

# Dentist Handbook

## National Processing Policies

### Introductory Note

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

### General Policies

General policies (GP) related to each category of procedure codes precede the category code listing. Policies for specific procedure codes are listed in each category after the codes and nomenclature.

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

- Allowance:** The amount of Delta Dental's payment for the procedure benefited.
- Approved Amount:** The total fee a participating dentist agrees to accept as payment in full for a procedure. It includes both the Delta Dental allowance and the patient responsibility. Participating dentists agree not to collect from the patient any difference between the approved amount and their actual fee for the procedure.
- Denied/Deny** If the fee for a procedure or service is denied, the procedure or service is not a benefit of the patient's coverage and the approved amount is collectable from the patient. As previously stated, specific group contract provisions take precedence over processing policies. It is recommended that the dental office contact the appropriate member company for the group account to determine the specific benefits, limitations and exclusions for each group.
- Disallowed:** If the fee for a procedure or service is disallowed, it is not benefited by Delta Dental nor collectable from the patient by a participating dentist.
- Alternative Benefit:** In cases where alternative methods of treatment exist, benefits are provided for the least costly, professionally acceptable treatment. This determination is not to recommend which treatment should be provided. It is a determination of benefits under terms of the

patient's coverage. The dentist and patient should decide the course of treatment. If the treatment rendered is other than the one benefited, the difference between Delta Dental's allowance and the approved amount for the actual treatment rendered is collectable from the patient.

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

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

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

- Documentation of extraordinary circumstances can be submitted for review by report.
- Fees for completion of claim forms and submission of documentation to Delta Dental to enable benefit determination are not benefits. They are not collectable from the patient by a participating dentist.
- **Infection control and OSHA compliance is included in the fee for the dental services provided. Separate fees are disallowed and not collectable separately from the patient by a participating dentist.**
- Multistage procedures are reported and benefited upon completion. The completion date is the date of insertion for removable prosthetic appliances. The completion date for immediate dentures is the date that the remaining teeth are removed and the denture is inserted. The completion date for fixed partial dentures and crowns, onlays, and inlays is the cementation date regardless of the type of cement utilized. The completion date for endodontic treatment is the date the canals are permanently filled.
- Charges for procedures determined not to be necessary or not meeting generally accepted standards of care may be denied or disallowed. Many of the processing policies that follow detail payment procedures that are based on the timing and sequence of inter-related procedures. However, the timing and sequencing of treatment is the responsibility of the dentist rendering care and should always be determined by the treating dentist based on the patient's needs.
- When a procedure is by report and subject to coverage under medical, it should be submitted to the patient's medical carrier first. When submitting to Delta Dental, a copy of the explanation of payment or payment voucher from the medical carrier should be included with the claim, plus a narrative describing the procedure performed, reasons for performing the procedure, pathology report if appropriate, and any other information deemed pertinent. In the absence of such information, the procedure will not be benefited by Delta Dental.

## DIAGNOSTIC            D0100 - D0999

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### **Clinical Oral Evaluations**

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

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

D0120    Periodic oral evaluation – established patient

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

D0140    Limited oral evaluation-problem focused

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

This evaluation is not a comprehensive evaluation. Therefore, a comprehensive oral evaluation (D0150) is allowed for the same patient and by the same dentist at a subsequent date.

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

**Benefits for oral evaluation for a patient under three years when billed on the same date and by the same dental office as a comprehensive oral evaluation (D0150) are considered included in the D0150 as the more inclusive procedure. The fee for the D0145 is DISALLOWED.**

Benefits for D0145 for a child over three years of age will be DENIED.

D0150    Comprehensive oral evaluation – new or established patient

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

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

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

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

Detailed and extensive oral evaluation-problem focused, by report is processed as comprehensive oral evaluation (D0150) for the first encounter with the dentist/dental office and subsequent submissions are processed as periodic oral evaluations (D0120).

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

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

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

**The fees for re-evaluation are DISALLOWED in conjunction with any other service or procedure by the same dentist/dental office. When covered, the re-evaluation is subject to the same processing policies as limited oral evaluation- problem focused (D0140).**

D0180 Comprehensive periodontal evaluation - new or established patient

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

This evaluation code will be used primarily by a periodontist for a referred patient from a general dentist and should not be reported in addition to a comprehensive oral evaluation (D0150) by the same dentist in the same treatment series. This procedure is not intended for use as a separate code for periodontal charting.

**If a D0180 is submitted with D4910 by the same dentist/dental office it is benefited as a D0120 and the difference in the approved amount between D0120 and D0180 is DISALLOWED.**

#### **Radiographs/Diagnostic Imaging (Including Interpretation)**

GP **Diagnostic services must be necessary. If the need is not evident from the information submitted, fees for radiographs are DISALLOWED.**

GP **Fees for duplication (copying) of radiographs for insurance purposes are DISALLOWED.**

GP **Fees for non-diagnostic radiographs, as determined by consultant review, are DISALLOWED.**

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

D0210 Intraoral-complete series (including bitewings).

**The fee for any type of bitewings submitted with a full mouth series are considered part of the full mouth series for payment and benefit purposes. Any fee in excess of a full mouth series is DISALLOWED.**

**In the absence of contract language for bitewing frequency limitation, bitewings, of any type, are DISALLOWED within 12 months of a full mouth series.**

**A separate fee for a panoramic x-ray (D0330) in conjunction with D0210 by the same dentist/dental office is DISALLOWED as a component part of D0210.**

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

- D0220 Intraoral-periapical-first film
- D0230 Intraoral-periapical-each additional film

**Routine working and final treatment radiographs taken by the same dentist/dental office for endodontic therapy are considered a component of the complete treatment procedure. Separate fees for these films are DISALLOWED.**

- D0240 Intraoral-occlusal film
- D0250 Extraoral-first film
- D0260 Extraoral-each additional film
- D0270 Bitewing-single film
- D0272 Bitewings-two films
- D0273 Bitewings- three films
- D0274 Bitewings-four films
- D0277 Vertical bitewings - 7 to 8 films

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

- D0290 Posterior-anterior or lateral skull and facial bone survey film
- D0310 Sialography
- D0320 Temporomandibular joint arthrogram including injection
- D0321 Other temporomandibular joint films, by report
- D0322 Tomographic survey
- D0330 Panoramic film

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

Benefits for subsequent panoramic radiographs taken within the contractual time limitation for a full mouth series are DENIED and the approved amount is collectable from the patient.

- D0340 Cephalometric film

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

- D0350 Oral/facial photographic images

**Oral/facial images are benefited only once per case in conjunction with orthodontic services. The fees for additional images taken during or after orthodontic treatment by the same dentist/dental office are included in the fee for orthodontics and DISALLOWED.**

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

- D0360 Cone beam ct – craniofacial data capture (includes axial, coronal and sagittal data.)

The fee for the cone beam-craniofacial data capture is DENIED as a specialized procedure.

D0362 Cone beam – two dimensional image reconstruction using existing data, includes multiple images

The fee for the cone beam – two dimensional image reconstruction using existing data, includes multiple images is DENIED as a specialized procedure.

