Avesis UPMC *for Kids* Health Plan, Inc.

Covered Benefits and Fee Schedule

Dental services listed in this Covered Benefits and Fee Schedule are to be performed by a dentist licensed in the state where services are being performed. All necessary radiographs should be taken by the General Dentist/Pediatric Dentist prior to submitting documentation to Avesis for Prior Authorization. The dentist shall perform routine Preventive and Restorative services in the general dental/pediatric dental setting unless an approved change of location is granted by Avesis.

ADA Category	CODE	PROCEDURE	UPMC *for Kids*	TEETH COVERED	AUTH REQUIRED	BENEFIT LIMITATIONS	ATTACHMENTS REQUIRED
Guidelines	**These rules comprise the foundation for the Avesis UPMC *for Kids* Dental Program.**						
GENERAL	• Dental Services are defined as any diagnostic, preventive or corrective procedures administered by or under the direct supervision of a Pennsylvania licensed dentist.						
GENERAL	• The PA CHIP Dental Program is limited to an annual maximum dental benefit expenditure of $1,500 per member with the exception of orthodontic services. Please refer to the Orthodontic Services section for more information regarding comprehensive orthodontic services.						
CLAIMS	• All claims must provide proper codes based upon the current edition of the ADA CDT Code						
CLAIMS	• Claims must be submitted within three hundred sixty five (365) days.						
CLAIMS	• Providers must mount and label the radiographs with the Member's name, ID number, Provider's name, ID number and tooth number (s). Radiographs will be returned to the Provider submitting them.						
CLAIMS	• Emergency claims must be submitted within thirty (30) days and include:						
CLAIMS	a) ADA Dental Claim Form						
CLAIMS	b) Letter explaining why services rendered were deemed emergency in nature						
CLAIMS	c) Appropriate Radiographs						
PRE-TREATMENT/ PRIOR AUTHORIZATION	• When submitting radiographs for the Pre-Treatment/Prior Authorization process, Providers must mount and label the radiographs with the Member's name, ID number, Provider's name, ID number and tooth number (s).						
PRE-TREATMENT/ PRIOR AUTHORIZATION	• When the Provider is unable to complete the approved treatment by the expiration date, a new Pre-Treatment/Prior Authorization listing the remaining services should be completed and submitted to Avesis Dental Director with a copy of the expired approval. The Provider may submit claims for those services already rendered under the original Pre-Treatment/Prior Authorization approval.						
PRE-TREATMENT/ PRIOR AUTHORIZATION	• Pre-Treatment/Prior Authorization approvals will expire within one hundred eighty (180) days. The twelfth month date for rendering treatment is the end of the twelfth month following the month of approval.						
PRE-TREATMENT/ PRIOR AUTHORIZATION	• Certain services require prior approval from Avesis. See the Authorization Required column below.						
PRE-TREATMENT/ PRIOR AUTHORIZATION	• A Provider should not begin treatment until after the Pre-Treatment/Prior Authorization approval is received.						
PRE-TREATMENT/ PRIOR AUTHORIZATION	• Specific services that require Pre-Treatment/Prior Authorization approval are indicated throughout this document.						
POST TREATMENT	• Specific services that require Post Treatment review are indicated throughout this document.						
POST TREATMENT	• Avesis will pay claims in the normal cycle and review documentation retrospectively. If disputes occur, Avesis reserves the right to make adjustments.						

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ADA Category	CODE	PROCEDURE	UPMC *for Kids*	TEETH COVERED	AUTH REQUIRED	BENEFIT LIMITATIONS	ATTACHMENTS REQUIRED
Guidelines	**These rules comprise the foundation for the Avesis UPMC *for Kids* Dental Program.**						
RADIOGRAPHS	• Full-Mouth series includes eight (8) frames for children under twelve (12) and 14 frames for children twelve (12) and older.						
RADIOGRAPHS	• A panoramic radiograph may be used in lieu of the full-mouth series, but as a diagnostic tool is not sufficient to allow the appropriate quality review of treatment plans.						
RADIOGRAPHS	• Providers must mount and label the films with the Member's name, ID number, Provider's name, ID number and tooth number (s). Radiographs will be returned to the Provider submitting them.						

Avesis UPMC *for Kids* Health Plan, Inc.
Covered Benefits and Fee Schedule

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ADA Category	CODE	PROCEDURE	UPMC *for Kids*	TEETH COVERED	AUTH REQUIRED	BENEFIT LIMITATIONS	ATTACHMENTS REQUIRED
DIAGNOSTIC	**These Diagnostic procedures comprise the Covered Benefits under the Avesis UPMC *for Kids* Dental Program. Should radiographs reimbursed be discovered to not be of diagnostic quality, properly mounted, dated and identified with the Member's name, Avesis will recoup the funds previously paid.**						
EXAM	D0120	Periodic Oral Evaluation	0-18	Intentionally left blank	No	Twice per benefit period. Applies to all oral evaluations including consultations.	None
EXAM	D0150	Comprehensive Oral Evaluation - New or Established Patient	0-18	Intentionally left blank	No	Twice per benefit period. Applies to all oral evaluations including consultations. Limited to one comprehensive exam per patient per dentist or dental group per lifetime.	None
RADIOGRAPH	D0210	Full Mouth Series	0-18	Intentionally left blank	No	One per 60 months per patient per dentist or dental group. Limited to one D0210 or D0330 every 5 years.	None

Avesis UPMC *for Kids* Health Plan, Inc.
Covered Benefits and Fee Schedule

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ADA Category	CODE	PROCEDURE	UPMC *for Kids*	TEETH COVERED	AUTH REQUIRED	BENEFIT LIMITATIONS	ATTACHMENTS REQUIRED
DIAGNOSTIC	**These Diagnostic procedures comprise the Covered Benefits under the Avesis UPMC *for Kids* Dental Program.**						
DIAGNOSTIC	D0220	Periapical, One Film	0-18	Intentionally left blank	No	See limitations for all radiographs. Inclusive for complete series x-ray and/or panoramic.	None
DIAGNOSTIC	D0230	Periapical, Each Additional Film	0-18	Intentionally left blank	No	See limitations for all radiographs. Inclusive for complete series x-ray and/or panoramic.	None
DIAGNOSTIC	D0240	Intraoral - Occlusal Film, One Film	0-18	Intentionally left blank	No	See limitations for all radiographs. Inclusive for complete series x-ray and/or panoramic.	None
DIAGNOSTIC	D0270	Bitewing, One Film	0-18	Posterior Teeth	No	One per 12 months	None
DIAGNOSTIC	D0272	Bitewing, Two Films	0-18	Posterior Teeth	No	One per 12 months	None
DIAGNOSTIC	D0274	Bitewing, Four Films	0-18	Posterior Teeth	No	One per 12 months	None
DIAGNOSTIC	D0277	Vertical Bitewings - 7 to 8 Films	0-18	Posterior Teeth	No	One set every 3 years	None
DIAGNOSTIC	D0330	Panoramic Option	0-18	Intentionally left blank	No	One per 60 months. Either a D0210 or D0330.	None

