UnitedHealthcare KanCare Medicaid Dental Quick Reference Guide

Effective: January 1, 2025

UHCdental.com/medicaid

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

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

Provider services

Phone: **1-855-878-5372**
7:45 a.m. – 4:30 p.m. CST Monday–Friday (IVR: 24/7)

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

Prior authorization

UnitedHealthcare Dental
Authorizations
PO Box 2135
Milwaukee, WI 53201

Appeals for service denials

UnitedHealthcare Appeals
PO Box 31364
Salt Lake City, UT 841

Toll-free: **1-855-878-5372**

Claims

UnitedHealthcare KS Claims
PO Box 1158
Milwaukee, WI 53201

EDI Payer ID

GP133

Inquiries, complaints and grievances

UnitedHealthcare Community Plan – Kansas
Attention: Appeals and Grievance
PO Box 31364
Salt Lake City, UT 84131-03

Retro-review claims

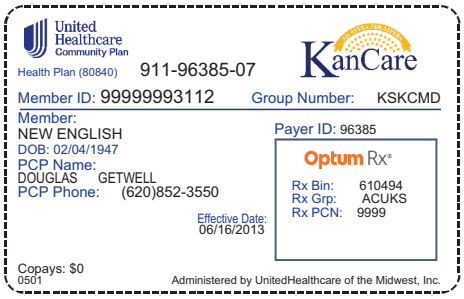
UnitedHealthcare KS Claims
PO Box 1158
Milwaukee, WI 53201

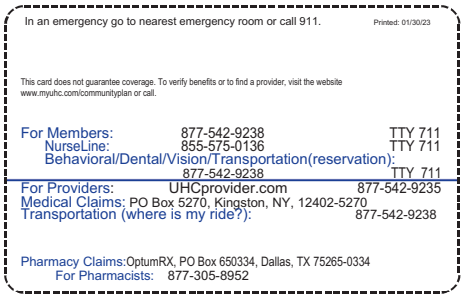
Claims may be submitted electronically via your clearinghouse, online via the provider portal or via the mailing addresses here.

Important notes

This guide is intended to be used for quick reference and may not contain all of the necessary information; it is subject to change without notice. For current detailed benefit information, please visit the Dental Hub or contact our Provider Services toll free number.

Sample member ID card





UHC KanCare CHIP (Ages 0-18) and Medicaid (Ages 0-20)

Code	Code description	Teeth or area covered	Review required	CHIP Age Range	Medicaid Age Range	Benefit limitations
D0120	Periodic Oral Evaluation - Established Patient		No	0-18	0-20	Only one exam every 6 months per provider or provider billing group. Only one exam (D0120, D0140, D0145, Do150, D0170) per date of service, per beneficiary, per provider or provider billing group.
D0140	Limited Oral Evaluation - Problem Focused		No	0-18	0-20	Only one exam (D0120, D0140, D0145, Do150, D0170) per date of service, per beneficiary, per provider or provider billing group. Limited oral evaluation is only covered when performed in conjunction with treatment to address an emergency situation. An emergency is defined as treatment medically necessary to treat pain, infection, swelling, uncontrolled bleeding, or traumatic injury.
D0145	Oral Evaluation, Patient Under Three		No	0-2	0-2	Only one exam (D0120, D0140, D0145, Do150, D0170) per date of service, per beneficiary, per provider or provider billing group.
D0150	Comprehensive Oral Evaluation - New or Established Patient		No	0-18	0-20	One comprehensive exam per beneficiary, per provider or provider billing group per lifetime. Only one exam (D0120, D0140, D0145, or D0150) every six months per beneficiary, per provider or provider billing group.
D0170	Reevaluation - limited, problem focused		No	0-18	0-20	One per 12 months. Established beneficiary to assess the status of a previously existing condition (not post- operative visit). Not covered with any other procedure other than radiographs.
D0210	Intraoral - Complete Series (Including Bitewings)		No	0-18	0-20	One per 36 months. The following are also considered an Intraoral Complete Series (D0210) D0330 and D0272 D0330 and D0273 D0330 and D0274 D0330 and D0277
D0220	Intraoral - Periapical First Film		No	0-18	0-20	One per day. Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and will not be reimbursed.
D0230	Intraoral - Periapical Each Additional Film		No	0-18	0-20	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and will not be reimbursed.

UHC KanCare CHIP (Ages 0-18) and Medicaid (Ages 0-20)

Code	Code description	Teeth or area covered	Review required	CHIP Age Range	Medicaid Age Range	Benefit limitations
D0240	Intraoral - Occlusal Film		No	0-18	0-20	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.
D0250	Extraoral – 2d projection radiographic image created using a stationary radiation source, and detector		No	0-18	0-20	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.
D0251	Extraoral – First Radiographic Image		No	0-18	0-20	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.
D0270	Bitewing - Single Film		No	0-18	0-20	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.
D0272	Bitewings - Two Films		No	0-18	0-20	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.
D0273	Bitewings - Three Films		No	0-18	0-20	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.
D0274	Bitewings - Four Films		No	0-18	0-20	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.
D0277	Vertical Bitewings - 7-8 Films		No	0-18	0-20	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.

UHC KanCare CHIP (Ages 0-18) and Medicaid (Ages 0-20)

Code	Code description	Teeth or area covered	Review required	CHIP Age Range	Medicaid Age Range	Benefit limitations
D0321	Other Temporomandibular Joint Films, By Report		No	0-18	0-20	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.
D0322	Tomographic Survey		No	0-18	0-20	Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.
D0330	Panoramic Film		No	0-18	0-20	One per 36 months. The following are also considered an Intraoral Complete Series (D0210) D0330 and D0272 D0330 and D0273 D0330 and D0274 D0330 and D0277
D0460	Pulp Vitality Test	1 - 32 51 - 82 (SN) A - T AS - TS (SN)	No	0-18	0-20	Maximum of three teeth per visit.
D0999	Unspecified Diagnostic Procedures, By Report		Yes	0-18	0-20	
D1110	Prophylaxis - Adult		No	13-18	13-20	Twice per calendar year. Title 21 Children Ages 13-18 Title 19 Children Ages 13-20 Includes scaling and polishing procedures to remove coronal plaque, calculus, and stains.
D1120	Prophylaxis - Child		No	0-12	0-12	Twice per calendar year. Title 21 Children Ages 0-12 Title 19 Children Ages 0-12 Includes scaling and polishing procedures to remove coronal plaque, calculus, and stains.
D1206	Topical Application Of Fluoride		No	0-18	0-20	1 application every 120 days
D1208	Topical Application Of Fluoride (excluding varnish)		No	0-18	0-20	1 application every 120 days
D1351	Sealant - Per Tooth		No	0-18	0-20	Once per 12 months. Occlusal surfaces only. Teeth must be caries free. Sealant is not covered when placed over restorations.
D1354	Application of caries arresting medicament - per tooth	1-32 51 - 82 (SN) A - T AS - TS (SN)	No	0-18	0-20	(Silver Diamine Fluoride Treatments) 2 applications per year per tooth and 6 applications per tooth per lifetime benefit limits
D1510	Space Maintainer - Fixed - Unilateral per quadrant/arch	Per quadrant 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	0-18	0-20	Once per 12 months per quadrant.
D1516	Space maintainer - fixed - bilateral, maxillary	01 (UA) 02 (LA)	No	0-18	0-20	One per 12 months per arch.
D1517	Space maintainer - fixed - bilateral, mandibular	01 (UA) 02 (LA)	No	0-18	0-20	One per 12 months per arch.
D1526	Space maintainer - removable - bilateral, maxillary	01 (UA) 02 (LA)	No	0-18	0-20	One per 12 months per arch.
D1527	Space maintainer - removable - bilateral, mandibular	01 (UA) 02 (LA)	No	0-18	0-20	One per 12 months per arch.

