to schedule member appointments appropriately to avoid inconveniencing the members with long wait times in excess of thirty (30) minutes. Members should be notified of anticipated wait times and given the option to reschedule their appointment.

### 10.2.A Appointment availability requirements for Connecticut

All PPO Providers in Connecticut are required to follow the required appointment availability standards:

- Urgent appointment wait times within 48 hours.
- Non-urgent appointments for primary care (general dentist) within 10 business days.
- Non-urgent appointments for specialist care within 15 business days.

In addition, the state regulator requires Connecticut dental providers to employ an answering service or a telephone answering machine during nonbusiness hours, which provides instructions on how plan enrollees may obtain urgent or emergency care when applicable, how to contact another provider who has agreed to be on call to triage or screen by phone, or if needed deliver urgent or emergency care. As part of the regulation, UnitedHealthcare is required to conduct random survey to ensure the after-hours standards are being met.

### **10.2.B Appointment availability requirements for Maryland**

All PPO Providers in Maryland are required to follow the required appointment availability standards:

- Urgent appointment wait times within 3 calendar days..
- Non-urgent appointments for primary care (general dentist) within 45 calendar days.
- Non-urgent appointments for specialist care within 60 calendar days.

In addition, the state regulator requires Maryland dental providers to employ an answering service or a telephone answering machine during nonbusiness hours, which provides instructions on how plan enrollees may obtain urgent or emergency care when applicable, how to contact another provider who has agreed to be on call to triage or screen by phone, or if needed deliver urgent or emergency care. As part of the regulation, UnitedHealthcare is required to conduct random survey to ensure the after-hours standards are being met.

### **10.3 Emergency coverage**

All network dental providers must be available to members during normal business hours. Providers will provide members access to emergency care 24 hours a day, seven days a week, through their practice or through other resources (such as another practice or a local emergency care facility). The out of office greeting must instruct callers what to do to obtain services after business hours and on weekends, particularly in the case of an emergency.

Member Services, Provider Services and Quality Management staff monitor and document all instances of provider unavailability to ensure continuity of care. UnitedHealthcare conducts periodic surveys to ensure that access and availability standards for members are in compliance with state requirements and UnitedHealthcare standards.

Network dentists are required to participate in all activities related to these surveys. Offices out of compliance will be required to submit a corrective action plan to UnitedHealthcare.

## Section 11: Office administration

### 11.1 New associates

As your office expands and new associates are added, please contact us to request an application. This allows us to credential the associate and set them up as a participating provider.

It is important to remember associates cannot see members as a participating provider until they have been credentialed by our organization.

To request a provider application packet, visit [UHCdental.com](https://UHCdental.com) > Join our network or contact Provider Services at **1-800-822-5333**.

### 11.2 Change of address, phone number, email address, fax or tax identification number

As a participating provider, it is crucial to notify us of any demographic changes within your practice. This ensures accurate claims processing and helps maintain up-to-date member directories.

Requests for demographic changes must be submitted in writing with supporting documentation. For example, a TIN change requires a new W9, while an office closing notice must be on office letterhead. In addition, when making changes, the old information and the requested updates, including names, TINs, and Practitioner IDs for all affected associates must be provided. Refer to Appendix A.2 for a sample of the Demographic Change Form, available on [UHCdental.com](https://UHCdental.com) under Resources > Resource Library.

Examples of changes requiring notification within 30 days include:

- Whether the participating provider is accepting new patients
- Office location addresses
- Office phone numbers
- Provider email addresses
- Provider group affiliations
- Provider specialties
- Provider licenses
- Tax identification numbers (TIN)
- National Provider Identifiers (NPI)
- Languages spoken/written by the provider or staff
- Ages served by the provider
- Office hours

Changes should be submitted to:

UnitedHealthcare - RMO  
ATTN: 400-Provider Services  
P.O. Box 30567  
Salt Lake City, UT 84130  
Fax: 1-855-363-9691  
Email: [dbpprvfx@uhc.com](mailto:dbpprvfx@uhc.com)

Credentialing updates should be sent to:

Email: [dbpcredsupport@uhc.com](mailto:dbpcredsupport@uhc.com)  
UnitedHealthcare Credentialing  
2300 Clayton Road, Suite 1000  
Concord, CA 94520

Participating providers are expected to validate and attest to demographic information available to DBP members every 90 days. Demographic information can be attested to through the Provider Self Service function of the provider portal at [UHCdental.com](https://UHCdental.com).

