Dental Program’s
Claims Processing Guidelines
APPLICABILITY

These claims guidelines may be applied to dental coverage for all members. The Dental Program performs the administrative functions for Plan Clients and will administer the dental plan benefits of Plan Clients using these guidelines.
Any updates and/or revisions to these guidelines will be communicated to all contracted dentists or dental practices.

GUIDELINES

These guidelines are used in the claim adjudication process and any retrospective review of claims for fraud and abuse evaluation.
Guidelines (G) related to each category of procedure codes precede the category code listing.
 Policies for specific procedure codes are listed in each category after the codes and nomenclature. In all cases, group contract provisions, limitations, and exclusions take precedence over processing policies. Since certain contractual items (e.g., time limits, frequency of procedures, age limits, etc.) can vary among groups, they have not all been listed with their associated procedure codes.
This document should not be interpreted as comprehensive and encompassing all possible limitations and exclusions. It is recommended that the dental office contact the customer service number for the Plan Client on the member’s identification card to determine the limitations and exclusions for each group.

FOR FOLLOWING DEFINITIONS APPLY TO THESE GUIDELINES:

ALLOWABLE: The amount used to calculate the appropriate benefit allowance consistent with “Maximum Allowed Amount.”

ALTERNATE BENEFIT: In cases where alternative methods of treatment exist, benefits are provided for the least costly professionally accepted treatment. This determination is not intended to reflect negatively on the dentist’s treatment plan or to recommend which treatment should be provided. It is a determination of benefits under terms of the Patient’s coverage. The dentist and Patient should decide the course of treatment. If the treatment rendered is other than the one Benefited the difference between allowance and the dentist charge for the actual treatment rendered is collectible from the Patient.

BENEFITED: Processed for payment subject to the Patient’s dental benefit contract stipulations including but not limited to copayments, deductibles, maximums, determination of the Allowable amount, etc.

BY REPORT AND SUBJECT TO COVERAGE UNDER MEDICAL: When a procedure is By Report And Subject To Coverage Under Medical, it should be submitted to the Patient’s medical carrier first. When submitting, include a copy of the explanation of payment or payment voucher from the medical carrier with the claim, plus a narrative describing the procedure performed, reasons for performing the procedure, pathology report if appropriate, and any other information deemed pertinent. In the absence of such information the procedure will not be Benefited.

DENIED: If the fee for a procedure is Denied, the fee charged is not payable and is chargeable to the Patient.

DISALLOW/DISALLOWED: If the fee for a procedure is Disallowed, it is not Benefited and is not collectible from the Patient by a contracting dentist.

IN CONJUNCTION WITH: A service which is considered part of another procedure or episode of treatment including, but not limited to services being rendered on the same day.

OPTIONAL: Procedures which are not covered, but for which an allowance is provided for a different procedure. This allowance can be applied to the Optional procedure, and the difference between the charged amount and the Allowable amount for the Optional procedure is collectible from the Patient by a contracting dentist.

PATIENT: The person who receives the treatment or service that is submitted for dental benefits. Patient may also mean, with respect to financial responsibilities only, the person (if different from the Patient) who is responsible to the dental office for any payment obligations of the Patient.

PROCESSED AS: When a procedure is Processed As a different procedure, contracting dentists agree to accept all the limitations, claims guidelines, and Allowable amounts that apply to the procedure that is Benefited by the Patient’s dental benefit contract.

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New Codes

D0251 Extra-oral posterior dental radiographic image - image limited to exposure of complete posterior teeth in both dental arches. This is a unique image that is not derived from another image. – processed the same as D0250

D0422 Collection and preparation of genetic sample material for laboratory analysis and report. Same as D0421

D0423 Genetic test for susceptibility to diseases – specimen analysis - Certified laboratory analysis to detect specific genetic variations associated with increased susceptibility for diseases. Same as D0421

D1354 Interim caries arresting medicament application - conservative treatment of an active, non-symptomatic carious lesion by topical application of a caries arresting or inhibiting medicament and without mechanical removal of sound tooth structure. Not covered

D4283 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site. Used in conjunction with D4273 – local anesthesia is usually considered a component part of periodontal procedures, but dependent upon the plan will allow up to 50% of D4273 – allow up to a maximum of 3 teeth per quadrant

D4285 Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site. Local anesthesia is usually considered a component part of periodontal procedures, but dependent upon the plan will allow up to 50% of D4278 – allow up to a maximum of 3 teeth per quadrant

D5221 Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth) – includes limited follow-up care only; does not include future rebasing / relining procedure(s). Same as D5211

D5222 Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth) – includes limited follow-up care only; does not include future rebasing / relining procedure(s). Same as D5212

D5223 Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) - includes limited follow-up care only; does not include future rebasing / relining procedure(s). Same as D5213

D5224 Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) - includes limited follow-up care only; does not include future rebasing / relining procedure(s). Same as D5214

D7881 Occlusal orthotic device adjustment NC - considered in the cost for the occlusal orthotic for first 6 months D8681 removable orthodontic retainer adjustment. Same as D8210

D8681 Removable orthodontic retainer adjustment. Same as D8210

D9223 Deep sedation/general anesthesia – each 15 minute increment - anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties. The level of anesthesia is determined by the anesthesia provider’s documentation of the anesthetics effects upon the central nervous system and not dependent upon the route of administration. Dental plans are not able to benefit anesthesia the same as can medical plans, therefore the benefit is derived from the division of a total of 1 hour of anesthesia divided by 4 – each fifteen minute time unit is ¼ of the total for 1 hour (prior 1 D9220 plus 2 D9221 time units).
Intravenous moderate (conscious) sedation/analgesia – each 15 minute increment - anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties. The level of anesthesia is determined by the anesthesia provider’s documentation of the anesthetics effects upon the central nervous system and not dependent upon the route of administration. Dental plans are not able to benefit anesthesia the same as can medical plans, therefore the benefit is derived from the division of a total of 1 hour of anesthesia divided by 4 – each fifteen minute time unit is ¼ of the total for 1 hour (prior 1 D9241 plus 2 D9242 time units)

Cleaning and inspection of removable complete denture, maxillary - this procedure does not include any adjustments. Processed the same as D9331

Cleaning and inspection of removable complete denture, mandibular - this procedure does not include any adjustments. Processed the same as D9331

Cleaning and inspection of removable partial denture, maxillary - this procedure does not include any adjustments. Processed the same as D9331

Cleaning and inspection of removable partial denture, mandibular- this procedure does not include any adjustments. Processed the same as D9331

Oclusal guard adjustment. Not-Covered for first 6 months post insertion of D9940 - adjustments included in fee for occlusal guard

Deleted Codes

Extra-oral – each additional radiographic image
Genetic test for susceptibility to oral disease
Temporary crown (fractured tooth)s
Deep sedation/general anesthesia – first 30 minutes
Deep sedation/general anesthesia – each additional 15 minutes
Intravenous moderate (conscious) sedation analgesia – first 30 minutes
Intravenous moderate (conscious) sedation analgesia – each additional 15 minutes
Cleaning and inspection of a removable appliance
The CDT code descriptions are provided for your convenience and may be abbreviated. For the complete description for each code refer to the current ADA CDT code book. We recommend you obtain a copy of the CDT 15 code set from the ADA, as it will identify new and deleted codes as well as code revisions. We encourage all dentists to refer to their copy of the ADA CDT 2015 manual for specific code information. CDT codes are © 2014 American Dental Association.

In all cases, specific group contract provisions, state or federal laws or requirements, limitations and exclusions take precedence over the Claims Processing Guidelines. Since certain contractual items (e.g. time limits, frequency of procedures, age limits, etc.) can vary among groups, they have not all been listed with their associated procedure codes. Therefore this document should not be interpreted as comprehensive and encompassing all possible limitations and exclusions. Dental offices should contact Customer Service on the member’s identification card to determine the specific limitations and exclusions for each group.

ALL PROCEDURES SUBMITTED ARE SUBJECT TO THE FOLLOWING GUIDELINES (G):

- Documentation of extraordinary circumstances can be submitted for review by report or on an appeal basis.
- Multi-stage procedures are reported and Benefited upon completion. The completion date is the date of insertion for removable prosthetic appliances.
  - The completion date for fixed partial dentures and crowns, onlays, and inlays is the cementation date regardless of the type of cement utilized. The completion date for root canal therapy is the date the canals are permanently filled.
- Many of the claims guidelines that follow detail payment procedures are based on the timing and sequence of inter-related procedures. However, the timing and sequencing of treatment is the responsibility of the dentist rendering care and should always be determined by the treating dentist based on the Patient’s dental needs.
- Fees for completion of claim forms, requests for pre-estimates of benefits or pre-determinations of benefit, and submission of documentation enable benefit determination and are not benefits paid by Plan Clients. They are not collectible from the Patient by a contracting dentist.
- Infection control and OSHA compliance are considered to be part of normal office overhead. Therefore, they are included in the fee for each procedure and not collectible separately from the Patient by a contracting dentist.
- A Plan Client may Disallow charges for procedures, which were not necessary or failed to meet generally accepted standards of care.
- For payment purposes, local anesthesia is an integral part of the procedure being performed and additional charges are Disallowed.

I. D0100 - D0999 DIAGNOSTIC

D0100 - D0180 CLINICAL ORAL EVALUATIONS

(Reminder: G = Guidelines)

G- Comprehensive and periodic evaluations include, but are not limited to, evaluation of all hard and soft tissues of the oral cavity, periodontal charting, oral cancer evaluation, blood pressure screenings, and base line EKG. Any additional fee for these procedures is Disallowed. Clinical oral evaluations are covered by contract and are subject to time limitations established by the group contract. The fees for consultation, diagnosis, and routine treatment planning are Disallowed as components of the fee for the evaluation, by the same dentist/dental office.

D0120 Periodic oral evaluations are Processed As periodic oral evaluations. Fees in excess of the Allowable amount for the periodic oral evaluations are Disallowed.

D0140 Limited oral evaluation – problem focused, are Allowed when definitive treatment is established by the group contract.

D0145 Oral evaluation for Patient under 3 years of age and counseling with Primary caregiver. Time limitation for evaluations is established by contract and should cross check with other evaluations. D0145 includes any caries susceptibility tests or oral hygiene instruction on the same date. When performed on the same date as D0145 any fees for susceptibility test and oral hygiene instruction are Disallowed. Benefits for D0145 when billed on the same date and by the same dental office as a comprehensive oral evaluation are considered to be included in the comprehensive evaluation as the more inclusive procedure. The fee for D0145 is Disallowed. Benefits for a child over 3 years of age will be processed as a periodic oral evaluation and subject to any contract limitations. Fees in excess of the Allowable amount for the periodic oral evaluation are Disallowed.

D0150 Comprehensive oral evaluation – new or established Patient is payable once per dentist. Additional
evaluations when billed by the same dentist/dental office are Processed As periodic evaluations and subject to contractual time limitations.

For patients under age of three, any other comprehensive exam code submitted will be payable as D0145.

D0160 Detailed and extensive oral evaluation problem focused, by report may be Processed As a comprehensive oral evaluation for the first encounter with the dentist/dental office and subsequent submissions are Processed As periodic oral evaluations (D0120).

For patients under age of three, any other comprehensive exam code submitted will be payable as D0145.

D0170 Re-evaluation - limited, problem focused (established Patient; not post-operative visit). The fees are Disallowed as a component of another service or procedure.

D0171 Re-evaluation – post-operative office visit. This procedure is Disallowed when submitted within 90 days post surgical procedure by the same dentist/dental office - considered incidental to surgery and part of global treatment. Denied if the treating dentist is different. It is processed the same as D0170.

D0180 Comprehensive periodontal evaluation-new or established Patients are Allowed and subject to the time limitations of the group contract. Additional evaluations when billed by the same dentist/dental office are Processed As periodic evaluations and subject to contractual time limitations.

For patients under age of three, any other comprehensive exam code submitted will be payable as D014

D0190 – D0191 PRE-DIAGNOSTIC

D0190 Screening of a Patient – May be Benefited based on the member's dental benefit plan. When D0190 is reported In Conjunction with a clinical oral evaluation (D0120-D0180), D0190 is disallowed.

D0191 Assessment of a Patient – May be Benefited based on the member's dental benefit plan. When D0190 is reported In Conjunction with a clinical oral evaluation (D0120-D0180), D0191 is Disallowed.

D0200 - D0399 DIAGNOSTIC IMAGING

G - Only necessary and appropriate diagnostic services can be charged to the Patient. Fees for unnecessary or inappropriate radiographs are Disallowed. Fees for duplication (copying) of radiographs are not a covered benefit, nor chargeable to the Patient by a participating dentist. The time limitation for radiographs is established by the contract.

D0210 – D0731 IMAGE CAPTURE WITH INTERPRETATION

D0210 Intraoral-complete series (including bitewings). Individually listed intraoral radiographs by the same dentist/dental office are considered a complete series, usually 14-22 images, intended to display the crowns and roots of all teeth, periapical areas and alveolar bone, if the fee for individual radiographs equals or exceeds the fee for a complete series on the same date of service, any fee in excess for the fee for a full mouth series of radiographs is Disallowed. When bitewings are processed as part of an intraoral complete series, a separate benefit for bitewings will be Disallowed if the full mouth time limitation has been met within the benefit period. When a separate fee is requested for a panoramic x-ray (D0330) In Conjunction With D0210, the fee for the D0330 is Disallowed as a component of D0210.

D0220 Intraoral - periapical - first film

D0230 Intraoral – periapicals - each additional film Individually listed intraoral radiographs are considered a complete series if the number of individual radiographs equals or exceed fourteen (14) films. The fee in excess of the Allowable amount for a complete series (D0210) is Disallowed. Working and final treatment radiographs taken for endodontic therapy are considered a component part of the complete treatment procedure, and separate fees for these films are Disallowed.

D0240 Intraoral-occlusal film

D0250 Extraoral-first film

D0251 Extra-oral posterior dental radiographic image - image limited to exposure of complete posterior teeth in both dental arches. This is a unique image that is not derived from another image. – processed the same as D0250

G - FDA guidelines on radiographs. The FDA has guidelines on the use of radiographs in dentistry.

D0270 Bitewings-single film

D0272 Bitewings-two films

D0273 Bitewings-three films

D0274 Bitewings-four films

D0277 Vertical bitewings - 7 to 8 films are considered for benefit purposes and goes against the time limit frequencies
for bitewings in the contract. The fee for any type of bitewings submitted with a full mouth series are considered part of the full mouth series for payment and benefit purposes. Any fee in excess of the full mouth series is Disallowed. In absence of contract language for bitewing frequency limitations, bitewings of any type are Disallowed within twelve (12) months of a full mouth series.

