



# 2025 HMO ACA CDT Guide

Dental Procedure Codes and Nomenclature  
Hawaii Procedure Guidelines



An Independent Licensee of the Blue Cross and Blue Shield Association

**NOTE:** These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

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## ABOUT THIS GUIDEBOOK

**This guide is organized according to the latest and most current edition of the American Dental Association (ADA) Current Dental Terminology (CDT) procedure codes. We accept only coding that is consistent with the verbal descriptors of CDT. However, the presence of a code in CDT does not mean that a subscriber has coverage available. We determine member benefits based on our administrative policies and the terms of the subscriber's certificate. As always, we remind you to check benefits and eligibility before performing services.**

Some of the categories of service have introductory sections to explain what information you need to provide to facilitate our claim processing. For a more complete description of procedures, please refer to the *American Dental Association, Current Dental Terminology – 2025*

We've designed these administrative guidelines and policies to promote our members' long-term oral health. We review our policies on an ongoing basis to determine clinical appropriateness and to reflect significant technical advances.

For each code, we have provided specific guidelines and recommendations with respect to time, age, or other contractual limitations or exclusions. We have also noted when procedures are not covered benefits. We also indicate procedure codes that require radiographic (X-ray) imaging documentation and other supplementary documentation. Please use this guide to determine the correct code to describe the service you provided to your patient. We hope that making our policies and guidelines clear and easily available will enable your office to receive the appropriate compensation for the services provided to our members, your patients.

### **If you need additional information on how to submit a claim, you can:**

- ✓ Refer to the Dental Administrative Manual
- ✓ Go to [www.hmsadental.com/providers](http://www.hmsadental.com/providers) to access administrative information
- ✓ Call the Dental Call Center at 808-948-6440 on Oahu or 1-800-792-4672 toll-free on the Neighbor Islands.

### **If you need additional information on how to submit a medical claim, you can:**

- ✓ Refer to the Dental Administrative Manual/How to submit a medical claim
- ✓ Go to [www.hmsadental.com/providers](http://www.hmsadental.com/providers) to access administrative information
- ✓ Call the Dental Call Center at 808-948-6440 on Oahu or 1-800-792-4672 toll-free on the Neighbor Islands.
- ✓ HMSA Dental does not auto-enroll providers for HMSA medical participation. Dentists must apply directly with HMSA for medical par status.

## UTILIZATION MANAGEMENT

**While we continue to conduct utilization review on submitted claims, we will no longer routinely require submission of radiographs or periodontal charting from participating HMSA PPO and HMO providers. Please refer to the *Submission Requirements* column for any specific requirements needed when submitting claims for treatment.**

### **What is “Necessary and Appropriate Treatment?”**

Our members’ subscriber certificates specify that all dental care must be “necessary and appropriate to diagnose or treat your dental condition” and defines dental care as inclusive of services, procedures, supplies, and appliances.” The member’s subscriber certificates identify the following criteria used to determine whether dental care is necessary and appropriate for the member. The dental care must be:

- ✓ Consistent with the prevention and treatment of oral disease or with the diagnosis and treatment of teeth that are decayed or fractured, or where the supporting structure is weakened by disease (including periodontal, endodontic, and related diseases).
- ✓ Furnished in accordance with standards of good dental practice.
- ✓ Not solely for the member’s or dentist’s convenience.

### **How Do We Determine Necessity and Appropriateness of Treatment?**

Based on a review of the submitted procedure documentation, our dental consultants determine available benefits for certain types of procedures, including, but not limited to, cast restorations, periodontal services, oral surgery services, and fixed and removable prosthetics. A dental consultant reviews the treatment plan objectively and determines whether the services are within the scope of benefits, and whether these services appear to be necessary and appropriate for the member. Based on these findings, we may determine that a service is not *necessary and appropriate* for the member, even if a dentist has recommended, approved, prescribed, ordered, or furnished the service.

### **Services That Are Non-Covered Due to Contractual Limitations**

There are situations in which specific services are not covered regardless of whether the procedure is a covered benefit. These are considered contractual limitations and are outlined in the Subscriber Certificate under “Limitations and Exclusions.” Examples include a service performed for cosmetic purposes rather than for tooth decay or fracture or a service that is exploratory in nature.

### **Information We Need to Review a Procedure**

We review procedures including, but not limited to, cast restorations, periodontal services, oral surgery services, and fixed and removable prosthetics. To thoroughly review a procedure, we may need pertinent documentation supporting your patient’s treatment. This *Guide* identifies the information you must submit for each procedure that requires review. **In cases where we request a detailed narrative, please supply details about the patient’s condition that will help us evaluate your claim and reimburse you appropriately.**

### **When Documentation Is Requested**

**While we continue to conduct utilization review on submitted claims, we will no longer routinely require submission of radiographs or periodontal charting from participating HMSA PPO and HMO providers.** Please refer to the *Submission Requirements* column for any specific requirements needed when submitting claims for treatment.

### **When we do request documentation, please remember that radiographs must be:**

- ✓ Preoperative radiographic images that are current and dated
- ✓ Labeled “left” or “right” side if they are duplicates
- ✓ Mounted if they are a full series
- ✓ Of diagnostic quality

### **Please remember to include:**

- ✓ The Member’s name and ID
- ✓ The dentist’s name and address

Refer to the specific code listing to determine what additional documentation is required.

## I. D0100-D0999 Diagnostic

**CLINICAL ORAL EVALUATIONS:** The codes in this section recognize the cognitive skills necessary for patient evaluation. The collection and recording of some data and components of the dental examination may be delegated; however, the evaluation, which includes diagnosis and treatment planning, is the responsibility of the dentist. As with all ADA procedure codes, there is no distinction made between the evaluations provided by general practitioners and specialists. Report additional diagnostic or definitive procedures separately.

CDT Code	Description of Service	Pediatric Service Type	HCR Pediatric Plan Ages 0 through 18 Procedure Guidelines or Frequency Limitation	HCR Pediatric Plan Ages 0 through 18 Submission Requirements	Adult Service Type	HCR Adult Plan Ages 19 and older Procedure Guidelines or Frequency Limitation	HCR Adult Plan Ages 19 and older Submission Requirements	Integral Considerations and Exclusions
D0120	periodic oral evaluation - established patient	Preventive	Two (2) per calendar year.	None	Preventive	Only two (2) evaluation codes in any combination are allowed per member per calendar year.  Note: If member is enrolled in Oral Health for Total Health, D0120 may be covered four (4) per calendar year.	None	This includes an oral cancer evaluation and periodontal screening where indicated and may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately.
D0140	limited oral evaluation - problem focused	Preventive	One (1) per day.	None	Preventive	Only two (2) evaluation codes in any combination are allowed per member per calendar year.	None	These may require interpretation of information acquired through additional diagnostic procedures. Definitive procedures may be required on the same date as the evaluation.
D0145	oral evaluation for a patient under three years of age and counseling with primary caregiver	Preventive	Two (2) per calendar year.	None	Preventive	Not a covered benefit.	None	None

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D0150	comprehensive oral evaluation - new or established patient	Preventive	Two (2) per calendar year.	None	Preventive	Only two (2) evaluation codes in any combination are allowed per member per calendar year.	None	The exam is a thorough evaluation and recording of the extraoral hard and soft tissues. This includes an evaluation for oral cancer where indicated, the evaluation and recording of the patient's dental and medical history and a general health assessment.
D0160	detailed and extensive oral evaluation - problem focused, by report	Preventive	Not a covered benefit.	None	Preventive	Only two (2) evaluation codes in any combination are allowed per member per calendar year.	None	A detailed and extensive problem focused evaluation entails extensive diagnosis and cognitive modalities based on the findings of a comprehensive oral evaluations. Integration of more extensive diagnostic modalities to develop a treatment plan for a specific problem is required. The condition requiring this type of evaluation should be described and documented. Examples of conditions requiring this type of evaluation may include dentofacial anomalies, complicated perio-prosthetic conditions, complex temporomandibular dysfunction, facial pain of unknown origin, sleep related breathing disorders, conditions requiring multi-disciplinary consultation, etc.
D0170	re-evaluation-limited, problem focused (established patient; not post-operative visit)	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0171	re-evaluation- post-operative office visit	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None

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D0180	comprehensive periodontal evaluation - new or established patient	Preventive	Not a covered benefit.	None	Preventive	Only two (2) evaluation codes in any combination are allowed per member per calendar year.	None	Indicated for patients showing signs or symptoms of periodontal disease and for patients with risk factors such as smoking or diabetes. It includes evaluation of periodontal conditions, probing and charting, evaluation and recording of the patient's dental and medical history and general health assessment. It may also include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships, and oral cancer evaluation.
D0190	screening of a patient	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0191	assessment of a patient	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0210	intraoral - comprehensive series of radiographic images	Preventive	One (1) full mouth x-ray every two (2) years cannot be in conjunction with D0330.	None	Preventive	One (1) in a two (2) year period D0210 or D0330.	None	Covered based on the last service date once every two (2) years, except for the Federal plan which is covered once every five (5) years, based on the last service date.
D0220	intraoral - periapical first radiographic image	Preventive	One (1) per day.	None	Preventive	Subject to clinical necessity.	None	Periapical films, for diagnostic purposes, are covered as needed. Intra-operative "working" radiographs are included with complete root canal therapy.
D0230	intraoral - periapical each additional radiographic image	Basic	Not to exceed six (6) films per date of service. (No waiting period).	None	Basic	Not to exceed six (6) films per date of service. (No waiting period).	None	Periapical films, for diagnostic purposes, are covered as needed. Intra-operative "working" radiographs are included with complete root canal therapy.

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D0240	intraoral - occlusal radiographic image	Preventive	One (1) per day.	None	Preventive	By report.	Arch identification	Not payable as a substitute for children's complete series of intraoral radiographs.
D0250	extra-oral- 2D projection radiographic image created using a stationary radiation source, and detector	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D0251	extra-oral posterior dental radiographic image	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D0270	bitewing - single radiographic image	Preventive	Two (2) set per calendar year.	None	Preventive	One (1) set per calendar year.	None	Any of these codes constitute a set of bitewings. When bitewings are taken within twelve (12) months of a FMX, these guidelines apply. <ul style="list-style-type: none"> <li>If bitewings have been taken prior to an FMX, no limitation applies and both procedures will be paid.</li> </ul> If bitewings are submitted within twelve (12) months after a FMX has been paid, then the bitewings are denied due to the one (1) in twelve (12) month limitation for bitewings. The member will be responsible for the cost of the bitewings.

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D0272	bitewings - two radiographic images	Preventive	Two (2) set per calendar year.	None	Preventive	One (1) set per calendar year.	None	Refer to details listed for Code D0270
D0273	bitewings - three radiographic images	Basic	Not a covered benefit.	None	Preventive	One (1) set per calendar year.	None	Refer to details listed for Code D0270
D0274	bitewings - four radiographic images	Preventive	Two (2) set per calendar year.	None	Preventive	One (1) set per calendar year.	None	Refer to details listed for Code D0270
D0277	vertical bitewings - 7 to 8 radiographic images	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D0310	sialography	Basic	One (1) per day. Dental Reviewed – justification for radiograph required.	None	Basic	Not a covered benefit.	None	None
D0320	temporomandibular joint arthrogram, including injection	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D0321	other temporomandibular joint radiographic images, by report	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D0322	tomographic survey	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None

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D0330	panoramic radiographic image	Basic	One (1) set in a two (2) year period and cannot be taken in conjunction with a full mouth x-ray.	None	Basic	One (1) set in a two (2) year period and cannot be taken in conjunction with a full mouth x-ray.	None	No waiting periods. Additional panoramic films may be allowed if taken by an Oral Surgeon and the previous film is more than twelve (12) months old.
D0340	2D cephalometric radiographic image - acquisition, measurement, and analysis	Basic	One (1) per day.	None	Basic	Not a covered benefit.	None	None
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0364	cone beam CT capture and interpretation with limited field of view - less than one whole jaw	Basic	One (1) per day if rendered by an Oral Surgeon.	None	Preventive	Not a covered benefit.	None	None
D0365	cone beam CT capture and interpretation with field of view of one full dental arch - mandible	Basic	One (1) per day if rendered by an Oral Surgeon.	None	Preventive	Not a covered benefit.	None	None
D0366	cone beam CT capture and interpretation with field of view of one full dental arch - maxilla, with or without cranium	Basic	One (1) per day if rendered by an Oral Surgeon.	None	Preventive	Not a covered benefit.	None	None

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D0367	cone beam CT capture and interpretation with field of view of both jaws; with or without cranium	Basic	One (1) per day if rendered by an Oral Surgeon.	None	Preventive	Not a covered benefit.	None	None
D0368	cone beam CT capture and interpretation for TMJ series including two or more exposures	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0369	maxillofacial MRI capture and interpretation	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0370	maxillofacial ultrasound capture and interpretation	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0371	sialoendoscopy capture and interpretation	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0372	intraoral tomosynthesis - comprehensive series of radiographic images	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None

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D0373	intraoral tomosynthesis – bitewing radiographic image	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0374	intraoral tomosynthesis – periapical radiographic image	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0380	cone beam CT capture with limited field of view - less than whole jaw	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0381	cone beam CT image capture with field of view of one full dental arch - mandible	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0382	cone beam CT image capture with field of view of one full dental arch - maxilla, with or without cranium	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0383	cone beam CT image capture with field of view of both jaws; with and without cranium	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0384	cone beam CT image capture for TMJ series including two or more exposures	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0386	maxillofacial ultrasound image capture	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None

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D0387	Intraoral tomosynthesis – comprehensive series of radiographic images – image capture only	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0388	intraoral tomosynthesis – bitewing radiographic image – image capture only	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0389	intraoral tomosynthesis – periapical radiographic image – image capture only	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0391	intraoral - complete series of radiographic images - image capture only	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0393	virtual treatment simulation using 3D image volume or surface scan	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0394	digital subtraction of two or more images or image volumes of the same modality	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0395	fusion of two (2) or more 3D image volumes of one (1) or more modalities	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None

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D0396	3D printing of a 3D dental surface scan	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0411	HbA1c in-office point of service testing	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0412	blood glucose level test - in-office using a glucose meter	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0414	laboratory processing of microbial specimen to include culture and sensitivity studies, preparation, and transmission of written report.	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None

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D0415	collection of microorganisms for culture and sensitivity	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0416	viral culture	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0417	collection and preparation of saliva sample for laboratory diagnostic testing	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0418	analysis of saliva sample	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0419	assessment of salivary flow by measurement	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0422	collection and preparation of genetic sample material for laboratory analysis and report	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0423	genetic test for susceptibility to diseases - specimen analysis	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0425	caries susceptibility tests	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None

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D0431	adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	Preventive	Covered under Enhanced Dental Benefits only.	None	Preventive	Covered under Enhanced Dental Benefits only.	None	Note: If adult member has a qualified medical condition (Oral Cancer), D0431 may be covered every six (6) months. Must be qualified and enrolled for Enhanced Dental Benefits.
D0460	pulp vitality tests	Preventive	Not a covered benefit.	None	Preventive	One (1) per member per calendar year.	None	May be billed in conjunction with evaluation codes or root canal therapy (D3310, D3320, and D3330). If more than one (1) tooth has pulp vitality testing on the same date of service, only one (1) will be paid.
D0470	diagnostic casts	Basic	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0472	accession of tissue, gross and microscopic examination, preparation, and transmission of written report	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0473	accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation, and transmission of written report	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None

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D0474	accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation, and transmission of written report	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0475	decalcification procedure	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0476	special stains for microorganisms	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0477	special stains, not for microorganisms	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0478	immunohistochemical stains	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0479	tissue in-situ hybridization, including interpretation	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None

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CDT Code	Description of Service	Pediatric Service Type	HCR Pediatric Plan Ages 0 through 18  Procedure Guidelines or Frequency Limitation	HCR Pediatric Plan Ages 0 through 18  Submission Requirements	Adult Service Type	HCR Adult Plan Ages 19 and older  Procedure Guidelines or Frequency Limitation	HCR Adult Plan Ages 19 and older  Submission Requirements	Integral Considerations and Exclusions
D0480	accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0481	electron microscopy	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0482	direct immunofluorescence	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0483	indirect immunofluorescence	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0484	consultation on slides prepared elsewhere	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0485	consultation, including preparation of slides from biopsy material supplied by referring source	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0486	laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0502	other oral pathology procedures, by report	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None

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D0600	non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin, and cementum	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0601	caries risk assessment and documentation, with a finding of low risk	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0602	caries risk assessment and documentation, with a finding of moderate risk	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0603	caries risk assessment and documentation, with a finding of high risk	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0604	antigen testing for a public health related pathogen including coronavirus	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0605	antibody testing for a public health related pathogen, including coronavirus	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0701	panoramic radiographic image - image capture only	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D0702	2-D cephalometric radiographic image - image capture only	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None

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CDT Code	Description of Service	Pediatric Service Type	HCR Pediatric Plan Ages 0 through 18  Procedure Guidelines or Frequency Limitation	HCR Pediatric Plan Ages 0 through 18  Submission Requirements	Adult Service Type	HCR Adult Plan Ages 19 and older  Procedure Guidelines or Frequency Limitation	HCR Adult Plan Ages 19 and older  Submission Requirements	Integral Considerations and Exclusions
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally image capture only	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D0705	extra-oral posterior dental radiographic image - image capture only	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D0706	intraoral - occlusal radiographic image - image capture only	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D0707	intraoral - periapical radiographic image - image capture only	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D0708	intraoral - bitewing radiographic image - image capture only	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D0709	intraoral - comprehensive series of radiographic images - image capture only	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D0801	3D intraoral surface scan – direct	Preventive	Integral	None	Preventive	Integral	None	None

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D0802	3D dental surface scan – indirect	Preventive	Integral	None	Preventive	Integral	None	None
D0803	3D facial surface scan – direct	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0804	3D facial surface scan – indirect	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D0999	unspecified diagnostic procedure, by report	Preventive	Not a covered benefit.	None	Preventive	By Report.	Individual Consideration. Detailed narrative required.	None

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## II. D1000-D1999 Preventive

**DENTAL PROPHYLAXIS:** When one (1) periodontal service and cleaning are completed on the same date of service, the plan will pay for the more extensive treatment (periodontal service).

CDT Code	Description of Service	Pediatric Service Type	HCR Pediatric Plan Ages 0 through 18  Procedure Guidelines or Frequency Limitation	HCR Pediatric Plan Ages 0 through 18  Submission Requirements	Adult Service Type	HCR Adult Plan Ages 19 and older  Procedure Guidelines or Frequency Limitation	HCR Adult Plan Ages 19 and older  Submission Requirements	Integral Considerations and Exclusions
D1110	prophylaxis - adult	Preventive	Two (2) per calendar year, limited to ages fifteen (15) through nineteen (19).	None	Preventive	Two (2) per calendar year, age nineteen (19) and older.	None	Covered according to the terms of dental plan. Code D1110 may be used for member's aged fifteen (15) and older.  Note: If member is enrolled in Oral Health for Total Health, D1110/D1120 or D4346 or D4910 may be covered once every three (3) months.
D1120	prophylaxis - child	Preventive	Two (2) per calendar year limited to ages 0 through age fourteen (14).	None	Preventive	Not a covered benefit.	None	Refer to details listed for code D1110
D1206	topical application of fluoride varnish	Preventive	Two (2) per calendar year, covered through age eighteen (18).	None	Preventive	Not a covered benefit.	None	D1206 can be used in combination with D1208 and vice versa, up to a total of two (2), topical or varnish fluoride applications per calendar year.  Note: If member has oral cancer or Sjögren's syndrome and is enrolled in Oral Health for Total Health, D1206 or D1208 may be covered once every three (3) months.