D0363 Cone beam – three dimensional image reconstruction using existing data, includes multiple images

The fee for the cone beam – three dimensional image reconstruction using existing data, includes multiple images is DENIED as a specialized procedure.

### **Tests and Examinations**

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

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

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

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

D0474           most inclusive  
D0473  
D0472

D0415 Collection of microorganisms for culture and sensitivity

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

D0416 Viral culture

Studies for determining pathologic agents are specialized procedures and the fees are DENIED.

D0417 Collection and preparation of saliva sample for laboratory diagnostic testing

The fees for the collection and preparation of a saliva sample are DENIED and the approved amount is collectable from the patient

D0418 Analysis of saliva sample

The fee for the analysis of a saliva sample are DENIED and the approved amount is collectable from the patient

D0421 Genetic test for susceptibility to oral diseases

Genetic tests for susceptibility to periodontal diseases are specialized procedures and fees are DENIED.

D0425 Caries susceptibility tests

The fees for caries susceptibility tests are DENIED and the approved amount is collectable from the patient.

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

Code D0431 is considered investigational and fees are DENIED.

D0460 Pulp vitality tests

Pulp vitality tests are payable per visit, not per tooth, and only for the diagnosis of emergency conditions. **Fees for pulp tests are DISALLOWED when performed on the same date by the same dentist/dental office as any other definitive procedure except D0140 limited oral evaluation- problem focused or D9110 palliative treatment.**

D0470 Diagnostic casts

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

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

#### **Oral Pathology Laboratory (use codes D0472 - D0474)**

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

**GP All oral pathology procedures must be accompanied by a pathology report to be considered for payment. A fee for pathology procedure not accompanied by a pathology report is DISALLOWED.**

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

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

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

D0475 Decalcification procedure

D0476 Special stains for microorganisms

D0477 Special stains, not for microorganisms

D0478 Immunohistochemical stains

D0479 Tissue in-site hybridization, including interpretation

D0480 Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report

D0481 Electron microscopy – diagnostic

D0482 Direct immunofluorescence

D0483 Indirect immunofluorescence

D0484 Consultation on slides prepared elsewhere

Consultation on slides prepared elsewhere is paid as D9310 – Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment).

D0485 Consultation, including preparation of slides from biopsy material supplied by referring source

Benefits should be administered with the same processing policies, system edits and paid as codes D0472, D0473 or D0474 based on the complexity of the report.

D0486 Laboratory accession of brush biopsy sample, microscopic examination, preparation and transmission of written report

D0502 Other oral pathology procedures, by report

The fees for other oral pathology procedures for routine surgical procedures are DENIED and the approved amount is collectable from the patient.

D0999 Unspecified diagnostic procedure, by report

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

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**GP A fee for a prophylaxis done during the same episode of treatment by the same dentist/dental office as a periodontal maintenance or scaling and root planing is considered to be part of those procedures and is DISALLOWED.**

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

**Dental Prophylaxis**

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

D1110 Prophylaxis-adult

D1120 Prophylaxis-child

**Topical Fluoride Treatment (office procedure)**

**GP A prophylaxis paste containing fluoride, a fluoride rinse, or fluoride swish in conjunction with a prophylaxis is considered a prophylaxis only and a separate fee is DISALLOWED.**

GP The age limitation for topical fluoride gel or varnish treatments is limited by contract usually up to age 19.

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

D1203 Topical application of fluoride-child

D1204 Topical application of fluoride-adult

D1206 Topical fluoride varnish; therapeutic application for moderate to high caries risk patients

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

Benefits for topical fluoride treatments are determined by the group contract.

**Other Preventive Services**

D1310 Nutritional counseling for the control of dental disease

The fee for nutritional counseling is DENIED and the approved amount is collectable from the patient.

D1320 Tobacco counseling for the control and prevention of oral disease

The fee for tobacco counseling is DENIED and the approved amount is collectable from the patient.

D1330 Oral hygiene instructions

The fee for oral hygiene instruction is DENIED and the approved amount is collectable from the patient.

D1351 Sealant-per tooth

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

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

The fees for sealants are DENIED and the approved amount is collectable from the patient when submitted documentation or the patient's claim history indicates an existing restoration on the occlusal surface of the same tooth.

**The fee for repair or replacement of a sealant by the same dentist within two years of initial placement is included in the fee for the initial placement and is DISALLOWED.** The fee for repair or replacement of a sealant by a different dentist within two years of initial placement is DENIED and the approved amount is collectable from the patient.

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

#### **Space Maintenance (passive appliances)**

GP The fee for repair or replacement of a space maintainer is DENIED and the approved amount is collectable from the patient.

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

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

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

D1510 Space maintainer-fixed unilateral

D1515 Space maintainer-fixed bilateral

D1520 Space maintainer-removable unilateral

D1525 Space maintainer-removable bilateral

D1550 Re-cementation of a space maintainer

One recementation of a space maintainer is allowed per dental office. The fees for subsequent requests for recementation by the same office are DENIED and the approved amount is collectable from the patient.

D1555 Removal of fixed space maintainer

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

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

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- GP** The fee for a restoration includes services such as, but not limited to, adhesives, etching, liners, bases, direct and indirect pulp caps, local anesthesia, polishing, occlusal adjustment, caries removal, and gingivectomy done on the same date of service as the restoration. A separate fee for any of these procedures by the same dentist/dental office is **DISALLOWED**.
- GP** A fee for the replacement of amalgam or composite restorations, same tooth and same surface(s), is **DISALLOWED** if done by the same dentist within 24 months of the initial restoration. Benefits may be **DENIED** and the approved amount for the restoration collectable from the patient if done by a different dentist/dental office.
- GP** When multiple restorations involving the proximal and occlusal surfaces of the same tooth are requested or performed, the allowance is limited to that of a multi-surface restoration. Any fee charged in excess of the allowance for the multi-surface restoration by the same dentist/dental office is **DISALLOWED**. A separate benefit may be allowed for a non contiguous restoration on the buccal or lingual surface(s) of the same tooth.
- GP** Any restoration involving two or more contiguous surfaces should be reported using the appropriate multiple surface restoration code.
- GP** When restorations not involving the occlusal surface are requested or performed on posterior teeth, the allowance is limited to that of a one surface restoration. Any fee charged in excess of the allowance for the one-surface restoration is **DISALLOWED**.
- GP** Benefits are allowed only once per surface in a 24 month interval, irrespective of the number or combination of procedures requested or performed. A fee for restoration of a surface within 24 months of previous treatment is **DISALLOWED** if done by the same dentist/dental office and **DENIED** and the approved amount is collectable from the patient if done by a different dentist/dental office.
- GP** Multistage procedures are reported and benefited upon completion. The completion date is the date of insertion for removable prosthetic appliances. The completion date for fixed partial dentures and crowns, onlays, and inlays is the cementation date regardless of the type of cement utilized.
- GP** If an indirectly fabricated restoration is performed by the same dentist within 24 months of the placement of an amalgam or composite restoration the Delta Dental payment and patient co-payment allowance for the amalgam or composite restorations will be deducted from the indirectly fabricated restoration benefit.
- GP** **Tooth preparation, temporary restorations, cement bases, impressions, laboratory fees and material, occlusal adjustment, gingivectomies (on the same date of service), and local anesthesia are considered to be included in the fee for a all restorations, and a separate fee for any of these procedures by the same dentist/dental office is DISALLOWED. Fees for buildups, not required for retention are DISALLOWED.**
- GP** The fees for restorations for altering occlusion, involving vertical dimension, replacing tooth structure lost by attrition, erosion, abrasion, abfraction, corrosion, TMD or for periodontal, orthodontic, or other splinting are **DENIED** and the approved amount is collectable from the patient.