UHC KanCare CHIP (Ages 0-18) and Medicaid (Ages 0-20)

Code	Code description	Teeth or area covered	Review required	CHIP Age Range	Medicaid Age Range	Benefit limitations
D1551	Re-cement or re-bond space maintainer - maxillary		No	0-18	0-20	Not covered within 6 months of initial placement
D1552	Re-cement or re-bond space maintainer - mandibular		No	0-18	0-20	Not covered within 6 months of initial placement
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant		No	0-18	0-20	Not covered within 6 months of initial placement
D1575	Distal shoe space maintainer-fixed, unilateral	Per quadrant 10 (UR), 20 (UL), 30 (LL), 40 (LR)	No	0-18	0-20	Once per 12 months per quadrant
D2140	Amalgam - One Surface, Primary Or Permanent	1 - 32 51 - 82 (SN) A - T AS - TS (SN)	No	0-18	0-20	1 in 12 months
D2150	Amalgam - Two Surfaces, Primary Or Permanent	1 - 32 51 - 82 (SN) A - T AS - TS (SN)	No	0-18	0-20	1 in 12 months
D2160	Amalgam - Three Surfaces, Primary Or Permanent	1 - 32 51 - 82 (SN) A - T AS - TS (SN)	No	0-18	0-20	1 in 12 months
D2161	Amalgam - Four Or More Surfaces, Primary Or Permanent	1 - 32 51 - 82 (SN) A - T AS - TS (SN)	No	0-18	0-20	1 in 12 months
D2330	Resin-Based Composite - One Surface, Anterior	6 - 11, 22 - 27 56 - 61 (SN) 72 - 77 (SN) C - H, M - R CS - HS (SN) MS - RS (SN)	No	0-18	0-20	1 in 12 months
D2331	Resin-Based Composite - Two Surfaces, Anterior	6 - 11, 22 - 27 56 - 61 (SN) 72 - 77 (SN) C - H, M - R CS - HS (SN) MS - RS (SN)	No	0-18	0-20	1 in 12 months
D2332	Resin-Based Composite - Three Surfaces, Anterior	6 - 11, 22 - 27 56 - 61 (SN) 72 - 77 (SN) C - H, M - R CS - HS (SN) MS - RS (SN)	No	0-18	0-20	1 in 12 months
D2335	Resin-Based Composite - Four Or More Surfaces Or Involving Incisal Angle	6 - 11, 22 - 27 56 - 61 (SN) 72 - 77 (SN) C - H, M - R CS - HS (SN) MS - RS (SN)	No	0-18	0-20	1 in 12 months

UHC KanCare CHIP (Ages 0-18) and Medicaid (Ages 0-20)

Code	Code description	Teeth or area covered	Review required	CHIP Age Range	Medicaid Age Range	Benefit limitations
D2390	Resin-Based Composite Crown, Anterior	6 - 11, 22 - 27 56 - 61 (SN) 72 - 77 (SN) C - H, M - R CS - HS (SN) MS - RS (SN)	No	0-18	0-20	1 in 12 months
D2391	Resin-Based Composite - One Surface, Posterior	1 - 5, 12 - 21, 28 - 32 51 - 55 (SN) 62 - 71 (SN) 78 - 82 (SN) A, B, I - L, S, T, AS (SN), BS (SN) IS - LS (SN), SS (SN),TS (SN)	No	0-18	0-20	1 in 12 months
D2392	Resin-Based Composite - Two Surfaces, Posterior	1 - 5, 12 - 21, 28 - 32 51 - 55 (SN) 62 - 71 (SN) 78 - 82 (SN) A, B, I - L, S, T, AS (SN), BS (SN) IS - LS (SN), SS (SN),TS (SN)	No	0-18	0-20	1 in 12 months
D2393	Resin-Based Composite - Three Surfaces, Posterior	1 - 5, 12 - 21, 28 - 32 51 - 55 (SN) 62 - 71 (SN) 78 - 82 (SN) A, B, I - L, S, T, AS (SN), BS (SN) IS - LS (SN), SS (SN),TS (SN)	No	0-18	0-20	1 in 12 months
D2394	Resin-Based Composite - Four Or More Surfaces, Posterior	1 - 5, 12 - 21, 28 - 32 51 - 55 (SN) 62 - 71 (SN) 78 - 82 (SN) A, B, I - L, S, T, AS (SN), BS (SN) IS - LS (SN), SS (SN),TS (SN)	No	0-18	0-20	1 in 12 months
D2710	Crown - Resin-Based Composite (Indirect)	6 - 11 22 - 27 56 - 61 (SN) 72 - 77 (SN)	Yes	0-18	0-20	Once per 60 months
D2740	Crown - Porcelain/Ceramic Substrate	1 - 32 51 - 82 (SN)	Yes	0-18	0-20	Once per 60 months
D2751	Crown - Porcelain Fused To Predominantly Base Metal	1 - 32 51 - 82 (SN)	Yes	0-18	0-20	Once per 60 months
D2752	Crown - Porcelain Fused To Noble Metal	1 - 32 51 - 82 (SN)	Yes	0-18	0-20	Once per 60 months
D2753	Crown - Porcelain fused to titanium and titanium allows	1 - 32 51 - 82 (SN)	Yes	0-18	0-20	Once per 60 months

UHC KanCare CHIP (Ages 0-18) and Medicaid (Ages 0-20)

Code	Code description	Teeth or area covered	Review required	CHIP Age Range	Medicaid Age Range	Benefit limitations
D2783	Crown - Full Cast High Noble Metal	1 - 32 51 - 82 (SN)	Yes	0-18	0-20	Once per 60 months
D2791	Crown - 3/4 porcelain/ceramic	1 - 32 51 - 82 (SN)	Yes	0-18	0-20	Once per 60 months
D2792	Crown - Full Cast Noble Metal	1 - 32 51 - 82 (SN)	Yes	0-18	0-20	Once per 60 months
D2910	Recement Inlay, Onlay, Or Partial Coverage Restoration	1 - 32 51 - 82 (SN)	No	0-18	0-20	
D2920	Recement Crown	1 - 32, 51-82 (SN)	No	0-18	0-20	
D2921	Reattachment of tooth fragment, incisal edge or cusp	1 - 32 51 - 82 (SN)	No	0-18	0-20	Not allowed same tooth, same surface(s), same DOS as D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394
D2928	Prefabricated Porcelain/Ceramic Crown Permanent Tooth	1- 32 51 - 82 (SN)	No	0-18	0-20	
D2929	Prefabricated Porcelain / Ceramic Crown – Primary Tooth	A-T	No	0-20	0-20	Once per 24 months
D2930	Prefabricated Stainless Steel Crown - Primary Tooth	A - T AS - TS (SN)	No	0-18	0-20	Once per 24 months.D2930 and D2934 cannot be placed on the same tooth during a 24-month period.
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth	1 - 32 51 - 82 (SN)	No	0-18	0-20	Once per 24 months.
D2934	Prefabricated Esthetic coated Stainless Steel Crown - Primary Tooth	C - H, M - R CS - HS (SN) MS - RS (SN)	No	0-18	0-20	Once per 24 months. D2930 and D2934 cannot be placed on the same tooth during a 24-month period.
D2940	Sedative Filling	1 - 32 51 - 82 (SN)	No	0-18	0-20	Temporary restoration intended to relieve pain. Not to be used as a base or liner under a restoration.
D2951	Pin Retention - Per Tooth, In Addition To Restoration	1 - 32 51 - 82 (SN)	No	0-18	0-20	
D2954	Prefabricated Post And Core In Addition To Crown	1 - 32 51 - 82 (SN)	Yes	0-18	0-20	Once per 60 months
D2957	Each additional Prefabricated post - same tooth	1 - 3, 14 - 19, 30 - 32 51- 53 (SN) 64 - 69 (SN) 80 - 82 (SN)	No	0-18	0-20	Once per 60 months
D3110	Pulp Cap Indirect (excluding restoration)	1 - 32 51 - 82(SN)	No	0-18	0-20	
D3220	Therapeutic Pulpotomy	1 - 32 51 - 82(SN) A - T AS - TS	No	0-18	0-20	One per tooth, per lifetime. Not covered within 30 days of D3310 - D3331 on same tooth.
D3221	Pulpal Debridement	1 - 32 51 - 82(SN) A - T AS - TS	No	0-18	0-20	One per tooth, per lifetime. Not covered within 30 days ofD3310 - D3331 on same tooth.
D3222	Partial Pulpotomy For Apexogenesis - Permanent Tooth	1 - 32 51 - 82(SN)	Yes	0-18	0-20	One per tooth, per lifetime. Should only be performed as preparation for endodontic treatment.

