

Policy

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Purpose

The purpose of this policy is to define dental services provided both from a medical necessity perspective under traditional Medicare that apply to Longevity Health Plans and those that fall under preventive, restorative, pain management, or repair procedures or supplies Supplemental benefit plans.

Definitions, Abbreviations, and Acronyms

Acronym	Meaning
LH	Longevity Health Plan, the Plan
CMS	Centers for Medicare and Medicaid Services

Policy

Medicare doesn't cover most dental care (including procedures and supplies like cleanings, fillings, tooth extractions, dentures, dental plates, or other dental devices).

Medicare Covered Dental Services

Medicare Part A (Hospital Insurance)

Medicare will pay for certain dental services in a hospital. Part A can pay for hospital stays there is an emergency or complicated dental procedures, even though it doesn't cover dental care. There are a few exceptions to this. Medicare Part A may cover certain dental services performed in a hospital if it's a necessary part of a covered service. For example, if you need a preliminary oral examination before a surgery or organ transplant or if you need reconstructive jaw surgery, you may be covered for these dental procedures because the care is related to another service that Medicare does cover. You may also be covered for extractions if they're needed to prepare your mouth for radiation for oral cancer. If you receive these services as an outpatient, you'd be covered under Part B.

If a member requires inpatient emergency hospital care because of a complication from a dental procedure, Part A will cover the medically necessary inpatient hospital treatment, even if the dental services aren't covered.

Even if Original Medicare covers a specific dental service, members may not be covered for post-treatment dental services once the specific issue has been treated. As an example, in the case of Medicare covering reconstructive jaw surgery, it may not continue paying for dental care after that operation.

Coverage Indications, Limitations, and/or Medical Necessity

[LCD - Dental Services \(L34574\) \(cms.gov\)](#)

Dental services are excluded from coverage in connection with the care, treatment, filling, removal, or replacement of teeth, or structures directly supporting the teeth, except for inpatient hospital services in connection with such dental procedures when hospitalization is required because of the individual's underlying medical condition and clinical status or the severity of the dental procedures.

Structures directly supporting the teeth means, the periodontium, which includes the gingivae, dentogingival junction, periodontal membrane, cementum, and alveolar process.

In an outpatient setting when an excluded service is the primary procedure involved, it is not covered regardless of its complexity or difficulty. An alveoloplasty and a frenectomy are excluded from coverage when either of these procedures is performed in connection with an excluded service: e.g. the non-covered extraction or the preparation of the mouth for dentures.

Non-Covered Services

(The only exception is for inpatient services: "except for inpatient hospital services in connection with such dental procedures when hospitalization is required because of the individual's underlying medical condition and clinical status or the severity of the dental procedures.")

1. The extraction of an impacted tooth
2. An alveoloplasty, (the surgical improvement of the shape and condition of the alveolar process), when performed for the preparation of the mouth for dentures
3. Frenectomy when performed for the preparation of the mouth for dentures
4. Extractions that are due to decay or periodontal disease
5. Extractions done for the purpose of obtaining dentures
6. Services related to chronic dental disease (i.e. gingivectomy)
7. Removal of a benign growth or radicular cyst, in the mouth, or from structures directly supporting the teeth means the periodontium, which includes the gingivae, dentogingival junction, periodontal membrane, cementum, and alveolar process)
8. Insertion of metallic implants used for enhancement of the structure of the jaws in order to support dentures or prosthesis
9. Excision of torus mandibularis or excision of a maxillary torus palatinus is usually performed to accommodate a denture. The removal of the torus palatinus (a bony protuberance of the hard palate) and torus mandibularis could be a covered service. However, **with rare exception**, this surgery is performed in connection with an excluded service; i.e., the preparation of the mouth for dentures. Under such circumstances, reimbursement is not made for this purpose.

Non-Covered Applicable Codes

The following procedure codes are not covered if performed primarily for dental-related related conditions. These codes are not covered if done with endodontic surgery or third molar removal.