## **Definitions**

### **Attrition**

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

### **Abrasion**

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

### **Erosion**

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

### **Abfraction**

Wedge-shaped lesions occurring in the cervical enamel. Can result from occlusal loading and flexure in the area. (Dorland's Illustrated Medical Dictionary, 25th edition 1975).

For classification of metals see the ADA CDT Manual.

## **Amalgam Restorations (including polishing)**

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

## **Resin-Based Composite Restorations-Direct**

- GP In the event an anterior proximal restoration involves a significant portion of the labial or lingual surface, it may be reported as D2331 or D2332, as appropriate.
- GP Preventive resin restorations are considered sealants for payment purposes. If no decay is present or the decay does not penetrate into the dentin, the procedure will be processed as a sealant. They are subject to all contractual limitations, exclusions, approved amounts and processing policies applicable to sealants. Any fee charged in excess of the allowance for a sealant is DENIED and collectable from the patient up to the approved amount for the restoration.
- D2330 Resin-based composite - one surface, anterior
- D2331 Resin-based composite - two surfaces, anterior
- D2332 Resin-based composite - three surfaces, anterior
- D2335 Resin-based composite - four or more surfaces or involving the incisal angle (anterior)
- D2390 Resin-based composite crown, anterior

- D2391 Resin - based composite - one surface, posterior
- D2392 Resin - based composite - two surfaces, posterior
- D2393 Resin - based composite - three or more surfaces, posterior
- D2394 Resin - based composite - four or more surfaces, posterior

GP Single surface resin restorations on posterior teeth are a benefit only on the buccal surfaces of bicuspids. If done on posterior molars, an alternate benefit allowance up to that for amalgam is made and any fee charged in excess of the allowance is DENIED and is collectable from the patient up to the approved amount for the resin-based posterior composite restoration.

GP Multi-surface posterior resin restorations are considered optional and an allowance is made for a comparable amalgam restoration according to the policies for amalgam. The difference between the allowance for the amalgam restoration and the approved amount for the resin restoration is DENIED and collectable from the patient.

### **Gold Foil Restorations**

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

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

### **Inlay/ Onlay Restorations**

GP When the retentive quality of a tooth qualifies for an onlay, benefits are based on the submitted procedure. If an alternate benefit allowance is applied, the difference between the allowance for the alternative benefit and the approved amount for the inlay/onlay restoration is DENIED and collectable from the patient.

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

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

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

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

- D2510 Inlay - metallic - one surface
- D2520 Inlay - metallic - two surfaces
- D2530 Inlay - metallic - three or more surfaces
- D2542 Onlay - metallic - two surfaces
- D2543 Onlay - metallic - three surfaces
- D2544 Onlay - metallic - four or more surfaces

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

- D2610 Inlay - porcelain/ceramic - one surface
- D2620 Inlay - porcelain/ceramic - two surfaces
- D2630 Inlay - porcelain/ceramic - three or more surfaces
- D2642 Onlay - porcelain/ceramic - two surfaces
- D2643 Onlay - porcelain/ceramic - three surfaces
- D2644 Onlay - porcelain/ceramic - four or more surfaces

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

- D2650 Inlay - resin - based composite - one surface
- D2651 Inlay - resin - based composite - two surfaces
- D2652 Inlay - resin - based composite - three or more surfaces
- D2662 Onlay - resin - based composite - two surfaces
- D2663 Onlay - resin - based composite - three surfaces
- D2664 Onlay - resin - based composite - four or more surfaces

#### **Crowns - Single Restorations Only**

- GP Crowns and indirectly fabricated restorations are optional benefits unless the tooth is damaged by decay or fracture to the point it cannot be restored by an amalgam or resin restoration. If the fee for a crown or indirectly fabricated restoration is not allowed, an alternate benefit allowance for an amalgam or resin restoration is made according to the policies for those restorations and the difference between the allowance for the amalgam or resin restoration and the approved amount for the crown or cast or indirectly fabricated restoration is DENIED and collectable from the patient.
- GP The fees for crowns and onlays are DENIED and the approved amount is collectable from the patient for children under 12 years of age.

For classification of metals see the ADA CDT Manual.

- D2710 Crown - resin-based composite (indirect)
- D2712 Crown -  $\frac{3}{4}$  resin-based composite (indirect)
- D2720 Crown - resin with high noble metal
- D2721 Crown - resin with predominantly base metal
- D2722 Crown - resin with noble metal
- D2740 Crown - porcelain/ceramic substrate
- D2750 Crown - porcelain fused to high noble metal
- D2751 Crown - porcelain fused to predominantly base metal
- D2752 Crown - porcelain fused to noble metal
- D2780 Crown -  $\frac{3}{4}$  cast high noble metal
- D2781 Crown -  $\frac{3}{4}$  cast predominantly base metal
- D2782 Crown -  $\frac{3}{4}$  cast noble metal
- D2783 Crown -  $\frac{3}{4}$  porcelain/ceramic
- D2790 Crown - full cast high noble metal
- D2791 Crown - full cast predominantly base metal
- D2792 Crown - full cast noble metal
- D2794 Crown - titanium
- D2799 Provisional crown

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

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

## Other Restorative Services

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

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

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

D2910 Recement inlay, onlay, or partial coverage restoration

D2915 Recement cast or prefabricated post and core

D2920 Recement crown

D2930 Prefabricated stainless steel crown - primary tooth

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

D2931 Prefabricated stainless steel crown - permanent tooth

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

D2932 Prefabricated resin crown

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

D2933 Prefabricated stainless steel crown with resin window

A prefabricated stainless steel crown with resin window is a benefit only on anterior primary teeth. If submitted for a posterior primary tooth or for a permanent tooth, an alternate benefit allowance for D2930 or D2931 is made. The difference between the allowance for the D2930 or D2931 and the approved amount for the D2933 is DENIED and collectable from the patient.

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

D2934 Prefabricated esthetic coated stainless steel crown – primary tooth

A prefabricated esthetic coated stainless steel crown is a benefit only on anterior primary teeth. If submitted for a posterior primary tooth or for a permanent tooth, an alternate benefit allowance for D2930

or D2931 is made. The difference between the allowance for the D2930 or D2931 and the approved amount for the D2934 is DENIED and collectable from the patient

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

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

D2940 Sedative filling

Sedative fillings are a benefit for emergency relief of pain.