For any questions, contact Provider Services at **1-800-822-5353** for guidance.

### **11.3 Office conditions**

Your dental office must meet applicable Occupational Safety & Health Administration (OSHA) and American Dental Association (ADA) standards.

You must submit to us an attestation from each dental office location, that the physical office meets ADA standards or describes how accommodation for ADA standards are made, and that medical record-keeping practices conform with our standards.

### **11.4 Sterilization and asepsis control**

Dental office sterilization protocols must meet OSHA requirements. All instruments should be heat sterilized where possible. Masks and eye protection should be worn by clinical staff where indicated; gloves should be worn during every clinical procedure. The dental office should have a sharps container for proper disposal of sharps. Disposal of medical waste should be handled per OSHA guidelines.

Sterilization and asepsis control fees are to be included within office procedure charges and should not be billed to members or the plan as a separate fee.

While standard practice is for sterilization costs to be included within office procedure charges, should your office charge this fee separately, these fees must be made known to patients in advance. This may not be a covered code on our fee schedules.

### **11.5 Recall system**

It is expected that offices will have an active and definable recall system to make sure that the practice maintains preventive services, including patient education and appropriate access. Examples of an active recall system include, but are not limited to: postcards, letters, phone calls, e-mails and advance appointment scheduling.

### **11.6 Transfer of dental records**

Your office shall copy all requested member dental files to another participating dentist as designated by UnitedHealthcare or as requested by the member. The member cannot be held liable for the cost of copying the patient dental files if the member is transferring to another provider. If your office terminates from UnitedHealthcare, dismisses the member from your practice or is terminated by UnitedHealthcare, the cost of copying files shall be borne by your office. Your office shall cooperate with UnitedHealthcare in maintaining the confidentiality of such member dental records at all times, in accordance with state and federal law.



## 11.7 Nondiscrimination

You will accept members as new patients and provide Covered Services in the same manner as such services are provided to other patients of your practice. You will not discriminate against any member on the basis of source of payment or in any manner in regards to access to, and the provision of, Covered Services. You will not unlawfully discriminate against any member, employee or applicant for employment on the basis of race, ethnicity, religion, national origin, ancestry, disability, medical condition, claims experience, evidence of insurability, source of payment, marital status, age, sexual orientation or gender.

## 11.8 Cultural competency

Cultural competence is of great importance to the field of dentistry. In an increasingly diverse society, it is necessary for dental professionals to be culturally competent health care providers. Cultural competence includes awareness and understanding of the many factors that influence culture and how that awareness translates into providing dental services within clients' cultural parameters.

UnitedHealthcare recognizes that the diversity of American society has long been reflected in our member population. UnitedHealthcare acknowledges the impact of race and ethnicity and the need to address varying risk conditions and dental care disparities. Understanding diverse cultures, their values, traditions, history and institutions is integral to eliminating dental care disparities and providing high-quality care. A culturally proficient health care system can help improve dental outcomes, quality of care and contribute to the elimination of racial and ethnic health disparities.

UnitedHealthcare is committed to providing a diverse provider network that supports the achievement of the best possible clinical outcomes through culturally proficient care for our members.

## 11.9 Provider directory requirements for California

### Notification of Acceptance/Non-Acceptance of New Patients.

Participating Dentists shall provide the following information to ensure compliance with the requirements of Section (j) (1) of CA Insurance Code § 10133.15:

Participating Dentist shall inform DBP within **five business days** when either of the following occurs:

1. Participating Dentist is not accepting new patients.
2. If Participating Dentist had previously not accepted new patients, the Participating Dentist is currently accepting new patients.

## Section 12: Medicare Advantage regulatory requirements

### Medicare Advantage regulatory requirements

This Medicare Advantage Regulatory Requirements Addendum (this “Addendum”) supplements and is made part of the provider agreement (the “Agreement”) between Dental Benefit Providers, Inc. its subsidiaries, and its affiliated companies (collectively, “DBP”) and the provider named in the Agreement (“Provider”).

#### 12.1 Applicability

This Addendum applies to the Covered Services that Provider provides to Medicare Advantage Customers. In the event of a conflict between this Addendum and other appendices or any provision of the Agreement, the provisions of this Addendum shall control except: (1) with regard to Benefit Plans outside the scope of this Addendum; or (2) as required by applicable law.