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CDT Code	Description of Service	Pediatric Service Type	HCR Pediatric Plan Ages 0 through 18  Procedure Guidelines or Frequency Limitation	HCR Pediatric Plan Ages 0 through 18  Submission Requirements	Adult Service Type	HCR Adult Plan Ages 19 and older  Procedure Guidelines or Frequency Limitation	HCR Adult Plan Ages 19 and older  Submission Requirements	Integral Considerations and Exclusions
D1208	topical application of fluoride - excluding varnish	Preventive	Two (2) per calendar year, covered through age eighteen (18).	None	Preventive	Not a covered benefit.	None	Refer to details listed for D1206.
D1301	immunization counseling	Preventive	Integral to exams D0120-D0180	None	Preventive	Integral	None	None
D1310	nutritional counseling for control of dental disease	Preventive	Integral	None	Preventive	Integral	None	None
D1320	tobacco counseling for the control and prevention of oral disease	Preventive	Integral	None	Preventive	Integral	None	None
D1321	counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high - risk substance use	Preventive	Integral	None	Preventive	Integral	None	None
D1330	oral hygiene instructions	Preventive	Integral	None	Preventive	Integral	None	None
D1351	sealant - per tooth	Preventive	One (1) per tooth every five (5) years for permanent 1st and 2nd molars.	Tooth Identification	Preventive	One (1) per tooth every five (5) years for permanent 1st and 2nd molars. Age 5 through 20.	None	None

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CDT Code	Description of Service	Pediatric Service Type	HCR Pediatric Plan Ages 0 through 18  Procedure Guidelines or Frequency Limitation	HCR Pediatric Plan Ages 0 through 18  Submission Requirements	Adult Service Type	HCR Adult Plan Ages 19 and older  Procedure Guidelines or Frequency Limitation	HCR Adult Plan Ages 19 and older  Submission Requirements	Integral Considerations and Exclusions
D1352	preventive resin restoration in a moderate to high caries risk patient - permanent tooth	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D1353	sealant repair - per tooth	Preventive	Not a covered benefit; provider liability within twelve (12) months of initial placement.	None	Preventive	Not a covered benefit.	None	None
D1354	interim caries arresting medicament application - per tooth	Preventive	Two (2) per tooth per calendar year.	Tooth Identification	Preventive	Two (2) per tooth per calendar year.	Tooth Identification	None
D1355	caries preventive medicament application - per tooth	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D1510	space maintainer - fixed, unilateral - per quadrant	Basic	Two (2) per arch per twenty-four (24) months.	Arch identification	Basic	Not a covered benefit.	None	The procedure code listed is not to be used to claim for the temporary replacement of teeth for adults.
D1516	space maintainer - fixed - bilateral, maxillary	Basic	Two (2) per arch per twenty-four (24) months.	Arch identification	Basic	Not a covered benefit.	None	The procedure code listed is not to be used to claim for the temporary replacement of teeth for adults.
D1517	space maintainer - fixed - bilateral, mandibular	Basic	Two (2) per arch per twenty-four (24) months.	Arch identification	Basic	Not a covered benefit.	None	The procedure code listed is not to be used to claim for the temporary replacement of teeth for adults.
D1520	space maintainer - removable, unilateral - per quadrant	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None

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CDT Code	Description of Service	Pediatric Service Type	HCR Pediatric Plan Ages 0 through 18  Procedure Guidelines or Frequency Limitation	HCR Pediatric Plan Ages 0 through 18  Submission Requirements	Adult Service Type	HCR Adult Plan Ages 19 and older  Procedure Guidelines or Frequency Limitation	HCR Adult Plan Ages 19 and older  Submission Requirements	Integral Considerations and Exclusions
D1526	space maintainer - removable - bilateral, maxillary	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D1527	space maintainer - removable - bilateral, mandibular	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D1551	re-cement or re-bond bilateral space maintainer - maxillary	Basic	One (1) in a calendar year.	Arch identification	Basic	Not a covered benefit.	None	Recementation is allowed if more than six (6) months have passed since insertion.
D1552	re-cement or re-bond bilateral space maintainer - mandibular	Basic	One (1) in a calendar year.	Arch identification	Basic	Not a covered benefit.	None	Recementation is allowed if more than six (6) months have passed since insertion.
D1553	re-cement or re-bond unilateral space maintainer - per quadrant	Basic	One (1) in a calendar year.	Arch identification	Basic	Not a covered benefit.	None	Recementation is allowed if more than six (6) months have passed since insertion.
D1556	removal of fixed unilateral space maintainer - per quadrant	Basic	One (1) in a calendar year.	Arch identification	Basic	Not a covered benefit.	None	None
D1557	removal of fixed bilateral space maintainer - maxillary	Basic	One (1) in a calendar year.	Arch identification	Basic	Not a covered benefit.	None	None
D1558	removal of fixed bilateral space maintainer - mandibular	Basic	One (1) in a calendar year.	Arch identification	Basic	Not a covered benefit.	None	None
D1575	distal shoe space maintainer - fixed, unilateral - per quadrant	Basic	Two (2) per arch per twenty-four (24) months.	Arch identification	Basic	Not a covered benefit.	None	None
D1781	vaccine administration – human papillomavirus – Dose 1	Preventative	Not a covered benefit.	None	Preventative	Not a covered benefit.	None	None

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D1782	vaccine administration – human papillomavirus – Dose 2	Preventative	Not a covered benefit.	None	Preventative	Not a covered benefit.	None	None
D1783	vaccine administration – human papillomavirus – Dose 3	Preventative	Not a covered benefit.	None	Preventative	None	Not a covered benefit.	None
D1999	unspecified preventive procedure, by report	Basic	By Report.	None	Basic	By Report.	None	None

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### III. D2000-D2999 Restorative

Local anesthesia is usually considered to be part of Restorative procedures

#### Explanation of Restorations

Location	Number of Surfaces	Characteristics
Anterior	1	Placed on one of the following five surface classifications – Mesial, Distal, Incisal, Lingual, or Facial (or Labial).
	2	Placed, without interruption, on two of the five surface classifications – e.g., Mesial - Lingual
	3	Placed, without interruption, on three of the five surface classifications – e.g., Lingual – Mesial – Facial (or Labial)
	4 or more	Placed, without interruption, on four or more of the five surface classifications – e.g., Mesial – Incisal – Lingual – Facial (or Labial)
Posterior	1	Placed on one of the following five surface classifications – Mesial, Distal, Occlusal, Lingual, or Buccal
	2	Placed, without interruption, on two of the five surface classifications – e.g., Mesial – Occlusal
	3	Placed, without interruption, on three of the five surface classifications – e.g., Lingual – Occlusal – Distal
	4 or more	Placed, without interruption, on four or more of the five surface classifications – e.g., Mesial – Occlusal – Lingual – Distal.

**Note:** Tooth surfaces are reported on the HIPAA standard electronic dental transaction and the ADA Dental Claim Form using the letters in the following table.

Surface	Code
Buccal	B
Distal	D
Facial (or Labial)	F
Incisal	I
Lingual	L
Mesial	M
Occlusal	O

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D2140	amalgam - one surface, primary or permanent	Basic	One (1) restoration per surface per tooth per twelve (12) month period.	Tooth identification, Surface identification	Basic	One (1) restoration per surface per tooth per twelve (12) month period.	Tooth identification, Surface identification	Coverage includes polishing. Limited to one (1) surface (O, M, D, B, and L) per twelve (12) month period regardless of materials used and how many separate restorations share the same surface. Example: Two separate restorations, MO and DO will be paid as a D2160 MOD. There is a twelve (12) -month waiting period between services
D2150	amalgam - two surfaces, primary or permanent	Basic	One (1) restoration per surface per tooth per twelve (12) month period.	Tooth identification, Surface identification	Basic	One (1) restoration per surface per tooth per twelve (12) month period.	Tooth identification, Surface identification	Refer to details listed for Code D2140.
D2160	amalgam - three surfaces, primary or permanent	Basic	One (1) restoration per surface per tooth per twelve (12) month period.	Tooth identification, Surface identification	Basic	One (1) restoration per surface per tooth per twelve (12) month period.	Tooth identification, Surface identification	Refer to details listed for Code D2140.
D2161	amalgam - four or more surfaces, primary or permanent	Basic	One (1) restoration per surface per tooth per twelve (12) month period.	Tooth identification, Surface identification	Basic	One (1) restoration per surface per tooth per twelve (12) month period.	Tooth identification, Surface identification	Refer to details listed for Code D2140.
D2330	resin-based composite - one surface, anterior	Basic	One (1) restoration per surface per tooth per twelve (12) month period.	Tooth identification, Surface identification	Basic	One (1) restoration per surface per tooth per twelve (12) month period.	Tooth identification, Surface identification	Limited to one (1) surface (I, M, D, B, and L) per twelve (12) month period regardless of materials used and how many separate restorations share the same surface. Example: Two (2) separate restorations, ML and DL will be paid as D2332 MLD, or MFD.

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D2331	resin-based composite - two surfaces, anterior	Basic	One (1) restoration per surface per tooth per twelve (12) month period.	Tooth identification, Surface identification	Basic	One (1) restoration per surface per tooth per twelve (12) month period.	Tooth identification, Surface identification	Refer to details listed for Code D2330.
D2332	resin-based composite - three surfaces, anterior	Basic	One (1) restoration per surface per tooth per twelve (12) month period.	Tooth identification, Surface identification	Basic	One (1) restoration per surface per tooth per twelve (12) month period.	Tooth identification, Surface identification	Refer to details listed for Code D2330.
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	Basic	One (1) restoration per surface per tooth per twelve (12) month period.	Tooth identification, Surface identification	Basic	One (1) restoration per surface per tooth per twelve (12) month period.	Tooth identification, Surface identification	Refer to details listed for Code D2330.
D2390	resin-based composite crown, anterior	Basic	Not a covered benefit.	None	Basic	One (1) per tooth per three (3) years. Alternate benefit, D2930 or D2931.	Tooth identification	Covered according to the terms of the member's dental plan. If the member elects to have a resin-based composite crown the member will be responsible for the difference between the stainless-steel crown allowance and the dentist's billed charge. There is a three (3) year waiting period between services.

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D2391	resin-based composite - one surface, posterior	Basic	One (1) restoration per surface per tooth per twelve (12) month period.	Tooth identification, Surface Identification	Basic	One (1) restoration surface per tooth per (12) months. Alternate benefit, D2140.	Tooth identification, Surface identification	Covered according to the terms of the member's dental plan. Stand-alone single facial restorations on bicuspids will be considered as exceptions and will be covered as composites. Specify surfaces and tooth numbers. Limited to one (1) surface (O, M, D, B, L) per twelve (12) month period regardless of materials used and how many separate restorations share the same surface. Example: Two (2) separate restorations, an MO and DO will be paid as D2393 MOD. There is a twelve (12) month waiting period between services. If a member elects to have a resin-based composite restoration on a posterior tooth, the member will be responsible for the difference between the alternate amalgam allowance and the dentist's charge.
D2392	resin-based composite - two surfaces, posterior	Basic	One (1) restoration per surface per tooth per twelve (12) month period.	Tooth identification, Surface identification	Basic	One (1) restoration surface per tooth per (12) months. Alternate benefit, D2150.	Tooth identification, Surface identification	Refer to details listed for Code D2391.

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D2393	resin-based composite - three surfaces, posterior	Basic	One (1) per tooth per two (2) years for duplicated restorative service(s).  One (1) per tooth per year for <b>non-duplicated</b> restorative surface(s).  Primary teeth A, B, I, J, K, L, S, T. Permanent teeth 1-5,12-21, 28-32.	Tooth identification, Surface identification	Basic	One (1) restoration per surface per tooth per twelve (12) months. Alternate benefit, D1260.	Tooth identification, Surface identification	Refer to details listed for Code D2391.
D2394	resin-based composite - four or more surfaces, posterior	Basic	One (1) per tooth per two (2) years for duplicated restorative service(s).  One (1) per tooth per year for <b>non-duplicated</b> restorative surface(s).  Primary teeth A, B, I, J, K, L, S, T. Permanent teeth 1-5,12-21, 28-32.	Tooth identification, Surface identification	Basic	One (1) restoration per surface per tooth per twelve (12) months. Alternate benefit, D2161.	Tooth identification, Surface identification	Refer to details listed for Code D2391.

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D2410	gold foil - one surface	Basic	Not a covered benefit.	None	Basic	One (1) per tooth per five (5) years. Alternate benefit, D2510.	None	None
D2420	gold foil - two surfaces	Basic	Not a covered benefit.	None	Basic	One (1) per tooth per five (5) years. Alternate benefit, D2520.	None	None
D2430	gold foil - three surfaces	Basic	Not a covered benefit.	None	Basic	One (1) per tooth per five (5) years. Alternate benefit, D2530.	None	None

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## 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

### **When services are covered:**

- To restore fractured or severely diseased teeth that cannot properly be restored by direct amalgam or resin restorations.
- Teeth must be endodontically and periodontally sound.

Onlays are defined as needing buccal and or lingual cusp reduction and coverage.

### **When services are not covered:**

- Cosmetic purposes or to restore or treat complications of non-covered procedures.
- To treat TMJ dysfunction.
- Increase vertical dimension.
- Restore occlusion lost through erosion, abrasion, or attrition.

Correction of congenital or developmental abnormalities.

### **Benefit criteria and limitations:**

- Restoration is covered only once every five (5) years.
- Members nineteen (19) years or older.
- Permanent teeth only.
- Service or completion date is the cementation date.
- Service includes preparation of teeth, indirect pulp caps, bases, liners, laboratory costs, temporary crowns/bridges, cementation, and local anesthesia.
- If an alternate benefit is paid, the member is responsible for the difference between The Plan allowance and provider's billed charge.

Gingivectomy performed in conjunction with an inlay/onlay is considered a part of the procedure and cannot be billed separately.

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D2510	inlay - metallic - one surface	Major	Not a covered benefit.	None	Major	One (1) per tooth per five (5) years. Alternate Benefit, D2542.	Tooth identification, Surface identification	Metallic inlays may be covered when clinical conditions such as extensive caries or fractures do not permit a direct restoration. Coverage is for permanent teeth only. Frequency limitations: There is a five (5) year waiting between services. The patient must be age nineteen (19) or older. Service or completion date is the cementation date.
D2520	inlay - metallic - two surfaces	Major	Not a covered benefit.	None	Major	One (1) per tooth per five (5) years. Alternate Benefit, D2150.	Tooth identification, Surface identification	Refer to details listed for code D2510.
D2530	inlay - metallic - three or more surfaces	Major	Not a covered benefit.	None	Major	One (1) per tooth per five (5) years. Alternate Benefit, D2160.	Tooth identification, Surface identification	Refer to details listed for code D2510.
D2542	onlay - metallic - two surfaces	Major	Not a covered benefit.	None	Major	One (1) per tooth per five (5) years. Alternate Benefit, D2150.	Tooth identification, Surface identification	Refer to details listed for code D2510.
D2543	onlay - metallic - three surfaces	Major	Not a covered benefit.	None	Major	One (1) per tooth per five (5) years. Alternate Benefit, D2160.	Tooth identification Surface identification	Refer to details listed for code D2510.
D2544	onlay - metallic - four or more surfaces	Major	Not a covered benefit.	None	Major	One (1) per tooth per five (5) years. Alternate Benefit, D2161.	Tooth identification Surface identification	Refer to details listed for code D2510.
D2610	inlay - porcelain/ceramic - one surface	Major	Not a covered benefit.	None	Major	One (1) per tooth per five (5) years. Alternate Benefit, D2140.	Tooth identification Surface identification	None

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CDT Code	Description of Service	Pediatric Service Type	HCR Pediatric Plan Ages 0 through 18 Procedure Guidelines or Frequency Limitation	HCR Pediatric Plan Ages 0 through 18 Submission Requirements	Adult Service Type	HCR Adult Plan Ages 19 and older Procedure Guidelines or Frequency Limitation	HCR Adult Plan Ages 19 and older Submission Requirements	Integral Considerations and Exclusions
D2620	inlay - porcelain/ceramic - two surfaces	Major	Not a covered benefit.	None	Major	One (1) per tooth per five (5) years. Alternate Benefit, D2150.	Tooth identification Surface identification	None
D2630	inlay - porcelain/ceramic - three or more surfaces	Major	Not a covered benefit.	None	Major	One (1) per tooth per five (5) years. Alternate benefit D2160.	Tooth identification Surface identification	None
D2642	onlay - porcelain/ceramic - two surfaces	Major	Not a covered benefit.	None	Major	One (1) per tooth per five (5) years. Alternate benefit D2150.	Tooth identification Surface identification	None
D2643	onlay - porcelain/ceramic - three surfaces	Major	Not a covered benefit.	None	Major	One (1) per tooth per five (5) years. Alternate benefit D2160.	Tooth identification	None
D2644	onlay - porcelain/ceramic - four or more surfaces	Major	Not a covered benefit.	None	Major	One (1) per tooth per five (5) years. Alternate benefit D2161	Tooth identification	None
D2650	inlay -resin-based composite - one surface	Major	Not a covered benefit.	None	Major	One (1) per tooth per five (5) years. Alternate benefit D2140	Tooth identification	None
D2651	inlay -resin-based composite - two surfaces	Major	Not a covered benefit.	None	Major	One (1) per tooth per five (5) years. Alternate benefit D2150.	Tooth identification	None
D2652	inlay -resin-based composite - three or more surfaces	Major	Not a covered benefit.	None	Major	One (1) per tooth per five (5) years. Alternate benefit D2160.	Tooth identification	None

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D2662	onlay - resin based composite - two surfaces	Major	Not a covered benefit.	None	Major	One (1) per tooth per five (5) years. Alternate benefit D2150.	Tooth identification Surface identification	None
D2663	onlay - resin based composite - three surfaces	Major	Not a covered benefit.	None	Major	One (1) per tooth per five (5) years. Alternate benefit D2160.	Tooth identification Surface identification	None
D2664	onlay - resin - based composite - four or more surfaces	Major	Not a covered benefit.	None	Major	One (1) per tooth per five (5) years. Alternate benefit D2161.	Tooth identification Surface identification	None

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## **CROWNS, SINGLE RESTORATIONS ONLY**

When services are covered:

- To restore fractured or severely diseased teeth which cannot properly be restored by direct amalgam or resin restorations.
- Teeth must be endodontically and periodontally sound.

When services are not covered:

- Cosmetic purposes or to restore or treat complications of non-covered procedures.
- To treat TMJ dysfunction.
- Increase vertical dimension.
- Restore occlusion lost through erosion, abrasion, or attrition.

Correction of congenital or developmental abnormalities

Benefit criteria and limitations:

- Restoration is covered only once every five (5) years.
- Members nineteen (19) years or older.
- Permanent teeth only.
- Service or completion date is the cementation date.
- Service includes preparation of teeth, indirect pulp cap, bases, liners, laboratory costs, temporary crowns/bridges, cementation, and local anesthesia.
- If an alternate benefit is paid, the member is responsible for the difference between The Plan allowance and provider's billed charge.

Gingivectomy performed in conjunction with a crown is considered a part of the procedure and cannot be billed separately.

