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Update: New York State Medicaid Program Dental Policy and Procedure Code Manual

The Department of Health has updated the following sections of the Dental Policy and Procedure Code Manual:

- Section II Dental Services - Services Not Within the Scope of the Medicaid Program
- Section V Dental Procedure Codes – (3) “Essential” Services, III. Restorative D2000 – D2999, IV. Endodontics D3000 – D3999, V. Periodontics D4000-D4999, VI.
- Prosthodontics D5000 – D5899, and VIII Implant Services D6000 - D6199

These updates are effective **January 31, 2024** and replace existing language. New language is indicated in a purple font. The New York State Department of Health will be hosting a webinar which will explain the new policies and criteria guidance on January 2, 2024. The updates will be published in the Dental Policy and Procedure Code Manual found online at https://www.emedny.org /ProviderManuals/Dental/index.aspx shortly.

Required forms for prior authorization, titled “Justification of Need for Replacement Prosthesis” and “Evaluation of the Dental Implant Patient”, are included with this notice. These forms do not need to be notarized, and Managed Care Organizations (MCOs) and Fee-for-Service (FFS) providers cannot impose additional criteria other than what is provided on these forms.

Services Not Within the Scope of the Medicaid Program
These services include but are not limited to:

- Fixed bridgework, except for cleft palate stabilization, or when a removeable prosthesis would be contraindicated;
- Immediate full or partial dentures;
- Crown lengthening, except when associated with medically necessary crown or endodontic treatment;
- Dental work for cosmetic reasons or because of the personal preference of the member of provider;
- Periodontal surgery, except when associated with implants or implant related services;
- Gingivectomy or gingivoplasty, except for the sole correction of severe hyperplasia or hypertrophy associated with drug therapy, hormonal disturbances, or congenital defects;
- Adult orthodontics, except in conjunction with, or as a result of, approved orthognathic surgery necessary in conjunction with an approved course of orthodontic treatment or the on-going treatment of clefts;
- Placement of sealants for members under 5 or over 15 years of age; and
- Improper use of panoramic images (**D0330**) along with intraoral complete series of images (**D0210**).

Section V Dental Procedure Codes
3 "Essential" Services
When reviewing requests for services the following guidelines will be used: Caries index, periodontal status, recipient compliance, dental history, medical history and the overall status and prognosis of the entire dentition, among other factors, will be taken into consideration when determining medical necessity. Treatment is considered appropriate where the prognosis of the tooth is favorable. Treatment may be appropriate where the total number of teeth which require or are likely to require treatment is not considered excessive or when maintenance of the tooth is considered essential or appropriate in view of the overall dental status of the recipient.

Treatment of deciduous teeth when exfoliation is reasonably imminent will not be routinely reimbursable. Claims submitted for the treatment of deciduous cuspids and molars for children ten (10) years of age or older, or other deciduous incisors in children five (5) years of age or older will be pended for professional review. As a condition for payment, it may be necessary to submit, upon request, radiographic images, and other information to support the appropriateness and necessity of these restorations. Extraction of deciduous teeth will only be reimbursed if injection of a local anesthetic is required.

As utilized in this Manual eight (8) posterior points of contact refers to four (4) maxillary and four (4) mandibular (molars/premolars) in natural or prosthetic functional contact with each other.

For the criteria to be used when determining medical necessity refer to the following specific sections of the Manual:

- Crowns (Section III);
- Endodontics (Section IV);
- Prosthodontics (Section VI); and
- Implant Services (Section VIII)

III. Restorative D2000 – D2999

Unless otherwise specified, the cost of analgesic and anesthetic agents is included in the reimbursement for the dental service.

The maximum fee for restoring a tooth with either amalgam or composite resin material will be the fee allowed for placement of a four-surface restoration. With the exception of the placement of reinforcement pins (use code D2951), fees for amalgam and composite restorations include tooth preparation, all adhesives (including amalgam and composite bonding agents), acid etching, cavity liners, bases, curing and pulp capping.

Caries index, periodontal status, and the overall status and prognosis of the entire dentition, as well as recipient compliance, dental history, and medical history, among other factors, will be taken into consideration when determining medical necessity. Treatment is considered appropriate where the prognosis of the tooth is favorable. Treatment may be appropriate where the total number of teeth which require or are likely to require treatment is not considered excessive or when maintenance of the tooth is considered essential or appropriate in view of the overall dental status of the recipient. Please review Scope of Program and Non-Reimbursable Services and Essential Services in Sections II and III of the NYS Medicaid Dental Policy and Procedure Code Manual.

Restorations placed solely for the treatment of abrasion, attrition, erosion or abfraction and are not associated with the treatment of any other pathology are beyond the scope of the program and will not be reimbursed. Restorative procedures should not be performed without documentation of clinical

necessity. Published “frequency limits” are general reference points on the anticipated frequency for that procedure. Actual frequency must be based on the clinical needs of the individual member.

If a non-covered surgical procedure is required to properly restore a tooth, any associated restorative or endodontic treatment will NOT be considered for reimbursement. Note, this provision does not apply to crown lengthening, which will be considered for reimbursement when associated with any medically necessary crown or endodontic treatment.