#### 12.2 Definitions

For purposes of this Addendum, the following terms shall have the meanings set forth below.

**Benefit Plan:** A certificate of coverage, summary plan description, or other document or agreement, whether delivered in paper, electronic, or other format, under which a Payer is obligated to provide coverage of Covered Services for a Customer.

**CMS Contract:** A contract between the Centers for Medicare & Medicaid Services (“CMS”) and a Medicare Advantage Organization for the provision of Medicare benefits pursuant to the Medicare Advantage Program under Title XVIII, Part C of the Social Security Act.

**Cost Sharing:** Those costs, if any, under a Benefit Plan that are the responsibility of the Customer, including deductibles, coinsurance, and copayments.

**Covered Service:** A health care service or product for which a Customer is entitled to receive coverage from a Payer, pursuant to the terms of the Customer’s Benefit Plan with that Payer.

**Customer:** A person eligible and enrolled to receive coverage from a Payer for Covered Services.

**Dual Eligible Customer:** A Medicare Advantage Customer who is: (a) eligible for Medicaid; and (b) for whom the state is responsible for paying Medicare Part A and B Cost Sharing.

**Medicare Advantage Benefit Plans:** Benefit Plans sponsored, issued or administered by a Medicare Advantage Organization as part of the Medicare Advantage program or as part of the Medicare Advantage program together with the Prescription Drug program under Title XVIII, Part C and Part D, respectively, of the Social Security Act (as those program names may change from time to time).

**Medicare Advantage Customer or MA Customer:** A Customer eligible for and enrolled in a Medicare Advantage Benefit Plan in which Provider participates pursuant to the Agreement.

**Medicare Advantage Organization or MA Organization:** For purposes of this Addendum, MA Organization is an appropriately licensed entity that has entered into: (a) a CMS Contract; and (b) a contract with DBP, either directly or indirectly, under which DBP provides certain administrative services for Benefit Plans sponsored, issued, or administered by MA Organization.

**Payer:** An entity obligated to a Customer to provide reimbursement for Covered Services under the Customer’s Benefit Plan, and authorized to access Provider’s services under the Agreement.

## 12.3 Provider requirements

### 12.3.a Data

Provider shall submit to DBP or MA Organization, as applicable, all risk adjustment data as defined in 42 CFR 422.310(a), and other Medicare Advantage program-related information as may be requested by MA Organization, within the timeframes specified and in a form that meets Medicare Advantage program requirements. By submitting data to DBP or MA Organization, Provider represents to MA Organization, and upon MA Organization's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

### 12.3.b Policies

Provider shall cooperate and comply with MA Organization's policies and procedures.

### 12.3.c Customer protection

Provider agrees that in no event, including but not limited to, non-payment by DBP, MA Organization or an intermediary, insolvency of, MA Organization or an intermediary, or breach by DBP of the Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any MA Customer or person (other than MA Organization or an intermediary) acting on behalf of the MA Customer for Covered Services provided pursuant to the Agreement or for any other fees that are the legal obligation of MA Organization under the CMS Contract. This provision does not prohibit Provider from collecting from MA Customers allowable Cost Sharing. This provision also does not prohibit Provider and an MA Customer from agreeing to the provision of services solely at the expense of the MA Customer, as long as Provider has clearly informed the MA Customer, in accordance with applicable law, that the MA Customer's Benefit Plan may not cover or continue to cover a specific service or services.

In the event of MA Organization's, DBP's or an intermediary's insolvency or other cessation of operations or termination of MA Organization's contract with CMS, Provider shall continue to provide Covered Services to an MA Customer through the later of the period for which premium has been paid to MA Organization on behalf of the MA Customer, or, in the case of MA Customers who are hospitalized as of such period or date, the MA Customer's discharge.

This provision shall be construed in favor of the MA Customer, shall survive the termination of the Agreement regardless of the reason for termination, including DBP's or MA Organization's insolvency, and shall supersede any contrary agreement, oral or written, between Provider and an MA Customer or the representative of an MA Customer if the contrary agreement is inconsistent with this provision.

For the purpose of this provision, an "intermediary" is a person or entity authorized to negotiate and execute the Agreement on behalf of Provider or on behalf of a network through which Provider elects to participate.

