

HEALTH CHOICE ARIZONA DENTAL BENEFITS MATRIX

X-rays must accompany requests for PA. Requests may not be faxed. CODES NOT INCLUDED IN MATRIX REQUIRE PRIOR AUTHORIZATION. In the case of a dental emergency, the need for prior authorization (PA) for codes indicated with an asterisk (*) is waived and treatment will be retrospectively reviewed. X-rays and treatment notes must be submitted with claim.

ADA CODE	PROCEDURE DESCRIPTION	COMMENTS AND LIMITATIONS	PA REQUIRED?	COVERED AGES	DOCUMENTATION REQUIRED
	<i>ORAL EXAMINATIONS</i>				
D0120	PERIODIC ORAL EVALUATION	ONE D0120 OR D0145 EVERY 6 MONTHS OR <i>BY REPORT, NOT PAYABLE WITHIN 6 MONTHS OF D0150, ADULTS BY AUTH ONLY</i>	NO	0-99	
D0140	LIMITED ORAL EVALUATION - PROBLEM FOCUSED	NOT REIMBURSABLE ON THE SAME DAY AS D0120, D0145, D0150 OR D9110. <i>PAYABLE FOR THE EVALUATION OF EMERGENCY DENTAL SERVICES ONLY.</i>	NO	0-99	
D0145	ORAL EVALUATION, UNDER 3 YEARS OF AGE	ONE D0120 OR D0145 EVERY 6 MONTHS, <i>NOT PAYABLE WITHIN 6 MONTHS OF D0150, OR BY REPORT</i>	NO	0-2	
D0150	COMPREHENSIVE ORAL EVALUATION	ONE D0150 PER <u>LIFETIME</u> PER PROVIDER OR GROUP NOT PAYABLE WITHIN 6 MONTHS OF A D0120, D0145 WHEN PERFORMED BY THE SAME PROVIDER OR GROUP <i>BY REPORT, ADULTS BY AUTH ONLY</i>	NO	0-99	
D0160	DETAILED AND EXTENSIVE ORAL EVALUATION - PROBLEM FOCUSED	TO BE USED BY RECEIVING PROVIDER WHEN REFERRED BY HEALTH CHOICE ARIZONA ONLY (ORAL SURGEONS, ENDODONTIST), ADULTS BY AUTH ONLY	YES	0-99	
D0180	COMPREHENSIVE PERIO EVALUATION	AS PERFORMED BY A PERIODONTIST AS A RESULT OF A REFERRAL	YES	0-99	
	<i>RADIOGRAPHS</i>	<i>IF THE COMBINED FEES FOR INDIVIDUAL X-RAYS ON A SINGLE CLAIM EQUAL OR EXCEED THE FEE FOR AN FMX (D0210), THE CLAIM WILL BE PAID AT THE FMX FEE.</i>			

ADA CODE	PROCEDURE DESCRIPTION	COMMENTS AND LIMITATIONS	PA REQUIRED?	COVERED AGES	DOCUMENTATION REQUIRED
D0210	INTRAORAL-COMPLETE SERIES (INCLUDING BITEWINGS)	D0210 OR D0330 LIMITED TO ONE EVERY 36 MONTHS, FMX IS DEFINED AS AT LEAST 6 FILMS TAKEN ON THE SAME DATE OF SERVICE THAT CONSISTS OF, AT A MINIMUM, 2 BW X-RAYS AND ANY 4 OTHER INDIVIDUAL FILMS (PA'S OR OCCLUSALS), ADULTS BY AUTH ONLY	NO	0-99	
D0220	INTRAORAL-PERIAPICAL-FIRST FILM		NO	0-99	
D0230	INTRAORAL-PERIAPICAL-EACH ADDITIONAL FILM	LIMITED TO 5 ON THE SAME DATE OF TREATMENT	NO	0-99	
D0240	INTRAORAL-OCCLUSAL		NO	0-99	
D0250	EXTRAORAL-FIRST FILM	MEDICALLY NECESSITY, BY REPORT	YES	0-99	TREATMENT NOTES, X-RAYS
D0260	EXTRAORAL-EACH ADDITIONAL FILM	MEDICALLY NECESSITY, BY REPORT	YES	0-99	TREATMENT NOTES, X-RAYS
D0270	BITEWING - 1 FILM	D0270, D0272, D0273, D0274 OR D277 LIMITED TO ONE EVERY 6 MONTHS, NOT PAYABLE WITHIN 6 MONTHS OF FMX , OR BY REPORT	NO	0-20	
D0272	BITEWINGS - 2 FILMS	D0270, D0272, D0273, D0274 OR D277 LIMITED TO ONE EVERY 6 MONTHS, NOT PAYABLE WITHIN 6 MONTHS OF FMX , OR BY REPORT	NO	0-20	
D0273	BITEWINGS - 3 FILMS	D0270, D0272, D0273, D0274 OR D277 LIMITED TO ONE EVERY 6 MONTHS, NOT PAYABLE WITHIN 6 MONTHS OF FMX , OR BY REPORT	NO	0-20	
D0274	BITEWINGS - 4 FILMS	D0270, D0272, D0273, D0274 OR D277 LIMITED TO ONE EVERY 6 MONTHS, NOT PAYABLE WITHIN 6 MONTHS OF FMX , OR BY REPORT	NO	0-20	
D0277	VERTICAL BITEWINGS- 7 TO 8 FILMS	LIMITED TO ONE EVERY 6 MONTHS, NOT PAYABLE WITHIN 6 MONTHS OF FMX , OR BY REPORT MEDICAL NECESSITY	YES	0-99	T
D0290	POSTERIOR-ANTERIOR OR LATERAL SKULL AND FACIAL BONE SURVEY FILM	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES, X-RAYS
D0310	SIALOGRAPHRY	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES
D0320	TEMPOROMANDIBULAR JOINT ARTHROGRAM, INCL. INJECTION	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES

