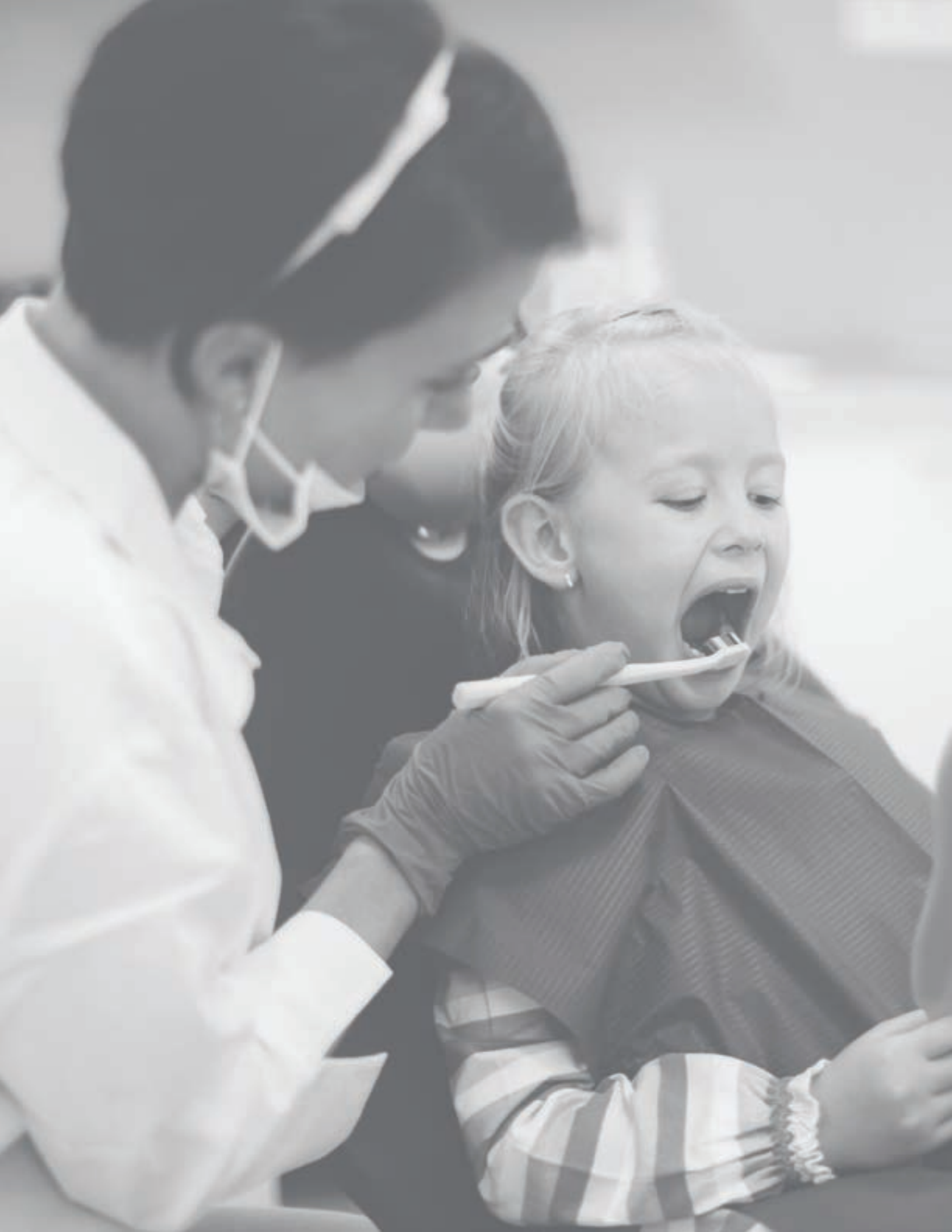
CareSource®

OHIO MEDICAID, MEDICARE ADVANTAGE AND MYCARE DENTAL PROVIDER MANUAL

DENTAL BENEFITS: COVERED SERVICES AND ASSOCIATED LIMITATIONS



CareSource®
Health Care with Heart

DEAR CARESOURCE® DENTAL PROVIDER,

CareSource values our relationship with you and is working to strengthen that partnership. At CareSource, our goal is to help you improve and maintain the dental health of our members. The Dental Manual is part of an initiative to improve efficiency and consistency in our dental management services and ensure our members have access to needed covered services.

The Dental Manual is intended to be a resource for you and a helpful link between your office and CareSource. It provides important information on topics such as covered services, claim submission, attachment guidelines, coordination of benefits, services that require prior authorization and how to submit a prior authorization. Our intention is to make it easier for you to do business with us.

As always, we are interested in your feedback. We will continue to update information periodically and as necessary.

Our secure online Provider Portal is available 24 hours a day. We are pleased to offer enhanced functionality on the Provider Portal. You can access it by going to **CareSource.com** and use it for many web-based transactions. New enhancements include online claim and prior authorization submission and the ability to quickly and easily manage authorizations and claim payments.

CareSource has partnered with SKYGEN USA to enhance the efficiency and consistency of our dental management services. SKYGEN USA will handle all claims payment on our behalf, and we encourage you to enroll in Electronic Funds Transfer (EFT) with them.

If you have inquiries about claim issues, covered services, patient eligibility or other member-related concerns, please check our website or contact CareSource Provider Services at **1-800-488-0134**, 8 a.m. to 6 p.m., Monday through Friday, Eastern Standard Time.

Authorizations are not a guarantee of payment. Authorizations are based on medical necessity and are contingent on eligibility, benefits and other factors. Benefits may be subject to limitations and/or qualifications and will be determined when the claim is received for processing.

Dental health is important for our members and much of it relies on you. Thank you for being a CareSource provider. We know you have a choice and we are pleased that you are part of our network.

TABLE OF CONTENTS

Unintentional typographical mistakes requiring correction will be communicated to health partners on our website or in writing when needed. Reimbursement and fees are subject to change and will be communicated with a minimum of 60 days' notice. Significant policy or procedure changes will be communicated in writing with 60 days' notification.

Please refer to the provider section on the website, ***CareSource.com****, for the dental manual and other available resources.*

ABOUT US

Welcome and thank you for becoming a participating provider with CareSource. We are a nonprofit, community-based health plan that serves consumers of:

- Ohio Medicaid, including families with low incomes, children, pregnant women, and people who are aged, blind or have disabilities. Ohio Medicaid also includes Healthy Start and Healthy Families.
- CareSource® MyCare Ohio (Medicare-Medicaid Plan), a managed care plan coordinating physical, behavioral, and long-term care services for individuals over the age of 18 who are dually eligible for both Medicaid and Medicare.
- CareSource Medicare Advantage, a managed care plan with an enhanced dental benefit that is not covered by original Medicare. Coverage includes preventive dental services such as cleaning, routine dental exams and dental X-rays.

CareSource distributes member rights and responsibility statements to the following groups upon their enrollment and annually thereafter:

- New members
- Existing members
- New health partners
- Existing health partners

Our goal is to create an integrated health care home for our members.

Our goal is to create an integrated health care home for our members. This means we focus on prevention and partnering with local health care providers to offer the services our members need to remain healthy.

As a managed health care organization, we strive to improve the health of our members by utilizing a contracted network of participating health care partners. Primary care providers (PCPs) within the network provide a range of primary care services to our members, and also coordinate patient care by referring them to specialists when needed or by obtaining prior authorization for certain services.

Who We Are

CareSource was founded on the principles of quality and service delivered with compassion and a thorough understanding of caring for underserved consumers. As a nonprofit, we are mission-driven to provide quality care to our members. We offer process efficiencies and value-added benefits for our members and participating providers.

Vision And Mission

- Our vision is transforming lives through innovative health and life services.
- Our mission is to make a lasting difference in our members' lives by improving their health and well-being.
- At CareSource, our mission is one we take to heart. In fact, we call our mission our "heartbeat." It is the essence of our company, and our unwavering dedication is the hallmark of our success.

COMMUNICATING WITH CARESOURCE

Hours of Operation

CareSource24® (All Plans)	24/7/365		Triage
Ohio Medicaid	M-F	8 a.m. - 6 p.m.	Provider Services
Ohio Medicaid	M-F	7 a.m. - 7 p.m.	Member Services
Ohio Medicare Advantage	M-F	7 a.m. - 7 p.m.	Provider Services
Ohio MyCare	M-F	7 a.m. - 7 p.m.	Provider Services

Please visit our website for our holiday schedule or contact Provider Services for more information.

Website: CareSource.com

Provider Portal: https://providerportal.caresource.com/OH/
Our secure Provider Portal offers member eligibility checks and dental history (including the specific tooth and four surface areas to all dental procedure codes), Claim Appeals, and coordination of benefits. New features include:

- Online claim submission
- Online prior authorization submission
- Online prior authorization status

Dental provider can now use our new designated Dental Provider Portal. Just log in to the CareSource Provider Portal, click on the “Dental Provider Login” link under the “Providers” heading, and register to use the Portal.

Network Notifications:
Network Notifications are published for CareSource providers to regularly communicate updates to policies and procedures. Network notifications are found on our CareSource website and the dedicated Dental Provider Portal.

Correspondence Address:
CareSource
P.O. Box 8738
Dayton, OH 45401-8738

Provider Appeals Address (Medicaid/Medicare):
Please visit our website for more information on how appeals can be submitted. Appeals can be submitted through our secure Provider Portal, or in writing via the address listed below.

Please Submit Written Appeals to:
CareSource
P.O. Box 2008
Dayton, OH 45401-2008

Claim Payment and EFT Enrollment:
CareSource has partnered with SKYGEN USA to enhance the efficiency and consistency of our dental management services. SKYGEN USA will now handle claim payment on our behalf. We encourage our providers to enroll directly with SKYGEN USA to receive Electronic Funds Transfer (EFT) payments. Visit our Provider Portal for more information.

Claims Mailing Address (Medicaid/Medicare/MyCare):
CareSource
Attn: Claims Department
P.O. Box 8730
Dayton, OH 45401-8730

Fraud, Waste And Abuse Address (Medicaid/Medicare/MyCare):
CareSource
Attn: Special Investigations Department
P.O. Box 1940
Dayton, OH 45401-1940

*Information reported to us can be reported **anonymously** and is kept **confidential** to the extent permitted by law.*

Prior Authorization Address:
CareSource
Att: OH Authorizations
P.O. Box 314
Milwaukee, WI 53201

How to Submit for Prior Authorization
Call: 1-800-488-0134
Fax: 1-888-752-0012
Online: Submit requests through our secure Provider Portal. New portal enhancements enable you to attach electronic files, review submitted authorizations and monitor status of previously submitted authorizations.
Dental health partners can now use our new designated Dental Provider Portal. Just log in to the CareSource Provider Portal, click on the “Dental Provider Login” link under the “Providers” heading, and register to use the Portal.

