Exhibit A Benefits Covered for EPSDT Under 21 Dental Program

Diagnostic services include the oral examinations and selected radiographs needed to assess the oral health, diagnose oral pathology, and develop an adequate treatment plan for the member's oral health.

Reimbursement for some or multiple radiographs of the same tooth or area may be denied if DentaQuest determines the number to be redundant, excessive or not in keeping with the federal guidelines relating to radiation exposure. The maximum amount paid for individual radiographs taken within 30 days will be limited to the allowance for a full mouth series.

Reimbursement for radiographs is limited to when required for proper treatment and/or diagnosis.

DentaQuest utilizes the guidelines published by the Department of Health and Human Services Center for Devices and Radiological Health. However, please consult the following benefit tables for benefit limitations.

All radiographs must be of diagnostic quality, properly mounted, dated and identified with the member's name. Radiographs not of diagnostic quality will not be reimbursed for, or if already paid for, DentaQuest will recoup the funds previously paid.

Reimbursement for procedures provided outside the recommended age limits require documentation of medical necessity such as in a form of a narrative. Note: Preventive and EPSDT services shall be covered.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Diagnostic

Code	Description	Age Limitation	Teeth Covered	Prepayment Review	Pre-Auth Required	Benefit Limitations	Documentation Required	Fee Rate
D0120	periodic oral evaluation - established patient	3-20		No	No	One of (D0120, D0145, D0150) per 6 Month(s) Per Provider OR Location.		**$36.88**
D0140	limited oral evaluation- problem focused	0-20		No	No	This procedure is not payable when submitted in conjunction with routine dental services on the same date of service		**$15.00**
D0145	oral evaluation for a patient under three years of age and counseling with primary caregiver	0-2		No	No	One of (D0120, D0145, D0150) per 6 Month(s) Per Provider OR Location.		**$65.65**
D0150	comprehensive oral evaluation - new or established patient	3-20		No	No	Limited one (D0150) per 3 years by the same provider. Not reimbursable if (D0120, D0145, D0150) was paid within 6 Month(s) by the same provider.		**$64.13**

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D0210	intraoral - complete series of radiographic images	0-20		No	No	One of (D0210, D0330) per 12 Month(s) Per Provider OR Location.		**$81.46**
D0220	intraoral - periapical first radiographic image	0-20		No	No	One (D0220) Per Day Per Patient.		**$19.89**
D0230	intraoral - periapical each additional radiographic image	0-20		No	No			**$16.81**
D0240	intraoral - occlusal radiographic image	0-20		No	No	Two of (D0240) per day Per Provider OR Location.		**$27.63**
D0272	bitewings - two radiographic images	0-20		No	No	One per (D0272) in 12-month per day Per Provider OR Location. Not allowed within 12-month period (D0210)		**$29.01**
D0330	panoramic radiographic image	3-20		No	No	One per (D0210, D0330) per 12 months per Provider OR Location.		**$77.23**
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	0-20		No	No	Two per (D0350) per day Per Provider OR Location.		**$37.12**
D0470	Diagnostic casts	0-20		No	No			**$64.22**
D0473	accession of tissue, gross and microscopic exam	0-20		No	No			**$74.49**
D0474	accession of tissue, gross and microscopic exam (surgical)	0-20		No	No			**$77.09**

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All sealants must be performed on a single date of service unless restorations or other treatment services are necessary. If restorative or other treatment services are necessary, sealants may be performed on the same date of service as the restorative or other treatment services. Sealants are available for the occlusal surface only. If there are circumstances that would not allow sealants to be applied in this manner, the contraindication(s) must be documented in the beneficiary's treatment record. Sealants are not reimbursable for teeth that have any previous occlusal restoration. Dental sealants may only be placed by persons licensed to do so under the Dental Practice Act of the State of Louisiana.

Sealants may be placed on the occlusal or occlusal-buccal surfaces of lower molars or occlusal or occlusal-lingual surfaces of upper molars.

Space maintainers are a covered service when indicated due to the premature loss of a posterior primary tooth. A lower lingual holding arch placed where there is not premature loss of the second primary molar is considered a transitional orthodontic appliance and not covered by this Plan.

BILLING AND REIMBURSEMENT FOR SPACE MAINTAINERS SHALL BE BASED ON THE CEMENTATION DATE.

Note: Preventive and EPSDT services shall be covered.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Preventative

Code	Description	Age Limitation	Teeth Covered	Prepayment Review	Pre-Auth Required	Benefit Limitations	Documentation Required	Fee Rate
D1110	prophylaxis - adult	12-20		No	No	One of (D1110, D1120) per 6 Month(s) Per patient. D4355 not allowed within 12 months **following D1110, or D1120.**		**$65.00**
D1120	prophylaxis - child	0-11		No	No	One of (D1110, D1120) per 6 Month(s) Per patient. D4355 not allowed within 12 months following D1110, or D1120.		**$47.41**
D1206	topical application of fluoride varnish	0-5		No	No	Application of topical fluoride varnish, delivered in a single visit and involving the entire oral cavity. Not to be used for desensitization. Procedure code D1206 is reimbursable once per 6-month period, for the same enrollee. A combination of D1208 and D1206 are NOT		**$32.88**

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						reimbursable in the same six-month period		
D1208	topical application of fluoride - excluding varnish	0-15		No	No	Application of topical fluoride delivered in a single visit and involving the entire oral cavity. Not to be used for desensitization. This procedure is limited to once per 6-month period. Excluding Varnish. A combination of D1208 and D1206 are NOT reimbursable in the same six-month period.		**$26.40**
D1351	sealant - per tooth	**0-9**	Teeth ,3, 14, 19, 30,	No	No	One of (D1351) per 24 Month(s) Per patient per tooth.	-	**$34.54**
D1351	Sealant – per tooth	**10-15**	Teeth 2,15, 18, 31	No	No	One of (D1351) per 24 Month(s) Per patient Per tooth.		**$34.54**
D1351	Sealant – per tooth	0-16		No	No	One of (D1351) per 24 Month(s) Per patient Per tooth.		**$34.54**
D1510	space maintainer-fixed, unilateral- per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	Not allowed within 12 months of initial placement by same provider/location/group		**$205.13**
D1516	Space maintainer, fixed, bilateral, maxillary	0-20		No	No	Not allowed within 12 months of initial placement by same provider/location/group		**$279.71**
D1517	Space maintainer, fixed, bilateral, mandibular	0-20		No	No	Not allowed within 12 months of initial placement by same provider/location/group		**$279.71**
D1551	Recementation of space maintainer maxillary	0-20		No	No	Not allowed within 12 months of initial placement by same provider/location/group, allowed once per 60 months.		**$52.49**
D1552	Recementation of space maintainer mandibular	0-20		No	No	Not allowed within 12 months of initial placement by same provider/location/group, allowed once per 60 months.		**$52.49**

