



# 2026 PPO Standard CDT Guide

Dental Procedure Codes and Nomenclature  
Hawaii Procedure Guidelines



An Independent Licensee of the Blue Cross and Blue Shield Association

## Table of Contents

<b>ABOUT THIS GUIDEBOOK .....</b>	<b>2</b>
<b>UTILIZATION MANAGEMENT .....</b>	<b>3</b>
<b>I. D0100-D0999 Diagnostic .....</b>	<b>5</b>
<b>II. D1000-D1999 Preventive.....</b>	<b>25</b>
<b>III. D2000-D2999 Restorative .....</b>	<b>33</b>
<b>IV. D3000-D3999 Endodontics .....</b>	<b>57</b>
<b>V. D4000-D4999 Periodontics .....</b>	<b>67</b>
<b>VI. D5000-D5899 Prosthodontics, Removable.....</b>	<b>82</b>
<b>VII. D5900-D5999 Maxillofacial Prosthetics .....</b>	<b>97</b>
<b>VIII. D6000-D6199 Implant Services.....</b>	<b>104</b>
<b>IX. D6200-D6999 Prosthodontics, Fixed.....</b>	<b>122</b>
<b>X. D7000-D7999 Oral &amp; Maxillofacial Surgery .....</b>	<b>137</b>
<b>XI. D8000-D8999 Orthodontics .....</b>	<b>160</b>
<b>XII. D9000-D9999 Adjunctive General Services.....</b>	<b>167</b>

## 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 – 2026*.

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 [hmsadental.com/providers](https://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 [hmsadental.com/providers](https://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	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D0120	periodic oral evaluation - established patient	Only two (2) evaluation codes in any combination are allowed per member per calendar year.	<p>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.</p> <p>Note: If member is enrolled in Oral Health for Total Health, D0120 may be covered four (4) per calendar year.</p>	None
D0140	limited oral evaluation - problem focused	Only two (2) evaluation codes in any combination are allowed per member per calendar year.	These may require interpretation of information acquired through additional diagnostic procedures. Definitive procedures may be required on the same date as the evaluation.	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: D0100- D0999 DIAGNOSTIC SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D0145</b>	<b>oral evaluation for a patient under three years of age and counseling with primary caregiver</b>	Only two (2) evaluation codes in any combination are allowed per member per calendar year.	Preferably within the first six (6) months of the eruption of the first primary tooth, including recording the oral and physical health history, especially of caries susceptibility, development of an appropriate preventive oral health regime and communication with and counseling of the child’s parent, legal guardian, and/or primary caregiver.	None
<b>D0150</b>	<b>comprehensive oral evaluation - new or established patient</b>	Only two (2) evaluation codes in any combination are allowed per member per calendar year.	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. In addition, the exam would include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, existing prostheses, occlusal relationships, periodontal conditions (including periodontal screening and/or charting), hard and soft tissue anomalies, etc. It may also require interpretation of information acquired through additional diagnostic procedures. This procedure applies to new patients or established patients who have been absent from active treatment three (3) or more years. The procedure also applies to established patients who have had a significant change in health conditions or other unusual circumstances.	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: D0100- D0999 DIAGNOSTIC SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D0160</b>	<b>detailed and extensive oral evaluation - problem focused, by report</b>	Only two (2) evaluation codes in any combination are allowed per member per calendar year.	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.	None
<b>D0170</b>	<b>re-evaluation-limited, problem focused (established patient; not post-operative visit)</b>	Not a covered benefit	None	None
<b>D0171</b>	<b>re-evaluation- post-operative office visit</b>	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: D0100- D0999 DIAGNOSTIC SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D0180</b>	<b>comprehensive periodontal evaluation - new or established patient</b>	Only two (2) evaluation codes in any combination are allowed per member per calendar year.	A comprehensive evaluation of periodontal conditions, including full mouth probing and periodontal charting. Indicated for patients exhibiting signs or symptoms of periodontal disease, systemic medical conditions, or patients with social risk factors. It includes an evaluation for oral cancer, an evaluation of the patient's medical history, a general wellness assessment, and includes an evaluation of current dental conditions.	None
<b>D0190</b>	<b>screening of a patient</b>	Not a covered benefit	A screening, including state or federally mandated screenings, to determine an individual's need to be seen by a dentist for diagnosis.	None
<b>D0191</b>	<b>assessment of a patient</b>	Not a covered benefit	A limited clinical inspection that is performed to identify possible signs of oral or systemic disease, malformation, or injury, and the potential need for referral for diagnosis and treatment.	None
<b>D0210</b>	<b>intraoral - comprehensive series of radiographic images</b>	One (1) in a three (3) year period D0210 or D0330. Frequency limits for certain plans may vary from this standard, please refer to your plan policy for details and confirmation.	Covered based on the last service date once every three (3) years, except for the Federal plan which is covered once every five (5) years, based on the last service date.	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: D0100- D0999 DIAGNOSTIC SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D0220	<b>intraoral - periapical first radiographic image</b>	One (1) per day (no waiting period)	<p>Periapical films, for diagnostic purposes, are covered as needed. Intra-operative “working” radiographs are included with complete root canal therapy.</p> <p>Periapical film taken with Panoramic film on the same day will deny and will be non-billable to the patient.</p>	None
D0230	<b>intraoral - periapical each additional radiographic image</b>	Not to exceed five (5) films per date of service. (No waiting period)	<p>Periapical films, for diagnostic purposes, are covered as needed. Intra-operative “working” radiographs are included with complete root canal therapy.</p> <p>Periapical film taken with Panoramic film on the same day will deny and will be non-billable to the patient.</p>	None
D0240	<b>intraoral - occlusal radiographic image</b>	By report	Not payable as a substitute for children’s complete series of intraoral radiographs.	Arch identification
D0250	<b>extra-oral- 2D projection radiographic image created using a stationary radiation source, and detector</b>	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: D0100- D0999 DIAGNOSTIC SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D0251	extra-oral posterior dental radiographic image	Not a covered benefit	None	None
D0270	bitewing – single (1) radiographic image	One (1) set per calendar year	<p><b>Any of these codes constitute a set of bitewings.</b>                      When bitewings are taken within twelve (12) months of a FMX, these guidelines apply.</p> <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> <li>• 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.</li> </ul>	None
D0272	bitewings – two (2) radiographic images	One (1) set per calendar year	Refer to details listed for Code D0270.	None
D0273	bitewings – three (3) radiographic images	One (1) set per calendar year	Refer to details listed for Code D0270.	None
D0274	bitewings - four (4) radiographic images	One (1) set per calendar year	Refer to details listed for Code D0270.	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: D0100- D0999 DIAGNOSTIC SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D0277	vertical bitewings - 7 to 8 radiographic images	One (1) set per calendar year, for patients fifteen (15) years and older.	<p>Vertical bitewings constitute a set of bitewings. When bitewings are taken within 12 months of a FMX, these guidelines apply.</p> <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> <p>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.</p>	None
D0310	sialography	Not a covered benefit	None	None
D0320	temporomandibular joint arthrogram, including injection	Not a covered benefit	None	None
D0321	other temporomandibular joint radiographic images, by report	Not a covered benefit	None	None
D0322	tomographic survey	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	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D0330	panoramic radiographic image	One (1) in a three (3) year period D0210 or D0330. Frequency limits for certain plans may vary from this standard, please refer to your plan policy for details and confirmation.	Panoramic film is allowable in place of a complete series (D0210) based on the last service date, with the frequency depending upon the terms of the dental plan. Allowance for a complete series varies among dental plans and ranges from one (1) per calendar year to one (1) every five (5) years. Additional panoramic film may be allowed for oral surgeons, provided any previous panoramic film or full mouth x-ray is more than twelve (12) months old.	None
D0340	2D cephalometric radiographic image - acquisition, measurement, and analysis	Not a covered benefit	None	None
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	Not a covered benefit	None	None
D0364	cone beam CT capture and interpretation with limited field of view - less than one whole jaw	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: D0100- D0999 DIAGNOSTIC SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D0365	cone beam CT capture and interpretation with field of view of one full dental arch - mandible	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	Not a covered benefit	None	None
D0367	cone beam CT capture and interpretation with field of view of both jaws; with or without cranium	Not a covered benefit	None	None
D0368	cone beam CT capture and interpretation for TMJ series including two or more exposures	Not a covered benefit	None	None
D0369	maxillofacial MRI capture and interpretation	Not a covered benefit	None	None
D0370	maxillofacial ultrasound capture and interpretation	Not a covered benefit	None	None
D0371	sialoendoscopy capture and interpretation	Not a covered benefit	None	None
D0372	intraoral tomosynthesis - comprehensive series of radiographic images	Alternate Benefit (L.E.A.T.) D0210	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: D0100- D0999 DIAGNOSTIC SERVICES**

<b>CDT Code</b>	<b>Description of Service</b>	<b>Procedure Guidelines or Frequency Limitation</b>	<b>Limitations, Exclusions, and Integral Considerations</b>	<b>Submission Requirements: Participating Providers</b>
<b>D0373</b>	<b>intraoral tomosynthesis – bitewing radiographic image</b>	Cover as L.E.A.T. benefit for D0270 BWXR	None	None
<b>D0374</b>	<b>intraoral tomosynthesis – periapical radiographic image</b>	Cover as L.E.A.T. benefit for D0220 PAXR	None	None
<b>D0380</b>	<b>cone beam CT capture with limited field of view - less than whole jaw</b>	Not a covered benefit	None	None
<b>D0381</b>	<b>cone beam CT image capture with field of view of one full dental arch - mandible</b>	Not a covered benefit	None	None
<b>D0382</b>	<b>cone beam CT image capture with field of view of one full dental arch - maxilla, with or without cranium</b>	Not a covered benefit	None	None
<b>D0383</b>	<b>cone beam CT image capture with field of view of both jaws; with or without cranium</b>	Not a covered benefit	None	None
<b>D0384</b>	<b>cone beam CT image capture for TMJ series including two or more exposures</b>	Not a covered benefit	None	None
<b>D0385</b>	<b>maxillofacial MRI image capture</b>	Not a covered benefit	None	None
<b>D0386</b>	<b>maxillofacial ultrasound image capture</b>	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	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D0387	intraoral tomosynthesis – comprehensive series of radiographic images – image capture	Not a covered benefit	None	None
D0388	intraoral tomosynthesis – bitewing radiographic image – image capture only	Not a covered benefit	None	None
D0389	intraoral tomosynthesis – periapical radiographic image – image capture only	Not a covered benefit	None	None
D0391	intraoral - complete series of radiographic images - image capture only	Not a covered benefit	None	None
D0393	virtual treatment simulation using 3D image volume or surface scan	Not a covered benefit	None	None
D0394	digital subtraction of two or more images or image volumes of the same modality	Not a covered benefit	None	None
D0395	fusion of two or more 3D image volumes of one or more modalities	Not a covered benefit	None	None
D0396	3D printing of a 3D dental surface scan	Not a covered benefit	Not a covered benefit	None
D0411	HbA1c in-office point of service testing	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: D0100- D0999 DIAGNOSTIC SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D0412	<b>blood glucose level test - in- office using a glucose meter</b>	Not a covered benefit	None	None
D0414	<b>laboratory processing of microbial specimen to include culture and sensitivity studies, preparation, and transmission of written report.</b>	Not a covered benefit	None	None
D0415	<b>collection of microorganisms for culture and sensitivity</b>	Not a covered benefit	None	None
D0416	<b>viral culture</b>	Not a covered benefit	None	None
D0417	<b>collection and preparation of saliva sample for laboratory analysis</b>	Not a covered benefit	None	None
D0418	<b>analysis of saliva sample - laboratory</b>	Not a covered benefit	None	None
D0419	<b>assessment of salivary flow by measurement</b>	Not a covered benefit	None	None
D0422	<b>collection and preparation of genetic sample material for laboratory analysis and report</b>	Not a covered benefit	None	None
D0423	<b>genetic test for susceptibility to diseases - specimen analysis</b>	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: D0100- D0999 DIAGNOSTIC SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D0425	caries susceptibility tests	Not a covered benefit	None	None
D0426	collection, preparation, and analysis of saliva sample – point-of-care	Not a covered benefit	None	None
D0431	adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	Not a covered benefit	None	None
D0460	pulp vitality tests	One (1) per member calendar year	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.	None
D0461	Testing for cracked tooth	Integral	None	None
D0470	diagnostic casts	Not a covered benefit	Not a covered benefit	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: D0100- D0999 DIAGNOSTIC SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D0472</b>	<b>accession of tissue, gross and microscopic examination, preparation, and transmission of written report</b>	Not a covered benefit	Not a covered benefit	None
<b>D0473</b>	<b>accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation, and transmission of written report</b>	Not a covered benefit	Not a covered benefit	None
<b>D0474</b>	<b>accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation, and transmission of written report</b>	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: D0100- D0999 DIAGNOSTIC SERVICES**

<b>CDT Code</b>	<b>Description of Service</b>	<b>Procedure Guidelines or Frequency Limitation</b>	<b>Limitations, Exclusions, and Integral Considerations</b>	<b>Submission Requirements: Participating Providers</b>
<b>D0475</b>	<b>decalcification procedure</b>	Not a covered benefit	None	None
<b>D0476</b>	<b>special stains for microorganisms</b>	Not a covered benefit	None	None
<b>D0477</b>	<b>special stains, not for microorganisms</b>	Not a covered benefit	None	None
<b>D0478</b>	<b>immunohistochemical stains</b>	Not a covered benefit	None	None
<b>D0479</b>	<b>tissue in-situ hybridization, including interpretation</b>	Not a covered benefit	None	None
<b>D0480</b>	<b>accession of exfoliative cytologic smears, microscopic examination, preparation, and transmission of written report</b>	Not a covered benefit	None	None
<b>D0481</b>	<b>electron microscopy</b>	Not a covered benefit	None	None
<b>D0482</b>	<b>direct immunofluorescence</b>	Not a covered benefit	None	None
<b>D0483</b>	<b>indirect immunofluorescence</b>	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: D0100- D0999 DIAGNOSTIC SERVICES**

<b>CDT Code</b>	<b>Description of Service</b>	<b>Procedure Guidelines or Frequency Limitation</b>	<b>Limitations, Exclusions, and Integral Considerations</b>	<b>Submission Requirements: Participating Providers</b>
<b>D0484</b>	<b>consultation on slides prepared elsewhere</b>	Not a covered benefit	None	None
<b>D0485</b>	<b>consultation, including preparation of slides from biopsy material supplied by referring source</b>	Not a covered benefit	None	None
<b>D0486</b>	<b>laboratory accession of transepithelial cytologic sample, microscopic examination, preparation, and transmission of written report</b>	Not a covered benefit	None	None
<b>D0502</b>	<b>other oral pathology procedures, by report</b>	Not a covered benefit	None	None
<b>D0600</b>	<b>non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin, and cementum</b>	Not a covered benefit	None	None
<b>D0601</b>	<b>caries risk assessment and documentation, with a finding of low risk</b>	Not a covered benefit	None	None
<b>D0602</b>	<b>caries risk assessment and documentation, with a finding of moderate risk</b>	Not a covered benefit	None	None
<b>D0603</b>	<b>caries risk assessment and documentation, with a finding of high risk</b>	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: D0100- D0999 DIAGNOSTIC SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D0604	antigen testing for a public health related pathogen including coronavirus	Not a covered benefit	None	None
D0605	antibody testing for a public health related pathogen, including coronavirus	Not a covered benefit	None	None
D0701	panoramic radiographic image - image capture only	Not a covered benefit	None	None
D0702	2-D cephalometric radiographic image - image capture only	Not a covered benefit	None	None
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally image capture only	Not a covered benefit	None	None
D0705	extra-oral posterior dental radiographic image - image capture only	Not a covered benefit	None	None
D0706	intraoral - occlusal radiographic image - image capture only	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: D0100- D0999 DIAGNOSTIC SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D0707	intraoral - periapical radiographic image - image capture only	Not a covered benefit	None	None
D0708	intraoral - bitewing radiographic image - image capture only	Not a covered benefit	None	None
D0709	intraoral - comprehensive series of radiographic images - image capture only	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: D0100- D0999 DIAGNOSTIC SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D0801</b>	<b>3D intraoral surface scan – direct</b>	Integral	<ul style="list-style-type: none"> <li>Denied as INTEGRAL when provided by the same dentist as Diagnostic casts (D0470).</li> <li>Denied as INTEGRAL when provided on the same date or within 30 days by the same dentist as a Space Maintainer (D1510, D1516, D1517, D1520, D1526, D1527, D1575), Inlay/Onlay restorations (D2510-D2664), Crown (D2710-D2799), Prefabricated crown (D2928-D2934), Indirectly fabricated post and core (D2952), veneer (D2960-D2962), Additional procedures to customize a crown to fit under an existing partial (D2971), Coping (D2975), Crown/Inlay/Onlay/Veneer Repair (D2980-D2983), Dentures (D5110-D5140), Partial dentures (D5211-D5286), Denture rebase and relines (D5710-D5765), Implant services (D6010-D6199), Fixed partial denture (D6205-D6794), and Orthodontic services (D8010-D8090, D8210-D8220, D8660, D8680).</li> </ul>	None
<b>D0802</b>	<b>3D dental surface scan – indirect</b>	Integral	Integral details listed for D0801 apply to D0802.	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: D0100- D0999 DIAGNOSTIC SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D0803	3D facial surface scan – direct	Not a covered benefit	None	None
D0804	3D facial surface scan – indirect	Not a covered benefit	None	None
D0999	unspecified diagnostic procedure, by report	By report	Individual Consideration. Detailed narrative required.	Detailed narrative

