DC Healthy Smiles Dental Program

Administered By Quality Plan Administrators, Inc.

Table of Maximum
Allowable Charges

Over 21 & under 21

Effective 08/01/2008

NOTE: This table of maximum allowable charges is specific for Chartered Health and Health Right Medicaid patients. The maximum allowable charges and reimbursements may change from time to time. The recipient of care is not responsible for deductibles or co-pays.

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INTRODUCTION

This is the table of maximum allowable charges for dental procedures performed on eligible members participating in the Chartered Health Plan. These allowances represent the maximum amount you are contractually allowed to collect from the department of Medicaid for services rendered.

Currently all dental procedures are reflected in this table. There may be changes that may occur after May 1, 2009. Notification will be immediate when changes are instituted.

Submit your normal charges when sending claims to QPA. Our claims payment system will adjust the fees so that the explanation of benefits shows both the submitted charge and the allowable QPA reimbursement. This allows QPA to maintain accurate data for reasonable and customary charges and your usual charge on our claim payment system. When your usual charge for a procedure is lower than the QPA allowance, your usual charge will become the maximum amount you may bill.

It is important to remember that eligibility/benefits are determined based on the date services are rendered, regardless of when they are submitted for payment.

Eligibility Requirements

- **When to Check Eligibility**

  All participating providers are responsible for verifying a patient's eligibility **at each visit**. The presentation of a member's identification card is not sufficient proof that the member is still eligible.

  QPA updates the list of active patients on a weekly basis; however, eligibility verification is still required at each visit.

- **How to Check Eligibility**

  In order to verify a member's eligibility, you may contact the Customer Services department at (202) 722-2744 or 1(800) 900-4112. Such verification does not guarantee payment for services rendered because patient eligibility data is subject to change. Even with presentation of the card, other identification may be necessary to verify identity.

- **QPA eligibility Access System**

  QPA has established a rapid response fax system as well as an interactive voice response (EBVS) system, both of which can be accessed via the segregated providers' selective access program. While the information gained from these automated response systems is the same as would be derived from customer service, the hours are extended and affords responses for unlimited eligibility requests.

- **Fax response and interactive voice response (IVR) system**

  QPA has acquired both of these response systems designed to rapidly address your eligibility and procedural history needs. The testing phase has been completed and you may utilize these functions.

Required Data Elements

- **Required Claim Information**

Both paper and electronic professional claims should include the standard CMS required data elements. Please pay particular attention to the following items:

Patient name

Patient date of birth

Patient demographic information

Member identification number

Group #

Rendering provider name

Payee name and address

Provider Signature

Provider Federal Tax Identification Number or Social Security Number

NPI number

Date of Service

All appropriate CDT codes

Amount billed for each procedure

Place of service code

Type of service

Anesthesia/sedation time in minutes (O.S.)

Replacement of previous prosthodontic appliance

Date of previous service

Pre authorization request

Actual Service

Pre and/or post operative radiographs as outlined in protocols

Additional information as outlined under the "by report" sections outlined on protocols.

- **Paper Claims Submission**

  Paper claims can be submitted to Quality Plan Administrators Claims Department at the following address: QPA requires a completely filled out correct American Dental Association dental claim form. All appropriate sections must be completely addressed in order to facilitate speedy adjudication.

Quality Plan Administrators
7824 Eastern Avenue, N.W.
Suite 100
Washington, DC 20011

- **Electronic Claims Submission**

  QPA accepts electronic claims submissions effective January 2008.

  QPA electronic claims payor id is: CX077

Although the vast majority of our network providers continue to utilize paper claims, we encourage submission of electronic claims. This form of claims management reduces errors and delays encountered by the routing of paper claims. Please feel free to call us regarding how you may get involved with electronic billing, including the transmission of radiographs electronically.

- **Claims Filing Limits**

  MAA has developed a claim filing limit within which QPA holds the provider responsible for filing claims. Strict adherence to this policy is strongly advised since deviation from this policy of claims submitted after 180 days will result in non payment. Additionally there is no recourse against the patient for the collection of these fees due to a lack of timely filing.

- **Pre-Authorization**

  There are some procedures that require pre-authorization which protects both the provider and the administration. QPA will minimize paperwork as much as possible to facilitate the care process. These are prosthodontics of all kinds as well as periodontal procedures. Additional information regarding specific plan design information can generally be obtained by contacting QPA through www.qualitplanadmin.com, or over the phone at (202) 722-2744.