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D1553	Recement or rebond unilateral space maintainer – per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	Not allowed within 12 months of initial placement by same provider/location/group, allowed once per 60 months.		**$52.49**
D1556	Removal of fixed unilateral space maintainer – per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	Not allowed by same provider/location/group that placed space maintainer.		**$51.80**
D1557	Removal of fixed bilateral space maintainer – maxillary	0-20		No	No	Not allowed by same provider/location/group that placed space maintainer.		**$51.80**
D1558	Removal of fixed bilateral space maintainer – mandibular	0-20		No	No	Not allowed by same provider/location/group that placed space maintainer.		**$51.80**
D1575	distal shoe space maintainer - fixed - unilateral- Per Quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No			**$205.13**

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Reimbursement includes local anesthesia.

Generally, once a particular restoration is placed in a tooth, a similar restoration will not be covered for at least thirty-six months, unless there is recurrent decay or material failure.

Payment is made for restorative services based on the number of surfaces restored, not on the number of restorations per surface, or per tooth, per day. A restoration is considered a two or more surface restoration only when two or more actual tooth surfaces are involved, whether they are connected or not. For providers to bill for a complex occlusal lingual restoration, the preparation must extend the full length of the buccal or lingual groove or fully restore the buccal or lingual pit in addition to the occlusal surface.

Tooth preparation, all adhesives (including amalgam and resin bonding agents), acid etching, copalite, liners, bases, and indirect pulp caps, curing, and polishing are included as part of the fee for the restoration.

BILLING AND REIMBURSEMENT FOR CAST CROWNS AND POST & CORES OR ANY OTHER FIXED PROSTHETICS SHALL BE BASED ON THE CEMENTATION DATE.

Note: Preventive and EPSDT services shall be covered.

When restorations involving multiple surfaces are requested or performed, that are outside the usual anatomical expectation, the allowance is limited to that of a one-surface restoration. Any fee charged in excess of the allowance for the one-surface restoration is DISALLOWED.

Unusual anatomic tooth/ surface combinations may include but are not limited to: routine billing of permanent posterior teeth billed with OBL combinations, and routine billing on all permanent teeth with MBD or MFD surface combinations. We expect all connected surfaces to be billed as a single restoration. Cases may be considered with photographic evidence of extent of decay or restoration.

The fee for crowns includes the temporary crown that is placed on the prepared tooth and worn while the permanent crown is being fabricated for permanent teeth. Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Restorative

Code	Description	Age Limitation	Teeth Covered	Prepayment Review	Pre-Auth Required	Benefit Limitations	Documentation Required	Fee Rate
D2140	Amalgam - one surface, primary	0-4	Teeth D, E, F, G, N, O, P, Q	No	No	One of (D2140, D2150, D2160, D2161) per 12 Month(s) Per patient per tooth, per surface Per Provider OR Location.		**$87.71**
D2140	Amalgam - one surface, primary	5-20	Teeth D, E, F, G, N, O, P, Q	Yes	No	One of (D2140, D2150, D2160, D2161) per 12 Month(s) Per patient per tooth, per surface Per Provider OR Location.	Preoperative X-Rays	**$87.71**

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D2140	Amalgam- one surface, permanent teeth only	0-20	Teeth 1 – 32	No	No	One of (D2140, D2150, D2160, D2161) per 12 Month(s) Per patient per tooth, per surface Per Provider OR Location. One of (D2140, D2150, D2160, D2161) per 12 Month(s) Per patient per tooth, per surface Per Provider OR Location.		**$101.25**
D2140	Amalgam - one surface, primary	0-20	Teeth A-C, H-M, R-T	No	No	One of (D2140, D2150, D2160, D2161) per 12 Month(s) Per patient per tooth, per surface Per Provider OR Location. One of (D2140, D2150, D2160, D2161) per 12 Month(s) Per patient per tooth, per surface Per Provider OR Location.		**$87.71**
D2150	Amalgam - two surfaces, primary	0-4	Teeth D, E, F, G, N, O, P, Q	No	No	One of (D2140, D2150, D2160, D2161) per 12 Month(s) Per patient per tooth, per surface Per Provider OR Location.		**$111.20**
D2150	Amalgam - two surfaces, primary	5-20	Teeth D, E, F, G, N, O, P, Q	Yes	No	One of (D2140, D2150, D2160, D2161) per 12 Month(s) Per patient per tooth, per surface Per Provider OR Location.	Preoperative X-Rays	**$111.20**
D2150	Amalgam – two surfaces primary teeth only	0-20	Teeth A-C, H-M, R-T.	No	No	One of (D2140, D2150, D2160, D2161) per 12 Month(s) Per patient per tooth, per surface Per Provider OR Location.		**$111.20**
D2150	Amalgam - two surfaces, permanent teeth only	0-20	Teeth 1 - 32, with two surfaces combo EXCEPT MO or DO	No	No	One of (D2140, D2150, D2160, D2161) per 12 Month(s) Per patient per tooth, per surface Per Provider OR Location.		**$124.74**
D2150	Amalgam - two surfaces, permanent teeth only	0-20	Teeth1-32, with two surfaces combo MO or DO.	No	No	One of (D2140, D2150, D2160, D2161) per 12 Month(s) Per patient per tooth, per surface Per Provider OR Location.		**$158.58**
D2160	amalgam - three surfaces, primary	0-4	Teeth D, E, F, G, N, O, P, Q	No	No	One of (D2140, D2150, D2160, D2161) per 12		**$134.68**