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ADA Category	CODE	PROCEDURE	UPMC *for Kids*	TEETH COVERED	AUTH REQUIRED	BENEFIT LIMITATIONS	ATTACHMENTS REQUIRED
PREVENTIVE	**These Preventive procedures comprise the Covered Benefits under the Avesis UPMC *for Kids* Dental Program. Space maintainers are covered only when indicated due to the premature loss of a posterior primary tooth.**						
PREVENTIVE	**"High Risk" members are pregnant members and those members that are determined to be "high risk" using the American Academy of Pediatric Dentistry Caries Risk Assessment tool, or other similar approved tool.**						
PREVENTIVE	D1110	Prophylaxis - Adult	12-18	Intentionally left blank	No	Limited to one (1) service per six months of either D1110 or D1120.	None
PREVENTIVE	D1120	Prophylaxis - Child	0-11	Intentionally left blank	No	Limited to one (1) service per six months of either D1110 or D1120.	None
PREVENTIVE	D1203	Topical Application of Fluoride - prophylaxis not included	0-15	Intentionally left blank	No	Limited to one (1) service per six months. "High Risk" members are eligible for 3 applications per benefit period.	None
PREVENTIVE	D1204	Topical Application of Fluoride - prophylaxis not included	16-18	Intentionally left blank	Yes	Limited to one (1) service per six months. "High Risk" members are eligible for 3 applications per benefit period.	None
PREVENTIVE	D1206	Topical Application of Fluoride varnish - prophylaxis not included	0-16	Intentionally left blank	No	Limited to one (1) service per six months. "High Risk" members are eligible for 3 applications per benefit period.	None
PREVENTIVE	D1351	Topical Application of Sealants, Per Tooth	5-18	Only for teeth numbers 2-5, 12-21, 28-31	No	Member must be less than 18 years of age. Limited to permanent molars free from caries and or restoration. Limited to 1 treatment per tooth every 3 years except when visible evidence of clinical failure is apparent.	None
PREVENTIVE	D1510	Space Maintainer - Fixed Unilateral	0-18	Intentionally left blank	No	Once per lifetime per quadrant.	Missing tooth numbers and arch/quadrants must be indicated on the claim.
PREVENTIVE	D1515	Space Maintainer - Fixed Bilateral	0-18	Intentionally left blank	No	Once per lifetime per quadrant.	Missing tooth numbers and arch/quadrants must be indicated on the claim.
PREVENTIVE	D1550	Re-cement Space Maintainer	0-18	Intentionally left blank	No		None
PREVENTIVE	D1555	Removal of Fixed Space Maintainer	0-18	Intentionally left blank	No	Not allowed by dentist of dental group that placed the space maintainer. Limited to once per lifetime per device.	None

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ADA Category	CODE	PROCEDURE	UPMC *for Kids*	TEETH COVERED	AUTH REQUIRED	BENEFIT LIMITATIONS	ATTACHMENTS REQUIRED
RESTORATIVE	**These Restorative procedures comprise the Covered Benefits under the Avesis UPMC *for Kids* Dental Program. Reimbursement for restorations includes local anesthetic, tooth preparation, all adhesives, acid etching, copalite, liners, bases, and curing. Payment is made for restorative surfaces based on the number of surfaces restored, not on the number of restorations per surface, or per tooth per day. All surfaces restored per day must be identified and billed under the most comprehensive code.**						
RESTORATIVE	D2140	Amalgam-one surface primary and permanent	0-18	1-32 and A-T	No	1) All surfaces must be identified. 2) Includes etchant.	None
RESTORATIVE	D2150	Amalgam-two surface primary and permanent	0-18	1-32 and A-T	No	1) All surfaces must be identified. 2) Includes etchant.	None
RESTORATIVE	D2160	Amalgam-three surface primary and permanent	0-18	1-32 and A-T	No	1) All surfaces must be identified. 2) Includes etchant.	None
RESTORATIVE	D2161	Amalgam-four or more surfaces primary and permanent	0-18	1-32 and A-T	No	1) All surfaces must be identified. 2) Includes etchant.	None
RESTORATIVE	D2330	Composite -One Surface Anterior	0-18	Only for teeth c-h and m-r or teeth 6-11and 22-27.	No	1) All surfaces must be identified. 2) Includes etchant.	None
RESTORATIVE	D2331	Composite -Two Surfaces Anterior	0-18	Only for teeth c-h and m-r or teeth 6-11and 22-27.	No	1) All surfaces must be identified. 2) Includes etchant.	None
RESTORATIVE	D2332	Resin based composite-Three Surfaces Anterior	0-18	Only for teeth c-h and m-r or teeth 6-11and 22-27.	No	1) All surfaces must be identified. 2) Includes etchant.	None
RESTORATIVE	D2335	Resin based composite-Four or more Surfaces Anterior	0-18	Only for teeth c-h and m-r or teeth 6-11and 22-27.	No	1) All surfaces must be identified. 2) Includes etchant.	None

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ADA Category	CODE	PROCEDURE	UPMC *for Kids*	TEETH COVERED	AUTH REQUIRED	BENEFIT LIMITATIONS	ATTACHMENTS REQUIRED
RESTORATIVE	D2390	Resin based composite crown - Anterior	0-18	Only for teeth c-h and m-r or teeth 6-11and 22-27.	No	Not reimbursable with construction of permanent crown for teeth 6-11, 22-27. Limited to permanent teeth and primary teeth with no permanent successors. Limited to once per tooth every 5 years when the tooth structure is insufficient to support restoration by another material such as amalgam and a lesser restoration procedure is not possible.	None
RESTORATIVE	D2391	Resin based composite-One Surface Posterior Permanent	0-18	Only for teeth a,b,i,j,k,l,s,t,1-5, 12-21, 28-32	No	1) All surfaces must be identified. 2) Includes etchant.	None
RESTORATIVE	D2392	Resin based composite -Two Surface Posterior Permanent	0-18	Only for teeth a,b,i,j,k,l,s,t,1-5, 12-21, 28-32	No	1) All surfaces must be identified. 2) Includes etchant.	None
RESTORATIVE	D2393	Resin based composite -Three Surface Posterior Permanent	0-18	Only for teeth a,b,i,j,k,l,s,t,1-5, 12-21, 28-32	No	1) All surfaces must be identified. 2) Includes etchant.	None
RESTORATIVE	D2394	Resin based composite - Four or more Surfaces Posterior Permanent	0-18	Only for teeth a,b,i,j,k,l,s,t,1-5, 12-21, 28-32	No	1) All surfaces must be identified. 2) Includes etchant.	None

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ADA Category	CODE	PROCEDURE	UPMC *for Kids*	TEETH COVERED	AUTH REQUIRED	BENEFIT LIMITATIONS	ATTACHMENTS REQUIRED
RESTORATIVE	D2710	Crown - resin based composite (indirect)	0-18	Only for teeth 4-13, 20-29	Yes	1) Limited to one (1) D2710, D2721, D2740, D2751, or D2791 per tooth every five (5) years. 2) Only one (1) crown of any type (excluding D2970 emergency related services) per tooth per calendar year. 3) Only covered when the tooth structure is insufficient to support restoration by another material such as amalgam and a lesser method such as amalgam or composite. 4) Limited to fully developed permanent teeth and primary teeth with no permanent successors.	Pre-Treatment Radiographs of adjacent and opposing teeth.
RESTORATIVE	D2721	Crown - resin based with predominately base metal	0-18	1 - 32	Yes	1) Limited to one (1) D2710, D2721, D2740, D2751, or D2791 per tooth every five (5) years. 2) Only one (1) crown of any type (excluding D2970 emergency related services) per tooth per calendar year. 3) Only covered when the tooth structure is insufficient to support restoration by another material such as amalgam and a lesser method such as amalgam or composite. 4) Limited to fully developed permanent teeth and primary teeth with no permanent successors.	Pre-Treatment Radiographs of adjacent and opposing teeth.