**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.

## 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	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D1110	prophylaxis - adult	Two (2) per calendar year age thirteen (13) and older	Covered according to the terms of dental plan. Code D1110 may be used for member's aged thirteen (13) and older. Code D1120 should be used for children aged twelve (12) and younger.  Note: If member is enrolled in Oral Health for Total Health, D1110/D1120 or D4346 or D4910 is covered once every three months.	None
D1120	prophylaxis - child	Two (2) per calendar year age twelve (12) and younger	Covered according to the terms of dental plan. Code D1110 may be used for member's aged thirteen (13) and older. Code D1120 should be used for children aged twelve (12) and younger.	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: D1000-D1999 PREVENTIVE SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D1206</b>	<b>topical application of fluoride varnish</b>	Two (2) per calendar year through age eighteen (18).	<p>Coverage is twice per calendar year for FFS/PPO Dental Plans. Fluoride varnish, code D1206, can be used in combination with D1208 up to a total of two (2), topical or varnish fluoride applications per calendar year. The patient must be age eighteen (18) or younger.</p> <p>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.</p>	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: D1000-D1999 PREVENTIVE SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D1208</b>	<b>topical application of fluoride - excluding varnish</b>	Two (2) per calendar year through age eighteen (18).	Coverage is two (2) per calendar year for FFS/PPO Dental Plans. Topical application of fluoride, code D1208, can be used in combination with D1206 up to a total of two (2), topical or varnish fluoride applications per calendar year. The patient must be age eighteen (18) or younger.  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.	None
<b>D1301</b>	<b>immunization counseling</b>	Not a covered benefit.	Integral to exams D0120-D0180	None
<b>D1310</b>	<b>nutritional counseling for control of dental disease</b>	Integral	None	None
<b>D1320</b>	<b>tobacco counseling for the control and prevention of oral disease</b>	Integral	None	None
<b>D1321</b>	<b>counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high - risk substance use</b>	Integral	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: D1000-D1999 PREVENTIVE SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D1330	oral hygiene instructions	Integral	None	None
D1351	sealant - per tooth	One (1) per tooth per lifetime up to age sixteen (16).	Sealants are a benefit of most dental plans, with a few exceptions. When covered, sealants are allowed for permanent molars only.	Tooth Identification
D1353	sealant repair – per tooth	Integral within twelve (12) months of placement of sealant by the same dentist. Otherwise, not a covered benefit	None	None
D1354	interim caries arresting medicament application – per tooth	Two (2) applications per tooth per year for members – No age limit.	None	None
D1355	caries preventive medicament application – per tooth	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: D1000-D1999 PREVENTIVE SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D1510	space maintainer – fixed, unilateral	One (1) per arch per lifetime, age thirteen (13) and younger.	The procedure codes listed are not to be used to claim for the temporary replacement of teeth for adults. Once per lifetime. For most dental plans, the patient must be age thirteen (13) or younger. This limitation may vary depending on the terms of the patient's dental plan.	Arch identification
D1516	space maintainer – fixed, bilateral maxillary	One (1) per arch per lifetime age	Refer to details listed for Code D1510.	Arch identification
D1517	space maintainer – fixed, bilateral mandibular	One (1) per arch per lifetime age	Refer to details listed for Code D1510.	Arch identification
D1520	space maintainer – removable, bilateral	One (1) per arch per lifetime age	Refer to details listed for Code D1510.	Arch identification
D1526	space maintainer – removable, bilateral maxillary	One (1) per arch per lifetime age	Refer to details listed for Code D1510.	Arch identification
D1527	space maintainer – removable, bilateral mandibular	One (1) per arch per lifetime age	Refer to details listed for Code D1510.	Arch identification
D1550	re-cement or re-bond space maintainer	One (1) in a twelve (12) month period.	Re-cementation is allowed if more than six (6) months have passed since insertion.	Arch identification

**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: D1000-D1999 PREVENTIVE SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D1551	<b>re-cement or re-bond bilateral space maintainer - maxillary</b>	One (1) per plan year. No age limit. Payable six (6) months post insertion.	None	Arch identification
D1552	<b>re-cement or re-bond bilateral space maintainer - mandibular</b>	One (1) per plan year. No age limit. Payable six (6) months post insertion.	None	Arch identification
D1553	<b>re-cement or re-bond unilateral space maintainer - per quadrant</b>	One (1) per plan year. No age limit. Payable six (6) months post insertion.	None	Arch identification
D1556	<b>removal of fixed unilateral space maintainer - per quadrant</b>	One (1) per space maintainer. Service only allowed if performed by provider other than provider placing space maintainer. No age limit	None	Arch identification
D1557	<b>removal of fixed bilateral space maintainer - maxillary</b>	One (1) per space maintainer. Service only allowed if performed by provider other than provider placing space maintainer. No age limit	None	Arch identification

**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: D1000-D1999 PREVENTIVE SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D1558	<b>removal of fixed bilateral space maintainer - mandibular</b>	One (1) per space maintainer. Service only allowed if performed by provider other than provider placing space maintainer. No age limit	None	Arch identification
D1575	<b>distal shoe space maintainer – fixed – unilateral</b>	One (1) per arch per lifetime age thirteen (13) and younger.	This code shares frequency limitation with Code D1510. Member benefit will cover either D1510 or D1575 and not both.	Arch identification
D1720	<b>influenza vaccine administration</b>	One (1) per calendar year	None	None
D1781	<b>vaccine administration – human papillomavirus – Dose 1</b>	Not a covered benefit	None	None
D1782	<b>vaccine administration – human papillomavirus – Dose 2</b>	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: D1000-D1999 PREVENTIVE SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D1783	vaccine administration – human papillomavirus – Dose 3	Not a covered benefit	None	None
D1999	unspecified preventive procedure, by report	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.

### 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

**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: D2000-D2999 RESTORATIVE SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D2140</b>	<b>amalgam - one surface, primary or permanent</b>	One (1) restoration per surface per tooth per twelve (12) month period	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.	Tooth identification, Surface identification
<b>D2150</b>	<b>amalgam - two surfaces, primary or permanent</b>	One (1) restoration per surface per tooth per twelve (12) month period	Refer to details listed for Code D2140.	Tooth identification, Surface identification
<b>D2160</b>	<b>amalgam - three surfaces, primary or permanent</b>	One (1) restoration per surface per tooth per twelve (12) month period	Refer to details listed for Code D2140.	Tooth identification, Surface identification
<b>D2161</b>	<b>amalgam - four or more surfaces, primary or permanent</b>	One (1) restoration per surface per tooth per twelve (12) month period	Refer to details listed for Code D2140.	Tooth identification, Surface identification

**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: D2000-D2999 RESTORATIVE SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D2330</b>	<b>resin-based composite - one surface, anterior</b>	One (1) restoration per surface per tooth per twelve (12) month period	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.	Tooth identification, Surface identification
<b>D2331</b>	<b>resin-based composite - two surfaces, anterior</b>	One (1) restoration per surface per tooth per twelve (12) month period	Refer to details listed for Code D2330.	Tooth identification, Surface identification
<b>D2332</b>	<b>resin-based composite - three surfaces, anterior</b>	One (1) restoration per surface per tooth per twelve (12) month period	Refer to details listed for Code D2330.	Tooth identification, Surface identification
<b>D2335</b>	<b>resin-based composite - four or more surfaces or involving incisal angle (anterior)</b>	One (1) restoration per surface per tooth per twelve (12) month period	Refer to details listed for Code D2330.	Tooth identification, Surface identification
<b>D2390</b>	<b>resin-based composite crown, anterior</b>	One (1) per tooth per three (3) years. Alternate benefit D2930 for primary teeth and D2931 for permanent teeth. Not subject to twelve (12) months	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.	Tooth identification

**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: D2000-D2999 RESTORATIVE SERVICES

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D2391</b>	<b>resin-based composite - one surface, posterior</b>	One (1) surface per tooth per twelve (12) months	<p>Covered according to the terms of the member's dental plan. Stand-alone single facial restorations on bicuspid 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.</p> <p>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.</p>	Tooth identification, Surface identification
<b>D2392</b>	<b>resin-based composite - two surfaces, posterior</b>	One (1) surface per tooth per twelve (12) months	Refer to details listed for Code D2391.	Tooth identification, Surface identification
<b>D2393</b>	<b>resin-based composite - three surfaces, posterior</b>	One (1) surface per tooth per twelve (12) months	Refer to details listed for Code D2391.	Tooth identification, Surface identification
<b>D2394</b>	<b>resin-based composite - four or more surfaces, posterior</b>	One (1) surface per tooth per twelve (12) months	Refer to details listed for Code D2391.	Tooth identification, Surface identification

**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: D2000-D2999 RESTORATIVE SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D2410	gold foil - one surface	Not a covered benefit	None	None
D2420	gold foil - two surfaces	Not a covered benefit	None	None
D2430	gold foil - three surfaces	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.

**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 fifteen (15) 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.

---

**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	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D2510	<b>inlay – metallic, 1 surface</b>	One (1) per tooth per five (5) years. See benefit criteria and limitations at the beginning of this section.	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 fifteen (15) or older. Service or completion date is the cementation date.	Tooth identification, Surface identification
D2520	<b>inlay – metallic, 2 surfaces</b>	One (1) per tooth per five (5) years. See benefit criteria and limitations at the beginning of this section.	Refer to details listed for Code D2510.	Tooth identification, Surface identification
D2530	<b>inlay – metallic, 3 or more surfaces</b>	One (1) per tooth per five (5) years. See benefit criteria and limitations at the beginning of this section.	Refer to details listed for Code D2510.	Tooth identification, Surface identification
D2542	<b>onlay – metallic, 2 surfaces</b>	One (1) per tooth per five (5) years. See benefit criteria and limitations at the beginning of this section.	Refer to details listed for Code D2510.	Tooth identification, Surface identification
D2543	<b>onlay – metallic, 3 surfaces</b>	One (1) per tooth per five (5) years. See benefit criteria and limitations at the beginning of this section.	Refer to details listed for Code D2510.	Tooth identification, Surface identification
D2544	<b>onlay – metallic, 4 or more surfaces</b>	One (1) per tooth per five (5) years. See benefit criteria and limitations at the beginning of this section.	Refer to details listed for Code D2510.	Tooth identification, Surface identification

**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: D2000-D2999 RESTORATIVE SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D2610</b>	<b>inlay – porcelain/ceramic, 1 surface</b>	One (1) per tooth per five (5) years. Alternate benefit; D2510.	Porcelain/ceramic inlays are considered cosmetic and are not a benefit of The Plan. However, an alternate benefit of an equivalent metallic inlay will be considered for payment when clinical conditions of extensive caries or fracture do not permit a direct restoration. Coverage is for permanent teeth only. If an alternate payment is made the member is responsible for any copayments and the difference between The Plans allowance and the provider's actual charge. There is a five (5) year waiting period between services. The patient must be age fifteen (15) or older.	Tooth identification, Surface identification
<b>D2620</b>	<b>inlay – porcelain/ceramic, 2 surfaces</b>	One (1) per tooth per five (5) years. Alternate benefit; D2520.	Refer to details listed for Code D2610.	Tooth identification, Surface identification
<b>D2630</b>	<b>inlay – porcelain/ceramic, 3 or more surfaces</b>	One (1) per tooth per five (5) years. Alternate benefit; D2530.	Refer to details listed for Code D2610.	Tooth identification, Surface identification

**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: D2000-D2999 RESTORATIVE SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D2642</b>	<b>onlay – porcelain/ceramic, 2 surfaces</b>	One (1) per tooth per five (5) years. Alternate benefit; D2542.	Porcelain/ceramic onlays are considered cosmetic and are not a benefit of The Plan. However, an alternate benefit of an equivalent metallic onlay will be considered for payment when clinical conditions of extensive buccal or lingual cusp coverage caries or fracture do not permit a direct restoration for permanent teeth only. If an alternate payment is made the member is responsible for any copayments and the difference between The Plan's allowance and the provider's actual charge. There is a five (5) year waiting period between services. The patient must be age fifteen (15) or older. Service or completion date is the cementation date.	Tooth identification, Surface identification
<b>D2643</b>	<b>onlay – porcelain/ceramic, 3 surfaces</b>	One (1) per tooth per five (5) years. Alternate benefit; D2543.	Refer to details listed for Code D2642.	Tooth identification, Surface identification
<b>D2644</b>	<b>onlay – porcelain/ceramic, 4 or more surfaces</b>	One (1) per tooth per five (5) years. Alternate benefit; D2544.	Refer to details listed for Code D2642.	Tooth identification, Surface identification

**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: D2000-D2999 RESTORATIVE SERVICES

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D2650</b>	<b>inlay – resin-based composite, 1 surface</b>	One (1) per tooth per five (5) years. Alternate benefit; D2510.	Resin-based composite inlays are considered cosmetic and are not a benefit of The Plan. However, an alternate benefit of an equivalent metallic inlay will be considered for payment when clinical conditions of extensive caries or fracture do not permit a direct restoration. Coverage is for permanent teeth only. If an alternate payment is made the member is responsible for any copayments and the difference between The Plans allowance and the provider's actual charge. There is a five (5) year waiting period between services. The patient must be age fifteen (15) or older. Service or completion date is the cementation date.	Tooth identification, Surface identification
<b>D2651</b>	<b>inlay – resin-based composite, 2 surfaces</b>	One (1) per tooth per five (5) years. Alternate benefit; D2520.	Refer to details listed for Code D2650.	Tooth identification, Surface identification
<b>D2652</b>	<b>inlay – resin-based composite, 3 or more surfaces</b>	One (1) per tooth per five (5) years. Alternate benefit; D2530.	Refer to details listed for Code D2650.	Tooth identification, Surface identification

**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: D2000-D2999 RESTORATIVE SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D2662</b>	<b>onlay – resin-based composite, 2 surfaces</b>	One (1) per tooth per five (5) years. Alternate benefit; D2542.	Resin-based composite onlays are considered cosmetic and are not a benefit of The Plan. However, an alternate benefit of an equivalent metallic onlay will be considered for payment when clinical conditions of buccal or lingual cusp coverage extensive caries or fracture do not permit a direct restoration. Coverage is for permanent teeth only. If an alternate payment is made the member is responsible for any copayments and the difference between The Plans allowance and the provider's actual charge. There is a five (5) year waiting period between services. The patient must be age fifteen (15) or older. Service or completion date is the cementation date.	Tooth identification, Surface identification
<b>D2663</b>	<b>onlay – resin-based composite, 3 surfaces</b>	One (1) per tooth per five (5) years. Alternate benefit; D2543.	Refer to details listed for Code D2662.	Tooth identification, Surface identification
<b>D2664</b>	<b>onlay – resin-based composite, 4 or more surfaces</b>	One (1) per tooth per five (5) years. Alternate benefit; D2544.	Refer to details listed for Code D2662.	Tooth identification, Surface identification

**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: D2000-D2999 RESTORATIVE SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D2710</b>	<b>crown – resin-based composite (indirect)</b>	One (1) per tooth per five (5) years for permanent teeth only. Alternate benefit D2791 for Molars only.	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 fused to molars are covered as an alternate benefit at the full metal crown rate. The member is responsible for the difference between allowance and the provider's billed charge. Indirect crowns placed on primary teeth are paid at the stainless-steel rate, except where the permanent tooth is congenitally missing. Five (5) year waiting period between services. Patient must be age fifteen (15) or older. Service or completion date is the cementation date.	Tooth identification

**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: D2000-D2999 RESTORATIVE SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D2712</b>	<b>crown - ¾ resin-based composite (indirect), does not include facial veneers</b>	One (1) per tooth per five (5) years for permanent teeth only. Alternate benefit D2780 for Molars only.	Refer to details listed for Code D2710.	Tooth identification
<b>D2720</b>	<b>crown – resin with high-noble metal</b>	One (1) per tooth per five (5) years for permanent teeth only. Alternate benefit D2790 for Molars only. No Alternate benefit applied for anterior teeth.	Refer to details listed for Code D2710.	Tooth identification
<b>D2721</b>	<b>crown – resin with predominantly base metal</b>	One (1) per tooth per five (5) years for permanent teeth only. Alternate benefit D2791 for Molars only. No Alternate benefit applied for anterior teeth.	Refer to details listed for Code D2710.	Tooth identification
<b>D2722</b>	<b>crown – resin with noble metal</b>	One (1) per tooth per five (5) years for permanent teeth only. Alternate benefit D2792 for Molars only. No Alternate benefit applied for anterior teeth.	Refer to details listed for Code D2710.	Tooth identification
<b>D2740</b>	<b>crown – porcelain/ceramic substrate</b>	One (1) per tooth per five (5) years for permanent teeth only. Alternate benefit D2790 for Molars only. No Alternate benefit applied for anterior teeth.	Refer to details listed for Code D2710.	Tooth identification

**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: D2000-D2999 RESTORATIVE SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D2750</b>	<b>crown – porcelain fused to high-noble metal</b>	One (1) per tooth per five (5) years for permanent teeth only. Alternate benefit D2790 for Molars only. No Alternate benefit applied for anterior teeth.	Refer to details listed for Code D2740.	Tooth identification
<b>D2751</b>	<b>crown – porcelain fused to predominantly base metal</b>	One (1) per tooth per five (5) years for permanent teeth only. Alternate benefit D2791 for Molars only. No Alternate benefit applied for anterior teeth.	Refer to details listed for Code D2740.	Tooth identification

**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: D2000-D2999 RESTORATIVE SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D2752</b>	<b>crown – porcelain fused to noble metal</b>	One (1) per tooth per five (5) years for permanent teeth only. Alternate benefit D2792 for Molars only. No Alternate benefit applied for anterior teeth.	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 fused to molars are covered as an alternate benefit at the full metal crown rate. The member is responsible for the difference between allowance and the provider's billed charge. Indirect crowns placed on primary teeth are paid at the stainless-steel rate, except where the permanent tooth is congenitally missing. Five (5) year waiting period between services. Patient must be age fifteen (15) or older. Service or completion date is the cementation date.	Tooth identification
<b>D2753</b>	<b>crown - porcelain fused to titanium and titanium alloys</b>	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: D2000-D2999 RESTORATIVE SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D2780</b>	<b>crown – ¾ cast high noble metal</b>	One (1) per tooth per five (5) years for permanent teeth only.	Refer to details listed for Code D2752.	Tooth identification
<b>D2781</b>	<b>crown – ¾ cast predominantly base metal</b>	One (1) per tooth per five (5) years for permanent teeth only.	Refer to details listed for Code D2752.	Tooth identification
<b>D2782</b>	<b>crown – ¾ cast noble metal</b>	One (1) per tooth per five (5) years for permanent teeth only.	Refer to details listed for Code D2752.	Tooth identification
<b>D2783</b>	<b>crown – ¾ porcelain/ceramic (not veneers)</b>	One (1) per tooth per five (5) years for permanent teeth only. Alternate benefit	Refer to details listed for Code D2752.	Tooth identification

**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	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D2790	crown – full cast high-noble metal	One (1) per tooth per five (5) years for permanent teeth only.	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 fused to molars are covered as an alternate benefit at the full metal crown rate. The member is responsible for the difference between allowance and the provider's billed charge. Indirect crowns placed on primary teeth are paid at the stainless-steel rate, except where the permanent tooth is congenitally missing. Five (5) year waiting period between services. Patient must be age fifteen (15) or older. Service or completion date is the cementation date.	Tooth identification

**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: D2000-D2999 RESTORATIVE SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D2791</b>	<b>crown – full cast predominantly base metal</b>	One (1) per tooth per five (5) years for permanent teeth only.	Refer to details listed for Code D2790.	Tooth identification
<b>D2792</b>	<b>crown – full cast noble metal</b>	One (1) per tooth per five (5) years for permanent teeth only.	Refer to details listed for Code D2790.	Tooth identification
<b>D2794</b>	<b>crown – titanium</b>	One (1) per tooth per five (5) years for permanent teeth only.	Refer to details listed for Code D2790.	Tooth identification
<b>D2799</b>	<b>provisional crown - further treatment or completion of diagnosis necessary prior to final impression.</b>	Not a covered benefit.	None	Tooth identification
<b>D2910</b>	<b>re-cement or re-bond inlay, onlay, veneer or partial coverage restoration</b>	Maximum two (2) in a five (5) year period. Age fifteen (15) or older.	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 fifteen (15) or older except for crown re-cementation.	Tooth identification

**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: D2000-D2999 RESTORATIVE SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core	Maximum two (2) in a five (5) year period. Age fifteen (15) or older	Refer to details listed for Code D2910.	Tooth identification
D2920	re-cement or re-bond crown	Maximum two (2) in a five (5) year period.	Refer to details listed for Code D2910.	Tooth identification
D2921	reattachment of tooth fragment, incisal edge, or cusp	Not a covered benefit.	None	None
D2928	prefabricated porcelain/ceramic crown – permanent tooth	Not a covered benefit.	None	None
D2929	prefabricated porcelain/ceramic crown- primary tooth	Not a covered benefit.	None	None
D2930	prefabricated stainless steel crown – primary tooth	No age limit. One (1) per tooth per three (3) years. Not subject to twelve (12) months wait for crowns.	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.	Tooth identification