CPT Code	Description
21030	Excision of benign tumor or cyst of maxilla or zygoma by enucleation and curettage
21032	Excision of maxillary torus palatinus
21040	Excision of benign tumor or cyst of mandible, by enucleation and/or curettage
21046	Excision of benign tumor or cyst of mandible; requiring intra-oral osteotomy (e.g., locally aggressive or destructive lesion(s))
21047	Excision of benign tumor or cyst of mandible; requiring extra-oral osteotomy and partial mandibulectomy (e.g., locally aggressive or destructive lesion[s])
21048	Excision of benign tumor or cyst of maxilla; requiring intra-oral osteotomy (e.g., locally aggressive or destructive lesion[s])
21060	Menisectomy, partial or complete, temporomandibular joint (separate procedure)
21110	Application of interdental fixation device for conditions other than fracture or dislocation, includes removal
21240	Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft)

CPT Code	Description
21242	Arthroplasty, temporomandibular joint, with allograft
21243	Arthroplasty, temporomandibular joint, with prosthetic joint replacement
21248	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); partial
21249	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); complete
21299	Unlisted craniofacial and maxillofacial procedure
21480	Closed treatment of temporomandibular dislocation; initial or subsequent
29800	Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy (separate procedure)
29804	Arthroscopy, temporomandibular joint, surgical
40814	Excision of lesion of mucosa and submucosa, vestibule of mouth; with complex repair
40816	Excision of lesion of mucosa and submucosa, vestibule of mouth; complex, with excision of underlying muscle
40840	Vestibuloplasty; anterior
40842	Vestibuloplasty; posterior, unilateral
40843	Vestibuloplasty; posterior, bilateral
40844	Vestibuloplasty; entire arch
40845	Vestibuloplasty; complex (including ridge extension, muscle repositioning)
40899	Unlisted procedure, vestibule of mouth
41820	Gingivectomy, excision gingiva, each quadrant
41821	Operculectomy, excision pericoronal tissues
41822	Excision of fibrous tuberosities, dentoalveolar structures
41823	Excision of osseous tuberosities, dentoalveolar structures
41825	Excision of lesion or tumor (except listed above), dentoalveolar structures; without repair
41828	Excision of hyperplastic alveolar mucosa, each quadrant (specify)
41830	Alveolectomy, including curettage of osteitis or sequestrectomy
41850	Destruction of lesion (except excision), dentoalveolar structures
41870	Periodontal mucosal grafting
41872	Gingivoplasty, each quadrant (specify)
41874	Alveoloplasty, each quadrant (specify)
41899	Unlisted procedure, dentoalveolar structures

Covered Services

1. Surgery related to the jaw or any structure connected to the jaw including structures of the facial area below the eyes, for example (mandible, teeth, gums, tongue, palate, salivary glands, sinuses, etc.)
2. Wiring of the teeth when performed in connection with the reduction of a jaw fracture
3. Reduction of any fracture of the jaw or any facial bone, including dental splints or other appliances, if used for this purpose
4. Reconstruction of a ridge if performed as a result of and at the same time as the surgical removal of a tumor (the total surgical procedure is covered)
5. Removal of a torus palatinus (a bony protuberance of the hard palate) **may be covered**, if the procedure is not performed to prepare the mouth for dentures
6. Extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease

7. Insertion of metallic implants if the implants are used to assist in or enhance the retention of a dental prosthetic as a result of a covered service

The extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease is also covered. This is an exception to the requirement that to be covered, a non-covered procedure or service performed by a dentist must be an incident to and integral part of a covered procedure or service performed by the dentist. Whether such services as the administration of anesthesia, diagnostic x-rays, and other related procedures are covered depends upon whether the primary procedure being performed by the dentist is itself covered. Thus, an x-ray taken in connection with the reduction of a fracture of the jaw or facial bone is covered. However, a single x-ray or x-ray survey taken in connection with the care or treatment of teeth or the periodontium is not covered. A dentist qualifies as a physician if, he/she is a doctor of dental surgery or dental medicine, and is legally authorized to practice dentistry in the state in which he/she performs such function, and who is acting within the scope of his/her license when he/she performs such functions. Such services include any otherwise covered service that may legally and alternatively be performed by doctors of medicine, osteopathy and dentistry; e.g., dental examinations to detect infections prior to certain surgical procedures, treatment of oral infections and interpretations of diagnostic x-ray examinations in connection with covered services. Payment for the services of dentists in an outpatient setting is limited to those procedures which are not primarily provided for the care, treatment, removal, or replacement of teeth or structures directly supporting the teeth. The coverage of any given dental service is not affected by the professional designation of the physician rendering the service; i.e., an excluded dental service remains excluded and a covered dental service is still covered whether furnished by a dentist or a doctor of medicine or osteopathy.