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ADA Category	CODE	PROCEDURE	UPMC *for Kids*	TEETH COVERED	AUTH REQUIRED	BENEFIT LIMITATIONS	ATTACHMENTS REQUIRED
RESTORATIVE	D2740	Crown - porcelain/ceramic substrate	0-18	1 - 32	Yes	1) Limited to one (1) D2710, D2721, D2740, D2751, or D2791 per tooth every five (5) years. 2) Only one (1) crown of any type (excluding D2970 emergency related services) per tooth per calendar year. 3) Only covered when the tooth structure is insufficient to support restoration by another material such as amalgam and a lesser method such as amalgam or composite. 4) Limited to fully developed permanent teeth and primary teeth with no permanent successors.	Pre-Treatment Radiographs of adjacent and opposing teeth.
RESTORATIVE	D2751	Crown - porcelain fused to predominantly base metal	0-18	Only for teeth 4-13, 20-29	Yes	1) Limited to one (1) D2710, D2721, D2740, D2751, or D2791 per tooth every five (5) years. 2) Only one (1) crown of any type (excluding D2970 emergency related services) per tooth per calendar year. 3) Only covered when the tooth structure is insufficient to support restoration by another material such as amalgam and a lesser method such as amalgam or composite. 4) Limited to fully developed permanent teeth and primary teeth with no permanent successors.	Pre-Treatment Radiographs of adjacent and opposing teeth.

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ADA Category	CODE	PROCEDURE	UPMC *for Kids*	TEETH COVERED	AUTH REQUIRED	BENEFIT LIMITATIONS	ATTACHMENTS REQUIRED
RESTORATIVE	D2791	Crown - full cast predominantly base metal	0-18	Only for teeth 2-15, 18-31	Yes	1) Limited to one (1) D2710, D2721, D2740, D2751, or D2791 per tooth every five (5) years. 2) Only one (1) crown of any type (excluding D2970 emergency related services) per tooth per calendar year. 3) Only covered when the tooth structure is insufficient to support restoration by another material such as amalgam and a lesser method such as amalgam or composite. 4) Limited to fully developed permanent teeth and primary teeth with no permanent successors.	Pre-Treatment Radiographs of adjacent and opposing teeth.
RESTORATIVE	D2930	Prefabricated stainless steel crown- primary tooth	0-18	Primary Teeth only (A - T)	No	1) Limited to one (1) per tooth per lifetime. 2) Only one (1) crown of any type (excluding D2970 emergency related services) per tooth per calendar year. 3) Only covered when the tooth structure is insufficient to support restoration by another material such as amalgam and a lesser method such as amalgam or composite. 4) No reimbursement for primary teeth with early loss.	None

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ADA Category	CODE	PROCEDURE	UPMC *for Kids*	TEETH COVERED	AUTH REQUIRED	BENEFIT LIMITATIONS	ATTACHMENTS REQUIRED
RESTORATIVE	D2931	Prefabricated stainless steel crown- permanent tooth	0-18	Permanent Teeth only (1 - 32)	No	1) Limited to one (1) per tooth per lifetime. 2) Only one (1) crown of any type (excluding D2970 emergency related services) per tooth per calendar year. 3) Only covered when the tooth structure is insufficient to support restoration by another material such as amalgam and a lesser method such as amalgam or composite. 4) No reimbursement for primary teeth with early loss.	None
RESTORATIVE	D2933	Prefabricated stainless steel crown with resin window	0-18	Only Anterior teeth 6 - 11, 22 - 27, c-h, m-r	No	1) No reimbursement for primary teeth with early loss. 2) Limited to one (1) per tooth per lifetime. 3) Only one (1) crown of any type (excluding D2970 emergency related services) per tooth per calendar year. 4) Only covered when the tooth structure is insufficient to support restoration by another material such as amalgam and a lesser method such as amalgam or composite.	None
RESTORATIVE	D2954	Pre-fabricated post and core	0-18	1 - 32	Post Review	Limited to once per tooth per lifetime.	Radiograph showing endodontic fill with claim.

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ADA Category	CODE	PROCEDURE	UPMC *for Kids*	TEETH COVERED	AUTH REQUIRED	BENEFIT LIMITATIONS	ATTACHMENTS REQUIRED
ENDODONTICS	**These Endodontic procedures comprise the Covered Benefits under the Avesis UPMC *for Kids* Dental Program.**						
ENDODONTICS	**Standards for review of Endodontics: A) Pre-operative long term prognosis of tooth. Loss of tooth structure, loss of periodontal support. B) Post-operative completeness of endodontic fill. Filling material not accepted by the Federal Food and Drug Administration (FDA) is not covered.**						
ENDODONTICS	**Complete root canal therapy includes pulpectomy, all appointments necessary to complete treatment, temporary fillings, filling & obturation of canals, intra-operative and fill radiographs.**						
ENDODONTICS	**In cases where a root canal filling does not meet Avesis' general criteria treatment standards, Avesis can require the procedure to be redone at no additional cost. Any reimbursement already made for an inadequate service may be recouped after review by the Avesis State Dental Director. Reimbursement includes local anesthesia.**						
ENDODONTICS	**A pulpotomy or palliative treatment is not to be billed in conjunction with root canal treatment on the same date.**						
ENDODONTICS	D3220	Therapeutic Pulpotomy (excluding final restoration) removal of pulp coronal to the dentinocemental junction and application of medicament, Primary and Permanent Teeth	0-18	1 - 32, A - T	No	If a root canal is within 45 days of the pulpotomy, total benefit for the root canal will include the allowance given for the pulpotomy.	None
ENDODONTICS	D3230	Pupal therapy - (resorbable filling) - anterior, primary tooth (excluding final restoration)	0-18	Anterior teeth only (c - h, m - r)	No	1) Limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11. 2) Limited to one (1) per tooth per lifetime. Not eligible for payment if root canal was started in the same day.	None
ENDODONTICS	D3240	Pupal therapy - (resorbable filling) - posterior, primary tooth (excluding final restoration)	0-18	a, b, I, j, k, l, s, t	No	1) Limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11. 2) Limited to one (1) per tooth per lifetime. Not eligible for payment if root canal was started in the same day.	None
ENDODONTICS	D3310	Root canal - anterior (excluding final restoration) permanent	0-18	Only for teeth 6-11and 22-27	Yes	1) Once per tooth per lifetime 2) The date the RCT is completed should be the date of service. 3) Reimbursement for a root canal includes opening and drainage, treatment planning, clinical procedures, follow-up care, radiographs during treatment, and post operative radiographs.	1) Pre -Treatment radiographs 2) Complete treatment plan.

