UnitedHealthcare Community Plan of Pennsylvania Medicaid Dental Quick Reference Guide

Effective: 01/01/2025

UHCdental.com/medicaid

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

To register for the Dental Hub, you will need information on a prior paid claim or a Registration code. To receive your Registration code and for other Dental Hub assistance, call Provider Services.

Provider services

Phone: **1-800-508-4876**
8 a.m. – 5 p.m. CST Monday–Friday (IVR: 24/7)

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

Prior authorization

UnitedHealthcare Dental
Authorizations
P.O. Box 779
Milwaukee, WI 53201

Appeals for service denials

UnitedHealthcare Community Plan
Attn: Appeals Department
UnitedHealthcare
P.O. Box 1091
Milwaukee, WI 53201

Toll-free: **1-800-508-4876**

Claims

UnitedHealthcare Dental Claims
P.O. Box 2173
Milwaukee, WI 53201

EDI Payer ID

GP133

Corrected claims

UnitedHealthcare 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 call our Provider Services toll free number.

United Healthcare® | Dental Benefit Providers®

Sample member ID card

Benefit coverage, limitations, and requirements

Exclusions & limitations

Please refer to the benefits grid for applicable exclusions and limitations and covered services. Standard ADA coding guidelines are applied to all claims.

Any service not listed as a covered service in the benefit grids is excluded.

Please call Provider Services at 1-800-508-4876 if you have any questions regarding frequency limitations.

General exclusions

1. Unnecessary dental services.
2. Any dental procedure performed solely for cosmetic/aesthetic reasons.
3. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury, or congenital anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.
4. Any dental procedure not directly associated with dental disease.
5. Any procedure not performed in a dental setting that has not had prior authorization.
6. Procedures that are considered experimental, investigational or unproven. This includes pharmacological regimens not accepted by the American Dental Association Council on Dental Therapeutics. The fact that an experimental, investigational or unproven service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be experimental, investigational or unproven in the treatment of that particular condition.
7. Service for injuries or conditions covered by workers' compensation or employer liability laws, and services that are provided without cost to the covered persons by any municipality, county or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
8. Expenses for dental procedures begun prior to the covered person's eligibility with the plan.
9. Dental services otherwise covered under the policy, but rendered after the date that an individual's coverage under the policy terminates, including dental services for dental conditions arising prior to the date that an individual's coverage under the policy terminates.
10. Services rendered by a provider with the same legal residence as a covered person or who is a member of a covered person's family, including a spouse, brother, sister, parent or child.
11. Charges for failure to keep a scheduled appointment without giving the dental office proper notification.

Benefit grid

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**.

Pennsylvania Medicaid

Code	Description	Age limits	Frequency limits	Other limits
D0120	Periodic Oral Evaluation - Established Patient	0-999	1 per 180 DAYS	D0120, D0145, D0150: 1 per 180 DAYS
D0140	Limited Oral Evaluation - Problem Focused	0-999	No limits	None
D0145	Oral Evaluation, Patient Under Three	0-2	1 per 180 DAYS	D0120, D0145, D0150: 1 per 180 DAYS
D0150	Comprehensive Oral Evaluation - New Or Established Patient	0-999	1 per 180 DAYS	D0120, D0145, D0150: 1 per 180 DAYS
D0160	Detailed And Extensive Oral Evaluation - Problem Focused, By Report	0-999	No limits	None
D0170	Re-Evaluation - Limited, Problem Focused	0-999	No limits	None
D0190	Screening of a Patient	0-999	1 per 1 YEAR	
D0191	Assessment of a Patient	0-999	1 per 1 YEAR	
D0210	Intraoral - Complete Series of Radiographic Images	0-999	1 per 5 FLOATING YEARS	None
D0220	Intraoral - Periapical First Radiographic Image	0-999	1 per 1 DAY	None
D0230	Intraoral - Periapical Each Additional Image	0-999	10 per 1 DAY	None
D0240	Intraoral - Occlusal Radiographic Image	0-999	2 per 1 DAY	None
D0250	Extraoral - 2D Projection Radiographic image	0-999	1 per 1 DAY	None
D0251	Extra-Oral Posterior Dental Radiographic Image	0-999	10 per 1 DAY	None
D0270	Bitewing - Single Radiographic Image	0-999	1 per 1 DAY	None
D0272	Bitewings - Two Radiographic Images	0-999	1 per 1 DAY	None
D0273	Bitewings - Three Radiographic Images	0-999	1 per 1 DAY	None
D0274	Bitewings - Four Radiographic Images	0-999	1 per 1 DAY	None
D0330	Panoramic Radiographic Image	0-999	1 per 5 FLOATING YEARS	None
D0340	2D Cephalometric Radiographic Image	0-21	1 per 1 DAY	None
D0372	intraoral tomosynthesis - comprehensive series of radiographic images; A radiographic survey of the whole mouth intended to display the crowns and roots of all teeth, periapical areas, interproximal areas and alveolar bone including edentulous areas	0-999	1 per 5 YEARS	None
D0373	intraoral tomosynthesis - bitewing radiographic image	0-999	4 per 1 day	None
D0374	intraoral tomosynthesis - periapical radiographic image	0-999	11 per 1 day	None
D1110	Prophylaxis - Adult	12-999	1 per 180 DAYS	D1110, D1120, D4910, D4346: 3 per 1 FLOATING YEAR
D1120	Prophylaxis - Child	0-11	1 per 180 DAYS	D1110, D1120, D4910, D4346: 3 per 1 FLOATING YEAR
D1206	Topical Application Of Fluoride Varnish	0-20	6 per 1 YEAR	None

Pennsylvania Medicaid

Code	Description	Age limits	Frequency limits	Other limits
D1208	Topical Application of Fluoride	0-20	1 per 180 DAYS	None
D1310	Nutritional Counseling For Control Of Dental Disease	0-999	1 per 180 DAYS	None
D1320	Tobacco Counseling For The Control And Prevention Of Oral Disease	0-20	1 per 1 DAY	Tobacco Cessation Counseling: 70 per 1 ACCUM YEAR
D1330	Oral Hygiene Instructions	0-999	1 per 180 DAYS	None
D1351	Sealant - Per Tooth	0-20	1 per LIFETIME	None
D1354	Interim Caries Arresting Medicament Application - per tooth	0-999	1 Per tooth per day, maximum of 10 teeth per day, 4 times per tooth per year, 6 times per tooth per lifetime	D1354: 1 per 6 MONTH
D1354	Interim Caries Arresting Medicament Application - per tooth	0-20	1 per 6 MONTHS	D1354 Additional Limit: 10 per DAY PER MEMBER
D1510	Space Maintainer - Fixed - Unilateral - per quadrant	0-20	4 per 1 LIFETIME	None
D1516	Space Maintainer - Fixed - Bilateral, maxillary	0-20	4 per 1 LIFETIME	None
D1517	Space Maintainer - Fixed - Bilateral, mandibular	0-20	4 per 1 LIFETIME	None
D1550	Re-Cement Or Re-Bond Space Maintainer	0-20	1 per 1 DAY	None
D1555	Removal Of Fixed Space Maintainer	0-20	4 per 1 DAY	None
D1558	Removal of fixed bilateral space maintainer – mandibular	0-20	1 per 1 day	None
D1999	Unspecified Preventive Procedure, By Report	0-999	No limits	None
D2140	Amalgam - One Surface, Primary Or Permanent	0-999	1 per 1 DAY	None
D2150	Amalgam - Two Surfaces, Primary Or Permanent	0-999	1 per 1 DAY	None
D2160	Amalgam - Three Surfaces, Primary Or Permanent	0-999	1 per 1 DAY	None
D2161	Amalgam - Four Or More Surfaces, Primary Or Permanent	0-999	1 per 1 DAY	None
D2330	Resin-Based Composite - One Surface, Anterior	0-999	1 per 1 DAY	None
D2331	Resin-Based Composite - Two Surfaces, Anterior	0-999	1 per 1 DAY	None
D2332	Resin-Based Composite - Three Surfaces, Anterior	0-999	1 per 1 DAY	None
D2335	Resin-Based Composite - Four Or More Surfaces Or Involving Incisal Angle	0-999	1 per 1 DAY	None
D2390	Resin-Based Composite Crown, Anterior	0-20	1 per 1 DAY	None
D2391	Resin-Based Composite - One Surface, Posterior	0-999	1 per 1 DAY	None
D2392	Resin-Based Composite - Two Surfaces, Posterior	0-999	1 per 1 DAY	None
D2393	Resin-Based Composite - Three Surfaces, Posterior	0-999	1 per 1 DAY	None
D2394	Resin-Based Composite - Four Or More Surfaces, Posterior	0-999	1 per 1 DAY	None
D2710	Crown - Resin-Based Composite (Indirect)	0-20	1 per 3 FLOATING YEARS	None
D2721	Crown - Resin With Predominantly Base Metal	0-20	1 per 5 FLOATING YEARS	None
D2740	Crown - Porcelain/Ceramic	0-20	1 per 5 FLOATING YEARS	None