- **Dental Claim review**

  In certain circumstances, radiographs and other diagnostic information relevant to claims and pre-treatment estimates are reviewed by licensed dentists who provide consulting services to QPA. Based on the documentation submitted, these dentists may make recommendations to QPA claims staff to assist in making benefit determination recommendations. For example they may advise adjudicators if there are less expensive treatments that meet generally accepted dental standards of care that could be considered for benefit determination purposes.

  Diagnostic documentation is required for review by our dental consultant staff and should be included with initial claim submission and pre authorization estimates involving services listed below.

  Required diagnostics are:

  - Most recent dated and labeled radiographs of diagnostic quality are required for full removable prosthesis.
  - Most recent dated and labeled radiographs of diagnostic quality of the respective upper and lower arch are required, for partial or full denture prosthetic pre-authorization purposes.
  - Most recent pre treatment periodontal charting (date) and, dated and labeled full mouth radiographs, or as completed a series as is available, are required for periodontal services.

  Occasionally, radiographs will be requested for procedures other than the ones specified above. Although digital x-rays can be submitted, all x-rays submitted should be of good diagnostic quality, labeled clearly and dated. **Duplicate radiographs should be labeled, indicating the right and left side. Periapical x-rays must be appropriately <u>mounted</u> and <u>labeled</u>.**

- **Claims review appeal process**

  A participating QPA dentist may, on a QPA participant's behalf, submit an appeal of benefit recommendation rendered by our dental consultant by following these guidelines, which will expedite the appeal process:

  - Submit a copy of the original claim form
  - Submit the original and any additional diagnostic information or extenuating circumstances
  - Submit a narrative report clearly identifying the basis for the appeal

- **Infection control**

  Infection control is not considered a separate billable dental procedure or service and cannot be billed to the participant or to QPA.

Becoming a QPA Provider

To become a participating QPA Provider, you must:

- Meet the credentialing requirements outlined below
- Be reviewed and approved by the QPA Credentialing Committee
- Have an executed contractual agreement with QPA
- Be willing to collaborate with QPA in coordinating and optimizing the delivery and quality of dental care to our patients
- Provide proof of specialty training

Role of the Dental Network Practitioners

The dental network practitioner agrees to provide care to network enrollees within the scope of services and parameters of care afforded by individual plans administered by QPA. There may be variances in scope as well as compensation among the plans administered by QPA. It is advisable to study the protocols for each plan. It is understood that providers will provide in writing risk factors associated with all services they performed. This informed consent must be provided by either the patient or guardian by their signature on the form provided by the practitioner. It is the responsibility of the provider to be sure that the patient understands the risks and be given information about alternative care if it exists. The provider must also be qualified to treat the complications of the procedures performed by them by virtue of their training.

Role of the Specialist Dental Provider

Every specialist dental provider on our network must meet the minimum credentialing requirements, specified by the DC Board of Dental Examiners and the American Dental Association. This generally means that an individual has graduated from a certified educational program and has met the requirement for Board Eligibility or Board Certification in a branch of dentistry recognized by the American dental association as a specialist. The provider will render specialized care that is designed to enhance the total care of an individual that exceeds the usual training afforded a general practitioner.

Provider Rights and Responsibilities

All Dental Practitioners:

Practitioners and Providers shall facilitate advance directives for individuals as defined in 42 C.F.R 489.100, a written instruction, such as a living will or durable power of attorney for health care recognized under District of Columbia law (whether statutory or as recognized by the courts of the District) relating to the provision of health care when the individual is incapacitated. Practitioners and Providers can receive information about procedures for advance directives from Caring Connections, 1-800-658-889, www.caringinfo.org.

General Dentists

1. Examine patients and develop a treatment plan that falls within the scope of acceptable care as outlined by the ADA for his or her patients.

2. Although a procedure may fall outside of the benefit structure for the plan coverage, the provider should, nevertheless recommend the appropriate care to the patient.

3. At all times, recommend procedures that are appropriate and fall within the code of behavior advocated by the Board of Dental Examiners for the District of Columbia. Have the right to appeal denials to QPA and while doing so, inform the patient. Appeals also extend to credentialing denials.

Specialists

1. Specialists must be appropriately credentialed by the American Dental Association in order to promote themselves or limit their practices under this classification.