UHC KanCare CHIP (Ages 0-18) and Medicaid (Ages 0-20)

Code	Code description	Teeth or area covered	Review required	CHIP Age Range	Medicaid Age Range	Benefit limitations
D3310	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)	6 - 11 22 - 27 56 - 61(SN) 72 - 77(SN)	No	0-18	0-20	One per tooth, per lifetime.
D3320	Endodontic Therapy, Bicuspid Tooth (Excluding Final Restoration)	4, 5, 12, 13, 20, 21, 28, 29, 54(SN), 55(SN), 62(SN), 63(SN), 70(SN), 71(SN), 78(SN), 79(SN)	No	0-18	0-20	One per tooth, per lifetime.
D3330	Endodontic Therapy, Molar (Excluding Final Restoration)	1 - 3, 14 - 19 30 - 32 51 - 53(SN) 64 - 69(SN) 80 - 82(SN)	No	0-18	0-20	One per tooth, per lifetime.
D3331	Treatment of root canal obstruction - non surgical	1 - 32 51 - 82 (SN)	Yes	0-18	0-20	
D3351	Apexification / Recalcification / Pulpal Regeneration - Initial Visit	1 - 32 51 - 82 (SN)	No	0-18	0-20	
D3352	Apexification / Recalcification / Pulpal Regeneration - Interim	1 - 32 51 - 82 (SN)	No	0-18	0-20	
D3353	Apexification / Recalcification / Pulpal Regeneration - Final Visit	1 - 32 51 - 82 (SN)	No	0-18	0-20	
D3410	Apicoectomy / Periradicular Surgery - Anterior	6 - 11, 22 - 27 56 - 61(SN) 72 - 77(SN)	No	0-18	0-20	
D3421	Apicoectomy / Periradicular Surgery - Bicuspid (First Root)	4, 5, 12, 13, 20, 21, 28, 29, 54(SN), 55(SN), 62(SN), 63(SN), 70(SN), 71(SN), 78(SN), 79(SN)	No	0-18	0-20	
D3425	Apicoectomy / Periradicular Surgery - Molar (First Root)	1 - 3, 14 - 19 30 - 32 51 - 53(SN) 64-69(SN) 80 - 82(SN)	No	0-18	0-20	
D3426	Apicoectomy / Periradicular Surgery - Each Additional Root)	1 - 5, 12 - 21 28 - 32 51 - 55(SN) 62 - 71(SN) 78 - 82(SN)	No	0-18	0-20	
D3427	Periradicular surgery without apicoectomy	1 - 32 51 - 82 (SN)	No	0-18	0-20	Not allowed same tooth, same DOS as D3410, D3421, D3425, D3426
D3430	Retrograde Filling, per root	1 - 32 51 - 82 (SN)	No	0-18	0-20	
D4210	Gingivectomy Or Gingivoplasty - Four Or More Contiguous Teeth	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	0-18	0-20	A minimum of four affected teeth in the quadrant.

UHC KanCare CHIP (Ages 0-18) and Medicaid (Ages 0-20)

Code	Code description	Teeth or area covered	Review required	CHIP Age Range	Medicaid Age Range	Benefit limitations
D4211	Gingivectomy Or Gingivoplasty - One To Three Contiguous Teeth	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	0-18	0-20	One to three affected teeth in the quadrant.
D4230	Anatomical Crown Exposure - 4 or more contiguous teeth per quadrant	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	0-18	0-20	Must be billed same date same tooth in conjunction with the restorative codes (D2140 - D2957).
D4231	Anatomical Crown Exposure - 1- 3 contiguous teeth per quadrant	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	0-18	0-20	Same date and same tooth in conjunction with the restorative code.
D4268	Surgical Revision Procedure per tooth	1 - 32 51 - 82 (SN)	Yes	0-18	0-20	Only covered after D4210.
D4341	Periodontal Scaling And Root Planing - Four Or More Teeth Per Quadrant	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	0-18	0-20	Four per 12 months. A minimum of four affected teeth in the quadrant.
D4342	Periodontal Scaling And Root Planing - One To Three Teeth Per Quadrant	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	0-18	0-20	Four per 12 months. One to three affected teeth in the quadrant.
D4346	Scaling in presence of generalized moderate or severe gingival inflammation- full mouth, after oral evaluation		Yes	0-18	0-20	Once per 12 months. Not covered on the same DOS as D1110, D1120, D4341, D4342, D4355, or D4910
D4355	Full Mouth Debridement		No	0-18	0-20	One per 12 months.
D4910	Periodontal Maintenance, office visit non-covered on the date of service		No	0-18	0-20	2 per code every accum year per patient
D5110	Complete Denture - Maxillary		Yes	0-18	0-20	One per 60 months.
D5120	Complete Denture - Mandibular		Yes	0-18	0-20	One per 60 months.
D5211	Maxillary Partial Denture - Resin Base		Yes	0-18	0-20	One per 60 months.
D5212	Mandibular Partial Denture - Resin Base		Yes	0-18	0-20	One per 60 months.
D5213	Maxillary Partial Denture - Cast Metal Framework With Resin Denture Bases		Yes	0-18	0-20	One per 60 months.
D5214	Mandibular Partial Denture - Cast Metal Framework With Resin Denture Bases		Yes	0-18	0-20	One per 60 months.
D5225	Maxillary Partial Denture - Flexible Base		Yes	0-18	0-20	One per 60 months.
D5226	Mandibular Partial Denture - Flexible Base		Yes	0-18	0-20	One per 60 months.

UHC KanCare CHIP (Ages 0-18) and Medicaid (Ages 0-20)

Code	Code description	Teeth or area covered	Review required	CHIP Age Range	Medicaid Age Range	Benefit limitations
D5282	Removable unilateral partial denture - one piece cast metal (including clasps and teeth), maxillary	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	0-18	0-20	One per 60 months
D5284	Removable unilateral partial denture - one piece flexible base (including clasps and teeth) - per quadrant	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	0-18	0-20	One per 60 months
D5286	Removable unilateral partial denture - one piece resin (including clasps and teeth) - per quadrant	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	0-18	0-20	Once per 60 months
D5410	Adjust Complete Denture - Maxillary		No	0-18	0-20	Not covered within 6 months of placement
D5411	Adjust Complete Denture - Mandibular		No	0-18	0-20	Not covered within 6 months of placement
D5421	Adjust Partial Denture - Maxillary		No	0-18	0-20	Not covered within 6 months of placement
D5422	Adjust Partial Denture - Mandibular		No	0-18	0-20	Not covered within 6 months of placement
D5511	Repair broken complete denture base, mandibular		No	0-18	0-20	
D5512	Repair broken complete denture base, maxillary		No	0-18	0-20	
D5520	Replace Missing Or Broken Teeth - Complete Denture (Each Tooth)	1 - 32	No	0-18	0-20	
D5611	Repair resin partial denture base, mandibular	02 (LA) 30 (LL) 40 (LR)	No	0-18	0-20	
D5612	Repair resin partial denture base, maxillary	01 (UA) 10 (UR) 20 (UL)	No	0-18	0-20	
D5621	Repair cast partial framework, mandibular	02 (LA) 30 (LL) 40 (LR)	No	0-18	0-20	
D5622	Repair cast partial framework, maxillary	01 (UA) 10 (UR) 20 (UL)	No	0-18	0-20	
D5630	Repair Or Replace Broken Clasp	1 (UA) 2 (LA) 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	0-18	0-20	
D5640	Replace Broken Teeth - Per Tooth	1 - 32	No	0-18	0-20	
D5650	Add Tooth To Existing Partial Denture	1 - 32	No	0-18	0-20	

UHC KanCare CHIP (Ages 0-18) and Medicaid (Ages 0-20)

Code	Code description	Teeth or area covered	Review required	CHIP Age Range	Medicaid Age Range	Benefit limitations
D5660	Add Clasp To Existing Partial Denture	1 (UA) 2 (LA) 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	0-18	0-20	
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)		No	0-18	0-20	
D5671	Replace all teeth and acrylic on cast metal framework (maxillary)		No	0-18	0-20	
D5750	Reline Complete Maxillary Denture (Laboratory)		No	0-18	0-20	One per 24 months. Not covered within 24 months of placement.
D5751	Reline Complete Mandibular Denture (Laboratory)		No	0-18	0-20	One per 24 months. Not covered within 24 months of placement.
D5760	Reline Maxillary Partial Denture (Laboratory)		No	0-18	0-20	One per 24 months. Not covered within 24 months of placement.
D5761	Reline Mandibular Partial Denture (Laboratory)		No	0-18	0-20	One per 24 months. Not covered within 24 months of placement.
D5850	Tissue Conditioning, Maxillary		No	0-18	0-20	
D5851	Tissue Conditioning, Mandibular		No	0-18	0-20	
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure		Yes	0-18	0-20	Once per 12 months
D6198	Remove interim implant component	1-32 51-82 (SN)	No	15-18	15-20	
D6930	Recement Fixed Partial Denture	1 (UA) 2 (LA) 10 (UR) 20 (UL) 30 (LL) 40 (LR)	No	0-18	0-20	
D7140	Extraction, Erupted Tooth Or Exposed Root	1 - 32 51- 82 (SN) A - T AS - TS (SN)	No	0-18	0-20	
D7210	Surgical Removal Or Erupted Tooth	1 - 32 51- 82 (SN) A - T AS - TS (SN)	No	0-18	0-20	Includes cutting of gingiva and bone, removal of tooth structure, and closure.
D7220	Removal Of Impacted Tooth - Soft Tissue	1-32 51-82 (SN)	Yes	0-18	0-20	Includes cutting of gingiva and bone, removal of tooth structure, and closure.
D7230	Removal Of Impacted Tooth - Partially Bony	1-32 51-82 (SN)	Yes	0-18	0-20	Includes cutting of gingiva and bone, removal of tooth structure, and closure.
D7240	Removal Of Impacted Tooth - Completely Bony	1-32 51-82 (SN)	Yes	0-18	0-20	Includes cutting of gingiva and bone, removal of tooth structure, and closure.

