Staywell FL Child Medicaid Plan Benefits

The following is a <u>complete</u> list of the dental procedures for which benefits are payable under this Plan. Non-listed procedures are not covered. This Plan does not allow alternate benefits. Members must visit a contracted provider to utilize covered benefits. <u>If elected, Member is responsible for non-covered service.</u>

CODE	DESCRIPTION	LIMITATIONS	AUTH REQ	DOCUMENTATION/X-RAYS REQ.
Diagnostic Services				
D0120	Periodic Oral Evaluation, Established Patient	1 D0120 or D0145 per 6 months	N	
D0140	Limited Oral Evaluation, Problem Focused		N	
D0145	Oral Evaluation For Patient Under 3 Years Of Age	1 D0120 or D0145 per 6 months	N	
D0150	Comprehensive Oral Evaluation	1 per 36 months per provider	N	
D0210	Full Mouth X-Ray	1 complete series x-rays or panoramic image per 36 months	N	
D0220	Periapical, First Image		N	
D0230	Periapical, Each Additional Image	Payable up to 5 units per date of service	N	
D0240	Intraoral, Occlusal Image	Payable up to 2 units per date of service	N	
D0250	Extraoral, First Image		N	
D0260	Extraoral, Each Additional Image		N	
D0270	Bitewing, Single Image	1 series per 6 months	N	
D0272	Bitewings, Two Images		N	
D0274	Bitewings, Four Images		N	
D0290	Posterior – Anterior Or Lateral Skill & Facial Bone Survey Image		N	
D0330	Panoramic Image	1 complete series x-rays or panoramic image per 36 months	N	
D0340	Cephalometric Image	In conjunction with orthodontic coverage	N	
D0350	Oral/Facial Photographic Images	1 unit per day, only when diagnostic-quality radiographic images cannot be taken	N	
D0470	Diagnostic Casts	In conjunction with orthodontic coverage	N	
Preventive Services				
D1110	Prophylaxis, Adult	1 per 6 months	N	
D1120	Prophylaxis, Child		N	
D1206	Topical Application of Fluoride Varnish	1 per 3 months age 0-3 1 per 6 months age 4 and above	N	
D1208	Topical Application Of Fluoride		N	
D1330	Oral Hygiene Instructions	1 per 6 months	N	
D1351	Sealant, Per Tooth	1 per tooth per 36 months Limited to 1st & 2nd molar only	N	

CODE	DESCRIPTION	LIMITATIONS	AUTH REQ	DOCUMENTATION/X-RAYS REQ.
Preventive Services (Continued)				
D1510	Space Maintainer, Fixed, Unilateral		N	Narrative required w/ submission of claim May be reimbursed for necessary maintance of a posterior space for a permanent successor to a prematurely lost deciduous tooth. Subject to pre-payment review.
D1515	Space Maintainer, Fixed, Bilateral			
D1550	Re-Cementation Of Space Maintainer			
Restorative Services				
D2140	Amalgam, One Surface	1 per surface per tooth per 36 month period (includes D2140-D2335 and D2391-D2394)	N	
D2150	Amalgam, Two Surfaces			
D2160	Amalgam, Three Surfaces			
D2161	Amalgam, Four Or More Surfaces			
D2330	Resin-Based Composite, One Surface, Anterior			
D2331	Resin-Based Composite, Two Surfaces, Anterior			
D2332	Resin-Based Composite, Three Surfaces, Anterior			
D2335	Resin-Based Composite, Four Or More Surfaces Anterior			
D2390	Resin-Based Composite Crown, Anterior	1 per tooth per 36 months	see documentation	children 6 and older require pre-authorization
D2391	Resin- Based Composite, One Surface, Posterior	1 per surface per tooth per 36 month period (includes D2140-D2335 and D2391-D2394)	N	
D2392	Resin-Based Composite, Two Surfaces, Posterior			
D2393	Resin-Based Composite, Three Surfaces, Posterior			
D2394	Resin-Based Composite, Four Surfaces, Posterior			
Crown & Crown Repair Services				
D2710	Crown, Resin Based Composite (Indirect)	Crowns are covered only if the tooth cannot be restored with an amalgam or resin restoration	Y	Pre-authorization, x-rays, and narrative required
D2721	Crown, Resin With Predominantly Base Metal			
D2740	Crown, Porcelain/Ceramic Substrate			
D2751	Crown, Porcelain Fused To Predominantly Base Metal			
D2920	Recement Crown	Not payable within 6 months of initial placement	N	