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ADA Category	CODE	PROCEDURE	UPMC *for Kids*	TEETH COVERED	AUTH REQUIRED	BENEFIT LIMITATIONS	ATTACHMENTS REQUIRED
ENDODONTICS	D3320	Root canal - bicuspid (excluding final restoration) Permanent	0-18	Only for teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	1) Once per tooth per lifetime 2) The date the RCT is completed should be the date of service. 3) Reimbursement for a root canal includes opening and drainage, treatment planning, clinical procedures, follow-up care, radiographs during treatment, and post operative radiographs.	1) Pre -Treatment radiographs 2) Complete treatment plan.
ENDODONTICS	D3330	Root canal - molar (excluding final restoration) Permanent	0-18	Only for teeth 1 - 3, 14 - 19, 30 - 32	Yes	1) Once per tooth per lifetime 2) The date the RCT is completed should be the date of service. 3) Reimbursement for a root canal includes opening and drainage, treatment planning, clinical procedures, follow-up care, radiographs during treatment, and post operative radiographs.	1) Pre -Treatment radiographs 2) Complete treatment plan.
ENDODONTICS	D3410	Apicoectomy/periradicular surgery – anterior	0-18	Only for teeth 6-11, 22- 27	Yes	1) Once per lifetime 2) Does not include placement of retrograde filling material. 3) This code should only be used in the presence of swelling or infection in an emergency situation. 4) Not allowed for molars. 5) Benefit is subject to review as an emergency dental service.	1) Pre -Treatment radiographs 2) Complete treatment plan.
ENDODONTICS	D3421	Apicoectomy/periradicular surgery – bicuspid (first root)	0-18	Only for teeth 4, 5, 12, 13, 20, 21, 28, 29	Yes	1) Once per lifetime 2) Does not include placement of retrograde filling material. 3) This code should only be used in the presence of swelling or infection in an emergency situation. 4) Not allowed for molars. 5) Benefit is subject to review as an emergency dental service.	1) Pre -Treatment radiographs 2) Complete treatment plan.

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ADA Category	CODE	PROCEDURE	UPMC *for Kids*	TEETH COVERED	AUTH REQUIRED	BENEFIT LIMITATIONS	ATTACHMENTS REQUIRED
ENDODONTICS	D3425	Apicoectomy/periradicular surgery – molar (first root)	0-18	Only for teeth 1 - 3, 14 - 19, 30 - 32	Yes	1) Once per lifetime 2) Does not include placement of retrograde filling material. 3) This code should only be used in the presence of swelling or infection in an emergency situation. 4) Not allowed for molars. 5) Benefit is subject to review as an emergency dental service.	1) Pre -Treatment radiographs 2) Complete treatment plan.
ENDODONTICS	D3426	Apicoectomy/periradicular surgery – each additional root	0-18	Only for teeth 1 - 5, 12 - 21, 28 - 32	Yes	1) Once per lifetime 2) Does not include placement of retrograde filling material. 3) This code should only be used in the presence of swelling or infection in an emergency situation. 4) Not allowed for molars. 5) Benefit is subject to review as an emergency dental service.	1) Pre -Treatment radiographs 2) Complete treatment plan.

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ADA Category	**CODE**	**PROCEDURE**	**UPMC *for Kids***	**TEETH COVERED**	**AUTH REQUIRED**	**BENEFIT LIMITATIONS**	**ATTACHMENTS REQUIRED**
PERIODONTICS	**These Periodontic procedures comprise the Covered Benefits under the Avesis UPMC *for Kids* Dental Program.**						
PERIODONTICS	**Standards for review of Periodontics: A) Pre-operative - long term prognosis of teeth. Loss of tooth structure, loss of periodontal support. B) Post-operative - removal**						
PERIODONTICS	**Claims for periodontal services must be prior authorized**						
PERIODONTICS	D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth present in the quadrant or bounded teeth spaces per quadrant	0-18	Intentionally left blank	Yes	1) Appropriate code must be put in the tooth number field on the claim form UR - upper right LR - lower right UL - upper left LL - lower left. 2) Evidence of subgingival calculus on radiographs. 3) Evidence of significant disease must be readily visible on radiograph along with evidence of bone loss and clinical probings of 4mm or greater in each quadrant. 4) Probings not older that six (6) months. 5) Limited to one (1) Periodontal Service per quadrant every three (3) years. No more than one (1) D4210 or D4341 service per quadrant every two (2) years.	1) Comprehensive periodontal evaluation documentation. 2) Narrative documenting necessity. 3) Pre-treatment radiographs
PERIODONTICS	D4341	Periodontal Scaling and Root Planing - four or more contiguous teeth present in the quadrant or bounded teeth spaces per quadrant	0-18	Intentionally left blank	Yes	1) Appropriate code must be put in the tooth number field on the claim form UR - upper right LR - lower right UL - upper left LL - lower left. 2) Evidence of subgingival calculus on radiographs. 3) Evidence of significant disease must be readily visible on radiograph along with evidence of bone loss and clinical probings of 4mm or greater in each quadrant. 4) Probings not older that six (6) months. 5) Limited to one (1) Periodontal Service per quadrant every three (3) years. No more than one (1) D4210 or D4341 service per quadrant every two (2) years.	1) Periodontal charting. 2) Narrative documenting necessity. 3) Pre-Treatment radiographs. 4) List number of quadrants required on Pre-Treatment/ Prior Approval estimate.
PERIODONTICS	D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	0-18	Intentionally left blank	No	Limited to one (1) per lifetime after three (3) years have elapsed since the last dental cleaning.	

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ADA Category	CODE	PROCEDURE	UPMC *for Kids*	TEETH COVERED	AUTH REQUIRED	BENEFIT LIMITATIONS	ATTACHMENTS REQUIRED
PERIODONTICS	D4910	Periodontal Maintenance	0-18	Intentionally left blank	Yes	Limited to members that have one or more of the following conditions: diabetes, immunodeficiency, or a systemic disease that impacts the periodontic health, use tobacco products, or members that have completed active periodontal therapy within the past two (2) years. Limited to two services per benefit period.	1) Narrative documenting previous periodontal treatment dates 2) Continuous documentation of significant hard and soft tissue changes.