Pennsylvania Medicaid

Code	Description	Age limits	Frequency limits	Other limits
D2751	Crown - Porcelain Fused To Predominantly Base Metal	0-20	1 per 5 FLOATING YEARS	None
D2791	Crown - Full Cast Predominantly Base Metal	0-20	1 per 5 FLOATING YEARS	None
D2910	Re-Cement Or Re-Bond Inlay, Onlay, Veneer Or Partial Coverage Restoration	0-999	1 per 1 DAY	None
D2915	Re-Cement or Re-Bond Cast Indirectly Fabricated Or Pre-Fabricated Post and Core	0-999	1 per 1 DAY	None
D2920	Re-Cement or Re-Bond Crown	0-999	1 per 1 DAY	None
D2930	Prefabricated Stainless Steel Crown - Primary Tooth	0-20	1 per 1 DAY	None
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth	0-20	1 per 1 DAY	None
D2932	Prefabricated Resin Crown	0-20	1 per 1 DAY	None
D2933	Prefabricated Stainless Steel Crown With Resin Window	0-20	1 per 1 DAY	None
D2934	Prefabricated Esthetic Coated Stainless Steel Crown - Primary Tooth	0-20	1 per 1 DAY	None
D2952	Post And Core In Addition To Crown, Indirectly Fabricated	0-20	1 per 1 DAY	None
D2954	Prefabricated Post And Core In Addition To Crown	0-20	1 per 1 DAY	None
D2980	Crown Repair	0-999	1 per 1 DAY	None
D2991	Application of hydroxyapatite regeneration medicament - per tooth	0-999	No limits	
D2999	Unspecified Restorative Procedure, By Report	0-999	No limits	None
D3220	Therapeutic Pulpotomy	0-20	6 per 1 DAY	None
D3230	Pulpal Therapy (Resorbable Filling) - Anterior, Primary Tooth	0-20	1 per 1 DAY	None
D3240	Pulpal Therapy (Resorbable Filling) - Posterior, Primary Tooth	0-20	1 per 1 DAY	None
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)	0-20	1 per LIFETIME	None
D3320	Endodontic Therapy Premolar Tooth (Excluding Final Restoration)	0-20	1 per LIFETIME	None
D3330	Endodontic Therapy, Molar tooth (Excluding Final Restoration)	0-20	1 per LIFETIME	None
D3410	Apicoectomy - Anterior	0-20	2 per 1 DAY	None
D3421	Apicoectomy - Premolar (First Root)	0-20	2 per 1 DAY	None
D3425	Apicoectomy - Molar (First Root)	0-20	2 per 1 DAY	None
D3426	Apicoectomy - Each Additional Root	0-20	2 per 1 DAY	None
D3921	Decoronation or submergence of an erupted tooth	0-20	1 tooth per 1 day	
D3999	Unspecified Endodontic Procedure, By Report	0-999	No limits	None
D4210	Gingivectomy Or Gingivoplasty - Four Or More Contiguous Teeth	0-20	4 per 24 MONTH	None
D4341	Periodontal Scaling And Root Planing - Four Or More Teeth Per Quadrant	0-20	1-2 quad per day up to 4 different quads in 24 months	None
D4342	periodontal scaling and root planing - one to three teeth per quadrant	0-999	1 quad per day up to 4 differ quads in 24 months	
D4346	Scaling in moderate or severe gingival inflammation	0-20	1 per 180 days	D1110, D1120, D4910 D4346: 3 per 1 YEAR
D4355	Full Mouth Debridement	0-20	1 per 1 FLOATING YEAR	None

Pennsylvania Medicaid

Code	Description	Age limits	Frequency limits	Other limits
D4910	Periodontal Maintenance	0-20	1 per 90 days	D1110, D1120, D4910, D4346: 3 per 1 YEAR
D5110	Complete Denture - Maxillary	0-999	1 per LIFETIME	Dentures-Upper (D5110, D5130, D5211, D5213): 1 per 1 LIFETIME
D5120	Complete Denture - Mandibular	0-999	1 per LIFETIME	Dentures-Lower (D5120, D5140, D5212, D5214): 1 per 1 LIFETIME
D5130	Immediate Denture - Maxillary	0-999	1 per LIFETIME	Dentures-Upper (D5110, D5130, D5211, D5213): 1 per 1 LIFETIME
D5140	Immediate Denture - Mandibular	0-999	1 per LIFETIME	Dentures-Lower (D5120, D5140, D5212, D5214): 1 per 1 LIFETIME
D5211	Maxillary Partial Denture - Resin Base	0-999	1 per LIFETIME	Dentures-Upper (D5110, D5130, D5211, D5213): 1 per 1 LIFETIME
D5212	Mandibular Partial Denture - Resin Base	0-999	1 per LIFETIME	Dentures-Lower (D5120, D5140, D5212, D5214): 1 per 1 LIFETIME
D5213	maxillary partial denture - cast metal framework with resin denture bases	6-999	1 per LIFETIME	Dentures-Upper (D5110, D5130, D5211, D5213): 1 per 1 LIFETIME
D5214	mandibular partial denture - cast metal framework with resin denture bases	6-999	1 per LIFETIME	Dentures-Lower (D5120, D5140, D5212, D5214): 1 per 1 LIFETIME
D5410	Adjust Complete Denture - Maxillary	0-999	1 per 1 DAY	None
D5411	Adjust Complete Denture - Mandibular	0-999	1 per 1 DAY	None
D5421	Adjust Partial Denture - Maxillary	0-999	1 per 1 DAY	None
D5422	Adjust Partial Denture - Mandibular	0-999	1 per 1 DAY	None
D5511	Repair Broken Complete Denture Base - Mandibular	6-120	1 per 1 DAY	None
D5512	Repair Broken Complete Denture Base - Maxillary	6-120	1 per 1 DAY	None
D5520	Replace Missing Or Broken Teeth - Complete Denture (Each Tooth)	0-999	3 per 1 DAY	None
D5611	Repair Resin Partial Denture Base - Mandibular	0-999	1 per 1 DAY	None
D5612	Repair Resin Partial Denture Base - Maxillary	0-999	1 per 1 DAY	None
D5621	Repair Cast Partial Framework - Mandibular	0-999	1 per 1 DAY	None
D5622	Repair Cast Partial Framework - Maxillary	0-999	1 per 1 DAY	None
D5630	Repair Or Replace Broken Retentive / Clasping Materials - Per Tooth	0-999	4 per 1 YEAR	None
D5640	Replace Broken Teeth - Per Tooth	0-999	3 per 1 DAY	None
D5650	Add Tooth To Existing Partial Denture	0-999	2 per 1 DAY	None
D5660	Add Clasp To Existing Partial Denture - Per Tooth	0-999	1 per lifetime per tooth	None
D5730	reline complete maxillary denture (direct)	0-999	1 per 1 DAY	None
D5731	reline complete mandibular denture (direct)	0-999	1 per 1 DAY	None