Dental Examination Prior to Kidney Transplantation

An oral or dental examination performed on an inpatient basis as part of a comprehensive workup prior to renal transplant surgery is a covered service. This is because the purpose of the examination is not for the care of the teeth or structures directly supporting the teeth. Rather, the examination is for the identification, prior to a complex surgical procedure, of existing medical problems where the increased possibility of infection would not only reduce the chances for successful surgery but would also expose the patient to additional risks in undergoing such surgery.

Part C Supplemental Dental Benefits

Each year Longevity Health Plans will determine the need for Supplemental Benefit packages to address the needs of the institutional population it serves based on several factors: population unmet needs, enhancements needed to improve outcomes, ability to effectively deliver the service and appropriate CMS annual bid process planning. As part of the supplemental benefits – some Plans may choose to offer dental services for preventive, restorative, repair, pain management related to dental issues and dental related supplies/services not covered by Original Medicare. The Plan will determine which dental services are covered in the health plan supplemental benefits and which are appropriate based on the member's plan and goals of care. All supplemental dental services will be coordinated with the member assigned advanced practice provider therefore require a referral for services to be rendered and paid by the health plan.

Each Health Plan will have a defined fee schedule for services rendered and the fee schedule shall be derived for the Plan state Medicaid dental plan benefits. Each dental plan will have a maximum allowable benefit amount each year. Supplemental benefit plan fee schedules and covered services shall be updated on an annual basis. Payment to approved dental providers shall be based on the approved service offerings, and appropriate approved fee schedules. Fee schedules will be updated annually in August of each year.

Dental providers are required to obtain a prior authorization for the dental treatment plan/services.

To ensure the member's goals of care and wishes are honored, all requests for member dental services, the provider must coordinate and review the proposed dental treatment plan with the Plan care coordinator/APP PRIOR to initiating any non-emergent care/services.

The most efficient method to do this is through initiating a pre-service determination request through the Health Plan provider portal or fax options.

Supplemental Dental Benefits Applicable Codes

The following procedure codes are covered for supplemental dental benefits:

PREVENTIVE DENTAL SERVICES	
<i>Oral Exams</i>	
CDT Code	Description
D0120	Periodic oral evaluation - established
D0140	Limited oral evaluation – problem focused
D0145	Oral evaluation for a patient less than 3 years of age and counseling with primary caregiver
D0150	Comprehensive oral evaluation – new or established patient
D0150	Comprehensive oral evaluation – new or established patient
D0160	Detailed and extensive oral evaluation – problem focused, by report
<i>Prophylaxis</i>	
CDT Code	Description
D1110	Prophylaxis – adult
D1120	Prophylaxis – child
<i>Dental X-rays</i>	
CDT Code	Description
D0210	Intraoral complete series intraoral - complete series of radiographic images
D0220	Intraoral periapical – first radiographic image.
D0230	Intraoral periapical – each additional radiographic image
D0240	Intraoral occlusal radiographic image
D0250	Extraoral, 2D radiographic image
D0251	Extra-oral posterior dental radiographic image
D0270	Bitewing – single radiographic image
D0272	Bitewings – two radiographic images
D0273	Bitewings – three radiographic images
D0274	Bitewings – four radiographic images
D0277	Vertical bitewings – 7 to 8 radiographic images
D0330	Panoramic radiographic image
D0340	Cephalometric radiographic image
<i>Fluoride Treatment</i>	
CDT Code	Description
D1206	Topical application of fluoride varnish
D1208	Topical application of fluoride – excluding varnish
COMPREHENSIVE DENTAL SERVICES	
<i>Diagnostic Services</i>	