CODE	DESCRIPTION	LIMITATIONS	AUTH REQ	DOCUMENTATION/X-RAYS REQ.
Crown & Crown Repair Services (Continued)				
D2930	Prefabricated Stainless Steel Crown, Primary Tooth		see documentation	Pre-Authorization is required for members age 6 and over.
D2931	Prefabricated Stainless Steel Crown, Permanent Tooth			
D2932	Prefabricated Resin Crown			
D2933	Prefabricated Stainless Steel Crown With Resin Window			
D2940	Protective Restoration	Not payable in conjunction with other restorative procedures on the same tooth	N	
D2950	Core Buildup, Including Any Pins When Required		N	Considered inclusive with crown. Separate fee may be allowed when submitted with supporting documentation
D2951	Pin Retention, Per Tooth, In Addition To Restoration		N	
D2954	Prefabricated Post & Core In Addition To Crown		N	
Endodontic Services				
D3110	Pulp Cap, Direct (Excluding Final Restoration)		N	X-rays required. Subject to pre -payment review
D3120	Pulp Cap, Indirect (Excluding Final Restoration)			
D3220	Therapeutic Pulpotomy (Excluding Final Restoration)			
D3221	Pulpal Debridement, Primary & Permanent Teeth			
D3222	Partial Pulpotomy for Apexogenesis, Permanent Tooth with incomplete root development		N	Pre and Post operative x-rays required. Subject to pre -payment review.
D3230	Pulpal Therapy (Resorbable Filling), Anterior, Primary Tooth (Excluding Final Restoration)		N	X-rays required. Subject to pre -payment review
D3240	Pulpal Therapy (Resorbable Filling) Posterior, Primary Tooth, (Excluding Final Restoration)			
D3310	Endodontic Therapy, Anterior		N	Requires good restorative and periodontal prognosis. Pre and Post operative x-rays required. Subject to pre -payment review.
D3320	Endodontic Therapy, Bicuspid			
D3330	Endodontic Therapy, Molar			

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Endodontic Services (Continued)				
D3331	Treatment Of Root Canal Obstruction; Non-Surgical Access		N	Requires good restorative and periodontal prognosis. Pre and Post operative x-rays required. Subject to pre - payment review.
D3333	Internal Root Repair Of Perforation Defects			
D3351	Apexification/Recalcification, Initial Visit (Apical Closure/Calcific Repair of Perforations, Etc.)			
D3352	Apexification/Recalcification, Interim Medication Replacement			
D3353	Apexification/Recalcification, Final Visit (Includes Completed Root Canal Therapy, Apical Closure/Calcific Repair of Perforations, Etc.)			
D3410	Apicoectomy, Anterior			
D3430	Retrograde Filling, Per Root			
Periodontal Services				
D4210	Gingivectomy/Gingivoplasty 4+ Teeth Per Quad	1 Per quad per 36 month period. Maximum 2 quads per date of service.	Y	Pre-authorization and x-rays required
D4211	Gingivectomy/Gingivoplasty 1-3 Teeth Per Quad			
D4240	Gingival Flap Procedure 4+ Teeth Per Quad	1 Per quad per 36 month period. Maximum 2 quads per date of service.		
D4241	Gingival Flap Procedure 1-3 Teeth Per Quad			
D4260	Osseous Surgery 4+ Teeth Site/Quad	1 Per quad per 36 month period. Maximum 2 quads per date of service.		
D4261	Osseous Surgery 1-3 Teeth Site/Quad			
D4341	Periodontal Scaling And Root Planing 4+/Quad	1 Per quad per 36 month period. Maximum 2 quads per date of service.		
D4342	Periodontal Scaling And Root Planing 1-3 Per Quad			
D4355	Full Mouth Debridement	1 per 24 month period	N	Narrative required w/ submission of claim. Subject opt pre-payment review.
Removable Prosthodontic Services				
D5110	Complete Denture, Maxillary	1 per arch per lifetime-with exception	Y	Pre-authorization and x-rays required
D5120	Complete Denture, Mandibular			
D5211	Maxillary Partial Denture, Resin Base	1 per arch per lifetime	Y	Pre-authorization and x-rays required
D5212	Mandibular Partial Denture, Resin Base			
D5213	Maxillary Partial Denture, Cast Metal Framework			
D5214	Mandibular Partial Denture, Cast Metal Framework			
D5410	Adjust Complete Denture, Maxillary	1 per arch per 12 month period	N	Narrative required w/ claim submission No additional payment is allowed within 6 months of delivery date
D5411	Adjust Complete Denture, Mandibular			
D5421	Adjust Partial Denture, Maxillary			
D5422	Adjust Partial Denture, Mandibular			
D5510	Repair Broken Complete Denture Base			
D5520	Replace Missing Or Broken Teeth, Complete Denture			

