Provider Manual

MARYLAND Healthy Smiles DENTAL PROGRAM

Version 16 | Effective January 1, 2025

Table of Contents

Provider Web Portal: Online, All the Time

Being reimbursed for the high-quality care you have provided to patients should be quick, easy, and convenient. SKYGEN's user-friendly Provider Web Portal offers a full set of self-service tools that help you get more done, faster.

Everything You Need - When You Need It - 24/7/365

Use the Provider Web Portal to:

- Check real-time eligibility for multiple patients—***at the same time***.
- Submit electronic preauthorization requests—***with attachments***.
- View a decision tree that shows you the same clinical guidelines our consultants use to evaluate your preauthorization requests.
- Use our claim estimator to find out in advance whether your claim will be paid or denied, and why—***before you render services***.
- Attach supporting documentation, such as EOBs and X-rays—***online, for no charge***.
- Submit ***pre-filled*** claim forms and review claim history—***with just a few clicks***.
- Check the real-time status of claims and preauthorization—***no need to wait for paper letters to arrive by postal mail***.
- View and print provider manuals, remittance reports, and more.

www.provider.MDhealthysmiles.com

When You Need Us – We Will Be There!

SKYGEN is committed to delivering world-class service to you and your patients. Our Maryland-based customer service teams will provide local service with the support of national resources. A dedicated provider relations representative will be available to answer your questions and arrange in-person visits. ***When you need us, we will be there!***

Contact us any time for assistance, training, or to arrange an onsite visit.

Call Provider Services: 844-275-8753

Email: providerservices@SKYGENUSA.com

Quick Contacts and Quick Reference to Common Questions

Quick Contacts	
Preauthorization mailing address	Maryland Healthy Smiles: Preauthorization PO Box 422 Milwaukee, WI 53201
Claims mailing address	Maryland Healthy Smiles: Claims PO Box 2186 Milwaukee, WI 53201
Corrected Claims mailing address	Maryland Healthy Smiles: Corrected Claims PO Box 541 Milwaukee, WI 53201 Corrected claims can also be submitted via Provider Web Portal or EDI Clearinghouses.
Grievances, Reconsiderations and Appeals mailing address	Maryland Healthy Smiles: Grievances/Appeals PO Box 393 Milwaukee, WI 53201
Electronic Funds Transfer	Fax: 262-721-0722 Email: providerservices@SKYGENUSA.com
Web Portal Team	855-434-9239 Email: providerportal@SKYGENUSA.com
Fraud and Abuse Hotline	844-809-9449 Email: fraud@SKYGENUSA.com
Provider Web Portal	www.provider.MDhealthysmiles.com
Landing Page	Dental.MDhealthysmiles.com

Quick Reference to Common Questions	
Participant Eligibility	To verify participant eligibility, you can either: ● Log on to Provider Web Portal: www.provider.MDhealthysmiles.com ● Call Interactive Voice Response (IVR) eligibility hotline: **844-275-8753**
Preauthorization Submission	Submit a preauthorization in one of the following formats: ● Provider Web Portal: www.provider.MDhealthysmiles.com ● Electronic submission via clearinghouse, Payer ID: **SCION** ● Paper 2024 ADA Dental Claim Form, sent via postal mail: Maryland Healthy Smiles: Preauthorization PO Box 422 Milwaukee, WI 53201 For help submitting preauthorization via Provider Web Portal, call the SKYGEN Web Portal Team: **855-434-9239**.
Claims Submission	The timely filing requirement is 12 months from the date of service. Submit claims through the following formats: ● Provider Web Portal: www.provider.MDhealthysmiles.com. For help submitting claims, call the SKYGEN Web Portal Team: **855-434-9239**. ● Electronic submission via clearinghouse, Payer ID: **SCION** ● Paper 2024 ADA Dental Claim Form, sent via postal mail: Maryland Healthy Smiles: Claims PO Box 2186 Milwaukee, WI 53201 Effective January 1, 2024 all claims must be submitted on the 2024 version of the ADA claim form. Any claims submitted on previous versions of the ADA form after May 1, 2024 will deny.

Quick Reference to Common Questions	
Grievances and Reconsiderations	To make a grievance or request reconsideration on behalf of the participant, either: ● Write to: Maryland Healthy Smiles: Grievances/Appeals PO Box 393 Milwaukee, WI 53201 ● Call Provider Services: **844-275-8753**
Preauthorization Reconsideration	Request reconsideration on behalf of a participant with their written consent. Write to SKYGEN within 30 days of the date of the denial notice. SKYGEN issues a decision within 30 days of receiving the request, unless an extension is granted. Expedited resolution is within three days. To request reconsideration of a denied preauthorization, write to: Maryland Healthy Smiles: Grievances/Appeals PO Box 393 Milwaukee, WI 53201
Claim Reconsideration	Request reconsideration within 30 days of the date of the denial notice. SKYGEN issues a decision within 30 days of receiving the request, unless an extension is granted. To request reconsideration of a claim denial, write to: Maryland Healthy Smiles: Grievances/Appeals PO Box 393 Milwaukee, WI 53201
EFT (Direct Deposit) Enrollment	To enroll in EFT payments: ● Send a completed EFT preauthorization agreement form and voided check by either fax or email: - Fax: 262-721-0722 - Email: providerservices@SKYGENUSA.com ● Enroll paperless through the Provider Web Portal. The EFT Preauthorization Agreement form is included in the Provider Manual and posted on the Provider Web Portal www.provider.MDhealthysmiles.com.
Provider Web Portal	For training on the Provider Web Portal, contact the SKYGEN Web Portal Team at providerportal@SKYGENUSA.com or call: **855-434-9239.**
Additional Provider Resources	For information about additional provider resources: ● Send email to Provider Services: providerservices@SKYGENUSA.com ● Call Provider Services: **844-275-8753**

Quick Contacts for Credentialing	
Electronic Provider Revalidation and Enrollment Portal (ePREP)	Phone: **844-463-7768** or ePREP.health.maryland.gov Contact ePREP for provider enrollment and credentialing related activities. For ePREP new enrollment and revalidation tips and how-to videos visit the MHSDP landing page Dental.MDhealthysmiles.com or Provider Web Portal www.provider.MDhealthysmiles.com.
Provider Services	**844-275-8753** Email: providerservices@SKYGENUSA.com
License Renewal	All license renewals must be completed with the Dental Board before the expiration date. If you have an out of state license, you must submit a supplemental application to update your license expiration date through ePREP.health.maryland.gov. Please contact ePREP for assistance with updating your renewed license.
Disenrollment from Healthy Smiles	Provider disenrollment must be done through ePREP, ePREP.health.maryland.gov. Please let your SKYGEN Field Representative know that you are disenrolling as a participating provider from the program.
Demographic changes, Affiliations and Disaffiliations	Demographic information including service address, billing address and contact information must be done through ePREP. Please update all affiliation and disaffiliation in ePREP, ePREP.health.maryland.gov

Welcome

Welcome to the Maryland Healthy Smiles Dental Program provider network! We are committed to providing our providers the best support possible and our participants the best possible care. We are pleased to have you on our team.

The State of Maryland has chosen SKYGEN to administer dental benefits for participants enrolled in the Maryland Healthy Smiles Dental Program (MHSDP).

Throughout your ongoing relationship with SKYGEN, refer to this provider manual for quick answers and useful information, including how to contact us, how to submit claims and preauthorization, and details regarding the benefit plans.

When you need answers, log on to www.provider.MDhealthysmiles.com, send an email message to providerservices@SKYGENUSA.com, or call Provider Services: **844-275-8753**.

SKYGEN retains the right to add to, delete from, and otherwise modify this provider manual. Contracted providers must acknowledge this provider manual and any other written materials provided by SKYGEN as proprietary and confidential.

To see an overview of the changes made in Provider Manual: Version 16, please see the revision history section.

*This manual describes SKYGEN policies and procedures that govern our administration of dental benefits for the Maryland Department of Health (MDH). SKYGEN makes every effort to maintain accurate information in this manual; however, we will not be held liable for any damages due to unintentional errors. If you discover an error, please report it to us by calling **844-275-8753**. If information in this manual differs from your Participating Agreement, the Participating Agreement takes precedence.*

Revision History: Version 16

Version 16 Revisions	Revision Effective Date
2025 ADA CDT Code Updates Editorial changes and revisions applicable to covered services under MHSDP have been made by the American Dental Association (ADA) and are reflected in this provider manual. For a complete list of changes made by the ADA effective January 1, 2025 visit www.ada.org. Refer to Benefit Plan Detail and Preauthorization Requirements for updates.	January 1, 2025
Version 15.2 Revisions	**Revision Effective Date**
Root Canal Treatment The clinical criteria requirements for root canal therapy (D3310, D3320, D3330) and retreatment of previous root canal retreatment (D3348) have been altered. Refer to Clinical Criteria Descriptions and Benefit Plan Detail and Preauthorization Requirements for limitations and requirements.	June 1, 2024
Non-Covered Service and Otherwise covered Service. See Non-Covered Service section	June 1, 2024
Rejected Claims See Rejected Claims section.	June 1, 2024
Benefit Plan Updates - Adults **D4342 Periodontal Scaling and Root Planing – one to three teeth** Effective June 1, 2024 this service is now covered for participants in the adult benefit package. Refer to Clinical Criteria Descriptions and Benefit Plan Detail and Preauthorization Requirements for limitations and requirements.	June 1, 2024
Place of Service Requirement – Dental Surgery Services Dental treatment requiring use of an outpatient department of a hospital or ambulatory surgical center (ASC) must be indicated by using the appropriate POS code on the preauthorization and claim. To ensure services rendered in an outpatient facility (hospital or ASC) meet the criteria for medical necessity, submit a preauthorization with the appropriate POS code for procedure code D9999 and include the required documentation listed under Preauthorization and Claims for Dental Surgery Services. To ensure payment, the correct place of service must be indicated on the claim.	August 1, 2024
Benefit Plan Updates – Children Effective September 1, 2024 the preauthorization requirements and/or benefit	September 1, 2024

limits have been updated for the following code sets: • D2960 – D2962 – does require preauthorization • D5650 – D5660 – does not require preauthorization • D5710 – D5721 – does require preauthorization • D5750 – D5761 – does not require preauthorization Refer to Clinical Criteria Descriptions and Benefit Plan Detail and Preauthorization Requirements for limitations and requirements.	
Full Mouth Debridement The clinical criteria requirements for full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit (D4355) have been altered. Refer to Clinical Criteria Descriptions and Benefit Plan Detail and Preauthorization Requirements for limitations and requirements.	September 1, 2024

Health Insurance Portability and Accountability Act (HIPAA)

As a healthcare provider, if you transmit any health information electronically your office is required to comply with all aspects of the Health Insurance Portability and Accountability Act (HIPAA) regulations that have gone/will go into effect as indicated in the final publications of the various rules covered by HIPAA.

SKYGEN has implemented numerous operational policies and procedures to ensure we comply with all HIPAA Privacy Standards, and we intend to comply with all Administrative Simplification and Security Standards by their compliance dates. We also expect all providers in our networks to work cooperatively with us to ensure compliance with all HIPAA regulations.

Together, you (the provider) and SKYGEN agree to conduct our respective activities in accordance with the applicable provisions of HIPAA and such implementing regulations.

When you contact Provider Services, you will need to supply your Tax ID or NPI number. When you call regarding participant inquiries, you will need to supply specific participant identification such as participant ID or Social Security Number, date of birth, name, and/or address.

As regulated by the Administrative Simplification Standards, the benefit tables included in this provider manual reflect the most current CDT coding standards recognized by the American Dental Association (ADA). Effective as of the date of this manual, the Maryland Healthy Smiles Dental Program/SKYGEN requires providers to submit all claims with the proper CDT codes listed in this manual. In addition, submit all paper claims on the paper 2024 ADA Dental Claim Form.

To request copies of SKYGEN HIPAA policies, call provider services or send an email to providerservices@SKYGENUSA.com. To report a potential security issue, call our hotline **844-809-9449** or send an email to fraud@SKYGENUSA.com.

Utilization Management

Community Practice Patterns

To ensure fair and appropriate reimbursement, the SKYGEN utilization management philosophy recognizes the relationships between the dentist's treatment planning, treatment costs, and outcomes. Community practice patterns typically influence the dynamics of these relationships. With this in mind, our utilization management guidelines help ensure healthcare dollars are distributed fairly and appropriately, as defined by the regionally based community practice patterns of local dentists and their peers. All utilization management analysis, evaluations, and outcomes relate to these community practice patterns.

SKYGEN utilization management recognizes individual dentist variance within these patterns among a community of dentists and accounts for such variance. To ensure fair comparisons within peer groups, our utilization management evaluates specialty dentists as a separate group and not with general dentists, since the types and nature of treatment may differ.

Evaluation

SKYGEN's utilization management evaluates claims submissions in such areas as:

- Diagnostic and preventive treatment.
- Patient treatment planning and sequencing.
- Type of treatment, outcomes, and cost effectiveness.

Results

With the objective of ensuring fair and appropriate reimbursement to providers, SKYGEN's utilization management helps identify providers whose treatment patterns show significant deviation from the normal practice patterns of the community of their peers (typically less than 5% of all dentists). SKYGEN is contractually obligated to report suspected fraud, waste, abuse, or misuse by participants and participating dental providers to MDH.

Non-Incentivization Policy

It is SKYGEN's practice to ensure our contracted providers make treatment decisions based on medical necessity for individual participants. Providers are never offered, nor shall they ever accept, any kind of financial incentives or any other encouragement to influence their treatment decisions. The SKYGEN utilization management team bases their decisions on only appropriateness of care, service, and existence of coverage. SKYGEN does not specifically reward practitioners or other individuals for issuing denials of coverage or care. If financial incentives exist for utilization management decision makers, they do not include or encourage decisions which result in underutilization.

Fraud, Waste and Abuse

SKYGEN conducts our business operations in compliance with ethical standards, contractual obligations, and all applicable federal and state statutes, regulations, and rules. We are committed to detecting, reporting, and preventing potential fraud, waste, and abuse, and we look to our providers to assist us. We expect our dental partners to share this same commitment, conduct their businesses similarly, and report suspected noncompliance, fraud, waste or abuse.

Definitions

Fraud, waste, and abuse are defined as:

Fraud: Fraud is intentional deception or misrepresentation made by a person with knowledge. The deception could result in some unauthorized benefit to themselves or some other person or entity. It includes any act which constitutes fraud under federal or state law.

Waste: Waste is the unintentional, thoughtless, or careless expenditures, consumption, mismanagement, use, or squandering of federal or state resources. Waste also includes incurring unnecessary costs as a result of inefficient or ineffective practices, systems, or controls.

Abuse: Abuse is defined as practices that are inconsistent with sound fiscal, business, or medical practices, and that result in the unnecessary cost to the government healthcare program or in reimbursement for services medically unnecessary or that fail to meet professionally recognized standards for health care. Abuse includes intentional infliction of physical harm, injury caused by negligent acts, or omissions, unreasonable confinement, sexual abuse, or sexual assault. Abuse also includes beneficiary practices that result in unnecessary costs to the healthcare program.

Provider Fraud: Provider fraud is any deception or misrepresentation committed intentionally, or through willful ignorance or reckless disregard, by a person or entity in order to receive benefits or funds to which they are not entitled. This may include deception by improper coding or other false statements by providers seeking reimbursement or false representations or other violations of federal healthcare program requirements, its associates, or contractors.

Reporting suspected fraud, waste, or abuse

To report a suspected case of noncompliance, fraud, waste, or abuse, call the SKYGEN Fraud and Abuse Hotline: **844-809-9449**, email: fraud@SKYGENUSA.com or write to:

SKYGEN
Attention: Fraud and Abuse
N92 W14612 Anthony Ave
Menomonee Falls, WI 53051

Deficit Reduction Act: The False Claims Act

Section 6034 of the Deficit Reduction Act of 2005 signed into law in 2006 established the Medicaid Integrity Program in section 1936 of the Social Security Act. The legislation directed the Secretary of the United States Department of Health and Human Services (HHS) to establish a comprehensive plan to combat provider fraud, waste, and abuse in the Medicaid program, beginning in 2006. The Comprehensive Medicaid Integrity Plan is issued for successive five-year periods.

Under the False Claims Act, those who knowingly submit or cause another person to submit false claims for payment of government funds are liable for up to three times the government's damages plus civil penalties of $5,500 to $11,000 for each false claim.

The False Claims Act allows private persons to bring a civil action against those who knowingly submit false claims. If there is a recovery in the case brought under the False Claims Act, the person bringing the suit may receive a percentage of the recovered funds.

For the party found responsible for the false claim, the government may exclude them from future participation in federal healthcare programs or impose additional obligations against the individual.

The False Claims Act is the most effective tool U.S. taxpayers have to recover the billions of dollars stolen through fraud every year. Billions of dollars in healthcare fraud have been exposed, largely through the efforts of whistleblowers acting under federal and state false claims acts.

For more information, see 31 USC 3729: False claims- U.S. Code.

Whistleblower Protection

The False Claims Act (FCA) provides protection to qui tam relators who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the FCA. 31 U.S.C. § 3730(h). Remedies include reinstatement with comparable seniority as the qui tam relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

Fraud and Abuse Hotlines

SKYGEN Fraud and Abuse Hotline: **844-809-9449**

Agency for Health Care Administration: **888-419-3456**

Participant Rights and Responsibilities

Participants of the Maryland Healthy Smiles Dental Program (MHSDP) have the following rights and responsibilities.

Participant Rights

SKYGEN is committed to the following core concepts in our approach to participant care:

- **Access** to providers and services.
- **Wellness** programs include participant education and disease management initiatives.
- **Outreach** programs that educate participants and give them the tools they need to make informed decisions about their dental care.
- **Feedback** that measures provider and participant satisfaction.

We believe all participants have the right to:

- **Privacy**, respectful treatment, and recognition of their dignity when receiving dental care.
- **Participate** fully with caregivers in making decisions about their health care.
- **Be fully informed** about the appropriate or medically necessary treatment options for any condition, regardless of the coverage or cost for the care discussed.
- **Voice a grievance** against the Maryland Healthy Smiles Dental Program/SKYGEN or any of its participating dental offices, or any of the care provided by these groups or people, when their performance has not met the participant's expectations.
- **Appeal** any decisions related to patient care and treatment.
- **Make recommendations** regarding our participant rights and responsibilities policies.
- **Receive relevant, updated information** about MHSDP, the services provided, the participating dentists and dental offices.

Participant Responsibilities

Along with rights, participants have important responsibilities, including:

- Becoming familiar with benefit plan coverage and rules.
- Giving dental providers complete and accurate information they need to provide care.
- Following treatment plans and instructions received from dental providers.
- Supporting the care given to other patients and behaving in a way that helps the clinic, dental office, and other dental locations run smoothly.
- Notifying Customer Service of any questions, concerns, problems, or suggestions.

Practice Guidelines

The State of Maryland accepts the dental periodicity schedule developed by the American

Academy of Pediatric Dentistry (AAPD) as the dental schedule for the MHSDP.

The EPSDT (Early and Periodic Screening, Diagnostic, and Treatment) program is a federally mandated program for children from birth through 20 years that emphasizes the importance of prevention, early detection, risk assessment, and timely treatment of conditions identified as a result of dental screening. Children enrolled in Medicaid or CHIP are eligible for full EPSDT benefits in Maryland until they turn 21.

- **Early:** A child's dental health is assessed as early as possible in the child's life by the Primary Care Dentist (PCD) in order to prevent or find potential diseases and/or disabilities in their early stages, when they are most effectively treated.
- **Periodic:** The PCD will assess a child's dental health at regularly scheduled intervals to assure that a condition, illness, or injury is not incipient or present.
- **Screening:** A dental health assessment to determine if a child is at risk and/or has a condition, illness, or injury that requires more definitive evaluation and/or treatment.
- **Diagnosis:** The definitive evaluation by appropriate dental practitioners to determine the nature, extent or cause of a condition, illness, or injury.
- **Treatment:** The dental services determined to be medically necessary for problems identified during screening or diagnostic evaluations.

Dental services should be provided at intervals that meet reasonable standards of dental practice.

AAPD Periodicity Schedule

Below is the recommended dental periodicity schedule chart from the Reference Manual of Pediatric Dentistry 2024-2025/ P. 305. Access this chart from the AAPD at www.aapd.org.

Service	6-12 months	12-24 months	2-6 years	6-12 years	12+ years
Clinical oral examination (1)	●	●	●	●	●
Assess oral growth and development (2)	●	●	●	●	●
Caries-risk assessment (3)	●	●	●	●	●
Radiographic assessment (4)	●	●	●	●	●
Prophylaxis and topical fluoride (3,4)	●	●	●	●	●
Fluoride supplementation (5)	●	●	●	●	●
Anticipatory guidance/counseling (6)	●	●	●	●	●
Oral hygiene counseling (3,7)	Parent	Parent	Patient/parent	Patient/parent	Patient
Dietary counseling (3,8)	●	●	●	●	●
Counseling for non nutritive habits (9)	●	●	●	●	●
Injury prevention and safety counseling (10)	●	●	●	●	●
Assess speech/language development (11)	●	●	●		
Assessment developing occlusion (12)			●	●	●
Assessment for pit and fissure sealants (13)			●	●	●
Periodontal-risk assessment (3,14)			●	●	●
Counseling for tobacco, vaping, and substance misuse				●	●
Counseling for human papilloma virus/vaccine				●	●
Counseling for intraoral/perioral piercing				●	●
Assess third molars					●
Transition to adult dental care					●

- First examination at the eruption of the first tooth and no later than 12 months. Repeat every six months or as indicated by child's risk status/susceptibility to disease. Includes assessment of pathology and injuries.
- By clinical examination.
- Must be repeated regularly and frequently to maximize effectiveness.
- Timing, types, and frequency determined by child's history, clinical findings, and susceptibility to oral disease.
- Consider when systemic fluoride exposure is suboptimal. Up to at least 16 years.
- Appropriate discussion and counseling should be an integral part of each visit for care.
- Initially, responsibility of parent; as child matures, jointly with parent; then, when indicated, only child.
- At every appointment; initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity. Monitor body mass index beginning at age two.
- At first, discuss the need for non nutritive sucking: digits vs. pacifiers; then the need to wean from the habit before malocclusion or deleterious effect on the dentofacial complex occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.
- Initially pacifiers, car seats, play objects, electric cords; secondhand smoke; when learning to walk; with sports and routine playing, including the importance of mouthguards; then motor vehicles and high-speed activities.
- Observation for age-appropriate speech articulation and fluency as well as achieving receptive and expressive language milestones.
- Identify: transverse, vertical, and sagittal growth patterns; asymmetry; occlusal disharmonies; functional status including temporomandibular joint dysfunction; esthetic influences on self-image and emotional development.
- For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; placed as soon as possible after eruption.
- Periodontal probing should be added to the risk-assessment process after the eruption of the first permanent molars.