2. All the above criteria obtain to specialists

3. Have the right to appeal to a body consisting of their peers.

Health Insurance Portability and Accountability Act (HIPAA)

Medical Records HIPAA Issues

QPA is committed to strict adherence with the privacy and security provisions of the Health Insurance Portability and Accountability Act (HIPAA) and expects that its practitioners and providers are familiar with their responsibilities under the HIPAA and take all necessary action to fully comply. Any member record containing clinical, social, financial, or any other data on a QPA member should be treated as strictly confidential and be protected from loss, tampering, alteration, destruction, and unauthorized or inadvertent disclosure. To maintain these standards, Practitioners should ensure that the following Standards for Availability, Confidentiality and Organization of Dental Records are met.

Practitioners' Dental records are to be maintained in a manner that is current, detailed, organized and permits for effective and confidential patient care and quality review. Practitioner offices are to have an organized dental record filing system that facilitates access and availability of records at all times.

The following elements should be in place:

- A designated staff-person qualified by training or experience, which has oversight of and access to the medical records storage system (paper or electronic system).
- The Office has a policy that includes the manner, in which the dental record is organized, the content of the medical record and the manner in which it is filed.
- If the practitioner has several offices, there is a system to obtain records from one office to another if a patient is seen at several office locations.
- Records for patients who have not been seen by the practitioner for a period of time may be stored off site and are easily accessible if the patient should return.
- The office implements and maintains procedures for maintaining and safeguarding the confidentiality of member dental records and treatment in accordance with applicable federal and state law.
- QPA and provider agree, that they will not divulge information, with an enrollee's employer or any outside agency without the members consent.
- Our providers must agree to act in accordance and comply with the provisions of HIPAA.

QPA reserves the right to inspect records on both announced and unannounced visits.

Release of Dental Records

A member has the right to review a copy of his/her dental records. A written authorization from the member or responsible party is required for the release of dental records. The authorization should include the following:

- Name of the institution/Practitioner that is to release information
- Member's full name
- Member's address
- Member's date of birth
- Description of type of information to be released (including dates of services)
- Date consent is signed
- A statement with respect to the Patients rights with respect to the release of psychotherapy notes if applicable
- A statement advising the member that they can revoke their authorization at any time

Copies of dental records should be released promptly upon written request and reasonable notice from the member or their representative. After the authorized release of dental record copies, the written authorization should be retained in the member's original dental records.

Report suspected waste, fraud and abuse to the appropriate agency

Issues involving QPA patients can be reported to the Customer Service Department or Grievance Coordinators for initial review. The process for reporting to official agencies will be supervised by the Compliance Officer or Risk Manager. Additionally, QPA shall ensure that no individual who reports plan violations or suspected fraud and abuse is retaliated against.

Understand your billing practices

Be diligent in supervising and training your billing personnel. It is your responsibility to ensure compliance with billing guidelines and regulations. Upcoding, unbundling, billing for phantom patients, and billing for services that have not been performed could be found to be fraudulent practices and may be forwarded to the appropriate legal entity for review. Underutilization of services might constitute fraud in a capitated network. Each member should be seen by his or her Dental Care Practitioner at least once a year; if only for preventative screenings.

Report suspected child abuse or neglect

Suspected abuse and/or evidence of abuse or neglect must be reported to the Child Protection Services Division of the DC Department of Human Services and/or the Metropolitan Police department. The Child Abuse and Neglect Reporting Hotline – for District referrals is **(202) 671 SAFE (202) 671-7233**. Appropriate referrals for case management and other social agencies should also be initiated.

Implement HIPAA Practitioner provisions

QPA is a HIPAA compliant company. It is essential that you understand the impact of this act on your practice.

See attached for detailed fee schedule

Proc. Code	Nomenclature	Medicaid Fee	Info Required	Pre-Auth
	<u>Diagnostic (D0100-D0999)</u> **Periodic Oral Evaluation-established patient (D0120)** An evaluation performed on a patient of record to determine any changes in the patients dental and medical health status since a previous comprehensive or periodic evaluation. This includes an oral cancer evaluation and periodontal screening where indicated, and may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately. **Limited Oral Evaluation-problem focused (D0140)** An evaluation limited to a specific oral health problem or complaint. This may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately. Typically, patients receiving this type of evaluation present with a specific problem and/or dental emergencies, trauma, acute infection, etc.			