UHC KanCare CHIP (Ages 0-18) and Medicaid (Ages 0-20)

Code	Code description	Teeth or area covered	Review required	CHIP Age Range	Medicaid Age Range	Benefit limitations
D7241	Removal Of Impacted Tooth - Completely Bony, Unusual Surgical Complications	1-32 51-82 (SN)	Yes	0-18	0-20	Includes cutting of gingiva and bone, removal of tooth structure, and closure. Unusual complications such as nerve dissection, separate closure of the maxillary sinus, or aberrant tooth position.
D7250	Surgical Removal Of Residual Tooth (Cutting Procedure)	1 - 32 51- 82 (SN) A - T AS - TS (SN)	No	0-18	0-20	Includes cutting of gingiva and bone, removal of tooth structure, and closure. Will not be paid to the providers or group that originally removed the tooth.
D7260	Oroantral Fistula Closure		No	0-18	0-20	
D7270	Reimplantation And/Or Stabilization Of Accidentally Evulsed / Displaced Tooth	1 - 32 51- 82 (SN) A - T AS - TS (SN)	No	0-18	0-20	Includes splinting and/or stabilization.
D7280	Surgical Access Of An Unerupted Tooth	1-32 51-82 (SN)	Yes	0-18	0-20	Will not be payable unless the orthodontic treatment has been authorized as a covered benefit.
D7285	Biopsy of Oral Tissue, Hard		No	0-18	0-20	
D7286	Biopsy of Oral Tissue, Soft		No	0-18	0-20	
D7320	Alveoloplasty Not In Conjunction With Extractions - Four Or More Teeth	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	0-18	0-20	No extractions performed in an edentulous area.
D7350	Vesibuloplasty - Ridge Extension (Including Soft Tissue Grafts)	Per quadrant - 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	0-18	0-20	
D7410	Excision Of Pericoronal Gingiva		No	0-18	0-20	
D7411	Excision Of Benign Lesion Greater Than 1.25 Cm		No	0-18	0-20	
D7412	Excision Of Benign Lesion, Complicated		No	0-18	0-20	
D7413	Excision Of Malignant Lesion Up To 1.25 Cm		No	0-18	0-20	
D7414	Excision Of Malignant Lesion Greater Than 1.25 Cm		No	0-18	0-20	
D7415	Excision Of Malignant Lesion, Complicated		No	0-18	0-20	
D7440	Excision Of Malignant Tumor - Lesion Diameter Up To 1.25 Cm		No	0-18	0-20	
D7441	Excision Of Malignant Tumor - Lesion Diameter Greater Than 1.25 Cm		No	0-18	0-20	
D7450	Removal Of Benign Odontogenic Cyst Or Tumor - Dia Up To 1.25 Cm		No	0-18	0-20	
D7451	Removal Of Benign Odontogenic Cyst Or Tumor - Dia Greater Than 1.25 Cm		No	0-18	0-20	

UHC KanCare CHIP (Ages 0-18) and Medicaid (Ages 0-20)

Code	Code description	Teeth or area covered	Review required	CHIP Age Range	Medicaid Age Range	Benefit limitations
D7460	Removal Of Benign Nonodontogenic Cyst Or Tumor - Dia Up To 1.25 Cm		No	0-18	0-20	
D7461	Removal Of Benign Nonodontogenic Cyst Or Tumor - Dia Greater Than 1.25 Cm		No	0-18	0-20	
D7471	Removal Of Lateral Exostosis (Maxilla Or Mandible)	1 (UA) 2 (LA)	Yes	0-18	0-20	Once per lifetime.
D7472	Removal Of Torus Palatinus		Yes	0-18	0-20	Once per lifetime.
D7473	Removal Of Torus Mandibularis		Yes	0-18	0-20	Once per lifetime.
D7490	Radical Resection Of Maxilla Or Mandible	1 (UA) 2 (LA)	No	0-18	0-20	
D7510	Incision And Drainage Of Abscess - Intraoral Soft Tissue		No	0-18	0-20	Not covered same date of service as D7511.
D7511	Incision And Drainage Of Abscess - Intraoral Soft Tissue - Complicated		No	0-18	0-20	
D7520	Incision And Drainage Of Abscess - Extraoral Soft Tissue		No	0-18	0-20	Not covered same date of service as D7521.
D7521	Incision And Drainage Of Abscess - Extraoral Soft Tissue - Complicated		No	0-18	0-20	
D7530	Removal Of Foreign Body From Mucosa		No	0-18	0-20	
D7540	Removal Of Reaction Producing Foreign Bodies		No	0-18	0-20	
D7550	partial ostectomy/ sequestrectomy for removal of non-vital bone		No	0-18	0-20	
D7560	maxillary sinusotomy for removal of tooth fragment or foreign body		No	0-18	0-20	
D7610	maxilla - open reduction (teeth immobilized, if present)		No	0-18	0-20	
D7620	maxilla - closed reduction (teeth immobilized, if present)		No	0-18	0-20	
D7630	mandible - open reduction (teeth immobilized, if present)		No	0-18	0-20	
D7640	mandible - closed reduction (teeth immobilized, if present)		No	0-18	0-20	
D7650	malar and/or zygomatic arch - open reduction		No	0-18	0-20	
D7660	malar and/or zygomatic arch - closed reduction		No	0-18	0-20	
D7670	alveolus - closed reduction, may include stabilization of teeth	1 - 32	No	0-18	0-20	May include stabilization.
D7680	facial bones - complicated reduction with fixation and multiple surgical approaches		Yes	0-18	0-20	

UHC KanCare CHIP (Ages 0-18) and Medicaid (Ages 0-20)

Code	Code description	Teeth or area covered	Review required	CHIP Age Range	Medicaid Age Range	Benefit limitations
D7710	maxilla - open reduction		No	0-18	0-20	
D7720	maxilla - closed reduction		No	0-18	0-20	
D7730	mandible - open reduction		No	0-18	0-20	
D7740	mandible - closed reduction		No	0-18	0-20	
D7750	malar and/or zygomatic arch - open reduction		No	0-18	0-20	
D7760	malar and/or zygomatic arch - closed reduction		No	0-18	0-20	
D7770	alveolus, open reduction stabilization of teeth		No	0-18	0-20	
D7780	facial bones - complicated reduction with fixation and multiple surgical approaches		No	0-18	0-20	
D7820	Closed Reduction Of Dislocation		No	0-18	0-20	
D7860	Arthrotomy		Yes	0-18	0-20	
D7865	Arthroplasty		Yes	0-18	0-20	
D7910	Suture Of Recent Small Wounds Up To 5 Cm		No	0-18	0-20	Not covered on same day as D7140, D7210, D7220, D7230, D7240, D7241, or D7250.
D7911	Complicated Suture - Up To 5 Cm		No	0-18	0-20	Not covered on same day as D7140, D7210, D7220, D7230, D7240, D7241, or D7250.
D7912	Complicated Suture - Greater Than 5 Cm		No	0-18	0-20	Not covered on same day as D7140, D7210, D7220, D7230, D7240, D7241, or D7250.
D7920	Skin Graft	1 (UA) 2 (LA) 10 (UR) 20 (UL) 30 (LL) 40 (LR)	Yes	0-18	0-20	
D7955	Repair of Maxillofacial soft or hard tissue		Yes	0-18	0-20	
D7961	Buccal / Labial Frenectomy (Frenulectomy)	1 (UA) 2 (LA)	No	0-18	0-20	
D7962	Lingual Frenectomy (Frenulectomy)	2 (LA)	No	0-18	0-20	
D7963	Frenuloplasty		No	0-18	0-20	Excision of frenum with excision or repositioning of abervant muscle and z- plasty or other local flap closure.
D7971	Excision Of Pericoronal Gingiva	1 - 32	No	0-18	0-20	
D7979	Non-surgical sialolithotomy		No	0-18	0-20	
D7980	Sialolithotomy		No	0-18	0-20	
D7981	excision of salivary gland, by report		No	0-18	0-20	
D7982	Sialodochoplasty		No	0-18	0-20	
D7983	Closure of Salivary Fistula		No	0-18	0-20	
D7990	Emergency Tracheotomy		No	0-18	0-20	

UHC KanCare CHIP (Ages 0-18) and Medicaid (Ages 0-20)