Provider Rights and Responsibilities

The MHSDP/SKYGEN has established the following core concepts in our approach to a positive provider experience:

- **Access** to flexible participation options in provider networks.
- **Outreach** programs that lower provider participation costs.
- **Technology** tools that increase efficiency and lower administrative costs.
- **Feedback** that measures provider and participant satisfaction.

Provider Rights

Enrolled participating providers have the right to:

- **Communicate with patients** about dental treatment options.
- **Recommend a course of treatment** to a participant, even if the treatment is not a covered benefit or approved by the MHSDP/SKYGEN.
- **File an appeal or grievance** about the procedures of the MHSDP/SKYGEN.
- **Supply accurate, relevant, and factual information** to a participant in conjunction with an appeal or grievance filed by the participant.
- **Object to policies, procedures, or decisions** made by the MHSDP/SKYGEN.
- **Discuss concerns and issues with participants** by contacting their SKYGEN provider representative or the SKYGEN Call Center.

Provider Responsibilities

Participating providers have the following responsibilities:

- Providers are responsible for keeping proper documentation as described in COMAR 10.44.30 and Maryland Medical Assistance Provider Agreement.
- Providers must adhere to payment procedures as described in COMAR 10.09.05.07
- Providers must adhere to COMAR 10.09.36.03 D
- Providers may not bill participants for covered CDT codes and procedures covered under the MHSDP under any circumstance.
- If a CDT code in a patient's recommended treatment plan is not an otherwise covered service (not approved by MHSDP/SKYGEN or not on the fee schedule), the participating dentist should not charge the program.
- Providers wishing to terminate participation with the MHSDP provider network must complete a disenrollment application with ePREP at ePREP.health.maryland.gov. For assistance call **844-463-7768**.
- Providers are responsible for ensuring that all demographic, affiliations and disaffiliations are up to date in ePREP.
- Providers may not bill both medical codes and dental codes for the same procedure.
- Providers are responsible for making patient records available upon request for the purpose of a chart review or chart audit as described in the Maryland Medical Assistance Provider Agreement.

- Providers may not “balance bill” a participant for any CDT code or procedure that is covered under the MHSDP. Any Medicaid providers that practice balance billing are in violation of their agreement with the States Medicaid Program and are subject to sanctions, including termination from the Program.
- Providers may not bill a participant if they are appealing a denied service until an administrative law judge renders a decision.

Clinical Chart Notes

Providers are required to maintain comprehensive patient documentation as specified in COMAR 10.44.30 and Payment Integrity Information Act of 2019, Subchapter IV—Improper Payments ‘‘§ 3351. The patients’ record, which includes clinical chart notes, is essential to the provision of quality oral health care.

- The recording of patients’ medical and dental history, present illness, clinical examination, diagnosis, completed treatment, overall prognosis and patient-homecare communications are fundamental to patient care.
- The record serves to determine the patients’ baseline findings and treatment plan.
- In addition to being a legal record, it is a comprehensive accounting of what transpired during the dental visit, and may be used in defense of malpractice allegations, and serves as the basis for insurance claims and forensic purposes.

Adequate documentation of registration information, which requires entry of these items:

- Patient first and last name
- Date of Birth
- Gender
- Report
- Telephone number
- Name and telephone number of the person to contact in case of emergency

Per the Maryland Department of Health, the chart notes for each participant should include the following:

- Registration data including a complete health history
- Initial examination data
- Periodontal and Occlusal status
- Treatment plan/alternative treatment plan
- Tooth charting noting the presence or absence of teeth, existing restorations, areas of decay, fractured teeth, periodontal charting as applicable, and any other documentation that is pertinent
- Radiographs, which are identified by patient name and date
- All informed consent forms must be signed and dated by parent and/or legal guardian and provider in their preferred language.
- If an interpreter is used, this must be noted in the record at every visit.
- Name of participant and their birthdate on each chart note page

- Chart notes for every DOS to include diagnosis, progress notes, preventative services, treatment rendered, and medical/dental consultations.
- DOS in the chart notes must match the date of service on the claim.
- Medical necessity of the procedures completed for that DOS should be documented.
- Tooth numbers and surfaces of teeth receiving treatment
- Name of provider (or initials) of the clinician providing the treatment, as well as that of the RDH
- Anesthesia administered, location and the amount given
- If nitrous oxide is used, the amount, duration, % oxygen flush, statement that the patient tolerated the procedure well (status) and any complications
- If abbreviations are used, they must be widely accepted and used universally in the office.
- The documentation in the chart notes for each DOS should match the claims submitted for those procedures.

The design of the record must provide the capability or periodic update, without the loss of documentation of the previous status, of the following information.

- Health history
- Medical alert
- Examination/ Recall data
- Periodontal status
- Treatment plan

The design of the record must ensure that all permanent components are attached or secured within the record and must be readily identified to the patient (i.e., patient name and identification number on each page). The organization of the record system must require that the individual records be assigned to each patient.

An adequate health history that requires documentation of these items:

- Current medical treatment
- Significant past illnesses
- Current medications
- Drug allergies
- Hematologic disorders
- Respiratory disorders
- Endocrine disorders
- Communicable diseases
- Neurologic disorders
- Signature and date by patient
- Signature and date by reviewing dentist
- History of alcohol and/or tobacco usage including smokeless tobacco

An adequate update of health history at subsequent recall examinations, which requires documentation of these items:

- Significant changes in health status
- Current medical treatment
- Current medications
- Dental problems/concerns
- Signature and date by reviewing dentist

A conspicuously placed medical alert inside the chart jacket that documents highly significant terms for health history. These items are:

- Health problems, which contraindicate certain types of dental treatment
- Health problems that require precautions or pre-medication prior to dental treatment
- Current medications that may contraindicate the use of certain types of drugs or dental treatment
- Drug sensitivities
- Infectious diseases that may endanger personnel or other patients

Adequate documentation of the initial and subsequent clinical examination, which is dated and requires descriptions of findings in these items:

- Blood pressure (recommended)
- Head/neck examination
- Soft tissue examination
- Periodontal assessment
- Occlusal classification
- Dentition charting

Radiographs, which are identified by patient name

- Dated
- Designated by patient's left and right side
- Mounted (if intraoral films)
- An indication of the patient's clinical problems/diagnosis

Adequate documentation of the treatment plan (including any alternate treatment options) that specifically describes all the services planned for the patient by entry of these items:

- Procedure
- Localization (area of mouth, tooth number, surface)

An adequate documentation of the periodontal status, if necessary, which is dated and requires charting of the location and severity of these items:

- Periodontal pocket depth
- Furcation involvement
- Mobility
- Recession
- Adequacy of attached gingiva
- Missing teeth

An adequate documentation of the patient's oral hygiene status and preventative efforts, which requires entry of these items:

- Gingival status
- Amount of plaque
- Amount of calculus
- Education provided to the patient
- Patient receptiveness/compliance
- Recall interval
- Date

An adequate documentation of medical and dental consultations within and outside the practice, which requires entry of these items:

- Provider to whom consultation is directed
- Information/services requested
- Consultant's response
- Date of service/procedure

Compliance:

- The patient record has one explicitly defined format that is currently in use
- There is consistent use of each component of the patient record by all staff
- The components of the record that are required for complete documentation of each patient's status and care are present
- Entries in the records are legible
- Entries of symbols and abbreviations in the records are uniform, easily interpreted and are commonly understood in the practice
- All clinicians treating MHSDP participants should be credentialed and have an active license in the state the services are being rendered

Positive Provider Support

Committed dentists are essential to the success of every government-sponsored dental program. Our MHSDP provider network is structured to give dentists the flexibility they need to participate in dental programs on their own terms. At SKYGEN, we are not only the benefits management partner for MDH, but we also consider ourselves ***your partner*** in patient care.

At SKYGEN, we consider ourselves allies of dental associations while maintaining flexibility within the changing political climate surrounding government-sponsored dental programs. We recognize the significant link between good dental care and overall patient health. SKYGEN conducts monthly data analysis to provide the state information about current industry standards. Additionally, we collaborate with thousands of providers across the country to deliver high-quality care to all participants of government-sponsored dental programs.

Provider Field Representative

As part of our commitment to partner with and serve each MHSDP participating provider, SKYGEN provider field representatives work in the field to assist you when you need it. Each

year, you can expect to meet with your designated provider field representative during a routine check-in. During this visit, your provider field representative will answer any questions you may have along with verifying the demographic information for your office, which populates our provider directory. This ensures that SKYGEN is keeping accurate and up to date information on file, to best serve our participants.

Your provider field representative is also available for additional visits to assist with any MHSDP education or training needs.

Flexible Participation Options

MHSDP invites all licensed dentists to participate in our provider network. Providers can choose their own level of participation for each of their practice locations. Providers can choose to:

- Be listed in a directory and accept appointments for all new patients
- Be excluded from directories and accept appointments for only new patients directed to their office from the MHSDP/SKYGEN
- Treat only emergencies or special needs cases on an individual basis

Provider Chart Audits

As the dental benefits administrator to MDH, SKYGEN conducts monthly data analysis following the Office of Inspector General (OIG) Methodology of Interquartile Ranges (IQR), to provide MDH information about current industry standards.

A provider may be identified as an outlier as a result of a monthly provider data analysis, taking into account site of service delivery, patient population, practice type, demographics, and other relevant factors, including:

- Pattern of higher than network average billing history of a service(s)
- Number of services provided per participant per visit
- Medicaid cost per patient
- Participant complaints and tipster inquiries

When a provider is identified as an outlier, they may be selected for a chart audit. If selected for a chart audit, providers are responsible for making patient records available upon request, as described in the Maryland Medical Assistance Provider Agreement. Chart audits are conducted electronically (unless otherwise specified) using an encrypted cloud-based application that meets HIPAA compliance and security requirements. All instructions for complying with the audit will be included in the request.

Upon completion of a chart audit review, the provider will receive documentation summarizing the results and SKYGEN will schedule an audit exit interview to discuss the audit findings.

Mobile Dental Unit

SKYGEN recognizes that mobile dental units are an essential part to a successful dental program. Each mobile dental unit must enroll with MDH's credentialing and enrollment vendor ePREP at ePREP.health.maryland.gov. Once enrolled in MHSDP, mobile dental units must adhere to the requirements described in COMAR 10.09.05.03E, including but not limited to:

- Have a contract with a brick-and-mortar dental office

- Utilize electronic technology that enables the same day exchange of patient records with the brick-and-mortar dental office, and the patient's dental office (upon request)
- Service area limited to 30 miles (rural) or 10 miles (urban) from the brick-and-mortar dental office
- Obtain, keep current, and make readily available all applicable county and city licenses or permits necessary to operate the mobile dental unit
- Participate in a required mobile dental unit site visit conducted by your designated Provider Field Representative twice each calendar year which will ensure the mobile dental unit is meeting all requirements described in COMAR 10.09.05.03E

As a mobile dental unit in the MHSDP, you are also expected to:

- Keep mobile dental unit/area/facility clean and well maintained
- Provide number of children expected to receive treatment (during specified timeframes)
- Provide a copy of permission form(s) and the process of gaining permission
- Provide protocol for how and where contaminated instruments are cleaned and processed
- Have a lead or lead-equivalent apron with thyroid collar onsite

Provider Credentialing and Enrollment

Please note that all applications for enrollment, re-enrollment, disenrollment, revalidation, addition of locations, demographic changes, license renewal and affiliation of a rendering provider to a group will be required to be submitted in electronic Provider Revalidation and Enrollment Portal (ePREP).

Maryland Medicaid requires all dental providers who operate a group practice to have separate National Provider Identifier (NPIs)/Medicaid ID numbers for each location. Maryland Medicaid providers that wish to be directly reimbursed by Maryland Medicaid must obtain and provide their Maryland State Department of Assessments and Taxation (SDAT) number for enrollment regardless of the state that services are provided from SDAT. A separate SDAT number is required for each NPI number. All groups are required to provide verification of Federal Tax ID (TIN), or Employer Identification Number (EIN) from the IRS.

For more information about ePREP please visit: https://mmcp.health.maryland.gov/Pages/ePREP.aspx.

You may also contact the ePREP call center at 1-844-4MD-PROV (**844-463-7768**) if you have any questions concerning your enrollment, credentialing, revalidation or disenrollment.

Please note that while SKYGEN is not affiliated with ePREP, we are still available for assisting MHSDP dental providers with other provider related issues or questions. For assistance, call SKYGEN 's Provider Services department at **844-275-8753**.

Provider Web Portal

SKYGEN's Provider Web Portal offers quick access to easy-to-use self-service tools for managing daily administration tasks. The Provider Web Portal offers you many benefits including:

- Lower administrative and participation costs, faster payment through streamlined claim and preauthorization submissions and real-time participant eligibility verification.
- Immediate access to participant information, claim and preauthorization history, and payment records at any time, 24 hours a day, seven days a week.

A web browser, internet connection, and a valid username and password are required for online access. From the Provider Web Portal, providers and authorized office staff can log in for secure access anytime from anywhere and handle a variety of day-to-day tasks, including:

- Verify eligibility for multiple participants simultaneously and review individual patient treatment history
- Set up office appointment rosters that automatically verify eligibility and fill in claim forms for online submission.
- Submit claims and preauthorizations with pre-filled forms and data entry shortcuts.
- Step through clinical guidelines as part of submitting preauthorizations for a quick indication of whether a service request is likely to be approved.
- Attach and securely send supporting documents, such as digital X-rays, EOBs, and treatment plans, for no extra charge.
- Generate a pricing estimate before submitting a claim for a quick indication of whether a service may be denied, and if so, the reason why.
- Check real-time status of claims and preauthorizations, review historical payment records.
- Review provider clinical profiling data relative to your peers.

Online help is available, offering quick answers, animated videos, and step-by-step instructions.

Provider Web Portal Registration

The Provider Web Portal is designed to keep administrative costs low, give immediate access to real-time information, and make it fast and easy to submit claims and preauthorizations. To register for the Provider Web Portal:

- Visit www.provider.MDhealthysmiles.com and Click 'register now'
- Select to register as one of three entities: payee, location, or provider
- Call **855-434-9239** or chat with the Web Portal Team to obtain your required ID number
- Register as a payee to have the option to view remittances and set up paperless EFT
- Register as a provider to view details specific to one provider
- Register as a location to view details specific to one location

Note: You will not have the ability to view remittances, or set up a paperless EFT payment when registered as a provider or location. As soon as you register, you can log in and start using the portal. If you do not find answers to your questions, or if you want personalized training for your office staff, call the SKYGEN Web Portal Team for assistance **855-434-9239**.

Electronic Payments

Electronic Funds Transfer (EFT)

SKYGEN and MDH recommend Electronic Funds Transfer (EFT) for claims payment. With EFT, we can pay claims more efficiently because funds are deposited directly into payee bank accounts, eliminating the steps of printing and mailing paper checks that may get lost and need to be reissued. **Although we can deposit the funds directly into your account, we have no access to ever recoup any payments from your account.**

To receive claims payments via EFT:

- Complete and sign the EFT Preauthorization Agreement. The form is included in this manual and is also available from the Provider Web Portal www.provider.MDhealthysmiles.com.
- Include a voided check with the EFT Preauthorization Agreement. The transaction cannot be processed without a voided check.
- Send the EFT Preauthorization Agreement form and voided check to SKYGEN by Fax: **262-721-0722** or email: providerservices@SKYGENUSA.com.
- Or providers can enroll in the EFT program paperless through the Provider Web Portal.

Allow up to six weeks for the EFT to be implemented after we receive your completed paperwork. Your remittance reports are posted online and made available from the Provider Web Portal as soon as your claims are paid.

Once you are enrolled in EFT, notify SKYGEN of any changes to bank accounts, including changes in Routing Number or Account Number, or if you switch to a different bank. Use the EFT Preauthorization Agreement form to submit your changes. SKYGEN is not responsible for delays in payment if we are not properly notified, in writing, of banking changes.

Electronic Remittance Reports

Your remittance reports are available electronically from the Provider Web Portal. For help registering for the portal or accessing your Remittance Reports, call the SKYGEN Web Portal Team: **855-434-9239**.

EFT Preauthorization Agreement

The SKYGEN EFT Preauthorization Agreement form is included in this provider manual and can be found on the Provider Web Portal www.provider.MDhealthysmiles.com.

Eligibility and participant Services

The Maryland Healthy Smiles Dental Program coverage groups include:

- Maryland Children (Under Age 21)
- Maryland REM Children (Under Age 21)
- Maryland Former Foster Care (Age 21 to 25)
- Maryland REM Adult (Age 21 and Older)
- Maryland Pregnant and Postpartum Adult (Age 21 and Older)
- Maryland Adult Dental Plan (Age 21 and Older) *Effective: 1/1/23*

If your patient has questions about enrolling in MHSDP or questions about loss of eligibility, refer them to their local health department, the Maryland Health Exchange, or ask them to call participant Services: **855-934-9812**.

*Note: participants whose eligibility indicates **"MD NO DENTAL"** do not have dental benefits or dental coverage under MHSDP.*

Eligibility for Pregnant and Postpartum Women

Some women are only eligible for Maryland Medicaid during pregnancy and the postpartum period. The postpartum period begins the day pregnancy ends and extends until the end of the twelfth month following the end of the pregnancy. *As an example, if the patient delivered a child on March 10, dental coverage will continue for that patient until the last day of March in the following year.* For information about covered services, see the Benefit Plan Detail and Preauthorization Requirements section.

Dental Home

Participants can be treated by any MHSDP participating provider, even if they have been assigned to a specific Primary Care Dentist (PCD) as part of the Dental Home Program. If scheduling problems arise, advise the participant to contact the SKYGEN participant Services Team at **855-934-9812** to update their PCD assignment. For more information on tactics you can take to help prevent missed appointments, see Preventing Missed Appointments.

Providers can view a roster of participants assigned to them at any time by logging into to the Provider Web Portal and following these steps:

- Click on ‘reports’ at the top of the toolbar
- Click ‘view primary care assignments’
- Keep default at ‘all’ for ‘location’ and ‘provider’
- Click ‘Print Report’ and ‘export to PDF’ or ‘export to Excel’

Participant ID Card

Participants receive MHSDP participant ID cards from SKYGEN. Providers are responsible for verifying that participants are eligible prior to rendering services and for determining whether participants have other dental insurance. It is possible for a participant's eligibility status to change at any time without notice. The presence of a participant ID card does not guarantee a participant's eligibility, nor does it guarantee provider payment. Presenting a participant ID card does not guarantee that a person is currently eligible for benefits in the Maryland Healthy Smiles Dental Program.

Sample participant ID Card

Verifying participant Eligibility

Verify participant eligibility and benefits on the **date of service**. To verify participant eligibility, you can either:

- Log on to Provider Web Portal www.provider.MDhealthysmiles.com.
- Call Interactive Voice Response (IVR) eligibility line: **844-275-8753**.

Because a participant's eligibility can change at any time without prior notice, verifying eligibility does not guarantee payment. The Provider Web Portal and IVR system are both available 24 hours a day, 7 days a week - giving you quick access to information.

Verifying Eligibility via Provider Web Portal

Our Provider Web Portal allows quick, accurate verification of a participant's eligibility for covered benefits, as of the date of service. Log in using your username and password at www.provider.MDhealthysmiles.com.

First-time users must register before using the Provider Web Portal. See Provider Web Portal Registration. For help registering or using the Provider Web Portal, call the SKYGEN Web Portal Team: **855-434-9239** or use the chat feature, by clicking 'chat here'.

Once logged-in, you can quickly verify eligibility for an individual patient or for a group of patients, and you can print an online eligibility summary report for your records. Providers must verify participant eligibility ***prior*** to services being rendered on the date of the visit.

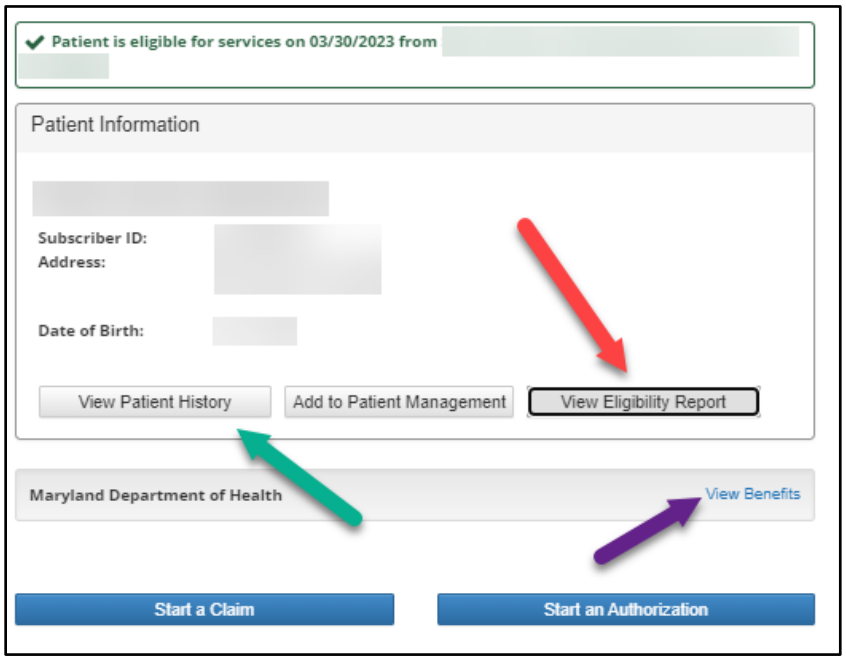
- After entering the patient information and clicking submit on the 'Verify Eligibility' screen, the 'Patient Information' box will pop open.
- At the top, it will say if the patient is eligible with MHSDP or not, however, this screen is

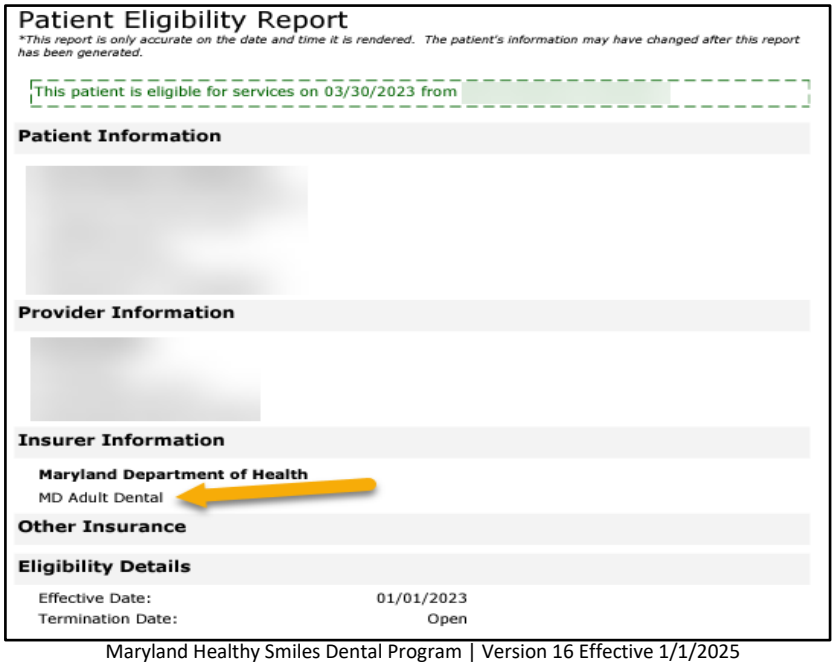
not verification of coverage.