CDT Code	Description
D0180	Comprehensive periodontal evaluation: new or established patient
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions; does not include cytology or biopsy procedures
D0460	Pulp vitality tests
D0470	Diagnostic casts
<i>Endodontics</i>	
CDT Code	Description
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to dentinocemental junction and application of medicament (not to be used for apexogenesis)
D3221	Pulpal debridement, primary and permanent teeth not to be used for apexogenesis
D3230	Pulpal therapy (resorbable filling) anterior, primary tooth (excluding final restoration)
D3240	Pulpal therapy (resorbable filling) posterior primary tooth (excluding final restoration)
D3310	Anterior tooth (excluding final restoration)
D3320	Bicuspid tooth (excluding final restoration)
D3330	Molar tooth (excluding final restoration)
D3332	Incomplete endodontic therapy; inoperable, unrestorable, or fractured tooth
D3346	Retreatment of previous root canal therapy, anterior, by report
D3347	Retreatment of previous root canal therapy, bicuspid, by report
D3348	Retreatment of previous root canal therapy, molar, by report
D3351	Apexification/recalcification: initial visit (apical closure/ calcific repair of perforations, root resorption, etc.)
D3352	Apexification/recalcification: interim medication replacement
D3353	Apexification/recalcification: final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.)
D3355	Pulpal regeneration – initial visit
D3356	Pulpal regeneration – interim medication replacement
D3357	Pulpal regeneration – completion of treatment
D3410	Apicoectomy - anterior
D3421	Apicoectomy – bicuspid (first root)
D3425	Apicoectomy – molar (first root)
D3426	Apicoectomy – (each additional root)
D3430	Retrograde filling – per root
D3450	Root amputation – per root
D3471	Surgical repair of root resorption – anterior
D3472	Surgical repair of root resorption – premolar
D3473	Surgical repair of root resorption – molar
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption – anterior
CDT Code	Description
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption – premolar
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption – molar
D3920	Hemisection (including any root removal), not including root canal therapy
D3921	Decoronation or submergence of an erupted tooth

D3950	Canal preparation and fitting of preformed dowel or post
<i>Extractions and other Maxillofacial Surgery/Services</i>	
CDT Code	Description
D7111	Extraction – coronal remnants, deciduous tooth
D7140	Extraction – erupted tooth or exposed root (elevation and/or forcep removal)
D7210	Surgical removal of an erupted tooth requiring removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated
D7220	Removal of impacted tooth – soft tissue
D7230	Removal of impacted tooth – partially bony
D7240	Removal of impacted tooth – completely bony
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications
D7250	Surgical removal of residual tooth roots (cutting procedure)
D7260	Oroantral fistula closure
D7261	Primary closure of a sinus perforation
D7280	Surgical access of unerupted tooth
D7281	Coronectomy: intentional partial tooth removal
D7285	Incisional biopsy of oral tissue – hard (bone, tooth)
D7286	Incisional biopsy of oral tissue – soft (all others)
D7310	Alveoloplasty in conjunction with extractions – per quadrant
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant
D7320	Alveoloplasty, not in conjunction with extractions – per quadrant
D7321	Alveoloplasty, not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant
D7340	Vestibuloplasty – ridge extension (secondary epithelialization)
D7350	Vestibuloplasty – ridge extension (incl. soft tissue grafts, muscle re-attachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)
D7410	Excision of benign lesion, up to 1.25 cm
D7411	Excision of benign lesion > 1.25 cm
D7441	Excision of malignant tumor-lesion, diameter >1.25 cm
D7450	Removal of benign odontogenic cyst or tumor lesion, diameter up to 1.25 cm
D7451	Removal of benign odontogenic cyst or tumor, lesion diameter > 1.25 cm
D7471	Removal of exostosis – per site
D7472	Removal of torus palatinus
D7473	Removal of torus mandibularis
D7485	Surgical reduction of osseous tuberosity
D7490	Radical resection of maxilla mandible
D7510	Incision and drainage of abscess – intraoral soft tissue
D7530	Removal of foreign body, mucosa, skin, or subcutaneous alveolar tissue
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body
D7920	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site
<i>Non-Routine Services</i>	
CDT Code	Description
D1320	Tobacco counseling for control and prevention of oral disease
D1351	Sealant – per tooth

