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Vermont Medicaid Dental Supplement

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

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Section 1 Introduction

The Vermont Medicaid Dental Supplement contains billing information and an alphabetical listing of reimbursable charges and information. Vermont Medicaid will accept only the 2019 ADA Dental Claim Form. Though dental practitioners are not required to include a diagnosis code when submitting claims to Vermont Medicaid, if they choose to include codes, they must be valid. For more information/instructions about the 2019 Dental Claim Forms, see the dental resources available on the Vermont Medicaid Portal. https://vtmedicaid.com/#/resources. Providers billing for services represented by CPT or HCPCS codes may bill using either the 2019 ADA Dental Claim Form or the CMS-1500 Claim Form. For more information see the Provider Manual: https://vtmedicaid.com/#/manuals.

1.1 HIPAA

Providers are reminded that the claim form field locator information available on the Vermont Medicaid Portal is for use with paper transactions. Providers using HIPAA compliant software to submit electronic claims may access the electronic requirements at the Washington Publishing website at https://wpc-edi.com/.

Section 2 Billing Information

2.1 Adult Program (AP)

The Adult Program is limited to $1,500 per individual per calendar year (annual cap).

If an individual reaches their 21st birthday and has received dental care during the course of the year, the dental benefit already paid will be applied to the annual $1,500 adult maximum benefit. The benefit is considered exhausted if the total reimbursement is greater than or equal to $1,500 and will not begin again until the start of the new calendar year.

2.1.1 Exception to Adult Program Limit for Pregnancy

Pregnant adults receiving benefits under the Vermont Medicaid program receive full dental benefits. This includes coverage of all medically necessary dental services in Section 7 (Dental Covered Services) that are listed as "no" for the adult dental benefit and without the adult annual cap on dental expenditures. This benefit will be in effect during pregnancy and for 12 months after the pregnancy ends. At the end of the 12-month period after pregnancy, individuals who remain eligible for Medicaid have the same benefit as other adults, including the annual cap. The adult dental cap applies through the end of the current calendar year.

It is the members' responsibility to contact Member Services (800.250.8427) to initiate steps to have their eligibility status reflect pregnancy.

All dental providers are reminded to use the HD Modifier at the end of each procedure code when submitting claims for members who are pregnant (during pregnancy and for 12 months after the pregnancy ends.) and receiving benefits under the Vermont Medicaid program. This will exclude the claim from the application of the adult dental cap.

2.1.2 Exception to Adult Program Emergency Dental Services

Emergency dental services for adults aged 21 and older are covered after the adult annual cap on dental expenditures has been reached. Emergency dental services are those used to treat acute pain, infection, or bleeding that can be delivered in a dental office rather than an emergency setting. Medically necessary emergency dental services include the dental service codes currently covered under the General Assistance (GA) Voucher Program administered by the Department for Children and Families. These emergency dental service codes will now be covered under the Medicaid dental benefit and Medicaid members will not need approval via the GA Program. Medicaid members under the age of 21, and those who are pregnant or in the 12-month postpartum eligibility period, are not subject to the annual cap on dental services.

The KX modifier should be added for billing at the end of each emergency procedure code submitted for adult members after the annual cap has been met (the covered codes are listed at Section 9 of this document). This will allow the claim to be paid after the cap has been met.

2.1.3 Exception to Adult Program Waiver Program Dental Services

Adult dental services are available without an annual cap on expenditures for individuals receiving services in the Department of Aging and Independent Living (DAIL) Developmental Disability Services (DDS) Waiver Program, or the Department of Mental Health (DMH) Community Rehabilitation and Treatment (CRT) Waiver Program. There is also coverage for medically necessary denture services for these groups. These groups of adults often have an increased need for dental services that exceeds the annual cap on dental expenditures. Members of each of these two waiver groups may self-identify with their dental provider or provide additional eligibility information.

For the DAIL DDS Waiver Program only, the CG modifier should be added for billing at the end of each procedure code submitted for adult members. This will allow the claim to be paid without utilizing the annual cap.

To confirm whether Medicaid members being treated are in these groups, call Gainwell Provider Services at 800-925-1706.

2.2 By Report

In Section 7, Dental Covered Services, when a procedure code is followed by the words "by report", providers are no longer required to send a description of the service along with the claim form to DVHA. However, it is important to enter a detailed description of what was done into your treatment notes in the event that a chart review is required later in connection with this claim.

2.3 Anesthesia

Dentists with appropriate anesthesia credentials may bill for general anesthesia administered in the office, on a 2019 ADA Dental Claim Form.

Local anesthesia, or topical anesthesia used by dentists are not reimbursable as a separate service. This would be covered as part of the reimbursement for the procedure.

2.4 Area of Oral Cavity

Claims for services that do not include Area of Oral Cavity information, when required, will be denied. When submitting claims, note the following directions to ensure the correct reporting of Item #25 (Area of Oral Cavity) per ADA instructions: Use of Item # 25 (Area of Oral Cavity) is conditional.

The following conditional use requirements apply:

- Always report the area of the oral cavity when the procedure reported in Item #29 (Procedure Code) refers to a quadrant or arch and the area of the oral cavity is not uniquely defined by the procedure's nomenclature.
    - Example: Report the applicable area of the oral cavity when the procedure code nomenclature includes a general reference to an arch or quadrant, such as D4263 bone replacement graft – first site in quadrant.
- Do not report the applicable area of the oral cavity when the procedure either:
    - Incorporates a specific area of the oral cavity in its nomenclature, such as D5110 complete denture – maxillary;

      -or-
    - Does not relate to any portion of the oral cavity, such as D9222 deep sedation/general anesthesia – first 15 minutes.

Area of oral cavity is designated by one of the following two-digit codes:

- 00-entire oral cavity, 01-maxillary arch, 02-mandibular arch, 10-upper right quadrant,
- 20-upper left quadrant, 30-lower left quadrant, 40-lower right quadrant.

In order to facilitate correct claims completion by providers, DVHA has identified the procedure codes that require the reporting of this field. Refer to the Procedure Codes that require reporting for Area of Oral Cavity section.

2.5 Attending Physician/Attending Practitioner

An attending physician/dental provider is the physician/dental provider who actually performs the service. The attending provider must be enrolled as a participating Vermont Medicaid provider.

When billing on the CMS-1500 claim form, the attending provider NPI # must appear in field 24 for each line of service being billed. The 2019 Dental Claim Form requires the attending provider NPI # to be listed in field 54.

2.6 Billing Members for Dental Services Exceeding Annual Cap

Providers may, after obtaining written acknowledgement of financial liability from the member, bill patients for amounts that exceed the adult annual capped payment amount but not more than the appropriate procedure code rate in the Vermont Medicaid HCPCS Code Fee Schedule, if it is a Vermont Medicaid covered service. Written acknowledgement of financial liability must be obtained from the member prior to performing services.

The provider must:

1. Verify that the member is still eligible for Medicaid on the date the service is provided; and
2. Meet the following conditions when billing for a Medicaid covered service:
    a. Bill any other liable third parties prior to billing Medicaid; and
    b. Accept the Medicaid payment rate as payment in full and bill the member only for any applicable co-payments once Medicaid has been accepted as a source of payment; and
    c. File a claim with the department or its agent, including all necessary information about the service and the identifying information from the member's identification document.
3. Meet the following conditions prior to billing a member for a service that is not covered by Medicaid:
    a. The provider must advise the member that Medicaid will not pay for the service before delivering the service; and
    b. The provider and patient must have a signed written agreement in place before delivering the services that specifically describes the services to be delivered and the amount that the member must pay.

2.7 Billing Members for Dental Services That Are Non-Covered by Vermont Medicaid

Providers may, after obtaining written acknowledgement of financial liability from the member, bill patients for services not covered by Vermont Medicaid. Providers must confirm and document verification that a service is not covered by Vermont Medicaid prior to billing a member.

See Vermont Medicaid General Billing and Forms Manual, Section 1.5, Notice That Vermont Medicaid Will Not Be Accepted, https://dvha.vermont.gov/providers/manuals for additional information.

Usual & Customary charges may not be billed to a Vermont Medicaid member without prior written communication to the member explaining their financial liability should they choose to receive a service that is not covered by Vermont Medicaid.

2.8 Date of Service

The date of service on the claim must be the date that the service was performed. When the service spans over several appointments, the date of service will be the date that the service started. For example: for orthodontics or crowns, the start date is billed as the date of service.

2.9 Dental Covered Services and Fees

The dental covered services are in Section 7 of this manual, and the most current version of this supplement is available on the DVHA website at https://dvha.vermont.gov/providers/dental. For information/instructions about code reimbursement rates and to determine if a prior authorization (PA) is required, visit the Fee Schedule on the Vermont Medicaid Portal: https://vtmedicaid.com/#/feeSchedule.

Procedure codes not covered by DVHA's Dental Program are not listed.

2.10 EPSDT Program – Well Child Health Care

EPSDT is a federally mandated benefit for all Vermont Medicaid eligible children under age 21. EPSDT requires the state to provide any health care service that is medically necessary, even if the service is not covered for adults. EPSDT services include periodic screenings to identify physical and mental conditions, vision, hearing, dental problems and follow-up diagnostic and treatment services.

All providers should deliver pediatric screening and preventive dental services according to the Vermont dental periodicity schedule found at: https://www.healthvermont.gov/sites/default/files/documents/pdf/Vermont Dental Periodicity Schedule.pdf

Vermont Medicaid tracks service delivery and follow-up and annually reports EPSDT CMS 416 measures by collection of data from Vermont Medicaid claims. The link to the CMS page is: https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html

The 2019 ADA Dental Claim Form requires EPSDT to be listed in field 1.

See the Vermont Medicaid General Billing and Forms Manual, Section 5.3.19, EPSDT Program Well – Child Health Care. https://vtmedicaid.com/#/home

2.11 Fluorides (By Prescription)

Vermont Medicaid reimburses for fluorides when prescribed by a participating physician or dentist for children and adults. Prescription strength topical fluorides are covered for products designed solely for use in the dental office. Fluoride must be applied separately from prophylaxis paste.

Fluorides in combination with vitamins are not covered. Please see Section 7, Dental Covered Services, for allowed billing codes and unit limitations.

2.12 Global (Post-Operative) Period

Effective for dates of service on and after June 1, 2016: Vermont Medicaid is enforcing a 10-day global period for certain dental procedure codes. During the dental global period, any palliative treatment for pain is considered included in the payment for the primary procedure for that date and will not be reimbursed separately. Please refer to Section 7, Dental Covered Services, for code specific guidance.

2.13 Hospital Calls

Use the appropriate procedure code for hospital calls when billing in conjunction with a surgery where the patient is admitted as an inpatient or outpatient at a hospital. The pre-operative exam and all other related services are reimbursed within the billed surgery codes. Do not submit for them separately.

2.14 Information Available (Voice Response System)

Dental Providers accessing the VRS have access to the following:

- Adult dental benefit (dollars spent)
- Last dental oral exam

See the Vermont Medicaid General Provider Manual, Section 4.1.2, Eligibility Verification for more information. https://vtmedicaid.com/#/manuals

2.15 Internal Control Number (ICN)

This term refers to the Internal Control Number (ICN) assigned by the Claims Processing Agent to each claim submitted.

See the Vermont Medicaid General Provider Manual, Section 10, Glossary of Terms & Phrases. https://vtmedicaid.com/#/manuals

2.16 Interpreter Services

A provider who pays for interpreter services for Vermont Medicaid members may bill procedure code T1013 for each 15 minutes of paid interpreter services provided, on-site or via telephone. This may include interpreter service outside of the actual healthcare provider encounter to fill out forms or review information/instructions.

Services for interpreters can be billed on the 2019 ADA Claim Form. One unit of service is equal to 15 minutes. These services do not count toward the adult maximum benefit.

2.17 Medical Necessity

See the Vermont Medicaid General Billing and Forms Manual, Section 2.4, Medical Necessity. https://vtmedicaid.com/#/manuals

2.18 Member Cost Sharing/Co-Pays

Certain members must participate in the cost of care for dental services.

The copayment for dental services is $3 per provider per date of service unless exemptions apply. Gainwell Technology will automatically deduct the copayment from the amount paid to the provider.

See Medicaid Health Care Administrative Rule 6.100 Medicaid Cost Sharing for the complete list of exceptions and exemptions.

Co-payments are never required of Vermont Medicaid members who are:

- Under age 21
- During pregnancy and for 12 months after the pregnancy ends.
- Living in a long-term care facility, nursing home, or hospice

Copayments are not required for preventive dental visits (see Section 2.19.1 below).

Copayments are also not required for emergency services.

Although some members are required to make co-payments under Vermont Medicaid, if the member is unable to make the payment, Vermont Medicaid providers may not deny services. Per section 1916(c) of the Social Security Act, “no provider participating under the State [Medicaid] plan may deny care of services to an individual eligible for [Medicaid] because of an individual's inability to pay [the copayment].”

2.18.1 Exceptions to Co-Payments

1. Preventive dental visits including one or more of the following preventive service codes do not have a copayment (D1110, D1206, D1208, D1320 & D0120). A copayment will apply when additional services are provided on the same date of service.
2. There is no co-payment for pregnant members and for 12 months after the pregnancy ends. Gainwell Technology may not have this information on file. When submitting claim forms to Gainwell Technology for payment, you must indicate pregnancy and 12 months after pregnancy by adding the “HD” modifier to the end of each procedure code. The “HD” modifier must be used for all procedures. For example, when submitting for a periodic oral evaluation, use procedure code D0120HD.

2.19 Missed Appointments/Late Cancellations

Please use the following codes for Missed or Cancelled appointments:

- D9986 – Missed Appointment
  Lay Description: The patient missed an appointment without prior notification.
- D9987 – Cancelled Appointment
  Lay Description: The patient cancels a previously scheduled appointment with the dentist.

Please note that these codes are not reimbursable by Vermont Medicaid and are used for reporting purposes only.

2.20 Modifiers

The DVHA permits the use of modifiers when billing exception situations apply: 1) to indicate a member is pregnant or in the 12 months after the pregnancy ends period, the modifier “HD” must be used to submit a HIPAA compliant transaction. Providers billing on paper shall bill using the “HD” modifier until notified further. 2) to indicate an adult

using emergency dental services covered after the adult annual cap on dental expenditures has been reached, use the “KX” modifier to submit a HIPPA compliant transaction. Providers billing on paper shall also bill using the “KX” modifier.

2.21 Multiple Page Claims

When billing a multiple page claim, you must indicate "page x of y" in Box 35, in the Remarks field of the dental claim form (see example below). The total billed amount should be reflected on the last page of the claim in field 33, the Total Fee field of the dental claim form.

Example: page 1 of 3 (1st page of claim), 2 of 3 (2nd page of claim) and 3 of 3 (3rd page of claim).

The attending dentist’s NPI number must appear on page 1of the claim in field locator 54.

2.22 Oral Surgery

Services which are defined as medical may be submitted on the CMS-1500 claim form or on the 2019 ADA Dental Claim Form using current CPT or HCPCS codes. If there is a CDT code on file for services provided, the provider may bill on the accepted ADA claim form using CDT codes.

2.23 Prior Authorization

Dental and orthodontic prior authorizations are handled by the Department of Vermont Health Access (DVHA). Dentists and oral surgeons must obtain authorization to perform certain dental and medical procedures. These procedures are listed in the VT Medicaid Fee Schedule at: https://vtmedicaid.com/#/feeSchedule/hcpcs.