### 12.3.d Dual eligible customers

Provider agrees that in no event, including but not limited to, non-payment by a State Medicaid Agency or other applicable regulatory authority, other state source, or breach by DBP of the Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Dual Eligible Customer, person acting on behalf of the Dual Eligible Customer, DBP or MA Organization (unless notified otherwise) for Medicare Part A and B Cost Sharing. Instead, Provider will either: (a) accept payment made by or on behalf of MA Organization as payment in full; or (b) bill the appropriate state source for such Cost Sharing amount. If Provider imposes an excess

charge on a Dual Eligible Customer, Provider is subject to any lawful sanction that may be imposed under Medicare or Medicaid. This provision does not prohibit Provider and a Dual Eligible Customer from agreeing to the provision of services solely at the expense of the Dual Eligible Customer, as long as Provider has clearly informed the Dual Eligible Customer, in accordance with applicable law, that the Dual Eligible Customer's Benefit Plan may not cover or continue to cover a specific service or services.

### 12.3.e Eligibility

Provider agrees to immediately notify DBP and MA Organization in the event Provider is or becomes excluded from participation in any federal or state health care program under Section 1128 or 1128A of the Social Security Act. Provider also shall not employ or contract for the provision of health care services, utilization review, medical social work or administrative services, with or without compensation, with any individual or entity that has been excluded from participation in any federal or state health care program under Section 1128 or 1128A of the Social Security Act.

### 12.3.f Laws

Provider shall comply with all applicable federal and Medicare laws, regulations, and CMS instructions, including but not limited to: (a) federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including but not limited to, applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. §3729 et seq.), and the anti-kickback statute (§1128B of the Social Security Act); and (b) HIPAA administrative simplification rules at 45 CFR Parts 160, 162, and 164.

### 12.3.g Federal funds

Provider acknowledges and agrees that MA Organization receives federal payments under the CMS Contract and that payments Provider receives from or on behalf of MA Organization are, in whole or in part, from federal funds. Provider is therefore subject to certain laws that are applicable to individuals and entities receiving federal funds.

### 12.3.h CMS contract

Provider shall perform the services set forth in the Agreement in a manner consistent with and in compliance with MA Organization's contractual obligations under the CMS Contract.

### 12.3.i Records

- **Maintenance; Privacy and Confidentiality; Customer Access.** Provider shall maintain records and information related to the services provided under the Agreement, including but not limited to MA Customer medical records and other health and enrollment information, in an accurate and timely manner. Provider shall maintain such records for at least ten (10) years or such longer period as required by law. Provider shall safeguard MA Customer privacy and confidentiality, including but not limited to the privacy and confidentiality of any information that identifies a particular MA Customer, and shall comply with all federal and state laws regarding confidentiality and disclosure of medical records or other health and enrollment information. Provider shall ensure that MA Customers have timely access to medical records and information that pertain to them, in accordance with applicable law.
- **Government Access to Records.** Provider acknowledges and agrees that the Secretary of Health and Human Services, the Comptroller General, or their designees shall have the right to audit, evaluate and inspect any pertinent books, contracts, medical records, patient care documentation and other records and information belonging to Provider that involve transactions related to the CMS Contract. This right shall extend through ten (10) years from the later of the final date of the CMS Contract period in effect at the time the records were created or the date of completion of any audit, or longer in certain

instances described in the applicable Medicare Advantage regulations. For the purpose of conducting the above activities, Provider shall make available its premises, physical facilities and equipment, records relating to MA Customers, and any additional relevant information CMS may require.

- **MA Organization Access to Records.** Provider shall grant MA Organization or its designees such audit, evaluation, and inspection rights identified in subsection 3.9(b) as are necessary for MA Organization to comply with its obligations under the CMS Contract. Whenever possible, MA Organization will give Provider reasonable notice of the need for such audit, evaluation or inspection, and will conduct such audit, evaluation or inspection at a reasonable time and place. Provider shall submit medical records of MA Customers to the MA Organization as may be requested, within the timeframes specified, for the purpose of (i) CMS audits of risk adjustment data and (ii) for other purposes medical records from providers are used by MA Organization, as specified by CMS. Provision of medical records must be in the manner consistent with HIPAA privacy statute and regulations.