D0340 Cephalometric film is payable only when done In Conjunction With orthodontic benefits. A cephalometric film taken In Conjunction With services other than orthodontic treatment is Denied. Cephalometric film is a covered benefit only for orthodontic cases when the group has orthodontic coverage.

D0350 2 D Oral facial photographic images obtained intraorally or extraorally are Benefited only once per case In Conjunction With orthodontic services. The fees for additional images taken during or after orthodontic treatment are included in the fee for the orthodontics and Disallowed. The fees for oral/facial images taken In Conjunction With any other procedure unless specifically requested by dental plan are Denied.

D0351 3D photographic image - This procedure is used for dental or maxillofacial diagnostic purposes. It is not applicable for a CAD-CAM procedure. D0364 Cone beam CT capture and interpretation – Benefits are Denied in accordance with group contracts and the fee is chargeable to the Patient.

D0365 Cone beam CT capture and interpretation – Benefits are Denied in accordance with group contracts and the fee is chargeable to the Patient.

D0366 Cone beam CT capture and interpretation – Benefits are Denied in accordance with group contracts and the fee is chargeable to the Patient.

D0367 Cone beam CT capture and interpretation – Benefits are Denied in accordance with group contracts and the fee is chargeable to the Patient.

D0368 Cone beam CT capture and interpretation – Benefits are Denied in accordance with group contracts and the fee is chargeable to the Patient.

D0369 Maxillofacial MRI capture and interpretation - Benefits are Denied in accordance with group contracts and the fee is chargeable to the Patient.

D0370 Maxillofacial ultrasound capture and interpretation - Benefits are Denied in accordance with group contracts and the fee is chargeable to the Patient.

D0371 Sialendoscopy - Benefits are Denied in accordance with group contracts and the fee is chargeable to the Patient.

D0380 – D0386 IMAGE CAPTURE ONLY

D0380 Cone beam CT capture only - Benefits are Denied in accordance with group contracts and the fee is chargeable to the Patient.

D0381 Cone beam CT capture only - Benefits are Denied in accordance with group contracts and the fee is chargeable to the Patient.

D0382 Cone beam CT capture only - Benefits are Denied in accordance with group contracts and the fee is chargeable to the Patient.

D0383 Cone beam CT capture only - Benefits are Denied in accordance with group contracts and the fee is chargeable to the Patient.

D0384 Cone beam CT capture only - Benefits are Denied in accordance with group contracts and the fee is chargeable to the Patient.

D0385 Maxillofacial MRI capture only - Benefits are Denied in accordance with group contracts and the fee is chargeable to the Patient.

D0386 Maxillofacial ultrasound capture only - Benefits are Denied in accordance with group contracts and the fee is chargeable to the Patient.

D0391 – D0396 INTERPRETATION AND REPORT ONLY

D0391 Interpretation of diagnostic image – Benefits are Denied in accordance with group contracts and the fee is chargeable to the Patient.

D0392 – D0395 POST PROCESSING OF IMAGE OR IMAGE SETS
D0393 Treatment simulation using 3D image interpretation. The use of 3D image volumes for simulation of treatment including, but not limited to, dental implant placement, orthognathic surgery and orthodontic tooth movement. Benefits are Denied in accordance with group contracts and the fee is chargeable to the Patient.

D0394 Digital subtraction of two or more images or image volumes of the same modality. Benefits are Denied in accordance with group contracts and the fees is chargeable to the Patient.

D0395 Fusion of two or more 3d image volumes of one or more modalities. Benefits are Denied in accordance with group contracts and the fees is chargeable to the Patient.

D0400 - D0603 TESTS AND EXAMINATIONS

G - When more than two procedures are performed on the same area of the mouth on the same day, benefits are based upon, but not limited to, the most inclusive procedure.

D0415 Collection of microorganisms for culture and sensitivity are Denied, unless specified as a covered service by the group contract.

D0416 Viral culture. Studies for determining pathologic agents are a specialized or elective procedure and the fees are Denied.

D0417 Collection and preparation of saliva sample for laboratory diagnostic testing are considered experimental and the fees are Denied. The Denied amount is collectible from the Patient.

D0418 Analysis of saliva samples are Denied and the approved amount is collectible from the Patient.

D0422 Collection and preparation of genetic sample material for laboratory analysis and report. Same as D0421

D0423 Genetic test for susceptibility to diseases – specimen analysis - Certified laboratory analysis to detect specific genetic variations associated with increased susceptibility for diseases. Same as D0421

D0425 Caries susceptibility tests. Caries susceptibility tests are not a benefit and are Denied.

D0431 Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures. The fees are Denied.

D0460 Pulp vitality tests when Benefited are per visit, not per tooth, and only for the diagnosis of emergency conditions. The fees for pulp tests are Disallowed when performed on the same date as any other definitive procedure except limited oral evaluation – problem focused or D9110 palliative treatment.

D0470 Diagnostic casts are Benefited only once per case In Conjunction With orthodontic services. The fees for additional casts taken during or after orthodontic treatment are included in the fee for orthodontic treatment and are Disallowed. The fee for diagnostic casts taken In Conjunction With any other procedure are Denied unless specified as covered service by the group contract.

D0601 Caries risk assessment and documentation, with a finding of low risk using recognized assessment tools. Considered inclusive of exam D0120 and D0150 with no additional fee unless group contract allows.

D0602 Caries risk assessment and documentation, with a finding of moderate risk using recognized assessment tools. Considered inclusive of exam D0120 and D0150 with no additional fee unless group contract allows.

D0603 Caries risk assessment and documentation, with a finding of high risk using recognized assessment tools. Considered inclusive of exam D0120 and D0150 with no additional fee unless group contract allows. D0999 Unspecified diagnostic procedure, by report. This code is Disallowed and reviewed on an appeal basis for benefit payment or denial.

D0472 - D0502 ORAL PATHOLOGY LABORATORY

G- When more than one procedure is performed on the same area of the mouth on the same day, benefits are based upon, but not limited to, the most inclusive procedure and the less inclusive procedure is Disallowed. Fees for the included procedure are Disallowed and not billable to the Patient by a participating dentist.

These interrelated procedures include, but are not limited to, the following hierarchy: D0474 most inclusive, D0473, D0472, D0480 least inclusive.

D0472 Accession of tissue, gross examination, preparation and transmission of written report

D0473 Accession of tissue, gross and microscopic examination, preparation and transmission of written report

D0474 Accession of tissue, gross and microscopic examination including assessment of the surgical margins for the presence of disease, preparation, and transmission of a written report

D0475 Decalcification procedure

D0476 Special stains for microorganisms

D0477 Special stains, not for microorganisms

D0478 Immunohistochemical stains

D0479 Tissue in-site hybridization, including interpretation

D0480 Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report. Refers to gross and microscopic evaluations of presumptively abnormal tissue(s) that have been...
previously excised, includes preparation and transmission of a written report.

D0481  Electron microscopy - diagnostic
D0482  Direct immunofluorescence
D0483  Indirect immunofluorescence
D0484  Consultation on slides prepared elsewhere is paid as D9310 – Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment).
D0485  Consultation, including preparation of slides from biopsy material supplied by referring source. The fees for pathology reports submitted by anyone, other than a licensed dentist are Denied, and the fee is collectible from the Patient.
D0486  Laboratory Accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report. This service may be a covered service as indicated by a group contract.
D0502  Other oral pathology procedures, by report. The fees for other oral pathology procedures In Conjunction With routine surgical procedures are Denied, and the Allowable amount is collectible from the Patient.

II. D1000 - D1999 PREVENTIVE

G- Dental prophylaxis benefits are determined by contract. A prophylaxis done on the same date by the same dentist/dental office as a periodontal maintenance, scaling and root planing, or periodontal surgery, is considered to be part of those procedures and the fee for the prophylaxis is Disallowed. Periodontal maintenance (D4910) is counted toward the contract limitation for prophylaxis. In absence of contract limitations, D4355 should be counted toward the contractual limitation for prophylaxis.

D1000 - D1199  DENTAL PROPHYLAXIS

D1110  Prophylaxis-adult. For payment purposes, the distinction between the adult and child dentition is determined by contract. Any fee in excess is Disallowed and not chargeable to the Patient. In the absence of group contract language regarding age, a person age fourteen (14) and older is considered an adult for benefit determination purposes of a prophylaxis-adult.
D1120  Prophylaxis-child. For payment purposes, the distinction between the adult and child dentition is determined by contract. Any fee in excess is Disallowed and not chargeable to the Patient. A child who exhibits a full dentition may be reviewed on an independent case basis and paid accordingly.

D1200 - D1299  TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)

G- A prophylaxis paste containing fluoride or a fluoride rinse is considered a prophylaxis only. Any fee in excess of the Allowable amount for a prophylaxis is Disallowed. The age limitation for topical fluoride gel or varnish treatments is limited by contract usually through age eighteen (18). The fees for fluoride gels, rinses, tablets, or other preparations intended for home applications are not benefited unless covered by contract.
D1206  Topical fluoride varnish; therapeutic application for moderate to high caries risk Patients. Benefits for topical fluoride varnish when used for desensitization are Denied.
D1208  Topical application of fluoride – excluding varnish– May be Benefited based on the member's dental benefit plan. This code replaces codes D1203 and D1204.

D1300 - D1354  OTHER PREVENTIVE SERVICES

D1310  Nutritional counseling for the control of dental disease. Nutritional counseling is not a benefit and is Denied.
D1320  Tobacco counseling for the control and prevention of oral disease. Tobacco counseling is not a benefit and is Denied.
D1330  Oral hygiene instructions. Oral hygiene instruction is not a benefit and is Denied, unless specified as a covered service by the group contract.
D1351  Sealant-per tooth Sealants and/or Preventive Resin Restorations are Benefited once per tooth on the occlusal surface of permanent first and second molars for Patients through age fifteen (15). The teeth must be free from caries or restorations on the occlusal surface. A sealant or preventive resin restoration done on the same date of service and on the same surface as a restoration is considered a component of the restoration, and the fee for the sealant or preventive resin restoration is Disallowed. Benefits for sealants or preventive resin restorations are Denied when the Patient’s claim history indicates a restoration on the occlusal surface of the same tooth. The fee for repair or replacement of a sealant or preventive resin restoration by the same dentist/dental office within two (2) years of initial placement is included in the fee for the initial placement and is Allowed. Sealants or preventive resin restorations requested within twenty-four (24) months since initial placement are Benefited, unless the group contract specifies a different time limitation.
D1352  Preventive Resin Restoration in a moderate to high caries risk patient – permanent tooth Sealants and/or
Preventive Resin Restorations are **Benefited** once per tooth on the occlusal surface of permanent first and second molars for **Patients** through age fifteen (15). The teeth must be free from caries or restorations on the occlusal surface. A sealant or preventive resin restoration done on the same date of service and on the same surface as a restoration is considered a component of the restoration, and the fee for the sealant or preventive resin restoration is **Disallowed**. Benefits for sealants or preventive resin restorations are **Denied** when the **Patient**’s claim history indicates a restoration on the occlusal surface of the same tooth. The fee for repair or replacement of a sealant or preventive resin restoration by the same dentist/dental office within two (2) years of initial placement is included in the fee for the initial placement and is **Disallowed**. Sealants or preventive resin restorations requested within twenty-four (24) months since initial placement are **Benefited**, unless the group contract specifies a different time limitation.

**D1353 Sealant repair – per tooth** – This procedure is disallowed when performed by the same dentist/dental office based on the same time limitation that exists for replacement of a sealant. It is allowed at 50% of D1351 when performed by a different provider or if after the time limitation for the same dentist

**D1353 Sealant repair – per tooth** – This procedure is disallowed when performed by the same dentist/dental office based on the same time limitation that exists for replacement of a sealant. It is allowed at 50% of D1351 when performed by a different provider or if after the time limitation for the same dentist

**D1354 Interim caries arresting medicament application - conservative treatment of an active, non-symptomatic carious lesion by topical application of a caries arresting or inhibiting medicament and without mechanical removal of sound tooth structure.** Not covered

**D1500 - D1999 SPACE MAINTENANCE (PASSIVE APPLIANCES)**

**G-** The fee for repair or replacement of a space maintainer is not a benefit and is **Denied**. Only one space maintainer is provided for a space except under unusual circumstances. Otherwise, the fees are **Denied**. The fees for space maintainers for missing primary anterior teeth, missing permanent teeth, or for persons age fourteen (14)* or over are not covered benefits and are **Denied**. (*this age varied based on the group contract). Space maintainer fees include all teeth, clasps and rests. Separate fees for these procedures are **Disallowed**.

**D1510 Space maintainer-fixed unilateral**

**D1515 Space maintainer-fixed bilateral**

**D1520 Space maintainer-removable unilateral**

**D1525 Space maintainer-removable bilateral**

**D1550 Re-cement or re-bond space maintainer.** One (1) reinsertion of a space maintainer is **Benefited** per same dentist/dental office. Subsequent requests for reinsertion by the same office are **Denied**.

**D1555 Removal of fixed space maintainer** Benefits for removal of fixed space maintainer by the same dentist/dental office who placed the appliance are **Disallowed** when submitted with reinsertion **Unspecified procedure by report**. Not covered unless by report documentation supports need and there is no other acceptable code.

**III. D2000 - D2999 RESTORATIVE**

(Benefits for multistage procedures are only available for completed services as determined by the date of insertion.)

**G-** The fee for a restoration includes services such as, but not limited to, adhesives, etching, liners, bases, direct and indirect pulp caps, local anesthesia, polishing, occlusal adjustment, caries removal, and gingivectomy done on the same date of service as the restoration. A separate fee for any of these procedures is **Disallowed**.

The fee for replacement of amalgam or composite restorations, same tooth and same surface(s), is **Disallowed** if done by the same dentist/dental office within twenty-four (24) months of the initial restoration. Benefits may be **Allowed** if done by a different dentist. When multiple restorations involving the proximal and occlusal surfaces of the same tooth are requested or performed, the benefit allowance is limited to that of a multi-surface restoration. Any fee in excess of the **Allowable** amount for the multi-surface restoration is **Disallowed**. A separate benefit may be **Allowed** for a restoration on the buccal or lingual surface(s) of the same tooth. When restorations not involving the occlusal surface are requested or performed on posterior teeth, the benefit allowance is limited to that of a one-surface restoration. Any fee in excess of the **Allowable** amount for the one surface restoration is **Disallowed**. Benefits are **Allowed** only once per surface in a twenty-four (24) month interval, irrespective of the number or combination of procedures requested or performed. The fee for restoration of a surface within twenty-four (24) months of previous treatment is **Disallowed** if done by the same dentist/dental office and **Denied**, if done by a different dentist/dental office, unless specified as a covered service by the group contract.