Request for dental prior authorization must be sent to:

Department of Vermont Health Access
Clinical Operations Unit
280 State Drive, NOB 1 South
Waterbury, VT 05671-1010

Fax: 802.879.5963

For more information see the Vermont Medicaid General Billing and Forms Manual at: https://vtmedicaid.com/#/manuals.

2.24 Radiographs – Submission Requirements

Radiographs should never be sent to the Vermont Medicaid processing agent when submitting claims, unless requested. Radiographs are required when submitting PA requests to the Department of Vermont Health Access Clinical Unit for orthodontic treatment.

2.25 Spenddown

Some persons become eligible for Vermont Medicaid benefits only after incurring a specific amount of healthcare costs over a specific period. Vermont Medicaid eligibility for this type of case begins on any day of the month in which the person incurs the specified amount. When the person is determined to be eligible for Vermont Medicaid, the Health Access Eligibility and Enrollment Unit (HAEEU) worker sends a letter to the provider informing the provider that the spend down amount has been met or that a remaining amount should be deducted from a particular bill before billing Vermont Medicaid for the remainder.

Claims, which are submitted with the first day of eligibility as the date of service must have the spend-down letter from the HAEEU office attached. If the spend down letter is not attached to the claim, the claim will be denied.

To complete the claim form involving a spend-down, the provider must do the following:

- Bill their usual and customary charge
- Total all detail charges billed
- The amount of spend down must be entered in the other insurance payment field
- The Notice of Spenddown Determination form is required to be attached to the claim

Reimbursement will be the Vermont Medicaid allowed amount, less the spend down amount.

See Vermont Medicaid General Billing and Forms Manual, Section 4.13, Spenddown, for additional information. https://vtmedicaid.com/#/manuals

2.26 Supernumerary Teeth

The Vermont Department of Health Access uses the ADA approved coding system in regard to billing for supernumerary teeth.

Permanent supernumerary teeth are identified using the numbers 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81 and 82. This coding system begins with the area of the upper right third molar, following around the upper arch and continuing on the lower arch to the area of the lower right third molar. For example: supernumerary tooth number 51 is adjacent to the upper right third molar 1 and supernumerary tooth 82 is adjacent to the lower right third molar number 32.

Primary (baby) supernumerary teeth are identified by the placement of the letter "S" following the letter identifying the adjacent primary tooth. For example: supernumerary "AS" is adjacent to "A". The list of primary supernumerary teeth is: AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS and TS.

2.27 TMJ Device

Vermont Medicaid reimburses for TMJ Splints. Providers may bill for members receiving this device on the CMS-1500 or the dental claim form. The TMJ Splint is not considered part of the annual adult maximum benefit and does not require a prior authorization.

2.28 Telemedicine

Vermont Medicaid is encouraging Medicaid-participating providers, including dentists, to utilize telemedicine for delivery of medically necessary and clinically appropriate services to Medicaid members when possible. For more information, see the DVHA website at: https://dvha.vermont.gov/sites/dvha/files/documents/News/DVHA Telemedicine %26 Emergency Telephonic Coverage_Dental Providers 04.10.2020.pdf

2.29 Unlisted Services

Some covered services may not be classified, or the classification may be difficult to determine. Providers may contact the Clinical Unit at the DVHA for assistance in determining the appropriate procedure code for billing.

2.30 Usual and Customary Charges

Various claim forms (CMS-1500, UB-04 and 837) require the submission of "Charge" or "Total Charges" or "Charge Amount" to be reported for each service billed. The provider's "usual and customary charge" or "uniform charge" is a dollar amount in effect at the time of the specific date of service. This is the amount to be reported on the claim. This usual and customary charge is the amount that the provider bills to insured and private-pay persons for the same service. If the provider has more than one charge for a service, the lowest charge will be reported to Vermont Medicaid, except if the charge has been reduced on an individual basis because of a sliding-fee scale based on the patient's documented inability to pay. Sale prices should be used during the sale period. If a service or item is offered free-of-charge by the provider, no charge will be made to Vermont Medicaid. Providers may not discriminate against Vermont Medicaid members by charging a higher fee for the same service than that charged to a private-pay patient, except as noted above regarding sliding-fee scale.

When only a portion of a service is completed, the dentist is only allowed to bill for the services rendered and not the entire service procedure. Orthodontia and dentures should be billed on the date the procedures were started.

Section 3 Procedure Codes

A list of procedure codes for covered dental services is available in Section 7 of this document and is on the DVHA web site at https://dvha.vermont.gov/providers/dental. Also, the on-line HCPCS Fee Schedule includes the D code, name of the procedure, rate on file and coverage criteria, https://vtmedicaid.com/#/feeSchedule/hcpcs. The procedure codes listed must be billed on the acceptable dental claim form.

Changes in the price on file will be reflected on the HCPCS Fee Schedule. The DVHA reserves the right to change the price on file for any item or service without prior notice. For these reasons, providers should be careful to retain the changes noted in the Remittance Advice and updated versions of the fee schedule. This file is for the convenience of the provider. Although the DVHA will attempt to keep the file 100% accurate, the actual price recorded in the computer system for reimbursement is the only accurate rate for the applicable date of service.

The Department of Vermont Health Access (DVHA) conducts code reviews on a quarterly or annual basis depending on the type of services that are being requested for consideration. Coverage reviews are initiated when a written prior authorization (PA) request is received by DVHA from a Vermont Medicaid enrolled provider for any Vermont Medicaid member.

DVHA does not review requests for coverage by a manufacturer, a manufacturer's representative, a Durable Medical Equipment vendor, or other third parties.

Refer to the Fee Schedule at https://dvha.vermont.gov/providers/codesfee-schedules for information about the code coverage and if the specific code in question, requires a prior authorization. Questions about this policy can be directed to the provider's assigned Gainwell Provider Services Representative.

Section 4 Adult and Children's Programs (Covered Services)

4.1 Clinical Oral Evaluation

The codes in this section recognize the cognitive skills necessary for patient evaluation. The collection and recording of some data and components of the dental examination may be delegated; however, the evaluation, diagnosis and treatment planning are the responsibility of the dentist. As with all procedure codes, there is no distinction made between the evaluations provided by general practitioners and specialists.

Report additional diagnostic and/or definitive procedures separately.

D0120 - Periodic Oral Evaluation

An evaluation performed on a patient to determine any changes in the patient's dental and medical health status since a previous comprehensive or periodic evaluation. This includes an oral cancer evaluation, periodontal screening where indicated and may require interpretation of information acquired through additional diagnostic procedures. The findings are discussed with the patient.

Report additional diagnostic procedures separately.

D0140 - Limited Oral Evaluation – Problem Focused

An evaluation limited to a specific oral health problem or complaint. This may require interpretation of information acquired through additional diagnostic procedures. Definitive procedures may be required on the same day as this evaluation. Typically, patients receiving this type of evaluation present with a specific problem and/or dental emergencies, trauma, acute infections, etc.

D0150 - Comprehensive Oral Evaluation

An evaluation used by a general dentist and/or a specialist when evaluating a patient comprehensively. This applies to new patients; established patients who have had a significant change in health conditions or other unusual circumstances, by report, or established patients who have been absent from active treatment for three or more years. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. This includes an evaluation for oral cancer, the evaluation and recording of the patient's dental and medical history and a general health assessment. It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, existing prostheses, occlusal relationships, periodontal conditions (including periodontal screening and/or charting), hard and soft tissue anomalies, etc.

D0170 - Re-evaluation – Limited, Problem Focused

Assessing the status of a previously existing condition. For example:

- A traumatic injury where no treatment was rendered but patient needs follow-up monitoring;
- Evaluation for undiagnosed continuing pain;
- Soft tissue lesion requiring follow-up evaluation.

This code is NOT to be used for a post-operative visit.

4.2 Radiographs

D0210 - Intraoral – Comprehensive series of radiographic images

D0220 - Intraoral – Periapical – First Radiographic Image

D0230 - Intraoral – Periapical – Each Additional Radiographic Image

D0240 - Intraoral – Occlusal - Radiographic Image

D0250 - Extra-oral – 2D Projection Radiographic Image

D0251 - Extra-oral – Posterior Dental Radiographic Image

D0270 - Bitewing – Single Radiographic Image

D0272 - Bitewings – 2 Radiographic Images

D0273 - Bitewings – 3 Radiographic Images

D0274 - Bitewings – 4 Radiographic Images

D0330 - Panoramic Radiographic Image

D0364 - Cone Beam CT Capture and Interpretation with Limited Field of View – Less Than One Whole Jaw

D0365 - Cone Beam CT Capture and Interpretation with Limited Field of View of One Full Dental Arch – Mandible

D0366 - Cone Beam CT Capture and Interpretation with Limited Field of View of One Full Dental Arch – Maxilla, with or without Cranium

D0367 - Cone Beam CT Capture and Interpretation with Limited Field of View of Both Jaws, With or Without Cranium

D0368 - Cone Beam CT Capture and Interpretation for TMJ Series Including Two or More Exposures

D0393 - Treatment Simulation using 3D Image Volume

Vermont Medicaid will not pay for any usually covered procedures if that procedure was done to support a non-covered procedure. For example: A CT scan would not be covered if the reason for doing the scan was to plan the placement of an implant. As implants are not covered, the scan done to plan the implant is also not covered.

4.3 Other Diagnostic Procedures

D0470 - Diagnostic Models

D0999 - Unspecified Diagnostic Procedures

4.4 Preventive Treatment

D1110 - Prophylaxis – Adult

Removal of plaque, calculus and stains from the tooth structures and implants in the permanent (adult) and transitional dentition. It is intended to control local irritational factors. Normal cleanings are once every 6 months.

4.5 Topical Fluoride Treatment

Prescription strength fluoride product designed solely for use in the dental office, delivered to the dentition under the general supervision of a dentist or physician. Fluoride must be applied separately from prophylaxis paste.

D1206 - Topical Fluoride Varnish; Therapeutic application for moderate to high caries risk patients

D1208 - Topical Application of Fluoride

4.6 Other Preventive Services

D1320 - Tobacco Counseling for the Control and Prevention of Oral Disease

Tobacco prevention and cessation services reduce patient risks of developing tobacco-related oral diseases and conditions and improves prognosis for certain dental therapies.

D1354 - Application of Caries Arresting Medicament Application – Per Tooth

Silver Diamine Fluoride can be used to arrest caries in a cavitated tooth. Application techniques and protocols are available from the ADA and other sources. Because arrested caries does not then progress into the pulp, DVHA has elected to cover this procedure with several populations in mind, such as: young children who may be better able to tolerate routine procedures when a year or two older, adults who have reached their annual cap and wish to wait for the new year for additional treatment, special needs patients who have one cavity and wish to delay O.R. admission until other needs might arise, institutionalized patients for whom definitive treatment is unavailable or contraindicated.

Research suggests that one application is effective, but a second application about six months later results in increased control. Covering a silver diamine lesion with a glass ionomer temporary filling will also extend the effects of the caries control. With the above scenarios in mind, DVHA hopes to allow for better outcomes for our member clients and more options for our providers to deliver good care. It is not our expectation, however, to see routine placement of Silver Diamine on multiple teeth of every patient at the time of initial or periodic oral exams. DVHA now allows 4 per tooth per lifetime. If a provider sees a case legitimately in need of unusual treatment, please either use the Prior Authorization form or bill with copious documentation to describe caries patterns and clinical circumstances, photos, radiographs, etc. Other medicaments for this purpose may be identified in the future that could have different protocols but will still come under the D1354 code.

4.7 Restorative

Local anesthesia is a component of all restorative procedures.

It is understood that interproximal lesions are usually approached through the occlusal surface, so a mesial lesion seen only on x-ray could legitimately be billed as an MO (D2150, 2 surface). It is permissible to have a DO placed one day and an MO on the same tooth on another day within a twelve-month period. That is, the claim will not be rejected because the O surface was restored twice in the same year. We will know that an O in combination with an M or D is different from a free-standing O. Two isolated O's within 12 months is still rejected. Note also that an MODO is only a three-surface restoration.

Another example: If tooth #8 has a small mesial restoration placed and billed one day (D2330, one surface) but shortly thereafter the patient suffers a traumatic incident that fractures away the MI corner of #8, if DVHA is billed for #8 MI (D2335, 4 surfaces including incisal edge), the claim will be denied. If, however, a note is included in the claim describing the circumstances, payment can be facilitated.

If an MO on #30 is followed by an MB billed within 12 months, the MB will be denied as the M surface had already been treated. A large cervical or buccal lesion is still one lesion even if it extends toward the mesial or distal of the tooth.

If there is some extraordinary circumstance that you can describe or document with x-rays, photo's, models or words, please submit these along with any claim that you believe might set off our "red flag" system. It will facilitate timely processing.

4.7.1 Amalgam Restorations

Tooth preparation, all adhesives (including amalgam bonding agents), liners and bases are included as part of the restoration. If pins are used, they should be reported separately (see D2951).

D2140 - Amalgam – One Surface, Primary or Permanent

D2150 - Amalgam – Two Surfaces, Primary or Permanent

D2160 - Amalgam – Three Surfaces, Primary or Permanent

D2161 - Amalgam – Four or more Surfaces, Primary or Permanent

4.7.2 Resin-Based Restorations

Resin-based composite refers to a broad category of materials including but not limited to composites. May include bonded composite, light-cured composite, etc. Tooth preparation, etching, adhesives (including resin bonding agents), liners and bases and curing are included as part of the restoration. Glass ionomers, when used as restorations should be reported with these codes. If pins are used, they should be reported separately (see D2951).

D2330 - Resin-Based Composite – One Surface, Anterior

D2331 - Resin-Based Composite – Two Surfaces, Anterior

D2332 - Resin-Based Composite – Three Surfaces, Anterior

D2335 - Resin-Based Composite - Four or more Surfaces, Anterior

D2390 - Resin-Based Composite Crown, Anterior

D2391 - Resin-Based Composite – One Surface, Posterior

D2392 - Resin-Based Composite – Two Surfaces, Posterior

D2393 - Resin-Based Composite – Three Surfaces, Posterior

D2394 - Resin-Based Composite – Four or more Surfaces, Posterior

4.7.3 Custom Crowns

D2920 - Re-cement Crown

4.7.4 Prefabricated Crowns

D2928 - Prefabricated Porcelain/Ceramic Crown - Permanent Tooth

D2930 - Stainless Steel Crown – Primary

D2931 - Stainless Steel Crown – Permanent

D2932 - Prefabricated Resin Crown

D2933 - Prefabricated Stainless-Steel Crown with Resin Window

4.8 Other Restorative Procedures

D2940 - Protective Restoration

Direct placement of a temporary restorative material to protect tooth and/or tissue form. This procedure may be used to relieve pain, promote healing, or prevent further deterioration. Not to be used for endodontic access closure, or as a base or liner under a restoration.

D2950 - Core Build-up – Including Pins

Core build-up refers to building up of anatomical crown when restorative crown will be placed, whether pins are used. A material is placed in the tooth preparation for a crown when there is insufficient tooth strength and retention for the crown procedure.