### 12.3.j MA organization accountability; delegated activities

Provider acknowledges and agrees that MA Organization oversees and is accountable to CMS for any functions and responsibilities described in the CMS Contract and applicable Medicare Advantage regulations, including those that DBP may sub-delegate to Provider. If DBP has sub-delegated any of MA Organization's functions and responsibilities under the CMS Contract to Provider pursuant to the Agreement, the following shall apply in addition to the other provisions of this Addendum:

- Provider shall perform those delegated activities specified in the Agreement, if any, and shall comply with any reporting responsibilities as set forth in the Agreement.
- If DBP has delegated to Provider any activities related to the credentialing of health care providers, Provider must comply with all applicable CMS requirements for credentialing, including but not limited to the requirement that the credentials of medical professionals must either be reviewed by MA Organization or its designee, or the credentialing process must be reviewed, pre-approved and audited on an ongoing basis by MA Organization or its designee.
- If DBP has delegated to Provider the selection of health care providers to be participating providers in the MA Organization's Medicare Advantage network, MA Organization retains the right to approve, suspend or terminate the participation status of such health care providers.
- Provider acknowledges that MA Organization or its designee shall monitor Provider's performance of any delegated activities on an ongoing basis. If MA Organization or CMS determines that Provider has not performed satisfactorily, MA Organization may revoke any or all delegated activities and reporting requirements. Provider shall cooperate with MA Organization and DBP regarding the transition of any delegated activities or reporting requirements that have been revoked by MA Organization.

### 12.3.k Subcontracts

If Provider has any arrangements, in accordance with the terms of the Agreement, with affiliates, subsidiaries, or any other subcontractors, directly or through another person or entity, to perform any of the services Provider is obligated to perform under the Agreement that are the subject of this Addendum, Provider shall ensure that all such arrangements are in writing, duly executed, and include all the terms contained in this Addendum. Provider shall provide proof of such to DBP or MA Organization upon request. Provider further agrees to promptly amend its agreements with subcontractors, in the manner requested by MA Organization or DBP, to meet any additional CMS requirements that may apply to the services.

### **12.3.I Offshoring**

Unless previously authorized by MA Organization in writing, all services provided pursuant to the Agreement that are subject to this Addendum must be performed within the United States, the District of Columbia, or the United States territories.

## **12.4 Other**

### **12.4.a Payment**

MA Organization or its designee shall promptly process and pay or deny Provider's claim no later than sixty (60) days after MA Organization or its designee receives all appropriate information as described in MA Organization's administrative procedures. If Provider is responsible for making payment to subcontracted providers for services provided to MA Customers, Provider shall pay them no later than sixty (60) days after Provider receives request for payment for those services from subcontracted providers.

### **12.4.b Regulatory amendment**

Upon the request of MA Organization, DBP may unilaterally amend this Addendum to comply with applicable laws and regulations and the requirements of applicable regulatory authorities, including but not limited to CMS. DBP or MA Organization shall provide written or electronic notice to Provider of such amendment and its effective date. Unless such laws, regulations or regulatory authority(ies) direct otherwise, the signature of Provider will not be required in order for the amendment to take effect.



# Appendix — Provider information

## A.1 Definitions

### A.1.a Preferred Provider Organizations (PPO)

In PPO plans, practitioners treat members at an agreed-upon rate for each procedure. There is an annual maximum of benefit paid out by the plan that varies by employer group. Typically, fees are paid partially by the member and partially by the insurance company.

Distinctions among the different types of plans are as follows:

**Traditional PPO Plans** – Members can seek care and still receive benefits if they go out of network. However, members' out-of-pocket expenses are less if they seek care from a participating dentist who charges contracted rates.

**Incentive PPO Plans** – Members have a richer benefit level (percentage covered) if they seek care at a participating dental office.

**Passive PPO Plans** – Members have the same benefit level (percentage covered) whether or not they use a participating office. However, if the member seeks care from a participating dentist, his/her out-of-pocket costs are lower.

**In-Network Only (INO) Plans** – Members only receive benefits if a participating dentist provides care. The plan benefits are the same as for the PPO network, with deductibles, maximums and coinsurance payments. Members must be referred to participating specialists (excluding orthodontists) under this plan to receive benefits.

Participating practitioners in these and other plans offered receive free advertising through online and print directory publications, and gain access to hundreds of employees within the local community.

### A.1.b Dental Health Maintenance Organization (DHMO) networks

DHMO plans offer a method of provider reimbursement wherein the insurance carrier or HMO pays the practitioner a fixed rate per month for assigned eligible members regardless of the utilization of dental services. In these plans, members select a designated primary care dentist that they access for all preventive, diagnostic and restorative care.