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						Month(s) Per patient per tooth, per surface Per Provider OR Location.		
D2160	amalgam - three surfaces, primary	5-20	Teeth D, E, F,G, N, O, P, Q	Yes	No	One of (D2140, D2150, D2160, D2161) per 12 Month(s) Per patient per tooth, per surface Per Provider OR Location.	Preoperative X-Rays	**$134.68**
D2160	Amalgam – three surfaces, primary	0-20	Teeth A-C, H-M, R-T	No	No	One of (D2140, D2150, D2160, D2161) per 12 Month(s) Per patient per tooth, per surface Per Provider OR Location.		**$134.68**
D2160	Amalgam – three surfaces, primary	0-20	Teeth 1 - 32 with three surfaces combo of OBL	No	No	One of (D2140, D2150, D2160, D2161) per 12 Month(s) Per patient per tooth, per surface Per Provider OR Location.		**$148.21**
D2160	amalgam - four or more surfaces, permanent	0-20	Teeth 1 - 32 with three surfaces combo except OBL.	No	No	One of (D2140, D2150, D2160, D2161) per 12 Month(s) Per patient per tooth, per surface Per Provider OR Location.		**$178.00**
D2161	amalgam - four or more surfaces, permanent	0-20	Teeth 1 - 32	No	No	One of (D2140, D2150, D2160, D2161) per 12 Month(s) Per patient per tooth, per surface Per Provider OR Location.		**$178.00**
D2330	resin-based composite - one surface, anterior	0-4	Teeth D, E, F, G, N, O, P and Q	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		**$102.90**
D2330	resin-based composite - one surface, anterior	5-20	Teeth D, E, F, G, N, O, P, Q	Yes	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.	Preoperative X-Rays	**$102.90**
D2330	Resin-based composite – One surface, anterior	0-20	Teeth C, H, M, R	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per		**$102.90**

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						tooth, per surface Per Provider OR Location.		
D2330	resin-based composite - one surface, anterior	0-20	Teeth 6-11, 22-27	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		**$129.98**
D2331	resin-based composite - two surfaces, anterior	0-4	Teeth D, E, F, G, N, O, P and Q	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		**$127.77**
D2331	resin-based composite - two surfaces, anterior	5-20	Teeth D, E, F, G, N, O, P, Q	Yes	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.	Preoperative X-Rays	**$127.77**
D2331	Resin-based composite – two surfaces, anterior	0-20	Teeth C, H, M, R	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		**$127.77**
D2331	resin-based composite - two surfaces, anterior	0-20	Teeth 6-11, 22-27 with two surfaces, combo except MI or DI.	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		**$168.39**
D2331	resin-based composite - two surfaces, anterior	0-20	Teeth 6-11, 22-27 with two surfaces, combos MI or DI only	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		**$171.09**
D2332	resin-based composite - three surfaces, anterior	0-4	Teeth D, E, F, G, N, O, P, Q	No	No	One of (D2330, D2331, D2332, D2335, D2390,		**$155.40**

						D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		
D2332	resin-based composite - three surfaces, anterior	5-20	Teeth D, E, F, G, N, O, P, Q	Yes	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.	Preoperative X-Rays	**$155.40**
D2332	resin-based composite - three surfaces, anterior	0-20	Teeth C, H, M and R	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		**$155.40**
D2332	resin-based composite - three surfaces, anterior	0-20	Teeth 6-11 and 22- 27	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		**$205.49**
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	0-4	Teeth D, E, F, G, N, O, P and Q	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		**$194.77**
D2335	Resin-based composite – four or more surfaces or involving incisal angle (Anterior)	5-20	Teeth D, E, F, G, N, O, P, Q	Yes	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.	Preoperative X-Rays	**$194.77**
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	0-20	Teeth C, H, M and R	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		**$194.77**

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D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	0-20	Teeth 6-11 and 22- 27 with four surfaces including surface I	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		**$269.23**
D2390	resin-based composite crown, anterior	0-4	Teeth D, E, F, G, N, O, P and Q	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		**$285.25**
D2390	resin-based composite crown, anterior	5-20	Teeth D, E, F, G, N, O, P and Q	Yes ~~No~~	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.	Preoperative X-Rays	**$285.25**
D2390	resin-based composite crown, anterior	0-20	Teeth C, H, M and R	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.	-	**$285.25**
D2390	resin-based composite crown, anterior	0-20	Teeth 6-11 and 22- 27	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		**$413.86**
D2391	resin-based composite - one surface, posterior	0-20	Teeth A, B, I, J, K, L, S and T.	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		**$87.71**
D2391	resin-based composite - one surface, posterior	0-20	Teeth 1-5, 12-21 and 28-32	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		**$101.25**

D2392	resin-based composite - two surfaces, posterior	0-20	Teeth A, B, I, J, K, L, S, T	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		**$111.20**
D2392	resin-based composite - two surfaces, posterior	0-20	Teeth 1-5, 12-21 and 28-32 with two surfaces combo except MO or DO	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		**$124.74**
D2392	resin-based composite - two surfaces, posterior	0-20	Teeth 1-5, 12-21 and 28-32 with two surfaces combo MO or DO	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		**$158.58**
D2393	resin-based composite - three surfaces, posterior	0-20	Teeth A, B, I, J, K, L, S and T.	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		**$134.68**
D2393	resin-based composite - three surfaces, posterior	0-20	Teeth 1-5, 12-21 and 28-32 with three surfaces combo except OBL	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		**$178.00**
D2393	resin-based composite - three surfaces, posterior	0-20	Teeth 1-5, 12-21 and 28-32 with three surfaces combo of OBL	No	No	One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		**$148.21**
D2394	resin-based composite - four or more surfaces, posterior	0-20	Teeth A, B, I, J, K, L, S and T.	No	No	One (D2335 or D2394) per day, same tooth, per billing provider. One of (D2330, D2331, D2332, D2335, D2390,		**$158.85**

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						D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		
D2394	resin-based composite - four or more surfaces, posterior - permanent teeth only	0-20	Teeth 1- 5, 12 - 21, 28-32.	No	No	One (D2335 or D2394) per day, same tooth, per billing provider. One of (D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, and D2394) per 12 months Per patient per tooth, per surface Per Provider OR Location.		**$178.00**
D2920	re-cement or re-bond crown	0-20	Teeth 1 - 32, A - T	No	No	Not allowed within 12 months of initial placement.		**$84.61**
D2929	prefabricated esthetic coated stainless steel crown - primary tooth	0-4	Teeth D, E, F, G, N, O, P and Q	No	No	One of (D2929, D2930, D2931, D2932, D2933, D2934) per 12 Month(s) Per patient per tooth.		**$370.37**
D2929	prefabricated esthetic coated stainless steel crown - primary tooth	5-20	Teeth D, E, F, G, N, O, P and Q	No	No	One of (D2929, D2930, D2931, D2932, D2933, D2934) per 12 Month(s) Per patient per tooth.	Preoperative X-rays	**$370.37**
D2929	prefabricated esthetic coated stainless steel crown - primary tooth	0 - 20	Teeth C, H, M, and R	No	No	One of (D2929, D2930, D2931, D2932, D2933, D2934) per 12 Month(s) Per patient per tooth.		**$370.37**
D2930	prefabricated stainless-steel crown - primary tooth	0-4	Teeth D, E, F, G, N, O, P and Q	No	No			**$215.83**
D2930	prefabricated stainless-steel crown - primary tooth	5-20	Teeth D, E, F, G, N, O, P and Q	Yes	No		Preoperative X-Rays	**$215.83**
D2930	prefabricated stainless-steel crown - primary tooth	0-20	Teeth A, B, C, H, I, J, K, L,M, R, S and T	No	No			**$215.83**
D2931	prefabricated stainless-steel crown-permanent tooth	0-20	Teeth 1-32	Yes	No	One of (D2929, D2930, D2931, D2932, D2933, D2934) per 12 Month(s) Per patient per tooth.	pre-operative x-ray(s)	**$341.88**
D2932	prefabricated resin crown	0-4	Teeth D, E, F, G, N, O, P and Q	No	No	One of (, D2929, D2930, D2931, D2932, D2933, D2934) per 12 Month(s) Per patient per tooth.		**$280.57**