- You must click 'View Eligibility Report' in order to obtain confirmation of eligibility. This will show the effective date and plan name the participant is enrolled in.
- You can also click 'View Benefits' to access a breakdown of benefits and 'View Patient History' to view the participant's service history.

It is important to review the 'Insurer Information' to verify which plan the participant is enrolled in.

- If the participant shows active in the pregnant or postpartum plan, they are eligible during pregnancy and their 12-month postpartum period. See Eligibility for Pregnant or Postpartum Women section.
- If the participant shows active in '**MD NO DENTAL'**, this means they are not eligible for dental coverage.





Verifying Eligibility via IVR

Use our Interactive Voice Response (IVR) system to verify eligibility for an unlimited number of patients. Call **844-275-8753**. Follow the prompts to identify yourself and the patient whose eligibility you are verifying.

Our system analyzes the information entered and verifies the patient's eligibility. If the system cannot verify the participant information, you will be transferred to a Customer Service Representative. You also have the option of transferring to a Customer Service Representative after completing eligibility checks, if you have other inquiries.

Specialist Referrals

A patient who requires a referral to a dental specialist can be referred directly to any specialist contracted with the MHSDP provider network without preauthorization from SKYGEN. The dental specialist is responsible for obtaining preauthorization for services, as defined in the Benefit Plan Detail and Preauthorization Requirements section of this provider manual.

Locate a specialist provider by using the 'Advanced Search' under the 'Provider Quick Search' on the participant Web Portal at www.participant.mdhealthysmiles.com. If you need help locating a specialist provider, call Provider Services: **844-275-8753**.

Appointment Availability Standards

The MHSDP has established appointment time requirements to ensure patients receive dental services within a time period appropriate to their health condition. We expect dental providers to meet these appointment standards for a number of important reasons, including:

- Ensure patients receive the care they need to protect their health
- Maintain participant satisfaction
- Reduce unnecessary use of alternative services such as emergency room visits.

SKYGEN will educate providers about appointment standards, monitor the adequacy of the process, and take corrective action if required. Dental providers are expected to meet the following minimum standards for appointment availability:

Summary: Appointment Availability Standards

Appointment Type	Appointment Required…
Emergency services	Within 48 hours
Specialist referral	Within 60 days, or sooner, per PCD request
Routine preventive, follow-up visits	Within 60 days
Comprehensive assessment	Within 90 days of patient enrollment

Missed Appointment Standards

Providers who participate in the MHSDP are not allowed to charge participants for missed appointments. The Centers for Medicare and Medicaid Services (CMS) interpret federal law to prohibit a provider from billing any Medicaid Plan participant for a missed appointment. In addition, your missed appointment policy for participants enrolled in MHSDP cannot be stricter than your policy for private or commercial patients.

If a MHSDP participant exceeds your office policy for missed appointments and you choose to discontinue seeing the patient, ask the patient to contact participant Services for a referral to another Dental Home: **855-934-9812**.

Preventing Missed Appointments

At SKYGEN, we understand the unnecessary costs and frustration that missed appointments cause a dental office. We also understand the health risks for patients who miss scheduled appointments.

Tactics for Dental Offices: Patient Communication

To help patients keep their dental appointments, consider implementing patient communication activities into your daily office workflow. These tactics have helped reduce missed appointments in other practices. Consider implementing any of the following suggestions that might work well for your office staff and your patients.

Get alternate phone numbers and email addresses: Get as much contact information as you can from your patients, so that you have alternate ways of reaching them if their living situation changes. Ask for a home phone number, home address, cell phone number, and email address.

Ask patients if they use public transportation: For patients who rely on public transportation, remind them to make their appointments according to the transportation schedule.

Repeat appointment date and time: When a patient makes an appointment with your office, state the day of the week and the date, and then repeat the date and time during the conversation. For example, *"Thanks for making an appointment for Thursday, July XX, Jane. We're looking forward to seeing you at 1:30 on July XX."*

Send patients appointment details: As soon as you make an appointment with a patient, follow up with an email message that confirms the appointment date and time, your office address and phone number, and a link to your website. If you do not have an email address for a patient, follow up with an appointment postcard, or send a letter and enclose an appointment card.

Offer patients options for appointment reminders: Ask patients whether they prefer to receive appointment reminders via telephone call, email message, or text message. Consider implementing HIPAA-compliant email and/or text messages that not only remind patients of upcoming appointments, but also let them respond to the message and confirm they received the notification. For patients who prefer to be reminded of appointments by a telephone call, ask for alternate phone numbers and ask what time of day is best to call.

Always confirm appointments" Always remind patients in advance of their upcoming appointments—either by telephone call, email message, and/or text message.

Motivate patients to keep appointments: When confirming appointments, remind patients that visiting the dentist regularly is important to their health, and that you are concerned about helping them stay healthy.

Tactics for Dental Offices: Patient Scheduling

When setting up patient scheduling, consider implementing the following proven tactics to help reduce missed appointments.

Continuing care appointments. For patients who do not have a history of missed appointments, schedule continuing care visits with appointment dates three to six months in advance. For patients who have a history of missed appointments, send a postcard or email message asking them to call your office to schedule an appointment a week or two before the next continuing care visit is due.

Subsequent appointments for completing procedures. If a dental procedure requires a subsequent appointment for completion, talk with the patient personally about the importance of the next appointment. Reinforce the message by sending the patient home with written information that highlights the importance of the dental procedure, what will happen at the next appointment and possible outcomes if the procedure is not completed on time.

Emergency appointments. After rendering emergency services, call the patient a few days later to schedule follow-up treatment.

Flexible office hours. Daytime obligations, including work and childcare, are obstacles that can prevent patients from keeping appointments—or even making appointments in the first place. To help make it easier for patients to get the dental care they need, consider setting up an office schedule that includes extended hours on selected days of the week and/or occasional weekend hours.

Reporting Missed Appointments

When a MHSDP participant does not keep an appointment, our participant Outreach Team wants to know about it. The Missed Appointment Log should be used to track MHSDP participant missed appointments. The Missed Appointment Log is included in this provider manual and can be found on the Provider Web Portal www.provider.MDhealthysmiles.com.

Submit the Missed Appointment Log by either:

- Email: outreachcoordinator@SKYGENUSA.com or
- Fax: **410-624-5486**.

The frequency you submit the log is up to you, however, it is more effective when it is submitted as close to the missed appointment as possible. SKYGEN recommends submitting the Missed Appointment Log weekly, if applicable.

You can also call Provider Services **844-275-8753** to report a missed appointment. Our Provider Services Team will track the missed appointments by logging them in our Customer Service system. These records are forwarded to our participant Outreach team for follow-up. participant Outreach will contact the participant personally and work with them to reschedule dental visits and provide education about the importance of keeping scheduled appointments.

If your office sends letters or postcards to participants who miss appointments, the following language may be helpful to include:

- “We noticed you missed your scheduled dental appointment. Regular checkups are needed to keep your teeth healthy. Call us to schedule another appointment.”
- “Call us to reschedule your missed appointment. If you cannot keep the appointment, call us in advance to reschedule. Missed appointments are very costly to us. Thank you for your help.”

Provider-Participant Termination

The MHSDP has established a policy regarding the dismissal of a Medicaid participant. Dismissal of the participant shall be evaluated on a case-by-case basis. Providers may dismiss a Medicaid participant from their practice for cause at any time, and "cause" is defined as any of the following six reasons:

- A documented, ongoing pattern of failure on the part of the participant to keep scheduled appointments or meet any other participant responsibilities
- The participant fails to follow the recommended treatment plan or medical instructions
- The provider cannot provide the level of care necessary to meet the participant's needs
- The provider moves out of the service area
- The participant and/or participant's family is abusive to the provider and/or practice staff, or poses a serious threat of harm to the provider, staff, and/or other patients
- Other reasons determined to be satisfactory to the Maryland Department of Health

Providers may not dismiss a Medicaid participant based on the participant's gender, race, religion, or sexual orientation. A participant covered under the Americans with Disabilities Act (ADA) may be dismissed only for reasons similar to those applied to a non-disabled participant. A participant may not be dismissed because of their disability or illness, or costs that the disability or illness might involve (e.g., providing an interpreter for a deaf participant). The grounds for dismissal of a MHSDP participant cannot be stricter than your policy for private or commercial patients.

Upon a decision to dismiss a MHSDP participant, the provider must complete the Provider-participant Termination Form and follow the procedure as listed within the form. Give no less than a 30-day written notice of termination to both the participant and SKYGEN. participants must be notified in writing of the provider's intent to terminate.

- Coverage of the participant's urgent and emergency care needs should continue for up to 30 days, or until the participant obtains a new dental provider (whichever occurs first).
- Medical records should be sent to the new provider upon receipt of written preauthorization from the participant.
- Provide the participant with contact information to participant services to obtain a list of providers within the MHSDP Network.

Following the receipt of the Provider-participant Termination Form, a participant outreach coordinator will contact the participant to assist with finding a new dental provider. The Provider-participant Termination Form, is included in this provider manual and can be found on the Provider Web Portal www.provider.MDhealthysmiles.com.

Liaison Services for Participants

Our liaison services for participants offers:

- Three-way appointment scheduling, when requested, whereby a Customer Service Representative helps a participant select an appropriate dental provider and then initiates a three-way telephone call with the dental office to schedule an office visit.
- Geo-mapping capabilities that allow a Customer Service Representative to offer turn-by-turn navigation directions to dental offices.
- Information about transportation for non-emergency dental visits
- If your patients need help requesting transportation please ask them to call their Local Health Department.

Non-Emergency Medical Transportation

If a MHSDP participant does not have any transportation, they may be able to get a ride to their local dental office. Non-Emergency Medical Transportation is for Medicaid covered services only.

Local Transportation Contacts

MHSDP participants should call their local department of health Monday through Friday from 8:00 a.m. to 4:30 p.m. at least two business days before their appointment to see if they qualify for a ride.

County	Local Health Department Phone Number	County	Local Health Department Phone Number
Allegany	301-759-5123	**Harford**	410-638-1671
Anne Arundel	410-222-7152	**Howard**	877-312-6571
Baltimore City	410-396-7433	**Kent**	410-778-7025
Baltimore County	410-887-2828	**Montgomery**	240-777-5890
Calvert	410-414-2489 or 443-978-6418	**Prince George's**	301-856-9555
Caroline	410-479-8014	**Queen Anne's**	443-262-4462
Carroll	410-876-4813	**St. Mary's**	301-475-4296
Cecil	410-996-5171	**Somerset**	443-523-1722
Charles	301-609-6923	**Talbot**	410-819-5648 or 410-819-5609
Dorchester	410-901-2426	**Washington**	240-313-3264
Frederick	301-600-3124	**Wicomico**	410-548-5142
Garrett	301-334-7727	**Worcester**	410-632-0092

Preauthorization Requirements and Clinical Criteria

Medical Necessity

SKYGEN defines medical necessity as accepted healthcare services and supplies provided by healthcare entities appropriate to the evaluation and treatment of a disease, condition, illness, or injury and consistent with the applicable standard of care.

Dental care is medically necessary to prevent and eliminate orofacial disease, infection, and pain, to restore form and function to the dentition, and to correct facial disfiguration or dysfunction. Medical necessity is the reason why a test, a procedure, or an instruction is performed, is different for each person and changes as the individual changes. The dental team must provide consistent methodical documentation of medical necessity for coding.

Consistent, Transparent Preauthorization Decisions

Trained paraprofessionals and dental consultants use predefined clinical guidelines to ensure a consistent approach for determining a preauthorization submitted for review.

When you submit an online preauthorization through the SKYGEN Provider Web Portal, you have the option of stepping through the guidelines yourself, for a quick indication of whether your preauthorization request is likely to be approved. Preauthorization requirements are also outlined in this provider manual. See Benefit Plan Detail and Preauthorization Requirements. When you submit a preauthorization through the Provider Web Portal, you can see at a glance whether documentation, such as X-rays or medical necessity narratives, are required. You can attach and send electronic documents as part of your online preauthorization request - saving you both time and money.

Preauthorization for Treatment

The MHSDP/SKYGEN has specific utilization criteria, as well as a preauthorization review process, to manage the utilization of services. Information regarding services that require preauthorization or supporting documentation is found in the Benefit Plan Detail and Preauthorization Requirements section.

All treatment started prior to the determination of coverage or approval of preauthorization will be performed at the financial risk of the dental office. If coverage is denied, the provider will be financially responsible and may not balance bill the participant, MHSDP, or SKYGEN.

Should a procedure need to be initiated to relieve pain and suffering in an emergency, you are to provide treatment to alleviate the patient's condition. For more details regarding emergency services, see the Emergency Treatment section in this provider manual.

Clinical Criteria Descriptions

SKYGEN criteria and guidelines for determining medical necessity were developed from information collected from the American Dental Association's Code Manuals, clinical articles and guidelines, as well as dental schools, practicing dentists, insurance companies, other dental related organizations, and local state or health plan requirements. A number of procedures require preauthorization before initiating treatment. When submitting a preauthorization for these procedures, follow the documentation requirements.

Diagnostic imaging (D0340)

- Documentation describes medical necessity for non-orthodontic purposes

Interim caries arresting medicament (D1354)

- Evidence of smooth surface caries and/or incipient lesions
- Consent form required for each application. Parent/Guardian must be present to sign the silver diamine fluoride (SDF) specific consent form and discuss treatment plan.

Crowns/onlays/coping (D2721, D2740-D2752, D2780-D2783, D2790-D2794)

- Root canals
  - Clinically acceptable RCT
  - Minimum 50% bone support
  - No periodontal furcation
  - No subcrestal caries
- Non-root canals
  - Anterior – 50% incisal edge/4+ surfaces involved
  - Bicuspid – 1 cusp/3+ surfaces involved
  - Molar – 2 cusps/4+ surfaces involved
  - Minimum 50% bone support
  - No periodontal furcation
  - No subcrestal caries
- Pre-operative X-ray showing apex of tooth

Core buildup (D2950)

- Minimum 50% bone support
- No Periodontal furcation
- No subcrestal caries, clinically acceptable RCT
- Anterior 50% incisal edge or 4+ surfaces involved
- Bicuspid - 1 cusp or 3+ surfaces involved
- Molar - 2 cusps or 4+ surfaces involved

Prefabricated post and cores (D2952-D2954)

- Minimum 50% bone support
- No periodontal furcation
- No subcrestal caries

- Clinically acceptable RCT

Post removal (D2955)

- Presence of post on pre-operative X-ray

Labial veneer (D2960-D2962)

- Age appropriate/fully erupted tooth
- Minimum 50% bone support
- No caries
- Clinically acceptable root canal
- Anterior fracture – 50% incisal edge

Root canal treatment (D3310-D3330)

- Minimum 50% bone support
- No periodontal furcation
- No subcrestal caries
- Closed apex
- At least one of the following:
  - Advanced decay encroaching on pulpal chamber/pulp horn; and/or pulpal exposure
  - Evidence of apical pathology/fistula
  - Pain from percussion / temp

Root canal retreatment (D3346-D3348)

- Minimum 50% bone support
- No periodontal furcation
- No subcrestal caries
- At least one of the following:
  - Advanced decay encroaching on pulpal chamber/pulp horn; and/or pulpal exposure
  - Evidence of apical pathology/fistula
  - Pain from percussion / temp

Apexification / recalcification (D3351-D3353)

- Deep caries
- Traumatic fracture with near pulpal exposure
- Pain from percussion, temperature
- History of trauma
- Presence of open root apex / apices

Apicoectomy / periradicular surgery / retrograde filling / root amputation (D3410, D3421, D3425, D3426, D3430, D3450)

- Minimum 50% bone support
- No caries below bone level

- Repair of root perforation or resorptive defect
- Exploratory curettage for root fractures
- Removal of extruded filling materials or instruments
- Removal of broken tooth fragments
- Sealing of accessory canals, etc.

Intentional reimplantation (D3470)

- Documentation supports procedure

Hemisection (D3920)

- Documentation supports procedure

Gingivectomy or gingivoplasty (D4210, D4211)

- Hyperplasia or hypertrophy from drug therapy, hormonal disturbances or congenital defects
- Generalized 5 mm or more pocketing indicated on the perio charting

Anatomical crown exposure (D4230, D4231)

- Documentation supports procedure, need to remove tissue/bone to provide anatomically correct gingival relationship

Gingival flap procedure (D4240, D4241)

- Periodontal classification of Type III or IV
- Lack of attached gingiva

Crown lengthening (D4249)

- Documentation supports procedure
- Greater than 50% bone support after surgery due to coronal fracture/caries
- Not on same day as restoration preparation

Osseous surgery (D4260, D4261)

- History of periodontal scaling and root planing
- No previous recent history of osseous surgery
- Periodontal classification of Type III or IV

Splinting (D4322, D4323)

- Documentation indicates periodontal mobility Type III or IV
- Documentation shows treatment plan of planned or completed periodontal therapy

Scaling and root planing (D4341, D4342)

- D4341
  - Limited to permanent dentition
  - Four or more teeth in the quadrant
  - 5 mm or more pocketing on 2 or more teeth indicated on the perio chart and
  - Presence of root surface calculus and/or noticeable loss of bone support on X-rays

- D4342
  - Limited to permanent dentition
  - One to three teeth in the quadrant
  - 5 mm or more pocketing on 1 or more teeth indicated on the perio charting and
  - Presence of root surface calculus and/or noticeable loss of bone support on X-rays

Full mouth debridement (D4355)

- Significant supragingival calculus present interfering with the ability to allow for a more comprehensive oral evaluation

Periodontal maintenance (D4910)

- Periodontal surgical or scaling and root planing procedure more than 90 days previous

Unscheduled dressing change (D4920)

- Documentation describes medical necessity

Full dentures (D5110, D5120)

- Existing denture greater than 5 years old and unserviceable
- Remaining teeth do not have adequate bone support or are not restorable

Partial dentures (D5211, D5212, D5225, D5226)

- Replacing one or more anterior teeth
- Replacing three or more posterior teeth (excluding 3rd molars)
- Existing partial denture greater than 5 years old and unserviceable
- Remaining teeth have greater than 50% bone support and are restorable

Denture rebase (D5710-D5721)

- Dentures greater than 6 months old

Overdenture (D5863-D5866)

- Remaining tooth roots supporting overdenture have healthy bone and periodontal support

Maxillofacial prosthetics (D5992, D5993)

- Documentation describes accident, facial trauma, disease, facial reconstruction, or other medical necessity needed

Impacted teeth – (asymptomatic impactions will not be approved (D7241)

- Documentation describes pain, swelling, etc. around tooth (must be symptomatic) and documentation noted in patient record
- Tooth impinges on the root of an adjacent tooth, is horizontal impacted, or shows a documented enlarged tooth follicle or potential cystic formation
- Documentation supports procedure for unusual surgical complications
- X-rays match type of impaction code described

Surgical removal of residual tooth roots (D7250)

- Tooth root is completely covered by tissue on X-ray and/or documentation indicates

cutting of soft tissue and bone, removal of tooth structures and closure

Coronectomy (D7251)

- Documentation describes neurovascular complication if entire impacted tooth is removed

Oroantral fistula closure / sinus perforation (D7260)

- Due to extraction, oral infection, or sinus infection

Tooth reimplantation / transplantation (D7270, D7272)

- Documentation describes accident and/or medical necessity

Surgical access of an unerupted tooth (D7280)

- Documentation supports impacted/unerupted tooth
- Tooth is beyond one year of normal eruption pattern

Biopsy / exfoliative cytological sample collection (D7284, D7285, D7286)

- Copy of pathology report or test results

Surgical repositioning of teeth (D7290)

- Documentation supports need for procedure

Alveoloplasty with extractions (D7310, D7311)

- In preparation for a prosthesis
- Other treatments such as radiation therapy and transplant surgery

Alveoloplasty without extractions (D7320, D7321)

- In preparation for a prosthesis
- Other treatments such as radiation therapy and transplant surgery

Vestibuloplasty (D7340, D7350)

- Documentation supports lack of ridge for denture placement

Excision of lesion / tumor (D7410, D7440, D7450, D7461)

- Copy of pathology report

Excision of bone tissue (D7471-D7473)

- Necessary for fabrication of a prosthesis

Frenulectomy (D7961-D7962)

- Documentation describes removal or release of mucosal and muscle of a buccal, labial or lingual frenum to treat such conditions as tongue-tied, diastema, tissue pull condition, etc.