Code	Code description	Teeth or area covered	Review required	CHIP Age Range	Medicaid Age Range	Benefit limitations
D8010	Limited Orthodontic Treatment Of The Primary Dentition		Yes - Prior Auth required	0-18	0-20	Limited to one replacement. Limited orthodontic treatment requires prior authorization and is only covered for eligible children with documented medical necessity.
D8020	Limited Orthodontic Treatment Of The Transitional Dentition		Yes - Prior Auth required	0-18	0-20	Limited to one replacement. Limited orthodontic treatment requires prior authorization and is only covered for eligible children with documented medical necessity.
D8070	Comprehensive Orthodontic Treatment Of The Transitional Dentition		Yes - Prior Auth required	0-18	0-20	Comprehensive orthodontic treatment requires prior authorization and is only covered for eligible children with documented medical necessity.
D8080	Comprehensive Orthodontic Treatment Of The Adolescent Dentition		Yes - Prior Auth required	0-18	0-20	Comprehensive orthodontic treatment requires prior authorization and is only covered for eligible children with documented medical necessity.
D8220	Fixed Appliance Therapy		Yes - Prior Auth required	0-18	0-20	Limited to one replacement. Removable appliance therapy requires prior authorization and is only covered for eligible children with documented medical necessity.
D8999	Unspecified Orthodontic Procedure, By Report		Yes - Prior Auth required	0-18	0-20	All orthodontic treatment requires prior authorization and is only covered for eligible children with documented medical necessity.
D9130	Temporomandibular joint dysfunction - non-invasive physical therapies		Yes	0-18	0-20	
D9212	Trigeminal Division Block		Yes	0-18	0-20	
D9219	Evaluation for deep sedation or general anesthesia		No	0-18	0-20	1 per patient per 12 months and limited to 1 per patient per provider in a lifetime.
D9222	Deep sedation/general anesthesia - first 15 minutes		Yes	0-18	0-20	
D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment		Yes	0-18	0-20	
D9230	Inhalation Of Nitrous/Analgesia, Anxiolysis		No	0-18	0-20	Not covered when billed with only diagnostic and/or preventative services (D0120 through D1203, D1515 through D1550, D9410, D9420).
D9239	Intravenous moderate (conscious) sedation/ analgesia - first 15 minutes		Yes	0-18	0-20	Narrative of medical necessity/treatment plan must be submitted with claim.
D9243	Intravenous moderate (conscious) sedation/anesthesia - each 15 minute increment		Yes	0-18	0-20	
D9310	Consultation - Diagnostic Service Provided By Dentist Or Physician		No	0-18	0-20	One per 12 months by same provider. One inpatient follow-up per beneficiary within a 10 day period by same provider. Not covered on same date of service as D0120 -D0170, D9410, D9420.

UHC KanCare CHIP (Ages 0-18) and Medicaid (Ages 0-20)

Code	Code description	Teeth or area covered	Review required	CHIP Age Range	Medicaid Age Range	Benefit limitations
D9311	Consultation with a medical health care professional		No	0-18	0-20	Once per 12 months by same provider. One inpatient follow- up per beneficiary within a 10 day period by same provider. Not covered on same DOS as D0120, D0170, D9410, or D9420
D9410	House/Extended Care Facility Call		No	0-18	0-20	Extended Care Facilities only.
D9420	Hospital Or Ambulatory Surgical Center Call		No	0-18	0-20	Hospital Facilities only
D9610	Therapeutic Drug Injection, By report		Yes	0-18	0-20	
D9613	Infiltration of sustained release therapeutic drug - single or multiple sites		No	0-18	0-20	
D9920	Behavior Management, By Report		Yes	0-18	0-20	
D9947	Custom sleep apnea appliance fabrication and placement		Yes	0-18	0-999	Limited to one replacement. Removable appliance therapy requires prior authorization and is only covered for eligible children with documented medical necessity.
D9948	Adjustment of custom sleep apnea appliance		Yes	0-18	0-999	Limited to one replacement. Removable appliance therapy requires prior authorization and is only covered for eligible children with documented medical necessity.
D9949	Repair of custom sleep apnea appliance		Yes	0-18	0-999	Limited to one replacement. Removable appliance therapy requires prior authorization and is only covered for eligible children with documented medical necessity.
D9999	Unspecified Adjunctive Procedure, By Report		Yes	0-18	0-20	

UHC KanCare Medicaid/Title 19 Adults 21 and over, UHC KanCare Medicaid Frail and Elderly

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Code	Description	Teeth or area covered	Review required	FE waiver eligible	Benefit limitations
D0120	Periodic Oral Evaluation - Established Patient		No		Only one exam per 36 months per provider or provider billing group. Only one exam (D0120, D0140, D0145, D0150, D0170) per date of service, per beneficiary, per provider or provider billing group.
D0140	Limited Oral Evaluation - Problem Focused		No		Only one exam (D0120, D0140, D0145, D0150, D0170) per date of service, per beneficiary, per provider or provider billing group. Limited oral evaluation is only covered when performed in conjunction with treatment to address an emergency situation. An emergency is defined as treatment medically necessary to treat pain, infection, swelling, uncontrolled bleeding, or traumatic injury.

UHC KanCare Medicaid/Title 19 Adults 21 and over, UHC KanCare Medicaid Frail and Elderly

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Code	Description	Teeth or area covered	Review required	FE waiver eligible	Benefit limitations
D0150	Comprehensive Oral Evaluation - New Or Established Patient		No		1 comprehensive exam per beneficiary, per provider or provider billing group per lifetime. Only one exam (D0120, D0145, or D0150) every six months per beneficiary per provider or provider billing group.
D0170	Re-Evaluation - Limited, Problem Focused		No		1 per 12 months Established beneficiary to assess the status of a previously existing condition (not post-operative visit). Not covered with any other procedure other than radiographs.
D0210	Intraoral - Complete Series of Radiographic Images		No		1 per 36 months. The following are also considered an Intraoral Complete Series (D0210) D0330 and D0272 D0330 and D0273 D0330 and D0274 D0330 and D0277
D0220	Intraoral - Periapical First Radiographic Image		No		1 per day. Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.
D0230	Intraoral - Periapical Each Additional Image		No		8 per day. Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.
D0240	Intraoral - Occlusal Radiographic Image		No		2 per year. Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.
D0250	Extraoral - 2D Projection Radiographic image		No		2 per day. Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.
D0251	Extra-Oral Posterior Dental Radiographic Image		No		2 per day. Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.
D0270	Bitewing - Single Radiographic Image		No		4 per 6 months. Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.
D0272	Bitewings - Two Radiographic Images		No		2 per 6 months. Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.

UHC KanCare Medicaid/Title 19 Adults 21 and over, UHC KanCare Medicaid Frail and Elderly

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Code	Description	Teeth or area covered	Review required	FE waiver eligible	Benefit limitations
D0273	Bitewings - Three Radiographic Images		No		1 per 6 months. Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.
D0274	Bitewings - Four Radiographic Images		No		1 per 36 months. Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.
D0277*	Vertical Bitewings - 7 To 8 Radiographic Images		No	✔	1 per 36 months. Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed. Only one bitewing code (D0270, D0272, D0273, D0274, D0277) per date of service, per beneficiary, per provider or provider billing group.
D0321*	Other Temporomandibular Joint Radiographic Images, By Report		No	✔	1 per 36 months. Any additional films (D0220 - D0340) performed on the same date of service as a complete intraoral series, or its equivalent, are considered content of service of the complete series and are not reimbursed.
D0322*	Tomographic survey		No		1 per 36 months
D0330	Panoramic Radiographic Image		No		1 per 36 months. The following are also considered an Intraoral Complete Series (D0210) D0330 and D0272 D0330 and D0273 D0330 and D0274 D0330 and D0277
D0372	intraoral tomosynthesis - comprehensive series of radiographic images		No	✔	1 per 36 months
D0373	intraoral tomosynthesis - bitewing radiographic image		No	✔	1 per 36 months
D0374	intraoral tomosynthesis - periapical radiographic image		No	✔	1 per 36 months
D0387	intraoral tomosynthesis - comprehensive series of radiographic images - image capture only		No	✔	1 per 36 months
D0388	intraoral tomosynthesis - bitewing radiographic image - image capture only		No	✔	1 per 36 months
D0389	intraoral tomosynthesis - periapical radiographic image - image capture only		No	✔	1 per 36 months
D0460	Pulp Vitality Tests		No	✔	Maximum of three teeth per visit.
D1110*	Prophylaxis - Adult		No	✔	2 per year. Includes scaling and polishing procedures to remove coronal plaque, calculus, and stains.