D1352	Preventive resin restoration in a moderate to high cariesrisk patient; permanent tooth
D1353	Sealant repair-per tooth
D7260	Oroantral fistula closure
D7261	Primary closure of a sinus perforation
D7280	Surgical access of unerupted tooth
D7285	Incisional biopsy of oral tissue – hard (bone, tooth)
D7286	Incisional biopsy of oral tissue – soft (all others)
<i>Prosthodontics, other Oral Maxillofacial Surgery/Services</i>	
CDT Code	Description
D5110	Complete denture – maxillary
D5120	Complete denture – mandibular
D5130	Immediate denture – maxillary
D5140	Immediate denture – mandibular
D5211	Maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)
D5212	Mandibular partial denture – resin base (including retentive/clasping materials, rests, and teeth)
D5213	Maxillary partial denture – cast metal framework with resin denture bases
D5214	Mandibular partial denture – cast metal framework with resin denture bases
D5221	Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)
D5222	Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
D5225	Maxillary partial denture - flexible base
D5226	Mandibular partial denture - flexible base
D5227	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)
D5228	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)
D5282	Removable unilateral partial denture – one piece cast metal (including clasps and teeth), maxillary
D5283	Removable unilateral partial denture – one piece cast metal (including clasps and teeth), mandibular
D5284	Removable unilateral partial denture – one piece flexible base (including clasps and teeth) – per quadrant
D5286	Removable unilateral partial denture – one piece resin (including clasps and teeth) – per quadrant
D5410	Adjust complete denture – maxillary
D5411	Adjust complete denture – mandibular
D5421	Adjust partial denture – maxillary
D5422	Adjust partial denture – mandibular
D5511	Repair broken complete denture base, mandibular
D5512	Repair broken complete denture base, maxillary
D5520	Replace missing or broken teeth (complete denture), each tooth
D5611	Repair resin partial denture base, mandibular
D5612	Repair resin partial denture base, maxillary

D5621	Repair cast partial framework, mandibular
D5612	Repair cast partial framework, maxillary
D5630	Repair or replace broken retentive/clasping materials per tooth
D5640	Repair broken teeth – per tooth
D5650	Add tooth to existing partial denture
D5660	Add clasp to existing partial denture – per tooth
D5670	Replace all teeth and acrylic on cast metal framework – maxillary
D5671	Replace all teeth and acrylic on cast metal framework – mandibular
D5710	Rebase complete maxillary denture
D5711	Rebase complete mandibular denture
D5720	Rebase maxillary partial denture
D5721	Rebase mandibular partial denture
D5725	Rebase hybrid prosthesis
D5730	Reline complete maxillary denture (chair side)
D5731	Reline complete mandibular denture (chair side)
D5740	Reline maxillary partial denture (chair side)
D5741	Reline mandibular partial denture (chair side)
D5750	Reline complete maxillary denture (laboratory)
CDT Code	Description
D5751	Reline complete mandibular denture (laboratory)
D5760	Reline upper maxillary denture (laboratory)
D5761	Reline mandibular partial denture (laboratory)
D5765	Soft liner for complete or partial removable denture – indirect
D5863	Overdenture – complete maxillary
D5864	Overdenture – partial maxillary
D5865	Overdenture – complete mandibular
D5866	Overdenture – partial mandibular
<i>Periodontics</i>	
CDT Code	Description
D4210	Gingivectomy or gingivoplasty – 4 or more contiguous teeth or tooth-bounded spaces per quadrant
D4211	Gingivectomy or gingivoplasty – 1 to 3 contiguous teeth or tooth bounded spaces per quadrant
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth
D4240	Gingival flap procedure, including root planing – 4 or more contiguous teeth or tooth-bounded spaces per quadrant
D4241	Gingival flap procedure - 1 to 3 contiguous teeth or tooth bounded spaces per quadrant
D4249	Clinical crown lengthening hard tissue
D4260	Osseous surgery (including flap and closure) – four or more contiguous teeth or tooth-bounded spaces per quadrant
D4261	Osseous surgery, one to three contiguous teeth or tooth bounded spaces per quadrant
D4263	Bone replacement graft – first site in quadrant
D4264	Bone replacement graft – each additional site in quadrant
D4266	Guided tissue regeneration resorbable barrier, per site
D4267	Guided tissue regeneration non-restorable barrier, per site (includes membrane removal)
D4268	Surgical revision procedure, per tooth