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ADA Category	CODE	PROCEDURE	UPMC *for Kids*	TEETH COVERED	AUTH REQUIRED	BENEFIT LIMITATIONS	ATTACHMENTS REQUIRED
PROSTHODONTICS	**These Prosthodontic procedures comprise the Covered Benefits under the Avesis UPMC *for Kids* Dental Program.**						
PROSTHODONTICS	**Standards for review of Prosthodontics: Pre-operative - radiographic review -- number of teeth lost - need for increased ability to masticate. Loss of bony structure, loss of periodontal support in remaining teeth. Provision for dentures for cosmetic purposes is not a covered service.**						
PROSTHODONTICS	**A partial denture that replaces only posterior permanent teeth must include three of more teeth on the dentures that are anatomically correct (natural size, shape and color) to be compensable (excluding third molars).**						
PROSTHODONTICS	**A preformed denture with teeth already mounted forming a denture module is not a covered service.**						
PROSTHODONTICS	D5110	Complete Denture Maxillary	0-18	Intentionally left blank	Yes	1) One per five (5) years. 2) Either D5110 or D5130 3) The date the impression is taken is the date of service. 4) The Provider must make all necessary corrections and adjustments for a period of six (6) months after seating the denture.	Panoramic Radiograph series. If this cannot be submitted, A Dentist may submit: 1) Full Mouth radiograph series 2) Photographs of the Member's mouth 3) Four (4) Bitewings 4) Four (4) periapicals or 5) Two (2) occlusals
PROSTHODONTICS	D5120	Complete Denture Mandibular	0-18	All Teeth	Yes	1) One per five (5) years. 2) Either D5120 or D5140 3) The date the impression is taken is the date of service. 4) The Provider must make all necessary corrections and adjustments for a period of six (6) months after seating the denture.	Panoramic Radiograph series. If this cannot be submitted, A Dentist may submit: 1) Full Mouth radiograph series 2) Photographs of the Member's mouth 3) Four (4) Bitewings 4) Four (4) periapicals or 5) Two (2) occlusals
PROSTHODONTICS	D5130	Immediate Denture Maxillary	0-18	All Teeth	Yes	1) One per five (5) years. 2) Either D5110 or D5130 3) The date the impression is taken is the date of service. 4) The Provider must make all necessary corrections and adjustments for a period of six (6) months after seating the denture.	Panoramic Radiograph series. If this cannot be submitted, A Dentist may submit: 1) Full Mouth radiograph series 2) Photographs of the Member's mouth 3) Four (4) Bitewings 4) Four (4) periapicals or 5) Two (2) occlusals

Avesis UPMC *for Kids* Health Plan, Inc.
Covered Benefits and Fee Schedule

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PROSTHODONTICS	D5140	Immediate Denture Mandibular	0-18	All Teeth	Yes	1) One per five (5) years. 2) Either D5120 or D5140 3) The date the impression is taken is the date of service. 4) The Provider must make all necessary corrections and adjustments for a period of six (6) months after seating the denture.	Panoramic Radiograph series. If this cannot be submitted, A Dentist may submit: 1) Full Mouth radiograph series 2) Photographs of the Member's mouth 3) Four (4) Bitewings 4) Four (4) periapicals or 5) Two (2) occlusals
PROSTHODONTICS	D5211	Maxillary Partial-Resin Base including any conventional clasps, rests, and teeth	0-18	One tooth partials are not covered unless replacing tooth number 6, 7, 8, 9, 10, 11, 22	Yes	1) One per five (5) years. 2) Either D5211 or D5213	Panoramic Radiograph series. If this cannot be submitted, A Dentist may submit: 1) Full Mouth radiograph series 2) Photographs of the Member's mouth 3) Four (4) Bitewings 4) Four (4) periapicals or 5) Two (2) occlusals
PROSTHODONTICS	D5212	Mandibular Partial-Resin Base including any conventional clasps, rests, and teeth	0-18	One tooth partials are not covered unless replacing tooth number 22, 23, 24, 25, 26, 27	Yes	1) One per five (5) years. 2) Either D5212 or D5214	Panoramic Radiograph series. If this cannot be submitted, A Dentist may submit: 1) Full Mouth radiography series 2) Photographs of the Member's mouth 3) Four (4) Bitewings 4) Four (4) periapicals or 5) Two (2) occlusals
PROSTHODONTICS	D5213	Maxillary partial denture - case metal framework with resin denture bases (including any conventional clasps, rests and teeth)	0-18	One tooth partials are not covered unless replacing tooth number 6, 7, 8, 9, 10, 11, 22	Yes	1) One per five (5) years. 2) Either D5211 or D5213	Panoramic Radiograph series. If this cannot be submitted, A Dentist may submit: 1) Full Mouth radiography series 2) Photographs of the Member's mouth 3) Four (4) Bitewings 4) Four (4) periapicals or 5) Two (2) occlusals

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PROSTHODONTICS	D5214	Mandibular Partial Denture -cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	0-18	One tooth partials are not covered unless replacing tooth number 22, 23, 24, 25, 26, 27	Yes	1) One per five (5) years. 2) Either D5212 or D5214	Panoramic Radiograph series. If this cannot be submitted, A Dentist may submit: 1) Full Mouth radiography series 2) Photographs of the Member's mouth 3) Four (4) Bitewings 4) Four (4) periapicals or 5) Two (2) occlusals
PROSTHODONTICS	D5410	Adjustment - Complete Denture Maxillary (Upper)	0-18	Intentionally left blank	No	Limited to two (2) adjustments per denture per benefit period after six (6) months have elapsed since initial placement.	For Member's where more than two adjustments per year are deemed necessary, must submit narrative regarding need.
PROSTHODONTICS	D5411	Adjustment - Complete Denture Mandibular (Lower)	0-18	Intentionally left blank	No	Limited to two (2) adjustments per denture per benefit period after six (6) months have elapsed since initial placement.	For Members where more than two adjustments per year are deemed necessary, must submit narrative regarding need.
PROSTHODONTICS	D5421	Adjustment - Partial Denture Upper	0-18	Intentionally left blank	No	Limited to two (2) adjustments per denture per benefit period after six (6) months have elapsed since initial placement.	For Members where more than two adjustments per year are deemed necessary, must submit narrative regarding need.
PROSTHODONTICS	D5422	Adjustment - Partial Denture Lower	0-18	Intentionally left blank	No	Limited to two (2) adjustments per denture per benefit period after six (6) months have elapsed since initial placement.	For Members where more than two adjustments per year are deemed necessary, must submit narrative regarding need.
PROSTHODONTICS	D5510	Repair broken complete denture base	0-18	Upper Arch (01, UA) or Lower Arch (02, LA)	No	1) A maximum of two (2) treatments per benefit period may be performed. 2) Service is not covered when the damage to the appliance is a result of abuse, misuse or neglect.	For Members where more than two treatments per year are deemed necessary, must submit narrative regarding need.
PROSTHODONTICS	D5520	Replace missing or broken teeth - complete denture (each tooth)	0-18	1 - 32	No	1) Maximum of three (3) teeth per benefit period. 2) Service is not covered when the damage to the appliance is a result of abuse, misuse or neglect.	None
PROSTHODONTICS	D5610	Repair resin denture base	0-18	Upper Arch (01, UA) or Lower Arch (02, LA)	No	1) A maximum of two (2) treatments per benefit period may be performed. 2) Service is not covered when the damage to the appliance is a result of abuse, misuse or neglect.	For Members where more than two treatments per year are deemed necessary, must submit narrative regarding need.