**A separate fee for sedative filling is DISALLOWED when performed in conjunction with a definitive restoration by the same dentist/dental office.**

02950 Core buildup, including any pins

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

**A separate fee for a buildup is DISALLOWED when radiographs indicate sufficient tooth structure remains to support a cast or indirectly fabricated restoration.**

D2951 Pin retention-per tooth, in addition to restoration

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

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

D2952 Post and core in addition to crown, indirectly fabricated

**An indirectly fabricated post and core in addition to crown is a benefit only on an endodontically treated tooth. The fee for an indirectly fabricated post and core is DISALLOWED when radiographs indicate an absence of endodontic treatment, incompletely filled canal space, or unresolved pathology associated with the involved tooth.**

**An indirectly fabricated post and core in anterior teeth is a benefit only when there is insufficient tooth structure to support a cast or indirectly fabricated restoration. If sufficient tooth structure remains, a fee for a post and core is DISALLOWED.**

D2953 Each additional indirectly fabricated post- same tooth

D2954 Prefabricated post and core in addition to crown

**A prefabricated post and core in addition to crown is a benefit only on an endodontically treated tooth. The fee for a prefabricated post and core is DISALLOWED when radiographs indicate an absence of endodontic treatment, incompletely filled canal space, or unresolved pathology associated with the involved tooth.**

**A prefabricated post and core in anterior teeth is a benefit only when there is insufficient tooth structure to support a cast or indirectly restoration. If sufficient tooth structure remains, a fee for a post and core is DISALLOWED.**

D2955 Post removal (not in conjunction with endodontic therapy)

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

D2957 Each additional prefabricated post in the same tooth

D2960 Labial veneer (resin laminate) – chairside

D2961 Labial veneer (resin laminate) - laboratory

D2962 Labial veneer (porcelain laminate) – laboratory

A veneer is considered optional. An alternate benefit allowance is made for the restorative procedure appropriate to the degree of tooth breakdown. The difference between the allowance for the restorative procedure and the approved amount for the veneer is DENIED and collectable from the patient.

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

D2970 Temporary crown (fractured tooth)

**The fee for a temporary crown by the same dentist/dental office is DISALLOWED as a component of the fee for a permanent crown.**

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

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

D2975 Coping

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

D2980 Crown repair, by report

D2999 Unspecified restorative procedure, by report

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

**Pulp Capping**

**GP A separate fee for a pulp cap by the same dentist/dental office is DISALLOWED as a component of a sedative filling.**

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

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

D3110 Pulp cap-direct (excluding final restoration)

D3120 Pulp cap-indirect (excluding final restoration)

**Pulpotomy**

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

A therapeutic pulpotomy is only benefited when performed on primary teeth. The fee for a pulpotomy provided on a permanent tooth is DENIED and the approved amount is collectable from the patient.

D3221 Pulpal debridement, primary and permanent teeth

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

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

**Endodontic Therapy on Primary Teeth**

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

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

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

**GP The fee for a root canal includes treatment x-rays and temporary restorations. Any additional fee charged by the same dentist/dental office is DISALLOWED.**

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

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

- D3310 Endodontic therapy - anterior (excluding final restoration)
- D3320 Endodontic therapy - bicuspid (excluding final restoration)
- D3330 Endodontic therapy - molar (excluding final restoration)

**A separate fee for palliative treatment is DISALLOWED when done in conjunction with root canal therapy by the same dentist/dental office on the same date of service.**

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

- D3331 Treatment of root canal obstruction; non-surgical access

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

Post removal is not included in this procedure.

- D3332 Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth

D3332 is subject to individual consideration, by report.

When approved, the procedure is subject to the same processing policies as the corresponding root canal therapy for the tooth involved (D3310-D3330).

- D3333 Internal root repair of perforation defects

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

**The fee for the procedure (D3333) is DISALLOWED when done in conjunction with an apicoectomy and/or retrograde filling by the same dentist/dental office.**

The fee for D3333 is DENIED if reported on a primary tooth.

#### **Endodontic Retreatment**

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

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

- D3346 Retreatment of previous root canal therapy - anterior
- D3347 Retreatment of previous root canal therapy - bicuspid
- D3348 Retreatment of previous root canal therapy – molar

#### **Apexification/Recalcification Procedures**

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

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

D3352 Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)

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

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

#### **Apicoectomy/Periradicular Services**

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

D3410 Apicoectomy/periradicular surgery - anterior

D3421 Apicoectomy/periradicular surgery - bicuspid (first root)

D3425 Apicoectomy/periradicular surgery - molar (first root)

D3426 Apicoectomy/periradicular surgery (each additional root)

D3430 Retrograde filling - per root

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

D3450 Root amputation - per root

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

D3460 Endodontic endosseous implant

D3470 Intentional reimplantation (including necessary splinting)

Intentional reimplantation is considered a specialized procedure. The fees are DENIED and the approved amount is collectable from the patient.

#### **Other Endodontic Procedures**

D3910 Surgical procedure for isolation of tooth with rubber dam

**A separate fee for isolation of a tooth with a rubber dam by the same dentist/dental office is DISALLOWED as a component of the fee for the procedure performed.**

D3920 Hemisection (including any root removal), not including root canal therapy

D3950 Canal preparation and fitting of preformed dowel or post

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

D3999 Unspecified endodontic procedure, by report

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

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

**D4260 (most inclusive), D4261, D4249, D4245, D4268, D4240, D4241, D4274, D4230, D4231, 4210, D4211, D4341, D4342, D4355, D4910, D1110, D1120(least inclusive)**

GP Periodontal services are only benefited when performed on natural teeth for treatment of periodontal disease. Unless otherwise specified by contract, benefits for these procedures when billed in conjunction with implants, ridge augmentation, extraction sites and/or periradicular surgery are DENIED and the approved amount is collectable from the patient.

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

GP The following categorizes procedures for reporting and adjudicating by quadrant, site or individual tooth in order to enhance standard benefits determination and expedite claims processing.

Periodontal therapy includes the following: previous periodontal surgery, osseous flap, scaling and root planning.

Diseased teeth/periodontium definition:

For processing purposes periodontally involved teeth that would qualify for surgical pocket reduction benefits under procedure codes D4210, D4211, D4240, D4241, D4260 and D4261 must be documented to have at least 5mm. pocket depths. If pocket depths are less than 5mm, the surgical procedure is DENIED and the approved amount collectable from the patient.

In the case of procedure codes D4341 and D4342 there must be documentation of at least 4mm. pockets on the diseased teeth/periodontium involved. **In the absence of 4mm. pockets, a benefit allowance for a prophylaxis (D1110) is made and any fee in excess of the approved amount for D1110 is DISALLOWED and not chargeable to the patient.**

Quadrant: D4210, D4230, and D4341: Four or more diseased teeth/periodontium distal to the midline are considered a quadrant. Tooth bounded spaces are not counted in making this determination. When these periodontal procedures do not meet all of these criteria use codes D4211, D4231 and D4342 respectively.