For codes **D2140**, **D2330** and **D2391**, only a single restoration will be reimbursable per surface. Occlusal surface restorations including all occlusal pits and fissures will be reimbursed as one-surface restorations whether or not the transverse ridge of an upper molar is left intact. Codes **D2150**, **D2160**, **D2161**, **D2331**, **D2332**, **D2335**, **D2781**, **D2392**, **D2393**, and **D2394** are compound restorations encompassing 2, 3, 4 or more contiguous surfaces. Restorations that connect contiguous surfaces must be billed using the appropriate multi-surface restorative procedure code.

Amalgam Restorations (Including Polishing)		
Code	**Description**	
D2140	**Amalgam - one surface, primary or permanent** (SURF/TOOTH)	$50.50
D2150	**Amalgam - two surfaces, primary or permanent** (SURF/TOOTH)	$67.67
D2160	**Amalgam - three surfaces, primary or permanent** (SURF/TOOTH)	$82.82
D2161	**Amalgam - four or more surfaces, primary or permanent** (SURF/TOOTH)	$98.98
Resin-Based Composite-Restorations Direct		
Code	**Description**	
D2330	**Resin-based composite - one surface, anterior** (SURF/TOOTH)	$50.50
D2331	**Resin-based composite - two surfaces, anterior** (SURF/TOOTH)	$73.73
D2332	**Resin-based composite - three surfaces, anterior** (SURF/TOOTH)	$87.87
D2335	**Resin-based composite - four or more surfaces or involving** incisal angle (anterior) (SURF/TOOTH)	$98.98
D2390	**Resin-based composite crown, anterior** (TOOTH)	$98.98
D2391	**Resin-based composite; one surface, posterior** (SURF/TOOTH) Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure	$50.50
D2392	**Resin-based composite - two surfaces, posterior** (SURF/TOOTH)	$67.67
D2393	**Resin-based composite - three surfaces, posterior** (SURF/TOOTH)	$82.82
D2394	**Resin-based composite – four or more surfaces, posterior** (SURF/TOOTH)	$98.98

Crowns – Single Restorations Only

The materials used in the fabrication of a crown (e.g., all-metal, porcelain, ceramic, resin) is at the discretion of the provider. The crown fabricated must correctly match the procedure code approved on the Prior Approval.

Crowns include any necessary core buildups.

Crowns for members under the age of 21 will be covered when medically necessary. In determining whether a requested crown is medically necessary, the following factors may be considered:

- The periodontal status, member compliance and overall status and prognosis of the tooth is favorable.
- The tooth is not routinely restorable with a filling.

Crowns for members 21 years of age and over will be covered when medically necessary. In determining whether a crown is medical necessary, the following factors may be considered:

- There is a documented medical condition which precludes extraction.
- The tooth is a critical abutment for an existing or proposed prosthesis.
- If the tooth is a posterior tooth, the following additional factors may be considered:
  - The periodontal status, member compliance and overall status and prognosis of the tooth is favorable.
  - The tooth is not routinely restorable with a filling.
  - There are eight (8) or more natural or prosthetic points of contact present.
  - If the posterior tooth is a molar, treatment of the molar is necessary to maintain functional or balanced occlusion of the patient's dentition.
  - Consideration for a third (3rd) molar will be given if the third (3rd) molar occupies the first (1st) or second (2nd) molar position.
  - Note: Requests for treatment on unopposed molars must include a narrative documenting medical necessity.
- If the tooth is an anterior tooth, the following additional factors may be considered:
  - The periodontal status, member compliance and overall status and prognosis of the tooth is favorable.
  - The tooth is not routinely restorable with a filling

Crowns - Single Restorations Only		
Code	**Description**	
D2710	**Crown – resin-based composite (indirect)** (laboratory) (TOOTH) (PA REQUIRED) Acrylic (processed) jacket crowns may be approved as restorations for severely fractured anterior teeth.	$292.90
D2720	**Crown – resin with high noble metal** (TOOTH) (PA REQUIRED)	$505.00
D2721	**Crown – resin with predominantly base metal** (TOOTH) (PA REQUIRED)	$505.00
D2722	**Crown – resin with noble metal** (TOOTH) (PA REQUIRED)	$505.00
D2740	**Crown – porcelain/ceramic** (TOOTH) (PA REQUIRED)	$505.00
D2750	**Crown – porcelain fused to high noble metal** (TOOTH) (PA REQUIRED)	$505.00
D2751	**Crown – porcelain fused to predominately base metal** (TOOTH) (PA REQUIRED)	$505.00
D2752	**Crown – porcelain fused to noble metal** (TOOTH) (PA REQUIRED)	$505.00
D2753	**Crown – porcelain fused to titanium and titanium alloys** (TOOTH) (PA REQUIRED)	$505.00
D2780	**Crown – ¾ cast high noble metal** (TOOTH) (PA REQUIRED)	$404.00
D2781	**Crown – ¾ cast predominantly base metal** (TOOTH) (PA REQUIRED)	$404.00
D2782	**Crown – ¾ cast noble metal** (TOOTH) (PA REQUIRED)	$404.00
D2790	**Crown – full cast high noble metal** (TOOTH) (PA REQUIRED)	$505.00

D2791	**Crown – full cast predominately base metal** (TOOTH) (PA REQUIRED)	$505.00
D2792	**Crown – full cast noble metal** (TOOTH) (PA REQUIRED)	$505.00
D2794	**Crown – Titanium and titanium alloys**	$505.00

Other Restorative Services
For all prefabricated crowns (**D2930**, **D2931**, **D2932**, **D2933**, **D2934**) there must be supporting documentation substantiating the need for the crown (e.g., radiographic images).