Proc. Code	Nomenclature	Medicaid Fee	Info Required	Pre-Auth
	Comprehensive Oral Evaluation- new or established patient (D0150) Used by a general dentist and/or a specialist when evaluating a patient comprehensively. This applies to new patients; established patients who have had a significant change in health conditions or other unusual circumstances, by report, or established patients who have been absent from active treatment for more than three or more years. Additional diagnostic procedures should be reported separately. **Detailed and extensive oral evaluation- problem focused, by report (D0160)** A detailed and extensive problem focused evaluation entails diagnostic and cognitive modalities based on the findings of a comprehensive oral evaluation. Integration of more extensive diagnostic modalities to develop a treatment plan for a specific problem is required. The condition requiring this type of evaluation should be described and documented.			

Proc. Code	Nomenclature	Medicaid Fee	Info Required	Pre-Auth
	Re-evaluation- limited, problem focused (D0170) Assessing the status of a previously existing condition. **Comprehensive Periodontal Evaluation (D0180)** This procedure is indicated for patients showing sings or symptoms of periodontal disease and for patients with risk factors such as smoking or diabetes.			
	Intraoral complete series of x- rays For benefit determination purposes, QPA considers a complete series of x rays (D0210) as: five or more periapical x rays (D0220 -D0230) with or bitewings x-rays (D0270 — D0274); or with three or more additional bitewings x-rays; or, a combination of panoramic film (D0330) and bitewing x-rays, or periapical x-rays. All periapical x-rays must indicate tooth numbers.			
D0120	Periodic oral evaluation	$35.00	One of (D0120, D0150, D0160) per 6 month(s)	
D0140	Limited oral evaluation	$50.00	Unlimited	
D0150	Comprehensive oral evaluation	$77.50	Once a Year	
D0160	Detailed and extensive oral evaluation	$67.50	Once a Year	Yes
D0170	Re-evaluation- limited, problem focused	$45.00	Evaluation done by same doctor	
D0180	Comprehensive periodontal evaluation	$77.50	Once a Year, must be 6 months from previous oral evaluation	
D0210	Intraoral- complete series	$91.00	One of (D0210, D0330) per 36 month(s)	
D0220	Intraoral- Periapical First Film	$20.00	Requires tooth #, NOT COVERED with same date of service as D0210/D0330, limited 1 unit per calendar year.	
D0230	Periapical- Each Additional Film	$16.00	Requires tooth #	

Proc. Code	Nomenclature	Medicaid Fee	Info Required	Pre-Auth
D0240	Intraoral- occlusal	$29.00	Requires tooth number; NOT COVERED with same DOS as D0210	
D0270	Bitewing- single film	$21.00	One per 12 months; NOT COVERED with same DOS as D0210	
D0272	Bitewings- two films	$40.00	One of (D0272 or D0274) per 12 month(s) NOT COVERED with same DOS as D0210	
D0274	Bitewing- four films	$48.00	One of (D0272, D0274) per 12 month(s); NOT COVERED in same year as D0270, NOT COVERED with same DOS as D0210	
D0290	Posterior- anterior or lateral skull and facial bone survey film	$314.00	By Report	
D0330	Panoramic film	$80.00	One of (D0210, D0330) per 36 month(s)	
D0340	Cephalometric film	$100.00	Ortho Only	
D0350	Oral/Facial Photographic Images	$59.00	Ortho Only	
D0460	Pulp vitality test	$39.00	By Report	
D0470	Diagnostics casts	$75.00	By Report	Yes
	Preventive (D1000-D1999)			
D1110	Prophylaxis- **adult** (14-20)	$77.50	Every 6 months	
D1120	Prophylaxis- **child** (0-13)	$47.00	Every 6 months	
D1203	Topical application of fluoride- Child	$29.00	Every 6 months	
D1204	Topical application of fluoride- Adult	$26.00	Every 6 months	

Proc. Code	Nomenclature	Medicaid Fee	Info Required	Pre-Auth
D1351	Sealant- per tooth	$38.00	Once every 36 months	
D1510	Space maintainer- fixed- unilateral **(Through age 12)**	$230.00	Indicate missing tooth numbers and Arch/Quadrant on claim	
D1515	Space maintainer- fixed- bilateral **(Through age 12)**	$325.00	Indicate missing tooth numbers and Arch/Quadrant on claim	
	Restorative (D2000— D2999) **Surface combinations** When QPA combines surfaces for restorations performed on the same tooth and same date of service, the dentist can only bill QPA for the approved multiple surface codes based upon current CDT code description. **Composites on molar teeth** When a composite restoration is submitted for a molar tooth, QPA will normally apply an alternate benefit of an equivalent amalgam restoration for payment determination. *****QPA Reserves the right to request x-rays for further review and auditing purposes.**			
D2140	Amalgam- one surface, primary or permanent	$90.00	Tooth Number and Surface	
D2150	Amalgam- two surfaces, primary or permanent	$115.00	Tooth Number and Surface	
D2160	Amalgam- three surfaces, primary or permanent	$139.00	Tooth Number and Surface	