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Code	Description	Age limits	Frequency limits	Other limits
D5740	reline maxillary partial denture (direct)	0-999	1 per 1 DAY	None
D5741	reline mandibular partial denture (direct)	0-999	1 per 1 DAY	None
D5750	reline complete maxillary denture (indirect)	0-999	1 per 1 DAY	None
D5751	reline complete mandibular denture (indirect)	0-999	1 per 1 DAY	None
D5760	reline maxillary partial denture (indirect)	0-999	1 per 1 DAY	None
D5761	reline mandibular partial denture (indirect)	0-999	1 per 1 DAY	None
D5899	Unspecified Removable Prosthodontic Procedure, By Report	0-999	No limits	None
D5999	Unspecified Maxillofacial Prosthesis, By Report	0-999	No limits	None
D6930	Re-Cement Or Re-Bond Fixed Partial Denture	0-999	1 per 1 DAY	None
D6980	Fixed Partial Denture Repair	0-999	1 per 1 DAY	None
D7140	Extraction, Erupted Tooth Or Exposed Root	0-999	1 per LIFETIME	Extractions (D7111, D7140 - D7241): 1 per 1 LIFETIME
D7210	Extraction, Erupted Tooth	0-999	1 per LIFETIME	Extractions (D7111, D7140 - D7241): 1 per 1 LIFETIME
D7220	Removal Of Impacted Tooth - Soft Tissue	0-999	1 per LIFETIME	Extractions (D7111, D7140 - D7241): 1 per 1 LIFETIME
D7230	Removal Of Impacted Tooth - Partially Bony	0-999	1 per LIFETIME	Extractions (D7111, D7140 - D7241): 1 per 1 LIFETIME
D7240	Removal Of Impacted Tooth - Completely Bony	0-999	1 per LIFETIME	Extractions (D7111, D7140 - D7241): 1 per 1 LIFETIME
D7250	Removal Of Residual Tooth (Cutting Procedure)	0-999	1 per LIFETIME	None
D7260	Oroantral Fistula Closure	0-999	1 per 1 DAY	None
D7270	Reimplantation And/Or Stabilization Of Accidentally Evulsed / Displaced Tooth	0-20	1 per 1 DAY	None
D7280	Exposure of an Unerupted Tooth	0-23	1 per LIFETIME	None
D7283	Placement Of Device To Facilitate Eruption Of Impacted Tooth	0-23	1 per LIFETIME	None
D7288	Brush Biopsy - Transepithelial Sample Collection	0-999	2 per 1 DAY	None
D7310	Alveoloplasty In Conjunction With Extractions - Four Or More Teeth	0-999	1 per 1 DAY	None
D7320	Alveoloplasty Not In Conjunction With Extractions - Four Or More Teeth	0-999	1 per 1 DAY	None
D7450	Removal Of Benign Odontogenic Cyst Or Tumor - Dia Up To 1.25 Cm	0-999	2 per 1 DAY	None
D7451	Removal Of Benign Odontogenic Cyst Or Tumor - Dia Greater Than 1.25 Cm	0-999	2 per 1 DAY	None
D7460	Removal Of Benign Nonodontogenic Cyst Or Tumor - Dia Up To 1.25 Cm	0-999	2 per 1 DAY	None
D7461	Removal Of Benign Nonodontogenic Cyst Or Tumor - Dia Greater Than 1.25 Cm	0-999	2 per 1 DAY	None
D7471	Removal Of Lateral Exostosis (Maxilla Or Mandible)	0-999	2 per 1 DAY	None
D7472	Removal Of Torus Palatinus	0-999	2 per 1 DAY	None
D7473	Removal Of Torus Mandibularis	0-999	2 per 1 DAY	None
D7485	Reduction Of Osseous Tuberosity	0-999	2 per 1 DAY	None

Pennsylvania Medicaid

Code	Description	Age limits	Frequency limits	Other limits
D7509	marsupialization of odontogenic cyst; Surgical decompression of a large cystic lesion by creating a long-term open pocket or pouch.	0-999	2 lesions per day	None
D7510	Incision And Drainage Of Abscess - Intraoral Soft Tissue	0-999	2 per 1 DAY	None
D7511	Incision And Drainage Of Abscess - Intraoral Soft Tissue - Complicated	0-999	2 per 1 DAY	None
D7520	Incision And Drainage Of Abscess - Extraoral Soft Tissue	0-999	2 per 1 DAY	None
D7521	Incision And Drainage Of Abscess - Extraoral Soft Tissue - Complicated	0-999	2 per 1 DAY	None
D7871	Non-Arthroscopic Lysis And Lavage	0-999	1 per 1 DAY	None
D7961	buccal / labial frenectomy (frenulectomy)	0-999	2 per 1 LIFETIME	None
D7962	lingual frenectomy (frenulectomy)	0-999	1 per LIFETIME	None
D7970	Excision Of Hyperplastic Tissue - Per Arch	0-999	2 per 1 DAY	None
D7999	Unspecified Oral Surgery Procedure, By Report	0-999	1 per 1 DAY	None
D8080	Comprehensive Orthodontic Treatment Of The Adolescent Dentition	0-20	1 per LIFETIME	None
D8210	Removable Appliance Therapy	0-20	1 per LIFETIME	None
D8220	Fixed Appliance Therapy	0-20	1 per LIFETIME	None
D8660	Pre-Orthodontic Treatment Examination To Monitor Growth And Development	0-22	1 per 1 FLOATING YEAR	None
D8670	Periodic Orthodontic Treatment Visit	0-22	1 per 25 DAYS	D8670: 7 per 1 LIFETIME
D8670	Periodic Orthodontic Treatment Visit	0-22	1 per 25 DAYS	D8670: 29 per 1 LIFETIME
D8670	Periodic Orthodontic Treatment Visit	0-22	1 per 76 DAYS	D8670: 7 per 1 LIFETIME
D8670	Periodic Orthodontic Treatment Visit	0-22	1 per 76 DAYS	D8670: 29 per 1 LIFETIME
D8680	Orthodontic Retention (Removal Of Appliances, Place Retainers)	0-22	1 per LIFETIME	None
D8703	Replacement of lost or broken retainer – maxillary	0-22	1 per LIFETIME	None
D8704	Replacement of lost or broken retainer – mandibular	0-22	1 per LIFETIME	None
D9110	Palliative (Emergency) Treatment Of Dental Pain - Minor Procedure	0-999	1 per 1 DAY	None
D9222	Deep Sedation/General Anesthesia - First 15 Minutes	0-999	1 per 1 DAY	None
D9223	Deep Sedation / General Anesthesia - Each subsequent 15 Minute Increment	0-999	9 per 1 DAY	None
D9230	Inhalation Of Nitrous/Analgesia, Anxiolysis	0-20	No limits	None
D9239	Intravenous Moderate (Conscious) Sedation/Analgesia - First 15 Minutes	0-999	1 per 1 DAY	None
D9243	Intravenous Moderate (Conscious) Sedation/Analgesia - Each Subsequent 15 Minute	0-999	9 per 1 DAY	None
D9248	Non-Intravenous Conscious Sedation	0-999	1 per 1 DAY	None
D9420	Hospital Or Ambulatory Surgical Center Call	0-999	No limits	None
D9920	Behavior Management, By Report	0-999	4 per 1 FLOATING YEAR	None
D9930	Treatment Of Complications (Post Surgical) - Unusual Circumstances, By Report	0-999	1 per 1 DAY	None
D9947		0-20	1 per 1 lifetime	
D9948	Adjustment of custom sleep apnea appliance	0-20	1 per 1 DAY	at least 180 days post placement

Pennsylvania Medicaid

Code	Description	Age limits	Frequency limits	Other limits
D9949	Repair of custom sleep apnea appliance	0-20	1 per 1 DAY	at least 180 days post placement
D9953	reline custom sleep apnea appliance (indirect); Resurface dentition side of appliance with new soft or hard base material as required to restore original form and function.	0-999	1 per 2 years per appliance	at least 180 days post placement
D9991	Dental Case Management - addressing appointment compliance barriers	2-20	1 per code every Accum Year	None
D9994	Dental Case Management - Patient education	0-999	1 per code every Accum Year	None
D9995	Teledentistry - Synchronous; Real-Time Encounter	0-999	1 per 1 DAY	None
D9996	Teledentistry - Asynchronous; Information Stored And Forwarded To Dentist	0-999	1 per 1 DAY	None
D9999	Unspecified Adjunctive Procedure, By Report	0-999	1 per 1 FLOATING YEAR	None