**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	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D2931	<b>prefabricated stainless steel crown – permanent tooth</b>	No age limit. One (1) per tooth per three (3) years. Not subject to twelve (12) months wait for crowns.	Refer to details listed for Code D2930.	Tooth identification
D2932	<b>prefabricated resin crown</b>	No age limit. One (1) per tooth per three (3) years. Not subject to twelve (12) months wait for crowns.	Refer to details listed for Code D2930.	Tooth identification
D2933	<b>prefabricated stainless steel crown with resin window</b>	Not a covered benefit.	None	None
D2934	<b>prefabricated esthetic coated stainless-steel crown – primary tooth</b>	Alternate benefit: D2930 No age limit. One (1) per tooth per three (3) years. Not subject to twelve (12) months wait for crowns.	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.	Tooth identification
D2940	<b>placement of interim direct restoration</b>	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: D2000-D2999 RESTORATIVE SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D2949	<b>restorative foundation for an indirect restoration</b>	Not a covered benefit. Always integral.	Integral to Restorative Procedure	None
D2950	<b>core buildup, including any pins when required</b>	One (1) per tooth per five (5) years for permanent teeth only.	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. One (1) every five (5) years. When combined in a claim with a cast or prefabricated post and core (D2952, D2954), core buildup (D2950) is not paid separately.	Tooth identification
D2951	<b>pin retention – per tooth, in addition to restoration</b>	Up to two (2) pins per tooth as a lifetime maximum	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.	Tooth identification

**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: D2000-D2999 RESTORATIVE SERVICES

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D2952	post and core in addition to crown; indirectly fabricated	One (1) per tooth per five (5) years.	None	None
D2953	each additional cast post – same tooth; indirectly fabricated	Not a covered benefit	None	None
D2954	prefabricated post and core in addition to crown	One (1) per tooth per five (5) years for permanent teeth only. Minimum age 15.	None	None
D2955	post removal	Not a covered benefit	None	None
D2956	removal of an indirect restoration on a natural tooth	Integral	None	Tooth identification
D2957	each additional prefabricated post – same tooth	Not a covered benefit	None	None
D2960	labial veneer (resin laminate) – chair side	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: D2000-D2999 RESTORATIVE SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D2961	<b>labial veneer (resin laminate) – laboratory</b>	By report Age fifteen (15) or older. Once per tooth per five (5) years permanent teeth only.	<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 bicuspids 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. The patient must be age fifteen (15) or older. Service or completion date is the cementation date.</p>	Tooth identification
D2962	<b>labial veneer (porcelain laminate) – laboratory</b>	By report Age fifteen (15) or older. Once per tooth per five (5) years permanent teeth only.	Refer to details listed for Code D2961.	Tooth identification
D2971	<b>additional procedures to construct new crown under existing partial denture framework</b>	One (1) per tooth per five (5) years. Permanent teeth only. Age fifteen (15) or older	One (1) per tooth per five (5) years. For members aged fifteen (15) and older. Must be reported with individual crown.	Tooth identification
D2975	<b>coping</b>	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: D2000-D2999 RESTORATIVE SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D2976	band stabilization – per tooth	Not a covered benefit.	None	None
D2980	crown repair necessitated by restorative material failure.	One (1) in five (5) years.	Age fifteen (15) or older.	Tooth identification
D2981	inlay repair necessitated by restorative material failure	One (1) in five (5) years.	Age fifteen (15) or older.	Tooth identification
D2982	onlay repair necessitated by restorative material failure	One (1) in five (5) years.	Age fifteen (15) or older.	Tooth identification
D2983	veneer repair necessitated by restorative material failure	One (1) in five (5) years.	Age fifteen (15) or older.	Tooth identification
D2989	excavation of a tooth resulting in the determination of non-restorability	Not a covered benefit.	None	None
D2990	resin infiltration of incipient smooth surface lesions	One (1) per tooth surface per twelve (12) months. Permanent teeth only. B or L surfaces (smooth surfaces only).	Allowed on the smooth surface (buccal or lingual) of permanent teeth only. One (1) per tooth surface per twelve (12) months. Permanent teeth only. B or L surfaces (smooth surfaces only).	Tooth identification
D2991	application of hydroxyapatite regeneration medicament – per tooth	Not a covered benefit.	None	None
D2999	unspecified restorative procedure, by report	By report.	Individual Consideration. Detailed narrative required.	Tooth identification, Detailed narrative

**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.

## 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.

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D3110	pulp cap direct (excluding final restoration)	One (1) per tooth per lifetime. No age limit.	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.	Tooth identification
D3120	pulp cap indirect (excluding final restoration)	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	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D3220	<b>therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to dentinocemental junction and application of medicament (not to be used for apexogenesis)</b>	One (1) per tooth per lifetime.	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.	Tooth identification
D3221	<b>pulpal debridement, primary and permanent teeth not to be used for apexogenesis</b>	One (1) per tooth per lifetime.	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.	Tooth identification
D3222	<b>partial pulpotomy for apexogenesis – permanent tooth with incomplete root development.</b>	Not a covered benefit.	None	None
D3230	<b>pulpal therapy (resorbable filling) anterior, primary tooth (excluding final restoration)</b>	Not a covered benefit.	None	None
D3240	<b>pulpal therapy (resorbable filling) posterior primary tooth (excluding final restoration)</b>	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: D3000-D3999 ENDODONTIC SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D3310	<b>endodontic therapy, anterior tooth (excluding final restoration)</b>	One (1) per tooth per lifetime. No age limit.	Pulpectomy, D3221, is considered part of the root canal therapy and is not paid separately. Root canal treatment does not include diagnostic evaluation and necessary diagnostic radiographs. These may be billed separately. If a root canal is not completed allowance for palliative treatment (D9110) may be made. One (1) per permanent tooth.	Tooth identification
D3320	<b>endodontic therapy, premolar tooth (excluding final restoration)</b>	One (1) per tooth per lifetime. No age limit.	Refer to details listed for Code D3310.	Tooth identification
D3330	<b>endodontic therapy, molar tooth (excluding final restoration)</b>	One (1) per tooth per lifetime. No age limit.	Refer to details listed for Code D3310.	Tooth identification
D3331	<b>treatment of root canal obstruction; non-surgical access</b>	Not a covered benefit	None	None
D3332	<b>incomplete endodontic therapy; inoperable, unrestorable, or fractured tooth</b>	Not a covered benefit. Benefit for Federal plan only. Please check with the Plan for member's eligibility for this service.	Services are not covered when performed on primary teeth.	Tooth identification
D3333	<b>internal root repair of perforation defects</b>	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: D3000-D3999 ENDODONTIC SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D3346	retreatment of previous root canal therapy - anterior	One (1) per tooth per lifetime. No Age limit.	Due to its complexity non-surgical root canal re-treatment is most frequently performed by endodontists. Coverage includes post-operative care and local anesthesia. Payable twelve (12) months post treatment following codes D3310, D3320, D3330. Once per tooth per lifetime. Re-treatment of previous root canal therapy is not payable with apicoectomy/periradicular services (D3410, D3421, D3425, D3426, and D3430) and apexification/re-calcification procedures. Post removal (D2955) not to be used with endodontic re-treatment (D3346, D3347, D3348).	Tooth identification
D3347	retreatment of previous root canal therapy - premolar	One (1) per tooth per lifetime. No Age limit.	Refer to details listed for Code D3346.	Tooth identification
D3348	retreatment of previous root canal therapy - molar	One (1) per tooth per lifetime. No Age limit.	Refer to details listed for Code D3346.	Tooth identification
D3351	apexification/recalcification: initial visit (apical closure/ calcific repair of perforations, root resorption, etc.)	One (1) per tooth per lifetime. No Age limit.	Apexification/recalcification (D3351, initial visit) includes opening tooth, preparation of canal spaces, first placement of medication and any necessary radiographs/diagnostic images. Permanent teeth only. (This procedure may include first phase of complete root canal therapy.	Tooth identification

**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: D3000-D3999 ENDODONTIC SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D3352	<b>apexification/recalcification regeneration: interim medication replacement</b>	One (1) per tooth per lifetime. No Age limit.	Apexification/recalcification (D3352, interim medication replacement) includes visits in which the intra-canal medication is replaced with new medication and any necessary radiographs/diagnostic images. Once per tooth. Permanent teeth only. (This procedure includes final root canal therapy).	Tooth identification
D3353	<b>apexification/recalcification: final visit (includes completed root canal therapy – apical closure/calccific repair of perforations, root resorption, etc.)</b>	One (1) per tooth per lifetime. No Age limit.	Apexification/recalcification (D3353, final visit) includes removal of intra-canal medication and procedures necessary to place final root canal filling material, including any necessary radiographs/diagnostic images. Once per tooth. Permanent teeth only. (This procedure includes last phase of complete root canal).	Tooth identification
D3355	<b>pulpal regeneration - initial visit</b>	One (1) per tooth per lifetime.	One (1) per tooth per lifetime. Not paid if claimed same day or if history of D3310, D3320, D3330 D3410, D3426 or D3430 on file.	Tooth identification
D3356	<b>pulpal regeneration - interim medication replacement</b>	One (1) per tooth per lifetime.	One (1) per tooth per lifetime. Not paid if claimed same day or if history of D3310, D3320, D3330 D3410, D3426 or D3430 on file.	Tooth identification

**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	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D3357	pulpal regeneration - completion of treatment	One (1) per tooth per lifetime.	One (1) per tooth per lifetime. Not paid if claimed same day or if history of D3310, D3320, D3330 D3410, D3426 or D3430 on file.	Tooth identification
D3410	apicoectomy - anterior	One (1) per permanent tooth root per lifetime. No age limit.	Apicoectomy (D3410, D3421, D3425, D3426) or retrograde filling (D3430) reported within 30 days after a root canal will deny as integral.	Tooth identification
D3421	apicoectomy - premolar (first root)	One (1) per permanent tooth root per lifetime. No age limit.	Apicoectomy (D3410, D3421, D3425, D3426) or retrograde filling (D3430) reported within 30 days after a root canal will deny as integral.	Tooth identification
D3425	apicoectomy - molar (first root)	One (1) per permanent tooth root per lifetime. No age limit.	Apicoectomy (D3410, D3421, D3425, D3426) or retrograde filling (D3430) reported within thirty (30) days after a root canal will deny as integral.	Tooth identification

**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: D3000-D3999 ENDODONTIC SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D3425</b>	<b>apicoectomy - molar (first root)</b>	One (1) per permanent tooth root per lifetime. No age limit.	Apicoectomy (D3410, D3421, D3425, D3426) or retrograde filling (D3430) reported within thirty (30) days after a root canal will deny as integral.	Tooth identification
<b>D3426</b>	<b>apicoectomy (each additional root)</b>	One (1) per permanent tooth root per lifetime. No age limit.	Apicoectomy (D3410, D3421, D3425, D3426) or retrograde filling (D3430) reported within thirty (30) days after a root canal will deny as integral.	Tooth identification
<b>D3429</b>	<b>bone graft in conjunction with periradicular surgery - each additional contiguous tooth in the same surgical site</b>	Not a covered benefit	None	None
<b>D3430</b>	<b>retrograde filling – per root</b>	One (1) per permanent tooth root per lifetime. No age limit.	Apicoectomy (D3410, D3421, D3425, D3426) or retrograde filling (D3430) reported within thirty (30) days after a root canal will deny as integral.	Tooth and root identification
<b>D3431</b>	<b>biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery</b>	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: D3000-D3999 ENDODONTIC SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D3432	<b>guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery</b>	Not a covered benefit.	None	None
D3450	<b>root amputation - per root</b>	One (1) per permanent tooth root per lifetime. No age limit.	Apicoectomy (D3410, D3421, D3425, D3426) or retrograde filling (D3430) reported within thirty (30) days after a root canal will deny as integral.	Tooth identification
D3460	<b>endodontic endosseous implant</b>	Not a covered benefit.	None	None
D3470	<b>intentional re-implantation (including necessary splinting)</b>	Not a covered benefit.	None	None
D3471	<b>surgical repair of root resorption - anterior</b>	One (1) per tooth root per lifetime.	Denied as integral if reported with an apicoectomy by the same dentist on the same date	Tooth identification
D3472	<b>surgical repair of root resorption – premolar</b>	One (1) per tooth root per lifetime.	Denied as integral if reported with an apicoectomy by the same dentist on the same date	Tooth identification
D3473	<b>surgical repair of root resorption – molar</b>	One (1) per tooth root per lifetime.	Denied as integral if reported with an apicoectomy by the same dentist on the same date	Tooth identification

**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	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D3501	<b>surgical exposure of root surface without apicoectomy or repair of root resorption – anterior</b>	One (1) per tooth root per lifetime.	Denied as integral if reported with an apicoectomy by the same dentist on the same date	Tooth identification
D3502	<b>surgical exposure of root surface without apicoectomy or repair of root resorption – premolar</b>	One (1) per tooth root per lifetime.	Denied as integral if reported with an apicoectomy by the same dentist on the same date	Tooth identification
D3503	<b>surgical exposure of root surface without apicoectomy or repair of root resorption – molar</b>	One (1) per tooth root per lifetime.	Denied as integral if reported with an apicoectomy by the same dentist on the same date	Tooth identification
D3910	<b>surgical procedure for isolation of tooth with rubber dam</b>	No age limit. No frequency limits.	None	None
D3911	<b>intraorifice barrier</b>	Not a covered benefit.	None	None
D3920	<b>hemisection (including any root removal), not including root canal therapy</b>	One (1) per tooth per lifetime.	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.	Tooth identification

**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	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D3921	decoronation or submergence of an erupted tooth.	One (1) per tooth per lifetime.	None	None
D3950	canal preparation and fitting of preformed dowel or post	Not a covered benefit.	None	None
D3999	unspecified endodontic procedure, by report	By report.	Individual Consideration. Detailed narrative required.	Tooth identification, Detailed narrative

**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.

## V. D4000-D4999 Periodontics

---

### 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.
- 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.
- 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.
- 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.

---

**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.

**SURGICAL SERVICES (INCLUDING USUAL POST-OPERATIVE SERVICES)**

Site: A term used to describe a single area, position, or locus. The word “site” is frequently used to indicate an area of soft tissue recession on a single tooth or an osseous defect adjacent to a single tooth, also used to indicate soft tissue defects and/or osseous defects in edentulous tooth positions.

- If two (2) contiguous teeth have areas of soft tissue recession, each tooth is a single site.
- If two (2) contiguous teeth have adjacent but separate osseous defects, each defect is a single site.
- If two (2) contiguous teeth have a communicating interproximal osseous defect, it should be considered a single site.
- All non-communicating osseous defects are single sites.
- All edentulous non-contiguous tooth positions are single sites.
- Up to two (2) contiguous edentulous tooth positions may be considered a single site.

Tooth Bounded Space: A space created by one (1) or more missing teeth that has a tooth on each side.

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D4210	gingivectomy or gingivoplasty – 4 or more contiguous teeth or tooth-bounded spaces, per quadrant	One (1) per quadrant in a three (3) year period. Requires perio charting on file.	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. Patient must be eighteen (18) years or older.	Quadrant identification

**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: D4000-D4999 PERIODONTIC SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D4211	<b>gingivectomy or gingivoplasty – one (1) to three (3) contiguous teeth or teeth bounded spaces per quadrant</b>	One (1) per quadrant in a three (3) year period. Requires perio charting on file.	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. Patient must be eighteen (18) years or older.	Tooth identification
D4212	<b>gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth.</b>	One (1) per quadrant in a three (3) year period. Requires perio charting on file.	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. Patient must be eighteen (18) years or older.	Tooth identification
D4230	<b>anatomical crown exposure - four or more contiguous teeth or bounded tooth spaces per quadrant</b>	Not a covered benefit.	None	None
D4231	<b>anatomical crown exposure – one (1) to three (3) teeth or bounded tooth spaces per quadrant</b>	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: D4000-D4999 PERIODONTIC SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D4240</b>	<b>gingival flap procedure, including root planing – four (4) or more contiguous teeth or tooth-bounded spaces per quadrant</b>	One (1) per quadrant in a three (3) year period.	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 eighteen (18) years or older.	Quadrant identification
<b>D4241</b>	<b>gingival flap procedure - one (1) to three (3) contiguous teeth or teeth bounded spaces per quadrant</b>	One (1) per quadrant in a three (3) year period.	Coverage of D4241 is allowed when one (1) to three (3) in a quadrant have periodontal pockets measuring five (5) mm or greater. Other procedures may be required concurrent to D4241 and should be reported separately using their own unique codes. May be performed once every three (3) years if needed. Patient must be eighteen (18) years or older.	Tooth identification
<b>D4245</b>	<b>apically repositioned flap</b>	Not a covered benefit.	None	Quadrant identification

**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: D4000-D4999 PERIODONTIC SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D4249</b>	<b>clinical crown lengthening - hard tissue</b>	No Frequency limit. Subject to clinical necessity in conjunction with a covered restorative procedure.	Coverage is provided for crown lengthening as a result of a crown fracture or extensive caries resulting in insufficient tooth volume to support a restoration without impinging upon the biologic width of the periodontal attachment of the tooth. Procedure should be performed in a healthy periodontal environment. May be performed once in a three (3) year period. Patient must be age eighteen (18) or older. If performed on the same day of any restorative procedure, the service will deny as integral and be provider liability.	Tooth identification
<b>D4260</b>	<b>osseous surgery (including elevation of a full thickness flap and closure) – four (4) or more contiguous teeth or tooth-bounded spaces per quadrant</b>	One (1) per quadrant in a three (3) year period.	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 eighteen (18) years or older. Other procedures may be required concurrent to D4260 or D4261 and should be reported using their own unique codes.	Quadrant identification

**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: D4000-D4999 PERIODONTIC SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D4261	<b>osseous surgery (including elevation of a full thickness flap and closure) - one (1) to three (3) contiguous teeth or tooth bounded spaces per quadrant</b>	One (1) per quadrant in a three (3) year period.	Osseous surgery is a benefit when one (1) to three (3) 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 eighteen (18) years or older. Other procedures may be required concurrent to D4260 or D4261 and should be reported using their own unique codes.	Tooth identification
D4263	<b>bone replacement graft - retained natural tooth - first site in quadrant</b>	Not a covered benefit.	None	None
D4264	<b>bone replacement graft - retained natural tooth - each additional site in quadrant</b>	Not a covered benefit.	None	None
D4265	<b>biologic materials to aid in soft and osseous tissue regeneration, per site</b>	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	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D4266	<p><b>guided tissue regeneration, natural teeth - resorbable barrier, per site guided tissue regeneration resorbable barrier, per site</b></p>	<p>One (1) per site in a three (3) year period.</p>	<p>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. Coverage is allowable once per site per three (3) year period. Services covered in conjunction with natural teeth and only in conjunction with covered periodontal surgical services. The patient must be age eighteen (18) or older. It is considered an adjunctive service for individual teeth and will not be included in the surgical quadrant code count. These codes should be a benefit only when they are covered services, only when submitted in addition to periodontal surgery codes (D4240, D4241, D4260, and D4261), and only when placed around natural teeth (not a benefit around implants, extraction sites, endodontic surgery, or edentulous areas). If denied, the liability will be on the member.</p> <p>If performed on same day and in the same area as codes D4277 or D4278, it will be member liability. The patient must be age eighteen (18) or older.</p>	<p>Tooth identification</p>

