Dental Benefits

Revised: September 23, 2024

Overview

Refer to the Overview section under Dental Services in the Minnesota Health Care Programs (MHCP) Provider Manual.

Covered Services

All MHCP covered services must be medically necessary, appropriate, and the most cost-effective for the medical needs of the MHCP member. Review the MHCP Fee Schedule for a current list of all MHCP covered codes. The services listed in the following tables have defined service limits and, for some, Prior Authorization (PA) requirements.

This following list of covered services is not all-inclusive. Refer to the Dental Authorization Requirement Tables for additional authorization criteria.

Diagnostic

Covered services include clinical oral evaluations, diagnostic imaging, and some tests and examinations.

Clinical Oral Evaluations

Keep all documentation with the member's record, including notation of the specific oral health problem or complaint.

CDT Code(s)	Description	Service Limits
D0120	Periodic exam	Once per year Cannot be performed on same date as D0140, D0145, D0150, D0160, D0180 or D4355
D0140	Limited exam	Once per day per facility Documentation must include notation of the

		specific oral health problem or complaint Cannot be performed on same date as D0120, D0145, D0150, D0160, D0180, D1110 or D1120
D0145	Oral evaluation for a patient under 3 years of age	Once per lifetime Cannot be performed on same date as D1330
D0150	Comprehensive exam	Once per five years Cannot be performed on same date as D0120, D0140, D0145, D0160,D0180 or D4355
D0160	Detailed and extensive oral evaluation	Cannot be performed on same date as D0120, D0140, D0145, D0150, D0180 or D4355
D0180	Comprehensive periodontal evaluation	Cannot be performed on same date as D0120, D0140, D0145 D0150, D0160 or D4355

Diagnostic Imaging

CDT Code(s)	Description	Service Limits
D0210	Intraoral comprehensive series of radiographic images (FMX)	1. Covered once every two years in the office setting 2. Covered as often as needed in the operating room or Ambulatory Surgery Center (ASC)
D0220 – D0240 D0250	Intraoral - periapical radiographic images Extra-oral - 2D projection radiographic Image	Four per date of service (does not include intraoral-complete series)
D0270 – D0274 D0277	Bitewings - 1 to 4 radiographic images Vertical bitewings - 7 to 8 radiographic images	One series per calendar year
D0330 D0340	Panoramic radiographic image 2D cephalometric radiographic image	Once per five years except: 1. With a scheduled outpatient facility or freestanding ASC procedure (include claim attachment identifying hospital or ASC name) 2. For a medically necessary diagnosis and follow-up of oral and maxillofacial pathology and trauma (include claim attachment with a description of the pathology or trauma and the medical diagnosis identified) 3. Once every two years for members who cannot cooperate for intraoral film due to disability or medical condition that does not allow for intraoral film placement (include claim attachment identifying disability or condition)

D0372	Intraoral tomosynthesis - comprehensive series of radiographic images	Covered for patients in operating room only.
D0373	Intraoral tomosynthesis - bitewing 1 to 4 radiographic images Vertical bitewings - 7 to 8 radiographic images	One series per calendar year.
D0374	Intraoral tomosynthesis - periapical radiographic image	Four per date of service (does not include intraoral-complete series)

Exceptions to Full-mouth X-rays

Exceptions Guidelines	Authorization Required	Documentation Required
When medically necessary for the diagnosis and follow-up of oral and maxillofacial pathology and trauma	No	AUC Cover Sheet Chart documentation
Once every two years for children who cannot cooperate for intraoral film due to disability or medical condition that does not allow for intraoral film placement	No	AUC Cover Sheet Chart documentation
When medically necessary for the diagnosis and treatment of symptomatic third molars if root formation has been completed since the last panoramic x-ray was taken	Yes	Diagnostic quality copy of the initial panoramic x-ray with the exposure date indicated

Preventive

Covered services include dental prophylaxis, topical fluoride treatment, some preventive services, and space maintenance and maintainers.