Exhibit A Benefits Covered for EPSDT Under 21 Dental Program

D2932	prefabricated resin crown	5-20	Teeth D, E, F, G, N, O, P and Q	Yes	No	One of (D2929, D2930, D2931, D2932, D2933, D2934) per 12 Month(s) Per patient per tooth.	Preoperative X-Rays	**$280.57**
D2932	prefabricated resin crown	0 - 20	Teeth C, H, M, R, 6- 11 and 22-27	No	No	One of (D2929, D2930, D2931, D2932, D2933, D2934) per 12 Month(s) Per patient per tooth.		**$280.57**
D2933	prefabricated stainless-steel crown with resin window	0-4	Teeth D, E, F, G, N, O, P and Q	No	No	One of (D2929, D2930, D2931, D2932, D2933, D2934) per 12 Month(s) Per patient per tooth.		**$285.75**
D2933	prefabricated stainless- steel crown with resin window	5-20	Teeth D, E, F, G, N, O, P and Q	Yes	No	One of (D2929, D2930, D2931, D2932, D2933, D2934) per 12 Month(s) Per patient per tooth.	Preoperative X-Rays	**$285.75**
D2933	prefabricated stainless-steel crown with resin window	0 - 20	Teeth C, H, M, and R	No	No	One of (D2929, D2930, D2931, D2932, D2933, D2934) per 12 Month(s) Per patient per tooth.		**$285.75**
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	0-4	Teeth D, E, F, G, N, O, P and Q	No	No	One of (D2929, D2930, D2931, D2932, D2933, D2934) per 12 Month(s) Per patient per tooth.		**$370.37**
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	5-20	Teeth D, E, F, G, N, O, P and Q	Yes	No	One of (D2929, D2930, D2931, D2932, D2933, D2934) per 12 Month(s) Per patient per tooth.	Preoperative X-Rays	**$370.37**
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	0 - 20	Teeth C, H, M, and R	No	No	One of (D2929, D2930, D2931, D2932, D2933, D2934) per 12 Month(s) Per patient per tooth.	Preoperative X-Rays	**$370.37**
D2950	core buildup, including any pins when required	0 - 20	Teeth 2 -15 and 18- 31	No	No	Not allowed with D2954		**$ 174.04**
D2951	pin retention - per tooth, in addition to restoration	0 - 20	Teeth 2 -5, 12 - 15, 18- 21, 28-31.	No	No	Only allowed one per 12 months with D2160 or D2161 same tooth.		**$ 47.65**
D2954	prefabricated post and core in addition to crown	0 - 20	Teeth 2 -15 and 18- 31	No	No	Not allowed with D2950	Inpatient Records	**$ 271.94**
D2999	unspecified restorative procedure, by report	0 - 20	Teeth 1 – 32, A-T	Yes	No		Preoperative	**By Report**

Exhibit A Benefits Covered for EPSDT Under 21 Dental Program

Reimbursement includes local anesthesia.

In cases where a root canal filling does not meet DentaQuest's general criteria treatment standards, DentaQuest can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

A pulpotomy, pulpectomy or palliative treatment is not to be billed in conjunction with a root canal treatment on the same date. Filling material not accepted by the Federal Food and Drug Administration (FDA) (e.g., Sargenti filling material) is not covered.

Complete root canal therapy includes, treatment plan, all appointments necessary to complete treatment, temporary fillings, filling & obturation of canals, intra-operative, fill radiographs, and follow-up care.

BILLING AND REIMBURSEMENT FOR INITIAL OR RETREATMENT ROOT CANALS SHALL BE BASED ON THE FILL DATE.

Note: Preventive and EPSDT services shall be covered.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Endodontics

Code	Description	Age Limitation	Teeth Covered	Prepayment Review	Pre-Auth Required	Benefit Limitations	Documentation Required	Fee Rate
D3110	Pulp cap - direct (excluding final restoration	0-20	Teeth 1 - 32	No	No	Not allowed with(D2950, D2954, D2999, D3220, D3240, D3310, D3320, or D3330) for the same tooth or same date of service or provider or location.		**$51.80**
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	0-4	Teeth D, E, F, G, N, O, P and Q	No	No	One of (D3220) per 24 month(s) Per Tooth		**$127.77**
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	5-20	Teeth D, E, F, G, N, O, P and Q	Yes	No	One of (D3220) per 24 month(s) Per Tooth	**Preoperative X-Rays**	**$127.77**
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	0-20	Teeth A, B, C, H, I, J, K, L, M, R, S and T	No	No	One of (D3220) per 24 month(s) Per tooth per provider or Location.		**$127.77**

