Dentist Handbook
National Processing Policies

Introductory Note

These national processing policies have been revised to reflect data code set requirements set forth under the Administrative Simplification Provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and related regulations. It is the policy of Delta Dental to comply with all such requirements as well as to require all Delta Dental member companies and their participating dentists to comply with such requirements. However, consistent with HIPAA, Delta Dental exercises its right to determine claims reimbursement procedures and requires the processing of such codes in accordance with the following policies, unless prohibited under other applicable law or specific group/individual contract provisions (described below). Notwithstanding, treatment of procedures under the national processing policies, dentists are required to utilize those procedure codes reflective of services rendered and in accordance with HIPAA. Amounts charged under any procedure shall not be inflated or manipulated in light of the processing policies. Delta Dental member companies shall ensure that their application of these processing policies is consistent with their contractual obligations to groups and enrollees.

General Policies

General policies (GP) 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.

Terms of group/individual contracts vary. Policies in this Handbook that address benefits, limitations and exclusions are "model" policies that have not been tailored to reflect the specific terms of applicable group/individual contracts. This Handbook may not fully or accurately reflect the terms of applicable group/individual contracts, and may be inconsistent with such terms. In all cases, the terms of group/individual contracts take precedence over Dentist Handbook policies. Please contact the member company listed on the patient's identification card for the specific terms of a group/individual contract.

For the purposes of this manual, the following definitions apply:

Allowance: The amount of Delta Dental's payment for the procedure benefitted.

Approved Amount: The total fee a participating dentist agrees to accept as payment in full for a procedure. It includes both the Delta Dental allowance and the

patient responsibility. Participating dentists agree not to collect from the patient any difference between the approved amount and their actual fee for the procedure.

Denied/Deny If the benefit for a procedure or service is denied, the procedure or service is not a benefit of the patient's coverage and the approved amount is collectable from the patient. Specific group/individual contract provisions take precedence over processing policies. It is recommended that the dental office contact the appropriate member company for the group/individual account to determine the specific benefits, limitations and exclusions.

Disallowed: If the fee for a procedure or service is disallowed, it is not benefitted by Delta Dental or collectable from the patient by a participating dentist.

Alternative Benefit: In cases where alternative methods of treatment exist, benefits are provided for the least costly, professionally acceptable treatment. This determination is not 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 benefitted, the difference between Delta Dental's allowance and the approved amount for the actual treatment rendered is collectable from the patient.

In Conjunction With: In conjunction with means as part of another procedure or course of treatment including, but not limited to, being rendered on the same day.

Processed as: When a procedure is processed as a different procedure, participating dentists agree to accept all the limitations, processing policies, and approved amounts that apply to the procedure Delta Dental benefits.

All services provided to Delta Dental members are subject to the following general policies:

- Documentation of extraordinary circumstances can be submitted for review by report.
- Individual consideration may be given if additional supporting documentation is provided (e.g. diagnostic quality radiographs, clinical notes, charting, etc.)
- Fees for completion of claim forms and submission of documentation to Delta Dental to enable benefit determination are not benefits. They are not collectable from the patient by a participating dentist.
- Infection control and OSHA compliance are included in the fee for the dental services provided. Separate fees are disallowed and not collectable separately from the patient by a participating dentist.

- Multistage procedures are reported and benefitted 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 of the final restoration regardless of the type of cement utilized. The completion date for endodontic treatment is the date the canals are permanently filled.
- Charges for procedures determined not to be necessary or not meeting generally accepted standards of care may be denied or disallowed. Many of the processing policies that follow, describe payment procedures that 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 needs.
- 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 to Delta Dental, a copy of the explanation of payment or payment voucher from the medical carrier should be included 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, Delta Dental will not benefit the procedure.
- The term specialized procedure describes a dental service or procedure that is used when unusual or extraordinary circumstances exist, and is not generally used when conventional methods are adequate.
- Additional supporting documentation may be requested in order to make a benefit determination
- Narratives as documentation are not considered legal entities nor are they contemporaneous in nature. The patient record/clinical notes are considered a legal document and are contemporaneous. The only acceptable legal written documentation for utilization review are the contemporaneous treatment notes.
- For payment purposes, local anesthesia is an integral part of the procedure being performed and additional fees are disallowed.

DIAGNOSTIC D0100 - D0999

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Clinical Oral Evaluations

GP The number and type of evaluations available for benefits are based on group/individual contract.

GP Comprehensive, periodic and periodontal evaluations include but are not limited to a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. This would include the evaluation and recording of the patient's dental and medical history and general health assessment. It may typically include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, existing prostheses, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, oral cancer evaluation, consultations, diagnosis, treatment planning, screening and assessment of a patient or other procedures typically part of a patient evaluation.

D0120 Periodic oral evaluation – established patient

The fees for consultation, diagnosis, and routine treatment planning are disallowed as components of the oral evaluation, by the same dentist/dental office.

D0140 Limited oral evaluation - problem focused

D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver

Oral evaluation includes any caries susceptibility tests (D0425) or oral hygiene instructions (D1330) provided on the same date. When performed on the same date, any fees for D0425 and D1330 are disallowed.

For patients under the age of three, any other comprehensive evaluation code submitted is benefited as D0145. Any fees in excess of D0145 are disallowed.

D0150 Comprehensive oral evaluation – new or established patient

A comprehensive oral evaluation is payable once per patient per dentist/dental office. Additional comprehensive evaluations of any type when billed by the same dentist/dental office are processed as periodic evaluations, and any fee charged in excess of the approved amount for the periodic evaluation is disallowed.

The fees for consultation, diagnosis, and routine treatment planning are disallowed as components of the oral evaluation, by the same dentist/dental office.

If the patient has not received any services for three years from the same dentist/dental office, a comprehensive evaluation may be benefitted.

D0160 Detailed and extensive oral evaluation-problem focused, by report

Any fees in excess of the approved amount for a comprehensive oral evaluation (D0150) or periodic oral evaluation (D0120) are disallowed.

If the patient has not received any services for three years from the same dentist/dental office, a comprehensive evaluation may be benefitted.

D0170 Re-evaluation-limited, problem focused (established patient, not post-op visit)

The fees for re-evaluation are disallowed in conjunction with any other procedure by the same dentist/dental office.

D0171 Re-evaluation – post operative office visit

The fees for re-evaluation are disallowed when submitted by the same dentist/dental office that performed the original procedure.

D0180 Comprehensive periodontal evaluation - new or established patient

A comprehensive periodontal evaluation is payable once per patient, per dentist/dental office. Additional comprehensive evaluations of any type when billed by the same dentist/dental office are processed as periodic evaluations, and any fee charged in excess for the approved amount for the periodic evaluation is disallowed.

This evaluation should not be reported in addition to a comprehensive oral evaluation (D0150) by the same dentist/dental office in the same treatment series. This procedure is not intended for use as a separate code for periodontal charting.

If a D0180 is submitted with D4910 by the same dentist/dental office it is benefitted as a D0120 and the difference in the approved amount is disallowed unless the D0180 is the initial evaluation by the dentist rendering the D4910.

Pre-Diagnostic Services

GP Benefits are determined by group/individual contract.

D0190 Screening of a patient

When reported in conjunction with an evaluation, the fee for screening of a patient is disallowed.

D0191 Assessment of a patient

When reported in conjunction with an evaluation, the fee for the assessment of a patient is disallowed.

Diagnostic Imaging

GP Fees for duplication (copying) of diagnostic images for insurance purposes are disallowed.

GP Benefits for diagnostic imaging, tests and examinations are determined by group/individual contract.

GP Images must be of diagnostic quality; properly oriented if submitted for document purposes, and with the date of exposure and a patient identifier indicated on all images. Images not of diagnostic quality are disallowed.

GP Individually listed intraoral radiographic images by the same dentist/dental office are considered a complete series if the fee for individual radiographic images equals or exceeds the fee for a complete series. Any amount charged in excess of the allowance for a complete series (D0210) is disallowed.

GP When image capture only procedures are submitted with capture and interpretation procedures, the fee for the image capture only procedure will be disallowed.

GP When interpretation of a diagnostic image procedure (D0391) is submitted with the capture and interpretation procedures, the fee for the interpretation of a diagnostic image (D0391) will be disallowed.

GP Limit two bitewing images for patients under age 10. A D0273 or D0274 submitted for a patient under age 10 may be processed as D0272 and the excess fees of D0272 are disallowed.

GP Diagnostic imaging codes (D0210 - D0371) include image capture and interpretation. The fee for interpretation of a diagnostic image by a practitioner not associated with the capture of the image is processed according to contract. In all other instances, the fees for interpretation are disallowed.

The FDA/ADA 2012 document Selection of Patients for Radiographic Examinations provides guidance for when the prescription of a full mouth series of radiographs is appropriate. These guidelines state that radiographs are to be prescribed by dentists only after reviewing the patient's health history and completing a clinical examination. Once a decision to obtain radiographs is made, it is the dentist's responsibility to follow the ALARA Principle (As Low as Reasonably Achievable) to minimize the patient's exposure to radiation. For most new patient encounters in dentate adults, and children or adolescents with transitional or permanent dentition, an individualized radiographic exam is appropriate, usually consisting of selected periapical images, posterior bitewings and a panoramic exam. A full mouth intraoral radiographic exam is usually performed when the patient has clinical evidence of generalized dental disease or history of extensive dental treatment. http://www.fda.gov/Radiation-EmittingProducts/RadiationEmittingProductsandProcedures/MedicalImaging/MedicalX-Rays/ucm116504.htm Table 1. from these guidelines is provided here:

TYPE OF ENCOUNTER	PATIENT AGE AND DENTAL DEVELOPMENTAL STAGE				
	Child with Primary Dentition (prior to eruption of first permanent tooth)	Child with Transitional Dentition (after eruption of first permanent tooth)	Adolescent with Permanent Dentition (prior to eruption of third molars)	Adult, Dentate or Partially Edentulous	Adult, Edentulous
New Patient* being evaluated for oral diseases	Individualized radiographic exam consisting of selected periapical/occlusal views and/or posterior bitewings if proximal surfaces cannot be visualized or probed. Patients without evidence of disease and with open proximal contacts may not require a radiographic exam at this time.	Individualized radiographic exam consisting of posterior bitewings with panoramic exam or posterior bitewings and selected periapical images.	Individualized radiographic exam consisting of posterior bitewings with panoramic exam or posterior bitewings and selected periapical images. A full mouth intraoral radiographic exam is preferred when the patient has clinical evidence of generalized oral disease or a history of extensive dental treatment.		Individualized radiographic exam, based on clinical signs and symptoms.
Recall Patient* with clinical caries or at increased risk for caries**	Posterior bitewing exam at 6-12 month intervals if proximal surfaces cannot be examined visually or with a probe			Posterior bitewing exam at 6-18 month intervals	Not applicable
Recall Patient* with no clinical caries and not at increased risk for caries**	Posterior bitewing exam at 12-24 month intervals if proximal surfaces cannot be examined visually or with a probe	Posterior bitewing exam at 18-36 month intervals		Posterior bitewing exam at 24-36 month intervals	Not applicable
Recall Patient* with periodontal disease	Clinical judgment as to the need for and type of radiographic images for the evaluation of periodontal disease. Imaging may consist of, but is not limited to, selected bitewing and/or periapical images of areas where periodontal disease (other than nonspecific gingivitis) can be demonstrated clinically.				Not applicable
Patient (New and Recall) for monitoring of dentofacial growth and development, and/or assessment of dental/skeletal relationships	Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development or assessment of dental and skeletal relationships	Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development, or assessment of dental and skeletal relationships. Panoramic or periapical exam to assess developing third molars		Usually not indicated for monitoring of growth and development. Clinical judgment as to the need for and type of radiographic image for evaluation of dental and skeletal relationships.	
Patient with other circumstances including, but not limited to, proposed or existing implants, other dental and craniofacial pathoses, restorative/endodontic needs, treated periodontal disease and caries remineralization	Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of these conditions				

Image Capture with Interpretation

D0210 Intraoral-complete series radiographic images.

The fee for any type of bitewings submitted with an intraoral-complete series are considered part of the full mouth series for payment and benefit purposes. Any fee in excess of a full mouth series is disallowed.

In the absence of contract language for bitewing frequency limitation, bitewings, of any type, are disallowed within 12 months of an intraoral-complete series.

A separate fee for a panoramic radiographic image (D0330) in conjunction with D0210 by the same dentist/dental office is disallowed as a component part of D0210.

When bitewings are processed as part of an intraoral complete series, a separate benefit for bitewings will not be allowed if the full mouth time limitation has been met within the benefit period.

D0220 Intraoral-periapical-first radiographic image

D0230 Intraoral-periapical-each additional radiographic image

Routine working and final treatment radiographic images taken by the same dentist/dental office for endodontic therapy are considered a component of the complete treatment procedure. Separate fees for these images are disallowed.

D0240 Intraoral-occlusal radiographic image

D0250 Extraoral- 2-D projection radiographic image created using a stationary radiation source and detector

Extraoral posterior radiographic image is denied unless covered by group/individual contract.

D0251 Extraoral posterior dental radiographic image

Extraoral posterior radiographic image is denied unless covered by group/individual contract.

D0270 Bitewing-single radiographic image

D0272 Bitewings-two radiographic images

D0273 Bitewings- three radiographic images

D0274 Bitewings-four radiographic images

D0277 Vertical bitewings - 7 to 8 radiographic images

Vertical bitewings are considered bitewings for benefit purposes. If the fee for the vertical bitewings with or without additional radiographic images equals or exceeds the fee for a complete series, it would be considered a complete series for payment, benefit, and time limitation purposes. The fee in excess of the fee for a complete series of radiographic images is disallowed.

D0310 Sialography

D0320 Temporomandibular joint arthrogram including injection

D0321 Other temporomandibular joint radiographic images, by report

D0322 Tomographic survey

D0330 Panoramic radiographic image

A panoramic radiographic image, with or without supplemental radiographic images (such as periapicals, bitewings, and/or occlusal radiographic images) is considered a complete series for time limitation purposes and any fee charged in excess of the allowance for a complete series (D0210) is disallowed.

Benefits for subsequent panoramic radiographic images taken within the contractual time limitation for an intraoral complete series are denied and the approved amount is collectable from the patient.

Benefits for panoramic image is limited to individuals age six and older.

D0340 2-D Cephalometric radiographic image – acquisition, measurement and analysis

A cephalometric radiographic image is payable only in conjunction with orthodontic benefits. The fee for a cephalometric radiographic image taken in conjunction with services other than orthodontic treatment is denied and the approved amount is collectable from the patient.

D0350 2D oral/facial photographic images obtained intraorally or extraorally

Oral/facial images are benefitted only once per case in conjunction with orthodontic services.

Benefits for oral/facial images taken in conjunction with any other procedure are denied, and the approved amount is collectable from the patient.

D0351 3D photographic image

3D photographic image is denied as a specialized technique, and the approved amount is collectable from the patient.