If an indirectly fabricated restoration is performed by the same dentist/dental office within twenty-four (24) months of the placement of an amalgam or composite restoration, the dental plan payment and **Patient** co-payment allowance for the amalgam or composite restoration will be deducted from the indirectly fabricated
restoration benefit. Fees for restorations for altering occlusion, involving vertical dimension, replacing tooth structure lost by attrition, erosion, abrasion, abfraction, corrosion, TMD or for periodontal, orthodontic or other splinting are **Denied** and the **Allowable** amount is collectible from the **Patient**. Restorations are **Benefited** only when the restoration is needed due to decay or actual loss of natural tooth structure.

For the classification of metals, see the ADA CDT Manual.

**D2140 - D2161** **AMALGAM RESTORATIONS (INCLUDING POLISHING)**

D2140 Amalgam - one surface, primary or permanent
D2150 Amalgam - two surfaces, primary or permanent
D2160 Amalgam - three surfaces, primary or permanent
D2161 Amalgam - four or more surfaces, primary or permanent

**D2330 - D2399** **RESIN-BASED COMPOSITE RESTORATIONS – DIRECT**

G- In the event an anterior proximal restoration involves a significant portion of the labial or lingual surface, it may be reported as D2331 or D2332, as appropriate. In a pit and fissure area, if the resin is limited to the enamel it is considered a sealant. If the resin extends into the dentin, the appropriate composite resin codes should be reported. Type 1 preventive resin restorations are considered to be sealants for benefit purposes. If no decay is present or the decay does not penetrate into the dentin the procedure should be processed as a sealant. The replacement of amalgam or composite restorations within twenty-four (24) months is **Disallowed** if done by the same dentist/dental office. Benefits may be **Allowed** if done by a different dentist. Special consideration may be given by report. Subject to contract language, an **Alternate Benefit** may be **Allowed** for resin-based composites placed in posterior teeth.

D2330 Resin-based composite - one surface, anterior
D2331 Resin-based composite - two surfaces, anterior
D2332 Resin-based composite - three surfaces, anterior
D2335 Resin-based composite - four or more surfaces or involving the incisal angle (anterior)
D2390 Resin-based composite - crown, anterior
D2391 Resin-based composite - one surface, posterior
D2392 Resin-based composite - two surfaces, posterior
D2393 Resin-based composite - three surfaces, posterior
D2394 Resin-based composite - four or more surfaces, posterior.

**D2400 - D2494** **GOLD FOIL RESTORATIONS**

G- An **Alternate Benefit** will be **Allowed** for an amalgam or resin restoration, according to the policies for amalgam and resin restorations. The additional fee is the **Patient’s** responsibility.

D2410 Gold foil - one surface
D2420 Gold foil - two surfaces
D2430 Gold foil - three surfaces

**D2500 - D2699** **INLAY/ONLAY RESTORATIONS**

G- When the retentive quality of a tooth qualifies for an Onlay, benefits are based on the submitted procedure. If an **Alternate Benefit** allowance is applied, the difference between the allowance for the **Alternate Benefit** and the **Allowable** amount for the inlay/onlay is collectible from the **Patient**. For inlay restorations, an **Alternate Benefit** will be **Allowed** for an amalgam restoration, according to the policies for amalgam restorations. The additional fee will be the **Patient’s** responsibility. Indirectly fabricated restorations include all models, temporaries and other associated procedures. Benefits for study models, temporaries, and other associated procedures are **Disallowed**. Onlays are considered to cover all of the cusps and include the inlay. Onlays are only **Benefited** when the tooth would otherwise qualify for a crown. An Inlay/Onlay is only **Benefited** when there has been actual loss of natural tooth structure due to decay or actual fracture to such an extent that the tooth cannot be restored by direct filling materials.

D2510 Inlay - metallic - one surface
D2520 Inlay - metallic - two surfaces
D2530 Inlay - metallic - three or more surfaces
D2542 Onlay - metallic - two surfaces
D2543 Onlay - metallic - three surfaces
D2544 Onlay - metallic - four or more surfaces
D2610 Inlay - porcelain/ceramic - one surface
D2620 Inlay - porcelain/ceramic - two surfaces
D2630 Inlay - porcelain/ceramic - three or more surfaces
D2642 Onlay - porcelain/ceramic - two surfaces
D2643 Onlay - porcelain/ceramic - three surfaces
D2644 Onlay - porcelain/ceramic - four or more surfaces
D2650 Inlay - resin-based composite - one surface
D2651 Inlay - resin-based composite - two surfaces
D2652 Inlay - resin-based composite - three or more surfaces
D2662 Onlay - resin-based composite - two surfaces
D2663 Onlay - resin-based composite - three surfaces
D2664 Onlay - resin-based composite - four or more surfaces

D2700 - D2899 CROWNS - SINGLE RESTORATION ONLY

G- The fees for crowns and onlays are Denied and the Allowable amount is collectible from the Patient for children under twelve (12) years of age. For the classification of metals, see the ADA CDT Manual. Indirectly fabricated restorations include all models, temporaries and other associated procedures. Separate fees for these procedures by the same dentist/dental office are Disallowed. Tooth preparations, temporary restorations, laboratory fees and materials, cement bases, impressions, occlusal adjustments, gingivectomies (on the same date of service), and local anesthesia are considered to be included in the fee for a crown restoration, and a separate fee for any of these procedures is Disallowed if performed on the same tooth. The fees for buildups not required for retention are Disallowed. The fees for restorations for altering occlusion, involving vertical dimension, treating TMD, replacing tooth structure lost by attrition, erosion, abrasion (wear), abfraction, or for periodontal, orthodontic, or other splinting are Denied, and collectible from the Patient.

A Crown is only Benefited when there has been loss of tooth structure to such an extent that the tooth cannot be restored by direct filling materials.

D2710 Crown - resin based composite (indirect)
D2712 Crown - ¼ resin-based composite (indirect)
D2720 Crown - resin with high noble metal
D2721 Crown - resin with predominantly base metal
D2722 Crown - resin with noble metal
D2740 Crown - porcelain/ceramic substrate
D2750 Crown - porcelain fused to high noble metal
D2751 Crown - porcelain fused to predominantly base metal
D2752 Crown - porcelain fused to noble metal
D2780 Crown - ½ cast high noble metal
D2781 Crown - ¼ cast predominately base metal
D2782 Crown - ½ cast noble metal
D2783 Crown - ¾ porcelain/ceramic D2790 Crown - full cast high noble metal
D2791 Crown - full cast predominantly base metal
D2792 Crown - full cast noble metal
D2794 Crown – Titanium
D2799 Provisional crown. Temporary fixed prostheses are not separate benefits and should be included in the fee for the permanent prosthesis. Benefits are Disallowed.

D2900 - D2999 OTHER RESTORATIVE SERVICES

G- The fee for recementation of an inlay or onlay or crown by the same dentist/dental office within six (6) months of initial placement is considered part of the fee for the original procedure and is Disallowed. Benefits may be Allowed to the same dentist/dental office for recementation after six (6) months have elapsed since initial placement, but only once in a twelve (12) month interval. Requests for benefits for recementation in excess of once in a twelve (12) month interval are Denied, and collectible from the Patient.

D2910 Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration
D2915 Re-cement or re-bond indirectly fabricated or prefabricated post and core
D2920 Re-cement or re-bond crown
D2921 Reattachment of tooth fragment, incisal edge or cusp. No research available justifying procedure as a long term solution; if group EOC allows coverage, benefit a single surface composite.
D2929 Prefabricated porcelain/ceramic crown – primary tooth – May be Benefited based on the member’s dental benefit plan. An Alternate Benefit will be Allowed for a prefabricated esthetic coated stainless steel crown primary tooth (D2934)
D2930 Prefabricated stainless steel crown – primary tooth. The fee for replacement of a stainless steel crown on a primary tooth by the same dentist or dental office within twenty-four (24) months is included in the initial crown
placement and is **Disallowed**.

**D2931** Prefabricated stainless steel crown - permanent tooth. The fee for replacement of a stainless steel crown on a permanent tooth within five (5) years is **Denied**.

**D2932** Prefabricated resin crown is **Benefited** only on anterior primary teeth.

**D2933** Prefabricated stainless steel crown with resin window is **Benefited** only on anterior primary teeth.

**D2934** Prefabricated esthetic coated stainless steel crown - primary tooth is a benefit only on anterior primary teeth.

**D2940** Protective Restoration is denied unless specified as a covered service by the group contract.

**D2941** Interim therapeutic restoration – primary dentition. Placement of an adhesive restorative material following caries debridement by hand or other method for the management of early childhood caries. Not considered a definitive restoration. **Denied** unless specified as a covered service by the group contract. When covered, benefit as D2940.

**D2949** Restorative foundation for an indirect restoration. Placement of restorative material to yield a more ideal form, including elimination of undercuts. **Disallowed** as inclusive of primary procedure.

**D2950** Core build up, including pins when required - refers to building up of coronal structure when there is insufficient retention for a separate extracoronal restorative procedure. A core buildup is not a filler to eliminate any undercut, box form or concave irregularity in a preparation. The fees for buildups not required for retention are **Disallowed**.

**D2951** Pin retention-per tooth, in addition to restoration is a benefit, once per tooth, when necessary on permanent tooth and when completed at the same appointment as the restoration. Additional pins on the same tooth are **Disallowed** as a component of the initial pin placement. The fee for pin retention when billed **In Conjunction With** a buildup is **Disallowed** as a component of the buildup procedure.

**D2952** Indirectly fabricated post and core in addition to crown is **Benefited** only on a completed endodontically treated tooth. **An indirectly fabricated post and core for an anterior tooth is **Benefited** only when there is insufficient tooth structure to support an indirectly fabricated restoration due to loss of actual tooth structure from caries or fracture. If sufficient tooth structure remains, the fee for the post and core is **Disallowed**.

**D2953** Each additional indirectly fabricated post - same tooth. This procedure is considered a component of an indirectly fabricated post and is **Disallowed** as a component of the first post.

**D2954** Prefabricated post and core in addition to crown is payable only on a completed endodontically treated tooth. If sufficient tooth structure remains, the fee for the post and core is **Disallowed**. **A prefabricated post and core for an anterior tooth is **Benefited** only when there is insufficient tooth structure to support an indirectly fabricated restoration. If sufficient tooth structure remains, the fee for the post and core is **Disallowed**.

**D2955** Post removal (not In Conjunction With endodontic therapy), The fee is **Disallowed** as a component of the fee for the retreatment if performed by the same dentist/dental office. This code is **Denied** in accordance with exclusions of group contracts.

**D2957** Each additional prefabricated post in the same tooth. This procedure is considered a component of an indirectly fabricated post and is **Disallowed** as a component of the first post.

**D2960** Labial veneer (resin laminate) – chair side

**D2961** Labial veneer (resin laminate) – laboratory

**D2962** Labial veneer (porcelain laminate) – laboratory. These codes are **Denied** in accordance with exclusions of group contracts.

**D2970** Coping - considered a specialized procedure. Additional fees are **Denied**.

**D2980** Crown repair, by report is **Benefited** subject to contract language.

**D2981** Inlay repair – May be **Benefited** based on the member's dental benefit plan.

**D2982** Onlay repair – May be **Benefited** based on the member's dental benefit plan.

**D2983** Veneer repair – May be **Benefited** based on the member's dental benefit plan.

**D2990** Resin infiltration of incipient smooth surface lesions - Benefits are **Denied** in accordance with group contracts and the fee is chargeable to the **Patient**.

**D2999** Unspecified restorative procedure, by report This code is **Disallowed** and reviewed on an appeal basis for benefit payment or denial.

**IV. D3000 - D3999 ENDODONTICS**

**G-** The fee for retreatment of root canal therapy or retreatment of apical surgery by the same dentist/dental office within twenty-four (24) months of initial treatment is **Disallowed** as a component of the fee for the original procedure. The fee for a pulp cap is **Disallowed** as a component of a sedative filling. The fees for direct or indirect pulp caps are **Disallowed** when provided on the same date as the final restoration for the same tooth.

**D3100 - D3199** **PULP CAPPING**

**D3110** Pulp cap-direct (excluding final restoration)
D3120  Pulp cap-indirect (excluding final restoration)

D3200 - D3299 PULPOTOMY

D3220  Therapeutic pulpotomy (excluding final restoration) is limited to primary teeth. A pulpotomy provided on a permanent tooth is Denied.

D3221  Pulpal debridement, primary and permanent teeth is Denied in accordance with exclusions of group contracts.

D3222  Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development. Benefit under individual consideration. Disallow when performed within thirty (30) days of a root canal or apexification procedures.

D3230 - 3240 ENDODONTIC THERAPY ON PRIMARY TEETH

D3230  Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)

D3300 - D3399 ENDODONTIC THERAPY (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES AND FOLLOW-UP CARE)

G- The fee for root canal therapy includes treatment x-rays and temporary restorations. Any additional fee above the Allowable amount for the root canal therapy is Disallowed.

D3310  Endodontic therapy - anterior tooth (excluding final restoration) D3320  Endodontic therapy – bicuspid tooth (excluding final restoration)

D3330  Endodontic therapy – molar tooth (excluding final restoration). The fee for palliative treatment is Disallowed when done In Conjunction With root canal therapy by the same dentist/dental office on the same date of service. Palliative treatment is payable on a separate date of service for relief of pain. Incompletely filled root canals are not payable, and the fee for the endodontic therapy is Disallowed. Post removal is not included in this procedure.

D3332  Incomplete endodontic therapy - inoperable or fractured tooth. This code is Denied in accordance with group contracts.

D3333  Internal root repair of perforation defects. The fee for this procedure is Disallowed when submitted for a permanent tooth. The fee is Denied if reported on a primary tooth.

D3340 - D3349 ENDODONTIC RETREATMENT

G- The fee for retreatment of root canal therapy or retreatment of apical surgery by the same dentist/dental office within twenty-four (24) months of initial treatment is Disallowed as a component of the fee for the original procedure. Separate fees for removal of posts, pins, old root canal filling material and procedures necessary to prepare the canal and place the canal filling are Disallowed as included in the fee for the retreatment.