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CDT Code	Description of Service	Pediatric Service Type	HCR Pediatric Plan Ages 0 through 18 Procedure Guidelines or Frequency Limitation	HCR Pediatric Plan Ages 0 through 18 Submission Requirements	Adult Service Type	HCR Adult Plan Ages 19 and older Procedure Guidelines or Frequency Limitation	HCR Adult Plan Ages 19 and older Submission Requirements	Integral Considerations and Exclusions
D2710	crown - resin - based composite (indirect)	Major	Not a covered benefit.	None	Major	One (1) per tooth per five (5) years for permanent teeth only.	Tooth identification	None
D2712	crown - 3/4 resin - based composite (indirect)	Major	Not a covered benefit.	None	Major	One (1) per tooth per five (5) years.	Tooth identification	None
D2720	crown - resin with high noble metal	Major	Not a covered benefit.	None	Major	One (1) per tooth per five (5) years for permanent teeth only.	Tooth identification	None
D2721	crown - resin with predominantly base metal	Major	Not a covered benefit.	None	Major	One (1) per tooth per five (5) years for permanent teeth only.	Tooth identification	None
D2722	crown - resin with noble metal	Major	Not a covered benefit.	None	Major	One (1) per tooth per five (5) years for permanent teeth only.	Tooth identification	None
D2740	crown - porcelain/ceramic	Major	One (1) per tooth per five (5) years for permanent teeth only. Alternate benefit; D2790 for molars, covered for anterior teeth.	Prior Authorization Required	Major	One (1) per tooth per five (5) years for permanent teeth only. Alternate benefit; D2790 for molars, covered for anterior teeth.	Tooth identification	None

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CDT Code	Description of Service	Pediatric Service Type	HCR Pediatric Plan Ages 0 through 18  Procedure Guidelines or Frequency Limitation	HCR Pediatric Plan Ages 0 through 18  Submission Requirements	Adult Service Type	HCR Adult Plan Ages 19 and older  Procedure Guidelines or Frequency Limitation	HCR Adult Plan Ages 19 and older  Submission Requirements	Integral Considerations and Exclusions
D2750	crown - porcelain fused to high noble metal	Major	One (1) per tooth per five (5) years for permanent teeth only. Alternate benefit: D2790 for molars, covered for anterior teeth.	<b>Prior Authorization Required</b>	Major	One (1) per tooth per five (5) years for permanent teeth only. Alternate benefit: D2790 for molars only, covered for anterior teeth.	Tooth identification	None
D2751	crown – porcelain fused to predominantly base metal	Major	One (1) per tooth per five (5) years for permanent teeth only. Alternate benefit D2791 for molars, covered for anterior teeth.	<b>Prior Authorization Required</b> , Tooth identification	Major	One (1) per tooth per five (5) years for permanent teeth only. Alternate benefit D2791 for molars, covered for anterior teeth.	Tooth identification	None
D2752	crown – porcelain fused to noble metal	Major	One (1) per tooth per five (5) years for permanent teeth only. Alternate benefit, D2792 for molars, covered for anterior teeth.	<b>Prior Authorization Required</b> , Tooth identification	Major	One (1) per tooth per five (5) years for permanent teeth only. Alternate benefit D2792 for molars, covered for anterior teeth.	Tooth identification	None
D2753	crown – porcelain fused to titanium and titanium alloys	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D2780	crown – ¾ cast high noble metal	Major	Not a covered benefit.	None	Major	One (1) per tooth per five (5) years for permanent teeth only.	Tooth identification	None
D2781	crown – ¾ cast predominantly base metal	Major	Not a covered benefit.	None	Major	One (1) per tooth per five (5) years for permanent teeth only.	Tooth identification	None

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D2782	crown – ¾ cast noble metal	Major	Not a covered benefit.	None	Major	One (1) per tooth per five (5) years for permanent teeth only.	Tooth identification	None
D2783	crown – ¾ porcelain/ceramic (not facial veneers)	Major	Not a covered benefit.	None	Major	One (1) per tooth per five (5) years for permanent teeth only.	Tooth identification	None
D2790	crown – full cast high-noble metal	Major	One (1) per tooth per five (5) years for permanent teeth only.	Prior Authorization Required	Major	One (1) per tooth per five (5) years for permanent teeth only.	Tooth identification	None
D2791	crown – full cast predominantly base metal	Major	One (1) per tooth per five (5) years for permanent teeth only.	Prior Authorization Required, Tooth identification	Major	One (1) per tooth per five (5) years for permanent teeth only.	Tooth identification	None
D2792	Crown – full cast noble metal	Major	One (1) per tooth per five (5) years for permanent teeth only.	Prior Authorization Required, Tooth identification	Major	One (1) per tooth per five (5) years for permanent teeth only.	Tooth identification	None

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CDT Code	Description of Service	Pediatric Service Type	HCR Pediatric Plan Ages 0 through 18  Procedure Guidelines or Frequency Limitation	HCR Pediatric Plan Ages 0 through 18  Submission Requirements	Adult Service Type	HCR Adult Plan Ages 19 and older  Procedure Guidelines or Frequency Limitation	HCR Adult Plan Ages 19 and older  Submission Requirements	Integral Considerations and Exclusions
D2794	crown - titanium and titanium alloys	Major	Not a covered benefit.	None	Major	One (1) per tooth per five (5) years for permanent teeth only.	Tooth identification	None
D2799	interim crown - further treatment or completion of diagnosis necessary prior to final impression	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	Basic	One (1) per tooth per day. Covered primary teeth A-T Covered permanent teeth 1-32	Tooth identification	Basic	Maximum two (2) in a five (5) year period. Age nineteen (19) or older	Tooth identification	Coverage is for two (2) re-cementations per inlay/onlay, crown, fixed partial denture, or cast or prefabricated post and core. Re-cementation of inlays, onlays, and fixed partial dentures may be performed on permanent teeth only. Crowns may be re-cemented on both primary and permanent teeth. Re-cementation is allowable if six (6) months have passed since the original cementation date. There is a twelve (12) month waiting period between re-cementations. The member must be age nineteen (19) or older except for crown re-cementation.
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core	Major	Not a covered benefit.	None	Basic	Maximum two (2) in a five (5) year period. Age nineteen (19) or older	Tooth identification	Refer to details for Code D2910.
D2920	re-cement or re-bond crown	Basic	One (1) per tooth per day. Covered primary teeth A-T Covered permanent teeth 1-32	Tooth identification	Basic	Maximum two (2) in a five (5) year period.	Tooth identification	Refer to details for Code D2910.

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D2921	reattachment of tooth fragment, incisal edge, or cusp	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D2928	prefabricated porcelain/ceramic crown - permanent tooth	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D2929	prefabricated porcelain/ceramic crown - primary tooth	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D2930	prefabricated stainless steel crown - primary tooth	Basic	One (1) Per Tooth Per 24 Months. Not Subject To 12 Month Wait for crowns.	Tooth identification	Basic	One (1) per tooth per three (3) years. Not subject to twelve (12) month wait for crowns.	Tooth identification	Coverage includes indirect pulp caps, bases, liners, and local anesthesia. Prefabricated stainless steel or resin crowns are not covered if used as temporary crowns. There is a three (3) year waiting period between services. Service or completion date is the cementation date.
D2931	prefabricated stainless steel crown – permanent tooth	Basic	One (1) Per Tooth Per 24 Months. Not Subject To 12 Month Wait for crowns.	Tooth identification	Basic	One (1) per tooth per three (3) years.	Tooth identification	Refer to details for Code D2930.
D2932	prefabricated resin crown	Basic	One (1) Per Tooth per two (2) years. Alternate benefit D2931.	Tooth identification	Basic	One (1) per tooth per three (3) years. Alternate benefit D2931.	Tooth identification	Refer to details for Code D2930.

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D2933	prefabricated stainless steel crown with resin window	Basic	One (1) Per Tooth per two (2) years. Alternate benefit D2930.	Tooth identification	Major	Not a covered benefit.	None	None
D2934	prefabricated esthetic coated stainless-steel crown - primary tooth	Basic	One (1) Per Tooth per two (2) years. Alternate benefit D2930.	Tooth identification	Basic	One (1) per tooth per three (3) year period. Alternate benefit D2930.	Tooth identification	Coverage includes bases, liners, and local anesthesia. Prefabricated stainless steel or resin crowns are not covered, if used as temporary crowns. There is a three (3) year waiting period between services. Alternate benefit D2930 Service or completion date is the cementation date.
D2940	placement of interim direct restoration	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D2949	restorative foundation for an indirect restoration	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	Integral to Restorative Procedure
D2950	core buildup, including any pins when required	Basic	Includes any pins for permanent teeth only 2 thru 15, 18 thru 31.	<b>Prior Authorization Required</b> , Tooth identification	Basic	One (1) per tooth per five (5) years for permanent teeth only. Age nineteen (19) or older.	Tooth identification	Core buildup is allowed for endodontically treated teeth. Core buildup is covered for vital teeth when more than 50 percent of the coronal tooth structure is missing. Core build up should not be reported when the procedure only involves a filler to eliminate any undercut, box form, or concave irregularity in the preparation. When combined in a claim with a cast or prefabricated post and core (D2952, D2954), core buildup (D2950) is not paid separately.

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D2951	pin retention - per tooth, in addition to restoration	Basic	Two (2) Per Tooth Per Lifetime. Permanent Teeth Excluding 3rd Molars.	<b>Prior Authorization Required</b> , Tooth identification	Basic	Up to two (2) times per twelve (12) months.	Tooth identification	Pins are covered for permanent teeth only.  Pin retention is not covered separately when claimed with cast-post and core, prefabricated-post and core, and core buildup (D2952, D2954, and D2950).  To be eligible for payment, services must occur twelve (12) months apart.
D2952	post and core in addition to crown, indirectly fabricated	Basic	One (1) per tooth per five (5) years. Permanent teeth 2 thru 15, 18 thru 31. Alternate benefit D2954.	<b>Prior Authorization Required</b> , Tooth identification	Basic	One (1) per tooth per five (5) years, Permanent teeth 2 thru 15, 18 thru 31. Alternate benefit D2954.	Service or completion date is the cementation date	Post and core are not included as part of a crown and are eligible for separate payment. Post and core are covered for permanent teeth that have received root canal therapy. Core build-up (D2950) and pin retention (D2951) are not covered separately if claimed with D2952, D2954, D6970 or D6972 on same tooth.
D2953	each additional indirectly fabricated post - same tooth	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D2954	prefabricated post and core in addition to crown	Basic	One (1) per tooth per five (5) years, Permanent teeth 2 thru 15, 18 thru 31.	<b>Prior Authorization Required</b>	Basic	One (1) per tooth per five (5) years. Permanent teeth 2 thru 15, 18 thru 31.	Tooth identification	Prefabricated post and core are not included as part of a crown and are eligible for separate payment. Prefabricated post and core are covered for permanent teeth that have received root canal therapy. Core build-up (D2950) and pin retention (D2951) are not covered separately if claimed with D2952, D2954, D6970 or D6972 on same tooth.

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D2955	post removal	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D2956	removal of an indirect restoration on a natural tooth	Major	Integral	None	Major	Integral	None	None
D2957	each additional prefabricated post - same tooth	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D2960	labial veneer (resin laminate - direct	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D2961	labial veneer (resin laminate) - indirect	Major	Not a covered benefit.	None	Major	Not a covered benefit.	Tooth identification	<p>Labial veneers are covered when the tooth, as a result of extensive caries, fracture, or root canal therapy, cannot be restored with a direct restoration on permanent teeth only. Only veneers on anterior teeth (#6 through #11, #22 through #27) are covered. Labial veneers are not a benefit if used on bicuspid or molars.</p> <p>Labial veneers are not a benefit if performed for cosmetic purposes or when normal dental attrition occurs. Five (5) year waiting period between services.</p>

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D2962	labial veneer (porcelain laminate) - indirect	Major	Not a covered benefit.	None	Major	Not a covered benefit.	Tooth identification	See details listed for Code D2961.
D2971	additional procedures to construct new crown under existing partial denture framework	Major	Not a covered benefit.	None	Basic	One (1) per tooth per five (5) years for permanent teeth only. Age nineteen (19) or older.	Tooth identification	Must be reported with individual crown.
D2975	coping	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D2976	band stabilization – per tooth	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D2980	crown repair necessitates by restorative material failure	Basic	Not a covered benefit.	None	Basic	One per five (5) years. Age nineteen (19) and older. Eligible six (6) months after delivery.	Tooth identification	Age nineteen (19) or older. Eligible six (6) months after delivery.
D2981	inlay repair necessitated by restorative material failure	Basic	Not a covered benefit.	None	Basic	One (1) per calendar year. Eligible six (6) months after delivery.	Tooth identification	Age nineteen (19) or older. Eligible six (6) months after delivery.

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D2982	onlay repair necessitated by restorative material failure	Basic	Not a covered benefit.	None	Basic	One (1) per calendar year. Eligible six (6) months after delivery.	Tooth identification	Age nineteen (19) or older. Eligible six (6) months after delivery.
D2983	veneer repair necessitated by restorative material failure	Basic	Not a covered benefit.	None	Basic	One (1) per tooth per five (5) years.	Tooth identification	Age nineteen (19) or older. Eligible six (6) months after delivery.
D2989	excavation of a tooth resulting in the determination of non-restorability	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D2990	resin infiltration of incipient smooth surface lesions	Major	Not a covered benefit.	None	Basic	One (1) per tooth per lifetime	Tooth identification	None
D2991	application of hydroxyapatite regeneration medicament – per tooth	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D2999	unspecified restorative procedure, by report	Major	Not a covered benefit.	None	Basic	By Report	Tooth identification	Individual Consideration. Detailed narrative required.

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## IV. D3000-D3999 Endodontics

**Please note the following:**

- Endodontic procedures include exams, pulp tests, pulpotomy, pulpectomy, extirpation of pulp, and pre-operative, operative, and post-operative radiographs/diagnostic images, filling of canals, bacteriologic cultures, and local anesthesia.
- Endodontic therapy performed specifically for coping or overdenture is not covered.
- Please bill claims for multiple-stage procedures only on the date of completion/insertion.
- Payment for endodontic services does not mean that benefits will be available for subsequent restorative services. Coverage for those services is still subject to exclusions listed under major restorative guidelines.

Local anesthesia is usually considered to be part of Endodontic procedures.

CDT Code	Description of Service	Pediatric Service Type	HCR Pediatric Plan Ages 0 through 18 Procedure Guidelines or Frequency Limitation	HCR Pediatric Plan Ages 0 through 18 Submission Requirements	Adult Service Type	HCR Adult Plan Ages 19 and older Procedure Guidelines or Frequency Limitation	HCR Adult Plan Ages 19 and older Submission Requirements	Integral Considerations and Exclusions
D3110	pulp cap direct (excluding final restoration)	Basic	Not a covered benefit.	None	Major	One (1) per tooth per lifetime	Tooth identification	Allowance for direct pulp cap may be made for exposure of a vital pulp. The service is limited to one (1) pulp cap per tooth, and the member is responsible for payment of charges for any repeat procedures. Once per tooth per lifetime. May be billed in conjunction with restorative codes.
D3120	pulp cap indirect (excluding final restoration)	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None

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D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to dentinocemental junction and application of medicament)	Basic	One (1) per tooth per day per lifetime, only primary teeth A-T.	Tooth identification	Major	One (1) per tooth per lifetime.	Tooth identification	To be performed on primary and permanent teeth. Not to be construed as the first stage of root canal therapy. Not to be construed as an emergency procedure to relieve pain or "open and broach." Once per tooth per lifetime. If root canal therapy is performed on the same tooth, there is no separate coverage for the therapeutic pulpotomy.
D3221	pulpal debridement, primary and permanent teeth	Basic	Not a covered benefit.	None	Major	One (1) per tooth per lifetime.	Tooth identification	The patient must not have been previously appointed for the problem and has been "added-in" to render emergent care only. Coverage includes local anesthetic. Pulpal debridement will not be paid if root canal therapy is completed the same day.
D3222	partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	Basic	One (1) per tooth per day per lifetime limited to permanent teeth 2 thru 15 and 18 thru 31.	None	Major	Not a covered benefit.	None	None
D3230	Pulpal therapy (resorbable filling) anterior, primary tooth (excluding final restoration)	Basic	One (1) per tooth per lifetime. Only anterior primary teeth (C-H, M-R).	Tooth identification	Major	Not a covered benefit.	None	None
D3240	pulpal therapy (resorbable filling)-posterior, primary tooth (excluding final restoration)	Basic	One (1) per tooth per lifetime. Only posterior primary teeth (A, B, I-L, S, T).	Tooth identification	Major	Not a covered benefit.	None	None

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D3310	therapy, anterior tooth (excluding final restoration)	Basic	One (1) per tooth per lifetime	Tooth identification	Major	One (1) per tooth per lifetime.	Tooth identification	None
D3320	endodontic therapy, premolar tooth (excluding final restoration)	Basic	One (1) per tooth per lifetime	Tooth identification	Major	One (1) per tooth per lifetime.	Tooth identification	None
D3330	endodontic therapy, molar tooth (excluding final restoration)	Basic	One (1) per tooth per lifetime	Tooth identification	Major	One (1) per tooth per lifetime.	Tooth identification	None
D3331	treatment of root canal obstruction; non-surgical access	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D3332	incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D3333	internal root repair of perforation defects	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D3346	retreatment of previous root canal therapy - anterior	Basic	One (1) per tooth per lifetime.	Tooth identification	Major	One (1) per tooth per lifetime.	Tooth identification	Not payable with Code D3410, D3421, D3425, D3430, D3426, D2955 per permanent teeth.

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D3347	retreatment of previous root canal therapy - premolar	Basic	One (1) per tooth per lifetime.	Tooth identification	Major	One (1) per tooth per lifetime.	Tooth identification	Refer to details for Code D3346.
D3348	retreatment of previous root canal therapy - molar	Basic	One (1) per tooth per lifetime.	Tooth identification	Major	One (1) per tooth per lifetime.	Tooth identification	Refer to details for Code D3346.
D3351	apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	Basic	One (1) per tooth per lifetime, Permanent teeth 2 thru 15 and 18 thru 31.	Tooth identification	Major	One (1) per tooth per lifetime.	Tooth identification	None
D3352	apexification/recalcification - interim medication replacement	Basic	One (1) per tooth per lifetime, Permanent teeth 2 thru 15 and 18 thru 31.	Tooth identification	Major	One (1) per tooth per lifetime.	Tooth identification	None
D3353	apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	Basic	One (1) per tooth per lifetime, Permanent teeth 2 thru 15 and 18 thru 31.	Tooth identification	Major	One (1) per tooth per lifetime.	Tooth identification	None

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D3355	pulpal regeneration - initial visit	Basic	Not a covered benefit.	None	Major	One (1) per tooth per lifetime.	None	None
D3356	pulpal regeneration - interim medication replacement	Basic	Not a covered benefit.	None	Major	One (1) per tooth per lifetime.	None	None
D3357	pulpal regeneration - completion of treatment	Basic	Not a covered benefit.	None	Major	One (1) per tooth per lifetime.	None	None
D3410	apicoectomy - anterior	Major	One (1) per permanent tooth root per lifetime.  (6 thru 11, 22 thru 27)	Tooth identification	Major	One (1) per permanent tooth per lifetime.	Tooth identification	Apicoectomy (D3410, D3421, D3425, D3426) or retrograde filling (D3430) reported within thirty (30) days after a root canal will deny as integral.
D3421	apicoectomy - premolar (first root)	Major	One (1) per permanent tooth root per lifetime.  (4,5,12,13,20,21,28,29)	Tooth identification	Major	One (1) per permanent tooth root per lifetime.	Tooth identification	See details listed for Code D3410.
D3425	apicoectomy - molar (first root)	Major	One (1) per permanent tooth root per lifetime.  (2,3,14,15,18,19,30,31)	Tooth identification	Major	One (1) per permanent tooth root per lifetime.	Tooth identification	See details listed for Code D3410.
D3426	apicoectomy (each additional root)	Basic	Not a covered benefit.	None	Major	One (1) per permanent tooth root per lifetime.	Tooth identification	See details listed for Code D3410.