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D0321	OTHER TEMPOROMANDIBULAR JOINT FILMS	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES
D0330	PANORAMIC FILM	D0210 OR D0330 LIMITED TO ONE EVERY 36 MONTHS, NOT PAYABLE FOR CHILDREN 5 YEARS OF AGE AND YOUNGER OR BY REPORT, ADULTS BY AUTH ONLY	NO	0-99	
D0340	CEPHALOMETRIC FILM	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES
D0350	ORAL/FACIAL IMAGES	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES
D0470	DIAGNOSTIC CASTS	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES, X-RAYS
D0502	OTHER ORAL PATHOLOGY PROCEDURES, BY REPORT	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES, X-RAYS
	<i>PREVENTIVE DENTAL PROCEDURES</i>				
D1110	PROPHYLAXIS-ADULT	TWICE A YEAR AT LEAST 6 MONTHS APART, ADULTS BY AUTH ONLY	NO	14-99	
D1120	PROPHYLAXIS-CHILD	TWICE A YEAR AT LEAST 6 MONTHS APART	NO	0-13	
D1203	TOPICAL APPLICATION OF FLUORIDE - CHILD	D1203, D1204 OR D1206 LIMITED TO ONE TWO TIMES A YEAR AND MUST BE AT LEAST 6 MONTHS APART	NO	0-13	
D1204	TOPICAL APPLICATION OF FLUORIDE - ADULT	D1203, D1204 OR D1206 LIMITED TO ONE TWO TIMES A YEAR AND MUST BE AT LEAST 6 MONTHS APART, ADULTS BY AUTH ONLY	NO	14-20	
D1206	TOPICAL FLUORIDE VARNISH	D1203, D1204 OR D1206 LIMITED TO ONE TWO TIMES A YEAR AND MUST BE AT LEAST 6 MONTHS APART	NO	0-20	
D1351	SEALANT-PER TOOTH	LIMITED TO TEETH #' 2, 3, 14, 15, 18, 19, 30, 31, WHEN NO DECAY OR RESTORATION PRESENT, LIMITED TO ONE EVERY 12 MONTHS	NO	0-20	
D1510*	SPACE MAINTAINER-FIXED UNILATERAL	POSTERIOR TEETH ONLY, PAID WHEN THERE IS BONE ABOVE THE ERUPTING PERMANENT TOOTH. RETRO REVIEW WHEN PLACED AT THE SAME TIME AS PRIMARY TOOTH EXTRACTION. NO REIMBURSEMENT FOR REPLACEMENT WITHIN 12 MONTHS OF ORIGINAL PLACEMENT WHEN BILLED BY SAME PROVIDER	YES	0-14	PRE-TREAT X-RAYS

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D1515*	SPACE MAINTAINER-FIXED BILATERAL	POSTERIOR TEETH ONLY, PAID WHEN THERE IS BONE ABOVE THE ERUPTING PERMANENT TOOTH. RETRO REVIEW WHEN PLACED AT THE SAME TIME AS PRIMARY TOOTH EXTRACTION. NO REIMBURSEMENT FOR REPLACEMNT WITHIN 12 MONTHS OF ORIGINAL PLACEMENT WHEN BILLED BY SAME PROVIDER	YES	0-14	PRE-TREAT X-RAYS
D1520*	SPACE MAINTAINER-REMOVABLE UNILATERAL	POSTERIOR TEETH ONLY, PAID WHEN THERE IS BONE ABOVE THE ERUPTING PERMANENT TOOTH. RETRO REVIEW WHEN PLACED AT THE SAME TIME AS PRIMARY TOOTH EXTRACTION. NO REIMBURSEMENT FOR REPLACEMNT WITHIN 12 MONTHS OF ORIGINAL PLACEMENT WHEN BILLED BY SAME PROVIDER	YES	0-14	PRE-TREAT X-RAYS
D1525*	SPACE MAINTAINER-REMOVABLE BILATERAL	POSTERIOR TEETH ONLY, PAID WHEN THERE IS BONE ABOVE THE ERUPTING PERMANENT TOOTH. RETRO REVIEW WHEN PLACED AT THE SAME TIME AS PRIMARY TOOTH EXTRACTION. NO REIMBURSEMENT FOR REPLACEMNT WITHIN 12 MONTHS OF ORIGINAL PLACEMENT WHEN BILLED BY SAME PROVIDER	YES	0-14	PRE-TREAT X-RAYS
D1550	RECEMENTATION OF SPACE MAINTAINER	POSTERIOR TEETH ONLY, PAID WHEN THERE IS BONE ABOVE THE ERUPTING PERMANENT TOOTH, NON EMERGENT PROCEDURE, NO RETRO REVIEW, NO REIMBURSEMENT FOR REPLACEMNT WITHIN 12 MONTHS OF ORIGINAL PLACEMENT WHEN BILLED BY SAME PROVIDER	YES	0-14	PRE-TREAT X-RAYS
D1555	REMOVAL OF FIXED SPACE MAINTAINER	MEDICAL NECESSITY; PAYABLE ONLY TO A DENTIST OR GROUP WHO DID NOT ORIGINALLY PLACE THE APPLIANCE.	YES	0-14	PRE-TREAT X-RAYS
	<i>RESTORATIVE DENTAL PROCEDURES</i>	<i>MULTIPLE SURFACES RESTORED ON THE SAME DATE OF SERVICE, WHETHER CONNECTING SURFACES OR NOT, WILL BE REIMBURSED FOR THE TOTAL NUMBER OF SURFACES RESTORED.</i>			
D2140	AMALGAM-ONE SURFACE, PRIMARY OR PERMANENT		NO	0-20	