D2951 - Pin Retention, Per Tooth

D2954 - Prefabricated Post and Core

D2981 - Inlay Repair Necessitated by Restorative Material Failure

D2982 - Onlay Repair Necessitated by Restorative Material Failure

D2983 - Veneer Repair Necessitated by Restorative Material Failure

4.9 Endodontics

Local anesthesia is a component of all endodontic procedures.

4.9.1 Pulpotomy

D3220 - Therapeutic Pulpotomy (Excluding final restoration)

Removal of pulp coronal to the dentinocemental junction and application of medicament. Pulpotomy is the surgical removal of a portion of the pulp with the aim of maintaining the vitality of the remaining portion by means of an adequate dressing.

D3221 - Pulpal Debridement, primary and permanent teeth

Pulpal debridement for the relief of acute pain prior to conventional root canal therapy. This procedure is not to be used when endodontic treatment is completed on the same day.

4.9.2 Endodontic Therapy for Primary Teeth

D3230 - Pulpal Therapy (resorbable filling), Anterior Primary Tooth

D3240 - Pulpal Therapy (resorbable filling), Posterior Primary Tooth

4.9.3 Endodontic Therapy

Regardless of the funding source for the initial endodontic procedure, endodontic retreatment is not a covered service.

D3310 - Anterior (Excluding Final Restoration)

D3320 - Bicuspid (Excluding Final Restoration)

D3330 - Molar (Excluding Final Restoration)

4.9.4 Apicoectomy/Periradicular Surgery

D3410 - Apicoectomy/Periradicular Surgery, Anterior

D3421 - Apicoectomy/Periradicular Surgery, Bicuspid (First Root)

For surgery on one root of a bicuspid. Does not include placement of retrograde filling material. If more than one root is treated, see D3426.

D3425 - Apicoectomy/Periradicular Surgery, Molar (First Root)

D3426 - Apicoectomy/Periradicular Surgery, Each Additional Root

Typically used for bicuspids and molar surgeries when more than one root is treated during the same procedure. This does not include retrograde filling material placement.

D3430 - Retrograde Filling – Per Root

D3471 – Surgical repair of root resorption – anterior

D3472 – Surgical repair of root resorption – premolar

D3473 – Surgical repair of root resorption – molar

D3501 – Surgical exposure of root surface without apicoectomy or repair of root resorption – anterior

D3502 – Surgical exposure of root surface without apicoectomy or repair of root resorption – premolar

D3503 – Surgical exposure of root surface without apicoectomy or repair of root resorption – molar

4.10 Periodontics

Local anesthesia is a component of all periodontal procedures.

4.10.1 Surgical Services (10 Day Global)

D4212 - Gingivectomy or Gingivoplasty to allow access for Restorative Procedure – Per Tooth

D4322 - Splint – Intra-coronal; Natural Teeth or Prosthetic Crowns (1/1/2022)

Additional procedure that physically links individual teeth or prosthetic crowns to provide stabilization and additional strength.

D4323 – Splint – Extra-coronal; Natural Teeth or Prosthetic Crowns (1/1/2022)

Additional procedure that physically links individual teeth or prosthetic crowns to provide stabilization and additional strength.

D4341 - Periodontal Scaling and Root Planing

D4342 - Periodontal Scaling and Root Planing, One to Three Teeth per Quadrant

Periodontal scaling and root planing is limited to 4 quadrants per patient per year. If more frequent scaling and root planing is required, use the Dental Services Prior Request Form to submit a prior authorization request to DVHA documenting the need for the additional scaling and root planing.

D4346 - Scaling in Presence of Generalized Moderate or Severe Gingival Inflammation, Full Mouth, After Oral Evaluation

D4355 - Full Mouth Debridement to Enable a Comprehensive Periodontal Evaluation and Diagnosis on a Subsequent Visit

The gross removal of plaque and calculus that interfere with the ability of the dentist to perform a comprehensive oral evaluation. This preliminary procedure does not preclude the need for additional procedures.

4.10.2 Other Periodontal Services

D4910 - Periodontal Maintenance

This procedure is instituted following periodontal therapy and continues at varying levels, determined by the clinical evaluation by the dentist. It includes removal of the bacterial plaque and

calculus from supragingival and subgingival regions, site specific scaling and root planing where indicated, and polishing the teeth.

This procedure is performed rather than a prophylaxis for patients following periodontal therapy.

Local anesthesia is a component of all periodontal procedures.

4.11 Removable Prosthodontics

When submitting for payment of prior authorized denture(s), use the start date (final impression date) as the date of service on the completed claim form. Do not submit the claim until the denture(s) are delivered.

Reimbursement includes all necessary post-delivery denture adjustments for 3 months.

Regardless of the funding source, dentures are limited to 1 per arch per 5 years. However, replacement denture(s) will be considered in less than 5 years in the following circumstances:

- The previous denture(s) have been stolen or destroyed in an accident and a police report has been filed.
- The previous denture(s) have been destroyed in a fire and a fire report has been filed.
- There are other equally compelling circumstances beyond the recipient's control.

Dentures will not be prior authorized if existing dentures are serviceable.

4.11.1 Denture Adjustments

D5410 - Adjust Complete Denture – Maxillary

D5411 - Adjust Complete Denture – Mandibular

D5421 - Adjust Partial Denture – Maxillary

D5422 - Adjust Partial Denture – Mandibular

4.11.2 Other Removable Prosthetic Services

D5850 - Tissue Conditioning – Maxillary

D5851 - Tissue Conditioning – Mandibular

D5992 - Adjust Maxillofacial Prosthetic appliance, by report

4.12 Fixed Prosthodontics

Local anesthesia is a component of all fixed prosthodontic procedures.

4.12.1 Implant Services

D6081 - Scaling and Debridement in the Presence of Inflammation or Mucositis of a Single Implant, including Cleaning of the Implant Surface, without Flap Entry and Closure

D6101 - Debridement of a Peri-implant Defect and Surface Cleaning of Exposed Implant Surfaces, including Flap Entry and Closure

D6102 - Debridement and Osseous Contouring of a Peri-implant Defect, Includes Surface Cleaning of Exposed Implant Surfaces and Flap Entry and Closure

D6103 - Bone Graft for Repair of Peri-implant Defect - Not Including Flap Entry and Closure

4.12.2 Other Prosthodontic Services

D6930 - Re-cement Bridge

4.13 Oral and Maxillofacial Surgery

Local anesthesia is a component of all oral and maxillofacial procedures.

4.13.1 Extractions

Includes local anesthesia, suturing if needed, and routine post-operative care.

D7111 - Extraction, Coronal Remnants – Deciduous Tooth Removal of Soft Tissue - retained Coronal Remnants.

D7140 - Extraction, Erupted Tooth or Exposed Root (elevation and/or forceps removal)

4.13.2 Surgical Extractions

Includes local anesthesia, suturing if needed, and routine post-operative care.

D7210 - Extraction of Erupted Tooth Requiring Elevation of Mucoperiosteal flap

D7220 - Removal of Impacted Tooth - Soft Tissue

D7230 - Removal of Impacted Tooth - Partially Bony

D7240 - Removal of Impacted Tooth - Completely Bony

D7241 - Removal of Impacted Tooth - Completely Bony, with Unusual Surgical Complications

D7250 - Removal of Residual Tooth Roots (cutting procedure)

D7251 - Coronectomy - Intentional Partial Tooth Removal

4.13.3 Other Surgical Procedures/Splints

D7260 - Oral Antral Fistula Closure

D7261 - Primary Closure of a Sinus Perforation

D7270 - Tooth Reimplantation and/or Stabilization of Accidentally Evulsed or Displaced Tooth, Includes Splinting and/or Stabilization.

D7284 – Excisional Biopsy of Minor Salivary Glands

D7285 - Incisional Biopsy of Oral Tissue – Hard (bone tooth)

D7286 - Incisional Biopsy of Oral Tissue – Soft

D7290 - Surgical Repositioning of Teeth

D7291 - Transseptal Fiberotomy/Supra Crestal Fiberotomy, by report

D7295 - Harvest of Bone for use in Autogenous Grafting Procedure

D7310 - Alveoloplasty in Conjunction with Extractions, Four or more Teeth or Tooth Spaces, per Quadrant

D7311 - Alveoloplasty in Conjunction with Extractions, One to three Teeth, per Quadrant

D7320 - Alveoloplasty not in Conjunction with Extractions, Four or more Teeth or Tooth Spaces, per Quadrant

D7321 - Alveoloplasty not in Conjunction with Extractions, One to three Teeth or Tooth Spaces, per Quadrant

D7340 - Vestibuloplasty – Ridge Extension, Secondary Epithelialization

D7350 - Vestibuloplasty – Ridge Extension (including soft tissue grafts, muscle reattachments, revision of soft tissue attachment, and management of hypertrophied and hyperplastic tissue)

D7410 - Excision of Benign Lesion up to 1.25 cm

D7411 - Excision of Benign Lesion greater than 1.25 cm

D7412 - Excision of Benign Lesion, Complicated

D7413 - Excision of Malignant Lesion up to 1.25 cm

D7414 - Excision of Malignant Lesion greater than 1.25 cm

D7415 - Excision of Malignant Lesion, Complicated

D7440 - Excision of Malignant Tumor – Lesion Diameter up to 1.25 cm

D7441 - Excision of Malignant Tumor – Lesion diameter greater than 1.25 cm

D7450 - Removal of Benign Odontogenic Cyst or Tumor - Lesion diameter up to 1.25 cm

D7451 - Removal of Benign Odontogenic Cyst or Tumor - Lesion diameter greater than 1.25 cm

D7460 - Removal of Benign Nonodontogenic Cyst or Tumor - Lesion diameter up to 1.25 cm

D7461 - Removal of Benign Nonodontogenic Cyst or Tumor - Lesion diameter greater than 1.25 cm

D7465 - Destruction of Lesion(s) by Physical or Chemical Methods, by report

D7471 - Removal of Lateral Exostosis (maxilla or mandible)

D7472 - Removal of Torus Palatinus

D7473 - Removal of Torus Mandibularis

D7485 - Surgical Reduction of Osseous Tuberosity

D7510 - Incision and Drainage of Abscess - Intraoral Soft Tissue

Incision and drainage of abscess requires the appropriate tooth number to be referenced on the claim form.

D7560 - Maxillary Sinusotomy for Removal of Tooth Fragment or Foreign Body

D7880 - Occlusal Orthotic Appliance (TMJ Splint)

D7881 - Occlusal Orthotic Device Adjustment

D7910 - Suture of recent Small Wounds, up to 5 cm

D7911 - Complicated Suture, up to 5 cm

D7912 - Complicated Suture, greater than 5 cm

D7922 - Placement of Intra-Socket Biological Dressing to Aid in Hemostasis or Clot Stabilization, Per Site

D7972 - Surgical Reduction of Fibrous Tuberosity

4.14 Adjunctive General Services

D9110 - Palliative Treatment of Dental Pain – per Visit

Treatment that relieves pain but is not curative; services provided do not have distinct procedure codes.

4.14.1 Anesthesia

D9222 - Deep Sedation/General Anesthesia - first 15-minutes

D9223 - Deep Sedation/General Anesthesia - each 15-minute increment

D9230 - Inhalation of Nitrous Oxide/Analgesia, Anxiolysis

D9239 - Intravenous Moderate (conscious) Sedation/Analgesia - first 15 minutes

D9243 - Intravenous Moderate (conscious) Sedation/Analgesia - each 15-minute increment

D9248 - Non-intravenous Conscious Sedation

Oral conscious sedation with central nervous system depressants which causes a moderately depressed level of consciousness. This does not include written prescriptions, mild sedatives and/or nitrous oxide sedation. Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties. The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetics effects upon the central nervous system and not dependent upon the route of administration.

4.14.2 Professional Visits

D9310 - Consultation Diagnostic service provided by Dentist other than requesting Dentist

D9420 - Hospital Call

4.14.3 Patient Management

D9920 - Behavior Management

Behavior management cannot be billed when one of the above methods of anesthesia is billed on the same date of service. If a provider feels strongly that a case had unusual or exceptional circumstances that should allow a combination of these codes, then a written report of those circumstances will be required, submitted on a paper billing form for review and possible payments.

4.14.4 Occlusal Therapy

D9932 - Cleaning and Inspection of Removable Complete Denture, Maxillary

D9933 - Cleaning and Inspection of Removable Complete Denture, Mandibular

D9934 - Cleaning and Inspection of Removable Partial Denture, Maxillary

D9935 - Cleaning and Inspection of Removable Partial Denture, Mandibular

D9942 - Repair and/or Reline Occlusal Guard

D9943 - Occlusal Guard Adjustment

D9944 - Occlusal Guard – hard appliance, full arch (Replaces D9940 Occlusal Guard)

D9945 - Occlusal Guard – soft appliance, full arch (Replaces D9940 Occlusal Guard)

D9946 - Occlusal Guard – hard appliance, partial arch (Replaces D9940 Occlusal Guard)

A removable dental appliance which is designed to minimize the effects of bruxism and other occlusal factors.

D9986 - Missed Appointment

D9987 - Cancelled Appointment

4.14.5 Interpreter Services

T1013 - Interpreter Services – 15 minutes

Section 5 Additional Children's Program (Ages 0–20 Inclusive)

Children also have access to all the codes under the adult program.

5.1 Clinical Oral Evaluations

D0145 - Oral Evaluation for a Patient under Three Years of Age and Counseling with Primary Caregiver

Diagnostic and preventive services performed for a child under the age of three, preferably within the first six months of the eruption of the first primary tooth, including recording the oral and physical health history, evaluation of caries susceptibility, development of an appropriate preventive oral health regimen and communication with and counseling of the child's parent, legal guardian and/or primary caregiver.

The reimbursement for procedure code D0145 includes all anticipatory guidance provided to the family, including oral hygiene instructions. Note that you cannot bill for oral hygiene instructions (procedure code D1330) on the same date of service as procedure code D0145.

5.2 Radiographs

D0340 - Cephalometric Radiographic Image

D0350 - Oral/Facial Photographic Image Obtained Intraorally or Extraorally

D0350 is intended to be used strictly for Orthodontic documentation. Therefore, the use of code D0350 is limited to Orthodontic purposes only.

This includes photographic images, including those obtained by intraoral and extraoral cameras, excluding radiographic images. These photographic images should be part of the patient's clinic record.

D0391 - Interpretation of Diagnostic Image by a Practitioner Not Associated with Capture of the Image, Including the Report

5.3 Preventive Treatment

D1120 - Prophylaxis – Child

Removal of plaque, calculus and stains from tooth structures and implants in the primary (deciduous) and transitional dentition. It is intended to control local irritational factors.

Normal cleanings are every six months.

Definitions:

- Primary (Deciduous) Dentition: Teeth developed and erupted first in order of time.
- Transitional Dentition: The final phase of the transition from primary to adult teeth, in which the deciduous molars and canines are in the process of shedding and the permanent successors are emerging.
- Permanent (Adult) Dentition: The dentition that is present after the cessation of growth.

5.4 Other Preventive Services

D1330 - Oral Hygiene Instructions

D1351 - Sealant – Per Tooth, Limited to Permanent First and Second Molars

D1351 U9 - Sealant – Per Tooth-Deciduous, First and Second Molars, Bicuspids and Anterior Teeth with Deep Pits and Fissures

When submitting claims for the placement of sealants on deciduous molars, bicuspids and anterior teeth you must add the "U9" modifier to the end of procedure code D1351. For example, when submitting for a sealant placed on tooth #28, use procedure code D1351U9.