Practitioners who participate with these plans receive a single monthly payment (capitation amount) along with a roster of assigned members. This is paid whether the member accesses care or not.

Covered services are provided by the practitioner at no additional charge to the member unless otherwise stated on the plan fee schedule. In some instances, there are member and/or plan copayments to offset the cost of a procedure.

In a DHMO plan, the members must only visit dentists that are part of their DHMO network. Members must be assigned to a practice before treatment is rendered.

**For certain procedures, referrals to a specialist may be needed. Our provider website and Provider Services line can help in locating specialists available within the member's plan.**



### **A.1.c Discount plans**

Discount Plans differ from traditional plans in that there are no claims to file or submit, and they are not insurance plans. The payment comes directly and solely from the member at the time of service. The member (or spouse/dependent) is entitled to a discount in accordance with the terms of your contract with UnitedHealthcare. The fee schedule is exactly the same as the UnitedHealthcare PPO fee schedule.

Members are educated to understand that the discount plans are not insurance and they are expected to pay in full upon delivery of service.

### **A.1.d Private label clients**

UnitedHealthcare partners with other insurance carriers and entities to assist in providing access to dental care through our network. In addition, they leverage our dental claims adjudication capabilities. In some instances, these carriers or entities retain their own company and/or product brand and the UnitedHealthcare relationship is invisible to their members. When other insurance carriers or entities use our network in this manner, it is referred to as a Private Label Arrangement.


As a participating practitioner with the National PPO and/or Medicare Plans, you will have access to private label members using the same contracted fee schedule that is outlined in your agreement. Private label members seeking treatment may show a membership identification card that is different from the typical UnitedHealthcare identification card. Refer to the Private label portfolio reference guide for a list of our Private Label clients, customer service number, claims address, and more. The guide can be found on the provider portal at [UHCdental.com/resources](https://UHCdental.com/resources).

### **A.1.e Distributor clients**

Distributor clients are clients who have contracted with UnitedHealthcare to utilize our network of dental practitioners, in much the same way as any other PPO client contracts with us to use our dental network. The distinction is that the claims are processed by the Distributor Client. The allowed amounts paid are in accordance with the terms of your agreement with UnitedHealthcare. The fee schedule is the exact same as the UnitedHealthcare PPO fee schedule.

## Attachments

## A.2 Demographic Change Form

Provider Information Demographic Change Submission Form				 <b>Dental Benefit Providers*</b>	
<b>Description of when to use form:</b> To be used by provider if the provider has made changes to ANY of their demographic information (name change, address change, TIN change, etc.). <i>Form must be signed at bottom to be processed. Please list all providers associated with this change. <b>Failure to sign, list all associated providers requesting the update or attach required documentation will delay your request.</b></i>					
<b>Providers:</b> To ensure your claims are processed correctly and on a timely basis, if you have had any changes to your demographic information, please ensure you submit your demographic changes <b>PRIOR</b> to submitting your claim(s) and within 30 days of the change taking place. For real-time updates and to reduce turn around times by 3-5 days, please visit the Self Service section after registration and log-in on <a href="http://uhcdental.com">uhcdental.com</a>					
Please check <b>ALL</b> the demographic items that <b>need</b> to be updated and complete all sections as appropriate. Please submit completed form using one of the methods to the right on this box:				<b>Mailing Address:</b> Dental Benefit Providers, Inc. (DBP-CA Inc) ATTN: Dental Provider Services PO Box 30567, Salt Lake City UT 84130 <b>Fax:</b> 248-733-6372 <b>Email:</b> <a href="mailto:dbpprvfx@uhc.com">dbpprvfx@uhc.com</a>	
<input type="checkbox"/> Please check box if making a TIN (Tax ID Number) change. <i>(Copy of updated W-9 form is required) May be subject to new contracting.</i>					
<b>Current Tax ID:</b>		<b>New Tax ID:</b>		<b>Effective date of change :</b> <input type="text"/> <b>Reprocess Claims? :</b> <input type="checkbox"/> Yes	
<input type="checkbox"/> Please check box if making a dentist name change. <i>(Copy of updated dental license is required)</i>					
<b>Current Name:</b>		<b>(Last) (First)</b>			
<b>New Name:</b>		<b>(Last) (First)</b>			
<input type="checkbox"/> Please check box if changing specialty. <i>(Copy of specialty certification is required)</i>				<input type="checkbox"/> Please check box if board certified.	
<b>Effective date of the following information change:</b> <input type="text"/>				<input type="checkbox"/> Please check if office is handicap accessible.	
<input type="checkbox"/> Please check box if updating practice name or address <b>PRACTICE LOCATION:</b> <small>(Only complete applicable fields)</small>					
<b>Previous Practice Name:</b>			<b>New Practice Name:</b>		
<b>Previous Physical Address:</b>			<b>New Physical Address:</b>		
(Suite #)			(Suite #)		
(City) (State) (Zip)			(City) (State) (Zip)		
<input type="checkbox"/> Please check box if updating mailing address <b>REMITTANCE ADDRESS:</b> <small>(Only complete applicable fields)</small>					
<b>Previous Remit Address:</b>			<b>New Remit Address</b>		
(Suite #)			(Suite #)		
(City) (State) (Zip)			(City) (State) (Zip)		
<b>ADDITIONAL DEMOGRAPHIC INFORMATION</b> <small>(Only complete applicable fields)</small>					
<b>Languages Spoken Other Than English:</b>		<b>Directory Office website:</b>		<b>Directory Email Address:</b>	
<b>Phone Number:</b>		<b>Fax Number:</b>		<b>Internal Email Address:</b>	
<b>New Office Hours:</b>	Mon	Tue	Wed	Thu	Fri
<input type="checkbox"/> Please check box if Associate Provider(s) need to be termed. <b>Term Reason:</b>				<input type="checkbox"/> Provider Left Practice <input type="checkbox"/> Other	
<b>Provider(s) associated with the requested change:</b>					
Notice*** <b>Effective Date</b> may be different than the date of signature on this form. Please be sure your effective date reflects the actual date the change took place.					
<b>AUTHORIZED SIGNATURE:</b>				<b>DATE:</b>	