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D2150	AMALGAM-TWO SURFACES, PRIMARY OR PERMANENT		NO	0-20	
D2160	AMALGAM-THREE SURFACES, PRIMARY OR PERMANENT		NO	0-20	
D2161	AMALGAM-FOUR OR MORE SURFACES, PRIMARY OR PERMANENT		NO	0-20	
D2330	RESIN-ONE SURFACE, ANTERIOR	ADULT CARE MUST MEET CRITERIA FOR EMERGENCY TREATMENT, SUBMIT X-RAY AND TREATMENT NOTES WITH CLAIM	NO	0-99	
D2331	RESIN-TWO SURFACES, ANTERIOR	ADULT CARE MUST MEET CRITERIA FOR EMERGENCY TREATMENT, SUBMIT X-RAY AND TREATMENT NOTES WITH CLAIM	NO	0-99	
D2332	RESIN-THREE SURFACES, ANTERIOR	ADULT CARE MUST MEET CRITERIA FOR EMERGENCY TREATMENT, SUBMIT X-RAY AND TREATMENT NOTES WITH CLAIM	NO	0-99	
D2335	RESIN-FOUR OR MORE SURFACES OR INVOLVING INCISAL ANGLE (ANTERIOR)	ADULT CARE MUST MEET CRITERIA FOR EMERGENCY TREATMENT, SUBMIT X-RAY AND TREATMENT NOTES WITH CLAIM	NO	0-99	
D2390 *	RESIN BASED COMPOSITE CROWN, ANTERIOR	BUILDUP INCLUDED IN REIMBURSEMENT , RETROSPECTIVELY REVIEWED FOR EMERGENCY TREATMENT ONLY WHEN PERFORMED IN CONJUNCTION WITH A PULPOTOMY ON THE SAME DATE OF SERVICE	YES	0-20	
D2391	RESIN BASED COMPOSITE, ONE SURFACE, POSTERIOR		NO	0-20	
D2392	RESIN BASED COMPOSITE, TWO SURFACES, POSTERIOR		NO	0-20	
D2393	RESIN BASED COMPOSITE, THREE SURFACES, POSTERIOR		NO	0-20	
D2394	RESIN BASED COMPOSITE, FOUR OR MORE SURFACES, POSTERIOR		NO	0-20	
	<i>FIXED CAST RESTORATIONS</i>	<i>PAYABLE ONLY ON SEAT DATE, INCLUDE PA OF FINAL CROWN SEAT WITH CLAIM</i>			
D2750	CROWN-PORCELAIN FUSED TO HIGH NOBLE METAL	LIMITED TO 18 - 20 YR. OLDS WITH COMPLETED ROOT CANAL THERAPY.	YES	18-20	ENDO POST OP FILM, FINAL CROWN SEAT FILM

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D2751	CROWN-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	LIMITED TO 18 - 20 YR. OLDS WITH COMPLETED ROOT CANAL THERAPY.	YES	18-20	ENDO POST OP FILM, FINAL CROWN SEAT FILM
D2752	CROWN-PORCELAIN FUSED TO NOBLE METAL	LIMITED TO 18 - 20 YR. OLDS WITH COMPLETED ROOT CANAL THERAPY.	YES	18-20	ENDO POST OP FILM, FINAL CROWN SEAT FILM
D2790	CROWN-FULL CAST HIGH NOBLE METAL	LIMITED TO 18 - 20 YR. OLDS WITH COMPLETED ROOT CANAL THERAPY.	YES	18-20	ENDO POST OP FILM, FINAL CROWN SEAT FILM
D2791	CROWN-FULL CAST PREDOMINANTLY BASE METAL	LIMITED TO 18 - 20 YR. OLDS WITH COMPLETED ROOT CANAL THERAPY.	YES	18-20	ENDO POST OP FILM, FINAL CROWN SEAT FILM
D2792	CROWN-FULL CAST NOBLE METAL	LIMITED TO 18 - 20 YR. OLDS WITH COMPLETED ROOT CANAL THERAPY.	YES	18-20	ENDO POST OP FILM, FINAL CROWN SEAT FILM
D2794	CROWN - TITANIUM	LIMITED TO 18 - 20 YR. OLDS WITH COMPLETED ROOT CANAL THERAPY.	YES	18-20	ENDO POST OP FILM, FINAL CROWN SEAT FILM
	<i>OTHER RESTORATIVE SERVICES</i>				
D2910	RECEMENT INLAY	MEDICAL NECESSITY	NO	0-99	X-RAYS
D2915	RECEMENT CAST OR PREFABRICATED POST AND CORE	MEDICAL NECESSITY	YES	0-99	V
D2920 *	RECEMENT CROWN	NO REIMBURSEMENT WHEN CROWN PLACED WITHIN PAST 12 MONTHS BY BILLING PROVIDER	NO	0-99	TREATMENT NOTES, X-RAYS
D2930 *	PREFABRICATED STAINLESS STEEL CROWN-PRIMARY TOOTH	BUILDUP INCLUDED IN REIMBURSEMENT, RETROSPECTIVELY REVIEWED FOR EMERGENCY TREATMENT ONLY WHEN PERFORMED IN CONJUNCTION WITH A PULPOTOMY ON THE SAME DATE OF SERVICE – POSTERIOR TEETH ONLY	YES	0-14	TREATMENT NOTES, X-RAYS
D2931*	PREFABRICATED STAINLESS STEEL CROWN-PERMANENT TOOTH	BUILDUP INCLUDED IN REIMBURSEMENT EXCEPT IN CASES OF EXTREME TOOTH LOSS	YES	0-99	TREATMENT NOTES, X-RAYS
D2932*	PREFABRICATED RESIN CROWN	BUILDUP INCLUDED IN REIMBURSEMENT	YES	0-20	TREATMENT NOTES, X-RAYS
D2933 *	PREFABRICATED STAINLESS STEEL CROWN WITH RESIN WINDOW – PRIMARY TOOTH	BUILDUP INCLUDED IN REIMBURSEMENT, RETROSPECTIVELY REVIEWED FOR EMERGENCY TREATMENT ONLY WHEN PERFORMED IN CONJUNCTION WITH A PULPOTOMY ON THE SAME DATE OF SERVICE	YES	0-20	TREATMENT NOTES, X-RAYS