Proc. Code	Nomenclature	Medicaid Fee	Info Required	Pre-Auth
D2161	Amalgam- four surfaces, primary or permanent	$165.00	Tooth # & Surface	
D2330	Resin- One surface, Anterior	$106.00	Tooth # & Surface	
D2331	Resin- Two Surfaces, Anterior	$135.00	Tooth # & Surface	
D2332	Resin- Three Surfaces, Anterior	$165.00	Tooth # & Surface	
D2335	Resin- Four or more surfaces, Anterior	$200.00	Tooth # & Surface	
D2391	Resin- based composite- one surface, posterior	$120.00	Tooth # & Surface	
D2392	Resin- based composite- two surfaces, posterior	$160.00	Tooth # & Surface	
D2393	Resin- based composite- three surfaces, posterior	$200.00	Tooth # & Surface	
D2394	Resin- based composite- four or more surfaces, posterior	$236.00	Tooth # & Surface	
D2710	Crown- Resin- based composite (indirect)	$400.00	Covered once per 60 months	
D2722	Crown- resin with noble metal	$915.00	Covered once per 60 months	
D2750	Crown- porcelain fused to high noble metal adult (21 & Up)	$500.00	Covered once per 60 months	
D2790	Crown- full cast high noble metal (under 21)	$600.00	Covered once per 60 months	
D2799	Crown- provisional (6 months)	$375.00	Covered once per 60 months	
D2920	Crown- recement	$75.00		
D2930	Prefabricated stainless steel crown- primary tooth	$300.00	Covered once per 60 months	
D2931	Prefabricated stainless steel crown- permanent tooth	$102.40	Covered once per 60 months	

Proc. Code	Nomenclature	Medicaid Fee	Info Required	Pre-Auth
D2934	Prefabricated esthetic coated stainless steel crown- primary tooth	$300.00	Covered once per 60 months	
D2970	Temporary Crown	$314.00	Pre-op X-rays	Yes
	Endodontics (D3000-D3999) Therapeutic Pulpotomy (excluding final restoration) removal of pulp coronal to the dentincemental junction and application of medicament (D3220)			
	A **Pulpotomy** is the surgical removal of a portion of the pulp with the aim of maintaining the vitality of the remaining portion by means of an adequate dressing. • To be performed on primary or permanent teeth • This is not construed as the first stage of root canal therapy.			
	Root Canal Therapy The following procedure(s) can not be billed as a separate charge to a MAA when performed in conjunction with root canal therapy on the same tooth: • Intra-operative treatment x-rays (D0220/D0230) • Pulp testing (D0460) • Pulpotomy (D3220) • Palliative treatment (D9110) *****QPA Reserves the right to request x-rays for further review and auditing purposes.**			

Proc. Code	Nomenclature	Medicaid Fee	Info Required	Pre-Auth
D3110	Pulp cap – direct (excluding final restoration)	$55.00	Pre-op X-rays *Cannot bill in conjunction with resin or amalgam of tooth	
D3220	Therapeutic Pulpotomy (excl. final restoration)	$134.00	Pre-op X-rays *Cannot bill in conjunction with RCT D3310 D3320 D3330	
D3310	Anterior (Excluding final restoration)	$498.00	Pre-op *and* Post-op x-rays	
D3320	Bicuspid (Excluding final restoration)	$591.00	Pre-op *and* Post-op x-rays	
D3330	Molar (Excluding final restoration)	$728.00	Pre-op *and* Post-op x-rays	
D3347	Retreatment of previous root canal therapy- bicuspid	$657.00	Pre-op *and* Post-op x-rays	Yes
D3351	Apexification/recalcification-initial visit	$248.00	Pre-op x-rays	Yes

Proc. Code	Nomenclature	Medicaid Fee	Info Required	Pre-Auth
D3426	Apicoectomy/periradicular surgery (each additional root)	$270.00	Pre-op *and* Post-op x-rays	Yes
D3430	Retrograde filling- per root	$180.00	Pre-op X-rays	
	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant (D4210)- Involves the excision of the soft tissue wall of the periodontal pocket by either an external or an internal bevel. It is performed to eliminate suprabony pockets after adequate initial preparation, to allow access for restorative dentistry in the presence of suprabony pockets, or to restore normal architecture when gingival enlargements or asymmetrical or unaesthetic topography is evident with normal bony configuration.			

