UnitedHealthcare Community Plan of Ohio Medicaid Dental Quick Reference Guide

Effective: May 1, 2024

UHCdental.com/medicaid

The Dental Hub may be used to check eligibility, submit claims, and access useful information regarding plan coverage.

Provider services

Phone: **1-855-642-5483**
8 a.m. – 6 p.m. ET Monday–Friday (IVR: 24/7)

Member eligibility, benefits, claims, authorizations, network participation and contract questions

Prior authorization

UnitedHealthcare Dental Authorizations
P.O. Box 2126
Milwaukee, WI 53201

Appeals for service denials

UnitedHealthcare Community Plan
Attn: Appeals Department
P.O. Box 31364
Salt Lake City, UT 84131-0364

Toll-free: **1-800-895-2017 (TTY 711)**

Claims

UnitedHealthcare OH Dental Claims
P.O. Box 2139
Milwaukee, WI 53201

EDI Payer ID

OHMD3

Claim disputes or adjustments

UnitedHealthcare OH Dental Claim Appeals
P.O. Box 1455
Milwaukee, WI 53201

Corrected claims

UnitedHealthcare OH Dental Corrected Claims
P.O. Box 481
Milwaukee, WI 53201

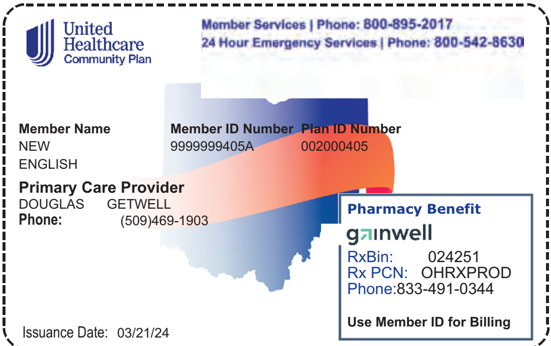
Claims may be submitted electronically via your clearinghouse, online via the Dental Hub or via the mailing addresses here.

Important notes

This guide is intended to be used for quick reference and may not contain all of the necessary information; it is subject to change without notice. For current detailed benefit information, please visit the Dental Hub or contact our Provider Services toll free number.

Dental Benefit Providers®

Sample member ID card



Benefit coverage, limitations, and requirements

The following Benefit Grid contains all covered dental procedures and is intended to align to all State and Federal regulatory requirements; therefore, this Grid is subject to change. For the most updated member benefits, exclusions, and limitations please visit our website at **UHCdental.com/medicaid**.

Code	Description	Age limits	Frequency limits	Auth required	Required documentation
D0120	Periodic Oral Exam	0-999	1 per 180 day(s) per member	N	
D0140	Limited Oral Evaluation - Problem Focused	0-999		N	
D0150	Comprehensive Oral Evaluation - New Or Established Patient	0-999	1 per 5 year(s) per member/ per provider or location	N	
D0180	Comprehensive periodontal evaluation	0-999	1 per 365 day(s) per member	N	
D0210	Intraoral - Comprehensive Series of Radiographic Images	0-999	1 per 5 year(s) per member	N	
D0220	Intraoral - Periapical First Radiographic Image	0-999		N	
D0230	Intraoral - Periapical Each Additional Image	0-999		N	
D0240	Intraoral - Occlusal Radiographic Image	0-999		N	
D0250	Extraoral - 2D Projection Radiographic image	0-999		N	
D0270	Bitewing - Single Radiographic Image	0-999	1 per 6 month(s) per member	N	
D0272	Bitewings - Two Radiographic Images	0-999	1 per 6 month(s) per member	N	
D0273	Bitewings - Three Radiographic Images	0-999	1 per 6 month(s) per member	N	
D0274	Bitewings - Four Radiographic Images	0-999	1 per 6 month(s) per member	N	
D0321	Other Temporomandibular Joint Radiographic Images, By Report	0-999		N	
D0330	Panoramic Radiographic Image	0-5	1 per 60 month(s) per member	Y	Narrative of Medical Necessity
D0330	Panoramic Radiographic Image	6-999	1 per 60 month(s) per member	N	
D0340	2D Cephalometric Radiographic Image	0-999		N	
D0350	Oral/Facial Photographic Images	0-999		N	
D0367	Cone Beam - Both Jaws	0-999	1 per 5 year(s) per member	Y	Narrative of Medical Necessity