Pennsylvania CHIP

Code	Description	Age limits	Frequency limits	Other limits
D0120	Periodic Oral Exam	0-999	1 per every 6 Months	
D0140	Limited Oral Evaluation - Problem Focused	0-999		
D0145	Oral Evaluation, Patient Under Three	0-3		
D0150	Comprehensive Oral Evaluation - New Or Established Patient	0-999	1 per every 6 Months	
D0160	Detailed And Extensive Oral Evaluation - Problem Focused, By Report	0-999	1 per every 6 Months	
D0170	Re-Evaluation - Limited, Problem Focused	0-999		
D0180	Comprehensive periodontal evaluation	0-999	1 per every 6 Months	
D0210	Intraoral - Comprehensive Series of Radiographic Images	0-999	1 per every 60 Months	1 per every 60 Months
D0220	Intraoral - Periapical First Radiographic Image	0-999	10 per every 12 Months	
D0230	Intraoral - Periapical Each Additional Image	0-999	10 per every 12 Months	
D0240	Intraoral - Occlusal Radiographic Image	0-999		
D0250	Extraoral - 2D Projection Radiographic image	0-999		
D0251	Extra-Oral Posterior Dental Radiographic Image	0-999	10 per every Day	
D0270	Bitewing - Single Radiographic Image	0-999	1 per every 6 Months	
D0272	Bitewings - Two Radiographic Images	0-999	1 per every 6 Months	
D0273	Bitewings - Three Radiographic Images	0-999	1 per every 6 Months	

Pennsylvania CHIP

Code	Description	Age limits	Frequency limits	Other limits
D0274	Bitewings - Four Radiographic Images	0-999	1 per every 6 Months	
D0277	Vertical Bitewings - 7 To 8 Radiographic Images	0-999	1 per every 12 Months	
D0330	Panoramic Radiographic Image	0-999	1 per every 60 Months	1 per every 60 Months
D0340	2D Cephalometric Radiographic Image	0-999		
D0350	Oral/Facial Photographic Images	0-999		
D0351	3D photographic image This procedure is for diagnostic purposes. Not applicable	0-999		
D0391	Interpretation Of Diagnostic Image	0-999		
D0415	Collection Of Microorganisms For Culture And Sensitivity	0-999		
D0422	Collection And Preparation Of Genetic Sample	0-999	1 per every Lifetime	
D0423	Genetic Test For Susceptibility To Diseases	0-999	1 per every Lifetime	
D0460	Pulp Vitality Tests	13-999	1 per every 30 Days	
D0470	Diagnostic Casts	0-999		
D1110	Prophylaxis - Adult	0-999	1 per every 6 Months	
D1120	Prophylaxis - Child	0-12 13-999	1 per every 6 Months	
D1206	Topical Application Of Fluoride Varnish	0-999	2 per every 12 Months	
D1208	Topical Application of Fluoride	0-999	2 per every 12 Months	
D1351	Sealant - Per Tooth	0-999	1 per tooth every 14 Days	
D1352	Preventive Resin Restoration	0-999	1 per tooth every 36 Months	
D1353	Sealant Repair - Per Tooth	0-999	1 per tooth every 36 Months	
D1354	Interim Caries Arresting Medicament Application - per tooth	0-20	10 per every Day	2 per tooth every Accum Year
		21-999	1 per tooth every 36 Months	2 per tooth every Accum Year
D1510	Space Maintainer - Fixed - Unilateral - per quadrant	0-18		
D1516	Space Maintainer - Fixed - Bilateral, maxillary	0-18		
D1517	Space Maintainer - Fixed - Bilateral, mandibular	0-18		
D1520	Space Maintainer - Removable - Unilateral - per quadrant	0-18		
D1526	Space Maintainer - Removable - Bilateral, maxillary	0-18		
D1527	Space Maintainer - Removable - Bilateral, mandibular	0-18		
D1551	Re-Cement Or Re-Bond Bilateral Space Maintainer - maxillary	0-18		

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Code	Description	Age limits	Frequency limits	Other limits
D1552	Re-Cement Or Re-Bond Bilateral Space Maintainer - mandibular	0-18		
D1553	Re-Cement Or Re-Bond Unilateral Space Maintainer - Per quadrant	0-18		
D1556	Removal Of Fixed Unilateral Space Maintainer - Per quadrant	0-18		
D1557	Removal Of Fixed Bilateral Space Maintainer - maxillary	0-18		
D1558	Removal Of Fixed Bilateral Space Maintainer - mandibular	0-18		
D1999	Unspecified Preventive Procedure, By Report	0-999		
D2140	Amalgam - One Surface, Primary Or Permanent	0-999	1 per tooth every 24 Months	
D2150	Amalgam - Two Surfaces, Primary Or Permanent	0-999	1 per tooth every 24 Months	
D2160	Amalgam - Three Surfaces, Primary Or Permanent	0-999	1 per tooth every 24 Months	
D2161	Amalgam - Four Or More Surfaces, Primary Or Permanent	0-999	1 per tooth every 24 Months	
D2330	Resin-Based Composite - One Surface, Anterior	0-999	1 per tooth every 24 Months	
D2331	Resin-Based Composite - Two Surfaces, Anterior	0-999	1 per tooth every 24 Months	
D2332	Resin-Based Composite - Three Surfaces, Anterior	0-999	1 per tooth every 24 Months	
D2335	Resin-Based Composite - Four Or More Surfaces Or Involving Incisal Angle	0-999	1 per tooth every 24 Months	
D2390	Resin-Based Composite Crown, Anterior	0-999		
D2391	Resin-Based Composite - One Surface, Posterior	0-999		
D2392	Resin-Based Composite - Two Surfaces, Posterior	0-999		
D2393	Resin-Based Composite - Three Surfaces, Posterior	0-999		
D2394	Resin-Based Composite - Four Or More Surfaces, Posterior	0-999		
D2510	Inlay - Metallic - One Surface	0-999		
D2520	Inlay - Metallic - Two Surfaces	0-999		
D2530	Inlay - Metallic - Three Surfaces	0-999		
D2542	Onlay - Metallic - Two Surfaces	0-999	1 per tooth every 60 Months	
D2543	Onlay - Metallic - Three Surfaces	0-999	1 per tooth every 60 Months	
D2544	Onlay - Metallic - Four Or More Surfaces	0-999	1 per tooth every 60 Months	
D2710	Crown - Resin-Based Composite (Indirect)	0-999	1 per tooth every 3 Years	1 per tooth every 5 Accum Years
D2721	Crown - Resin With Predominantly Base Metal	0-999	1 per tooth every 5 Years	1 per tooth every 5 Accum Years
D2740	Crown - Porcelain/Ceramic	0-999	1 per tooth every 60 Months	1 per tooth every 5 Accum Years

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Code	Description	Age limits	Frequency limits	Other limits
D2750	Crown - Porcelain Fused To High Noble Metal	0-999	1 per tooth every 60 Months	
D2751	Crown - Porcelain Fused To Predominantly Base Metal	0-999	1 per tooth every 60 Months	1 per tooth every 5 Accum Years
D2752	Crown - Porcelain Fused To Noble Metal	0-999	1 per tooth every 60 Months	1 per tooth every 5 Accum Years
D2780	Crown - 3/4 Cast High Noble Metal	0-999	1 per tooth every 60 Months	
D2781	Crown - 3/4 Cast Predominantly Base Metal	0-999	1 per tooth every 60 Months	
D2783	Crown - 3/4 Porcelain/Ceramic	0-999	1 per tooth every 60 Months	
D2790	Crown - Full Cast High Noble Metal	0-999	1 per tooth every 60 Months	
D2791	Crown - Full Cast Predominantly Base Metal	0-999	1 per tooth every 60 Months	1 per tooth every 5 Accum Years
D2792	Crown - Full Cast Noble Metal	0-999	1 per tooth every 60 Months	
D2794	crown – titanium and titanium alloys	0-999	1 per tooth every 60 Months	
D2910	Re-Cement Or Re-Bond Inlay, Onlay, Veneer Or Partial Coverage Restoration	0-999		
D2915	Re-Cement or Re-Bond Cast Indirectly Fabricated Or Pre-Fabricated Post and Core	0-999		
D2920	Re-Cement or Re-Bond Crown	0-999		
D2929	Prefabricated Porcelain / Ceramic Crown - Primary Tooth	0-14		
D2930	Prefabricated Stainless Steel Crown - Primary Tooth	0-999	1 per tooth every 60 Months	
D2931	prefabricated stainless steel crown – permanent tooth	0-999	1 per tooth every 60 Months	
D2932	Prefabricated Resin Crown	0-999		
D2933	Prefabricated Stainless Steel Crown With Resin Window	0-999		
D2934	Prefabricated Esthetic Coated Stainless Steel Crown - Primary Tooth	0-999		
D2940	Protective Restoration	0-999		
D2950	Core Buildup, Including Any Pins When Required	0-999	1 per tooth every 60 Months	
D2951	Pin Retention - Per Tooth, In Addition To Restoration	0-999		
D2952	Post And Core In Addition To Crown, Indirectly Fabricated	0-999		
D2954	Prefabricated Post And Core In Addition To Crown	0-999	1 per tooth every Lifetime	
D2955	Post Removal	0-999		
D2971	Additional procedures to customize a crown to fit under an existing partial dent	0-999		
D2980	Crown Repair	0-999	1 per tooth every 12 Months	