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D2934 *	PREFABRICATED ESTHETIC COATED STAINLESS STEEL CROWN-PRIMARY TOOTH	BUILDUP INCLUDED IN REIMBURSEMENT, RETROSPECTIVELY REVIEWED FOR EMERGENCY TREATMENT ONLY WHEN PERFORMED IN CONJUNCTION WITH A PULPOTOMY ON THE SAME DATE OF SERVICE	YES	0-20	
D2940	SEDATIVE FILLING	PAID ONLY WHEN BILLED ON SEPARATE DATES FROM PERMANENT FILLING. ALSO NOT PAYABLE WHEN PERFORMED IN CONJUNCTION WITH ENDODONTIC PROCEDURES. AN ENDODONTIC PROCEDURE IS DEEMED STARTED WHEN PULP HAS BEEN EXPOSED.	NO	0-99	TREATMENT NOTES, X-RAYS
D2950	CORE BUILD-UP, INCLUDING ANY PINS	PRIMARY TEEETH -INCLUDED IN THE COST OF THE COST OF A CROWN. PERMANENT TEETH - COVERED ONLY IF MORE THAN 1/2 OF THE TOOTH STRUCTURE IS ABSENT ON PERMANENT MOLARS. NOT PAYABLE FOR PERMANENT ANTERIOR AND BICUSPID TEETH UNLESS TREATMENT FOLLOWS RCT, SUBMIT FINAL ENDO FILM.	YES	0-99	TREATMENT NOTES, X-RAYS
D2951	PIN RETENTION-PER TOOTH, IN ADDITION TO RESTORATION	COVERED ONLY IF MORE THAN 1/2 OF THE TOOTH STRUCTURE IS ABSENT AND SUBMITTED WITH TREATMENT NOTES.	YES	0-99	TREATMENT NOTES, X-RAYS
D2952	CAST POST AND CORE IN ADDITION TO CROWN	MEDICAL NECESSITY	YES	18-20	TREATMENT NOTES, X-RAYS
D2954	PREFABRICATED POST AND CORE IN ADDITION TO CROWN	LIMITED TO MBRS 18-20 YR OLDS FOR TEETH THAT HAVE BEEN TREATED WITH RCT - SUBMIT WITH RCT POST-OP X-RAY	YES	18-20	TREATMENT NOTES, X-RAYS
D2970*	TEMPOARY CROWN (FRACTURED TOOTH)	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES, X-RAYS
	<i>ENDODONTIC PROCEDURES</i>	<i>PRE- AND POST-OPERATIVE X-RAYS ARE CONSIDERED TO BE INCLUDED IN RCT FEE. BW X-RAY SHOWING OPPOSING TOOTH IS REQUIRED FOR PAYMENT.</i>			
D3110	PULP CAP-DIRECT	POSTERIOR TEETH ONLY, PAID ONLY WHEN BILLED ON SEPARATE DATES FROM SEDATIVE, TEMPOARY OR PERMANENT FILING	NO	0-99	TREATMENT NOTES, X-RAYS

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D3120	PULP CAP-INDIRECT	POSTERIOR TEETH ONLY, PAID ONLY WHEN BILLED ON SEPARATE DATES FROM SEDATIVE, TEMPORARY OR PERMANENT FILING	NO	0-99	TREATMENT NOTES, X-RAYS
D3220 *	THERAPEUTIC PULPOTOMY (EXCLUDING FINAL RESTORATION) REMOVAL OF PULP CORONAL	RETRO REVIEW FOR EMERGENCY TREATMENT OR TREATMENT CHANGES ONLY, PRE- OP X-RAYS REQUIRED FOR PAYMENT	YES	0-99	TREATMENT NOTES, X-RAYS
D3221*	PULPAL DEBRIDEMENT	PAYABLE IF SUBSEQUENT RCT IS TO BE REFERRED FOR SPECIALTY CARE, OTHERWISE IT IS CONSIDERED THE START OF RCT.	YES	0-99	TREATMENT NOTES, X-RAYS
D3222*	PARTIAL PULPOTOMY FOR APEXOGENESIS – PERMANENT TOOTH WITH INCOMPLETE ROOT DEVELOPMENT.	RETRO REVIEW FOR EMERGENCY TREATMENT OR TREATMENT CHANGES ONLY, PRE AND POST OP X-RAYS REQUIRED FOR PAYMENT.	YES	5-12	TREATMENT NOTES, X-RAYS
D3230 *	PULPAL THERAPY (RESTORABLE FILLING)- ANTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION)	RETRO REVIEW FOR EMERGENCY TREATMENT OR TREATMENT CHANGES ONLY, PRE AND POST OP X-RAYS REQUIRED FOR PAYMENT	YES	0-12	TREATMENT NOTES, X-RAYS
D3240 *	PULPAL THERAPY (RESORBABLE FILLING)- POSTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION)	RETRO REVIEW FOR EMERGENCY TREATMENT OR TREATMENT CHANGES ONLY, PRE- AND POST OP X-RAYS REQUIRED FOR PAYMENT	YES	0-14	X-RAYS
D3310 *	ANTERIOR (EXCLUDING FINAL RESTORATION)	RETRO REVIEW FOR EMERGENCY TREATMENT OR TREATMENT CHANGES ONLY, PRE- AND POST-OP X-RAYS REQUIRED FOR PAYMENT. ONLY PAYABLE WHEN OPPOSING TOOTH IS PRESENT.	YES	0-99	PRE & POST OP X-RAYS AND BW X-RAY SHOWING OPPOSING TOOTH
D3320 *	BICUSPID (EXCLUDING FINAL RESTORATION)	RETRO REVIEW FOR EMERGENCY TREATMENT OR TREATMENT CHANGES ONLY, PRE- AND POST-OP X-RAYS REQUIRED FOR PAYMENT. ONLY PAYABLE WHEN OPPOSING TOOTH IS PRESENT.	YES	0-20	PRE & POST OP X-RAYS AND BW X-RAY SHOWING OPPOSING TOOTH
D3330 *	MOLAR (EXCLUDING FINAL RESTORATION)	RETRO REVIEW FOR EMERGENCY TREATMENT OR TREATMENT CHANGES ONLY, PRE- AND POST-OP X-RAYS REQUIRED FOR PAYMENT. ONLY PAYABLE WHEN OPPOSING TOOTH IS PRESENT.	YES	0-20	PRE & POST OP X-RAYS AND BW X-RAY SHOWING OPPOSING TOOTH
D3331	TREATMENT ROOT CANAL DESTRUCTION NON SURG ACCESS	MEDICAL NECESSITY	YES	0-99	PRE & POST OP X-RAYS AND BW X-RAY SHOWING OPPOSING TOOTH

