

## Provider Notification

In response to significant fiscal challenges facing the State and continuing growth in the Medicaid population, AHCCCS will implement several changes to the adult benefit package.

### Population

The changes to the benefit package will impact **all** adults 21 years of age and older, unless otherwise specified. This population includes both Acute Care AHCCCS members as well as members in the Arizona Long Term Care System (ALTCs). At this time, these changes also apply to American Indians regardless of whether they receive services through managed care or fee for service. AHCCCS will provide notice if there are any changes.

For AHCCCS eligible individuals with incomes at or below 100% of the federal poverty level (FPL) who are also Medicare eligible as a Qualified Medicare Beneficiary (also known as QMB Dual Members), AHCCCS will continue to pay the applicable cost sharing (deductibles, co-pays, and coinsurance) for Medicare covered services that are no longer covered by AHCCCS. For AHCCCS members with incomes greater than 100% FPL who are also Medicare eligible (known as non-QMB Dual Members), AHCCCS will not pay cost sharing for Medicare covered services that are no longer covered by AHCCCS. Managed care members and providers are encouraged to contact the member's Health Plan/ Program Contractor to determine the circumstances under which Medicare cost sharing applies.

AHCCCS eligible members who are under the age of 21 years old will continue to receive the full benefit package available under the Early Periodic Screening Diagnosis and Treatment (EPSDT) Program.

### Effective Date of Benefit Changes

AHCCCS is actively working with the Centers for Medicare and Medicaid Services (CMS) regarding the implementation of the legislatively mandated benefit changes as well as other changes to services authorized by ARS §36-2907. The benefit changes will be effective October 1, 2010. Please refer to the Attachments A and B for details.

### Non-Covered Services & Member Billing

Although the Agency cannot provide you with legal advice, please be aware that AHCCCS rule R9-22-702 permits AHCCCS registered providers to bill AHCCCS members under very limited situations. The specific factual circumstances underlying each particular case are important in making such a determination, and providers are encouraged to consult with an attorney or legal advisor in making these decisions. However, State Law ARS §36-2903.01 L. prohibits providers from billing members, their representatives, or their financially responsible relatives for services that were reimbursed OR SHOULD BE reimbursed by the AHCCCS Program.

Administrative regulation R9-22-702 sets forth certain exceptions when AHCCCS members may be billed. Subsection D of this rule describes situations where providers may bill AHCCCS members after certain prerequisites are satisfied, including but not limited to advance written agreement by the member to pay the provider for a service which otherwise would not be covered or authorized by the health plan. Note that this provision does NOT permit a provider to bill a member for a service which *could* have been reimbursed by a health plan had the provider complied with plan requirements (such as obtaining prior authorization or timely filing a claim) but because the provider failed to do so, the provider was not paid. An example of this scenario is when a health plan would have reimbursed the provider for physical therapy but the provider neglected to timely file the claim with the health plan; in this example, the provider cannot bill the member because the denial of payment by the plan was due to the provider's failure to comply with the claim filing deadlines.

Because the specific facts in each case must be taken into consideration before determining whether billing a member is permissible, it may be helpful to discuss this matter with an attorney. For additional general information, you may also contact the AHCCCS Office of Inspector General at [AHCCCSFraud@azahcccs.gov](mailto:AHCCCSFraud@azahcccs.gov).

Additional information about the benefit changes can be found at <http://www.azahcccs.gov/reporting/legislation/2010/BenefitChanges.aspx>. Questions regarding the benefit changes can be e-mailed to [LegislativeBenefitChange@azahcccs.gov](mailto:LegislativeBenefitChange@azahcccs.gov).

**AHCCCS BENEFIT CHANGE IMPLEMENTATION 10/1/2010  
(Limited to Adult (Acute and ALTCS) Members 21 Years of Age and Older)**

**Attachment A**

<b>BENEFIT TYPE</b>	<b>BENEFIT CHANGE</b>	<b>CODES NO LONGER BILLABLE *</b>
<b>Insulin Pumps</b>	AHCCCS will eliminate coverage of Insulin pumps. Supplies, equipment maintenance and repair of component parts will remain a covered benefit. Documentation that establishes the need to replace a component not operating effectively must be provided at the time prior authorization is sought.	E0784
<b>Percussive Vests</b>	AHCCCS will eliminate coverage of percussive vests. Supplies, equipment maintenance and repair of component parts will remain a covered benefit. Documentation that establishes the need to replace a component not operating effectively must be provided at the time prior authorization is sought.	E0483
<b>Bone-Anchored Hearing Aids</b>	AHCCCS will eliminate coverage of Bone-Anchored Hearing AID (BAHA). Supplies, equipment maintenance and repair of component parts will remain a covered benefit. Documentation that establishes the need to replace a component not operating effectively must be provided at the time prior authorization is sought.	L8690, L8692
<b>Cochlear Implants</b>	AHCCCS will eliminate coverage of cochlear implants. Supplies, equipment maintenance and repair of component parts will remain a covered benefit. Documentation that establishes the need to replace a component not operating effectively must be provided at the time prior authorization is sought.	L8614
<b>Prosthetics</b>	AHCCCS is limiting this benefit change to apply only to the elimination of microprocessor controlled lower limbs and microprocessor controlled joints for lower limbs.	L5856, L5857, L5858 and L5973
<b>Orthotics</b>	AHCCCS will eliminate coverage of orthotics. Orthotics are described as devices prescribed by a physician or other licensed professionals of the healing arts to support a weak or deformed portion of the body. AHCCCS considers orthotics to generally be items in codes L0001-L4999 with some exceptions. (There are some supplies which are also listed in this range of orthotic codes. Those supplies will <b>not</b> be eliminated.)  Equipment maintenance and repair of component parts will remain a covered benefit. Documentation that establishes the need to replace a component not operating effectively must be provided at the time prior authorization is sought.	L0001 – L4999, Refer to <b>Attachment A-1</b> for exceptions-
<b>Emergency Dental Service</b>	Emergency adult dental services are eliminated. However, in accordance with federal law and the State Plan, AHCCCS will cover medical and surgical services furnished by a dentist only to the extent that such services may be performed under State law either by a physician or by a dentist and such services would be considered a physician service if furnished by a physician. For members 21 years of age and older, the services must be related to the treatment of a medical condition such as acute pain, infection, or fracture of the jaw. The covered services include examination of the oral cavity, required radiographs, complex oral surgical procedures such as treatment of maxillofacial fractures, administration of an appropriate anesthesia and the prescription of pain medication and antibiotics. Certain pre-transplant services (e.g. dental cleanings, fillings, restorations, extractions) and prophylactic extraction of teeth in preparation for radiation treatment of cancer of the jaw, neck or head are also covered.	Refer to <b>Attachment A-2</b> for list of dental covered codes
<b>Services by Podiatrist</b>	Foot and Ankle Services provided by a podiatrist are no longer covered. Those services may be reimbursed if rendered by another clinician such as a physician, NP, or PA.	Not Applicable

\* Codes no longer billable for dates of service on or after 10/1/2010 unless otherwise noted

**AHCCCS BENEFIT CHANGE IMPLEMENTATION 10/1/2010  
(Limited to Adult (Acute and ALTCS) Members 21 Years of Age and Older)**

**Attachment A**

<b>BENEFIT TYPE</b>	<b>BENEFIT CHANGE</b>	<b>CODES NO LONGER BILLABLE *</b>
<b>Well Exams</b>	Well visits are no longer covered. Well exams means physical examinations in the absence of any known disease or symptom or any specific medical complaint by the patient precipitating the examination. However, pap smears, mammograms, and colonoscopies will still continue to be covered.	<b>CPT codes:</b> 99385 - 99387, 99395 - 99397 and S5190 <b>OR</b> professional claim (regardless of procedure code) with primary dx of V72.31 V70.0 V70.9
<b>Transplants</b>	<p><b>Effective 10/1/2010, the following non-experimental transplants will not be covered (excluded from coverage) for persons age 21 years and older.</b></p> <p><b>Exception:</b> members who are in the "prep and transplant" phase or one of the post-transplant care phases for one of these transplants prior to 10/1/2010 will remain covered for the transplant and subsequent care. (This means that prior to October 1, the tissue has been harvested, the organ has been procured, or the transplant surgery has been performed)</p> <p><b>Transplants not covered</b></p> <ul style="list-style-type: none"> <li>• Pancreas after kidney transplants</li> <li>• Lung transplants</li> <li>• Allogeneic unrelated hematopoietic cell (bone marrow) transplants</li> <li>• Liver transplants for members with a diagnosis of Hepatitis C</li> <li>• Heart transplants for non-ischemic cardiomyopathies</li> <li>• Any other transplants not listed as covered.</li> </ul> <p>"Non-ischemic cardiomyopathy" is defined as a condition in which the underlying cardiac abnormality has not resulted in irreversible permanent damage to the heart muscle. Members with "non-ischemic cardiomyopathy" have sufficient cardiac function to circulate adequate volumes of blood and oxygen to the heart muscle and other body organs.</p> <p>"Ischemic cardiomyopathy" is defined as an underlying cardiac abnormality that causes insufficient blood flow to the heart, resulting in permanent damage to the heart muscle. There are several causes of ischemic cardiomyopathy, including: 1) atherosclerotic coronary artery disease, which results in narrow blood vessels in the heart; 2) ventricular hypertrophy that impedes blood flow due to compression of arteries within the heart muscle; 3) heart failure with an ejection fraction that is not sufficient to provide adequate blood and oxygen to the heart muscle. The term "ischemic cardiomyopathy" when used in the context of this benefit restriction does not imply that the underlying cause of the cardiac abnormality is restricted to ischemia; rather, it is used to denote that the underlying cardiac abnormality results in ischemia with permanent, irreversible damage to the heart muscle.</p> <p><b>Effective 10/1/2010, transplants which are covered</b> for persons age 21 years and older are limited to only: Heart, Liver, Kidney (cadaveric and live donor), Simultaneous Pancreas/Kidney (SPK), Autologous and Allogeneic Related Hematopoietic Cell Transplants, Cornea, and Bone. In order to be covered, the transplant must be medically necessary, not experimental, and not for the purpose of research.</p>	Specific transplant case types are eliminated.