DENTAL SERVICES THAT REQUIRE PRIOR AUTHORIZATION FOR MEDICAID

- Orthodontia services
- Root canals – if three or more root canal procedures are scheduled within six months
- All dentures
- All partial dentures
- Porcelain crowns (authorized for permanent anterior teeth only)
- Post and core in addition to crown (authorized for permanent anterior teeth without sufficient tooth structure to support a crown only)
- Frenulectomy
- Excision hyperplastic tissue
- Gingivectomy or gingivoplasty
- Scaling and root planing
- Impacted tooth removal – complete bony with complications
- Surgical removal of a residual tooth root
- Surgical removal of unerupted teeth
- Surgical removal of supernumerary teeth
- Removal of lateral exostosis,
- Removal of torus palatinus
- Removal of torus mandibularis unspecified temporomandibular joint therapy (TMJ)
- Unspecified TMJ films
- Removable appliances
- Fixed appliances
- All unspecified/miscellaneous dental codes
  - Any provider who is not participating with CareSource must obtain prior authorization for all non-emergency services rendered to a CareSource member.
  - CareSource accepts high quality diagnostic photographs and X-rays.
- Plaster models are no longer accepted for prior authorization.

D101. DIAGNOSTIC SERVICES FOR MEDICAID

A. Clinical Examination

The following dental examination codes may be billed for any place of service in accordance with the coverage and limitations set forth below.

D0120 Periodic oral examination

- This includes an evaluation performed on an established patient to determine whether the patient's dental and medical health has changed since a previous comprehensive or periodic evaluation. The periodic oral examination includes periodontal screening and may require interpretation of information gathered through additional diagnostic procedures. Additional diagnostic procedures should be reported separately.
- The periodic oral evaluation may not occur more than once every 180 days. Examinations occurring more frequently will not be reimbursed.
- The periodic oral evaluation may not occur in combination with the comprehensive oral evaluation and not until 180 days after the comprehensive oral evaluation.

D0140 Limited oral evaluation – problem focused

- This is an evaluation limited to a specific oral health problem or complaint. It may require interpretation of information gathered through additional diagnostic procedures. Additional diagnostic procedures should be reported separately.
- This evaluation will include any necessary palliative treatment.
- Evaluations solely for the purpose of adjusting dentures or in conjunction with multi-visit procedures are not covered (for example, endodontics and orthodontia).
- No payment is made if performed in conjunction with either a comprehensive oral evaluation, periodic oral evaluation or periodontal evaluation.

D0150 Comprehensive oral evaluation – new or established patient

- This code is typically used by a general dentist and/or specialist when evaluating a patient comprehensively. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. It may require interpretation of information gathered through additional diagnostic procedures. Additional diagnostic procedures should be reported separately.
- This code includes evaluation and recording of the patient's dental and medical history and a general health assessment. It also includes evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies and an oral cancer screening.

- The comprehensive oral evaluation is limited to one per provider-location-patient relationship per 5 years. The comprehensive oral evaluation may not occur in combination with the periodic evaluation.

D0180 Comprehensive periodontal evaluation - new or established patient

- Prior authorization is required for members under the age of 21.
- No payment is made for a comprehensive periodontal evaluation performed in conjunction with either a comprehensive oral evaluation or a periodic oral evaluation.
- The comprehensive periodontal evaluation may not occur more than once every 365 days. Examinations occurring more frequently will not be reimbursed.

B. Radiographs/Diagnostic Imaging (including interpretation)

All radiographs submitted with prior authorization requests must be current and labeled with the member name, date of birth, date taken and, the name of the provider or of the provider's office, and must indicate left or right side.

Periapical films must show complete visibility of the periodontal ligament, crown and entire root structure.

A bitewing image must completely show the crowns with little or no overlapping. A bitewing image cannot be substituted for a periapical image when endodontic treatment is necessary.

All radiographs and diagnostic photographs must be of diagnostic quality, properly mounted, properly exposed, clearly focused, clearly readable and free from defect for the area of the mouth on which these studies were performed.

D0210 Intraoral – complete series (including bitewings)

- A complete series of radiographs will consist of a minimum of 12 films, including all periapical, bitewings and occlusal film necessary for the diagnosis.
- A complete series of radiographs is covered only once every five years. If a complete series of radiographs is required more frequently, prior authorization must be obtained.

D0220 Intraoral periapical – first film

D0230 Each additional intraoral periapical film

D0250 Extraoral first film – extraoral first film is covered as an adjunct complex treatment

D0270 Bitewing – single film

- Bitewings radiographs, in combination with other radiographs or when made alone, are covered once every six months if they do not exceed the limitations included in this section.

D0272 Bitewing – two films

- Bitewings radiographs, in combination with other radiographs or when made alone, are covered once every six months if they do not exceed the limitations included in this section.

D0273 Bitewing – three films

- Bitewings radiographs, in combination with other radiographs or when made alone, are covered once every six months if they do not exceed the limitations included in this section.

D0274 Bitewing – complete series – minimum of four films

- The complete bitewing series is reimbursable only for patients ages 12 and older whose permanent second molars have erupted.
- Bitewing films must show complete visibility of clinical crowns with no overlapping. They cannot be substituted for periapical films in cases where endodontic treatment is requested.
- Bitewings radiographs, in combination with other radiographs or when made alone, are covered once every six months if they do not exceed the limitations included in this section.

D0321 Temporomandibular joint films

- You must submit a letter of medical necessity; these require prior authorization.

D0330 Panoramic film

- The panoramic film is an extraoral radiograph on which the maxilla and mandible are depicted on a single film.
- All bitewing and periapical films needed to render the necessary radiographic diagnosis are included in the fee for panoramic radiographs.
- A panoramic radiograph is covered only once every five years. A minimum of five years must elapse between the provision of panoramic radiographs and a complete series of radiographs or the service will not be reimbursed.
- Panoramic radiographs are covered for patients ages six and older. Prior authorization must be obtained for panoramic radiographs of patients younger than six.

- Panoramic films must show complete visibility of tooth crowns, roots, and bony and soft tissues in both arches with little or no overlapping of the teeth.

D0340 Cephalometric film with tracing

- Prior authorization is not required for cephalometric films and tracings when performed as part of an authorized comprehensive orthodontic treatment plan. Please refer to the section on “Orthodontic Services for Medicaid” for instructions.

D0350 Oral/facial images (includes intraoral and extraoral images)

- Prior authorization is not required for diagnostic photographs when performed as part of an authorized evaluation or workup, or when they are used for evaluating a treatment option that this manual states requires diagnostic photographs.

C. Diagnostic cast

D0470 Diagnostic cast

- Diagnostic casts for evaluation of treatment will be reimbursed, but are not required to be submitted for review. CareSource only accepts intraoral photographs. Cast models are no longer accepted. Payment will only be made in conjunction with treatment that requires a diagnostic cast.

D102. PREVENTIVE SERVICES FOR MEDICAID

A. Prophylaxis

Prophylaxis includes the necessary scaling and/or polishing of the teeth to remove plaque, calculus and stains of primary transitional or permanent dentition.

D1110 Dental prophylaxis – adult

- Dental prophylaxis for patients ages 14 years and older will not be reimbursed more than once every 180 days.
- No payment is made for prophylaxis performed in conjunction with gingivectomy, gingivoplasty or scaling and root planing.

D1120 Dental prophylaxis – child

- Dental prophylaxis for patients ages 13 and younger will not be reimbursed more than once every 180 days.
- No payment is made for prophylaxis performed in conjunction with gingivectomy, gingivoplasty or scaling and root planing.

B. Fluoride Treatment

Use of a polishing compound that incorporates fluoride as part of prophylaxis is not considered to be a separate topical fluoride treatment.

Topical application of fluoride to a tooth being prepared for restoration, application of fluoride by the patient and application of sodium fluoride as a desensitizing agent are not covered fluoride treatments.

D1206 Topical application of fluoride varnish

- Topical fluoride treatments are limited to one application every 180 days for patients under the age of 21.
- Topical fluoride treatments may be provided and billed by PCPs and pediatricians.

D1208 Topical application of fluoride (including sodium, stannous and acid phosphate fluoride, foam, gel, varnish and in-office rinse)

- Topical fluoride treatments are limited to one application every 180 days for patients under the age of 21.
- Treatment that incorporates fluoride with the polishing compound is considered part of the prophylaxis procedure and not a separate topical fluoride treatment.

The following treatments are not covered:

- topical application of fluoride to the prepared portion of a tooth prior to restoration
- the use of self or home fluoride application procedures
- the application of sodium fluoride as a desensitizing agent

C. Other Preventive Services

D1320 Tobacco counseling for control and prevention of oral disease

- Coverage is limited to patients with a history of tobacco use.
- This service must be provided in conjunction with another dental service.
- Documentation of tobacco use, extent of counseling session and provision of cessation assistance or referral must be maintained in the clinical record.
- Tobacco counseling is limited to twice per 365 days.

D1351 Sealant (permanent, per tooth)

Pit and fissure sealants are covered on previously unrestored occlusal areas of permanent molars subject to the following limitations:

- Sealants are covered on permanent first molars and on permanent second molars for patients under the age of 18.

- Treatments in all other situations will not be reimbursed.
- Sealants are covered on teeth 2, 3, 14, 15, 18, 19, 30 and 31 only.
- Sealants are covered every two years.

D1354 Interim caries arresting medicament application

- No payment is made in conjunction with a restoration or crown on the same tooth.
- Payment is limited to a fixed amount (flat rate of one unit) per patient, per date of service, regardless of number of units billed or teeth treated.
- Interim caries arresting medicament application is limited to 6 applications per lifetime.

D. Space Maintenance (passive appliances)

The preservation of arch length should be the main consideration in the evaluation of a patient for a space maintainer. Space maintainers are covered after the loss of a young permanent tooth or the premature loss of a primary tooth if the dentist cannot determine when the permanent tooth will erupt. Coverage is limited to patients under the age of 21.

Covered services:

- **D1510 Space maintainer – fixed – unilateral**
- **D1515 Space maintainer – fixed – bilateral**
- **D1520 Space maintainer – removable – unilateral**
- **D1525 Space maintainer – removable – bilateral**

D103. RESTORATIVE SERVICES FOR MEDICAID

A. Amalgam Restorations (including polishing)

- Bases and copalite or calcium hydroxide liners placed under a restoration will be considered part of the restoration and are not reimbursable as separate procedures.
- Local anesthesia is included in the fee for all restorative services.
- No more than three restorations per tooth per date of service will be reimbursed regardless of the number of surfaces restored.
- Claims for amalgam restorations must indicate the tooth surface and tooth number treated.
- A tooth surface can be named only once, whether alone or in combination with restorations on other surfaces.

- On maxillary first and second molars, the occlusal surface can be named twice, whether performed alone or in combination with restorations of another surface.
- Preventive restoration is not covered.

Covered benefit:

- **D2140 Amalgam – one surface – primary or permanent tooth**
- **D2150 Amalgam – two surfaces – primary or permanent tooth**
- **D2160 Amalgam – three surfaces – primary or permanent tooth**
- **D2161 Amalgam – four or more surfaces – primary or permanent tooth**

B. Resin-Based Composite Restorations

- Resin-based composite restorations are covered for anterior teeth and Class I, Class II or Class V restorations on posterior teeth.
- Posterior resin-based restorations will be reimbursed at the same fee as the comparable amalgam restoration.
- The fee for resin-based composite restorations will include any necessary acid etching.
- No more than three restorations per tooth per date of service will be reimbursed regardless of the number of surfaces restored.
- Bases and copalite or calcium hydroxide liners placed under a restoration will be considered part of the restoration and are not reimbursable as separate procedures.
- Local anesthesia is included in the fee for all restorative services.
- A tooth surface can be named only once, whether alone or in combination with restorations on other surfaces.
- On maxillary first and second molars, the occlusal surface can be named twice, whether performed alone or in combination with restorations of another surface.
- On anterior teeth, the facial and lingual surfaces can be named twice, whether performed alone or in combination with restorations of another surface.
- If the incisal angle on an anterior tooth is involved, then only one four-surface restoration can be claimed for the tooth and no additional surfaces or restorations will be allowed.
- Single surface resin-based composite restorations must involve repair of decay in the dentin.
- Claims for resin-based composite restorations must indicate the tooth surface and tooth number treated.