D4270	Pedicle soft tissue graft procedure
D4273	Autogenous connective tissue graft procedure, (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft
D4276	Combined connective tissue and pedicle graft, per tooth
D4277	Free soft tissue graft procedure (including recipient and donor surgical site), first tooth, implant, or edentulous tooth position in graft
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites), each additional contiguous tooth, implant, or edentulous tooth position in same graft site
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant, or edentulous tooth position in same graft site
D4341	Periodontal scaling and root planing, 4 or more teeth per quadrant
D4342	Periodontal scaling and root planing, 1 - 3 teeth per quadrant
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after evaluation
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit
D4910	Periodontal maintenance procedures (following active therapy)
D4921	Gingival irrigation – per quadrant
<i>Restorative Services</i>	
CDT Code	Description
D2140	Amalgam – 1 surface, permanent or primary
D2150	Amalgam – 2 surfaces, permanent or primary
D2160	Amalgam – 3 surfaces, permanent or primary
D2161	Amalgam – 4 or more surfaces, permanent or primary
D2330	Resin-based composite, 1 surface, anterior
D2331	Resin-based composite, 2 surfaces, anterior
D2332	Resin-based composite, 3 surfaces, anterior
D2335	Resin-based composite, 4 or more surfaces or involving incisal angle, anterior
D2390	Resin-based composite crown, anterior
D2391	Resin-based composite, 1 surface, posterior, permanent or primary
D2392	Resin-based composite, 2 surfaces, posterior, permanent, or primary
D2393	Resin-based composite, 3 surface, posterior, permanent, or primary
D2394	Resin-based composite, 4 or more surfaces, posterior permanent, or primary
D2510	Inlay – metallic, 1 surfaces
D2520	Inlay – metallic, 2 surfaces
D2530	Inlay – metallic, 3 or more surfaces
D2542	Onlay – metallic, 2 surfaces
D2543	Onlay – metallic, 3 surfaces
D2544	Onlay – metallic, 4 or more surfaces
D2610	Inlay – porcelain/ceramic, 1 surface
D2620	Inlay – porcelain/ceramic, 2 surfaces
D2630	Inlay – porcelain/ceramic, 3 or more surfaces
D2642	Onlay – porcelain/ceramic, 2 surfaces