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D3428	bone graft in conjunction with periradicular surgery - per tooth, single site	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D3429	bone graft in conjunction with periradicular surgery - each additional contiguous tooth in the same surgical site	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D3430	retrograde filling - per root	Basic	Not a covered benefit.	None	Major	One (1) per tooth per lifetime	Tooth and root identification	None
D3431	biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D3432	guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D3450	root amputation – per root	Basic	Not a covered benefit.	None	Major	One (1) per permanent tooth root per lifetime.	Tooth identification	None
D3460	endodontic endosseous implant	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D3470	intentional re-implantation (including necessary splinting)	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D3471	surgical repair of root resorption - anterior	Basic	Not a covered benefit.	None	Major	One (1) per tooth root per lifetime.	None	Denied as integral if reported with an apicoectomy by the same dentist on the same date or any time after
D3472	surgical repair of root resorption - premolar	Basic	Not a covered benefit.	None	Major	One (1) per tooth root per lifetime.	None	Denied as integral if reported with an apicoectomy by the same dentist on the same date or any time after

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D3473	surgical repair of root resorption - molar	Basic	Not a covered benefit.	None	Major	One (1) per tooth root per lifetime.	None	Denied as integral if reported with an apicoectomy by the same dentist on the same date or any time after
D3501	surgical exposure of root surface without apicoectomy or repair of root resorption - anterior	Basic	Not a covered benefit.	None	Major	One (1) per tooth root per lifetime.	None	Denied as integral if reported with an apicoectomy by the same dentist on the same date or any time after
D3502	surgical exposure of root surface without apicoectomy or repair of root resorption – premolar	Basic	Not a covered benefit.	None	Major	One (1) per tooth root per lifetime.	None	Denied as integral if reported with an apicoectomy by the same dentist on the same date or any time after
D3503	surgical exposure of root surface without apicoectomy or repair of root resorption – molar	Basic	Not a covered benefit.	None	Major	One (1) per tooth root per lifetime.	None	Denied as integral if reported with an apicoectomy by the same dentist on the same date or any time after
D3910	surgical procedure for isolation of tooth with rubber dam	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D3911	intraorifice barrier	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D3920	hemisection (including any root removal), not including root canal therapy	Basic	Not a covered benefit.	None	Major	One (1) per tooth per lifetime.	Tooth identification	Allowance is for permanent teeth only. Root canal therapy for the remaining root is covered separately. May be performed once per tooth. Root canal therapy may be completed before hemisection services are claimed. A crown/retainer may be allowed for the remaining crown segment, but a pontic for the resected portion of the tooth and root will not be allowed.
D3921	decoronation or Submergence of an Erupted Tooth	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None

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D3950	canal preparation and fitting of preformed dowel or post	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D3999	unspecified endodontic procedure, by report	Basic	Not a covered benefit.	None	Major	Individual Consideration. Detailed narrative required.	None	None

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## V. D4000-D4999 Periodontics

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### Procedure Billing Guidelines

- A quadrant is defined as four (4) or more contiguous teeth in a quadrant. A partial quadrant is defined as one (1) to three (3) teeth in a quadrant.
  - For billing purposes, a sextant is not a recognized designation by the American Dental Association.
  - Periodontal services are benefits when performed for the treatment of periodontal disease around natural teeth. There are no benefits for these procedures when billed in conjunction with or in preparation for implants, ridge augmentation, extractions sites and endodontic surgeries.
  - Benefits for all periodontal services are limited to two (2) quadrants per date of service. If you wish to request an exception due to a medical condition that may require your patient to receive extended treatment, please include a detailed narrative including general or intravenous anesthesia record, medical condition, and length of appointment time for consideration.
  - Payment for definitive periodontal service includes follow-up evaluation for both surgical and non-surgical procedures.
  - To be covered, alveolar crestal bone loss and subgingival calculus must be evident radiographically for scaling and root planing.
  - When more than one (1) periodontal service is completed within the same site or quadrant on the same date of service, the Plan will pay for the more extensive treatment as payment for the total service.
  - When one (1) periodontal service and cleaning are completed on the same date of service, the plan will pay for the more extensive treatment (periodontal service).
  - If scaling and root planing are performed on the same date and in the same quadrant as periodontal surgery, no payment will be made for scaling and root planing. The liability will fall on the provider.
  - Codes D4266 and D4267 are adjunctive services for individual teeth and will not be included in the surgical quadrant code count above. The codes will be considered for benefits when submitted in addition to periodontal surgery codes (D4240, D4241, D4260, and D4261), and only when placed around natural teeth (not a covered benefit around implants, extraction sites, endodontic surgery, or edentulous areas). If denied, the liability will be the member's responsibility.
  - Services are not covered if it is performed on the same day and in the same area as codes D4277 or 4278 and become the member's responsibility.
  - We provide payment only for one (1) surgical procedure per quadrant per thirty-six (36) months. No more than two (2) quadrants of surgical or non-surgical services may be covered when done on the same date of service.
  - Any type of restorative prosthetic service (including crown, inlay, onlay, restoration or extraction) done on same date of service and in the same area as periodontal surgery (4240, 4241, 4260, 4261, 4212) are covered as integral to the restorative service.
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D4210	gingivectomy or gingivoplasty – 4 or more contiguous teeth or tooth-bounded spaces, per quadrant	Basic	Not a covered benefit.	None	Major	One (1) per quadrant per 36 months.	Quadrant identification	Coverage is allowed when four (4) or more teeth in a quadrant have periodontal pockets measuring five (5) mm. May be performed once every three (3) years if needed. Age nineteen (19) and older.
D4211	gingivectomy or gingivoplasty – one (1) to three (3) contiguous teeth or teeth bounded spaces per quadrant	Basic	Not a covered benefit.	None	Major	One (1) per quadrant per 36 months.	Tooth identification	Refer to details listed for Code D4210.
D4212	gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth.	Basic	Not a covered benefit.	None	Major	One (1) per quadrant per 36 months.	Tooth identification	Gingivectomy (D4210, D4211, D4212) reported for the same date of service, same provider, same area as any crown, inlay, onlay, restoration or extraction will deny as integral. May be performed once every three (3) years if needed. Age nineteen (19) and older.
D4230	anatomical crown exposure - four or more contiguous teeth or bounded tooth spaces per quadrant	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D4231	anatomical crown exposure – one (1) to three (3) teeth	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None

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D4240	gingival flap procedure, including root planing – four (4) or more contiguous teeth or tooth-bounded spaces per quadrant	Basic	Not a covered benefit.	None	Major	One (1) per quadrant per 36 months.	Quadrant identification	Coverage of D4240 is allowed when four (4) or more teeth in a quadrant have periodontal pockets measuring five (5) mm or greater. If less than four (4) teeth are involved, use CDT code D4241. Other procedures may be required concurrent to D4240 and should be reported separately using their own unique codes. May be performed once every three (3) years if needed. Patient must be nineteen (19) years or older.
D4241	gingival flap procedure - one (1) to three (3) contiguous teeth or teeth bounded spaces per quadrant	Basic	Not a covered benefit.	None	Major	One (1) per quadrant per 36 months.	Tooth identification	Refer to details listed for Code D4240.
D4245	apically repositioned flap	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D4249	clinical crown lengthening - hard tissue	Basic	Not a covered benefit.	None	Major	One (1) per tooth per lifetime, by report.	Tooth identification	Coverage is provided for crown lengthening when as a result of a crown fracture or extensive caries, there is insufficient tooth volume to support a restoration without impinging upon the biologic width of the periodontal attachment of the tooth. The summary measurement of the sulcus depth and biologic width should be a minimum of three (3) mm . Procedure should be performed in a healthy periodontal environment. Patient must be age nineteen (19) or older. If performed on the same day of any restorative procedure, the service will deny as integral and be provider liability.

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D4260	osseous surgery (including elevation of a full thickness flap and closure) – four (4) or more contiguous teeth or tooth-bounded spaces per quadrant	Basic	Not a covered benefit.	None	Major	One (1) per quadrant per 36 months.	Quadrant identification	Osseous surgery is a benefit when four (4) or more teeth in a quadrant have periodontal pockets measuring five (5) mm or greater. May be performed once in a three (3) year period. Patient must be nineteen (19) years or older. Other procedures may be required concurrent to D4260 or D4261 and should be reported using their own unique codes.
D4261	osseous surgery (including elevation of a full thickness flap and closure) - one (1) to three (3) contiguous teeth or tooth bounded spaces per quadrant	Basic	Not a covered benefit.	None	Major	One (1) per quadrant per 36 months.	Tooth identification	Refer to details listed for Code D4260.
D4263	bone replacement graft – first site in quadrant	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D4264	bone replacement graft – each additional site in quadrant	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D4265	biologic materials to aid in soft and osseous tissue regeneration	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D4266	guided tissue regeneration, natural teeth- resorbable barrier, per site	Basic	Not a covered benefit.	None	Major	One (1) per quadrant per 36 months. Dental Adviser review is required.	Tooth identification	Services covered in conjunction with natural teeth and only in when submitted in addition to periodontal surgery codes (D4240, D4241, D4260, and D4261). If performed on same day and in the same area as codes D4277 or D4278, it will be member liability.

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D4267	Guided tissue regeneration, natural teeth- non-resorbable barrier, per site (includes membrane removal)	Basic	Not a covered benefit.	None	Major	One (1) per quadrant per 36 months. Dental Adviser review is required.	Tooth identification	None
D4268	surgical revision procedure, per tooth	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D4270	pedicle soft tissue graft procedure	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D4273	autogenous connective tissue graft procedures (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D4274	distal or proximal wedge procedure (when not performed in conjunction with surgical procedures on the same anatomical area)	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D4275	non-autogenous connective tissue graft (including recipient and donor material) first tooth, implant, or edentulous tooth position in graft	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D4276	combined connective tissue and double pedicle graft, per tooth	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None

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D4277	free soft tissue graft procedure (including recipient and donor surgical sites), first tooth, implant, or edentulous tooth position in graft.	Basic	Not a covered benefit.	None	Major	One (1) per quadrant per 36 months.	Tooth identification	Narrative/remarks describing the procedure and tooth numbers are required with the claim. The patient must be age nineteen (19) or older.
D4278	free soft tissue graft procedure (including recipient and donor surgical sites), each additional contiguous tooth, implant, or edentulous tooth position in same graft site.	Basic	Not a covered benefit.	None	Major	One (1) per quadrant per 36 months.	Tooth identification	Narrative/remarks describing the procedure and tooth numbers are required with the claim. The patient must be age nineteen (19) or older.
D4283	autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant or edentulous tooth position in graft	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
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	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None

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D4286	removal of non-resorbable barrier	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D4322	splint – Intra- coronal; natural	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D4323	splint – extra-coronal; natural	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D4341	periodontal scaling and root planing, 4 or more teeth per quadrant	Basic	One (1) per quadrant in a two (2) year period.	<b>Prior Authorization Required</b> , Quadrant identification	Major	One (1) per quadrant in a two (2) year period, age nineteen (19) and older  <i>Note: If member has diabetes, CAD, stroke or is pregnant and is enrolled in Oral Health for Total Health, D4341 or D4342 may be covered once per quadrant every twenty-four (24) months.</i>	Quadrant identification	Periodontal scaling and root planing may be used as a definitive treatment in some stages of periodontal disease and/or as a part of pre-surgical procedures in others. D4341 is a benefit when four (4) or more teeth in a quadrant have periodontal pockets measuring four (4) mm or greater. D4342 is a benefit when less than four (4) teeth in a quadrant have periodontal pockets measuring four (4) mm or greater. Once every two (2) years. Must demonstrate radiographic alveolar bone loss and subgingival calculus to be a benefit.
D4342	periodontal scaling and root planing, 1 - 3 teeth per quadrant	Basic	One (1) per quadrant in a two (2) year period.	<b>Prior Authorization Required</b> , Tooth identification	Major	Refer to details listed for Code D4341.	Tooth identification	Refer to details listed for Code D4341.
D4346	scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	Preventive	Two (2) per calendar year, in addition to D4910, age thirteen (13) and older.	None	Preventive	Two (2) per calendar year, in addition to D4910, age thirteen (13) and older.	None	This code will be interchangeable with code D1110. The code will be covered as a Preventive service and will share the same frequency limitations, processing guidelines, relationship to other codes, provider / member liability as code D1110.

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D4355	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	Basic	One (1) per 24 months.	None	Major	Not a covered benefit.	Note: If member is enrolled in Oral Health for Total Health, D4355 may be covered one (1) every twenty-four (24) months.	Service denied if performed on the same day as D1110, D1120, D4341, D4342
D4381	localized delivery of antimicrobial agents via a controlled-release vehicle into diseased crevicular tissue, per tooth	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D4910	periodontal maintenance	Basic	Covered	None	Major	Two (2) per calendar year in addition to regular prophylaxis.  <i>Note: If member is enrolled in Oral Health for Total Health, D1110/D1120 or D4346 or D4910 may be covered once every three (3) months.</i>	None	Periodontal maintenance includes removal of the bacterial plaque and calculus from supragingival, and subgingival regions, site-specific scaling and root planing where indicated, and polishing the teeth. If new or recurring periodontal disease appears, additional diagnostic and treatment procedures must be considered. Periodontal maintenance is covered two (2) times per calendar year following surgical and definitive non-surgical therapy. The patient must be age eighteen (18) or older. Periodontal maintenance should not be performed on same day as periodontal surgery.

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D4920	unscheduled dressing change (by someone other than treating dentist or their staff)	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D4921	gingival irrigation with a medicinal agent – per quadrant	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D4999	unspecified periodontal procedure, by report	Basic	Not a covered benefit.	None	Major	By Report.	Detailed narrative. Individual consideration.	None

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## VI. D5000-D5899 Prosthodontics, Removable

Please bill claims for multiple-stage procedures on the date of completion/insertion. Services may be non-covered for the following conditions:

- Untreated bone loss: An abutment tooth has poor-to-hopeless prognosis from either a restorative or periodontal perspective
- Periapical pathology or unresolved, incomplete, or failed endodontic therapy
- Treatment of TMJ to increase vertical dimension or restore occlusion

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D5110	complete denture – maxillary	Major	One (1) per arch per five (5) year period.	None	Major	One (1) per arch per five (5) year period.	None	Complete denture coverage includes routine post-delivery care.
D5120	complete denture – mandibular	Major	One (1) per arch per five (5) year period.	None	Major	One (1) per arch per five (5) year period.	None	Complete denture coverage includes routine post-delivery care.
D5130	immediate denture – maxillary	Major	One (1) per arch per five (5) year period.	None	Major	One (1) per arch per five (5) year period.	None	Immediate dentures are not considered temporary dentures. Coverage includes routine follow-up care. Once every five (5) years.
D5140	immediate denture – mandibular	Major	One (1) per arch per five (5) year period.	None	Major	One (1) per arch per five (5) year period.	None	Immediate dentures are not considered temporary dentures. Coverage includes routine follow-up care. Once every five (5) years.
D5211	maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	Major	One (1) per arch per five (5) year period.	None	Major	One (1) per arch per five (5) year period.	Tooth identification	Partial denture includes acrylic resin-based denture with resin or wrought wire clasps (D5211, D5212). Coverage includes routine post-delivery care. Precision attachments are not a benefit for removable partial dentures. One (1) partial denture, per arch, in a five (5)-year period.
D5212	mandibular partial denture - resin base (including retentive /clasping materials, rests, and teeth)	Major	One (1) per arch per five (5) year period.	None	Major	One (1) per arch per five (5) year period.	Tooth identification	Refer to details listed for Code D5211

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D5213	maxillary and partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	Major	One (1) per arch per five (5) year period.	None	Major	One (1) per arch per five (5) year period.	Tooth identification	Refer to details listed for Code D5211
D5214	mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	Major	One (1) per arch per five (5) year period.	None	Major	One (1) per arch per five (5) year period.	Tooth identification	Refer to details listed for Code D5211
D5221	immediate maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D5222	immediate mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D5223	immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None

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D5224	immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D5225	maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	Major	Not a covered benefit.	None	Major	One (1) per arch per five (5) year period.	None	None
D5226	mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	Major	Not a covered benefit.	None	Major	One (1) per arch per five (5) year period.	None	None
D5227	immediate maxillary Partial Denture - Flexible Base (including any clasps, rests, and teeth)	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D5228	immediate mandibular partial denture - flexible Base (including any clasps, rests, and teeth)	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D5282	removable unilateral partial denture - one piece cast metal (including retentive clasping materials, rests, and teeth), maxillary	Major	Not a covered benefit.	None	Major	One (1) per arch per five (5) year period.	Arch identification	None

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D5283	removable unilateral partial denture - one piece cast metal (including retentive clasping materials, rests, and teeth), mandibular	Major	Not a covered benefit.	None	Major	One (1) per arch per five (5) year period.	Arch identification	None
D5284	removable unilateral partial denture - one-piece flexible base (including retentive clasping materials rests and teeth) per quadrant	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D5286	removable unilateral partial denture - one piece resin (including retentive clasping materials rests and teeth) per quadrant	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D5410	adjust complete denture – maxillary	Basic	One (1) per day.	None	Basic	Two (2) per calendar year, age nineteen (19) and older.	None	Coverage is available six (6) months after the date of insertion of the complete or partial denture. Two (2) adjustments are allowed per arch per calendar year.
D5411	adjust complete denture – mandibular	Basic	One (1) per day.	None	Basic	Two (2) per calendar year, age nineteen (19) and older.	None	Coverage is available six (6) months after the date of insertion of the complete or partial denture. Two (2) adjustments are allowed per arch per calendar year.
D5421	adjust partial denture – maxillary	Basic	One (1) per day.	None	Basic	Two (2) per calendar year, age nineteen (19) and older.	None	Coverage is available six (6) months after the date of insertion of the complete or partial denture. Two (2) adjustments are allowed per arch per calendar year.
D5422	adjust partial denture – mandibular	Basic	One (1) per day.	None	Basic	Two (2) per calendar year, age nineteen (19) and older.	None	Coverage is available six (6) months after the date of insertion of the complete or partial denture. Two (2) adjustments are allowed per arch per calendar year.