**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: D4000-D4999 PERIODONTIC SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D4267	<b>guided tissue regeneration, natural teeth - non-resorbable barrier, per site (includes membrane removal)</b>	One (1) per site in a three (3) year period.	Refer to details listed for Code D4266.	Tooth identification
D4268	<b>surgical revision procedure, per tooth</b>	Not a covered benefit	None	None
D4270	<b>pedicle soft tissue graft procedure</b>	Not a covered benefit	None	None
D4273	<b>autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft</b>	Not a covered benefit	None	None
D4274	<b>mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)</b>	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: D4000-D4999 PERIODONTIC SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D4275	<b>non-autogenous connective tissue graft (including recipient and donor material) first tooth, implant, or edentulous tooth position in graft</b>	Not a covered benefit	None	None
D4276	<b>combined connective tissue and double pedicle graft, per tooth</b>	Not a covered benefit	None	None
D4277	<b>free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft</b>	One (1) per tooth per lifetime	Narrative/remarks describing the procedure and tooth numbers are required with the claim. The patient must be age eighteen (18) or older.	Tooth identification
D4278	<b>free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site</b>	One (1) per tooth per lifetime	Narrative/remarks describing the procedure and tooth numbers are required with the claim. The patient must be age eighteen (18) or older.	Tooth identification
D4283	<b>autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant, or edentulous tooth position in same graft site</b>	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	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D4285	<b>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</b>	Not a covered benefit	None	None
D4286	<b>removal of non-resorbable barrier</b>	Not a covered benefit	None	None
D4322	<b>splint - intra -coronal; natural teeth or prosthetic crowns</b>	Not a covered benefit	None	None
D4323	<b>splint - extra -coronal; natural teeth or prosthetic crowns</b>	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	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D4341	<b>periodontal scaling and root planing – four (4) or more teeth per quadrant</b>	One (1) per quadrant in a two (2) year period, age eighteen (18) and older.	<p>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. Patient must be eighteen (18) years and older. Must demonstrate radiographic alveolar bone loss and subgingival calculus to be a benefit.</p> <p>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.</p>	Quadrant identification
D4342	<b>periodontal scaling and root planing - one (1) to three (3) teeth per quadrant</b>	One (1) per quadrant in a two (2) year period, age eighteen (18) and older.	Refer to details listed for Code D4341.	Tooth identification

**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	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D4346	scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	Twice (2) per calendar year age 13 and older.	<p>This code will be interchangeable with code D1110. This code will be covered as a preventative service and will share the same frequency limitations, processing guidelines, relationship to other codes, provider/ member liability as code D1110.</p> <p>Note: If member is enrolled in Oral Health for Total Health, D1110/D1120 or D4346 or D4910 is covered once every three months.</p>	None
D4355	full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	Not a covered benefit.	<p>Note: If member is enrolled in Oral Health for Total Health, D4355 may be covered one (1) every twenty-four (24) months.</p>	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	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D4381	<p><b>localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth</b></p>	<p>Benefit for Federal plan only.</p>	<p>One (1) treatment per tooth per twenty-four (24) months. Up to three (3) teeth per quadrant or ten (10) teeth overall with 5-6 mm pocket depths and bleeding on probing with, or subsequent to active and maintained periodontal treatment. This treatment should not be used to treat generalized disease. Not covered for treatment of periodontal abscess or in conjunction with periodontal surgery. If denied for above criteria not being met, it is a member liability. Patient must be eighteen (18) years and older.</p>	<p>Detailed Narrative Tooth/teeth identification(s)</p>

**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	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D4910	Periodontal maintenance	Two (2) per calendar year in addition to regular prophy.	<p>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.</p> <p>Note: If member is enrolled in Oral Health for Overall Health, D1110/D1120 or D4346 or D4910 may be covered One (1) every three (3) months.</p>	None
D4920	unscheduled dressing change (by someone other than treating dentist or their staff)	Not a covered benefit.	None	None
D4921	gingival irrigation with a medicinal agent- per quadrant	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	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D4999	unspecified periodontal procedure, by report	By report.	Individual Consideration. Detailed narrative required	Detailed narrative

**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.

## 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

Local anesthesia is usually considered to be part of Removable Prosthodontic procedures

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D5110	complete denture - maxillary	One (1) in five (5) years.	Complete denture coverage includes routine post-delivery care.	None
D5120	complete denture - mandibular	One (1) in five (5) years.	Complete denture coverage includes routine post-delivery care.	None
D5130	immediate denture - maxillary	One (1) in five (5) years.	Immediate dentures are not considered temporary dentures. Coverage includes routine follow-up care. Once every five (5) years. The patient must be age fifteen (15) years or older.	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: D5000-D5899 PROSTHODONTICS, REMOVABLE**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D5140	<b>immediate denture - mandibular</b> <b>Immediate denture – mandibular</b>	One (1) in five (5) years.	Immediate dentures are not considered temporary dentures. Coverage includes routine follow-up care. One (1) Once every five (5) years. The patient must be age fifteen (15) years or older.	None
D5211	<b>maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)</b>	One (1) in five (5) years, age fifteen (15) and older.	Partial denture includes acrylic resin-based denture with resin or wrought wire clasps. 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. The patient must be age fifteen (15) or older	Tooth identification
D5212	<b>mandibular partial denture - resin base (including retentive /clasping materials, rests, and teeth)</b>	One (1) in five (5) years, age fifteen (15) and older.	Refer to details listed for Code D5211.	Tooth identification
D5213	<b>maxillary and partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)</b>	One (1) in five (5) years, age fifteen (15) and older.	Refer to details listed for Code D5211.	Tooth identification

**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: D5000-D5899 PROSTHODONTICS, REMOVABLE**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D5214</b>	<b>mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)</b>	One (1) in five (5) years, age fifteen (15) and older.	Refer to details listed for Code D5211.	Tooth identification
<b>D5221</b>	<b>immediate maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)</b>	One (1) in five (5) years, age fifteen (15) and older.	Refer to details listed for Code D5211.	Tooth identification
<b>D5222</b>	<b>immediate mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)</b>	One (1) in five (5) years, age fifteen (15) and older.	Refer to details listed for Code D5211.	Tooth identification
<b>D5223</b>	<b>immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)</b>	One (1) in five (5) years, age fifteen (15) and older.	Refer to details listed for Code D5211.	Tooth identification

**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: D5000-D5899 PROSTHODONTICS, REMOVABLE**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D5224</b>	<b>immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)</b>	One (1) in five (5) years, age fifteen (15) and older.	Partial denture includes acrylic resin-based denture with resin or wrought wire clasps. 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. The patient must be age fifteen (15) or older	Tooth identification
<b>D5225</b>	<b>maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth)</b>	One (1) in five (5) years, age fifteen (15) and older.	Refer to details listed for Code D5224.	Tooth identification
<b>D5226</b>	<b>mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth)</b>	One (1) in five (5) years, age fifteen (15) and older.	Refer to details listed for Code D5224.	Tooth identification
<b>D5227</b>	<b>immediate maxillary partial denture - flexible base (including any clasps, rests, and teeth)</b>	One (1) in five (5) years, age fifteen (15) and older.	None	Tooth identification
<b>D5228</b>	<b>immediate mandibular partial denture - flexible base (including any clasps, rests, and teeth)</b>	One (1) in five (5) years, age fifteen (15) and older.	None	Tooth identification

**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: D5000-D5899 PROSTHODONTICS, REMOVABLE**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D5282	<b>removable unilateral partial denture - one piece cast metal (including retentive clasping materials, rests, and teeth), maxillary</b>	One (1) in five (5) years, age fifteen (15) and older.	Refer to details listed for Code D5224.	Tooth identification
D5283	<b>removable unilateral partial denture - one piece cast metal (including retentive clasping materials, rests, and teeth), mandibular</b>	One (1) in five (5) years, age fifteen (15) and older.	Refer to details listed for Code D5224.	Tooth identification
D5284	<b>removable unilateral partial denture - one-piece flexible base (including retentive clasping materials rests and teeth) per quadrant</b>	Not a covered benefit.	None	None
D5286	<b>removable unilateral partial denture - one-piece flexible base (including retentive/clasping materials, rests, and teeth) - per quadrant</b>	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: D5000-D5899 PROSTHODONTICS, REMOVABLE**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D5410	adjust complete denture - maxillary	Two (2) per calendar year, age fifteen (15) and older.	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. Patient must be age fifteen (15) or older.	None
D5411	adjust complete denture - mandibular	Two (2) per calendar year, age fifteen (15) and older.	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. Patient must be age fifteen (15) or older.	None
D5421	adjust partial denture - maxillary	Two (2) per calendar year, age fifteen (15) and older.	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. Patient must be age fifteen (15) or older.	None
D5422	adjust partial denture - mandibular	Two (2) per calendar year, age fifteen (15) and older.	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. Patient must be age fifteen (15) or older.	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: D5000-D5899 PROSTHODONTICS, REMOVABLE**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D5511</b>	<b>repair broken complete denture base, mandibular</b>	One (1) per calendar year, age fifteen (15) and older.	Six (6) months must have elapsed since insertion of the denture, or the services will be disallowed. One (1) repair per year. The patient must be age fifteen (15) or older.	None
<b>D5512</b>	<b>repair broken complete denture base, mandibular</b>	One (1) per calendar year, age fifteen (15) and older.	Six (6) months must have elapsed since insertion of the denture, or the services will be disallowed. One (1) repair per year. The patient must be age fifteen (15) or older.	None
<b>D5520</b>	<b>replace missing or broken teeth - complete denture (per tooth)</b>	One (1) per calendar year, age fifteen (15) and older.	Six (6) months must have elapsed since insertion of the denture, or the services will be disallowed. Once per denture tooth per year. The patient must be age fifteen (15) or older.	Tooth identification
<b>D5611</b>	<b>repair resin partial denture base, mandibular</b>	One (1) per calendar year, age fifteen (15) and older.	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. The patient must be age fifteen (15) or older.	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: D5000-D5899 PROSTHODONTICS, REMOVABLE**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D5612</b>	<b>repair resin partial denture base, maxillary</b>	One (1) per calendar year, age fifteen (15) and older.	Refer to details listed for Code D5611.	None
<b>D5621</b>	<b>repair cast partial framework, mandibular</b>	One (1) per calendar year, age fifteen (15) and older.	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. The patient must be age fifteen (15) or older.	None
<b>D5622</b>	<b>repair cast partial framework, maxillary</b>	One (1) per calendar year, age fifteen (15) and older.	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. The patient must be age fifteen (15) or older.	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: D5000-D5899 PROSTHODONTICS, REMOVABLE**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D5630</b>	<b>repair or replace broken retentive/clasping materials - per tooth</b>	One (1) per calendar year, age fifteen (15) and older.	Six (6) months must have elapsed since insertion of the denture, or the services will be disallowed. Coverage for code D5630 includes repair of rests. Coverage for code D5640 includes repair of broken tooth. Coverage will be paid according to plan benefits, or once a year if the plan does not have another limitation. The patient must be age fifteen (15) or older.	None
<b>D5640</b>	<b>replace missing or broken teeth – partial denture – per tooth</b>	One (1) per calendar year, age fifteen (15) and older.	Refer to details listed for Code D5630.	Tooth identification
<b>D5650</b>	<b>add tooth to existing partial denture – per tooth</b>	One (1) per calendar year, age fifteen (15) and older.	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. The patient must be age fifteen (15) or older.	Tooth identification

**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: D5000-D5899 PROSTHODONTICS, REMOVABLE**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D5660</b>	<b>add clasp to existing partial denture - per tooth</b>	One (1) per calendar year, age fifteen (15) and older.	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 One (1) per year if the plan does not have another limitation. The patient must be age fifteen (15) or older.	Tooth identification
<b>D5670</b>	<b>replace all teeth and acrylic on cast metal framework (maxillary)</b>	Not a covered benefit.	None	None
<b>D5671</b>	<b>replace all teeth and acrylic on cast metal framework (mandibular)</b>	Not a covered benefit.	None	None
<b>D5710</b>	<b>rebase complete maxillary denture</b>	One (1) in a three (3) year period, age fifteen (15) and older.	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. Patient must be age fifteen (15) or older.	None
<b>D5711</b>	<b>rebase complete mandibular denture</b>	One (1) in a three (3) year period, age fifteen (15) and older.	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. Patient must be age fifteen (15) or older.	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: D5000-D5899 PROSTHODONTICS, REMOVABLE**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D5720	rebase maxillary partial denture	One (1) in a three (3) year period, age fifteen (15) and older.	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. Patient must be age fifteen (15) or older.	None
D5721	rebase mandibular partial denture	One (1) in a three (3) year period, age fifteen (15) and older.	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. Patient must be age fifteen (15) or older.	None
D5725	rebase hybrid prosthesis	Not a covered benefit.	None	None
D5730	reline complete maxillary denture (direct)	One (1) in a three (3) year period, age fifteen (15) and older.	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. Patient must be age fifteen (15) or older.	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	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D5731</b>	<b>reline complete mandibular denture (direct)</b>	One (1) in a three (3) year period, age fifteen (15) and older.	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. Patient must be age fifteen (15) or older.	None
<b>D5740</b>	<b>reline maxillary partial denture (direct)</b>	One (1) in a three (3) year period, age fifteen (15) and older.	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. Patient must be age fifteen (15) or older.	None
<b>D5741</b>	<b>reline mandibular partial denture (direct)</b>	One (1) in a three (3) year period, age fifteen (15) and older.	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. Patient must be age fifteen (15) or older.	None
<b>D5750</b>	<b>reline complete maxillary denture (indirect)</b>	One (1) in a three (3) year period, age fifteen (15) and older.	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. Patient must be age fifteen (15) or older.	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: D5000-D5899 PROSTHODONTICS, REMOVABLE**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D5751</b>	<b>reline complete mandibular denture (indirect)</b>	One (1) in a three (3) year period, age fifteen (15) and older.	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. Patient must be age fifteen (15) or older.	None
<b>D5760</b>	<b>reline maxillary partial denture (indirect)</b>	One (1) in a three (3) year period, age fifteen (15) and older.	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. Patient must be age fifteen (15) or older.	None
<b>D5761</b>	<b>reline mandibular partial denture (indirect)</b>	One (1) in a three (3) year period, age fifteen (15) and older.	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. Patient must be age fifteen (15) or older.	None
<b>D5765</b>	<b>soft liner for complete or partial removable denture - indirect</b>	Not a covered benefit.	None	None
<b>D5810</b>	<b>interim complete denture (maxillary)</b>	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: D5000-D5899 PROSTHODONTICS, REMOVABLE**

<b>CDT Code</b>	<b>Description of Service</b>	<b>Procedure Guidelines or Frequency Limitation</b>	<b>Limitations, Exclusions, and Integral Considerations</b>	<b>Submission Requirements: Participating Providers</b>
<b>D5811</b>	<b>interim complete denture (mandibular)</b>	Not a covered benefit.	None	None
<b>D5820</b>	<b>interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary</b>	Not a covered benefit.	None	None
<b>D5821</b>	<b>interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular</b>	Not a covered benefit.	None	None
<b>D5850</b>	<b>tissue conditioning, maxillary</b>	Two (2) per calendar year, age fifteen (15) and older.	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.	None
<b>D5851</b>	<b>tissue conditioning, mandibular</b>	Two (2) per calendar year, age fifteen (15) and older.	Refer to details listed for Code. D5850.	None
<b>D5862</b>	<b>precision attachment, by report</b>	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: D5000-D5899 PROSTHODONTICS, REMOVABLE**

<b>CDT Code</b>	<b>Description of Service</b>	<b>Procedure Guidelines or Frequency Limitation</b>	<b>Limitations, Exclusions, and Integral Considerations</b>	<b>Submission Requirements: Participating Providers</b>
<b>D5863</b>	<b>overdenture - complete maxillary – natural tooth borne</b>	One (1) in five (5) years.	Alternate Benefit to a full denture (D5110)	None
<b>D5864</b>	<b>overdenture - partial maxillary – natural tooth borne</b>	Not a covered benefit.	Alternate Benefit to a cast partial denture (D5213)	None
<b>D5865</b>	<b>overdenture - complete mandibular – natural tooth borne</b>	One (1) in five (5) years.	Alternate Benefit to a full denture (D5120)	None
<b>D5866</b>	<b>overdenture - partial mandibular– natural tooth borne</b>	Not a covered benefit.	None	None
<b>D5867</b>	<b>replacement of replaceable part of semi-precision or precision attachment of natural tooth borne prosthesis, per attachment</b>	Not a covered benefit.	None	None
<b>D5875</b>	<b>modification of removable prosthesis following implant surgery</b>	Not a covered benefit.	None	None
<b>D5876</b>	<b>add metal substructure to acrylic complete denture (per arch)</b>	Not a covered benefit.	None	None
<b>D5877</b>	<b>Duplication of a complete denture – maxillary</b>	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. D5900-D5999 Maxillofacial Prosthetics

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D5878	Duplication of a complete denture – mandibular	Not a covered benefit.	None	None
D5899	unspecified removable prosthodontic procedure, by report	By report.	Individual consideration	Tooth identification. Arch identification
D5909	maxillary guidance prosthesis with guide flange	Not a covered benefit.	None	None
D5911	facial moulage (sectional)	Not a covered benefit.	None	None
D5912	facial moulage (complete)	Not a covered benefit.	None	None
D5913	nasal prosthesis	Not a covered benefit.	None	None
D5914	auricular prosthesis	Not a covered benefit.	None	None
D5915	orbital prosthesis	Not a covered benefit.	None	None
D5916	ocular prosthesis	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: D5900-D5999 MAXILLOFACIAL PROSTHETICS**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D5919	facial prosthesis	Not a covered benefit.	None	None
D5922	nasal septal prosthesis	Not a covered benefit.	None	None
D5923	ocular prosthesis, interim	Not a covered benefit.	None	None
D5924	cranial prosthesis	Not a covered benefit.	None	None
D5925	facial augmentation implant prosthesis	Not a covered benefit.	None	None
D5926	nasal prosthesis, replacement	Not a covered benefit.	None	None
D5927	auricular prosthesis, replacement	Not a covered benefit.	None	None
D5928	orbital prosthesis, replacement	Not a covered benefit.	None	None
D5929	facial prosthesis, replacement	Not a covered benefit.	None	None
D5930	maxillary guidance prosthesis without guide flange	Not a covered benefit.	None	None
D5931	obturator prosthesis, surgical	Not a covered benefit.	None	None
D5932	obturator prosthesis, definitive	Not a covered benefit.	None	None
D5933	obturator prosthesis, modification	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: D5900-D5999 MAXILLOFACIAL PROSTHETICS**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D5934	mandibular guidance prosthesis with guide flange	Not a covered benefit.	None	None
D5935	mandibular guidance prosthesis without guide flange	Not a covered benefit.	None	None
D5936	obturator prosthesis, interim	Not a covered benefit.	None	None
D5937	trismus appliance (not for TMD treatment)	Not a covered benefit.	None	None
D5938	resection prosthesis, maxillary complete removable	Not a covered benefit.	None	None
D5939	resection prosthesis, mandibular complete removable	Not a covered benefit.	None	None
D5940	resection prosthesis, maxillary partial removable	Not a covered benefit.	None	None
D5941	resection prosthesis, mandibular partial removable	Not a covered benefit.	None	None
D5942	resection prosthesis, maxillary implant/abutment supported removable prosthesis for edentulous arch	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: D5900-D5999 MAXILLOFACIAL PROSTHETICS**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D5943	resection prosthesis, mandibular implant/abutment supported removable prosthesis for edentulous arch	Not a covered benefit.	None	None
D5944	resection prosthesis, maxillary implant/abutment supported removable prosthesis for the partial edentulous arch	Not a covered benefit.	None	None
D5945	resection prosthesis, mandibular implant/abutment supported removable prosthesis for the partial edentulous arch	Not a covered benefit.	None	None
D5946	resection prosthesis, maxillary implant/abutment supported fixed prosthesis for edentulous arch	Not a covered benefit.	None	None
D5947	resection prosthesis, mandibular implant/abutment supported fixed prosthesis for edentulous arch	Not a covered benefit.	None	None
D5948	resection prosthesis, maxillary implant/abutment supported fixed prosthesis for the partial edentulous arch	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: D5900-D5999 MAXILLOFACIAL PROSTHETICS**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D5949	resection prosthesis, mandibular implant/abutment supported fixed prosthesis for the partial edentulous arch	Not a covered benefit.	None	None
D5951	feeding aid	Not a covered benefit.	None	None
D5952	speech aid prosthesis, pediatric	Not a covered benefit.	None	None
D5953	speech aid prosthesis, adult	Not a covered benefit.	None	None
D5954	palatal augmentation prosthesis	Not a covered benefit.	None	None
D5955	palatal lift prosthesis, definitive	Not a covered benefit.	None	None
D5958	palatal lift prosthesis, interim	Not a covered benefit.	None	None
D5959	palatal lift prosthesis, modification	Not a covered benefit.	None	None
D5960	speech aid prosthesis, modification	Not a covered benefit.	None	None
D5982	surgical stent for soft tissue healing	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: D5900-D5999 MAXILLOFACIAL PROSTHETICS**