UHC KanCare Medicaid/Title 19 Adults 21 and over, UHC KanCare Medicaid Frail and Elderly

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Code	Description	Teeth or area covered	Review required	FE waiver eligible	Benefit limitations
D1206	Topical Application Of Fluoride		No		1 application every 120 days
D1208	Topical Application Of Fluoride (Excluding Varnish)		No		1 application every 120 days
D1310	Nutritional Counseling		No		Once per year with other covered service.
D1320	Tobacco Counseling		No		Limit of twice per year with other covered service. Documentation of counseling activities and/or referral to remain in the member's dental chart
D1330	Oral Hygiene Instruction		No		One per year with covered service
D1351	Sealant - Per Tooth		No		1 per 12 months. Occlusal surfaces only. Teeth must be caries free. Sealant is not covered when placed over restorations.
D1353	Sealant Repair per tooth		No		Once per 12 months. Occlusal surface only. Teeth must be caries free. Sealant is not covered when placed over restorations
D1354	Application of caries arresting medicament - per tooth	1-32 51 - 82 (SN) A - T AS - TS (SN)	No	✔	(Silver Diamine Fluoride Treatments) 2 applications per year per tooth and 6 applications per tooth per lifetime benefit limits
D2140	Amalgam - One Surface, Primary Or Permanent	All Teeth (Teeth 1 through 32, A through T)	No		1 per 12 months
D2150	Amalgam - Two Surfaces, Primary Or Permanent	All Teeth (Teeth 1 through 32, A through T)	No		1 per 12 months
D2160	Amalgam - Three Surfaces, Primary Or Permanent	All Teeth (Teeth 1 through 32, A through T)	No		1 per 12 months
D2161	Amalgam - Four Or More Surfaces, Primary Or Permanent	All Teeth (Teeth 1 through 32, A through T)	No		1 per 12 months
D2330	Resin-Based Composite - One Surface, Anterior	Anterior Teeth (Teeth 6 - 11, 22 - 27, C - H, M - R)	No		1 per 12 months
D2331	Resin-Based Composite - Two Surfaces, Anterior	Anterior Teeth (Teeth 6 - 11, 22 - 27, C - H, M - R)	No		1 per 12 months
D2332	Resin-Based Composite - Three Surfaces, Anterior	Anterior Teeth (Teeth 6 - 11, 22 - 27, C - H, M - R)	No		1 per 12 months

UHC KanCare Medicaid/Title 19 Adults 21 and over, UHC KanCare Medicaid Frail and Elderly

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Code	Description	Teeth or area covered	Review required	FE waiver eligible	Benefit limitations
D2335	Resin-Based Composite - Four Or More Surfaces Or Involving Incisal Angle	Anterior Teeth (Teeth 6 - 11, 22 - 27, C - H, M - R)	No		1 per 12 months
D2390	Resin-Based Composite Crown, Anterior	Anterior Teeth (Teeth 6 - 11, 22 - 27, C - H, M - R)	No		1 per 12 months
D2391	Resin-Based Composite - One Surface, Posterior	Posterior Teeth (1-5, 12-21, 28-32, A, B, I, J, K, L, S, T)	No		1 per 12 months
D2392	Resin-Based Composite - Two Surfaces, Posterior	Posterior Teeth (1-5, 12-21, 28-32, A, B, I, J, K, L, S, T)	No		1 per 12 months
D2393	Resin-Based Composite - Three Surfaces, Posterior	Posterior Teeth (1-5, 12-21, 28-32, A, B, I, J, K, L, S, T)	No		1 per 12 months
D2394	Resin-Based Composite - Four Or More Surfaces, Posterior	Posterior Teeth (1-5, 12-21, 28-32, A, B, I, J, K, L, S, T)	No		1 per 12 months
D2710	Crown - Resin-Based Composite (Indirect)	All Permanent Teeth (Teeth 1 through 32)	Yes		1 per 60 months
D2740	Crown - Porcelain/Ceramic	All Permanent Teeth (Teeth 1 through 32)	Yes		1 per 60 months
D2751	Crown - Porcelain Fused To Predominantly Base Metal	All Permanent Teeth (Teeth 1 through 32)	Yes		1 per 60 months
D2752	Crown - Porcelain Fused To Noble Metal	All Permanent Teeth (Teeth 1 through 32)	Yes		1 per 60 months
D2753	Crown - Porcelain Fused To Titanium And Titanium Alloys	All Permanent Teeth (Teeth 1 through 32)	Yes		1 per 60 months
D2783	Crown - 3/4 Porcelain/Ceramic	All Permanent Teeth (Teeth 1 through 32)	Yes		1 per 60 months
D2791	Crown - Full Cast Predominantly Base Metal	All Permanent Teeth (Teeth 1 through 32)	Yes		1 per 60 months
D2792	Crown - Full Cast Noble Metal	All Permanent Teeth (Teeth 1 through 32)	Yes		1 per 60 months

UHC KanCare Medicaid/Title 19 Adults 21 and over, UHC KanCare Medicaid Frail and Elderly

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Code	Description	Teeth or area covered	Review required	FE waiver eligible	Benefit limitations
D2910	Re-Cement Or Re-Bond Inlay, Onlay, Veneer Or Partial Coverage Restoration	All Permanent Teeth (Teeth 1 through 32)	No		
D2920	Re-Cement or Re-Bond Crown	All Teeth (Teeth 1 through 32, A through T)	No		
D2921	Reattachment Of Tooth Fragment, Incisal Edge Or Cusp	All Permanent Teeth (Teeth 1 through 32)	No		Not allowed same tooth, same surface(s), same DOS as D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394
D2928	Prefabricated Porcelain/Ceramic Crown Permanent Tooth	1- 32 51 - 82 (SN)	No	✔	
D2930	Prefabricated Stainless Steel Crown - Primary Tooth	Primary Teeth (Teeth A through T)	No		1 per 24 months
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth	All Permanent Teeth (Teeth 1 through 32)	No		1 per 24 months
D2940	Protective Restoration	All Teeth (Teeth 1 through 32, A through T)	No		1 per day per patient per tooth. Temporary restoration intended to relieve pain. Not to be used as a base or liner under a restoration.
D2951	Pin Retention - Per Tooth, In Addition To Restoration	All Permanent Teeth (Teeth 1 through 32)	No		
D2954	Prefabricated Post And Core In Addition To Crown	All Teeth (Teeth 1 through 32, A through T)	Yes		1 per 60 months
D2957	Each Additional Prefabricated Post - Same Tooth	All Permanent Teeth (Teeth 1 through 32)	Yes		1 per 60 months
D3110	Pulp Cap - Direct (Excluding Final Restoration)	All Permanent Teeth (Teeth 1 through 32)	No	✔	
D3220	Therapeutic Pulpotomy	All Teeth (Teeth 1 through 32, A through T)	No	✔	1 per tooth, per lifetime. Not covered within 30 days of D3310 - D3331 on same tooth.
D3221	Pulpal Debridement - Primary And Permanent Teeth	All Teeth (Teeth 1 through 32, A through T)	No	✔	1 per tooth, per lifetime. Not covered within 30 days of D3310 - D3331 on same tooth.
D3222	Partial Pulpotomy For Apexogenesis - Permanent Tooth	All Permanent Teeth (Teeth 1 through 32)	Yes	✔	1 per tooth, per lifetime. Should only be performed as preparation for endodontic treatment.

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Code	Description	Teeth or area covered	Review required	FE waiver eligible	Benefit limitations
D3310*	Endodontic Therapy, Anterior Tooth (Excluding Final Restoration)	Permanent Anterior (Teeth 6 - 11, 22 - 27)	No	✔	1 per tooth, per lifetime.
D3320*	Endodontic Therapy Premolar Tooth (Excluding Final Restoration)	Bicuspids (Teeth 4, 5, 12, 13, 20, 21, 28, 29)	No	✔	1 per tooth, per lifetime.
D3330*	Endodontic Therapy, Molar tooth (Excluding Final Restoration)	Permanent Molars (Teeth 1 - 3, 14 - 19, 30 - 32)	No	✔	1 per tooth, per lifetime.
D3331*	Treatment Of Root Canal Obstruction; Non-Surgical Access	All Permanent Teeth (Teeth 1 through 32)	Yes	✔	
D3351	Apexification / Recalcification - Initial Visit	All Permanent Teeth (Teeth 1 through 32)	No	✔	
D3352	Apexification / Recalcification - Interim	All Permanent Teeth (Teeth 1 through 32)	No	✔	
D3353	Apexification / Recalcification - Final Visit	All Permanent Teeth (Teeth 1 through 32)	No	✔	
D3410	Apicoectomy - Anterior	Permanent Anterior (Teeth 6 - 11, 22 - 27)	No	✔	
D3421	Apicoectomy - Premolar (First Root)	Bicuspids (Teeth 4, 5, 12, 13, 20, 21, 28, 29)	No	✔	
D3425	Apicoectomy - Molar (First Root)	Permanent Molars (Teeth 1 - 3, 14 - 19, 30 - 32)	No	✔	
D3426	Apicoectomy - Each Additional Root)	Permanent Posterior (Teeth 1 - 5, 12 - 21, 28 - 32)	No	✔	
D3427	Periradicular Surgery Without Apicoectomy	All Permanent Teeth (Teeth 1 through 32)	No		Not allowed same tooth, same DOS as D3410, D3421, D3425, D3426
D3430	Retrograde Filling - Per Root	All Permanent Teeth (Teeth 1 through 32)	No	✔	