D4240, D4260: Four or more diseased teeth/periodontium or bounded tooth spaces distal to the midline are considered a quadrant. A tooth bounded space counts as one space irrespective of the number of teeth that would normally exist in the space. When these procedures do not meet all of these criteria use codes D4241 and D4261 respectively.

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

Site: D4245, D4249, D4263, D4264, D4265, D4266, D4267, D4270, D4271, D4274, and D4275  
One to three diseased teeth/periodontium per quadrant: D4211, D4231 D4241, D4261, D4342

Per tooth: D4268, D4273, D4276 D4381

**Surgical Services (including usual postoperative care)**

**GP Periodontal surgical procedures include all necessary postoperative care, finishing procedures (D1110, D1120, D4341, D4342, D4355, D4910), evaluations for three months, as well as any surgical re-entry (except soft tissue grafts) for three years. When a surgical procedure is billed within three months of the initial surgical procedure by the same dentist/dental office, the fee for the surgery is DISALLOWED. In the absence of documentation of extraordinary circumstances, the fee for additional surgery by the same dentist/dental office for three years is DISALLOWED.**

**In the absence of documentation of extraordinary circumstances, fees for additional surgery by the same dentist/dental office within three years of the initial surgery are DISALLOWED (except soft tissue grafts).** If extraordinary circumstances are present the benefits will be DENIED and are the patient's responsibility up to the approved amount for the surgery.

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

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

**GP Providing more than two D4245, D4265, D4266, D4267, D4268, D4270, D4271, D4273, D4275, D4276 or osseous grafts (D4263,D4264) within any given quadrant should be highly unusual and additional submissions will only be considered on a by report basis. Requested fees for more than two sites in a quadrant may be DISALLOWED.** When documentation of exceptional circumstances is submitted, benefits may be DENIED, unless covered, dependent on group contract language.

D4210 Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant  
D4211 Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant,

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

Only diseased teeth/periodontium,(see definition on page 20) are eligible for benefit consideration.  
Bounded tooth spaces are not counted as the procedure does not require a flap extension.

D4230 Anatomical crown exposure – four or more contiguous teeth per quadrant  
D4231 Anatomical crown exposure – one to three teeth per quadrant

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

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

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

Benefits are based upon, but not limited to, the most inclusive procedure. A tooth bounded space counts as one space irrespective of the number of teeth that would normally exist in the space. Only diseased teeth/periodontium, use definition on page 20, are eligible for benefit consideration.

D4245 Apically positioned flap

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

D4249 Clinical crown lengthening - hard tissue

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

**Crown lengthening is a benefit per site, not per tooth, and only when bone is removed and sufficient time is allowed for healing. Any fee for crown lengthening is DISALLOWED when performed on the same date as crown preparation or restorations by the same dentist/dental office without adequate documentation.**

D4260 Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.

D4261 Osseous surgery (including flap entry and closure) – one to three contiguous teeth, or tooth bounded spaces per quadrant.

No more than two quadrants of osseous surgery on the same date of service are benefited, in the absence of a narrative explaining exceptional circumstance.

**For benefit purposes, the fee for osseous surgery includes crown lengthening, osseous contouring, distal or proximal wedge surgery, scaling and root planing, gingivectomy, frenectomy, anatomical crown exposure, and flap procedures. A separate fee for any of these procedures done on the same date, in the same surgical area by the same dentist/dental office, as D4260 is DISALLOWED. A separate benefit may be available for soft tissue grafts, osseous grafts, exostosis removal, hemisection, extraction, apicoectomy, root amputations, and new attachment procedures.**

For dental benefit reporting purposes a quadrant is defined as four or more contiguous teeth and tooth bounded spaces per quadrant. A tooth bounded space counts as one space irrespective of the number of teeth that would normally exist in the space. Only diseased teeth/periodontium, (see definition on page 20), are eligible for benefit consideration.

D4263 Bone replacement graft - first site in quadrant

D4264 Bone replacement graft - each additional site in quadrant

Benefits for bone grafting are available only when billed for natural teeth and performed for periodontal purposes. When billed in conjunction with implants, ridge augmentations, extraction sites, periradicular surgery, etc., the fee for bone grafting is DENIED and the approved amount is collectable from the patient.

D4265 Biologic materials to aid in soft and osseous tissue regeneration

Biologic materials may be eligible for stand-alone benefits when reported with periodontal flap surgery and only when billed for natural teeth and performed for periodontal purposes. Benefits for these procedures when billed in conjunction with implants, ridge augmentation, extraction sites, periradicular surgery, etc. are DENIED as a specialized or elective procedure.

When submitted with a D4263, D4264, D4267, D4270, D4273, D4275 or D4276 in the same surgical site, the fee for the D4265 is DENIED. When a D4265 is submitted with an extraction or periradicular surgery, the D4265 is DENIED and the approved amount is collectable from the patient. If a D4265 is reported with D7950, D7951 or D7955 refer to medical.

- D4266 Guided tissue regeneration - resorbable barrier, per site,  
D4267 Guided tissue regeneration - nonresorbable barrier, per site, (includes membrane removal)

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

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

- D4268 Surgical revision procedure, per tooth

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

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

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

- D4270 Pedicle soft tissue graft procedure

When multiple sites are provided within a single quadrant, a maximum of two sites are benefited unless extraordinary circumstances are documented.

- D4271 Free soft tissue graft procedure (including donor site surgery)

When multiple sites are provided within a single quadrant, a maximum of two sites are benefited unless extraordinary circumstances are documented.

- D4273 Subepithelial connective tissue graft procedures, per tooth

When multiple teeth are provided within a single quadrant, a maximum of two teeth are benefited unless extraordinary circumstances are documented.

- D4274 Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)

Distal wedge procedure is limited to the distal aspect of a periodontally affected tooth adjacent to an edentulous site. Based on pocket depths, benefits will be allowed as submitted for a D4274.

- D4275 Soft tissue allograft

D4275 may be eligible for benefit consideration in lieu of D4265, D4266, D4267, D4270, D4271, D4273 or D4276.

When multiple sites are provided within a single quadrant, a maximum of two sites are benefited unless extraordinary circumstances are documented.

**Benefits for frenulectomy (D7960) or frenuloplasty (D7963) are DISALLOWED when performed in conjunction with D4275 or D4276.**

- D4276 Combined connective tissue and double pedicle graft per tooth

This procedure may be eligible for consideration in lieu of D4265, D4266, D4267, D4270, D4271, D4273, or D4275 under dentist consultant review based upon documentation of clinical conditions (Miller Class III).

When multiple teeth are provided within a single quadrant, a maximum of two teeth are benefited unless extraordinary circumstances are documented.

**Benefits for frenulectomy (D7960) or frenuloplasty (D7963) are DISALLOWED when performed in conjunction with D4275 or D4276.**

#### **Non-surgical periodontal services**

D4320 Provisional splinting - intracoronal

D4321 Provisional splinting - extracoronal

The fee for splinting is DENIED and the approved amount is collectable from the patient.