CODE	DESCRIPTION	LIMITATIONS	AUTH REQ	DOCUMENTATION/X-RAYS REQ.
Removable Prosthodontic Services (Continued)				
D5610	Repair Resin Denture Base, Partial Denture		N	Narrative required w/ claim submission No additional payment is allowed within 6 months of delivery date
D5620	Repair Cast Framework, Partial Denture			
D5630	Repair Or Replace Broken Clasp, Partial Denture			
D5640	Replace Broken Teeth, Partial Denture			
D5650	Add Tooth To Existing Partial Denture			
D5660	Add Clasp To Existing Partial Denture			
D5730	Reline Complete Maxillary Denture (Chairside)	1 per arch per 12 month period	N	Narrative required w/ claim submission No additional payment is allowed within 6 months of delivery date
D5731	Reline Complete Mandibular Denture (Chairside)			
D5740	Reline Maxillary Partial Denture (Chairside)			
D5741	Reline Mandibular Partial Denture (Chairside)			
D5750	Reline Complete Maxillary Denture (Laboratory)			
D5751	Reline Complete Mandibular Denture (Laboratory)			
D5760	Reline Maxillary Partial Denture (Laboratory)			
D5761	Reline Mandibular Partial Denture (Laboratory)			
D5820	Interim Partial Denture (Maxillary)	1 per lifetime	Y	Pre-authorization with x-rays and narrative required
D5899	Unspecified Removable Prosthodontic Procedure, By Report		Y	Pre-Authorization and narrative of medical necessity required
Fixed Prosthodontic Services				
D6985	Pediatric Partial Denture, Fixed	1 per lifetime	Y	Pre-authorization with x-rays and narrative of medical necessity required
Oral & Maxillofacial Services				
D7111	Extractions, Coronal Remnants, Deciduous Tooth	Prophlactic extractions of asymptomatic impacted or erupted teeth is not a covered benefit	Yes, for 3rd molar extractions	Third Molar Extractions require Pre-Treatment Approval. All other non-third molar extractions require post-treatment radiographs submission with claim.
D7140	Extraction, Erupted Tooth/Exposed Root			
D7210	Surgical Removal Of Erupted Tooth			
D7220	Removal Of Impacted Tooth, Soft Tissue			
D7230	Removal Of Impacted Tooth, Partially Bony			
D7240	Removal Of Impacted Tooth, Complete Bony			
D7241	Removal Of Impacted Tooth, Complete Bony Complicated			
D7250	Surgical Removal Residual Tooth Roots		N	