<b>CDT Code</b>	<b>Description of Service</b>	<b>Procedure Guidelines or Frequency Limitation</b>	<b>Limitations, Exclusions, and Integral Considerations</b>	<b>Submission Requirements: Participating Providers</b>
<b>D5983</b>	<b>radiation carrier</b>	Not a covered benefit.	None	None
<b>D5984</b>	<b>radiation shield</b>	Not a covered benefit.	None	None
<b>D5985</b>	<b>radiation cone locator</b>	Not a covered benefit.	None	None
<b>D5986</b>	<b>fluoride gel carrier</b>	Not a covered benefit.	None	None
<b>D5987</b>	<b>commissure splint</b>	Not a covered benefit.	None	None
<b>D5988</b>	<b>surgical splint</b>	Not a covered benefit.	None	None
<b>D5991</b>	<b>vesiculobullous disease medicament carrier</b>	Not a covered benefit.	None	None
<b>D5992</b>	<b>adjust maxillofacial prosthetic appliance, by report</b>	Not a covered benefit.	None	None
<b>D5993</b>	<b>maintenance and cleaning of a maxillofacial prosthesis (extra-or intra-oral) other than required adjustments, by report</b>	Not a covered benefit.	None	None
<b>D5995</b>	<b>periodontal medicament carrier with peripheral seal - laboratory processed - maxillary</b>	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: D5900-D5999 MAXILLOFACIAL PROSTHETICS

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D5996</b>	<b>periodontal medicament carrier with peripheral seal - laboratory processed - mandibular</b>	Not a covered benefit.	None	None
<b>D5999</b>	<b>unspecified maxillofacial prosthesis, by report</b>	By report.	Individual Consideration	Detailed narrative

**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.

## VIII. D6000-D6199 Implant Services

---

### 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 (3<sup>rd</sup>) 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.

---

**CDT: D6000-D6199 IMPLANT SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D6010</b>	<b>surgical placement of implant body; endosteal implant</b>	One (1) per tooth per lifetime. Patient must be age fifteen (15) or older. Not all plans cover this benefit. Please check with the Plan for member's eligibility for this service.	All new members subject to twelve (12) month waiting period. Covers second stage surgery and placement of healing cap.	Tooth area identification
<b>D6011</b>	<b>surgical access to an implant body (second stage implant surgery)</b>	One (1) per tooth per lifetime. Patient must be age fifteen (15) or older. Not all plans cover this benefit. Please check with the Plan for member's eligibility for this service.	All new members subject to twelve (12) month waiting period. Covers second stage surgery and placement of healing cap. INTEGRATAL to the placement of the implant for all plans.	Tooth area identification
<b>D6012</b>	<b>surgical placement of interim implant body for transitional prosthesis: endosteal implant</b>	Not a covered benefit	None	None
<b>D6013</b>	<b>surgical placement of mini implant</b>	Limited to two (2) per arch in order to stabilize a denture. Not all plans cover this benefit. Please check with the Plan for member's eligibility for this service.	Allowance for D6013 will be 30% of the allowance for D6010.	Tooth area identification
<b>D6040</b>	<b>surgical placement; eposteal implant</b>	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: D6000-D6199 IMPLANT SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D6049</b>	<b>scaling and debridement of a single implant in the presence of peri-implantitis inflammation, bleeding upon probing and increased pocket depths, including cleaning of the implant surfaces, without flap entry and closure</b>	<p>IMPLANT RIDER</p> <p>Limited to two (2) of Implant maintenance (D6080, D6180, D6081, 2 NEW CODES) per calendar year.</p>	<p>Denied as MISREPORTED when reported by the same Dentist on the same date as Prophy (D1110), Periodontal Maintenance (D4910), or Scaling in the presence of inflammation (D4346).</p> <p>Integral with 4341/4342 in same quadrant.</p>	Tooth Identification
<b>D6050</b>	<b>surgical placement: transosteal implant</b>	Not a covered benefit.	None	None
<b>D6051</b>	<b>placement of interim implant abutment</b>	Not a covered benefit.	None	None
<b>D6055</b>	<b>connecting bar - implant supported or abutment supported</b>	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: D6000-D6199 IMPLANT SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D6056</b>	<b>prefabricated abutment - includes modification and placement</b>	One (1) per tooth in a five (5) year period; age fifteen (15) and older. Not all plans cover this benefit. Please check with the Plan for member's eligibility for this service.	All new members subject to twelve (12) month waiting period.	Tooth identification
<b>D6057</b>	<b>custom fabricated abutment - includes placement</b>	One (1) per tooth in a five (5) year period; age fifteen (15) and older. Not all plans cover this benefit. Please check with the Plan for member's eligibility for this service.	All new members subject to twelve (12) month waiting period.	Tooth identification
<b>D6058</b>	<b>abutment supported porcelain/ceramic crown</b>	One (1) per tooth in a five (5) year period; age fifteen (15) and older. Not all plans cover this benefit. Please check with the Plan for member's eligibility for this service.	All new members subject to twelve (12) month waiting period.	Tooth identification
<b>D6059</b>	<b>abutment supported porcelain fused to metal crown (high noble metal)</b>	One (1) per tooth in a five (5) year period; age fifteen (15) and older. Not all plans cover this benefit. Please check with the Plan for member's eligibility for this service.	All new members subject to twelve (12) month waiting period. .	Tooth identification

**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: D6000-D6199 IMPLANT SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D6060</b>	<b>abutment supported porcelain fused to metal crown (predominantly base metal)</b>	One (1) per tooth in a five (5) year period; age fifteen (15) and older. Not all plans cover this benefit. Please check with the Plan for member's eligibility for this service.	All new members subject to twelve (12) month waiting period.	Tooth identification
<b>D6061</b>	<b>abutment supported porcelain fused to metal crown (noble metal)</b>	One (1) per tooth in a five (5) year period; age fifteen (15) and older. Not all plans cover this benefit. Please check with the Plan for member's eligibility for this service.	All new members subject to twelve (12) month waiting period.	Tooth identification
<b>D6062</b>	<b>abutment supported cast metal crown (high noble metal)</b>	One (1) per tooth in a five (5) year period; age fifteen (15) and older. Not all plans cover this benefit. Please check with the Plan for member's eligibility for this service.	All new members subject to twelve (12) month waiting period.	Tooth identification
<b>D6063</b>	<b>abutment supported cast metal crown (predominantly base metal)</b>	One (1) per tooth in a five (5) year period; age fifteen (15) and older. Not all plans cover this benefit. Please check with the Plan for member's eligibility for this service.	All new members subject to twelve (12) month waiting period.	Tooth identification

**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: D6000-D6199 IMPLANT SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D6064</b>	<b>abutment supported cast metal crown (noble metal)</b>	One (1) per tooth in a five (5) year period; age fifteen (15) and older. Not all plans cover this benefit. Please check with the Plan for member's eligibility for this service.	All new members subject to twelve (12) month waiting period.	Tooth identification
<b>D6065</b>	<b>implant supported porcelain/ceramic crown</b>	One (1) per tooth in a five (5) year period; age fifteen (15) and older. Not all plans cover this benefit. Please check with the Plan for member's eligibility for this service.	All new members subject to twelve (12) month waiting period.	Tooth identification
<b>D6066</b>	<b>implant supported crown - porcelain fused to high noble alloys</b>	One (1) per tooth in a five (5) year period; age fifteen (15) and older. Not all plans cover this benefit. Please check with the Plan for member's eligibility for this service.	All new members subject to twelve (12) month waiting period.	Tooth identification
<b>D6067</b>	<b>implant supported crown - high noble alloys</b>	One (1) per tooth in a five (5) year period; age fifteen (15) and older. Not all plans cover this benefit. Please check with the Plan for member's eligibility for this service.	All new members subject to twelve (12) month waiting period.	Tooth identification

**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	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D6068	<b>abutment supported retainer for porcelain/ceramic FPD</b>	One (1) per tooth in a five (5) year period; age fifteen (15) and older. Not all plans cover this benefit. Please check with the Plan for member's eligibility for this service.	All new members subject to twelve (12) month waiting period.	Tooth identification
D6069	<b>abutment supported retainer for porcelain fused to metal FPD (high noble metal)</b>	One (1) per tooth in a five (5) year period; age fifteen (15) and older. Not all plans cover this benefit. Please check with the Plan for member's eligibility for this service.	All new members subject to twelve (12) month waiting period.	Tooth identification
D6070	<b>abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)</b>	One (1) per tooth in a five (5) year period; age fifteen (15) and older. Not all plans cover this benefit. Please check with the Plan for member's eligibility for this service.	All new members subject to twelve (12) month waiting period.	Tooth identification
D6071	<b>abutment supported retainer for porcelain fused to metal FPD (noble metal)</b>	One (1) per tooth in a five (5) year period; age fifteen (15) and older. Not all plans cover this benefit. Please check with the Plan for member's eligibility for this service.	All new members subject to twelve (12) month waiting period.	Tooth identification
D6072	<b>abutment-supported retainer for cast metal FPD (high noble metal)</b>	One (1) per tooth in a five (5) year period; age fifteen (15) and older. Not all plans cover this benefit. Please check with the Plan for member's eligibility for this service.	All new members subject to twelve (12) month waiting period.	Tooth identification

**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: D6000-D6199 IMPLANT SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D6073	<b>abutment supported retainer for cast metal FPD (predominantly base metal)</b>	One (1) per tooth in a five (5) year period; age fifteen (15) and older. Not all plans cover this benefit. Please check with the Plan for member's eligibility for this service.	All new members subject to twelve (12) month waiting period.	Tooth identification
D6074	<b>abutment supported retainer for cast metal FPD (noble metal)</b>	One (1) per tooth in a five (5) year period; age fifteen (15) and older. Not all plans cover this benefit. Please check with the Plan for member's eligibility for this service.	All new members subject to twelve (12) month waiting period.	Tooth identification
D6075	<b>implant supported retainer for ceramic FPD</b>	One (1) per tooth in a five (5) year period; age fifteen (15) and older. Not all plans cover this benefit. Please check with the Plan for member's eligibility for this service.	All new members subject to twelve (12) month waiting period.	Tooth identification
D6076	<b>implant supported retainer for metal FPD - high noble alloys</b>	One (1) per tooth in a five (5) year period; age fifteen (15) and older. Not all plans cover this benefit. Please check with the Plan for member's eligibility for this service.	All new members subject to twelve (12) month waiting period.	Tooth identification

**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: D6000-D6199 IMPLANT SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D6077</b>	<b>implant-supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)</b>	One (1) per tooth in a five (5) year period; age fifteen (15) and older. Not all plans cover this benefit. Please check with the Plan for member's eligibility for this service.	All new members subject to twelve (12) month waiting period.	Tooth identification
<b>D6080</b>	<b>implant maintenance procedures when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments. This procedure includes active debriding of the implant(s) and examination of all aspects of the implant system, including the occlusion and stability of the prosthesis</b>	D6080, D6081, D6180 Frequency limitations – Two services per calendar year.	Covered for PPO and plans with the implant rider. Not covered if same date of service and by the same Provider as a Prophylaxis (D1110), Periodontal maintenance (D4910), or Scaling in the presence of inflammation (D4346).	None
<b>D6081</b>	<b>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</b>	D6080, D6081, D6180 Frequency limitations – Two services per calendar year.	Covered for PPO and plans with the implant rider. Not covered if same date of service and by the same Provider as a Prophylaxis (D1110), Periodontal maintenance (D4910), or Scaling in the presence of inflammation (D4346).	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: D6000-D6199 IMPLANT SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D6082	implant supported crown - porcelain fused to predominantly base alloys	One (1) per tooth per five (5) years.	None	None
D6083	implant supported crown - porcelain fused to noble alloys	One (1) per tooth per five (5) years.	None	None
D6084	implant supported crown - porcelain fused to titanium or titanium alloys	One (1) per tooth per five (5) years.	None	None
D6085	interim implant crown	Not a covered benefit.	None	None
D6086	implant supported crown - predominantly base alloys	One (1) per tooth per five (5) years.	None	None
D6087	implant supported crown - noble alloys	One (1) per tooth per five (5) years.	None	None
D6088	implant supported crown - titanium and titanium alloys	One (1) per tooth per five (5) years.	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	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D6089	<b>accessing and retorquing loose implant screw – per screw</b>	If plan covers implants: Once per tooth per twelve (12) months. Age fifteen (15) or older. Not all plans cover this benefit. Please check with the Plan for member’s eligibility for this service.	Considered a basic service.	Tooth identification
D6090	<b>Repair of implant/abutment supported prosthesis</b>	One (1) per arch per six (6) months. Age fifteen (15) or older. Not all plans cover this benefit. Please check with the Plan for member’s eligibility for this service.	All new members subject to twelve (12) month waiting period. Denied as INTEGRAL when reported within a 5-year period of the initial placement of the restoration	Tooth identification
D6091	<b>replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment</b>	Not a covered benefit.	None	None
D6092	<b>re-cement or re-bond implant/abutment supported crown</b>	If plan covers implants: Once per tooth per twelve (12) months. Age fifteen (15) or older. Not all plans cover this benefit. Please check with the Plan for member’s eligibility for this service.	Considered a basic service.	Tooth identification

**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: D6000-D6199 IMPLANT SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D6093	<b>re-cement or re-bond implant/abutment supported fixed partial denture</b>	One (1) per bridge per twelve (12) months. Age fifteen (15) or older. Not all plans cover this benefit. Please check with the Plan for member's eligibility for this service.	Considered a basic service.	Tooth identification
D6094	<b>abutment supported crown - titanium and titanium alloys</b>	One (1) per tooth per five (5) years. Age fifteen (15) and older.	All new members subject to twelve (12) month waiting period.	Tooth identification
D6096	<b>remove broken implant retaining screw</b>	One (1) per arch per six (6) months. Age fifteen (15) or older. Not all plans cover this benefit. Please check with the Plan for member's eligibility for	All new members subject to twelve (12) month waiting period.	Tooth identification
D6097	<b>abutment supported crown - porcelain fused to titanium or titanium alloys</b>	One (1) per tooth per five (5) years. Age fifteen (15) and older.	All new members subject to twelve (12) month waiting period.	None
D6098	<b>implant supported retainer - porcelain fused to predominantly base alloys</b>	One (1) per tooth per five (5) years. Age fifteen (15) and older.	All new members subject to twelve (12) month waiting period.	None
D6099	<b>implant supported retainer for FPD - porcelain fused to noble alloys</b>	One (1) per tooth per five (5) years. Age fifteen (15) and older.	All new members subject to twelve (12) month waiting period.	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: D6000-D6199 IMPLANT SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D6100	<b>surgical removal of implant body</b>	One (1) per tooth per five (5) years. Age fifteen (15) and older.	All new members subject to twelve (12) month waiting period.	Tooth identification
D6101	<b>debridement of peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure</b>	Not a covered benefit.	None	None
D6102	<b>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</b>	Not a covered benefit.	None	None
D6103	<b>bone graft for repair of peri-implant defect - does not include flap entry and closure</b>	Not a covered benefit.	None	None
D6104	<b>bone graft at time of implant placement</b>	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: D6000-D6199 IMPLANT SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D6105	<b>removal of implant body not requiring bone removal nor flap elevation</b>	One (1) per tooth per five (5) years. Age fifteen (15) and older.	All new members subject to twelve (12) month waiting period.	Tooth identification
D6106	<b>guided tissue regeneration – resorbable barrier, per implant</b>	Not a covered benefit	None	None
D6107	<b>guided tissue regeneration – non-resorbable barrier, per implant</b>	Not a covered benefit	None	None
D6110	<b>implant/abutment supported removable denture for edentulous arch - maxillary</b>	Paid as an alternate benefit using D5110 allowance. Member is responsible for difference between provider’s charge and allowance.	Alternate Benefit. Use code D5110.	None
D6111	<b>implant/abutment supported removable denture for edentulous arch - mandibular</b>	Paid as an alternate benefit using D5120 allowance. Member is responsible for difference between provider’s charge and allowance.	Alternate Benefit. Use code D5120.	None
D6112	<b>implant/abutment supported removable denture for partially edentulous arch - maxillary</b>	Paid as an alternate benefit using D5213 allowance. Member is responsible for difference between provider’s charge and allowance.	Alternate Benefit. Use code D5213.	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: D6000-D6199 IMPLANT SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D6113	<b>implant/abutment supported removable denture for partially edentulous arch - mandibular</b>	Paid as an alternate benefit using D5214 allowance. Member is responsible for difference between provider's charge and allowance.	Alternate Benefit. Use code D5214.	None
D6114	<b>implant/abutment supported fixed denture for edentulous arch - maxillary</b>	Paid as an alternate benefit using D5110 allowance. Member is responsible for difference between provider's charge and allowance.	Alternate Benefit. Use code D5110.	None
D6115	<b>implant/abutment supported fixed denture for edentulous arch - mandibular</b>	Paid as an alternate benefit using D5120 allowance. Member is responsible for difference between provider's charge and allowance.	Alternate Benefit. Use code D5120.	None
D6116	<b>implant/abutment supported fixed denture for partially edentulous arch - maxillary</b>	Paid as an alternate benefit using D5213 allowance. Member is responsible for difference between provider's charge and allowance.	Alternate Benefit. Use code D5213.	None
D6117	<b>implant/abutment supported fixed denture for partially edentulous arch - mandibular</b>	Paid as an alternate benefit using D5214 allowance. Member is responsible for difference between provider's charge and allowance.	Alternate Benefit. Use code D5214.	None
D6118	<b>implant/abutment supported interim fixed denture for edentulous arch - mandibular</b>	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: D6000-D6199 IMPLANT SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D6119	implant/abutment supported interim fixed denture for edentulous arch - maxillary	Not a covered benefit.	None	None
D6120	implant supported retainer - porcelain fused to titanium and titanium alloys	One (1) per tooth per five (5) years. Age fifteen (15) and older.	None	None
D6121	implant supported retainer for metal FPD - predominantly base alloys	One (1) per tooth per five (5) years. Age fifteen (15) and older.	None	None
D6122	implant support retainer for metal FPD - noble alloys	One (1) per tooth per five (5) years. Age fifteen (15) and older.	None	None
D6123	implant supported retainer for metal FPD - titanium and titanium alloys	One (1) per tooth per five (5) years. Age fifteen (15) and older.	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: D6000-D6199 IMPLANT SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D6180</b>	<b>implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed including cleansing of prosthesis and abutments</b>	D6080, D6081, D6180 Frequency limitations – Two services per calendar year.	Covered for PPO and plans with the implant rider. Not covered if same date of service and by the same Provider as a Prophylaxis (D1110), Periodontal maintenance (D4910), or Scaling in the presence of inflammation (D4346).	None
<b>D6190</b>	<b>radiographic/surgical implant index, by report</b>	Not a covered benefit.	None	None
<b>D6191</b>	<b>semi - precision abutment - placement</b>	Not a covered benefit.	None	None
<b>D6192</b>	<b>semi - precision attachment - placement</b>	Not a covered benefit.	None	None
<b>D6193</b>	<b>replacement of an implant screw</b>	Once (1) per tooth per 3- year period. Not all plans cover this benefit. Please check with the Plan for member's eligibility for this service.	Covered for PPO and plans with the implant rider. Denied as INTEGRAL when reported on the same tooth, by the same Dentist within 12 months of recementation of an abutment.or implant supported crown or retainer, or implant/abutment supported fixed denture.	Tooth identification

**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: D6000-D6199 IMPLANT SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D6194	<b>abutment supported retainer crown for FPD - titanium and titanium alloys</b>	One (1) per tooth per five (5) years. Age fifteen (15) and older.	All new members subject to twelve (12) month waiting period.	Tooth identification
D6195	<b>abutment supported retainer - porcelain fused to titanium and titanium alloys</b>	One (1) per tooth per five (5) years. Age fifteen (15) and older.	None	None
D6196	<b>removal of an indirect restoration on an implant retained abutment</b>	Integral	None	None
D6197	<b>replacement of restorative material used to close an access opening of a screw-retained</b>	Not a covered benefit.	None	None
D6198	<b>remove interim implant component</b>	Not a covered benefit.	None	None
D6199	<b>unspecified implant procedure, by report</b>	By report.	Individual Consideration.	Tooth identification, Detailed narrative

**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

---

### 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 prosthesis.

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 fifteen (15) 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.