Proc. Code	Nomenclature	Medicaid Fee	Info Required	Pre-Auth
	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant (D4211) Involves the excision of the soft tissue wall of the periodontal pocket by either an external or an internal bevel. It is performed to eliminate suprabony pockets after adequate initial preparation, to allow access for restorative dentistry in the presence of suprabony pockets, or to restore normal architecture when gingival enlargements or asymmetrical or unesthetic topography is evident with normal bony configuration.			
	Gingival flap procedure. including root planning - four or more contiguous teeth or bounded teeth spaces per quadrant (D4240) A soft tissue flap is reflected or resected to allow debridement of the root surface and the removal of granulation tissue. Osseous recontouring is not accomplished in conjunction with this procedure. May include open flap curettage, reverse bevel flap surgery, modified Kirkland flap procedure, Widman surgery, and modified Widman surgery. This procedure is performed in the presence of moderate to deep probing depths, loss of attachment; need to maintain esthetics, need for increased			

	access to the root surface and alveolar bone, and to determine the presence of a cracked tooth, fractured root, or external root resorption. Other procedures may be required concurrent to D4240 and should be reported separately using their own unique codes.			
	Gingival flap procedure. including root planning - one to three contiguous teeth or bounded teeth spaces per quadrant (D4241) A soft tissue flap is reflected or resected to allow debridement of the root surface and the removal of granulation tissue. Osseous recontouring is not accomplished in conjunction with this procedure. May include open flap curettage, reverse bevel flap surgery, modified Kirkland flap procedure, and modified Widman surgery. This procedure is performed in the presence of moderate to deep probing depths, loss of attachment; need to maintain esthetics, need for increased access to the root surface and alveolar bone, or to determine the presence of a cracked tooth, fractured root, or external root resorption. Other procedures may be required concurrent to D4241 and should be reported separately using their own unique code. *****QPA Reserves the right to request x-rays for further review and auditing purposes**			

	Bone replacement graft- first in quadrant (D4263) This procedure involves the use of osseous autografts, osseous allografts, or non-osseous grafts to stimulate periodontal regeneration when the disease process has led to deformity of the bone. This procedure does not include flap entry and closure, wound debridement, osseous contouring, or the placement of biologic materials to aid in osseous tissue regeneration of barrier membranes. Other separate procedures may be required concurrent to 04263 and should be reported using their own unique codes.			
	Bone replacement graft — each additional site in quadrant (D4264) This procedure involves the use of osseous autografts, osseous allografts, or non-osseous grafts to stimulate periodontal regeneration when the disease process has led to a deformity of the bone. This procedure does not include flap entry and closure, wound debridement, osseous contouring, or the placement of biologic materials to aid in osseous tissue regeneration or barrier membranes. This code is used if performed concurrently with D4263 and allows reporting of the exact number of sites involved.			

Proc. Code	Nomenclature	Medicaid Fee	Info Required	Pre-Auth
	Periodontal scaling and root planning- four or more teeth per quadrant (D4341) This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. It is indicated for patients with periodontal disease and is therapeutic, not prophylactic, in nature. Infrabony pockets in excess of 4-5mm must be demonstrated diagnostically. Procedure requires local anesthesia.			
	Benefit determination guidelines for full mouth debridement (D4355) The gross removal of plaque and calculus that interfere with the ability of the dentist to perform a comprehensive oral evaluation. This preliminary procedure does not preclude the need for additional procedures. Billed in lieu of Procedure D1110 only *****QPA Reserves the right to request x-rays for further review and auditing purposes.**			

Proc. Code	Nomenclature	Medicaid Fee	Info Required	Pre-Auth
D4211	Gingivectomy or gingivoplasty- one to three contiguous teeth or bounded teeth spaces per quadrant.	$160.00	Pre-op x-rays *and* Periodontal Charting	Yes
D4240	Gingival flap procedure, incl. root planning- four or more contiguous teeth or bounded teeth spaces per quadrant.	$125.00		
D4241	Gingival flap procedure, incl. root planning- one to three contiguous teeth or bounded teeth spaces per quadrant.	$125.00		
D4249	Clinical crown lengthening – hard tissue	$496.00		Yes
D4263	Bone replacement graft- first site in quadrant	$452.00	Pre-op X-rays	Yes
D4264	Bone replacement graft- each additional site in quadrant	$339.00	Pre-op X-rays	Yes
D4341	Periodontal scaling and root planning- four or more teeth per quadrant	$181.00	Pre-op X-rays *and* Periodontal Charting	Yes
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$130.00	Limited one per year in lieu of Prophylaxis	