D0364 Cone beam CT capture and interpretation with limited field of view – less than one whole jaw

The fee for the cone beam CT capture and interpretation with limited field of view – less than one whole jaw is denied.

D0365 Cone beam CT capture and interpretation with field of view of one full dental arch – mandible

The fee for cone beam CT capture and interpretation with field of view of one full dental arch – mandible is denied.

D0366 Cone beam CT capture and interpretation with field of view of one full dental arch – maxilla with or without cranium

The fee for cone beam CT capture and interpretation with field of view of one full dental arch – maxilla with or without cranium is denied.

D0367 Cone beam CT capture and interpretation with field of view of both jaws, with and without cranium

The fee for cone beam CT capture and interpretation with field of view of both jaws, with and without cranium is denied.

D0368 Cone beam CT capture and interpretation for TMJ series including two or more exposures.

The fee for cone beam CT capture and interpretation for TMJ series including two or more exposures is denied.

D0369 Maxillofacial MRI capture and interpretation

The fee for maxillofacial MRI capture and interpretation is denied.

D0370 Maxillofacial ultrasound capture and interpretation

The fee for maxillofacial ultrasound, capture and interpretation is denied.

D0371 Sialoendoscopy capture and interpretation

The fee for sialoendoscopy capture and interpretation is denied.

Diagnostic Imaging – Image Capture Only

GP When image capture only procedures are submitted with capture and interpretation procedures, the fee for the image capture only procedure will be disallowed.

D0380 Cone beam CT image capture with limited field of view – less than one whole jaw

The fee for cone beam CT image capture with limited field of view – less than one whole jaw is denied.

D0381 Cone beam CT image capture with field of view one full dental arch – mandible

The fee for cone beam CT image capture with field of view one full dental arch – mandible is denied.

D0382 Cone beam CT image capture with field of view one full dental arch – maxilla, with and without cranium

The fee for cone beam CT image capture with field of view one full dental arch – maxilla, with and without cranium is denied.

D0383 Cone beam CT image capture field of view both jaws, with or without cranium

The fee for cone beam CT image capture field of view both jaws, with or without cranium is denied.

D0384 Cone beam CT image capture for TMJ series including two or more exposures

The fee for cone beam CT image capture for TMJ series including two or more exposures is denied.

D0385 Maxillofacial MRI image capture

The fee for maxillofacial MRI image capture is denied.

D0386 Maxillofacial ultrasound image capture

The fee for maxillofacial ultrasound image capture is denied.

Interpretation and Report Only

D0391 Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report

Benefits for interpretation of diagnostic image by a practitioner not associated with capture of the image, including report are denied.

Post Processing of Image or Image Sets

D0393 Treatment simulation using 3-D image volume

Treatment simulation using 3-D image volume is denied as a specialized technique.

D0394 Digital subtraction of two or more images or image volumes of the same modality

Digital subtraction of two or more images or image volumes is denied as a specialized technique.

D0395 Fusion of one two or more 3-D image volumes of the same modality

Fusion of two or more 3-D image volumes from the same modality is denied as specialized technique.

Tests and Examinations

D0411 HbA1c in-office point of service testing

Benefits for HbA1c in-office point of service testing are denied unless covered by group/individual contract.

When D0411 is submitted on the same date/same dentist/dental office as D0412, D0412 is disallowed.

D0412 Blood glucose level test: in office using a glucose meter

Benefits for blood glucose level test are denied unless covered by group/individual contract.

Fees for D0412 are disallowed on the same date/same dentist/dental office as D0411.

D0414 Laboratory processing of microbial specimen to include culture and sensitivity studies, preparation and transmission of written report

Benefits for laboratory processing of microbial specimen are denied unless covered by group/individual contract.

D0415 Collection of microorganisms for culture and sensitivity

Benefits for bacteriologic studies for determination of sensitivity of pathologic agents to antibiotics are denied and the approved amount is collectable from the patient.

D0416 Viral culture

Studies for determining pathologic agents are specialized procedures and the benefits are denied.

D0417 Collection and preparation of saliva sample for laboratory diagnostic testing

Benefits for the collection and preparation of a saliva sample are denied and the approved amount is collectable from the patient.

D0418 Analysis of saliva sample

Benefits for the analysis of a saliva sample are denied and the approved amount is collectable from the patient.

D0422 Collection and preparation of genetic sample material for laboratory analysis and report

Genetic tests for susceptibility to periodontal diseases are denied unless covered by group/individual contract.

D0423 Genetic test for susceptibility to diseases – specimen analysis

Genetic tests for susceptibility to periodontal diseases are denied unless covered by group/individual contract.

D0425 Caries susceptibility tests

Benefits for caries susceptibility tests are denied and the approved amount is collectable from the patient.

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

Adjunctive pre-diagnostic tests that aid in the detection of mucosal abnormalities are considered investigational and fees are denied.

D0460 Pulp vitality tests

Pulp vitality tests are payable per visit, not per tooth, and only for the diagnosis of emergency conditions. Fees for pulp tests are disallowed when performed on the same date by the same dentist/dental office as any other definitive procedure except radiographic images, limited oral evaluation – problem focused (D0140), protective restoration (D2940), palliative treatment (D9110), radiographic images (D0210 - D0391), and consultation (D9310).

D0470 Diagnostic casts
Diagnostic casts are a benefit once when performed in conjunction with orthodontic services. The fees for additional casts taken during or after orthodontic treatment by the same dentist/dental office are included in the fee for orthodontics and are disallowed.

The fees for cast restorations and prosthetic procedures include diagnostic casts. Any fees charged for diagnostic casts in excess of the approved amount for these procedures by the same dentist/dental office are disallowed. Benefits for diagnostic casts taken in conjunction with any other procedure are denied and the approved amount is collectable from the patient.

Oral Pathology Laboratory

GP All oral pathology procedures must be accompanied by a pathology report to be considered for payment. The fee for an oral pathology procedure not accompanied by a pathology report is disallowed.

GP The benefits for pathology reports submitted by anyone other than a licensed dentist are denied, and the approved amount is collectable from the patient.

GP 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.

GP Fees for the included procedures are disallowed and not billable to the patient by a participating dentist. These inter-related procedures include, but are not limited to, the following hierarchy:

Most inclusive	D0474
	D0473
	D0472
	D0480

GP All oral pathology procedures are by report and subject to medical coverage. Pathology reports, procedures D0472, D0473, and D0474 include preparation of tissue (sectioning, staining, etc.) and gross and microscopic examination. The fees for D0475, D0480, D0482 and D0483 are disallowed as being a component of the pathology procedures.

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 surgical margins for presence of disease, preparation and transmission of 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

D0481 Electron microscopy

D0482 Direct immunoflourescence

D0483 Indirect immunoflourescence

D0484 Consultation on slides prepared elsewhere

Consultation on slides prepared elsewhere is benefitted 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

D0486 Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report

D0502 Other oral pathology procedures, by report

Benefits for other oral pathology procedures for routine surgical procedures are denied and the approved amount is collectable from the patient.

D0600 Non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin, and cementum

The fees for D0600 are disallowed when submitted with an evaluation.

D0601 Caries risk assessment and documentation, with a finding of low risk

The fee for caries risk assessment is disallowed for children under age three.

The fee for caries risk assessment is disallowed when submitted with other risk assessment codes on the same date of service by the same dentist/dental office.

D0602 Caries risk assessment and documentation, with a finding of moderate risk

The fee for caries risk assessment is disallowed for children under age three.

The fee for caries risk assessment is disallowed when submitted with other risk assessment codes on the same date of service by the same dentist/dental office.

D0603 Caries risk assessment and documentation, with a finding of high risk

The fee for caries risk assessment is disallowed for children under age three.

The fee for caries risk assessment is disallowed when submitted with other risk assessment codes on the same date of service by the same dentist/dental office.

D0999 Unspecified diagnostic procedure, by report

Benefits for medical procedures such as but not limited to urine analysis, blood studies and skin tests are denied and the approved amount is collectable from the patient.

PREVENTIVE D1000 - D1999

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GP A fee for a prophylaxis done during the same episode of treatment by the same dentist/dental office as a periodontal maintenance, scaling in the presence of generalized moderate or severe gingival inflammation, scaling and root planing or periodontal surgery is considered to be part of those procedures and is disallowed.

GP Periodontal maintenance (D4910) is counted toward the contract limitation for prophylaxis and full mouth debridement (D4355).

Dental Prophylaxis

GP For payment purposes, the distinction between the adult and child dentition may be determined by contract. In the absence of group/individual contract language regarding age, a person age 14 and older is considered an adult for benefit determination purposes of a prophylaxis-adult. Any fee, for persons less than age 14 in excess of the approved amount for D1120 is disallowed and not chargeable to the patient.

D1110 Prophylaxis-adult

When submitted with D4346, the fees for D1110 are disallowed by the same dentist/dental office.

D1120 Prophylaxis-child

When submitted with D4346, the fees for D1120 are disallowed by the same dentist/dental office.

Fees for toothbrush prophylaxis are disallowed.

Topical Fluoride Treatment (office procedure)

GP Using prophylaxis paste containing fluoride, a fluoride rinse, or fluoride swish in conjunction with a prophylaxis is considered a prophylaxis only and a separate fee for

this type of topical fluoride application is disallowed on the same date of service and by the same dentist/dental office as the prophylaxis.

GP The age limitation for topical fluoride gel or varnish treatments determined by group/individual contract.

GP Fluoride gels, rinses, tablets, or other preparations intended for home applications are denied and the approved amount is collectable from the patient.

D1206 Topical fluoride varnish

The application of topical fluoride varnish, delivered on a single visit and involving the entire oral cavity. Benefits for topical fluoride varnish when used for desensitization or as cavity liner are denied.

D1208 Topical application of fluoride - excluding varnish

Other Preventive Services

D1310 Nutritional counseling for the control of dental disease

The benefit for nutritional counseling is denied and the approved amount is collectable from the patient.

D1320 Tobacco counseling for the control and prevention of oral disease

The benefit for tobacco counseling is denied unless covered by group/individual contract.

D1330 Oral hygiene instructions

The benefit for oral hygiene instruction is denied and the approved amount is collectable from the patient.

D1351 Sealant-per tooth

Sealants are payable once per tooth on the occlusal surface of permanent first and second molars for patients through age 15. The teeth must be free from overt dentinal caries (incipient caries sealing is preferred) or restorations on the occlusal surface. Special consideration for late eruption can be given by report.

A separate fee for sealant done on the same date of service and on the same surface as a restoration by the same dentist/dental office is considered a component of the restoration and is disallowed.

Benefits for sealants are denied and the approved amount is collectable from the patient when submitted documentation or the patient's claim history indicates an existing 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 24 months of initial placement is included in the fee for the initial placement and is disallowed. The benefit for repair or replacement of a sealant by a different dentist/dental office within 24 months of initial placement is denied and the approved amount is collectable from the patient.

Benefits for repair or replacement of sealants requested after 24 months have elapsed since initial placement are denied and the approved amount is collectable from the patient.

D1352 Preventive resin restoration in a moderate to high caries risk patient – permanent tooth

When covered by group/individual contract fees for preventive resin restoration completed on the same date of service and on the same surface as a restoration by the same dentist/dental office are disallowed as a component of the restoration.

Fees for replacement of preventive resin restoration are disallowed if performed within 24 months of initial placement of preventive resin restoration and/sealant by the same dentist/dental office.

D1353 Sealant repair – per tooth

Fees for repairing sealants completed on the same date of service and on the same surface as a restoration by the same dentist/dental office are disallowed as a component of the restoration.

Benefits to repair sealants are denied when submitted documentation or the patient's claims history indicates a restoration on the occlusal surface of the same tooth.

Fees for repair or replacement of a sealant are disallowed if performed within 24 months of initial placement by the same dentist/dental office.

Benefits for repairing sealants requested 24 months or more following the initial placement are denied or covered based on group/individual contract.

D1354 Interim caries arresting medicament application- per tooth

Benefits are limited to two applications per tooth per benefit year.

Benefits for more than two applications per tooth per benefit year are denied.

Fees for D1354 are disallowed when done on the same date of service as a restoration.

Benefits for restorations placed within three month of interim caries arresting medicament application are denied.

Space Maintenance (passive appliances)

GP The benefits for repair or replacement of a space maintainer are denied and the approved amount is collectable from the patient.

GP Only one space maintainer is provided for a space per quadrant per lifetime. Additional appliances are denied and the approved amount is collectable from the patient.

GP Space maintainers for missing primary anterior teeth, missing permanent teeth, or for persons age 14 or over are denied and the approved amount is collectable from the patient.

GP Space maintainer fees include all teeth, clasps and rests. Any fee charged in excess of the approved amount for the appliance by the same dentist/dental office is disallowed.

D1510 Space maintainer-fixed unilateral

D1516 space maintainer – fixed – bilateral, maxillary

D1517 space maintainer – fixed – bilateral, mandibular

D1520 Space maintainer-removable unilateral

D1526 Space maintainer – removable - bilateral, maxillary

D1527 Space maintainer – removable - bilateral, mandibular

D1550 Re-cement or rebond space maintainer

One recementation or rebonding is allowed per space maintainer. Benefits for subsequent requests for recementation or rebonding by the same office are denied and the approved amount is collectable from the patient.

D1555 Removal of fixed space maintainer

The fee for removal of a fixed space maintainer by the same dentist/dental office who placed the appliance is disallowed.

The fee for removal of a fixed maintainer is disallowed when submitted with recementation.

D1575 Distal shoe space maintainer - fixed – unilateral

Limited to children 8 and younger.

Fees for repairs and adjustments by same dentist/dental office are disallowed.

D1999 Unspecified preventive procedure, by report

RESTORATIVE D2000 - D2999

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GP 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 by the same dentist/dental office is disallowed.

GP A fee for the replacement of amalgam or composite restorations, same tooth and same surface(s), is disallowed if done by the same dentist/dental office within 24 months of the initial restoration. Benefits may be denied and the approved amount for the restoration collectable from the patient if done by a different dentist/dental office.

GP When multiple restorations involving the proximal and occlusal surfaces of the same tooth are requested or performed, the allowance is limited to that of a multi-surface restoration. Any fee charged in excess of the allowance for the multi-surface restoration by the same dentist/dental office is disallowed. A separate benefit may be allowed for a noncontiguous restoration on the buccal or lingual surface(s) of the same tooth.

GP Any restoration involving two or more contiguous surfaces should be reported using the appropriate multiple surface restoration code.

GP When restorations not involving the occlusal surface are requested or performed on posterior teeth, the allowance is limited to that of a one surface restoration. Any fee charged in excess of the allowance for the one-surface restoration is disallowed.

GP Benefits are allowed only once per surface in a 24 month interval, irrespective of the number or combination of procedures requested or performed. A fee for restoration of a surface within 24 months of previous treatment is disallowed if done by the same dentist/dental office. Benefits are denied and the approved amount is collectable from the patient if done by a different dentist/dental office.

GP Multistage procedures are reported and benefitted 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.