Code	Description	Age limits	Frequency limits	Auth required	Required documentation
D0372	intraoral tomosynthesis – comprehensive series of radiographic images	0-999		Y	Narrative of Medical Necessity, Supporting Medical Records
D0373	intraoral tomosynthesis – bitewing radiographic image	0-999		Y	Narrative of Medical Necessity, Supporting Medical Records
D0374	intraoral tomosynthesis – periapical radiographic image	0-999		Y	Narrative of Medical Necessity, Supporting Medical Records
D0387	intraoral tomosynthesis – comprehensive series of radiographic images – image ca	0-999		Y	Narrative of Medical Necessity, Supporting Medical Records
D0388	intraoral tomosynthesis – bitewing radiographic image – image capture only	0-999		Y	Narrative of Medical Necessity, Supporting Medical Records
D0389	intraoral tomosynthesis – periapical radiographic image – image capture only	0-999		Y	Narrative of Medical Necessity, Supporting Medical Records
D0396	3D Printing of a 3D Dental Surface Scan	0-999			
D0411	Test For Diabetes	0-999		Y	Narrative of Medical Necessity
D0412	Test For Diabetes	0-999		Y	Narrative of Medical Necessity
D0470	Diagnostic Casts	0-999		N	
D0604	antigen testing for a public health related pathogen, including coronavirus	0-999		N	
D0605	antibody testing for a public health related pathogen, including coronavirus	0-999		N	
D0606	Molecular testing for a public health related pathogen, including coronavirus	0-999		N	
D0801	3D dental surface scan – direct	0-999		Y	Narrative of Medical Necessity, Supporting Medical Records
D0802	3D dental surface scan – indirect A surface scan of a diagnostic cast	0-999		Y	Narrative of Medical Necessity, Supporting Medical Records
D0803	3D facial surface scan – direct	0-999		Y	Narrative of Medical Necessity, Supporting Medical Records
D0804	3D facial surface scan – indirect A surface scan of constructed facial feature	0-999		Y	Narrative of Medical Necessity, Supporting Medical Records
D1110	Prophylaxis - Adult	14-999	1 per 180 day(s) per member	N	
D1120	Prophylaxis - Child	0-13	1 per 180 day(s) per member	N	
D1206	Topical Application Of Fluoride Varnish	0-20	1 per 180 day(s) per member	N	
D1208	Topical Application of Fluoride	0-20	1 per 180 day(s) per member	N	
D1301	Immunication Counseling	0-999			
D1320	Tobacco Counseling For The Control And Prevention Of Oral Disease	0-999	2 per 365 day(s) per member	N	
D1321	counseling for the control and prevention of adverse oral, behavioral, and system	0-999	2 per 365 day(s) per member	N	
D1351	Sealant - Per Tooth	0-20		N	
D1354	Interim Caries Arresting Medicament Application - per tooth	0-999	3 per 1 year per patient per tooth	N	
D1510	Space Maintainer - Fixed - Unilateral - per quadrant	0-20		N	
D1516	Space Maintainer - Fixed - Bilateral, maxillary	0-20		N	
D1517	Space Maintainer - Fixed - Bilateral, mandibular	0-20		N	
D1520	Space Maintainer - Removable - Unilateral - per quadrant	0-20		N	

Code	Description	Age limits	Frequency limits	Auth required	Required documentation
D1526	Space Maintainer - Removable - Bilateral, maxillary	0-20		N	
D1527	Space Maintainer - Removable - Bilateral, mandibular	0-20		N	
D2140	Amalgam - One Surface, Primary Or Permanent	0-999		N	
D2150	Amalgam - Two Surfaces, Primary Or Permanent	0-999		N	
D2160	Amalgam - Three Surfaces, Primary Or Permanent	0-999		N	
D2161	Amalgam - Four Or More Surfaces, Primary Or Permanent	0-999		N	
D2330	Resin-Based Composite - One Surface, Anterior	0-999		N	
D2331	Resin-Based Composite - Two Surfaces, Anterior	0-999		N	
D2332	Resin-Based Composite - Three Surfaces, Anterior	0-999		N	
D2335	resin-based composite – four or more surfaces (anterior)	0-999		N	
D2390	Resin-Based Composite Crown, Anterior	0-999		N	
D2391	Resin-Based Composite - One Surface, Posterior	0-999		N	
D2392	Resin-Based Composite - Two Surfaces, Posterior	0-999		N	
D2393	Resin-Based Composite - Three Surfaces, Posterior	0-999		N	
D2394	Resin-Based Composite - Four Or More Surfaces, Posterior	0-999		N	
D2740	Crown - Porcelain/Ceramic	0-999		Y	Current pre-op x- rays; Narrative of medical necessity if decay not evident on films
D2751	Crown - Porcelain Fused To Predominantly Base Metal	0-999		Y	Current pre-op x- rays; Narrative of medical necessity if decay not evident on films
D2752	Crown - Porcelain Fused To Noble Metal	0-999		Y	Current pre-op x- rays; Narrative of medical necessity if decay not evident on films
D2920	Re-Cement or Re-Bond Crown	0-999		N	
D2928	prefabricated porcelain/ceramic crown – permanent tooth	0-999		N	
D2929	Prefabricated Porcelain / Ceramic Crown - Primary Tooth	0-999		N	
D2930	Prefabricated Stainless Steel Crown - Primary Tooth	0-999		N	
D2931	prefabricated stainless steel crown – permanent tooth	0-999		N	
D2933	Prefabricated Stainless Steel Crown With Resin Window	0-999		N	
D2934	Prefabricated Esthetic Coated Stainless Steel Crown - Primary Tooth	0-999		N	
D2940	Protective Restoration	0-999	1 per 180 days per tooth; Max 5 per lifetime	N	
D2941	Interim Therapeutic Restoration - Primary Dentition	0-999	1 per 180 days per tooth; Max 5 per lifetime	N	
D2950	Core Buildup, Including Any Pins When Required	0-999		N	
D2951	Pin Retention - Per Tooth, In Addition To Restoration	0-999	Pin retention is reimbursed per tooth, up to a maximum of 3 pins per tooth	N	
D2952	Post And Core In Addition To Crown, Indirectly Fabricated	0-999		Y	Current pre-op x-rays; For any tooth with endodontic procedure planned or performed, a periapical x-ray of the final endodontic procedure is required