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

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

**There must be documentation of at least 4mm pocket depths on the diseased teeth/periodontium involved. In the absence of 4mm pockets, D4341 is processed as prophylaxis (D1110) and any fee in excess of the approved amount for D1110 is DISALLOWED.**

A bounded tooth space does not count for benefit consideration as the procedure does not require flap extension. Only diseased teeth/periodontium (see definition page 20) are eligible for benefit consideration.

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

**A separate fee for prophylaxis (D1110) is DISALLOWED when done during the same episode of treatment as D4341 by the same dentist/dental office.**

For interim root planing, see D4910.

**A separate fee for D4341 billed in conjunction with (30 days prior or 90 days following) periodontal surgery procedures by the same dentist/dental office is DISALLOWED as a component of the surgical procedure.**

D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis

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

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

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

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

1. A D4381 may be benefited, subject to dental consultant review if the following conditions exist:

- a. It is being performed six weeks to six months following initial therapy (scaling and root planning or periodontal surgery).
  - b. It is being performed for a patient of record on periodontal maintenance following initial therapy (scaling and root planning or periodontal surgery).
  - c. If either 1 or 2 are met, it involves no more than two refractory sites (teeth) per quadrant with pocket depths of at least 5mm and less than 10mm.
2. If different teeth are treated in the quadrant, within twelve months, benefits are DENIED and the approved amount is collectable from the patient.
  3. If the same teeth are re-treated within 24 months, benefits are DENIED and the approved amount is collectable from the patient.
  4. Teeth must have 5mm – 10mm pocketing to be eligible for benefits. If less than 5 mm pocketing, benefits are DENIED and the approved amount is collectable from the patient.
  5. Benefits are provided for up to two teeth per quadrant. If three or more teeth are submitted, the entire case is DENIED and the approved amount is collectable from the patient.
  6. When submissions are requested outside time parameters, benefits are DENIED and the approved amount is collectable from the patient.

#### **Other Periodontal Services**

D4910 Periodontal maintenance

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

**The fee for a separate evaluation is eligible for benefit consideration based on group contract. If a D0180 is submitted with a D4910 it is benefited as a D0120 and the difference in the approved amount between the D0120 and the D0180 is DISALLOWED unless the D0180 is the initial evaluation by the dentist rendering the D4910.**

**Because surgery includes finishing and follow up procedures for three months following surgery, the fee for a D4910 within three months following surgery by the same dentist/dental office is DISALLOWED.**

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

**The definition of the same dentist includes providers in the same dental office. A fee for dressing change submitted by a doctor of the same office is DISALLOWED as a component of the surgical procedure.**

D4999 Unspecified periodontal procedure, by report

## PROSTHODONTICS (REMOVABLE) D5000 - D5899

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

- GP Characterizations, staining, overdentures, or metal bases are considered specialized techniques or procedures. An alternate benefit allowance is made for a conventional denture. Any fee charged in excess of the allowance for conventional denture is DENIED and the difference between the allowance for the conventional denture and the approved amount for the procedure performed is collectable from the patient.
- GP The fees for full or partial dentures include any reline/rebase, adjustment or repair required within six months of delivery by the same dentist/dental office, except in the case of immediate dentures. Except in the case of immediate dentures, the fees for these services by the same dentist/dental office are DISALLOWED.**
- GP Benefits may be DENIED and the approved amount is collectable from the patient if repair or replacement within contractual time limitations is the patient's fault.
- GP The fees for restorations for altering occlusion, involving vertical dimension, treating TMD, replacing tooth structure lost by attrition, erosion, abrasion(wear), abfraction, corrosion or for periodontal, orthodontic or other splinting are DENIED and the approved amount is collectable from the patient.
- GP The fees for cast or indirectly fabricated restorations and prosthetic procedures include all models, temporaries and other associated procedures. Any fees charged for these procedures in excess of the approved amounts for the cast or indirectly fabricated restorations or prosthetic procedures by the same dentist/dental office are DISALLOWED.**
- GP Multistage procedures are reported and benefited upon completion. The completion date is the date of insertion for removable prosthetic appliances. The completion date for immediate dentures is the date that the remaining teeth are removed and the denture is inserted. The completion date for fixed partial dentures and crowns, onlays, and inlays is the cementation date regardless of the type of cement utilized.

### **Complete Dentures (including routine post-delivery care)**

- D5110 Complete denture, maxillary  
D5120 Complete denture, mandibular  
D5130 Immediate denture, maxillary  
D5140 Immediate denture, mandibular

### **Partial Dentures (including routine post-delivery care)**

- GP A posterior fixed bridge and a removable partial denture are not a benefit in the same arch within a five year period. An allowance for a removable partial denture is made and any fee charged in excess of the allowance is DENIED and the approved amount is collectable from the patient.
- GP The fees for fixed bridges or removable cast partials are DENIED and the approved amount is collectable from the patient, for patients under age 16.
- D5211 Maxillary partial denture-resin base (including any conventional clasps, rests, and teeth)  
D5212 Mandibular partial denture-resin base (including any conventional clasps, rests, and teeth)

- D5213 Maxillary partial denture-cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)
- D5214 Mandibular partial denture- cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)
- D5225 Maxillary partial denture – flexible base (including any clasps, rests, and teeth)
- D5226 Mandibular partial denture – flexible base (including any clasps, rests, and teeth)
- D5281 Removable unilateral partial denture-one piece cast metal (including clasps and teeth)

### Adjustments to Dentures

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

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

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

### Repairs to Complete Dentures

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

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

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

### Repairs to Partial Dentures

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

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

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

**The fee for a D5670 or D5671 cannot exceed two-thirds of the fee for a new appliance, and any excess fee by the same dentist/dental office is DISALLOWED.**

#### **Denture Rebase Procedures**

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

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

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

#### **Denture Reline Procedures**

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

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

D5730 Reline complete maxillary denture (chairside)  
D5731 Reline complete mandibular denture (chairside)  
D5740 Reline maxillary partial denture (chairside)  
D5741 Reline mandibular partial denture (chairside)  
D5750 Reline complete maxillary denture (laboratory)  
D5751 Reline complete mandibular denture (laboratory)  
D5760 Reline maxillary partial denture (laboratory)  
D5761 Reline mandibular partial denture (laboratory)

#### **Interim Prosthesis**

D5810 Interim complete denture (maxillary)  
D5811 Interim complete denture (mandibular)

The fees for interim complete dentures are DENIED and the approved amount is collectable from the patient.

D5820 Interim partial denture (maxillary)  
D5821 Interim partial denture (mandibular)

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

#### **Other Removable Prosthetic Services**

D5850 Tissue conditioning, maxillary  
D5851 Tissue conditioning, mandibular

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

Tissue conditioning is not a benefit more than twice per denture unit per thirty-six months, and the fee for tissue conditioning is DENIED and the approved amount is collectable from the patient if done more frequently.

D5860 Overdenture-complete, by report

D5861 Overdenture-partial, by report

An overdenture is considered a specialized procedure and is not a benefit. Any fee charged in excess of the allowance is DENIED and the approved amount is collectable from the patient up to the approved amount for the overdenture.