- Preventive resin-based restorations are not covered services.

Covered services:

- **D2330 Resin-based composite restoration – one surface – anterior**
- **D2331 Resin-based composite restoration – two surfaces – anterior**
- **D2332 Resin-based composite restoration – three surfaces – anterior**
- **D2335 Resin-based composite restoration – four or more surfaces or involving incisal (anterior)**
- **D2391 Resin-based composite restoration – one surface – posterior**
- **D2392 Resin-based composite restoration – two surfaces – posterior**
- **D2393 Resin-based composite restoration – three surfaces – posterior**
- **D2394 Resin-based composite restoration – four or more surfaces – posterior**

C. Crowns

D2390 Resin-base composite crown, anterior

- An anterior resin-based composite crown may be covered only for a patient younger than 21.
- All claims submitted for crowns must indicate the tooth number treated.

D2740 Crown-porcelain/ceramic

- Prior authorization is required for porcelain porcelain/ceramic fused to noble metal for permanent anterior teeth, teeth numbers 6-11 and 22-27, if provided for a functional need. Crowns only for cosmetic reasons will not be reimbursed.
- The fee includes the temporary crown placed on the prepared tooth and worn while the permanent crown is being prepared.
- A periapical radiograph and a panoramic film or full mouth X-rays of the involved tooth/teeth must be submitted with each request to determine the overall health of the teeth and gums. See “Radiographs/Diagnostic Imaging” section (including interpretation) for more information.
- All claims submitted for crowns must indicate the tooth number treated.
- Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma, and must involve four or more surfaces and at least 50 percent of the incisal edge.

D2751 Crown-porcelain fused to predominantly based metal

- Prior authorization is required for porcelain fused to predominantly based metal for permanent anterior teeth, teeth numbers 6-11 and 22-27, if provided for a functional need. Crowns only for cosmetic reasons will not be reimbursed.
- The fee includes the temporary crown placed on the prepared tooth and worn while the permanent crown is being prepared.
- A periapical radiograph and a panoramic film or full mouth X-rays of the involved tooth/teeth must be submitted with each request to determine the overall health of the teeth and gums. See “Radiographs/Diagnostic Imaging” section (including interpretation) for more information.
- All claims submitted for crowns must indicate the tooth number treated.
- Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma and must involve four or more surfaces and at least 50 percent of the incisal edge.

D2752 Porcelain fused to noble metal

- Prior authorization is required for porcelain fused to noble metal for permanent anterior teeth, teeth numbers 6-11 and 22-27, if provided for a functional need. Crowns only for cosmetic reasons will not be reimbursed.
- The fee includes the temporary crown placed on the prepared tooth and worn while the permanent crown is being prepared.
- A periapical radiograph and a panoramic film or full mouth X-ray of the involved tooth/teeth must be submitted with each request to determine the overall health of the teeth and gums. See “Radiographs/Diagnostic Imaging” section (including interpretation) for more information.
- All claims submitted for crowns must indicate the tooth number treated.
- Permanent anterior teeth must have pathologic destruction to the tooth by caries or trauma, and must involve four or more surfaces and at least 50 percent of the incisal edge.

Crowns for the following reasons will not be reimbursed/authorized:

- a lesser, more conservative restoration is possible
- a primary tooth
- cosmetic reasons or to alter vertical dimension
- tooth/teeth having advanced periodontal disease

D. Other Restorative Services

D2930 Prefabricated stainless steel crown – primary tooth

- Stainless steel crowns are allowed only for teeth when multi-surface restorations are needed and there is a poor prognosis for restoration with amalgam or other materials.

D2931 Prefabricated stainless steel crown – permanent tooth

- Stainless steel crowns are allowed only for teeth when multi-surface restorations are needed and there is a poor prognosis for restoration with amalgam or other materials.

D2933 Prefabricated open-face stainless steel crowns (or stainless steel crowns with resin window)

- Open-face prefabricated stainless steel crowns and stainless steel crowns with acrylic facings are covered for anterior teeth only.
- Stainless steel crowns are covered only for teeth that need multi-surface restorations and that have a poor prognosis for restoration with amalgam or other materials.
- The fee for open-face stainless steel crowns and stainless steel crowns with acrylic facings includes any necessary composite restoration.

D2934 Prefabricated esthetic coated stainless steel crown - primary tooth

- Prefabricated esthetic coated stainless steel is allowed only for teeth where multi-surface restorations are needed and a poor prognosis for restoration with amalgam or other materials.

D2950 Core buildup, including any pins when required

- Coverage is limited to permanent teeth.
- This service must be provided in preparation for or in conjunction with an adult crown procedure.
- Core buildup is limited to once per tooth per date of service.

D2951 Pin retention (per tooth in addition to restoration)

- A maximum of three pins per tooth will be reimbursed.

D2952 Cast post and core in addition to crown

- Prior authorization is required for cast post and core.
- A periapical radiograph and a panoramic film or a full mouth series of X-rays of the involved tooth/teeth must be submitted with each request to determine the overall health of the teeth and gums.
- Cast post and cores will only be authorized for properly endodontically treated permanent anterior teeth 6-11 and 22-27 that do not have sufficient tooth structure to support a crown.

- Tooth should be properly filled after completion of root canal therapy.
- Overall health of remaining teeth and gums must be in good overall health.

D2954 Prefabricated post and core in addition to crown

- Prior authorization is required for prefabricated post and core.
- A periapical radiograph and a panoramic film or a full mouth series of X-rays of the involved tooth/teeth must be submitted with each request to determine the overall health of the teeth and gums.
- Prefabricated post and cores will only be authorized for properly endodontically treated permanent anterior teeth 6-11 and 22-27 that do not have sufficient tooth structure to support a crown.
- Tooth should be properly filled after completion of root canal therapy.
- Overall health of remaining teeth and gums must be in good overall health.

D104. ENDODONTIC SERVICES FOR MEDICAID

A. Therapeutic Pulpotomy and Pulpal Therapy

D3220 Therapeutic pulpotomy/pulpal therapy

- Therapeutic pulpotomy or pulpal therapy is a covered service.
- Pulpotomy and pulpal therapy will not be reimbursed as separate procedures in combination with root canal therapy.
- Restoration for the completed pulpotomy or therapeutic pulpal therapy should be billed as a separate procedure.
- Coverage is limited to patients younger than 21.

B. Complete Root Canal Therapy

- Root canal therapy is covered only for permanent teeth. Root canal therapy on primary teeth is not a covered service.
- Prior authorization is required for root canal therapy for three or more procedures planned/scheduled within six months. Root canal therapy must be performed only when the overall health of the dentition and periodontium is good except for the endodontically indicated tooth or teeth.
- Radiographs, including periapicals, panoramic film or full mouth series of radiographs, submitted must show periapical radiolucency or widening of periodontal ligament. Symptoms should include chronic pain (as evidenced by sensitivity to hot or cold, percussion or palpation) fistula associated with the tooth or chronic infection. If pathology is not visible on the radiograph, root canal treatment should be clinically documented.

- The tooth must demonstrate at least 50 percent bone support.
- The fee for root canal therapy includes all diagnostic tests, evaluations, radiographs and postoperative treatments.

D3310 Root canal therapy – anterior (excluding final restoration)

- Prior authorization is required for root canal therapy if three or more procedures are planned/scheduled within six months.

D3320 Root canal therapy – bicuspids (excluding final restoration)

- Prior authorization is required for root canal therapy if three or more procedures are planned/scheduled within six months.

D3330 Root canal therapy – molars (excluding final restoration)

- Prior authorization is required for root canal therapy if three or more procedures are planned/scheduled within six months.

C. Apexification/Recalcification Procedures

Apical closure does not include root canal therapy.

D3351 Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)

- Apexification includes opening tooth, pulpectomy, preparation of canal spaces, first placement of medication and necessary radiographs.

D3352 Apexification/recalcification – interim medication replacement (apical closure/calcific repair or perforations, root resorption, etc.)

- This procedure is for visits in which the intracanal medication is replaced with new medication and necessary radiographs are taken.

D3353 Apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.)

- This procedure includes removal of intracanal medication, placement of final root canal filling material and necessary radiographs.

D. Apicoectomy/Periradicular Surgery Services

D3410 Apicoectomy-anterior

- Apicoectomy surgery services are covered only on anterior permanent teeth.

D105. PERIODONTIC SERVICES FOR MEDICAID

A. Gingivectomy or Gingivoplasty

D4210 Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant

- Prior authorization is required. Complete radiographs of the mouth, letter of medical necessity and diagnostic photographs must be submitted for review.
- Gingivectomy and gingivoplasty coverage is limited to correct severe hyperplasia or hypertrophic gingivitis.

D4211 Gingivectomy or gingivoplasty, one to three contiguous teeth per quadrant

- Prior authorization is required. Complete radiographs of the mouth, letter of medical necessity and diagnostic photographs must be submitted for review.
- Gingivectomy and gingivoplasty coverage is limited to correct severe hyperplasia or hypertrophic gingivitis.

B. Periodontic Scaling and Root Planing

Prior authorization is required.

The required documentation of the need for periodontal scaling and root planing must include the following items:

1. A periodontal treatment plan and history.

   Periodontal History should include:
   a. Periodontal treatment done in the past and when; outcomes of that treatment; current oral hygiene; motivation for successful treatment.
   b. Treatment Plan should include pre-periodontal scaling and root planing plans, oral hygiene, number of visits expected for scaling and root planing; preventive maintenance; recall plan; if oral rinses planned.

2. A completed copy of an ADA periodontal chart to include:
   a. Pocket depths (charting all six surfaces)
   b. Furcation involvement
   c. Mobility
   d. Mucogingival relationship
   e. Bleeding and suppuration
   f. Attachment loss
   g. A completed Evaluation Form to Scaling and Root Planing

3. Current upper and lower anterior periapical radiographs of isolated teeth (dated within six months of request) and current bitewing radiographs showing at least 3mm of crestal bone. Radiographs must have proper angulation.

4. The radiographs must demonstrate calculus on the root surfaces of the teeth or bone loss related to periodontal disease.Periodontal scaling and root planing is only covered once every 24 months per quadrant.