Code	Description	
D2920	**Re-cement or re-bond crown** (TOOTH)	$30.30

Claims for recementation of a crown by the original provider within one year of placement, or claims for subsequent recementations of the same crown, will be pended for professional review. Documentation to justify the need and appropriateness of such recementations may be required as a condition for payment.

Code	Description	
D2930	**Prefabricated stainless steel crown - primary tooth** (TOOTH)	$117.16
D2931	**Prefabricated stainless steel crown - permanent tooth** (TOOTH)	$117.16
D2932	**Prefabricated resin crown** (TOOTH)	$117.16

Must encompass the complete clinical crown and should be utilized with the same criteria as for full crown construction. This procedure is limited to one occurrence per tooth within two years. If replacement becomes necessary during that time, claims submitted will be pended for professional review. To justify the appropriateness of replacements, documentation must be included as a claim attachment. Placement on deciduous anterior teeth is generally not reimbursable past the age of five (5) years of age, unless medically necessary based on the clinical needs of the individual member.

Code	Description	
D2933	**Prefabricated stainless steel crown with resin window** (TOOTH) Restricted to primary anterior teeth, permanent maxillary bicuspids and first molars.	$131.30
D2934	**Prefabricated esthetic coated stainless steel crown – primary tooth** (TOOTH)	$131.30
D2951	**Pin retention - per tooth, in addition to restoration** (TOOTH)	$29.29

IV. Endodontics D3000 – D3999

All radiographic images taken during the course of root canal therapy and all post-treatment radiographic images are included in the fee for the root canal procedure. At least one pre-treatment radiographic image demonstrating the need for the procedure, and one post-treatment radiographic image that demonstrates the result of the treatment, must be maintained in the member's record.

Surgical root canal treatment or apicoectomy may be considered appropriate and covered when the root canal system cannot be acceptably treated non-surgically, there is active root resorption, or access to the canal is obstructed. Treatment may also be covered where there is gross over or under

extension of the root canal filling, periapical or lateral pathosis persists, or there is a fracture of the root.

Pulp capping, either direct or indirect, is not reimbursable.

Root canal therapy for members under the age of 21 will be covered when medically necessary. In determining whether a requested root canal is medically necessary, the following factors may be considered:

- The periodontal status, member compliance and overall status and prognosis of the tooth is favorable.
- The tooth is not routinely restorable with a filling

Root canal therapy for members 21 and over will be covered when medically necessary. In determining whether requested endodontic treatment is medically necessary, the following factors may be considered:

- There is a documented medical condition which precludes an extraction
- The tooth is a critical abutment for an existing or proposed prosthesis
- If the tooth is a ***posterior tooth***, the following additional factors may be considered:
    - The periodontal status, member compliance and overall status and prognosis of the tooth is favorable
    - There are eight or more natural or prosthetic posterior points of contact present
    - If the posterior tooth is a molar, treatment of the molar is necessary to maintain functional or balanced occlusion of the patient's dentition
    - Consideration for a third molar will be given if the third molar occupies the first or second molar position
    - **Note:** Requests for treatment on unopposed molars must include a narrative documenting medical necessity
- If the tooth is an ***anterior tooth***, the following additional factors may be considered:
    - The periodontal status, member compliance and overall status and prognosis of the tooth is favorable

Pulpotomy

Pulpotomy		
Code	**Description**	
D3220	**Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament** (TOOTH)	$87.87

To be performed on primary or permanent teeth **up until the age of 21 years**. This is not to be considered as the first stage of root canal therapy. Pulp capping (placement of protective dressing or cement over exposed or nearly exposed pulp for protection from injury or as an aid in healing and repair) is not reimbursable. This procedure code may not be used when billing for an "emergency pulpotomy", which should be billed as palliative treatment.

Endodontic Therapy on Primary Teeth
Endodontic therapy on primary teeth with succedaneous teeth and placement of resorbable filling. This includes pulpectomy, cleaning, and filling of canals with resorbable material.

	Endodontic Therapy on Primary Teeth	
Code	**Description**	
D3230	**Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)** (TOOTH) (PA REQUIRED)	$151.50
D3240	**Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)** (TOOTH) (PA REQUIRED)	$237.35

Endodontic Therapy (Including Treatment Plan, Clinical Procedures, and Follow-Up Care)
Includes primary teeth without succedaneous teeth and permanent teeth.