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D5511	repair broken complete denture base, mandibular	Basic	One (1) per day.	None	Basic	One (1) per calendar year, age nineteen (19) and older.	None	Six (6) months must have elapsed since insertion of the denture, or the services will be disallowed. One (1) repair per year.
D5512	repair broken complete denture base, maxillary	Basic	One (1) per day.	None	Basic	One (1) per calendar year, age nineteen (19) and older.	None	Six (6) months must have elapsed since insertion of the denture, or the services will be disallowed. One (1) repair per year.
D5520	replace missing or broken teeth (complete denture) – per tooth	Basic	One (1) per day.	Tooth identification	Basic	One (1) per calendar year, age nineteen (19) and older.	Tooth identification	Six (6) months must have elapsed since insertion of the denture, or the services will be disallowed. One (1) repair per year.
D5611	repair resin partial denture base, mandibular	Basic	One (1) per day.	None	Basic	One (1) per calendar year, age nineteen (19) and older.	None	Six (6) months must have elapsed since insertion of the denture, or the services will be disallowed. Coverage will be paid according to plan benefits, or once a year if the plan does not have another limitation.
D5612	repair resin partial denture base, maxillary	Basic	One (1) per day.	None	Basic	One (1) per calendar year, age nineteen (19) and older.	None	Refer to details listed for Code D5611
D5621	repair cast partial framework, mandibular	Basic	One (1) per day.	None	Basic	One (1) per calendar year, age nineteen (19) and older.	None	Refer to details listed for Code D5611
D5622	repair cast partial framework, maxillary	Basic	One (1) per day.	None	Basic	One (1) per calendar year, age nineteen (19) and older.	None	Refer to details listed for Code D5611
D5630	repair or replace broken retentive/clasping materials - per tooth	Basic	One (1) per day.	None	Basic	One (1) per calendar year, age nineteen (19) and older.	None	Refer to details listed for Code D5611

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D5640	replace missing or broken teeth – partial denture – per tooth	Basic	Three (3) per day.	Tooth identification	Basic	One (1) per calendar year, age nineteen (19) and older.	Tooth identification	Refer to details listed for Code D5640.
D5650	add tooth to existing partial denture – per tooth	Basic	One (1) per day.	Tooth identification	Basic	One (1) per calendar year, age nineteen (19) and older.	Tooth identification	Six (6) months must have elapsed since insertion of the denture, or the services will be disallowed. Coverage will be paid according to plan benefits, or once a year if the plan does not have another limitation.
D5660	add clasp to existing partial denture - per tooth	Basic	Two (2) per day.	Tooth identification	Basic	One (1) per calendar year, age nineteen (19) and older.	Tooth identification	Refer to details listed for Code D5650.
D5670	replace all teeth and acrylic on cast metal framework (maxillary)	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D5671	replace all teeth and acrylic on cast metal framework (mandibular)	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D5710	rebase complete maxillary denture	Basic	No limitation.	Prior Authorization Required	Basic	One (1) in a three (3) year period, age nineteen (19) and older.	None	Coverage of a rebase is available six (6) months after the date of insertion of the denture. One (1) rebase is allowed per arch per thirty-six (36) months.
D5711	rebase complete mandibular denture	Basic	One (1) every two (2) years following insertion of initial denture.	Prior Authorization Required	Basic	One (1) in a three (3) year period, age nineteen (19) and older.	None	Coverage of a rebase is available six (6) months after the date of insertion of the denture. One (1) rebase is allowed per arch per thirty-six (36) months.
D5720	rebase maxillary partial denture	Basic	One (1) every two (2) years following insertion of initial denture.	Prior Authorization Required	Basic	One (1) in a three (3) year period, age nineteen (19) and older.	None	Coverage of a rebase is available six (6) months after the date of insertion of the denture. One (1) rebase is allowed per arch per thirty-six (36) months.

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D5721	rebase mandibular partial denture	Basic	One (1) every two (2) years following insertion of initial denture.	Prior Authorization Required	Basic	One (1) in a three (3) year period, age nineteen (19) and older.	None	Coverage of a rebase is available six (6) months after the date of insertion of the denture. One (1) rebase is allowed per arch per thirty-six (36) months.
D5725	rebase hybrid prosthesis	Basic	Not a covered benefit.	None	Basic	One (1) in a three (3) year period, age nineteen (19) and older.	None	None
D5730	reline complete maxillary denture (direct)	Basic	One (1) every two (2) years following insertion of initial denture.	Prior Authorization Required	Basic	One (1) in a three (3) year period, age nineteen (19) and older.	None	Coverage of a reline is available beginning six (6) months after the date of insertion of the denture. One (1) reline is allowed per arch per thirty-six (36) months.
D5731	reline complete mandibular denture (direct)	Basic	Not a covered benefit.	Prior Authorization Required	Basic	One (1) in a three (3) year period, age nineteen (19) and older.	None	Coverage of a reline is available beginning six (6) months after the date of insertion of the denture. One (1) reline is allowed per arch per thirty-six (36) months
D5740	reline maxillary partial denture (direct)	Basic	One (1) every two (2) years following insertion of initial denture.	Prior Authorization Required	Basic	One (1) in a three (3) year period, age nineteen (19) and older.	None	Coverage of a reline is available beginning six (6) months after the date of insertion of the denture. One (1) reline is allowed per arch per thirty-six (36) months.
D5741	reline mandibular partial denture (direct)	Basic	One (1) every two (2) years following insertion of initial denture.	Prior Authorization Required	Basic	One (1) in a three (3) year period, age nineteen (19) and older.	None	Coverage of a reline is available beginning six (6) months after the date of insertion of the denture. One (1) reline is allowed per arch per thirty-six (36) months.
D5750	reline complete maxillary denture (indirect)	Basic	One (1) every two (2) years following insertion of initial denture.	Prior Authorization Required	Basic	One (1) in a three (3) year period, age nineteen (19) and older.	None	Coverage of a reline is available beginning six (6) months after the date of insertion of the denture. One (1) reline is allowed per arch per thirty-six (36) months.

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D5751	reline complete mandibular denture (indirect)	Basic	One (1) every two(2) years following insertion of initial denture.	Prior Authorization Required	Basic	One (1) in a three (3) year period, age nineteen (19) and older.	None	Coverage of a reline is available beginning six (6) months after the date of insertion of the denture. One (1) reline is allowed per arch per thirty-six (36) months.
D5760	reline maxillary partial denture (indirect)	Basic	One (1) every two (2) years following insertion of initial denture.	Prior Authorization Required	Basic	One (1) in a three (3) year period, age nineteen (19) and older.	None	Coverage of a reline is available beginning six (6) months after the date of insertion of the denture. One (1) reline is allowed per arch per thirty-six (36) months.
D5761	reline mandibular partial denture (indirect)	Basic	One (1) every two (2) years following insertion of initial denture.	Prior Authorization Required	Basic	One (1) in a three (3) year period, age nineteen (19) and older.	None	Coverage of a reline is available beginning six (6) months after the date of insertion of the denture. One (1) reline is allowed per arch per thirty-six (36) months.
D5765	soft liner for complete or partial removable denture - indirect	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D5810	interim complete denture (maxillary)	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D5811	interim complete denture (mandibular)	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D5820	interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None

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D5821	interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D5850	tissue conditioning, maxillary	Major	Not a covered benefit.	None	Major	Two (2) per calendar year.	None	A maximum of two (2) tissue conditioning treatment per arch is covered prior to impressions for reline or denture prosthesis. The patient is responsible for the charges related to additional treatments if any. Service covered twice per arch per calendar year. The patient must be age fifteen (15) or older.
D5851	tissue conditioning, mandibular	Major	Not a covered benefit.	None	Major	Two (2) per calendar year.	None	A maximum of two (2) tissue conditioning treatment per arch is covered prior to impressions for reline or denture prosthesis. The patient is responsible for the charges related to additional treatments if any. Service covered twice per arch per calendar year. The patient must be age fifteen (15) or older
D5862	precision attachment, by report	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D5863	overdenture - complete maxillary	Major	Not a covered benefit.	None	Major	One (1) in five (5) years. Alternate benefit: D5110.	None	None
D5864	overdenture - partial maxillary	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D5865	overdenture - complete mandibular	Major	Not a covered benefit.	None	Major	One (1) in five (5) years. Alternate benefit: D5120.	None	None

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D5866	overdenture - partial mandibular	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D5867	replacement of replaceable part of semi-precision or precision attachment, per attachment	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D5875	modification of removable prosthesis following implant surgery	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D5876	add metal substructure to acrylic full denture (per arch)	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D5899	unspecified removable prosthodontic procedure, by report	Major	Not a covered benefit.	None	Basic	By Report Individual consideration.	Tooth identification Arch identification	None

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## VII. D5900-D5999 Maxillofacial Prosthetics

**MAXILLOFACIAL PROSTHETICS:** The Maxillofacial Prosthetics Codes D5925 through D5999 require special handling. These services require an approved Prior Authorization before treatment. The Prior Authorization along with documentation outlining medical necessity should be submitted with the claim to determine dental benefits. Claims denied for dental benefits can be submitted directly to the Member's Medical carrier on a current medical claim form (CMS1500) with the appropriate Medical CPT codes and required details. All follow-up questions should be addressed to the member's medical plan.

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D5911	facial moulage (sectional)	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D5912	facial moulage (complete)	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D5913	nasal prosthesis	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D5914	auricular prosthesis	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D5915	orbital prosthesis	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D5916	ocular prosthesis	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D5919	facial prosthesis	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D5922	nasal septal prosthesis	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D5923	ocular prosthesis, interim	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None

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D5924	cranial prosthesis	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D5925	facial augmentation implant prosthesis	Major	Claim to be submitted to medical carrier.	Prior Authorization and Medical Necessity Documentation required	Major	Not a covered benefit.	None	None
D5926	nasal prosthesis, replacement	Major	Claim to be submitted to medical carrier.	Prior Authorization and Medical Necessity Documentation required	Major	Not a covered benefit.	None	None
D5927	auricular prosthesis, replacement	Major	Claim to be submitted to medical carrier.	Prior Authorization and Medical Necessity Documentation required	Major	Not a covered benefit.	None	None
D5928	orbital prosthesis, replacement	Major	Claim to be submitted to medical carrier.	Prior Authorization and Medical Necessity Documentation required	Major	Not a covered benefit.	None	None
D5929	facial prosthesis, replacement	Major	Claim to be submitted to medical carrier.	Prior Authorization and Medical Necessity Documentation required	Major	Not a covered benefit.	None	None

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D5931	obturator prosthesis, surgical	Major	Claim to be submitted to medical carrier.	Prior Authorization and Medical Necessity Documentation required	Major	Not a covered benefit.	None	None
D5932	obturator prosthesis, definitive	Major	Claim to be submitted to medical carrier.	Prior Authorization and Medical Necessity Documentation required	Major	Not a covered benefit.	None	None
D5933	obturator prosthesis, modification	Major	Claim to be submitted to medical carrier.	Prior Authorization and Medical Necessity Documentation required	Major	Not a covered benefit.	None	None
D5934	mandibular resection prosthesis with guide flange	Major	Claim to be submitted to medical carrier.	Prior Authorization and Medical Necessity Documentation required	Major	Not a covered benefit.	None	None
D5935	mandibular resection prosthesis without guide flange	Major	Claim to be submitted to medical carrier.	Prior Authorization and Medical Necessity Documentation required	Major	Not a covered benefit.	None	None
D5936	obturator prosthesis, interim	Major	Claim to be submitted to medical carrier.	Prior Authorization and Medical Necessity Documentation required	Major	Not a covered benefit.	None	None
D5937	trismus appliance (not for TMD treatment)	Major	Claim to be submitted to medical carrier.	Prior Authorization and Medical Necessity Documentation required	Major	Not a covered benefit.	None	None
D5951	feeding aid	Major	Claim to be submitted to medical carrier.	Prior Authorization and Medical Necessity Documentation required	Major	Not a covered benefit.	None	None

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D5952	speech aid prosthesis, pediatric	Major	Claim to be submitted to medical carrier.	Prior Authorization and Medical Necessity Documentation required	Major	Not a covered benefit.	None	None
D5953	speech aid prosthesis, adult	Major	Claim to be submitted to medical carrier.	Prior Authorization and Medical Necessity Documentation required	Major	Not a covered benefit.	None	None
D5954	palatal augmentation prosthesis	Major	Claim to be submitted to medical carrier.	Prior Authorization and Medical Necessity Documentation required	Major	Not a covered benefit.	None	None
D5955	palatal lift prosthesis, definitive	Major	Claim to be submitted to medical carrier.	Prior Authorization and Medical Necessity Documentation required	Major	Not a covered benefit.	None	None
D5958	palatal lift prosthesis, interim	Major	Claim to be submitted to medical carrier.	Prior Authorization and Medical Necessity Documentation required	Major	Not a covered benefit.	None	None
D5959	palatal lift prosthesis, modification	Major	Claim to be submitted to medical carrier.	Prior Authorization and Medical Necessity Documentation required	Major	Not a covered benefit.	None	None
D5960	speech aid prosthesis, modification	Major	Claim to be submitted to medical carrier.	Prior Authorization and Medical Necessity Documentation required	Major	Not a covered benefit.	None	None
D5982	surgical stent	Major	Claim to be submitted to medical carrier.	Prior Authorization and Medical Necessity Documentation required	Major	Not a covered benefit.	None	None
D5983	radiation carrier	Major	Claim to be submitted to medical carrier.	Prior Authorization and Medical Necessity Documentation required	Major	Not a covered benefit.	None	None

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D5984	radiation shield	Major	Claim to be submitted to medical carrier.	Prior Authorization and Medical Necessity Documentation required	Major	Not a covered benefit.	None	None
D5985	radiation cone locator	Major	Claim to be submitted to medical carrier.	Prior Authorization and Medical Necessity Documentation required	Major	Not a covered benefit.	None	None
D5986	fluoride gel carrier	Major	Claim to be submitted to medical carrier.	Prior Authorization and Medical Necessity Documentation required	Major	Not a covered benefit.	None	None
D5987	commissure splint	Major	Claim to be submitted to medical carrier.	Prior Authorization and Medical Necessity Documentation required	Major	Not a covered benefit.	None	None
D5988	surgical splint	Major	Claim to be submitted to medical carrier.	Prior Authorization and Medical Necessity Documentation required	Major	Not a covered benefit.	None	None
D5991	vesiculobullous disease medicament carrier	Major	Claim to be submitted to medical carrier.	Prior Authorization and Medical Necessity Documentation required	Major	Not a covered benefit.	None	None
D5992	adjust maxillofacial prosthetic appliance, by report	Major	Claim to be submitted to medical carrier.	Prior Authorization and Medical Necessity Documentation required	Major	Not a covered benefit.	None	None

**NOTE:** These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.



CDT Code	Description of Service	Pediatric Service Type	HCR Pediatric Plan Ages 0 through 18 Procedure Guidelines or Frequency Limitation	HCR Pediatric Plan Ages 0 through 18 Submission Requirements	Adult Service Type	HCR Adult Plan Ages 19 and older Procedure Guidelines or Frequency Limitation	HCR Adult Plan Ages 19 and older Submission Requirements	Integral Considerations and Exclusions
D5993	maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral) other than required adjustments, by report	Major	Claim to be submitted to medical carrier.	Prior Authorization and Medical Necessity Documentation required	Major	Not a covered benefit.	None	None
D5995	periodontal medicament carrier with peripheral seal – laboratory processed - maxillary	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D5996	periodontal medicament carrier with peripheral seal – laboratory processed - mandibular	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D5999	unspecified maxillofacial prosthesis, by report	Major	Claim to be submitted to medical carrier.	Prior Authorization and Medical Necessity Documentation required	Major	Not a covered benefit.	None	None

**NOTE:** These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

## VII. D6000-D6199 Implant Services

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### Coverage

#### General Information

Verify member coverage code and eligibility prior to providing implant services as some plans recognize implant services and some do not. Additionally, some implant services may be covered as an alternate benefit. When services are available as an alternate benefit, the Member is responsible for the difference between The Plan's payment and the providers charge. **All plans exclude coverage for third (3rd) molar implants.**

#### Implant Services

Benefits for dental implants, abutments, and implant/abutment supported crowns are covered up to the member's annual maximum. Coverage may be provided as an alternate benefit.

Coverage for implant services has a maximum lifetime dollar amount and covers the surgical placement of endosteal implants with a minimum age qualification of fifteen (15) for the replacement of teeth numbers 2-15 and teeth numbers 18-31.

#### The implant benefit does not cover the following services:

- Special preparatory radiographic or imaging studies (i.e., tomographic, CT, or MRI)
- Adjunctive periodontal (D4000 series) or surgical (D7000 series) procedures in preparation for implant placement, in association with implant placement, or in association with salvage attempts of a failing implant; (covers implants only)
- Maxillofacial prosthetic procedure D5982, surgical stent (implant positioning type); (covers implants only)

#### Please also note:

- Routine radiographs/diagnostic imaging (i.e., periapical, and panoramic) may be covered under the member's general dental insurance policy to the same extent and under the same conditions and guidelines as those applied to a natural tooth.
- The frequency limitation for dental implants is once per tooth (replacement) per lifetime.

Local anesthesia is usually considered to be part of Implant Services procedures.

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CDT Code	Description of Service	Pediatric Service Type	HCR Pediatric Plan Ages 0 through 18  Procedure Guidelines or Frequency Limitation	HCR Pediatric Plan Ages 0 through 18  Submission Requirements	Adult Service Type	HCR Adult Plan Ages 19 and older  Procedure Guidelines or Frequency Limitation	HCR Adult Plan Ages 19 and older  Submission Requirements	Integral Considerations and Exclusions
D6010	surgical placement of implant body: endosteal implant	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6011	surgical access to an implant body (second stage implant surgery)	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6012	surgical placement of interim implant body for transitional prosthesis, endosteal implant	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6013	surgical placement of mini-implant	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6040	surgical placement, eposteal implant	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6050	surgical placement, transosteal implant	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6051	placement of interim implant abutment	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6055	connecting bar - implant supported or abutment supported	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6056	prefabricated abutment - includes modification and placement	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None

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CDT Code	Description of Service	Pediatric Service Type	HCR Pediatric Plan Ages 0 through 18  Procedure Guidelines or Frequency Limitation	HCR Pediatric Plan Ages 0 through 18  Submission Requirements	Adult Service Type	HCR Adult Plan Ages 19 and older  Procedure Guidelines or Frequency Limitation	HCR Adult Plan Ages 19 and older  Submission Requirements	Integral Considerations and Exclusions
D6057	custom fabricated abutment - includes placement	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6058	abutment supported porcelain/ceramic crown	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6059	abutment supported porcelain fused to metal crown (high noble metal)	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6060	abutment supported porcelain fused to metal crown (predominantly base metal)	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6061	abutment supported porcelain fused to metal crown (noble metal)	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6062	abutment supported cast metal crown (high noble metal)	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6063	abutment supported cast metal crown (predominantly base metal)	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6064	abutment supported cast metal crown (noble metal)	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6065	implant supported porcelain/ceramic crown	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None

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CDT Code	Description of Service	Pediatric Service Type	HCR Pediatric Plan Ages 0 through 18  Procedure Guidelines or Frequency Limitation	HCR Pediatric Plan Ages 0 through 18  Submission Requirements	Adult Service Type	HCR Adult Plan Ages 19 and older  Procedure Guidelines or Frequency Limitation	HCR Adult Plan Ages 19 and older  Submission Requirements	Integral Considerations and Exclusions
D6066	implant supported crown - porcelain fused to high noble alloys	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6067	implant supported crown - high noble alloys	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6068	abutment supported retainer for porcelain/ceramic FPD	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6069	abutment-supported retainer for porcelain fused to metal FPD (high noble metal)	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6070	abutment-supported retainer for porcelain fused to metal FPD (predominately base metal)	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6071	abutment-supported retainer for porcelain fused to metal FPD (noble metal)	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6072	abutment-supported retainer for cast metal FPD (high noble metal)	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None

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CDT Code	Description of Service	Pediatric Service Type	HCR Pediatric Plan Ages 0 through 18  Procedure Guidelines or Frequency Limitation	HCR Pediatric Plan Ages 0 through 18  Submission Requirements	Adult Service Type	HCR Adult Plan Ages 19 and older  Procedure Guidelines or Frequency Limitation	HCR Adult Plan Ages 19 and older  Submission Requirements	Integral Considerations and Exclusions
D6073	abutment-supported retainer for cast metal FPD (predominately base metal)	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6074	abutment-supported retainer for cast metal FPD (noble metal)	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6075	implant-supported retainer for ceramic FPD	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6076	implant supported retainer for FPD - porcelain fused to high noble alloys	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6077	implant supported retainer for metal FPD - high noble alloys	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6080	implant maintenance procedures when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None