CDT Code(s)	Description	Service Limits
D1110	Prophylaxis - adult	Twice per calendar year MHCP will pay for up to two additional D1110 per year, with a maximum of four per year.Provider is obligated to maintain treatment plan and rationale for increased D1110 in the dental record. Prior authorization is no longer required for additional D1110.
D1120	Prophylaxis - child	Twice per calendar year MHCP will pay for up to two additional D1120 per year, with a maximum of four per year. Provider is obligated to maintain treatment plan and rationale for increased D1120 in the dental record.

D1206 and D1208	Topical fluoride treatment	Once per six months Cannot be performed on same date as D9910
D1301	Immunization Counseling	Once per member per year
D1310	Nutritional Counseling for control of dental disease	Once per member per year
D1320	Tobacco Counseling for the control and prevention of oral disease	Once per member per year
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use	Once per member per year
D1330	Oral hygiene instructions	Once per member per year Cannot be performed on same date as D0145
D1351	Sealant - per tooth	Permanent molars only (tooth numbers 1-3, 14-16, 17-19, 30-32) Once per tooth per five years
D1354	Application of caries arresting medicament – per tooth	Once per six months per tooth Tooth number is required

Restorative

Covered services include amalgam restorations, resin-based composite restorations, some crowns, and other restorative services. MHCP prohibits balance billing posterior composites to the member (billing the MHCP member for the difference between what MHCP pays and what the provider charges). MHCP will reimburse all posterior fillings at the amalgam rate.

CDT Code(s)	Description	Service Limits
D2140 – D2161	Amalgam restorations (including polishing)	Limited to once per 90 days for the same tooth
D2330 – D2394	Resin-based composite restorations	Limited to once per 90 days for the same tooth
D2710 - D2722	Crowns- single restorations Resin or resin/metal	Authorization is required for D2720 - D2722 Laboratory resin crowns that meet the specifications of utilization review
D2930-D2934	Prefabricated stainless steel and/or resin crowns	
D2940	Protective restoration	Allowed only for relief of pain Cannot be performed on same date as D9110
D2976	Band Stabilization per tooth	Limited to once per 90 days for the same tooth
D2989	Excavation of tooth resulting in the determination of non-restorability	Limited to once per tooth number
D2991	Application of hydroxyapatite regeneration medicament – per	Once per tooth number per 180 days

	tooth	

Noncovered Pulp Cap Services
Direct (D3110) and Indirect (D3120) pulp caps **are not** a covered service and may not be billed to the member. Refer to Noncovered Services section under Dental Services in the MHCP Provider Manual for more information.

Endodontics
Covered services include pulpotomy, endodontic therapy on primary teeth, endodontic therapy, endodontic retreatment, apexification/recalcification, some apicoectomy/periradicular services, and other endodontic procedures.

MHCP covers anterior, premolar, and molar endodontics once per tooth per lifetime.

Periodontics
Covered services include some surgical services, some non-surgical periodontal services, and other periodontal services.

CDT Code(s)	Description	Service Limits
D4341 and D4342	Periodontal scaling and root planing	Once per two years Cannot be performed on same day as D1110 or D4355 Authorization is always required Must meet the specifications of utilization criteria Use oral cavity indicators to designate the quadrants where the service was or will be provided: 10 (upper right), 20 (upper left), 30 (lower left), or 40 (lower right)
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	Once per five years Cannot be performed on same date as D1110, D0150, D0160, or D0180
D4322	Splint – intra-coronal	Once per 12 months
D4323	Splint – extra-coronal	Once per 12 months
D4910	Periodontal maintenance	Effective July 1, 2021, D4910 periodontal maintenance is allowed once every 91 days for 730 days following a paid service line with periodontal scaling and root planing (per quadrant) D4341 or D4342. After 24 months, D4910 is not payable unless D4341 or D4342 are performed again under a new prior authorization.