Pre-orthodontic treatment examination to monitor growth and development (D8660)

- One of (D8660) per 12 months per patient
- D8660 will be denied if submitted without D8080 and D8670
- D8660 will be denied when a D8080 is not approved due to mixed dentition (with the exceptions of a cleft palate, evidence of congenitally missing permanent dentition, or evidence that the ectopic position of a succedaneous tooth is resulting in the failed exfoliation of the associated primary tooth)
- Once D8080 and D8660 are approved, no additional D8660 will approve thereafter
- Documentation must show a fully erupted set of permanent teeth (with the exceptions

of cleft palate, evidence of congenitally missing permanent dentition, or evidence that the ectopic position of a succedaneous tooth is resulting in the failed exfoliation of the associated primary tooth)

Orthodontic Continuation of Care (D8999)

- Completed Request Form: Continuation of Care
- The provider submitting for continuation of care must be different than the provider who originally banded the participant when the case was originally approved through the State of Maryland
- D8670 preauthorized services will be limited to a total of 24 payments regardless of the number of providers rendering treatment; however, if a D8090 has previously been paid, a cumulative maximum of 12 D8670 payments is available
- A provider may not bill for broken brackets, wires, or additional adjustments beyond the maximum of 24 (12 if D8090 previously paid)
- Providers may not characterize adjustments beyond the maximum of 24 as "cosmetic" services in order to bill the participant for additional adjustments. Billing for such adjustments constitutes balance billing and MAY NOT be done
- Participant in treatment moving to Maryland from out-of-state
- Participant in treatment moving within Maryland such distance where impractical to continue treatment with previous provider
- Exceptional conditions where current provider is unable to complete treatment
- If it is deemed original State of Maryland contracted provider received D8670 payments in excess of expected treatment progress, payment recoupment may occur; D8999 must include a D8680 and D8670 (if remaining are available) on the preauthorization

Comprehensive orthodontic treatment (HLD Score) (D8080, D8090)

- D8080 is inclusive of banding, debanding, and retention, and adjunctive appliances such as, but not limited to, palatal expanders, habit appliances, fixed bite plates, and fixed functional appliances.
- Separators are all inclusive to D8080. There is no billable code for separator placement. The appliance must be delivered and/or cemented in order to submit the D8080 for payment.
- D8080 is allowed one per lifetime per patient
- Maximum of 24 D8670's for comprehensive Orthodontic treatments per participant per lifetime (or)
- Maximum of 12 D8670's for Self-Ligating Orthodontic treatments per participant per lifetime
- Documentation shows current / historical cleft palate condition with treatment recommendation in either mixed or full dentition
- Documentation shows severe traumatic deviations caused by facial accidents rather than congenital deformity and does not include traumatic occlusions or cross bites
- If there is planned use of self-ligating braces, D8090 MUST be submitted with a preauthorization request for D8080

- Documentation supports HLD Index Form score sheet total of 15 points or greater. HLD scores of under 15 are not considered a covered service.
- Approved D8080 / D8090 Comprehensive Orthodontic Treatment cases are based on the participant's dentition and include all necessary treatment at the time, and providers should not request or bill for any additional treatment services
- A provider may not bill for broken brackets, wires, or additional adjustments beyond the maximum of 24 (or 12 if a D8090 has been paid)
- Providers may not characterize adjustments beyond the maximum of 24 (or 12 if a D8090 has been paid) as "cosmetic" services in order to bill the participant for additional adjustments; billing for such adjustments constitutes balance billing and MAY NOT be done
- A preauthorization submitted with D8080 or D8080/D8090 must include D8660 and D8670 on the same preauthorization
- If a preauthorization is denied for orthodontic services because the HLD score is under 15, based on COMAR 10.09.05.04 criteria requirements, the service is not covered.

Orthodontic retention (D8680)

- Debanding by a provider or location other than the provider or location that was paid for initial banding (D8080, D8090)
- Only payable when original provider differs from the provider performing the continuation of care for de-banding and retention

Orthodontic repair / replacement of lost or broken retainer (D8703, D8704) / re-bonding or re-cementation / repair of fixed retainer (D8698, D8699)

- Narrative of active orthodontic case with documentation of debanding date (One per arch per lifetime allowed within 24 months of debanding date)

Palliative (emergency) treatment (D9110)

- Documentation describes medical necessity for procedure

House/extended care facility call (D9410)

- Includes visits to nursing homes, long-term care facilities, hospice sites, institutions, etc.
- Report required in addition to reporting appropriate CDT codes for actual services performed

Hospital or ambulatory surgical center call (D9420)

- Care provided outside the dentist's office to a patient who is in a hospital or ambulatory surgical center
- Approved preauthorization for D9999

Occlusal adjustment – limited (D9951)

- Adjustment not done on same date as restorative, prosthetic or endodontic treatment

Occlusal adjustment – complete (D9952)

- Documentation describes medical necessity for complex case needs (facebow, interocclusal records, tracings, diagnostic wax-up, etc.

Hospital operating room or outpatient facility request (D9999)

- Completed Facility Referral Form: Confirmation of Medical Necessity
- Preauthorization to include narrative describing the health complication or conduct disorder (See the Facility Referral Form for details)
- Preauthorization for all services require prior approval
- Treatment plan or narrative if uncertain
- Documentation (X-rays, photographs, etc.) supporting the treatment plan (if applicable)
- D9999 must be on the claim form with the appropriate place of service (POS) code. Enter POS 24 for Ambulatory Surgery Center or 22 Outpatient Operating Room.

EPSDT Guidelines

For MHSDP participants under the age of 21, if a service or CDT code is not listed as a covered benefit, please submit a preauthorization with the EPSDT box checked along with a letter of medical necessity for review. If the preauthorization is approved, the claim must be submitted for reimbursement with the EPSDT box selected.

For non-covered orthodontic services to be considered under EPSDT guidelines, a preauthorization with the EPSDT box selected must be submitted ***prior*** to the preauthorization request for comprehensive orthodontic treatment. If the services are approved as medically necessary under EPSDT guidelines, they must be completed ***prior*** to the preauthorization submission for comprehensive orthodontic treatment.

Dental Surgery Services

Reimbursement of the facility charges for dental services performed in the outpatient department of a hospital or at an ambulatory surgical center (ASC) are part of the dental carve out and will be covered by the Maryland Medicaid Program. The anesthesiologist services related to those dental services are also part of the dental carve out and will be covered and reimbursed by the Maryland Medicaid Program.

The Maryland Medicaid Program does not require preauthorization for services rendered in the outpatient department of a hospital or in an ASC. Additionally, there are no anesthesiology procedure codes that must be preauthorized. However, dental services that are to be performed outside your office, either in an outpatient department of a hospital or at an ASC, must be approved by SKYGEN to ensure the services meet the medical necessity criteria for services rendered in an outpatient facility (hospital or ASC).

Preauthorization and Claims for Dental Surgery Services

In order to render services outside the dental office, either in an outpatient department of a hospital or at an ambulatory surgery center (ASC), the provider must complete a Facility Referral Form: Confirmation of Medical Necessity. Submit this form and the appropriate place of service (POS) with a preauthorization, and be approved by SKYGEN to ensure the services meet the medical necessity criteria for services rendered in an outpatient facility (hospital or ASC).

A copy of the Facility Referral Form: Confirmation of Medical Necessity is included in this

provider manual. You can also download an electronic copy of the form from the Provider Web Portal: www.provider.MDhealthysmiles.com.

Preauthorization for Dental Surgery

To ensure services rendered in an outpatient department of a hospital or ASC meet the criteria for medical necessity, submit a preauthorization for procedure code D9999 and include the following required documentation:

Prior to providing services in an ASC or Outpatient Hospital, providers must:

- Complete a Facility Referral Form which is in the Provider Manual and on the provider web portal.
- Identify the health complication or conduct disorder by checking the appropriate box on the Facility Referral Form. (If option #1 is selected on the facility form a narrative is not required for children 0-5 years old; however, a narrative is required for children ages 6 and older; for options #2–6, a narrative is required regardless of age.)
- Provide a treatment plan (always required regardless of age).
- Provide documentation supporting the treatment plan if available (X-rays, photographs, etc.)

When submitting claims for services that are rendered outside of the dental office, either in an ambulatory surgery center or outpatient hospital, the claims must:

- Have an approved authorization for D9999 listed on the claim with a $0 billed amount.
- List a Place of Service (POS) code of 24 (Ambulatory Surgery Center) or 22 (Outpatient Hospital).
- Include all dental services that were performed associated with the approved D9999.
- Be itemized and submitted as one claim.

Providers may submit a preauthorization along with any required documentation directly to SKYGEN through our Provider Web Portal: www.provider.MDhealthysmiles.com. Alternately, mail paper preauthorizations along with all required documentation to:

Maryland Healthy Smiles: Preauthorization
P.O. Box 422
Milwaukee, WI 53201

In an emergency, fax the preauthorization request for D9999 (submitted on a paper 2024 ADA Dental Claim Form), along with all required documentation to: **877-276-1336**.

Claims for Dental Surgery

Providers are responsible for submitting Medicaid claims accurately for adjudication. This includes indicating the correct place of service (POS) where the dental treatment was rendered. To ensure that claims are submitted to properly adjudicate and track the services rendered in the outpatient facility (hospital or ASC), claims for services performed must be submitted with the appropriate POS codes. If a claim for services performed at an outpatient facility is not submitted with the appropriate POS code, the claim will be denied.

Providers may submit claims along with any additional documentation directly to SKYGEN through our Provider Web Portal: www.provider.MDhealthysmiles.com.

Emergency Treatment

Should a procedure need to be initiated to relieve pain and suffering in an emergency, you are to provide treatment to alleviate the patient's condition. To receive reimbursement for emergency treatment, submit documentation supporting the emergency and all required documentation along with the claim for services rendered. SKYGEN uses the same clinical criteria (and requires the same supporting documentation) for claims submitted after emergency treatment as it would have used to determine preauthorization for the same services.

Preauthorization Requirement vs. Claim Submission Requirement

The Benefit Plan Detail and Preauthorization Requirements section shows all of the covered services under MHSDP and lists if each service requires a preauthorization, has a claim submission requirement or has no requirements. If a service has a requirement for preauthorization, the preauthorization must be done prior to rendering services. For example: D2740 requires a pre-operative X-ray showing the apex of the tooth in order to be considered for preauthorization.

If a service has a claim submission requirement, the documentation must be submitted with the claim. For example: D0431 does not require a preauthorization but does require the lab/pathology report be submitted with the claim.

If you have any questions about preauthorization or claim submission requirements, please contact Provider Services, **844-275-8753**.

Preauthorization Submission Procedures

Information regarding services that require preauthorization and supporting documentation is in the Benefit Plan Detail and Preauthorization Requirements section.

If a service requires a preauthorization, the provider must submit a preauthorization to be approved prior to the date the service is rendered or, on the date of service (DOS) of the procedure, prior to rendering the service. Retro-preauthorization is not permitted. All preauthorizations expire six months after the date they are received. It is the responsibility of the provider to submit a subsequent preauthorization to continue treatment, if needed, upon the expiration of the preauthorization.

Any preauthorization submitted without the required documents will be put on hold. An outreach call will be made within 48 hours in addition to a letter being sent requesting the documents needed in order to review the preauthorization and make a determination. If the required documents are not received within five days of the preauthorization submission date, the preauthorization will be denied. When a preauthorization is denied and due to missing the required documents it must be resubmitted with the required documents to obtain prior approval before services are rendered. Any claims submitted without the required approved preauthorization will be denied for reimbursement.

SKYGEN will make a decision on a request for preauthorization within two business days from the date we receive the request, provided all information is complete. SKYGEN will honor preauthorization for six months after the date of the receipt of approval. ***A preauthorization does not guarantee payment***. The participant must be eligible for benefits at the time services are provided. SKYGEN reviewers and licensed dental consultants approve or deny preauthorization requests based on whether:

- The item or service is medically necessary;
- A less expensive service would adequately meet the participant's needs; and
- The proposed item or service conforms to commonly accepted standards in the dental community.

SKYGEN accepts preauthorizations submitted in any of the following formats:

- Provider Web Portal, www.provider.MDhealthysmiles.com
- Electronic submission via clearinghouse, Payer ID: **SCION**
- Paper - 2024 ADA Dental Claim Form, available from the American Dental Association

Summary: Preauthorization Timelines

Preauthorization Request	Timeline
Decision on preauthorization request	SKYGEN approves or denies requests within two business days.
Preauthorization expiration	SKYGEN honors preauthorization for six months after the date of the receipt of approval.

Claim Submission Procedures

SKYGEN accepts claims submitted in any of the following formats:

- Provider Web Portal, www.provider.MDhealthysmiles.com
- Electronic submission via clearinghouse, Payer ID: **SCION**
- Paper 2024 ADA Dental Claim Form, available from the American Dental Association

Submitting Claims via Provider Web Portal

Providers may submit claims directly to SKYGEN through our Provider Web Portal: www.provider.MDhealthysmiles.com. Submitting claims via the web portal has several significant advantages:

- The online dental form has built-in features that automatically verify participant eligibility, pre-fill the claim form with participant information, and make data entry quick and easy.
- The online process allows you to attach and send electronic documents as part of submitting a claim—***for no charge***.
- Before submitting a claim—or before rendering services—you can generate an online claim estimate to find out how much you are likely to be paid or whether your claim will be denied—and the reasons why.
- Claims enter our benefits administration system faster—which means you receive a decision faster.
- As soon as a claim is paid, its status is instantly updated online, and a Remittance Report is available for review.

If you have questions about submitting claims online, attaching electronic documents, or accessing the Provider Web Portal, call the Web Portal Team: **855-434-9239**.

Submitting Claims via Clearinghouses

Providers may submit electronic claims and preauthorizations to SKYGEN directly via their preferred clearinghouse. Your clearinghouse and/or software vendor can provide you with information you may need to ensure electronic files are forwarded to SKYGEN.

The SKYGEN Payer ID is **SCION**. By using this unique Payer ID when submitting your electronic files, your clearinghouse can ensure that claims and preauthorizations are routed successfully to SKYGEN.

Clearinghouse Information:

DentalXChange *(Formerly EHG)* *Also contracted for attachment services	**Vyne Dental** *(dba Tesia Clearinghouse)* *Providers can use ***Fast Attach™*** for attachment services	**SDS** *Providers can use ***Fast Attach™*** for attachment services
www.dentalxchange.com	https://vynedental.com/	https://sdata.us/
1-800-576-6412	**1-800-724-7240**	**1-855-297-4436**

Attaching Electronic Documents

If you use the Provider Web Portal, www.provider.MDhealthysmiles.com, you can quickly and easily send electronic documents as part of submitting a claim or preauthorization—***for no charge***. SKYGEN, in conjunction with National Electronic Attachment, Inc. (NEA) also allows enrolled providers to submit documents electronically via FastAttach®.

This program allows secure transmissions of radiographs, periodontics charts, intraoral pictures, narratives and Explanation of Benefits (EOB). See Coordination of Benefits (COB) for more details required for paper, web portal or electronic claims sent via clearing houses. FastAttach® is compatible with most claims clearinghouses and practice management systems. For more information, visit http://www.nea-fast.com or call NEA at **800-782-5150**.

Submitting Claims on Paper Forms

To ensure timely processing of paper claims, at a minimum, the following information must be included on the paper 2024 ADA Dental Claim Form:

- Name (Last, First, Middle Initial, Suffix) Address, City, State, Zip Code (Item 20)
- Date of Birth (MM/DD/CCYY) (Item 21)
- Policy/Subscriber ID (Item 15)
- Billing Dentist or Dental Entity (Item 48-51)
- Treating Dentist and Treatment Location Information (Item 53-56)
- Procedure Date, for each service line (Item 24)
- Tax ID Number (TIN)

Use approved ADA dental codes, as published in the current CDT book or as defined in this manual, to identify all services. Include on the form all quadrants, tooth numbers, and surfaces for dental codes that require identification (extractions, root canals, amalgams and resin fillings).

SKYGEN recognizes tooth letters A through T for primary teeth and tooth numbers 1 to 32 for permanent teeth. Designate supernumerary teeth with codes AS through TS or 51 through 82. Designation of the tooth can be determined by using the nearest erupted tooth. If the tooth closest to the supernumerary tooth is 1, then chart the supernumerary tooth as 51. Likewise, if the nearest tooth is A, chart the supernumerary tooth as AS.

ICD-10 diagnosis codes are not required on the dental claim. If your dental practice submits dental claims with diagnosis codes as part of your procedural practice with a current date of service, a valid ICD-10 diagnosis code must be used. If an invalid ICD-10 diagnosis code is used, the claim will be rejected. A new claim must then be submitted with a valid ICD-10 diagnosis code or no diagnosis code on the dental claim. Missing, incorrect, or illegible information could result in the claim being returned to the submitting provider's office, causing a delay in payment. Use the proper postage when mailing bulk documentation. Mail with postage due will be returned. Mail paper claims to:

Maryland Healthy Smiles: Claims
PO Box 2186
Milwaukee, WI 53201

X-ray Return Policy: To request that X-rays are returned, providers must include a self-addressed stamped envelope with X-rays. Otherwise, X-rays are shredded. Mail paper preauthorization to:

Maryland Healthy Smiles: Preauthorization
PO Box 422
Milwaukee, WI 53201

If SKYGEN denies approval for any requested service, the participant will receive written notice of the reasons for each denial and will be notified of how to request reconsideration or appeal the decision. The requesting provider will also receive notice of the decision. To request reconsideration or appeal a denied preauthorization decision with SKYGEN, see the Grievances, Reconsiderations and Appeals section of this provider manual.

Coordination of Benefits (COB)

The MHSDP/SKYGEN is the payer of last resort. When a participant arrives for an appointment, always ask if they have other dental insurance coverage. When MHSDP/SKYGEN is the secondary insurance carrier, submit a copy of the primary carrier's Explanation of Benefits (EOB) with the claim.

An EOB should include the following pieces if information:

- Name of the insurance company that paid the claim
- Name of the patient
- Date of service
- Itemized list of the services performed
- Information relating to how the payment was determined such as deductible, coinsurance, copay and remarks codes.

Key rules to follow in order to ensure a claim submitted with COB is processed correctly are:

- EOB must be legible
- The participant information (name/DOB) listed on the EOB must match what is submitted on the claim
- All services listed on the claim must be on the EOB (Please note that all services on EOB do not need to be on the claim)
- Date of service on the claim must match the EOB
- Submitted charges on the claim must match the EOB
- If EOB shows non-payment of a service code, there must be a valid explanation of non-payment present on the EOB. (A denial reason "this is a duplicate of a previously processed claim" is an example of an invalid reason for non-payment)

For paper claims, the primary payer information/EOB must be included and attached.

For claims submitted through the Provider Web Portal, the EOB must be attached, uploaded and the COB fields completed.

For electronic claim submissions via a clearinghouse, the primary payer information must be included on the claim submission. The electronic claim must have the primary payer

information completed in the correct segments (loops) and entered by service line, according to the clearinghouse's "Companion Guide," in addition to the EOB attachment through NEA, FastAttach®, or your clearinghouse. If the Coordination of Benefits (COB) fields are not completed, the claim will process incorrectly, and a corrected paper claim will need to be submitted with the primary insurer's EOB. When a primary carrier's payment meets or exceeds the MHSDP fee schedule amount, the MHSDP/SKYGEN will consider the claim paid in full and no further payment will be made on the claim.

Timely Filing Limits

SKYGEN must receive claims requesting payment within 12 months from the date of service. Claims submitted more than 12 months from the date of service will be denied for "untimely filing." If a claim is denied for untimely filing, you may not bill the participant. If the MHSDP/SKYGEN is not the primary carrier, the claim still must be received within 12 months from the date of service.

Rejected Claims

A claim will be rejected if it is submitted with one, or more errors including but not limited to: invalid version of ADA claim form, missing tax ID, missing subscriber ID, missing/invalid NPI. When a claim is rejected, it does not enter the claim processing system. A letter will be mailed to the address listed on the claim form explaining the reason for the rejection. Providers can correct the error and resubmit the claim.

Resubmitting a Denied Claim

To resubmit a claim that has been denied with additional information, follow the Claim Submission Procedures section of this provider manual.

The following are examples of when a denied claim should be resubmitted as a new claim with the updated information per your normal claim submission channels:

- If a claim or service was denied due to missing tooth or surface;
- Incomplete or incorrect information;
- You have since obtained preauthorization for services

If you received a claim or service denial which you do not agree with, including denials for no preauthorization, see the Grievances, Reconsiderations and Appeals section for information on submitting a request for reconsideration.

However, if a service line on a claim was paid that should not have been paid—or if a claim was paid to the wrong payee or on behalf of the wrong participant, then submit a "corrected" claim to reverse the incorrect payment and reprocess the claim with the corrected information. For example, if a claim is submitted and paid with the wrong provider NPI or clinic location, incorrect payee Tax ID, wrong participant, incorrect procedure code, etc., then the paid claim must be corrected and reprocessed. Please see Submitting a Corrected Claim section for more information.

Submitting a Corrected Claim

When Should I Submit a Corrected Claim? A corrected claim should ONLY be submitted when an original claim or service was PAID based upon incorrect information. A Corrected Claim must be submitted in order for the original claim to be adjusted with the correct information. As part of this process, the original claim will be recouped, and a new claim processed in its place with any necessary changes.

If a claim or service originally denied due to incorrect or missing information, or was not previously processed for payment, **DO NOT submit a corrected claim**. Please review the Resubmitting a Denied Claim section for instructions. Denied services have no impact on participant tooth history or service accumulators, and, as such, do not require reprocessing.

What Scenarios are subject to the Corrected Claim Process? A corrected claim should only be submitted if the original service(s) were paid based on incorrect information. Some examples of correction(s) that need to be made to a prior paid claim are:

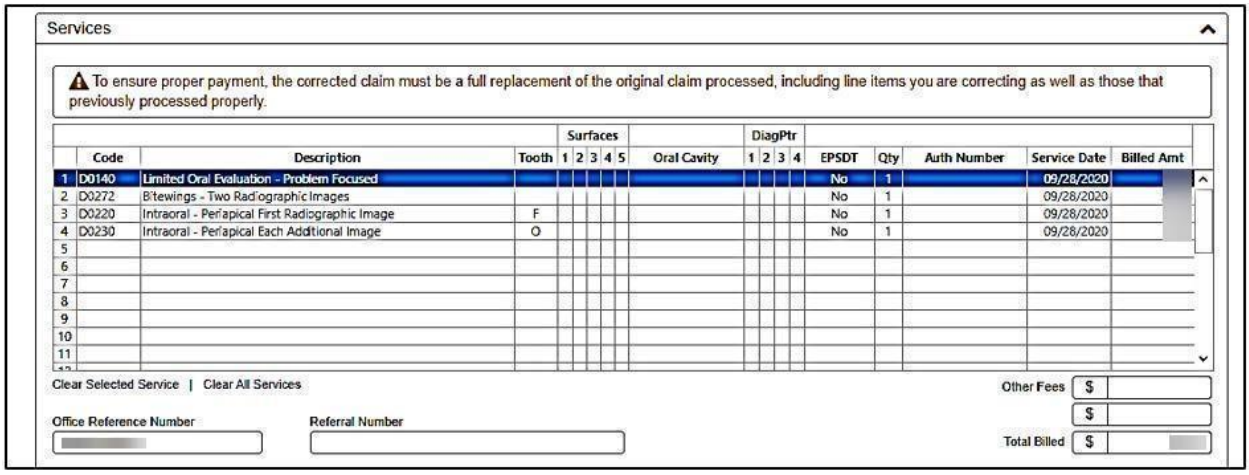
- Incorrect NPI or location, Payee Tax ID, Incorrect participant, or Procedure codes
- Services originally billed and paid at incorrect fees (including no fees)
- Services originally billed and paid without primary insurance

Providers can submit their corrected claims via the Provider Web Portal or through clearinghouse files. Timely filing limits for corrected claims is 18 months from the date of service.