\* Codes no longer billable for dates of service on or after 10/1/2010 unless otherwise noted

**AHCCCS BENEFIT CHANGE IMPLEMENTATION 10/1/2010  
(Limited to Adult (Acute and ALTCS) Members 21 Years of Age and Older)**

**Attachment A**

<b>BENEFIT TYPE</b>	<b>BENEFIT CHANGE</b>	<b>CODES NO LONGER BILLABLE *</b>
<b>Physical Therapy</b>	<p>Outpatient physical therapy visits are limited to 15 visits per contract year (10/1--9/30). Outpatient physical therapy refers to any occurrence of codes 97001-97546; All provider types except for 13 (Occupational Therapist) 22 – (Nursing Home); All places of service excluding 31 (Nursing Home) 32 (Nursing facility), and 33 (Custodial Care Facility); Count each unique date of service as a visit; Form Type to include OP Hospital or 1500.</p> <p><b>Refer to Attachment B for more detail regarding Medicaid only members, QMB duals, and Medicare Primary (non QMB duals)</b></p>	Not Applicable
<b>Bariatric Surgery</b>	Bariatric surgery will not be eliminated. However, specific criteria for coverage for bariatric surgery will be developed and added to the AHCCCS Medical Policy Manual.	Not Applicable
<b>DME</b>	Per discussions with CMS, AHCCCS will not make changes to the current DME policy (DME does not include orthotics or prosthetics)	Not Applicable
<b>Transportation</b>	If approved by CMS, changes to non-emergency medical transportation will be implemented sometime after October 1, 2010. If implemented, there will be no impact to children, or members in the Arizona Long Term Care System, or members who live outside of Maricopa and Pima Counties.	Not Applicable

\* Codes no longer billable for dates of service on or after 10/1/2010 unless otherwise noted

## ORTHOTICS EXCEPTIONS

CODE	DESCRIPTION
L0859	Addition to Halo procedure, magnetic resonance image compatible systems rings and pins, any material.
L0861	Addition to halo procedure, replacement liner/interface material
L0980	Peroneal straps, pair
L0982	Stocking supporter grips, set of four (4)
L0984	Protective body sock, each
L2810	Addition to lower extremity orthosis, knee control, condylar pad
L2840	Addition to lower extremity orthosis, tibial length sock, fracture or equal, each
L2850	Addition to lower extremity orthosis, femoral length sock, fracture or equal, each
L4000	Replace girdle for spinal orthosis (ctlso or so)
L4002	Replacement strap, any orthosis, includes all components, any length, any type
L4010	Replace trilateral socket brim
L4020	Replace quadrilateral socket brim, molded to patient model
L4030	Replace quadrilateral socket brim, custom fitted
L4060	Replace high roll cuff
L4070	Replace proximal and distal upright for kafo
L4080	Replace metal bands kafo, proximal thigh
L4090	Replace metal bands kafo-afo, calf or distal thigh
L4100	Replace leather cuff kafo, proximal thigh
L4110	Replace leather cuff kafo-afo, calf or distal thigh
L4130	Replace pretibial shell
L4205	Repair of orthotic device, labor component, per 15 minutes
L4210	Repair of orthotic device, repair or replace minor parts
L4392	Replacement, soft interface material, static afo
L4394	Replace soft interface material, foot drop splint

**DENTAL HCPC CODES INFORMATION**  
**(Limited To Adult Members 21 Years Of Age And Older)**

**Note:**

- Reimbursement of dental codes are limited to members under age 21 except for the limited set of codes indicated by "X" below for medically necessary services.
- Adult pre-transplant recipients may receive additional dental treatment in preparation for a transplant. The additional codes available for pre-transplant recipients are indicated by "T" below.

<b>Code</b>	<b>Codes indicated by an "X", remain reimbursable for members 21 years of age and older</b>	<b>Additional codes limited to transplant preparation for adults are indicted by "T"</b>	<b>Description (may be truncated)</b>
D0120		T	Periodic oral evaluation - established patient
D0140	X		Limited oral evaluation - problem focused
D0150		T	Comprehensive oral evaluation - new or established patient
D0160		T	Detailed and extensive oral evaluation - problem focused, by report
D0180		T	Comprehensive periodontal evaluation - new or established patient
D0210		T	Intraoral-complete series (including bitewings)
D0220	X		Intraoral-periapical-first film
D0230	X		Intraoral-periapical-each additional film
D0240	X		Intraoral-occlusal film
D0250	X		Extraoral-first film
D0260	X		Extraoral-each additional film
D0270		T	Bitewing-single film
D0272		T	Bitewings-two films
D0273		T	Bitewings - three films
D0274		T	Bitewings-four films
D0277		T	Vertical bitewings - 7 to 8 films
D0290	X		Posterior-anterior or lateral skull and facial bone survey film

D0320	X	Temporomandibular joint arthrogram, including injection
D0321	X	Other temporomandibular joint films, by report
D0330	X	Panoramic film
D0502	T	Other oral pathology procedures, by report
D0999	T	Unspecified diagnostic procedure, by report
D1110	T	Prophylaxis-adult
D1204	T	Topical application of fluoride - adult
D2140	T	Amalgam-one surface, primary or permanent
D2150	T	Amalgam-two surfaces, primary or permanent
D2160	T	Amalgam-three surfaces, primary or permanent
D2161	T	Amalgam-four or more surfaces, primary or permanent
D2330	T	Resin-one surface, anterior
D2331	T	Resin-two surfaces, anterior
D2332	T	Resin-three surfaces, anterior
D2335	T	Resin-four or more surfaces or involving incisal angle (anterior)
D2390	T	Resin-based composite crown, anterior
D2391	T	Resin-based composite - one surface, posterior
D2392	T	Resin-based composite - two surfaces, posterior
D2393	T	Resin-based composite - three surfaces, posterior
D2394	T	Resin-based composite - four or more surfaces, posterior
D2799	T	Provisional crown
D2910	T	Recement inlay, onlay or partial coverage restoration
D2915	T	Recement cast or prefabricated post and core
D2920	T	Recement crown
D2931	T	Prefabricated stainless steel crown-permanent tooth
D2932	T	Prefabricated resin crown
D2940	T	Sedative filling
D2950	T	Core build-up, including any pins
D2951	T	Pin retention-per tooth, in addition to restoration
D2952	T	Post and core in addition to crown, indirectly fabricated
D2954	T	Prefabricated post and core in addition to crown
D2999	T	Unspecified restorative procedure, by report
D3221	T	Pulpal debridement, primary and permanent teeth

D3310	T	Endodontic therapy, anterior tooth (excluding final restoration)
D3346	T	Retreatment of previous root canal therapy-anterior
D3410	T	Apicoectomy/periradicular surgery-anterior
D3430	T	Retrograde filling-per root
D3999	T	Unspecified endodontic procedure, by report
D4210	T	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded or
D4211	T	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded
D4240	T	Gingival flap procedure, including root planing - four or more contiguous teeth
D4241	T	Gingival flap procedure, including root planing - one to three contiguous teeth
D4260	T	Osseous surgery (including flap entry and closure) - four or more contiguous
D4261	T	Osseous surgery (including flap entry and closure) - one to three contiguous
D4341	T	Periodontal scaling and root planing - four or more teeth per quadrant
D4342	T	Periodontal scaling and root planing - one to three teeth, per quadrant
D4355	T	Full mouth debridement to enable comprehensive evaluation and diagnosis
D4910	T	Periodontal maintenance
D4920	T	Unscheduled dressing change (by someone other than treating dentist)
D4999	T	Unspecified periodontal procedure, by report
D6930	T	Recement bridge
D7140	T	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210	T	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap
D7220	T	Removal of impacted tooth-soft tissue
D7230	T	Removal of impacted tooth-partially bony
D7240	T	Removal of impacted tooth-completely bony
D7241	T	Removal of impacted tooth-completely bony, with unusual surgical complications

	T	
D7250		Surgical removal of residual tooth roots (cutting procedure)
D7260	X	Oral antral fistula closure
D7261	X	Primary closure of a sinus perforation
D7285	X	Biopsy of oral tissue - hard (bone, tooth)
D7286	X	Biopsy of oral tissue - soft
D7292	X	Surgical placement: temporary anchorage device [screw retained plate] requiring
D7293	X	Surgical placement: temporary anchorage device requiring surgical flap
D7294	X	Surgical placement: temporary anchorage device without surgical flap
D7410	X	Excision of benign lesion up to 1.25 cm
D7411	X	Excision of benign lesion greater than 1.25 cm
D7412	X	Excision of benign lesion, complicated
D7413	X	Excision of malignant lesion up to 1.25 cm
D7414	X	Excision of malignant lesion greater than 1.25 cm
D7415	X	Excision of malignant lesion, complicated
D7440	X	Excision of malignant tumor-lesion diameter up to 1.25 cm
D7441	X	Excision of malignant tumor-lesion diameter greater than 1.25 cm
D7450	X	Removal of benign odontogenic cyst or tumor-lesion diameter up to 1.25 cm
D7451	X	Removal of benign odontogenic cyst or tumor-lesion diameter greater than 1.25 cm
D7460	X	Removal of benign nonodontogenic cyst or tumor-lesion diameter up to 1.25 cm
D7461	X	Removal of benign nonodontogenic cyst or tumor-lesion diameter greater than
D7465	X	Destruction of lesion(s) by physical or chemical methods, by report
D7490	X	Radical resection of maxilla or mandible
D7510	X	Incision and drainage of abscess-intraoral soft tissue
D7511	X	Incision and drainage of abscess - intraoral soft tissue - complicated
D7520	X	Incision and drainage of abscess-extraoral soft tissue
D7521	X	Incision and drainage of abscess - extraoral soft tissue - complicated