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Code	Description	Age limits	Frequency limits	Other limits
D2981	Inlay Repair	0-999		
D2983	Veneer Repair	0-999		
D2990	Resin Infiltration of Incipient Smooth Surface Lesions	0-999	1 per tooth every 36 Months	
D2999	Unspecified Restorative Procedure, By Report	0-999		
D3110	Pulp Cap - Direct (Excluding Final Restoration)	0-999		
D3120	Pulp Cap - Indirect (Excluding Final Restoration)	0-999		
D3220	Therapeutic Pulpotomy	0-999		
D3221	Pulpal Debridement - Primary And Permanent Teeth	0-999	1 per tooth every Lifetime	
D3222	Partial Pulpotomy For Apexogenesis - Permanent Tooth	0-999	1 per tooth every Lifetime	
D3230	Pulpal Therapy (Resorbable Filling) - Anterior, Primary Tooth	0-6	1 per tooth every Lifetime	
D3230	Pulpal Therapy (Resorbable Filling) - Anterior, Primary Tooth	7-11	1 per tooth every Lifetime	
D3240	Pulpal Therapy (Resorbable Filling) - Posterior, Primary Tooth	7-11	1 per tooth every Lifetime	
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)	0-999		
D3320	Endodontic Therapy Premolar Tooth (Excluding Final Restoration)	0-999		
D3330	Endodontic Therapy, Molar tooth (Excluding Final Restoration)	0-999		
D3332	Incomplete Endodontic Therapy	0-999		
D3333	Internal Root Repair Of Perforation Defects	0-999		
D3346	Retreatment Of Previous Root Canal Therapy - Anterior	0-999		
D3347	Retreatment Of Previous Root Canal Therapy - Premolar	0-999		
D3348	Retreatment Of Previous Root Canal Therapy - Molar	0-999		
D3351	Apexification / Recalcification - Initial Visit	0-999		
D3352	Apexification / Recalcification - Interim	0-999		
D3353	Apexification / Recalcification - Final Visit	0-999		
D3354	Pulpal Regeneration	0-999		
D3355	Pulpal Regeneration - Initial Visit	0-999		
D3356	Pulpal Regeneration - Interim Medication Replacement	0-999		
D3357	Pulpal Regeneration - Completion Of Treatment	0-999		
D3410	Apicoectomy - Anterior	0-999		
D3421	Apicoectomy - Premolar (First Root)	0-999		
D3425	Apicoectomy - Molar (First Root)	0-999		
D3426	Apicoectomy - Each Additional Root)	0-999		
D3430	Retrograde Filling - Per Root	0-999		
D3450	Root Amputation - Per Root	0-999		
D3501	surgical exposure of root surface without apicoectomy or repair of root resorpti	0-999		

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Code	Description	Age limits	Frequency limits	Other limits
D3502	surgical exposure of root surface without apicoectomy or repair of root resorpti	0-999		
D3503	surgical exposure of root surface without apicoectomy or repair of root resorpti	0-999		
D3920	Hemisection (Including Any Root Removal), Not Including Root Canal Therapy	0-999		
D3999	Unspecified Endodontic Procedure, By Report	0-999		
D4210	Gingivectomy Or Gingivoplasty - Four Or More Contiguous Teeth	0-999	1 per quadrant every 36 Months	
D4211	Gingivectomy Or Gingivoplasty - One To Three Contiguous Teeth	0-999	1 per quadrant every 36 Months	
D4212	Gingevectomy/Gingivoplasty To Allow Access For Restorative Procedure, Per Tooth	0-999	1 per tooth every 36 Months	
D4240	Gingival Flap Procedure, Including Root Planing - Four Or More Contiguous Teeth	0-999	1 per quadrant every 36 Months	
D4241	Gingival Flap Procedure, Including Root Planing - One To Three Contiguous Teeth	0-999	1 per quadrant every 36 Months	
D4249	Clinical Crown Lengthening - Hard Tissue	0-999	1 per tooth every Lifetime	
D4260	Osseous Surgery (Including Flap And Closure) - Four Or More Teeth	0-999	1 per quadrant every 36 Months	
D4261	Osseous Surgery (Including Flap And Closure) - One To Three Teeth	0-999	1 per quadrant every 36 Months	
D4263	Bone Replacement Graft - First Site In Quadrant	0-999	1 per tooth every 36 Months	
D4266	Guided Tissue Generation, Natural Teeth - Resorbable Barrier, Per Site	0-999		
D4267	Guided Tissue Regeneration, Natural Teeth - Nonresorbable Barrier, Per Site (Inc	0-999		
D4270	Pedicle Soft Tissue Graft Procedure	0-999	1 per tooth every 36 Months	
D4273	Autogenous Connective Tissue Graft Proc, First Tooth, Implant Or Tooth Position	0-999	1 per tooth every 36 Months	
D4275	Non-Autogenous Connective Tissue Graft, First Tooth, Implant Or Tooth Position	0-999	1 per tooth every 36 Months	
D4277	Free Soft Tissue Graft Procedure (Including Donor Site Surgery) First	0-999		
D4278	Free Soft Tissue Graft Procedure (Including Donor Site Surgery) Each Additional	0-999		
D4283	Autogenous Connective Tissue Graft Procedures, Each Additional	0-999		
D4285	Non-Autogenous Connective Tissue Graft, Each Additional	0-999	1 per tooth every 36 Months	
D4341	Periodontal Scaling And Root Planing - Four Or More Teeth Per Quadrant	0-999	1 per quadrant every 24 Months	
D4342	Periodontal Scaling And Root Planing - One To Three Teeth Per Quadrant	0-999	1 per quadrant every 24 Months	
D4355	Full Mouth Debridement To Enable Comprehensive Periodontal Evaluation And Diagno	0-999	1 per every Lifetime	

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Code	Description	Age limits	Frequency limits	Other limits
D4910	Periodontal Maintenance	0-999	1 per every 4 Years	
D4920	Unscheduled Dressing Change (By Someone Other Than Treating Dentist Or Staff)	0-999		
D4921	Gingival Irrigation With a Medicinal Agent - Per Quadrant	0-999		
D5110	Complete Denture - Maxillary	0-999	1 per every 60 Months	
D5120	Complete Denture - Mandibular	0-999	1 per every 60 Months	
D5130	Immediate Denture - Maxillary	0-999	1 per every 60 Months	
D5140	Immediate Denture - Mandibular	0-999	1 per every 60 Months	
D5211	Maxillary Partial Denture - Resin Base	0-999	1 per every 60 Months	
D5212	Mandibular Partial Denture - Resin Base	0-999	1 per every 60 Months	
D5213	maxillary partial denture - cast metal framework with resin denture bases	0-999	1 per every 60 Months	
D5214	mandibular partial denture - cast metal framework with resin denture bases	0-999	1 per every 60 Months	
D5221	immediate maxillary partial denture – resin base	0-999	1 per every 60 Months	
D5222	immediate mandibular partial denture – resin base	0-999	1 per every 60 Months	
D5223	immediate maxillary partial denture – cast metal framework with resin base	0-999	1 per every 60 Months	
D5224	immediate mandibular partial denture – cast metal framework with resin base	0-999	1 per every 60 Months	
D5282	removable unilateral partial denture - one piece cast metal (including retentive	0-999	1 per every 60 Months	
D5283	removable unilateral partial denture - one piece cast metal (including retentive	0-999	1 per every 60 Months	
D5410	Adjust Complete Denture - Maxillary	0-999		
D5411	Adjust Complete Denture - Mandibular	0-999		
D5421	Adjust Partial Denture - Maxillary	0-999		
D5422	Adjust Partial Denture - Mandibular	0-999		
D5511	Repair Broken Complete Denture Base - Mandibular	0-999		
D5512	Repair Broken Complete Denture Base - Maxillary	0-999		
D5520	Replace Missing Or Broken Teeth - Complete Denture (Each Tooth)	0-999		
D5611	Repair Resin Partial Denture Base - Mandibular	0-999		
D5612	Repair Resin Partial Denture Base - Maxillary	0-999		
D5621	Repair Cast Partial Framework - Mandibular	0-999		
D5622	Repair Cast Partial Framework - Maxillary	0-999		