	Endodontic Therapy	
Code	**Description**	
D3310	**Endodontic therapy – anterior tooth (excluding final restoration)** (TOOTH) (PA REQUIRED)	$252.50
D3320	**Endodontic therapy – premolar tooth (excluding final restoration)** (TOOTH) (PA REQUIRED)	$303.00
D3330	**Endodontic therapy – molar tooth (excluding final restoration)** (TOOTH) (PA REQUIRED)	$404.00

Endodontic Retreatment

	Endodontic Retreatment	
Code	**Description**	
D3346	**Retreatment of previous root canal therapy – anterior** (TOOTH) (PA REQUIRED)	$252.50
D3347	**Retreatment of previous root canal therapy – premolar** (TOOTH) (PA REQUIRED)	$303.00
D3348	**Retreatment of previous root canal therapy – molar** (TOOTH) (PA REQUIRED)	$404.00

Apexification / Recalcification Procedures

	Apexification / Recalcification Procedures	
Code	**Description**	
D3351	**Apexification / recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)** (TOOTH) *Includes opening tooth, pulpectomy, preparation of canal spaces, first placement of medication and necessary radiographic images. (This procedure includes first phase of complete root canal therapy.)*	$82.82
D3352	**Apexification / recalcification - interim medication replacement** (TOOTH) *For visits in which the intra-canal medication is replaced with new medication. Includes any necessary radiographs. There may be several of these visits. The published fee is the maximum reimbursable amount regardless of the number of visits.*	$80.80
D3353	**Apexification / recalcification - final visit (include completed root canal therapy – apical closure/calcific repair of perforations, root**	$104.03

	resorption, etc.) (TOOTH) *Includes the removal of intra-canal medication and procedures necessary to place final root canal filling material including necessary radiographs. (This procedure includes last phase of complete root canal therapy.)*	

Apicoectomy
Periradicular surgery is a term used to describe surgery to the root surface (e.g., apicoectomy), repair of a root perforation or resorptive defect, exploratory curettage to look for root fractures, removal of extruded filling materials or instruments, removal of broken root fragments, sealing of accessory canals, etc. This does not include retrograde filling material placement. Performed as a separate surgical procedure and includes periapical curettage.

	Apicoectomy	
Code	**Description**	
D3410	**Apicoectomy - anterior** (TOOTH) (PA REQUIRED)	$161.60
D3421	**Apicoectomy - premolar (first root)** (TOOTH) (PA REQUIRED) If more than one root is treated, see D3426	$161.60
D3425	**Apicoectomy - molar (first root)** (TOOTH) (PA REQUIRED) If more than one root is treated, see D3426	$181.80
D3426	**Apicoectomy (each additional root)** (TOOTH) (PA REQUIRED)	$60.60
D3430	**Retrograde filling - per root** (TOOTH) (PA REQUIRED)	$50.50

Other Endodontic Procedures

Code	Description	
D3999	**Unspecified endodontic procedure, by report** (Report Needed)	(BR)

V. Periodontics D4000-D4999

Surgical Services (Including Usual Post-Operative Care)
D4210 and **D4211** are reimbursable solely for the correction of severe hyperplasia or hypertrophy associated with drug therapy, hormonal disturbances or congenital defects.

- The provider must keep in the treatment record detailed documentation describing the need for gingivectomy or gingivoplasty including pretreatment photographs depicting the condition of the tissues.

Clinical Crown Lengthening- hard tissue		
Code	**Description**	
D4249	**Clinical Crown Lengthening – hard tissue** (PA REQUIRED)	$75.00

- Crown lengthening requires reflection of a full thickness flap and removal of bone, altering the crown to root ratio.
- The periodontal status, member compliance, and overall status and prognosis of the tooth may be taken into consideration when determining medical necessity.

- Crown lengthening is reimbursable solely when associated with medically necessary crown or root canal procedure.
- All requests for coverage of a crown lengthening should include a complete treatment plan addressing all areas of pathology. The provider must keep in the treatment record detailed documentation describing the need for crown lengthening including pretreatment photographs depicting the condition of the tissues.
- Coverage of a crown lengthening should be requested at the same time as a request for coverage of a crown and/or a root canal.
- If the need for crown lengthening is discovered during a procedure, then providers should refer to Prior Approval Change Request information on page 18.

VI. Prosthodontics

Full and/or partial dentures are covered by Medicaid **when they are determined to be medically necessary**, including when necessary to alleviate a serious condition or one that is determined to affect employability. This service requires prior approval.

Complete dentures and partial dentures, whether unserviceable, lost, stolen, or broken will not be replaced for a minimum of eight (8) years from initial placement except when determined to be medically necessary by the Department or its agent. Prior approval requests for replacement dentures prior to eight (8) years must include a completed Justification of Need for Replacement Prosthesis form signed by the patient's dentist, explaining the specific circumstances that necessitates replacement of the denture. If replacement dentures are requested within the eight (8) year period after they have already been replaced once, then the dentist's supporting documentation must include an explanation of preventative measures instituted to alleviate the need for further replacements.