D7530	X	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue
D7540	X	Removal of reaction-producing foreign bodies-musculoskeletal system
D7550	X	Partial ostectomy/sequestrectomy for removal of non-vital bone
D7560	X	Maxillary sinusotomy for removal of tooth fragment or foreign body
D7610	X	Maxilla-open reduction (teeth immobilized if present)
D7620	X	Maxilla-closed reduction (teeth immobilized if present)
D7630	X	Mandible-open reduction (teeth immobilized if present)
D7640	X	Mandible-closed reduction (teeth immobilized if present)
D7650	X	Malar and/or zygomatic arch-open reduction
D7660	X	Malar and/or zygomatic arch-closed reduction
D7670	X	Alveolus - closed reduction, may include stabilization of teeth
D7671	X	Alveolus - open reduction, may include stabilization of teeth
D7680	X	Facial bones-complicated reduction with fixation and multiple surgical
D7710	X	Maxilla-open reduction
D7720	X	Maxilla-closed reduction
D7730	X	Mandible-open reduction
D7740	X	Mandible-closed reduction
D7750	X	Malar and/or zygomatic arch-open reduction
D7760	X	Malar and/or zygomatic arch-closed reduction
D7770	X	Alveolus - open reduction stabilization of teeth
D7771	X	Alveolus, closed reduction stabilization of teeth
D7780	X	Facial bones-complicated reduction with fixation and multiple surgical
D7810	X	Open reduction of dislocation
D7820	X	Closed reduction of dislocation
D7830	X	Manipulation under anesthesia
D7840	X	Condylectomy
D7850	X	Surgical discectomy; with/without implant
D7852	X	Disc repair
D7854	X	Synovectomy
D7856	X	Myotomy

D7858	X	Joint reconstruction
D7860	X	Arthrotomy
D7865	X	Arthroplasty
D7870	X	Arthrocentesis
D7871	X	Non-arthroscopic lysis and lavage
D7872	X	Arthroscopy-diagnosis, with or without biopsy
D7873	X	Arthroscopy-surgical: lavage and lysis of adhesions
D7874	X	Arthroscopy-surgical: disc repositioning and stabilization
D7875	X	Arthroscopy-surgical: synovectomy
D7876	X	Arthroscopy-surgical: discectomy
D7877	X	Arthroscopy-surgical: debridement
D7880	X	Occlusal orthotic appliance
D7899	X	Unspecified tmd therapy, by report
D7910	X	Suture of recent small wounds up to 5 cm
D7911	X	Complicated suture-up to 5 cm
D7912	X	Complicated suture-greater than 5 cm
D7920	X	Skin graft (identify defect covered, location, and type of graft)
D7940	X	Osteoplasty-for orthognathic deformities
D7941	X	Osteotomy - mandibular rami
D7943	X	Osteotomy - mandibular rami with bone graft; includes obtaining the graft
D7944	X	Osteotomy-segmented or subapical
D7945	X	Osteotomy-body of mandible
D7946	X	Lefort i (maxilla-total)
D7947	X	Lefort i (maxilla-segmented)
D7948	X	Lefort ii or lefort iii (osteoplasty of facial bones for midface hypoplasia or
D7949	X	Lefort ii or lefort iii-with bone graft
D7950	X	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla -
D7951	X	Sinus augmentation with bone or bone substitutes
D7953	X	Bone replacement graft for ridge preservation - per site
D7955	X	Repair of maxillofacial soft and/or hard tissue defect
D7970		Excision of hyperplastic tissue-per arch

T

D7971		T	Excision of pericoronal gingiva
D7972		T	Surgical reduction of fibrous tuberosity
D7980	X		Sialolithotomy
D7981	X		Excision of salivary gland, by report
D7982	X		Sialodochoplasty
D7983	X		Closure of salivary fistula
D7990	X		Emergency tracheotomy
D7991	X		Coronoidectomy
D7995	X		Synthetic graft-mandible or facial bones, by report
D7996	X		Implant-mandible for augmentation purposes (excluding alveolar ridge), by report
D7997	X		Appliance removal (not by dentist who placed appliance), includes removal of
D7998	X		Intraoral placement of a fixation device not in conjunction with a fracture
D7999	X		Unspecified oral surgery procedure, by report
D9220	X		Deep sedation/general anesthesia-first 30 minutes
D9221	X		Deep sedation/general anesthesia-each additional 15 minutes
D9230	X		Analgesia, anxiolysis, inhalation of nitrous oxide
D9241	X		Intravenous conscious sedation/analgesia - first 30 minutes
D9242	X		Intravenous conscious sedation/analgesia - each additional 15 minutes
D9248	X		Non-intravenous conscious sedation
D9310		T	Consultation - diagnostic service provided by dentist or physician other than
D9410	X		House/extended care facility call
D9420	X		Hospital call
D9610		T	Therapeutic parenteral drug, single administration
D9930		T	Treatment of complications (postsurgical) - unusual circumstances, by report
D9951		T	Occlusal adjustment-limited

**APPLICATION OF PHYSICAL THERAPY 15 VISIT OUTPATIENT LIMIT  
ACUTE & ALTCS MEMBERS 21 YEARS OF AGE AND OLDER**

CONDITION	CONTRACTOR IMPLEMENTATION (Fiscal Implications)
Member is Medicaid only and is not Medicare eligible. (Also known as non dual)	Contractor is responsible for the visit up to 15 PT visits per contract year.
Member is Dual Eligible (Also known as Medicare Primary, non QMB dual)	<p>Contractor is responsible for Medicare cost sharing (copay, coinsurance, and deductible) up to 15 PT visits.</p> <ul style="list-style-type: none"> <li>• In the event that the 15 PT visit limit is reached prior to the Medicare maximum dollar amount, the Contractor will pay the Medicare cost sharing up to the 15 visit limit per contract year. As part of their Medicare benefit, members may opt to receive service up to Medicare maximum dollar amount; <b>however</b> the Medicare cost sharing for any visits beyond the 15 visit limit allowed by AHCCCS are the members' responsibility.</li> <li>• In the event that the member exhausts the Medicare dollar maximum amount prior to utilizing the 15 PT visit limit allowed by AHCCCS, the additional visits up to maximum of 15 are the responsibility of the Contractor.</li> </ul>
Member is QMB Dual	<p>Contractor is responsible for Medicare cost sharing up to Medicare maximum dollar amount.</p> <ul style="list-style-type: none"> <li>• In the event that the 15 PT visit limit is reached prior to the Medicare maximum dollar amount, the Contractor will continue to pay the Medicare cost sharing for PT visits until the Medicare maximum dollar amount for therapy is reached.</li> <li>• In the event that member exhausts the Medicare maximum dollar amount prior to utilizing the 15 PT visit limit allowed by AHCCCS, the additional visits up to maximum of 15 are the responsibility of the Contractor.</li> </ul>

**Definitions:**

**Visit** - a visit equals PT services received in one day per provider. The 15 visit limit applies regardless that the member has the same contractor or changes contractors during the contract year.

**Setting** - Any out patient place of service. (nursing homes, nursing facilities and custodial care setting are considered inpatient settings).

**Dual Eligible (Non-QMB Dual)** - An individual who is Medicare and Medicaid eligible with income above 100%FPL. The individual does not qualify for QMB.

**QMB Dual** -An individual who is Medicare and Medicaid eligible with income not exceeding 100%FPL.

# University Family Care Dental Care Matrix

Effective October 1, 2010

**IMPORTANT: Regardless of prior authorization requirements for individual procedure codes, prior authorization is required when billed charges exceed \$750 per treatment plan (excluding exam and x-ray).**