D4341 Periodontal scaling and root planing, four or more teeth per quadrant

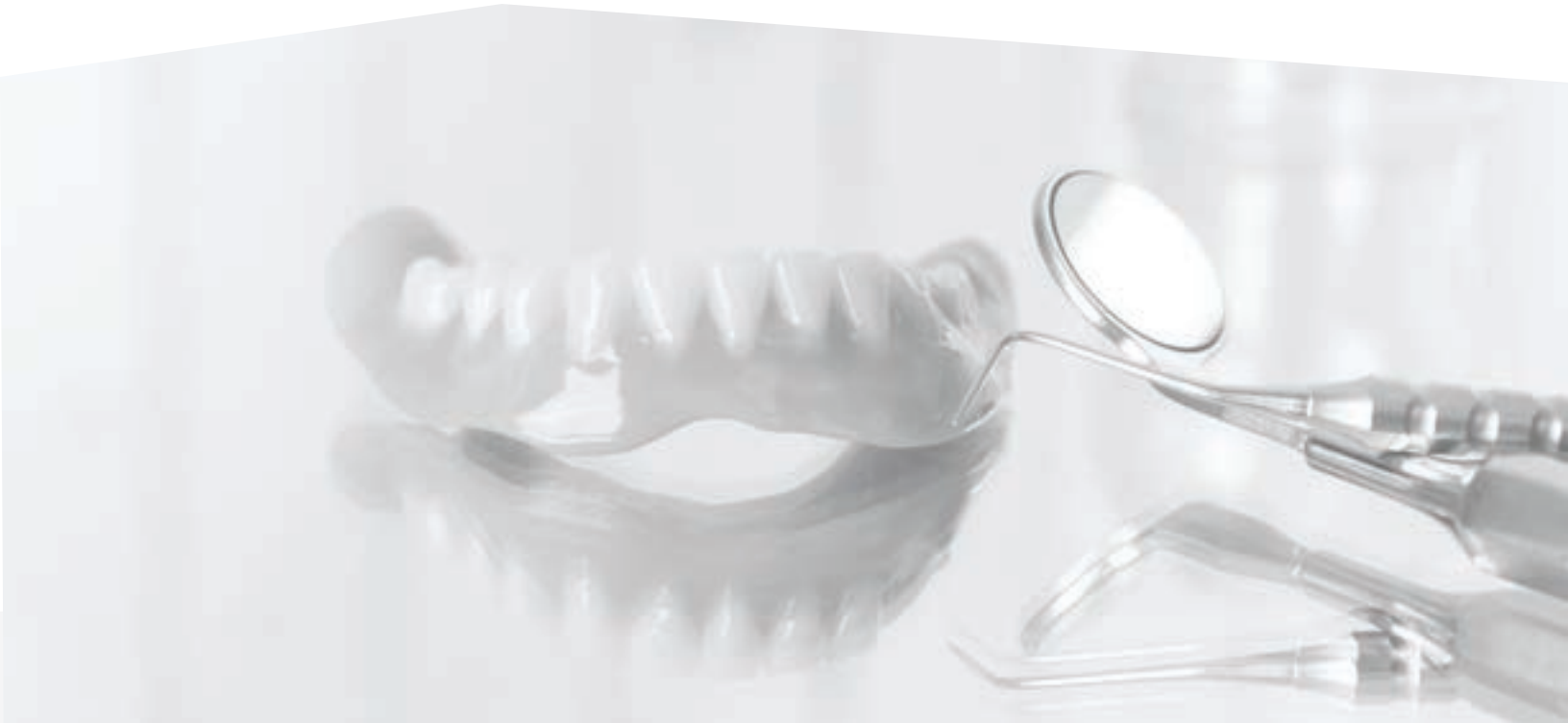
- Periodontal scaling and root planing is only covered once every 24 months per quadrant.
- No payment is made for scaling and root planing performed in conjunction with oral prophylaxis, gingivectomy, or gingivoplasty.

D4342 Periodontal scaling and root planing, One to three teeth per quadrant

- Periodontal scaling and root planing is only covered once every 24 months per quadrant.
- No payment is made for scaling and root planing performed in conjunction with oral prophylaxis, gingivectomy or gingivoplasty.

D4910 Periodontal maintenance

- No payment is made for periodontic maintenance if no scaling or root planing was performed within the previous 24 months.
- No payment is made for periodontic maintenance performed in conjunction with prophylaxis or within 30 days of scaling and root planing.
- Periodontal maintenance is only covered once every 365 days.



D106. REMOVABLE PROSTHODONTIC SERVICES FOR MEDICAID

A. Complete Dentures (including routine post-delivery care)

- Prior authorization is required for all complete dentures.
- The need for dentures should be based on the total condition of the mouth, the desire to wear dentures and the ability to adjust to dentures. Natural teeth that have healthy bones must not be removed. Authorization for dentures must be received before the teeth are extracted.
- In cases where the recipient is not edentulous prior to requesting dentures, complete radiographs of the mouth must be submitted with each denture request.
  - Radiographs must be taken prior to extractions.
  - Radiographs are not necessary for those individuals edentulous prior to requesting dentures.
  - Request for edentulous individual must include clinical ddocumentation of edentulism on the prior authorization request.
- The dentist is responsible for constructing a complete, functional denture.
- A denture – complete, partial or combination – cannot be replaced or remade within eight years, except in very unusual circumstances for which new dentures can be justified.
- A preformed denture is not a covered service (e.g., with teeth already mounted or set in acrylic prior to initial impressions).
- A denture will not be authorized if the patient's dental history reveals that any or all dentures made in recent years have been unsatisfactory because of psychological or physiological reasons that cannot be remediated.
- Prosthetic devices shall be seated in the mouth before a claim is submitted for payment.
- The fee for dentures includes all visits necessary for the construction of the denture and the required six month follow-up visits for corrections.

Prior authorization required, benefit limits may apply:

D5110 Complete upper denture – maxillary

D5120 Complete lower denture – mandibular

B. Partial Dentures

- Prior authorization is required for all partial dentures.
- Partial dentures are considered medically necessary when several teeth are missing in the arch and masticatory function is severely impaired. Partial dentures are also considered medically necessary when anterior teeth are missing in the arch, affecting the patient's appearance.
- Partial dentures cannot be replaced, remade or exchanged for complete dentures for at least eight years, except in very unusual circumstances for which new dentures can be justified.
- The dentist is responsible for constructing a completely functional partial denture.
- Prosthetic devices shall be seated in the mouth before a claim is submitted for payment.
- The fee for dentures includes all visits necessary for the construction of the denture and the required six month follow-up visits for corrections.

Prior authorization required, benefit limits may apply:

D5211 Maxillary partial denture (resin-base) including conventional clasps, rests and teeth

- This procedure includes acrylic resin-based dentures with resin or wrought-wire clasps.

D5212 Mandibular lower partial denture – (resin-base) including conventional clasps, rests and teeth

- This procedure includes acrylic resin-base denture with resin or wrought-wire clasps.

D5213 Maxillary upper denture partial cast-metal framework with resin denture bases (including conventional clasps, rests and teeth)

D5214 Mandibular denture partial – cast-metal framework with resin denture bases (including conventional clasps, rests and teeth)

C. Repairs to Dentures

Repairs to complete dentures:

- **D5511 Repair broken complete denture base mandibular**
- **D5512 Repair broken complete denture base maxillary**
- **D5520 Replace missing or broken teeth – complete denture (each tooth)**

Repairs to partial dentures:

- **D5611 Repair resin partial denture base, mandibular**
- **D5612 Repair resin partial denture base, maxillary**
- **D5621 Repair cast partial framework, mandibular**
- **D5622 Repair cast partial framework, maxillary**
- **D5630 Repair or replace broke clasp per tooth**
- **D5640 Replace broken teeth per tooth**
- **D5650 Add tooth to existing partial denture per tooth**
- **D5660 Add clasp to existing partial denture**

D. Denture Reline Procedures

- The reline must consist of the re-adaptation of the denture to the present oral tissues using accepted dental practice standards and procedures. The denture must be processed and finished with materials corresponding to the existing denture. Chair side self-curing materials are not covered.
- All complete and partial denture relining procedures include all necessary corrections for six months after the denture has been relined.
- A complete or partial denture reline will not be covered more than once every four years, and not until four years after the construction of a complete or partial denture (except in unusual circumstances that must be documented).

Benefit limits may apply:

- **D5750 Reline complete maxillary denture**
- **D5751 Reline complete mandibular denture**
- **D5760 Reline partial maxillary denture**
- **D5761 Reline partial mandibular denture**

D107. ORAL SURGERY SERVICES FOR MEDICAID

A. Extractions

- A tooth may be removed only if it cannot be saved because it is broken down, poorly supported by the alveolar bone and/or affected by a pathological condition.
- Extractions that render a patient ***edentulous*** **must be deferred until authorization to construct a denture has been given**, except in an absolute emergency. Documentation must be provided to support the absolute emergency removal of teeth.
- The extraction of an impacted tooth will be authorized only when the impaction makes removal necessary.
- Prophylactic removal of asymptomatic teeth or teeth exhibiting no overt clinical pathology is covered only when at least one tooth is symptomatic.
- Local anesthesia, suturing and routine postoperative care are included in the fee for extractions.

D7140 Extraction – erupted tooth or exposed root (elevation and/or forceps removal)

- This includes routine removal of tooth, structure, minor smoothing of socket bone, and closure, as necessary.
- This code may be billed once per tooth and not in combination with another extraction or root recovery code.

D7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth

- This includes related cutting of gingiva and bone, removal of tooth structure, minor smoothing of socket bone and closure.
- This code cannot be billed with any other extraction or root recovery code for the same tooth.

D7220 Removal of impacted tooth – soft tissue must be teeth 1, 16, 17, 32 (any other teeth require prior authorization)

- A soft-tissue impaction occurs when a tooth requires an incision of overlying soft tissue and removal of the tooth without necessity of removing bone. Partial eruption of a tooth with portions of the crown at or above the occlusal plane does not disqualify the tooth as a soft-tissue impaction if the tooth's position is such that soft tissue covers portions of the occlusal surface, for example, a distoangular position.
- Third molars do not require prior authorization (teeth 1, 16, 17, 32).
- Removal of all other teeth require prior authorization.

D7230 Removal of impacted tooth – partially bony teeth 1, 16, 17, 32 (any other teeth require prior authorization)

- A partial bony impaction occurs when the crown of the tooth is partially covered by bone. This tooth may or may not be partially erupted. This type of impaction requires an incision of overlying soft tissue, elevation of a flap, removal of bone and removal of the tooth. Partial eruption of a tooth with portions of the crown at or above the occlusal plane does not disqualify this tooth from being classified a partial bony impaction if bone covers the greatest convexity of the distal portion of the crown. For example, a distoangular position within the ramus of the mandible.
- A radiograph of the impaction must be maintained in the patient's clinical record.

D7240 Removal of impacted tooth – complete bony

- A complete bony impaction occurs when the crown of the tooth is completely covered by bone, or a substantial part of the tooth above the greatest convexity of the crown is covered by bone on both the mesial and distal sides, as demonstrated radiographically.
- For a horizontally impacted lower third molar to be classified as a complete bony impaction, the central groove of the crown must not be above the occlusal plane. This type of impaction requires an incision of overlying soft tissue, elevation of a flap, removal of bone, and sectioning of the tooth, if necessary, for removal.
- A radiograph of the impaction must be maintained in the patient's clinical record.

D7241 Removal of impacted tooth – complete bony with unusual surgical complications

- Prior authorization is required for this procedure. A radiograph of the impaction must be submitted with the request. Providers must submit the full mouth series or panoramic film for review.