Code	Description	Age limits	Frequency limits	Auth required	Required documentation
D2954	Prefabricated Post And Core In Addition To Crown	0-999		Y	Current pre-op x-rays; For any tooth with endodontic procedure planned or performed, a periapical x-ray of the final endodontic procedure is required
D2976	Band Stabilization - per tooth	0-999	1 per lifetime		
D2989	Evacation of a Tooth Resulting in the Determination of Non-restorability	0-999			
D2991	Application of Hydroxyapatite Regeneration Medicament - per tooth	0-999	2 per year		
D3220	Therapeutic Pulpotomy	0-999		N	
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)	0-999		N	
D3320	Endodontic Therapy Premolar Tooth (Excluding Final Restoration)	0-999		N	
D3330	Endodontic Therapy, Molar tooth (Excluding Final Restoration)	0-999		N	
D3351	Apexification / Recalcification - Initial Visit	0-999		N	
D3352	Apexification / Recalcification - Interim	0-999		N	
D3353	Apexification / Recalcification - Final Visit	0-999		N	
D3410	Apicoectomy - Anterior	0-999		N	
D4210	Gingivectomy Or Gingivoplasty - Four Or More Contiguous Teeth	0-999		Y	Current pre-op x-rays; Complete current 6 point periodontal charting; Narrative of medical necessity
D4211	Gingivectomy Or Gingivoplasty - One To Three Contiguous Teeth	0-999		Y	Current pre-op x-rays; Complete current 6 point periodontal charting; Narrative of medical necessity
D4286	removal of non-resorbable barrier	0-999		Y	Narrative of medical necessity
D4341	Periodontal Scaling And Root Planing - Four Or More Teeth Per Quadrant	0-999	1 per 24 month(s) per member	Y	Panoramic x-ray or full series Complete, current 6 point periodontal; charting
D4342	Periodontal Scaling And Root Planing - One To Three Teeth Per Quadrant	0-999	1 per 24 month(s) per member	Y	Panoramic x-ray or full series Complete, current 6 point periodontal; charting
D4910	Periodontal Maintenance	0-999	1 per 12 month(s) per member	N	
D5110	Complete Denture - Maxillary	0-999	1 per 8 year(s) per member	Y	Panoramic x-ray or full mouth series
D5120	Complete Denture - Mandibular	0-999	1 per 8 year(s) per member	Y	Panoramic x-ray or full mouth series
D5130	Immediate Denture - Maxillary	0-999	1 per 8 year(s) per member	Y	Panoramic x-ray or full mouth series
D5140	Immediate Denture - Mandibular	0-999	1 per 8 year(s) per member	Y	Panoramic x-ray or full mouth series
D5211	Maxillary Partial Denture - Resin Base	0-999	1 per 8 year(s) per member	Y	Panoramic x-ray or full mouth series
D5212	Mandibular Partial Denture - Resin Base	0-999	1 per 8 year(s) per member	Y	Panoramic x-ray or full mouth series
D5213	maxillary partial denture - cast metal framework with resin denture bases	0-999	1 per 8 year(s) per member	Y	Panoramic x-ray or full mouth series
D5214	mandibular partial denture - cast metal framework with resin denture bases	0-999	1 per 8 year(s) per member	Y	Panoramic x-ray or full mouth series
D5225	maxillary partial denture - flexible base (including retentive/ clasping materials, rests, and teeth)	0-999	1 per 8 year(s) per member	Y	Panoramic x-ray or full mouth series
D5226	mandibular partial denture - flexible base (including retentive/ clasping materials, rests, and teeth)	0-999	1 per 8 year(s) per member	y	Panoramic x-ray or full mouth series