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Code	Description	Age limits	Frequency limits	Other limits
D5630	Repair Or Replace Broken Retentive / Clasping Materials - Per Tooth	0-999		
D5640	Replace Broken Teeth - Per Tooth	0-999		
D5650	Add Tooth To Existing Partial Denture	0-999		
D5660	Add Clasp To Existing Partial Denture - Per Tooth	0-999		
D5670	Replace All Teeth And Acrylic On Cast Metal Framework (Maxillary)	0-999		
D5671	Replace All Teeth And Acrylic On Cast Metal Framework (Mandibular)	0-999		
D5710	Rebase Complete Maxillary Denture	0-999	1 per every 36 Months	
D5711	Rebase Complete Mandibular Denture	0-999	1 per every 36 Months	
D5720	Rebase Maxillary Partial Denture	0-999	1 per every 36 Months	
D5721	Rebase Mandibular Partial Denture	0-999	1 per every 36 Months	
D5730	reline complete maxillary denture (direct)	0-999	1 per every 36 Months	
D5731	reline complete mandibular denture (direct)	0-999	1 per every 36 Months	
D5740	reline maxillary partial denture (direct)	0-999	1 per every 36 Months	
D5741	reline mandibular partial denture (direct)	0-999	1 per every 36 Months	
D5750	reline complete maxillary denture (indirect)	0-999	1 per every 36 Months	
D5751	reline complete mandibular denture (indirect)	0-999	1 per every 36 Months	
D5760	reline maxillary partial denture (indirect)	0-999	1 per every 36 Months	
D5761	reline mandibular partial denture (indirect)	0-999	1 per every 36 Months	
D5850	Tissue Conditioning, Maxillary	0-999		
D5851	Tissue Conditioning, Mandibular	0-999		
D5863	Overdenture - Complete Maxillary	0-999		
D5864	Overdenture - Partial Maxillary	0-999		
D5865	Overdenture - Complete Mandibular	0-999		
D5866	Overdenture - Partial Mandibular	0-999		
D5999	Unspecified Maxillofacial Prosthesis, By Report	0-999		
D6010	Surgical Placement Of Implant Body: Endosteal Implant	0-999	1 per tooth every 60 Months	
D6012	Surgical placement of interim implant body for transitional prosthesis: endostea	0-999	1 per tooth every 60 Months	
D6040	Surgical Placement: Eposteal Implant	0-999	1 per arch every 60 Months	

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Code	Description	Age limits	Frequency limits	Other limits
D6050	Surgical Placement: Transosteal Implant	0-999	1 per tooth every 60 Months	
D6055	Connecting Bar - Implant Supported Or Abutment Supported	0-999	1 per tooth every 60 Months	
D6056	Prefabricated Abutment - Includes Modification And Placement	0-999	1 per tooth every 60 Months	
D6057	Custom Fabricated Abutment - Includes Placement	0-999	1 per tooth every 60 Months	
D6058	Abutment Supported Porcelain/Ceramic Crown	0-999	1 per tooth every 60 Months	
D6059	Abutment Supported Porcelain Fused To Metal Crown (High Noble Metal)	0-999	1 per tooth every 60 Months	
D6060	Abutment Supported Porcelain Fused To Metal Crown (Predominantly Base Metal)	0-999	1 per tooth every 60 Months	
D6061	Abutment Supported Porcelain Fused To Metal Crown (Noble Metal)	0-999	1 per tooth every 60 Months	
D6062	Abutment Supported Cast Metal Crown (High Noble Metal)	0-999	1 per tooth every 60 Months	
D6063	Abutment Supported Cast Metal Crown (Predominantly Base Metal)	0-999	1 per tooth every 60 Months	
D6064	Abutment Supported Cast Metal Crown (Noble Metal)	0-999	1 per tooth every 60 Months	
D6065	Implant Supported Porcelain/Ceramic Crown	0-999	1 per tooth every 60 Months	
D6066	implant supported crown – porcelain fused to metal crown (titanium, titanium all	0-999	1 per tooth every 60 Months	
D6067	implant supported metal crown – (titanium, titanium alloy, high noble metals all	0-999	1 per tooth every 60 Months	
D6068	Abutment Supported Retainer For Porcelain/Ceramic Fpd	0-999	1 per tooth every 60 Months	
D6069	Abutment Supported Retainer For Porcelain Fused To Metal Fpd (High Noble Metal)	0-999	1 per tooth every 60 Months	
D6070	Abutment Supported Retainer For Porcelain Fused To Metal Fpd (Base Metal)	0-999	1 per tooth every 60 Months	
D6071	Abutment Supported Retainer For Porcelain Fused To Metal Fpd (Noble Metal)	0-999	1 per tooth every 60 Months	
D6072	Abutment Supported Retainer For Cast Metal Fpd (High Noble Metal)	0-999	1 per tooth every 60 Months	
D6073	Abutment Supported Retainer For Cast Metal Fpd (Base Metal)	0-999	1 per tooth every 60 Months	
D6074	Abutment Supported Retainer For Cast Metal Fpd (Noble Metal)	0-999	1 per tooth every 60 Months	
D6075	Implant Supported Retainer For Ceramic Fpd	0-999	1 per tooth every 60 Months	
D6076	implant supported retainer for porcelain fused to metal FPD – porcelain fused to	0-999	1 per tooth every 60 Months	

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Code	Description	Age limits	Frequency limits	Other limits
D6077	implant supported retainer for cast metal FPD – high noble alloys	0-999	1 per tooth every 60 Months	
D6080	Implant Maintenance Procedures, Including Removal And Reinsertion Of Prosthesis	0-999	1 per tooth every 60 Months	
D6090	Repair Implant Supported Prosthesis, By Report	0-999	1 per tooth every 60 Months	
D6091	Replacement Of Semi-Precision Or Precision Attachment	0-999	1 per tooth every 60 Months	
D6095	Repair Implant Abutment, By Report	0-999	1 per tooth every 60 Months	
D6100	Surgical removal of implant body removal, by report	0-999	1 per tooth every 60 Months	
D6101	Debridement Of A Peri-Implant Defect And Surface Cleaning	0-999	1 per tooth every 60 Months	
D6102	Debridement/Osseous Contouring Of Peri-Implant Defect; Includes Surface Cleaning	0-999	1 per tooth every 60 Months	
D6103	Bone Graft For Repair Of Peri-Implant Defect - Not Including Flap Entry/ Closure	0-999		
D6104	Bone Graft At Time Of Implant Placement	0-999		
D6110	Implant/Abutment Supported Removable Denture For Edentulous Maxillary Arch	0-999	1 per every 60 Months	
D6111	Implant/Abutment Supported Removable Denture For Edentulous Mandibular Arch	0-999	1 per every 60 Months	
D6112	Implant/Abutment Supported Removable Denture-Partially Edentulous Maxillary Arch	0-999	1 per every 60 Months	
D6113	Implant/Abutment Supported Removable Denture-Partially Edentulous Mand. Arch	0-999	1 per every 60 Months	
D6114	Implant/Abutment Supported Fixed Denture For Edentulous Maxillary Arch	0-999	1 per every 60 Months	
D6115	Implant/Abutment Supported Fixed Denture For Edentulous Mandibular Arch	0-999	1 per every 60 Months	
D6116	Implant/Abutment Supported Fixed Denture-Partially Edentulous Maxillary Arch	0-999	1 per every 60 Months	
D6117	Implant/Abutment Supported Fixed Denture-Partially Edentulous Mandibular Arch	0-999	1 per every 60 Months	
D6190	Radiographic/Surgical Implant Index, By Report	0-999	1 per tooth every 60 Months	
D6210	Pontic - Cast High Noble Metal	0-999	1 per tooth every 60 Months	
D6211	Pontic - Cast Predominantly Base Metal	0-999	1 per tooth every 60 Months	
D6212	Pontic - Cast Noble Metal	0-999	1 per tooth every 60 Months	
D6214	pontic – titanium and titanium alloys	0-999	1 per tooth every 60 Months	
D6240	Pontic - Porcelain Fused To High Noble Metal	0-999	1 per tooth every 60 Months	