Exhibit A Benefits Covered for EPSDT Under 21 Dental Program

D3222	partial pulpotomy for apexogenesis- permanent tooth with incomplete root development	0-20	Teeth 2-15 and 18- 31	No	No	One of (D3222) per 24 month(s) Per tooth per provider or Location.	pre-operative x-ray(s)	**$127.77**
D3240	pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	0-20	Teeth A, J, K, T	No	No			**$205.82**
D3310	endodontic therapy, anterior tooth (excluding final restoration)	0-20	Teeth 6 - 11, 22 - 27	Yes	No	One of (D3310) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)	**$455.84**
D3320	endodontic therapy, premolar tooth (excluding final restoration)	0-20	Teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	No	One of (D3320) per 1 Lifetime Per patient per tooth.	pre-operative x-ray(s)	**$535.25**
D3330	endodontic therapy, molar tooth (excluding final restoration)	0 - 20	Teeth 2, 3, 14, 15, 18, 19, 30 and 31	Yes	No	One of (D3330) per 1Lifetime Per patient per tooth.	pre-operative x-ray(s)	**$642.31**
D3346	retreatment of previous root canal therapy-anterior	0 - 20	Teeth 6 - 11, 22 - 27	Yes	No	One of (D3346) per 1 Lifetime Per patient per tooth. Not billable by same provider/location that performed original root canal therapy	pre-operative x-ray(s)	**$529.73**
D3352	apexification/recalcification - interim medication replacement	0 - 20	Teeth 2-15 and 18- 31	Yes	No	This service is limited to a maximum of three (3) treatments per tooth with the root canal being billed separately. A time period of 90 days must elapse between the final D3352 treatment and start of the root canal.	pre-operative x-ray(s)	**$164.38**
D3410	apicoectomy - anterior	0 - 20	Teeth 6 - 11, 22 - 27	Yes	No		pre-operative x-ray(s)	**$437.87**
D3430	retrograde filling - per root	0 - 20	Teeth 6 - 11, 22 - 27	Yes	No	Only approved in conjunction with code D3410.	pre-operative x-ray(s)	**$174.04**
D3999	unspecified endodontic procedure, by report	0 - 20	Teeth 1 – 32, A - T	Yes	No		Narrative of medical necessity pre- operative x-ray(s)	**By Report**

Exhibit A Benefits Covered for EPSDT Under 21 Dental Program

Reimbursement includes local anesthesia, suturing if needed, and routine post-operative care.

Note: Preventive and EPSDT services shall be covered.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Periodontics

Code	Description	Age Limitation	Teeth Covered	Prepayment Review	Pre-Auth Required	Benefit Limitations	Documentation Required	Fee Rate
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No		Narrative of medical necessity and preoperative X-Rays	**$399.88**
D4341	periodontal scaling and root planing - four or more teeth per quadrant	13 - 20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	Yes	No	One D4341 per 12 month(s) quadrant, Not allowed within month(s) of D1110 or D1120	Narrative of medical necessity and preoperative X-Rays	**$158.85**
D4355	full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	0 - 20		Yes	No	One of (D4355) per 12 months per patient. Not allowed within 12 month(s) of D1110 or D1120. Not allowed with D0150.		**$117.41**
D4999	unspecified periodontal procedure, by report	0 - 20		Yes	No		Narrative of medical necessity and preoperative X-Rays	**By Report**

Exhibit A Benefits Covered for EPSDT Under 21 Dental Program

A preformed denture with teeth already mounted forming a denture module is not a covered service. Provisions for a removable prosthesis will be considered when there is evidence that masticatory function is impaired, when the existing prosthesis is unserviceable, or when masticatory insufficiencies are likely to impair the general health of the member (medically necessary). Payment for dentures includes any necessary adjustments during the six (6) month period following delivery and routine post-delivery care, or relines during the twelve (12) month period following delivery and routine postdelivery care.

Medicaid may provide an acrylic interim partial denture (D5820/D5821) in the mixed dentition or beyond the mixed dentition stages in the following cases:

- Missing one or two maxillary permanent anterior tooth/teeth;
- Missing two mandibular permanent anterior teeth; or • Missing three or more permanent teeth in the same arch (of which at least one must be anterior).
- Medicaid may provide a partial denture in cases where the beneficiary has matured beyond the mixed dentition stage in the following cases:
- Missing three or more maxillary anterior teeth;
- Missing two or more mandibular anterior teeth;
- Missing at least 3 adjacent posterior permanent teeth in a single quadrant when the prosthesis would restore masticatory function (third molars not considered for replacement);
- Missing at least 2 adjacent posterior permanent teeth in both quadrants of the same arch when the prosthesis would restore masticatory function in at least one quadrant (third molars not considered for replacement); or
- Missing a combination of two or more anterior and at least one posterior

Cast partials (D5213 and D5214) will be considered only for those beneficiaries who are 18 years of age or older. In addition, the coronal and periodontal integrity of the abutment teeth and the overall condition of the remaining teeth will dictate whether a cast or acrylic partial is approved. Radiographic images should verify that all pre-prosthetic services have been successfully completed. On beneficiaries requiring extensive restorations, periodontal services, extractions, etc. post treatment radiographic images may be requested prior to approval of a cast partial denture.

BILLING AND REIMBURSEMENT FOR COMPLETE OR PARTIAL REMOVABLE DENTURES OR ANY FIXED PROSTHETICS SHALL BE BASED ON THE INSERTION/CEMENTATION DATE.

Note: Preventive and EPSDT services shall be covered.

Fabrication of a removable prosthetic includes multiple steps(appointments) these multiple steps (impressions, try-in appointments, delivery etc.) are inclusive in the fee for the removable prosthetic and as such not eligible for additional compensation.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Exhibit A Benefits Covered for EPSDT Under 21 Dental Program

Prosthodontics, Removable

Code	Description	Age Limitation	Teeth Covered	Prepayment Review	Pre-Auth Required	Benefit Limitations	Documentation Required	Fee Rate
D5110	complete denture - maxillary	0 - 20	Per Arch (01, UA)	Yes	No	One of (D5110/D5130) per 60 Month(s) Per patient.	pre-operative x-ray(s)	**$837.66**
D5120	complete denture - mandibular	0 - 20	Per Arch (02, LA)	Yes	No	One of (D5120/D5140) per 60 Month(s) Per patient.	pre-operative x-ray(s)	**$837.66**
D5130	Immediate denture - maxillary	0 - 20	Per Arch (01, UA,)	Yes	No	One of (D5130, D5140) per 60 Month(s) Per patient.	pre-operative x-ray(s)	**$837.66**
D5140	Immediate denture - mandibular	0 - 20	Per Arch (02, LA)	Yes	No	Per patient. One of (D5130, D5140) per 60 Month(s) Per patient.	pre-operative x-ray(s)	**$837.66**
D5211	maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)	0 - 20	Per Arch (01, UA)	Yes	No	One of (D5211, D5213) per 60 Month(s) Per patient.	pre-operative x-ray(s)	**$795.36**
D5212	mandibular partial denture – resin base (including retentive/clasping materials, rests, and teeth)	0 - 20	Per Arch (02, LA)	Yes	No	One of (D5212, D5214) per 60 Month(s) Per patient.	pre-operative x-ray(s)	**$795.36**
D5213	maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	18 – 20	Per Arch (01, UA)	Yes	No	One of (D5211, D5213) per 60 Month(s) Per patient.	pre-operative x-ray(s)	**$1164.27**
D5214	mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	18 – 20	Per Arch (02LA)	Yes	No	One of (D5212, D5214) per 60 Month(s) Per patient.	pre-operative x-ray(s)	**$1164.27**
D5511	Repair broken complete denture base, mandibular	0 - 20		No	No	Not covered within 12 months of placement.	pre-operative x-ray(s)	**$211.53** *Total of $ 296.14 limit in denture repairs per arch, see manual for details*
D5512	Repair broken complete denture base, maxillary	0 - 20		No	No	Not covered within 12 months of placement.	pre-operative x-ray(s)	**$211.53** *Total of $ 296.14 limit in denture repairs per arch, see manual for details.*