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D3332	INCOMPLETE ENDODONTIC THERAPY INOPER OR FX TOOTH	MEDICAL NECESSITY	YES	0-99	PRE & POST OP X-RAYS AND BW X-RAY SHOWING OPPOSING TOOTH
D3333	INTERNAL ROOT REPAIR OF PERFORATION DEFECTS	MEDICAL NECESSITY	YES	0-99	PRE & POST OP X-RAYS AND BW X-RAY SHOWING OPPOSING TOOTH
D3346	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY-ANTERIOR	MEDICAL NECESSITY. ONLY PAYABLE WHEN OPPOSING TOOTH IS PRESENT AND ARCH INTEGRITY IS INTACT.	YES	0-99	PRE & POST OP X-RAYS AND BW X-RAY SHOWING OPPOSING TOOTH
D3347	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY-BICUSPID	MEDICAL NECESSITY. ONLY PAYABLE WHEN OPPOSING TOOTH IS PRESENT AND ARCH INTEGRITY IS INTACT.	YES	0-99	PRE & POST OP X-RAYS AND BW X-RAY SHOWING OPPOSING TOOTH
D3348	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY-MOLAR	MEDICAL NECESSITY. ONLY PAYABLE WHEN OPPOSING TOOTH IS PRESENT AND ARCH INTEGRITY IS INTACT.	YES	0-99	PRE & POST OP X-RAYS AND BW X-RAY SHOWING OPPOSING TOOTH
D3351 *	APEXIFICATION/RECALCIFICATION-INITIAL VISIT	MEDICAL NECESSITY. ONLY PAYABLE WHEN OPPOSING TOOTH IS PRESENT AND ARCH INTEGRITY IS INTACT.	YES	0-99	PRE & POST OP X-RAYS AND BW X-RAY SHOWING OPPOSING TOOTH
D3352	APEXIFICATION/RECALCIFICATION-INTERIM MEDICATION REPLACEMENT	MEDICAL NECESSITY. ONLY PAYABLE WHEN OPPOSING TOOTH IS PRESENT AND ARCH INTEGRITY IS INTACT.	YES	0-99	PRE & POST OP X-RAYS AND BW X-RAY SHOWING OPPOSING TOOTH
D3353	APEXIFICATION/RECALCIFICATION-FINAL VISIT (INCLUDES COMPLETED ROOT CANAL)	MEDICAL NECESSITY. ONLY PAYABLE WHEN OPPOSING TOOTH IS PRESENT AND ARCH INTEGRITY IS INTACT.	YES	0-99	PRE & POST OP X-RAYS AND BW X-RAY SHOWING OPPOSING TOOTH
D3410	APICOECTOMY/PERIRADICULAR SURGERY-ANTERIOR	MEDICAL NECESSITY	YES	0-99	PRE & POST OP X-RAYS AND BW X-RAY SHOWING OPPOSING TOOTH
D3421	APICOECTOMY/PERIRADICULAR SURGERY-BICUSPID (FIRST ROOT)	MEDICAL NECESSITY	YES	0-99	PRE & POST OP X-RAYS AND BW X-RAY SHOWING OPPOSING TOOTH
D3425	APICOECTOMY/PERIRADICULAR SURGERY-MOLAR (FIRST ROOT).	MEDICAL NECESSITY	YES	0-99	PRE & POST OP X-RAYS AND BW X-RAY SHOWING OPPOSING TOOTH
D3426	APICOECTOMY/PERIRADICULAR SURGERY (EACH ADDITIONAL ROOT)	MEDICAL NECESSITY	YES	0-99	PRE & POST OP X-RAYS AND BW X-RAY SHOWING OPPOSING TOOTH

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D3430	RETROGRADE FILLING-PER ROOT	MEDICAL NECESSITY	YES	0-99	PRE & POST OP X-RAYS AND BW X-RAY SHOWING OPPOSING TOOTH
D3450	ROOT AMPUTATION-PER ROOT	MEDICAL NECESSITY	YES	0-99	PRE & POST OP X-RAYS AND BW X-RAY SHOWING OPPOSING TOOTH
D3470*	INTENTIONAL REIMPLANTTON, INCLUDING NECESSARY SPLINTING	MEDICAL NECESSITY	YES	0-20	PRE & POST OP X-RAYS AND BW X-RAY SHOWING OPPOSING TOOTH
D3920	HEMISECTION (INCLUDING ANY ROOT REMOVAL), NOT INCLUDING ROOT CANAL	MEDICAL NECESSITY	YES	0-99	PRE & POST OP X-RAYS AND BW X-RAY SHOWING OPPOSING TOOTH
	<i>PERIODONTAL PROCEDURES</i>	MUST MEET DENTAL CLINICAL CRITERIA TO BE CONSIDERED FOR APPROVAL/PAYMENT			
D4210	GINGIVECTOMY OR GINGIVOPLASTY-PER QUADRANT	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES, PERIO CHART, AND X-RAYS
D4211	GINGIVECTOMY OR GINGIVOPLASTY-PER TOOTH	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES, PERIO CHART, AND X-RAYS
D4240	GINGIVAL FLAP PROCEDURE, INCLUDING ROOT PLANING-PER QUADRANT	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES, PERIO CHART, AND X-RAYS
D4241	GINGIVAL FLAP PROCEDURE, ONE TO THREE TEETH PER QUAD	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES, PERIO CHART, AND X-RAYS
D4249	CLINICAL CROWN LENGTHENING-HARD TISSUE	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES, PERIO CHART, AND X-RAYS
D4260	OSSEOUS SURGERY (INCLUDING FLAP ENTRY AND CLOSURE)-PER QUADRANT	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES, PERIO CHART, AND X-RAYS
D4261	OSSEOUS SURGERY - ONE TO THREE TEETH PER QUAD	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES, PERIO CHART, AND X-RAYS