D3346  Retreatment of previous root canal therapy – anterior

D3347  Retreatment of previous root canal therapy – bicuspid

D3348  Retreatment of previous root canal therapy – molar

D3350 - D3359 APEXIFICATION/RECALCIFICATION

G- If the apex is fully developed, this treatment is not indicated and benefits are Denied.

D3351  Apexification/recalcification – initial visit (apical closure / calcific repair of perforations, root resorption, etc.)

D3352  Apexification – Interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)

D3353  Apexification/recalcification - final visit (includes completed root canal therapy, apical closure, calcific repair of perforations, root resorption, etc.)

D3355 – D3357 PULPAL REGENERATION

D3355  Pulpal regeneration – initial visit. For benefit determination this procedure is paid the same as apexification procedure for benefit determination when appropriate.

D3356  Pulpal regeneration – interim medication replacement. For benefit determination this procedure is paid the same as an interim apexification procedure when appropriate.

D3357  Pulpal regeneration - completion of treatment Does not include final restoration. - This code is Denied.
D3400 - D3499 APICOECTOMY/PERIRADICULAR SERVICES D3410 Apicoectomy – Anterior
D3421 Apicoectomy - Bicuspid (first root)
D3425 Apicoectomy - Molar (first root)
D3426 Apicoectomy - Apicoectomy - (each additional root) The fee for a biopsy is Disallowed In Conjunction
With other surgery at the same site/same day.
D3427 Periradicular surgery without apicoectomy
D3428 Bone Graft in conjunction with periradicular surgery – per tooth, single site includes non-autogenous
graft material. Benefits for these procedures when billed In Conjunction With implants, ridge
augmentation, extractions sites, periradicular surgery etc. are Denied. If the contract covers dental implants
this procedure may be Benefited at the time of extraction
D3429 Bone Graft in conjunction with periradicular surgery – each additional tooth – includes non-
autogenous graft material. Benefits for these procedures when billed In Conjunction With implants, ridge
augmentation, extraction sites, periradicular surgery etc. are Denied. If the contract covers dental implants
this procedure may be Benefited at the time of extraction
D3430 Retrograde filling – per root includes all retrograde procedures per root.
D3431 Biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular
surgery. Benefits are available only when billed for natural teeth. Benefits for these procedures when billed
In Conjunction With implants, ridge augmentation, etc. are Denied. Other modifiers are Denied as
investigational when submitted for periodontal regenerative purpose.
D3432 Guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery.
Benefits are available only when billed for natural teeth. Benefits for these procedures when billed In
Conjunction With implants, ridge augmentation, etc. are Denied. Other modifiers are Denied as
investigational when submitted for periodontal regenerative purposes.
D3450 Root amputation - per root is Disallowed when performed In Conjunction With an apicoectomy.
D3460 Endodontic endosseous implant is Denied, and is collectible from the Patient.
D3470 Intentional reimplantation (including necessary splinting) is Denied, and is collectible from the Patient.

D3910 – D3999 OTHER ENDODONTIC PROCEDURES
D3910 Surgical procedure for isolation of tooth with rubber dam is Disallowed as a component of the fee
for the procedure performed.
D3920 Hemisection (including any root removal), not including root canal therapy
D3950 Canal preparation and fitting of preformed dowel or post. This code is Allowed on teeth with
completed root canal therapy.
D3999 Unspecified endodontic procedure, by report. This code is Disallowed and reviewed on an appeal basis for
benefit payment or denial.

V. D4000 - 4999 PERIODONTICS

G- When more than one (1) periodontal or surgical procedure is provided on the same teeth on the same day,
benefits are based upon, but not limited to, the most inclusive procedure. Periodontal services are only
Benefited when performed on natural teeth for treatment of periodontal disease. Unless otherwise specified
by contract, benefits for these procedures when billed In Conjunction With implants, ridge augmentation,
extractions sites and/or periradicular surgery are Denied and the fee is collectible from the Patient. Laser
disinfection is considered a technique, and not a procedure. The fees are Disallowed.

D4100 - D4299 SURGICAL SERVICES

G- Periodontal surgical procedures include all necessary post-operative care, finishing procedures, and
evaluations for three (3) months, as well as any surgical re-entry for three (3) years. When a surgical
procedure is billed within three (3) months of the initial surgical procedure, the surgery is Disallowed. In the
absence of documentation of extraordinary circumstances, additional surgery is Disallowed for three (3)
years. Periodontally involved teeth, which would qualify for surgical pocket reduction benefits must be
documented to have 5 mm pocket depths. Full quadrant fees for procedures submitted by quadrant are
available when a minimum of four (4) qualified diseased teeth are documented anywhere in the quadrant.
The following categorizes procedures for reporting and adjudicating by quadrant, site or individual tooth in
order to enhance standard benefits determination and expedite claims processing. Quadrant - D4210, D4260,
D4240, D4341. One to three (3) teeth, per quadrant - D4211, D4241, D4261, D4342. Per tooth - D4268,
D4273, D4276. Providing more than two D4245, D4265, D4266, D4267, D4268, D4270, D4271, D4273,
D4275, D 4320, D4321, D4276 or osseous grafts within any given quadrant is considered highly unusual and
additional submissions are only considered on a report basis. Anything more than two (2) sites in a
quadrant are **Disallowed**. Laser disinfection is a technique, not a procedure. Fees for laser disinfection are **Disallowed**.

D4210 Gingivectomy or gingivoplasty four or more contiguous teeth or tooth bounded space – per quadrant

D4211 **Gingivectomy or gingivoplasty one to three teeth per quadrant** is **Disallowed** when performed **In Conjunction With** the preparation of a crown or other restoration.

D4212 **Gingivectomy/gingivoplasty to allow for restorative procedure— May be **Benefited** based on the member's dental benefit plan.** This is **Disallowed** when performed the same day as a restorative procedure.

D4230 **Anatomical crown exposure – four or more contiguous teeth per quadrant**

D4230 **Anatomical crown exposure – one to three teeth per quadrant** D4230/D4231 are considered primarily cosmetic in nature and should be **Denied** if the group contract excludes cosmetic procedures.

D4240 **Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.** By definition, procedure D4240 includes root planing and therefore would not precede or follow nonsurgical root planing in the same episode of treatment.

D4241 **Gingival flap procedure, including root planing - one to three teeth per quadrant**

D4245 **Apically repositioned flap.** By definition, procedure D4241 and D4245 includes root planing and the fee for root planing will be **Disallowed** if it precedes or follows a D4241 or D4245 within the same episode of treatment.

D4249 **Clinical crown lengthening – hard tissue** The fee for crown lengthening is **Disallowed** when performed **In Conjunction With** osseous surgery on the same teeth. This procedure is carried out to expose sound tooth structure by removal of bone several weeks before restorative or prosthodontic procedures. It is not generally provided in the presence of periodontal disease. Benefits are **Disallowed** if done **In Conjunction With** a crown preparation and impression. Crown lengthening is payable per site, not per tooth, and is a benefit only when bone is removed and sufficient time is allowed for healing. The fee for crown lengthening is **Disallowed** when performed on the same date as crown preparation or restorations.

G- This code may be **Denied** in accordance with group contracts and if **Denied**, the fee is collectable from the **Patient**. It is generally recommended that a minimum of six weeks be allowed for sufficient healing before final preparations for the restorative or prosthetic procedure. Healing time will vary depending on the extent of the surgery. D4249 is **Disallowed** when billed by the same dentist/dental office on the same date as the restorative or prosthodontic procedure.

D4260 **Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant** No more than two (2) quadrants of osseous surgery on the same date of service are **Benefited**. **Unless an appeal is submitted with additional information.** The fee for osseous surgery includes osseous contouring, distal or proximal wedge surgery, scaling and root planing, gingivectomy, and flap procedures. A separate benefit may be available for soft tissue grafts, osseous grafts, exostosis removal, hemisection, extraction, apicoectomy, root amputations, and new attachment procedures.

D4261 **Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant** No more than two (2) quadrants of osseous surgery on the same date of service are **Benefited**, unless an appeal is submitted with additional information. The fee for osseous surgery includes osseous contouring, distal or proximal wedge surgery, scaling and root planing, gingivectomy, and flap procedures. A separate benefit may be available for soft tissue grafts, osseous grafts, exostosis removal, hemisection, extraction, apicoectomy, root amputations, and new attachment procedures.

D4263 **Bone graft - first site in quad** - This procedure involves the use of grafts to stimulate periodontal regeneration when the disease process has led to a deformity of the bone. This procedure does not include flap entry and closure, wound debridement, osseous contouring, or the placement of biologic materials to aid in osseous tissue regeneration or barrier membranes. Other separate procedures delivered concurrently are documented with their own codes. Benefits for these procedures when billed **In Conjunction With** implants, ridge augmentation, etc. are **Denied**. Other modifiers are **Denied** as investigational when submitted for periodontal regenerative purposes.

D4264 **Bone graft - each additional site in quad** - This procedure involves the use of grafts to stimulate periodontal regeneration when the disease process has led to a deformity of the bone. This procedure does not include flap entry and closure, wound debridement, osseous contouring, or the placement of biologic materials to aid in osseous tissue regeneration or barrier membranes. Other separate procedures delivered concurrently are documented with their own codes. Benefits are available only when billed for natural teeth. Benefits for these procedures when billed **In Conjunction With** implants, ridge augmentation, etc. are **Denied**. Other modifiers are **Denied** as investigational when submitted for periodontal regenerative purposes.

D4265 **Biologic materials to aid in soft and osseous tissue regeneration.** Benefits are available only when billed for natural teeth. Benefits for these procedures when billed **In Conjunction With** implants, ridge...
augmentation, etc. are **Denied**. Other modifiers are **Denied** as investigational when submitted for periodontal regenerative purposes.

**D4266** Guided tissue regeneration – resorbable barrier, per site

**D4267** Guided tissue regeneration – nonresorbable barrier, per site (includes membrane removal) These codes are **Denied** in accordance with group contracts and if **Denied** the fee is collectible from the Patient.

**D4268** Surgical revision procedure, per tooth. The fee is considered a component of the surgical procedure and is **Denied**. If treatment is performed by the same office/dentist within thirty-six (36) months, the fee for the procedure is **Denied**. It may be eligible for consideration under dentist consultant review. If performed within the specified time limits by a different office/dentist, the contractual time limits would apply and the fee would be **Denied**.

**D4270** Pedicle soft tissue graft procedure

**D4273** Subepithelial connective tissue graft procedure, per tooth

**D4274** Distal or proximal wedge procedure (when not performed In Conjunction With surgical procedures in the same anatomical area)

**D4275** Soft tissue allograft. The fee for this procedure is **Denied**. Fees for Frenulectomy (D7960) or frenuloplasty (D7963) are **Denied** when performed in conjunction with D4275 or D4276.

**D4276** Combined connective tissue and double pedicle graft, per tooth. The fee for this procedure is **Denied**. Fees for Frenulectomy (D7960) or frenuloplasty (D7963) are **Denied** when performed in conjunction with D4275 or D4276.

**D4277** Free soft tissue graft – first tooth and edentulous tooth. May be **Benefited** based on the member’s dental benefit plan. The benefit for pedicle and free soft tissue grafts is per tooth. For additional teeth in same quadrant bill using D4278.

**D4278** Free soft tissue graft – additional contiguous tooth may be **Benefited** based on the member’s dental benefit plan. The benefit for pedicle and free soft tissue grafts is per contiguous tooth in the same quadrant. When multiple additional grafts are done in a single quadrant, the fee is limited to the lesser of the Allowable amount for a full quadrant of osseous surgery (D4260) or two (2) sites. Any fee in excess of the lesser of the allowed amount for D4260 full quadrant or two (2) graft sites is **Denied**, unless there is documentation of special need.

**D4283** Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site. Used in conjunction with D4273 – local anesthesia is usually considered a component part of periodontal procedures, but dependent upon the plan will allow up to 50% of D4273 – allow up to a maximum of 3 teeth per quadrant.

**D4285** Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site. Local anesthesia is usually considered a component part of periodontal procedures, but dependent upon the plan will allow up to 50% of D4278 – allow up to a maximum of 3 teeth per quadrant.

**D4300 - D4399** NON-SURGICAL PERIODONTAL SERVICES

**D4320** Provisional splinting – intracoronal. The fee for splinting is **Denied**.

**D4321** Provisional splinting – extracoronal. The fee for splinting is **Denied**.

**D4341** Periodontal scaling and root planing - four or more teeth per quadrant. In the absence of a contractual time limitation on frequency of benefits for D4341/D4342, retreatment performed by the same dentist/dental office within thirty-six months of initial therapy is **Denied**. The fee for retreatment done by a different dentist within thirty-six months (36) is **Denied**. The fee for prophylaxis (D1110) is **Denied** when done on the same date of service as D4341/D4342. The fee for a D4341/D4342 billed In Conjunction With periodontal surgery procedures is **Denied** as a component of the surgical procedure.

**G**- Scaling and root planing are only **Benefited** when there has been loss of attachment and/or loss of bone structure such that a pocket is of 4mm or greater.

**D4342** Periodontal scaling and root planing, one to three teeth per quadrant. In the absence of a contractual time limitation on frequency of benefits for D4341/D4342, retreatment performed by the same dentist/dental office within thirty-six months of initial therapy is **Denied**. The fee for retreatment done by a different dentist within thirty-six months is **Denied**. The fee for prophylaxis (D1110) is **Denied** when done on the same date of service as D4341/D4342. The fee for a D4341/D4342 billed In Conjunction With periodontal surgery procedures is **Denied** as a component of the surgical procedure.

**G**- Scaling and root planing are only **Benefited** when there has been loss of attachment and/or loss of bone structure such that a pocket is of 4mm or greater.

**D4355** Full mouth debridement to enable comprehensive evaluation and diagnosis. In the absence of a
Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report. Benefits are Denied.

**OTHER PERIODONTAL SERVICES**

**D4900 - D4999**

**D4910** Periodontal maintenance procedures. The fee for a separate evaluation is eligible for benefit consideration based on group contract. If a D0180 is submitted with a D4910, it is Benefited as a D0120 and the difference is the Allowable amount between the D0120 and the D0180 and is Disallowed unless the D0180 is the initial evaluation by the dentist rendering the D4910. Benefits for D4910 include prophylaxis, scaling and root planing procedures. Benefits for these procedures are Disallowed when billed In Conjunction With D4910. Benefits for D4910 when billed within three (3) months of periodontal therapy are Disallowed.