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Code	Description	Age limits	Frequency limits	Other limits
D6241	Pontic - Porcelain Fused To Predominantly Base Metal	0-999	1 per tooth every 60 Months	
D6242	Pontic - Porcelain Fused To Noble Metal	0-999	1 per tooth every 60 Months	
D6245	Pontic - Porcelain/Ceramic	0-999	1 per tooth every 60 Months	
D6545	Retainer - Cast Metal For Resin Bonded Fixed Prosthesis	0-999	1 per tooth every 60 Months	
D6548	Retainer - Porcelain/Ceramic For Resin Bonded Fixed Prosthesis	0-999	1 per tooth every 60 Months	
D6549	Resin Retainer - For Resin Bonded Fixed Prosthesis	0-999	1 per tooth every 60 Months	
D6740	Retainer Crown - Porcelain/Ceramic	0-999	1 per tooth every 60 Months	
D6750	Retainer Crown - Porcelain Fused To High Noble Metal	0-999	1 per tooth every 60 Months	
D6751	Retainer Crown - Porcelain Fused To Predominantly Base Metal	0-999	1 per tooth every 60 Months	
D6752	Retainer Crown - Porcelain Fused To Noble Metal	0-999	1 per tooth every 60 Months	
D6780	Retainer Crown - 3/4 Cast High Noble Metal	0-999	1 per tooth every 60 Months	
D6781	Retainer Crown - 3/4 Cast Predominantly Base Metal	0-999	1 per tooth every 60 Months	
D6782	Retainer Crown - 3/4 Cast Noble Metal	0-999	1 per tooth every 60 Months	
D6783	Retainer Crown - 3/4 Porcelain/Ceramic	0-999	1 per tooth every 60 Months	
D6790	Retainer Crown - Full Cast High Noble Metal	0-999	1 per tooth every 60 Months	
D6791	Retainer Crown - Full Cast Predominantly Base Metal	0-999	1 per tooth every 60 Months	
D6792	Retainer Crown - Full Cast Noble Metal	0-999	1 per tooth every 60 Months	
D6930	Re-Cement Or Re-Bond Fixed Partial Denture	0-999		
D6980	Fixed Partial Denture Repair	0-999		
D7140	Extraction, Erupted Tooth Or Exposed Root	0-999		1 per tooth every Lifetime
D7210	Extraction, Erupted Tooth	0-999		1 per tooth every Lifetime
D7220	Removal Of Impacted Tooth - Soft Tissue	0-999		1 per tooth every Lifetime
D7230	Removal Of Impacted Tooth - Partially Bony	0-999		1 per tooth every Lifetime
D7240	Removal Of Impacted Tooth - Completely Bony	0-999		1 per tooth every Lifetime

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Code	Description	Age limits	Frequency limits	Other limits
D7241	Removal Of Impacted Tooth - Completely Bony, Unusual Surgical Complications	0-999		1 per tooth every Lifetime
D7250	Removal Of Residual Tooth (Cutting Procedure)	0-999		
D7251	Coronectomy - Intentional Partial Tooth Removal - Impacted Teeth Only	0-999		
D7260	Oroantral Fistula Closure	0-999		
D7261	Primary Closure Of Sinus Perforation	0-999		
D7270	Reimplantation And/Or Stabilization Of Accidentally Evulsed / Displaced Tooth	0-999		
D7280	Exposure of an Unerupted Tooth	0-999		
D7282	Mobilization Of Erupted Or Malpositioned Tooth To Aid Eruption	0-999		
D7283	Placement Of Device To Facilitate Eruption Of Impacted Tooth	0-999	1 per tooth every Lifetime	
D7285	Incisional Biopsy Of Oral Tissue - Hard (Bone, Tooth)	0-999		
D7286	Incisional Biopsy Of Oral Tissue - Soft	0-999		
D7288	Brush Biopsy - Transepithelial Sample Collection	0-999		
D7291	Transseptal Fiberotomy/Supra Crestal Fiberotomy, By Report	0-999		
D7310	Alveoloplasty In Conjunction With Extractions - Four Or More Teeth	0-999	1 per quadrant every Lifetime	
D7311	Alveoloplasty In Conjunction With Extractions - One To Three Teeth	0-999	1 per quadrant every Lifetime	
D7320	Alveoloplasty Not In Conjunction With Extractions - Four Or More Teeth	0-999	1 per quadrant every Lifetime	
D7321	Alveoloplasty Not In Conjunction With Extractions - One To Three Teeth	0-999	1 per quadrant every Lifetime	
D7471	Removal Of Lateral Exostosis (Maxilla Or Mandible)	0-999	1 per arch every Lifetime	
D7472	Removal Of Torus Palatinus	0-999		
D7473	Removal Of Torus Mandibularis	0-999		
D7485	Reduction Of Osseous Tuberosity	0-999		
D7510	Incision And Drainage Of Abscess - Intraoral Soft Tissue	0-999		
D7511	Incision And Drainage Of Abscess - Intraoral Soft Tissue - Complicated	0-999		
D7520	Incision And Drainage Of Abscess - Extraoral Soft Tissue	0-999		
D7521	Incision And Drainage Of Abscess - Extraoral Soft Tissue - Complicated	0-999		
D7910	Suture Of Recent Small Wounds Up To 5 Cm	0-999		
D7921	Collection And Application Of Autologous Blood Concentrate Product	0-999	1 per every 36 Months	
D7953	Bone Replacement Graft For Ridge Preservation - Per Site	0-999		
D7961	buccal / labial frenectomy (frenulectomy)	0-999		
D7962	lingual frenectomy (frenulectomy)	0-999		
D7971	Excision Of Pericoronal Gingiva	0-999		
D7997	Appliance Removal (Not By Dentist Who Placed Appliance)	0-999		
D8010	Limited Orthodontic Treatment Of The Primary Dentition	0-18		
D8020	Limited Orthodontic Treatment Of The Transitional Dentition	0-18		

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Code	Description	Age limits	Frequency limits	Other limits
D8030	Limited Orthodontic Treatment Of The Adolescent Dentition	0-999		
D8040	Limited Orthodontic Treatment Of The Adult Dentition	0-999		
D8070	Comprehensive Orthodontic Treatment Of The Transitional Dentition	0-20	1 per every Lifetime	
D8080	Comprehensive Orthodontic Treatment Of The Adolescent Dentition	0-999	1 per every Lifetime	
D8090	Comprehensive Orthodontic Treatment Of The Adult Dentition	0-20	1 per every Lifetime	
D8210	Removable Appliance Therapy	0-20		
D8220	Fixed Appliance Therapy	0-999		
D8660	Pre-Orthodontic Treatment Examination To Monitor Growth And Development	0-20		
D8670	Periodic Orthodontic Treatment Visit	0-20	1 per every 76 Days (FQHC)	29 per every Lifetime
D8670			1 per every 25 Days	29 per every Lifetime
D8680	Orthodontic Retention (Removal Of Appliances, Place Retainers)	0-999	1 per every Lifetime	
D9110	Palliative (Emergency) Treatment Of Dental Pain - Per Visit	0-999		
D9222	Deep Sedation/General Anesthesia - First 15 Minutes	0-999	1 per every Day	
D9223	Deep Sedation / General Anesthesia - Each subsequent 15 Minute Increment	0-999	9 per every Day	
D9230	Inhalation Of Nitrous/Analgesia, Anxiolysis	0-999		
D9239	Intravenous Moderate (Conscious) Sedation/Analgesia - First 15 Minutes	0-999	1 per every Day	
D9243	Intravenous Moderate (Conscious) Sedation/Analgesia - Each Subsequent 15 Minute	0-999	9 per every Day	
D9248	Non-Intravenous Conscious Sedation	0-999		
D9310	Consultation - Diagnostic Service Provided By Dentist Or Physician	0-999		
D9610	Therapeutic Parenteral Drug, Single Administration	0-999		
D9930	Treatment Of Complications (Post Surgical) - Unusual Circumstances, By Report	0-999		
D9932	Cleaning And Inspection of Removable Complete Denture, Maxillary	0-999	1 per every 60 Months	
D9933	Cleaning And Inspection of Removable Complete Denture, Mandibular	0-999	1 per every 60 Months	
D9934	Cleaning And Inspection of Removable Partial Denture, Maxillary	0-999	1 per every 60 Months	
D9935	Cleaning And Inspection of Removable Partial Denture, Mandibular	0-999	1 per every 60 Months	
D9943	Occlusal Guard Adjustment	0-999	1 per every 24 Months	
D9944	Occlusal Guard-hard appliance, full arch	13-999	1 per every 12 Months	
D9945	Occlusal Guard-soft appliance, full arch	13-999	1 per every 12 Months	

Pennsylvania CHIP

Code	Description	Age limits	Frequency limits	Other limits
D9946	Occlusal Guard-hard appliance, partial arch	13-999	1 per every 12 Months	
D9994	Dental Case Management - Patient education	0-999	1 per year	
D9995	Teledentistry - Synchronous; Real-Time Encounter	0-999	1 per every Day	
D9996	Teledentistry - Asynchronous; Information Stored And Forwarded To Dentist	0-999	1 per every Day	
D9999	Unspecified Adjunctive Procedure, By Report	0-999		

Pennsylvania Medicaid - Benefit Limit Exception (BLE) Process

Regulatory information

Section 6.8 of the Pennsylvania PROMISe™ Provider Handbook states that there are certain benefits offered to recipients age 21 and over outside of the standard benefit allowances. In order to access these additional benefits, providers must use the standard UHC BLE form and must follow the process below.