WPN: Prov W9

Rev Oct 2024



## Attachments

## A.3 Provider Remittance Advice (PRA) sample — continued

20190313-003794 UHC01R 201903135030237500 31366643 03/13/19-FL-N-P--N-N



**EXPLANATION OF  
DENTAL PLAN  
REIMBURSEMENT  
THIS IS NOT A BILL**

Sheet: Page 3 of 4  
Date: 03/13/2019  
Check No: 0011111111  
Check Amt: \$51.10

JOHN DOE DDS  
1234 ANY AVE  
CITY FL 00000-0000

PROVIDER OR MBR NAME AND ID NO; PROVIDER NETWORK STATUS; GROUP NO; CLAIM NO ADA CODE DESCRIPTION	DATE OF SERVICE	TOOTH NO	AMOUNT CLAIMED	AMOUNT ALLOWED	DEDUCT APPLIED	OTHER INS	PATIENT RESP	AMOUNT PAID	EOB CODE
JOHN DOE NPI Submitted: 0000000000 MEMBER, JANE 12345670000; Out of Network; 11111100; 190000000000									
ADA CODE D2393 resin-based composite - three surfaces, posterior	03/11/19	12	350.00	77.00	50.00	0.00	336.50	13.50	K69
ADA CODE D1110 prophylaxis - adult	03/11/19	01 32	120.00	47.00	0.00	0.00	82.40	37.60	PSC
<b>SUB-TOTAL</b>			470.00	124.00	50.00	0.00	418.90	51.10	

**Notes:**

PSC The charge exceeds the allowable amount for this procedure.

K69 Patient responsible for difference in cost between service rendered and the fee for the service on which the plan benefit is based.

Plan underwritten by UnitedHealthcare Insurance Company

	AMOUNT CLAIMED	AMOUNT ALLOWED	DEDUCT APPLIED	OTHER INS	PATIENT RESP	AMOUNT PAID
<b>TOTAL</b>	470.00	124.00	50.00	0.00	418.90	51.10

DEN-PEOB1

## Attachments

### A.3 Provider Remittance Advice (PRA) sample — continued

Page 4 of 4

For Claim Submissions and ReSubmissions:

To ensure that that your claims are processed in a timely manner, please mail your claims to the following address:

P.O. Box 30567  
Salt Lake City, UT 84130-0567

If your claim has been denied and additional documentation was requested, please mail the additional documentation, with the original ADA claim form, to the same address as the initial claim, (listed above).

Sending correspondence to the appropriate addresses will ensure that your claim or resubmission is reviewed as quickly as possible.