Code	Description	Age limits	Frequency limits	Auth required	Required documentation
D5282	removable unilateral partial denture - one piece cast metal (including retentive	0-999		Y	Narrative of Medical Necessity
D5283	removable unilateral partial denture - one piece cast metal (including retentive	0-999		Y	Narrative of Medical Necessity
D5511	Repair Broken Complete Denture Base - Mandibular	0-999		N	
D5512	Repair Broken Complete Denture Base - Maxillary	0-999		N	
D5520	Replace Missing Or Broken Teeth - Complete Denture (Each Tooth)	0-999		N	
D5611	Repair Resin Partial Denture Base - Mandibular	0-999		N	
D5612	Repair Resin Partial Denture Base - Maxillary	0-999		N	
D5621	Repair Cast Partial Framework - Mandibular	0-999		N	
D5622	Repair Cast Partial Framework - Maxillary	0-999		N	
D5630	Repair Or Replace Broken Retentive / Clasping Materials - Per Tooth	0-999		N	
D5640	Replace Broken Teeth - Per Tooth	0-999		N	
D5650	Add Tooth To Existing Partial Denture	0-999		N	
D5660	Add Clasp To Existing Partial Denture - Per Tooth	0-999		N	
D5750	reline complete maxillary denture (indirect)	0-999	1 per 3 year(s) per member	N	
D5751	reline complete mandibular denture (indirect)	0-999	1 per 3 year(s) per member	N	
D5760	reline maxillary partial denture (indirect)	0-999	1 per 3 year(s) per member	N	
D5761	reline mandibular partial denture (indirect)	0-999	1 per 3 year(s) per member	N	
D5876	add metal substructure to acrylic full denture (per arch) Use of metal substruct	0-999		Y	Narrative of Medical Necessity
D5899	Unspecified Removable Prosthodontic Procedure, By Report	0-999		Y	Panoramic x-ray or full mouth series; Narrative of medical
D5913	Nasal Prosthesis	0-999		Y	Current radiographs or images demonstrating the condition; Narrative of medical necessity; Surgical history; Associated Diagnosis
D5915	Orbital Prosthesis	0-999		Y	Current radiographs or images demonstrating the condition; Narrative of medical necessity; Surgical history; Associated Diagnosis
D5916	Ocular Prosthesis	0-999		Y	Current radiographs or images demonstrating the condition; Narrative of medical necessity; Surgical history; Associated Diagnosis
D5931	Obturator Prosthesis, Surgical	0-999		Y	Current radiographs or images demonstrating the condition; Narrative of medical necessity; Surgical history; Associated Diagnosis
D5932	Obturator Prosthesis, Definitive	0-999		Y	Current radiographs or images demonstrating the condition; Narrative of medical necessity; Surgical history; Associated Diagnosis
D5934	Mandibular Resection Prosthesis With Guide Flange	0-999		Y	Current radiographs or images demonstrating the condition; Narrative of medical necessity; Surgical history; Associated Diagnosis
D5935	Mandibular Resection Prosthesis Without Guide Flange 0-999	0-999		Y	Current radiographs or images demonstrating the condition; Narrative of medical necessity; Surgical history; Associated Diagnosis
D5955	Palatal Lift Prosthesis, Definitive	0-999		Y	Current radiographs or images demonstrating the condition; Narrative of medical necessity; Surgical history; Associated Diagnosis

Code	Description	Age limits	Frequency limits	Auth required	Required documentation
D5999	Unspecified Maxillofacial Prosthesis, By Report	0-999		Y	Pre-op x-rays; Narrative of medical necessity
D6089	Accessing and Retorquing Loose Implant Screw - per screw	0-999			
D6096	Remove Broken Implant Retaining Screw	0-999		Y	Narrative of medical necessity
D6105	Removal of implant body not requiring bone removal or flap elevation	0-999		Y	Narrative of medical necessity
D6106	Guided tissue regeneration - resorbable barrier, per implant	0-999		Y	Narrative of medical necessity
D6107	guided tissue regeneration – non-resorbable barrier, per implant	0-999		Y	Narrative of medical necessity
D6118	Implant / Abutment Supported Interim Fixed Denture For Edentulous Arch - Mandibu	0-999		Y	Narrative of medical necessity
D6119	Implant / Abutment Supported Interim Fixed Denture For Edentulous Arch - Maxilla	0-999		Y	Narrative of medical necessity
D6197	Replacement of restorative material use to close an access opening of a screw-retained implant supported prosthesis	0-999		Y	Narrative of medical necessity
D7140	Extraction, Erupted Tooth Or Exposed Root	0-999	1 per 1 lifetime per member	N	
D7210	Extraction, Erupted Tooth	0-999	1 per 1 lifetime per member	N	
D7220	Removal Of Impacted Tooth - Soft Tissue	0-999	1 per 1 lifetime per member	N	Tooth #1, #16, #17, and #32 do not require prior authorization for this code.
D7220	Removal Of Impacted Tooth - Soft Tissue	0-999	1 per 1 lifetime per member	Y	Teeth 2-15, 18-31; Current pre-op panoramic x-ray; Narrative of medical necessity
D7230	Removal Of Impacted Tooth - Partially Bony	0-999	1 per 1 lifetime per member	N	
D7240	Removal Of Impacted Tooth - Completely Bony	0-999	1 per 1 lifetime per member	Y	Current pre-op panoramic x-ray; Narrative of medical necessity
D7241	Removal Of Impacted Tooth - Completely Bony, Unusual Surgical Complications	0-999	1 per 1 lifetime per member	Y	Current pre-op panoramic x-ray; Narrative of medical necessity
D7250	Removal Of Residual Tooth (Cutting Procedure)	0-999	1 per 1 lifetime per member	Y	Current Pre-op x-ray; Narrative of medical necessity
D7260	Oroantral Fistula Closure	0-999	1 per 1 lifetime per member	N	
D7270	Reimplantation And/Or Stabilization Of Accidentally Evulsed / Displaced Tooth	0-999		N	
D7280	Exposure of an Unerupted Tooth	0-999	1 per 1 lifetime per member	Y	Current pre-op panoramic x-ray or PA of entire tooth; Narrative of medical necessity
D7283	Placement Of Device To Facilitate Eruption 0-999 Of Impacted Tooth	0-999	1 per 1 lifetime per member	Y	Current Pre-op x-ray; Narrative of medical necessity
D7284	Excisional Biopsy of Minor Salivary Glands	0-999		Y	Narrative of medical necessity
D7285	Incisional Biopsy Of Oral Tissue - Hard (Bone, Tooth)	0-999		N	
D7286	Incisional Biopsy Of Oral Tissue - Soft	0-999		N	
D7296	Corticotomy - One To Three Teeth Or Tooth 0-999 Spaces, Per Quadrant	0-999		Y	Narrative of Medical Necessity
D7297	Corticotomy - Four Or More Teeth Or Tooth 0-999 Spaces, Per Quadrant	0-999		Y	Narrative of Medical Necessity
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	0-999	1 per 1 lifetime per member	N	
D7311	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	0-999	1 per 1 lifetime per member	N	