Submitting Corrected Claims via the Web Portal

Providers will be able to make corrections on original claims via the Provider Web Portal. Providers will have the ability to:

- Edit or correct ADA dental claim form fields



- Review attachments/documents associated with the original claim to determine if they should remain attached to the corrected claim
- Remove attachments/documents that either no longer apply to the corrected claim, or were originally attached in error
    - Note: By default, all original documents will be attached to the new, corrected claim. Providers will have to select the option to remove document(s) as needed.

Corrections will be allowed one time on an original dental claim when submitted via Provider Web Portal.

- If additional corrections are required after a corrected claim is submitted, the provider will need to submit the correction based on the most recently submitted corrected claim, not the original claim.
- The portal will provide a message stating the claim can no longer be corrected if the provider attempts to correct the original claim more than once.

Submitting Corrected Claims via EDI

Corrected claims via Clearinghouse File will be accepted when a specific set of criteria is met to ensure the original claim can be identified. In order for a submission to be considered a corrected claim, it must include:

- Claim frequency code of 7 (Replacement) or 8 (Void/Cancel) in CLM05-3 element along with claim or encounter identifier in REF*F8 element
- Original claim in a paid status
- Original claim does not have previously resubmitted services, or a corrected claim already processed
- Original claim does not have associated service adjustments or refunds
- Corrected claim must have a data match to the original claim on at least three of the four items: Enrollee ID, Provider ID, Location ID, and/or Tax ID

If a corrected claim submitted via clearinghouse file does not meet these requirements, our system will consider the submission to be a new claim. The provider would then need to send another submission on the file that does meet the above requirements for consideration.

Submitting Corrected Claims via Paper

SKYGEN will continue to accept paper corrected claims but encourages providers to submit electronically going forward. Paper corrected claim submissions must include the following:

- 2024 ADA form and all required information
- The ADA form must be clearly noted **“Corrected Claim**” across the top of the form
- In the remarks field (Item 35) on the ADA form, indicate the original paid encounter number and record all corrections you are requesting to be made.

- Attach supporting documentation and send documentation in the same package with the **Corrected** paper claim form. *NOTE: If all information does not fit in Item 35, please attach an outline of corrections to the claim form.*

  Submit to:

  Maryland Healthy Smiles: Corrected Claims
  P.O. Box 541
  Milwaukee, WI 53201

Receipt and Audit of Claims

To ensure timely, accurate payment to each participating provider, SKYGEN audits claims for completeness as they are received. This audit validates participant eligibility, procedure codes, and provider identification information. A Dental Reimbursement Analyst reviews any claim conditions that would result in nonpayment. When potential problems are identified, your office may be asked to help resolve the issue. For questions about claims submission or remittances, call Provider Services: **844-275-8753.**

Claims Adjudication and Payment

The SKYGEN benefits administration software system imports claim and preauthorization data, evaluates and edits the data for completeness and correctness, analyzes the data for clinical appropriateness and coding correctness, audits against plan and benefit limits, calculates the appropriate payment amounts, and generates payments and remittance summaries. The system also evaluates and automatically matches claims and services that require preauthorization and matches the claims and services to the appropriate participant record for efficient and accurate claims processing.

As soon as the system prices and pays claims, checks and electronic payments are generated, and remittance summaries are posted and available for online review from the Provider Web Portal: www.provider.MDhealthysmiles.com.

Grievances, Reconsiderations and Appeals

The MHSDP/SKYGEN are committed to providing high-quality dental services to all participants. As part of that commitment, we work to ensure all participants and providers have every opportunity to exercise their rights to a fair and timely resolution to any grievances, reconsideration requests and appeals.

Our procedures for handling and resolving grievances (complaints) and reconsiderations are designed to:

- Ensure fair, just, and speedy resolutions by working cooperatively with providers and supplying any documentation related to grievances and/or reconsiderations, upon request
- Treat providers and participants with dignity and respect at all levels of the grievances and reconsiderations resolution process

- Inform providers and participants of their full rights as they relate to grievance, reconsideration and appeal resolutions, including their rights of appeal at each step in the process
- Resolve grievances and reconsiderations in a satisfactory and acceptable manner within the MHSDP/SKYGEN protocol
- Efficiently monitor the resolution of grievances, to allow for tracking and identifying unacceptable patterns of care over time

Differences sometimes arise between dental providers and insurers or their benefit administrators regarding preauthorization determinations and payment decisions. Since many of these issues result from misunderstanding of service coverage, processing policy, or payment levels, we encourage providers to contact us for explanations and education. For assistance, call Provider Services: **844-275-8753**.

A designated SKYGEN Specialist is dedicated to the expedient, satisfactory resolution of both provider and participant grievances and reconsiderations.

Grievances

If your office has an unpleasant experience with MHSDP/SKYGEN and you would like to file a complaint/grievance, we would like to hear about it. SKYGEN takes an active role assisting providers and participants who have grievances. If you have a grievance, you can either:

- Send a written grievance to:
  Maryland Healthy Smiles: Grievances/Appeals
  PO Box 393
  Milwaukee, WI 53201
- Call Provider Services: **844-275-8753**

Grievance Investigation and Resolution

SKYGEN logs all grievances we receive, whether received verbally or in writing, in our Customer Service system. The system automatically routes all grievances to our Appeals, Complaints and Grievances department for review and resolution. SKYGEN investigates and resolves grievances within the following time frames:

- **Emergency, clinical issues**: within 24 hours of receipt or by close of the next business day.
- **Non-emergency clinical issues**: within five days of receipt.
- **Non-clinical issues**: within 30 days of receipt.

A licensed Dental Consultant reviews and resolves any quality-of-care issue that is related to a clinical issue. For all inquiries that are clinical in nature, the Specialist gathers clinical documentation and routes it to a licensed Dental Consultant for review and determination. To handle emergency clinical situations, the Specialist follows department protocol to expedite the resolution, which includes immediately notifying an on-call Dental Consultant.

All clinical documentation is available for Dental Consultants to review online through our web-based benefits management system. Electronic copies of clinical documents are attached to the inquiry in the Customer Service system and to any related preauthorization records in the integrated Preauthorization Determination system. To ensure Dental Consultants have the

information they need to make complete and fair determinations, the Specialist works closely with the Appeals, Complaints and Grievances team to obtain necessary information and clarifications from providers.

Peer to Peer and Reconsideration Requests

Participating providers who disagree with claim payment or preauthorization decisions made by SKYGEN reviewers have two options available to dispute the decision: Peer-to-peer request, or request for reconsideration.

Peer to Peer Request

If you disagree with the preauthorization decision or wish to speak to the dental reviewer, you can request a peer-to-peer review by contacting SKYGEN within two business days of the denial determination by calling Provider Services, **844-275-8753**.

A peer-to-peer request is part of the State's utilization review process. In accordance with HIPAA regulations, the peer-to-peer review will only be used for payment, treatment and health care operation purposes and does not require a release of information, consent or preauthorization from the patient. If a request for a peer-to-peer review is not received within two business days, the denial determination will stand.

Reconsiderations

Participating providers who disagree with claim payment decisions or preauthorization decisions made by SKYGEN reviewers may submit a written request for reconsideration on the participant's behalf within 30 days of the original denial date. SKYGEN will review the request and render a decision within 30 days. SKYGEN will deliver expedited resolutions within three days.

When submitting a request for reconsideration, include your name and your clinic address, participant's name and participant ID, reasons you disagree with the decision and additional documentation that supports your request, such as X-rays, treatment plans, medical records, etc.

Send written request for reconsiderations to:

Maryland Healthy Smiles:
Grievances/Appeals
P.O. Box 393
Milwaukee, WI 53201

Participant Fair Hearing

If the participant disagrees with the preauthorization decisions made by SKYGEN reviewers, the participant may file an appeal within 90 days of the original denial date, by requesting a Fair Hearing through the MDH Office of Administrative Hearings (OAH). As noted in COMAR 10.09.05.10 and COMAR 10.01.04, a Fair Hearing may be requested by giving a clear statement, oral, electronic, or written.

Maryland Healthy Smiles:
Grievances/Appeals
P.O. Box 393
Milwaukee, WI 53201

Once the participant's appeal has been received and date stamped, it will be forwarded to MDH. The participant will then receive a Fair Hearing date via mail from the MDH OAH. Please note that the scheduling of a Fair Hearing could take up to one year. If you have questions about filing a reconsideration request or an appeal, contact Provider Services, **844-275-8753.**

Summary: Grievance, Reconsideration and Appeal Timelines

Grievance, Reconsideration and Appeal Action	Timeline
Grievance related to clinical issue—emergency	SKYGEN investigates and resolves within 24 hours of receipt or by close of the next business day.
Grievance related to clinical issue—non-emergency	SKYGEN investigates and resolves within five days of receipt.
Grievance related to non-clinical issue	SKYGEN investigates and resolves within 30 days of receipt.
Claim reconsideration	Providers must request reconsideration within 30 days of the notice of decision. SKYGEN renders a decision within 30 days of receiving the request.
Preauthorization reconsideration – non-expedited	Participants (or providers on behalf of a participant) must request reconsideration within 30 days of the original preauthorization denial date. Providers must have the participant's written consent to appeal a decision on the participant's behalf. SKYGEN renders a decision within 30 days of receiving the request.
Preauthorization reconsideration — expedited	SKYGEN renders a decision within three days of receiving the expedited request.
Preauthorization Appeal to OAH — participants	Participants must appeal within 90 days of the original preauthorization denial date.

Orthodontia

Orthodontic Coverage Criteria

Comprehensive orthodontic treatment is a considered benefit under MHSDP if it is found to meet clinical criteria. The participant must present with the following conditions:

- A fully erupted set of permanent teeth, with the exception of documentation showing congenitally missing or impacted teeth, or severe traumatic deviations (i.e., facial accidents);
- A score of at least 15 points on the Handicapping Labio-Lingual Deviations Index (HLD);
- Dentofacial abnormalities that severely compromise the participant's physical health; and
- A handicapping malocclusion.

***Orthodontic services for cosmetic purposes are not a covered benefit.**

HLD Index No. 4|Handicapping Labio-Lingual Deviations Form

For the MHSDP, SKYGEN's clinical criteria for comprehensive orthodontics requires documentation on an HLD Index No. 4 Form, with a total score of 15 points or higher. Please submit all required supporting documentation along with the completed form.

A copy of the HLD Index No. 4 Form is included in this provider manual. You can also download an electronic copy of the form from the Provider Web Portal: www.provider.MDhealthysmiles.com.

Covered Orthodontic Services

The following services are the only orthodontic treatments that are considered as a covered benefit under the MHSDP (please note the CDT codes listed below are in order of preauthorization and claims submission):

- D8660 - Pre-orthodontic treatment examination to monitor growth and development
- D8080 - Comprehensive orthodontic treatment
- D8080 with D8090 – Comprehensive orthodontic treatment (self-ligating)
- D8670 – Periodic orthodontic treatment visit
- D8703 – Replacement of lost or broken retainer (maxillary)
- D8704 – Replacement of lost or broken retainer (mandibular)
- D8698 – Re-cement or re-bond fixed retainer (maxillary)
- D8699 – Re-cement or re-bond fixed retainer (mandibular)
- D8999 – Orthodontic continuation of care
- D8680 – Orthodontic retention (removal of appliances, construction and placement of retainer(s)

For a complete, comprehensive list of these orthodontic services with the age limitations, frequency limitations and preauthorization requirements by plan, please see the Benefit Plan Detail and Preauthorization Requirements section.

Preauthorization of Comprehensive Orthodontic Treatment

All orthodontic services require preauthorization and must be rendered by a participating MHSDP provider. Preauthorization approval is required prior to rendering treatment. For comprehensive orthodontic treatment, the following documentation is required:

- Treatment Plan;
- 6 - 8 Diagnostic quality photos;
- X-rays (Panoramic or FMX and Cephalometric);
- Completed HLD Index No. 4 Form;
- Clinical summary with diagnosis; and
- 2024 ADA form requesting preauthorization for the following procedure codes (Item 29):
    - D8660;
    - D8080 for comprehensive orthodontia with up to 24 D8670s or;
    - D8080 with D8090 for self-ligating orthodontia with up to 12 D8670s

Each preauthorization under MHSDP have a 6-month expiration date, with the exception of preauthorization for periodic orthodontic treatment, which is valid for:

- 24 months for D8670s submitted with traditional comprehensive orthodontic treatment (D8080); or
- 12 months for D8670s submitted with self-ligating braces (D8080 with D8090)

If the treatment is not completed before the expiration date, a subsequent preauthorization for the remaining amount of D8670's must be submitted.

If a preauthorization for comprehensive orthodontic treatment is denied, providers are still able to receive payment for D8660, if the D8660 was approved on the preauthorization.

Orthodontic Claim Submission Guidelines

Claims must be submitted with the date of the service rendered. It is important to review the preauthorization approval expiration date and make sure any subsequent preauthorization needed for the ongoing treatment are up to date prior to rendering services. **Payment will not be made if there is not an active preauthorization on file.**

Claims should be submitted following the procedures listed below:

- The claim for D8660 includes the diagnostic workup, clinical evaluation, X-rays (D0330, D0340), photographs (D0350), diagnostic casts if taken (D0470), orthodontic treatment plan, Consultation-diagnostic service (D9310), and completion of the HLD form.
- A claim for D9310 may not be submitted with the same DOS or within 6 months of D8660.
- The claim for D8080 (or D8080 with D8090 for self-ligating orthodontia) should be submitted once the patient has been fully banded.
- A claim for D8670 may not be submitted with the same DOS as D8080. The initial claim for D8670 will occur on the first visit for a periodic adjustment following the banding visit.

- Claims for D8670 are only to be submitted for the date the participant was in the office for their periodic adjustment. Claims for monthly adjustments should never be submitted if the participant is not seen that month.
- A claim for D0140 cannot be submitted for the same DOS as D8670, or for orthodontic emergencies.
- Claims may not be submitted for broken brackets, wires or bands.

When a claim is submitted for D8080 (or D8080 with D8090 for self-ligating orthodontia) it will receive the full contracted orthodontic case rate payment. The case rate payment will cover:

- Comprehensive or self-ligating orthodontic treatment;
- Banding or placement of orthodontic appliances (brackets, wires, bands);
- Debanding or removal of orthodontics;
- Orthodontic retention (construction and placement);
- Broken brackets, wires or bands; and
- Any additional hardware such as expanders and functional appliances etc., needed to bring the patient to functional dentition.

Orthodontic Continuation of Care (COC) and Requirements

Participants of the MHSDP are eligible to continue orthodontic treatment with a different provider if the original provider who initially banded them is unable to complete treatment. This is also an option for participants who began orthodontic treatment under a different insurance and have recently become eligible for the MHSDP. participants are eligible for continuation of care (COC) once per lifetime. Preauthorization for COC is required.

To transition a participant's orthodontic benefits to MHSDP, SKYGEN requires a Request Form-Continuation of Care to request reimbursement. Please submit all required supporting documentation along with the completed form. A copy of the Request Form-Continuation of Care is included in this provider manual. You can also download an electronic copy of the form from the Provider Web Portal: www.provider.MDhealthysmiles.com.

Please submit the preauthorization request with the following documentation:

- Continuation for Care (COC) Request Form
- 6-8 diagnostic quality intra-oral/extra-oral photos
- The name and address of the previous orthodontist
- Reason for the continuation of care request and treatment plan
- Remaining amount of monthly adjustment required to complete treatment
- 2024 ADA claim form which includes the CDT codes (Item 29):
  - D8999 – COC transfer fee
  - D8670 – periodic orthodontic treatment (quantity needed for the six month preauthorization period)
  - D8680 – debanding and retention

Preauthorization requests for continuation of orthodontic care can be submitted via the Provider Web Portal or mailed to:

Maryland Healthy Smiles: Continuation of Care
PO Box 422
Milwaukee, WI 53201

Please be advised that under comprehensive orthodontic treatment, each participant has a maximum quantity of D8670 allowed. The COC request will be denied if the quantity of D8670 requested exceeds the amount the participant has available. In order to obtain the amount of D8670 the patient has exhausted, you can review the participant's clinical history on the Provider Web Portal or contact Provider Services, **844-275-8753**.

Non-Covered Service

Covered Services

A covered service is a service that is included within the participant's benefit package. Please see the Benefit Plan Detail and Preauthorization Requirements section for the list of covered services by benefit plan.

Otherwise Covered Services

A service is deemed to be an otherwise covered service when the service is not included in the participant's benefit package, but meets EPSDT guidelines.

- Providers cannot charge the member when a covered service is denied for preauthorization.
- If a service is an EPSDT request providers can bill the members if the request is denied .
- Anytime the member decides to request a fair hearing the provider must wait for the decision from the administrative law judge before entering into an agreement.

If preauthorization is obtained and the service is properly rendered, the Provider must "Accept payment by the Program as payment in full for covered services rendered and make no additional charge to any person for covered services." COMAR 10.09.36.03 "If the Program denies payment or requests repayment on the basis that an otherwise covered service was not medically necessary or preauthorized, the provider may not seek payment for that service from the participant." COMAR 10.09.36.03 D. This provision prohibits the provider from entering into a financial agreement with the participant when a request for preauthorization is denied.

Appeal rights are given only to participants for a denied preauthorization. Regardless of whether the participant appeals, a provider is prohibited from entering into a financial agreement with the participant for a denied preauthorization of a covered service.

Non-Covered Services

A service is deemed to be non-covered when:

- Service is not covered under the participants benefit package, and participant is under 21 or FFC and do not meet EPSDT guidelines.
- Service is not included under the adult benefit package.

Any request for reimbursement of a non-covered service will be outright rejected, and no appeal rights for the participant or the provider are available for the Program's rejection of these requests.

Providers may enter into a financial agreement with a participant for a non-covered service. However, if the service is for a denied EPSDT request and the participant wishes to appeal the denial with the Office of Administrative Hearings (OAH), the provider must wait for a decision from the Administrative Law Judge (ALJ) before entering into the financial agreement.

Forms and Documents

Examples of the forms and documents applicable to the MHSDP are posted on the following pages. The forms and documents are available to be downloaded from the Provider Web Portal: www.provider.MDhealthysmiles.com. Listed below are the applicable forms and documents.

- EFT Preauthorization Agreement
- Missed Appointment Log
- Request Form-Continuation of Care (COC)
- Handicapping Labio-Lingual Deviation (HLD) Index
- Provider-participant Termination Form
- Facility Referral Form

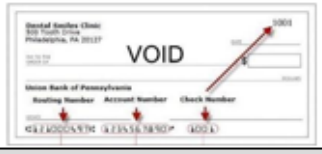
Electronic Funds Transfer (EFT) Preauthorization Agreement

MARYLAND Healthy Smiles DENTAL PROGRAM

SKYGEN

Electronic Funds Transfer (EFT) Preauthorization Agreement

Get your reimbursement faster and easier with EFT! To receive your payments by EFT, please complete this form and return it with a scanned or faxed copy of a voided check. (This Preauthorization Agreement will not be valid without a voided check.)

Submission Options	
Send this completed form and voided check to SKYGEN via:	**Fax:** 262-721-0722 *or* **Email:** providerservices@SKYGENUSA.com
Submission Reason	
Select one checkbox.	❑New EFT Preauthorization | ❑Account or bank change to existing EFT Preauthorization
Provider Information	
Provider Name *(Include d/b/a, if any.)*	Taxpayer Identification Number / *Select one checkbox.* ❑ SSN | ❑EIN
Street Address	
City / State / Zip Code	
Phone Number Email Address	
Financial Institution Information	
Financial Institution Name	Financial Institution Routing Number *(Include 9 digits with any leading zeros.)*
Account Number *(Include up to 10 digits with any leading zeros.)*	*To indicate account type, select one checkbox.* ❑Checking Account | ❑Savings Account
Note: The Preauthorization Agreement will not be valid if a voided check is not submitted with this form.	
Preauthorization	
I agree to receive all vendor payments from SKYGEN LLC by electronic funds transfer according to the terms of the EFT program. I agree to return to SKYGEN any EFT payment incorrectly disbursed by SKYGEN I agree to hold harmless SKYGEN LLC and its agencies and departments for any delays or errors caused by inaccurate or outdated registration information or by the financial institution listed above.	
Printed Name	Title
Authorized Signature	Date

Missed Appointment Log

SKYGEN

Maryland Healthy Smiles Dental Program Missed Appointment Log

Providers, complete the columns below						SKYGEN will complete the columns below			
Date Log Submitted	Date of Missed Appt.	Member Last Name	Member First Name	Member Medicaid Number	Provider Name	Date Member Called	Date entered in Enterprise	Call Made by (Initials)	Comment

Request Form-Continuation of Care (COC)

MARYLAND Healthy Smiles DENTAL PROGRAM

Request Form - Continuation of Care

Member Name _____

Member ID _____

Member Date of Birth _____

Banding Date _____

Total Dollars Paid to Date for Existing Case _____

Remaining Monthly Visits _____

Previous Carrier or Managed Care Organization _____

Provider Name _____

Provider NPI _____

Provider Address _____ **City, State, Zip** _____

Procedure

1. Complete this form to transition the above listed member's benefits to the Maryland Healthy Smiles Dental Program.
2. Submit this form and all required documentation, along with a claim form noting CDT Code D8999, # of D8670's, and D8680 (request form) to SKYGEN.
3. Send all documents to the following address to avoid any disruption in compensation:

   Maryland Healthy Smiles: Continuation of Care
   P.O. Box 422
   Milwaukee, WI 53201

Required Documentation

Submit documentation with the following information for your reimbursement.