GP If an indirectly fabricated restoration is performed by the same dentist/dental office within 24 months of the placement of an amalgam or composite restoration the Delta Dental payment and patient co-payment allowance for the amalgam or composite restorations will be deducted from the indirectly fabricated restoration benefit.

GP Tooth preparation, temporary restorations, cement bases, impressions, laboratory fees and material, occlusal adjustment, gingivectomies (on the same date of service), and local anesthesia are considered to be included in the fee for all restorations, and a separate fee for any of these procedures by the same dentist/dental office is disallowed. Fees for buildups, not required for retention are disallowed.

GP Benefits 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 approved amount is collectable from the patient.

GP Biomimetic restorations (e.g. Biodentine) are denied as investigational.

Definitions

Attrition

1. The frictional wearing of the teeth over time. Severe attrition, due to bruxing may be evident. (Treatment Planning in Dentistry; Mosby 2006).
2. The loss of tooth structure from tooth to tooth contact. (Lee, Eakle. J Prosthet Dent 1996; 75:487).

Abrasion

1. Wearing away or notching of the teeth by a mechanical means, such as tooth brushing. (Treatment Planning in Dentistry; Mosby 2006).
2. The grinding or wearing away of tooth substance by mastication, incorrect brushing methods, bruxism or similar causes. (Mosby's Dental Dictionary).
3. The abnormal wearing away of a substance or tissue by a mechanical process. (Mosby's Dental Dictionary).
4. The loss of tooth structure from the mechanical rubbing of teeth by some object or objects (no source)
5. The act or result of the grinding or wearing away of a substance, such as a tooth worn by mastication, bruxing or tooth brushing. (The Glossary of Operative Dentistry Terms).

Erosion

1. The wasting away or loss of substance of a tooth by a chemical process that does not involve known bacterial action. (Treatment Planning in Dentistry; Mosby 2006).
2. The process and the results of loss of dental hard tissue that is chemically etched away from the tooth surface, by acid and/or chelation, without bacterial involvement. (ten Cate & Imfeld, Eur J Oral Sci 1996; 104:241).

Abfraction

Pathological loss of tooth structure owing to biomechanical forces (flexion, compression, or tension) or chemical degradation; it is most visible as V-shaped notches in the cervical area of a tooth. (Mosby's Medical Dictionary, 9th edition; 2009 Elsevier)

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

Resin–Based Composite Restorations-Direct

GP 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.

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

GP Benefits for resin based composite restorations on posterior teeth are determined by group/individual contract.

D2391 Resin - based composite - one surface, posterior

D2392 Resin - based composite - two surfaces, posterior

D2393 Resin - based composite - three or more surfaces, posterior

D2394 Resin - based composite - four or more surfaces, posterior

Gold Foil Restorations

GP An alternate benefit allowance is made for an amalgam or resin restoration, according to the policies for amalgam or resin restorations. The difference between the allowance for the amalgam or resin restoration and the approved amount for the gold foil restoration is denied and collectable from the patient.

D2410 Gold foil - one surface

D2420 Gold foil - two surfaces

D2430 Gold foil - three surfaces

Inlay/ Onlay Restorations

Inlay: An intra-coronal dental restoration, made outside the oral cavity to conform to the prepared cavity, which does not restore any cusp tips.

Onlay: A dental restoration made outside the oral cavity that covers one or more cusp tips and adjoining occlusal surfaces, but not the entire external surface.

GP 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 alternative benefit and the approved amount for the inlay/onlay restoration is denied and collectable from the patient.

GP For inlay restorations, an alternate benefit allowance is made for an amalgam or resin restoration, according to the policies for amalgam and resin restorations. The difference between the allowance for the amalgam or resin restoration and the approved amount for the inlay restoration is denied and collectable from the patient.

GP Crowns and indirectly fabricated restorations are optional benefits unless the tooth is damaged by decay or fracture to the point it cannot be restored by an amalgam or resin restoration. If the fee for a crown or indirectly fabricated restoration is not allowed, an alternate benefit allowance for an amalgam or resin restoration is made according to the policies for those restorations and the difference between the

allowance for the amalgam or resin restoration and the approved amount for the crown or indirectly fabricated restoration is denied and collectable from the patient.

GP Benefits for crowns and onlays are denied and the approved amount is collectable from the patient for children under 12 years of age.

GP Onlays are considered to cover one or more cusps and include the inlay. Onlays are only benefitted when the tooth would otherwise qualify for a crown based on degree of breakdown.

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

Porcelain/ceramic inlays/onlays include all indirect ceramic and porcelain type inlays/onlays.

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

Resin-based composite inlays/onlays must utilize indirect technique.

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

Crowns - Single Restorations Only

GP Crowns and indirectly fabricated restorations are optional benefits unless the tooth is damaged by decay or fracture to the point it cannot be restored by an amalgam or resin restoration. If the fee for a crown or indirectly fabricated restoration is not allowed, an alternate benefit allowance for an amalgam or resin restoration is made according to the policies for those restorations and the difference between the allowance for the amalgam or resin restoration and the approved amount for the crown or indirectly fabricated restoration is denied and collectable from the patient.

GP Benefits for crowns and onlays are denied and the approved amount is collectable from the patient for children under 12 years of age.

D2710 Crown - resin-based composite (indirect)

D2712 Crown – ¾ 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

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 - ¾ cast high noble metal

D2781 Crown - ¾ cast predominantly base metal

D2782 Crown - ¾ 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

The fee for a provisional crown by the same dentist/dental office is disallowed as a component of the fee for a permanent crown.

When a temporary or provisional crown is billed as a therapeutic measure for a fractured tooth, it may be benefitted subject to individual consideration.

Other Restorative Services

GP Delta Dental considers the cementation date to be that date upon which the completed or indirectly fabricated post, prefabricated post and core, inlay, onlay, crown, or fixed partial denture is first delivered to the mouth. The type of cement used is not a determining factor (whether permanent or temporary).

GP Fees for recementation or rebonding of indirectly fabricated or prefabricated post and cores, inlays, onlays, crowns, and fixed partial dentures are disallowed if done within six months of the initial seating date by the same dentist or dental office.

GP Benefits may be paid for one recementation or rebonding after six months have elapsed since initial placement. Subsequent requests for recementation or rebonding by the same provider are denied and the approved amount is collectable from the patient. Benefits may be paid when billed by a provider other than the one who seated the bridge or performed the previous recementation or rebonding.

GP Post recement or rebond (D2915) and crown recement or rebond (D2920) are not allowed on the same tooth on the same day by the same dentist/dental office. The allowance will be made only for D2920 when D2915 and D2920 are submitted together. The fee for D2915 will be disallowed

GP Fees for crown, inlay, onlay and veneer repairs are disallowed within 24 months of the original restoration.

D2910 Recement or rebond inlay, onlay, veneer or partial coverage restoration

D2915 Recement or rebond indirectly fabricated or prefabricated post and core

D2920 Recement or rebond crown

D2921 Reattachment of tooth fragment, incisal edge or cusp

Fees for the replacement of amalgam or composite restorations or attachment of tooth fragment within 24 months are disallowed if done by the same dentist/dental office. Benefits may be allowed if done by a different dentist.

D2929 Prefabricated porcelain/ceramic crown – primary tooth

A fee for replacement of a prefabricated porcelain/ceramic crown by the same dentist/dental office within 24 months is included in the initial crown placement and is disallowed.

D2930 Prefabricated stainless steel crown - primary tooth

A fee for replacement of a stainless steel crown on a primary tooth by the same dentist/dental office within 24 months is included in the initial crown placement and is disallowed.

D2931 Prefabricated stainless steel crown - permanent tooth

A fee for replacement of a stainless steel crown on a permanent tooth by the same dentist/dental office within 24 months is included in the initial crown placement and is disallowed.

D2932 Prefabricated resin crown

A prefabricated resin crown is a benefit only on anterior primary teeth. If submitted for a posterior primary tooth or for a permanent tooth, an alternate benefit allowance for D2930 or D2931 is made. The difference between the allowance for the D2930 or D2931 and the approved amount for the D2932 is denied and collectable from the patient.

D2933 Prefabricated stainless steel crown with resin window

A prefabricated stainless steel crown with resin window is a benefit only on anterior primary teeth. If submitted for a posterior primary tooth or for a permanent tooth, an

alternate benefit allowance for D2930 or D2931 is made. The difference between the allowance for the D2930 or D2931 and the approved amount for the D2933 is denied and collectable from the patient.

A fee for replacement of a stainless steel crown on a primary or permanent tooth by the same dentist/dental office within 24 months is included in the initial crown placement and is disallowed.

D2934 Prefabricated esthetic coated stainless steel crown – primary tooth

A prefabricated esthetic coated stainless steel crown is a benefit only on anterior primary teeth. If submitted for a posterior primary tooth or for a permanent tooth, an alternate benefit allowance for D2930 or D2931 is made. The difference between the allowance for the D2930 or D2931 and the approved amount for the D2934 is denied and collectable from the patient

A fee for replacement of a stainless steel crown on a primary or permanent tooth by the same dentist/dental office within 24 months is included in the initial crown placement and is disallowed

Benefits may be allowed with the same processing policies and edits as a D2933 if performed on permanent teeth and subject to individual consideration.

D2940 Protective restoration

Protective restorations are a benefit for emergency relief of pain.

A separate fee for protective restoration is disallowed when performed in conjunction with a definitive restoration or endodontic access closure by the same dentist/dental office on the same date of service.

D2941 Interim therapeutic restoration – primary dentition

Interim therapeutic restoration is disallowed in conjunction with definitive restoration within 24 months.

D2949 Restorative foundation for an indirect restoration

This procedure is a component of the definitive indirect restoration. Fees are disallowed.

02950 Core buildup, including any pins when required

Substructures are a benefit only when necessary to retain an indirectly fabricated restoration due to extensive loss of tooth structure from caries or fracture. The procedure should not be reported when the procedure only involves a filler to eliminate any undercut, box form, or concave irregularity in the preparation. Fees for buildups not required for retention are disallowed.

A separate fee for a buildup is disallowed when radiographs indicate sufficient tooth structure remains to support an indirectly fabricated restoration.

D2951 Pin retention-per tooth, in addition to restoration

Pin retention is a benefit once per tooth when necessary on a permanent tooth and when completed at the same appointment. Fees for additional pins on the same tooth by the same dentist/dental office are disallowed as a component of the initial pin placement.

A fee for pin retention when billed in conjunction with a buildup by the same dentist/dental office is disallowed as a component of the buildup procedure.

D2952 Post and core in addition to crown, indirectly fabricated

An indirectly fabricated post and core in addition to crown is a benefit only on an endodontically treated tooth. The fee for an indirectly fabricated post and core is disallowed when radiographs indicate an absence of endodontic treatment and incompletely filled canal space. Unresolved radiolucencies may be a reason to disallow, but will be evaluated based on the time since the completion of the endodontic service and co-joint signs and symptoms.

An indirectly fabricated post and core in anterior teeth is a benefit only when there is insufficient tooth structure to support a cast restoration.

When radiographs indicate more than half of the coronal tooth structure remains, the benefits for post and core are denied.

D2953 Each additional indirectly fabricated post- same tooth

D2954 Prefabricated post and core in addition to crown

A prefabricated post and core in addition to crown is a benefit only on an endodontically treated tooth. The fee for a prefabricated post and core is disallowed

when radiographs indicate an absence of endodontic treatment and incompletely filled canal space.

A prefabricated post and core in anterior teeth is a benefit only when there is insufficient tooth structure to support a cast restoration.

When radiographs indicate more than half of the coronal tooth structure remains, the benefits for post and core are denied.

D2955 Post removal

The fee for post removal when the procedure is submitted by the same dentist/office rendering retreatment is disallowed as a component of the fee for the retreatment.

D2957 Each additional prefabricated post in the same tooth

D2960 Labial veneer (resin laminate) – chairside

D2961 Labial veneer (resin laminate) - laboratory

D2962 Labial veneer (porcelain laminate) – laboratory

Benefit are determined by group/individual contract.

A veneer could be a benefit in cases where the criteria for a crown is met. In such a case the policies for indirectly fabricated restorations apply.

D2971 Additional procedures to construct new crown under existing partial denture framework

D2975 Coping

Copings are considered an integral part of the final restoration. Additional fees are denied.

D2980 Crown repair, necessitated by restorative material failure

Fees for a crown repair completed on the same date of service as a new crown are disallowed.

Fees for repairs are disallowed within 24 months of the original restoration by the same dentist/dental office. Benefits are denied if done by a different dentist/dental office.

D2981 Inlay repair, necessitated by restorative material failure

Fees for inlay repairs completed on the same date of service as a new inlay are disallowed.

D2982 Onlay repair, necessitated by restorative material failure

Fees for onlay repairs completed on the same date of service as a new onlay are disallowed.

Fees for repairs are disallowed within 24 months of the original restoration by the same dentist/dental office. Benefits are denied if done by a different dentist/dental office.

D2983 Veneer repair, necessitated by restorative material failure

Fees for veneer repairs completed on the same date of service as a new veneer are disallowed.

Fees for repairs are disallowed within 24 months of the original restoration by the same dentist/dental office. Benefits are denied if done by a different dentist/dental office.

D2990 Resin infiltration of incipient smooth surface lesions

Benefits for resin infiltration of incipient smooth surface lesions are denied as investigational.

D2999 Unspecified restorative procedure, by report

ENDODONTICS D3000 - D3999

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GP Endodontic retreatment may include the removal of a post, pin(s), old root canal filling material, and the procedures necessary to prepare the canals and place the canal filling. This includes complete root canal therapy. Separate fees for these procedures by the same dentist/dental office are disallowed as included in the fees for the retreatment.

Pulp Capping

GP Fees for direct or indirect pulp caps are disallowed when provided by the same dentist/dental office in conjunction with the final restoration for the same tooth.

GP Benefits for root canal therapy done in conjunction with an overdenture are denied and the approved amount is collectable from the patient.

D3110 Pulp cap-direct (excluding final restoration)

Fees for the pulp cap performed with a restoration by the same dentist/dental offices are disallowed.

D3120 Pulp cap-indirect (excluding final restoration)

Pulpotomy

D3220 Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament.

The benefit for a pulpotomy provided on a permanent tooth is processed as palliative treatment (D9110) and the fees in excess of the palliative treatment are disallowed.

Fee for therapeutic pulpotomy are disallowed in conjunction with a root canal procedure.

D3221 Pulpal debridement, primary and permanent teeth

The fee for gross pulpal debridement is disallowed when endodontic treatment is completed on the same tooth on the same day by the same dentist/dental office. Unusual cases may be referred for individual consideration.

Fees for palliative treatment are disallowed when submitted by the same dentist/dental office.

D3222 Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development

Fees for Partial pulpotomy for apexogenesis are disallowed when performed within 30 days/same tooth/same dentist/same dental office as root canal therapy or codes D3351-D3353.

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)

Benefits for a root canal are denied when a pulpectomy or pulpotomy are billed and radiographs reveal insufficient root structure, internal resorption, furcal perforation or extensive periapical pathosis.