Proc. Code	Nomenclature	Medicaid Fee	Info Required	Pre-Auth
	Prosthodontics, removable (D5000-D5899) **Initial and replacement dentures** For initial dentures, please indicate extraction dates on the submitted claim. For replacement dentures, please indicate date of fabrication of the original dentures on submitted claim.			
	***** For auditing purposes unscheduled office visits and/or request for x-rays will be made. Results will be submitted to the investigation department of MAA for the examination of QPA records.** For benefit determination purposes, QPA considers all adjustments performed on complete/immediate dentures within the first six months to be a part of the total treatment of denture insertion. No payment will be made for adjustments or relines performed in the first 6 months after initial placement. **Partial dentures (D5211-D5214)** The QPA fee for partial dentures includes an allowance for all teeth and all clasps. *****QPA Reserves the right to request x-rays for further review and auditing purposes.**			

Proc. Code	Nomenclature	Medicaid Fee	Info Required	Pre-Auth
D5110	Complete denture, maxillary	$1,120.00	One per 60 months	
D5120	Complete denture, mandibular	$1,125.00	One per 60 months	
D5211	Maxillary partial denture- resin base	$838.00	One per 60 months	
D5212	Mandibular partial denture -resin base (Under 21)	$1200.00	One per 60 months	
D5213	Maxillary partial denture- cast metal framework with resin denture bases	$1,200.00	One per 60 months	
D5214	Mandibular partial denture- cast metal framework with resin denture bases	$1,200.00	One per 60 months	
D5610	Repair resin denture base	$145.00		
D5640	Replace broken teeth- per tooth	$125.00		
D5982	Surgical Stent	$380.00	Pre-op x-rays	Yes
D6010	Surgical placement of implant body endosteal implant	$750.00	Pre-op x-rays	Yes
D6056	Prefabricated abutment includes placement	$375.00	Pre-op x-rays	Yes
D6058	Abutment supported porcelain/ceramic crown	$375.00	Pre-op x-rays	Yes
	Oral and Maxillofacial Surgery (D7000-D7999) ***QPA Reserves the right to request x-rays for further review.			

Proc. Code	Nomenclature	Medicaid Fee	Info Required	Pre-Auth
D7140	Extraction, erupted tooth or exposed root	$110.00		
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap removal of bone and/or sectioning of tooth.	$192.00		
D7220	Removal of impacted tooth- soft tissue	$210.00		
D7230	Removal of impacted tooth- partially bony	$285.00		
D7240	Removal of impacted tooth- completely bony	$350.00		
D7250	Surgical removal of residual tooth roots	$350.00		
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$375.00		
D7280	Surgical exposure of an unerupted tooth, to expose the crown of an impacted tooth not intended to be extracted.	$341.00		
D7282	Mobilization of an erupted or malpositioned tooth to aid eruption	$352.00		
D7285	Biopsy of oral tissue- Hard	$359.00	Pathology Report	Yes
D7286	Biopsy of oral tissue- soft	$201.00	Pathology Report	

Proc. Code	Nomenclature	Medicaid Fee	Info Required	Pre-Auth
D7310	Alveoloplasty in conjunction with extractions- four or more teeth or tooth spaces, per quadrant	$200.00	Per Quadrant (10,20,30,40)	Yes
D7320	Alveoloplasty not in conjunction with extractions- four or more teeth or tooth spaces	$295.00	Pre-op x-rays Per Quadrant (10,20,30,40)	Yes
D7340	Vestibuloplasty- ridge extension	$635.00	By Report Per Quadrant (10,20,30,40)	Yes
D7350	Stomatoplasty complicated	$2,050.00	By Report Per Quadrant (10,20,30,40)	Yes
D7451	Removal of benign odontogenic cyst or tumor	$593.00	By Report	Yes
D7460	Removal of benign nonodontogenic cyst or tumor	$330.00	By Report	Yes
D7471	Removal of lateral exostosis (based on established criteria)	$556.00	By Report	Yes
D7472	Removal of torus palatinus	$685.00	By Report	Yes