**D4920** Unscheduled dressing change (by someone other than treating dentist or their staff) The definition of the same dentist/dental office includes different dentists in the same dental office. The fee for a dressing change submitted by a dentist of the same office is Disallowed as a component of the surgical procedure.

**D4921** Gingival irritation - per quad Irrigation of gingival pockets with medicinal agent. Not to be used to report use of mouth rinses or non-invasive chemical debridement. Denied as not covered

**D4999** Unspecified periodontal procedure, by report. This code is Disallowed and reviewed on an appeal basis for benefit payment or denial.

**VI. D5000 - D5899 PROTHODONTICS (REMOVABLE)**

**G-** The fees for cast restorations and prosthetic procedures include all models, temporaries and other associated procedures. Any fees charged for these procedures in excess of the Allowable amounts for the cast restorations or prosthetic procedures by the same dentist/dental office are Disallowed. Multistage procedures are reported and Benefited upon completion. The completion date is the date of insertion for removable prosthetic appliances. The completion date for immediate dentures is the date that the remaining teeth are removed and the denture is inserted. The completion date for fixed partial dentures and crowns, onlays, and inlays is the cementation date regardless of the type of cement utilized. The completion date for root canal therapy is the date the canals are permanently filled. Characterizations, staining, overdentures, or metal bases are considered specialized procedures. An Optional allowance is made for a conventional denture. Any additional fee is the Patient's responsibility. Restorations for altering occlusion, involving vertical dimension, replacing tooth structure lost by attrition, erosion, abrasion (wear) or for periodontal, orthodontic or other splinting are not a benefit. Benefits are Denied. The fee for full or partial dentures includes any reline/rebase, adjustment, or repair required within six (6) months of delivery.

**D5000 - D5199** COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)

**D5110** Complete denture, maxillary

**D5120** Complete denture, mandibular

**D5130** Immediate denture, maxillary

**D5140** Immediate denture, mandibular

**D5200 - D5399** PARTIAL DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)

**G-** A posterior fixed bridge and a removable partial denture are not Benefited in the same arch. The benefit is limited to the allowance for the partial removable denture. Fixed bridges or removable cast partials are not a benefit for Patients under age sixteen (16). Partial dentures are subject to a contractual time limitation for replacement.

**D5211** Maxillary partial denture-resin base (including any conventional clasps, rests, and teeth)

**D5212** Mandibular partial denture-resin base (including any conventional clasps, rests, and teeth)

**D5213** Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)

**D5214** Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)

**D5221** Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth) – includes limited follow-up care only; does not include future rebasing / relining procedure(s). Same as D5211

**D5222** Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth) – includes limited follow-up care only; does not include future rebasing / relining procedure(s). Same as
D5212

D5223 Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) - includes limited follow-up care only; does not include future rebasing / relining procedure(s). Same as D5213

D5224 Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) – includes limited follow-up care only; does not include future rebasing / relining procedure(s). Same as D5214

D5225 Maxillary partial denture – flexible base (including any clasps, rests, and teeth)

D5226 Mandibular partial denture – flexible base (including any clasps, rests, and teeth)

D5281 Removable unilateral partial denture-one piece cast metal (including clasps and teeth)

D5400 - D5499 ADJUSTMENTS TO DENTURES

G- The fees for full or partial dentures include any adjustments or repairs required within six (6) months of delivery. If performed by the same dentist/dental office within six (6) months of initial placement, the fees for adjustments or repairs are Disallowed. The fees for adjustments to complete or partial dentures are limited to two (2) adjustments per denture per twelve (12) months (after six (6) months have elapsed since initial placement, unless specified by the group contract).

D5410 Adjust complete denture – maxillary
D5411 Adjust complete denture – mandibular
D5421 Adjust partial denture – maxillary
D5422 Adjust partial denture – mandibular

D5500 - D5599 REPAIRS TO COMPLETE DENTURES

G- Repairs of complete or partial dentures if performed within six (6) months of initial placement are Disallowed.

D5510 Repair broken complete denture base
D5520 Replace missing or broken teeth-complete denture (each tooth)

D5600 - D5699 REPAIRS TO PARTIAL DENTURES

D5610 Repair resin denture base
D5620 Repair cast framework
D5630 Repair or replace broken clasp
D5640 Replace broken teeth-per tooth
D5650 Add tooth to existing partial denture
D5660 Add clasp to existing partial denture
D5670 Replace all teeth and acrylic on cast metal framework (maxillary)
D5671 Replace all teeth and acrylic on cast metal framework (mandibular)

D5700 - D5729 DENTURE REBASE PROCEDURES

G- Rebasc is a benefit per contract limitation. The fee for a rebase includes the fee for relining. The fee for a reline billed In Conjunction With (within six (6) months of) a rebase is Disallowed. The fee for a rebase includes adjustments required within six (6) months of delivery. The fee for an adjustment billed within six (6) months of a rebase is Disallowed.

D5710 Rebase complete maxillary denture
D5711 Rebase complete mandibular denture
D5720 Rebase maxillary partial denture
D5721 Rebase mandibular partial denture

D5700 - D5799 DENTURE RELINE PROCEDURES

G- Relines are benefits per contract limitations. The fee for a reline includes adjustments required within six (6) months of delivery. The fee for an adjustment billed within six (6) months of a reline is Disallowed.

D5730 Reline complete maxillary denture (chair side)
D5731 Reline complete mandibular denture (chair side)
D5740 Reline maxillary partial denture (chair side)
D5741 Reline mandibular partial denture (chair side)
D5750 Reline complete maxillary denture (laboratory)
D5751 Reline complete mandibular denture (laboratory)
D5760 Reline maxillary partial denture (laboratory)
D5761 Reline mandibular partial denture (laboratory)
**INTERIM PROSTHESIS**

D5810  Interim complete denture (maxillary)
D5811  Interim complete denture (mandibular). Temporary complete dentures are not a benefit and are **Denied**.
D5820  Interim partial denture (maxillary)
D5821  Interim partial denture (mandibular). An interim partial denture is **Benefited** only in children age sixteen (16) or under for missing anterior permanent teeth.

**OTHER REMOVABLE PROSTHETIC SERVICES**

D5850  Tissue conditioning, maxillary
D5851  Tissue conditioning, mandibular - The fee for tissue conditioning is **Disallowed** if performed on the same day the denture is delivered or a reline/rebase is provided.
D5862  Precision attachment, by report. The fee for a precision attachment is **Denied**, and is collectible from the Patient.
D5863  Overdenture – complete maxillary
D5864  Overdenture – partial maxillary
D5865  Overdenture – complete mandibular
D5866  Overdenture – partial mandibular
D5867  Replacement of replaceable part of semi-precision or precision attachment (male or female component) The fee for a precision attachment is **Denied**, and is collectible from the Patient.
D5875  **Modification of a removable prosthodontic procedure, by report.** This code is **Disallowed** and reviewed on an appeal basis for benefit payment or denial.

**MAXILLOFACIAL PROSTHETICS**

G-  The fees for maxillofacial prosthetics are **Denied**, and are collectible from the Patient.

D5911  Facial moulage (sectional)
D5912  Facial moulage (complete)
D5913  Nasal prosthesis
D5914  Auricular prosthesis
D5915  Orbital prosthesis
D5916  Ocular prosthesis
D5919  Facial prosthesis
D5922  Nasal septal prosthesis
D5923  Ocular prosthesis, interim
D5924  Cranial prosthesis
D5925  Facial augmentation implant prosthesis
D5926  Nasal prosthesis, replacement
D5927  Auricular prosthesis, replacement
D5928  Orbital prosthesis, replacement
D5929  Facial prosthesis, replacement
D5931  Obturator prosthesis, surgical
D5932  Obturator prosthesis, definitive
D5933  Obturator prosthesis, modification
D5934  Mandibular resection prosthesis with guide flange
D5935  Mandibular resection without guide flange
D5936  Obturator prosthesis, interim
D5937  Trismus appliance (not for TMD treatment)
D5951  Feeding aid
D5952  Speech aid prosthesis, pediatric
D5953  Speech aid prosthesis, adult
D5954  Palatal augmentation prosthesis
D5955  Palatal lift prosthesis, definitive
D5958  Palatal lift prosthesis, interim
D5959  Palatal lift prosthesis, modification
D5960  Speech aid prosthesis, modification Treatment prostheses
D5982  Surgical stent
CARRIERS

D5991 Vaniculobullous disease medicament carrier. A custom fabricated carrier that covers the teeth and alveolar mucosa, or alveolar mucosa alone, an is used to deliver prescription medicaments for treatment of immunologically mediated vaniculobullous disease

D5992 Adjusted maxillofacial prosthetic appliance, by report

D5993 Maintenance and cleaning of a maxillofacial prosthesis (extra or intaoral) other than required adjustments.

D5994 Periodontal medicament carrier with peripheral seal laboratory processed. A custom fabricate, laboratory processed carrier that covers the teeth and alveolar mucosa. Used as a vehicle to deliver prescribed medicaments for sustained contact with the gingival, alveolar mucosa, and into the periodontal sulcus or pocket.

D5999 Unspecified maxillofacial prosthesis, by report. This code is Disallowed and reviewed on an appeal basis for benefit payment or denial.

VIII. D6000 - D6199 IMPLANT SERVICES

G- The fees for implant services are Denied, and are collectible from the Patient, unless the contract specifies that implant services are a benefit.

D6010 Surgical placement of implant body: endosteal implant

D6011 Second stage implant surgery - Surgical access to an implant body for placement of a healing cap or to enable placement of an abutment. Considered to be part of D6010 and fees for D6011 are Disallowed. Same provider/dental office (TIN) disallow, different provider allow.

D6012 Surgical placement of interim implant body for transitional prosthesis: endosteal implant Benefits are Denied. This is considered part of the transitional prosthesis, which is not a covered benefit.

D6013 Surgical placement of mini implant

D6040 Surgical placement: eposteaal implant

D6050 Surgical placement: transosteal implant

IMPLANT SUPPORTED PROSTHETICS

G- An Optional allowance designated by an employer group is made for a conventional denture, partial or crown, and any excess fee is the Patient’s responsibility. Where benefited by contract, fees for the connection of an implant to a natural tooth bridge is Disallowed.

D6052 Semi-precision attachment abutment - includes placement of keeper assembly - unless the contract specifies that it is a benefit, otherwise not covered.

D6053 Implant/abutment supported removable denture for completely edentulous arch

D6054 Implant/abutment supported removable denture for partially edentulous arch

D6055 Dental implant supported connecting bar

D6056 Prefabricated abutment

D6057 Custom abutment

D6051 Interim abutment

D6058 Abutment supported porcelain/ceramic crown

D6059 Abutment supported porcelain fused to metal crown (high noble metal)

D6060 Abutment supported porcelain fused to metal crown (predominantly base metal)

D6061 Abutment supported porcelain fused to metal crown (noble metal)

D6062 Abutment supported cast metal crown (high noble metal)

D6063 Abutment supported cast metal crown (predominantly base metal)

D6064 Abutment supported cast metal crown (noble metal)

D6065 Implant supported porcelain/ceramic crown

D6066 Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)

D6067 Implant supported metal crown (titanium, titanium alloy, high noble metal)

D6068 Abutment supported retainer for porcelain/ceramic FPD

D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal)
Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)
Abutment supported retainer for porcelain fused to metal FPD (noble metal)
Abutment supported retainer for cast metal FPD (high noble metal)
Abutment supported retainer for cast metal FPD (predominantly base metal)
Abutment supported retainer for cast metal FPD (noble metal)
Implant supported retainer for ceramic FPD
Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)
Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)
Re-cement or re-bond implant/abutment supported crown
Re-cement or re-bond implant/abutment supported fixed partial denture
Abutment supported crown - (titanium)
Implant/abutment supported fixed denture for completely edentulous arch
Implant/abutment supported fixed denture for partially edentulous arch
Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments - This procedure includes active debridging of the implant(s) and examination of all aspects of the implant system(s), including the occlusion and stability of the superstructure. The patient is also instructed in thorough daily cleansing of the implant(s). This is not a per implant code, and is indicated for implant supported fixed prostheses – allow once every 12 months per contract

OTHER IMPLANT SERVICES
Implant maintenance procedures, including: removal of prosthesis, cleansing of prosthesis and abutments, reinsertion of prosthesis
Repair implant supported prosthesis, by report
Replacement of semi-precious or precision attachment (male or female component) of implant/abutment supported prostheses, per attachment. Denied as a specialized procedure, unless group contract specifies that this implant code is a covered benefit.
Recement implant/abutment supported crown
Recement implant/abutment supported fixed partial denture. Fees for recementations are Disallowed if done within six (6) months of the initial seating date by the same dentist/dental office. Benefits may be paid for one (1) recementation after six (6) months have elapsed since the initial placement. Subsequent requests for recementation by the same dentist/dental office are Denied. These procedures are a covered benefit only for groups that have implant coverage.
Repair implant abutment, by report
Implant removal, by report
Debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure – May be Benefited based on the member's dental benefit plan. The fee for D6102 when submitted In Conjunction With D4260 or D4261 is Disallowed.
Debridment and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure – May be Benefited based on the member's dental benefit plan. The fee for D6102 when submitted In Conjunction With D4260 or D4261 is Disallowed.
Bone graft for repair of peri-implant defect – does not include flap entry and closure. Placement of a barrier membrane or biologic materials to aid in osseous regeneration are reported separately – May be Benefited based on the member's dental benefit plan. The fee for D6102 when submitted In Conjunction With D4260 or D4261 is Disallowed.
Bone graft at time of implant placement– May be Benefited based on the member's dental benefit plan. This is Denied if there is no implant coverage.
Implant /abutment supported removable denture for edentulous arch – maxillary – This procedure is mapped to the pricing and rules for D6053
Implant /abutment supported removable denture for edentulous arch – mandibular - This procedure is mapped to the pricing and rules for D6053
Implant /abutment supported removable denture for partially edentulous arch – maxillary - This procedure is mapped to the pricing and rules for D6054
Implant /abutment supported removable denture for partially edentulous arch – mandibular - This procedure is mapped to the pricing and rules for D6054
Implant /abutment supported fixed denture for edentulous arch – maxillary - This procedure is mapped
to the pricing and rules for D6078

D6115 Implant /abutment supported fixed denture for edentulous arch – mandibular - This procedure is mapped to the pricing and rules for D6078

D6116 Implant /abutment supported fixed denture for partially edentulous arch – maxillary - This procedure is mapped to the pricing and rules for D6079

D6117 Implant /abutment supported fixed denture for partially edentulous arch – mandibular - This procedure is mapped to the pricing and rules for D6079

D6190 Radiographic/surgical implant index, by report. Benefits are Denied unless implant services are covered, per contract. Under contracts with implant coverage, diagnostic and treatment facilitating aids are considered a part of definitive treatment and separate benefits for an index to the same dentist/dental office are Disallowed.