The surfaces eligible for sealants are limited to Occlusal (O), Buccal (B), Occlusal-Buccal (OB) and Occlusal-Lingual (OL) as well as any deep pits and fissures on anterior teeth.

D1352 - Preventive Resin Restoration in a Moderate to High Caries Risk Patient – Permanent Tooth

5.4.1 Space Maintenance

D1510 - Space Maintainer – Fixed – Unilateral – Per Quadrant

D1516 - Space Maintainer – fixed – bilateral, maxillary
(Replaces D1515 - Space Maintainer – fixed, bilateral)

D1517 - Space Maintainer – fixed – bilateral, mandibular
(Replaces D1515 - Space Maintainer – fixed, bilateral)

D1526 - Space Maintainer – removable – bilateral, maxillary
(Replaces D1525 - Space Maintainer - removable - bilateral)

D1527 - Space Maintainer – removable – bilateral, mandibular
(Replaces D1525 - Space Maintainer - removable - bilateral)

D1551 - Re-Cement or Re-Bond Bilateral Space Maintainer – maxillary

D1552 - Re-Cement or Re-Bond Bilateral Space Maintainer – mandibular

D1553 - Re-Cement or Re-Bond Bilateral Space Maintainer – Per Quadrant

D1575 - Distal Shoe Space Maintainer – Fixed – Unilateral – Per Quadrant

5.4.2 Custom Crowns

D2720 - Crown – Resin to High Noble Metal

D2740 - Crown – Porcelain/Ceramic substrate

D2750 - Crown – Porcelain to High Noble

D2751 - Crown – Porcelain to Base Metal

D2752 - Crown – Porcelain to Noble Metal

D2753 - Crown – Porcelain Fused to Titanium and Titanium Alloys

D2790 - Crown – Full Cast High Noble Metal

D2791 - Crown – Full Cast Base Metal

D2792 - Crown – Full Cast Noble Metal

5.5 Other Restorative Procedures

D2952 - Post and Core in Addition to Crown, Indirectly Fabricated

Post and core are custom fabricated as a single unit.

D2960 - Labial Veneer (Resin Laminate) – Direct

D2980 - Crown Repair, by report

D2999 - Unspecified Restorative Procedure, by report

5.5.1 Apexification/Recalcification Procedures

D3351 - Apexification/Recalcification – Initial Visit

D3352 - Apexification/Recalcification – Interim Medication Placement

D3353 - Apexification/Recalcification – Final Visit

5.5.2 Apexification/Recalcification Procedures

D3355 - Pulpal Regeneration – Initial Visit (if <16)

D3356 - Pulpal Regeneration – Interim Medication Replacement (if <16)

D3357 - Pulpal Regeneration – Completion of Treatment (if <16)

5.5.3 Apicoectomy/Periradicular Surgery

D3450 - Root Amputation – per Root

5.6 Other Endodontic Procedures

D3910 - Surgical Procedure for Isolation of Tooth with Rubber Dam

D3920 - Hemisection (Including any Root Removal Not Including Root Canal Therapy)

D3999 - Unspecified Endodontic Procedure, by report

5.7 Periodontics

Local anesthesia is a component of all periodontal procedures.

5.7.1 Surgical Services

D4210 - Gingivectomy or Gingivoplasty, Four or more Contiguous Teeth or Bounded Teeth Spaces, per Quadrant

D4211 - Gingivectomy or Gingivoplasty, One to three Contiguous Teeth or Bounded Teeth Spaces, per Quadrant

D4240 - Gingival Flap Procedure, Including Root Planning – Four or more Contiguous Teeth or Bounded Teeth Spaces, per Quadrant

D4241 - Gingival Flap Procedure, Including Root Planing – One to three Contiguous Teeth or Bounded Teeth Spaces, per Quadrant

D4249 - Clinical Crown Lengthening-Hard Tissue

D4260 - Osseous Surgery (including elevation of a full thickness flap entry and closure) - Four or more Teeth, per Quadrant

D4261 - Osseous Surgery (including elevation of a full thickness flap entry and closure) - One to three Teeth, per Quadrant

D4263 - Bone replacement graft- retained natural tooth

D4270 - Pedicle Soft Tissue Graft Procedure

D4277 - Free Soft Tissue Graft Procedure (including donor site surgery), First Tooth or Edentulous Tooth Position in Graft

D4278 - Free Soft Tissue Graft Procedure (including donor site surgery), Each Additional Tooth or Edentulous Tooth position in same Graft Site

D4999 - Unspecified Periodontal Procedure, by report

5.8 Removable Prosthodontics

5.8.1 Complete Dentures, Immediate Dentures and Overdentures

D5110 - Complete Denture – Maxillary

D5120 - Complete Denture – Mandibular

D5130 - Immediate Denture – Maxillary

D5140 - Immediate Denture – Mandibular

5.8.2 Partial Dentures

D5211 - Maxillary Partial Denture – Resin Base

D5212 - Mandibular Partial Denture – Resin Base

D5213 - Maxillary Partial Denture – Cast Framework

D5214 - Mandibular Partial Denture – Cast Framework

D5225 - Maxillary Partial Denture – Flexible Base (including retentive/clasping materials, rests, and teeth)

D5226 - Mandibular Partial Denture – Flexible Base (including retentive/clasping materials, rests, and teeth)

5.8.3 Denture Repairs

D5511 - Repair Broken Complete Denture Base - Mandibular

D5512 - Repair Broken Complete Denture Base - Maxillary

D5520 - Repair Missing or Broken Teeth – Complete Denture

D5611 - Repair Resin Denture Base – Mandibular

D5612 - Repair Resin Denture Base – Maxillary

D5621 - Repair Cast Framework, Partial Mandibular

D5622 - Repair Cast Framework, Partial Maxillary

D5630 - Repair or Replace Broken Clasp – Partial Denture – per Tooth

D5640 - Replace Broken Teeth on Existing Partial – per Tooth

D5650 - Add Tooth to Existing Partial Denture

D5660 - Add Clasp to Existing Partial Denture – per Tooth

5.8.4 Denture Rebases

D5710 - Rebase Complete Maxillary Denture (Laboratory)

D5711 - Rebase Complete Mandibular Denture (Laboratory)

D5720 - Rebase Maxillary Partial Denture (Laboratory)

D5721 - Rebase Mandibular Partial Denture (Laboratory)

5.8.5 Denture Relines

D5750 - Reline Complete Maxillary Denture (Indirect)

D5751 - Reline Complete Mandibular Denture (Indirect)

D5760 - Reline Maxillary Partial Denture (Indirect)

D5761 - Reline Mandibular Partial Denture (Indirect)

5.8.6 Interim Prosthesis

D5820 - Interim partial denture (Including retentive/clasping materials, rests, and teeth), maxillary

D5821 - Interim partial denture (Including retentive/clasping materials, rests, and teeth), mandibular

5.8.7 Other Removable Prosthetic Services

D5863 - Overdenture – Complete Maxillary

D5864 - Overdenture – Partial Maxillary

D5865 - Overdenture – Complete Mandibular

D5866 - Overdenture – Partial Mandibular

D5899 - Unspecified Removable Prosthodontic Procedure, by report

5.9 Fixed Prosthodontics

Local anesthesia is a component of all fixed prosthodontic procedures.

5.9.1 Fixed Partial Denture Pontics

D6055 - Connecting Bar - Implant Supported or Abutment Supported

D6210 - Pontic - Cast High Noble Metal

D6211 - Pontic - Cast Predominantly Base Metal

D6212 - Pontic - Cast Noble Metal

D6214 - Pontic - Titanium

D6240 - Pontic - Porcelain Fused to High Noble Metal

D6241 - Pontic - Porcelain Fused to Predominantly Base Metal

D6242 - Pontic - Porcelain Fused to Noble Metal

D6243 - Pontic - Porcelain Fused to Titanium and Titanium Alloys

D6250 - Pontic - Resin with High Noble Metal

D6251 - Pontic - Resin with Predominantly Base Metal

D6252 - Pontic - Resin with Noble Metal

D6545 - Cast Metal Retainer for Acid Etched Bridge

5.9.2 Fixed Partial Denture Retainers – Crowns

D6750 - Crown – Porcelain Fused to High Noble Metal

D6751 - Crown – Porcelain Fused to Base Metal

D6752 - Crown – Porcelain Fused to Noble Metal

D6753 - Retainer Crown – Porcelain Fused to Titanium and Titanium Alloys

D6790 - Crown – Full Cast High Noble Metal

D6791 - Crown – Full Cast Base Metal

D6792 - Crown – Full Cast Noble Metal

5.9.3 Other Prosthodontic Services

D6980 - Bridge Repair, by report

D6985 - Pediatric Partial Denture, fixed

Reimbursement includes all necessary post-delivery denture adjustments for 3 months.

D6999 - Unspecified Fixed Prosthodontic Procedure, by report

5.10 Oral and Maxillofacial surgery

D7280 - Exposure of an Unerupted Tooth

D7282 - Mobilization of Erupted or Malpositioned Tooth to Aid Eruption to Move/Luxate Teeth to Eliminate Ankylosis, not in Conjunction with an Extraction

D7283 - Placement of Device to Facilitate Eruption of Impacted Tooth

D7610 to D7680 - Fracture of Bones of the Facial Structures

D7810 to D7877 - Related to Temporomandibular Joint Problems

D7899 - Related to Temporomandibular Joint Problems

D7971 - Excision of Pericoronal Gingiva

D7961 - Buccal/labial frenectomy (frenulectomy)

D7962 - Lingual frenectomy (frenulectomy)

D7971 - Excision of Pericoronal Gingiva

5.10.1 Miscellaneous Surgical Procedures

D7999 - Unspecified Surgical Procedure, by report

5.11 Orthodontics

Definitions:

Primary (Deciduous) Dentition: *Teeth developed and erupted first in order of time.*

Transitional Dentition: *The final phase of the transition from primary to adult teeth, in which the deciduous molars and canines are in the process of shedding and the permanent successors are emerging.*

Adolescent Dentition: *The dentition that is present after the normal loss of primary teeth and prior to cessation of growth that would affect orthodontic treatment.*

Adult (Permanent) Dentition: *The dentition that is present after the cessation of growth that would affect orthodontic treatment.*

Reimbursement for orthodontic treatment includes all necessary maintenance to and replacement of brackets and wires.

When submitting for payment of prior authorized orthodontic appliances, please place a "U" to indicate upper and an "L" to indicate lower in the "surface" section of the claim form.

5.11.1 Limited Orthodontic Treatment

D8010 - Limited Orthodontic Treatment of the Primary Dentition

D8020 - Limited Orthodontic Treatment of the Transitional Dentition

D8030 - Limited Orthodontic Treatment of the Adolescent Dentition

D8040 - Limited Orthodontic Treatment of the Adult Dentition

5.11.2 Comprehensive Orthodontic Treatment

D8070 - Comprehensive Orthodontic Treatment of the Transitional Dentition
(See new 2022 Prior Authorization Form)

D8080 - Comprehensive Orthodontic Treatment of the Adolescent Dentition
(See new 2022 Prior Authorization Form)

D8090 - Comprehensive Orthodontic Treatment of the Adult Dentition
(See new 2022 Prior Authorization Form)

5.11.3 Treatment to Control Harmful Habits

D8210 - Removable Appliance Therapy

D8220 - Fixed Appliance Therapy

5.11.4 Other Orthodontic Services

D8695 - Removal of Fixed Orthodontic Appliances for Reasons other than Completion of Treatment

D8698 - Re-Cement or Re-Bond Fixed Retainer – Maxillary

D8699 - Re-Cement or Re-Bond Fixed Retainer – Mandibular

D8701 - Repair of Fixed Retainer, Includes Reattachment – Maxillary

D8702 - Repair of Fixed Retainer, Includes Reattachment – Mandibular

D8703 - Replacement of Lost or Broken Retainer – Maxillary

D8704 - Replacement of Lost or Broken Retainer – Mandibular

D8999 - Unspecified Orthodontic Procedure, by report

5.12 Adjunctive General Services

5.12.1 Occlusal Therapy

D9950 - Occlusal Analysis – Mounted Case

D9951 - Occlusal Adjustment – Limited

D9952 - Occlusal Adjustment – Complete

5.12.2 Miscellaneous Services

D9973 - External Bleaching – Per Tooth

D9974 - Internal Bleaching – Per Tooth

5.12.3 Unspecified Care

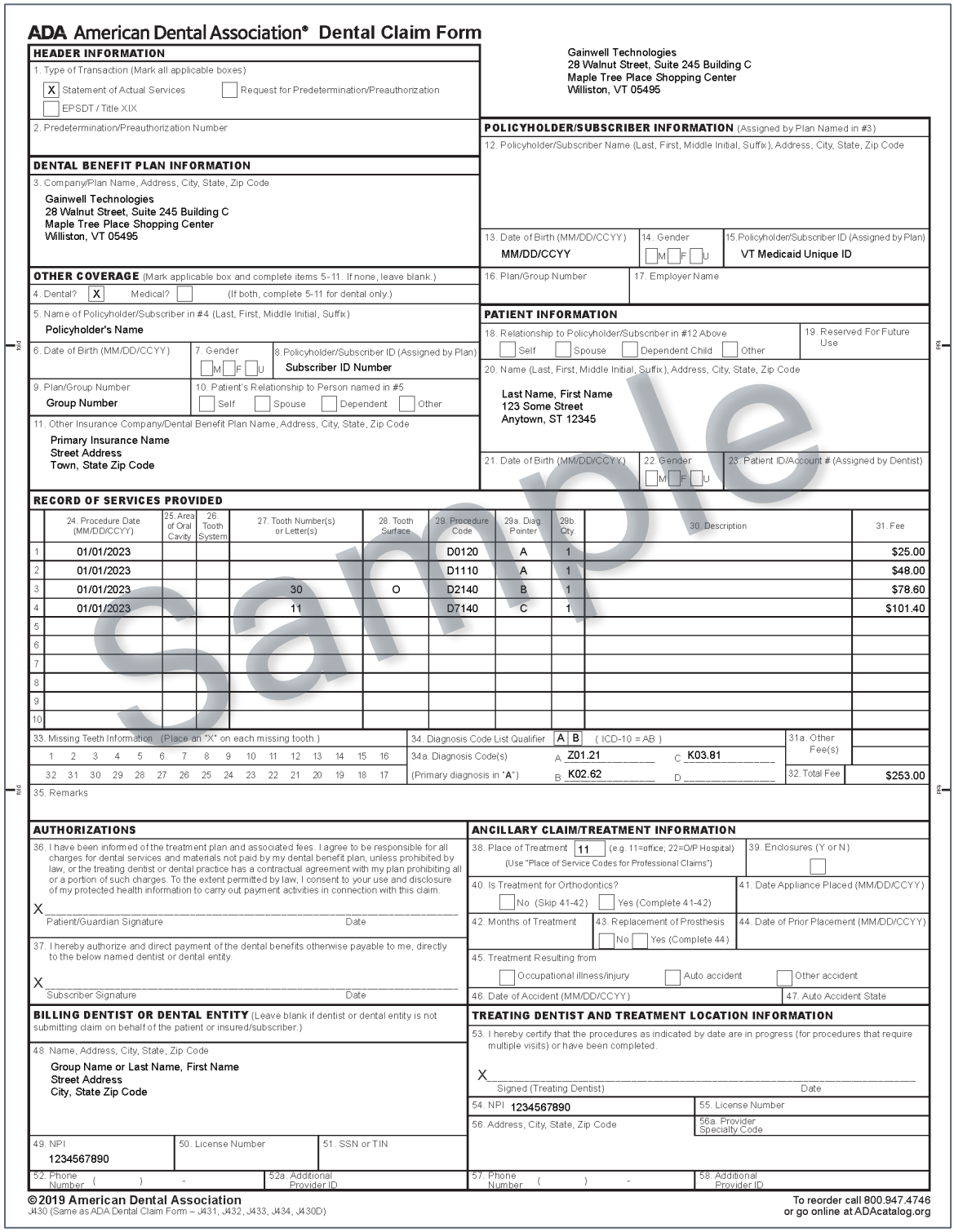
D9986 - Missed Appointment

D9987 - Cancelled Appointment

D9999 - Unspecified Adjunctive Procedure, by report

Section 6 2019 ADA Dental Claim Form

All information on the 2019 dental claim forms should be typed or legibly printed. For more information/instructions about the 2019 Dental Claim Forms, see the dental resources available on the Vermont Medicaid Portal.
https://vtmedicaid.com/assets/resources/2019ADAFormDetailedInst.pdf



ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
[X] Statement of Actual Services [ ] Request for Predetermination/Preauthorization
[ ] EPSDT / Title XIX

2. Predetermination/Preauthorization Number

Gainwell Technologies
28 Walnut Street, Suite 245 Building C
Maple Tree Place Shopping Center
Williston, VT 05495

DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code
Gainwell Technologies
28 Walnut Street, Suite 245 Building C
Maple Tree Place Shopping Center
Williston, VT 05495

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? [X] Medical? [ ] (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
Policyholder's Name

6. Date of Birth (MM/DD/CCYY)

7. Gender [ ] M [ ] F [ ] U

8. Policyholder/Subscriber ID (Assigned by Plan)
Subscriber ID Number

9. Plan/Group Number
Group Number

10. Patient's Relationship to Person named in #5
[ ] Self [ ] Spouse [ ] Dependent [ ] Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code
Primary Insurance Name
Street Address
Town, State Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (Assigned by Plan Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY)
MM/DD/CCYY

14. Gender [ ] M [ ] F [ ] U

15. Policyholder/Subscriber ID (Assigned by Plan)
VT Medicaid Unique ID

16. Plan/Group Number

17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above
[ ] Self [ ] Spouse [ ] Dependent Child [ ] Other

19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
Last Name, First Name
123 Some Street
Anytown, ST 12345

21. Date of Birth (MM/DD/CCYY)

22. Gender [ ] M [ ] F [ ] U

23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	01/01/2023					D0120	A	1		$25.00
2	01/01/2023					D1110	A	1		$48.00
3	01/01/2023			30	O	D2140	B	1		$78.60
4	01/01/2023			11		D7140	C	1		$101.40
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier [A] [B] (ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A")
A Z01.21 C K03.81
B K02.62 D

31a. Other Fee(s)

32. Total Fee $253.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.
X _____
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.
X _____
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N) [ ]

40. Is Treatment for Orthodontics? [ ] No (Skip 41-42) [ ] Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment

43. Replacement of Prosthesis [ ] No [ ] Yes (Complete 44)

44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from
[ ] Occupational illness/injury [ ] Auto accident [ ] Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
Group Name or Last Name, First Name
Street Address
City, State Zip Code

49. NPI 1234567890

50. License Number

51. SSN or TIN

52. Phone Number ( ) -

52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.
X _____
Signed (Treating Dentist) Date

54. NPI 1234567890

55. License Number

56. Address, City, State, Zip Code

56a. Provider Specialty Code

57. Phone Number ( ) -

58. Additional Provider ID

J430 (Same as ADA Dental Claim Form – J431, J432, J433, J434, J430D)

To reorder call 800.947.4746
or go online at ADAcatalog.org

Section 7 Dental Covered Services

For information/instructions about code reimbursement rates and if a PA is required, visit the Fee Schedule on the Vermont Medicaid Portal: https://vtmedicaid.com/#/feeSchedule.

All codes are covered during pregnancy and for 12 months after pregnancy ends (including all medically necessary codes listed as N for the Adult Program).

See other updates/exceptions for the Adult Program in Sections 2.1.2 and 2.1.3 relating to Emergency Services and Waiver Program Services.

* Additional information in the Dental Supplement

** Individual Consideration

CDT Code	Description	Adult Program	Frequency Allowed	$1,500 Cap	Dental Therapist	Independently Billing Dental Hygienist	Global Period (Days)
D0120	Periodic Oral Evaluation	Y	1 per 180 days	N	Y	N	0
D0120 - PA is not required for additional services. Providers must maintain documentation that additional services are medically necessary.							
D0140	Limited Oral Evaluation – Problem Focused	Y	1 per date of service	N	Y	N	0
D0145	Oral Evaluation for a patient under three years of age and counseling with primary caregiver	N	1 per 180 days	N/A	Y	Y	0
D0145 - Limited to children under three years of age. PA required for additional services. Note that you cannot bill for oral hygiene instructions (procedure code D1330) on the same date of service as procedure code D0145.							
D0150	Comprehensive Oral Evaluation	Y	1 per provider per 3 years	Y	Y	N	0
D0150 - PA required for additional services.							
D0170	Re-evaluation – Limited, Problem Focused	Y	1 per date of service	N	Y	N	0
D0170 - Assessing the status of a previously existing condition.							
D0210	Intraoral – Comprehensive series of radiographic images	Y	1 per year	Y	Y	N	0
D0220	Intraoral – Periapical – First radiographic image	Y	6 per date of service	Y	Y	N	0
D0230	Intraoral – Periapical – Each Additional radiographic image	Y	6 per date of service	Y	Y	N	0
D0240	Intraoral – Occlusal - radiographic image	Y	1 set per 180 days	Y	Y	N	0
D0240 - PA required for additional services.							
D0250	Extra-oral - 2D projection radiographic image	Y	1 per 180 days	Y	N	N	0
D0251	Extra-oral - posterior dental radiographic image	Y	1 per 180 days	Y	N	N	0
D0270	Bitewing –single radiographic image	Y	1 per 180 days	Y	Y	N	0

CDT Code	Description	Adult Program	Frequency Allowed	$1,500 Cap	Dental Therapist	Independently Billing Dental Hygienist	Global Period (Days)
D0272	Bitewings – 2 radiographic images	Y	1 set per 180 days	Y	Y	N	0
D0273	Bitewings – 3 radiographic images	Y	1 set per 180 days	Y	Y	N	0
D0274	Bitewings – 4 radiographic images	Y	1 set per 180 days	Y	Y	N	0
D0330	Panoramic radiographic image	Y	1 per year	Y	Y	N	0
D0250 – D0330 - PA required for additional services.							
D0340	Cephalometric radiographic image	N	1 per 2 years	N/A	N	N	0
D0350	Oral/Facial Photographic Image obtained intraorally or extraorally	N	1 set per 2 years	N/A	N	N	0
D0350 - This includes photographic images, including those obtained by intraoral and extraoral cameras, excluding radiographic images. These photographic images should be part of the patient's clinic record.							
D0364	Cone Beam CT Capture and Interpretation with Limited Field of View – Less Than One Whole Jaw; report area of oral cavity	Y	As needed	Y	N	N	0
D0365	Cone Beam CT Capture and Interpretation with Limited Field of View of One Full Dental Arch – Mandible	Y	As needed	Y	N	N	0
D0366	Cone Beam CT Capture and Interpretation with Limited Field of View of One Full Dental Arch – Maxilla, with or without Cranium	Y	As needed	Y	N	N	0
D0367	Cone Beam CT Capture and Interpretation with Limited Field of View of Both Jaws, With or Without Cranium	Y	As needed	Y	N	N	0
D0368	Cone Beam CT Capture and Interpretation for TMJ Series Including Two or More Exposures	Y	As needed	Y	N	N	0
D0391	Interpretation of Diagnostic Image by a Practitioner Not Associated with Capture of the Image, Including the Report	N	As needed	N/A	N	N	0
D0393	Treatment Simulation Using 3D Image Volume	Y	As needed	Y	N	N	0
D0470	Diagnostic Models	Y	1 set per 2 years	Y	N	N	0
D0999	Unspecified diagnostic procedures	Y	As needed	Y	N	N	0
D0999 - ** Individual Consideration							
D1110	Prophylaxis – Adult (normal freq of 180 days)	Y	1 per 180 days	N	Y	Y	0
D1120	Prophylaxis – Child (normal freq of 180 days)	N	1 per 180 days	N/A	Y	Y	0
D1206	Topical Fluoride Varnish; Therapeutic application for moderate to high caries risk patients	Y	1 per 180 days	N	Y	Y	0
D1208	Topical Application of Fluoride	Y	1 per 180 days	N	Y	Y	0

CDT Code	Description	Adult Program	Frequency Allowed	$1,500 Cap	Dental Therapist	Independently Billing Dental Hygienist	Global Period (Days)
D1110 – D1208 - PA is not required for additional services. Providers must maintain documentation that additional services are medically necessary.							
D1320	Tobacco Counseling for the Control and Prevention of Oral Disease	Y	1 per 90 days	N	Y	Y	0
D1330	Oral Hygiene Instructions	N	2 per year, ≤ 4-years old	N/A	Y	Y	0
D1330 - Oral hygiene instructions are limited to children 4 years old and younger. PA required for additional services							
D1351	Sealant – Per Tooth and anteriors with deep pits and fissures	N	1 tooth per 5 years	N/A	Y	Y	5 yrs
D1351 - Once a sealant is placed, the provider is responsible for the maintenance of that sealant for a period of 5 years. Limited to permanent first and second molars.							
D1351 U9	Sealant – Per Tooth-Deciduous second molars and bicuspids	N	1 tooth per 5 years	N/A	Y	Y	5 yrs
D1351 U9 - Once a sealant is placed, the provider is responsible for the maintenance of that sealant for a period of 5 years. *							
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth	N	1 tooth per 5 years	N/A	Y	N	10
D1354	Application of caries arresting medicament – per tooth	Y	4 per tooth per lifetime	N	Y	Y	10
D1354 - Applications must be at least 120 days apart. Be sure to identify tooth number when submitting a claim. PA required for additional services. *							
D1510	Space Maintainer – Fixed – Unilateral – Per Quadrant	N	1 per 2 years	N/A	N	N	0
D1510 - Excludes a distal shoe space maintainer. When submitting for payment for space maintainers, indicate a corresponding tooth number on the completed claim form.							
D1516	Space Maintainer – Fixed – Bilateral, maxillary	N	1 per 2 years	N/A	Y	N	0
D1517	Space Maintainer – Fixed – Bilateral, mandibular	N	1 per 2 years	N/A	Y	N	0
D1526	Space Maintainer – Removable – Bilateral, maxillary	N	1 per 2 years	N/A	Y	N	0
D1527	Space Maintainer – Removable – Bilateral, mandibular	N	1 per 2 years	N/A	Y	N	0
D1551	Re-Cement or Re-Bond Bilateral Space Maintainer – maxillary	N	As needed	N/A	Y	N	0
D1552	Re-Cement or Re-Bond Bilateral Space Maintainer – mandibular	N	As needed	N/A	Y	N	0
D1553	Re-Cement or Re-Bond Unilateral Space Maintainer – Per Quadrant	N	As needed	N/A	Y	N	0
D1575	Distal Shoe Space Maintainer – Fixed – Unilateral Per Quadrant; State Quadrant	N	1 per 2 years	N/A	N	N	10
D1516 - D1575 - When submitting for payment for space maintainers, indicate a corresponding tooth number on the completed claim form.							

CDT Code	Description	Adult Program	Frequency Allowed	$1,500 Cap	Dental Therapist	Independently Billing Dental Hygienist	Global Period (Days)
D2140	Amalgam – One Surface, Primary or Permanent	Y	Once per surface per year per tooth	Y	Y	N	10
D2150	Amalgam – Two Surfaces, Primary or Permanent	Y	Once per surface per year per tooth	Y	Y	N	10
D2160	Amalgam – Three Surfaces, Primary or Permanent	Y	Once per surface per year per tooth	Y	Y	N	10
D2161	Amalgam – Four or more Surfaces, Primary or Permanent	Y	Once per surface per year per tooth	Y	Y	N	10
D2140 – D2161 - Tooth preparation, all adhesives (including amalgam bonding agents), liners and bases are included as part of the restoration. If pins are used, they should be reported separately (seeD2951).							
D2330	Resin-Based Composite – One Surface, Anterior	Y	Once per surface per year per tooth	Y	Y	N	10
D2331	Resin-Based Composite – Two Surfaces, Anterior	Y	Once per surface per year per tooth	Y	Y	N	10
D2332	Resin-Based Composite – Three Surfaces, Anterior	Y	Once per surface per year per tooth	Y	Y	N	10
D2335	Resin-Based Composite – Four or more Surfaces, Anterior	Y	Once per surface per year per tooth	Y	Y	N	10
D2390	Resin-Based Composite crown, Anterior	Y	Once per surface per year per tooth	Y	Y	N	10
D2391	Resin-Based Composite – One Surface, Posterior	Y	Once per surface per year per tooth	Y	Y	N	10
D2392	Resin-Based Composite – Two Surfaces, Posterior	Y	Once per surface per year per tooth	Y	Y	N	10
D2393	Resin-Based Composite – Three Surfaces, Posterior	Y	Once per surface per year per tooth	Y	Y	N	10
D2394	Resin-Based Composite – Four or more Surfaces, Posterior	Y	Once per surface per year per tooth	Y	Y	N	10
D2330 – D2394 - Resin-based composite refers to a broad category of materials including but not limited to composites. May include bonded composite, light-cured composite, etc. Tooth preparation, etching, adhesives (including resin bonding agents), liners and bases and curing are included as part of the restoration. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used, they should be reported separately (see D2951).							
D2720	Crown – Resin to High Noble Metal	N	1 per tooth per 5 years	N/A	N	N	10