Each retainer and each pontic constitutes a unit in a fixed partial denture.

Local anesthesia is usually considered to be part of Fixed Prosthodontic procedures.

The term "fixed partial denture" or FPD is synonymous with fixed bridge or bridgework.

Fixed partial denture prosthetic procedures include routine temporary prosthetics. When indicated, interim or provisional codes should be reported separately.

---

**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: D6200-D6999 PROSTHODONTICS, FIXED**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D6205</b>	<b>pontic - indirect resin-based composite</b>	One (1) per tooth per five (5) years, age fifteen (15) and older.	Alternate benefit D6240 for anterior and bicuspids. Alternate benefit D6210 for molars. X-rays required.	Tooth identification
<b>D6210</b>	<b>pontic - cast high noble metal</b>	One (1) per tooth, in a five (5) year period.	None	Tooth identification
<b>D6211</b>	<b>pontic - cast predominantly base metal</b>	One (1) per tooth, in a five (5) year period.	None	Tooth identification
<b>D6212</b>	<b>pontic - cast noble metal</b>	One (1) per tooth, in a five (5) year period.	None	Tooth identification
<b>D6214</b>	<b>pontic - titanium and titanium alloys</b>	One (1) per tooth, in a five (5) year period.	None	Tooth identification
<b>D6240</b>	<b>pontic - porcelain fused to high noble metal</b>	One (1) per tooth per five (5) years, age fifteen (15) and older.	Alternate benefit D6210 for molars.	Tooth identification
<b>D6241</b>	<b>pontic - porcelain fused to predominantly base metal</b>	One (1) per tooth per five (5) years, age fifteen (15) and older.	Alternate benefit D6211 for molars.	Tooth identification

**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: D6200-D6999 PROSTHODONTICS, FIXED**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D6242</b>	<b>pontic - porcelain fused to noble metal</b>	One (1) per tooth per five (5) years, age fifteen (15) and older.	Alternate benefit D6212 for molars.	Tooth identification
<b>D6243</b>	<b>pontic - porcelain/ceramic</b>	One (1) per tooth per five (5) years, covered for anterior. Age fifteen (15) and older.	Alternate benefit D6212 for molars.	Tooth identification
<b>D6245</b>	<b>pontic - porcelain/ceramic</b>	One (1) per tooth per five (5) years, covered for anterior. Age fifteen (15) and older.	Alternate benefit D6240 for anterior and bicuspid. Alternate benefit D6210 for molars.	Tooth identification
<b>D6250</b>	<b>pontic - resin with high noble metal</b>	One (1) per tooth per five (5) years, covered for anterior. Age fifteen (15) and older.	Alternate benefit D6210 for molars.	Tooth identification
<b>D6251</b>	<b>pontic - resin with predominantly base metal</b>	One (1) per tooth per five (5) years, covered for anterior. Age fifteen (15) and older.	Alternate benefit D6211 for molars.	Tooth identification
<b>D6252</b>	<b>pontic - resin with noble metal</b>	One (1) per tooth per five (5) years, covered for anterior. Age fifteen (15) and older.	Alternate benefit D6212 for molars.	Tooth identification
<b>D6253</b>	<b>interim pontic - further treatment or completion of diagnosis necessary prior to final impression</b>	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: D6200-D6999 PROSTHODONTICS, FIXED**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D6280</b>	<b>implant maintenance procedures when a full arch removable implant/abutment supported denture is removed and reinserted, including cleansing of prosthesis and abutments-per arch</b>	Two (2) per yr per arch procedure is similar to a prophylaxis Basic regardless of implant coverage.  Limited to two (2) of Implant maintenance (D6080, D6180, D6081, 2 NEW CODES) per calendar year.	IMPLANT RIDER	Arch Identification
<b>D6545</b>	<b>retainer - cast metal for resin bonded fixed prosthesis</b>	One (1) in a five (5) year period.	Metal retainers are covered. Coverage is for permanent teeth only. Five (5) year waiting period between services. The patient must be age fifteen (15) or older. Service or completion date is the cementation date.	Tooth identification
<b>D6548</b>	<b>retainer - porcelain/ceramic for resin bonded fixed prosthesis</b>	One (1) in a five (5) year period. Alternate benefit: D6545.	See details listed for D6545.	Tooth identification
<b>D6549</b>	<b>resin retainer - for resin bonded fixed prosthesis</b>	One (1) in a five (5) year period. Alternate benefit: D6545. Member is responsible for difference between provider's charge and allowance.	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. Coverage includes laboratory charges, liners, bases, and local anesthesia. Five (5) year waiting period between services. The patient must be age fifteen (15) or older. Service or completion date is the cementation date.	Tooth identification

**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: D6200-D6999 PROSTHODONTICS, FIXED**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D6600</b>	<b>retainer inlay - porcelain/ceramic, two (2) surfaces</b>	One (1) per tooth per five (5) years Alternate benefit: D2520.	See details listed for D6545.	Tooth identification, Surface identification
<b>D6601</b>	<b>retainer inlay - porcelain/ceramic, three (3) or more surfaces</b>	One (1) per tooth per five (5) years. Alternate benefit: D2530	Coverage is for permanent teeth only. Porcelain/ceramic inlay/onlays are paid at the metallic rate as an alternate benefit with the member responsible for the difference between The Plan's payment and the provider's actual charge. Five (5)-year waiting period between services. The patient must be age fifteen (15) or older. Service or completion date is the cementation date.	Tooth identification, Surface identification
<b>D6602</b>	<b>retainer inlay - cast high noble metal, two (2) surfaces</b>	One (1) per tooth per five (5) years. Age fifteen (15) and older.	Metal inlay/onlay retainers are covered. Coverage is for permanent teeth only. Five (5) year waiting period between services. The patient must be age fifteen (15) or older. Service or completion date is the cementation date.	Tooth identification, Surface identification

**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: D6200-D6999 PROSTHODONTICS, FIXED**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D6603</b>	<b>retainer inlay - cast high noble metal, three (3) or more surfaces</b>	One (1) per tooth per five (5) years. Age fifteen (15) and older.	Metal inlay/onlay retainers are covered. Coverage is for permanent teeth only. Five (5) year waiting period between services. The patient must be age fifteen (15) or older. Service or completion date is the cementation date.	Tooth identification, Surface identification
<b>D6604</b>	<b>retainer inlay - cast predominantly base metal, two (2) surfaces</b>	One (1) per tooth per five (5) years. Age fifteen (15) and older.	Metal inlay/onlay retainers are covered. Coverage is for permanent teeth only. Five (5) year waiting period between services. The patient must be age fifteen (15) or older. Service or completion date is the cementation date.	Tooth identification, Surface identification
<b>D6605</b>	<b>retainer inlay - cast predominantly base metal, two (2) surfaces</b>	One (1) per tooth per five (5) years.	Metal inlay/onlay retainers are covered. Coverage is for permanent teeth only. Five (5) year waiting period between services. The patient must be age fifteen (15) or older. Service or completion date is the cementation date.	Tooth identification, Surface identification

**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	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D6606	<b>retainer inlay - cast predominantly base metal, three (3) or more surfaces</b>	One (1) per tooth per five (5) years.	Metal inlay/onlay retainers are covered. Coverage is for permanent teeth only. Five (5) year waiting period between services. The patient must be age fifteen (15) or older. Service or completion date is the cementation date.	Tooth identification, Surface identification
D6607	<b>retainer inlay - cast noble metal, two (2) surfaces</b>	One (1) per tooth per five (5) years.	Metal inlay/onlay retainers are covered. Coverage is for permanent teeth only. Five (5) year waiting period between services. The patient must be age fifteen (15) or older. Service or completion date is the cementation date.	Tooth identification, Surface identification
D6608	<b>retainer inlay - cast noble metal, three (3) or more surfaces</b>	One (1) in a five (5) year period. Alternate benefit: D2542.	Coverage is for permanent teeth needing buccal/lingual cusp coverage only. Porcelain/ceramic inlay/onlays are paid at the metallic rate as an alternate benefit with the member responsible for the difference between The Plan's payment and the provider's actual charge. Five (5) year waiting period between services. The patient must be age fifteen (15) or older. Service or completion date is the cementation date.	Tooth identification Surface identification, must include B or L surface

**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	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D6611	<b>retainer onlay - cast high noble metal, three (3) or more surfaces</b>	One (1) in a five (5) year period. Age fifteen (15) and older.	Metal inlay/onlay retainers are covered. Coverage is for permanent teeth needing buccal/lingual cusp coverage only. Five (5) year waiting period between services. The patient must be age fifteen (15) or older. Service or completion date is the cementation date.	Tooth identification Surface identification, must include B or L surface
D6612	<b>retainer onlay - cast predominantly base metal, two (2) surfaces</b>	One (1) in a five (5) year period. Age fifteen (15) and older.	Metal inlay/onlay retainers are covered. Coverage is for permanent teeth needing buccal/lingual cusp coverage only. Five (5) year waiting period between services. The patient must be age fifteen (15) or older. Service or completion date is the cementation date.	Tooth identification Surface identification, must include B or L surface
D6613	<b>retainer onlay - cast predominantly base metal, three (3) or more surfaces</b>	One (1) in a five (5) year period. Age fifteen (15) and older.	Metal inlay/onlay retainers are covered. Coverage is for permanent teeth needing buccal/lingual cusp coverage only. Five (5) year waiting period between services. The patient must be age fifteen (15) or older. Service or completion date is the cementation date.	Tooth identification Surface identification, must include B or L surface

**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	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D6614	<b>retainer onlay - cast noble metal, two (2) surfaces</b>	One (1) in a five (5) year period. Age fifteen (15) and older.	Metal inlay/onlay retainers are covered. Coverage is for permanent teeth needing buccal/lingual cusp coverage only. Five (5) year waiting period between services. The patient must be age fifteen (15) or older. Service or completion date is the cementation date.	Tooth identification Surface identification, must include B or L surface
D6615	<b>retainer onlay - cast noble metal, three (3) or more surfaces</b>	One (1) in a five (5) year period. Age fifteen (15) and older.	Metal inlay/onlay retainers are covered. Coverage is for permanent teeth needing buccal/lingual cusp coverage only. Five (5) year waiting period between services. The patient must be age fifteen (15) or older. Service or completion date is the cementation date.	Tooth identification Surface identification, must include B or L surface
D6624	<b>retainer inlay - titanium</b>	One (1) in a five (5) year period. Age fifteen (15) and older.	Metal inlay/onlay retainers are covered. Coverage is for permanent teeth only. Five (5) year waiting period between services. The patient must be age fifteen (15) or older. Service or completion date is the cementation date.	Tooth identification, Surface identification

**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	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D6634	retainer onlay - titanium	One (1) in a five (5) year period. Age fifteen (15) and older.	Metal inlay/onlay retainers are covered. Coverage is for permanent teeth needing buccal/lingual cusp coverage only. Five (5) year waiting period between services. The patient must be age fifteen (15) or older. Service or completion date is the cementation date.	Tooth identification Surface identification, must include B or L surface
D6710	retainer crown - indirect resin-based composite	One (1) per tooth in a five (5) year period. Alternate benefit: D6750 for anterior and bicuspids, D6790 for molars.	Five (5) year waiting period between services. Patient must be age fifteen (15) or older. Service or completion date is the cementation date.	Tooth identification
D6720	retainer crown - resin with high noble metal	One (1) per tooth in a five (5) year period. Alternate benefit: D6790 for molars.	Five (5) year waiting period between services. Patient must be age fifteen (15) or older. Service or completion date is the cementation date.	Tooth identification
D6721	retainer crown - resin with predominantly base metal	One (1) per tooth in a five (5) year period. Alternate benefit: D6791 for molars.	Five (5) year waiting period between services. Patient must be age fifteen (15) or older. Service or completion date is the cementation date.	Tooth identification
D6722	retainer crown - resin with noble metal	One (1) per tooth in a five (5) year period. Alternate benefit: D6792 for molars.	Five (5) year waiting period between services. Patient must be age fifteen (15) or older. Service or completion date is the cementation date.	Tooth identification

**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: D6200-D6999 PROSTHODONTICS, FIXED**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D6740	retainer crown - porcelain/crown	One (1) per tooth in a five (5) year period Alternate benefit: D6790 for molars. Alternate benefit: D6750 for anterior and bicuspid.	Five (5) year waiting period between services. Patient must be age fifteen (15) or older. Service or completion date is the cementation date.	Tooth identification
D6750	retainer crown - porcelain fused to high noble metal	One (1) per tooth in a five (5) year period Alternate benefit: D6790 for molars.	Five (5) year waiting period between services. Patient must be age fifteen (15) or older. Service or completion date is the cementation date.	Tooth identification
D6751	retainer crown - porcelain fused to predominantly base metal	One (1) per tooth in a five (5) year period Alternate benefit: D6791 for molars.	Five (5) year waiting period between services. Patient must be age fifteen (15) or older. Service or completion date is the cementation date.	Tooth identification

**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	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D6752</b>	<b>retainer crown - porcelain fused to noble metal</b>	One (1) per tooth in a five (5) year period. Alternate benefit: D6792 for molars.	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 fifteen (15) or older. For Permanent teeth only. Service or completion date is the cementation date.	Tooth identification
<b>D6753</b>	<b>retainer crown - porcelain fused to titanium and titanium alloys</b>	One (1) per tooth in a five (5) year period. Alternate benefit: D6792 for molars, covered for anterior.	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	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D6780	retainer crown - 3/4 cast high noble metal	One (1) in a five (5) year period. Age fifteen (15) and older.	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 fifteen (15) or older. For permanent teeth only. Service or completion date is the cementation date.	Tooth identification
D6781	retainer crown - 3/4 cast predominantly base metal	One (1) in a five (5) year period. Age fifteen (15) and older.	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 fifteen (15) or older. For permanent teeth only. Service or completion date is the cementation date.	Tooth identification
D6782	retainer crown - 3/4 cast high noble metal	One (1) in a five (5) year period. Age fifteen (15) and older.	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 fifteen (15) or older. For permanent teeth only. Service or completion date is the cementation date.	Tooth identification

**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: D6200-D6999 PROSTHODONTICS, FIXED**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D6783	retainer crown - 3/4 porcelain/ceramic	One (1) in a five (5) year period Alternate benefit: D6780 for all teeth.	Five (5) year waiting period between services. Patient must be age fifteen (15) or older. For permanent teeth only. Service or completion date is the cementation date.	Tooth identification
D6784	retainer crown 3/4 - titanium and titanium alloys	One (1) in a five (5) year period. Age fifteen (15) and older.	None	None
D6790	retainer crown - full cast high noble metal	One (1) in a five (5) year period. Age fifteen (15) and older.	None	None
D6791	retainer crown - full cast predominantly base metal	One (1) in a five (5) year period. Age fifteen (15) and older.	None	None
D6792	retainer crown - full cast noble metal	One (1) in a five (5) year period. Age fifteen (15) and older.	None	None
D6793	interim retainer crown - further treatment or completion of diagnosis necessary prior to final impression	Not a covered benefit.	None	None
D6794	retainer crown - titanium and titanium alloys	One (1) in a five (5) year period. Age fifteen (15) and older.	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	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D6920	connector bar	Not a covered benefit.	None	None
D6930	re-cement or re-bond fixed partial denture	Two (2) in a five (5) year period. Age fifteen (15) and older.	Plan covers two (2) recementations per fixed partial denture in five (5) years and Recementation of a fixed partial denture if more than six (6) months have passed from the date of cementation. There is a twelve (12) month waiting period between recementations. Patient must be age fifteen (15) or older. For permanent teeth only.	Tooth identification
D6940	stress breaker	Not a covered benefit.	None	None
D6950	precision attachment	Not a covered benefit.	None	None
D6980	fixed partial denture repair necessitated by restorative material failure	By report.	Coverage is for permanent teeth only. There is a five (5) year waiting period between services. Must be age fifteen (15) or older.	Tooth identification
D6985	pediatric partial denture, fixed	Not a covered benefit.	None	None
D6999	unspecified fixed prosthodontic procedure, by report	By report.	Individual Consideration.	Detailed narrative

**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.

## X. D7000-D7999 Oral & Maxillofacial Surgery

Local anesthesia is usually considered to be part of Oral and Maxillofacial Surgical procedures.  
 For dental benefit reporting purposes, a quadrant is defined as four (4) or more contiguous teeth and/or teeth spaces distal to the midline.