Prosthodontics

Removable Prosthodontics
Covered services include complete and partial dentures, adjustments and repairs, rebase and relines, interim prosthesis, and other prosthetic services.

Fixed Prosthodontics
Covered services include fixed partial denture pontics, some retainers, retainer crowns, and other fixed partial denture services.

MHCP will approve the removable partial denture if the member is missing an anterior tooth and radiographs demonstrate adequate space for replacement of the missing anterior tooth, or if:

- The member has less than 10 posterior teeth in occlusion, or
- The partial is required to stabilize occlusion by minimizing tipping or extrusion of existing teeth

MHCP will allow a removable partial denture **opposing a complete denture** to provide balancing occlusion. Balancing occlusion is lacking when five posterior teeth are missing or both molars are missing on one side.

Service Limits
Initial placement or replacement of a removable prosthesis is limited to once every three years per member unless one or more of these conditions apply:

- Replacement of a removable prosthesis in excess of this limit is eligible for payment if the replacement is necessary because the removable prosthesis was misplaced, stolen, or damaged due to circumstances beyond the member's control. When applicable, providers must consider the member's degree of physical and mental impairment in determining whether the circumstances were beyond a member's control.
- Replacement of a partial prosthesis is eligible for payment if the existing prosthesis cannot be modified or altered to meet the member's dental needs.

Prosthodontic Documentation Instruction
Service for a removable prosthesis must include instruction in the use and care of the prosthesis and any adjustment necessary to achieve a proper fit during the six months immediately following the provision of the prosthesis. Document the instruction and the necessary adjustments, if any, in the member's dental record.

House Calls for Removable Prosthesis
House calls (D9410) for fitting removable prosthesis is a covered services limited to up to five visits in a calendar year. Bill house calls D9410 with D5992; D9410 will pay at the current rate and D5992 will pay at $0.

Undeliverable Removable Prostheses Instruction
MHCP pays a percentage payment of the scheduled allowable for undeliverable removable prostheses. All authorization requirements are still applicable. Submit an attachment for the claim that documents the following:

- Reason for non-delivery noted in the patient chart
- Explanation which includes the incurred lab charges and the percent of work completed

Fax a completed AUC Uniform Cover Sheet for Health Care Claims with the required documentation by end of the next business day after submitting the electronic claim. Keep the completed prosthesis in the provider's office, in a deliverable condition, for a period of at least two years. MHCP prorates payment based on the percentage completed and utilization review (analysis of the distribution of treatment based on claims information).

CDT Code(s)	Description	Service Limits
D5110 - D5140 D5810 and D5811	Complete dentures (including routine post-delivery care)	One removable appliance per dental arch per three years. Authorization is not required for initial placement of complete dentures. Subsequent complete dentures Authorization is always required, and are limited to one arch every three years. Replacement dentures fabricated after three years do not require a prior authorization.
D5211 – D5226 D5820 and D5821	Partial dentures (including routine post-delivery care)	One removable appliance per dental arch per three years. Authorization is always required
D5410 – D5422 D5511-D5520	Adjustments and repairs to complete dentures	D5520 is only limited to five teeth per 180 days
D5611 - D5671	Repairs to partial dentures	D5640 and D5650 are limited to five teeth per 180 days
D5710 – D5721 D5730 – D5761	Denture rebase and reline procedures	
D5850 and D5851	Tissue conditioning, maxillary or mandibular	Insertion of tissue conditioning liners are limited to once per denture unit: • As a preparation for taking impressions for the relining of existing dentures • For the fabrication of new dentures Bill tissue conditioning once at the completion of treatment, regardless of the number of visits involved
D5863 –D5866	Overdenture	Authorization is always required For each dental arch, removable prostheses are limited to one every three years

Maxillofacial Prosthetics
Covered services include some prostheses and some carriers.