Proc. Code	Nomenclature	Medicaid Fee	Info Required	Pre-Auth
D7473	Removal of torus mandibularis	$645.00	By report	Yes
D7510	Incision and drainage of abscess-Intraoral	$155.00	By report	Yes
D7520	Incision and drainage of abscess-extraoral	$250.00	By report	Yes
D7530	Curettage of fistulous tract	$247.00	By report	Yes
D7820	Closed reduction of dislocation	$112.50	By Report	
D7840	Condylectomy	$675.00	By Report and x-rays	Yes

Proc. Code	Nomenclature	Medicaid Fee	Info Required	Pre-Auth
D7850	Surgical discectomy, with or without implant	$630.00	By Report and x-rays	Yes
D7860	Arthrotomy	$450.00	By Report and x-rays	Yes
D7870	Arthrocentesis	$36.00	By Report	
D7910	Suture of recent small wounds up to 5cm	$190.00	By Report	
D7911	Complicated suture- up to 5cm	$307.00	By Report	
D7940	Osteoplasty- for orthognathic deformities	$2,000.00	By Report	Yes
D7950	Osseous, Osteperiosteal, or cartilage graft of the mandible or maxilla- autogenous or nonautogenous, by report	$2,890.00		Yes
D7953	Bone replacement graft for ridge preservation- per site	$581.25	By Report	Yes
D7960	Frenulectomy	$313.00	By Report	Yes
D7972	Surgical reduction of fibrous tuberosity	$675.00	By Report	Yes

Proc. Code	Nomenclature	Medicaid Fee	Info Required	Pre-Auth
	Orthodontic Services **(8000-8999)** **Orthodontic Treatment is covered for Adolescents and Adults**			
D8080	Comprehensive Orthodontic Treatment of the Adolescent	$5,000.00	Models and Pre-op X-rays	Yes
D8090	Comprehensive Orthodontic Treatment of the Adult	$5,000.00	Models and Pre-op X-rays	Yes
D8210	Removable Appliance Therapy	$552.00	Pre-op X-rays	Yes
D8220	Fixed or Cemented	$677.00	Pre-op X-rays	Yes
D8680	Retention	$557.00	Pre-op	Yes
D8999	Unspecified Orthodontic Procedure By Report	$150.00	By Report	

Proc. Code	Nomenclature	Medicaid Fee	Info Required	Pre-Auth
	Adjunctive General Services **(D9000-D9999)** **Deep sedation general anesthesia- first 30 min (D9220)** Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients.			
	Deep sedation/general anesthesia- each additional 15 minutes (D9221) Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients.			

	Consultation- diagnostic service provided by dentist or physician other than requesting dentist or physician (D9310) A patient encounter with a practitioner whose opinion or advice regarding evaluation and/or management of a specific problem; may be requested by another practitioner or appropriate source. The consultation includes an oral evaluation. The consulted practitioner may initiate diagnostic and/or therapeutic services. **Hospital Call (9420**) May be reported when providing treatment in a hospital or ambulatory surgical center, in addition to reporting appropriate code numbers for actual services performed. **Occlusal guard (D9940)** Removable dental appliances, which are designed to minimize the effects of bruxism (grinding) and other occlusal factors. **Occlusal adjustment-limited (D9951)** May also be known as equilibration; reshaping the occlusal surface of teeth to create harmonious contact relationships between the maxillary and mandibular teeth.			

Proc. Code	Nomenclature	Medicaid Fee	Info Required	Pre-Auth
	Occlusal adjustment-complete (D9952) Occlusal adjustment may require several appointments of varying length, and sedation may be necessary to attain adequate relaxation of the musculature.			
D9110	Palliative (emergency) treatment of dental pain	$85.00		
D9220	Deep sedation/general anesthesia-first 30 min	$260.00		Yes
D9221	Deep sedation/general anesthesia-each additional 15 minutes	$112.00		Yes
D9230	Analgesia / Inhalation of nitrous oxide	$46.00		
D9310	Consultation- diagnostic service provided by dentist or physician other than requesting dentist or physician	$112.50		
D9420	Hospital call	$33.00	*QPA Approval Required*	Yes
D9430	Consultant Evaluation Examination	$67.50	*QPA Approved Consult Only*	
D9940	Occlusal guard	$476.00	By Report	Yes
D9951	Occlusal adjustment- limited	$116.00	By Report	
D9952	Occlusal adjustment- complete	$474.00	By Report	

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