CDT Code	Description	Adult Program	Frequency Allowed	$1,500 Cap	Dental Therapist	Independently Billing Dental Hygienist	Global Period (Days)
D2740	Crown – Porcelain/Ceramic substrate	N	1 per tooth per 5 years	N/A	N	N	10
D2750	Crown – Porcelain to High Noble	N	1 per tooth per 5 years	N/A	N	N	10
D2751	Crown – Porcelain to Base Metal	N	1 per tooth per 5 years	N/A	N	N	10
D2752	Crown – Porcelain to Noble Metal	N	1 per tooth per 5 years	N/A	N	N	10
D2753	Crown – Porcelain Fused to Titanium and Titanium Alloys	N	1 per tooth per 5 years	N/A	N	N	10
D2790	Crown – Full Cast High Noble Metal	N	1 per tooth per 5 years	N/A	N	N	10
D2791	Crown – Full Cast Base Metal	N	1 per tooth per 5 years	N/A	N	N	10
D2792	Crown – Full Cast Noble Metal	N	1 per tooth per 5 years	N/A	N	N	10
D2720 – D2792 - When submitting for payment for custom crowns, use the start date (final impression date) as the date of service on the completed claim. Do not submit the claim until the custom crown is delivered.							
D2920	Recement Crown	Y		Y	Y	N	10
D2928	Prefabricated Porcelain/Ceramic Crown – Permanent Tooth	Y	1 per tooth per 2 years	Y	Y	N	10
D2930	Stainless Steel Crown – Primary	Y	1 per tooth per 2 years	Y	Y	N	10
D2931	Stainless Steel Crown – Permanent	Y	1 per tooth per 2 years	Y	Y	N	10
D2932	Prefabricated Resin Crown	Y	1 per tooth per 2 years	Y	Y	N	10
D2933	Prefabricated Stainless Steel Crown with Resin Window	Y	1 per tooth per 2 years	Y	Y	N	10
D2940	Protective Restoration	Y		Y	Y	N	10
D2940 - When submitting for a protective restoration, indicate the corresponding tooth number and tooth surfaces on the completed claim form.							
D2950	Core Build-up – Including Pins	Y	1 per tooth per lifetime	Y	Y	N	10
D2951	Pin Retention, Per Tooth	Y	1 per tooth per 2 years	Y	N	N	10
D2952	Post and Core in addition to crown, indirectly fabricated	N	1 per tooth per lifetime	N/A	N	N	10
D2952 - Post and core are custom fabricated as a single unit.							
D2954	Prefabricated Post and Core	Y	1 per tooth per lifetime	Y	N	N	10
D2954 - Core is built around a prefabricated post. This procedure includes the core material.							
D2960	Labial Veneer – Laminate	N	1 per year	N/A	N	N	10

CDT Code	Description	Adult Program	Frequency Allowed	$1,500 Cap	Dental Therapist	Independently Billing Dental Hygienist	Global Period (Days)
D2980	Crown Repair, by report	N	As needed	N/A	N	N	10
D2999	Unspecified Restorative Procedure, by report	N	As needed	N/A	N	N	10
D2999 - ** Individual Consideration							
D3220	Therapeutic Pulpotomy (Excluding final restoration)	Y	1 per tooth per lifetime	Y	Y	N	10
D3220 - To be performed on primary or permanent teeth. This is not to be construed as the first stage of root canal therapy. *							
D3221	Pulpal Debridement, primary and permanent teeth *	Y	1 per tooth per lifetime	Y	N	N	10
D3230	Pulpal Therapy (resorbable filling) Anterior Primary Tooth	Y	1 per tooth per lifetime	Y	N	N	10
D3230 - Anterior Primary Tooth							
D3240	Pulpal Therapy (resorbable filling) Posterior Primary Tooth	Y	1 per tooth per lifetime	Y	N	N	10
D3240 - Posterior Primary Tooth							
D3310	Anterior (Excluding Final Restoration)	Y	1 per tooth per lifetime	Y	N	N	10
D3320	Bicuspid (Excluding Final Restoration)	Y	1 per tooth per lifetime	Y	N	N	10
D3330	Molar (Excluding Final Restoration)	Y	1 per tooth per lifetime	Y	N	N	10
D3310 – D3330 - When submitting for payment for completed endodontic therapy, use the start date as the date of service on the completed claim. Do not submit the claim until endodontic treatment is completed. *							
D3351	Apexification/Recalcification – Initial Visit	N	1 per tooth per lifetime	N/A	N	N	10
D3352	Apexification/Recalcification – Interim Medication Placement	N	1 per tooth per lifetime	N/A	N	N	10
D3353	Apexification/Recalcification – Final Visit	N	1 per tooth per lifetime	N/A	N	N	10
D3355	Pulpal Regeneration – Initial Visit (if <16)	N	1 per tooth per lifetime	N/A	N	N	10
D3355 - Includes opening tooth, preparation of canal spaces, and placement of medication. X-ray needs to show apex of the roots.							
D3356	Pulpal Regeneration – Interim Medication Replacement (if <16)	N	1 per tooth per lifetime	N/A	N	N	10
D3356 - X-ray needs to show apex of the roots.							
D3357	Pulpal Regeneration – Completion of Treatment (if <16)	N	1 per tooth per lifetime	N/A	N	N	10
D3357 - Does not include final restoration. X-ray needs to show apex of the roots.							
D3410	Apicoectomy/Periradicular Surgery; Anterior	Y	1 per tooth per lifetime	Y	N	N	10
D3421	Apicoectomy/Periradicular Surgery; Bicuspid (First Root)	Y	1 per tooth per lifetime	Y	N	N	10

CDT Code	Description	Adult Program	Frequency Allowed	$1,500 Cap	Dental Therapist	Independently Billing Dental Hygienist	Global Period (Days)
D3421 - Does not include placement of retrograde filling material. If more than one root is treated, see D3426.							
D3425	Apicoectomy/Periradicular Surgery; Molar (First Root)	Y	1 per tooth per lifetime	Y	N	N	10
D3426	Apicoectomy/Periradicular Surgery; Each Additional Root	Y	1 per tooth per lifetime	Y	N	N	10
D3426 - Typically used for bicuspids and molar surgeries when more than one root is treated during the same procedure. This does not include retrograde filling material placement.							
D3430	Retrograde Filling – Per Root	Y	1 per tooth per lifetime	Y	N	N	10
D3450	Root Amputation – Per Root	Y	1 per tooth per lifetime	Y	N	N	10
D3471	Surgical Repair of Root Resorption - Anterior	Y	1 per tooth per lifetime	Y	N	N	10
D3472	Surgical Repair of Root Resorption – Premolar	Y	1 per tooth per lifetime	Y	N	N	10
D3473	Surgical Repair of Root Resorption – Molar	Y	1 per tooth per lifetime	Y	N	N	10
D3501	Surgical Exposure of Root Surface without Apicoectomy or Repair of Root Resorption – Anterior	Y	1 per tooth per lifetime	Y	N	N	10
D3502	Surgical Exposure of Root Surface without Apicoectomy or Repair of Root Resorption – Premolar	Y	1 per tooth per lifetime	Y	N	N	10
D3503	Surgical Exposure of Root Surface without Apicoectomy or Repair of Root Resorption – Molar	Y	1 per tooth per lifetime	Y	N	N	10
D3910	Surgical Procedure for Isolation of Tooth with Rubber Dam	N	1 per tooth per lifetime	N/A	N	N	10
D3920	Hemisection (Including any Root Removal. Not Including Root Canal Therapy)	N	1 per tooth per lifetime	N/A	N	N	10
D3999	Unspecified Endodontic Procedure, by report	N	As needed	N/A	N	N	10
D3999 - ** Individual Consideration							
D4210	Gingivectomy or Gingivoplasty, Four or more contiguous teeth or bounded teeth spaces per quadrant	N	4 procedures per lifetime	N/A	N	N	10
D4211	Gingivectomy or Gingivoplasty, One to three contiguous teeth or bounded teeth spaces, per quadrant	N	4 procedures per lifetime	N/A	N	N	10
D4212	Gingivectomy or Gingivoplasty to Allow Access for Restorative Procedure per Tooth	Y	4 procedures per lifetime	Y	N	N	10
D4240	Gingival Flap Procedure, Including Root Planning – Four or more contiguous teeth or bounded teeth spaces per quadrant	N	4 procedures per lifetime	N/A	N	N	10

CDT Code	Description	Adult Program	Frequency Allowed	$1,500 Cap	Dental Therapist	Independently Billing Dental Hygienist	Global Period (Days)
D4241	Gingival Flap Procedure, Including Root Planing – One to three contiguous teeth or bounded teeth spaces, per quadrant	N	4 procedures per lifetime	N/A	N	N	10
D4249	Clinical Crown Lengthening-Hard Tissue	N	4 procedures per lifetime	N/A	N	N	10
D4249 - This procedure is employed to allow restorative procedures or crown with little or no tooth structure exposed to the Oral cavity. Requires reflection of a flap and is performed in a healthy periodontal environment.							
D4260	Osseous Surgery (including elevation of a full thickness flap entry and closure) - four or more teeth per quadrant	N	4 procedures per lifetime	N/A	N	N	10
D4260 - Four or more contiguous teeth or bound teeth space, per quadrant							
D4261	Osseous Surgery (including elevation of a full thickness flap entry and closure) - one to three teeth per quadrant	N	4 procedures per lifetime	N/A	N	N	10
D4263	Bone replacement graft- retained natural tooth	N	4 procedures per lifetime	N/A	N	N	10
D4270	Pedicle Soft Tissue Graft Procedure	N	4 procedures per lifetime	N/A	N	N	10
D4277	Free Soft Tissue Graft Procedure	N	4 procedures per lifetime	N/A	N	N	10
D4277 - (including donor site surgery) first tooth or Edentulous Tooth position in Graft.							
D4278	Free Soft Tissue Graft Procedure	N	4 procedures per lifetime	N/A	N	N	10
D4278 - (including donor site surgery) each additional tooth or Edentulous Tooth position in same Graft Site							
D4322	Splint – Intra-coronal – state tooth #'s	Y	4 procedures per lifetime	Y	N	N	10
D4323	Splint – Extra-coronal – state tooth #'s	Y	4 procedures per lifetime	Y	N	N	10
D4341	Periodontal Scaling and Root Planing	Y	4 quadrants per year	Y	Y	Y	10
D4341 - Four or more contiguous teeth per Quadrant. PA required for additional services.							
D4342	Periodontal Scaling and Root Planing	Y	4 quadrants per year	Y	Y	Y	10
D4342 - One to three teeth per Quadrant. PA required for additional services.							
D4346	Scaling in presence of generalized moderate or severe gingival inflammation	Y	1 per 180 days	Y	N	N	10
D4346 - Full mouth, after oral evaluation.							
D4355	Full Mouth Debridement to Enable a Comprehensive Periodontal Evaluation and Diagnosis on a subsequent visit	Y	1 per 2 years	Y	Y	Y	10
D4355 - A prophylaxis cannot be completed on the same date of service as a full mouth debridement. PA required for additional services.							

CDT Code	Description	Adult Program	Frequency Allowed	$1,500 Cap	Dental Therapist	Independently Billing Dental Hygienist	Global Period (Days)
D4910	Periodontal Maintenance	Y	1 per 180 days	Y	Y	Y	10
D4910 - This procedure is performed rather than a prophylaxis for patients following periodontal therapy. PA required for additional services.							
D4999	Unspecified Periodontal Procedure, by report	N		N/A	N	N	10
D4999 - ** Individual Consideration.							
D5110	Complete Denture – Maxillary	N	1 per arch per 5 years	N/A	N	N	90
D5120	Complete Denture – Mandibular	N	1 per arch per 5 years	N/A	N	N	90
D5110 – D5120 - Following the delivery of an immediate denture, a complete denture cannot be prior authorized for a minimum of 5 years.							
D5130	Immediate Denture – Maxillary	N	1 per arch per lifetime	N/A	N	N	90
D5140	Immediate Denture – Mandibular	N	1 per arch per lifetime	N/A	N	N	90
D5130 – D5140 - An immediate denture will be prior authorized if 6 or fewer anterior teeth only are remaining in the arch.							
D5211	Maxillary Partial Denture – Resin Base	N	1 per arch per 5 years	N/A	N	N	90
D5212	Mandibular Partial Denture – Resin Base	N	1 per arch per 5 years	N/A	N	N	90
D5213	Maxillary Partial Denture – Cast Framework	N	1 per arch per 5 years	N/A	N	N	90
D5214	Mandibular Partial Denture – Cast Framework	N	1 per arch per 5 years	N/A	N	N	90
D5225	Maxillary Partial Denture – Flexible Base	N	1 per arch per 5 years	N/A	N	N	90
D5226	Mandibular Partial Denture – Flexible Base	N	1 per arch per 5 years	N/A	N	N	90
D5211 – D5226 - Including Any Conventional Clasps, Rests and Teeth.							
D5410	Adjust Complete Denture – Maxillary	Y	1 per denture per 180 days	Y	N	N	0
D5411	Adjust Complete Denture – Mandibular	Y	1 per denture per 180 days	Y	N	N	0
D5421	Adjust Partial Denture – Maxillary	Y	1 per denture per 180 days	Y	N	N	0
D5422	Adjust Partial Denture – Mandibular	Y	1 per denture per 180 days	Y	N	N	0
D5511	Repair Broken Complete Denture Base - Mandibular	N	1 per denture per 180 days	N/A	Y	N	0
D5512	Repair Broken Complete Denture Base - Maxillary	N	1 per denture per 180 days	N/A	Y	N	0

CDT Code	Description	Adult Program	Frequency Allowed	$1,500 Cap	Dental Therapist	Independently Billing Dental Hygienist	Global Period (Days)
D5520	Repair Missing or Broken Teeth – Complete Denture	N	1 per denture per 180 days	N/A	Y	N	0
D5611	Repair Resin Denture Base – Mandibular	N	1 per denture per 180 days	N/A	Y	N	0
D5612	Repair Resin Denture Base – Maxillary	N	1 per denture per 180 days	N/A	Y	N	0
D5621	Repair Cast Framework, Partial Mandibular	N	1 per denture per 180 days	N/A	N	N	0
D5622	Repair Cast Framework, Partial Maxillary	N	1 per denture per 180 days	N/A	N	N	0
D5630	Repair or Replace Broken Clasp – Partial Denture – state tooth #	N	1 per denture per 180 days	N/A	Y	N	0
D5640	Replace Broken Teeth on Existing Partial – Per Tooth – state tooth # (s)	N	1 per denture per 180 days	N/A	Y	N	0
D5650	Add Tooth to Existing Partial Denture – state tooth #	N	1 per denture per 180 days	N/A	N	N	0
D5660	Add Clasp to Existing Partial Denture – state tooth #	N	1 per denture per 180 days	N/A	N	N	0
D5710	Rebase Complete Maxillary Denture (Laboratory)	N	1 per denture per 2 years	N/A	Y	N	90
D5711	Rebase Complete Mandibular Denture (Laboratory)	N	1 per denture per 2 years	N/A	Y	N	90
D5720	Rebase Maxillary Partial Denture (Laboratory)	N	1 per denture per 2 years	N/A	Y	N	90
D5721	Rebase Mandibular Partial Denture (Laboratory)	N	1 per denture per 2 years	N/A	Y	N	90
D5750	Reline Complete Maxillary Denture (Laboratory)	N	1 per denture per 2 years	N/A	Y	N	90
D5751	Reline Complete Mandibular Denture (Laboratory)	N	1 per denture per 2 years	N/A	Y	N	90
D5760	Reline Maxillary Partial Denture (Laboratory)	N	1 per denture per 2 years	N/A	Y	N	90
D5761	Reline Mandibular Partial Denture (Laboratory)	N	1 per denture per 2 years	N/A	Y	N	90
D5820	Interim partial denture (maxillary)	N	1 per tooth per 2 years	N/A	N	N	90
D5821	Interim partial denture (mandibular)	N	1 per tooth per 2 years	N/A	N	N	90
D5820 – D5821 - Including Any Necessary Clasps and Rests.							
D5850	Tissue Conditioning – Maxillary	Y	1 per denture per 2 years	Y	N	N	0
D5851	Tissue Conditioning – Mandibular	Y	1 per denture per 2 years	Y	N	N	0