Code	Description	Age limits	Frequency limits	Auth required	Required documentation
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	0-999	1 per 1 lifetime per member	N	
D7450	Removal Of Benign Odontogenic Cyst Or Tumor - Dia Up To 1.25 Cm	0-999		N	
D7451	Removal Of Benign Odontogenic Cyst Or Tumor - Dia Greater Than 1.25 Cm	0-999		N	
D7460	Removal Of Benign Nonodontogenic Cyst Or Tumor - Dia Up To 1.25 Cm	0-999		N	
D7461	Removal Of Benign Nonodontogenic Cyst Or Tumor - Dia Greater Than 1.25 Cm	0-999		N	
D7471	Removal Of Lateral Exostosis (Maxilla Or Mandible)	0-999		N	
D7472	Removal Of Torus Palatinus	0-999		N	
D7473	Removal Of Torus Mandibularis	0-999		N	
D7509	marsupialization of odontogenic cyst Surgical decompression of a large cystic le	0-999		Y	Narrative of Medical Necessity
D7510	Incision And Drainage Of Abscess – Intraoral Soft Tissue	0-999		N	
D7520	Incision And Drainage Of Abscess – Extraoral Soft Tissue	0-999		N	
D7670	Alveolus - Closed Reduction, May Include Stabilization Of Teeth	0-999		N	
D7671	Alveolus - Open Reduction, May Include Stabilization Of Teeth	0-999		Y	Current panoramic x-ray; Narrative of medical necessity
D7899	Unspecified Tmd Therapy, By Report	0-999		Y	Narrative of medical necessity; TMJ radiographs
D7956	guided tissue regeneration, edentulous area – resorbable barrier, per site	0-999		Y	Narrative of Medical Necessity
D7957	guided tissue regeneration, edentulous area – non-resorbable barrier, per site	0-999		Y	Narrative of Medical Necessity
D7961	buccal / labial frenectomy (frenulectomy)	0-999		N	
D7962	lingual frenectomy (frenulectomy)	0-999		N	
D7970	Excision Of Hyperplastic Tissue - Per Arch	0-999		N	
D7979	Non-Surgical Sialolithotomy	0-999		Y	Narrative of Medical Necessity
D8080	Comprehensive Orthodontic Treatment Of The Adolescent Dentition	0-999	1 per 1 lifetime per member	Y	Completed OH HLD modification score sheet Lateral and frontal photographs of the patient with lips together; Lateral cephalometric film with lips together, including a tracing; A complete series of intraoral images; Diagnostic model or equivalent; A treatment plan, including the projected length of treatment
D8210	Removable Appliance Therapy	0-999		Y	Narrative of medical necessity
D8220	Fixed Appliance Therapy	0-999		Y	Narrative of medical necessity
D8670	Periodic Orthodontic Treatment Visit	0-999	22 per 1 lifetime per member	Y	Approved D8080 case
D8680	Orthodontic Retention (removal of appliances, construction and placement of retainer(s)	0-999	2 per 1 lifetime per member	Y	Diagnostic quality photos submitted with prior authorization or with claim submission
D8695	Removal Of Fixed Orthodontic Appliances	0-999		Y	Narrative of Medical Necessity
D9130	Temporomandibular Joint Dysfunction - Non-invasive Physical Therapies	0-999		Y	Narrative of Medical Necessity
D9222	Deep Sedation/General Anesthesia - First 15 Minutes	0-999	1 per 1 day per member	N	
D9223	Deep Sedation / General Anesthesia - Each subsequent 15 Minute Increment	0-999	4 per 1 day per member	N	