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CDT Code	Description of Service	Pediatric Service Type	HCR Pediatric Plan Ages 0 through 18  Procedure Guidelines or Frequency Limitation	HCR Pediatric Plan Ages 0 through 18  Submission Requirements	Adult Service Type	HCR Adult Plan Ages 19 and older  Procedure Guidelines or Frequency Limitation	HCR Adult Plan Ages 19 and older  Submission Requirements	Integral Considerations and Exclusions
D6081	scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths includes cleaning of the implant surfaces, without flap entry and closure	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6082	implant supported crown – porcelain fused to predominantly base alloys	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6083	implant supported crown – porcelain fused to noble alloys	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6084	implant supported crown – porcelain fused to titanium and titanium alloys	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6085	interim implant crown	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6086	implant supported crown – predominantly base alloys	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6087	implant supported crown – noble alloys	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6088	implant supported crown – titanium and titanium alloys	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6089	accessing and retorquing loose implant screw – per screw	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D6090	repair of implant/abutment supported prosthesis	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None

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CDT Code	Description of Service	Pediatric Service Type	HCR Pediatric Plan Ages 0 through 18  Procedure Guidelines or Frequency Limitation	HCR Pediatric Plan Ages 0 through 18  Submission Requirements	Adult Service Type	HCR Adult Plan Ages 19 and older  Procedure Guidelines or Frequency Limitation	HCR Adult Plan Ages 19 and older  Submission Requirements	Integral Considerations and Exclusions
D6091	replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6092	recement or re-bond implant/abutment-supported crown	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6093	recement or re-bond implant/abutment-supported fixed partial denture	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6094	abutment supported crown titanium and titanium alloys	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6096	remove broken implant retaining screw	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D6097	abutment supported crown – porcelain fused to titanium and titanium alloys	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6098	implant supported retainer – porcelain fused to predominantly base alloys	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None

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CDT Code	Description of Service	Pediatric Service Type	HCR Pediatric Plan Ages 0 through 18  Procedure Guidelines or Frequency Limitation	HCR Pediatric Plan Ages 0 through 18  Submission Requirements	Adult Service Type	HCR Adult Plan Ages 19 and older  Procedure Guidelines or Frequency Limitation	HCR Adult Plan Ages 19 and older  Submission Requirements	Integral Considerations and Exclusions
D6099	implant supported retainer for FPD – porcelain fused to noble alloys	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6100	implant removal, by report	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6101	debridement of peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6102	debridement and osseous contouring of peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6103	bone graft for repair of peri-implant defect - does not include flap entry and closure	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D6104	bone graft a time of implant placement	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6105	removal of implant body not requiring bone removal nor flap elevation	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None

**NOTE:** These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

CDT Code	Description of Service	Pediatric Service Type	HCR Pediatric Plan Ages 0 through 18  Procedure Guidelines or Frequency Limitation	HCR Pediatric Plan Ages 0 through 18  Submission Requirements	Adult Service Type	HCR Adult Plan Ages 19 and older  Procedure Guidelines or Frequency Limitation	HCR Adult Plan Ages 19 and older  Submission Requirements	Integral Considerations and Exclusions
D6106	guided tissue regeneration – resorbable barrier, per implant	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6107	guided tissue regeneration – non-resorbable barrier, per implant	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6110	implant /abutment supported removable denture for edentulous arch – maxillary	Major	Not a covered benefit.	None	Major	Not a covered benefit. Alternate benefit D5110.	None	None
D6111	implant /abutment supported removable denture for edentulous arch – mandibular	Major	Not a covered benefit.	None	Major	Not a covered benefit. Alternate benefit D5120.	None	None
D6112	implant /abutment supported removable denture for partially edentulous arch – maxillary	Major	Not a covered benefit.	None	Major	Not a covered benefit. Alternate benefit D5213.	None	None
D6113	implant /abutment supported removable denture for partially edentulous arch – mandibular	Major	Not a covered benefit.	None	Major	Not a covered benefit. Alternate benefit D5214.	None	None
D6114	implant /abutment supported fixed denture for edentulous arch – maxillary	Major	Not a covered benefit.	None	Major	Not a covered benefit. Alternate benefit D5110.	None	None
D6115	implant /abutment supported fixed denture for edentulous arch – mandibular	Major	Not a covered benefit.	None	Major	Not a covered benefit. Alternate benefit D5120.	None	None
D6116	implant /abutment supported fixed denture for partially edentulous arch – maxillary	Major	Not a covered benefit.	None	Major	Not a covered benefit. Alternate benefit D5214.	None	None

**NOTE:** These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

CDT Code	Description of Service	Pediatric Service Type	HCR Pediatric Plan Ages 0 through 18  Procedure Guidelines or Frequency Limitation	HCR Pediatric Plan Ages 0 through 18  Submission Requirements	Adult Service Type	HCR Adult Plan Ages 19 and older  Procedure Guidelines or Frequency Limitation	HCR Adult Plan Ages 19 and older  Submission Requirements	Integral Considerations and Exclusions
D6117	implant /abutment supported fixed denture for partially edentulous arch – mandibular	Major	Not a covered benefit.	None	Major	Not a covered benefit. Alternate benefit D5214.	None	None
D6118	implant/abutment supported interim fixed denture for edentulous arch – mandibular. Used when a period of healing is necessary prior to fabrication and placement of a permanent prosthetic	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6119	implant/abutment supported interim fixed denture for edentulous arch - maxillary	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6120	implant supported retainer - porcelain fused to titanium and titanium alloys	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6121	implant supported retainer for metal FPD - predominantly base alloys	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6122	implant support retainer for metal FPD - noble alloys	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6123	implant supported retainer for metal FPD - titanium and titanium alloys	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6180	implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed including cleansing of prosthesis and abutments	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None

**NOTE:** These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

CDT Code	Description of Service	Pediatric Service Type	HCR Pediatric Plan Ages 0 through 18  Procedure Guidelines or Frequency Limitation	HCR Pediatric Plan Ages 0 through 18  Submission Requirements	Adult Service Type	HCR Adult Plan Ages 19 and older  Procedure Guidelines or Frequency Limitation	HCR Adult Plan Ages 19 and older  Submission Requirements	Integral Considerations and Exclusions
D6190	radiographic/surgical implant index, by report	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6191	semi - precision abutment - placement	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6192	semi - precision attachment - placement	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6193	replacement of an implant screw	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6194	abutment supported retainer crown for FPD - titanium and titanium alloys	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6195	abutment supported retainer - porcelain fused to titanium and titanium alloys	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6197	replacement of restorative material used to close an access opening of a screw-retained	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6198	remove interim implant component	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None

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CDT Code	Description of Service	Pediatric Service Type	HCR Pediatric Plan Ages 0 through 18  Procedure Guidelines or Frequency Limitation	HCR Pediatric Plan Ages 0 through 18  Submission Requirements	Adult Service Type	HCR Adult Plan Ages 19 and older  Procedure Guidelines or Frequency Limitation	HCR Adult Plan Ages 19 and older  Submission Requirements	Integral Considerations and Exclusions
D6199	unspecified implant procedure, by report	Major	Not a covered benefit.	None	Major	Not a covered benefit.	Tooth identification	None

**NOTE:** These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

## IX. D6200-D6999 Prosthodontics, Fixed

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### **When services are covered:**

- Coverage to restore the normal complement of teeth.
- Edentulous space must have adequate mesial-distal and vertical dimension to accommodate a functional pontic.
- Abutment teeth must be endodontically and periodontally sound.

### **When services are not covered:**

- Cosmetic purposes or to restore or treat complications of non-covered procedures.
- To treat TMJ dysfunction.
- Increase vertical dimension.
- Restore occlusion lost through erosion, abrasion, or attrition.
- Correction of congenital or developmental abnormalities.

### **Benefit criteria and limitations:**

- Restoration is covered only once every five (5) years.
  - Members nineteen (19) years or older.
  - Permanent teeth only.
  - Service or completion date is the cementation date.
  - Service includes preparation of teeth, indirect pulp cap, bases, liners, laboratory costs, temporary crowns/bridges, cementation, and local anesthesia.
  - If an alternate benefit is paid, the member is responsible for the difference between The Plan allowance and provider's billed charge.
  - Gingivectomy performed in conjunction with an inlay/onlay is considered a part of the procedure and cannot be billed separately.
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CDT Code	Description of Service	Pediatric Service Type	HCR Pediatric Plan Ages 0 through 18 Procedure Guidelines or Frequency Limitation	HCR Pediatric Plan Ages 0 through 18 Submission Requirements	Adult Service Type	HCR Adult Plan Ages 19 and older Procedure Guidelines or Frequency Limitation	HCR Adult Plan Ages 19 and older Submission Requirements	Integral Considerations and Exclusions
D6205	pontic - indirect resin-based composite	Major	Not a covered benefit.	None	Major	Once per tooth per five (5) years, age nineteen (19) and older.	Tooth identification	None
D6210	pontic - cast high noble metal	Major	Not a covered benefit.	None	Major	Once per tooth, in a five (5) year period.	Tooth identification	Cantilever fixed partial dentures with one (1) pontic are covered. One (1) in five (5) years. The patient must be age nineteen (19) or older. Service or completion date is the cementation date.
D6211	pontic - cast predominantly base metal	Major	Not a covered benefit.	None	Major	Once per tooth, in a five (5) year period.	Tooth identification	Refer to details listed for Code D6210
D6212	pontic - cast noble metal	Major	Not a covered benefit.	None	Major	Once per tooth, in a five (5) year period.	Tooth identification	Refer to details listed for Code D6210
D6214	pontic - titanium and titanium alloys	Major	Not a covered benefit.	None	Major	Once per tooth, in a five (5) year period.	Tooth identification	Refer to details listed for Code D6210
D6240	pontic - porcelain fused to high noble metal	Major	Not a covered benefit.	None	Major	Once per tooth, in a five (5) year period. Alternate benefit: D6210 for molars. Covered for anterior teeth.	Tooth identification	Refer to details listed for Code D6210
D6241	pontic - porcelain fused to predominantly base metal	Major	Not a covered benefit.	None	Major	Once per tooth, in a five (5) year period. Alternate benefit: D6211 for molars only.	Tooth identification	Refer to details listed for Code D6210
D6242	pontic - porcelain fused to noble metal	Major	Not a covered benefit.	None	Major	Once per tooth, in a five (5) year period. Alternate benefit: D6212 for molars only.	Tooth identification	Cantilever fixed partial dentures with one (1) pontic are covered. One (1) in five (5) years. The patient must be age nineteen (19) or older. Service or completion date is the cementation date.

**NOTE:** These CDT Procedure Guidelines are to be used as a reference for claim submission based on the level of benefits for each subscriber's plan. Particular details will vary from plan to plan. Verification of eligibility and individual plan benefits is required to determine the specific level of benefit coverage.

CDT Code	Description of Service	Pediatric Service Type	HCR Pediatric Plan Ages 0 through 18 Procedure Guidelines or Frequency Limitation	HCR Pediatric Plan Ages 0 through 18 Submission Requirements	Adult Service Type	HCR Adult Plan Ages 19 and older Procedure Guidelines or Frequency Limitation	HCR Adult Plan Ages 19 and older Submission Requirements	Integral Considerations and Exclusions
D6243	pontic - porcelain fused to titanium and titanium alloys	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6245	pontic - porcelain/ceramic	Major	Not a covered benefit.	None	Major	Once per tooth in a five (5) year period. Alternate benefit: D6210 for molars, D6240 for anterior and bicuspid.	None	None
D6250	pontic - resin with high noble metal	Major	Not a covered benefit.	None	Major	Once per tooth, in a five (5) year period.	Tooth identification	Cantilever fixed partial dentures with one (1) pontic are covered. One (1) in five (5) years. The patient must be age nineteen (19) or older. Service or completion date is the cementation date.
D6251	pontic - resin with predominantly base metal	Major	Not a covered benefit.	None	Major	Once per tooth, in a five (5) year period.	Tooth identification	Refer to details for Code D6250.
D6252	pontic - resin with noble metal	Major	Not a covered benefit.	None	Major	One (1) per tooth, in a five (5) year period.	Tooth identification	Cantilever fixed partial dentures with one (1) pontic are covered. One (1) in five (5) years. The patient must be age nineteen (19) or older. Service or completion date is the cementation date.
D6253	interim pontic - further treatment or completion of diagnosis necessary prior to final impression	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None

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## FIXED PARTIAL DENTURE RETAINERS – INLAYS/ONLAYS

- Porcelain/ceramic retainers are paid at the metallic rate as an alternate benefit with the member responsible for the difference between The Plan payment and the provider's actual charge. Coverage includes laboratory charges, liners, bases, and local anesthesia.
- Resin retainers are paid at the metallic rate as an alternate benefit with the member responsible for the difference between The Plan payment and the provider's actual charge. Porcelain/ceramic coverage is for permanent teeth needing buccal/lingual cusp coverage only.

• The patient must be age nineteen (19) or older.

Service or completion date is the cementation date

CDT Code	Description of Service	Pediatric Service Type	HCR Pediatric Plan Ages 0 through 18 Procedure Guidelines or Frequency Limitation	HCR Pediatric Plan Ages 0 through 18 Submission Requirements	Adult Service Type	HCR Adult Plan Ages 19 and older Procedure Guidelines or Frequency Limitation	HCR Adult Plan Ages 19 and older Submission Requirements	Integral Considerations and Exclusions
D6545	retainer - cast metal for resin bonded fixed prosthesis	Major	Not a covered benefit.	None	Major	One (1) in a five (5) year period.	Tooth identification	Metal retainers are covered. Coverage is for permanent teeth only. Five (5) year waiting period between services. The patient must be age nineteen (19) or older. Service or completion date is the cementation date.
D6548	retainer - porcelain/ceramic for resin bonded fixed prosthesis	Major	Not a covered benefit.	None	Major	Not a covered benefit. Alternate Benefit D6545.	None	None
D6549	resin retainer - for resin bonded fixed prosthesis	Major	Not a covered benefit.	None	Major	Not a covered benefit. Alternate Benefit D6545.	None	None
D6600	retainer inlay - porcelain/ceramic, two surfaces	Major	Not a covered benefit.	None	Major	One (1) per tooth per five (5) years. Alternate benefit D6602.	Tooth identification	None
D6601	retainer inlay - porcelain/ceramic, three or more surfaces	Major	Not a covered benefit.	None	Major	One (1) per tooth per five (5) years. Alternate benefit D6603.	Tooth identification	None

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D6602	retainer inlay - cast high noble metal, two surfaces	Major	Not a covered benefit.	None	Major	One (1) per tooth per five (5) years.	Tooth identification, Surface identification	Metal inlay/onlay retainers are covered. Coverage is for permanent teeth only. Five (5) year waiting period between services. The patient must be age nineteen (19) or older. Service or completion date is the cementation date.
D6603	retainer inlay - cast high noble metal, three or more surfaces	Major	Not a covered benefit.	None	Major	One (1) per tooth per five (5) years.	Tooth identification, Surface identification	Metal inlay/onlay retainers are covered. Coverage is for permanent teeth only. Five (5) year waiting period between services. The patient must be age nineteen (19) or older. Service or completion date is the cementation date.
D6604	retainer inlay - cast predominantly base metal, two surfaces	Major	Not a covered benefit.	None	Major	One (1) per tooth per five (5) years.	Tooth identification, Surface identification	Refer to details listed for Code D6603
D6605	retainer inlay - cast predominantly base metal, three or more surfaces	Major	Not a covered benefit.	None	Major	One (1) per tooth per five (5) years.	Tooth identification, Surface identification	Refer to details listed for Code D6603
D6606	retainer inlay - cast noble metal, two surfaces	Major	Not a covered benefit.	None	Major	One (1) per tooth per five (5) years.	Tooth identification, Surface identification	Refer to details listed for Code D6603
D6607	retainer inlay - cast noble metal, three or more surfaces	Major	Not a covered benefit.	None	Major	One (1) per tooth per five (5) years.	Tooth identification, Surface identification	Metal inlay/onlay retainers are covered. Coverage is for permanent teeth only. Five (5) year waiting period between services. The patient must be age nineteen (19) or older. Service or completion date is the cementation date.
D6608	retainer onlay - porcelain/ceramic, two surfaces	Major	Not a covered benefit.	None	Major	One (1) per tooth per five (5) years. Alternate benefit D6610.	Tooth identification, Surface identification	None

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D6609	retainer onlay - porcelain/ceramic, three or more surfaces	Major	Not a covered benefit.	None	Major	One (1) per tooth per five (5) years. Alternate benefit D6611.	Tooth identification, Surface identification	None
D6610	retainer onlay - cast high noble metal, two surfaces	Major	Not a covered benefit.	None	Major	One (1) in a five (5) year period.	Tooth identification Surface identification, must include B or L surface	None
D6611	retainer onlay - cast high noble metal, three or more surfaces	Major	Not a covered benefit.	None	Major	One (1) in a five (5) year period.	Tooth identification Surface identification, must include B or L surface	None
D6612	retainer onlay - cast predominantly base metal, two surfaces	Major	Not a covered benefit.	None	Major	One (1) in a five (5) year period.	Tooth identification Surface identification, must include B or L surface	None
D6613	retainer onlay - cast predominantly base metal, three or more surfaces	Major	Not a covered benefit.	None	Major	One (1) in a five (5) year period.	Tooth identification Surface identification, must include B or L surface	None
D6614	retainer onlay - cast noble metal, two surfaces	Major	Not a covered benefit.	None	Major	One (1) in a five (5) year period.	Tooth identification Surface identification, must include B or L surface	None

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D6615	retainer onlay - cast noble metal, three or more surfaces	Major	Not a covered benefit.	None	Major	One (1) in a five (5) year period.	Tooth identification Surface identification, must include B or L surface	None
D6624	retainer inlay - titanium	Major	Not a covered benefit.	None	Major	One (1) in a five (5) year period.	Tooth identification Surface identification, must include B or L surface	None
D6634	retainer onlay - titanium	Major	Not a covered benefit.	None	Major	One (1) in a five (5) year period.	Tooth identification Surface identification, must include B or L surface	None

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## FIXED PARTIAL DENTURE RETAINERS – CROWNS

- Crowns are covered when as a result of extensive caries or fracture the tooth cannot be restored with a direct restoration.
- Porcelain/ceramic, porcelain fused to metal, resin, and resin with metal and metal crowns are covered for anterior and bicuspid teeth meeting policy guidelines.
- Resin/porcelain crowns or resin/porcelain on metal crowns placed on molars are covered as an alternate benefit at the full metal crown rate.
- For Permanent teeth only.
- Service or completion date is the cementation date

CDT Code	Description of Service	Pediatric Service Type	HCR Pediatric Plan Ages 0 through 18 Procedure Guidelines or Frequency Limitation	HCR Pediatric Plan Ages 0 through 18 Submission Requirements	Adult Service Type	HCR Adult Plan Ages 19 and older Procedure Guidelines or Frequency Limitation	HCR Adult Plan Ages 19 and older Submission Requirements	Integral Considerations and Exclusions
D6710	retainer crown - indirect resin-based composite	Major	Not a covered benefit.	None	Major	One (1) in a five (5) year period.	Tooth identification	Five (5) year waiting period between services. Patient must be age nineteen (19) or older. Service or completion date is the cementation date
D6720	retainer crown - resin with high noble metal	Major	Not a covered benefit.	None	Major	One (1) in a five (5) year period.	Tooth identification	Five (5) year waiting period between services. Patient must be age nineteen (19) or older. Service or completion date is the cementation date
D6721	retainer crown - resin with predominantly base metal	Major	Not a covered benefit.	None	Major	One (1) in a five (5) year period.	Tooth identification	Five (5) year waiting period between services. Patient must be age nineteen (19) or older. Service or completion date is the cementation date
D6722	retainer crown - resin with noble metal	Major	Not a covered benefit.	None	Major	One (1) in a five (5) year period.	Tooth identification	Five (5) year waiting period between services. Patient must be age nineteen (19) or older. Service or completion date is the cementation date
D6740	retainer crown - porcelain/crown	Major	Not a covered benefit.	None	Major	One (1) per tooth in a five (5) year period. Alternate Benefit: D6790 for molars and D6750 for anterior and bicuspid.	None	None