CDT Code	Description	Adult Program	Frequency Allowed	$1,500 Cap	Dental Therapist	Independently Billing Dental Hygienist	Global Period (Days)
D5863	Overdenture – Complete Maxillary	N	1 per denture per 2 years	N/A	N	N	90
D5864	Overdenture – Partial Maxillary	N	1 per denture per 2 years	N/A	N	N	90
D5865	Overdenture – Complete Mandibular	N	1 per denture per 2 years	N/A	N	N	90
D5866	Overdenture – Partial Mandibular	N	1 per denture per 2 years	N/A	N	N	90
D5899	Unspecified Removable Prosthodontic Procedure, by report	N	1 per denture per 2 years	N/A	N	N	0
D5899 - ** Individual Consideration							
D6055	Connecting Bar-Implant Supported or Abutment supported	N	1 per denture per 2 years	N/A	N	N	10
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surface, without flap entry and closure	Y	1 per tooth per year	Y	N	N	10
D6081 - This procedure is not performed in conjunction with D1110 or D4910.							
D6101	Debridement of a Peri-implant Defect and Surface Cleaning of exposed Implant Surfaces, including Flap Entry and Closure	Y	1 per tooth per year	Y	N	N	10
D6102	Debridement and Osseous Contouring of a Peri-implant Defect, Includes Surface Cleaning of Exposed Implant Surfaces and Flap Entry and Closure	Y	1 per tooth per year	Y	N	N	10
D6103	Bone Graft for Repair of Peri-implant Defect - Not Including Flap Entry and Closure	Y	1 per tooth per year	Y	N	N	10
D6101 – D6103 - No intention is implied for payment for implants; but the maintenance of existing implants is supported.							
D6210	Pontic – Cast High Noble Metal	N	1 per arch per 5 years	N/A	N	N	90
D6211	Pontic – Cast Base Metal	N	1 per arch per 5 years	N/A	N	N	90
D6212	Pontic – Cast Noble Metal	N	1 per arch per 5 years	N/A	N	N	90
D6240	Pontic – Porcelain Fused to High Noble Metal	N	1 per arch per 5 years	N/A	N	N	90
D6241	Pontic – Porcelain Fused to Base Metal	N	1 per arch per 5 years	N/A	N	N	90
D6242	Pontic – Porcelain Fused to Noble Metal	N	1 per arch per 5 years	N/A	N	N	90
D6243	Pontic – Porcelain Fused to Titanium and Titanium Alloys	N	1 per tooth per 5 years	N/A	N	N	90
D6250	Pontic – Resin with High Noble Metal Retainer	N	1 per tooth per 5 years	N/A	N	N	90

CDT Code	Description	Adult Program	Frequency Allowed	$1,500 Cap	Dental Therapist	Independently Billing Dental Hygienist	Global Period (Days)
D6251	Pontic – Resin with Predominantly Base Metal Retainer	N	1 per tooth per 5 years	N/A	N	N	90
D6252	Pontic – Resin with Noble Metal Retainer	N	1 per tooth per 5 years	N/A	N	N	90
D6545	Cast Metal Retainer for Acid Etched Bridge	N	1 per arch per 5 years	N/A	N	N	90
D6750	Crown – Porcelain Fused to High Noble Metal	N	1 per tooth per 5 years	N/A	N	N	90
D6751	Crown – Porcelain Fused to Base Metal	N	1 per tooth per 5 years	N/A	N	N	90
D6752	Crown – Porcelain Fused to Noble Metal	N	1 per tooth per 5 years	N/A	N	N	90
D6753	Retainer Crown - Porcelain Fused to Titanium and Titanium Alloys	N	1 per tooth per 5 years	N/A	N	N	90
D6790	Crown – Full Cast High Noble Metal Retainer	N	1 per tooth per 5 years	N/A	N	N	90
D6791	Crown – Full Cast Base Metal Retainer	N	1 per tooth per 5 years	N/A	N	N	90
D6792	Crown – Full Cast Noble Metal Retainer	N	1 per tooth per 5 years	N/A	N	N	90
D6210 – D6792 - Reimbursement includes all necessary post-delivery fixed denture adjustments for 90 days.							
D6930	Recement Bridge	Y	As needed	Y	Y	N	0
D6980	Bridge Repair, by report	N	As needed	N/A	N	N	0
D6985	Pediatric Partial Denture, fixed	N	1 per arch per 5 years	N/A	N	N	0
D6930 – D6985 - When submitting for payment for cast bridges, use the start date (final impression date) as the date of service on the completed claim. Do not submit the claim until the cast bridge is delivered.							
D6999	Unspecified Fixed Prosthodontic Procedure, by report	N	**	N/A	N	N	0
D6999 - ** Individual Consideration							
D7111	Extraction, Coronal Remnants – Deciduous Tooth Removal of soft tissue-retained coronal remnants	Y	1 per tooth per lifetime	Y	Y	N	10
D7111 - Includes removal of tooth structure, minor smoothing of socket bone and closure, as necessary.							
D7140	Extraction, Erupted Tooth or Exposed Root	Y	1 per tooth per lifetime	Y	Y	N	10
D7140 - Includes removal of tooth structure, minor smoothing of socket bone and closure, as necessary (elevation and/or forceps removal).							
D7210	Extraction of Erupted Tooth Requiring Elevation of Mucoperiosteal flap	Y	1 per tooth per lifetime	Y	N	N	10
D7210 - Flap and Removal of Bone and/or Section of Tooth. Includes cutting of gingiva and bone, removal of tooth structure, minor smoothing of socket bone and closure.							

CDT Code	Description	Adult Program	Frequency Allowed	$1,500 Cap	Dental Therapist	Independently Billing Dental Hygienist	Global Period (Days)
D7220	Removal of impacted tooth - soft Tissue	Y	1 per tooth per lifetime	Y	N	N	10
D7220 - Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation.							
D7230	Removal of impacted tooth - partially bony	Y	1 per tooth per lifetime	Y	N	N	10
D7230 - Part of crown covered by bone; requires mucoperiosteal flap elevation and bone removal.							
D7240	Removal of impacted tooth - completely bony	Y	1 per tooth per lifetime	Y	N	N	10
D7240 - Most of crown is covered by bone; requires mucoperiosteal flap elevation and bone removal.							
D7241	Removal of impacted tooth -completely bony, with unusual surgical complications	Y	1 per tooth per lifetime	Y	N	N	10
D7241 - Most or all the crown covered by bone; unusually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required or aberrant tooth position.							
D7250	Removal of residual tooth Roots (cutting procedure)	Y	1 per tooth per lifetime	Y	N	N	10
D7250 - Includes cutting of soft tissue and bone, removal of tooth structure, and closure.							
D7251	Coronectomy - intentional partial tooth removal	Y	1 per tooth per lifetime	Y	N	N	10
D7260	Oral antral fistula Closure – report quadrant	Y	As needed	N	N	N	10
D7260 - Subsequent to surgical removal of tooth, exposure of sinus requiring repair, or immediate closure of oroantral or oralnasal communication in absence of fistulous tract.							
D7261	Primary Closure of a sinus perforation – report quadrant	Y	As needed	N	N	N	10
D7261 - Subsequent to surgical removal of tooth, exposure of sinus requiring repair, or immediate closure of oroantral or oralnasal communication in absence of fistulous tract.							
D7270	Tooth Reimplantation and/or stabilization of accidentally evulsed or displaced tooth	Y	As needed	N	Y	N	10
D7270 - Includes splinting and/or stabilization.							
D7280	Exposure of an Unerupted Tooth	N	1 per tooth per lifetime	N/A	N	N	10
D7280 - An incision is made, and the tissue is reflected, and bone removed as necessary to expose the crown of an impacted tooth not intended to be extracted.							
D7282	Mobilization of Erupted or Malpositioned Tooth to Aid Eruption to move/luxate teeth to eliminate ankylosis	N	1 per tooth per lifetime	N/A	N	N	10
D7282 - Not in conjunction with an extraction.							
D7283	Placement of Device to Facilitate Eruption of Impacted Tooth	N	1 per tooth per lifetime	N/A	N	N	10
D7283 - Placement of an orthodontic bracket, band or other device on an unerupted tooth, after its exposure, to aid in its eruption.							
D7284	Excisional biopsy of minor salivary glands	Y	As needed	N	N	N	10

CDT Code	Description	Adult Program	Frequency Allowed	$1,500 Cap	Dental Therapist	Independently Billing Dental Hygienist	Global Period (Days)
D7285	Incisional biopsy of oral tissue- hard (bone tooth) – report quadrant	Y	As needed	N	N	N	10
D7286	Incisional biopsy of oral tissue – Soft – report quadrant	Y	As needed	N	N	N	10
D7290	Surgical repositioning of teeth	Y	As needed	Y	N	N	10
D7291	Transseptal Fiberotomy/Supra Crestal Fiberotomy – report quadrant	Y	As needed	Y	N	N	10
D7295	Harvest of bone for use in autogenous grafting procedure – report quadrant	Y	As needed	Y	N	N	10
D7310	Alveoloplasty in Conjunction with Extractions, Four or more Teeth or Tooth Spaces, per quadrant	Y	4 quadrants per 365 days	N	N	N	10
D7311	Alveoloplasty in Conjunction with Extractions, One to three Teeth, per quadrant	Y	4 quadrants per 365 days	N	N	N	10
D7320	Alveoloplasty not in Conjunction with Extractions, Four or more Teeth or Tooth Spaces, per quadrant	Y	4 quadrants per 365 days	N	N	N	10
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	Y	4 quadrants per 365 days	N	N	N	10
D7340	Vestibuloplasty – Ridge Extension – report quadrant	Y	1 per lifetime	N	N	N	10
D7340 - Secondary Epithelialization.							
D7350	Vestibuloplasty – Ridge Extension – report quadrant	Y	1 per lifetime	N	N	N	10
D7350 - Including soft tissue grafts, muscle reattachments, revision of soft tissue attachment, and management of hypertrophied and hyperplastic tissue.							
D7410	Excision of Benign Lesion up to 1.25 cm – report quadrant	Y	As needed	N	N	N	10
D7411	Excision of Benign Lesion greater than 1.25 cm – report quadrant	Y	As needed	N	N	N	10
D7412	Excision of Benign Lesion, Complicated – report quadrant	Y	As needed	N	N	N	10
D7412 - Requires extensive undermining with advancement or rotational flap closure.							
D7413	Excision of Malignant Lesion up to 1.25 cm – report quadrant	Y	As needed	N	N	N	10
D7414	Excision of Malignant Lesion greater than 1.25 cm – report quadrant	Y	As needed	N	N	N	10
D7415	Excision of Malignant Lesion, Complicated – report quadrant	Y	As needed	N	N	N	10
D7415 - Requires extensive undermining with advancement or rotational flap closure.							
D7440	Excision of Malignant Tumor – Lesion diameter up to 1.25 cm – report quadrant	Y	As needed	N	N	N	10

CDT Code	Description	Adult Program	Frequency Allowed	$1,500 Cap	Dental Therapist	Independently Billing Dental Hygienist	Global Period (Days)
D7441	Excision of Malignant Tumor – Lesion diameter greater than 1.25 cm – report quadrant	Y	As needed	N	N	N	10
D7450	Removal of benign Odontogenic Cyst or Tumor - Lesion diameter up to 1.25 cm - report quadrant	Y	As needed	N	N	N	10
D7451	Removal of benign odontogenic Cyst or Tumor - Lesion diameter greater than 1.25 cm – report quadrant	Y	As needed	N	N	N	10
D7460	Removal of benign nonodontogenic Cyst or Tumor - Lesion diameter up to 1.25 cm	Y	As needed	N	N	N	10
D7461	Removal of benign nonodontogenic Cyst or Tumor - Lesion diameter greater than 1.25 cm – report quadrant	Y	As needed	N	N	N	10
D7465	Destruction of lesion(s) by physical or chemical methods, by report – report quadrant	Y	As needed	N	N	N	10
D7471	Removal of Lateral Exostosis (maxilla or mandible) – report quadrant	Y	As needed	N	N	N	10
D7472	Removal of Torus Palatinus	Y	As needed	N	N	N	10
D7473	Removal of Torus Mandibularis	Y	As needed	N	N	N	10
D7485	Surgical Reduction of Osseous Tuberosity – report quadrant	Y	1 quadrant per lifetime	N	N	N	10
D7510	Incision and Drainage of Abscess-intraoral soft tissue – report quadrant	Y	As needed	N	N	N	10
D7510 - When submitting for the incision and drainage of an abscess, indicate a corresponding tooth number on the completed claim form.							
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	Y	As needed	N	N	N	10
D7610 to D7680	Fracture of bones of the facial structures	-	-	-	N	N	-
D7610 – D7680 - Codes are not reimbursable; however, certain CPT codes may be reimbursable to dentists.							
D7810 to D7877	Related to Temporomandibular joint problems	-	-	-	N	N	-
D7810 – D7877 - Codes are not reimbursable; however, certain CPT codes may be reimbursable to dentists.							
D7880	Occlusal Orthotic Appliance (TMJ Splint)	Y	1 appliance per 2 years	N	N	N	10
D7881	Occlusal orthotic device adjustment	Y	As needed	Y	N	N	10
D7880 - Providers may use a CMS-1500 medical claim form or an ADA dental claim form when submitting for payment of an occlusal orthotic appliance.							
D7899	Related to Temporomandibular joint problems	-	-	-	N	N	-

CDT Code	Description	Adult Program	Frequency Allowed	$1,500 Cap	Dental Therapist	Independently Billing Dental Hygienist	Global Period (Days)
D7899 - Codes are not reimbursable; however, certain CPT codes may be reimbursable to dentists.							
D7910	Suture of recent Small Wounds – report quadrant	Y	As needed	N	N	N	10
D7910 - Note that suturing of recent small wounds excludes the closure of surgical incisions.							
D7911	Complicated suture, up to 5 cm – report quadrant	Y	As needed	N	N	N	10
D7912	Complicated suture, greater than 5 cm – report quadrant	Y	As needed	N	N	N	10
D7922	Placement of Intra-Socket Biological Dressing to Aid in Hemostasis or Clot Stabilization, Per Site – state tooth #	Y	1 per tooth per lifetime	Y	N	N	10
D7911 – D7912 - Reconstruction requiring delicate handling of tissues and wide undermining for meticulous closure.							
D7961	Buccal/Labial Frenectomy (Frenulectomy)	N	3 per lifetime	N/A	N	N	10
D7962	Lingual Frenectomy (Frenulectomy)	N	1 per lifetime	N/A	N	N	10
D7961 – D7962 - Separate procedure not incidental to another procedure.							
D7971	Excision of Pericoronal Gingiva – state tooth #	N	As needed	N/A	N	N	10
D7971 - Removal of inflammatory or hypertrophied tissues surrounding partially erupted/impacted tooth.							
D7972	Surgical Reduction of Fibrous Tuberosity – report quadrant	Y	As needed	N	N	N	10
D7999	Unspecified Surgical Procedure, by report	N	**	N/A	N	N	10
D7999 - ** Individual Consideration							
D8010	Limited Orthodontic Treatment of the Primary Dentition	N	1 per lifetime	N/A	N	N	10
D8020	Limited Orthodontic Treatment of the Transitional Dentition	N	1 per lifetime	N/A	N	N	10
D8030	Limited Orthodontic Treatment of the Adolescent Dentition	N	1 per lifetime	N/A	N	N	10
D8040	Limited Orthodontic Treatment of the Adult Dentition	N	1 per lifetime	N/A	N	N	10
D8070	Comprehensive Orthodontic Treatment of the Transitional Dentition	N	1 per lifetime	N/A	N	N	10
D8080	Comprehensive Orthodontic Treatment of the Adolescent Dentition	N	1 per lifetime	N/A	N	N	10
D8090	Comprehensive Orthodontic Treatment of the Adult Dentition	N	1 per lifetime	N/A	N	N	10
D8010 – D8090 - Includes any post treatment records such as radiographs, photographs and study models.							
D8210	Removable Appliance Therapy	N	1 per lifetime	N/A	N	N	10
D8220	Fixed Appliance Therapy	N	1 per lifetime	N/A	N	N	10
D8695	Removal of fixed orthodontic appliances for reasons other than completion of treatment	N	1 per lifetime	N/A	N	N	10