Procedure Code	Procedure Code Description	Benefit Limitations	Special Billing Requirements	Covered Benefit less than 21 Years	Covered Benefit 21 Years and Older
<b>Important Note: All other dental procedures not included on this document are not covered benefits</b>					
<b>*Replacement of restorations and other services within a 2 year period at the same office is not billable.</b>					
<b>*Post operative treatment for services rendered within three months of original service at the same office is not billable.</b>					
<b>Clinical Oral Examinations</b>					
D0120	Periodic oral evaluation	Benefit limited to once every 6 months, plus one day		C	T-PA
D0140	Limited oral evaluation - Problem Focused			C	C
D0145	Oral evaluation for patient under three years of age and counseling with primary caregiver			C	N
D0150	Comprehensive oral evaluation, New or Established Patient		X-rays required for claims submission, ages 4 through 20	C	T-PA
D0160	Detailed and extensive oral evaluation-problem focused			C-PA**	T-PA**
D0180	Comprehensive periodontal evaluation-new or established patient			C-PA**	T-PA**
<b>Radiographs</b>					
<b>If the combined fees for itemized x-rays on a single claims equal or exceed the fee for FMX (D0210), the maximum payable will equal FMX (D0210)</b>					
D0210	Intraoral-complete (FMX) including bitewings	Benefit limited to once every three years	Narrative required for claims submission for ages 21 and older only	C-min. 6 yrs old	T-PA**
D0220	Intraoral-periapical - 1st film			C	C
D0230	Intraoral-periapical - each additional film			C	C
D0240	Intraoral - occlusal film			C	C
D0250	Extraoral - first film			C	C
D0260	Extraoral - each additional film			C	C
D0270	Bitewing - single film			C	T-PA
D0272	Bitewings - two films	Benefit limited to once every 6 months, plus one day		C-min. age 2 yrs. old	T-PA**
D0273	Bitewings - three films	Benefit limited to once every 6 months, plus one day		C-min. age 10 yrs. old	T-PA**
D0274	Bitewings - four films	Benefit limited to once every 6 months, plus one day		C-min. age 10 yrs. old	T-PA**
D0277	Vertical bitewings-7 to 8 films			N	T-PA**
D0290	Posterior - anterior or lateral skull and facial bone survey film			C-PA**	C-PA**
D0310	Sialography			C-PA**	N
D0320	Temporomandibular joint arthrogram, including injection			C-PA**	C-PA**
D0321	Other TMJ films, by report			C-PA**	C-PA**
D0330	Panoramic film		D0330 billed in conjunction with bitewings will be paid as D0210. D0330 covered for adults - if necessary - with narrative describing need for panoramic film versus periapical x-ray required for claims submission or for trauma or for third molars #1, #16, #17, #32.	C-min. age 5 yrs. old	C-PA**
D0340	Cephalometric film			C-PA**	N
D0350	Oral/facial images (includes intra and extraoral images)			C-PA**	N
<b>Test and Laboratory Examinations</b>					
D0470	Diagnostic casts			C-PA**	N
D0502	Other oral pathology procedures, by report			C-PA**	T-PA**
D0999	Unspecified diagnostic procedure, by report		Narrative required with claims submission	C-PA	T-PA
D1110	Prophylaxis - adult	Benefit limited to once every 6 months plus one day		C - Age 14-20	T-PA
D1120	Prophylaxis - child	Benefit limited to once every 6 months plus one day		C - Age 0-13	N
D1203	Topical application of Fluoride not including prophylaxis - child	Benefit limited to once every 6 months plus one day		C - Age 0-13	N
D1204	Topical application of Fluoride not including prophylaxis - adult	Benefit limited to once every 6 months plus one day		C - Age 14-20	T-PA
D1206	Topical fluoride varnish, therapeutic application			C	N

**C:** Covered Service    **N:** Non-Covered Service  
**T:** Covered for members listed for transplant only

**C-PA:** Covered with prior authorization or retrospective review  
**\*\*:** Prior approval of UPH Medical/Dental Director required

# University Family Care Dental Care Matrix

Effective October 1, 2010

**IMPORTANT: Regardless of prior authorization requirements for individual procedure codes, prior authorization is required when billed charges exceed \$750 per treatment plan (excluding exam and x-ray).**

Procedure Code	Procedure Code Description	Benefit Limitations	Special Billing Requirements	Covered Benefit less than 21 Years	Covered Benefit 21 Years and Older
D1351	Sealant - per tooth	Sealant coverage is limited to treatment of the occlusal surface of permanent first and second molars and second primary molars for ages 3-20 only. Benefit limited to once every 3 years, Teeth A, J, K, T, 2, 3, 14, 18, 19, 30, 31. <b>As of May 1, 2009, dental sealants on primary second molars are no longer a covered benefit. Teeth A, J, H, T.</b>		C-max. age 15 yrs old	N
D1510	Space maintainer - fixed-unilateral	Coverage is limited to space maintenance for unerupted teeth and following premature loss of primary molars. All adjustments must occur within 6 months after placement.	Full arch x-rays and narrative are required with claims submission	C-PA, max age 14 yrs old	N
D1515	Space maintainer - fixed-bilateral	Coverage is limited to space maintenance for unerupted teeth and following premature loss of primary molars. All adjustments must occur within 6 months after placement.	Full arch x-rays and narrative are required with claims submission	C-PA, max age 14 yrs old	N
D1520	Space maintainer - removable-unilateral	Coverage is limited to space maintenance for unerupted teeth and following premature loss of primary molars. All adjustments must occur within 6 months after placement.	Full arch x-rays and narrative are required with claims submission	C-PA, max age 14 yrs old	N
D1525	Space maintainer - removable-bilateral	Coverage is limited to space maintenance for unerupted teeth and following premature loss of primary molars. All adjustments must occur within 6 months after placement.	Full arch x-rays and narrative are required with claims submission	C-PA, max age 14 yrs old	N
D1550	Recementation space maintainer			C-max age 14 yrs old	N
D1555	Removal of fixed space maintainer			C-max age 14 yrs old	N
<b>Dental Procedures - Restorative</b>					
<b>Anterior restorations on primary teeth require PA for ages 5 and up. Posterior restorations on primary teeth require PA for ages 9 and up.</b>					
D2140	Amalgam - 1 surface, primary or permanent			C	T-PA
D2150	Amalgam - 2 surfaces, primary or permanent			C	T-PA
D2160	Amalgam - 3 surfaces, primary or permanent			C	T-PA
D2161	Amalgam - 4+ surfaces, primary or permanent			C	T-PA
D2330	Resin - 1 surface, anterior			C	T-PA
D2331	Resin - 2 surfaces, anterior			C	T-PA
D2332	Resin - 3 surfaces, anterior			C	T-PA
D2335	Resin - 4+ surfaces, anterior Or involving the incisal angle, anterior			C	T-PA
D2390	Resin - based composite crown, anterior		3 or more teeth require PA	C	T-PA
D2391	Resin - based composite - 1 surface, posterior	Used to restore a carious lesion into dentin. Not a preventive procedure.		C	T-PA
D2392	Resin - based composite - 2 surfaces, posterior	Used to restore a carious lesion into dentin. Not a preventive procedure.		C	T-PA
D2393	Resin - based composite - 3 surfaces, posterior	Used to restore a carious lesion into dentin. Not a preventive procedure.		C	T-PA
D2394	Resin - based composite □ 4+ surfaces, posterior	Used to restore a carious lesion into dentin. Not a preventive procedure.		C	T-PA
<b>Cast Fixed Restorations</b>					
D2750	Crown-porcelain fused to high noble metal			C-PA**, Age 18-20 only	N

**C:** Covered Service    **N:** Non-Covered Service  
**T:** Covered for members listed for transplant only

**C-PA:** Covered with prior authorization or retrospective review  
**\*\*:** Prior approval of UPH Medical/Dental Director required

# University Family Care Dental Care Matrix

Effective October 1, 2010

**IMPORTANT: Regardless of prior authorization requirements for individual procedure codes, prior authorization is required when billed charges exceed \$750 per treatment plan (excluding exam and x-ray).**

Procedure Code	Procedure Code Description	Benefit Limitations	Special Billing Requirements	Covered Benefit less than 21 Years	Covered Benefit 21 Years and Older
D2751	Crown - porcelain fused to predominantly base metal	Benefit limited to anterior and bicuspids only on functional permanent endodontically treated teeth, except third molars	Post-operative x-ray of root canal required with claims submission	C, Age 18-20 only	N
D2752	Crown - porcelain fused to noble metal	Benefit limited to anterior and bicuspids only on functional permanent endodontically treated teeth, except third molars	Post-operative x-ray of root canal required with claims submission	C-PA, Age 18-20 only	N
D2790	Crown-full cast high noble metal			C-PA, Age 18-20 only	N
D2791	Crown - full cast predominantly base metal	Benefit limited to molars only on functional permanent endodontically treated teeth, except third molars	Post-operative x-ray of root canal required with claims submission	C-PA, Age 18-20 only	N
D2792	Crown - full cast noble metal	Benefit limited to molars only on functional permanent endodontically treated teeth, except third molars	Post-operative x-ray of root canal required with claims submission	C-PA, Age 18-20 Only	N
D2794	Crown - titanium			C-PA, Age 18-20 only	N
D2799	Provisional Crown			N	T-PA
<b>Other Restorative Services</b>					
D2910	Recent inlay, onlay, or partial coverage restoration		Narrative required with claims submission	C-min age 18 yrs old	T-PA
D2915	Recent cast or prefabricated post and core			C	T-PA
D2920	Recent crown		Narrative required with claims submission	C	T-PA
D2930	Prefabricated stainless steel crown - primary tooth			C-PA for 3 or more teeth	N
D2931	Prefabricated stainless steel crown - permanent tooth			C	T-PA
D2932	Prefabricated resin crown			C-PA for 3 or more teeth	T-PA for 3 or more teeth
D2933	Prefabricated stainless steel crown w/resin window - primary tooth			C-PA for 3 or more teeth	N
D2934	Prefabricated esthetic coated stainless steel crown-primary tooth			C-PA	N
D2940	Sedative filling	Not covered when done in conjunction with pulpotomies, root canals and/or permanent restorations		C-PA	T-PA
D2950	Core buildup, including any pins	This procedure is covered subject to prior authorization with submission of x-rays, and only covered for permanent endodontically treated teeth		C-PA	T-PA
D2951	Pin retention - per tooth, in addition to restoration	3 pins per tooth maximum		C-PA**	T-PA**
D2952	Cast post and core in addition to crown - indirectly fabricated			C-PA**	T-PA**
D2954	Prefabricated post and core in addition to crown			C-PA	T-PA
D2970	Temporary crown (recent tooth fracture)		X-rays required with claims submission for under age 21, Narrative and x-rays required with claims submission for age 21 and over.	C	N
D2999	Unspecified restorative procedure, by report			C-PA**	T-PA**
<b>Dental Procedures - Endodontic</b>					
D3110	Pulp cap - direct	Not covered if done in conjunction with permanent restoration. Pulp caps are covered on permanent teeth only. Excluding final restoration		C	N
D3120	Pulp cap - indirect	Not covered if done in conjunction with permanent restoration. Pulp caps are covered on permanent teeth only. Excluding final restoration		C	N
D3220	Therapeutic pulpotomy		Narrative and x-rays required with claims submission for age 21 and older	C-PA for 3 or more teeth	N
D3221	Gross pulpal debridement, primary and permanent teeth			C-PA**	T-PA**