B. Other Surgical Procedures

D7250 Surgical removal of a residual tooth root (cutting procedure)

- Prior authorization is required for this procedure.
- This procedure involves surgical removal of a residual tooth root.
- A full mouth radiographic series or panoramic film must be submitted with the prior authorization request for review.
  - Authorization will be granted only in cases when remnants of a tooth root remain as a result of an incomplete prior extraction.
  - Authorization will not be granted for the same provider or dental group who was reimbursed for the dental extraction.
  - Authorization will not be granted for root remnants of a tooth root due to decay or trauma.

D7270 Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth

- Prior authorization is not required for reimplantation and/or stabilization of an accidentally avulsed or displaced tooth and/or alveolus.
- Includes splinting and/or stabilization.

D7280 Surgical access of unerupted tooth

- Prior authorization is required.
- This procedure is limited to situations in which an orthodontic attachment is placed to facilitate eruption. Radiographs of the area and treatment plan must be submitted as well as documentation that the member is currently receiving orthodontia services.
- This service will be reimbursed only if D8080 has been approved.
- This service is limited to one per tooth.

D7283 Placement of device to facilitate eruption of impacted tooth

- Prior authorization is required.
- This procedure is limited to situations in which device is used to facilitate eruption.
- Radiographs of the area and treatment plan must be submitted as well as documentation the member is currently receiving orthodontia services.
- This service will be reimbursed only if D8080 has been approved.
- This service is limited to 1 per tooth.

D7999 Surgical removal of supernumerary tooth

- In order to request prior authorization for removal of supernumerary tooth/teeth, use the code D7999 and the correct tooth number.
- Prior authorization is required for this procedure. A radiograph must be submitted with the request.

How to code D7999

Providers must use the below codes when submitting supernumerary tooth removal claims:

Teeth 1-4	Supernumerary 51-54
Teeth 5-8	Supernumerary 55-58
Teeth 9-12	Supernumerary 59-62
Teeth 13-16	Supernumerary 63-66
Teeth 17-20	Supernumerary 67-70
Teeth 21-24	Supernumerary 71-74

Teeth 25-28	Supernumerary 75-78
Teeth 29-32	Supernumerary 79-82
Deciduous teeth A-C	Supernumerary AS-CS
Deciduous teeth D-G	Supernumerary DS-GS
Deciduous teeth H-J	Supernumerary HS-JS
Deciduous teeth K-M	Supernumerary KS-MS
Deciduous teeth N-Q	Supernumerary NS-QS
Deciduous teeth R-T	Supernumerary RS-TS

C. Biopsy

D7285 Incisional biopsy of oral tissue – hard (bone, tooth)

- This code involves biopsy of osseous lesions and is not used for apicoectomy/periradicular surgery.

D7286 Incisional biopsy of oral tissue – soft

- Use this code for surgical removal of an architecturally intact specimen only.
- This code is not used at the same time as codes for apicoectomy/periradicular curettage.

D. Alveoloplasty – Surgical Preparation of Ridges for Dentures

Alveoloplasty is a covered service only when provided in conjunction with the construction of a prosthodontic appliance. Alveoloplasty is limited to 1 per quadrant.

Covered benefit:

- **D7310 Alveoloplasty – Age restriction is 16-120; in conjunction with extractions – four or more teeth or tooth spaces, per quadrant**
- **D7320 Alveoloplasty – Age restriction is 16-120; not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant**

E. Surgical Excision

The removal of cysts or tumors is covered on a by-report basis.

The following charges must be included:

- **D7450 Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm**
- **D7451 Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm**

- **D7460 Removal of benign non-odontogenic cyst or tumor – lesion diameter up to 1.25 cm**
- **D7461 Removal of benign non-odontogenic cyst or tumor – lesion diameter greater than 1.25 cm**

D7471 Removal of lateral exostosis (maxilla or mandible)

- Prior authorization is required. You must submit diagnostic photographs with area of treatment marked.

D7472 Removal of torus palatinus

- Prior authorization is required. You must submit diagnostic photographs with area of treatment marked.

D7473 Removal of torus mandibularis

- Prior authorization is required. You must submit diagnostic photographs with area of treatment marked.

F. Surgical Incision

Incision and drainage of abscesses is covered on a by-report basis. A detailed explanation of the findings and treatment must be submitted.

D7510 Incision and drainage of abscess – intraoral soft tissue

D7520 Incision and drainage of abscess – extraoral soft tissue

G. Treatment of Fractures

Treatment of fractures should be billed using codes from the American Medical Association's Current Procedural Terminology book.

D7670 Alveolus – closed reduction (may include stabilization of teeth)

- This procedure may be billed as a CPT code or dental code.

D7671 Alveolus – open reduction (may include stabilization of teeth)

- This procedure may be billed as a CPT code or dental code.

H. Other Repair Procedures

D7960 Frenulectomy - also known as frenectomy or frenotomy – separate procedure not incidental to another procedure

- Prior authorization is required for this procedure.
- Diagnostic photographs with areas clearly demonstrated.

D7970 Excision of hyperplastic tissue – per arch

- Prior authorization is required for this procedure.
- Diagnostic photographs must be submitted.

I. Oral Surgery Services

- Oral surgery services should be billed using procedure codes from the surgery section of this handbook.
- Regardless of the code used, all claims must be submitted on the appropriate claim type.

D108. ORTHODONTIC SERVICES FOR MEDICAID

A. General Requirements

To be eligible for comprehensive orthodontic services, the patient must meet all of the following:

- Be actively enrolled with CareSource at the time the member is banded for orthodontic treatment.
- Be under the age of 21 years of age.
- Expect treatment to be completed by the member's 21st birthday or confirm that member accepts cost of treatment beyond 21st birthday.
- Have good oral hygiene documented in the treatment plan and must have documented cleaning prior to orthodontia placement.
- Be free of caries and have sealants on all eligible permanent molars at the time of banding.
- Have all permanent dentition or be at least 13 years of age or missing all primary dentition. Exceptions to having all permanent dentition are as follows:
  - Member has a primary tooth retained due to ectopic or missing permanent tooth.
  - Member may have a primary tooth present if they have a cleft palate, severe traumatic deviations, skeletal abnormalities, post-trauma involving the oral cavity.
  - Member has an impacted maxillary central or lateral incisor.
  - Member may have primary teeth if they are 13 years of age or older.

B. Provider Requirements

Provider must follow all providers requirements in order to be reimbursed for orthodontic services.

All dental providers must be in compliance with the rules and regulations of the Ohio State Dental Board, including the standards for documentation and record maintenance.

Dentists (D.D.S., D.M.D) who provide orthodontic services with CareSource must be credentialed as an orthodontist or as a dentist with orthodontic privileges, achieving at least one of the qualifications listed below:

- Completion of a dental pediatric specialty residency
- Completion of a minimum of 150 hours of continuing education in orthodontics, which included clinical participation or submission of 5 personally completed comprehensive orthodontic cases on children who meet the CareSource Guidelines for Comprehensive Orthodontic Treatment. (Proof of the completion of continuing education hours (and the 5 classes, if required) must be presented at the time of the request for Orthodontic Privileges.)

Orthodontic specialists are eligible to provide orthodontic services if they have satisfactorily completed an orthodontic residency training program approved by the Council on Dental Education of the American Dental Association.

C. Coverage Benefits and Requirements:

Minor treatment to control harmful habits or minor tooth movement (D8210, D8220)

- Special orthodontic appliances are a covered benefit for minor treatment to control harmful habits – thumb sucking, tongue thrust and bruxism or as interceptive appliance for minor tooth movement.
- Providers must obtain prior authorization for orthodontic appliances.
- Radiographs and diagnostic photographs must be submitted with each request. Each orthodontic appliance is limited to once per arch per lifetime. (1 removable and 1 fixed).

Comprehensive Orthodontia Treatment will only be considered after 1 year of completion of appliance therapy.

Comprehensive Orthodontia Treatment (D8080) – Coverage is available to members for resolution of functional concerns in the adolescent dentition

- Qualification for comprehensive orthodontia treatment, including banding and extended care, requires submission of documentation to support the classification of the malocclusion and the functional concerns.
- The patient must be at least 13 years of age or have all permanent dentition erupted.

- Completion of the Evaluation for Comprehensive Orthodontic Treatment form is required and findings must support that a functional concern exists.

The following conditions and the severity will be considered in determining medical necessity for a functional condition. All clinical workup submitted must support conditions identified. Generally, multiple conditions will be required to meet medical necessity including but not limited to:

- Full tooth Class II molar malocclusion
- Full tooth Class III molar malocclusion
- Anterior tooth impaction, unerupted with radiographic evidence to support a diagnosis of impaction (lack of eruptive space, angularly malposed, totally imbedded in the bone) as compared to ectopically erupted anterior teeth, which may be malposed but have erupted into the oral cavity and is not a qualifying element
- Excessive anterior crowding
- Anterior open bite that demonstrates that all maxillary and mandibular incisors have no incisal contact
- Posterior open bite shall demonstrate a vertical separation of several posterior teeth and not confused with the delayed natural eruption of a few teeth
- Posterior cross bite with an associated midline deviation and mandibular shift, a Brodie bite with a mandibular arch totally encumbered by an overlapping buccally occluding maxillary arch, or a posterior maxillary arch totally lingually malpositioned to the mandibular arch
- Anterior crossbite involving more than two (2) incisors in cross bite and demonstrates gingival inflammation, gingival recession or severe enamel wear
- Excessive overbite with a majority of the mandibular incisors causing palatal tissue damage, which is demonstrated in the workup, submitted
- Excessive overjet > 9mm
- Excessive reverse overjet – 3.5mm

Comprehensive Orthodontia services should be completed within 36 months from authorization date. Maximum reimbursement for Comprehensive Orthodontia Treatment will include initial banding and up to 23 subsequent maintenance visits and retention.

Code (D8080) is to be submitted when brackets and bands are placed on both arches.

Payment will not be made for active treatment after retention (D8680) has been paid.

D. Prior Authorization Requirements

Prior authorization for comprehensive orthodontia requires all clinical workup documents listed below:

- Color photos to include:
  - Frontal of face with participant smiling
  - Right or left profile
  - Full maxillary arch (occlusal view)
  - Full mandibular arch (occlusal view)
  - Right side occluded in centric with molars visible
  - Left side occluded in centric with molars visible
  - Anterior occluded in centric occlusion
- Cephalometric radiograph
- Diagnostic full mouth radiographs with participant's name and date visible or Diagnostic Panoramic Film with participant's name and date visible
- Treatment Plan
- Evaluation Form or Comprehensive Orthodontic Treatment Form
- Provider must provide written statement of participant's overall dental health, verifying no carious lesions, participant's motivation, ability to cooperate for orthodontic care, including oral hygiene and appliance maintenance/care and parent's/guardian's understanding as to the necessity of his/her/their support of member's following home instructions and keeping scheduled appointments (Completed Attestation Form).

If there is inadequate information or if not all of the clinical workup is provided for review, the request could result in an adverse decision.

E. Reimbursement

Effective October 1, 2018, any member who is banded with an approved authorization providers will utilize the codes below for billing purposes.

D8080	**Compare dental tx adolescent**	**$624.00**
D8210	**Orthodontic rem appliance tx**	**$205.00**
D8220	**Fixed appliance therapy habt**	**$300.00**
D8670	**Periodic orthodontic tx visit**	**$261.94**
D8680	**Orthodontic retention**	**$205.00**

CareSource reimburses for the clinical workup necessary for the prior authorization

review process, which includes the comprehensive oral evaluation – new or established patient (D0150), the panoramic radiograph (D0330), the cephalometric film with tracing (D0340), color oral/facial photographic images (D0350) and diagnostic models (D0470).