General Guidelines for All Removable Prosthesis:

- Requests for partial dentures will be reviewed based on the presence/absence of eight (8) points of natural or prosthetic posterior occlusal contact and/or one (1) missing maxillary anterior or two (2) missing mandibular teeth.
- Complete and/or partial dentures will be approved only when the existing prosthesis is not serviceable and cannot be relined or rebased. Reline or rebase of an existing prosthesis will not be reimbursed when such procedures are performed in addition to a new prosthesis for the same arch within six (6) months of the delivery of a new prosthesis. Only "tissue conditioning" (**D5850** or **D5851**) is payable within six (6) months prior to the delivery of new prosthesis.
- Six (6) months of post-delivery care from the date of insertion is included in the reimbursement for all newly fabricated prosthetic appliances. This included rebasing, relining, adjustments, and repairs.
- Cleaning of removable prosthesis or soft tissue not directly related to natural teeth or implants is not a covered service. Prophylaxis and/or scaling and root planning is only payable when performed on natural dentition.
- "Immediate" prosthetic appliances are not a covered service. An appropriate length of time for healing should be allowed before taking final impressions. Generally, it is expected that tissue will need a minimum of four (4) to six (6) weeks for healing. Claims for denture insertion occurring within four (4) weeks of extraction(s) will pend for professional review.
- Claims are not to be submitted until the denture(s) are completed and delivered to the member. The "date of service" used on the claim is the date that the denture(s) are delivered. If the prosthesis cannot be delivered or the member has lost eligibility following the date of the "decisive appointment" claims should be submitted following the guidelines for "Interrupted Treatment".

- Medicaid payment is considered payment in-full. Except for members with a “spend down,” members cannot be charged beyond the Medicaid fee. Deposits, down-payments, or advance payments are prohibited.
- All treatment notes, radiographic images, laboratory prescriptions and laboratory invoices should be made part of the member's treatment record to be made available upon request in support of any treatment provided, and;
- The total cost of repairs should not be excessive and should not exceed 50% of the cost of a new prosthesis. If the total cost of repairs and/or relines is to exceed 50% of the cost of a new prosthesis, a prior approval request for a new prosthesis should be submitted with a detailed description of the existing prosthesis including why any replacement would be necessary per Medicaid guidelines and would be more appropriate than repair of the existing prosthesis.

Complete Dentures (Including Routine Post-Delivery Care)
Radiographs are not routinely required to obtain prior approval for full dentures. The guidelines published by the ADA and the U.S. Department of Health and Human Services on the use of x-rays should be followed. Additional information is found here: The Selection of Patients for Dental Radiographic Examinations | FDA.

Complete Dentures (Including Routine Post-Delivery Care)		
Code	**Description**	
D5110	**Complete denture – maxillary** (PA REQUIRED)	$565.60
D5120	**Complete denture – mandibular** (PA REQUIRED)	$565.60

Partial Dentures (Including Routine Post-Delivery Care)
Caries index, periodontal status, recipient compliance, dental history, medical history and the **overall status and prognosis of the entire dentition**, among other factors, will be taken into consideration when determining medical necessity. Scope of Program and Non-Reimbursable Services and Essential Services in Sections II and III of the NYS Medicaid Dental Policy and Procedure Code Manual.

Requirements for the placement of partial dentures are:

- All phase I restorative treatment which includes extractions, removal of all decay and restoration with permanent filling materials, endodontic therapy, crowns, etc. must be completed prior to taking the final impressions(s) or partial dentures(s).
- Partial dentures can be considered for ages 15 years and above; an “Interim Prosthesis” (procedure codes D5820 and/or D5821) can be considered for individuals 5 to 15 years of age.

Partial Dentures (Including Routine Post-Delivery Care)		
Code	**Description**	
D5211	**Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)** (PA REQUIRED)	$353.50
D5212	**Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)** (PA REQUIRED)	$353.50
D5213	**Maxillary partial denture – cast metal framework with resin denture base (including retentive/clasping materials, rests, and teeth)** (PA REQUIRED)	$565.60

D5214	**Mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)** (PA REQUIRED)	$565.60
D5225	**Maxillary partial denture – flexible base (including retentive/clasping materials, rests and teeth)** (PA REQUIRED)	$565.60
D5226	**Mandibular partial denture – flexible base (including retentive/clasping materials, rests, and teeth)** (PA REQUIRED)	$565.60

Adjustments to Dentures
Adjustments within six months of the delivery of the prosthesis are considered part of the payment for the prosthesis. Adjustments (procedure codes **D5410**, **D5411**, **D5421**, and **D5422**) are not reimbursable on the same date of service as the initial insertion of the prosthetic appliance OR; on the same date of service as any repair, rebase, or reline procedure code.

Adjustments to Dentures		
Code	**Description**	
D5410	**Adjust complete denture – maxillary**	$25.25
D5411	**Adjust complete denture – mandibular**	$25.25
D5421	**Adjust partial denture – maxillary**	$25.25
D5422	**Adjust partial denture – mandibular**	$25.25

Prosthetic Appliance Repairs
Limitation: The total cost of repairs should not be excessive and should not exceed 50% of the cost of a new prosthesis. If the total cost of repairs is to exceed 50% of the cost of a new prosthesis, a prior approval request for a new prosthesis should be submitted with a detailed description of the existing prosthesis and why any replacement would be necessary per Medicaid guidelines and would be more appropriate than repair of the existing prosthesis.