**C:** Covered Service    **N:** Non-Covered Service  
**T:** Covered for members listed for transplant only

**C-PA:** Covered with prior authorization or retrospective review  
**\*\*:** Prior approval of UPH Medical/Dental Director required

# University Family Care Dental Care Matrix

Effective October 1, 2010

**IMPORTANT: Regardless of prior authorization requirements for individual procedure codes, prior authorization is required when billed charges exceed \$750 per treatment plan (excluding exam and x-ray).**

Procedure Code	Procedure Code Description	Benefit Limitations	Special Billing Requirements	Covered Benefit less than 21 Years	Covered Benefit 21 Years and Older
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding restoration)		Post-operative x-ray of root canal required with claims submission	C-PA	N
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding restoration)		Post-operative x-ray of root canal required with claims submission	C-PA	N
<b>Root Canal Therapy (Including Follow-up Care)</b>					
<b>Initial x-ray for root canal therapy (RCT) is a covered benefit. Subsequent x-rays are considered included in the fee for RCT and are not billable.</b>					
D3310	Anterior (excluding final restoration)	For adults age 21 and over, 6 upper/lower anteriors if trauma/infection on a restorable tooth. Coverage is limited to permanent teeth working films, postoperative films and cultures but excludes final restoration	Post-operative x-ray of root canal required with claims submission	C-PA	T-PA
D3320	Bicuspid (excluding final restoration)	For adults age 21 and over, 6 upper/lower anteriors if trauma/infection on a restorable tooth. Coverage is limited to permanent teeth working films, postoperative films and cultures but excludes final restoration	Post-operative x-ray of root canal required with claims submission	C-PA	N
D3330	Molar (excluding final restoration)		Post-operative x-ray of root canal required with claims submission	C-PA	N
D3331	Treatment of root canal obstruction; non-surgical access		Narrative and x-rays required with claims submission	C-PA	N
D3332	Incomplete endodontic therapy; inoperable or fractured tooth			C-PA**	N
D3333	Internal root repair or perforation defects			C-PA**	N
D3346	Retreatment of previous root canal therapy - anterior	For adults age 21 and over, 6 upper/lower anteriors if trauma/infection on a restorable tooth. Coverage is limited to permanent teeth working films, postoperative films and cultures but excludes final restoration	Narrative and pre and post-operative x-rays required with claims submission	C-PA	T-PA
D3347	Retreatment of previous root canal therapy - bicuspid	For adults age 21 and over, 6 upper/lower anteriors if trauma/infection on a restorable tooth. Coverage is limited to permanent teeth working films, postoperative films and cultures but excludes final restoration	Narrative and pre and post-operative x-rays required with claims submission	C-PA	N
D3348	Retreatment of previous root canal therapy - molar	Coverage is limited to permanent teeth. Allowance includes post-operative films and cultures but excludes final restoration.	Narrative and pre and post-operative x-rays required with claims submission	C-PA	N
D3351	Apexification/recalcification - Initial visit (apical closure/calific repair of perforations, root resorbion, etc.)		Narrative and x-rays required with claims submission	C-PA	N
D3352	Apexification/recalcification - interim medication (apical closure/calific repair of perforations, root resorbion, etc.)		Narrative and x-rays required with claims submission	C-PA	N
D3353	Apexification/recalcification - final visit (includes completed root canal therapy)		Narrative and pre and post-operative x-rays required with claims submission	C-PA	N
D3410	Apicoectomy/periradicular surgery - anterior		Narrative and x-rays required with claims submission	C-PA	T-PA
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)		Narrative and x-rays required with claims submission	C-PA	N
D3425	Apicoectomy/periradicular surgery - molar (first root)		Narrative and x-rays required with claims submission	C-PA	N
D3426	Apicoectomy/periradicular surgery (each additional root)		Narrative and x-rays required with claims submission	C-PA	N
D3430	Retrograde filling - per root		Narrative and x-rays required with claims submission	C-PA	T-PA
D3450	Root amputation - per root		Narrative and x-rays required with claims submission	C-PA	N
D3470	Intentional replantation (including necessary splinting)			C-PA**	N
D3920	Hemisection (including any root removal), not including root canal therapy		Narrative and x-rays required with claims submission	C-PA	N
D3999	Unspecified procedure <input type="checkbox"/> by report			C-PA**	T-PA**

**C:** Covered Service    **N:** Non-Covered Service  
**T:** Covered for members listed for transplant only

**C-PA:** Covered with prior authorization or retrospective review  
**\*\*:** Prior approval of UPH Medical/Dental Director required

# University Family Care Dental Care Matrix

Effective October 1, 2010

**IMPORTANT: Regardless of prior authorization requirements for individual procedure codes, prior authorization is required when billed charges exceed \$750 per treatment plan (excluding exam and x-ray).**

Procedure Code	Procedure Code Description	Benefit Limitations	Special Billing Requirements	Covered Benefit less than 21 Years	Covered Benefit 21 Years and Older
<b>Dental Procedures - Periodontics</b>					
D4210	Gingivectomy or gingivoplasty- 4 or more contiguous teeth or bounded teeth spaces per quadrant		Narrative and x-rays required with claims submission	C-PA	T-PA
D4211	Gingivectomy or gingivoplasty - 1 to 3 teeth per quadrant		Narrative and x-rays required with claims submission	C-PA	T-PA
D4240	Gingival flap procedure, including root planing - 4 or more contiguous teeth or bounded teeth spaces per quadrant		Narrative and x-rays required with claims submission	C-PA	T-PA
D4241	Gingival flap procedure, including root planing - 1-3 teeth per quadrant		Narrative and x-rays required with claims submission	C-PA	T-PA
D4249	Clinical crown lengthening - hard tissue	Must be done at least 6 weeks prior to restorative.	Narrative and x-rays required with claims submission	C-PA	N
D4260	Osseous surgery (including flap entry and closure) - 4 or more contiguous teeth or bounded teeth spaces per quadrant		Narrative and x-rays required with claims submission	C-PA	T-PA
D4261	Osseous surgery (including flap entry and closure) - 1 -3 teeth per quadrant		Narrative and x-rays required with claims submission	C-PA	T-PA
D4263	Bone replacement graft; first site in quadrant		Narrative and x-rays required with claims submission	C-PA	N
D4264	Bone replacement graft; each additional site in quadrant		Narrative and x-rays required with claims submission	C-PA	N
D4265	Biologic material to aid in soft and osseous tissue regeneration		Narrative and x-rays required with claims submission	C-PA	N
D4266	Guided tissue regeneration; resorbable barrier; per site		Narrative and x-rays required with claims submission	C-PA	N
D4267	Guided tissue regeneration; non-resorbable barrier; per site		Narrative and x-rays required with claims submission	C-PA	N
D4270	Pedicle soft tissue graft procedure		Narrative and x-rays required with claims submission	C-PA	N
D4271	Free soft tissue graft procedure		Narrative and x-rays required with claims submission	C-PA	N
D4273	Subepithelial connective tissue graft procedure (including donor site surgery)			C-PA**	N
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)			C-PA**	N
D4275	Soft tissue allograft			C-PA**	N
D4276	Combined connective tissue and double pedicle graft			C-PA**	N
D4320	Provision splint - intracoronal		Narrative and x-rays required with claims submission	C-PA	N
D4321	Provision splint - extracoronal		Narrative and x-rays required with claims submission	C-PA	N
D4341	Periodontal scaling and root planing - 4 or more contiguous teeth or bounded teeth spaces per quadrant		Narrative and x-rays and perio charting required with claims submission	C-PA	T-PA
D4342	Periodontal scaling and root planing - 1-3 teeth per quadrant		Narrative and x-rays and perio charting required with claims submission	C-PA	T-PA
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis		Narrative and x-rays and perio charting required with claims submission	C-PA	T-PA
D4910	Periodontal maintenance procedures (following active therapy)			C-PA**	T-PA**
D4920	Unscheduled dressing change		Narrative required with claims submission	C-PA	T-PA
D4999	Unspecified periodontal procedure, by report			C-PA**	T-PA**
<b>Dental Procedures - Prosthodontics (When Medically Necessary)</b>					
D5110	Complete denture - maxillary		Narrative and x-rays required with claims submission	C-PA	N
D5120	Complete denture - mandibular		Narrative and x-rays required with claims submission	C-PA	N
D5130	Immediate denture - maxillary		Narrative and x-rays required with claims submission	C-PA	N
D5140	Immediate denture - mandibular		Narrative and x-rays required with claims submission	C-PA	N
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)		Narrative and x-rays required with claims submission	C-PA	N
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)		Narrative and x-rays required with claims submission	C-PA	N
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)			C-PA**	N
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)			C-PA**	N

**C:** Covered Service    **N:** Non-Covered Service

**C-PA:** Covered with prior authorization or retrospective review

**T:** Covered for members listed for transplant only

**\*\*:** Prior approval of UPH Medical/Dental Director required

# University Family Care Dental Care Matrix

Effective October 1, 2010

**IMPORTANT: Regardless of prior authorization requirements for individual procedure codes, prior authorization is required when billed charges exceed \$750 per treatment plan (excluding exam and x-ray).**