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D7111	extraction, coronal remnants - primary tooth	One (1) per tooth per lifetime. No age limit.	The Plan coverage includes local anesthetic, suturing, if needed, and routine postoperative care. One (1) per tooth.	Tooth identification
D7140	extraction, erupted tooth, or exposed root (elevation and/or forceps removal)	One (1) per tooth per lifetime. No age limit.	The Plan coverage includes local anesthetic, suturing, if needed, and routine postoperative care. One (1) per tooth.	Tooth identification
D7210	extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	One (1) per tooth per lifetime. No age limit.	Surgical removal of an erupted tooth requiring removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated. One (1) per tooth	Tooth identification

**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	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D7220</b>	<b>removal of impacted tooth - soft tissue</b>	One (1) per tooth per lifetime. No age limit.	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. One (1) per tooth.	Tooth identification
<b>D7230</b>	<b>removal of impacted tooth - partially bony</b>	One (1) per tooth per lifetime. No age limit.	See details listed for D7220.	Tooth identification
<b>D7240</b>	<b>removal of impacted tooth - completely bony</b>	One (1) per tooth per lifetime. No age limit.	See details listed for D7220.	Tooth identification
<b>D7241</b>	<b>removal of impacted tooth - completely bony, with unusual surgical complications</b>	By Report.	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.	Tooth identification
<b>D7250</b>	<b>removal of residual tooth roots (cutting procedure)</b>	One (1) per tooth per lifetime. No age limit.	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.	Tooth identification

**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	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D7251	<b>coronectomy - intentional partial tooth removal, impacted teeth only</b>	One (1) per tooth per lifetime. No age limit.	Procedure includes local anesthesia, suturing if needed and routine post-operative care. Once per tooth per lifetime.	Radiographs and narrative documentation required with submission.
D7252	<b>partial extraction for immediate implant placement</b>	Limited to 1 of Partial extraction for immediate implant placement per permanent maxillary anterior tooth (#6, 7, 8, 9, 10, 11) per lifetime.	<p>Covered for plans with the implant rider. If this surgical service is approved, associated GA/IV Anesthesia may also be approved as this service is defined as potentially dentally/medically necessary and the standard of dental treatment by this plan for GA/IV Anesthesia.</p> <p>Gingival flap procedure same day/same quad/same provider Apicoectomy, Root amputation, endodontic endosseous implant, intentional re-implantation, surgical rubber dam isolation, hemisection, Gingivectomy, any oral surgery service, or any type of GTR will deny as MISREPORTED.</p> <p>Benefit will be OFFSET by any benefit paid for Gingivectomy when Gingivectomy is reported same area, same DOS, same Dentist as any Crown, Inlay, Onlay, Restoration, or Extraction</p> <p>Benefit will be OFFSET by any benefit paid for Root removal same tooth when Root removal is reported for the same tooth and by the same Dentist. A8155/A8156</p> <p>Benefit will be OFFSET by any benefit paid for Removal of small cyst (D7450, D7451) same date when Removal of small cyst is reported on the same date, same tooth,</p>	Tooth identification

**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.

			<p>same Dentist as an Apicoectomy, Extraction, or Impaction. (H-7 #4)</p> <p>Benefit will be OFFSET by any benefit paid for Incise and Drain (D7510, D7511) when reported on the same date and by the same provider.</p>	
<b>D7259</b>	<b>nerve dissection</b>	Limited to one (1) Nerve dissection (D7259) per permanent tooth per lifetime.	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).	Tooth identification
<b>D7260</b>	<b>oroantral fistula closure</b>	By Report, to be paid by medical.	None	None
<b>D7261</b>	<b>primary closure of a sinus perforation</b>	By Report.	One (1) per maxillofacial posterior tooth.	None
<b>D7270</b>	<b>tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth</b>	One (1) per tooth per lifetime. No age limit.	Reimplantation is limited to permanent teeth. The procedure code is not used for intentional reimplantation (D3470) and surgical repositioning of teeth (D7290). One (1) per tooth per lifetime	Tooth identification

**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: D7000-D7999 ORAL & MAXILLOFACIAL SURGERY**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D7272	<b>tooth transplantation (includes re-implantation from one site to another and splinting and/or stabilization)</b>	Not a covered benefit.	None	None
D7280	<b>exposure of an unerupted tooth</b>	One (1) per tooth per lifetime. No age limit.	A narrative and tooth numbers must accompany the claim.	Tooth identification
D7282	<b>mobilization of erupted or malpositioned tooth to aid eruption</b>	Not a covered benefit.	None	None
D7283	<b>placement of device to facilitate eruption of impacted tooth</b>	Not a covered benefit.	None	None
D7284	<b>excisional biopsy of minor salivary glands</b>	No limitations.	None	None
D7285	<b>incisional biopsy of oral tissue - hard (bone, tooth)</b>	By Report.	None	None
D7286	<b>incisional biopsy of oral tissue - soft</b>	By Report.	None	None
D7287	<b>exfoliative cytological sample collection</b>	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: D7000-D7999 ORAL & MAXILLOFACIAL SURGERY**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D7288	brush biopsy - transepithelial sample collection	Not a covered benefit.	None	None
D7290	surgical repositioning of teeth	Not a covered benefit.	None	None
D7291	transseptal fiberotomy/supra crestal fiberotomy, by report	Not a covered benefit.	None	None
D7292	placement of temporary anchorage device [screw retained plate] requiring flap	Not a covered benefit.	None	None
D7293	placement of temporary anchorage device requiring flap	Not a covered benefit.	None	None
D7294	placement of temporary anchorage device without flap	Not a covered benefit.	None	None
D7295	harvest of bone for use in autogenous grafting procedure	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: D7000-D7999 ORAL & MAXILLOFACIAL SURGERY**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D7296	corticotomy – one (1) to three (3) teeth or tooth spaces, per quadrant	Not a covered benefit.	None	None
D7297	corticotomy - four (4) or more teeth or tooth spaces per quadrant	Not a covered benefit.	None	None
D7298	removal of temporary anchorage device [screw retained plate], requiring flap	Not a covered benefit.	None	None
D7299	removal of temporary anchorage device, requiring flap	Not a covered benefit.	None	None
D7300	removal of temporary anchorage device without flap	Not a covered benefit.	None	None
D7310	alveoloplasty in conjunction with extractions – four (4) or more teeth or tooth spaces, per quadrant	No limitations.	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.	Tooth identification Quadrant identification

**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: D7000-D7999 ORAL & MAXILLOFACIAL SURGERY**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D7311	<b>alveoloplasty in conjunction with extractions - one (1) to three (3) teeth or tooth spaces, per quadrant</b>	No limitations.	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.	Tooth identification
D7320	<b>alveoloplasty not in conjunction with extractions – four (4) or more teeth or tooth spaces, per quadrant</b>	No limitations.	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.	Tooth identification Quadrant identification
D7321	<b>alveoloplasty not in conjunction with extractions – one (1) to three (3) teeth or tooth spaces, per quadrant</b>	No limitations.	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.	Tooth identification
D7340	<b>vestibuloplasty - ridge extension (secondary epithelialization)</b>	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: D7000-D7999 ORAL & MAXILLOFACIAL SURGERY**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D7350	vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	Not a covered benefit.	None	None
D7410	excision of benign lesion up to 1.25 cm	By report, to be paid by Medical.	None	None
D7411	excision of benign lesion greater than 1.25 cm	By report, to be paid by Medical.	None	None
D7412	excision of benign lesions, complicated	By report, to be paid by Medical.	None	None
D7413	excision of malignant lesion up to 1.25 cm	By report, to be paid by Medical.	None	None
D7414	excision of malignant lesion greater than 1.25 cm	By report, to be paid by Medical.	None	None
D7415	excision of malignant lesion, complicated	By report, to be paid by Medical.	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: D7000-D7999 ORAL & MAXILLOFACIAL SURGERY**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D7440	excision of malignant tumor - lesion diameter up to 1.25 cm	By report, to be paid by Medical.	None	None
D7441	excision of malignant tumor - lesion diameter greater than 1.25 cm	By report, to be paid by Medical.	None	None
D7450	removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	No limitations.	The Plan covers the removal of odontogenic cysts or tumors.	None
D7451	removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	Not a covered benefit.	None	None
D7460	removal of benign nonodontogenic cysts or tumor - lesion diameter up to 1.25 cm	By report, to be paid by Medical.	None	None
D7461	removal of benign nonodontogenic cysts or tumor - lesion diameter greater 1.25 cm	By report, to be paid by Medical.	None	None
D7465	destruction of lesion(s) by physical or chemical method, by report	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: D7000-D7999 ORAL & MAXILLOFACIAL SURGERY**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D7471</b>	<b>removal of lateral exostosis (maxilla or mandible)</b>	By report.	None	Detailed narrative
<b>D7472</b>	<b>removal of torus palatinus</b>	By report.	None	Detailed narrative
<b>D7473</b>	<b>removal of torus mandibularis</b>	One per site per lifetime.	None	Detailed narrative
<b>D7485</b>	<b>reduction of osseous tuberosity</b>	Not a covered benefit.	None	None
<b>D7490</b>	<b>radical resection of maxilla or mandible</b>	Not a covered benefit.	None	None
<b>D7509</b>	<b>marsupialization of odontogenic cyst</b>	No limitations.	The Plan covers the removal of odontogenic cysts or tumors.	None
<b>D7510</b>	<b>incision and drainage of abscess - intraoral soft tissue</b>	No limitations.	Procedure is not to be used for endodontic access and drainage through a tooth or for open and broach.	Tooth and Arch identification; A brief narrative describing treatment, location and/or tooth number must accompany claim.

**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: D7000-D7999 ORAL & MAXILLOFACIAL SURGERY**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D7511</b>	<b>incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)</b>	By report.	Procedure is not to be used for endodontic access and drainage through a tooth or for open and broach.	A brief narrative describing treatment, location and/or tooth number must accompany claim.
<b>D7520</b>	<b>incision and drainage of abscess - extraoral soft tissue</b>	By report.	None	None
<b>D7521</b>	<b>incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)</b>	By report.	None	None
<b>D7530</b>	<b>removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue</b>	Not a covered benefit.	None	None
<b>D7540</b>	<b>removal of reaction producing foreign bodies, musculoskeletal system</b>	Not a covered benefit.	None	None
<b>D7550</b>	<b>partial ostectomy/sequestrectomy for removal of non-vital bone</b>	By report.	None	None
<b>D7560</b>	<b>maxillary sinusotomy for removal of tooth fragment or foreign body</b>	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: D7000-D7999 ORAL & MAXILLOFACIAL SURGERY**  
**CDT: D7000-D7999 ORAL & MAXILLOFACIAL SURGERY**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D7610	maxilla - open reduction (teeth immobilized if present)	Not a covered benefit.	None	None
D7620	maxilla - closed reduction (teeth immobilized if present)	Not a covered benefit.	None	None
D7630	mandible - open reduction (teeth immobilized if present)	Not a covered benefit.	None	None
D7640	mandible - closed reduction (teeth immobilized if present)	Not a covered benefit.	None	None
D7650	malar and/or zygomatic arch - open reduction	Not a covered benefit.	None	None
D7660	malar and/or zygomatic arch - closed reduction	Not a covered benefit.	None	None
D7670	alveolus - closed reduction, may include stabilization of teeth	Not a covered benefit.	None	None
D7671	alveolus - open reduction, may include stabilization of teeth	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: D7000-D7999 ORAL & MAXILLOFACIAL SURGERY**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D7680	facial bones-complicated reduction with fixation and multiple surgical approaches	Not a covered benefit.	None	None
D7710	maxilla - open reduction	Not a covered benefit.	None	None
D7720	maxilla - closed reduction	Not a covered benefit.	None	None
D7730	mandible - open reduction	Not a covered benefit.	None	None
D7740	mandible - closed reduction	Not a covered benefit.	None	None
D7750	malar and/or zygomatic arch - open reduction	Not a covered benefit.	None	None
D7760	malar and/or zygomatic arch - closed reduction	Not a covered benefit.	None	None
D7770	alveolus - open reduction stabilization of teeth	Not a covered benefit.	None	None
D7771	alveolus, closed reduction stabilization of teeth	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: D7000-D7999 ORAL & MAXILLOFACIAL SURGERY**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D7780	facial bones-complicated reduction with fixation and multiple approaches	Not a covered benefit.	None	None
D7810	open reduction of dislocation	Not a covered benefit.	None	None
D7820	closed reduction of dislocation	Not a covered benefit.	None	None
D7830	manipulation under anesthesia	Not a covered benefit.	None	None
D7840	condylectomy	Not a covered benefit.	None	None
D7850	surgical discectomy, with/without implant	Not a covered benefit.	None	None
D7852	disc repair	Not a covered benefit.	None	None
D7854	synovectomy	Not a covered benefit.	None	None
D7856	myotomy	Not a covered benefit.	None	None
D7858	joint reconstruction	Not a covered benefit.	None	None
D7860	anthrotomy	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: D7000-D7999 ORAL & MAXILLOFACIAL SURGERY**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D7865	arthroplasty	Not a covered benefit.	None	None
D7870	arthrocentesis	Not a covered benefit.	None	None
D7871	non-arthroscopic lysis and lavage	Not a covered benefit.	None	None
D7871	non-arthroscopic lysis and lavage	Not a covered benefit.	None	None
D7872	arthroscopy - diagnosis, with or without biopsy	Not a covered benefit.	None	None
D7873	arthroscopy: lavage and lysis of adhesions	Not a covered benefit.	None	None
D7874	arthroscopy: disc repositioning and stabilization	Not a covered benefit.	None	None
D7875	arthroscopy: synovectomy	Not a covered benefit.	None	None
D7876	arthroscopy: discectomy	Not a covered benefit.	None	None
D7877	arthroscopy: debridement	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: D7000-D7999 ORAL & MAXILLOFACIAL SURGERY**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D7880	occlusal orthotic device, by report	Not a covered benefit.	None	None
D7881	occlusal orthotic device adjustment	Not a covered benefit.	None	None
D7899	unspecified TMD therapy, by report	Not a covered benefit.	None	None
D7910	suture of recent small wounds up to 5 cm	By Report.	None	None
D7911	complicated suture - up to 5 cm	Not a covered benefit.	None	None
D7912	complicated suture - greater than 5 cm	Not a covered benefit.	None	None
D7920	skin graft (identify defect covered, location and type of graft)	Not a covered benefit.	None	None
D7921	collection and application of autologous blood concentrate product	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	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D7922	placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	Always integral.	None	None
D7939	indexing for osteotomy using dynamic robotic assisted or dynamic navigation	Not a covered benefit.	None	None
D7940	osteoplasty - for orthognathic deformities	Not a covered benefit.	None	None
D7941	osteotomy - mandibular rami	Not a covered benefit.	None	None
D7943	osteotomy - mandibular rami with bone graft; includes obtaining the graft	Not a covered benefit.	None	None
D7944	osteotomy - segmented or subapical	Not a covered benefit.	None	None
D7945	osteotomy - body of mandible	Not a covered benefit.	None	None
D7946	LeFort I (maxilla – total)	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: D7000-D7999 ORAL & MAXILLOFACIAL SURGERY**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D7947	LeFort I (maxilla – segmented)	Not a covered benefit.	None	None
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) – without bone graft	Not a covered benefit.	None	None
D7949	LeFort II or LeFort III – with bone graft	Not a covered benefit.	None	None
D7950	osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report	Not a covered benefit.	None	None
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	Not a covered benefit.	None	None
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) – without bone graft	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: D7000-D7999 ORAL & MAXILLOFACIAL SURGERY**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D7949	LeFort II or LeFort III – with bone graft	Not a covered benefit.	None	None
D7950	osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report	Not a covered benefit.	None	None
D7951	sinus augmentation with bone or bone substitutes via a lateral open approach	Not a covered benefit.	None	None
D7952	sinus augmentation via a vertical approach	Not a covered benefit.	None	None
D7953	bone replacement graft for ridge preservation - per site	Not a covered benefit.	None	None
D7955	repair of maxillofacial soft and/or hard tissue defect	Not a covered benefit.	None	None
D7956	guided tissue regeneration, edentulous area – resorbable barrier, per site	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: D7000-D7999 ORAL & MAXILLOFACIAL SURGERY**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D7957	guided tissue regeneration, edentulous area – non-resorbable barrier, per site	Not a covered benefit.	None	None
D7961	buccal/labial frenectomy (frenulectomy)	One (1) per lifetime.	None	Arch identification; Detailed narrative
D7962	lingual frenectomy (frenulectomy)	One (1) per lifetime.	None	Arch identification; Detailed narrative
D7963	frenuloplasty	No limitations.	None	Arch identification; Detailed narrative
D7970	excision of hyperplastic tissue - per arch	One (1) per arch per benefit period.	Not payable if filed in conjunction with D4210 or D4211	Arch identification; Operative report
D7971	excision of pericoronal gingiva	No limitations.	None	None
D7972	surgical reduction of fibrous tuberosity	Not a covered benefit.	None	None
D7979	non - surgical sialolithotomy	Not a covered benefit.	None	None
D7980	surgical sialolithotomy	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: D7000-D7999 ORAL & MAXILLOFACIAL SURGERY**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D7981	excision of salivary gland, by report	Not a covered benefit.	None	None
D7982	sialodochoplasty	Not a covered benefit.	None	None
D7983	closure of salivary fistula	Not a covered benefit.	None	None
D7990	emergency tracheotomy	Not a covered benefit.	None	None
D7991	coronoidectomy	Not a covered benefit.	None	None
D7993	surgical placement of craniofacial implant - extra oral	Not a covered benefit.	None	None
D7994	surgical placement: zygomatic implant	Not a covered benefit.	None	None
D7995	synthetic graft-mandible or facial bones, by report	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: D7000-D7999 ORAL & MAXILLOFACIAL SURGERY**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D7996	implant- mandible for augmentation purposes (excluding alveolar ridge), by report	Not a covered benefit.	None	None
D7997	appliance removal (not by dentist who placed appliance), includes removal of archbar	Not a covered benefit.	None	None
D7998	intraoral placement of a fixation device not in conjunction with a fracture	Not a covered benefit.	None	None
D7999	unspecified oral surgery procedure, by report	By report.	Individual Consideration.	Tooth identification, Detailed narrative

**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.

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

---

### **Orthodontic Benefit Administration**

#### **Limited Orthodontic Treatment**

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

#### **Interceptive Orthodontic Treatment**

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

#### **Comprehensive Orthodontic Treatment**

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

#### **How to Submit Claims - Please follow these guidelines when submitting claims for orthodontic treatment:**

Limited, Interceptive and Minor Treatment. Submit a claim with the appropriate CDT procedure code, including the total treatment fee and the placement date of the appliance. We will make payment after receipt of initial claim for treatment.

---

**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.

**Comprehensive Treatment.** One (1) installment equal to 25% of the lifetime maximum; pro-rated payments continue monthly until the treatment has ended or a new treatment plan including complete treatment plan information is submitted. For patients, whose comprehensive treatment started after their orthodontic benefits became effective, submit the claim with the appropriate CDT procedure code, including the treatment charge and the date treatment began. Payment will be prorated by comparing the banding date to the effective date of coverage and remaining length of treatment. (Accumulation transfers will be considered if provided by prior carrier.) If comprehensive treatment began before the patient's orthodontic benefits became effective, submit the monthly visits and your monthly fee using the appropriate CDT procedure code.

When submitting claims for the services included in orthodontic records, itemize the appropriate CDT procedure code for each service (e.g., radiographs, evaluation, study models) with your usual fee. If you have questions regarding a patient's coverage, effective dates, or benefits, call our Dental Call Center at 808-948-6440 on Oahu or 800-792-4672 from Neighbor Islands.