Implant Services
Covered services include some pre-surgical services, some implant supported prosthetics, abutment supported single crowns, fixed partial denture (FPD) retainers, and other implant services. Use the Dental Implants Authorization Form (DHS-3538) (PDF).

CDT Code(s)	Description	Service Limits
D6092 and D6093	Re-cement or re-bond implant/abutment supported crown or fixed partial denture	Subject to utilization review
D6058 – D6094	Single crowns, abutment supported	Authorization is always required
D6068 – D6194	Fixed partial denture (FPD) retainer, abutment supported	Authorization is always required

Oral and Maxillofacial Surgery

Covered services include extractions, other surgical procedures, excision of soft tissue lesions, excision of intra-osseous lesions, and excision of bone tissue, some surgical incision, and other repair procedures.

The primary services or procedures must be covered services under MHCP for ancillary services to be covered. If the primary procedure is not a covered service, regardless of the complexity or difficulty, MHCP will not cover services such as the administration of anesthesia, diagnostic x-rays and other related procedures.

Dentists and oral surgeons who perform medical procedures must follow the practitioner and general authorization guidelines for exams, consultation, radiology, surgery, anesthesia, and laboratory services.

CDT Code(s)	Description	Service Limits
D7220 – D7251	Extractions	Authorization is always required

Orthodontics

All MHCP Orthodontia Programs

Orthodontia services require prior authorization. Submit prior authorization requests to the medical reviewer, medical review agent. Medical review agent will approve all prior authorizations with a three-year limit from the time of request to allow adequate time for service delivery. Coverage limits based on program still apply. Providers must consider this in treatment plans.

Orthodontic care usually requires lengthy treatment. MHCP recommends that the provider discuss the expected eligibility period with the family and the county human services agency before initiating treatment. This will clarify the eligibility policies and help reduce denial of payment due to subsequent ineligibility. A member's eligibility can terminate or may go from fee-for-service to a managed care organization on a month-to-month basis.

Providers are encouraged to consult with patients, parents or guardians regarding non-compliance and disregard for instructions. Providers may terminate treatment and remove all appliances until a later time when the member is more mature and can follow instructions. Compliance is critical for a successful orthodontic outcome. Non-compliance with orthodontic treatment can negatively affect the memberby exacerbating oral disease.

CDT Code(s)	Description	Service Limits
D8010 – D8040	Limited orthodontic treatment	Authorization is always required

D8070 – D8090	Comprehensive orthodontic treatment	

Adjunctive General Services

Covered services include some unclassified treatments, anesthesia, some professional consultation and professional visits, drugs, and some miscellaneous services.

CDT Code(s)	Description	Service Limits
D9110	Palliative (emergency) treatment of dental pain	Once per day
D9222 – D9248	Anesthesia, deep sedation, nitrous oxide/analgesia, anxiolysis	The determination of medical necessity for general anesthesia in conjunction with dental services must consider the information related to general anesthesia established under the "Behavior Guidance for the Pediatric Dental Patie by the American Academy of Pediatric Dentistry and the American Dental Society Anesthesia ADSA | American Dental Society of Anesthesiology (adsahome.org)
D9410	House or extended care facility call	Cannot be billed alone. Must be used in conjunction with another MHCP covered service Cannot be performed on same date as D1330 or D0999 MHCP considers services performed in a school,Head Start, day program, or group home program as house calls
D9610 and D9612	Therapeutic parenteral drug	
D9630	Drugs or medicaments dispensed in the office for home use	
D9910	Application of desensitizing medicament	
D9920	Behavior management	When additional staff time is required to accommodate behavioral challenges and sedation is not used
D9951	Occlusal adjustment - limited	Once per day
D9952	Occlusal adjustment - complete	Authorization is always required

Community Health Worker – Patient Education

Refer to the Community Health Worker (CHW) section in the MHCP Provider Manual for patient education covered services.