D6194 Abutment supported retainer crown for FPD (titanium)

D6199 Unspecified implant procedure, by report. This code is Disallowed and reviewed on an appeal basis for benefit payment or denial.

IX. D6200 - D6999 PROSTHODONTICS, FIXED

(Each abutment and each pontic constitute a unit in a fixed partial denture)

G- The fees for cast restorations and prosthetic procedures include all models, temporaries and other associated procedures. Any fees charged for these procedures by the same dentist/dental office in excess of the Allowable amounts for the cast restorations or prosthetic procedures are Disallowed. Payment will be based on the number of pontics necessary for the space, not to exceed the normal complement of teeth. A posterior fixed bridge and a removable partial denture are not Benefited in the same arch. An allowance for a removable partial denture is made, and the difference is collectible from the Patient. Fixed prosthodontics are not a benefit for children under sixteen (16) years of age. Prosthetics (fixed) are subject to a contractual time limitation for replacement. The fees for restorations for altering occlusion, involving vertical dimension, treating TMD, replacing tooth structure lost by attrition, erosion, abrasion (wear), cosmetic or for periodontal, orthodontic, or other splinting are Denied. An allowance of a conventional fixed prosthesis is provided for porcelain/ceramic or resin bridges. The difference between the Allowable amount for the conventional fixed prosthesis and the Allowable amount for porcelain/ceramic bridge is chargeable to the Patient. Multistage procedures are reported and Benefited upon completion. The completion date is the date of insertion for removable prosthetic appliances. The completion date for immediate dentures is the date that the remaining teeth are removed and the denture is inserted. The completion date for fixed partial dentures and crowns, onlays, and inlays is the cementation date regardless of the type of cement utilized. The fees for cast restorations and prosthetic procedures include all models, temporaries, laboratory charges and material, and other associated procedures. Any fees for these procedures are Disallowed.

D6200 - D6499 FIXED PARTIAL DENTURE PONTICS

D6205 Pontic-indirect resin-based composite
D6210 Pontic-cast high noble metal
D6211 Pontic-cast predominantly base metal
D6212 Pontic-cast noble metal
D6214 Pontic-titanium
D6240 Pontic-porcelain fused to high noble metal
D6241 Pontic-porcelain fused to predominantly base metal
D6242 Pontic-porcelain fused to noble metal
D6245 Pontic-porcelain/ceramic
D6250 Pontic-resin with high noble metal
D6251 Pontic-resin with predominantly base metal
D6252 Pontic-resin with noble metal
D6253 Provisional pontic

D6500 – D6699 FIXED PARTIAL DENTURE RETAINERS – INLAYS/ONLAYS

D6545 Retainer-cast metal for resin bonded fixed prosthesis
D6548 Retainer porcelain/ceramic for resin bonded fixed prosthesis
D6549 Resin retainer – for resin bonded fixed prosthesis – This procedure is mapped to the pricing and rules for D6545

D6600 Inlay - porcelain/ceramic, two surfaces
D6601 Inlay – porcelain/ceramic – three or more surfaces
D6602 Inlay - cast high noble metal, two surfaces
D6603 Inlay - cast high noble metal, three or more surfaces
D6604 Inlay cast predominantly base metal, two surfaces
D6605 Inlay cast predominantly base metal, three or more surfaces
D6606 Inlay cast noble metal, two surfaces
D6607 Inlay cast noble metal, three or more surfaces
D6608 Onlay – porcelain/ceramic, two surfaces
D6609 Onlay – porcelain/ceramic, three or more surfaces
D6610 Onlay cast high noble metal, two surfaces
D6611 Onlay cast high noble metal, three or more surfaces
D6612 Onlay cast predominantly base metal, two surfaces
D6613 Onlay cast predominantly base metal, three or more surfaces
D6614 Onlay cast noble metal, two surfaces
D6615 Onlay cast noble metal, three or more surfaces
D6624 Inlay titanium
D6634 Onlay titanium

**D6700 – D6799 FIXED PARTIAL DENTURE RETAINERS-CROWNS**

D6710 Crown – indirect resin based composite. Benefits will be considered for a conventional fixed prosthesis. The difference between the Allowable amount for the conventional prosthesis and the Allowable amount for the D6710 is Denied and collectible from the Patient.

D6720 Crown-resin with high noble metal
D6721 Crown-resin with predominantly base metal
D6722 Crown-resin with noble metal
D6740 Crown-porcelain/ceramic
D6750 Crown-porcelain fused to high noble metal
D6751 Crown-porcelain fused to predominantly base metal
D6752 Crown-porcelain fused to noble metal
D6780 Crown-¾ cast high noble metal
D6781 Crown-¾ cast predominantly base metal
D6782 Crown-¾ cast noble metal
D6783 Crown-¾ porcelain/ceramic
D6790 Crown-full cast high noble metal
D6791 Crown-full cast predominantly base metal
D6792 Crown-full cast noble metal
D6793 Provisional retainer crown
D6794 Crown-titanium

**D6900 - D6999 OTHER FIXED PARTIAL DENTURE SERVICES**

D6920 Connector bar. The fee for a connector bar is Denied, unless the contract specifies that it is a benefit.

D6930 Re-cement or re-bond fixed partial denture The fee for recementation of a fixed partial denture by the same dentist/dental office within six (6) months of the seating date is Disallowed as a component of the fee for the original procedure. Benefits for recementation (after six (6) months have elapsed since the initial placement) are limited to once in a twelve (12) month period. Fees for subsequent requests for recementation by the same dentist/dental office are Denied. Benefits may be processed when billed by a dentist/dental office other than the one who seated the bridge or performed the previous recementation.

D6940 Stress breaker. The fee is Denied, unless the contract specifies that it is a benefit.

D6950 Precision attachment is Denied, unless the contract specifies that it is a benefit.

D6975 Coping-metal is Denied, and is collectible from the Patient.

D6980 Fixed partial denture repair, by report

D6985 Pediatric partial denture, fixed. The fee for this service is Denied.

D6999 Unspecified fixed prosthodontic procedure, by report. This code is Disallowed and reviewed on an appeal basis for benefit payment or denial.

**X. D7000 – D7999 ORAL AND MAXILLOFACIAL SURGERY**

G- The fee for all oral and maxillofacial surgery includes routine post-operative care. Fees for exploratory surgery and unsuccessful attempts at extractions are not payable by dental plan or chargeable to the Patient.
Impaction codes are based on the anatomical position of the tooth and the surgical procedure necessary for removal.

**EXTRACTIONS**

D7000 – D7199 EXTRAC TIONS - INCLUDES LOCAL ANESTHESIA, SUTURING, AND ROUTINE POST-OPERATIVE CARE

D7111 Coronal remnants – deciduous tooth. This procedure is considered part of any other (primary) surgery in the same site on the same day and the fee is Disallowed.

D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)

D7200 – D7259 SURGICAL EXTRACTIONS - INCLUDES LOCAL ANESTHESIA, SUTURING, AND ROUTINE POST-OPERATIVE CARE

G- Surgical removals of third molars are only Benefited if they are associated with symptoms or oral pathology.

- D7210 Surgical removal of erupted tooth including elevation of the mucoperiosteal flap if indicated and removal of bone and/or section of tooth

- D7220 Removal of impacted tooth-soft tissue D7230 Removal of impacted tooth-partially bony D7240

- Removal of impacted tooth-completely bony

- D7241 Removal of impacted tooth-completely bony, with unusual surgical complications

- D7250 Surgical removal of residual tooth roots (cutting procedure) The fee for root recovery is Disallowed if submitted for the same date of service as a surgical extraction done by the same dentist/dental office.

- D7251 Coronectomy – intentional partial tooth removal

- D7270 Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth The fee includes removal of the splint by the same dentist/dental office. A separate fee for these services is Disallowed.

**OTHER SURGICAL PROCEDURES**

D7260 Oroantral fistula closure

D7261 Primary closure of a sinus perforation. Procedure is by report. If submitted with D7241 reference the CDT descriptor for D7241 and Disallow D7261.

D7272 Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization) The fee for tooth transplantation is Denied.

D7280 Surgical exposure of an unerupted tooth This service may be paid under orthodontic benefits.

D7282 Mobilization of erupted or malpositioned tooth to aid eruption This procedure is by report. When done In Conjunction With other surgery in this immediate area, the fee is Disallowed.

D7283 Placement of device to facilitate eruption of impacted tooth Procedure is by report, benefits are payable under the contracts orthodontic coverage in groups that have orthodontic coverage.

D7285 Incisional biopsy of oral tissue-hard (bone, tooth)

D7286 Incisional biopsy of oral tissue-soft is only payable for oral structures. A pathology report must be included. The fee for a biopsy is Disallowed In Conjunction With other surgery at the same site/same day. Biopsy of oral tissue is only Benefited for oral structures.

D7287 Exfoliative cytological sample collection. These codes are Denied in accordance with group contracts.

D7288 Brush biopsy – transepithelial sample collection. This service may be a covered service as indicated by a group contract.

D7290 Surgical repositioning of teeth is a benefit subject to contract.

D7291 Transseptal fiberotomy / supra crestal fiberotomy by report is considered and is subject to contractual limitations.

D7292 Surgical placement of temporary anchorage device [screw retained plate] requiring flap; includes device removal

D7293 Surgical placement of temporary anchorage device requiring flap; includes device removal

D7294 Surgical placement of temporary anchorage device without flap; includes device removal Anchorage device Benefits are Denied and the fee is chargeable to the Patient.

D7295 Harvest of bone for use in autogenous grafting procedure

**ALVEOLOPLASTY**

D7300 - D7339 ALVEOLOPLASTY- SURGICAL PREPARATION OF RIDGE

G - A quadrant for oral surgery purposes is defined as four (4) or more continuous teeth and/or teeth spaces distal to the midline.

D7310 Alveoloplasty In Conjunction With extractions- four or more teeth or tooth spaces, per quadrant. The fee for D7310 performed by the same dentist/dental office in the same surgical area on the same date of
service as surgical extractions (D7210-D7230) is Disallowed.

D7311 Alveoplasty In Conjunction With extractions – one to three teeth or tooth spaces per quadrant. The fee for D7311 performed by the same dentist/dental office in the same surgical area on the same date of service as surgical extractions (D7210-D7230) is Disallowed. The fee for surgical extractions includes an alveoplasty. The fee is Disallowed no matter how many surgical extractions are performed in the quadrant. A quadrant is four or more contiguous teeth and/or teeth spaces distal to the midline.

D7320 Alveoplasty not In Conjunction With extractions - four or more teeth or tooth spaces, per quadrant
D7321 Alveoplasty not In Conjunction With extractions - one to three teeth or tooth spaces, per quadrant. Count bounded tooth spaces for D7321 partial quadrant code. A bounded tooth space counts as one space irrespective of the number of teeth that would normally exist in the space.

D7340 - D7399 VESTIBULOPLASTY
G- All procedures are By Report And Subject To Coverage Under Medical.
D7340 Vestibuloplasty-ridge extension (secondary epithelialization)
D7350 Vestibuloplasty-ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)

D7400 - D7429 SURGICAL EXCISION OF SOFT TISSUE LESIONS
G- All procedures are By Report And Subject To Coverage Under Medical.
The fee for excision of hard & soft tissue lesions is Disallowed on the same date as other surgery in the same site.
D7410 Excision of benign lesion up to 1.25 cm
D7411 Excision of benign lesion greater than 1.25 cm. D7412 Excision of benign lesion, complicated
D7413 Excision of malignant lesion up to 1.25 cm
D7414 Excision of malignant lesion greater than 1.25 cm
D7415 Excision of malignant lesion, complicated

D7430 - D7469 SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS
G- All procedures are By Report And Subject To Coverage Under Medical.
The fees for these procedures are Disallowed unless the pathology laboratory report is submitted upon appeal.
D7440 Excision of malignant tumor - lesion diameter up to 1.25 cm
D7441 Excision of malignant tumor - lesion diameter greater than 1.25 cm
D7450 Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm
D7451 Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm. The fee for excision of hard & soft tissue lesions is Disallowed on the same date as other surgery in the same site.
D7460 Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm
D7461 Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm
D7465 Destruction of lesion(s) by physical methods, by report

D7470 - D7599 EXCISION OF BONE TISSUE
G- All procedures are By Report And Subject To Coverage Under Medical. D7471 Removal of lateral exostosis – (maxilla or mandible)
D7472 Removal of torus palatinus
D7473 Removal of torus mandibularis
D7485 Surgical reduction of osseous tuberosity
D7490 Radical resection of mandible with bone graft