Exhibit A Benefits Covered for EPSDT Under 21 Dental Program

D5520	replace missing or broken teeth - complete denture (each tooth)	0 - 20	Teeth 2-15 and 18- 31	No	No	Not covered within 12 months of placement.	pre-operative x-ray(s)	**$110.00** *Total of $ 296.14 limit in denture repairs per arch, see manual for details.*
D5611	Repair resin denture base, partial denture, mandibular	0 - 20		No	No	Not covered within 12 months of placement.	pre-operative x-ray(s)	**$211.53** *Total of $ 296.14 limit in denture repairs per arch, see manual for details.*
D5612	Repair resin partial denture base, maxillary	0 - 20		No	No	Not covered within 12 months of placement.	pre-operative x-ray(s)	**$211.53** *Total of $ 296.14 limit in denture repairs per arch, see manual for details.*
D5630	repair or replace broken retentive/clasping materials per tooth	0 - 20	Teeth 1-32	No	No	Not covered within 12 months of placement.	pre-operative x-ray(s)	**$ 201.38** *Total of $ 296.14 limit in denture repairs per arch, see manual for details.*
D5640	replace broken teeth-per tooth	0 - 20	Teeth 2-15 and 18- 31	No	No	Not covered within 12 months of placement.	pre-operative x-ray(s)	**$ 110.00** *Total of $ 296.14 limit in denture repairs per arch, see manual for details.*
D5650	add tooth to existing partial denture	0 - 20	Teeth 2-15 and 18- 31	No	No	Not covered within 12 months of placement.	pre-operative x-ray(s)	**$ 110.00** *Total of $ 296.14 limit in denture repairs per arch, see manual for details.*
D5660	add clasp to existing partial denture	0 - 20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	No	Not covered within 12 months of placement.	pre-operative x-ray(s)	**$119.00** *Total of $ 296.14 limit in denture repairs per arch, see manual for details.*
D5750	reline complete maxillary denture (indirect)	0 - 20		No	No	Not covered within 12 months of placement.	pre-operative x-ray(s)	**$402.75**
D5751	reline complete mandibular denture (indirect)	0 - 20		No	No	Not covered within 12 months of placement. Allowed once per 60 months.	pre-operative x-ray(s)	**$402.75**
D5760	reline maxillary partial denture (indirect)	0 - 20		No	No	Not covered within 12 months of placement.	pre-operative x-ray(s)	**$351.99**

Exhibit A Benefits Covered for EPSDT Under 21 Dental Program

						Allowed once per 60 months.		
D5761	reline mandibular partial denture (indirect)	0 - 20		No	No	Not covered within 12 months of placement. Allowed once per 60 months.	pre-operative x-ray(s)	**$351.99**
D5820	Interim partial denture - maxillary	6 – 20		Yes	No	One of (D5820) per 12 Month(s) Per patient	pre-operative x-ray(s)	**$634.59**
D5821	Interim partial denture - mandibular	6 – 20		Yes	No	One of (D5821) per 12 Month(s) Per patient	pre-operative x-ray(s)	**$634.59**
D5899	unspecified removable prosthodontic procedure, by report	0 - 20		Yes	No		pre-operative x-ray(s)	**By report**
D5986	Fluoride gel carrier	0 - 20	Per Arch (01, 02, LA, UA)	Yes	No		pre-operative x-ray(s)	**$98.76**

Exhibit A Benefits Covered for EPSDT Under 21 Dental Program

Prosthodontics, fixed

Code	Description	Age Limitation	Teeth Covered	Prepayment Review	Pre-Auth Required	Benefit Limitations	Documentation Required	Fee Rate
D6241	Pontic – porcelain fused to predominantly base metal	0 - 20	Teeth 7, 8, 9, and 10	Yes	No	One of (D6241) per 60 Month(s) Per patient Must be billed with D6545, no other missing maxillary teeth. Replaces one maxillary anterior tooth.	pre-operative x-ray(s)	**$828.68**
D6545	Retainer - cast metal for resin bonded fixed prosthesis	0 - 20	Teeth 6, 7, 8, 9, 10 and 11	Yes	No	One of (D6545) per 60 Month(s) per patient per tooth, Maximum of two D6545 per 60 Month(s).	pre-operative x-ray(s)	**$667.34**
D6999	Unspecified fixed prosthodontic procedure, by report	0 - 20	Teeth 1 - 32	Yes	No		narrative of medical necessity	**By Report**

Exhibit A Benefits Covered for EPSDT Under 21 Dental Program

Reimbursement includes local anesthesia, suturing if needed, and routine post-operative care.

The extraction of asymptomatic impacted teeth is not a covered benefit. Symptomatic conditions would include pain, beyond normal eruptive pain, and/or infection or demonstrated malocclusion causing a shifting of existing dentition.