Procedure Code	Procedure Code Description	Benefit Limitations	Special Billing Requirements	Covered Benefit less than 21 Years	Covered Benefit 21 Years and Older
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)		Narrative required with claims submission	C-PA	N
D5410	Adjust complete denture - maxillary		Narrative required with claims submission	C-PA	N
D5411	Adjust complete denture - mandibular		Narrative required with claims submission	C-PA	N
D5421	Adjust partial denture - maxillary		Narrative required with claims submission	C-PA	N
D5422	Adjust partial denture - mandibular		Narrative required with claims submission	C-PA	N
D5510	Repair broken complete denture base		Narrative required with claims submission	C-PA	N
D5520	Replace missing or broken teeth - complete denture (each tooth)		Narrative required with claims submission	C-PA	N
D5610	Repair resin denture base		Narrative required with claims submission	C-PA	N
D5620	Repair cast framework		Narrative required with claims submission	C-PA	N
D5630	Repair or replace broken clasp		Narrative required with claims submission	C-PA	N
D5640	Replace broken teeth - per tooth		Narrative required with claims submission	C-PA	N
D5650	Add tooth to existing partial denture			C-PA**	N
D5660	Add clasp to existing partial denture			C-PA**	N
D5710	Rebase complete maxillary denture		Narrative required with claims submission	C-PA	N
D5711	Rebase complete mandibular denture		Narrative required with claims submission	C-PA	N
D5720	Rebase maxillary partial denture		Narrative required with claims submission	C-PA	N
D5721	Rebase mandibular partial denture		Narrative required with claims submission	C-PA	N
D5730	Reline maxillary complete denture (chair side)	Coverage for relines is limited to service dates more than 6 months after delivery	Narrative required with claims submission	C-PA	N
D5731	Reline mandibular denture (chair side)	Coverage for relines is limited to service dates more than 6 months after delivery	Narrative required with claims submission	C-PA	N
D5740	Reline maxillary partial denture (chair side)	Coverage for relines is limited to service dates more than 6 months after delivery	Narrative required with claims submission	C-PA	N
D5741	Reline mandibular partial denture (chair side)	Coverage for relines is limited to service dates more than 6 months after delivery	Narrative required with claims submission	C-PA	N
D5750	Reline maxillary complete denture (laboratory)	Coverage for relines is limited to service dates more than 6 months after delivery	Narrative required with claims submission	C-PA	N
D5751	Reline mandibular complete denture (laboratory)	Coverage for relines is limited to service dates more than 6 months after delivery	Narrative required with claims submission	C-PA	N
D5760	Reline maxillary partial denture	Coverage for relines is limited to service dates more than 6 months after delivery	Narrative required with claims submission	C-PA	N
D5761	Reline mandibular partial denture	Coverage for relines is limited to service dates more than 6 months after delivery	Narrative required with claims submission	C-PA	N
D5820	Interim partial denture (use for anterior flipper) - maxillary		Narrative and x-rays required with claims submission	C-PA	N
D5821	Interim partial denture (use for anterior flipper) - mandibular		Narrative and x-rays required with claims submission	C-PA	N
D5850	Tissue conditioning - maxillary		Narrative required with claims submission	C-PA	N
D5851	Tissue conditioning - mandibular		Narrative required with claims submission	C-PA	N
D5899	Unspecified removable prosthodontic procedure			C-PA**	N
<b>Dental Procedures - Maxillofacial Prosthetics (When Medically Necessary)</b>					
D5911	Facial moulage - sectional		Narrative required with claims submission	C-PA	N
D5912	Facial moulage □ complete		Narrative required with claims submission	C-PA	N

**C:** Covered Service    **N:** Non-Covered Service  
**T:** Covered for members listed for transplant only

**C-PA:** Covered with prior authorization or retrospective review  
**\*\*:** Prior approval of UPH Medical/Dental Director required

# University Family Care Dental Care Matrix

Effective October 1, 2010

**IMPORTANT: Regardless of prior authorization requirements for individual procedure codes, prior authorization is required when billed charges exceed \$750 per treatment plan (excluding exam and x-ray).**

Procedure Code	Procedure Code Description	Benefit Limitations	Special Billing Requirements	Covered Benefit less than 21 Years	Covered Benefit 21 Years and Older
D5913	Nasal prosthesis		Narrative required with claims submission	C-PA	N
D5914	Auricular prosthesis		Narrative required with claims submission	C-PA	N
D5915	Orbital prosthesis		Narrative required with claims submission	C-PA	N
D5916	Ocular prosthesis		Narrative required with claims submission	C-PA	N
D5919	Facial prosthesis		Narrative required with claims submission	C-PA	N
D5922	Nasal septal prosthesis		Narrative required with claims submission	C-PA	N
D5923	Ocular prosthesis, interim		Narrative required with claims submission	C-PA	N
D5924	Cranial prosthesis		Narrative required with claims submission	C-PA	N
D5925	Facial augmentation implant prosthesis		Narrative required with claims submission	C-PA	N
D5926	Nasal prosthesis, replacement		Narrative required with claims submission	C-PA	N
D5927	Auricular prosthesis, replacement		Narrative required with claims submission	C-PA	N
D5928	Orbital prosthesis, replacement		Narrative required with claims submission	C-PA	N
D5929	Facial prosthesis, replacement		Narrative required with claims submission	C-PA	N
D5931	Obturator prosthesis- surgical		Narrative required with claims submission	C-PA	N
D5932	Obturator prosthesis <input type="checkbox"/> definitive		Narrative required with claims submission	C-PA	N
D5933	Obturator prosthesis, modification		Narrative required with claims submission	C-PA	N
D5934	Mandibular resection prosthesis with guide flange		Narrative required with claims submission	C-PA	N
D5935	Mandibular resection prosthesis without guide flange		Narrative required with claims submission	C-PA	N
D5936	Obturator/prosthesis, interim		Narrative required with claims submission	C-PA	N
D5937	Trismus appliance (not for TMJ treatment)		Narrative required with claims submission	C-PA	N
D5951	Feeding aid		Narrative required with claims submission	C-PA, max age 2 yrs old	N
D5952	Speech aid prosthesis <input type="checkbox"/> pediatric		Narrative required with claims submission	C-PA, max age 16 yrs old	N
D5953	Speech aid prosthesis <input type="checkbox"/> adult			C-PA, min age 16 yrs old	N
D5954	Palatal augmentation prosthesis		Narrative required with claims submission	C-PA	N
D5955	Palatal lift prosthesis - definitive		Narrative required with claims submission	C-PA	N
D5958	Palatal lift prosthesis <input type="checkbox"/> interim		Narrative required with claims submission	C-PA	N
D5959	Palatal lift prosthesis, modification		Narrative required with claims submission	C-PA	N
D5960	Speech aid prosthesis, modification		Narrative required with claims submission	C-PA	N
D5982	Surgical stent		Narrative required with claims submission	C-PA	N
D5983	Radiation carrier		Narrative required with claims submission	C-PA	N
D5984	Radiation shield		Narrative required with claims submission	C-PA	N
D5985	Radiation cone locator		Narrative required with claims submission	C-PA	N
D5986	Fluoride gel carrier		Narrative required with claims submission	C-PA	N
D5987	Commissure splint		Narrative required with claims submission	C-PA	N

**C:** Covered Service    **N:** Non-Covered Service  
**T:** Covered for members listed for transplant only

**C-PA:** Covered with prior authorization or retrospective review  
**\*\*:** Prior approval of UPH Medical/Dental Director required

# University Family Care Dental Care Matrix

Effective October 1, 2010

**IMPORTANT: Regardless of prior authorization requirements for individual procedure codes, prior authorization is required when billed charges exceed \$750 per treatment plan (excluding exam and x-ray).**

Procedure Code	Procedure Code Description	Benefit Limitations	Special Billing Requirements	Covered Benefit less than 21 Years	Covered Benefit 21 Years and Older
D5988	Surgical splint		Narrative required with claims submission	C-PA	N
D5999	Unspecified maxillofacial prosthesis, by report		Narrative required with claims submission	C-PA	N
<b>Dental Procedures - Implant Services</b>					
		Not a covered benefit		N	N
<b>Dental Procedures - Prosthodontics - Fixed</b>					
D6930	Recent fixed partial denture			C	T-PA
D6999	Unspecified fixed prosthodontic procedure, by report			C-PA**	N
<b>Oral and Maxillofacial Surgery (Symptomatic Teeth Only)</b>					
D7111	Coronal remnants-deciduous tooth		X-rays and clinical notes required for claims submission	C-PA or retro review for emergency	N
D7140	Extraction □ erupted tooth or exposed root (elevation and/or forceps removal)		X-rays and clinical notes required for claims submission	C-PA or retro review for emergency	T-PA or retro review for emergency
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth including cutting of gingival and bone, removal of tooth structure, minor smoothing of socket bone and closure		X-rays and clinical notes required for claims submission	C-PA or retro review for emergency	T-PA or retro review for emergency
D7220	Removal of impacted tooth - soft tissue - occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation		X-rays and clinical notes required for claims submission	C-PA or retro review for emergency	T-PA or retro review for emergency
D7230	Removal of impacted tooth - partially bony - part of crown covered by bone; requires mucoperiosteal flap elevation and bone removal		X-rays and clinical notes required for claims submission	C-PA or retro review for emergency	T-PA or retro review for emergency
D7240	Removal of impacted tooth - completely bony - most or all of crown covered by bone; requires mucoperiosteal flap elevation and bone removal.		X-rays and clinical notes required for claims submission	C-PA or retro review for emergency	T-PA or retro review for emergency
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications - most or all of 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		X-rays and clinical notes required for claims submission	C-PA or retro review for emergency	T-PA or retro review for emergency
D7250	Surgical removal of residual tooth roots (cutting procedure) includes cutting of soft tissue and bone, removal of tooth surface and closure (completely submerged in bone)		X-rays and clinical notes required for claims submission	C-PA or retro review for emergency	T-PA or retro review for emergency
D7260	Oral antral fistula closure		X-rays and clinical notes required for claims submission	C-PA or retro review for emergency	C-PA or retro review for emergency
D7261	Primary closure of a sinus perforation		X-rays and clinical notes required for claims submission	C-PA or retro review for emergency	C-PA or retro review for emergency
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth - accident		X-rays and clinical notes required for claims submission	C-PA or retro review for emergency	N
D7280	Surgical access of an unerupted tooth - ortho			C-PA**	N
D7281	Surgical exposure of impacted or unerupted tooth			C-PA**	N
D7282	Mobilization of erupted or malpositioned tooth to aid eruption			C-PA**	N
D7283	Placement of device to facilitate eruption of impacted tooth			C-PA**	N
D7285	Biopsy of oral tissue - hard		clinical notes required for claims submission	C-PA	C-PA
D7286	Biopsy of oral tissue - soft		clinical notes required for claims submission	C-PA**	C-PA**
D7292	Surgical placement: temporary anchorage device requiring surgical flap			C-PA**	C-PA**
D7293	Surgical placement: temporary anchorage device requiring surgical flap			C-PA**	C-PA**
D7294	Surgical placement: temporary anchorage device without surgical flap			C-PA**	C-PA**
D7310	Alveoplasty in conjunction with extractions - per quadrant		X-rays and clinical notes required for claims submission	C-PA	N
D7311	Alveoplasty in conjunction with extractions- one to three teeth or tooth spaces per quadrant		X-rays and clinical notes required for claims submission	C-PA	N
D7320	Alveoplasty - per quadrant		X-rays and clinical notes required for claims submission	C-PA	N
D7321	Alveoplasty not in conjunction with extractions-1 to 3 teeth or tooth spaces per quadrant		X-rays and clinical notes required for claims submission	C-PA	N