D7500 – 7599 SURGICAL INCISION
G- All procedures are By Report And Subject To Coverage Under Medical.
D7510 Incision and drainage of abscess-intraoral soft tissue
D7511 Incision and drainage of abscess-intraoral soft tissue-complicated. The fee for surgical incision is Disallowed when done on the same date and by the same dentist/dental office as endodontics, extractions, palliative treatment, or other definitive service.
D7520 Incision and drainage of abscess-extraoral soft tissue
D7521 Incision and drainage of abscess- extraoral soft tissue-complicated. Incision and drainage of abscess-extraoral soft tissue is Benefited only if a dentally related infection is present. If dentally related infection is not present, the fee is Denied.
D7530 Removal of foreign body from mucosa, skin or subcutaneous alveolar tissue
D7540 Removal of reaction producing foreign bodies, musculoskeletal system
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7550</td>
<td>Partial ostectomy/sequestrectomy for removal of non-vital bone</td>
</tr>
<tr>
<td>D7560</td>
<td>Maxillary sinusotomy for removal of tooth fragment or foreign body</td>
</tr>
<tr>
<td>D7600 - D7699</td>
<td><strong>TREATMENT OF FRACTURES-SIMPLE</strong></td>
</tr>
<tr>
<td>G-</td>
<td>All procedures are By Report And Subject To Coverage Under Medical. A separate fee for splinting, wiring or banding is Disallowed.</td>
</tr>
<tr>
<td>D7610</td>
<td>Maxilla-open reduction (teeth immobilized, if present)</td>
</tr>
<tr>
<td>D7620</td>
<td>Maxilla-closed reduction (teeth immobilized, if present)</td>
</tr>
<tr>
<td>D7630</td>
<td>Mandible-open reduction (teeth immobilized, if present)</td>
</tr>
<tr>
<td>D7640</td>
<td>Mandible-closed reduction (teeth immobilized, if present)</td>
</tr>
<tr>
<td>D7650</td>
<td>Malar and/or zygomatic arch-open reduction</td>
</tr>
<tr>
<td>D7660</td>
<td>Malar and/or zygomatic arch-closed reduction</td>
</tr>
<tr>
<td>D7670</td>
<td>Alveolus-closed reduction, may include stabilization of teeth</td>
</tr>
<tr>
<td>D7671</td>
<td>Alveolus, open reduction, may include stabilization of teeth</td>
</tr>
<tr>
<td>D7680</td>
<td>Facial bones-complicated reduction with fixation and multiple surgical approaches</td>
</tr>
<tr>
<td>D7700 - D7799</td>
<td><strong>TREATMENT OF FRACTURES-COMPOUND</strong></td>
</tr>
<tr>
<td>G-</td>
<td>All procedures are By Report And Subject To Coverage Under Medical. A separate fee for splinting, wiring or banding is Disallowed.</td>
</tr>
<tr>
<td>D7710</td>
<td>Maxilla-open reduction</td>
</tr>
<tr>
<td>D7720</td>
<td>Maxilla-closed reduction</td>
</tr>
<tr>
<td>D7730</td>
<td>Mandible-open reduction</td>
</tr>
<tr>
<td>D7740</td>
<td>Mandible-closed reduction</td>
</tr>
<tr>
<td>D7750</td>
<td>Malar and/or zygomatic arch-open reduction</td>
</tr>
<tr>
<td>D7760</td>
<td>Malar and/or zygomatic arch-closed reduction</td>
</tr>
<tr>
<td>D7770</td>
<td>Alveolus-open reduction, stabilization of teeth</td>
</tr>
<tr>
<td>D7771</td>
<td>Alveolus, closed reduction stabilization of teeth</td>
</tr>
<tr>
<td>D7780</td>
<td>Facial bones-complicated reduction with fixation and multiple surgical approaches</td>
</tr>
<tr>
<td>D7800 - D7899</td>
<td><strong>REDUCTION OF DISLOCATION AND MANAGEMENT OF OTHER TEMPOROMANDIBULAR JOINT DYSFUNCTIONS, PROCEDURES, WHICH ARE AN INTEGRAL PART OF A PRIMARY PROCEDURE, SHOULD NOT BE REPORTED SEPARATELY.</strong></td>
</tr>
<tr>
<td>G-</td>
<td>All procedures are not a benefit unless covered under a TMJ rider and subject to coverage under medical.</td>
</tr>
<tr>
<td>D7810</td>
<td>Open reduction of dislocation</td>
</tr>
<tr>
<td>D7820</td>
<td>Closed reduction of dislocation D7830 Manipulation under anesthesia</td>
</tr>
<tr>
<td>D7840</td>
<td>Condylectomy</td>
</tr>
<tr>
<td>D7850</td>
<td>Surgical discectomy, with/without implant</td>
</tr>
<tr>
<td>D7852</td>
<td>Disc repair</td>
</tr>
<tr>
<td>D7854</td>
<td>Synovectomy</td>
</tr>
<tr>
<td>D7856</td>
<td>Myotomy</td>
</tr>
<tr>
<td>D7858</td>
<td>Joint reconstruction</td>
</tr>
<tr>
<td>D7860</td>
<td>Arthroscopy</td>
</tr>
<tr>
<td>D7865</td>
<td>Arthroplasty</td>
</tr>
<tr>
<td>D7870</td>
<td>Arthrocentesis</td>
</tr>
<tr>
<td>D7871</td>
<td>Non-arthroscopic lysis and lavage</td>
</tr>
<tr>
<td>D7872</td>
<td>Arthroscopy-diagnosis, with or without biopsy</td>
</tr>
<tr>
<td>D7873</td>
<td>Arthroscopy-surgical: lavage and lysis of adhesions</td>
</tr>
<tr>
<td>D7874</td>
<td>Arthroscopy-surgical: disc repositioning and stabilization</td>
</tr>
<tr>
<td>D7875</td>
<td>Arthroscopy-surgical: synovectomy</td>
</tr>
<tr>
<td>D7876</td>
<td>Arthroscopy-surgical: discectomy</td>
</tr>
<tr>
<td>D7877</td>
<td>Arthroscopy-surgical: debridement</td>
</tr>
<tr>
<td>D7880</td>
<td>Occlusal orthotic device, by report</td>
</tr>
<tr>
<td>D7881</td>
<td>Occlusal orthotic device adjustment NC - considered in the cost for the occlusal orthotic for first 6 months D8681 removable orthodontic retainer adjustment. Same as D8210</td>
</tr>
<tr>
<td>D7899</td>
<td>Unspecified TMD procedure, by report</td>
</tr>
<tr>
<td>D7900 - D7910</td>
<td><strong>REPAIR OF TRAUMATIC WOUNDS</strong></td>
</tr>
<tr>
<td>G-</td>
<td>Repair of traumatic wounds is limited to oral structures.</td>
</tr>
</tbody>
</table>
D7910  Suture of recent small wounds up to 5 cm

D7911 - D7919  **COMPLICATED SUTURING (RECONSTRUCTION REQUIRING DELICATE HANDLING OF TISSUES AND WIDE UNDERMINING FOR METICULOUS CLOSURE)**

  G- Complicated suturing is limited to oral structures and subject to coverage under medical.

D7911  Complicated suture - up to 5 cm

D7912  Complicated suture - greater than 5 cm

D7920 - D7999  **OTHER REPAIR PROCEDURES**

  G- All procedures except D7960, D7970, and D7971 are **By Report And Subject To Coverage Under Medical**.

D7920  Skin grafts (identify defect covered, location and type of graft)

D7921  Collection and application of autologous blood concentrate product - Benefits are **Denied** in accordance with group contracts and the fee is chargeable to the **Patient**.

D7940  Osteoplasty-for orthognathic deformities

D7941  Osteotomy - mandibular rami

D7943  Osteotomy - mandibular rami with bone graft; includes obtaining the graft

D7944  Osteotomy - segmented or subapical-per sextant or quadrant

D7945  Osteotomy - body of mandible

D7946  LeFort I (maxilla-total) D7947 LeFort I (maxilla-segmented)

D7948  LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion)-without bone graft

D7949  LeFort II or LeFort III-with bone graft

D7950  Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla autogenous or non-autogenous, by report - This procedure code may be used for ridge augmentation or reconstruction to increase height, width and/or volume of residual alveolar ridge. It includes obtaining autograft, and/or allograft graft material. Placement of a barrier membrane, if used, should be reported separately.

D7951  Sinus augmentation with bone or bone substitutes

D7952  Sinus augmentation – via a vertical approach **BY REPORT AND SUBJECT TO COVERAGE UNDER MEDICAL**

D7953  Bone replacement graft for ridge preservation – per site: Graft is placed in an extraction or implant removal site at the time of the extraction or removal to preserve ridge integrity (e.g., clinically indicated in preparation for implant reconstruction or where alveolar contour is critical to planned prosthetic reconstruction). Does not include obtaining graft material. Membrane, if used should be reported separately. Benefits for osseous autografts and/or osseous allografts are available only when billed for natural teeth for periodontal purposes using periodontal procedure codes (D4263-D4264).

Benefits for these procedures when billed **In Conjunction With** implants, ridge augmentation, extraction sites, periradicular surgery etc. are **Denied**. If the contract covers dental implants this procedure may be **Benefited** at the time of extraction.

D7955  Repair of maxillofacial soft and/or hard tissue defect - Reconstruction of surgical, traumatic, or congenital defects of the facial bones, including the mandible, may utilize autograft, allograft, or alloplastic graft materials in conjunction with soft tissue procedures to repair and restore the facial bones to form and function. This does not include obtaining the graft and these procedures may require multiple surgical approaches. This procedure does not include edentulous maxilla and mandibular reconstruction for prosthetic considerations.

D7960  Frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure - Surgical removal or release of mucosal and muscle elements of a buccal, labial or lingual frenum that is associated with a pathological condition, or interferes with proper oral development or treatment. The fee for a frenulectomy is **Disallowed** when billed **In Conjunction With** any other surgical procedure(s) in the same area.

D7963  Frenuloplasty. A separate fee for frenuloplasty is **Disallowed** when billed **In Conjunction With** any other surgical procedure(s) in the same surgical area by the same dentist/dental office.

D7970  Excision of hyperplastic tissue-per arch. The fee for excision of hyperplastic tissue is **Disallowed** when billed **In Conjunction With** other surgical procedure(s) in the same area.

D7971  Excision of pericoronal gingival. The fee for excision of pericoronal gingival is **Disallowed** when billed **In Conjunction With** other surgical procedure(s) in the same area.

D7972  Surgical reduction of fibrous tuberosity. This procedure is by report if covered service.

D7980  Sialolithotomy

D7981  Excision of salivary gland, by report
D7982  Sialodochoplasty
D7983  Closure of salivary fistula
D7990  Emergency tracheotomy
D7991  Coronoidectomy
D7995  Synthetic graft-mandible or facial bones, by report
D7996  Implant-mandible for augmentation purposes (excluding alveolar ridge), by report
D7997  Appliance removal (not by the dentist who placed the appliance), includes removal of archbar. The fee for appliance removal is **Denied**.
D7998  **Intraoral placement of fixation device Not In Conjunction With a fracture.** This procedure is **Disallowed** by the same dentist/dental office when billed **In Conjunction With** any surgical procedure. Fractures for which splinting, wiring or banding is considered part of the complete procedure.
D7999  Unspecified oral surgery procedure, by report. This code is **Disallowed** and reviewed on an appeal basis for benefit payment or denial.

**X. D8000 - D8999 ORTHODONTICS**

**G**- All procedures are subject to orthodontic coverage under the plan. Surgical procedures should be reported separately under the appropriate codes. Since there is no unique code for Invisalign procedures, the benefit is based on the approved fee for conventional orthodontics. Any additional fee up to the submitted amount for Invisalign is **Denied** and is chargeable to the **Patient**.

**Limited Orthodontic Treatment**
Orthodontic treatment with a limited objective, not necessarily involving the entire dentition. It may be directed at the only existing problem, or at only one aspect of a larger problem in which a decision is made to defer or forego more comprehensive therapy.

**Interceptive Orthodontic Treatment**
Interceptive orthodontics is an extension of preventive orthodontics that may include localized tooth movement. Such treatment may occur in the primary or transitional dentition and may include such procedures as the redirection of ectopically erupting teeth, correction of dental crossbite or recovery of space loss where overall space is inadequate. When initiated during the incipient stages of a developing problem, interceptive orthodontics may reduce the severity of the malformation and mitigate its cause. Complicating factors such as skeletal disharmonies, overall space deficiency, or other conditions may require subsequent comprehensive therapy.

**Comprehensive Orthodontic Treatment**
Comprehensive orthodontic care includes a coordinated diagnosis and treatment leading to the improvement of a patient’s craniofacial dysfunction and/or dentofacial deformity which may include anatomical, functional and/or esthetic relationships. Treatment may utilize fixed and/or removable orthodontic appliances and may also include functional and/or orthopedic appliances in growing and non-growing patients. Adjunctive procedures to facilitate care may be required. Comprehensive orthodontics may incorporate treatment phases focusing on specific objectives at various stages of dentofacial development.

**LIMITED ORTHODONTIC TREATMENT**
D8010  Limited orthodontic treatment of the primary dentition
D8020  Limited orthodontic treatment of the transactional dentition
D8030  Limited orthodontic treatment of the adolescent dentition
D8040  Limited orthodontic treatment of the adult dentition

**INTERCEPTIVE ORTHODONTIC TREATMENT**
D8050  Interceptive orthodontic treatment of the primary dentition
D8060  Interceptive orthodontic treatment of the transitional dentition

**COMPREHENSIVE ORTHODONTIC TREATMENT**
D8070  Comprehensive orthodontic treatment of the transitional dentition
D8080  Comprehensive orthodontic treatment of the adolescent dentition

**MINOR TREATMENT TO CONTROL HARMFUL HABITS**
D8210  Removable appliance therapy
D8220  Fixed appliance therapy

**OTHER ORTHODONTIC SERVICES**
Pre-orthodontic treatment examination to monitor growth and development. This procedure is included in the orthodontic case fee. A separate fee is Disallowed to the same dentist/dental office.

Periodic orthodontic treatment visit. This procedure is included in the orthodontic case fee. A separate fee is Disallowed to the same dentist/dental office.

Orthodontic retention (removal of appliance, construction and placement of retainer(s)

Removable orthodontic retainer adjustment. Same as D8210

Repair of orthodontic appliance

Replacement of lost or stolen retainer

Re-cement or re-bond fixed retainer. This procedure is included in the orthodontic case fee. A separate fee is Disallowed to the same dentist/dental office.

Repair of fixed retainers, includes reattachment. This procedure is included in the orthodontic case fee. A separate fee is Disallowed to the same dentist/dental office.

Unspecified orthodontic procedure, by report. This code is Disallowed and reviewed on an appeal basis for benefit payment or denial.

XII. D9000 - D9999 ADJUNCTIVE GENERAL SERVICES

UNCLASSIFIED TREATMENT

Palliative (emergency) treatment of dental pain-minor procedure. The fee for palliative treatment is Disallowed when any other definitive treatment is performed on the same date except limited radiographs and tests necessary to diagnose the emergency condition. The fee for palliative treatment is Benefited on a per-visit basis, once on the same date, and includes all procedures necessary for the relief of pain. Evaluation is not considered as the relief of pain. A pulpotomy is not considered part of the root canal if performed on a separate date of service and is Processed As palliative treatment.

Fixed Partial Denture Sectioning. This procedure is only a benefit if a portion of a fixed prosthesis is to remain intact and serviceable following sectioning and extractions or other treatment. If this code is part of the process or removing and replacing a fixed prosthesis, it is considered integral to the fabrication of the fixed prosthesis and separate fee from this code is Disallowed. A separate fee for polishing and recontouring of the retained portion of the prosthesis is Disallowed.

ANESTHESIA

The fee for local anesthesia is Disallowed when performed In Conjunction With any other procedure. The fee for general anesthesia is a benefit only when administered by a properly licensed dentist in a dental office In Conjunction With covered surgical procedures or when necessary due to concurrent medical conditions. The fee for general anesthesia is Denied when billed In Conjunction With services other than covered oral surgery procedures.