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Code	Description	Teeth or area covered	Review required	FE waiver eligible	Benefit limitations
D3471	surgical repair of root resorption - anterior	Permanent Anterior (Teeth 6 - 11, 22 - 27)	No	✔	1 per lifetime.
D3472	surgical repair of root resorption - molar	Bicuspids (Teeth 4, 5, 12, 13, 20, 21, 28, 29)	No	✔	1 per lifetime.
D3473	surgical repair of root resorption - molar	Permanent Molars (Teeth 1 - 3, 14 - 19, 30 - 32)	No	✔	
D3501	surgical exposure of root surface without apicoectomy or repair of root resorption	All Permanent Teeth (Teeth 1 through 32)	No	✔	
D3502	surgical repair of root resorption - molar	All Permanent Teeth (Teeth 1 through 32)	No	✔	
D3503	surgical exposure of root surface without apicoectomy or repair of root resorption	All Permanent Teeth (Teeth 1 through 32)	No	✔	
D4210	Gingivectomy Or Gingivoplasty - Four Or More Contiguous Teeth	Quadrants (LL, LR, UR, UL)	Yes		1 per 12 months. A minimum of four affected teeth in the quadrant.
D4211	Gingivectomy Or Gingivoplasty - One To Three Contiguous Teeth	Quadrants (LL, LR, UR, UL)	Yes		1 per 12 months. One to three affected teeth in the quadrant.
D4230	Anatomical Crown Exposure - Four Or More Contiguous Teeth Per Quadrant	Quadrants (LL, LR, UR, UL)	Yes		1 per lifetime. Must be billed same date same tooth in conjunction with the restorative codes (D2140 - D2957).
D4231	Anatomical Crown Exposure - One To Three Teeth Per Quadrant	Quadrants (LL, LR, UR, UL)	Yes		1 per lifetime. Must be billed same date same tooth in conjunction with the restorative codes (D2140 - D2957).
D4268	Surgical Revision Procedure, Per Tooth	All Permanent Teeth (Teeth 1 through 32)	Yes		Only covered after D4210.
D4341	Periodontal Scaling And Root Planing - Four Or More Teeth Per Quadrant	Quadrants (LL, LR, UR, UL)	Yes		1 per 12 months. A minimum of four affected teeth in the quadrant.
D4342	Periodontal Scaling And Root Planing - One To Three Teeth Per Quadrant	Quadrants (LL, LR, UR, UL)	Yes		1 per 12 months. One to three affected teeth in the quadrant.
D4346	Scaling in moderate or severe gingival inflammation		Yes		1 per 12 months. Not covered on the same DOS as D1110, D1120, D4341, D4342, D4355, D4910.
D4355	Full Mouth Debridement		No		1 per 12 months.
D4910	Description: Periodontal Maintenance, office visit non-covered on the date of service		No	✔	2 per code every accum year per patien

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Code	Description	Teeth or area covered	Review required	FE waiver eligible	Benefit limitations
D5110	Complete Denture - Maxillary		Yes		1 per 60 months.
D5120	Complete Denture - Mandibular		Yes		1 per 60 months.
D5211	Maxillary Partial Denture - Resin Base		Yes		1 per 60 months.
D5212	Mandibular Partial Denture - Resin Base		Yes		1 per 60 months.
D5213	maxillary partial denture - cast metal framework with resin denture bases		Yes		1 per 60 months.
D5214	mandibular partial denture - cast metal framework with resin denture bases		Yes		1 per 60 months.
D5225	Maxillary Partial Denture - Flexible Base		Yes		1 per 60 months.
D5226	Mandibular Partial Denture - Flexible Base		Yes		1 per 60 months.
D5282	Removable Unilateral Partial Denture - One Piece Cast Metal - Maxillary		Yes		1 per 60 months.
D5283	Removable Unilateral Partial Denture - One Piece Cast Metal - Mandibular		Yes		1 per 60 months.
D5284	Removable Unilateral Partial Denture - One Piece Flexible Base	Quadrants (LL, LR, UR, UL)	Yes		1 per 60 months.
D5286	Removable Unilateral Partial Denture - One Piece Resin	Quadrants (LL, LR, UR, UL)	Yes		1 per 60 months.
D5410	Adjust Complete Denture - Maxillary		No		1 per year. Not covered within 6 months of placement.
D5411	Adjust Complete Denture - Mandibular		No		1 per year. Not covered within 6 months of placement.
D5421	Adjust Partial Denture - Maxillary		No		1 per year. Not covered within 6 months of placement.
D5422	Adjust Partial Denture - Mandibular		No		1 per year. Not covered within 6 months of placement.
D5511	Repair Broken Complete Denture Base - Mandibular		Yes		
D5512	Repair Broken Complete Denture Base - Maxillary		Yes		
D5520	Replace Missing Or Broken Teeth - Complete Denture (Each Tooth)	All Permanent Teeth (Teeth 1 through 32)	No		
D5611	Repair Resin Partial Denture Base - Mandibular		Yes		
D5621	Repair Cast Partial Framework - Mandibular		Yes		
D5622	Repair Cast Partial Framework - Maxillary		Yes		
D5630	Repair Or Replace Broken Retentive / Clasping Materials - Per Tooth	All Permanent Teeth (Teeth 1 through 32)	No		

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Code	Description	Teeth or area covered	Review required	FE waiver eligible	Benefit limitations
D5640	Replace Broken Teeth - Per Tooth	All Permanent Teeth (Teeth 1 through 32)	No		
D5650	Add Tooth To Existing Partial Denture	All Permanent Teeth (Teeth 1 through 32)	No		
D5660	Add Clasp To Existing Partial Denture - Per Tooth	All Permanent Teeth (Teeth 1 through 32)	No		
D5670	Replace All Teeth And Acrylic On Cast Metal Framework (Maxillary)		No		
D5671	Replace All Teeth And Acrylic On Cast Metal Framework (Mandibular)		No		
D5730	Reline Complete Maxillary Denture (Chairside)		No		1 per 24 months. Not covered within 24 months of placement. Covered for Frail Elderly benefit plan only.
D5731	Reline Complete Mandibular Denture (Chairside)		No		1 per 24 months. Not covered within 24 months of placement. Covered for Frail Elderly benefit plan only.
D5750	Reline Complete Maxillary Denture (Laboratory)		No		1 per 24 months. Not covered within 24 months of placement.
D5751	Reline Complete Mandibular Denture (Laboratory)		No		1 per 24 months. Not covered within 24 months of placement.
D5760	Reline Maxillary Partial Denture (Laboratory)		No		1 per 24 months. Not covered within 24 months of placement.
D5761	Reline Mandibular Partial Denture (Laboratory)		No		1 per 24 months. Not covered within 24 months of placement.
D5850	Tissue Conditioning, Maxillary		No		
D5851	Tissue Conditioning, Mandibular		No		
D5912	Facial Moulage (Complete)		No		
D6081	Scaling and debridement	All Permanent Teeth (Teeth 1 through 32)	Yes	✔	1 per 12 months.
D6100	Implant Removal, By Report	All Permanent Teeth (Teeth 1 through 32)	Yes		1 per lifetime per patient per tooth
D6930	Re-Cement Or Re-Bond Fixed Partial Denture	All Permanent Teeth (Teeth 1 through 32)	No		
D7140	Extraction, Erupted Tooth Or Exposed Root	All Teeth (Teeth 1 through 32, A through T, SN)	No		1 per lifetime per patient per tooth
D7210	Extraction, Erupted Tooth	All Teeth (Teeth 1 through 32, A through T, SN)	No		1 per lifetime per patient per tooth. Includes cutting of gingiva and bone, removal of tooth structure and closure.

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Code	Description	Teeth or area covered	Review required	FE waiver eligible	Benefit limitations
D7220	Removal Of Impacted Tooth - Soft Tissue	All Teeth (Teeth 1 through 32, A through T, SN)	Yes		1 per lifetime per patient per tooth. Removal of asymptotic tooth not covered. Includes cutting of gingiva and bone, removal of tooth structure, and closure.
D7230	Removal Of Impacted Tooth - Partially Bony	All Teeth (Teeth 1 through 32, A through T, SN)	Yes		1 per lifetime. Removal of asymptotic tooth not covered. Includes cutting of gingiva and bone, removal of tooth structure, and closure.
D7240	Removal Of Impacted Tooth - Completely Bony	All Teeth (Teeth 1 through 32, A through T, SN)	Yes		1 per lifetime per patient per tooth. Removal of asymptotic tooth not covered. Includes cutting of gingiva and bone, removal of tooth structure, and closure.
D7241	Removal Of Impacted Tooth - Completely Bony, Unusual Surgical Complications	All Teeth (Teeth 1 through 32, A through T, SN)	Yes		1 per lifetime per patient per tooth. Removal of asymptotic tooth not covered. Includes cutting of gingiva and bone, removal of tooth structure, and closure. Unusual complications such as nerve dissection, separate closure of the maxillary sinus, or aberrant tooth position.
D7250	Removal Of Residual Tooth (Cutting Procedure)	All Teeth (Teeth 1 through 32, A through T, SN)	No		1 per lifetime per patient per tooth. Includes cutting of gingiva and bone, removal of tooth structure, and closure. Will not be paid to the providers or provider billing group that originally removed the tooth.
D7260	Oroantral Fistula Closure		Yes		
D7270	Reimplantation And/Or Stabilization Of Accidentally Evulsed / Displaced Tooth	All Permanent Teeth (Teeth 1 through 32)	No		Includes splinting and/or stabilization.
D7280	Exposure of an Unerupted Tooth	Teeth 2 - 15, 18 - 31	Yes		
D7285	Incisional Biopsy Of Oral Tissue - Hard (Bone, Tooth)		No		
D7286	Incisional Biopsy Of Oral Tissue - Soft		No		
D7310	Alveoloplasty In Conjunction With Extractions - Four Or More Teeth	Quadrants (LL, LR, UR, UL)	No		Covered for MFP Frail Elderly benefit plan only.
D7320	Alveoloplasty Not In Conjunction With Extractions - Four Or More Teeth	Quadrants (LL, LR, UR, UL)	Yes		No extractions performed in an edentulous area. Not covered when performed on the same day as an extraction for the same tooth.
D7350	Vesibuloplasty - Ridge Extension (Including Soft Tissue Grafts)	Quadrants (LL, LR, UR, UL)	Yes		
D7410	Excision Of Benign Lesion Up To 1.25 Cm		No		
D7411	Excision Of Benign Lesion Greater Than 1.25 Cm		No		
D7412	Excision Of Benign Lesion, Complicated		No		