Code	Description	Age limits	Frequency limits	Auth required	Required documentation
D9230	Inhalation Of Nitrous/Analgesia, Anxiolysis	0-20		N	
D9230	Inhalation Of Nitrous/Analgesia, Anxiolysis	21-999		Y	Narrative of medical necessity
D9239	Intravenous Moderate (Conscious) Sedation/Analgesia - First 15 Minutes	0-999	1 per 1 day per member	N	
D9243	Intravenous Moderate (Conscious) Sedation/Analgesia - Each Subsequent 15 Minute	0-999	4 per 1 day per member	N	
D9610	Therapeutic Parenteral Drug, Single Administration	0-999	1 per 1 day per member	N	
D9612	Therapeutic Parenteral Drugs, Two Or More Administrations	0-999	1 per 1 day per member	N	
D9613	Infiltration of sustained release therapeutic drug, per quadrant	0-999		Y	Narrative of Medical Necessity
D9920	Behavior Management, By Report	0-999		Y	Narrative of Medical Necessity
D9944	Occlusal Guard-hard appliance, full arch	0-999		N	
D9945	Occlusal Guard-soft appliance, full arch	0-999		N	
D9946	Occlusal Guard-hard appliance, partial arch	0-999		N	
D9947	Custom sleep apnea appliance fabrication and placement	0-999		Y	Narrative of Medical Necessity
D9948	Adjustment of custom sleep apnea appliance	0-999		Y	Narrative of Medical Necessity
D9949	Repair of custom sleep apnea appliance	0-999		Y	Narrative of Medical Necessity
D9953	reline custom sleep apnea appliance (indirect) Resurface dentition side of appli	0-999		Y	Narrative of Medical Necessity
D9954	Fabrication and Delivery of Oral Appliance Therapy (OAT) Morning Repositioning Device	0-999			
D9955	Oral Appliance Therapy (OAT) Titration Visit	0-999			
D9961	Duplicate / Copy Patient's Records	0-999		Y	Narrative of Medical Necessity
D9990	Translation Services	0-999		Y	Narrative of Medical Necessity
D9995	Teledentistry - Synchronous; Real-Time Encounter	0-999		N	
D9996	Teledentistry - Asynchronous; Information Stored And Forwarded To Dentist	0-999		Y	Narrative of Medical Necessity
D9997	Dental case management	0-999		Y	Narrative of Medical Necessity
D9999	Unspecified Adjunctive Procedure, By Report	0-999		Y	Description of procedure and narrative of medical necessity

*See page 10 for additional information regarding Orthodontic treatment.

Orthodontic Treatment

Orthodontic treatment is considered to be medically necessary in the presence of a handicapping malocclusion. The HLD Ohio Modification Scoresheet is used to determine the presence of a handicapping malocclusion. Orthodontic treatment is considered to be medically necessary when one of the following criteria have been met:

- An automatically qualifying condition as reported on part A of the the HLD Ohio Modification Scoresheet including:
  - Cleft palate
  - Craniofacial anomaly such as Crouzon Syndrome/Craniofacial Dysostosis, Hemifacial Hypertrophy/Congenital Hemifacial Hyperplasia; Parry-Romberg Syndrome/Progressive Hemifacial Atrophy; Pierre-Robin Sequence/Complex; or Treacher-Collins Syndrome/Mandibulofacial Dysostosis
  - Deep impinging overbite with soft tissue damage to the palate
  - Anterior crossbite with gingival recession or loose permanent teeth
  - Severe traumatic deviation
  - Overjet 9mm or greater or reverse overjet 3.5mm or greater
- A score of 26 or more on part B of the HLD Ohio Modification Scoresheet, reporting elements of malocclusion related to:
  - Overjet
  - Reverse overjet
  - Open bite
  - Ectopic teeth
  - Anterior crowding of the maxilla
  - Anterior crowding of the mandible
  - Labio-lingual spread
  - Posterior unilateral crossbite
- The presence of other medical conditions that are exacerbated by a handicapping malocclusion as reported on part C of the HLD Ohio Modification Scoresheet, including but not limited to:
  - Temporomandibular dysfunction, chronic pain, malnutrition
  - Respiration or speech pathology
  - Mental, emotional, behavioral, or psychosocial problems
- Qualification under the Early Periodic Screening, Diagnostic, and Treatment benefit, as reported on part D of the HLD Ohio Modification Scoresheet

Removal of fixed orthodontics appliances for reasons other than completion of treatment

Removal of fixed orthodontic appliances for reasons other than completion of treatment is a decision to be made by the treating provider based on an individual patient basis. Reasons include, but are not limited to:

- Patient non-compliance (AAOMS)
- Military deployment (Department of the Army)
- Prior to radiation therapy to the head or neck if the appliances will be in the radiation field (NIH, AAPD)

- Prior to highly stomatotic chemotherapy (NIH, AAPD)
- Complications related to IV bisphosphonates and other medical conditions (AAOMS)

Orthodontic continuity of care

Providers may submit Continuity of Care (COC) requests using three (3) methods of submission:

1. Online via the provider web portal (Dental Hub) at **UHCdental.com/medicaid**
2. Electronic submission via payer ID OHMD3
3. By mail to:
   UnitedHealthcare Community Plan of Ohio
   P.O. Box 2126
   Milwaukee, WI 53201

All COC requests must be submitted on the ADA form and must include the following contents:

- Code D8999 to recognize COC case
- Code D8670 identifying the number of adjustments remaining/requested
- Copy of EOB/remit showing paid banding
- Copy of original approval from prior Medicaid vendor or private insurer
- Payment history from prior insurer(s)

Periodic treatment visits

In transitioning to UnitedHealthcare Dental Benefits Provider, we will be switching from quarterly allowed adjustments to monthly allowed adjustments. Moreover, reimbursement for code D8670 has also been split into a monthly reimbursement fee versus a quarterly reimbursement fee. This will ensure members are receiving adequate orthodontic care.