Reimbursement for comprehensive orthodontia (D8080) covers the cost of all appliances and materials throughout treatment, including the first maintenance visit and the removal of any appliances, brackets, wires and etc. at the completion of treatment. Code (D8080) is to be submitted when brackets and bands are placed on both arches.

A flat, contractual fee for each maintenance visit (D8670) may be billed when the member is seen at least once in the billing quarter while in active treatment. Claims may be submitted only for maintenance visits during which the member is seen and evaluated in the office. Broken appointments are not considered as maintenance visits.

The comprehensive reimbursement at the end of treatment (D8680) covers the cost of the retainers and post-treatment visits Payment will not be made for active treatment after retention (D8680) has been paid.

Comprehensive orthodontia services should be completed within 36 months from the authorization date. Maximum reimbursement for comprehensive orthodontia treatment will include initial banding and up to eight quarterly maintenance visits and retention.

F. Loss of Eligibility for Orthodontia Coverage

Eligibility for benefits is lost for orthodontic coverage when:

- The member loses their eligibility with CareSource. However, if a member enrolls in another Medicaid program or is enrolled with Medicaid FFS, that program could provide continued coverage for orthodontia. A request would need to be submitted to the other program to determine the benefit eligibility, if any.
- The member reaches his/her 21st birthday. Members at risk for not completing orthodontia by their 21st birthday should be advised that additional expenses after turning 21 are the responsibility of the member. If a member turns 21 and is still in active orthodontic treatment, the services and costs associated with continued treatment will be the responsibility of the member.

No other benefits related to the orthodontic treatment (e.g. surgical procedures or other orthodontic appliances or procedures) will be covered after the member loses coverage.

G. Early Termination of Orthodontic Benefits

Case termination prior to completion of treatment should rarely occur. All efforts should be made to complete the active phase of treatment. If circumstances occur beyond control of the dentist (such as the member moving out of the state/area) that prevents the orthodontic treatment completion, the provider should notify CareSource immediately.

Participating providers can request that a CareSource member be involuntarily dismissed from their practice if a member does not respond to recommended patterns of treatment or behavior. Examples include noncompliance with medication schedules, skipping scheduled appointments or failure to modify behavior as requested. Any time a member misses three or more consecutive appointments, health partners are asked to notify our Care Management department for assistance.

CareSource requires that a provider's office make at least three attempts to educate the member about non-compliant behavior and document them in the patient's record. Please remember that CareSource's outreach staff can assist you in educating the member. After three attempts, providers may initiate the dismissal by following the guidelines below:

- The provider office must notify the member of the dismissal by certified letter.
- A copy of the letter must be sent to CareSource at the following address:

  CareSource
  Attn: Member Services Manager
  P.O. Box 1947
  Dayton, OH 45401-1947
  Fax: (937) 396-3095

In addition, CareSource's Orthodontic Form for Non-Compliance/Termination must be completed and submitted to the dental prior authorization department.

H. Continuity of Care for Transfer of Orthodontic Treatment

Continuation of care may be considered for a member if, (1) that member has been actively receiving comprehensive orthodontia services previously approved by Medicaid or by another Medicaid managed care plan, and (2) if the member has been compliant with the treatment schedule and treatment plan.

The Orthodontic Continuation of Care Form must be submitted to CareSource listing:

1. The initial provider's name and address.
2. The member's history and current status.
3. The anticipated length of the remaining treatment and treatment goals yet to be achieved.
4. A copy of the original Medicaid approval letter for the member.
5. Estimated reimbursement to finish the goals of the orthodontic treatment.
6. Previous payment to the provider for orthodontic services if the member is changing coverage and staying with the same health provider.

Photographs must be submitted demonstrating the current condition of the member's dentition.

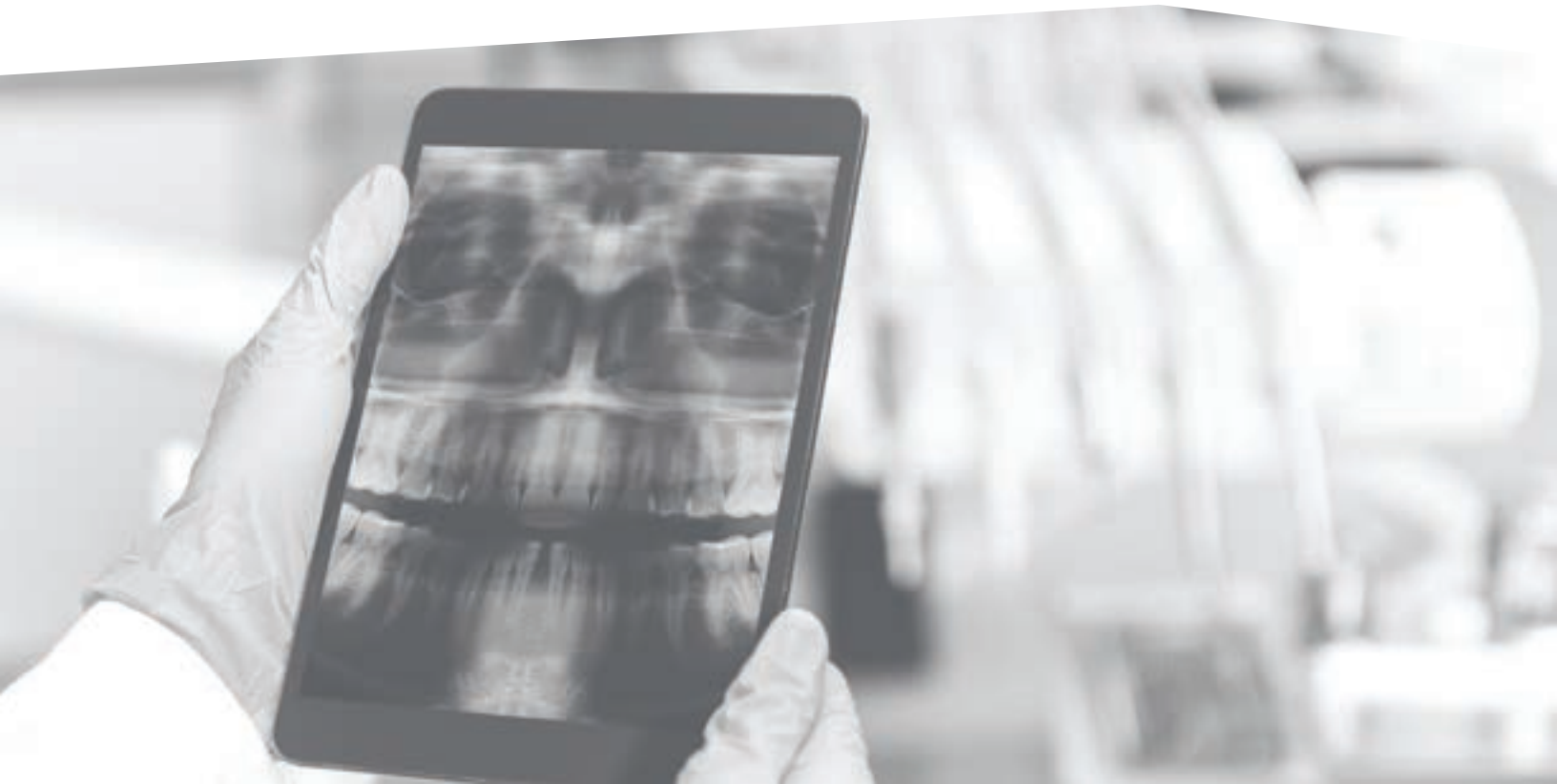
Orthodontic continuation of care for members currently in treatment when enrolling with CareSource and having been self-pay or covered by non-Medicaid insurance will need the following documentation submitted:

1. The initial health partner's name and address.
2. The member's history status.
3. The anticipated length of the remaining treatment and treatment goals yet to be achieved.
4. Completed CareSource evaluation form for Comprehensive Orthodontic Treatment.
5. A full clinical workup including photographs, cephalometric radiograph and panoramic radiograph at the current stage of treatment.
6. Estimated reimbursement to finish the goals of the orthodontic treatment.
7. Previous payment to the health partner for orthodontic services if the member is changing coverage and staying with the same health partner.

For members not previously covered by CareSource or other Medicaid coverage, guidelines for comprehensive orthodontics will be applied based upon the current conditions of the oral complex.

CareSource will not cover services for members coming onto CareSource who have conditions related to past non-compliance or delays in re-establishing orthodontic treatment once on CareSource.

If it is felt by the parent/guardian/member (if over 18 years old) and requesting dentist that debanding would be in the best interest of the member, CareSource will consider covering the debanding and retention for members currently in treatment if treatment is denied.



D109. OTHER COVERED SERVICES FOR MEDICAID

A. Anesthesia

D9222 Deep sedation/general anesthesia – first 15 minutes

- General anesthesia is a covered service when administered by an eligible provider and may be reimbursed separately from the dental procedure.
- Anesthesia is generally covered for surgical or restorative procedures. Payment may also be made when a patient would be unable to undergo a nonsurgical procedure without sedation.
- Payment for deep sedation/general anesthesia services is made at a fixed amount (flat rate of one unit) per patient, per date of service regardless of anesthesia time or procedure codes and units billed.
- The cost of analgesic and local anesthetic agents is included in the fees associated with covered dental services reimbursed by the Medicaid program and is not reimbursed separately.

D9223 Deep sedation/general anesthesia – each 15 minutes increment

- General anesthesia is a covered service when administered by an eligible provider and may be reimbursed separately from the dental procedure.
- Anesthesia is generally covered for surgical or restorative procedures. Payment may also be made when a patient would be unable to undergo a nonsurgical procedure without sedation.
- Payment for deep sedation/general anesthesia services is made at a fixed amount (flat rate of one unit) per patient, per date of service regardless of anesthesia time or procedure codes and units billed.
- The cost of analgesic and local anesthetic agents is included in the fees associated with covered dental services reimbursed by the Medicaid program and is not reimbursed separately.

D9230 Inhalation of nitrous oxide/analgesia

- Covered for members under the age of 21.
- Cannot be billed in conjunction with general anesthesia D9222/D9223 or Intravenous sedation D9239/D9243.

D9239 Intravenous moderate (conscious) sedation/analgesia-first 15 minutes

- Anesthesia is generally covered for surgical or restorative procedures.

- Payment may also be made when a patient would be unable to undergo a nonsurgical procedure without sedation.
- Payment is made at a fixed amount (flat rate) per, patient per date of service.

D9243 Intravenous moderate (conscious) sedation/analgesia-each 15 minutes increment

- Anesthesia is generally covered for surgical or restorative procedures.
- Payment may also be made when a patient would be unable to undergo a nonsurgical procedure without sedation.
- Payment is made at a fixed amount (flat rate) per, patient per date of service.