D5862 Precision attachment, by report

The fee for a precision attachment is DENIED and the approved amount for the precision attachment is collectable from the patient.

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

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

D5875 Modification of a removable prosthesis following implant surgery

The fees for implant services for most groups are DENIED the approved amount for the D5875 is collectable from the patient unless contract specifies that implants are a benefit.

The fees for implant services are DENIED, and the approved amount is collectable from the patient.

D5899 Unspecified removable prosthodontic procedure, by report

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GP The fees for maxillofacial prosthetics are DENIED and the approved amount is collectable from the patient.

- D5911 Facial moulage (sectional)
- D5912 Facial moulage (complete)
- D5913 Nasal prosthesis
- D5914 Auricular prosthesis
- D5915 Orbital prosthesis
- D5916 Ocular prosthesis
- D5919 Facial prosthesis
- D5922 Nasal septal prosthesis
- D5923 Ocular prosthesis, interim
- D5924 Cranial prosthesis
- D5925 Facial augmentation implant prosthesis
- D5926 Nasal prosthesis, replacement
- D5927 Auricular prosthesis, replacement
- D5928 Orbital prosthesis, replacement
- D5929 Facial prosthesis, replacement
- D5931 Obturator prosthesis, surgical
- D5932 Obturator prosthesis, definitive
- D5933 Obturator prosthesis, modification
- D5934 Mandibular resection prosthesis with guide flange
- D5935 Mandibular resection prosthesis without guide flange
- D5936 Obturator prosthesis, interim
- D5937 Trismus appliance (not for TMD treatment)
- D5951 Feeding aid
- D5952 Speech aid prosthesis, pediatric
- D5953 Speech aid prosthesis, adult
- D5954 Palatal augmentation prosthesis
- D5955 Palatal lift prosthesis, definitive
- D5958 Palatal lift prosthesis, interim
- D5959 Palatal lift prosthesis, modification
- D5960 Speech aid prosthesis, modification
- D5982 Surgical stent
- D5983 Radiation carrier
- D5984 Radiation shield
- D5985 Radiation cone locator
- D5986 Fluoride gel carrier
- D5987 Commissure splint
- D5988 Surgical splint
- D5991 Topical medicament carrier
- D5999 Unspecified maxillofacial prosthesis, by report

## IMPLANT SERVICES      D6000 - D6199 IMPLANT SERVICES

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GP Unless the group contract specifies implants are covered, the fees for implant services are DENIED and the approved amount is collectable.

**GP When benefited by contract, fees for the replacement of implants and their restorations within five year are DISALLOWED if done by the same dentist/dental office. Benefits may be allowed if done by a different dentist/dental office.** Special considerations may be given by report.

D6010 Surgical placement of implant body: endosteal implant

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

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

D6040 Surgical placement: eposteal implant

D6050 Surgical placement: transosteal implant

### **Implant supported prosthetics**

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

D6053 Implant/abutment supported removable denture for completely edentulous arch

Benefits are based on the accepted fee for a D5110 or D5120. The difference between the allowance for the conventional prosthesis and the approved amount for the D6053 is DENIED and collectable from the patient.

D6054 Implant/abutment supported removable denture for partially edentulous arch

Benefits are based on the accepted fee for a D5213 or D5214. The difference between the allowance for the conventional prosthesis and the approved amount for the D6054 is DENIED and collectable from the patient.

D6055 Dental implant supported connecting bar

D6056 Prefabricated abutment – includes placement

Benefits for a D6056 are DENIED as a specialized procedure and the approved amount is collectable from the patient unless implants are covered by contract.

D6057 Custom abutment - includes placement

Benefits for a D6057 are DENIED as a specialized procedure and the approved amount is collectable from the patient unless implants are covered by contract.

- D6058 Abutment supported porcelain/ceramic crown
- D6059 Abutment supported porcelain fused to metal crown (high noble metal)
- D6060 Abutment supported porcelain fused to metal crown (predominantly base metal)
- D6061 Abutment supported porcelain fused to metal crown (noble metal)
- D6062 Abutment supported cast metal crown (high noble metal)
- D6063 Abutment supported cast metal crown (predominantly base metal)
- D6064 Abutment supported cast metal crown (noble metal)
- D6094 Abutment supported crown (titanium)
- D6065 Implant supported porcelain/ceramic crown
- D6066 Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)
- D6067 Implant supported metal crown (titanium, titanium alloy, high noble metal)
- D6068 Abutment supported retainer for porcelain/ceramic FPD
- D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal)
- D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)
- D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal)
- D6072 Abutment supported retainer for cast metal FPD (high noble metal)
- D6073 Abutment supported retainer for cast metal FPD (predominantly base metal)
- D6074 Abutment supported retainer for cast metal FPD (noble metal)
- D6194 Abutment supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)
- D6075 Implant supported retainer for ceramic FPD
- D6076 Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy or high noble metal)
- D6077 Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal)
- D6078 Implant/abutment supported fixed denture for completely edentulous arch

Benefits are based on the accepted fee for a D5110 or D5120. The difference between the allowance for the conventional prosthesis and the approved amount for the D6078 is DENIED and collectable from the patient.

- D6079 Implant/abutment supported fixed denture for partially edentulous arch

Benefits are based on the accepted fee for a D5213 or D5214. The difference between the allowance for the conventional prosthesis and the approved amount for the D6079 is DENIED and collectable from the patient.

**Other Implant Services**

- D6080 Implant maintenance procedures, including: removal of prosthesis, cleansing of prosthesis and abutments, reinsertion of prosthesis
- D6090 Repair implant supported prosthesis, by report
- D6091 Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment.

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

- D6092 Recement implant/abutment supported crown

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

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

- D6093 Recement implant/abutment supported fixed partial denture

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

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

- D6095 Repair implant abutment, by report
- D6100 Implant removal, by report
- D6190 Radiographic/surgical implant index, by report

**Benefits are DENIED unless implant services are covered, per contract. Under contracts with implant coverage, diagnostic and treatment facilitating aids are considered a part of definitive treatment and separate benefits for an index to the same dentist/dental office are DISALLOWED.**

- D6199 Unspecified implant procedure, by report

## PROSTHODONTICS, FIXED      D6200 - D6999

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- GP      Fixed prosthodontics are subject to contractual time limits
- GP      Benefits will be based on the number of pontics necessary for the space, not to exceed the normal complement of teeth.
- GP      A posterior fixed bridge and a removable partial denture are not benefits in the same arch within a five (5) year period. An allowance for a removable partial denture is made and any fee charged in excess of the allowance is DENIED and the approved amount is collectable from the patient.
- GP      The fees for cast or indirectly fabricated restorations and prosthetic procedures include all models, temporaries, laboratory charges and materials, and other associated procedures. Any fees charged for these procedures by the same dentist/dental office in excess of the approved amounts for the cast or indirectly fabricated restorations or prosthetic procedures are DISALLOWED.**
- GP      The fees for fixed prosthodontics are DENIED and the approved amount is collectable from the patient for children under 16 years of age.
- GP      Cementation date is the delivery date. The type of cement used is not a determining factor (whether permanent or temporary)
- GP      The fees for restorations for altering occlusion, involving vertical dimension, treating TMD, replacing tooth structure lost by attrition, erosion, abrasion(wear), abfraction, corrosion or for periodontal, orthodontic or other splinting are DENIED and the approved amount is collectable from the patient.
- GP      Multistage procedures are reported and benefited upon completion. The completion date is the date of insertion for removable prosthetic appliances. The completion date for immediate dentures is the date that the remaining teeth are removed and the denture is inserted. The completion date for fixed partial dentures and crowns, onlays, and inlays is the cementation date regardless of the type of cement utilized.
- GP      An allowance of a conventional fixed prosthesis is provided for porcelain/ceramic or resin bridges. The difference between the allowance for the conventional fixed prosthesis and the approved amount for the porcelain/ceramic or resin bridge is collectable from the patient.