Repairs to Complete Dentures		
Code	**Description**	
D5511	**Repair broken complete denture base, mandibular**	$65.65
D5512	**Repair broken complete denture base, maxillary**	$65.65
D5520	**Replace missing or broken teeth – complete denture (each tooth)** (TOOTH)	$42.42

Repairs to Partial Dentures		
Code	**Description**	
D5611	**Repair resin partial denture base, mandibular**	$67.67
D5612	**Repair resin partial denture base, maxillary**	$67.67
D5621	**Repair cast partial framework, mandibular**	$121.20
D5622	**Repair cast partial framework, maxillary**	$121.20
D5630	**Repair or replace broken retentive/clasping materials-per tooth** (TOOTH)	$131.30
D5640	**Replace broken teeth-per tooth** (TOOTH)	$60.60

D5650	**Add tooth to existing partial denture** (TOOTH)	$65.65
D5660	**Add clasp to existing partial denture-per tooth** (TOOTH)	$103.02

Denture Rebase Procedures
Rebase procedures are not payable within six months prior to the delivery of a new prosthesis. Only "tissue conditioning" (**D5850** and **D5851**) is payable within six months prior to the delivery of a new prosthesis.

Repairs to Complete Dentures		
Code	**Description**	
D5710	**Rebase - complete maxillary denture** (PA REQUIRED)	$171.70
D5711	**Rebase - complete mandibular denture** (PA REQUIRED)	$171.70
D5720	**Rebase – maxillary partial denture** (PA REQUIRED)	$175.74
D5721	**Rebase – mandibular partial denture** (PA REQUIRED)	$175.74

Denture Reline Procedures
Reline procedures are not payable within six months prior to the delivery of a new prosthesis. For cases in which it is impractical to complete a laboratory reline, prior approval for an office ("chairside" or "cold cure") reline may be requested with credible documentation which would preclude a laboratory reline. Only "tissue conditioning" (D5850 and D5851) is payable within six months prior to the delivery of a new prosthesis.

Denture Reline Procedures		
Code	**Description**	
D5730	**Reline complete maxillary denture (direct)** (PA REQUIRED)	$126.25
D5731	**Reline complete mandibular denture (direct)** (PA REQUIRED)	$126.25
D5740	**Reline maxillary partial denture (direct)** (PA REQUIRED)	$85.85
D5741	**Reline mandibular partial denture (direct)** (PA REQUIRED)	$85.85
D5750	**Reline complete maxillary denture (indirect)**	$171.70
D5751	**Reline complete mandibular denture (indirect)**	$171.70
D5760	**Reline maxillary partial denture (indirect)**	$126.25
D5761	**Reline mandibular partial denture (indirect)**	$126.25

Interim Prosthesis
Reimbursement is limited to once per year and only for children between 5 and 15 years of age. Codes **D5820** and **D5821** are not to be used in lieu of space maintainers. All claims will be pended for professional review prior to payment.

Interim Prosthesis		
Code	**Description**	
D5820	**Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary**	$175.74
D5821	**Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular**	$175.74

Other Removable Prosthetic Services
Codes **D5850** and **D5851** are for treatment reline using materials designed to heal unhealthy ridges prior to more definitive final restoration. This is the **ONLY** type of reline reimbursable within six (6) months prior to the delivery of a new prosthesis. Insertion of tissue conditioning liners in existing dentures will be limited to once per denture unit. D5850 and D5851 are not reimbursable under age 15 and should be billed one time at the completion of treatment, regardless of the number of visits involved.

Other Removable Prosthetic Services		
Code	**Description**	
D5850	**Tissue conditioning, maxillary**	$25.25
D5851	**Tissue conditioning, mandibular**	$25.25
D5899	**Unspecified removable prosthodontic procedure, by report** (REPORT NEEDED)	(BR)

VIII. Implant Services D6000 - D6199

Dental implants, including single implants, and implant related services, will be covered by Medicaid when medically necessary. Prior approval requests for implants must have supporting documentation from the patient's dentist. The patient's dentist's office must submit a completed Evaluation of the Dental Implant Patient form documenting, among other things, the patient's medical history, current medical conditions being treated, list of all medications currently being taken by the patient, explaining why implants are medically necessary and why other covered functional alternatives for prosthetic replacement will not correct the patient's dental condition, and certifying that the patient is an appropriate candidate for implant placement. If the patient's dentist indicates that the patient is currently being treated for a serious medical condition, the Department may request further documentation from the patient's treating physician.

General Guidelines:

- The dentist's explanation as to why other covered functional alternatives for prosthetic replacement will not correct the patient's dental condition will be reviewed based on the presence/absence of eight (8) points of natural or prosthetic posterior occlusal contact and/or one (1) missing maxillary anterior or two (2) missing mandibular teeth.
- A complete treatment plan addressing all phases of care is required and should include the following:
    - Accurate pretreatment charting;
    - Complete treatment plan addressing all areas of pathology;
    - Inter-arch distances;
    - Number, type and location of implants to be placed;
    - Design and type of planned restoration(s);

    - Sufficient number of current, diagnostic radiographs and/or CT scans allowing for the evaluation of the entire dentition.
- If bone graft augmentation is needed there must be a 4 to 6-month healing period before a dental implant can be placed
- Dental implant code D6010 will be re-evaluated via intraoral radiographs or CT scans prior to the authorization of abutments, crowns, or dentures four to six months after dental implant placement.
- Treatment on an existing implant / implant prosthetic will be evaluated on a case- by-case basis.
- Implant and implant related codes not listed will be considered on a case-by-case basis.
- Documentation must include a list of all medications currently being taken and all conditions currently being treated.
- All cases will be considered based upon supporting documentation and current standard of care.