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PROSTHODONTICS	D5620	Repair cast framework	0-18	Upper Arch (01, UA) or Lower Arch (02, LA)	No	1) A maximum of two (2) treatments per benefit period may be performed. 2) Service is not covered when the damage to the appliance is a result of abuse, misuse or neglect.	For Members where more than two treatments per year are deemed necessary, must submit narrative regarding need.
PROSTHODONTICS	D5630	Repair or replace broken clasp	0-18	Intentionally left blank	No	1) A maximum of two (2) treatments per benefit period may be performed. 2) Service is not covered when the damage to the appliance is a result of abuse, misuse or neglect.	For Members where more than two treatments per year are deemed necessary, must submit narrative regarding need.
PROSTHODONTICS	D5640	Replace broken teeth per tooth	0-18	1 - 32	No	1) Maximum of three (3) teeth per benefit period. 2) Service is not covered when the damage to the appliance is a result of abuse, misuse or neglect.	None
PROSTHODONTICS	D5650	Add tooth to existing partial denture	0-18	1 - 32	No	1) Limited to a maximum of two (2) services per benefit period.	None
PROSTHODONTICS	D5660	Adding clasp to existing partial denture	0-18	Intentionally left blank	No	1) Limited to a maximum of two (2) treatments per benefit period.	None
PROSTHODONTICS	D5730	Reline complete maxillary denture (chairside)	0-18	Intentionally left blank	No	1) One per three (3) years 2) Not covered within six months of initial placement.	For Members where more than two treatments per year are deemed necessary, must submit narrative regarding need.
PROSTHODONTICS	D5731	Reline complete mandibular denture (chairside)	0-18	Intentionally left blank	No	1) One per three (3) years 2) Not covered within six months of initial placement.	For Members where more than two treatments per year are deemed necessary, must submit narrative regarding need.
PROSTHODONTICS	D5740	Reline maxillary partial denture (chairside)	0-18	Intentionally left blank	No	1) One per three (3) years 2) Not covered within six months of initial placement.	For Members where more than two treatments per year are deemed necessary, must submit narrative regarding need.
PROSTHODONTICS	D5741	Reline mandibular complete denture (chairside)	0-18	Intentionally left blank	No	1) One per three (3) years 2) Not covered within six months of initial placement.	For Members where more than two treatments per year are deemed necessary, must submit narrative regarding need.
PROSTHODONTICS	D5750	Reline complete maxillary denture (laboratory)	0-18	Intentionally left blank	No	1) One per three (3) years 2) Not covered within six months of initial placement.	For Members where more than two treatments per year are deemed necessary, must submit narrative regarding need.

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PROSTHODONTICS	D5751	Reline complete mandibular denture (laboratory)	0-18	Intentionally left blank	No	1) One per three (3) years 2) Not covered within six months of initial placement.	For Members where more than two treatments per year are deemed necessary, must submit narrative regarding need.
PROSTHODONTICS	D5760	Reline maxillary partial denture (laboratory)	0-18	Intentionally left blank	No	1) One per three (3) years 2) Not covered within six months of initial placement.	For Members where more than two treatments per year are deemed necessary, must submit narrative regarding need.
PROSTHODONTICS	D5761	Reline mandibular partial denture (laboratory)	0-18	Intentionally left blank	No	1) One per three (3) years 2) Not covered within six months of initial placement.	For Members where more than two treatments per year are deemed necessary, must submit narrative regarding need.
PROSTHODONTICS	D6211	Pontic - predominantly base metal	0-18	1-32	Yes	1) Limited to one (1) every five (5) years. 2) Only covered in cases where the service is medically necessary as a result of an accident or injury.	1) Pre-Treatment radiographs of adjacent and opposing teeth. 2) Resulting from external trauma only. 3) Generally limited to replacement of two missing anterior teeth.
PROSTHODONTICS	D6241	Pontic - porcelain fused to predominantly base metal	0-18	1-32	Yes	1) Limited to one (1) every five (5) years. 2) Only covered in cases where the service is medically necessary as a result of an accident or injury.	1) Pre-Treatment radiographs of adjacent and opposing teeth. 2) Resulting from external trauma only. 3) Generally limited to replacement of two missing anterior teeth.
PROSTHODONTICS	D6751	Crown - porcelain fused to predominantly base metal	0-18	1-32	Yes	1) Limited to one (1) every five (5) years. 2) Only covered if the tooth cannot be restored by another material such as amalgam or a less intensive restorative procedure. 3) Only covered in cases where the service is medically necessary as a result of an accident or injury.	1) Pre-Treatment radiographs of adjacent and opposing teeth. 2) Resulting from external trauma only. 3) Generally limited to replacement of two missing anterior teeth.

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PROSTHODONTICS	D6791	Crown - full cast predominantly base metal	0-18	1-32	Yes	1) Limited to one (1) every five (5) years. 2) Only covered if the tooth cannot be restored by another material such as amalgam or a less intensive restorative procedure. 3) Only covered in cases where the service is medically necessary as a result of an accident or injury.	1) Pre-Treatment radiographs of adjacent and opposing teeth. 2) Resulting from external trauma only. 3) Generally limited to replacement of two missing anterior teeth.
PROSTHODONTICS	D6930	Recement fixed partial denture	0-18	Intentionally left blank	No	1) Limited to one (1) every five (5) years. 2) Only covered in cases where the service is medically necessary as a result of an accident or injury.	None
PROSTHODONTICS	D6980	Fixed partial denture repair, by report	0-18	Intentionally left blank	No	1) Limited to one (1) every five (5) years. 2) Only covered in cases where the service is medically necessary as a result of an accident or injury.	None

Avesis UPMC *for Kids* Health Plan, Inc.
Covered Benefits and Fee Schedule

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ORAL SURGERY	**These Oral Surgery procedures comprise the Covered Benefits under the Avesis UPMC *for Kids* Dental Program. *Note: Some oral surgery services may be fully or partially covered under a member's medical benefits.**						
ORAL SURGERY	**Standards for review of Oral Surgery: A) Pre-operative long term prognosis of tooth. Loss of tooth structure, loss of periodontal support. B) Post-operative complete removal of tooth and roots.**						
ORAL SURGERY	**Reimbursement for oral surgery procedures includes local anesthesia, suturing and routine post - operative care.**						
ORAL SURGERY	**When extracting permanent supernumerary teeth, must use tooth numbers 51 through 82 which begin with the area of the upper right 3rd molar.**						
ORAL SURGERY	**When extracting primary supernumerary teeth, the teeth are to be identified by placing the letter "S" following the adjacent primary tooth.**						
ORAL SURGERY	**Extractions for asymptomatic impacted teeth are not a covered benefit unless removal constitutes the most cost - effective dental procedure for the provision of dentures.**						
ORAL SURGERY	D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0-18	1 - 32, 51 - 82, A - T, AS - TS	No	Intentionally left blank	None
ORAL SURGERY	D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth including cutting gingiva and bone and/or tooth and closure	0-18	1 - 32, 51 - 82, A - T, AS - TS	No	Includes cutting of gingiva and bone, removal of tooth structure and closure.	None
ORAL SURGERY	D7220	Removal of impacted tooth - soft tissue	0-18	1 - 32, 51 - 82	Yes	Removal of asymptomatic teeth not covered.	Pre-Treatment radiographs of adjacent and opposing teeth.
ORAL SURGERY	D7230	Removal of impacted tooth - partially bony - crown of tooth is completely covered by bone	0-18	1 - 32, 51 - 82	Yes	Removal of asymptomatic teeth not covered.	Pre-Treatment radiographs of adjacent and opposing teeth.
ORAL SURGERY	D7240	Removal of impacted tooth - completely bony - crown of tooth is completely covered by bone	0-18	1 - 32, 51 - 82	Yes	Removal of asymptomatic teeth not covered.	Pre-Treatment radiographs of adjacent and opposing teeth.
ORAL SURGERY	D7250	Surgical removal of residual tooth roots (cutting procedure)	0-18	1 - 32, 51 - 82, A - T, AS - TS	Yes	1) Not reimbursable to dentist or dental group that removed the tooth. 2) Removal of asymptomatic tooth not covered.	Pre-Treatment radiographs.
ORAL SURGERY	D7260	Oroantral fistula closure	0-18	Intentionally left blank	Yes	May be considered a benefit under the medical program.	1) Pre-Treatment radiographs. 2) Narrative
ORAL SURGERY	D7270	Tooth re-implantation and/or stabilization of accidentally avulsed or displaced tooth	0-18	1 - 32	Yes	1) May be considered a benefit under the medical program. 2) Includes splinting and/or stabilization.	1) Post Treatment radiographs. 2) Narrative
ORAL SURGERY	D7280	Surgical access of an unerupted tooth	0-18	1 - 32	Yes	Will not be payable unless the orthodontic treatment has been authorized as a covered benefit.	1) Pre-Treatment radiographs. 2) Narrative
ORAL SURGERY	D7283	Placement of device to facilitate eruption of impacted tooth	0-18	Intentionally left blank	No	None	None