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D4263	BONE REPLACEMENT GRAFT-FIRST SITE IN QUADRANT	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES, PERIO CHART, AND X-RAYS
D4264	BONE REPLACEMENT GRAFT-EACH ADDITIONAL SITE IN QUADRANT	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES, PERIO CHART, AND X-RAYS
D4265	BIOLOGICAL MATTER TO AID IN SOFT & OSSEOUS TISS REGEN	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES, PERIO CHART, AND X-RAYS
D4266	GUIDED TISSUE REGENERATION-RESORBABLE BARRIER, PER SITE, PER TOOTH	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES, PERIO CHART, AND X-RAYS
D4267	GUIDED TISSUE REGENERATION NON-RESORBABLE	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES, PERIO CHART, AND X-RAYS
D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES, PERIO CHART, AND X-RAYS
D4271	FREE SOFT TISSUE GRAFT PROCEDURE (INCLUDING DONOR SITE SURGERY)	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES, PERIO CHART, AND X-RAYS
D4273	SUBEPITHELIAL CONNECTIVE TISSUE GRAFT PROCEDURES	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES, PERIO CHART, AND X-RAYS
D4274	DISTAL OR PROXIMAL WEDGE PROCEDURE (WHEN NOT PERFORMED IN CONJUNCTION WITH SURGI	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES, PERIO CHART, AND X-RAYS
D4275	SOFT TISSUE ALLOGRAFT	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES, PERIO CHART, AND X-RAYS
D4276	COMBINED CONNECTIVE TISSUE & DOUBLE PEDICLE GRAFT	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES, PERIO CHART, AND X-RAYS
D4320	PROVISIONAL SPLINTING-INTRACORONAL	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES, PERIO CHART, AND X-RAYS

ADA CODE	PROCEDURE DESCRIPTION	COMMENTS AND LIMITATIONS	PA REQUIRED?	COVERED AGES	DOCUMENTATION REQUIRED
D4321	PROVISIONAL SPLINTING-EXTRACORONAL	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES, PERIO CHART, AND X-RAYS
D4341	PERIODONTAL SCALING AND ROOT PLANING-PER QUADRANT	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES, PERIO CHART, AND X-RAYS
D4342	PERIODONTAL SCALING AND ROOT PLANING, 1 TO 3 TEETH PER QUAD	MEDICAL NECESSITY	YES	0-99	
D4355	FULL MOUTH DEBRIDEMENT	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES, PERIO CHART, AND X-RAYS
D4910	PERIODONTAL MAINTENANCE PROCEDURES (FOLLOWING ACTIVE THERAPY)	MEDICAL NECESSITY, LIMITED TO ONE PER LIFETIME ONLY 6 MONTHS AFTER D4341	YES	0-99	TREATMENT NOTES, PERIO CHART, AND X-RAYS
D4920	UNSCHEDULED DRESSING CHANGE (BY SOMEONE OTHER THAN TREATING DENTIST)	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES
	<i>PROSTHODONTIC PROCEDURES (WHEN MEDICALLY NECESSARY)</i>				
D5110	COMPLETE DENTURE - MAXILLARY	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES
D5120	COMPLETE DENTURE - MANDIBULAR	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES
D5130	IMMEDIATE DENTURE - MAXILLARY	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES
D5140	IMMEDIATE DENTURE - MANDIBULAR	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES
D5211	UPPER PARTIAL-RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES
D5212	LOWER PARTIAL-RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES
D5213	MAXILLARY PARTIAL DENTURE - CAST METAL FRAMEWORK WITH RESIN DENTURE BASES	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES
D5214	MANDIBULAR PARTIAL DENTURE - CAST METAL FRAMEWORK WITH RESIN DENTURE BASES	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES
D5281	REMOVABLE UNILATERAL PARTIAL DENTURE-ONE PIECE CAST METAL	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES
D5410	ADJUST COMPLETE DENTURE - MAXILLARY	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES
D5411	ADJUST COMPLETE DENTURE - MANDIBULAR	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES
D5421	ADJUST PARTIAL DENTURE - MAXILLARY	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES

ADA CODE	PROCEDURE DESCRIPTION	COMMENTS AND LIMITATIONS	PA REQUIRED?	COVERED AGES	DOCUMENTATION REQUIRED
D5510 – D5999	OTHER PROSTHODONTIC PROCEDURES	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES
D6999	UNSPECIFIED FIXED PROSTHODONTIC PROCEDURE	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES
	ORAL & MAXILLOFACIAL SURGERY PROCEDURES (SYMPTOMATIC TEETH ONLY) <i>ALL THIRD MOLAR EXTRACTIONS REQUIRE PA. WHEN PERFORMED AS EMERGENCY TREATMENT, PA X-RAYS (OR PANO) AND CHART NOTES SHOWING PALLIATIVE TREATMENT (TREATMENT FOR PERICORONITIS IS REQUIRED.</i>	<i>EXTRACTIONS OF NATURALLY EXFOLIATING TEETH ARE NOT A COVERED BENEFIT. EXTRACTIONS ARE COVERED ONLY IF THE TOOTH IS SYMPTOMATIC AND/OR EXHIBITS PATHOLOGY.</i>			<i>DIAGNOSTIC QUALITY PA X-RAYS OR PANO MUST ACCOMPANY REFERRAL AND PRIOR AUTHORIZAION REQUESTS FOR THE REMOVAL OF SYMPTOMATIC THIRD MOLARS.</i>
D7111	CORONAL REMNANT - DECIDUOUS TOOTH	LIMITED TO 2 EXTRACTIONS PER DAY	NO	0-20	
D7140	EXTRACTION, ERRUPTED OR EXPOSED TOOTH	ALTHOUGH NO PA IS REQUIRED, CLAIM SUBMISSION REQUIRES PRETREAT X-RAYS AND CHART NOTES, LIMITED TO 21 PER DAY	PERMANENT TEETH - RETRO REVIEW REQUIRED	0-99	TREATMENT NOTES, X-RAYS
D7210 *	SURGICAL REMOVAL OF ERUPTED TOOTH REQUIRING ELEVATION OF MUCOPERIOSTEAL FLAP AND REMOVAL OF BONE AND/OR SECTION OF TOOTH	MEDICAL NECESSITY, PRE-OP X-RAY AND CHART NOTES ARE REQUIRED FOR PAYMENT IN THE CASE OF EMERGENCY TREATMENT	YES	0-99	TREATMENT NOTES, X-RAYS
D7220 *	REMOVAL OF IMPACTED TOOTH-SOFT TISSUE	MEDICAL NECESSITY, PRE-OP X-RAY AND CHART NOTES ARE REQUIRED FOR PAYMENT IN THE CASE OF EMERGENCY TREATMENT	YES	0-99	TREATMENT NOTES, X-RAYS
D7230 *	REMOVAL OF IMPACTED TOOTH-PARTIALLY BONY	MEDICAL NECESSITY, PRE-OP X-RAY AND CHART NOTES ARE REQUIRED FOR PAYMENT IN THE CASE OF EMERGENCY TREATMENT	YES	0-99	TREATMENT NOTES, X-RAYS
D7240 *	REMOVAL OF IMPACTED TOOTH-COMPLETLY BONY	MEDICAL NECESSITY, PRE-OP X-RAY AND CHART NOTES ARE REQUIRED FOR PAYMENT IN THE CASE OF EMERGENCY TREATMENT	YES	0-99	TREATMENT NOTES, X-RAYS
D7241 *	REMOVAL OF IMPACTED TOOTH-COMPLETLY BONY, WITH UNUSUAL SURGICAL COMPLICATIONS	MEDICAL NECESSITY, PRE-OP X-RAY AND CHART NOTES ARE REQUIRED FOR PAYMENT IN THE CASE OF EMERGENCY TREATMENT	YES	0-99	TREATMENT NOTES, X-RAYS
D7250 *	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)	MEDICAL NECESSITY, PRE-OP X-RAY AND CHART NOTES ARE REQUIRED FOR PAYMENT IN THE CASE OF EMERGENCY TREATMENT	YES	0-99	TREATMENT NOTES, X-RAYS
D7260 – D7294	OTHER ORAL SURGICAL PROCEDURES	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES, X-RAYS

ADA CODE	PROCEDURE DESCRIPTION	COMMENTS AND LIMITATIONS	PA REQUIRED?	COVERED AGES	DOCUMENTATION REQUIRED
D7310	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS - PER QUADRANT	MEDICAL NECESSITY AND COVERED ONLY WHEN DENTURES HAVE BEEN APPROVED OR BY REPORT	YES	0-99	TREATMENT NOTES, X-RAYS
D7311	ALVEOLOPLAST IN CONJUNCTION WITH EXTRACTIONS, 1 TO 3 TEETH	MEDICAL NECESSITY AND COVERED ONLY WHEN DENTURES HAVE BEEN APPROVED OR BY REPORT	YES	0-99	
D7320	ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS - PER QUADRANT	MEDICAL NECESSITY AND COVERED ONLY WHEN DENTURES HAVE BEEN APPROVED OR BY REPORT	YES	0-99	TREATMENT NOTES, X-RAYS
D7321	ALVEOLOPLASTY NOT INCONJUNCTION WITH EXTRACTIONS, 1 TO 3 TEETH	MEDICAL NECESSITY AND COVERED ONLY WHEN DENTURES HAVE BEEN APPROVED OR BY REPORT	YES	0-99	
D7410 – D7490	OTHER ORAL SURGICAL PROCEDURES	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES, X-RAYS
D7510	INCISION AND DRAINAGE OF ABSCESS-INTRAORAL SOFT TISSUE	MEDICAL NECESSITY, MAY NOT BE BILLED ON THE SAME DATE OF SERVICE AS EXTRACTION	YES	0-99	TREATMENT NOTES, X-RAYS
D7511	INCISION & DRAINAGE OF ABSCESS, INTRAORAL, COMPLICATED	MEDICAL NECESSITY, MAY NOT BE BILLED ON THE SAME DATE OF SERVICE AS EXTRACTION	YES	0-99	TREATMENT NOTES, X-RAYS
D7520	INCISION AND DRAINAGE OF ABSCESS-EXTRAORAL SOFT TISSUE	MEDICAL NECESSITY, MAY NOT BE BILLED ON THE SAME DATE OF SERVICE AS EXTRACTION	YES	0-99	TREATMENT NOTES, X-RAYS
D7521	INCISION & DRAINAGE OF ABSCESS EXTRAORAL, COMPLICATED	MEDICAL NECESSITY, MAY NOT BE BILLED ON THE SAME DATE OF SERVICE AS EXTRACTION	YES	0-99	TREATMENT NOTES, X-RAYS
D7530 – D7999	OTHER SURGICAL PROCEDURES	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES, X-RAYS
	<i>ORTHODONTIC TREATMENT</i>				
D8010 – D8999	<i>ALL ORTHODONTIC TREATMENT MUST BE PRIOR AUTHORIZED</i>	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES, X-RAYS
	<i>ADJUNCTIVE GENERAL SERVICES</i>				
D9110*	PALLIATIVE (EMERGENCY) TREATMENT OF DENTAL PAIN-MINOR PROCEDURES AND TREATMENT IS NOT DEFINED BY AN EXISTING ADA CODE.	MAY NOT BE BILLED WITH D0140 ON THE SAME DATE OF SERVICE. PAYABLE PER VISIT, NOT PER TOOTH AND INCLUDES ALL TREATMENT RENDERED AT VISIT OTHER THAN DIAGNOSTIC X-RAYS.	REQUIRES RETROSPECTIVE REVIEW	0-99	TREATMENT NOTES, X-RAYS
D9120	FIXED PARTIAL DENTURE SECTIONING	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES, X-RAYS
D9210	LOCAL ANESTHESIA NOT IN CONJUNCTION WITH OPERATIVE OR SURGICAL PROCEDURE	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES, X-RAYS