For procedure codes **D6010** and **D6013** the following must be submitted:
- Full mouth radiographs or a diagnostic panorex including periapicals of site requesting dental implant(s).

	Implant Services	
Code	**Description**	
D6010	**Surgical placement of implant body** (TOOTH) (PA REQUIRED) POST OPERATIVE CARE: 90 DAYS) Full mouth radiographs or diagnostic panorex including periapicals of site requesting dental implant(s) must be provided.	$1010.00
D6013	**Surgical placement of mini implant** (TOOTH) (PA REQUIRED) (POST OPERATIVE CARE: 90 DAYS) Full mouth radiographs or diagnostic panorex including periapicals of site requesting dental implant(s) must be provided.	$505.00

For procedure codes **D6055-D6057** the following must be submitted:
- Periapical radiograph of the integrated implant(s), and,
- Panorex of sufficient number of radiographs showing the complete arch and the placed implant(s)

Code	**Description**	
D6055	**Connecting bar – implant supported or abutment supported** (ARCH) (PA REQUIRED)	$404.00
D6056	**Prefabricated abutment – includes modification and placement** (TOOTH) (PA REQUIRED)	$404.00
D6057	**Custom fabricated abutment – includes placement**	$404.00

For procedure codes **D6058** – **D6067**, **D6094** the following must be submitted:
- Periapical radiograph of integrated implant with abutment
- Intra-oral photograph of healed abutment showing healthy gingiva

Code	**Description**	
D6058	**Abutment supported porcelain/ceramic crown** (TOOTH) (PA REQUIRED)	$808.00

D6059	**Abutment supported porcelain fused to metal crown (high noble metal)** (TOOTH) (PA REQUIRED)	$808.00
D6060	**Abutment supported porcelain fused to metal crown (predominantly base metal)** (TOOTH) (PA REQUIRED)	$808.00
D6061	**Abutment supported porcelain fused to metal crown (noble metal)** (TOOTH) (PA REQUIRED)	$808.00
D6062	**Abutment supported cast metal crown (high noble metal)** (TOOTH) (PA REQUIRED)	$808.00
D6063	**Abutment supported cast metal crown (predominately base metal)** (TOOTH) (PA REQUIRED)	$808.00
D6064	**Abutment supported cast metal crown (noble metal)** (TOOTH) (PA REQUIRED)	$808.00
D6065	**Implant supported porcelain/ceramic crown** (TOOTH) (PA REQUIRED)	$808.00
D6066	**Implant supported crown - porcelain fused to high noble alloys** (TOOTH) (PA REQUIRED)	$808.00
D6067	**Implant supported crown - high noble alloys** (TOOTH) (PA REQUIRED)	$808.00
D6081	**Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning on the implant surfaces without flap entry and closure** (TOOTH) (REPORT NEEDED) • Cannot bill for same date of service as D1110 or D4910. • Cannot bill for same date of service and same quadrant as D4341, D4342.	(BR)
D6090	**Repair implant supported prosthesis (ARCH) (REPORT NEEDED)**	(BR)
D6091	**Replacement of replaceable part of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment** (QUAD) (REPORT NEEDED)	(BR)
D6092	**Re-cement or re-bond implant/abutment supported crown** (TOOTH) (REPORT NEEDED)	(BR)
D6093	**Re-cement or re-bond implant/abutment supported fixed partial denture** (QUAD) (REPORT NEEDED)	(BR)
D6094	**Abutment supported crown – titanium and titanium alloys** (TOOTH) (PA REQUIRED)	$808.00
D6095	**Repair implant abutment** (TOOTH) (REPORT NEEDED)	(BR)
D6096	**Remove broken implant retaining screw** (TOOTH) (REPORT NEEDED)	(BR)
D6100	**Surgical Removal of Implant Body** (TOOTH) (REPORT NEEDED) (POST OPERATIVE CARE: 10 DAYS)	(BR)

For procedure codes **D6101** – **D6103** the following must be submitted:

- Pre-operative radiographic image of defect
- Detailed narrative
  Intra-oral photograph of defect area

Code	Description	
D6101	**Debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure** (TOOTH) (PA REQUIRED) (POST OPERATIVE CARE: 30 DAYS)	$252.50

D6102	**Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure** (TOOTH) (PA REQUIRED) (POST OPERATIVE CARE: 30 DAYS)	$404.00
D6103	**Bone graft for repair of peri-implant defect – does not include flap entry and closure** (TOOTH) (PA REQUIRED) (POST OPERATIVE CARE: 30 DAYS)	$202.00
D6104	**Bone graft at time of implant placement** (TOOTH) (PA REQUIRED) (POST OPERATIVE CARE: 90 DAYS)	$252.50

For procedure codes **D6110** – **D6113** the following must be submitted:

- Periapical radiograph of integrated implant(s) with abutment placed
- IO photo of healed abutment showing healthy gingiva