Note: Preventive and EPSDT services shall be covered.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Oral and Maxillofacial Surgery

Code	Description	Age Limitation	Teeth Covered	Prepayment Review	Pre-Auth Required	Benefit Limitations	Documentation Required	Fee Rate
D7111	extraction, coronal remnants - primary tooth	0-20	Teeth A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	No	No			**$87.71**
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0-9	Teeth 1 - 32, 51 – 82, A -T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, T S	No	No			**$107.04**
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	10-20	A, B, C, H, I, J, K, L, M, R, S, T	Yes	No		Preoperative X-Ray	**$107.04**
D7140	extraction, erupted tooth or exposed root (elevation and/or forceps removal)	10-20	Teeth 1 - 32, 51 – 82, D, E, F, G, N, O, P, Q, AS, BS,CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS,O S, PS, QS, RS, SS, TS	No	No			**$107.04**
D7210	surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation mucoperiosteal flap if indicated	1-20	Teeth 1 - 32, 51 – 82, A - T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Yes	No		pre-operative x-ray(s)	**$176.12**

D7220	removal of impacted tooth- soft tissue	1-20	Teeth 1 - 32, 51 – 82, A -T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS,TS	Yes	No		pre-operative x-ray(s)	**$203.75**
D7230	Removal of impacted tooth-partially bony	1-20	Teeth 1-32, 51 - 82, A -T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS,TS	Yes	No		pre-operative x-ray(s)	**$271.11**
D7240	Removal of impacted tooth-completely bony	1-20	Teeth 1 - 32, 51 -82, A -T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS,TS	Yes	No		pre-operative x-ray(s)	**$332.52**
D7241	Removal of impacted tooth-completely bony	1-20	Teeth 1 -32, 51– 82,,A –T, and AS-TS	Yes	No		pre-operative x-ray(s)	**$376.41**
D7250	surgical removal of residual tooth roots (cutting procedure)	1-20	Teeth 1 - 32, 51 – 82, A-T, and AS - TS	Yes	No		pre-operative x-ray(s)	**$195.46**
D7270	tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth	1-20	Teeth 1-32	Yes	No		narr. of med. necessity, post-op x-ray(s)	**By Report Maximum Fee $345.29**
D7280	Surgical access of an unerupted tooth	1-20	Teeth 2- 15 and 18- 31	Yes	No		narr. of med. necessity, pre-op x-ray(s)	**$310.79**
D7283	Placement of device to facilitate eruption of impacted tooth	1-20	Teeth 2- 15 and 18- 31	Yes	No		narr. of med. necessity, pre-op x-ray(s)	**$332.90**
D7285	Incisional biopsy of oral tissue-hard (bone, tooth)	1-20	Per Quadrant (01, 02, 10, 20, 30, 40, LL, LR, UL, UR)	Yes	No		Pathology report & Preoperative X-Rays	**By Report Maximum Fee $263.83**
D7286	Incisional biopsy of oral tissue-soft	1-20	Per Quadrant (01, 02, 10, 20,	Yes	No		Pathology report	**206.51**

Exhibit A Benefits Covered for EPSDT Under 21 Dental Program

			30, 40, LL, LR, UL, UR)					
D7291	Transeptal fiberotomy, by report	1-20	Per Arch (01, 02,L A, UA)	Yes	No			**$152.03**
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	1-20	Per Quadrant (01, 02, 10, 20, 30, 40, LL, LR, UL, UR)	Yes	No		narr. of med. necessity, pre-op x-ray(s)	**$189.92**
D7510	Incision and drainage of abscess - intraoral soft tissue	1-20	Teeth 1 – 32, 51-82, A-T, AS-TS	Yes	No		narrative of medical necessity	**$148.48**
D7880	occlusal orthotic device, by report	1-20	Per Arch (01, 02,L A, UA)	Yes	No		narr. of med. necessity, pre-op x-ray(s)	**$461.69**
D7910	suture small wounds up to 5 cm	1-20		Yes	No		Narrative of Medical Necessity	**$190.61**
D7961	Buccal/labial frenectomy – (frenulectomy) separate procedure not incidental to another procedure	1-20	Per Quadrant (01,02, 10, 20, 30, 40, LL, LR, UL, UR)	Yes	No		Diagnostic photographs & Narrative of medical necessity	**$211.21**
D7962	Lingual frenectomy (frenulectomy)	1-20	(02, 30, 40)	Yes	No	One of (D7962) per lifetime	Pathology Report	**$211.21**
D7997	appliance removal (not by dentist who placed appliance), includes removal of arch bar	1-20		Yes	No		narr. of med. necessity, pre-op x-ray(s)	**By Report Maximum Fee $324.91**
D7999	unspecified oral surgery procedure, by report	1-20		Yes	No		narr. of med. necessity, pre-op x-ray(s)	**By Report**

Exhibit A Benefits Covered for EPSDT Under 21 Dental Program

DentaQuest Louisiana Medicaid Members age 20 and under may qualify for orthodontic care under the program. If the orthodontic treatment plan is approved prior to the enrollee obtaining 20 1/2 years of age, treatment must be initiated prior to the enrollee obtaining 21 years of age, such treatment may continue as long as the enrollee remains eligible.

Treatment should not begin prior to receiving notification from DentaQuest indicating coverage or non-coverage for the proposed treatment plan. Dentists who begin treatment before receiving an approved or denied prior authorization are financially obligated to complete treatment at no charge to the Member; or face possible termination of their provider agreement. Providers cannot bill prior to services being performed.

Comprehensive orthodontic treatment is approved by DentaQuest only in those instances that are related to an identifiable syndrome such as cleft lip and/or palate, Crouzon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy: other severe craniofacial deformities that result in age appropriate surgical cases as determined by a DentaQuest Dental Consultants.

The request for pre-authorization must include sufficient diagnostic material to demonstrate the syndrome and/or deformity listed above and the fee normally charged for a similar case. If approved, DentaQuest will authorize a maximum of three (3) units of the appropriate comprehensive orthodontic procedure code and assign a fee for each unit (please see fee schedule for total maximum allowable billable fees). The pre-authorization is valid for 180 days.

Providers are reminded that DentaQuest reimbursement is payment in full for the procedure code. To receive reimbursement for comprehensive orthodontic procedure codes, the provider must submit three (3) claims with three (3) distinct dates of service. The first date of service may occur no earlier than the date that diagnostic records were obtained; the second date of service no earlier than the date of banding; and the final date of service no earlier than 90 days after banding. DentaQuest reimbursement includes the brackets/appliance.

During comprehensive orthodontia treatment, Providers will ONLY be paid for one D8070, D8080,or D8090; two D8999's. All other services rendered during this time are considered an inclusive part of treatment and the case rate. Any other services will not be individually reimbursed.

DentaQuest requires the following information for possible payment of continuation of care cases: Completed Orthodontic Continuation of Care Form, completed ADA claim form listing services to be rendered and a copy of Member's prior approval including the total approved case fee, banding fee, and periodic orthodontic treatment fees. If the Member is private pay or transferring from a commercial insurance program, original diagnostic photographs (or OrthoCAD equivalent), radiographs (optional). Release for treatment from previous orthodontic provider.

Interceptive Orthodontic treatment may occur in the primary or transitional dentition and may include such procedures as the redirection of ectopically erupting teeth, correction of isolated dental crossbite (only one or two teeth, anterior or posterior), or recovery of recent minor space loss where overall space is adequate. The fee assigned for fixed appliance therapy includes the brackets/appliance, all visits and adjustments.