Endodontic Therapy (including treatment plan, clinical procedures and follow-up care)

GP The fee for a root canal includes all radiographic images during treatment and temporary restorations. Any additional fees by the same dentist/dental office are disallowed.

GP When a radiographic image indicates obturation of an endodontically treated tooth has been performed without the use of a biologically acceptable nonresorbable semisolid or solid core material, fees for the endodontic therapy and/or restoration of the tooth are disallowed.

GP The completion date for endodontic therapy is the date that the canals are permanently filled.

GP Difficult removal of broken instrument or posts by a different dentist/dental office is subject to individual consideration.

D3310 Endodontic therapy - anterior tooth (excluding final restoration)

D3320 Endodontic therapy - premolar tooth (excluding final restoration)

A separate 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.

Incompletely filled root canals are not a benefit and the fee for the endodontic therapy is disallowed.

D3330 Endodontic therapy – molar tooth (excluding final restoration)

A separate 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.

Incompletely filled root canals are not a benefit and the fee for the endodontic therapy is disallowed.

D3331 Treatment of root canal obstruction; non-surgical access

D3331 is considered a component of a root canal. The fee for the procedure by the same dentist/dental office is disallowed.

The fee for D2955, post removal, is not included in this procedure.

D3332 Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth

D3332 is subject to individual consideration, by report.

D3333 Internal root repair of perforation defects

Internal root repair is considered apexification/recalcification – initial visit (D3351) for benefit purposes. It is subject to the same processing policies as apexification/recalcification – initial visit.

The fee for) internal root repair of perforation defects is disallowed when done in conjunction with an apicoectomy and/or retrograde filling by the same dentist/dental office.

The benefit for D3333 is denied if reported on a primary tooth.

The fee for internal root repair of perforation defects is disallowed on the same date of service as apicoectomy.

The fee for internal root repair of perforation defects is disallowed if perforation is iatrogenic by the same dentist/dentist office.

Endodontic Retreatment

GP Endodontic retreatment may include the removal of a post, pin(s), old root canal filling material, and the procedures necessary to prepare the canals and place the canal filling. This includes complete root canal therapy. Separate fees for these procedures by the same dentist/dental office are disallowed as included in the fees for the retreatment.

GP The fee for retreatment of root canal therapy or retreatment of apical surgery by the same dentist/dental office within 24 months of initial treatment is disallowed as a component of the fee for the original procedure. Benefits by another dentist/dental office are denied.

D3346 Retreatment of previous root canal therapy – anterior

D3347 Retreatment of previous root canal therapy – premolar

D3348 Retreatment of previous root canal therapy – molar

Apexification/Recalcification

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

Apexification is eligible for benefits on permanent teeth with incomplete root development or for repair of a perforation.

D3352 Apexification/recalcification - interim medication replacement

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

Apexification/recalcification - final visit benefits are administered as the same processing policies as D3310, D3320, or D3330 (depending on tooth type) and any fee charged in excess of the approved amount for the D3310, D3320, or D3330 (depending on the tooth type) is disallowed.

Pulpal Regeneration

D3355 Pulpal Regeneration - initial visit

This procedure is considered experimental and benefits are denied and the approved amount is collectable from the patient.

D3356 Pulpal regeneration – interim medication replacement

This procedure is considered experimental and benefits are denied and the approved amount is collectable from the patient.

D3357 Pulpal regeneration – completion of treatment

This procedure is considered experimental and benefits are denied and the approved amount is collectable from the patient.

Apicoectomy/Periradicular Services

GP The fee for biopsy of oral tissue is disallowed as included in the fee for a surgical procedure (e.g. apicoectomy) when performed in the same location and on the same date of service by the same dentist/dental office.

D3410 Apicoectomy - anterior

D3421 Apicoectomy - premolar (first root)

D3425 Apicoectomy - molar (first root)

D3426 Apicoectomy (each additional root)

D3427 Periradicular surgery without apicoectomy

Disallow when performed on the same tooth by the same dentist/dental office on the same date as apicoectomy (D3410-D3426), retrograde filling (D3430), and root amputation (D3450).

D3428 Bone graft in conjunction with periradicular surgery - per tooth; first surgical site

Benefits for these procedures when billed in conjunction with periradicular surgery are denied as specialized technique.

D3429 Bone graft in conjunction with periradicular surgery - each additional contiguous tooth in same surgical site.

Benefits for these procedures when billed in conjunction with periradicular surgery are denied as specialized technique.

D3430 Retrograde filling - per root

Retrograde filling includes all retrograde procedures per root. Any fee charged in excess of the allowance for a retrograde filling by the same dentist/dental office is disallowed.

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 periradicular surgery, etc. are denied as a specialized technique.

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 periradicular surgery are denied as a specialized technique.

D3450 Root amputation - per root

A separate fee for root amputation is disallowed when performed in conjunction with an apicoectomy by the same dentist/dental office.

D3460 Endodontic endosseous implant

D3470 Intentional reimplantation (including necessary splinting)

Intentional reimplantation is considered a specialized procedure. Benefits are denied and the approved amount is collectable from the patient.

Other Endodontic Procedures

D3910 Surgical procedure for isolation of tooth with rubber dam

A separate fee for isolation of a tooth with a rubber dam by the same dentist/dental office 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

A separate fee for canal preparation and fitting of preformed dowel or post by the same dentist/dental office is disallowed as a component of the fee for the post or root canal therapy.

D3999 Unspecified endodontic procedure, by report

PERIODONTICS D4000 - D4999

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GP When more than one surgical procedure is provided on the same teeth on the same day, benefits are based upon, but not limited to, the most inclusive procedure.

GP The fee for the following services: D1110, D1120, D4355, and/or D4910 may be disallowed if the services are rendered by the same dentist/dental office within 30 days after the most recent scaling and root planing (D4341, D4342) or other periodontal therapy.

GP Fees for the included procedures are disallowed and not billable to the patient by a participating dentist/dental office. These inter-related services include but are not limited to the following hierarchy:

D4260 (most inclusive), D4261, D6103, D4249, D4245, D4268, D4240, D4241, D6102, D4274, D4210, D4211, D4212, D4341, D4342, D4346, D4355, D4910, D1110, D1120 (least inclusive)

GP Periodontal services are only benefitted 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, extraction sites and/or periradicular surgery are denied and the approved amount is collectable from the patient.

GP The fee for biopsy (D7285, D7286), frenulectomy (D7960) and excision of hard and soft tissue lesions (D7410, D7411, D7450, D7451) are disallowed when the procedures are by the same dentist/ dental office performed on the same date, same surgical site/area, and any other surgical procedure. Request for individual consideration can always be submitted, by report, for the dental consultant for review.

GP Laser disinfection is a technique, not a procedure. Fees for laser disinfection are disallowed. If done as a standalone procedure, the benefit for laser disinfection is denied and the approved amount is collectable from the patient.

GP The fees for low level laser therapy when performed as part of another procedure are disallowed. When billed as a standalone procedure, benefits for low level laser therapy are denied as investigational.

GP Benefits for laser biostimulation as a standalone procedure are denied as investigational.

GP Periodontal charting is considered as part of the oral evaluation (D0120, D0150, D0160, D0180). If periodontal evaluation and oral evaluation are billed on the same date of service the fee for the oral evaluation (D0120, D0150, D0160) is a benefit and the fee for the periodontal evaluation is disallowed.

GP When periodontal charting is requested for surgical and non-surgical procedures it must be submitted with a periodontal chart dated no more than 12 months prior to the date of service.

GP Perioscopy is a technique not a procedure. The fees for perioscopy are disallowed.

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.

Radiographs must show loss of alveolar crest height beyond the normal 1-1.5 millimeter distance to the cemento-enamel junction (CEJ). Note: panoramic radiographs per American Academy of Periodontology have limited value in the diagnosis of periodontal disease.

In the case of procedure codes D4341 and D4342 there must be radiographic documentation of bone loss or loss of clinical attachment on the diseased teeth/periodontium involved. In the absence of bone loss or loss of clinical attachment, a benefit allowance for a prophylaxis (D1110) or scaling in the presence of moderate to severe gingival inflammation (D4346) is made and any fee in excess of the approved amount for D1110 is chargeable to the patient.

Prior to periodontal surgery, a waiting period of a minimum of four weeks should typically follow periodontal scaling and root planing to allow for healing and re-evaluation and to assess tissue response.

Quadrant: D4210, D4260, D4240 D4341

Site: a site is defined by the current ADA CDT manual.

Sites: D4249, D4263, D4264, D4265, D4266, D4267, D4268, D4270, D4273, , D4275, D4276, D4277, D4278, D4283, D4285, D4320, D4321, D6081, D6101, D6102 and D6103

One to three diseased teeth/periodontium per quadrant: D4211, D4231 D4241, D4261, D4342

Per tooth: D4212, D4268, D4273, D4276, D4277, D4278, D4283, D4285, D6081, D6101, D6102, D6103

Per implant: D6101, D6102, D6103

Surgical Services (including usual postoperative care)

GP A separate fee for all necessary postoperative care, finishing procedures (D1110, D1120, D4341, D4342, D4355, D4910), evaluations, or other surgical procedures on the same date of service or for three months following the initial periodontal surgery in relation to both natural teeth and implants by the same dentist/dental office is disallowed. In the absence of documentation of extraordinary circumstances, the fee for additional surgery or for any surgical re-entry by the same dentist/dental office for 36 months is disallowed.

If extraordinary circumstances are present the benefits will be denied and are the patient's responsibility up to the approved amount for the surgery.

GP If periodontal surgery is performed less than four weeks after scaling and root planing, the fee for the surgical procedure or the scaling and root planing may be disallowed following consultant review.

GP Periodontally involved teeth which would qualify for surgical pocket reduction benefits under these procedure codes (D4210, D4211, D4240, D4241, D4260, D4261) must be documented to have at least 5 mm pocket depths and bone loss beyond 1-1.5 millimeters. If pocket depths are under 5 mm, then benefits are denied.

GP Benefits for periodontal surgical services are available only when billed for natural teeth. Benefits for these procedures when billed in conjunction with implants, ridge augmentation, extraction sites, periradicular surgery, etc. are denied as a specialized or elective procedure.

GP Providing more than two, D4265, D4266, D4267, D4270, D4273, D4275, D4276, D4277, D4278, D4283, D4285 D6101, D6102, or osseous grafts (D4263,D4264, D6103) within any given quadrant should be highly unusual and additional submissions will only be considered on a by report basis. When documentation of exceptional circumstances is submitted, benefits may be denied, unless covered, dependent on group/individual contract language.

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

D4211 Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant

A separate fee for gingivectomy or gingivoplasty - per tooth is disallowed when performed in conjunction with the preparation of a crown or other restoration by the same dentist/dental office.

Only diseased teeth/periodontium are eligible for benefit consideration. Bounded tooth spaces are not counted as the procedure does not require a flap extension.

D4212 Gingivectomy or gingivoplasty – to allow access for restorative procedures – per tooth

A separate fee for any gingivectomy or gingivoplasty procedure - per tooth is disallowed when performed in conjunction with the preparation of a crown or other restoration by the same dentist/dental office.

D4230 Anatomical crown exposure – four or more contiguous teeth or tooth bounded spaces teeth per quadrant

Anatomical crown exposure is considered cosmetic in nature and therefore denied by group/individual contracts that exclude cosmetic services.

D4231 Anatomical crown exposure – one to three teeth or tooth bounded spaces per quadrant

Anatomical crown exposure is considered cosmetic in nature and therefore denied by group/individual contracts that exclude cosmetic services.

D4240 Gingival flap procedure, including root planing – four or more contiguous teeth or tooth bounded spaces per quadrant

D4241 Gingival flap procedure, including root planing - one to three contiguous teeth, or tooth bounded spaces per quadrant

Benefits are based upon, but not limited to, the most inclusive procedure. A tooth bounded space counts as one space irrespective of the number of teeth that would normally exist in the space. Only diseased natural teeth/periodontium are eligible for benefit consideration.

D4245 Apically positioned flap

Benefits are based upon, but not limited to, the most inclusive procedure.

D4249 Clinical crown lengthening - hard tissue

A separate fee for crown lengthening is disallowed when performed in conjunction with osseous surgery on the same teeth by the same dentist/dental office.

Crown lengthening is a benefit per site, not per tooth, when adjacent teeth are included. This procedure is carried out to expose sound tooth structure by removal of bone before restorative or prosthodontic procedures. It is not generally provided in the presence of periodontal disease. This is only a benefit when bone is removed and sufficient time is allowed for healing.

The fees for crown lengthening are disallowed when performed on the same date as the final restoration placement.

D4260 Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.

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 quadrants of osseous surgery on the same date of service are benefitted, in the absence of a narrative explaining exceptional circumstance.

For benefit purposes, the fee for osseous surgery includes crown lengthening, osseous contouring, distal or proximal wedge surgery, scaling and root planing, gingivectomy, frenectomy, frenuloplasty, debridements, periodontal maintenance, prophylaxis, anatomical crown exposure, surgical drainage and flap procedures. A separate fee for any of these procedures done on the same date, in the same surgical area by the same dentist/dental office, as D4260 is disallowed. A separate benefit may be available for soft tissue grafts, bone replacement grafts, guided tissue regeneration, biologic materials with demonstrated efficacy in aiding periodontal tissue regeneration, exostosis removal, hemisection, extraction, apicoectomy, root amputations.

For dental benefit reporting purposes a quadrant is defined as four or more contiguous teeth and tooth bounded spaces per quadrant. A tooth bounded space counts as one space irrespective of the number of teeth that would normally exist in the space. Only diseased natural teeth/periodontium are eligible for benefit consideration.

D4263 Bone replacement graft – retained natural tooth first site in quadrant

Up to two teeth per quadrant may be benefitted.

Bone replacement grafts are denied when submitted with apicoectomy sites, implants, mucogingival/soft tissue grafts, periradicular surgery, ridge augmentation or preservation procedures, sinus elevation, defects from cyst removal, hemisections or with extractions.

D4264 Bone replacement graft – retained natural tooth, each additional site in quadrant

Up to two teeth per quadrant may be benefitted.

Bone replacement grafts are denied when submitted with apicoectomy sites, implants, mucogingival/soft tissue grafts, periradicular surgery, ridge augmentation or preservation procedures, sinus elevation, defects from cyst removal, hemisections or with extractions.

D4265 Biologic materials to aid in soft and osseous tissue regeneration

Biologic materials may be eligible for stand-alone benefits when reported with periodontal flap surgery (D4240, D4241, D4245, D4260 and D4261)
Benefits are available only when billed for natural teeth.

When submitted with a D4263, D4264, D4266, D4267, D4270, D4273, D4275, D4276, D4277, D4278, D4283, D4285, D4341, or D4342 in the same surgical site, the fee for the D4265 is denied.

Benefits for D4265 when billed in conjunction with implants or other oral surgical procedures are denied as a specialized procedure.