For Appeals:

If you are dissatisfied with the Plan's payment of the claims listed herein, you have the right to file a complaint with the Plan. Written complaints should be mailed to:

Dental Appeals/Complaints  
P.O. Box 30569  
Salt Lake City, UT 84130

(PRC001)

Sample Provider Remittance Advice (PRA) for illustration only; actual information varies depending on payer, plan and other requirements.

## A.4 Fraud, waste and abuse training tools for staff

Providers are required to establish written policies for their employees, contractors or agents and to provide training to their staff on the following policies and procedures:

1. Provide detailed information about the Federal False Claims Act
2. Cite administrative remedies for false claims and statements
3. Reference state laws pertaining to civil or criminal penalties for false claims and statements.
4. With respect to the role of such laws in preventing and detecting fraud, waste and abuse in federal health care programs, include as part of such written policies, detailed provisions regarding care providers policies and procedures for detecting and preventing fraud, waste and abuse.

The required training materials can be found at the website listed below. The website provides information on the following topics:

- FWA in the Medicare Program
- The major laws and regulations pertaining to FWA
- Potential consequences and penalties associated with violations
- Methods of preventing FWA
- How to report FWA
- How to correct FWA

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/MLN4649244>

## A.5 Provider rights bulletin

If you elect to participate/continue to participate with the plan, please complete the application in its entirety; sign and date the Attestation Form, and provide current copies of the requested documents. You also have the following rights:

### To review your information

You may review any information the plan has utilized to evaluate your credentialing application, including information received from any outside source (e.g., malpractice insurance carriers; state license boards), with the exception of references or other peer-review protected information.

### To correct erroneous information

If the credentialing information you provided varies substantially from information obtained from other sources, we will notify you in writing within 15 business days of receipt of the information. You will have an additional 15 business days to submit your reply in writing. Within two business days, the plan will send a written notification acknowledging receipt of the information.

### To be informed of status of your application

You may submit your application status questions in writing or telephonically.

### To appeal adverse committee decisions

In the event you are denied participation or continued participation, you have the right to appeal the decision in writing within 30 days of the date of receipt of the rejection/denial letter.

**NY 137 Rule**

If you are a provider in NY who is new to the area or is joining a participating group with the plan, you have a right to provisional credentialing if the process takes more than 90 days.

All written/telephonic inquiries about credentialing or recredentialing must be sent to the following addresses or phone numbers:

Credentialing Department  
2300 Clayton Road  
Suite 1000  
Concord, CA 94520  
Phone: 1-855-918-2265  
Fax: 1-855-363-9691

**A.6 CMS preclusion list**

The Centers for Medicare and Medicaid Services (CMS) has a Preclusion List effective for claims with dates of service on or after January 1, 2019. The Preclusion List applies to both Medicare Advantage (MA) plans as well as Part D plans.

The Preclusion is comprised of a list of prescribers and individuals or entities who:

- Are revoked from Medicare, are under an active reenrollment bar, and CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program; or
- Have engaged in behavior for which CMS could have revoked the prescriber, individual or entity to the extent possible if they had been enrolled in Medicare and that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program.

Providers receive notification from CMS of their placement on the Preclusion List, via letter, and will have the opportunity to appeal with CMS before the preclusion is effective. There is no opportunity to appeal with UnitedHealthcare. If you are listed on the Preclusion list you cannot participate with any UnitedHealthcare plan.

Through the Preclusion List, which CMS updates monthly, CMS advises MA and Part D plans of the date upon which providers' claims must be rejected or denied due to precluded status ("claim-rejection date"). As of the claim-rejection date, a precluded provider's claims will no longer be paid, pharmacy claims will be rejected, and the provider will be terminated from the United Healthcare network; additionally, the precluded provider must hold Medicare beneficiaries harmless from financial liability for services or items provided on or after the claim-rejection date.





**Dental Benefit  
Providers®**

All documents regarding the recruitment and contracting of providers, payment arrangements, and detailed product information are confidential proprietary information that may not be disclosed to any third party without the express written consent of Dental Benefit Providers, Inc.

UnitedHealthcare Dental® coverage provided by or through UnitedHealthcare Insurance Company, located in Hartford, Connecticut, or its affiliates. Administrative services provided by Dental Benefit Providers, Inc., Dental Benefit Administrative Services (CA only), United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number DPOL.06.TX (11/15/2006) and associated COC form number DCOC.CER.06.

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