** See Attachment A for CDT codes to be used in conjunction with General Anesthesia.

Local anesthesia not In Conjunction With operative or surgical procedures

Regional block anesthesia

Trigeminal division block anesthesia

Local anesthesia in conjunction with operative or surgical procedures

Evaluation for deep sedation or general anesthesia. This procedure is Disallowed.

Deep sedation/general anesthesia – each 15 minute increment – anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties. The level of anesthesia is determined by the anesthesiologist’s documentation of the anesthetic effects upon the central nervous system and not dependent upon the route of administration. Dental plans are not able to benefit anesthesia the same as can medical plans, therefore the benefit is derived from the division of a total of 1 hour of anesthesia divided by 4 – each fifteen minute time unit is 1/4 of the total for 1 hour (prior 1 D9220 plus 2 D9221 time units)

Administration of nitrous oxide, anxiolysis, analgesia. The fee for analgesia, anxiolysis, and inhalation of nitrous oxide is Denied. This service may be a covered service as indicated by a group contract.

Intravenous moderate (conscious) sedation/analglesia – each 15 minute increment - anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel.
personnel and the doctor may safely leave the room to attend to other patients or duties. The level of anesthesia is determined by the anesthesia provider’s documentation of the anesthetics effects upon the central nervous system and not dependent upon the route of administration. Dental plans are not able to benefit anesthesia the same as can medical plans, therefore the benefit is derived from the division of a total of 1 hour of anesthesia divided by 4 – each fifteen minute time unit is ¼ of the total for 1 hour (prior 1 D9241 plus 2 D9242 time units)

D9248 Non-intravenous moderate (conscious) sedation The fee for non-intravenous sedation is Denied. This service may be a covered service as indicated by a group contract. ** See Attachment A for CDT codes to be used in conjunction with IV Sedation.

D9300 - D9399 PROFESSIONAL CONSULTATION
D9310 Consultation (diagnostic service provided by dentist or physician other than requesting dentist or physician). When covered, the consultation is subject to the same frequency limitations and processing policies as a comprehensive evaluation (D0150). The fee for a consultation is Disallowed when billed In Conjunction With an evaluation or definitive service. This code is processed in accordance with group contracts.

D9400 - D9599 PROFESSIONAL VISITS G- The fees for all procedures are Denied.
D9410 House/extended care facility call
D9420 Hospital or ambulatory surgical center call
D9430 Office visit for observation (during regularly scheduled hours) – no other services performed
D9440 Office visit – after regularly scheduled hours
D9450 Case presentation, detailed and extensive treatment planning

D9600 - D9899 DRUGS
G- The fees for all procedures are Denied.
D9610 Therapeutic parenteral drug, single administration
D9612 Therapeutic parenteral drugs, two or more administrations, different medications
D9630 Other drugs and/or medicaments, by report

D9900 - D9999 MISCELLANEOUS SERVICES
D9910 Application of desensitizing medicaments. The fee for the application of desensitizing medicaments is Denied.
D9911 Application of desensitizing resin for cervical and/or root surface, per tooth. The fee for application of a desensitizing resin is Denied.
D9920 Behavior management, by report. The fee for behavior management is Denied.
D9930 Treatment of complications (post-surgical) - unusual circumstances, by report. The fee for dry socket is Disallowed and included in the fee for the extraction by the same dentist/dental office.
D9932 Cleaning and inspection of removable complete denture, maxillary - this procedure does not include any adjustments. Processed the same as D9931
D9933 Cleaning and inspection of removable complete denture, mandibular - this procedure does not include any adjustments. Processed the same as D9931
D9934 Cleaning and inspection of removable partial denture, maxillary - this procedure does not include any adjustments. Processed the same as D9931
D9935 Cleaning and inspection of removable partial denture, mandibular- this procedure does not include any adjustments. Processed the same as D9931

G- The fees for procedure codes D9940-D9974 are Denied, unless indicated by group contract as a covered service.

D9940 Occlusal guards, by report
D9941 Fabrication of athletic mouth-guard
D9942 Repair or reline of occlusal guard is not a covered benefit unless it is contract specific. The fee is Denied. If covered contractually, the fee for the occlusal guard includes any adjustment or repair required within six (6) months of delivery. Fees for the adjustment or repair of the occlusal guard are Disallowed if performed by the same dentist/dental office within six (6) months of initial placement. If covered contractually, the fee for repair of an occlusal guard cannot exceed one-half of the fee for a new appliance, and any excess fee is Disallowed.
D9943 Occlusal guard adjustment. Not-Covered for first 6 months post insertion of D9940 - adjustments included in fee for occlusal guard
D9950 Occlusion analysis-mounted case
D9951 Occlusal adjustment-limited
D9952 Occlusal adjustment-complete
D9970 Enamel microabrasion.
D9971 Odotoplasty 1-2 teeth; includes removal of enamel projections.
D9972 External bleaching per arch
D9973 External bleaching per tooth
D9974 Internal bleaching per tooth.
D9975 External bleaching – home application - Benefits are Denied in accordance with group contracts and the fee is chargeable to the Patient.
D9985 Sales Tax This procedure is Denied as not covered
D9986 Missed appointment. This procedure is not covered.
D9987 Cancelled appointment. This procedure is not covered
D9999 Unspecified adjunctive procedure, by report. This code is Disallowed and reviewed on an appeal basis for benefit payment or denial.
Attachment A

These codes apply to complex surgical procedures and do not include simple extractions. This procedure is payable only when performed in conjunction with covered complex oral surgery procedures. The IV sedation and General Anesthesia will be Benefited with the following CDT procedures:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3410</td>
<td>apicoectomy/periradicular surgery - anterior</td>
</tr>
<tr>
<td>3421</td>
<td>apicoectomy/periradicular surgery - bicuspid, (first root)</td>
</tr>
<tr>
<td>3425</td>
<td>apicoectomy/periradicular surgery - molar (first root)</td>
</tr>
<tr>
<td>3426</td>
<td>apicoectomy/periradicular surgery (each additional root)</td>
</tr>
<tr>
<td>4212</td>
<td>Gingivectomy/gingivoplasty to allow for restorative procedure - May be BENEFITED based on the member’s dental benefit plan. This is DISALLOWED when performed the same day as a restorative procedure.</td>
</tr>
<tr>
<td>4260</td>
<td>osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant</td>
</tr>
<tr>
<td>4261</td>
<td>osseous surgery (including flap entry and closure) - one to three teeth, per quadrant</td>
</tr>
<tr>
<td>4263</td>
<td>bone replacement graft - first site in quadrant</td>
</tr>
<tr>
<td>4264</td>
<td>bone replacement graft - each additional site in quadrant</td>
</tr>
<tr>
<td>4268</td>
<td>surgical revision procedure, per tooth</td>
</tr>
<tr>
<td>4270</td>
<td>pedicle soft tissue graft procedure</td>
</tr>
<tr>
<td>4273</td>
<td>sub epithelial connective tissue graft procedures</td>
</tr>
<tr>
<td>4274</td>
<td>distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)</td>
</tr>
<tr>
<td>4275</td>
<td>soft tissue allograft</td>
</tr>
<tr>
<td>4276</td>
<td>combined connective tissue and double pedicle graft</td>
</tr>
<tr>
<td>4277</td>
<td>Free soft tissue graft – first tooth and D4278: Free soft tissue graft – additional contiguous tooth– May be BENEFITED based on the member’s dental benefit plan. The benefit for pedicle and free soft tissue grafts is per site. When multiple adjacent grafts are done in a single quadrant, the fee is limited to the lesser of the ALLOWABLE amount for a full quadrant of osseous surgery (D4260) or two (2) sites. Any fee in excess of the lesser of the ALLOWED amount for D4260 full quadrant or two (2) graft sites is DISALLOWED, unless there is documentation of special need.</td>
</tr>
<tr>
<td>6010</td>
<td>surgical placement of implant body: endosteal implant</td>
</tr>
<tr>
<td>6040</td>
<td>surgical placement: eposteal implant</td>
</tr>
<tr>
<td>6050</td>
<td>surgical placement: tranosteal implant</td>
</tr>
<tr>
<td>6100</td>
<td>implant removal, by report</td>
</tr>
<tr>
<td>6101</td>
<td>Debridement/repair of periimplant defects– May be BENEFITED based on the member’s</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>6102</td>
<td>Debridement/repair of periimplant defects– May be BENEFITED based on the member's dental benefit plan. The fee for D6102 when submitted In Conjunction With D4260 or D4261 is DISALLOWED.</td>
</tr>
<tr>
<td>6103</td>
<td>Debridement/repair of periimplant defects– May be BENEFITED based on the member's dental benefit plan. The fee for D6102 when submitted In Conjunction With D4260 or D4261 is DISALLOWED.</td>
</tr>
<tr>
<td>6104</td>
<td>Bone graft at time of implant placement– May be BENEFITED based on the member's dental benefit plan. This is DENIED if there is no implant coverage.</td>
</tr>
<tr>
<td>7210</td>
<td>surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth</td>
</tr>
<tr>
<td>7220</td>
<td>removal of impacted tooth - soft tissue</td>
</tr>
<tr>
<td>7230</td>
<td>removal of impacted tooth - partially bony</td>
</tr>
<tr>
<td>7240</td>
<td>removal of impacted tooth - completely bony</td>
</tr>
<tr>
<td>7241</td>
<td>removal of impacted tooth - completely bony, with unusual surgical complications</td>
</tr>
<tr>
<td>7250</td>
<td>surgical removal of residual tooth roots (cutting procedure)</td>
</tr>
<tr>
<td>7260</td>
<td>oroantral fistula closure</td>
</tr>
<tr>
<td>7261</td>
<td>primary closure of a sinus perforation</td>
</tr>
<tr>
<td>7280</td>
<td>surgical access of an unerupted tooth</td>
</tr>
<tr>
<td>7281</td>
<td>surgical exposure of impacted or unerupted tooth to aid eruption.</td>
</tr>
<tr>
<td>7285</td>
<td>biopsy of oral tissue, - hard (bone, tooth)</td>
</tr>
<tr>
<td>7286</td>
<td>biopsy of oral tissue - soft (all others). For surgical removal of specimen ONLY.</td>
</tr>
<tr>
<td>7310</td>
<td>alveolectomy in conjunction with extractions - per quadrant</td>
</tr>
<tr>
<td>7320</td>
<td>alveolectomy not in conjunction with extractions - per quadrant</td>
</tr>
<tr>
<td>7340</td>
<td>vestibuloplasty - ridge extension (secondary epithelialization)</td>
</tr>
<tr>
<td>7350</td>
<td>vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)</td>
</tr>
<tr>
<td>7411</td>
<td>excision of benign lesion greater than 1.25 cm</td>
</tr>
<tr>
<td>7412</td>
<td>excision of benign lesion, complicated</td>
</tr>
<tr>
<td>7413</td>
<td>excision of malignant lesion up to 1.25 cm</td>
</tr>
<tr>
<td>7414</td>
<td>excision of malignant lesion greater than 1.25 cm</td>
</tr>
<tr>
<td>7874</td>
<td>arthroscopy - surgical: disc repositioning and</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
</tr>
<tr>
<td>7415</td>
<td>excision of malignant lesion, complicated</td>
</tr>
<tr>
<td>7440</td>
<td>excision of malignant tumor - lesion diameter up to 1.25</td>
</tr>
<tr>
<td>7441</td>
<td>excision of malignant tumor - lesion diameter greater than 1.25</td>
</tr>
<tr>
<td>7450</td>
<td>removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm</td>
</tr>
<tr>
<td>7451</td>
<td>removal of benign odontogenic cyst or tumor - lesion diameter</td>
</tr>
<tr>
<td>7460</td>
<td>removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm</td>
</tr>
<tr>
<td>7461</td>
<td>removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm</td>
</tr>
<tr>
<td>7471</td>
<td>removal of lateral exostosis (maxilla or mandible)</td>
</tr>
<tr>
<td>7472</td>
<td>removal of torus palatinus</td>
</tr>
<tr>
<td>7473</td>
<td>removal of torus mandibularis</td>
</tr>
<tr>
<td>7485</td>
<td>surgical reduction of osseous tuberosity</td>
</tr>
<tr>
<td>7490</td>
<td>radical resection of mandible with bone graft</td>
</tr>
<tr>
<td>7550</td>
<td>partial ostectomy/sequestrectomy for removal of non-vital bone</td>
</tr>
<tr>
<td>7560</td>
<td>maxillary sinusotomy for removal of tooth fragment or foreign body</td>
</tr>
<tr>
<td>7610</td>
<td>maxilla - open reduction (teeth immobilized, if present)</td>
</tr>
<tr>
<td>7620</td>
<td>maxilla - closed reduction (teeth immobilized, if present)</td>
</tr>
<tr>
<td>7630</td>
<td>mandible - open reduction (teeth immobilized, if present)</td>
</tr>
<tr>
<td>7640</td>
<td>mandible - closed reduction (teeth immobilized, if present)</td>
</tr>
<tr>
<td>7650</td>
<td>malar and/or zygomatic arch - open reduction</td>
</tr>
<tr>
<td>7660</td>
<td>malar and/or zygomatic arch - closed reduction</td>
</tr>
<tr>
<td>7670</td>
<td>alveolus - closed reduction, may include stabilization of teeth</td>
</tr>
<tr>
<td>7671</td>
<td>alveolus - open reduction, may include stabilization of teeth</td>
</tr>
<tr>
<td>7680</td>
<td>facial bones - complicated reduction with fixation and</td>
</tr>
<tr>
<td>7710</td>
<td>maxilla - open reduction</td>
</tr>
<tr>
<td>7720</td>
<td>maxilla - closed reduction mucoperiosteal flap and removal of bone and/or section of tooth</td>
</tr>
<tr>
<td>7730</td>
<td>mandible - open reduction</td>
</tr>
<tr>
<td>7740</td>
<td>mandible - closed reduction</td>
</tr>
<tr>
<td>7750</td>
<td>malar and/or zygomatic arch - open reduction</td>
</tr>
<tr>
<td>7760</td>
<td>malar and/or zygomatic arch - closed reduction</td>
</tr>
<tr>
<td>7770</td>
<td>alveolus, open reduction stabilization of teeth</td>
</tr>
<tr>
<td>7771</td>
<td>alveolus, closed reduction stabilization of teeth</td>
</tr>
</tbody>
</table>