Code	Description	
D6110	**Implant/abutment supported removable denture for edentulous arch – maxillary** (PA REQUIRED)	$1010.00
D6111	**Implant/abutment supported removable denture for edentulous arch – mandibular** (PA REQUIRED)	$1010.00
D6112	**Implant/abutment supported removable denture for partially edentulous arch – maxillary** (PA REQUIRED)	$909.00
D6113	**Implant/abutment supported removable denture for partially edentulous arch – mandibular** (PA REQUIRED)	$909.00
D6190	**Radiographic/surgical implant index, by report** (ARCH) (REPORT NEEDED)	(BR)
D6191	**Semi-precision abutment - placement** (TOOTH) (PA REQUIRED) This procedure is the initial placement, or replacement, or a semi-precision abutment on the implant body.	$202.00
D6192	**Semi-precision attachment – placement** (TOOTH) (PA REQUIRED) This procedure involves the luting of the initial, or replacement, semi-precision Attachment to the removable prosthesis	$50.50
D6199	**Unspecified implant procedure, by report** (REPORT NEEDED) The following procedure codes are a covered benefit only when associated with an implant or an implant-related service **D4245**, **D4266**, **D4267**, **D4273**, **D4278**, **D4283**, **D4285**	(BR)

Code	Description	
D4245	**Apically positioned flap** (TOOTH (PA REQUIRED) (POST OPERATIVE CARE: 14 DAYS) Procedure is used to preserve keratinized gingiva in conjunction with osseous resection and second stage implant procedure. Procedure may also be used to preserve keratinized/attached gingiva during surgical exposure of labially impacted teeth and may be used during treatment of peri-implantitis.	$126.25
D4266	**Guided tissue regeneration – resorbable barrier, per site** (TOOTH) (PA REQUIRED) (POST OPERATIVE CARE: 14 DAYS) This procedure does not include flap entry and closure, or, when indicated, wound debridement, osseous contouring, bone replacement grafts, and placement of biologic materials to aid in osseous regeneration. This procedure can be used for periodontal defects around natural teeth.	$126.25
D4267	**Guided tissue regeneration – non-resorbable barrier, per site (includes membrane removal)** (TOOTH) (PA REQUIRED) (POST OPERATIVE CARE:	$151.50

	14 DAYS) This procedure does not include flap entry and closure, or, when indicated, wound debridement, osseous contouring, bone replacement grafts, and placement of biologic materials to aid in osseous regeneration. This procedure can be used for periodontal defects around natural teeth.	
D4273	**Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant or edentulous tooth position in graft** (TOOTH) (PA REQUIRED) (POST OPERATIVE CARE: 14 DAYS) There are two surgical sites. The recipient site utilizes a split thickness incision, retaining the overlapping flap of gingiva and/or mucosa. The connective tissue is dissected from a separate donor site leaving an epithelialized flap for closure	$303.00
D4275	**Non-autogenous connective tissue graft (including recipient site and donor material) – first tooth, implant, or edentulous tooth position in graft** (TOOTH) (PA REQUIRED) (POST OPERATIVE CARE: 14 DAYS)	$404.00
D4277	**Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft** (TOOTH) (PA REQUIRED) (POST OPERATIVE CARE: 14 DAYS) There is only a recipient surgical site utilizing split thickness incision, retaining the overlaying flap of gingiva and/or mucosa. A donor surgical site is not present.	$404.00
D4278	**Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site** (TOOTH) (PA REQUIRED) (POST OPERATIVE CARE: 14 DAYS) Used in conjunction with **D4277**	$303.00
D4283	**Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site** (TOOTH) (PA REQUIRED) (POST OPERATIVE CARE: 14 DAYS) Used in conjunction with **D4273**.	$202.00
D4285	**Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site.** (TOOTH) (PA REQUIRED) (POST OPERATIVE CARE: 14 DAYS) Used in conjunction with **D4275**.	$303.00

The following procedure codes are a covered benefit only when associated with an implant or an implant-related service: **D7951**, **D7952**, **D7953**.

Code	Description	
D7951	**Sinus augmentation with bone or bone substitutes via a lateral open approach** (QUAD) (PA REQUIRED) (POST OPERATIVE CARE: 14 DAYS) The augmentation of the sinus cavity to increase alveolar height for reconstruction of edentulous portions of the maxilla. This procedure is performed via a lateral open approach. This includes obtaining the bone or bone substitutes. Placement of a barrier membrane if used should be reported separately	$808.00
D7952	**Sinus augmentation with bone or bone substitutes via a vertical approach** (QUAD) (PA REQUIRED) (POST OPERATIVE CARE: 14 DAYS) The augmentation of the sinus to increase alveolar height by vertical access through the ridge crest by raising the floor of the sinus and grafting as necessary. This includes obtaining the bone or bone substitutes	$808.00

D7953	**Bone replacement graft for ridge preservation – per site** (TOOTH) (PA REQUIRED) (POST OPERATIVE CARE: 10 DAYS) Graft is placed in an extraction or implant removal site at the time of extraction or removal to preserve ridge integrity (e.g., clinically indicated in preparation for implant reconstruction or where alveolar contour is critical to planned prosthetic reconstruction) Does not include obtaining graft material. Membrane if used should be reported separately.	$252.50