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Code	Description	Teeth or area covered	Review required	FE waiver eligible	Benefit limitations
D7413	Excision Of Malignant Lesion Up To 1.25 Cm		No		
D7414	Excision Of Malignant Lesion Greater Than 1.25 Cm		No		
D7415	Excision Of Malignant Lesion, Complicated		No		
D7440	Excision Of Malignant Tumor - Lesion Diameter Up To 1.25 Cm		No		
D7441	Excision Of Malignant Tumor - Lesion Diameter Greater Than 1.25 Cm		No		
D7450	Removal Of Benign Odontogenic Cyst Or Tumor - Dia Up To 1.25 Cm		No		
D7451	Removal Of Benign Odontogenic Cyst Or Tumor - Dia Greater Than 1.25 Cm		No		
D7460	Removal Of Benign Nonodontogenic Cyst Or Tumor - Dia Up To 1.25 Cm		No		
D7461	Removal Of Benign Nonodontogenic Cyst Or Tumor - Dia Greater Than 1.25 Cm		No		
D7471	Removal Of Lateral Exostosis (Maxilla Or Mandible)	Arches (UA, LA)	Yes		1 per lifetime.
D7472	Removal Of Torus Palatinus		Yes		1 per lifetime.
D7473	Removal Of Torus Mandibularis		Yes		1 per lifetime.
D7490	Radical Resection Of Maxilla Or Mandible		Yes		
D7510	Incision And Drainage Of Abscess - Intraoral Soft Tissue		No		Not covered same date of service as D7511.
D7511	Incision And Drainage Of Abscess - Intraoral Soft Tissue - Complicated		No		
D7520	Incision And Drainage Of Abscess - Extraoral Soft Tissue		No		Not covered same date of service as D7521.
D7521	Incision And Drainage Of Abscess - Extraoral Soft Tissue - Complicated		No		
D7530	Removal Of Foreign Body From Mucosa		No		
D7540	Removal Of Reaction Producing Foreign Bodies		No		
D7550	Partial Ostectomy/Sequestrectomy For Removal Of Non-Vital Bone	Quadrants (LL, LR, UR, UL)	No		
D7560	Maxillary Sinusotomy For Removal Of Tooth Fragment Or Foreign Body		Yes		
D7610	Maxilla - Open Reduction (Teeth Immobilized, If Present)		No		

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Code	Description	Teeth or area covered	Review required	FE waiver eligible	Benefit limitations
D7620	Maxilla - Closed Reduction (Teeth Immobilized, If Present)		No		
D7630	Mandible - Open Reduction (Teeth Immobilized, If Present)		No		
D7640	Mandible - Closed Reduction (Teeth Immobilized, If Present)		No		
D7650	Malar And/Or Zygomatic Arch - Open Reduction		No		
D7660	Malar And/Or Zygomatic Arch - Closed Reduction		No		
D7670	Alveolus - Closed Reduction, May Include Stabilization Of Teeth		No		May include stabilization.
D7680	Facial Bones - Complicated Reduction With Fixation And Multiple Surgical		Yes		
D7710	Maxilla - Open Reduction		No		
D7720	Maxilla - Closed Reduction		No		
D7730	Mandible - Open Reduction		No		
D7740	Mandible - Closed Reduction		No		
D7750	Malar And/Or Zygomatic Arch - Open Reduction		No		
D7760	Malar And/Or Zygomatic Arch - Closed Reduction		No		
D7770	Alveolus - Open Reduction Stabilization Of Teeth		No		
D7780	Facial Bones - Complicated Reduction With Fixation And Multiple Approaches		No		
D7820	Closed Reduction Of Dislocation		No		
D7860	Arthrotomy		Yes		
D7865	Arthroplasty		Yes		
D7910	Suture Of Recent Small Wounds Up To 5 Cm		No		Not covered on same day as D7140, D7210, D7220, D7230, D7240, D7241 or D7250.
D7911	Complicated Suture - Up To 5 Cm		No		Not covered on same day as D7140, D7210, D7220, D7230, D7240, D7241 or D7250.
D7912	Complicated Suture - Greater Than 5 Cm		No		Not covered on same day as D7140, D7210, D7220, D7230, D7240, D7241 or D7250.
D7920	Skin Graft (Identify Defect Covered, Location And Type Of Graft)		Yes		
D7955	Repair Of Maxillofacial Soft And/Or Hard Tissue Defect		Yes	✔	
D7961	Buccal/Labial Frenectomy (Frenulectomy)	01 (UA) 02 (LA)	No	✔	
D7962	Lingual Frenectomy (Frenulectomy)	02 (LA)	No	✔	

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Code	Description	Teeth or area covered	Review required	FE waiver eligible	Benefit limitations
D7963	Frenuloplasty		No		2 per lifetime. Excision of frenum with excision or repositioning of abervant muscle and z-plasty or other local flap closure.
D7971	Excision Of Pericoronal Gingiva	All Permanent Teeth (Teeth 1 through 32)	No		
D7979	Non-Surgical Sialolithotomy		Yes		
D7980	Surgical Sialolithotomy		No		
D7981	Excision Of Salivary Gland, By Report		No		
D7982	Sialodochoplasty		No		
D7983	Closure Of Salivary Fistula		Yes		
D7990	Emergency Tracheotomy		No		
D9212	Trigeminal Division Block Anesthesia		Yes		
D9219	Evaluation For Moderate Sedation, Deep Sedation or General Anesthesia		No		One time per beneficiary per provider or provider billing group per lifetime. One time per beneficiary per 12 months.
D9222	Deep Sedation/General Anesthesia - First 15 Minutes		Yes		D9222/D9223 will not be considered for payment when ONLY diagnostic services are provided on the same date of service.
D9223	Deep Sedation / General Anesthesia - Each subsequent 15 Minute Increment		Yes		D9222/D9223 will not be considered for payment when ONLY diagnostic services are provided on the same date of service.
D9230	Inhalation Of Nitrous/Analgesia, Anxiolysis		No		Not covered when billed with diagnostic and/or preventive services (D0120 through D1208, D1516 through D1556, D9410, D9420).
D9239	Intravenous Moderate (Conscious) Sedation/Analgesia - First 15 Minutes		Yes		D9239/D9243 will not be considered for payment when ONLY diagnostic services are provided on the same date of service.
D9248	Non-Intravenous Conscious Sedation		No		D9239/D9243 will not be considered for payment when ONLY diagnostic services are provided on the same date of service.
D9310	Consultation - Diagnostic Service Provided By Dentist Or Physician		No		1 per 12 months by same provider. One inpatient follow-up per beneficiary within a 10-day period by same provider. Not covered on same date of service as D0120 -D0170, D9410, D9420.
D9311	Consultation with a medical health care professional		No		1 per 12 months by same provider. One inpatient follow-up per beneficiary within a 10 day period by same provider. Not covered on same date of service as D0120-D0170, D9410, D9420.
D9410	House/Extended Care Facility Call		No		1 per day per patient per (provider and location). Extended Care Facilities only.
D9420	Hospital Or Ambulatory Surgical Center Call		No		1 per day per patient per (provider and location) Hospital Facilities only.
D9610	Therapeutic Parenteral Drug, Single Administration		Yes		1 per day

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Code	Description	Teeth or area covered	Review required	FE waiver eligible	Benefit limitations
D9613	Sustained Release Therapeutic Drug		Yes		1 per day
D9920	Behavior Management, By Report		Yes		
D9999	Unspecified Adjunctive Procedure, By Report		Yes		

For children receiving EPSDT services, any limits on services may be exceeded when medically necessary.