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ORAL SURGERY	D7288	Brush biopsy - transepithelial sample collection	0-18	Intentionally left blank	No	None	None
ORAL SURGERY	D7310	Alveoloplasty in conjunction with extractions - per quadrant	0-18	Per quadrant - 10 (UR), 20 (UL), 30 (LL), 40 (LR)	Post Review	1) Once per lifetime 2) Minimum of three (3) extractions in the affected quadrant.	Pre-Treatment radiographs.
ORAL SURGERY	D7320	Alveoloplasty **"not"** in conjunction with extractions - per quadrant	0-18	Per quadrant - 10 (UR), 20 (UL), 30 (LL), 40 (LR)	Post Review	1) Once per lifetime 2) No extractions performed in the edentulous area.	1) Pre-Treatment radiographs. 2) Narrative
ORAL SURGERY	D7450	Removal of benign odontogenic cyst or tumor up to 1.25 cm.	0-18	Intentionally left blank	Post Review	1) Appropriate code must be put in the tooth number field on the claim form UR - upper right LR - lower right UL - upper left LL - lower left. 2) May be considered a benefit under the Medical Program.	1) Pre-Treatment radiograph. 2) Pathology Report.
ORAL SURGERY	D7451	Removal of benign odontogenic cyst or tumor 1.25 cm. or greater	0-18	Intentionally left blank	Post Review	1) Appropriate code must be put in the tooth number field on the claim form UR - upper right LR - lower right UL - upper left LL - lower left. 2) May be considered a benefit under the Medical Program.	1) Pre-Treatment radiograph. 2) Pathology Report.
ORAL SURGERY	D7460	Removal of benign non-odontogenic cyst or tumor up to 1.25 cm.	0-18	Intentionally left blank	Post Review	1) Appropriate code must be put in the tooth number field on the claim form UR - upper right LR - lower right UL - upper left LL - lower left. 2) May be considered a benefit under the Medical Program.	1) Pre-Treatment radiograph. 2) Pathology Report.
ORAL SURGERY	D7461	Removal of benign non-odontogenic cyst or tumor 1.25 cm. or larger	0-18	Intentionally left blank	Post Review	1) Appropriate code must be put in the tooth number field on the claim form UR - upper right LR - lower right UL - upper left LL - lower left. 2) May be considered a benefit under the Medical Program.	1) Pre-Treatment radiograph. 2) Pathology Report.
ORAL SURGERY	D7471	Removal of exostosis-lateral maxilla or mandibular	0-18	Upper Arch (01, UA) or Lower Arch (02, LA)	No	Once per lifetime	None
ORAL SURGERY	D7472	Removal of torus palatinus	0-18	Upper Arch (01, UA)	No	None	None
ORAL SURGERY	D7473	Removal of torus mandibularis	0-18	Lower Arch (02, LA)	No	None	None
ORAL SURGERY	D7485	Surgical reduction of osseious tuberosity	0-18	Intentionally left blank	No	None	None

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ORAL SURGERY	D7510	Incision and drainage of abscess intraoral - soft tissue	0-18	Intentionally left blank	No		Narrative
ORAL SURGERY	D7511	Incision and drainage of abscess intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	0-18	Intentionally left blank	No		Narrative
ORAL SURGERY	D7520	Incision and drainage of abscess extraoral - soft tissue	0-18	Intentionally left blank	No		Narrative
ORAL SURGERY	D7521	Incision and drainage of abscess extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	0-18	Intentionally left blank	No		Narrative
ORAL SURGERY	D7960	Frenulectomy -frenectomy or frenotomy (separate procedure)	0-18	Intentionally left blank	Yes	Once per lifetime per area.	1) Pre-Treatment radiographs. 2) Narrative