D4266 Guided tissue regeneration - resorbable barrier, per site

Benefits for GTR are denied in conjunction with soft tissue grafts in the same surgical area.

Benefits for these procedures when billed in conjunction with implants, ridge augmentation, extraction sites, periradicular surgery, etc., are denied and the approved amount collectible from the patient.

D4267 Guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal)

Benefits for GTR are denied in conjunction with soft tissue grafts in the same surgical area.

Benefits for these procedures when billed in conjunction with implants, ridge augmentation, extraction sites, periradicular surgery, etc., are denied and the approved amount collectible from the patient.

D4268 Surgical revision procedure, per tooth

The fee for D4268 is considered a component of the surgical procedure and is disallowed.

If D4268 is performed by the same dentist/dental office within 36 months of previous periodontal surgery, the fee for the procedure is disallowed. It may be eligible for consideration under dentist consultant review.

If D4268 is performed within the specified time limits by a different office/dentist, the contractual time limits would apply and the fee is denied and the approved amount is collectable from the patient.

D4270 Pedicle soft tissue graft procedure

When multiple grafts are provided within a single quadrant, benefits are limited up to two teeth or soft tissue grafts per quadrant.

D4273 Autogenous connective tissue graft procedures, (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft

Benefits for GTR, in conjunction with soft tissue grafts in the same surgical area, are denied.

Benefits are limited to up to two teeth or soft tissue grafts per quadrant.

D4274 Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)

D4275 Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft

D4275 may be eligible for benefit consideration in lieu of D4265, D4266, D4267, D4270, D4273, D4276, D4277 and D4278.

When multiple sites are provided within a single quadrant benefits are limited to up to two teeth or soft tissue grafts per quadrant.

Benefits for frenulectomy (D7960) or frenuloplasty (D7963) are disallowed when performed in conjunction with D4275, D4276 or D4285.

Benefits are limited to up to two teeth or soft tissue grafts per quadrant

D4276 Combined connective tissue and double pedicle graft per tooth

This procedure may be eligible for consideration in lieu of D4265, D4266, D4267, D4270, D4273, D4275, D4277, or D4278 under dentist consultant review based upon documentation of clinical conditions (Miller Class III).

When multiple teeth are grafted within a single quadrant, a maximum of two natural teeth or soft tissue grafts are benefitted unless extraordinary circumstances are documented.

Benefits for frenulectomy (D7960) or frenuloplasty (D7963) are disallowed when performed in conjunction with D4270, D4273, D4275, D4276, D4277, D4278, D4283 or D4285.

D4277 Free soft tissue graft procedure (including recipient and donor surgical sites) - first tooth, implant or edentulous tooth site in graft

When multiple grafts are provided within a single quadrant, a maximum of two teeth or soft tissue grafts are benefitted unless extraordinary circumstances are documented.

Benefits for GTR and or bone grafts, in conjunction with soft tissue grafts in the same surgical area, are denied.

Fees for a frenulectomy D7960 or frenuplasty D7963 are disallowed when performed in conjunction with soft tissue grafts contiguous tooth position in same graft site).

D4278 Free soft tissue graft procedure (including recipient and donor sites) – each additional contiguous tooth position in same graft site

Allow up to two teeth per quadrant.

Benefits for GTR and or bone grafts, in conjunction with soft tissue grafts in the same surgical area, are denied.

Fees for a frenulectomy D7960 or frenuplasty D7963 are disallowed when performed in conjunction with soft tissue grafts contiguous tooth position in same graft site).

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

A maximum of two teeth or soft tissue grafts per quadrant are benefitted.

Benefits for GTR and or bone grafts, in conjunction with soft tissue grafts in the same surgical area, are denied.

Fees for a frenulectomy D7960 or frenuplasty D7963 are disallowed when performed in conjunction with soft tissue grafts contiguous tooth position in same graft site).

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

A maximum of two teeth or soft tissue grafts per quadrant are benefitted.

Benefits for GTR and or bone grafts, in conjunction with soft tissue grafts in the same surgical area, are denied.

Fees for a frenulectomy D7960 or frenuplasty D7963 are disallowed when performed in conjunction with soft tissue grafts contiguous tooth position in same graft site).

Non-surgical periodontal services

D4320 Provisional splinting – intracoronal

Benefits for splinting are denied.

D4321 Provisional splinting - extracoronal

The benefit for splinting is denied and the approved amount is collectable from the patient.

D4341 Periodontal scaling and root planing - four or more teeth or spaces per quadrant

In absence of radiographic documentation of bone loss and clinical attachment loss fees are disallowed. Benefits of a prophylaxis or scaling in the presence of generalized moderate or severe gingival inflammation may be given.

Adult prophylaxis procedures (D1110), full mouth scaling (D4346) or debridement (D4355) are considered a component when submitted on the same date of service as D4341 and the fees are disallowed.

Fees for D4341, when billed in conjunction with periodontal surgery procedures by the same dentist/dental office are disallowed as a component of the surgical procedure.

In the absence of a contractual time limitation on frequency of benefits for D4341, any fee for retreatment performed by the same dentist within 24 months of initial therapy is disallowed.

No more than two full quadrants of scaling and root planing will be benefitted on the same date of service. The fees for more than two quadrants of D4341 are disallowed in the absence of supporting documentation (diagnostic quality radiographs (demonstrating alveolar bone loss), periodontal probing depths with at least 4mm pockets, proof of clinical attachment loss, and may also include evidence of length of the appointment in which the procedures were provided, information related to local anesthetic used, and/or a copy of the clinical progress notes).

D4342 Periodontal scaling and root planing - one to three teeth, per quadrant

In absence of radiographic documentation of bone loss and clinical attachment loss fees are disallowed. Benefits of a prophylaxis or scaling in the presence of generalized moderate or severe gingival inflammation may be given.

Adult prophylaxis procedures (D1110), full mouth scaling (D4346) or debridement (D4355) are considered a component when submitted on the same date of service as D4342and the fees are disallowed.

Fees for D4342, when billed in conjunction with periodontal surgery procedures by the same dentist/dental office are disallowed as a component of the surgical procedure.

In the absence of a contractual time limitation on frequency of benefits for D4341, any fee for retreatment performed by the same dentist within 24 months of initial therapy is disallowed. Retreatment done by a different dentist within 24 months is denied and the approved amount is collectable from the patient.

D4346 Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation

Benefits for D4346 include prophylaxis, fees for D1110, D1120 or D4355 are disallowed when submitted with D4346 by the same dentist/dental office.

Fees for D4346 are disallowed when submitted with D4910 by the same dentist/dental office.

D4355 Full mouth debridement to enable comprehensive oral evaluation and diagnosis on a subsequent visit

In absence of group/individual contract language, the procedure is benefitted once in a lifetime. A D4355 may be benefitted in order to do a proper evaluation and diagnosis if the patient has not been to the dentist in several years, and the dentist is unable to accomplish an effective prophylaxis under normal conditions.

Fees for full mouth debridement are disallowed on the same date of service as D0150, D0160 or D0180.

D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth

Localized delivery of chemotherapeutic agents is denied and the approved amount is collectable from the patient. A D4381 may be a contractual benefit, for refractory cases by individual consideration.

When covered contractually, D4381 is subject to the following processing policies:

1. A D4381 may be benefitted, subject to dental consultant review if the following conditions exist:
   a. It is being performed six weeks to six months following initial therapy (scaling and root planning or periodontal surgery).
   b. It is being performed for a patient of record on periodontal maintenance following initial therapy (scaling and root planning or periodontal surgery)
   c. If either 1 or 2 are met, it involves no more than two refractory sites (teeth) per quadrant with pocket depths of at least 5mm and less than 10 mm.

2. If different teeth are treated in the quadrant, within twelve months, benefits are denied and the approved amount is collectable from the patient.

3. If the same teeth are re-treated within 24 months, benefits are denied and the approved amount is collectable from the patient.

4. Teeth must have 5mm – 10 mm pocketing to be eligible for benefits. If less than 5 mm pocketing, benefits are denied and the approved amount is collectable from the patient.

5. Benefits are provided for up to two teeth per quadrant. If three or more teeth are submitted, the entire case is denied and the approved amount is collectable from the patient.

6. When submissions are requested outside time parameters, benefits are denied and the approved amount is collectable from the patient.

Other Periodontal Services

D4910 Periodontal maintenance

Benefits for D4910 include prophylaxis and scaling and root planing procedures. Separate fees for these procedures by the same dentist/dental office are disallowed when billed in conjunction with periodontal maintenance (D4910).

If a D0180 is submitted with a D4910 it is benefitted as a D0120 and the difference in the approved amount between the D0120 and the D0180 is disallowed unless the D0180 is the initial evaluation by the dentist rendering the D4910.

Fees for D4910 when billed within 30 days of periodontal therapy by the same dentist/dental office are disallowed.

D4920 Unscheduled dressing change (by someone other than the treating dentist)

The definition of the same dentist includes dentists and staff in the same dental office. A fee for dressing change performed by the same dentist or staff in the same dental office is disallowed within 30 days following the surgical procedure.

D4921 Gingival irrigation – per quadrant

Medicaments and solutions used for gingival irrigation are not covered benefits and the benefits are denied.

Fees for gingival irrigation are disallowed when performed with any periodontal service.

D4999 Unspecified periodontal procedure, by report

PROSTHODONTICS (REMOVABLE) D5000 - D5899

Terms of group/individual contracts vary. Policies in this Handbook that address benefits, limitations and exclusions are "model" policies that have not been tailored to reflect the specific terms of applicable group/individual contracts. This Handbook may not fully or accurately reflect the terms of applicable group/individual contracts, and may be inconsistent with such terms. In all cases, the terms of group/individual contracts take precedence over Dentist Handbook policies. Please contact the member company listed on the patient's identification card for the specific terms of a group/individual contract.

GP Characterizations, staining, overdentures, or metal bases are considered specialized techniques or procedures. An alternate benefit allowance is made for a conventional denture. Any fee charged in excess of the allowance for conventional denture is denied and the difference between the allowance for the conventional denture and the approved amount for the procedure performed is collectable from the patient.

GP The fees for full or partial dentures include any reline/rebase, adjustment or repair required within six months of delivery by the same dentist/dental office, except in the case of immediate dentures. Except in the case of immediate dentures, the fees for these services by the same dentist/dental office are disallowed.

GP Benefits may be denied and the approved amount is collectable from the patient if repair or replacement within contractual time limitations is the patient's fault.

GP The benefits for restorations for altering occlusion, involving vertical dimension, treating TMD, replacing tooth structure lost by attrition, erosion, abrasion (wear), abfraction, corrosion or for periodontal, orthodontic or other splinting are denied and the approved amount is collectable from the patient.

GP The fees for cast or indirectly fabricated restorations and prosthetic procedures include all models, temporaries and other associated procedures. Any fees charged for these procedures in excess of the approved amounts for the cast or indirectly fabricated restorations or prosthetic procedures by the same dentist/dental office are disallowed.

GP Multistage procedures are reported and benefitted 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.

Complete Dentures (including routine post-delivery care)

D5110 Complete denture, maxillary

D5120 Complete denture, mandibular

D5130 Immediate denture, maxillary

D5140 Immediate denture, mandibular

Partial Dentures (including routine post-delivery care)

GP A posterior fixed bridge and a removable partial denture are not a benefit in the same arch within a five year period. An allowance for a removable partial denture is made and any fee charged in excess of the allowance is denied and the approved amount is collectable from the patient.

GP The fees for fixed bridges or removable cast partials are denied and the approved amount is collectable from the patient, for patients under age 16.

D5211 Maxillary partial denture-resin base (including retentive/clasping materials, rests, and teeth)

D5212 Mandibular partial denture-resin base (including retentive/clasping materials, 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)

D5222 Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)

D5223 Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)

D5224 Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)

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

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

D5282 Removable unilateral partial denture – one piece cast metal (including clasps and teeth), maxillary

D5283 Removable unilateral partial denture – one piece cast metal (including clasps and teeth), mandibular

Adjustments to Dentures

GP The fees for full or partial dentures include any adjustments or repairs required within six months of delivery, except in the case of immediate dentures. If performed by the same dentist/dental office within six months of initial placement, fees for adjustments or repairs are disallowed.

GP The fees for adjustments to complete or partial dentures are limited to two adjustments per denture per twelve months (after six months has elapsed since initial placement). More frequent adjustments are denied and the approved amount is collectable from the patient.

D5410 Adjust complete denture - maxillary

D5411 Adjust complete denture - mandibular

D5421 Adjust partial denture - maxillary

D5422 Adjust partial denture - mandibular

Repairs to Complete Dentures

GP The fee for the repair of a complete denture cannot exceed one-half of the fee for a new appliance, and any excess fee by the same dentist/dental office is disallowed.

GP The fees for full or partial dentures include any adjustments or repairs required within six months of delivery, except in the case of immediate dentures. If performed by the same dentist/dental office within six months of initial placement, fees for adjustments or repairs are disallowed.

D5511 Repair broken complete denture base, mandibular

Fees for repairs of complete dentures, if performed within six months of initial placement by the same dentist/dental office are disallowed.

D5512 Repair broken complete denture base, maxillary

Fees for repairs of complete dentures, if performed within six months of initial placement by the same dentist/dental office are disallowed.

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

Repairs to Partial Dentures

GP The fee for the repair of a partial denture cannot exceed one-half of the fee for a new appliance, and any excess fee by the same dentist/dental office is disallowed.

GP The fees for full or partial dentures include any adjustments or repairs required within six months of delivery, except in the case of immediate dentures. If performed by the same dentist/dental office within six months of initial placement, fees for the adjustments or repairs are disallowed.

D5611 Repair resin partial denture base, mandibular

Fees for repairs of resin partial dentures, if performed within six months of initial placement by the same dentist/dental office are disallowed.

D5612 Repair resin partial denture base, maxillary

Fees for repairs of resin partial dentures, if performed within six months of initial placement by the same dentist/dental office are disallowed.

D5621 Repair cast framework, mandibular

Fees for repairs of cast partial dentures, if performed within six months of initial placement by the same dentist/dental office are disallowed.

D5622 repair cast partial framework, maxillary

Fees for repairs of cast partial dentures, if performed within six months of initial placement by the same dentist/dental office are disallowed.

D5630 Repair or replace broken retentive clasping materials - per tooth

D5640 Replace broken teeth-per tooth

D5650 Add tooth to existing partial denture

D5660 Add clasp to existing partial denture – per tooth

D5670 Replace all teeth and acrylic on cast metal framework (maxillary)

D5671 Replace all teeth and acrylic on cast metal framework (mandibular)

The fee for a D5670 or D5671 cannot exceed one-half of the fee for a new appliance, and any excess fee by the same dentist/dental office is disallowed.

Denture Rebase Procedures

GP The fee for the rebase includes the fee for relining. When the fee for a reline performed in conjunction with rebase (within six months of) by the same dentist/dental office the fee for the reline is disallowed.

GP The fee for a rebase includes adjustments required within six months of delivery. A fee for an adjustment performed within six months of a reline or rebase by the same dentist/dental office is disallowed.