Members Eligible for BLE

Pennsylvania Medicaid Members age 21 and over.

Procedures Eligible for BLE

The BLE process will be required for the following procedures.

Code	Procedure	Frequency allowed without a BLE
D0120	periodic oral evaluation	1/180 Days
D1110	prophylaxis - adult	1/180 Days
D5110	complete denture - maxillary	1/1 Lifetime
D5130	immediate denture - maxillary	1/1 Lifetime
D5211	maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	1/1 Lifetime Regardless of Code*
D5213	maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and	1/1 Lifetime Regardless of Code*
D5120	complete denture - mandibular	1/1 Lifetime Regardless of Code*
D5140	immediate denture - mandibular	1/1 Lifetime Regardless of Code*
D5212	mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	1/1 Lifetime Regardless of Code*
D5214	mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and	1/1 Lifetime Regardless of Code*
D2710	crown, resin-based composite (indirect)	None
D2721	crown - resin with predominantly base metal	None
D2740	crown - porcelain/ceramic	None
D2751	crown - porcelain fused to predominantly base metal	None

Code	Procedure	Frequency allowed without a BLE
D2791	crown - full cast predominantly base metal	None
D2910	recement or re-bond inlay, onlay, veneer or partial coverage restoration	None
D2915	recement or re-bond cast indirectlty fabricated or prefabricated post and core	None
D2920	recement or re-bond crown	None
D2952	cast post and core in addition to crown	None
D2954	prefabricated post and core in addition to crown	None
D2980	crown repair necessitated by restorative material failure	None
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	None
D4341	periodontal scaling and root planing - four or more teeth per quadrant	None
D4342	periodontal scaling and root planing for one to three teeth per quadrant,	None
D4355	full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	None
D4910	periodontal maintenance	None
D3310	endodontic therapy, anterior tooth (excluding final restoration)	None
D3320	endodontic therapy, premolar tooth (excluding final restoration)	None
D3330	endodontic therapy, molar tooth (excluding final restoration)	None
D3410	Apicoectomy - anterior	None
D3421	Apicoectomy - premolar (first root)	None
D3425	Apicoectomy - molar (first root)	None
D3426	Apicoectomy (each additional root)	None

*The lifetime limit for dentures will begin with claims payment history on and after dates of service April 27, 2015 due to Medicaid expansion. Additional dentures will require an approved BLE request.

BLE process

- **Authorization:** To access procedures that are eligible for BLE, providers must submit an authorization on the standard ADA form and attach the UnitedHealthcare BLE form. This may be an electronic or a paper authorization. Without an approved authorization, BLE claim will be denied.
  Note: It is not required to have a denied authorization before seeking a BLE service. BLE Services are initiated by the submission of an authorization along with a BLE form.

- **Diagnosis Code:** To request BLE services, providers must use diagnosis code Z98.818 in the diagnosis code field on the standard ADA form. This will enable the claim system to allow the additional BLE services. Without this diagnosis code, procedures will be subject to standard limitations.
  Note: The diagnosis code must be present on both the authorization request and the claim in order to be paid for BLE services.

- **UnitedHealthcare BLE Form:** Providers must attach the approved UHC BLE form to the authorization request. Providers will use this form to indicate the reason the BLE is necessary according to the state criteria. Providers must check the appropriate box and include a description of the medical needs that require the requested service(s) in the appropriate section. Without a complete UnitedHealthcare BLE form, the request will be denied.

  – A UnitedHealthcare Dental Consultant will review the authorization request along with the attached UnitedHealthcare BLE form and make a determination. The determination will be communicated in writing and on the online provider portal. See "Member and Provider Communication" section.

- **Claim:** If the BLE authorization request is approved, the provider will perform the requested treatment and submit the corresponding claim documentation.
  - **Diagnosis Code:** The same diagnosis code (Z98.818) must be documented in the diagnosis code field on the standard ADA claim form. This will enable the claim system to allow the additional BLE services. Without this diagnosis code, procedures will be subject to standard limitations.
    Note: The diagnosis code must be present on both the authorization request and the claim in order to be paid for BLE services.

Criteria for approval

Upon receipt of the BLE authorization request, UnitedHealthcare Dental Consultants will review the documentation submitted to determine if the BLE is approved. UnitedHealthcare Dental Consultants use the criteria defined by the State of Pennsylvania, as reflected on the UnitedHealthcare BLE Form.

The following qualifiers will be evaluated:

- The BLE request will be reviewed to determine if one of the criteria is met without requiring supporting medical record documentation of the condition.
  1. Diabetes
  2. Coronary Artery Disease
  3. Cancer of the Face, Neck, and Throat (does not include stage 0 or stage 1 noninvasive basal or sarcoma cell cancers of the skin)
  4. Intellectual Disability
  5. Current Pregnancy
- Does the patient have a serious chronic systemic illness or other serious health condition, and denial of the exception will jeopardize the life of the recipient?
- Does the patient have a serious chronic systemic illness or other serious health condition and denial of the exception will result in the serious deterioration of the health of the recipient?
- Would granting the exception be a cost-effective alternative for the MA Program
- Would granting the exception be necessary in order to comply with Federal law?

Along with checking the appropriate boxes, providers must include a description of the medical needs that require the requested services in the appropriate field and should include supplemental information to substantiate the selected qualifier.

Member and provider communication

UnitedHealthcare will communicate the determination of the BLE request in writing to both the member and the provider. The communication will be mailed to the member, faxed to the provider, and made available online via the provider portal.

BLE Request Form

SKYGEN USA.
POWERING HEALTHCARE FOR THE DIGITAL AGE

SKYGEN/Pennsylvania Plans Dental Benefit Limit Exception (BLE) Request Form

Failure to complete this form in its entirety will result in this form being returned unprocessed. This form must be attached to a completed ADA dental claim form and mailed to:
SKYGEN Attention: UPMC Health Plan BLE Authorizations, *P.O. Box 351 Milwaukee WI 53201*

Member Last Name_____ First Name_____

Member ID Number_____ Member Date of Birth____

Provider Last Name_____ First Name _____

Provider NPI #_____ Provider Telephone (____)_

Benefit Request Type ☐ Prospective ☐ Retrospective - Date(s) of Service _____

Benefit Limit Criteria to be reviewed (check all that apply):

☐ Member has a serious chronic systemic illness or other serious health condition and denial of the exception will jeopardize the life of the Member.

☐ Member has a serious chronic illness or other serious health condition and denial of the exception will result in the serious deterioration of the health of the Member.

☐ Granting the exception is a cost - effective alternative for Plan.

☐ Granting the exception is necessary in order to comply with Federal law.

This request must include documentation supporting the need for the service, including but not limited to chart documentation to include a treatment plan, radiographs (if applicable), and medical and dental history.

Explain why the Member meets criteria for a benefit limit exception in the space below. The explanation should be in narrative form and include a comprehensive justification (attach additional pages as necessary).

_____

_____

_____

SKYGEN will notify the Provider and Member of its decision **within 2 business days of receiving the request or within 2 business days of receiving additional information if requested by Skygen.**

I attest that the information provided and statements made herein are true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Provider Signature_____ Date_____