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D6750	retainer crown - porcelain fused to high noble metal	Major	Not a covered benefit.	None	Major	One (1) in a five (5) year period. Alternate benefit: D6790 for molars.	Tooth identification	Five (5) year waiting period between services. Patient must be age nineteen (19) or older. Service or completion date is the cementation date
D6751	retainer crown - porcelain fused to predominantly base metal	Major	Not a covered benefit.	None	Major	One (1) in a five (5) year period. Alternate benefit: D6791 for molars.	Tooth identification	Five (5) year waiting period between services. Patient must be age nineteen (19) or older. Service or completion date is the cementation date
D6752	retainer crown - porcelain fused to noble metal	Major	Not a covered benefit.	None	Major	One (1) in a five (5) year period. Alternate benefit: D6792 for molars.	Tooth identification	Crowns are covered when as a result of extensive caries or fracture the tooth cannot be restored with a direct restoration. Porcelain/ceramic, porcelain fused to metal, resin, and resin with metal and metal crowns are covered for anterior and bicuspid teeth meeting policy guidelines. Resin/porcelain crowns or resin/porcelain on metal crowns placed on molars are covered as an alternate benefit at the full metal crown rate. Five (5) year waiting period between services. Patient must be age nineteen (19) or older. For Permanent teeth only. Service or completion date is the cementation date
D6753	retainer crown - porcelain fused to titanium and titanium alloys	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	Refer to details listed for Code D6752
D6780	retainer crown - 3/4 cast high noble metal	Major	Not a covered benefit.	None	Major	One (1) in a five (5) year period.	Tooth identification	Refer to details listed for Code D6752
D6781	retainer crown - 3/4 cast predominantly base metal	Major	Not a covered benefit.	None	Major	One (1) in a five (5) year period.	Tooth identification	Refer to details listed for Code D6752
D6782	retainer crown - 3/4 cast high noble metal	Major	Not a covered benefit.	None	Major	One (1) in a five (5) year period.	Tooth identification	Refer to details listed for Code D6752

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D6783	retainer crown - 3/4 porcelain/ceramic	Major	Not a covered benefit.	None	Major	One (1) in a five (5) year period. Alternate benefit: D6780.	None	None
D6784	retainer crown 3/4 - titanium and titanium alloys	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6790	retainer crown - full cast high noble metal	Major	Not a covered benefit.	None	Major	One (1) in a five (5) year period.	Tooth identification	Crowns are covered when as a result of extensive caries or fracture the tooth cannot be restored with a direct restoration. Five (5) year waiting period between services. Patient must be age nineteen (19) or older. For permanent teeth only. Service or completion date is the cementation date.
D6791	retainer crown - full cast predominantly base metal	Major	Not a covered benefit.	None	Major	One (1) in a five (5) year period.	Tooth identification	Refer to details listed for Code D6790.
D6792	retainer crown - full cast noble metal	Major	Not a covered benefit.	None	Major	One (1) in a five (5) year period.	Tooth identification	Refer to details listed for Code D6790.
D6793	interim retainer crown - further treatment or completion of diagnosis necessary prior to final impression	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6794	retainer crown - titanium and titanium alloys	Major	Not a covered benefit.	None	Major	One (1) in a five (5) year period.	Tooth identification	Crowns are covered when as a result of extensive caries or fracture the tooth cannot be restored with a direct restoration. Five (5) year waiting period between services. Patient must be age nineteen (19) or older. For permanent teeth only. Service or completion date is the cementation date.

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D6920	connector bar	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6930	re-cement or re-bond fixed partial denture	Major	Not a covered benefit.	None	Basic	Two (2) in a five (5) year period.	Tooth identification	Plan covers two (2) recementations per fixed partial denture in five (5) years and Recementation of a fixed partial denture if more than 6 months have passed from the date of cementation. There is a twelve (12) month waiting period between recementations. Patient must be age nineteen (19) or older. For permanent teeth only.
D6940	stress breaker	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6950	precision attachment	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6980	fixed partial denture repair necessitated by restorative material failure	Basic	Not a covered benefit.	None	Basic	One (1) per five (5) year period.	Tooth identification	None
D6985	pediatric partial denture, fixed	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D6999	unspecified fixed prosthodontic procedure, by report	Major	Not a covered benefit.	None	Major	By Report. Individual consideration.	Detailed narrative	None

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## X. D7000-D7999 Oral & Maxillofacial Surgery

**EXTRACTIONS:** Includes local anesthesia, suturing if needed, and routine post-operative care.

- Surgical Extractions (for all ages) are Major benefits.
- Simple surgical extractions (D7111, D7140) are Basic benefits for ACA plans 206, 207, 218, 220 and 202. Please refer to Member's Guide to Benefit for coverage details.
- Bone grafts (D4264, D4265) and GTR membranes (D4266, D4267) are not covered in conjunction with oral surgery codes (D7000-D7999).
- Palliative (emergency treatment of dental pain – minor procedures (D9110) is a covered procedure and paid separately unless submitted in conjunction with a definitive procedure on the same date of service.

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D7111	extraction, coronal remnants - primary tooth	Basic	One (1) per tooth per lifetime. Covered teeth (A-T).	Tooth identification	Basic	One (1) per tooth per lifetime. Covered teeth (A-T).	Tooth identification	The Plan coverage includes local anesthetic, suturing, if needed, and routine postoperative care. Once per tooth.
D7140	extraction, erupted tooth, or exposed root (elevation and/or forceps removal)	Basic	One (1) per tooth per lifetime, covers all primary and permanent teeth.	Tooth identification	Basic	One (1) per tooth per lifetime. Covered teeth (A-T).	Tooth identification	The Plan coverage includes local anesthetic, suturing, if needed, and routine postoperative care. Once per tooth.
D7210	extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	Basic	One (1) per tooth per lifetime, covers all primary and permanent teeth.	Tooth identification	Major	One (1) per tooth per lifetime.	Tooth identification	Surgical removal of an erupted tooth requiring removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated. Once per tooth

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D7220	removal of impacted tooth - soft tissue	Basic	One (1) per tooth per lifetime, covers all primary and permanent teeth.	Tooth identification	Major	One (1) per tooth per lifetime.	Tooth identification	Procedures include local anesthesia, suturing if needed and routine postoperative care. D7241 is a "by report" procedure and will be reviewed by the Dental Consultant or Dental Director. Once per tooth
D7230	removal of impacted tooth - partially bony	Basic	One (1) per tooth per lifetime, covers all primary and permanent teeth.	Tooth identification	Major	One (1) per tooth per lifetime.	Tooth identification	Refer to details listed for Code D7220.
D7240	removal of impacted tooth - completely bony	Basic	One (1) per tooth per lifetime, covers all primary and permanent teeth.	Tooth identification	Major	One (1) per tooth per lifetime.	Tooth identification	Refer to details listed for Code D7220.
D7241	removal of impacted tooth - completely bony, with unusual surgical complications	Basic	One (1) per tooth per lifetime.	Tooth identification	Major	By Report, One (1) per tooth per lifetime.	Tooth identification	Refer to details listed for Code D7220.
D7250	removal of residual tooth roots (cutting procedure)	Basic	One (1) per tooth per lifetime.	Tooth identification	Major	One (1) per tooth per lifetime.	Tooth identification	Coverage includes local anesthesia, suturing if needed, and routine post-operative care. Extraction of a tooth and surgical removal of a residual root of the same tooth, on the same service date are not paid separately.
D7251	coronectomy - intentional partial tooth removal, impacted teeth only	Basic	Not a covered benefit.	None	Major	One (1) per tooth per lifetime.	Tooth identification	Radiographs and narrative documentation required with submission.
D7252	partial extraction for immediate implant placement	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None

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D7259	nerve dissection	Major	Not a covered benefit.	None	Major	Limited to one (1) Nerve dissection (D7259) per permanent tooth per lifetime.	Tooth identification	Denied as INTEGRAL when reported on the same tooth, on the same date, and by the same Dentist as a Removal of impacted tooth - completely bony, with unusual surgical complications (D7241).
D7260	oroantral fistula closure	Basic	By Report.	By report	Major	Not a covered benefit.	None	None
D7261	primary closure of a sinus perforation	Basic	One (1) per Lifetime.	None	Major	By Report. One (1) per Maxillofacial posterior tooth.	Detailed narrative	None
D7270	tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth	Basic	One (1) tooth per lifetime, covers teeth 1 thru 32.	Tooth identification	Major	One (1) per tooth per lifetime.	Tooth identification	Reimplantation is limited to permanent teeth. The procedure code is not used for intentional reimplantation (D3470) and surgical repositioning of teeth (D7290). Once per tooth per lifetime
D7272	tooth transplantation (includes re-implantation from one site to another and splinting and/or stabilization)	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7280	exposure of an unerupted tooth	Basic	Limited to cases approved for Ortho and teeth 2 thru 15 and 18 thru 31.	None	Major	One (1) per tooth per lifetime.	Tooth identification and detailed narrative	A narrative and tooth numbers must accompany the claim.
D7282	mobilization of erupted or malpositioned tooth to aid eruption	Basic	Limited to cases approved for Ortho and teeth 2 thru 15 and 18 thru 31.	None	Major	Not a covered benefit.	None	None

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D7283	placement of device to facilitate eruption of impacted tooth	Basic	Limited to cases approved for Ortho and teeth 2 thru 15 and 18 thru 31.	None	Major	Not a covered benefit.	None	None
D7284	excisional biopsy of minor salivary glands	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7285	incisional biopsy of oral tissue - hard (bone, tooth)	Basic	By Report.	None	Major	Not a covered benefit.	None	None
D7286	incisional biopsy of oral tissue - soft	Basic	By Report.	None	Major	Not a covered benefit.	None	None
D7287	exfoliative cytological sample collection	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7288	brush biopsy - transepithelial sample collection	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7290	surgical repositioning of teeth	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7291	transseptal fiberotomy/supra crestal fiberotomy, by report	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None

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D7292	placement of temporary anchorage device [screw retained plate] requiring flap	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7293	placement of temporary anchorage device requiring flap	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7294	placement of temporary anchorage device without flap	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7295	harvest of bone for use in autogenous grafting procedure	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7296	corticotomy - one to three teeth or tooth spaces, per quadrant	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7297	corticotomy - four or more teeth or tooth spaces per quadrant	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7298	removal of temporary anchorage device [screw retained plate], requiring flap	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7299	removal of temporary anchorage device, requiring flap	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None

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D7300	removal of temporary anchorage devise without flap	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7310	alveoloplasty in conjunction with extractions – four (4) or more teeth or tooth spaces, per quadrant	Basic	Four (4) per day.	None	Major	No limitations.	Tooth identification Quadrant identification	The Plan coverage includes suturing, local anesthetic, and routine postoperative care. For reporting purposes, a quadrant is defined as four (4) or more contiguous teeth and/or tooth spaces distal to the midline.
D7311	alveoloplasty in conjunction with extractions - one (1) to three (3) teeth or tooth spaces, per quadrant	Basic	Four (4) per day.	None	Major	No limitations.	Tooth identification	The Plan coverage includes suturing, local anesthetic, and routine postoperative care. For reporting purposes, a quadrant is defined as four (4) or more contiguous teeth and/or tooth spaces distal to the midline.
D7320	alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	Basic	Four (4) per day.	None	Major	No limitations.	Tooth identification Quadrant identification	The Plan coverage includes suturing, local anesthetic, and routine postoperative care. For reporting purposes, a quadrant is defined as four (4) or more contiguous teeth and/or tooth spaces distal to the midline.
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	Basic	Four (4) per day.	None	Major	No limitations.	Tooth identification	<i>The Plan coverage includes suturing, local anesthetic, and routine postoperative care. For reporting purposes, a quadrant is defined as four (4) or more contiguous teeth and/or tooth spaces distal to the midline.</i>
D7340	vestibuloplasty - ridge extension (secondary epithelialization)	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7350	vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None

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D7410	excision of benign lesion up to 1.25 cm	Basic	By Report.	None	Major	Submit claim to medical carrier for payment.	None	None
D7411	excision of benign lesion greater than 1.25 cm	Basic	By Report.	None	Major	Submit claim to medical carrier for payment.	None	None
D7412	excision of benign lesions, complicated	Basic	By Report.	None	Major	Submit claim to medical carrier for payment.	None	None
D7413	excision of malignant lesion up to 1.25 cm	Basic	By Report.	None	Major	Submit claim to medical carrier for payment.	None	None
D7414	excision of malignant lesion greater than 1.25 cm	Basic	By Report.	None	Major	Submit claim to medical carrier for payment.	None	None
D7415	excision of malignant lesion, complicated	Basic	By Report.	None	Major	Submit claim to medical carrier for payment.	None	None
D7440	excision of malignant tumor - lesion diameter up to 1.25 cm	Basic	Not a covered benefit.	None	Major	Submit Claim to Medical Carrier for payment.	None	None

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CDT Code	Description of Service	Pediatric Service Type	HCR Pediatric Plan Ages 0 through 18  Procedure Guidelines or Frequency Limitation	HCR Pediatric Plan Ages 0 through 18  Submission Requirements	Adult Service Type	HCR Adult Plan Ages 19 and older  Procedure Guidelines or Frequency Limitation	HCR Adult Plan Ages 19 and older  Submission Requirements	Integral Considerations and Exclusions
D7441	excision of malignant tumor - lesion diameter greater than 1.25 cm	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7450	removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	Basic	Not a covered benefit.	None	Major	No limitations.	None	The Plan covers the removal of odontogenic cysts or tumors.
D7451	removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	Basic	Not a covered benefit.	None	Major	No limitations.	None	The Plan covers the removal of odontogenic cysts or tumors
D7460	removal of benign nonodontogenic cysts or tumor - lesion diameter up to 1.25 cm	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7461	removal of benign nonodontogenic cysts or tumor - lesion diameter greater 1.25 cm	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7465	destruction of lesion(s) by physical or chemical method, by report	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None

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CDT Code	Description of Service	Pediatric Service Type	HCR Pediatric Plan Ages 0 through 18  Procedure Guidelines or	HCR Pediatric Plan Ages 0 through 18  Submission Requirements	Adult Service Type	HCR Adult Plan Ages 19 and older  Procedure Guidelines or Frequency Limitation	HCR Adult Plan Ages 19 and older  Submission Requirements	Integral Considerations and Exclusions
D7471	removal of lateral exostosis (maxilla or mandible)	Basic	Not a covered benefit.	None	Major	One (1) per site per lifetime.	Detailed narrative	None
D7472	removal of torus palatinus	Basic	Not a covered benefit.	None	Major	One (1) per site per lifetime.	Detailed narrative	None
D7473	removal of torus mandibularis	Basic	Not a covered benefit.	None	Major	One (1) per site per lifetime.	Detailed narrative	None
D7485	reduction of osseous tuberosity	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7490	radical resection of maxilla or mandible	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7509	marsupialization of odontogenic cyst	Basic	Not a covered benefit.	Submit to Medical for benefit determination	Major	Not a covered benefit.	None	None
D7510	incision and drainage of abscess - intraoral soft tissue	Basic	Teeth A thru T and 1 thru 32.	Tooth and Arch identification; A brief narrative describing treatment, location and/or tooth number must accompany claim.	Major	Covered when reported in conjunction with extractions.	Tooth and Arch identification; A brief narrative describing treatment, location and/or tooth number must accompany claim.	Procedure is not to be used for endodontic access and drainage through a tooth or for open and broach.
D7511	incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	Basic	Not a covered benefit.	None	Major	By Report.	A brief narrative describing treatment, location and/or tooth number must accompany claim.	Procedure is not to be used for endodontic access and drainage through a tooth or for open and broach.

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CDT Code	Description of Service	Pediatric Service Type	HCR Pediatric Plan Ages 0 through 18  Procedure Guidelines or Frequency Limitation	HCR Pediatric Plan Ages 0 through 18  Submission Requirements	Adult Service Type	HCR Adult Plan Ages 19 and older  Procedure Guidelines or Frequency Limitation	HCR Adult Plan Ages 19 and older  Submission Requirements	Integral Considerations and Exclusions
D7520	incision and drainage of abscess - extraoral soft tissue	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7521	incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7530	removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7540	removal of reaction producing foreign bodies, musculoskeletal system	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7550	partial ostectomy/sequestrectomy for removal of non-vital bone	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7560	maxillary sinusotomy for removal of tooth fragment or foreign body	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7610	maxilla - open reduction (teeth immobilized if present)	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None

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D7620	maxilla - closed reduction (teeth immobilized if present)	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7630	mandible - open reduction (teeth immobilized if present)	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7640	mandible - closed reduction (teeth immobilized if present)	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7650	malar and/or zygomatic arch - open reduction	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7660	malar and/or zygomatic arch - closed reduction	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7670	alveolus - closed reduction, may include stabilization of teeth	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7671	alveolus - open reduction, may include stabilization of teeth	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7680	facial bones-complicated reduction with fixation and multiple surgical approaches	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None

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D7710	maxilla - open reduction	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7720	maxilla - closed reduction	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7730	mandible - open reduction	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7740	mandible - closed reduction	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7750	malar and/or zygomatic arch - open reduction	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7760	malar and/or zygomatic arch - closed reduction	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7770	alveolus - open reduction stabilization of teeth	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7771	alveolus - closed reduction, stabilization of teeth	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7780	facial bones – complicated reduction with fixation and multiple surgical approaches	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7810	open reduction of dislocation	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None

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D7820	closed reduction of dislocation	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7830	manipulation under anesthesia	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7840	condylectomy	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7850	surgical discectomy, with/without implant	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7852	disc repair	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7854	synovectomy	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7856	myotomy	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7858	joint reconstruction	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7860	arthrotomy	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7865	arthroplasty	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7870	arthrocentesis	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7871	non-arthroscopic lysis and lavage	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7872	arthroscopy - diagnosis, with or without biopsy	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7873	arthroscopy: lavage and lysis of adhesions	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None

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D7874	arthroscopy: disc repositioning and stabilization	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7875	arthroscopy: synovectomy	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7876	arthroscopy: discectomy	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7877	arthroscopy: debridement	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7880	occlusal orthotic device, by report	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7881	occlusal orthotic device adjustment	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7899	unspecified TMD therapy, by report	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7910	suture of recent small wounds up to 5 cm	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7911	complicated suture - up to 5 cm	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7912	complicated suture - greater than 5 cm	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7920	skin graft (identify defect covered, location and type of graft)	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None

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D7921	collection and application of autologous blood concentrate product	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7922	placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	Basic	Always integral.	None	Major	Always integral.	None	None
D7939	indexing for osteotomy using dynamic robotic assisted or dynamic navigation	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7940	osteoplasty - for orthognathic deformities	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7941	osteotomy - mandibular rami	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7943	osteotomy - mandibular rami with bone graft; includes obtaining the graft	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7944	osteotomy - segmented or subapical	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7945	osteotomy - segmented or subapical	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7946	LeFort I (maxilla - total)	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7947	LeFort I (maxilla – segmented)	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None

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D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) – without bone graft	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7949	LeFort II or LeFort III – with bone graft	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7950	osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7951	sinus augmentation with bone or bone substitutes via a lateral open approach	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7952	sinus augmentation via a vertical approach	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7953	bone replacement graft for ridge preservation - per site	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7955	repair of maxillofacial soft and/or hard tissue defect	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7956	guided tissue regeneration, edentulous area – resorbable barrier, per site	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None

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D7957	guided tissue regeneration, edentulous area – non-resorbable barrier, per site	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7961	buccal/labial frenectomy (frenulectomy)	Basic	One (1) per site per lifetime.	Arch identification; Detailed narrative	Major	One (1) per lifetime.	Arch identification; Detailed narrative	None
D7962	lingual frenectomy (frenulectomy)	Basic	One (1) per lifetime.	Arch identification; Detailed narrative	Major	One (1) per lifetime.	Arch identification; Detailed narrative	None
D7963	frenuloplasty	Basic	Not a covered benefit.	None	Major	One (1) per lifetime.	Arch identification; Detailed narrative	None
D7970	excision of hyperplastic tissue - per arch	Basic	One (1) per five (5) years.	Arch identification; Operative report	Major	One (1) per five (5) years.	Arch identification; Operative report	Not payable if filed in conjunction with D4210 or D4211
D7971	excision of pericoronal gingiva	Basic	One (1) per five (5) year period. This procedure applies to the excision of tissue distal to the 2 <sup>nd</sup> and 3 <sup>rd</sup> molars.	Detailed narrative	Major	One (1) per five (5) years.	None	None
D7972	surgical reduction of fibrous tuberosity	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None

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D7979	non - surgical sialolithotomy	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7980	surgical sialolithotomy	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7981	excision of salivary gland, by report	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7982	sialodochoplasty	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7983	closure of salivary fistula	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7990	emergency tracheotomy	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7991	coronoidectomy	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7993	surgical placement of craniofacial implant - extra oral	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7994	surgical placement: zygomatic implant	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None

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D7995	synthetic graft-mandible or facial bones, by report	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7996	implant- mandible for augmentation purposes (excluding alveolar ridge), by report	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7997	appliance removal (not by dentist who placed appliance), includes removal of archbar	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7998	intraoral placement of a fixation device not in conjunction with a fracture	Basic	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D7999	unspecified oral surgery procedure, by report	Basic	Not a covered benefit.	None	Major	By Report.	Tooth identification, Detailed narrative	Individual Consideration. Detailed narrative required.