D5710 Rebase complete maxillary denture

D5711 Rebase complete mandibular denture

D5720 Rebase maxillary partial denture

D5721 Rebase mandibular partial denture

Denture Reline Procedures

GP The fee for a reline includes adjustments required within six months of delivery. A fee for an adjustment billed within six months of a reline by the same dentist/dental office is disallowed.

GP The fee for the rebase includes the fee for relining. The fee for a reline performed in conjunction with (within six months of) a rebase by the same dentist/dental office is disallowed.

D5730 Reline complete maxillary denture (chairside)

D5731 Reline complete mandibular denture (chairside)

D5740 Reline maxillary partial denture (chairside)

D5741 Reline mandibular partial denture (chairside)

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)

The benefits for interim complete dentures are denied and the approved amount is collectable from the patient.

D5820 Interim partial denture (maxillary)

D5821 Interim partial denture (mandibular)

An interim partial denture is a benefit only in children age 16 or under for missing anterior permanent teeth. If submitted for any other reasons, the fees for D5820 and D5821 are denied and the approved amount is collectable from the patient.

Other Removable Prosthetic Services

D5850 Tissue conditioning, maxillary

D5851 Tissue conditioning, mandibular

A separate fee for tissue conditioning is disallowed if performed by the same dentist/dental office on the same day the denture is delivered or a reline/rebase is provided.

Tissue conditioning is not a benefit more than twice per denture unit per 36 months, and the benefit for tissue conditioning is denied and the approved amount is collectable from the patient if done more frequently.

D5862 Precision attachment, by report

The benefit for a precision attachment is denied and the approved amount is collectable from the patient.

D5863 Overdenture – complete maxillary

Complete and partial overdentures are considered specialized techniques and the benefit for an overdenture procedure is denied. An allowance will be made for a conventional denture, and any excess fee is chargeable to the patient.

D5864 Overdenture – partial maxillary

Complete and partial overdentures are considered specialized techniques and the benefit for an overdenture procedure is denied. An allowance will be made for a conventional denture, and any excess fee is chargeable to the patient.

D5865 Overdenture - complete mandibular

Complete and partial overdentures are considered specialized techniques and the benefit for an overdenture procedure is denied. An allowance will be made for a conventional denture, and any excess fee is chargeable to the patient.

D5866 Overdenture – partial mandibular

Complete and partial overdentures are considered specialized techniques and the benefit for an overdenture procedure is denied. An allowance will be made for a conventional denture, and any excess fee is chargeable to the patient.

D5867 Replacement of replaceable part of semi-precision or precision attachment (male or female component)

The benefit for this procedure (D5867) is denied, and the approved amount is collectable from the patient.

D5875 Modification of a removable prosthesis following implant surgery

The benefits for implant services are denied and the approved amount is collectable from the patient unless contract specifies that implants are a benefit.

D5876 add metal substructure to acrylic full denture (per arch)

The benefits are denied as a specialized technique.

D5899 Unspecified removable prosthodontic procedure, by report

MAXILLOFACIAL PROSTHETICS D5900 - D5999

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GP The benefits for maxillofacial prosthetics are denied and the approved amount is collectable 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 prosthesis 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

D5982 Surgical stent

D5984 Radiation shield

D5985 Radiation cone locator

D5987 Commissure splint

D5988 Surgical splint

D5992 Adjust maxillofacial prosthetic appliance, by report

D5993 Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral) other than required adjustments, by report

Carriers

D5983 Radiation carrier

D5986 Fluoride gel carrier

D5991 Vesiculobullous disease medicament carrier

Benefits are denied unless the group/individual contract specifies that maxillofacial prosthetics are a benefit.

D5992 Adjust maxillofacial prosthetic appliance, by report

D5993 Maintenance and cleaning of a maxillofacial prosthesis (extra- or intra-oral) other than required adjustments, by report

Benefits are denied unless the group/individual contract specifies that maxillofacial prosthetics are a benefit

D5994 Periodontal medicament carrier with peripheral seal – laboratory processed

Benefits are DENIED unless the group/individual contract specifies that maxillofacial prosthetics are a benefit

D5999 Unspecified maxillofacial prosthesis, by report

IMPLANT SERVICES D6000 - D6199 IMPLANT SERVICES

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GP Unless the group/individual contract specifies implants are covered, the benefits for implant services are denied and the approved amount is collectable.

GP When benefitted, implant time limitations are established by contract.

GP Benefits for implants are denied for patients under the age of 19 and the approved amount is collectible from the patient.

GP Fixed partial denture prosthetic procedures include the routine use of temporary prosthetics during the time for normal laboratory fabrication of the completed prosthesis. Interim or provisional appliances are disallowed when reported less than six months.

D6010 Surgical placement of implant body: endosteal implant

D6011 Second stage implant surgery

D6012 Surgical placements of interim implant body for transitional prosthesis: endosteal implant

Benefits are denied and the approved amount is collectible from the patient. This procedure is considered part of the transitional prosthesis, which is not a covered benefit.

D6013 Surgical placement of mini implant

D6040 Surgical placement: eposteal implant

D6050 Surgical placement: transosteal implant

Implant Supported Prosthetics

GP Where benefitted by contract, benefits for the placement of an implant to natural tooth bridge are denied. Special consideration may be given by report particularly where there is documentation of semi-ridged fixation between the tooth and implant and where other risk factors are not present.

D6051 Interim abutment

D6052 Semi-precision attachment abutment

Benefits are denied and the approved amount is collective from the patient unless the contract specifies this is a benefit.

D6055 Connecting bar – implant supported or abutment supported

D6056 Prefabricated abutment – includes modification and placement

D6057 Custom fabricated abutment - includes placement

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)

D6094 Abutment supported crown (titanium)

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)

D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)

D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal)

D6072 Abutment supported retainer for cast metal FPD (high noble metal)

D6073 Abutment supported retainer for cast metal FPD (predominantly base metal)

D6074 Abutment supported retainer for cast metal FPD (noble metal)

D6194 Abutment supported retainer for cast metal FPD (titanium)

D6075 Implant supported retainer for ceramic FPD

D6076 Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy or high noble metal)

D6077 Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal)

Other Implant Services

D6080 Implant maintenance procedures, including: removal of prosthesis, cleansing of prosthesis and abutments, reinsertion of prosthesis

Benefits are denied unless covered by group/individual contract.

D6081 Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure

When covered by group/individual contract, fees for D6081 are disallowed when performed in the same quadrant by the same dentist/dental office as D4341/D4342 or D4240/4241, D4260/D4261 or D6101/D6102.
Fees for retreatment by the same dentist/dental office within 24 months of initial therapy are disallowed.

Fees for D6081 are disallowed when performed within 12 months of restoration (D6058-D6077, D6085, D6094, D6118, D6119, D6194) placement by same dentist/dental office.

Fees for D6081 are disallowed when performed in conjunction with D1110, D4346 or D4910.

D6085 Provisional implant crown

Benefits are denied unless covered by group/individual contract.

D6090 Repair implant supported prosthesis, by report

D6091 Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment.

Benefits are denied as a specialized procedure unless the contract specifies that implant procedures are covered benefits.

D6092 Recement or rebond implant/abutment supported crown

Fee for the recementation or rebonding of crowns are disallowed if done within six months of the initial seating date by the same dentist/dental office.

Benefits may be paid for one recementation or rebonding after six months have elapsed since the initial placement. Subsequent requests for recementation or rebond by the same dentist/dental office are denied. Benefits may be paid when billed by a dentist/dental office other than the one who seated the crown or performed the previous recementation or rebond.

D6093 Recement or rebond implant/abutment supported fixed partial denture

Fee for recementation or rebonding for fixed partial dentures are disallowed if done within six months of the initial seating date by the same dentist/dental office.

Benefits may be paid for one recementation or rebonding after six months have elapsed since the initial placement. Subsequent requests for recementation or rebond by the same dentist/dental office are denied. Benefits may be paid when billed by a dentist other than the one who seated the crown or performed the previous recementation or rebond.

D6095 Repair implant abutment, by report

D6096 Remove broken implant retaining screw

Benefits are denied, unless implants are covered by group/individual contract.

D6100 Implant removal, by report

D6101 Debridement of a periimplant defect or defects surrounding a single implant and surface cleaning of exposed implant surfaces, including flap entry and closure

Benefits are denied unless covered by group/individual contract.

Fees for D6101 are disallowed in conjunction with osseous surgery (D4260 or DD4261)

Fees for D6101 are disallowed when performed in the same surgical site by the same dentist/dental office on the same date of service as D6102.

D6102 Debridement and osseous contouring of a periimplant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces and includes flap entry and closure

Benefits are denied unless covered by group/individual contract.

Fees for D6102 are disallowed in conjunction with osseous surgery (D4260 or DD4261)

Fees for other procedures done on the same date as D6102 are disallowed.

D6103 Bone graft for repair of periimplant defect – does not include flap entry and closure. Placement of a barrier membrane or biologic materials to aid in osseous regeneration are reported separately.

Benefits for D6103 when billed in conjunction with implants, implant removal, ridge augmentation or preservation, in extraction site, periradicular surgery, etc. are DENIED.

D6104 Bone graft at time of implant placement

Benefits for D6104 when billed in conjunction with implants, implant removal, ridge augmentation or preservation, in extraction site, periradicular surgery, etc. are DENIED.

D6110 Implant /abutment supported removable denture for edentulous arch – maxillary

Benefits are determined by group/individual contract. An alternate benefit of the conventional complete denture may be given.

D6111 Implant /abutment supported removable denture for edentulous arch – mandibular

Benefits are determined by group/individual contract. An alternate benefit of the conventional complete denture may be given.

D6112 Implant /abutment supported removable denture for partially edentulous arch – maxillary

Benefits are determined by group/individual contract. An alternate benefit of the conventional partial denture may be given.

D6113 Implant /abutment supported removable denture for partially edentulous arch – mandibular

Benefits are determined by group/individual contract. An alternate benefit of the conventional partial denture may be given.

D6114 Implant /abutment supported fixed denture for edentulous arch – maxillary

Benefits are determined by group/individual contract. An alternate benefit of the conventional complete denture may be given.

D6115 Implant /abutment supported fixed denture for edentulous arch – mandibular
Benefits are determined by group/individual contract. An alternate benefit of the conventional complete denture may be given.

D6116 Implant /abutment supported fixed denture for partially edentulous arch – maxillary
Benefits are determined by group/individual contract. An alternate benefit of the conventional partial denture may be given.

D6117 Implant /abutment supported fixed denture for partially edentulous arch – mandibular

Benefits are determined by group/individual contract. An alternate benefit of the conventional partial denture may be given.

D6118 Implant/abutment supported interim fixed denture for edentulous arch – mandibular

Benefits for implant abutment supported fixed denture are denied.

D6119 implant/abutment supported interim fixed denture for edentulous arch – maxillary

Benefits for implant abutment supported fixed denture are denied.

D6190 Radiographic/surgical implant index, by report

Benefits for implant index are denied as a specialized procedure.

D6199 Unspecified implant procedure, by report

PROSTHODONTICS, FIXED D6200 - D6999

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GP Fixed prosthodontics are subject to contractual time limits.

GP Benefits will be based on the number of pontics necessary for the space, not to exceed the normal complement of teeth.

GP A posterior fixed bridge and a removable partial denture are not benefits in the same arch within the frequency limitations. An allowance for a removable partial denture is made and any fee charged in excess of the allowance is denied and the approved amount is collectable from the patient.

GP The fees for cast or indirectly fabricated restorations and prosthetic procedures include all models, temporaries, laboratory charges and materials, and other associated procedures. Any fees charged for these procedures by the same dentist/dental office in excess of the approved amounts for the cast or indirectly fabricated restorations or prosthetic procedures are disallowed.

GP The fees for fixed prosthodontics are denied and the approved amount is collectable from the patient for children under 16 years of age.

GP Cementation date is the delivery date. The type of cement used is not a determining factor (whether permanent or temporary).

GP The fees for restorations for altering occlusion, involving vertical dimension, treating TMD, replacing tooth structure lost by attrition, erosion, abrasion (wear), abfraction, corrosion or for periodontal, orthodontic or other splinting are denied and the approved amount is collectable from the patient.

GP Multistage procedures are reported and benefitted 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.

GP An allowance of a conventional fixed prosthesis is provided for porcelain/ceramic or resin bridges. The difference between the allowance for the conventional fixed prosthesis and the approved amount for the porcelain/ceramic or resin bridge is collectable from the patient.

GP Fixed partial denture prosthetic procedures include the routine use of temporary prosthetics during the time for normal laboratory fabrication of the completed prosthesis. Interim or provisional appliances are disallow when reported less than six months.

GP Benefits for cantilevered second molar pontics are denied unless unusual circumstances exist.

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

Temporary and provisional fixed prostheses are not separate benefits and are included in the fee for the permanent prostheses. The fees for the temporary fixed prostheses by the same dentist/dental office are disallowed.

Fixed Partial Denture Retainers – Inlays/Onlays

D6545 Retainer-cast metal for resin bonded fixed prosthesis

D6548 Retainer- porcelain/ceramic for resin bonded fixed prosthesis

Benefits will be considered for a conventional fixed prosthesis. The difference between the allowance for the conventional prosthesis and the approved amount for the D6548 is denied and collectable from the patient.

D6549 Resin retainer – for resin bonded fixed prosthesis

D6600 Retainer inlay - porcelain/ceramic, two surfaces

Benefits will be considered for a conventional fixed prosthesis. The difference between the allowance for the conventional prosthesis and the approved amount for the D6600 is denied and collectable from the patient.

D6601 Retainer inlay - porcelain/ceramic, three or more surfaces

Benefits will be considered for a conventional fixed prosthesis. The difference between the allowance for the conventional prosthesis and the approved amount for the D6601 is denied and collectable from the patient.

D6602 Retainer inlay - cast high noble metal, two surfaces

D6603 Retainer inlay - cast high noble metal, three or more surfaces

D6604 Retainer inlay - cast predominantly base metal, two surfaces

D6605 Retainer inlay - cast predominantly base metal, three or more surfaces

D6606 Retainer inlay - cast noble metal, two surfaces

D6607 Retainer inlay - cast noble metal, three or more surfaces

D6608 Retainer onlay - porcelain/ceramic, two surfaces

Benefits will be considered for a conventional fixed prosthesis. The difference between the allowance for the conventional prosthesis and the approved amount for the D6608 is denied and collectable from the patient.

D6609 Retainer onlay - porcelain/ceramic, three or more surfaces

Benefits will be considered for a conventional fixed prosthesis. The difference between the allowance for the conventional prosthesis and the approved amount for the D6609 is denied and collectable from the patient.