HLD Ohio Modification Scoresheet (page 1)

HANDICAPPING LABIO-LINGUAL DEVIATION INDEX (HLD) OHIO MODIFICATION SCORE SHEET

UnitedHealthcare Community Plan of Ohio

Patient Name: ______________________ Medicaid ID #: __________ DOB:______
Provider Name: ______________________ Medicaid provider #______ NPI: ______

All necessary dental work completed? Yes___ No___ *Patient oral hygiene:* Excellent__Fair___Poor__

PROCEDURE (use this score sheet and a Boley Gauge or disposable ruler):

- Indicate by checkmark next to A, B, C or D which criteria you are submitting for review
- Position the patient's teeth in centric occlusion
- Record all measurements in the order given and round off to the nearest millimeter (mm).
- Enter score of "0" if the condition is absent

A____ CONDITIONS 1-6 ARE AUTOMATIC QUALIFIERS (indicate with an "X" if condition is present and score no further)

1) Cleft palate _______
2) Craniofacial anomaly (attach description of condition from a credentialed specialist) _______
3) Deep impinging overbite WITH tissue damage to the palate. (attach image of tissue laceration) _______
4) Anterior crossbite with gingival recession or loose permanent tooth _______
5) Severe traumatic deviation (ie: accidents, tumors, etc; attach description)
6) Overjet 9mm or greater or reverse overjet (mandibular protrusion) 3.5mm or greater _______

B____ CONDITIONS 7-14 MUST SCORE 26 POINTS OR MORE TO QUALIFY

7) **Overjet** (one upper central incisor to the most labial lower incisor) mm____x1= _______
8) **Reverse overjet** (mandibular protrusion) mm____x1= _______
9) **Open bite** (incisal edge of maxillary central to mandibular central incisor) mm____x1= _______
10) **Ectopic teeth** (excluding third molars) # of teeth____x3= _______

    Note: if anterior crowding and ectopic eruption are present in the anterior portions of the mouth, score only the most severe condition. Do not score both.

11) **Anterior crowding of maxilla** (greater than 3.5mm). if present score __1__x5=_______
12) **Anterior crowding of mandible** (greater than 3.5mm). if present score __1__x5=_______
13) **Labio-lingual spread** (either measure a displaced tooth from the normal arch form or labial-lingual distance between adjacent anterior teeth) mm____x1= _______
14) **Posterior unilateral crossbite** (must involve two or more adjacent teeth, one of which must be a molar) __1__x4=_______

C____MEDICAL NECESSITY (indicate with an "X" for consideration)

If the participant does not meet the qualifying criteria in sections A or B, the Plan will consider whether orthodontic benefits should be provided based on other evidence of medical necessity. The treating orthodontist must submit a written, detailed explanation of the medical necessity for orthodontia along with a completed HLD index, the prior authorization request form, and treatment plan.

a. If medical necessity is based on a medical condition that is exacerbated or complicated by the patient's malocclusion (ie: TMJ dysfunction, chronic pain, malnutrition) additional documentation from a licensed physician, board certified to diagnose the medical condition must be presented. This documentation should justify the need for orthodontia services and must be submitted along with the documentation from the orthodontist.

HLD Ohio Modification Scoresheet (page 2)

b. If medical necessity is based on respiration or speech problems that are exacerbated or complicated by the patient's malocclusion (ie: postural abnormalities associated with mouth breathing, speech impairment), additional documentation from a licensed physician, respiratory therapist, or speech therapist board certified to diagnose the medical condition must be presented. This documentation should justify the need for orthodontia services and must be submitted along with the documentation from the orthodontist.

c. If medical necessity is based on the presence of mental, emotional, behavioral, or psychosocial problems that are exacerbated or complicated by the patient's malocclusion (ie: social withdrawal, low self-esteem, socially unacceptable eating behaviors), additional documentation from a licensed psychiatrist, psychologist, or social worker must be presented. This documentation should justify the need for orthodontia services and must be submitted along with the documentation from the orthodontist.

D____ EPSDT-SS EXCEPTION (indicate with an "X" for consideration)

If a participant does not meet the automatic qualifying conditions in section A nor scores a 26 or greater in section B, the patient may be eligible for orthodontia under the Early and Periodic Screening, Diagnosis and Treatment exception if medical necessity is documented. Attach medical evidence and appropriate documentation for each of the following areas on a separate piece of paper in addition to completing the HLD score sheet above.

a) Principle diagnosis and associated diagnoses
b) Clinical significance or functional impairment caused by the condition
c) Specific types of services to be rendered by each discipline associated with the total treatment plan
d) The therapeutic goals to be achieved by each discipline, and anticipated time for achievement of goals
e) Description of the ways in which the proposed treatment is expected to ameliorate illness or injury
f) The extent to which health care services have been previously provided to address the condition, and results demonstrated by prior care
g) Any other documentation which may assist the department in making the required determination.

HLD Scoring Instructions (page 1)

HLD SCORING INSTRUCTIONS:

The intent of the HLD index is to measure the presence or absence, and the degree, of the handicapped occlusion caused by the components of the Index, and not to diagnose 'malocclusion.' All measurements are made with a scaled millimeter ruler. Absence of any conditions must be recorded by entering '0.' (Refer to the attached score sheet.)
The following documentation is required to be submitted.