## Dentition

**Primary Dentition:** Teeth developed and erupted first in order of time.

**Transitional Dentition:** The final phase of the transition from primary to adult teeth, in which the deciduous molars and canines are in the process of shedding and the permanent successors are emerging.

**Adolescent Dentition:** The dentition that is present after the normal loss of primary teeth and prior to cessation of growth that would affect orthodontic treatment.

**Adult Dentition:** The dentition that is present after the cessation of growth that would affect orthodontic treatment.

All of the following orthodontic treatment codes may be used more than once for the treatment of a particular patient depending on the circumstance. A patient may require more than one interceptive procedure or more than one limited procedure depending on their problem.

## Limited Orthodontic Treatment

Orthodontic treatment utilizing any therapeutic modality with a limited objective or scale of treatment. Treatment may occur in any stage of dental development or dentition.

The objective may be limited by:

Not involving the entire dentition

Not attempting to address the full scope of the existing or developing orthodontic problem.

Mitigating an aspect of a greater malocclusion (i.e., crossbite, overjet, overbite, arch length, anterior alignment, one phase of multi-phase treatment, treatment prior to the permanent dentition, etc.)

A decision to defer or forego comprehensive treatment.

---

**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: D8000-D8999 ORTHODONTICS**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D8010</b>	<b>limited orthodontic treatment of the primary dentition</b>	A limited number of dental plans have orthodontic benefits.	For those plans that do include benefits for orthodontics see the Dental Manual, Orthodontia section for details on claim submission.	Diagnosis, banding date, and estimated length of treatment must be submitted with the claim.
<b>D8020</b>	<b>limited orthodontic treatment of the transitional dentition</b>	A limited number of dental plans have orthodontic benefits.	For those plans that do include benefits for orthodontics see the Dental Manual, Orthodontia section for details on claim submission.	Diagnosis, banding date, and estimated length of treatment must be submitted with the claim.
<b>D8030</b>	<b>limited orthodontic treatment of the adolescent dentition</b>	A limited number of dental plans have orthodontic benefits.	For those plans that do include benefits for orthodontics see the Dental Manual, Orthodontia section for details on claim submission.	Diagnosis, banding date, and estimated length of treatment must be submitted with the claim.
<b>D8040</b>	<b>limited orthodontic treatment of the adult dentition</b>	A limited number of dental plans have orthodontic benefits.	For those plans that do include benefits for orthodontics see the Dental Manual, Orthodontia section for details on claim submission.	Diagnosis, banding date, and estimated length of treatment must be submitted with the claim.
<b>D8070</b>	<b>comprehensive orthodontic treatment of the transitional dentition</b>	A limited number of dental plans have orthodontic benefits.	For those plans that do include benefits for orthodontics see the Dental Manual, Orthodontia section for details on claim submission.	Diagnosis, banding date, and estimated length of treatment must be submitted with the claim.

**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: D8000-D8999 ORTHODONTICS**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D8080</b>	<b>comprehensive orthodontic treatment of the adolescent dentition</b>	A limited number of dental plans have orthodontic benefits.	For those plans that do include benefits for orthodontics see the Dental Manual, Orthodontia section for details on claim submission.	Diagnosis, banding date, and estimated length of treatment must be submitted with the claim.
<b>D8090</b>	<b>comprehensive orthodontic treatment of the adult dentition</b>	A limited number of dental plans have orthodontic benefits.	For those plans that do include benefits for orthodontics see the Dental Manual, Orthodontia section for details on claim submission.	Diagnosis, banding date, and estimated length of treatment must be submitted with the claim.
<b>D8091</b>	<b>comprehensive orthodontic treatment associated with orthognathic surgery when additional surgical intervention is planned</b>	A limited number of dental plans have orthodontic benefits.	Covered under Ortho Rider. For those plans that do include benefits for orthodontics see the Dental Manual, Orthodontia section for details on claim submission. Limited to dependent children under Age 19.	Diagnosis, banding date, and estimated length of treatment must be submitted with the claim.
<b>D8210</b>	<b>removable appliance therapy</b>	A limited number of dental plans have orthodontic benefits.	For those plans that do include benefits for orthodontics see the Dental Manual, Orthodontia section for details on claim submission.	Diagnosis, banding date, and estimated length of treatment must be submitted with the claim.
<b>D8220</b>	<b>fixed appliance therapy</b>	A limited number of dental plans have orthodontic benefits.	For those plans that do include benefits for orthodontics see the Dental Manual, Orthodontia section for details on claim submission.	Diagnosis, banding date, and estimated length of treatment must be submitted with the claim.

**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: D8000-D8999 ORTHODONTICS

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D8660</b>	<b>pre-orthodontic treatment examination to monitor growth and development</b>	A limited number of dental plans have orthodontic benefits.	For those plans that do include benefits for orthodontics see the Dental Manual, Orthodontia section for details on claim submission.	Diagnosis, banding date, and estimated length of treatment must be submitted with the claim.
<b>D8670</b>	<b>periodic orthodontic treatment visit</b>	A limited number of dental plans have orthodontic benefits.	For those plans that do include benefits for orthodontics see the Dental Manual, Orthodontia section for details on claim submission.	Diagnosis, banding date, and estimated length of treatment must be submitted with the claim.
<b>D8671</b>	<b>periodic orthodontic treatment visit for comprehensive treatment associated with orthognathic surgery</b>	A limited number of dental plans have orthodontic benefits.	For those plans that do include benefits for orthodontics see the Dental Manual, Orthodontia section for details on claim submission. Limited to dependent children under Age 19. Integral to D8091.	Diagnosis, banding date, and estimated length of treatment must be submitted with the claim.
<b>D8680</b>	<b>orthodontic retention (removal of appliances, construction, and placement of retainer(s))</b>	A limited number of dental plans have orthodontic benefits.	Covered under Ortho Rider, Integral to D8091. For those plans that do include benefits for orthodontics see the Dental Manual, Orthodontia section for details on claim submission.	Diagnosis, banding date, and estimated length of treatment must be submitted with the claim.
<b>D8681</b>	<b>removable orthodontic retainer adjustment</b>	Not a covered benefit.	None	None
<b>D8695</b>	<b>removal of fixed orthodontic appliances for reasons other than completion of treatment</b>	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: D8000-D8999 ORTHODONTICS

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D8696</b>	<b>repair of orthodontic appliance - maxillary</b>	A limited number of dental plans have orthodontic benefits.	For those plans that do include benefits for orthodontics see the Dental Manual, Orthodontia section for details on claim submission.	Diagnosis, banding date, and estimated length of treatment must be submitted with the claim.
<b>D8697</b>	<b>repair of orthodontic appliance - mandibular</b>	A limited number of dental plans have orthodontic benefits.	For those plans that do include benefits for orthodontics see the Dental Manual, Orthodontia section for details on claim submission.	Diagnosis, banding date, and estimated length of treatment must be submitted with the claim.
<b>D8698</b>	<b>re-cement or re-bond fixed retainer - maxillary</b>	A limited number of dental plans have orthodontic benefits.	For those plans that do include benefits for orthodontics see the Dental Manual, Orthodontia section for details on claim submission.	Diagnosis, banding date, and estimated length of treatment must be submitted with the claim.
<b>D8699</b>	<b>re-cement or re-bond fixed retainer - mandibular</b>	A limited number of dental plans have orthodontic benefits.	For those plans that do include benefits for orthodontics see the Dental Manual, Orthodontia section for details on claim submission.	Diagnosis, banding date, and estimated length of treatment must be submitted with the claim.
<b>D8701</b>	<b>repair of fixed retainer, includes reattachment - maxillary</b>	Covered.	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	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D8702	repair of fixed retainer, includes reattachment - mandibular	Covered.	None	None
D8703	replacement of lost or broken retainer - maxillary	A limited number of dental plans have orthodontic benefits.	For those plans that do include benefits for orthodontics see the Dental Manual, Orthodontia section for details on claim submission.	Diagnosis, banding date, and estimated length of treatment must be submitted.
D8704	replacement of lost or broken retainer - mandibular	Not a covered benefit.	None	None
D8999	unspecified orthodontic procedure, by report	By report.	Individual Consideration. Detailed narrative required.	Detailed narrative

**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.

## XII. D9000-D9999 Adjunctive General Services

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D9110	Palliative treatment of dental pain – per visit	No limitations.	To be considered palliative, the procedure should alleviate but not curative; services provided do not have distinct procedure codes. Coverage is for the palliative 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.	<p>Tooth Quadrant or Arch identification</p> <p>A narrative description of procedure must accompany the claim</p> <p>Tooth identification</p>
D9120	fixed partial denture sectioning	By report.	Routine removal of a fixed partial denture prior to remake of the prosthesis is not covered separately. The procedure is by report. The patient must be age fifteen (15) and older	A narrative describing the procedure and tooth numbers are required with the claim
D9128	photobiomodulation therapy – first 15-minute increment, or any portion thereof	Not a covered benefit.	None	None
D9129	photobiomodulation therapy – each subsequent 15-minute increment, or any portion thereof	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: D9000-D9999 ADJUNCTIVE GENERAL SERVICES

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D9130	temporomandibular joint dysfunction - non-invasive physical therapies	Not a covered benefit.	None	None
D9210	local anesthesia not in conjunction with operative or surgical procedures	Not a covered benefit.	Considered part of total fee for non-surgical or surgical services.	None
D9211	regional block anesthesia	Not a covered benefit.	Considered part of total fee for non-surgical or surgical services.	None
D9212	trigeminal division block anesthesia	Not a covered benefit.	Considered part of total fee for non-surgical or surgical services.	None
D9215	local anesthesia in conjunction with operative or surgical procedures	Not a covered benefit.	Considered part of total fee for non-surgical or surgical services.	None
D9219	evaluation for moderate sedation, deep sedation, or general anesthesia	Not a covered benefit.	None	None
D9222	administration of deep sedation/general anesthesia - first 15 minute increment, or any portion thereof with or without co-administration of nitrous oxide	Deep sedation, general anesthesia is a covered benefit when medically necessary and claimed in conjunction with a covered oral surgical procedure code.	General anesthesia will be paid only when performed in conjunction with a covered oral surgical procedure code.	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: D9000-D9999 ADJUNCTIVE GENERAL SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D9223</b>	<b>administration of deep sedation/general anesthesia - each subsequent 15-minute increment, or any portion thereof</b>	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.	General anesthesia will be paid only when performed in conjunction with a covered oral surgical procedure code. Limited to two (2) times per session.	None
<b>D9224</b>	<b>Administration of general anesthesia with advanced airway – first 15-minute increment, or any portion thereof</b>	Not a covered benefit.	None	None
<b>D9225</b>	<b>general anesthesia with advanced airway – each subsequent 15-minute increment, or any portion thereof</b>	Not a covered benefit.	None	None
<b>D9230</b>	<b>administration of nitrous oxide when nitrous oxide is administered as a single agent</b>	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: D9000-D9999 ADJUNCTIVE GENERAL SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D9239</b>	<b>administration of moderate sedation - intravenous- first 15 minute increment, or any portion thereof. When moderate sedation is achieved by administration and titration of drug(s) intravenously. With or without co-administration of nitrous oxide</b>	Covered benefit when medically necessary and claimed in conjunction with a covered oral surgical procedure code.	Intravenous moderate (conscious) sedation/analgesia will be paid only when performed in conjunction with a covered oral surgical procedure code.	None
<b>D9243</b>	<b>administration of moderate sedation – intravenous - each subsequent 15-minute increment, or any portion thereof</b>	Covered benefit when medically necessary and claimed in conjunction with a covered oral surgical procedure code. Limited to two (2) times per session.	Intravenous moderate (conscious) sedation/analgesia will be paid only when performed in conjunction with a covered oral surgical procedure code. Limited to two (2) times per session.	None
<b>D9244</b>	<b>in-office administration of minimal sedation – single drug – enteral</b>	Not a covered benefit.	None	None
<b>D9245</b>	<b>administration of moderate sedation – enteral</b>	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: D9000-D9999 ADJUNCTIVE GENERAL SERVICES

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D9246	administration of moderate sedation – non-intravenous parenteral – first 15-minute increment, or any portion thereof	Not a covered benefit.	None	None
D9247	administration of moderate sedation – non-intravenous parenteral – each subsequent 15-minute increment, or any portion thereof	Not a covered benefit.	None	None
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	Not a covered benefit.	None	None
D9311	consultation with a medical health care professional	Not a covered benefit.	None	None
D9410	house/extended care facility call	Not a covered benefit.	None	None
D9420	hospital or ambulatory surgical center call	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: D9000-D9999 ADJUNCTIVE GENERAL SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D9430	office visit for observation (during regularly scheduled hours) - no other services performed	Not a covered benefit.	None	None
D9440	office visit - after regularly scheduled hours	By report.	This procedure may be paid in addition to other dental procedures.	Detailed narrative
D9450	case presentation, subsequent to detailed and extensive treatment planning	Not a covered benefit.	None	None
D9610	therapeutic parenteral drug, single administration	Not a covered benefit.	None	None
D9612	therapeutic parenteral drug, two (2) or more administrations, different medications	Not a covered benefit.	None	None
D9613	infiltration of sustained release therapeutic drug, per quadrant	Not a covered benefit.	None	None
D9630	drugs or medicaments dispensed in the office for home use	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: D9000-D9999 ADJUNCTIVE GENERAL SERVICES**

<b>CDT Code</b>	<b>Description of Service</b>	<b>Procedure Guidelines or Frequency Limitation</b>	<b>Limitations, Exclusions, and Integral Considerations</b>	<b>Submission Requirements: Participating Providers</b>
<b>D9910</b>	<b>application of desensitizing medicament</b>	Not a covered benefit.	None	None
<b>D9911</b>	<b>application of desensitizing resin for cervical and/or root surface, per tooth</b>	Not a covered benefit.	None	None
<b>D9912</b>	<b>pre-visit patient screening</b>	Not a covered benefit.	None	None
<b>D9913</b>	<b>administration of neuromodulators</b>	Not a covered benefit.	None	None
<b>D9914</b>	<b>administration of dermal fillers</b>	Not a covered benefit.	None	None
<b>D9920</b>	<b>behavior management, by report</b>	Not a covered benefit.	None	None
<b>D9930</b>	<b>treatment of complications (post-surgical) - unusual circumstances, by report</b>	Not a covered benefit.	None	None
<b>D9932</b>	<b>cleaning and inspection of removable complete denture, maxillary</b>	Not a covered benefit.	Integral to other services.	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: D9000-D9999 ADJUNCTIVE GENERAL SERVICES

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D9933	cleaning and inspection of removable complete denture, mandibular	Not a covered benefit.	Integral to other services.	None
D9934	cleaning and inspection of removable partial denture, maxillary	Not a covered benefit.	Integral to other services.	None
D9935	cleaning and inspection of removable partial denture, mandibular	Not a covered benefit.	Integral to other services.	None
D9936	cleaning and inspection of occlusal guard – per appliance	Not a covered benefit.	Integral to other services.	None
D9938	fabrication of a custom removable clear plastic temporary aesthetic appliance	Not a covered benefit.	None	None
D9939	placement of a custom removable clear plastic temporary aesthetic appliance	Not a covered benefit.	None	None
D9941	fabrication of athletic mouthguard	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: D9000-D9999 ADJUNCTIVE GENERAL SERVICES**

<b>CDT Code</b>	<b>Description of Service</b>	<b>Procedure Guidelines or Frequency Limitation</b>	<b>Limitations, Exclusions, and Integral Considerations</b>	<b>Submission Requirements: Participating Providers</b>
<b>D9942</b>	<b>repair and/or reline of occlusal guard</b>	Not a covered benefit.	None	None
<b>D9943</b>	<b>occlusal guard adjustment</b>	Not a covered benefit.	None	None
<b>D9944</b>	<b>occlusal guard - hard appliance, full arch</b>	Not a covered benefit.	None	None
<b>D9945</b>	<b>occlusal guard - soft appliance, full arch</b>	Not a covered benefit.	None	None
<b>D9946</b>	<b>occlusal guard – hard appliance, partial arch</b>	Not a covered benefit.	None	None
<b>D9947</b>	<b>custom sleep apnea appliance fabrication and placement</b>	Not a covered benefit.	None	None
<b>D9948</b>	<b>adjustment of custom sleep apnea appliance</b>	Not a covered benefit.	None	None
<b>D9949</b>	<b>repair of custom sleep apnea appliance</b>	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: D9000-D9999 ADJUNCTIVE GENERAL SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D9950</b>	<b>occlusion analysis - mounted case</b>	Not a covered benefit.	None	None
<b>D9951</b>	<b>occlusal adjustment - limited</b>	Not a covered benefit.	None	None
<b>D9952</b>	<b>occlusal adjustment - complete</b>	Not a covered benefit.	None	None
<b>D9953</b>	<b>reline custom sleep apnea appliance (indirect)</b>	Not a covered benefit.	None	None
<b>D9954</b>	<b>fabrication and delivery of oral appliance therapy (OAT) morning repositioning device</b>	Not a covered benefit.	None	None
<b>D9955</b>	<b>oral appliance therapy (OAT) titration visit</b>	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: D9000-D9999 ADJUNCTIVE GENERAL SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
<b>D9956</b>	<b>administration of home sleep apnea test</b>	Not a covered benefit.	None	None
<b>D9957</b>	<b>screening for sleep related breathing disorders</b>	Not a covered benefit.	None	None
<b>D9959</b>	<b>unspecified sleep apnea services procedure, by report</b>	Not Covered.	None	Tooth Quadrant or Arch identification and a detailed narrative.
<b>D9961</b>	<b>duplicate /copy patient's records</b>	Not a covered benefit.	None	None
<b>D9970</b>	<b>enamel microabrasion</b>	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: D9000-D9999 ADJUNCTIVE GENERAL SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D9971	odontoplasty - per tooth	Not a covered benefit.	None	None
D9972	external bleaching - per arch - performed in office	Not a covered benefit.	None	None
D9973	external bleaching - per tooth	Not a covered benefit.	None	None
D9974	internal bleaching - per tooth	Not a covered benefit.	None	None
D9975	external bleaching for home application, per arch; includes materials and fabrication of custom trays	Not a covered benefit.	None	None
D9985	sales tax	Covered benefit for Federal plan only.	Tax is reimbursable for federal plan members based on the HMSA eligible charge for covered services.	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: D9000-D9999 ADJUNCTIVE GENERAL SERVICES

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D9986	missed appointment	Not a covered benefit.	None	None
D9987	cancelled appointment	Not a covered benefit.	None	None
D9990	certified translation or sign-language services - per visit	Not a covered benefit.	None	None
D9991	dental case management - addressing appointment compliance barriers	Not a covered benefit.	None	None
D9992	dental case management - care coordination	Not a covered benefit.	None	None
D9993	dental case management - motivational interviewing	Not a covered benefit.	None	None
D9994	dental case management - patient education to improve health literacy	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: D9000-D9999 ADJUNCTIVE GENERAL SERVICES**

CDT Code	Description of Service	Procedure Guidelines or Frequency Limitation	Limitations, Exclusions, and Integral Considerations	Submission Requirements: Participating Providers
D9995	teledentistry - synchronous; real-time encounter	Not a covered benefit.	None	None
D9996	teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	Not a covered benefit.	None	None
D9997	dental case management - patients with special health care needs	Not a covered benefit.	None	None
D9999	unspecified adjunctive procedure, by report	By report.	Individual Consideration.	Tooth Quadrant or Arch identification and a detailed narrative.

**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.