D6610 Retainer onlay - cast high noble metal, two surfaces

D6611 Retainer onlay - cast high noble metal, three or more surfaces

D6612 Retainer onlay - cast predominantly base metal, two surfaces

D6613 Retainer onlay - cast predominantly base metal, three or more surfaces

D6614 Retainer onlay - cast noble metal, two surfaces

D6615 Retainer onlay - cast noble metal, three or more surfaces

D6624 Retainer inlay - titanium

D6634 Retainer onlay - titanium

Fixed Partial Denture Retainers-Crowns

D6710 Retainer crown – indirect resin based composite

Benefits will be considered for a conventional fixed prosthesis. The difference between the allowance for the conventional prosthesis and the approved amount for the D6710 is denied and collectable from the patient.

D6720 Retainer crown - resin with high noble metal

D6721 Retainer crown - resin with predominantly base metal

D6722 Retainer crown - resin with noble metal

D6740 Retainer crown- porcelain/ceramic

D6750 Retainer crown-porcelain fused to high noble metal

D6751 Retainer crown-porcelain fused to predominantly base metal

D6752 Retainer crown-porcelain fused to noble metal

D6780 Retainer crown-¾ cast high noble metal

D6781 Retainer crown- ¾ cast predominantly base metal

D6782 Retainer crown- ¾ cast noble metal

D6783 Retainer crown- ¾ porcelain/ceramic

D6790 Retainer crown-full cast high noble metal

D6791 Retainer crown-full cast predominantly base metal

D6792 Retainer crown-full cast noble metal

D6793 Provisional retainer crown

Temporary fixed prostheses are not separate benefits and are included in the fee for the permanent prostheses. The fees for the temporary fixed prostheses by the same dentist/dental office are disallowed.

D6794 Retainer crown-titanium

Other Fixed Partial Denture Services

D6920 Connector bar

The fee for a connector bar is denied and the approved amount is collectable from the patient.

D6930 Recement or rebond fixed partial denture

Delta Dental considers the cementation date to be that date upon which the completed bridge is first delivered to the mouth. The type of cement used is not a determining factor (whether permanent or temporary).

Fees for recementation or rebonding of inlays, onlays, crowns, and fixed partial dentures are disallowed if done within six months of the initial seating date by the same dentist/dental office.

Benefits may be paid for one recementation or rebonding after six months have elapsed since initial placement. Subsequent requests for recementation or rebond by the same dentist/dental office are denied and the approved amount is collectable from the patient. Benefits may be paid when billed by a provider other than the one who seated the bridge or performed the previous recementation or rebonding.

D6940 Stress breaker

The benefit for a stress breaker is denied and the approved amount is collectable from the patient.

D6950 Precision attachment

The benefit for a precision attachment is denied and the approved amount is collectable from the patient.

D6980 Fixed partial denture repair necessitated by restorative material failure

The fee for the repair of a fixed partial denture cannot exceed one-half of the fee for a new appliance, and any fee charged in excess of the allowance by the same dentist/dental office is disallowed.

D6985 Pediatric partial denture, fixed

The fee for a pediatric partial denture, fixed is denied and the approved amount is collectable from the patient.

D6999 Unspecified fixed prosthodontic procedure, by report

ORAL AND MAXILLOFACIAL SURGERY D7000 - D7999

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GP The fee for all oral and maxillofacial surgery includes local anesthesia, suturing if needed, and routine postoperative care, including treatment of dry sockets. Separate fees for these procedures when performed in conjunction with oral and maxillofacial surgery are disallowed. If performed by another dentist these procedures are denied and the approved amount is collectable from the patient.

GP Fees for exploratory surgery or unsuccessful attempts at extractions are disallowed.

GP Impaction codes are based on the anatomical position of the tooth, rather than the surgical procedure necessary for removal.

GP The fees for biopsy (D7285, D7286), frenulectomy (D7960), frenuloplasty (D7963) and excision of hard and soft tissue lesions (D7411, D7450, D7451) are disallowed when the procedure is performed on the same day, same surgical site/area, by the same dentist/dental office and any other surgical procedure. Requests for individual consideration can always be submitted by report for dental consultant review.

Extractions (includes local anesthesia, suturing if needed, and routine postoperative care)

D7111 Extraction, coronal remnants - primary tooth

D7111 is considered part of any other primary surgery in the same surgical area on the same date and the fee is disallowed if performed by the same dentist/dental office.

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

Surgical Extractions-(includes local anesthesia, suturing if needed, and routine postoperative care)

D7210 Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated.

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 Removal of residual tooth roots (cutting procedure)

The fee for root recovery is disallowed if submitted in conjunction with a surgical extraction (in the same surgical area) by the same dentist/dental office.

D7251 Coronectomy – intentional partial tooth removal

Depending on the group/individual coverage, coronectomy may be benefitted under individual consideration and only for documented probable neurovascular complications as proximity to mental foramen, inferior alveolar nerve, sinus, etc.

Other Surgical Procedures

D7260 Oroantral fistula closure

D7261 Primary closure of a sinus perforation

When submitted with D7241, the fees for D7261 are disallowed.

D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth

D7270 includes anesthesia, suturing, postoperative care and removal of the splint by the same dentist/dental office.

D7272 Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)

The benefit for tooth transplantation is denied and the approved amount is collectable from the patient.

D7280 Exposure of an unerupted tooth

D7280 may be considered under orthodontic benefits. Benefits are denied in the absence of orthodontic benefits.

D7282 Mobilization of erupted or malpositioned teeth to aid eruption

The fee for D7282 is disallowed when performed by the same dentist/dental office in conjunction with other surgery in immediate area.

D7283 Placement of device to facilitate eruption of impacted tooth

Benefits are determined by group/individual contract. Benefits are denied in absence of orthodontic benefits.

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

D7286 Incisional biopsy of oral tissue - soft (all others)

A fee for biopsy of oral tissue is disallowed if not submitted with a pathology report. The fee for biopsy of oral tissue is disallowed as included in the fee for a surgical procedure (e.g. apicoectomy, extraction, etc.) when performed by the same dentist/dental office in the same surgical area and on the same date of service.

Biopsy of oral tissue is only benefitted for oral structures.

D7287 Exfoliative cytological sample collection

By report and subject to coverage under the medical plan.

D7288 Brush biopsy – transepithelial sample collection

By report and subject to coverage under the medical plan. If covered under dental a pathology report must be included.

D7290 Surgical repositioning of teeth

D7291 Transseptal fiberotomy, supra crestal fiberotomy by report

Benefits are denied unless covered by group/individual contract.

D7292 Placement of temporary anchorage device [screw retained plate] requiring flap, includes device removal

D7293 Placement of temporary anchorage device requiring flap, includes device removal

D7294 Placement: temporary anchorage device without surgical flap

Benefits are denied and the fee is chargeable to the patient. D7292, D7293 and D7294 are considered specialized procedures and not covered benefits.

If the group/individual contract includes orthognathic surgery, these procedures are included in the surgery.

D7295 Harvest of bone for use in autogenous grafting procedure

D7296 Corticotomy – one to three teeth or tooth spaces, per quadrant

Benefits for corticotomy are denied.

D7297 Corticotomy – four or more teeth or tooth spaces, per quadrant

Benefits for corticotomy are denied.

Alveoloplasty-Preparation of Ridge for Dentures

GP A quadrant for oral surgery purposes is defined as four 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 extractions (D7140, D7210-D7250) is disallowed.

D7311 Alveoloplasty 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 extractions (D7140, D7210-D7250) is disallowed.

D7320 Alveoloplasty not in conjunction with extractions- four or more teeth or tooth spaces per quadrant

D7321 Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces per quadrant

Count tooth bounded spaces for D7321 partial quadrant code.

A tooth bounded space counts as one space irrespective of the number of teeth that would normally exist in the space.

Vestibuloplasty

GP All procedures are by report and subject to coverage under the medical plan.

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)

Excision of Soft Tissue Lesions

GP All procedures are by report and subject to coverage under the medical plan.

GP The fee for D7410 and D7411 is disallowed as included in the fee for another surgery performed in the same area of the mouth on the same day by the same dentist/dental office.

GP Pathology laboratory report is required. If no report is submitted, the fee for the procedure is disallowed.

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

D7465 Destruction of lesion(s) by physical or chemical method, by report

Excision of Intra-Osseous Lesions

GP All procedures are by report and subject to coverage under the medical plan.

GP Pathology laboratory report is required. If no report is submitted, the fee for the procedure is disallowed.

GP The fee for D7450 and D7451 is disallowed as included in the fee for another surgery performed in the same area of the mouth on the same day by the same dentist/dental office.

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

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

Excision of Bone Tissue

GP All procedures are by report and subject to coverage under the medical plan. Individual consideration may be available by report.

D7471 Removal of lateral exostosis (maxilla or mandible)

D7472 Removal of torus palatinus

D7473 Removal of torus mandibularis

D7485 Reduction of osseous tuberosity

D7490 Radical resection of maxilla or mandible

If considered under dental, the fee for D7490 is disallowed unless pathology laboratory report is submitted.

Surgical Incision

GP All procedures are by report and are subject to coverage under the medical plan. If not covered under medical. Procedures D7530-D7560 require a pathology report.

D7510 Incision and drainage of abscess - intraoral soft tissue

The fee for surgical incision is disallowed when done on the same date (in the same operative area) and by the same dentist/dental office as endodontics (D3000-D3999), oral surgery (D7000-D7999), palliative treatment and surgical periodontal procedures (D4210-D4278).

D7511 Incision and drainage of abscess-intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)

The fee for surgical incision is disallowed when done on the same date (in the same operative area) 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 (includes drainage of multiple fascial spaces)

Incision and drainage of abscess - extraoral soft tissue is a benefit only if a dentally related infection is present. If it is not related to a dental infection, the benefit for treatment is denied and the approved amount is collectable from the patient.

D7530 Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue

D7540 Removal of reaction producing foreign bodies, musculoskeletal system

D7550 Partial ostectomy/sequestrectomy for removal of non-vital bone

D7560 Maxillary sinusotomy for removal of tooth fragment or foreign body

Treatment of Closed Fractures

GP All procedures are by report and are subject to coverage under the medical plan.

GP A separate fee for splinting, wiring or banding is disallowed when performed by the same dentist/ dental office rendering the primary procedure.

D7610 Maxilla - open reduction (teeth immobilized if present)

D7620 Maxilla - closed reduction (teeth immobilized if present)

D7630 Mandible - open reduction (teeth immobilized if present)

D7640 Mandible - closed reduction (teeth immobilized if present)

D7650 Malar and/or zygomatic arch - open reduction

D7660 Malar and/or zygomatic arch - closed reduction

D7670 Alveolus - closed reduction, may include stabilization of teeth

D7671 Alveolus - open reduction, may include stabilization of teeth

D7680 Facial bones - complicated reduction with fixation and multiple surgical approaches

Treatment of Open Fractures

GP All procedures are by report and are subject to coverage under the medical plan.

GP A separate fee for splinting, wiring or banding is disallowed when performed by the same dentist/ dental office rendering the primary procedure.

D7710 Maxilla - open reduction

D7720 Maxilla - closed reduction

D7730 Mandible - open reduction

D7740 Mandible - closed reduction

D7750 Malar and/or zygomatic arch - open reduction

D7760 Malar and/or zygomatic arch - closed reduction

D7770 Alveolus - open reduction stabilization of teeth

D7771 Alveolus, closed reduction stabilization of teeth

D7780 Facial bones - complicated reduction with fixation and multiple approaches

Reduction of Dislocation and Management of Other Temporomandibular Joint Dysfunctions

GP All procedures are denied and the approved amount is collectable from the patient unless covered by the subscriber's group/individual contact and are subject to coverage under the medical plan.

GP When covered by the group/individual contract all procedures are by report and subject to coverage under the medical plan. The fees for procedures that are an integral part of a primary procedure should not be reported separately and are disallowed.

D7810 Open reduction of dislocation

D7820 Closed reduction of dislocation

D7830 Manipulation under anesthesia

D7840 Condylectomy

D7850 Surgical discectomy, with/without implant

D7852 Disc repair

D7854 Synovectomy

D7856 Myotomy

D7858 Joint reconstruction

D7860 Arthrotomy

D7865 Arthroplasty

D7870 Arthrocentesis

D7871 Non - arthroscopic lysis and lavage

Benefits are denied unless related TMJ services are covered by group/individual contract.

D7872 Arthroscopy - diagnosis, with or without biopsy

D7873 Arthroscopy - lavage and lysis of adhesions

D7874 Arthroscopy - disc repositioning and stabilization

D7875 Arthroscopy - synovectomy

D7876 Arthroscopy - discectomy

D7877 Arthroscopy - debridement

D7880 Occlusal orthotic device, by report

D7881 Occlusal orthotic device adjustment

Benefits for occlusal orthotic devise adjustments are denied unless covered by group/individual contract.

When covered by contract, all adjustments within 6 months from initial placement are disallowed.

Allow one per year following six months from initial placement.

D7899 Unspecified TMD therapy, by report

Repair of Traumatic Wounds

GP Repair of traumatic wounds is limited to oral structures.

D7910 Suture of recent small wounds up to 5 cm

Complicated Suturing (reconstruction requiring delicate handling of tissues and wide undermining for meticulous closure)

GP Complicated suturing is limited to oral structures.

D7911 Complicated suture - up to 5 cm

D7912 Complicated suture - greater than 5 cm

Other Repair Procedures

GP All procedures except D7960, D7970, and D7971 are by report and subject to coverage under medical plan.

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

D7921 Collection and application of autologous blood concentrate product

The benefit for collection and application of autologous blood concentrate product is DENIED as investigational and is not a covered benefit.

D7940 Osteoplasty - for orthognathic deformities

D7941 Ostectomy - mandibular rami

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

D7944 Ostectomy - segmented or subapical - per sextant or quadrant

D7945 Ostectomy - 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 retusion) - without bone graft

D7949 LeFort II or LeFort III - with bone graft

D7950 Osseous, osteoperiosteal, or cartilage graft of the mandible - autogenous or nonautogenous, by report

Benefits for D7950 when billed in conjunction with implants, implant removal, ridge augmentation, extraction sites, periradicular surgery etc. are denied as a specialized procedure**.**

D7951 Sinus augmentation with bone or bone substitutes via lateral open approach

Benefits for D7951 when billed in conjunction with implants, implant removal, ridge augmentation, extraction sites, periradicular surgery etc. are denied as a specialized procedure**.**

D7952 Sinus augmentation via vertical approach

Benefits for D7951 when billed in conjunction with implants, implant removal, ridge augmentation, extraction sites, periradicular surgery etc. are denied as a specialized procedure

D7953 Bone replacement graft for ridge preservation – per site

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, implant removal, ridge augmentation, extraction sites, periradicular surgery etc. are denied as an investigational procedure. If the contract covers dental implants this procedure may be a benefit at the time of extraction.

D7955 Repair of maxillofacial soft and hard tissue defect

D7960 Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure

A separate fee for frenulectomy is disallowed when billed in conjunction with any other surgical procedure(s) in the same surgical area, by the same dentist/dental office.

D7963 Frenuloplasty

Fees for frenuloplasty are 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 surgical area by the same dentist/dental office.