B. Dental Service Performed Outside the Office

Dental services rendered to patients in long-term care facilities or private homes are covered and subject to the following policies and limitations:

- Updated copies of the patient's medical and dental history, diagnosis, prognosis and treatment plan must be maintained in the patient's long-term care facility and in the health partner's office. These records must include a clinical examination and charting of the oral cavity and teeth, including pulp testing when indicated. The charting diagram must reflect the total condition of the mouth.
- Copies of the request for treatment signed by the patient, family member, responsible guardian, or attending physician, must be maintained with the patient's records at the long-term care facility and the provider's office.
- The request for treatment statement should be as follows:
  - I am currently residing at (insert facility) and am requesting that Dr. (insert provider's name) provide me with dental services that I need.

When requesting dental services that require prior authorization, a copy of the request for treatment must be submitted along with any necessary diagnostic photographs or radiographs. When requesting complete or partial dentures for patients in long-term care facilities, the dentist must submit a copy of the patient's most recent nursing-care plan with the request.

The dental exam does not require prior authorization and may be billed for each patient examined. The dental exam may not occur more than once every 180 days per patient.

C. Inpatient Hospital Services

All inpatient hospital admissions require prior authorization and must be coordinated through the CareSource Medical Management department.

D. Temporomandibular Joint (TMJ) Therapy

D7899 Unspecified TMJ therapy

- All treatment for temporomandibular joint disorder requires prior authorization. Panoramic radiographs, diagnostic photographs and a report of clinical findings and symptoms must be submitted with each request for pre-determination.
- The fee for Temporomandibular Joint Therapy includes six months of adjustments.

E. Maxillofacial Prosthetics

D5999 Unspecified maxillofacial prosthesis

- Prior authorization is required for maxillofacial prosthetics. The dentist must submit a detailed treatment plan, full mouth radiographs and hospital operative report, if applicable, for authorization.

F. Miscellaneous

D9420 Hospital call is not a covered service and is included in the payment for the procedure

- The administration of general anesthesia will be covered for surgical and restorative procedures when performed by an eligible provider as defined in rule 5160-5-01 of the Ohio Administrative Code.
- The cost of analgesic and local anesthetic agents is included in the fees associated with dental services reimbursed by the Medicaid program.

D9610 Therapeutic parenteral drug, single administration

- Therapeutic drug injections are authorized once per visit. The J-code and/or NDC number.

D9620 Therapeutic parenteral drug, two or more administration, different medications

- Therapeutic drug injections are authorized on a once per visit, by-report basis. The J-code and/or NDC number.

D9999 Miscellaneous services (complications, unspecified adjunctive procedure)

- This code is used for unusual and/or specialized treatment necessary to safeguard the health of the patient.
- Prior authorization is required for these procedures. The dentist must submit detailed information on the difficulty of the procedure.
- Complete radiographs of the mouth must be included, if indicated, for authorization.
- An estimate of the usual fee charged for the service must also be submitted.

DENTAL SERVICES FOR MEDICARE

In general, preventive dental services (such as cleaning, routine dental exams, and dental X-rays) are not covered by original Medicare. CareSource covers one oral exam and cleaning every year.

DIAGNOSTIC SERVICES FOR MEDICARE		
Code	Description	Prior Authorization
D0120	Periodic oral evaluation	No
D0150	Comprehensive oral evaluation	No
D0180	Comprehensive periodontal evaluation	No
D0210	Intraoral - complete film series	No
D0220	Intraoral - periapical fi st film	No
D0230	Intraoral - periapical each additional film	No
D0240	Intraoral - occlusal film	No
D0250	Extraoral - first film	No
D0270	Bitewing - single film	No
D0272	Bitewings - two films	No
D0273	Bitewings - three fi ms	No
D0274	Bitewings - four films	No
D0277	Vertical bitewings - seven to eight films	No
D0460	Pulp vitality tests	Yes
D0472	Accession of tissue, gross examination, preparation and transmission of written report	Yes
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	Yes
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	Yes
D0480	Accession of exfoliative cytologic smears, microscopic examination preparation and transmission of written report	Yes
D0502	Other oral pathology procedure, by report	Yes
D0999	Unspecified diagnostic procedure, by report	Yes
D1110	Prophylaxis - adult	No
D1120	Prophylaxis - child	No
D1208	Topical application of fluoride	No
D2999	Unspecified restorative procedure, by report	Yes
D3999	Unspecified endodontic procedure, by report	Yes
D4263	Bone replacement graft-first site in quadrant	Yes
D4264	Bone replacement graft-each additional site in quadrant	Yes
D4268	Surgical revision procedure, per tooth	Yes

Code	Description	Prior Authorization
D4270	Pedicle soft tissue graft procedure	Yes
D4271	Free soft tissue graft procedure	Yes
D4273	Subepithelial connective tissue graft procedure, per tooth	Yes
D4355	Full mouth debridement	Yes
D4381	Localized deliver antimicrobial agents via a controlled release vehicle into disease crevicular tissue, per tooth by report	Yes
D5911	Facial moulage sectional	Yes
D5912	Facial moulage complete	Yes
D5983	Radiation carrier	Yes
D5984	Radiation shield	Yes
D5985	Radiation cone locator	Yes
D5987	Commissure splint	Yes
D6920	Dental connector bar	Yes
D7111	Extraction coronal remnants - deciduous tooth	Yes
D7140	Extraction erupted tooth or exposed root (elevation and/or forceps removal)	Yes
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	Yes
D7220	Removal of impact tooth - soft tissue	Yes
D7230	Removal of impact tooth - partially bony	Yes
D7240	Removal of impact tooth - completely bony	Yes
D7241	Removal of impact tooth - completely bony with unusual surgical complications	Yes
D7250	Surgical removal of residual tooth roots	Yes
D7260	Oroantral fistula closure	Yes
D7261	Primary closure of a sinus perforation	Yes
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	Yes
D7940	Osteotomy - for orthognathic deformities	Yes
D9110	Palliative (emergency) treatment of dental pain	Yes
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	Yes
D9248	Non-intravenous conscious sedation	Yes
D9630	Other drugs and/or medicaments, by report	Yes
D9930	Treatment of complications (post-surgical)	Yes
D9940	Occlusal guard, by report	Yes
D9950	Occlusion analysis	Yes
D9951	Occlusal adjustment-limited	Yes
D9952	Occlusal adjustment-complete	Yes

CareSource

Orthodontic Evaluation and Pre-Determination Form

Patient Name and Address:	CareSource Member ID Number:	
	Patient Date of Birth:	Patient Phone Number:
Health Partner Name and Address:	Health Partner Number:	
	Date:	Health Partner Phone Number:

Criteria for Comprehensive Orthodontic Treatment

****REQUIRED:** From the list below, please check the symptoms and signs or physical conditions you observe in this patient. Five checked boxes does not guarantee authorization, but will be considered with other supporting clinical information. Symptoms should be documented with additional supportive information as appropriate.

Dentofacial Abnormality

- ☐ Marked protruding upper jaw and teeth
- ☐ Underdeveloped lower jaw and teeth, receding chin
- ☐ Excessively spaced front teeth
- ☐ Upper or lower teeth protruding so much that lips cannot be brought together without strain
- ☐ Marked protruding lower jaw and teeth
- ☐ Extremely “crooked” front teeth
- ☐ Marked asymmetry of lower face or transverse deficiencies
- ☐ Clefts of lip or face
- ☐ Abnormalities of dental development
- ☐ Other _____

Tissue Damage Related to Malocclusion

- ☐ Marked recession of gums
- ☐ Loosened permanent teeth
- ☐ Other _____

Mastication Related to Malocclusion

- ☐ Extreme grimacing or excessive motions of the oral-facial muscles during swallowing
- ☐ Socially unacceptable behavior during eating because of necessary compensation or anatomic facial deviations
- ☐ Pain in jaw joints when eating
- ☐ Other _____

Respiration and Speech Related to Malocclusion

- ☐ Postural abnormalities with breathing difficulties
- ☐ Malocclusion of jaws related to chronic mouth breathing
- ☐ Lisping or other speech articulation errors in children 9 years or older
- ☐ History of or recommendation for speech therapy
- ☐ Other _____

****REQUIRED**: Please provide documentation of medical functional impairment directly related to the orthodontic condition. Attach additional pages, if necessary. The presence and degree of impairment can be documented through progress notes, interprofessional consultations, narratives and other diagnostics from the patient’s general dentist, orthodontist, primary care provider, behavioral health specialist or speech therapist.

_____

_____

**Is there a participating CareSource orthodontia provider you would like to refer your patient to?

Name of Provider _____

Orthodontia Health Partner Signature:	Date:

When faxing information, please remember to include all pages of supporting documentation along with this form.

Approved prior authorizations are contingent upon the eligibility of member at the time of service and the claim timely filing limits. Authorizations are not a guarantee of payment. Authorizations are based on medical necessity and are contingent upon eligibility and benefits (and other factors). Benefits may be subject to limitations and/or qualifications and will be determined when the claim is received for processing.

OH-P-157b

CareSource

Orthodontist Confirmation Form

Date: _____

Dear Orthodontia Health Partner: _____

(Member name) has been referred to you for an orthodontia workup and possible treatment. S/he will contact your office to make an appointment. Initial evaluation by the referring dentist suggests this patient has a severe handicapping condition** and may benefit from orthodontia treatment. If, after examination, you do not feel that the member meets CareSource/ODJFS criteria as having the most severe handicapping orthodontic condition, or is not a candidate for comprehensive orthodontic treatment at this time, please complete this form and return it to CareSource.

Following your workup of the patient, please confirm:

This patient is not a suitable candidate for orthodontia treatment for the following reason:

_____

_____

_____

_____

(CareSource will notify the patient that services are not authorized.)

Please fax this letter to CareSource at **1-888-752-0012** or send to:

CareSource
P.O. Box 1307
Dayton, OH 45401-1307

Patient Contact Information

Patient Name and Address:
CareSource Member ID Number:
Address:
Phone:

** CareSource defines a severe handicapping condition as one that severely impairs the patient's ability to eat or speak properly or is associated with significant structural and/or skeletal abnormalities. Imperfections of teeth alignment and bite asymmetry that do not impair mastication and other abnormalities that are primarily cosmetic do not qualify as a severe handicapping condition.

Note: Approved prior authorizations are contingent upon the eligibility of member at the time of service and the claim timely filing limits. Authorizations are not a guarantee of payment. Authorizations are based on medical necessity and are contingent upon eligibility and benefits (and other factors). Benefits may be subject to limitations and/or qualifications and will be determined when the claim is received for processing.

OH-P-156c

CareSource

Orthodontic Continuation of Care Form

Member ID Number: _____

Member Name: _____

Date of Birth: _____

Name of previous health partner that issued approval: _____

Banding date: _____

Balance expected for future dates of service: _____

Services remaining to be covered: _____

Additional information required:

Documentation listing services to be rendered, which may include ADA form.

If the member is transferring from another insurance or Medicaid program: a copy of original orthodontic approval.

If the member is private pay or transferring from commercial insurance please provide the original diagnostic photographs, radiographs and supportive documentation.

OH-P-487b

CareSource

Evaluation Form for Comprehensive Orthodontic Treatment

Member Name: _____ **CareSource ID #:** _____

Member's Birthdate: _____ **Exam Date:** _____

CONDITIONS

If you check conditions 1-3, you do not need to document any other conditions. Complete a narrative of findings supporting functional concerns and submit this form with required Work-up.