- ☐ 6–8 Diagnostic quality extra-oral/intra-oral photos
- ☐ Name and address of previous dentist
- ☐ Reason for COC request
- ☐ Additional number of months that D8670 is requested

Notes _____

SKYGEN

HLD Index No. 4|Handicapping Labio-Lingual Deviations Form

MARYLAND Healthy Smiles DENTAL PROGRAM

SKYGEN

HLD Index No. 4 | Handicapping Labio-Lingual Deviations **Provider** Form

Patient Name: _____ **ID Number:** _____

Treating Dentist (Signature)/Date: _____/_____

Procedure	Required Documents
1. Occlude patient or models in centric position. 2. Record all measurements in the order given, rounded off to nearest millimeter. 3. If condition is absent, enter score of "0." 4. Start by measuring overjet of the most protruding incisor. 5. Measure overbite from the labio-incisal edge of the overlapped front tooth (or teeth) to the point of maximum coverage. 6. Do not double-score ectopic eruption and anterior crowding. Record only the more serious condition.	Submit all required documents with this form. ❑ Ceph films ❑ Panorex/FMX x-rays ❑ 6-8 diagnostic quality extra-oral/intra-oral photos ❑ Narratives (clinical summarywith diagnosis, treatment plan, etc.)

Conditions Observed	HLD Score
	Treating Dentist
Cleft palate. Submit a cleft palate in mixed dentition only if you can justify in a report why a child should be treated before full dentition. Will intermittent treatment be required? Score 15	
Severe traumatic deviations. Refers to facial accidents, not congenital deformity (does not include traumatic occlusions or crossbites). Score 15	
Overjet. Measure overjet in millimeters and subtract 2mm from your score. Two millimeters of overjet considered normal. Overjet_____minus 2 mm	
Overbite. Measure overbite in millimeters and subtract 3 mm from your score. Three millimeters of overbite considered normal. Overbite_____minus 3 mm	
Mandibular protrusion. Measure in millimeters, multiplyby 5. Protrusion_____x 5	
Open bite. Measure opening between maxillary and mandibular incisors in millimeters, multiply by 4. Opening_____ x 4	
Labio-lingual spread. Measure total spacing between anterior teeth in millimeters.	
Anterior crowding. Anteriors so crowded that extractions are prerequisite to treatment. Arch length insufficiency must exceed 3.5 mm to score points. If crowding exceeds 3.5 mm in an arch, score 5 forthe arch. Maxilla_____ Mandibular_____	
Ectopic eruption. Unusual pattern of eruption, such as high labial cuspids. Do not score if teeth are scored under anterior crowding. Multiply teethby 3. Teeth_____x 3	
Posterior crossbite. Score 5 points for left or right posterior crossbite. Max Score 5	
A score of 15 or higher indicates a physical handicap. TOTAL	

Provider-Participant Termination Form

MARYLAND Healthy Smiles DENTAL PROGRAM

Maryland Healthy Smiles Dental Program

Provider-Member Termination Form

Fill in the following information and continue with the **Procedure** *and* **Required Documents** *sections on the back page.*

Member Termination Date *(Day notification letter sent to the member)*	
Anticipated End Date *(30 days from the above date)*	

Provider/Location Information		
Location Name		**Phone Number**
Provider Name		**Email Address**
City	**State**	**Zip Code**

Member Information		
Name	**Member ID/MA Number**	**Phone Number**
City	**State**	**Zip Code**

Today's Date	
Provider's Signature	

Providers may not dismiss a Medicaid member based on the member's gender, race, religion, or sexual orientation. Further, a member covered under the Americans with Disabilities Act (ADA) may be dismissed only for reasons similar to those applied to a non-disabled member. A member may not be dismissed because of their disability or illness, or costs that the disability or illness might involve (e.g., providing an interpreter for a deaf member).

SKYGEN

Procedure

1. Compose and *SEND* a notification letter to the members mailing address to initiate a pending termination. This notice *MUST* include the following five requirements:
   a. An agreement by the provider to give *no less than a 30-day written notice* of termination to *BOTH* the member and SKYGEN (per *COMAR 10.09.05.01(10)*)
   b. An agreement by the provider to continue coverage of the member's urgent and emergency care needs for *up to 30 days*, or until the member obtains a new dental provider (whichever occurs first)
   c. A request for SKYGEN to provide the member with options of providers within the Maryland Healthy Smiles Dental Program (MHSDP) Network
   d. A notice that the member's medical records will be sent to the new provider upon receipt of written authorization from the member
   e. The following phone number to assist the member in finding a new dental provider

      Member Services: 855-934-9812
2. Complete this form to transition the member's dental care to another provider in the MHSDP Network.

(Continued in the next column.)

3. Fax or email this form and all Required Documentation to SKYGEN at the following:

   Provider Services Fax Number: 262-721-0722

   Email: providerservices@skygenusa.com

Required Documentation

Submit all required documents with this form to SKYGEN USA to request your provider-member termination.

- ❑ Completed Provider–Member Termination Form
- ❑ Duplicate copy of the member notification letter for SKYGEN USA's reference

Note: In addition, please be sure to *send* the original member notification letter to the member's mailing address.

Policy and necessary "cause" for dismissal

The Maryland Department of Health has established a policy regarding dismissal of a Medicaid member. Dismissal of the member shall be evaluated on a case-by-case basis. Providers may dismiss a Medicaid member from their practice *for cause* at any time, and "*cause*" is defined as any of the following six reasons:

Please select a checkbox to indicate the qualifying "cause" or reason that applies to this member.

1. A documented, ongoing pattern of failure on the part of the member to keep scheduled appointments or meet any other member responsibilities	
2. The member fails to follow the recommended treatment plan or medical instructions	
3. The provider cannot provide the level of care necessary to meet the member's needs	
4. The provider moves out of the service area	
5. The member and/or member's family is abusive to the provider and/or practice staff, or poses a serious threat of harm to the provider, staff, and/or other patients	
6. Other reasons determined to be satisfactory to the Maryland Department of Health (MDH) NOTE: FOR THE CAUSE #6 CHECKBOX, PLEASE WRITE THE OTHER REASON OR "CAUSE" BELOW	

SKYGEN

Facility Referral Form: Confirmation of Medical Necessity

MARYLAND
Healthy Smiles
DENTAL PROGRAM

Facility Referral Form

Confirmation of Medical Necessity

Member Name _____ **Member ID** _____

Treating Provider Name/NPI _____/_____

Name of Facility/Date of Procedure _____/_____

Provider Contact Person Name/Phone _____/_____

**Use correct place of service (POS) codes on claim when submitting for payment: 24 - Ambulatory Surgery Center or 22 - Outpatient Hospital.*

Procedure

1. Complete this form to indicate why it is medically necessary for dental services to be performed in a hospital operating room or other outpatient facility.
2. Submit this form and all required documentation, along with an authorization for procedure code D9999 (facility referral), to SKYGEN for review and determination.
3. Send all documentation via the Provider Web Portal at www.provider.MDhealthysmiles.com or mail to:
   Maryland Healthy Smiles: Authorizations
   PO Box 422
   Milwaukee, WI 53201

Required Documentation

Submit documentation that confirms in-office treatment is not appropriate for the patient.

- ❑ Narrative describing health complication or conduct disorder (If option #1 is checked below, this documentation is required for ages 6 and older; for options #2–6, it is always required.)
- ❑ Treatment plan (always required)
- ❑ Documentation that supports the treatment plan (x-rays, photographs, etc.), if available

Medically necessary reasons for dental treatment in a hospital or outpatient facility

SKYGEN considers the use of hospital or outpatient facilities during the delivery of dental services to be medically necessary when documentation (including narrative, radiographs, etc.) demonstrates the presence of any one of the following health complications or conduct disorders.

Select the qualifying health complication or conduct disorder that applies to this patient	
1. Young children requiring extensive operative procedures such as multiple restorations, treatment of abscesses and/or oral surgical procedures, if authorization documentation indicates that in-office treatment (nitrous oxide, conscious sedation, or IV sedation) is not appropriate and hospitalization is not solely based upon reducing, avoiding or controlling apprehension, or upon provider or member convenience (Please be sure to review *Required Documentation* above.)	❑
2. Patients requiring extensive dental procedures and classified by the American Society of Anesthesiologists (ASA) as class III or class IV (Class III – patients with uncontrolled disease or significant systemic disease; Class IV – patients with severe systemic disease that is a constant threat to life)	❑
3.Medically compromised patients whose medical history indicates that the monitoring of vital signs and the availability of resuscitative equipment is necessary during extensive dental procedures	❑
4.Patients requiring extensive dental procedures with a medical history of Intellectual and Developmental Disabilities (IDD) and/or acquired disabilities necessitating treatment under general anesthesia.	❑
5.Patients requiring extensive dental procedures who have documentation of psychosomatic disorders that require special treatment	❑
6.Cognitively disabled individuals requiring extensive dental procedures whose prior history indicates hospitalization is appropriate	❑

Diagnostic-quality preoperative radiographs and/or photographs taken before the patient is admitted to the hospital or outpatient facility or before treatment begins must be present in the patient's chart. Documentation examined as part of a retrospective review must substantiate the treatment rendered. If treatment cannot be confirmed as medically necessary during an audit, paid claims may be recouped.

SKYGEN

Benefit Plan Detail and Preauthorization Requirements

The following benefit plan details and related preauthorization requirements apply to the Maryland Healthy Smiles Dental Program benefit plans:

- Maryland Children (Under Age 21)
- Maryland REM Children (Under Age 21)
- Maryland REM Adults (Age 21 and Older)
- Maryland Pregnant and Postpartum Adult (Age 21 and Older)
- Maryland Former Foster Care (Age 21 to 25)
- Maryland Adult Dental Plan (Age 21 and Older) *Effective 1/1/2023*

Note: If ***update** appears beneath a code number in the table, the code is revised. The revision and effective date are available in the Revision History: Version 16 section.

*Please note that participants whose eligibility indicates **"MD NO DENTAL"** do not have dental benefits or dental coverage under MHSDP.*

For children under age 21, the benefits, limitations, and preauthorization requirements are identical between the Medicaid and REM plans. The only difference is the REM plan allows prophylaxis, full mouth debridement, and bitewings-two single radiographic images (D0272) more frequently. For adults age 21 and over, the benefits, limitations, and preauthorization requirements are identical between the Medicaid and REM plans. The only difference is the REM plan allows prophylaxis, full mouth debridement, and bitewings-two single radiographic images (D0272) more frequently.

In the following tables, if '**yes**' is indicated in the **Preauthorization** column, then a service requires a preauthorization. If documentation is indicated in the **Requirement** column, then supporting documentation is required before the preauthorization can be approved or the claim can be paid. When a preauthorization is required, submit it (along with any required documentation) to SKYGEN for approval before beginning non-emergency or routine treatment. If immediate treatment is required in an emergency, submit required documentation after treatment with the claim. For more information about the preauthorization submission process and requirements please see the Preauthorization Requirements and Clinical Criteria section of this provider manual.

Children/REM Children (under 21), Former Foster Care (21 to 25)

For children under age 21, the benefits, limitations, and preauthorization requirements are identical between the Medicaid and REM plans. The only difference is the REM plan allows prophylaxis, full mouth debridement, and bitewings-two single radiographic images (D0272) more frequently. See **'Limitations'** column below for additional details.

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
D0120	Periodic oral evaluation-established patient	0-25		Two of (D0120) per 12 months per patient. Cannot be billed within 120 days as (D0150, D0145 or D0160) by the same provider or location.	No	
D0140	Limited oral evaluation-problem focused	0-25		Not reimbursable on the same day as D0120, D0145, D0150 or D0160. Not allowed with Routine Services.	No	
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	0-2		Two of (D0145) per 12 months per provider OR location. Cannot be billed within 120 days as (D0120, D0150 or D0160) by the same provider or location.	No	
D0150	Comprehensive oral evaluation-new or established patient	0-25		One of (D0150) per provider OR location every 3 years. Cannot be billed within 120 days as (D0120, D0145 or D0160) by the same provider or location.	No	
D0160	Detailed and extensive oral evaluation-problem focused, by report	0-25		One of (D0160) per provider OR location every 3 years. Cannot be billed within 120 days as (D0120, D0145 or D0150) by the same provider or location.	No	

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
D0210	Intraoral-comprehensive series of radiographic images	0-25		One of (D0210) per 36 months per provider OR location. One of (D0210, D0330) per 36 months per provider.	No	
D0220	Intraoral-periapical first radiographic image	0-25		One of (D0220) allowed on the same DOS of endodontic treatment.	No	
D0230	Intraoral-periapical each additional radiographic image	0-25			No	
D0240	Intraoral-occlusal radiographic image	0-25		Two of (D0240) per 12 months per patient.	No	
D0250	Extraoral-first radiographic image	0-25			No	
D0270	Bitewing-single radiographic image	2-25		One of (D0270, D0272, D0273, D0274) per 6 months per provider.	No	
D0272	Bitewings-two radiographic images	2-25		One of (D0270, D0272, D0273, D0274) per 6 months per provider.	No	
D0273	Bitewings-three radiographic images	10-25		One of (D0270, D0272, D0273, D0274) per 6 months per provider.	No	
D0274	Bitewings-four radiographic images	10-25		One of (D0270, D0272, D0273, D0274) per 6 months per provider.	No	
D0310	Sialography	0-25			No	
D0320	Temporomandibular joint arthrogram, including injection	0-25			No	
D0321	Other temporomandibular joint films, by report	0-25			No	
D0330	Panoramic radiographic image	6-25		One of (D0330) per 36 months per provider OR location. One of (D0210, D0330) per 36 months per provider. Non orthodontic cases.	No	

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
D0340	Cephalometric radiographic image	0-25		One of (D0340) per 36 months per patient. Non-orthodontic cases.	No	Narrative of medical necessity submitted with claim
D0431	Adjunctive pre-diagnostic test that: aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	0-20		One D0431 per 12 months per patient.	No	Narrative of medical necessity submitted with claim
D0460	Pulp vitality tests	0-25		One per visit. Includes multiple teeth and contralateral comparison(s), as indicated.	No	
D1110	Prophylaxis-adult	14-25		One of (D1110, D1120) per 3 months per patient only for REM Children Under 21. Two of (D1110, D1120) per 12 months per patient for all other children under 21. Minimum of 120 days between prophylaxis. Includes scaling and polishing procedures to remove coronal plaque, calculus and stains.	No	
D1120	Prophylaxis-child	0-13		One of (D1110, D1120) per 3 months per patient only for REM Children Under 21. Two of (D1110, D1120) per 12 months per patient for all other children under 21. Minimum of 120 days between prophylaxis. Includes scaling and polishing procedures to remove coronal plaque, calculus and stains.	No	

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
D1206	Topical application of fluoride varnish	0-5		Four of (D1206) per 12 months per patient per provider. Maximum 8 of (D1206) per 12 months per patient regardless of provider. Minimum of 30 days required between applications.	No	
D1206	Topical application of fluoride varnish	6-25		Four of (D1206) per 12 months per patient per provider. Minimum of 30 days required between applications.	No	
D1208	Topical application of fluoride- excluding varnish	0-25		One of (D1208) per 3 months per patient for REM Children Under 21 only. One of (D1208) per 6 months per patient for all other children under 21.	No	
D1330	Oral hygiene instructions	0-25		One of (D1330) per 12 months per patient.	No	
D1351	Sealant-per tooth	0-25	2-5, 12-15, 18-21, 28-31	One of (D1351, D1352) per 1 lifetime per patient per tooth. Covered only for the occlusal surfaces of posterior permanent teeth without restorations or decay.	No	
D1352	Preventive resin restoration	0-25	2-5, 12-15, 18-21, 28-31	One of (D1351, D1352) per 1 lifetime per patient per tooth. Covered only for the occlusal surfaces of posterior permanent teeth without restorations or decay.	No	
D1354	Interim Caries Arresting Medicament Application - per tooth	0-6	1-32, A-T	1 of (D1354) per six months per tooth; 4 applications per tooth per lifetime max. No restorations or extractions within 6 months of application. Cannot bill	No	

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
				on same day as D3110, D3120, D2941 or D9910. Parent/Guardian must be present to sign the SDF specific consent form and discuss treatment plan.		
D1354	Interim Caries Arresting Medicament Application - per tooth	7-25	1-32, A-T	1 of (D1354) per six months per tooth; 4 applications per tooth per lifetime max. No restorations or extractions within 6 months of application. Cannot bill on same day as D3110, D3120, D2941 or D9910. Parent/Guardian must be present to sign the SDF specific consent form and discuss treatment plan.	**Yes**	Narrative of medical necessity; photos optional.
D1510	Space maintainer-fixed-unilateral	0-25	LL, LR, UR, UL	One of (D1510) per 24 months per patient per quadrant	No	
D1516	Space maintainer – fixed – bilateral, maxillary	0-25		One per 24 months for D1516 or D1526	No	
D1517	Space maintainer – fixed – bilateral, mandibular	0-25		One per 24 months for D1517 or D1527	No	
D1520	Space maintainer-removable-unilateral	0-25	LL, LR, UR, UL	One of (D1520) per 24 months per patient per quadrant	No	
D1526	Space maintainer – removable– bilateral, maxillary	0-25		One per 24 months for D1516 or D1526	No	
D1527	Space maintainer – removable– bilateral, mandibular	0-25		One per 24 months for D1517 or D1527	No	
D1553	Re-cement or re-bond unilateral space maintainer-per quadrant	0-25	LL, LR, UR, UL	Not covered within 6 months of initial placement.	No	

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
D1556	Removal of fixed unilateral space maintainer- per quadrant	0-25	LL, LR, UR, UL	Not allowed by the dental office that provided initial placement.	No	
D2140	Amalgam-one surface, primary or permanent	0-25	1-32, A-T	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 months per patient per tooth, per surface. One of (D2140, D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per six months per patient per tooth regardless of surface.	No	
D2150	Amalgam - two surfaces, primary or permanent	0-25	1-32, A-T	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 months per patient per tooth, per surface. One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per six months per patient per tooth regardless of surface.	No	
D2160	Amalgam-three surfaces, primary or permanent	0-25	1-32, A-T	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 months per patient per tooth, per surface. One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per six months per patient per tooth regardless of surface.	No	

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
D2161	Amalgam-four or more surfaces, primary or permanent	0-25	1-32, A-T	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 months per patient per tooth, per surface. One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per six months per patient per tooth regardless of surface.	No	
D2330	Resin-based composite-one surface, anterior	0-25	6-11, 22-27, C-H, M-R	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 months per patient per tooth, per surface. One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per six months per patient per tooth regardless of surface.	No	
D2331	Resin-based composite-two surfaces, anterior	0-25	6-11, 22-27, C-H, M-R	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 months per patient per tooth, per surface. One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per six months per patient per tooth regardless of surface.	No	

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
D2332	Resin-based composite-three surfaces, anterior	0-25	6-11, 22-27, C-H, M-R	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 months per patient per tooth, per surface. One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per six months per patient per tooth regardless of surface.	No	
D2335	Resin-based composite-four or more surfaces	0-25	6-11, 22-27, C-H, M-R	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 months per patient per tooth, per surface. One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per six months per patient per tooth regardless of surface.	No	
D2390	Resin-based composite crown, anterior	0-25	6-11, 22-27, C-H, M-R	Not payable on the same day of service as D3310-D3348.	No	
D2391	Resin-based composite-one surface, posterior	0-25	1-5, 12-21, 28-32, A, B, I- L, S, T	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 months per patient per tooth, per surface. One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per six months per patient per tooth regardless of surface.	No	

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
D2392	Resin-based composite-two surfaces, posterior	0-25	1-5, 12-21, 28-32, A, B, I- L, S, T	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 months per patient per tooth, per surface. One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per six months per patient per tooth regardless of surface.	No	
D2393	Resin-based composite-three surfaces, posterior	0-25	1-5, 12-21, 28-32, A, B, I- L, S, T	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 months per patient per tooth, per surface. One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per six months per patient per tooth regardless of surface.	No	
D2394	Resin-based composite-four or more surfaces, posterior	0-25	1-5, 12-21, 28-32, A, B, I- L, S, T	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per 24 months per patient per tooth, per surface. One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per six months per patient per tooth regardless of surface.	No	
D2721	Crown-resin with predominantly base metal	0-25	1-32	One of (D2721) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative X-ray showing apex of tooth

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
D2740	Crown-porcelain/ceramic substrate	0-25	1-32	One of (D2740) per 60 months per patient per Tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative X-ray showing apex of tooth
D2750	Crown-porcelain fused to high noble metal	0-25	1-32	One of (D2750) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative X-ray showing apex of tooth
D2751	Crown-porcelain fused to predominantly base metal	0-25	1-32	One of (D2751) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative X-ray showing apex of tooth
D2752	Crown-porcelain fused to noble metal	0-25	1-32	One of (D2752) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative X-ray showing apex of tooth
D2780	Crown-¾ cast high noble metal	0-25	1-32	One of (D2780) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative X-ray showing apex of tooth
D2781	Crown-¾ cast predominantly base metal	0-25	1-32	One of (D2781) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative X-ray showing apex of tooth
D2782	Crown-¾ cast noble metal	0-25	1-32	One of (D2782) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative X-ray showing apex of tooth
D2783	Crown-¾ porcelain/ceramic	0-25	1-32	One of (D2783) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative X-ray showing apex of tooth

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
D2790	Crown-full cast high noble metal	0-25	1-32	One of (D2790) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative X-ray showing apex of tooth
D2791	Crown-full cast predominantly base metal.	0-25	1-32	One of (D2791) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative X-ray showing apex of tooth
D2792	Crown-full cast noble metal	0-25	1-32	One of (D2792) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative X-ray showing apex of tooth
D2794	Crown-titanium	0-25	1-32	One of (D2794) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative X-ray showing apex of tooth
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	0-25	1-32		No	
D2920	Re-cement or re-bond crown	0-25	1-32, A-T	Not allowed within 6 months of initial placements.	No	
D2928	Prefabricated porcelain/ceramic crown-permanent tooth	0-25	1-5, 12-21, 28-32	One of (D2928) per 36 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	No	
D2929	Prefabricated porcelain/ceramic crown-primary tooth	0-25	C-H, M-R	One of (D2929) per 36 months per patient per tooth.	**Yes**	Pre-operative X-ray showing apex of tooth
D2930	Prefabricated stainless steel crown -primary tooth	0-25	A-T	One of (D2930) per 36 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	No	
D2931	Prefabricated stainless steel crown- permanent tooth	0-25	1-32	One of (D2931) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	No	
D2932	Prefabricated resin crown	0-25	6-11, 22-27, C-H, M-R	One of (D2932) per 36 months per patient per tooth. Not payable on the same day of service as D3310-D3348	No	