Exhibit A Benefits Covered for EPSDT Under 21 Dental Program

Orthodontics

Code	Description	Age Limitation	Teeth Covered	Prepayment Review	Pre-Auth Required	Benefit Limitations	Documentation Required	Fee Rate
D8010	Limited treatment of primary dentition~~Interceptive orthodontic treatment of the primary dentition~~	0-20		No	Yes	~~1 per lifetime (D8010, D8020)~~ The fee assigned for fixed appliance therapy includes the brackets/appliance, all visits and adjustments.	~~Diagnostic digital photographs, study models, pan or peri xrays, narr/ treatment plan~~ pan **or** peri x-rays, narr/ treatment plan	**Maximum Fee $438.00**
D8020	Limited treatment of transitional dentition~~Interceptive orthodontic treatment of the transitional dentition~~	0-20		No	Yes	~~1 per lifetime (D8010, D8020)~~ The fee assigned for fixed appliance therapy includes the brackets/appliance, all visits and adjustments.	~~Diagnostic digital photographs, study models, pan or peri xrays,narr/treatment plan~~ pan **or** peri x-rays, narr/ treatment plan	**Maximum Fee $438.00**
D8070	comprehensive orthodontic treatment of the transitional dentition	0-20		No	Yes	One of (D8070, D8080 and D8090) per 1 Lifetime Per patient.	Diagnostic digital photographs, study models, pan **or** peri x-rays, narr/ treatment plan~~pan or peri xrays, narr/treatment plan~~	**Maximum Fee $4,182.00**
D8080	comprehensive orthodontic treatment of the adolescent dentition	0-20		No	Yes	One of (D8070, D8080 and D8090) per 1 Lifetime Per patient.	Diagnostic digital photographs,study models, ~~pan or peri xrays, narr/treatment plan~~pan **or** peri x-rays, narr/ treatment plan	**Maximum Fee $4,281.00**
D8090	comprehensive orthodontic treatment of the adult dentition	0-20		No	Yes	One of (D8070, D8080 and D8090) per 1 Lifetime Per patient.		**Maximum Fee $4,515.00**
D8220	fixed appliance therapy (includes appliances for thumb sucking and tongue thrusting)	5-8		No	Yes	**Harmful Habits Only**	Pano, narrative of medical necessity and photographs	**534.71**

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D8999	unspecified orthodontic procedure, by report	0-20		No	Yes		**Narrative**	**By Report**

Reimbursement includes local anesthesia. General Anesthesia and IV Sedation will be reviewed on a case-by-case basis for medical necessity.

Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in the continuous attendance of the enrollee. Anesthesia services are considered completed when the enrollee can be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients. Intravenous conscious sedation/analgesia can only be performed by doctors who hold a valid permit from the Louisiana State Board of Dentistry for parenteral sedation.

Note: Preventive and EPSDT services shall be covered.

Any reimbursement already made for an inadequate service may be recouped after the DentaQuest Consultant reviews the circumstances.

Adjunctive General Services

Code	Description	Age Limitation	Teeth Covered	Prepayment Review	Pre-Auth Required	Benefit Limitations	Documentation Required	Fee Rate
D9110	palliative (emergency) treatment of dental pain - minor procedure	0-20		No	No	One of (D9110) per Day(s) Per Provider OR Location. Two of (D9110) per 12 month(s) Per Provider OR Location. Not allowed with any other services other than x-		$79.43

						rays and emergency exams.		
D9222	Deep sedation/general anesthesia- first 15 minutes	0-20		No	No	Not allowed in conjunction with, D9239, D9243, D9230 or D9248.	Anesthesia time record is required when billing narrative of medical necessity	$147.79
D9223	Deep sedation/general anesthesia- each additional 15 increment	0-20		No	No	Not allowed in conjunction with, D9239, D9243, D9230or D9248.	Anesthesia time record is required when billing narrative of medical necessity	$100.15
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	0-20		No	No	Not allowed in conjunction with, D9239,D 9243, or D9248.		$49.72
D9239	Intravenous moderate conscious sedation/analgesia – first 15 minutes	0-20		Yes	No	Not allowed in conjunction with, D9230, or D 9248.	narrative of medical necessity	$147.79
D9243	intravenous moderate (conscious) sedation/analgesia - each subsequent 15-minute increment	0-20		Yes	No	Not allowed in conjunction with, D9230, or D 9248. Three (3) of D9243 per day, per patient.	narrative of medical necessity	$100.15
D9248	non-intravenous moderate (conscious) sedation	0-20		Yes	No	One of (D9230, D9248, D9243) per 1 Day(s) Per patient. Not allowed with D9230, D9239, D9243, or D9920.	narrative of medical necessity	$169.83
D9420	hospital or ambulatory surgical center call	0-5		No	No	One of (D9420) per 6 month(s) Per patient.		$106.18
D9420	hospital or ambulatory surgical center call	6-20		No	Yes	One of (D9420) per 6 month(s) Per patient.	narrative of medical necessity. Must document physical or mental disability	$106.18
D9440	office visit - after regularly scheduled hours	0-20		Yes	No		narrative of medical necessity	$79.59
D9920	behavior management, by report	0-7		No	No	Four of (D9920) per 12 Month(s) per Provider or Location		$70.10
D9920	behavior management, by report	8-20		Yes	No	Four of (D9920) per 12 Month(s) per Provider or Location	narrative of medical necessity	$70.10

Exhibit A Benefits Covered for EPSDT Under 21 Dental Program

D9944	Occlusal guard – hard appliance, full arch	13-20	Per arch 01, 02, LA, UA	Yes	No	One of (D9944, D9945, D9946) per patient per 12 months. Narrative req. for PPR.	narrative of medical necessity	$473.96
D9945	Occlusal guard – soft appliance, full arch	13-20	Per arch 01, 02, LA, UA	Yes	No	One of (D9944, D9945, D9946) per patient per 12 months. Narrative req. for PPR.	narrative of medical necessity	$473.96
D9946	Occlusal guard – hard appliance, partial arch	13-20	oral cavity designator 01 and 02	Yes	No	One of (D9944, D9945, D9946) per patient per 12 months. Narrative req. for PPR.	narrative of medical necessity	$473.96
D9951	Occlusal adjustment – limited	13-20	oral cavity designator 01 and 02	No	No		narrative of medical necessity	$145.04
D9999	Unspecified adjunctive procedure, by report	0-20		No	Yes		Narrative	By Report