**C:** Covered Service    **N:** Non-Covered Service    **C-PA:** Covered with prior authorization or retrospective review  
**T:** Covered for members listed for transplant only    **\*\*:** Prior approval of UPH Medical/Dental Director required

# University Family Care Dental Care Matrix

Effective October 1, 2010

**IMPORTANT: Regardless of prior authorization requirements for individual procedure codes, prior authorization is required when billed charges exceed \$750 per treatment plan (excluding exam and x-ray).**

Procedure Code	Procedure Code Description	Benefit Limitations	Special Billing Requirements	Covered Benefit less than 21 Years	Covered Benefit 21 Years and Older
D7410	Excision benign lesion □ 1.25 cm		Narrative and x-rays required for claims submission	C-PA	C-PA
D7411	Excision benign lesion ->1.25 cm		Narrative and x-rays required for claims submission	C-PA	C-PA
D7412	Excision of benign lesion, complicated		Narrative and x-rays required for claims submission	C-PA	C-PA
D7413	Excision malignant lesion-1.25 cm		Narrative and x-rays required for claims submission	C-PA	C-PA
D7414	Excision malignant lesion- >1.25 cm		Narrative and x-rays required for claims submission	C-PA	C-PA
D7415	Excision of malignant lesion, complicated		Narrative and x-rays required for claims submission	C-PA	C-PA
D7440	Excision malignant tumor-1.25 cm		Narrative and x-rays required for claims submission	C-PA	C-PA
D7441	Excision malignant tumor->1.25 cm		Narrative and x-rays required for claims submission	C-PA	C-PA
D7450	Removal benign odontogenic cyst or tumor -1.25 cm		Narrative and x-rays required for claims submission	C-PA	C-PA
D7451	Removal benign odontogenic cyst or tumor ->1.25 cm		Narrative and x-rays required for claims submission	C-PA	C-PA
D7460	Removal benign nonodontogenic cyst or tumor -1.25 cm		Narrative and x-rays required for claims submission	C-PA	C-PA
D7461	Removal benign nonodontogenic cyst or tumor ->1.25 cm		Narrative and x-rays required for claims submission	C-PA	C-PA
D7465	Destruction of lesion(s) by physical or chemical methods, by report			C-PA**	C-PA**
D7471	Removal of lateral exostosis-(maxilla or mandible)		Narrative and x-rays required for claims submission	C-PA	N
D7472	Removal of torus palatinus		Narrative and x-rays required for claims submission	C-PA	N
D7473	Removal of torus mandibulars		Narrative and x-rays required for claims submission	C-PA	N
D7485	Surgical reduction of osseous tuberosity		Narrative and x-rays required for claims submission	C-PA	N
D7490	Radical resection of mandible with bone graft		Narrative and x-rays required for claims submission	C-PA	C-PA
D7510	Incision and drainage of abscess - intraoral soft tissue	Not covered on the same date of service as extraction unless documentation of sent/drain placement	X-rays and clinical notes required for claims submission	C-PA	C-PA
D7511	Incision and drainage of abscess-intraoral soft tissue-complicated	Not covered on the same date of service as extraction unless documentation of sent/drain placement	X-rays and clinical notes required for claims submission	C-PA	C-PA
D7520	Incision/drain abscess - extraoral soft tissue		X-rays and clinical notes required for claims submission	C-PA	C-PA
D7521	Incision and drainage of abscess-extraoral soft tissue-complicated		X-rays and clinical notes required for claims submission	C-PA	C-PA
D7530	Removal or foreign body from mucosa, skin, or subcutaneous Aeolar tissue		Narrative and x-rays required for claims submission	C-PA	C-PA
D7540	Removal of reaction-producing foreign bodies - musculoskeletal system		Narrative and x-rays required for claims submission	C-PA	C-PA
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone		Narrative and x-rays required for claims submission	C-PA	C-PA
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body		Narrative and x-rays required for claims submission	C-PA	C-PA
<b>Treatment of Fractures (When Medically Necessary)</b>					
D7610	Maxilla-open reduction, teeth immobilized if present		Narrative required for claims submission	C-PA	C-PA
D7620	Maxilla-closed reduction, teeth immobilized if present		Narrative required for claims submission	C-PA	C-PA
D7630	Mandible-open reduction, teeth immobilized if present		Narrative required for claims submission	C-PA	C-PA
D7640	Mandible-closed reduction, teeth immobilized if present		Narrative required for claims submission	C-PA	C-PA
D7650	Malar and/ or zygomatic arch □open reduction		Narrative required for claims submission	C-PA	C-PA
D7660	Malar and/ or zygomatic arch □closed reduction		Narrative required for claims submission	C-PA	C-PA
D7670	Alveolus-closed reduction may include stabilization of teeth		Narrative required for claims submission	C-PA	C-PA

**C:** Covered Service    **N:** Non-Covered Service  
**T:** Covered for members listed for transplant only

**C-PA:** Covered with prior authorization or retrospective review  
**\*\*:** Prior approval of UPH Medical/Dental Director required

# University Family Care Dental Care Matrix

Effective October 1, 2010

**IMPORTANT: Regardless of prior authorization requirements for individual procedure codes, prior authorization is required when billed charges exceed \$750 per treatment plan (excluding exam and x-ray).**

Procedure Code	Procedure Code Description	Benefit Limitations	Special Billing Requirements	Covered Benefit less than 21 Years	Covered Benefit 21 Years and Older
D7671	Alveolus-open reduction may include stabilization of teeth		Narrative required for claims submission	C-PA	C-PA
D7680	Facial bones-complicated reduction with fixation and multiple surgical approaches		Narrative required for claims submission	C-PA	C-PA
D7710	Maxilla -open reduction-compound		Narrative required for claims submission	C-PA	C-PA
D7720	Maxilla-closed reduction □ compound		Narrative required for claims submission	C-PA	C-PA
D7730	Mandible □ open reduction-compound		Narrative required for claims submission	C-PA	C-PA
D7740	Mandible- closed reduction-compound		Narrative required for claims submission	C-PA	C-PA
D7750	Malar and/ or zygomatic arch □ open reduction-compound		Narrative required for claims submission	C-PA	C-PA
D7760	Malar and/ or zygomatic arch □ closed reduction-compound		Narrative required for claims submission	C-PA	C-PA
D7770	Alveolus-open reduction-stabilization of teeth		Narrative required for claims submission	C-PA	C-PA
D7771	Alveolus-closed reduction-stabilization of teeth		Narrative required for claims submission	C-PA	C-PA
D7780	Facial bones-complicated reduction with fixation and multiple surgical approaches		Narrative required for claims submission	C-PA	C-PA
<b>Reduction of Dislocation and Management of Other Temporomandibular Joint Dysfunctions (When Medically Necessary)</b>					
D7810	Open reduction-dislocation		Narrative required for claims submission	C-PA	C-PA
D7820	Closed reduction-dislocation		Narrative required for claims submission	C-PA	C-PA
D7830	Manipulation under anesthesia		Narrative required for claims submission	C-PA	C-PA
D7840	Condylectomy			C-PA**	C-PA**
D7850	Surgical disectomy-w/ or w/o implant			C-PA**	C-PA**
D7852	Disc repair			C-PA**	C-PA**
D7854	Synovectomy			C-PA**	C-PA**
D7856	Myotomy			C-PA**	C-PA**
D7858	Joint reconstruction			C-PA**	C-PA**
D7860	Arthrotomy			C-PA**	C-PA**
D7865	Arthroplasty			C-PA**	C-PA**
D7870	Arthrocentesis			C-PA**	C-PA**
D7871	Non-arthroscopic lysis and lavage			C-PA**	C-PA**
D7872	Arthroscopy-diagnosis, with or without biopsy			C-PA**	C-PA**
D7873	Arthroscopy-surgical: lavage and lysis of adhesions			C-PA**	C-PA**
D7874	Arthroscopy-surgical: disc repositioning and stabilization			C-PA**	C-PA**
D7875	Arthroscopy-surgical: synovectomy			C-PA**	C-PA**
D7876	Arthroscopy-surgical: disectomy			C-PA**	C-PA**
D7877	Arthroscopy-surgical: debridement			C-PA**	C-PA**
D7880	Occlusal orthotic appliance			C-PA**	C-PA**
D7899	Unspecified TMD therapy, by report			C-PA**	C-PA**
<b>Repair of Traumatic Wounds</b>					
D7910	Suture small wounds up to 5 cm		Narrative required for claims submission	C-PA	C-PA
D7911	Complicated suture up to 5 cm		Narrative required for claims submission	C-PA	C-PA
D7912	Complex suture - more than 5 cm		Narrative required for claims submission	C-PA	C-PA
D7920	Skin graft			C-PA**	C-PA**
D7940	Osteoplasty-orthognathic			C-PA**	C-PA**
D7941	Osteotomy-ramus, closed			C-PA**	C-PA**
D7943	Osteotomy-mandibular rami with bone graft, includes obtaining the graft			C-PA**	C-PA**
D7944	Osteotomy-segmented or subapical-per sex			C-PA**	C-PA**
D7945	Osteotomy-body of mandible			C-PA**	C-PA**
D7946	Lefort I (maxilla-total)			C-PA**	C-PA**
D7947	Lefort I (maxilla-segmented)			C-PA**	C-PA**
D7948	Lefort II or III (osteoplasty of)			C-PA**	C-PA**
D7949	Lefort II or III -with bone graft		Narrative and x-rays required for claims submission	C-PA	C-PA
D7950	Osseous, osteoperiosteal, periosteal, or		Narrative and x-rays required for claims submission	C-PA	C-PA
D7951	Sinus augmentation with bone or bone substitute			C-PA**	C-PA**