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
D2933	Prefabricated stainless steel crown with resin window	0-25	6-11, 22-27, C-H, M-R	One of (D2933) per 36 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	No	
D2934	Prefabricated esthetic coated stainless steel crown-primary tooth	0-25	A-T	One of (D2934) per 36 months per patient per tooth.	No	
D2940 *update	Placement of interim direct restoration	0-25	1-32, A-T	One of (D2940) per tooth per lifetime. Temporary restoration intended to relieve pain. Not to be used as a base or liner under a restoration.	No	
D2950	Core buildup, including any pins when required	0-25	1-32	One of (D2950) per 60 months per patient per tooth. One of (D2950, D2952, D2954) per 60 months per patient per tooth. Refers to building up of anatomical crown when restorative crown will be placed. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative X-rays
D2951	Pin retention-per tooth, in addition to restoration	0-25	1-32		No	
D2952	Cast post and core in addition to crown	0-25	1-32	One of (D2952) per 60 months per patient per tooth. One of (D2950, D2952, D2954) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative X-rays
D2954	Prefabricated post and core in addition to crown	0-25	1-32	One of (D2954) per 60 months per patient per tooth. One of (D2950, D2952, D2954) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative X-rays

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
D2955	Post removal (not in conjunction with endodontic therapy)	0-25	1-32	Not covered with D3346, D3347, or D3348 on same day of service.	**Yes**	Pre-operative X-rays
D2960 *update	Labial veneer (laminate)-chair	0-25	6-11	One of (D2960) per 60 months per patient per tooth.	**Yes**	Pre-operative periapical X-ray, narrative of medical necessity
D2961 *update	Labial veneer (resin laminate)- laboratory	0-25	6-11	One of (D2961) per 60 months per patient per tooth.	**Yes**	Pre-operative periapical X-ray, narrative of medical necessity
D2962 *update	Labial veneer (porcelain laminate)- laboratory	0-25	6-11	One of (D2962) per 60 months per patient per tooth.	**Yes**	Pre-operative periapical X-ray, narrative of medical necessity
D2980	Crown repair, by report	0-25	1-32		No	
D3110	Pulp cap-direct (excluding final restoration)	0-25	1-32		No	
D3120	Pulp cap-indirect (excluding final restoration)	0-25	1-32, A-T		No	
D3220	Therapeutic pulpotomy (excluding final restoration)- removal of pulp coronal to the dentinocemental junction and application of medicament	0-25	1-32, A-T		No	
D3221	Pulpal debridement, primary and permanent teeth	0-25	1-32, A-T		No	
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	0-25	C-H, M-R	One of (D3230) per 1 lifetime per patient per tooth.	No	
D3240	Pulpal therapy (resorbable filling)- posterior, primary tooth (excluding final restoration)	0-25	A, B, I-L, S, T	One of (D3240) per 1 lifetime per patient per tooth.	No	

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	0-25	6-11, 22-27	One of (D3310) per 1 lifetime per patient per tooth. Not payable on the same day of service as D2390, D2721-D2794, D2929-D2934, D2950, D2952, or D2954.	**Yes**	Pre-operative X-rays
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	0-25	4, 5, 12, 13, 20, 21, 28, 29	One of (D3320) per 1 lifetime per patient per tooth. Not payable on the same day of service as D2390, D2721-D2794, D2929-D2934, D2950, D2952, or D2954.	**Yes**	Pre-operative X-rays
D3330	Endodontic therapy, molar (excluding final restoration)	0-25	1-3, 14-19, 30-32	One of (D3330) per lifetime per patient per tooth. Not payable on the same day of service as D2390, D2721-D2794, D2929-D2934, D2950, D2952, or D2954. Not payable within 30 days of (D3220)	**Yes**	Pre-operative X-rays
D3346	Retreatment of previous root canal therapy-anterior	0-25	6-11, 22-27	One of (D3346) per lifetime per patient per tooth. Not allowed within 24 months of initial treatment by the same dentist or dental office per tooth. Not payable on the same day of service as D2390, D2721-D2794, D2929-D2934, D2950, D2952, or D2954.	**Yes**	Pre-operative X-rays (excluding bitewings)
D3347	Retreatment of previous root canal therapy-bicuspid	0-25	4, 5, 12, 13, 20, 21, 28, 29	Not allowed within 24 months of initial treatment by the same dentist or dental office per tooth. Not payable on the same day of service as D2390, D2721-D2794, D2929-D2934, D2950, D2952, or D2954.	**Yes**	Pre-operative X-rays (excluding bitewings)

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
D3348	Retreatment of previous root canal therapy-molar	0-25	1-3, 14-19, 30-32	One of (D3348) per lifetime per patient per tooth. Not allowed within 24 months of initial treatment by the same dentist or dental office per tooth. Not payable on the same day of service as D2390, D2721-D2794, D2929-D2934, D2950, D2952, or D2954. Not payable within 30 days of (D3220)	**Yes**	Pre-operative X-rays (excluding bitewings)
D3351	Apexification/recalcification-initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	0-25	1-32	One of (D3351) per lifetime per patient per tooth. Not allowed within 24 months of initial treatment by the same dentist or dental office per tooth. Not allowed after a D3310, D3320, D3330, D3346, D3347, or D3348.	**Yes**	Pre-operative X-rays (excluding bitewings)
D3352	Apexification/recalcification-interim medication replacement	0-25	1-32	One of (D3352) per lifetime per patient per tooth. Not allowed after a D3310, D3320, D3330, D3346, D3347, or D3348.	**Yes**	Date of initial apexification visit
D3353	Apexification/recalcification-final visit (includes completed root canal therapy-apical closure/calcific repair of perforations, root resorption, etc.)	0-25	1-32	One of (D3353) per lifetime per patient per tooth. Not allowed after a D3310, D3320, D3330, D3346, D3347, or D3348.	**Yes**	Date of initial apexification visit
D3410	Apicoectomy-anterior	0-25	6-11, 22-27	One of (D3410) per lifetime per patient per tooth.	**Yes**	Pre-operative X-rays (excluding bitewings)
D3421	Apicoectomy-bicuspid (first root)	0-25	4, 5, 12, 13, 20, 21, 28, 29	One of (D3421) per lifetime per patient per tooth.	**Yes**	Pre-operative X-rays (excluding bitewings)
D3425	Apicoectomy-molar (first root)	0-25	1-3, 14-19, 30-32	One of (D3425) per lifetime per patient per tooth.	**Yes**	Pre-operative X-rays (excluding bitewings)

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
D3426	Apicoectomy (each additional root)	0-25	1-5, 12-21, 28-32	One of (D3426) per lifetime per patient per tooth.	**Yes**	Pre-operative X-rays (excluding bitewings)
D3430	Retrograde filling-per root	0-25	1-32	One of (D3430) per lifetime per patient per tooth.	**Yes**	Pre-operative X-rays (excluding bitewings)
D3450	Root amputation-per root	0-25	1-32	One of (D3450) per lifetime per patient per tooth.	**Yes**	Pre-operative X-rays (excluding bitewings)
D3470	Intentional reimplantation	0-25	1-32	One of (D3470) per lifetime per patient per tooth.	**Yes**	Narrative of medical necessity, pre-operative X-rays
D3920	Hemisection (including any root removal), not including root canal therapy	0-25	1-3, 14-19, 30-32	One of (D3920) per lifetime per patient per tooth.	**Yes**	Pre-operative X-rays (excluding bitewings)
D4210	Gingivectomy or gingivoplasty-four or more contiguous teeth or tooth bounded spaces per quadrant	0-25	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	One of (D4210) per 24 months per patient per quadrant. One of (D4210, D4211) per 24 months per patient per quadrant. One of each quadrant per 24 months, a minimum of four teeth in the affected quadrant. Limited to two quadrants per 12 months.	**Yes**	Pre-operative X-rays, periodontal charting, narrative of medical necessity; photos optional
D4211	Gingivectomy or gingivoplasty-one to three contiguous teeth or tooth bounded spaces per quadrant	0-25	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	One of (D4211) per 24 months per patient per quadrant. One of (D4210, D4211) per 24 months per patient per quadrant. One of each quadrant per 24 months, a minimum of four teeth in the affected quadrant. Limited to two quadrants per 12 months.	**Yes**	Pre-operative X-rays, periodontal charting, narrative of medical necessity; photos optional
D4230	Anatomical crown exposure-4+ teeth per quad	0-25		One of (D4230) per lifetime per patient.	**Yes**	Pre-operative X-rays, periodontal charting, narrative of medical necessity; photos

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
						optional
D4231	Anatomical crown exposure-1 to 3 teeth per quad	0-25		One of (D4231) per lifetime per patient.	**Yes**	Pre-operative X-rays, periodontal charting, narrative of medical necessity; photos optional
D4240	Gingival flap procedure, including root planing-four or more contiguous teeth or tooth bound spaces per quadrant	0-25	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	One of (D4240) per 24 months per patient per quadrant. One of (D4240, D4241) per 24 months per patient per quadrant. A minimum of four teeth in the affected quadrant.	**Yes**	Pre-operative X-rays, periodontal charting, narrative of medical necessity; photos optional
D4241	Gingival flap procedure, including root planing-one to three contiguous teeth or tooth bound spaces per quadrant	0-25	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	One of (D4241) per 24 months per patient per quadrant. One of (D4240, D4241) per 24 months per patient per quadrant. A minimum of four teeth in the affected quadrant.	**Yes**	Pre-operative X-rays, periodontal charting, narrative of medical necessity; photos optional
D4249	Clinical crown lengthening-hard tissue	0-25	1-32	One of (D4249) per 24 months per patient per tooth. Crown lengthening requires reflection of a flap.	**Yes**	Narrative of medical necessity, pre-operative X-rays, periodontal charting; photos optional
D4260	Osseous surgery (including elevation of a full thickness flap and closure)- four or more contiguous teeth or tooth bounded spaces per quadrant	0-25	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	One of (D4260) per 24 months per patient per quadrant. One of (D4260, D4261) per 24 months per patient per quadrant. Minimum of four teeth in the affected quadrant.	**Yes**	Pre-operative X-rays, periodontal charting, narrative of medical necessity; photos optional

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
D4261	Osseous surgery (including elevation of a full thickness flap and closure)- one to three contiguous teeth or tooth bounded spaces per quadrant	0-25	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	One of (D4261) per 24 months per patient per quadrant. One of (D4260, D4261) per 24 months per patient per quadrant. Minimum of four teeth in the affected quadrant.	**Yes**	Pre-operative X-rays, periodontal charting, narrative of medical necessity; photos optional
D4322	Splint-intra-coronal natural teeth or prosthetic crown	0-25	Per Arch (01, 02, LA, UA)		No	Narrative of medical necessity and pre-operative X-rays or photos submitted with claim
D4323	Splint-extra-coronal natural teeth or prosthetic crown	0-25	Per Arch (01, 02, LA, UA)		No	Narrative of medical necessity and pre-operative X-rays or photos submitted with claim
D4341	Periodontal scaling and root planning - four or more teeth per quadrant	0-25	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	One of (D4341, D4342) per 24 months per patient per quadrant. A minimum of four teeth in the affected quadrant. Limited to permanent dentition.	**Yes**	Pre-operative X-rays, periodontal charting
D4342	Periodontal scaling and root planning - one to three teeth per quadrant	0-25	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	One of (D4341, D4342) per 24 months per patient per quadrant. One to three teeth in the affected quadrant. Limited to permanent dentition.	**Yes**	Pre-operative X-rays, periodontal charting
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	0-25		One of (D4355) per 12 months per patient for REM Children Under 21 only. One of (D4355) per 24 months per patient for all other children under 21. Not allowed on the same day as	No	Narrative of medical necessity and pre-operative X-rays or photos submitted with claim

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
				D1110.		
D4910	Periodontal maintenance procedures	0-25		Two of (D4910) per 12 months per patient. (Not allowed within 90 days of D4341 and D4342)	**Yes**	Date of previous periodontal surgical or SRP service
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	0-25		Not payable original treating dentist.	**Yes**	Narrative of medical necessity, name of original treating dentist
D5110	Complete denture-maxillary	0-25	Per Arch (01, UA)	One of (D5110) per 60 months per patient.	**Yes**	Full mouth X-rays or panorex
D5120	Complete denture-mandibular	0-25	Per Arch (02, LA)	One of (D5120) per 60 months per patient.	**Yes**	Full mouth X-rays or panorex
D5211	Maxillary partial denture-resin base (including any conventional clasps, rests and teeth)	0-25		One of (D5211, D5225) per 60 months per patient.	**Yes**	Full mouth X-rays or panorex
D5212	Mandibular partial denture-resin base (including any conventional clasps, rests and teeth)	0-25		One of (D5212, D5226) per 60 months per patient.	**Yes**	Full mouth X-rays or panorex
D5225	Maxillary partial denture-flexible base	0-25		One of (D5211, D5225) per 60 months per patient.	**Yes**	Full mouth X-rays or panorex
D5226	Mandibular partial denture-flexible base	0-25		One of (D5212, D5226) per 60 months per patient.	**Yes**	Full mouth X-rays or panorex
D5410	Adjust complete denture-maxillary	0-25		Not covered within six months of placement.	No	
D5411	Adjust complete denture-mandibular	0-25		Not covered within six months of placement.	No	

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
D5421	Adjust partial denture- maxillary	0-25		Not covered within six months of placement.	No	
D5422	Adjust partial denture- mandibular	0-25		Not covered within six months of placement.	No	
D5511	Repair broken complete denture base, mandibular	0-25			No	
D5512	Repair broken complete denture base, maxillary	0-25			No	
D5520	Replace missing or broken teeth- complete denture- per tooth	0-25	1-32		No	
D5611	Repair resin partial denture base, mandibular	0-25			No	
D5612	Repair resin partial denture base, maxillary	0-25			No	
D5621	Repair cast partial framework, mandibular	0-25			No	
D5622	Repair cast partial framework, maxillary	0-25			No	
D5630	Repair or replace broken clasp	0-25			No	
D5640	Replace missing or broken teeth- partial denture- per tooth	0-25	1-32		No	
D5650 *update	Add tooth to existing partial denture- per tooth	0-25	1-32		No	
D5660 *update	Add clasp to existing partial denture	0-25			No	
D5710 *update	Rebase complete maxillary denture	0-25		One of (D5710, D5750) per 24 months per patient. Not covered within six months of placement.	**Yes**	Date of service of denture

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
D5711 *update	Rebase complete mandibular denture	0-25		One of (D5711, D5751) per 24 months per patient. Not covered within six months of placement.	**Yes**	Date of service of denture
D5720 *update	Rebase maxillary partial denture	0-25		One of (D5720, D5760) per 24 months per patient. Not covered within 6 months of placement.	**Yes**	Date of service of denture
D5721 *update	Rebase mandibular partial denture	0-25		One of (D5721, D5761) per 24 months per patient. Not covered within six months of placement.	**Yes**	Date of service of denture
D5750 *update	Reline complete maxillary denture (laboratory)	0-25		One of (D5750, D5710) per 24 months per patient. Not covered within six months of placement.	No	
D5751 *update	Reline complete mandibular denture (laboratory)	0-25		One of (D5751, D5711) per 24 months per patient. Not covered within six months of placement.	No	
D5760 *update	Reline maxillary partial denture (laboratory)	0-25		One of (D5760, D5720) per 24 months per patient. Not covered within six months of placement.	No	
D5761 *update	Reline mandibular partial denture (laboratory)	0-25		One of (D5761, D5721) per 24 months per patient. Not covered within six months of placement.	No	
D5850	Tissue conditioning, maxillary	0-25		Prior to the new denture impression only.	No	
D5851	Tissue conditioning, mandibular	0-25		Prior to the new denture impression only.	No	
D5863	Overdenture-complete maxillary	0-25		One of (D5863) per 60 months per patient.	**Yes**	Narrative of medical necessity, pre-operative

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
						X-rays
D5864	Overdenture-partial maxillary	0-25		One of (D5864) per 60 months per patient.	**Yes**	Narrative of medical necessity, pre-operative X-rays
D5865	Overdenture-complete mandibular	0-25		One of (D5865) per 60 months per patient.	**Yes**	Narrative of medical necessity, pre-operative X-rays
D5866	Overdenture-partial mandibular	0-25		One of (D5866) per 60 months per patient.	**Yes**	Narrative of medical necessity, pre-operative X-rays
D5992	Adjust maxillofacial prosthetic appliance, by report	0-25	Per Arch (01, 02, LA, UA)	One of (D5992) per 6 months per patient per arch.	**Yes**	Narrative of medical necessity
D5993	Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral) other than required adjustments.	0-25	Per Arch (01, 02, LA, UA)	One of (D5993) per 6 months per patient per arch.	**Yes**	Narrative of medical necessity
D6930	Re-cement or re-bond fixed partial denture	0-25			No	
D7111	Extraction, coronal remnants-deciduous tooth	0-25	A-T		No	
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0-25	1-32, 51-82, A-T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS		No	

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	0-25	1-32, 51-82, A-T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS		No	
D7220	Removal of impacted tooth-soft tissue	0-25	1-32, 51-82	Removal of asymptomatic tooth not covered.	No	
D7230	Removal of impacted tooth-partially bony	0-25	1-32, 51-82	Removal of asymptomatic tooth not covered.	No	
D7240	Removal of impacted tooth-completely bony	0-25	1-32, 51-82	Removal of asymptomatic tooth not covered.	No	
D7241	Removal of impacted tooth-completely bony, with unusual surgical complications	0-25	1-32, 51-82	Removal of asymptomatic tooth not covered.	**Yes**	Narrative of medical necessity, pre-operative X-rays (excluding bitewings)
D7250	Surgical removal of residual tooth roots (cutting procedure)	0-25	1-32, 51-82, A-T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Not paid to the dentist or group that removed the tooth.	**Yes**	Narrative of medical necessity, pre-operative X-rays (excluding bitewings)

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
D7251	Coronectomy-intentional partial tooth removal, impacted teeth only, performed when a neurovascular complication is likely if the entire impacted tooth is removed.	0-25	1-32, 51-82, A-T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	One of (D7251) per lifetime per patient per tooth.	**Yes**	Narrative of medical necessity, pre-operative X-rays (excluding bitewings)
D7260	Oroantral fistula closure	0-25			**Yes**	Narrative of medical necessity
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	0-25	1-32	Includes splinting and/or stabilization.	**Yes**	Narrative of medical necessity
D7272	Tooth transplantation (includes reimplantation from one site to another)	0-25	1-32	One of (D7272) per lifetime per patient per tooth.	**Yes**	Narrative of medical necessity
D7280	Surgical access of an unerupted tooth	0-25	1-32	Not payable unless the orthodontic treatment has been authorized as a covered benefit.	**Yes**	Narrative of medical necessity, pre-operative X-rays
D7284 ***update**	Excisional biopsy of minor salivary glands	0-25		Not payable on the same day of service as D7286.	**No**	Copy of pathology report submitted with claim
D7285	Incisional biopsy of oral tissue-hard (bone, tooth)	0-25			No	Copy of pathology report submitted with claim
D7286	Incisional biopsy of oral tissue-soft	0-25			No	Copy of pathology report submitted with claim
D7290	Surgical repositioning of teeth	0-25	1-32	One of (D7290) per lifetime per patient per tooth. Includes all teeth on the same day of service.	**Yes**	Narrative of medical necessity, pre-operative X-rays

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
D7310	Alveoloplasty in conjunction with extractions-four or more teeth or tooth spaces, per quadrant	0-25	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	One of (D7310, D7311) per lifetime per patient per quadrant. Minimum of three extractions in the affected quadrant.	No	Pre-operative X-rays (excluding bitewings) submitted with claim
D7311	Alveoloplasty in conjunction with extractions-one to three teeth or tooth spaces, per quadrant	0-25	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	One of (D7310, D7311) per lifetime per patient per quadrant.	**Yes**	Pre-operative X-rays (excluding bitewings)
D7320	Alveoloplasty not in conjunction with extractions-four or more teeth or tooth spaces, per quadrant	0-25	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	One of (D7320, D7321) per lifetime per patient per quadrant. No extractions performed in an edentulous area.	**Yes**	Narrative of medical necessity, pre-operative X-rays (excluding bitewings)
D7321	Alveoloplasty not in conjunction with extractions-one to three teeth or tooth spaces, per quadrant	0-25	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	One of (D7320, D7321) per lifetime per patient per quadrant. No extractions performed in an edentulous area.	**Yes**	Narrative of medical necessity, pre-operative X-rays (excluding bitewings)
D7340	Vestibuloplasty-ridge extension (secondary epithelialization)	0-25	Per Arch (01, 02, LA, UA)		**Yes**	Narrative of medical necessity, pre-operative X-rays (excluding bitewings)
D7350	Vestibuloplasty-ridge extension	0-25	Per Arch (01, 02, LA, UA)		**Yes**	Narrative of medical necessity, pre-operative X-rays (excluding bitewings)
D7410	Radical excision-lesion diameter up to 1.25cm	0-25			No	Copy of pathology report submitted with claim
D7440	Excision of malignant tumor-lesion diameter up to 1.25cm	0-25			No	Copy of pathology report submitted with claim

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
D7450	Removal of odontogenic cyst or tumor-lesion diameter up to 1.25cm	0-25			No	Copy of pathology report submitted with claim
D7451	Removal of odontogenic cyst or tumor-lesion greater than 1.25cm	0-25			No	Copy of pathology report submitted with claim
D7460	Removal of nonodontogenic cyst or tumor-lesion diameter up to 1.25cm	0-25			No	Copy of pathology report submitted with claim
D7461	Removal of nonodontogenic cyst or tumor-lesion greater than 1.25cm	0-25			No	Copy of pathology report submitted with claim
D7471	Removal of exostosis-per site	0-25	Per Arch (01, 02, LA, UA)		**Yes**	Narrative of medical necessity, X-rays or photos optional
D7472	Removal of torus palatinus	0-25			**Yes**	Narrative of medical necessity, X-rays or photos optional
D7473	Removal of torus mandibularis	0-25			**Yes**	Narrative of medical necessity, X-rays or photos optional
D7510	Incision and drainage of abscess- intraoral soft tissue	0-25	1-32, 51-82, A-T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS		No	
D7520	Incision and drainage of abscess- extraoral soft tissue	0-25			No	

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	0-25	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)		No	
D7961	Bucal / Labial Frenulectomy – separate procedure not incidental to another procedure	0-25		One of (D7961) per lifetime per patient. The frenum may be excised when the tongue has limited mobility; for large diastemas between teeth; or when the frenum interferes with a prosthetic appliance; or when it is the etiology of periodontal tissue disease.	**Yes**	Narrative of medical necessity, X-rays or photos optional
D7962	Lingual Frenulectomy – separate procedure not incidental to another procedure	0-25		One of (D7962) per lifetime per patient. The frenum may be excised when the tongue has limited mobility; for large diastemas between teeth; or when the frenum interferes with a prosthetic appliance; or when it is the etiology of periodontal tissue disease.	**Yes**	Narrative of medical necessity, X-rays or photos optional
D7970	Excision of hyperplastic tissue-per arch	0-25	Per Arch (01, 02, LA, UA)	For removal of tissue over a previous edentulous denture bearing area to improve prognosis of a proposed denture.	No	
D7971	Excision of pericoronal gingiva	0-25	1-32	One of (D7971) per lifetime per patient per tooth.	No	