CDT Code	Description	Adult Program	Frequency Allowed	$1,500 Cap	Dental Therapist	Independently Billing Dental Hygienist	Global Period (Days)
D8698	Re-Cement or Re-Bond Fixed Retainer – Maxillary	N	As needed	N/A	N	N	10
D8699	Re-Cement or Re-Bond Fixed Retainer – Mandibular	N	As needed	N/A	N	N	10
D8701	Repair of Fixed Retainer, Includes Reattachment – Maxillary	N	As needed	N/A	N	N	10
D8702	Repair of Fixed Retainer, Includes Reattachment – Mandibular	N	As needed	N/A	N	N	10
D8703	Replacement of Lost or Broken Retainer – Maxillary	N	1 per lifetime	N/A	N	N	10
D8704	Replacement of Lost or Broken Retainer – Mandibular	N	1 per lifetime	N/A	N	N	10
D8999	Unspecified Orthodontic Procedure, by report	N	-	N/A	N	N	0
D8999 - ** Individual Consideration							
D9110	Palliative Treatment of Dental Pain – per visit	Y	As needed	N	Y	N	10
D9222	Deep sedation/general anesthesia -first 15-minutes	Y	As needed	Y	N	N	0
D9223	Deep sedation/general anesthesia - each 15-minute increment	Y	As needed	Y	N	N	0
D9230	Inhalation of Nitrous Oxide/ analgesia, anxiolysis	Y	As needed	Y	Y	N	0
D9239	Intravenous moderate (conscious) sedation/analgesia – first 15 minutes	Y	As needed	Y	N	N	0
D9243	Intravenous moderate (conscious) sedation/analgesia - each 15-minute increment	Y	As needed	Y	N	N	0
D9248	Non-intravenous conscious sedation	Y	As needed	Y	N	N	0
D9310	Consultation Diagnostic service provided by Dentist other than requesting dentist	Y	As needed	Y	N	N	0
D9420	Hospital Call	Y	As needed	Y	N	N	0
D9920	Behavior Management	Y	As needed	Y	Y	N	0
D9920 - Behavior management cannot be billed when one of the methods of anesthesia is billed on the same date of service. *							
D9932	Cleaning and inspection of removable complete denture, maxillary	Y	1 per 180 days	Y	N	N	10
D9933	Cleaning and inspection of removable complete denture, mandibular	Y	1 per 180 days	Y	N	N	10
D9934	Cleaning and inspection of removable partial denture, maxillary	Y	1 per 180 days	Y	N	N	10
D9935	Cleaning and inspection of removable partial denture, mandibular	Y	1 per 180 days	Y	N	N	10
D9942	Repair and/or Reline Occlusal Guard	Y	1 per year	Y	N	N	10

CDT Code	Description	Adult Program	Frequency Allowed	$1,500 Cap	Dental Therapist	Independently Billing Dental Hygienist	Global Period (Days)
D9943	Occlusal Guard adjustment *	Y	1 per year	Y	N	N	10
D9944	Occlusal Guard – hard appliance, full arch, report arch	Y	1 per 2 years	Y	N	N	10
D9945	Occlusal Guard – soft appliance, full arch, report arch	Y	1 per 2 years	Y	N	N	10
D9946	Occlusal Guard – hard appliance, partial arch, report arch	Y	1 per 2 years	Y	N	N	10
D9950	Occlusal Analysis – Mounted Case *	N	As needed	N/A	N	N	10
D9951	Occlusal Adjustment – Limited *	N	2 per lifetime	N/A	N	N	10
D9952	Occlusal Adjustment – Complete *	N	3 per lifetime	N/A	N	N	10
D9974	Internal Bleaching – Per Tooth	N	2 per lifetime	N/A	N	N	10
D9986	Missed Appointment	N	N/A	N/A	Y	N	0
D9987	Cancelled Appointment	N	N/A	N/A	Y	N	0
D9986 – D9987 - Please note that these codes are not reimbursable by Vermont Medicaid and are used for reporting purposes only.							
D9999	Unspecified Adjunctive Procedure, by report	N	As needed	N/A	N	N	10
D9999 - ** Individual Consideration.							
T1013	Interpreter Services – 15 minutes	Y	As needed	N	Y	N	0
T1013 - Can be submitted on the ADA Dental Claim Form. Indicate the number of 15-minute increments (units).							

Section 8 Procedure Codes that Require Area of Oral Cavity

Code	Procedure Description
D0364	Cone Beam CT Capture and Interpretation with Limited Field of View - Less Than One Whole Jaw
D1510	Space Maintainer - Fixed – Unilateral – Per Quadrant
D1553	Recement or Rebond Unilateral Space Maintainer – Per Quadrant
D4210	Gingivectomy or Gingivoplasty, Four or more Contiguous Teeth or Bounded Teeth Spaces, per Quadrant
D4211	Gingivectomy or Gingivoplasty, One to three Contiguous Teeth or Bounded Teeth Spaces, per Quadrant
D4240	Gingival Flap Procedure, Including Root Planing – Four or more Contiguous Teeth or Bounded Teeth Spaces, per Quadrant
D4241	Gingival Flap Procedure, Including Root Planing – One to three contiguous teeth or bounded teeth spaces, per quadrant
D4260	Osseous Surgery (including elevation of a full thickness flap entry and closure) - four or more teeth per quadrant
D4261	Osseous Surgery (including elevation of a full thickness flap entry and closure) - one to three teeth per quadrant
D4270	Pedicle Soft Tissue Graft Procedure
D4277	Free Soft Tissue Graft Procedure (including recipient and donor sites surgery), First Tooth Site
D4278	Free Soft Tissue Graft, Each Additional Contiguous Tooth in same Graft Site
D4341	Periodontal Scaling and Root Planing Four or more contiguous teeth per Quadrant
D4342	Periodontal Scaling and Root Planing One to three teeth, per Quadrant
D5899	Unspecified Removable Prosthodontic Procedure, by report
D7260	Oral Antral Fistula Closure
D7261	Primary Closure of a Sinus Perforation
D7285	Incisional Biopsy of Oral Tissue - Hard (bone tooth)
D7286	Incisional Biopsy of Oral Tissue – Soft
D7291	Transseptal Fiberotomy/supra crestal Fiberotomy, by report
D7295	Harvest of Bone for use in Autogenous Grafting Procedure
D7310	Alveoloplasty in Conjunction with Extractions, Four or more Teeth or Tooth Spaces, per Quadrant
D7311	Alveoloplasty in Conjunction with Extractions, One to three Teeth, per Quadrant
D7320	Alveoloplasty not in Conjunction with Extractions, Four or more Teeth or Tooth Spaces, per Quadrant
D7321	Alveoloplasty not in Conjunction with Extractions, One to Three or Tooth Spaces, per Quadrant
D7340	Vestibuloplasty – Ridge Extension, Secondary Epithelialization
D7350	Vestibuloplasty – Ridge Extension (including soft tissue grafts, muscle reattachments, revision of soft tissue attachment, and management of hypertrophied and hyperplastic tissue)
D7410	Excision of Benign Lesion up to 1.25 cm
D7411	Excision of Benign Lesion greater than 1.25 cm
D7412	Excision of Benign Lesion, Complicated
D7413	Excision of Malignant Lesion up to 1.25 cm
D7414	Excision of Malignant Lesion greater than 1.25 cm

Code	Procedure Description
D7415	Excision of Malignant Lesion, Complicated
D7440	Excision of Malignant Tumor – Lesion Diameter up to 1.25 cm
D7441	Excision of Malignant Tumor – Lesion diameter greater than 1.25 cm
D7450	Removal of Benign Odontogenic Cyst or Tumor - Lesion diameter up to 1.25 cm
D7451	Removal of Benign Odontogenic Cyst or Tumor - Lesion diameter greater than 1.25 cm
D7460	Removal of Benign Nonodontogenic Cyst or Tumor - Lesion diameter up to 1.25 cm
D7461	Removal of Benign Nonodontogenic Cyst or Tumor - Lesion diameter greater than 1.25 cm
D7465	Destruction of Lesion(s) by Physical or Chemical Methods, by report
D7471	Removal of Lateral Exostosis (maxilla or mandible)
D7473	Removal of Torus Mandibularis
D7485	Surgical Reduction of Osseous Tuberosity
D7510	Incision and Drainage of Abscess - Intraoral Soft Tissue
D7560	Maxillary Sinusotomy for Removal of Tooth Fragment or Foreign Body
D7910	Suture of recent Small Wounds, up to 5 cm
D7911	Complicated Suture, up to 5 cm
D7912	Complicated Suture, greater than 5 cm
D7961	Buccal/Labial Frenectomy
D7962	Lingual Frenectomy
D7971	Excision of Pericoronal Gingiva
D7972	Surgical Reduction of Fibrous Tuberosity
D7999	Unspecified Surgical Procedure, by report
D8210	Removable Appliance Therapy
D8220	Fixed Appliance Therapy
D8999	Unspecified Orthodontic Procedure, by report
D9110	Palliative (Emergency) Treatment of Dental Pain
D9944	Occlusal Guard – Hard Appliance, Full Arch
D9945	Occlusal Guard – Soft Appliance, Full Arch
D9946	Occlusal Guard – Hard Appliance, Partial Arch
D9999	Unspecified Adjunctive Procedure, by report

Section 9 Adult Emergency Dental Services

Vermont Medicaid Procedure Codes Covered for Emergency Dental Treatment for Adults after the Annual Cap on Expenditures has been Reached - Effective 07/01/2023.

Note: These codes are now covered under the Medicaid dental benefit and Medicaid members will not need approval via the General Assistance Voucher Program administered by the Department for Children and Families. Providers should use the "KX" modifier at the end of each procedure code when submitting claims for adult members using emergency procedures after their annual cap has been reached. This will allow the claim to pay after the annual cap has been met.

Procedure Code	Description
D0140	Limited Oral Evaluation - Problem Focused
D0150	Comprehensive Oral Evaluation
D0170	Re-evaluation - Limited, Problem Focused
D0220	Intraoral-Periapical – First Radiographic Image
D0230	Intraoral-Periapical – Each Additional Radiographic Image
D0240	Intraoral-Occlusal Radiographic Image
D0250	Extra-oral – 2D Projection Radiographic Image
D0251	Extra-oral Posterior Dental Radiographic Image
D0270	Bitewing-Single Radiographic Image
D0272	Bitewings-2 Radiographic Images
D0274	Bitewings-4 Radiographic Images
D0330	Panoramic Radiographic Image
D2940	Protective Restoration
D3220	Therapeutic Pulpotomy (Excluding Final Restoration)
D3221	Pulpal Debridement, Primary and Permanent Teeth
D7111	Extraction, Coronal Remnants – Deciduous Tooth
D7140	Extraction, Erupted Tooth or Exposed Root
D7210	Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap
D7220	Removal of Impacted Tooth – Soft Tissue
D7230	Removal of Impacted Tooth – Partially Bony
D7240	Removal of Impacted Tooth – Completely Bony
D7241	Removal of Impacted Tooth – Completely Bony, With Unusual Surgical Complications
D7250	Surgical Removal of Residual Tooth Roots (Cutting Procedure)
D7260	Oral Antral Fistula Closure
D7261	Primary Closure of a Sinus Perforation
D7270	Tooth Reimplantation and/or Stabilization of Accidentally Evulsed or Displaced Tooth
D7285	Incisional Biopsy of Oral Tissue – Hard (Bone, Tooth)
D7286	Incisional Biopsy of Oral Tissue – Soft
D7410	Excision of Benign Lesion up to 1.25 cm

Procedure Code	Description
D7411	Excision of Benign Lesion greater than 1.25 cm
D7412	Excision of Benign Lesion, Complicated
D7413	Excision of Malignant Lesion up to 1.25 cm
D7414	Excision of Malignant Lesion greater than 1.25 cm
D7415	Excision of Malignant Lesion, Complicated
D7440	Excision of Malignant Tumor – Lesion Diameter up to 1.25 cm
D7441	Excision of Malignant Tumor – Lesion Diameter greater than 1.25 cm
D7450	Removal of Benign Odontogenic Cyst or Tumor – Lesion Diameter up to 1.25 cm
D7451	Removal of Benign Odontogenic Cyst or Tumor – Lesion Dia. greater than1.25 cm
D7460	Removal of Benign Nonodontogenic Cyst or Tumor – Lesion Diameter up to 1.25 cm
D7461	Removal of Benign Nonodontogenic Cyst or Tumor – Lesion Dia. greater than 1.25cm
D7465	Destruction of Lesion(s) by Physical or Chemical Methods, By Report
D7510	Incision and Drainage of Abscess – Intraoral Soft Tissue
D7560	Maxillary Sinusotomy for Removal of Tooth Fragment or Foreign Body
D7910	Suture of Recent Small Wounds up to 5 cm
D7911	Complicated Suture – up to 5 cm
D7912	Complicated Suture – greater than 5 cm
D9110	Palliative (Emergency) Treatment of Dental Pain – Minor Procedures
D9222	Deep Sedation/General Anesthesia – First 15 Minutes
D9223	Deep Sedation/General Anesthesia – Each 15 Minute Increment
D9230	Inhalation of Nitrous Oxide/ Analgesia, Anxiolysis
D9239	Intravenous Moderate (Conscious) Sedation/Analgesia – First 15 Minutes
D9243	Intravenous Moderate (Conscious) Sedation/Analgesia – Each 15 Minute Increment
D9248	Non-intravenous Conscious Sedation
D9920	Behavior Management

Section 10 Special Investigations Unit

Vermont Medicaid pays only for services that are actually provided and that are medically necessary. In filing a claim for reimbursement, the code(s) should be chosen that most accurately describes the service that was provided. It is a felony under Vermont law 33VSA Sec. 141(d) knowingly to do, attempt, or aid and abet in any of the following when seeking for receiving reimbursement from Vermont Medicaid:

- Billing for services not rendered or more services than actually performed
- Providing and billing for unnecessary services
- Billing for a higher level of services than actually performed
- Charging higher rates for services to Vermont Medicaid than other providers
- Coding billing records to get more reimbursement
- Misrepresenting an unallowable service on bill as another allowable service
- Falsely diagnosing so Vermont Medicaid will pay more for services

For more information on overpayments and potential interest charges, visit the General Provider Manual, section 6. https://vtmedicaid.com/#/manuals

Suspected fraud, waste or abuse should be reported to the DVHA Special Investigations Unit at https://dvha.vermont.gov/providers/special-investigations-unit, telephone 802.241.9210, or the Vermont Medicaid Fraud Control Unit of the Vermont's Attorney General's Office, telephone 802.828.5511.