D7971 Excision of pericoronal gingiva

The fee for excision of pericoronal gingiva is disallowed when billed in conjunction with other surgical procedure(s) in the same surgical area by the same dentist/dental office.

D7972 Surgical reduction of fibrous tuberosity

D7979 Non-surgical sialolithotomy

D7980 Surgical 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 dentist who placed appliance), includes removal of archbar

The benefit for appliance removal is denied as a non-covered procedure unless the contract specifies that the related oral surgery services are a benefit. If covered, disallow 45 days following appliance placement.

D7998 Intraoral placement of a fixation devise not in conjunction with fracture

This procedure is by report and subject to coverage under the medical plan.

This procedure is disallowed by the same dentist/dental office when billed in conjunction with any surgical procedure not in conjunction with fractures for which splinting, wiring or banding is considered part of the complete procedure (e.g., D7270, D7272).

D7999 Unspecified oral surgery procedure, by report

ORTHODONTICS D8000 - D8999

Terms of group/individual contracts vary. Policies in this Handbook that address benefits, limitations and exclusions are "model" policies that have not been tailored to reflect the specific terms of applicable group/individual contracts. This Handbook may not fully or accurately reflect the terms of applicable group/individual contracts, and may be inconsistent with such terms. In all cases, the terms of group/individual contracts take precedence over Dentist Handbook policies. Please contact the member company listed on the patient's identification card for the specific terms of a group/individual contract.

GP Surgical procedures should be reported separately under the appropriate procedure codes.

GP Delta Dental does not consider mail away and other do-it-yourself aligner kits to be a covered benefit.

Limited orthodontic treatment should be used with:

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 should be used with:

Interceptive orthodontics is an extension of preventive orthodontics includes 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 adequate. 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 should be used with:

Comprehensive orthodontic care includes a coordinated diagnosis and treatment leading to the improvement of the patient's craniofacial dysfunction and/or dentofacial deformity which may include anatomical, functional and/or aesthetic 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 several 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 transitional 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

D8090 Comprehensive orthodontic treatment of the adult dentition

Minor Treatment to Control Harmful Habits

D8210 Removable appliance therapy

D8220 Fixed appliance therapy

Other Orthodontic Services

D8660 Pre-orthodontic treatment examination to monitor growth and development

Fees for D8660 are disallowed with any other evaluation.

Fees for D8660 are disallowed when submitted with D8070, D8080 or D8090.

D8670 Periodic orthodontic treatment visit

D8680 Orthodontic retention (removal of appliances, construction and placement of retainer(s)

A separate fee for orthodontic retention is disallowed within 24 months of placement by the same dentist/dental office.

Benefits for D8680 are denied if performed by a different dentist/dental office.

D8681 Removable orthodontic retainer adjustment

Fees for removable orthodontic retainer adjustments are disallowed if performed by the same dentist/dental office providing orthodontic treatment. Benefits are denied if performed by a different dentist/dental office.

D8690 Orthodontic treatment

D8691 Repair of orthodontic appliance

The benefit for repair of an orthodontic appliance is denied, and the approved amount is collectable from the patient.

D8692 Replacement of lost or broken retainer

The benefit for replacement of a lost or broken retainer is denied, and the approved amount is collectable from the patient.

D8693 Rebond or recement fixed retainer

A separate fee for rebonding or recementing, and/or repair, as required of fixed retainers is disallowed unless performed by a different dentist/dental office.

D8694 Repair of fixed retainers, includes reattachment

This procedure is included in the orthodontic case fee. Fees for D8694 are disallowed within 24 months following placement of the fixed retainer by the same dentist/dental office.

Benefits for D8694 performed after 24 months are denied.

D8695 Removal of fixed orthodontic appliances for reasons other than completion of treatment

Benefits for removal of fixed orthodontic appliances for reasons other than completion of treatment are denied.

D8999 Unspecified Orthodontic procedure, by report

ADJUNCTIVE GENERAL SERVICES D9000 - D9999

Terms of group/individual contracts vary. Policies in this Handbook that address benefits, limitations and exclusions are "model" policies that have not been tailored to reflect the specific terms of applicable group/individual contracts. This Handbook may not fully or accurately reflect the terms of applicable group/individual contracts, and may be inconsistent with such terms. In all cases, the terms of group/individual contracts take precedence over Dentist Handbook policies. Please contact the member company listed on the patient's identification card for the specific terms of a group/individual contract.

Unclassified Treatment

D9110 Palliative (emergency) treatment of dental pain-minor procedures

The fee for palliative treatment is disallowed when any other definitive treatment is performed on the same date by the same dentist/dental office.

Limited radiographic images (D0210-D0391) and tests necessary to diagnose the emergency condition are considered separately.

Palliative treatment is a benefit 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 separate fee for palliative treatment is disallowed when billed on the same date as root canal therapy by the same dentist/dental office.

The fee for D9110 is disallowed in conjunction with pupal debridement (D3221) by the same dentist/dental office.

D9120 Fixed partial denture sectioning

This procedure is only a benefit if a portion of the fixed prosthesis is to remain intact and serviceable following sectioning and extraction 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 a separate fee for this code is disallowed.

Polishing and recontouring are considered an integral part of the fixed partial denture sectioning. Additional fees are disallowed.

D9130 Temporomandibular joint dysfunction – non-invasive physical therapies

Benefits for temporomandibular joint dysfunction physical therapies are denied unless covered by group contract

Anesthesia

D9210 Local anesthesia not in conjunction with operative or surgical procedures

D9211 Regional block anesthesia

D9212 Trigeminal division block anesthesia

D9215 Local anesthesia in conjunction with operative or surgical procedures

A separate fee for local anesthesia is disallowed whether stand alone or in conjunction with any other procedure.

D9219 Evaluation for moderate sedation, deep sedation or general anesthesia

A separate fee for evaluation for moderate sedation, deep sedation or general anesthesia is disallowed
with moderate sedation, deep sedation, or general anesthesia.

D9222 Deep sedation/general anesthesia – first 15 minutes

Deep sedation/general anesthesia is a benefit only when administered;
(1) with appropriate monitoring by a properly licensed provider who is acting in compliance with applicable State rules and regulations, and
(2) In conjunction with oral surgical procedures (D7000-D7999) when covered, or when necessary due to concurrent medical conditions. Otherwise, the benefit for deep sedation/general anesthesia is denied.

The benefit for deep sedation/general anesthesia is denied when billed by anyone other than an appropriately licensed and qualified provider.

D9223 Deep sedation/general anesthesia – each subsequent 15 minute increment

Deep sedation/general anesthesia is a benefit only when administered;
(1) with appropriate monitoring by a properly licensed provider who is acting in compliance with applicable State rules and regulations, and

(2) In conjunction with oral surgical procedures (D7000-D7999) when covered, or when necessary due to concurrent medical conditions. Otherwise, the benefit for deep sedation/general anesthesia is denied.

The benefit for deep sedation/general anesthesia is denied when billed by anyone other than an appropriately licensed and qualified provider.

Providing more than one hour of deep sedation or general anesthesia for routine dental procedures is unusual. When documentation of exceptional circumstances is submitted, benefits may be approved, dependent on group/individual contract.

D9230 Inhalation of nitrous oxide/anxiolysis, analgesia

The benefit for analgesia is denied and the approved amount is collectable from the patient.

When covered by group contract inhalation of nitrous oxide/anxiolysis, analgesia is disallowed when submitted more than once on the same date, and/or in conjunction with IV sedation and general anesthesia.

D9239 Intravenous moderate (conscious) sedation/analgesia- first 15 minutes

Intravenous moderate (conscious) sedation/analgesia is a benefit only when administered;
(1) In a dental office with appropriate monitoring by an appropriately licensed and qualified dentist who is acting in compliance with applicable rules and regulations, and
(2) In conjunction with oral surgical procedures (D7000-D7999) when covered, or when necessary due to concurrent medical conditions. Otherwise, the benefit for intravenous moderate (conscious) sedation/analgesia is denied.

D9243 Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment

Intravenous moderate (conscious) sedation/analgesia is a benefit only when administered
(1) In a dental office with appropriate monitoring by an appropriately licensed and qualified dentist who is acting in compliance with applicable rules and regulations, and
(2) In conjunction with oral surgical procedures (D7000-D7999) when covered, or when necessary due to concurrent medical conditions. Otherwise, the benefit for intravenous moderate (conscious) sedation/analgesia is denied.

The benefit for intravenous moderate (conscious) sedation/analgesia is denied when billed by anyone other than an appropriately licensed and qualified dentist.

D9248 Non-intravenous conscious sedation

The benefit for non-intravenous conscious sedation is denied, and the approved amount is collectable from the patient.

Professional Consultation

D9310 Consultation (diagnostic service provided by dentist or physician other than requesting dentist or physician.)

A separate fee for a consultation is disallowed when billed in conjunction with an examination/evaluation by the same dentist/dental office.

The benefit for a consultation in connection with non-covered services is denied and the approved amount is collectable from the patient.

Consultation (D9310) may be benefitted when the service is provided by a dentist whose opinion or advice regarding an evaluation and/or management of a specific problem may be requested by another dentist, physician or appropriate service. The dentist performing the consultation may initiate diagnostic or therapeutic services.

When covered, the consultation is subject to the same frequency limitations and processing policies as a comprehensive evaluation (D0150).

D9311 Consultation with medical health care professional

The fees for the consultation with a health care professional concerning medical issues is disallowed as part of the overall patient management.

Professional Visits

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
Fees for an office visit for observation are disallowed when billed with other procedures.

D9440 Office visit - after regularly scheduled hours

D9450 Case presentation, detailed and extensive treatment planning

The benefit for detailed and extensive treatment planning is denied and the approved amount is collectable from the patient.

The fee for extensive treatment planning may be benefitted for complex treatment planning cases involving multiple treatment disciplines and multiple providers of care.

When covered, the D9450 is subject to the same frequency limitations and processing policies as a comprehensive evaluation (D0150).

Drugs

GP The benefits for drugs are denied and the approved amount is collectable from the patient.

D9610 Therapeutic drug injection, by report

D9612 Therapeutic parenteral drugs, two or more administrations, different medications

D9613 Infiltration of sustained release therapeutic drug – single or multiple sites

Benefits for infiltration of sustained release therapeutic drug are denied as a specialized technique unless covered by group/individual contract. When covered, it is only a benefit when submitted with surgical extractions.

D9630 Drugs or medicaments dispensed in the office for home use

Miscellaneous Services

D9910 Application of desensitizing medicament

The benefit for application of desensitizing medicaments is denied and the approved amount is collectable from the patient.

D9911 Application of desensitizing resin for cervical and /or root surface, per tooth

The benefit for application of a desensitizing resin is denied, and the approved amount is collectable from the patient.

D9920 Behavior management, by report

The benefit for behavior management is denied and the approved amount is collectable from the patient.

D9930 Treatment of complications (postsurgical)-unusual circumstances, by report

The fee for treatment of routine postsurgical complications is disallowed when done by the first treating dentist.

Benefits for dry socket are disallowed and are included in the fee for the extraction by the same dentist/dental office.

D9932 Cleaning and inspection of removable complete denture, maxillary

Fees for cleaning and inspection of a removable complete denture are disallowed when done with a reline or rebase procedure unless covered by group/individual contract. In all other instances, benefits for cleaning and inspection of a removable complete denture are denied.

D9933 Cleaning and inspection of removable complete denture, mandibular

Fees for cleaning and inspection of a removable complete denture are disallowed when done with a reline or rebase procedure unless covered by group/individual contract. In all other instances, benefits for cleaning and inspection of a removable complete denture are denied.

D9934 Cleaning and inspection of removable partial denture, maxillary

Fees for cleaning and inspection of a removable partial denture are disallowed when done with a reline or rebase procedure. In all other instances, benefits for cleaning and inspection of a removable partial denture are denied.

D9935 Cleaning and inspection of removable partial denture, mandibular

Fees for cleaning and inspection of a removable partial denture are disallowed when done with a reline or rebase procedure. In all other instances, benefits for cleaning and inspection of a removable partial denture are denied.

D9941 Fabrication of athletic mouthguard

Fabrication of athletic mouthguard is denied unless covered by group/individual contract.

D9942 Repair or reline of occlusal guard

Benefits to repair or reline of an occlusal guard are denied and the approved amount collectible from the patient unless it is covered by the group/individual contract.

If covered, the fee for the occlusal guard includes any adjustment or repair required with six 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 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

Benefits for occlusal guard adjustments are denied unless covered by group/individual contract.

When covered by contract all adjustments within 6 months are disallowed.

Allow one per year following six months from initial placement.

D9944 occlusal guard – hard appliance, full arch

Benefits for occlusal guards are denied unless covered by group/individual contract.

D9945 occlusal guard – soft appliance, full arch

Benefits for occlusal guards are denied unless covered by group/individual contract.

D9946 occlusal guard – hard appliance, partial arch

Benefits for occlusal guards are denied unless covered by group/individual contract.

D9950 Occlusion analysis - mounted case

D9951 Occlusal adjustment - limited

D9952 Occlusal adjustment – complete

D9961 duplicate/copy patient's records

Benefits for duplicate/copy patient’s records is denied.

D9970 Enamel microabrasion

The benefits for enamel microabrasion are denied and the approved amount is collectable from the patient.

D9971 Odontoplasty 1-2 teeth includes removal of enamel projections

The benefit for odontoplasty is denied and is the approved amount is collectable from the patient.

D9972 External bleaching per arch – performed in office

The benefit for bleaching is denied, and the approved amount is collectable from the patient.

D9973 External bleaching per tooth

The benefit for bleaching is denied, and the approved amount is collectable from the patient.

D9974 Internal bleaching per tooth

The benefit for bleaching is denied, and the approved amount is collectable from the patient.

D9975 External bleaching for home application, per arch - includes materials and fabrication of custom tray

D9985 Sales tax

Sales/service fee are denied and the approved amount is collectable from the patient.

D9986 Missed appointment

Missed appointments are denied and the approved amount is collectable from the patient.

D9987 Cancelled appointment

Cancelled appointments are denied and the approved amount is collectable from the patient.

D9990 certified translation or sign-language services – per visit

The fees for translation services are considered inclusive in overall patient management and are disallowed.

D9991 Dental case management – addressing appointment compliance barriers

The fees for addressing appointment compliance barriers are considered inclusive in overall patient management and are disallowed.

D9992 Dental case management – care coordination

The fees for care coordination are considered inclusive in overall patient management and are disallowed.

D9993 Dental case management – motivational interviewing

Fees for motivational interviewing are disallowed when submitted on same date of service as D1310, D1320, D1330.

D9994 Dental case management – patient education to improve oral health literacy

Fees for patient education to improve oral health literacy are DISALLOWED when submitted on same date of service as D1310, D1320, D1330.

D9995 Teledentistry – synchronous; real-time encounter

The fees for teledentistry are considered inclusive in overall patient management and are disallowed.

D9996 Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review

The fees for teledentistry are considered inclusive in overall patient management and are disallowed.

D9999 Unspecified adjunctive procedure, by report