- A completed HLD Scoring Index Sheet
- A narrative describing the nature of the severe physically handicapping malocclusion, along with any documentation relevant to determining the nature and extent of the handicap.
- A panoramic and/or mounted full mouth series of intra-oral X-rays.
- A cephalometric X-ray with teeth in centric occlusion and cephalometric analysis/tracing.
- Facial photographs of frontal and profile views.
- Intra-oral photographs depicting right and left occlusal relationships as well as an anterior view.
- Maxillary and mandibular occlusal photographs.
- Photos of articulated models can be submitted optionally *(Do NOT send stone casts).*

The following information is intended to clarify scoring rules for sections A) and B) of the HLD Index:

1. Cleft Palate Deformity: The cleft must be demonstrated with diagnostic casts, digital photographs of orthodontically trimmed study models; or intraoral photograph of the palate demonstrating soft tissue destruction. If the cleft cannot be demonstrated by one of these methods, a consultation report by a qualified specialist or Craniofacial Panel must accompany the submission.
2. Cranio-facial Anomaly: Attach consultation report by a qualified specialist or Craniofacial Panel, in addition to all standard documentation.
3. Deep Impinging Overbite: Mark only if the lower incisors are causing tissue damage to the palate. Do not score if tissue destruction is not present. Attach intraoral photograph showing soft tissue destruction, in addition to all standard documentation.
4. Crossbite of Individual Anterior Teeth: Include supportive diagnostic intra-oral photographs and periodontal chart demonstrating the crossbite and resulting gingival recession/tooth mobility, in addition to all standard documentation.
5. Severe Traumatic Deviation: Traumatic deviations are, for example, loss of a premaxilla segment by burns or by accident; the result of osteomyelitis; or other gross pathology. Do not score deviations that were not caused by trauma/disease. Submit a description of the trauma/disease, and prior treatment for the condition, in addition to all standard documentation.
6. Overjet 9mm or greater, or reverse overjet 3.5mm or greater: Overjet is recorded with the patient's teeth in centric occlusion and is measured from the labial surface of a lower central incisor to the labial surface of the corresponding upper central incisors. Do not use lateral incisors or canines for measurement. This measurement should record the **greatest** distance between any one upper central incisor and it's corresponding lower central or lateral incisor. If the overjet is greater than or equal to 9mm or reverse overjet) is greater than of equal to 3.5mm, place an "X" in item 6 and score no further. If the overjet is less than the above values, record individual millimeter measurements in item 7 or 8.
7. Overjet equal to or less than 9mm: See instructions for measuring overjet or reverse overjet in item 6. above.
8. Reverse overjet equal to or less than 3.5mm: See instructions for measuring overjet or reverse overjet in item 6. above.
9. Open Bite: This condition is defined as the absence of occlusal contact in the anterior region. It is measured from incisal edge of a maxillary central incisor to incisal edge of a corresponding mandibular incisor, in millimeters. Do not use lateral incisors or canines for measurement. Do not record teeth that are still erupting.
10. Ectopic Eruption: Count each tooth, **excluding third molars**. Each qualifying tooth must be impeded from full normal eruption and indicate that more than 50% of the crown as blocked and is not within the arch. Count only one tooth when there are mutually blocked out teeth. Enter the number of qualifying teeth on the score sheet and multiply by three (3). If anterior crowding (condition #11) also exists in the same arch, score the condition that scores the most points. **DO NOT COUNT BOTH CONDITIONS.** However, posterior ectopic teeth can still be counted separately from anterior crowding when they occur in the same arch.

HLD Scoring Instructions (page 2)

11, 12. Anterior Crowding: Arch length insufficiency must exceed 3.5mm. Score one (1) for a crowded maxillary arch and/or one (1) for a crowded mandibular arch. Enter total on the score sheet and multiply by five (5). If ectopic eruption (condition #10) exists in the anterior region of the same arch, count the condition that scores the most points. **DO NOT COUNT BOTH CONDITIONS.** However, posterior ectopic teeth can still be counted separately from anterior crowding when they occur in the same arch.
13. Labio-Lingual Spread: A Boley Gauge (or a disposable ruler) is used to determine the extent of deviation from a normal arch. Where there is only a protruded or lingually displaced anterior tooth, the measurement should be made from the incisal edge of that tooth to the normal arch line. Otherwise, the total distance between the most protruded anterior tooth and the most lingually displaced adjacent anterior tooth is measured. In the event that multiple anterior crowding of teeth is observed, all deviations from the normal arch should be measured for labio-lingual spread, but **only the most severe individual measurement should be entered on the score shee**t.
14. Posterior Unilateral Crossbite: This condition involves two or more adjacent teeth, one of which must be a molar. The crossbite must be one in which the maxillary posterior teeth involved may either be both completely palatal or completely buccal in relation to the mandibular posterior teeth, with no cusp/fossa contact. The presence of posterior unilateral crossbite is indicated by a score of four (4) on the score sheet. **NO SCORE FOR BI-LATERIAL CROSSBITE.**

B2B M57474-X 12/24 © 2024 United HealthCare Services, Inc. All Rights Reserved.