D2643	Onlay – porcelain/ceramic, 3 surfaces
D2644	Onlay – porcelain/ceramic, 4 or more surfaces
D2650	Inlay – resin-based composite, 1 surface
D2651	Inlay – resin-based composite, 2 surfaces
D2652	Inlay – resin-based composite, 3 or more surfaces
D2662	Onlay – resin-based composite, 2 surfaces
D2663	Onlay – resin-based composite, 3 surfaces
D2664	Onlay – resin-based composite, 4 or more surfaces
D2740	Crown – porcelain/ceramic substrate
D2750	Crown – porcelain fused to high-noble metal
D2751	Crown – porcelain fused to predominantly base metal
D2752	Crown – porcelain fused to noble metal
D2753	Crown - porcelain fused to titanium and titanium alloys
D2780	Crown – ¾ cast high noble metal
D2781	Crown – ¾ cast predominantly base metal
D2782	Crown – ¾ cast noble metal
D2783	Crown – ¾ porcelain/ceramic (not veneers)
D2790	Crown – full cast high-noble metal
D2791	Crown – full-cast predominantly base metal
D2792	Crown – full-cast noble metal
D2794	Crown – titanium
D2799	Interim crown – further treatment or completion of diagnosis necessary prior to final impression
D2910	Re-cement or re-bond inlay, onlay, veneer, or partial coverage restoration
D2929	Re-cement or re-bond crown
D2929	Prefabricated porcelain/ceramic crown – primary tooth
D2930	Prefabricated stainless steel crown – primary tooth
D2931	Prefabricated stainless steel crown – permanent tooth
D2932	Prefabricated resin crown
D2933	Prefabricated stainless steel crown with resin window
D2934	Prefabricated esthetic coated stainless steel crown – primary tooth
D2950	Core build-up, including any pins when required
D2951	Pin retention – per tooth, in addition to restoration
D2952	Post and core in addition to crown; indirectly fabricated
D2954	Prefabricated post and core in addition to crown
D2962	Labial veneer (porcelain laminate) – laboratory
D2980	Crown repair, necessary by restorative material failure
D2981	Inlay repair necessitated by restorative material failure
D2982	Only repair necessitated by restorative material failure
D2983	Veneer repair necessitated by restorative material failure

Reimbursement

Fee schedules are determined by the prevailing usual and customary rate (UCR).

Once the pre-service treatment plan request is received, the Plan shall coordinate the review with the member's care coordinator/primary care provider. Based on discussions with the member or their legal authorized representative the plan will be partially approved with changes, fully approved or denied (with reasons provided).

Regardless of the Fee schedule for services: Full dentures shall only be provided once every 5 years but can be adjusted as needed.

2022 Longevity Health Plans with Supplemental Dental Benefit Coverage

State	Fee Schedule	Maximum Annual Benefit
Colorado	Colorado Medicaid July 1, 2022 schedule	\$5000*
Michigan	Michigan Delta Dental Medicaid	\$5000*

2023 Longevity Health Plans with Supplemental Dental Benefit Coverage

State	Current Fee Schedule	Maximum Annual Benefit
Colorado	Colorado Dental Fee schedule 7/1/2022	XXX
Michigan	Michigan state fee schedule 1-1-2022	XXX
New York	New York Medicaid Fee Schedule-2022	\$5000
North Carolina	North Carolina Medicaid Fee Schedule-4/1/202	XXX

In all cases Longevity Health Plans will not cover transport fees for mobile dentistry if the dental services are provided in the nursing home with a designated office space to deliver services in the nursing home. Failure to submit justification for dentistry transport services will result in denial of payment for those services.

Provider and member appeal rights, process for submission of preservice treatment plan requests follow the same process as all providers as outlined on the Longevity Health Plan website For Provider section. [Home - Longevity Health Plan](#)

Pre-Service Review, Authorization, and Payment by Longevity Health Plan for Services Rendered

Non emergent services under the supplemental dental plan:

1. Longevity Health Plans reserves the right to review all requests for payment of dental services that appear to be excessive and not in alignment with the member's goals of care, treatment plans, are a medically needed.
2. Approved pre-service requests for Dental treatment plan review shall not be guarantee of payment for those services but provider a higher likelihood of prompt payment. Utilization management team once the treatment plan is reviewed and certified by the member's care coordinator that is aligns with their goals of care, medical plan and wishes, will submit the approval for services requested. If not aligned with member goals of care, medical treatment plan or not aligned with the member's wishes, they plan will be denied and entered into the authorization system. All provider and member notifications shall follow the Plan notification process as with all other prior authorizations or referrals.
3. Dental providers submitting claims for services rendered need to ensure treatment of services do not exceed the maximum benefit allowably by the Plan.
4. Codes submitted for payment that are not on the current approved fee schedules shall be denied for payment.

Change Log

Document Version	Major or Minor Revision?	Date	Name	Comments
NEW		11/7/2022	Heidi Wold	NEW

Appendices



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 MI%20Medicaid%20.>%20%20NY%20Medical-Fee-Schedule-July-General 2-10-2022 NC df