1. _____ Cleft Palate Deformities
2. _____ Severe Traumatic Deviations (e.g. accidental loss of premaxilla, gross pathology)
3. _____ Facial discrepancy requiring combined orthodontics and orthognathic surgery
4. _____ Overbite as a percentage (%) _____%
5. _____ Deep impinging overbite w/2 or more teeth causing damage visible in Workup
6. _____ Overjet in mm _____
7. _____ Reverse overjet in mm _____
8. _____ Anterior Open Bite – Tooth # (mm) _____
9. _____ Anterior Crowding
   i. Mandibular Space needed in mm _____
   ii. Maxillary Space needed in mm _____
10. _____ Anterior Spacing
    i. Mandibular in mm _____
    ii. Maxillary in mm _____
11. _____ Anterior Crossbite – Must be more than two teeth in maxillary arch
    i. Tooth numbers _____
12. _____ Posterior Crossbite – More than two teeth with one being a molar or Brodie bite
    i. Tooth numbers _____
13. _____ Class II _____ Class III _____ malocclusion – at least one full tooth
14. _____ Impacted Cuspids, bicuspids* or incisors that will not erupt without surgical intervention
    i. Tooth numbers _____
15. _____ Congenitally missing teeth
    i. Tooth numbers _____
16. _____ Speech problems or History of Speech Therapy*
17. _____ Temporomandibular Joint Involvement (Complete TMD Workup Form)
18. _____ Psychosocial Concerns**
19. _____ Periodontal Concerns***

* Provide documentation from speech therapist, school nurse/guidance counsellor or other professional who has dealt with the member's speech concerns

** Provide documentation of the nature of the concern, when it occurred, who it was reported to and the response from the party (e.g. /school principal or health professional's evaluation and follow-up)

*** Provide periodontal charting demonstrating the concerns and other preventive treatment history

I certify that I am the treating health partner and that the medical necessity information is true and accurate

Treating Dentist Signature:	Date:

OH-P-1001

CareSource

Orthodontic Form for Non-Compliance/Termination with Comprehensive or Interceptive Orthodontic Treatment

Member Information

Last Name: _____ First Name: _____

CareSource ID#: _____ Authorization Number: _____

Health Partner's Information

Name: _____ CareSource Health Partner ID #: _____

Address: _____ Phone/Fax number(s): _____

Patient Compliance

Date Banded: _____ Number of months of care completed: _____

Number of Actual Patient Visits since Banding?: _____

Member was not complying with my office policy as noted below:

Deficiencies in compliance as noted above have reached a point that they are likely to interfere with achieving the goals of treatment.

____ I have offered to remove the appliances.
____ I have offered to fabricate retainers for the patient to maintain the treatment that currently exists.

Arrangements have been made to remove the appliances and health partner retainers Yes No

Treating Dentist Signature:	Date:

Recipient's Acknowledgement:

I have decided that I want to discontinue the orthodontic treatment for:
I understand that the treatment is not completed at this time and has not met the original goals when the treatment was started.
I understand that CareSource will only cover what remains of the orthodontic treatment costs as the result of my termination of care with this health partner if termination is not the result of non- compliance initiated by the providing dentist.

Parent/Guardian/Member (if over 18 yrs old) Signature:	Date:

OH-P-1002

CareSource TMD Screening Examination Form

Member Name: _____ CareSource ID#: _____

Health Partner Name: _____ Location: _____

Clinical Examination

Palpation Over Joint Area

Perceptible Click on Palpation:

Right ☐None ☐Slight ☐Moderate ☐Severe
Left ☐None ☐Slight ☐Moderate ☐Severe

Perceptible Crepitus on Palpation:

Right ☐None ☐Slight ☐Moderate ☐Severe
Left ☐None ☐Slight ☐Moderate ☐Severe

Palpation in External Auditory Meatus

Perceptible Click on Palpation:

Right ☐None ☐Slight ☐Moderate ☐Severe
Left ☐None ☐Slight ☐Moderate ☐Severe

Perceptible Crepitus on Palpation:

Right ☐None ☐Slight ☐Moderate ☐Severe
Left ☐None ☐Slight ☐Moderate ☐Severe

Maximum Comfortable Opening

Non Assisted ___mm Assisted ___mm

Range of Motion

Opening _____ mm
Right Lateral _____ mm
Left Lateral _____ mm

Deviation of Mandibular Midline On Opening

None___ Direction___ Amount___mm

Muscle Tension and/or Pain Response

	RIGHT	LEFT
Masseter	☐Yes ☐No	☐Yes ☐No
Temporalis Tendon	☐Yes ☐No	☐Yes ☐No
Suprahyoid	☐Yes ☐No	☐Yes ☐No
Stylohyoid	☐Yes ☐No	☐Yes ☐No
Lateral Pterygoid	☐Yes ☐No	☐Yes ☐No

TMD History

History of TMD Trauma ☐Yes ☐No
History of TMD Treatment ☐Yes ☐No

What brings on the pain? _____

Intensity? (Mild, Moderate, Severe) _____

Duration? _____

What relieves the pain? _____

OH-P-1003

CareSource

Orthodontic Treatment Plan Acknowledgements Form for Comprehensive Orthodontic Treatment

Treating Dentist's Acknowledgements:

I attest that the following are true statements:

1. The requested treatment is the least restrictive, most cost effective treatment for the malocclusion
2. The member has received an oral examination and was found to be free of untreated oral disease or other conditions that may make orthodontic treatment unsuccessful or harmful
3. The member demonstrates oral hygiene habits consistent with being able to prevent inflammation and dental decay during orthodontic treatment
4. Sealants are in place on all of the member's unrestored erupted permanent molars

Treating Dentist Signature:	Date:

Member's Acknowledgements:

I understand and agree to:

1. Adhere to the treatment plan
2. Comply with an oral hygiene regiment as instructed
3. Attend any scheduled appointment
4. Properly wear and maintain the appliances

I am aware that:

1. The health partner has a right to discontinue treatment for non-compliance
2. CareSource will not pay for the cost of treatment if I am not eligible for their coverage or have reached my 21st birthday
3. CareSource will not cover the cost of orthodontic treatment again if treatment is terminated due to non-compliance

Recipient/Legal Guardian Signature:	Date:

Health partner: Submit this form along with the recipient's Prior Authorization Request

OH-P-1000

CareSource

Evaluation Form to Scaling and Root Planing

Member Name: _____ CareSource ID#: _____

Member's Birthdate: _____ Exam Date: _____

Required Documentation

Periodontal History: Yes ☐ No ☐

If yes: Procedure(s): _____ Date: _____ NA: ☐

Additional Comments:

_____

_____

_____

___ ADA Periodontal Chart or equivalent that exhibits pocket depths of all six surfaces charted attached

___ Required Diagnostic Bitewings (4) and Anterior Periapical Radiographs (mounted, labeled and dated within last 6 months) demonstrating root surface calculus and bone loss

Date Radiographs Taken: _____

Teeth radiographically demonstrating root surface calculus and/or bone loss:

Tooth#	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32

Periodontal Treatment Plan:

Scaling and Root Planing 4 or more Teeth (D4341) UR UL LR LL

Scaling and Root Planing 1 – 3 Teeth (D4342) UR UL LR LL

Periodontal Maintenance (D4910) _____ at _____ months

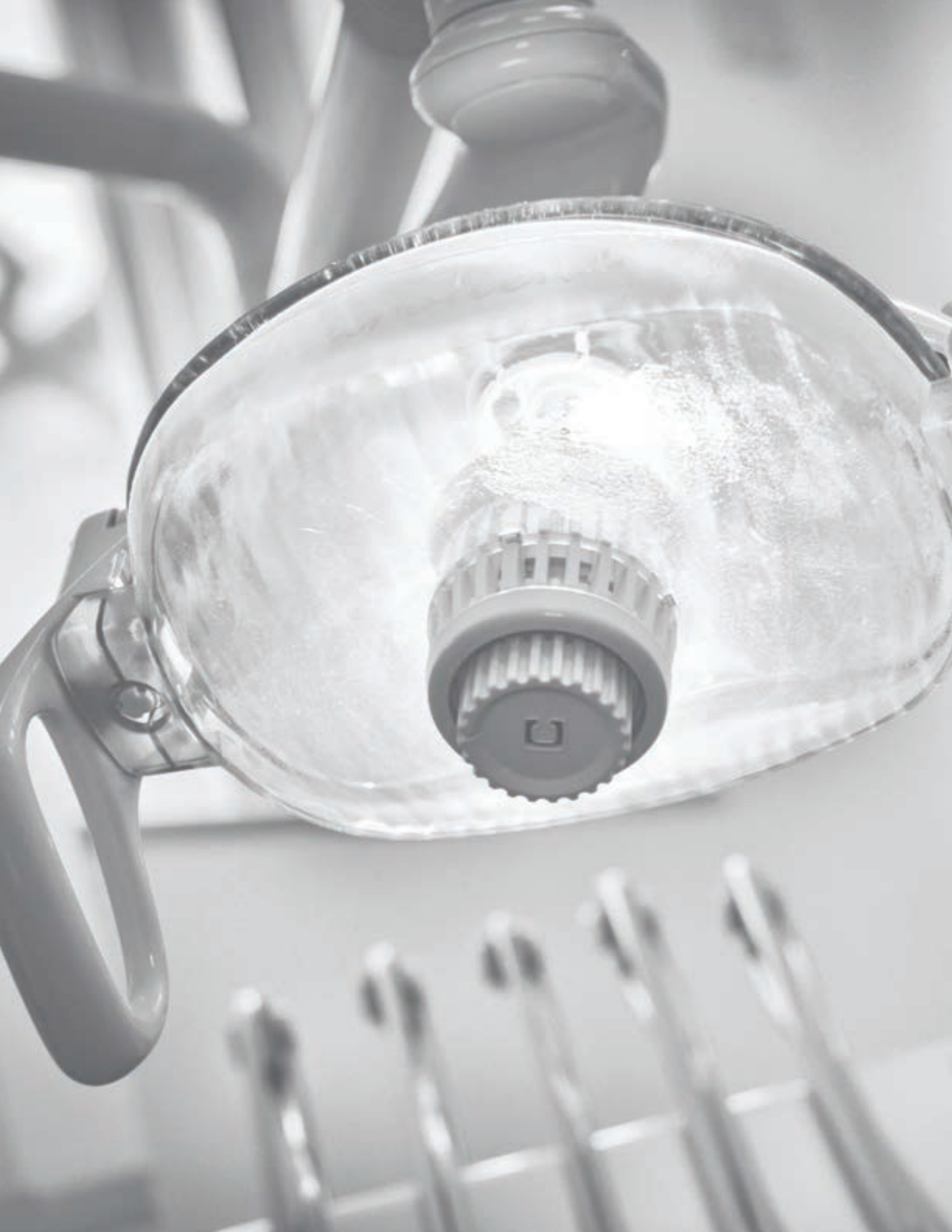
Dental Prophylaxis (D1110) _____ at _____ months

Please Note:

1. Periodontal maintenance is only covered 1 per 365 day.
2. Periodontal maintenance is not covered if no history of scaling and root planing within the previous 24 months.
3. Periodontal maintenance is not covered in conjunction with an oral prophylaxis or within 30 days of scaling and root planing.
4. Scaling and root planing is only covered 1 per 24 months per quadrant.

*Please also include ADA request form properly filled out with each periodontal request.

OH-P-1447



CareSource®

CareSource.com

September 2018
OH-P-0024I