ADA CODE	PROCEDURE DESCRIPTION	COMMENTS AND LIMITATIONS	PA REQUIRED?	COVERED AGES	DOCUMENTATION REQUIRED
D9220	GENERAL ANESTHESIA-FIRST 30 MINUTES	MEDICAL NECESSITY, AGE 5 YEARS AND YOUNGER OR BY REPORT. ANESTHESIA RECORDS ARE REQUIRED FOR PAYMENT. PROVIDER MUST HAVE APPROPRIATE ANESTHESIA PERMIT ON FILE WITH HCA IN ORDER TO RECEIVE PAYMENT.	YES	0-99	TREATMENT PLAN, ANESTHESIA OR SEDATION RECORDS ARE REQUIRED FOR PAYMENT
D9221	GENERAL ANESTHESIA-EACH ADDITIONAL 15 MINUTES	MEDICAL NECESSITY, AGE 5 YEARS AND YOUNGER, OR BY REPORT. ANESTHESIA RECORDS ARE REQUIRED FOR PAYMENT. PROVIDER MUST HAVE APPROPRIATE ANESTHESIA PERMIT ON FILE WITH HCA IN ORDER TO RECEIVE PAYMENT.	YES	0-99	TREATMENT PLAN, ANESTHESIA OR SEDATION RECORDS ARE REQUIRED FOR PAYMENT
D9230	ANALGESIA, ANXIOLYSIS, INHALATION OF NITROUS OXIDE	COVERED FOR MEMBERS UP TO AGE 10, MAY BE CONSIDERED FOR MEMBERS OVER THE AGE OF 10 WITH MEDICAL NECESSITY DOCUMENTATION. NOT PAYABLE WHEN BILLED WITH D9248 ON THE SAME DATE OF SERVICE.	NO – UNDER 10 YRS OF AGE YES – 11 YEARS OF AGE AND OLDER	0-99	TREATMENT NOTES, X-RAYS
D9241	IV CONSCIOUS SEDATION/ANALGESIA-1ST 30 MIN	MEDICAL NECESSITY, AGE 10 AND YOUNGER, OR BY REPORT. PROVIDER MUST HAVE APPROPRIATE SEDATION PERMIT ON FILE WITH HCA IN ORDER TO RECEIVE PAYMENT.	YES	0-99	TREATMENT NOTES, X-RAYS
D9242	IV CONSCIOUS SEDATION/ANALGESIA-EA ADDIT 15 MIN	MEDICAL NECESSITY, AGE 10 AND YOUNGER, OR BY REPORT. PROVIDER MUST HAVE APPROPRIATE SEDATION PERMIT ON FILE WITH HCA IN ORDER TO RECEIVE PAYMENT.	YES	0-99	TREATMENT NOTES, X-RAYS
D9248	NON-INTRAVENOUS CONSCIOUS SEDATION (ORAL MEDS) – LIMITED TO ONE BILLING PER VISIT; LIMITED TO 2 VISITS PER TREATMENT PLAN PER PATIENT.	MEDICAL NECESSITY, AGE 10 AND YOUNGER OR BY REPORT, INCLUDES ORAL MEDICATION, BEHAVIORAL MANAGEMENT AND NITROUS OXIDE ADMINISTRATION. ANESTHESIA RECORDS ARE REQUIRED FOR PAYMENT. PROVIDER MUST HAVE APPROPRIATE SEDATION PERMIT ON FILE WITH HCA IN ORDER TO RECEIVE PAYMENT.	YES	0-99	TREATMENT PLAN, ANESTHESIA OR SEDATION RECORDS ARE REQUIRED FOR PAYMENT
D9310 - D9410	OTHER ADJUCTIVE SERVICES	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES, X-RAYS
D9420	HOSPITAL CALL	NOT PAYABLE IN CONJUNCTION TO DENTAL TREATMENT PERFORMED IN A HOSPITAL OR SURGICAL CENTER	YES	0-99	TREATMENT NOTES
D9430 – D9911	OTHER ADJUCTIVE SERVICES	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES, X-RAYS

ADA CODE	PROCEDURE DESCRIPTION	COMMENTS AND LIMITATIONS	PA REQUIRED?	COVERED AGES	DOCUMENTATION REQUIRED
D9630	OTHER DRUGS AND/OR MEDICAMENTS	THIS IS NOT A BILLABLE CODE PER AHCCCS	NA	NA	NA
D9920	BEHAVIORAL MANAGEMENT	NO REIMBURSEMNT - SEE D9248	NA	0	
D9930	POST OPERATIVE COMPLICATIONS	NOT PAYABLE FOR DRY SOCKET DRESSING FOLLOWING EXTRACTIONS.	NO	0-99	TREATMENT NOTES, X-RAYS
D9940 – D9999	OTHER ADJUCTIVE SERVICES	MEDICAL NECESSITY	YES	0-99	TREATMENT NOTES, X-RAYS