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ADA Category	CODE	PROCEDURE	UPMC *for Kids*	TEETH COVERED	AUTH REQUIRED	BENEFIT LIMITATIONS	ATTACHMENTS REQUIRED
ORTHODONTICS	**These Orthodontic procedures comprise the Covered Benefits under the Avesis UPMC *for Kids* Dental Program. Once a member has been approved for comprehensive orthodontic treatment, payment will be paid to the authorized dental provider as a lump sum at the beginning of the member's course of treatment. The lump sum payment received by the provider from UPMC for Kids is payment in full for the full course of treatment. Providers will not be required to refund any portion of this payment, nor may the provider bill the member directly, if the member ceases to have active coverage under UPMC for Kids during the course of treatment. Payments associated with comprehensive orthodontic services are subject to a lifetime limit of $5,200 per member regardless of whether the claims are paid out using D8080 or D8690 codes. • Members must have a fully erupted set of permanent teeth to be eligible for comprehensive orthodontic services • All orthodontic services require prior approval, a written plan of care and must be rendered by a participating provider. • Orthodontic treatment must be considered medically necessary and be the only method considered capable of preventing irreversible damage to the member's teeth or their supporting structures and restoring he member's oral structure to health and function. • A medically necessary orthodontic services is an orthodontic procedure that addresses a harmful habit (e.g. tongue thrusting) that is causing deformative changes to the teeth and/or jaw structure or is a limited, interceptive, or comprehensive orthodontic treatment that is intended to treat a severe dentofacial abnormality or serious handicapping malocclusion. Orthodontic services for cosmetic purposes are not covered. • Orthodontia procedures will only be approved for dentofacial abnormalities that severely compromise the member's physical health or for serious handicapping malocclusions. Presence of a serious handicapping malocclusion is determined by the magnitude of the following variables: degree of malalignment, missing teeth, angle classification, overjet and overbite, open bite and crossbite. Dentofacial abnormalities that severely compromise the member's physical health may be manifested by: (1) Markedly protruding upper jaw and teeth, protruding lower jaw and teeth, or the protrusion of upper and lower teeth so that the lips cannot be brought together. (2) Under-developed lower jaw and receding chin. (3) Marked asymmetry of the lower face. • A "handicapping" malocclusion is a condition that constitutes a hazard to the maintenance of oral health and interferes with the well being of the recipient by causing: (1) Obvious difficulty in eating because of the malocclusion, so as to require a liquid of semisoft diet, cause pain in jaw joints during eating, or extreme grimacing or excessive motions of the or facial muscles during eating because of necessary compensation for anatomic deviations. (2) Obvious severe breathing difficulties related to the malocclusion, such as unusually long lower face with downward rotation of the mandible in which lips cannot be brought together, or chronic moth breathing and postural abnormalities relating to breathing difficulties (3) Lisping or other speech articulation errors that are directly related to orofacial abnormalities and cannot be corrected by means other than orthodontic intervention. • Members who score 25 or higher on the Salzmann Evaluation index upon examination and evaluation by an orthodontist may be considered to meet the criteria required to substantiate the medical necessity for orthodontic treatment of a serious handicapping malocclusion.**						
Orthodontics	D8660	Pre-Orthodontic visit	0-18	Medically Necessary - not allowed for cosmetic reasons	Post Review	1) Only covered as a separate service if member is determined to be ineligible for other orthodontic services. 2) Limited to once per benefit period. 3) When covered as a separate service, payments associated with this code are applied to the $1,500 annual dental program benefit limit instead of the $5,200 comprehensive orthodontic treatment lifetime benefit limit.	1) Complete narrative describing Member's condition, compliance with and need for treatment, estimated treatment period 2) Study models 3) Radiographs

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Orthodontics	D8680	Orthodontic retention (removal of appliances, construction and placement of retainers)	0-18	Intentionally left blank	Yes	1) Can only be billed separately if not associated with comprehensive orthodontic treatment services. 2) When covered as a separate service, payments associated with this code are applied to the $1,500 annual dental program benefit limit instead of the $5,200 comprehensive orthodontic lifetime benefit limit.	1) Narrative 2) Radiographs
Orthodontics	D8690	Orthodontic treatment (alternative billing to a contract fee)	0-18	Intentionally left blank	Yes	1) Used when a patient under active treatment transfers from one provider to another. The new provider bills under this code and receives a prorated amount determined by Avesis. Payments associated with this code will be applied toward the $5,200 comprehensive orthodontic treatment lifetime benefit limit. Payments associated with this code are **NOT** applied toward the $1,500 annual dental program limit.	1) Narrative 2) Radiographs
Orthodontics	D8080	Comprehensive orthodontic treatment of adolescent dentitioin	0-20	Intentionally left blank	Yes	1) Comprehensive treatment of adolescent dentition. 2) Limited to once per lifetime. 3) Comprehensive treatment also includes the following services: D8660 (Pre-orthodontic visit) and D8680 (Orthodontic retention). 4) Payments associated with this code are applied to the $5,200 comprehensive orthodontic lifetime benefit limit and **NOT** the $1,500 annual dental program benefit limit.	1) Narrative 2) Radiographs
Adjunctive Services	**These Adjunctive Service procedures comprise the Covered Benefits under the Avesis UPMC *for Kids* Dental Program.**						
Adjunctive Services	**Local anesthesia is considered part of the treatment procedure and no additional payment will be made for it.**						
Adjunctive Services	**Use of IV sedation, general anesthesia, analgesia and non-intravenous conscious sedation can be authorized prior to treatment or reviewed retrospectively. Medical necessity must be demonstrated as these services are not routinely used for the apprehensive dental patient.**						
Adjunctive Services	**For procedure codes D9220, D9241 and D9248, the person responsible for the administration must have a current valid permit from the Pennsylvania State Board of Dentistry to do so.**						

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Unclassified Treatment	D9110	Palliative (emergency) treatment of dental pain, minor procedure	0-18	Intentionally left blank	No	1) Not allowed with any other services other than radiographs and/or behavior management. 2) Benefit is subject to review as an emergency dental service.	None
Anesthesia/Analgesia	D9220	Deep Sedation/ General Anesthesia - first 30 minutes	0-18	Intentionally left blank	Yes	1) Only one D9220, D9241, D9248, or D9920 on same date of service. 2) This service may be covered by the member's medical insurance, or the member may be subject to limits relating to facility type, provider type, or member age. Certain services may only be approved to be used with certain procedure may only be billed separately under certain circumstances and/or may require prior authorization.	1) Narrative detailing medical necessity and dental treatment done or to be done. 2) The person responsible for the administration must have a current valid permit from the Pennsylvania State Board of Dentistry to do so.
Anesthesia/Analgesia	D9221	Deep Sedation/ General Anesthesia - each additional 15 minutes	0-18	Intentionally left blank	Yes	1) Not covered on the same date of service as D9241 or D9248. 2) This service may be covered by the member's medical insurance, or the member may be subject to limits relating to facility type, provider type, or member age. Certain services may only be approved to be used with certain procedure may only be billed separately under certain circumstances and/or may require prior authorization.	1) Narrative detailing medical necessity and dental treatment done or to be done. 2) The person responsible for the administration must have a current valid permit from the Pennsylvania State Board of Dentistry to do so.
Anesthesia/Analgesia	D9241	Intravenous Sedation - first 30 minutes	0-18	Intentionally left blank	Yes	1) Only one D9220, D9241, D9248, or D9920 on same date of service. 2) This service may be covered by the member's medical insurance, or the member may be subject to limits relating to facility type, provider type, or member age. Certain services may only be approved to be used with certain procedure may only be billed separately under certain circumstances and/or may require prior authorization.	1) Narrative detailing medical necessity and dental treatment done or to be done. 2) The person responsible for the administration must have a current valid permit from the Pennsylvania State Board of Dentistry to do so.

Avesis UPMC *for Kids* Health Plan, Inc.
Covered Benefits and Fee Schedule

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Anesthesia/Analgesia	D9242	Intravenous Sedation - each additional 15 minutes	0-18	Intentionally left blank	Yes	1) Not covered on the same date of service as D9220 or D9248. 2) This service may be covered by the member's medical insurance, or the member may be subject to limits relating to facility type, provider type, or member age. Certain services may only be approved to be used with certain procedure may only be billed separately under certain circumstances and/or may require prior authorization.	1) Narrative detailing medical necessity and dental treatment done or to be done. 2) The person responsible for the administration must have a current valid permit from the Pennsylvania State Board of Dentistry to do so.
Anesthesia/Analgesia	D9248	Non-Intravenous Conscious Sedation	0-18	Intentionally left blank	No	Only one D9220, D9241, D9248, or D9920 on same date of service.	1) Narrative detailing medical necessity should be maintained in the patient record. 2) The person responsible for the administration must have a current valid permit from the Pennsylvania State Board of Dentistry to do so.