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## **XI. D8000-D8999 Orthodontics**

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### **Orthodontic Benefit Administration**

- Orthodontic benefits are covered for age 0 through 18, and limited to the repair of cleft lip and palate or other severe facial birth defects or injury for which the function of speech, swallowing, or chewing shall be restored.
- Prior Authorization is required for medically necessary orthodontic care.
- Approved medically necessary orthodontic benefits are only eligible when seeing an HMSA participating orthodontist.
- A limited number of HCR plans cover cosmetic orthodontic procedures. Prior authorization is not required for cosmetic orthodontic care. Refer to member's plan for orthodontic eligibility requirements or refer to the member's plan Guide to Benefits for specific orthodontic benefits.

### **Interceptive Orthodontic Treatment**

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

### **Comprehensive Orthodontic Treatment**

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

### **ORTHODONTICS**

- Approved Medically necessary orthodontic care is only a benefit, when performed by an HMSA participating orthodontist.
  - Medically necessary orthodontic care (D8050, C8060, D8070, D8080 and D8090) is limited to the repair of cleft lip and palate or other severe facial birth defects or injury for which the function of speech, swallowing, or chewing shall be restored. No wait period is required
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D8010	limited orthodontic treatment of the primary dentition	Ortho	Not a covered benefit.	None	Ortho	Not a covered benefit.	None	None
D8020	limited orthodontic treatment of the transitional dentition	Ortho	Not a covered benefit.	None	Ortho	Not a covered benefit.	None	None
D8030	limited orthodontic treatment of the adolescent dentition	Ortho	Not a covered benefit.	None	Ortho	Not a covered benefit.	None	None
D8040	limited orthodontic treatment of the adult dentition	Ortho	Not a covered benefit.	None	Ortho	Not a covered benefit.	None	None
D8070	comprehensive orthodontic treatment of the transitional dentition	Ortho	(24) month waiting period; and limited to the repair of the cleft lip and palate or other severe facial birth defects or injury for which the function of speech, allowing or chewing shall be restored.	Prior Authorization Required	Ortho	Not a covered benefit.	None	None
D8080	comprehensive orthodontic treatment of the adolescent dentition	Ortho	(24) month waiting period; and limited to the repair of the cleft lip and palate or other severe facial birth defects or injury for which the function of speech, allowing or chewing shall be restored.	Prior Authorization Required	Ortho	Not a covered benefit.	None	None

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D8090	comprehensive orthodontic treatment of the adult dentition	Ortho	(24) month waiting period; and limited to the repair of the cleft lip and palate or other severe facial birth defects or injury for which the function of speech, allowing or chewing shall be restored.	Prior Authorization Required	Ortho	Not a covered benefit.	None	None
D8091	comprehensive orthodontic treatment associated with orthognathic surgery when additional surgical intervention is planned	Ortho	Medically Necessary only. Limited to members age 19 and under.	Prior Authorization Required	Ortho	Not a covered benefit	None	Approved Medically necessary orthodontic care is only a benefit when performed by an HMSA participating orthodontist.
D8210	removable appliance therapy	Ortho	Not a covered benefit.	None	Ortho	Not a covered benefit.	None	None
D8220	fixed appliance therapy	Ortho	Not a covered benefit.	None	Ortho	Not a covered benefit.	None	None
D8660	pre-orthodontic treatment examination to monitor growth and development	Ortho	Not a covered benefit.	Prior Authorization Required	Ortho	Not a covered benefit.	None	None
D8670	periodic orthodontic treatment visit	Ortho	Not a covered benefit.	None	Ortho	Not a covered benefit.	None	None
D8671	periodic orthodontic treatment visit for comprehensive treatment associated with orthognathic surgery	Ortho	Integral to D8091.	Prior Authorization Required	Ortho	Not a covered benefit	None	Approved Medically necessary orthodontic care is only a benefit when performed by an HMSA participating orthodontist.
D8680	orthodontic retention (removal of appliances, construction, and	Ortho	Not a covered benefit.	None	Ortho	Not a covered benefit.	None	None

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	placement of retainer(s))							
D8681	removable orthodontic retainer adjustment	Ortho	Not a covered benefit.	None	Ortho	Not a covered benefit.	None	None
D8695	removal of fixed orthodontic appliances for reasons other than completion of treatment	Ortho	Not a covered benefit.	None	Ortho	Not a covered benefit.	None	None
D8696	repair of orthodontic appliance - maxillary	Ortho	Not a covered benefit.	None	Ortho	Not a covered benefit.	None	None
D8697	repair of orthodontic appliance - mandibular	Ortho	Not a covered benefit.	None	Ortho	Not a covered benefit.	None	None
D8698	re-cement or re-bond fixed retainer - maxillary	Ortho	Not a covered benefit.	None	Ortho	Not a covered benefit.	None	None
D8699	re-cement or re-bond fixed retainer - mandibular	Ortho	Not a covered benefit.	None	Ortho	Not a covered benefit.	None	None
D8701	repair of fixed retainer, includes reattachment - maxillary	Ortho	Not a covered benefit.	None	Ortho	Not a covered benefit.	None	None
D8702	repair of fixed retainer, includes reattachment - mandibular	Ortho	Not a covered benefit.	None	Ortho	Not a covered benefit.	None	None
D8703	replacement of lost or broken retainer - maxillary	Ortho	Not a covered benefit.	None	Ortho	Not a covered benefit.	None	None

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CDT Code	Description of Service	Pediatric Service Type	HCR Pediatric Plan Ages 0 through 18 Procedure Guidelines or Frequency Limitation	HCR Pediatric Plan Ages 0 through 18 Submission Requirements	Adult Service Type	HCR Adult Plan Ages 19 and older Procedure Guidelines or Frequency Limitation	HCR Adult Plan Ages 19 and older Submission Requirements	Integral Considerations and Exclusions
D8704	replacement of lost or broken retainer - mandibular	Ortho	Not a covered benefit.	None	Ortho	Not a covered benefit.	None	None
D8999	unspecified orthodontic procedure, by report	Ortho	Not a covered benefit.	None	Ortho	Not a covered benefit.	None	None

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## XII. D9000-D9999 Adjunctive General Services

CDT Code	Description of Service	Pediatric Service Type	HCR Pediatric Plan Ages 0 through 18 Procedure Guidelines or Frequency Limitation	HCR Pediatric Plan Ages 0 through 18 Submission Requirements	Adult Service Type	HCR Adult Plan Ages 19 and older Procedure Guidelines or Frequency Limitation	HCR Adult Plan Ages 19 and older Submission Requirements	Integral Considerations and Exclusions
D9110	palliative treatment of dental pain – per visit	Basic	One (1) per tooth per year.	Tooth Quadrant or Arch identification A narrative description of procedure must accompany the claim Tooth identification	Basic	By Report.	Tooth Quadrant or Arch identification A narrative description of procedure must accompany the claim Tooth identification	Palliative treatment is covered when a painful emergency condition requires immediate treatment for relief. To be considered palliative, the procedure should alleviate but not cure. Coverage is for the emergency treatment (per visit) providing no other eligible services, except diagnostic radiographs, are performed. One (1) palliative service per visit. If submitted in conjunction with definitive procedures palliative treatment will be denied.
D9120	fixed partial denture sectioning	Major	Not a covered benefit.	None	Basic	By Report.	None	None
D9130	temporomandibular joint dysfunction - non-invasive physical therapies	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D9210	local anesthesia not in conjunction with operative or surgical procedures	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D9211	regional block anesthesia	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D9212	trigeminal division block anesthesia	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D9215	local anesthesia in conjunction with operative or surgical procedures	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D9219	evaluation for moderate sedation, deep sedation, or general anesthesia	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None

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CDT Code	Description of Service	Pediatric Service Type	HCR Pediatric Plan Ages 0 through 18 Procedure Guidelines or Frequency Limitation	HCR Pediatric Plan Ages 0 through 18 Submission Requirements	Adult Service Type	HCR Adult Plan Ages 19 and older Procedure Guidelines or Frequency Limitation	HCR Adult Plan Ages 19 and older Submission Requirements	Integral Considerations and Exclusions
D9222	deep sedation/general anesthesia - first 15 minutes	Basic	Deep sedation, general anesthesia is a covered benefit when medically necessary and claimed in conjunction with a covered oral surgical procedure code.	None	Basic	Deep sedation, general anesthesia is a covered benefit when medically necessary and claimed in conjunction with a covered oral surgical procedure code.	None	General anesthesia will be paid only when performed in conjunction with a covered oral surgical procedure code.
D9223	deep sedation/general anesthesia - each subsequent 15-minute increment	Basic	Deep sedation/ general anesthesia is a covered benefit when medically and claimed in conjunction with a covered oral surgical procedure code. Limited to two (2) times per session.	None	Basic	Deep sedation/ general anesthesia is a covered benefit when medically and claimed in conjunction with a covered oral surgical procedure code. Limited to two (2) times per session.	None	General anesthesia will be paid only when performed in conjunction with a covered oral surgical procedure code.
D9230	inhalation of nitrous oxide/analgesia, anxiolysis	Basic	Limited to under thirteen (13) years old and only in conjunction with a treatment service.	None	Basic	Not a covered benefit.	None	None

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CDT Code	Description of Service	Pediatric Service Type	HCR Pediatric Plan Ages 0 through 18  Procedure Guidelines or Frequency Limitation	HCR Pediatric Plan Ages 0 through 18  Submission Requirements	Adult Service Type	HCR Adult Plan Ages 19 and older  Procedure Guidelines or Frequency Limitation	HCR Adult Plan Ages 19 and older  Submission Requirements	Integral Considerations and Exclusions
D9239	intravenous moderate (conscious) sedation/analgesia-first 15 minutes	Basic	Intravenous moderate (conscious) sedation/analgesia is a covered benefit when medically necessary and claimed in conjunction with a covered oral surgical procedure code. Intravenous moderate (conscious) sedation/analgesia is a covered benefit when medically necessary and claimed in conjunction with a covered oral surgical procedure code.	None	Basic	Intravenous moderate (conscious) sedation/analgesia is a covered benefit when medically necessary and claimed in conjunction with a covered oral surgical procedure code.	None	General anesthesia will be paid only when performed in conjunction with a covered oral surgical procedure code.

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CDT Code	Description of Service	Pediatric Service Type	HCR Pediatric Plan Ages 0 through 18 Procedure Guidelines or Frequency Limitation	HCR Pediatric Plan Ages 0 through 18 Submission Requirements	Adult Service Type	HCR Adult Plan Ages 19 and older Procedure Guidelines or Frequency Limitation	HCR Adult Plan Ages 19 and older Submission Requirements	Integral Considerations and Exclusions
D9243	intravenous moderate (conscious) sedation/analgesia- each subsequent 15-minute increment	Basic	<p>Covered for Intravenous moderate (conscious) sedation/analgesia, but limited to the following:</p> <ul style="list-style-type: none"> <li>Covered when performed in conjunction with a covered oral surgical procedure</li> <li>Administered in a hospital setting</li> <li>Services cannot be safely performed in an office setting due to underlying medical conditions</li> <li>Services cannot be safely performed in a dental office due to an uncooperative patient, or extensive oral treatment is necessary to prevent dental or medical complications.</li> <li>Limited to two (2) 15-minute increments per session.</li> </ul>	None	Basic	Intravenous moderate (conscious) sedation/analgesia is a covered benefit when medically necessary and claimed in conjunction with a covered oral surgical procedure code. Limited to two (2) times per session.	None	General anesthesia will be paid only when performed in conjunction with a covered oral surgical procedure code.

CDT Code	Description of Service	Pediatric Service Type	HCR Pediatric Plan Ages 0 through 18 Procedure Guidelines or Frequency Limitation	HCR Pediatric Plan Ages 0 through 18 Submission Requirements	Adult Service Type	HCR Adult Plan Ages 19 and older Procedure Guidelines or Frequency Limitation	HCR Adult Plan Ages 19 and older Submission Requirements	Integral Considerations and Exclusions
D9248	non-intravenous conscious sedation	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	Basic	One (1) per day, limited to Peds, Oral Surgery and Endo specialties.	None	Preventive	Not a covered benefit.	None	None
D9311	consultation with a medical health care professional	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D9410	house/extended care facility call	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D9420	hospital or ambulatory surgical center call	Basic	One (1) per day.	None	Preventive	Not a covered benefit.	None	None

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CDT Code	Description of Service	Pediatric Service Type	HCR Pediatric Plan Ages 0 through 18 Procedure Guidelines or Frequency Limitation	HCR Pediatric Plan Ages 0 through 18 Submission Requirements	Adult Service Type	HCR Adult Plan Ages 19 and older Procedure Guidelines or Frequency Limitation	HCR Adult Plan Ages 19 and older Submission Requirements	Integral Considerations and Exclusions
D9430	office visit for observation (during regularly scheduled hours) - no other services performed	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D9440	office visit - after regularly scheduled hours	Basic	Not a covered benefit.	None	Basic	By Report. No frequency limitations.	Detailed narrative	This procedure may be paid in addition to other dental procedures
D9450	case presentation, subsequent to detailed and extensive treatment planning	Preventive	Not a covered benefit.	None	Preventive	Not a covered benefit.	None	None
D9610	therapeutic parenteral drug, single administration	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D9612	therapeutic parenteral drug, two or more administrations, different medication	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D9613	infiltration of sustained release therapeutic drug, per quadrant	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D9630	drugs or medicaments dispensed in the office for home use	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None

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CDT Code	Description of Service	Pediatric Service Type	HCR Pediatric Plan Ages 0 through 18 Procedure Guidelines or Frequency Limitation	HCR Pediatric Plan Ages 0 through 18 Submission Requirements	Adult Service Type	HCR Adult Plan Ages 19 and older Procedure Guidelines or Frequency Limitation	HCR Adult Plan Ages 19 and older Submission Requirements	Integral Considerations and Exclusions
D9910	application of desensitizing medicament	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D9911	application of desensitizing resin for cervical and/or root surface, per tooth	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D9912	pre-visit patient screening	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D9913	administration of neuromodulators	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D9914	administration of dermal fillers	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D9920	behavior management, by report	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D9930	treatment of complications (post-surgical) - unusual circumstances, by report	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None

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D9932	cleaning and inspection of removable complete denture, maxillary	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D9933	cleaning and inspection of removable complete denture, mandibular	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D9934	cleaning and inspection of removable partial denture, maxillary	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D9935	cleaning and inspection of removable partial denture, mandibular	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D9938	fabrication of a custom removable clear plastic temporary aesthetic appliance	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D9939	placement of a custom removable clear plastic temporary aesthetic appliance	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D9941	fabrication of athletic mouthguard	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D9942	repair and/or reline of occlusal guard	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None

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CDT Code	Description of Service	Pediatric Service Type	HCR Pediatric Plan Ages 0 through 18 Procedure Guidelines or Frequency Limitation	HCR Pediatric Plan Ages 0 through 18 Submission Requirements	Adult Service Type	HCR Adult Plan Ages 19 and older Procedure Guidelines or Frequency Limitation	HCR Adult Plan Ages 19 and older Submission Requirements	Integral Considerations and Exclusions
D9943	occlusal guard adjustment	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D9944	occlusal guard - hard appliance, full arch	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D9945	occlusal guard - soft appliance, full arch	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D9946	occlusal guard - hard appliance, partial arch	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D9947	custom sleep apnea appliance fabrication and placement	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D9948	adjustment of custom sleep apnea appliance	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None
D9949	repair of custom sleep apnea appliance	Major	Not a covered benefit.	None	Major	Not a covered benefit.	None	None

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D9950	occlusion analysis - mounted case	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D9951	occlusal adjustment - limited	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D9952	occlusal adjustment - complete	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D9953	reline custom sleep apnea appliance (indirect)	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D9954	fabrication and delivery of oral appliance therapy (OAT) morning repositioning device	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D9955	oral appliance therapy (OAT) titration visit	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D9956	administration of home sleep apnea test	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None

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D9957	screening for sleep related breathing disorders	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D9959	unspecified sleep apnea services procedure, by report	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D9961	duplicate/copy patient's records	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D9970	enamel microabrasion	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D9971	odontoplasty - per tooth	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D9972	external bleaching – per arch – performed in office	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D9973	external bleaching – per tooth	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None

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D9974	internal bleaching – per tooth	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D9975	external bleaching for home application, per arch; includes materials and fabrication of custom trays	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D9985	sales tax	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D9986	missed appointment	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D9987	cancelled appointment	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D9990	certified translation or sign-language services - per visit	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D9991	dental case management - addressing appointment compliance barriers	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None

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D9992	dental case management - care coordination	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D9993	dental case management - motivational interviewing	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D9994	dental case management - patient education to improve health literacy	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D9995	teledentistry - synchronous; real-time encounter	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D9996	teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None
D9997	dental case management - patients with special health care needs	Basic	Not a covered benefit.	None	Basic	Not a covered benefit.	None	None

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D9999	unspecified adjunctive procedure, by report	Basic	By Report.	None	Basic	By Report. Individual consideration.	Tooth Quadrant or Arch identification and a detailed narrative.	None

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