Authorization

The criteria for services which require a prior authorization are listed on Dental Authorization Requirement Tables. Submit requests electronically using MN–ITS user guides for Submit an Authorization Request for Dental Services, or for consolidated providers Submit an Authorization Request for Dental Services with Consolidated NPIs. Do not submit authorization requests to the

medical review agent for services that do not require authorization or are noncovered services; they incur unnecessary costs and the medical review agent will not approve these requests.

Billing

Drugs
Enter additional information in the notes section of the 837D, including the name of the drug, National Drug Code and dosage.

Orthodontic Billing
Use D8660 pre-orthodontic treatment visit to report orthodontic full case study.

Comprehensive orthodontic treatment
- Use D8999 for initial banding and write "initial banding" in the narrative.
- Bill adjustments utilizing the appropriate comprehensive code (D8070, D8080 or D8090).

Non-comprehensive orthodontic treatment
- MHCP does not reimburse for initial banding.
- Bill adjustments utilizing the appropriate limited orthodontic treatment code (D8010, D8020, D8030 or D8040).

MHCP considers replacement or recementing of one or two brackets due to reasonable wear and tear a part of the total orthodontic treatment. Recementing of brackets due to a failure of the patient to comply with provider instructions is a noncovered service and the provider may bill the member for the cost. Since recementation of brackets is not a covered service, the provider is not required to submit charges to MHCP.

The retention phase of orthodontic treatment is a component of the total orthodontic care for which the provider is reimbursed. The type of retention is a choice made by the provider. Do not bill the member.

MHCP authorization and Third Party Liability (TPL) or other insurance billing instructions
If MHCP approves an authorization for an initial appliance placement and subsequent monthly adjustments, bill the TPL or other insurance following the correct method based on whether the TPL or insurance pays an initial down payment or pays over the entire course of the orthodontic treatment.

1. When TPL or other insurance pays an initial down payment and subsequent payments over the course of the treatment (monthly, quarterly, semi-annual or annual payments):
   a. Bill the approved initial appliance placement code and indicate the TPL or other insurance initial down payment amount on the claim.
   b. Bill monthly adjustments (one month at a time) indicating the TPL or other insurance actual monthly payment or the prorated monthly amount based on the total remaining TPL or other insurance payment expected, divided by the total months of orthodontic treatment.
2. When TPL or other insurance pays over the entire course of the orthodontic treatment (monthly, quarterly, semi-annual, annual or lump sum payments):
   a. Bill the approved initial appliance placement code and monthly adjustments (one month at a time).
   b. Indicate the actual TPL or other insurance monthly payment or the prorated monthly amount based on the total TPL or other insurance payment expected, divided by the total months of orthodontic treatment.

If the MHCP authorization approves only monthly adjustments, bill the TPL or other insurance according to the following if the TPL or other insurance makes payments over the course of the treatment:

1. Indicate the TPL or other insurance actual monthly payment (one month at a time).
2. Use the calculated prorated monthly amount based on the total TPL or other insurance payment expected, divided by the total months of orthodontic treatment. Use one of the following two examples to calculate the prorated payment amounts:
   a. TPL or other insurance total payment $1,500 divided by the expected course of treatment (24 months) equals $62.50 as the monthly prorated payment.
   b. Your charge for the braces is $4,800 with an expected course of treatment of 24 months. The TPL or other insurance will pay a total of $2,400 in three installments ($1,000 at the beginning of the treatment, $1,000 at the beginning of the second year, and $400 at the end of the treatment). TPL or other insurance is paying 60 percent of your total charge; therefore, when billing MHCP, the TPL or other insurance paid amount should be 60 percent of your billed amount.

Legal References

Minnesota Rules, 9505.0270 (Dental Services)
Minnesota Statutes, 256B.0625, subdivision 9 (Covered Services; Dental services)
Minnesota Statutes, 256B.0625, subdivision 25b (Authorization with third-party liability)
Minnesota Statutes, 256B.0625, subdivision 49 (Community health worker)