CODE	DESCRIPTION	LIMITATIONS	AUTH REQ	DOCUMENTATION/X-RAYS REQ.
D7260	Oroantral Fistula Closure		N	Narrative required w/ submission of claim
D7261	Primary Closure Of A Sinus Perforation			
D7270	Tooth Reimplantation And/Or Stabilization			
Oral & Maxillofacial Services (Continued)				
D7280	Surgical Access Of An Unerupted Tooth		Y	Pre-authorization and narrative of medical necessity required
D7283	Placement Of Device To Facilitate Eruption Of Impacted Tooth		Y	Pre-authorization, x-rays and narrative required
D7310	Alveoloplasty In Conjunction With Extractions 4+ Teeth Per Quad		Y	
D7320	Alveoloplasty Not In Conjunction With Extractions 4+ Teeth Per Quad		Y	
D7510	Incision & Drainage Of Abscess, Intraoral Soft Tissue		N	Not payable on same day as extraction
D7520	Incision & Drainage Of Abscess, Extraoral Soft Tissue		N	
D7880	Occlusal Orthotic Device, By Report		N	Narrative required w/ submission of claim
D7970	Excision Of Hyperplastic Tissue, Per Arch		Y	Pre-authorization, x-rays, photo and periodontal charting required
D7999	Unspecified Oral Surgery Procedure, By Report		Y	Pre-authorization, x-rays and narrative required
Orthodontic Services				
Prior Authorization including Medicaid Orthodontic Initial Accessment Form (AIF), study models, cephalometric and panoramic film is required for all orthodocntic services. A maximun of five (5) broken brackets will be considered covered as part of the orthodontic coverage with no additional payment to the provider. If the member exceeds five (5) broken brackes during the treatment period the provider may pass on additional costs to the member. The member must be eligible on each date of service. If the member becomes ineligible during active orthodontic treatment, the member is responsible to pay any remaining balance.				
D8070	Comprehensive Orthodontic Treatment Of The Transitional Dentition	1 per lifetime	Y	Medicaid Orthodontic Initial Accessment Form - (AIF), study models, cephalometric and panoramic films must be submitted with Pre-authorization.
D8080	Comprehensive Orthodontic Treatment Of The Adolescent Dentition			
D8090	Comprehensive Orthodontic Treatment Of The Adult Dentition			
D8210	Removable Appliance Therapy		Y	Pre-authorization required
D8220	Fixed Appliance Therapy			
D8660	Pre-Orthodontic Treatment Visit		Y	Includes diagnostic casts, photographs, panoramic, cephalometric and tracing
D8670	Periodic Orthodontic Treatment Visit		Y	Limited to a maximum of 24 monthly visits or 36 months following the banding date whichever occurs first. An extension beyone this may be approved for severe cses such as surgical orthonathic or cleft cases.

CODE	DESCRIPTION	LIMITATIONS	AUTH REQ	DOCUMENTATION/X-RAYS REQ.
D8692	Replacement Of Lost Or Broken Retainer		Y	
D8999	Unspecified Orthodontic Procedure, By Report		Y	
	Adjunctive General Services			
D9110	Palliative Treatment Of Dental Pain, Minor Procedure		N	Narrative required with claim submission No additional payment allowed if submitted w/ procedures other than x-rays and/or limited exam on the same date of service, for purpose of relief of pain
D9220	Deep Sedation/GA, 1st 30 Minutes	Limited to Medical Necessity	Y	Pre-authorization and narrative required
D9221	Deep Sedation/GA, Each Additional 15 Minutes			
D9230	Inhalation Of Nitrous Oxide/Analgesia		N	
D9241	IV Conscious Sedation/Analgesia, 1st 30 Minutes	Limited to Medical Necessity	Y	Pre-authorization and narrative required
D9242	IV Conscious Sedation/Analgesia, Each Additional 15 Minutes			
D9248	Non-IV Conscious Sedation	3 per 12 month period	N	
D9310	Consultation, Diagnostic Service Provided by Dentist or Physician Other Than Requesting Dentist or Physician		N	Narrative required w/ submission of claim
D9420	Hospital or Ambulatory Surgical Center Call		Y	Pre-authorization and narrative required
D9920	Behavior Management, By Report		Y	Pre-authorization and narrative required
D9999	Unspecified Adjunctive Procedure, By Report		Y	Narrative required w/ submission of claim