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
D8080	Comprehensive orthodontic treatment of the adolescent or adult dentition. Inclusive of banding, debanding, adjunctive appliances and retention. Covered if HLD 15 or above	0-25		One of (D8080) per lifetime per patient. Inclusive of adjunctive appliances such as, but not limited to, palatal expanders, habit appliances, fixed bite plates, and fixed functional appliances. One of (D8080) is comprehensive and includes treatment for broken, repaired, or replacement of brackets or wires. participants may not be billed for this treatment	**Yes**	Pretreatment documentation of D8660 along with the quantity of adjustments D8670 requested, Ceph X-ray, Panorex or FMX, 6-8 diag quality extra-oral/intra-oral photos, clinical summary with diagnosis, completed HLD score sheet, and treatment plan.
D8090	Comprehensive orthodontic treatment of the adolescent or adult dentition using self-ligating appliances	0-25		Code allowed only for comprehensive orthodontic cases where self-ligating appliances are used. Not a separately reimbursable service. One of (D8090) per lifetime per patient.	**Yes**	Pretreatment documentation of D8660, D8080 along with the quantity of adjustments D8670 requested, (maximum of 12) Ceph X-ray, Panorex or FMX, 6-8 diag quality extra-oral/intra-oral photos, clinical summary with diagnosis, completed HLD score sheet, and treatment plan.
D8660	Pre-orthodontic treatment examination to monitor growth and development	0-25		Only reimbursable in conjunction with a request for comprehensive orthodontic treatment (D8080). One of (D8660) per 12 months per patient. Not reimbursable on the same date of service as consultation (D9310) per	No	D8660 will be denied if billed without D8080. D8660 will be denied when a D8080/D8090 is not approved due to mixed dentition (with the exceptions of cleft

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
				participant. Not reimbursable within 6 months of consultation (D9310) per provider or location.		palate, evidence of congenitally missing permanent dentition, or evidence that the ectopic position of a succedaneous tooth is resulting in the failed exfoliation of the associated primary tooth). Once D8080 and D8660 are approved, no additional D8660 will approve thereafter.
D8670	Periodic orthodontic treatment visit	0-25		24 of (D8670) per lifetime per patient. Maximum of 24 visits reimbursed. For comprehensive orthodontic treatment using self-ligating appliances (D8090), a maximum of 12 of (D8670) per 1 lifetime per patient.	**Yes**	Approved D8080 or D8080/D8090. The number of D8670's needed must be submitted on the preauthorization with D8660, D8080, (and D8090 if applicable) for the initial comprehensive treatment. The number of D8670's needed must be submitted on the preauthorization with D8999 and D8680 for continuation of care. All subsequent preauthorization requests for D8670 must be accompanied by the original approved preauthorization determination letter for

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
						D8080, D8080/D8090, or D8999 with the quantity requested.
D8680	Orthodontic retention (removal of appliances)	0-25		One of (D8680) per lifetime per patient. Only payable when the original payee differs from the payee performing the continuation of care for debanding and retention. Must have approved D8999 on file.	**Yes**	6-8 diagnostic quality extra-oral / intra-oral photos
D8698	Re-cement or re-bond fixed retainers- Maxillary	0-25		One of (D8698) allowed per patient within 24 months of the date of debanding. Must have approved D8080 or D8999 on file.	**Yes**	Narrative of active orthodontic case with date of debanding indicated
D8699	Re-cement or re-bond fixed retainer- Mandibular	0-25		One of (D8699) allowed per patient within 24 months of the date of debanding. Must have approved D8080 or D8999 on file.	**Yes**	Narrative of active orthodontic case with date of debanding indicated
D8703	Replacement of lost or broken retainer- Maxillary	0-25		One per arch per lifetime-Allowed within 24 months of date of debanding.	**Yes**	Narrative of active orthodontic case with date of debanding

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
				Must have approved D8080 or D8999 on file.		indicated
D8704	Replacement of lost or broken retainer- Mandibular	0-25		One per arch per lifetime- Allowed within 24 months of the date of debanding. Must have approved D8080 or D8999 on file.	**Yes**	Narrative of active orthodontic case with date of debanding indicated
D8999	Orthodontic Continuation of Care	0-25		One of (D8999) per lifetime per patient. The payee submitting for continuation of care must be different than the payee who originally banded the participant when the case was originally approved through the state of Maryland.	**Yes**	Completed Request Form: Continuation of Care, 6-8 diagnostic quality extra-oral/ intraoral photos, name and address of previous dentist, reason for COC request. Preauthorization must include a D8680 and the additional number of months that D8670 is requested (if remaining are available)
D9110 ***update**	Palliative (emergency) treatment of dental pain	0-25		Not allowed with any other services other than radiographs.	No	Narrative of medical necessity submitted with claim

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
D9222	Deep sedation/general anesthesia – first 15 minutes. Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties. The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetic effects upon the central nervous system and not dependent upon the route of administration	0-25		One per day.	No	
D9223	Deep sedation/general anesthesia- each 15 minutes	0-25		Maximum of 90 minutes (six units). Not paid with D9230, D9243, or D9248. Five per day (must have approved D9222) – existing code service edits.	No	
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	0-25		Not paid with D9223, D9243 or D9248.	No	

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
D9239	Intravenous moderate (conscious) sedation/analgesia—first 15 minutes Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties. The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetic effects upon the central nervous system and not dependent upon the route of administration.	0-25		One per day.	No	
D9243	Intravenous moderate (conscious) sedation/analgesia-each 15 minutes	0-25		Maximum of 90 minutes (six units). Not paid with D9223, D9230 or D9248. Five per day (must have approved D9239) – existing code service edits.	No	
D9248	Non-intravenous moderate (conscious) sedation	0-25		Not paid with 9223, D9230 or D9243.	No	

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
D9310	Consultation-diagnostic service provided by dentist or physician other than requesting dentist or physician	0-25		Diagnostic service provided by a dentist other than a practitioner providing treatment. Not covered within 90 days of D0120, D0140, or D0150. Not reimbursable on the same date of service as pre-orthodontic treatment examination (D8660) per participant. Not reimbursable within 6 months of pre-orthodontic treatment examination (D8660) per provider or location.	No	
D9410	House/extended care facility call	0-25			**Yes**	Yes, report required
D9420	Hospital or ambulatory surgical center call	0-25			No	Only billable with service when provider has been approved to provide services outside of their office in ASC or OP dept. of a hospital
D9910	Application of desensitizing medicament	0-25		One per visit. Not used for bases, liners or adhesives used under restorations.	No	
D9941	Fabrication of athletic mouthguard	0-25		One of (D9941) per 12 months per patient.	No	
D9944	occlusal guard – hard appliance, full arch	0-25		One per 24 months for codes (D9944-D9946)	No	
D9945	occlusal guard – soft appliance, full arch	0-25		One per 24 months for codes (D9944-D9946)	No	
D9946	occlusal guard – hard appliance, partial arch	0-25		One per 24 months for codes (D9944-D9946)	No	
D9951	Occlusal adjustment-limited	0-25		One of (D9951) per 12 months effective 6/1/18 Not covered with any restorative procedure on the same date of service.	No	Tooth number and narrative of medical necessity submitted with claim

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
D9952	Occlusal adjustment-complete	0-25		One of (D9952) per 12 months per patient. Not covered with any restorative procedure on the same date of service.	No	Full mouth X-rays, periodontal charting, restoration treatment plan, narrative of medical necessity submitted with claim
D9999	Unspecified adjunctive procedure by report	0-25			**Yes**	Completed Facility Referral Form, Confirmation of Medical Necessity: Narrative #1 (six or older) #2 (ages two - six), Treatment plan, X-rays, photos, etc., D9999 on claim form

Adults Age 21 and Over

For adults age 21 and over the benefits, limitations, and preauthorization requirements are identical between the Medicaid and REM plans. The only difference is the REM plan allows prophylaxis, full mouth debridement, and bitewings-two single radiographic images (D0272) more frequently. See **'Limitations'** column below for additional details.

Benefit plans included below are:

- Adult Dental Plan (Over the age of 21)
- Pregnant and Postpartum Adult (Over the age of 21)
- REM Adults (Over the age of 21)

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
D0120 *update	Periodic oral evaluation-established patient	21 and older		Two (D0120) per 12 months per patient. Cannot be billed within 120 days as (D0150, D0145 or D0160) by the same provider or location.	No	
D0140	Limited oral evaluation-problem focused	21 and older		Only billed on evaluation to alleviate pain. Cannot be billed in conjunction with routine or planned services	No	
D0150 *update	Comprehensive oral evaluation-new or established patient	21 and older		One of (D0150) per provider OR location every 3 years. Cannot be billed within 120 days as (D0120, D0145 or D0160) by the same provider or location.	No	
D0210	Intraoral- comprehensive series of radiographic images	21 and older		One of (D0210) per 36 months per provider OR location. One of (D0210, D0330) per 36 months per provider.	No	
D0220	Intraoral-periapical first radiographic image	21 and older		One of (D0220) allowed on the same DOS of endodontic treatment.	No	

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
D0230	Intraoral-periapical each additional radiographic image	21 and older			No	
D0270	Bitewing-single radiographic image	21 and older		One of (D0270) per six months per patient for REM Adults 21 and over. One of (D0270, D0272, D0273, D0274) per 12 months per patient for other adults	No	
D0272	Bitewings-two radiographic images	21 and older		One of (D0272) per six months per patient for REM Adults 21 and over. One of (D0270, D0272, D0273, D0274) per 12 months per patient for other adults.	No	
D0273	Bitewings-three radiographic images	21 and older		One of (D0273) per six months per patient for REM Adults 21 and over. One of (D0270, D0272, D0273, D0274) per 12 months per patient for other adults.	No	
D0274	Bitewings-four radiographic images	21 and older		One of (D0274) per six months per patient for REM Adults 21 and over. One of (D0270, D0272, D0273, D0274) per 12 months per patient for other adults.	No	
D0330	Panoramic radiographic image	21 and older		One of (D0210) per 36 months per provider OR location. One of (D0210, D0330) per 36 months per provider.	No	

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
D1110	Prophylaxis-adult	21 and older		One of (D1110) per three months per patient for REM Adults 21 and over. Two of (D1110) per 12 months per patient for other adults Minimum of 120 days between services. Includes scaling and polishing procedures to remove coronal plaque, calculus and stains.	No	
D1206	Topical application of fluoride varnish	21 and older		One of (D1206/D1208) per six months per patient.	No	
D1208	Topical application of fluoride- excluding varnish	21 and older		One of (D1208) per three months per patient for REM Adults 21 and over. One of (D1208) per six months per patient for other adults.	No	
D2140	Amalgam-one surface, primary or permanent	21 and older	1-32, A-T	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per **24** months per patient per tooth, per surface. One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per six months per patient per tooth, regardless of surface.	No	

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
D2150	Amalgam-two surfaces, primary or permanent	21 and older	1-32, A-T	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per **24** months per patient per tooth, per surface. One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per six months per patient per tooth, regardless of surface.	No	
D2160	Amalgam-three surfaces, primary or permanent	21 and older	1-32, A-T	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per **24** months per patient per tooth, per surface. D2335, D2391, D2392, D2393, D2394) per six months per patient per tooth, regardless of surface.	No	
D2161	Amalgam-four or more surfaces	21 and older	1-32, A-T	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per **24** months per patient per tooth, per surface. One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per six months per patient per tooth, regardless of surface.	No	

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
D2330	Resin-based composite-one surface	21 and older	6-11, 22-27, C-H, M-R	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per **24** months per patient per tooth, per surface. One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per six months per patient per tooth, regardless of surface.	No	
D2331	Resin-based composite - two surfaces, anterior	21 and older	6-11, 22-27, C-H, M-R	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per **24** months per patient per tooth, per surface. One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per six months per patient per tooth, regardless of surface.	No	
D2332	Resin-based composite-three surfaces, anterior	21 and older	6-11, 22-27, C-H, M-R	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per **24** months per patient per tooth, per surface. One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per six months per patient per tooth, regardless of surface.	No	

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
D2335 *update	Resin-based composite-four or more surfaces	21 and older	6-11, 22-27, C-H, M-R	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per **24** months per patient per tooth, per surface. One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per six months per patient per tooth, regardless of surface.	No	
D2391	Resin-based composite-one surface, posterior	21 and older	1-5, 12-21, 28-32, A, B, I- L, S, T	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per **24** months per patient per tooth, per surface. One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per six months per patient per tooth, regardless of surface.	No	
D2392	Resin-based composite-two surfaces, posterior	21 and older	1-5, 12-21, 28-32, A, B, I- L, S, T	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per **24** months per patient per tooth, per surface. One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per six months per patient per tooth, regardless of surface.	No	

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
D2393	Resin-based composite-three surfaces, posterior	21 and older	1-5, 12-21, 28-32, A, B, I- L, S, T	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per **24** months per patient per tooth, per surface. One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per six months per patient per tooth, regardless of surface.	No	
D2394	Resin-based composite-four or more surfaces, posterior	21 and older	1-5, 12-21, 28-32, A, B, I- L, S, T	One of (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per **24** months per patient per tooth, per surface. One of (D2140 D2150, D2160 D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) per six months per patient per tooth, regardless of surface.	No	
D2740	Crown-porcelain/ceramic substrate	21 and older	1-32	One of (D2740) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative X-ray showing apex of tooth
D2750	Crown-porcelain fused to high noble metal	21 and older	1-32	One of (D2750) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative X-ray showing apex of tooth
D2751	Crown-porcelain fused to predominantly base metal	21 and older	1-32	One of (D2751) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative X-ray showing apex of tooth
D2752	Crown-porcelain fused to noble metal	21 and older	1-32	One of (D2752) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative X-ray showing apex of tooth

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
D2780	Crown-¾ cast high noble metal	21 and older	1-32	One of (D2780) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative X-ray showing apex of tooth
D2781	Crown-¾ cast predominantly base metal	21 and older	1-32	One of (D2781) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative X-ray showing apex of tooth
D2782	Crown-¾ cast noble metal	21 and older	1-32	One of (D2782) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative X-ray showing apex of tooth
D2783	Crown-¾ porcelain/ceramic	21 and older	1-32	One of (D2783) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative X-ray showing apex of tooth
D2790	Crown-full cast high noble metal	21 and older	1-32	One of (D2790) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative X-ray showing apex of tooth
D2791	Crown-full cast predominantly base metal	21 and older	1-32	One of (D2791) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative X-ray showing apex of tooth
D2792	Crown-full cast noble metal	21 and older	1-32	One of (D2792) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative X-ray showing apex of tooth
D2794	Crown-titanium	21 and older	1-32	One of (D2794) per 60 months per patient per tooth. Not payable on the same day of service as D3310, D3320, or D3330.	**Yes**	Pre-operative X-ray showing apex of tooth
D2920	Re-cement or re-bond crown	21 and older	1-32	Two of (D2920) per lifetime per patient per tooth. Not allowed within six months of initial placement.	No	

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
D2931	Prefabricated stainless steel crown- permanent tooth	21 and older	1-32	One of (D2931) per 60 months per patient per tooth. Not payable on the same day of service as D3310, D3320, or D3330.	No	
D2940 *update	Protective restoration	21 and older	1-32, A-T	One of (D2940) per tooth per lifetime. Temporary restoration intended to relieve pain. Not used as a base or liner under a restoration.	No	
D2950	Core buildup, including any pins when required	21 and older	1-32	One of (D2950) per 60 months per patient per tooth. One of (D2950, D2952, D2954) per 60 months per patient per tooth. Refers to building up of anatomical crown when restorative crown will be placed. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative X-rays
D2952	Cast post and core in addition to crown	21 and older	1-32	One of (D2952) per 60 months per patient per tooth. One of (D2950, D2952, D2954) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative X-rays
D2954	Prefabricated post and core in addition to crown	21 and older	1-32	One of (D2954) per 60 months per patient per tooth. One of (D2950, D2952, D2954) per 60 months per patient per tooth. Not payable on the same day of service as D3310-D3348.	**Yes**	Pre-operative X-rays
D2951	Pin retention-per tooth, in addition to restoration	21 and older	1-32		No	

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
D3110	Pulp cap-direct (excluding final restoration)	21 and older	1-32		No	
D3120	Pulp cap-indirect (excluding final restoration)	21 and older	1-32, A-T		No	
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	21 and older	6-11, 22-27	One of (D3310) per lifetime per patient per tooth. Not payable on the same day of service as D2740-D2794, or D2931.	**Yes**	Pre-operative X-rays
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	21 and older	4, 5, 12, 13, 20, 21, 28, 29	One of (D3320) per lifetime per patient per tooth. Not payable on the same day of service as D2740-D2794, or D2931.	**Yes**	Pre-operative X-rays
D3330	Endodontic therapy, molar (excluding final restoration)	21 and older	1-3, 14-19, 30-32	One of (D3330) per lifetime per patient per tooth. Not payable on the same day of service as D2740-D2794, or D2931.	**Yes**	Pre-operative X-rays
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	A minimum of four teeth in the affected quadrant. Limit of two Quadrants per 12 months.	**Yes**	Pre-operative X-rays, periodontal charting, narrative of medical necessity; photos optional
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	One of (D4341, D4342) per 12 months per patient per quadrant. A minimum of four teeth in the affected quadrant. Limit of four quadrants per 12 months. Limited to permanent dentition.	**Yes**	Pre-operative X-rays, periodontal charting
D4342 *update	Periodontal scaling and root planning - one to three teeth per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	One of (D4341, D4342) per 12 months per patient per quadrant. One to three teeth in the affected quadrant. Limited to permanent dentition.	**Yes**	Pre-operative X-rays, periodontal charting

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
D4355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis on a subsequent visit	21 and older		One of (D4355) per 12 months per patient for REM Adults 21 and over. One of (D4355) per 24 months per patient for other adults. Not allowed with D1110 on same date of service.	No	Narrative of medical necessity and pre-operative X-rays or photos submitted with claim
D4910	Periodontal maintenance procedures	21 and older		Two of (D4910) per 12 months per patient. Must follow active periodontal treatment. (Not allowed within 90 days of D4341 and D4342)	**Yes**	Date of previous periodontal surgical or SRP service
D5410	Adjust complete denture-maxillary	21 and older		Not covered within six months of placement.	No	
D5411	Adjust complete denture-mandibular	21 and older		Not covered within six months of placement.	No	
D5421	Adjust partial denture-maxillary	21 and older		Not covered within six months of placement.	No	
D5422	Adjust partial denture-mandibular	21 and older		Not covered within six months of placement.	No	
D6930	Re-cement or re-bond fixed partial denture	21 and older		Two of (D6930) per lifetime per patient per bridge.	No	
D7111	Extraction, coronal remnants-deciduous tooth	21 and older	A-T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS		No	

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	21 and older	1-32, 51-82, A-T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS		No	
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	21 and older	1-32, 51-82, A-T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS		No	
D7220	Removal of impacted tooth-soft tissue	21 and older	1-32, 51-82	Removal of asymptomatic tooth not covered.	No	
D7230	Removal of impacted tooth-partially bony	21 and older	1-32, 51-82	Removal of asymptomatic tooth not covered.	No	
D7240	Removal of impacted tooth-completely bony	21 and older	1-32, 51-82	Removal of asymptomatic tooth not covered.	No	
D7250	Surgical removal of residual tooth roots (cutting procedure)	21 and older	1-32, 51-82, A-T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Not paid to the dentist or group that removed the tooth. Removal of asymptomatic tooth not covered.	**Yes**	Narrative of medical necessity, pre-operative X-rays (excluding bitewings)

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
D7284 *update	Excisional biopsy of minor salivary glands	21 and older		Not payable on the same day of service as D7286.	No	Copy of pathology report submitted with claim
D7285	Incisional biopsy of oral tissue-hard (bone, tooth)	21 and older			No	Copy of pathology report submitted with claim
D7286	Incisional biopsy of oral tissue-soft	21 and older			No	Copy of pathology report submitted with claim
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	One of (D7310) per lifetime per patient per quadrant. Minimum of three extractions in the affected quadrant.	No	Pre-operative X-rays (excluding bitewings) submitted with claim
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	21 and older	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	One of (D7320) per lifetime per patient per quadrant. No extractions performed in an edentulous area.	**Yes**	Pre-operative X-rays (excluding bitewings)
D7510	Incision and drainage of abscess - intraoral soft tissue	21 and older	1-32, 51-82, A-T, AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS, TS	Not allowed with extraction.	No	
D9110	Palliative (emergency) treatment of dental pain	21 and older	No	Not allowed with any other services other than radiographs. Not allowed in relation to recently rendered services.	No	Narrative of medical necessity submitted with claim

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
D9222	Deep sedation/general anesthesia – first 15 minutes. Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties. The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetic effects upon the central nervous system and not dependent upon the route of administration.	21 and older			No	
D9223	Deep sedation/general anesthesia- each 15 minutes	21 and older		Maximum of 90 minutes (six units). Not paid with D9230, D9243 or D9248. Five per day (must have approved D9222) – existing code service edits.	No	
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	21 and older		Not paid with D9223, D9243 or D9248.	No	

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
D9239	Intravenous moderate (conscious) sedation/analgesia-first 15 minutes Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties. The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetic effects upon the central nervous system and not dependent upon the route of administration.	21 and older			No	
D9243	Intravenous moderate (conscious) sedation/analgesia-each 15 minutes	21 and older		Maximum of 90 minutes (six units). Not paid with D9223, D9230 or D9248. Five per day (must have approved D9239) – existing code service edits.	No	
D9248	Non-intravenous moderate (conscious) sedation	21 and older		Not paid with 9223, D9230 or D9243.	No	

Code	Description	Age	Tooth / Quadrant / Arch	Limitations	Preauthorization	Requirement
D9999 *update	Unspecified adjunctive procedure, by report	21 and older			**Yes**	Facility Referral Form: Confirmation of Med Necessity Narrative for #1 (only ages six or older), narrative for #2-6), treatment plan, X-rays, photos, etc., D9999 on claim form.

SKYGEN USA, LLC runs the Maryland Healthy Smiles Dental Program on behalf of The Maryland Department of Health Medicaid Administration.

Maryland Healthy Smiles
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Maryland
DEPARTMENT OF HEALTH

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