**C:** Covered Service    **N:** Non-Covered Service  
**T:** Covered for members listed for transplant only

**C-PA:** Covered with prior authorization or retrospective review  
**\*\*:** Prior approval of UPH Medical/Dental Director required

# University Family Care Dental Care Matrix

Effective October 1, 2010

**IMPORTANT: Regardless of prior authorization requirements for individual procedure codes, prior authorization is required when billed charges exceed \$750 per treatment plan (excluding exam and x-ray).**

Procedure Code	Procedure Code Description	Benefit Limitations	Special Billing Requirements	Covered Benefit less than 21 Years	Covered Benefit 21 Years and Older
D7953	Bone replacement graft for ridge preservation-per site			C-PA**	C-PA**
D7955	Repair soft/hard tissue defect		Narrative and x-rays required for claims submission	C-PA	C-PA
D7960	Frenulectomy - separate procedure		Narrative and x-rays required for claims submission	C-PA	C-PA
D7963	Frenuloplasty			C-PA**	C-PA**
D7970	Excise hyperplastic tissue/arch		Narrative and x-rays required for claims submission	C-PA	C-PA
D7971	Excision pericoronal gingiva		Narrative and x-rays required for claims submission	C-PA	C-PA
D7972	Surgical reduction of fibrous tuberosity		Narrative required for claims submission	C-PA	C-PA
D7980	Sialolithotomy		Narrative and x-rays required for claims submission	C-PA	C-PA
D7981	Excision of salivary gland-by report		Narrative and x-rays required for claims submission	C-PA	C-PA
D7982	Sialodochoplasty		Narrative and x-rays required for claims submission	C-PA	C-PA
D7983	Closure of salivary fistula		Narrative and x-rays required for claims submission	C-PA	C-PA
D7990	Emergency tracheotomy		Narrative required for claims submission	C-PA	C-PA
D7991	Coronoidectomy		Narrative required for claims submission	C-PA	C-PA
D7995	Synthetic graft-mandible or facial bones, by report		Narrative required for claims submission	C-PA	C-PA
D7996	Implant-mandible for augmentation purposes (excluding alveolar ridge), by report		Narrative required for claims submission	C-PA	C-PA
D7997	Appliance removal (not by dentist who placed appliance), includes removal of arch bar		Narrative and x-rays required for claims submission	C-PA	C-PA
D7998	Intraoral placement of a fixation device not in conj. w/ fracture			C-PA**	C-PA**
D7999	Unspecified oral surgery procedure, by r		Narrative required for claims submission	C-PA	C-PA
<b>Orthodontics (When Medically Necessary)</b>					
D8010	Limited orthodontic treatment; of the primary dentition			C-PA**	N
D8020	Limited orthodontic treatment; of the transitional dentition			C-PA**	N
D8030	Limited orthodontic treatment; of the adolescent dentition.			C-PA**	N
D8040	Limited orthodontic treatment; of the adult dentition			C-PA**	N
D8050	Interceptive orthodontic treatment; of the primary dentition			C-PA**	N
D8060	Interceptive orthodontic treatment; of the transitional dentition			C-PA**	N
D8070	Comprehensive orthodontic treatment; of the transitional dentition			C-PA**	N
D8080	Comprehensive orthodontic treatment; of the adolescent dentition			C-PA**	N
D8090	Comprehensive orthodontic treatment; of the adult dentition			C-PA**	N
D8210	Removable appliance therapy			C-PA**	N
D8220	Fixed appliance therapy			C-PA**	N
D8660	Pre-orthodontic treatment visit			C-PA**	N
D8670	Periodic orthodontic treatment visit (as part of contract)			C-PA**	N
D8680	Orthodontic retention (removal of appliances, construction and placement of retainers)			C-PA**	N
D8690	Orthodontic treatment (alternative billing to contract fee, services provided by dentists other than original treating dentist)			C-PA**	N
D8691	Repair of orthodontic appliance			C-PA**	N
D8692	Replacement of lost or broken retainer			C-PA**	N
D8693	Rebonding or recementing; and/or repair of fixed retainer			C-PA**	N
D8999	Unspecified orthodontic procedure, by report			C-PA**	N
<b>Adjunctive General Services</b>					
D9110	Palliative (emergency) treatment of dental pain - minor procedure	Not a covered procedure if other procedures are reported on same date, same tooth, except diagnostic x-ray films and emergency exam	Narrative required for claims submission		
D9120	Fixed partial denture sectioning			C-PA	N
<b>Anesthesia</b>					
D9210	Local anesthesia not in conjunction with operative or surgical procedures.			C-PA**	N

**C:** Covered Service    **N:** Non-Covered Service  
**T:** Covered for members listed for transplant only

**C-PA:** Covered with prior authorization or retrospective review  
**\*\*:** Prior approval of UPH Medical/Dental Director required

# University Family Care Dental Care Matrix

Effective October 1, 2010

**IMPORTANT: Regardless of prior authorization requirements for individual procedure codes, prior authorization is required when billed charges exceed \$750 per treatment plan (excluding exam and x-ray).**

Procedure Code	Procedure Code Description	Benefit Limitations	Special Billing Requirements	Covered Benefit less than 21 Years	Covered Benefit 21 Years and Older
D9220	Deep sedation/general anesthesia - first 30 minutes		Narrative required for claims submission for age 0-20, medical records required for claims submission for age 21 and over	C-PA	C-PA
D9221	Deep sedation/general anesthesia - each additional 15 minutes		Narrative required for claims submission for age 0-20, medical records required for claims submission for age 21 and over	C-PA	C-PA
D9230	Analgesia		Age 0-9, no narrative needed, Age 10 and over, narrative required for claims submission	C-PA	C-PA
D9241	Intravenous conscious sedation/analgesia; first 30 minutes		Narrative required for claims submission for age 0-20, medical records required for claims submission for age 21 and over	C-PA	C-PA
D9242	Intravenous conscious sedation/analgesia; each additional 15 minutes		Narrative required for claims submission for age 0-20, medical records required for claims submission for age 21 and over	C-PA	C-PA
D9248	Non-intravenous conscious sedation	Covered for age 0-10 unless narrative for need accompanies PA request and is approved	Narrative required for claims submission for age 0-20, medical records required for claims submission for age 21 and over	C-PA	C-PA
<b>Professional Consultation</b>					
D9310	Consultation (diagnostic service provided by dentists or physician other than practitioner providing treatment)			C-PA**	T-PA
<b>Professional Visits</b>					
D9410	House call/extended care facility call	Mobile unit only	Narrative required for claims submission	C-PA	C-PA
D9420	Hospital call		Narrative required for claims submission	C-PA	C-PA
D9430	Office visit for observation (during regularly scheduled hours) no other services performed		Narrative required for claims submission	C-PA	N
D9440	Office visit - after regularly scheduled hours	Payment will be made on basis of services rendered or visit, whichever is greater	Narrative required for claims submission.	C-PA	N
D9610	Therapeutic drug injection			C-PA**	T-PA**
D9612	Therapeutic parenteral drugs			C-PA**	N
D9920	Behavior management	Papoose Board for Restraint only		N	N
D9930	Treatment of complications (post surgical)		Narrative required for claims submission.	C-PA	T-PA
D9940	Occlusal guard, includes adjustments for 24 months			C-PA**	N
D9951	Occlusal adjustment □limited	Coverage is limited to adjustment performed in conjunction with treatment of periodontal disease	Narrative and x-rays required for claims submission.	C-PA	T-PA
D9999	Unspecified adjunctive procedure, by report		X-rays and clinical notes required for claims submission.	C-PA	N

**C:** Covered Service    **N:** Non-Covered Service  
**T:** Covered for members listed for transplant only

**C-PA:** Covered with prior authorization or retrospective review  
**\*\*:** Prior approval of UPH Medical/Dental Director required