### **Fixed Partial Denture Pontics**

D6205    Pontic-indirect resin-based composite

Benefits will be considered for a conventional fixed prosthesis. The difference between the allowance for the conventional prosthesis and the approved amount for the D6205 is DENIED and collectable from the patient.

- D6210    Pontic-cast high noble metal  
D6211    Pontic-cast predominantly base metal  
D6212    Pontic-cast noble metal  
D6214    Pontic-titanium  
D6240    Pontic-porcelain fused to high noble metal

- D6241 Pontic-porcelain fused to predominantly base metal
- D6242 Pontic-porcelain fused to noble metal
- D6245 Pontic-porcelain/ceramic

Benefits will be considered for a conventional fixed prosthesis. The difference between the allowance for the conventional prosthesis and the approved amount for the D6245 is DENIED and collectable from the patient.

- D6250 Pontic-resin with high noble metal
- D6251 Pontic-resin with predominantly base metal
- D6252 Pontic-resin with noble metal
- D6253 Provisional pontic

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

**Fixed Partial Denture Retainers - Inlays/Onlays**

- D6545 Retainer-cast metal for resin bonded fixed prosthesis
- D6548 Retainer- porcelain/ceramic for resin bonded fixed prosthesis

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

- D6600 Inlay - porcelain/ceramic, two surfaces

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

- D6601 Inlay - porcelain/ceramic, three or more surfaces

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

- D6602 Inlay - cast high noble metal, two surfaces
- D6603 Inlay - cast high noble metal, three or more surfaces
- D6604 Inlay - cast predominantly base metal, two surfaces
- D6605 Inlay - cast predominantly base metal, three or more surfaces
- D6606 Inlay - cast noble metal, two surfaces
- D6607 Inlay - cast noble metal, three or more surfaces
- D6608 Onlay -porcelain/ceramic, two surfaces

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

- D6609 Onlay - porcelain/ceramic, three or more surfaces

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

- D6610 Onlay - cast high noble metal, two surfaces
- D6611 Onlay - cast high noble metal, three or more surfaces
- D6612 Onlay - cast predominantly base metal, two surfaces
- D6613 Onlay - cast predominantly base metal, three or more surfaces
- D6614 Onlay - cast noble metal, two surfaces
- D6615 Onlay - cast noble metal, three or more surfaces
- D6624 Inlay - titanium
- D6634 Onlay - titanium

**Fixed Partial Denture Retainers-Crowns**

- D6710 Crown – indirect resin based composite

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

- D6720 Crown - resin with high noble metal
- D6721 Crown - resin with predominantly base metal
- D6722 Crown - resin with noble metal
- D6740 Crown- porcelain/ceramic

Benefits will be considered for a conventional fixed prosthesis(D6721). The difference between the allowance for the conventional prosthesis and the approved amount for the D6740 is DENIED and collectable from the patient.

- D6750 Crown-porcelain fused to high noble metal
- D6751 Crown-porcelain fused to predominantly base metal
- D6752 Crown-porcelain fused to noble metal
- D6780 Crown-¾ cast high noble metal
- D6781 Crown- ¾ cast predominantly base metal
- D6782 Crown- ¾ cast noble metal
- D6783 Crown- ¾ porcelain/ceramic

Benefits will be considered for a conventional fixed prosthesis. The difference between the allowance for the conventional prosthesis and the approved amount for the D6783 is DENIED and collectable from the patient.

- D6790 Crown-full cast high noble metal
- D6791 Crown-full cast predominantly base metal
- D6792 Crown-full cast noble metal
- D6793 Provisional retainer crown

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

- D6794 Crown-titanium

**Other Fixed Partial Denture Services**

- D6920 Connector bar

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

- D6930 Recement fixed partial denture

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

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

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

D6940 Stress breaker

The fee for a stress breaker is DENIED and the approved amount for the stress breaker is collectable from the patient.

D6950 Precision attachment

The fee for a precision attachment is DENIED and the approved amount for the precision attachment is collectable from the patient.

D6970 Post and core in addition to fixed partial denture retainer, indirectly fabricated

A cast post and core is a benefit only on a successfully endodontically treated tooth. **A fee for the post and core is DISALLOWED when radiographs indicate an absence of endodontic treatment, incompletely filled canal space, or unresolved pathology associated with the involved tooth.**

**A post and core is a benefit for an anterior tooth only when there is insufficient tooth structure to support a cast restoration. If sufficient tooth structure remains, any fee for the post and core is DISALLOWED.**

D6972 Prefabricated post and core in addition to fixed partial denture retainer

**A post and core is a benefit only on a successfully endodontically treated tooth. A fee for the post and core is DISALLOWED when radiographs indicate an absence of endodontic treatment, incompletely filled canal space, or unresolved pathology associated with the involved tooth.**

**A post and core is a benefit for an anterior tooth only when there is insufficient tooth structure to support a cast restoration. If sufficient tooth structure remains, any fee for the post and core is DISALLOWED.**

D6973 Core build up for retainer, including any pins

**A substructure is only a benefit when necessary to retain a cast or indirectly fabricated restoration due to extensive loss of tooth structure from caries or fracture. Any fee for a buildup not required for retention is DISALLOWED. The procedure should not be reported when the procedure only involves a filler to eliminate any undercut, box form, or concave irregularity in the preparation.**

**The fee for a buildup is DISALLOWED when radiographs indicate sufficient tooth structure remains to support a retainer.**

D6975 Coping-metal

The fee for a coping is DENIED and the approved amount is collectable from the patient.

D6976 Each additional indirectly fabricated post – same tooth

D6977 Each additional prefabricated post- same tooth

D6980 Fixed partial denture repair, by report

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

D6985 Pediatric partial denture, fixed

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

D6999 Unspecified fixed prosthodontic procedure, by report

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- GP **The fee for all oral and maxillofacial surgery includes local anesthesia, suturing if needed, and routine postoperative care. Separate fees for these procedures when performed in conjunction with oral and maxillofacial surgery are DISALLOWED.** If performed by another dentist these procedures are DENIED and the approved amount is collectable from the patient.
- GP **Fees for exploratory surgery or unsuccessful attempts at extractions are DISALLOWED.**
- GP Impaction codes are based on the anatomical position of the tooth, rather than the surgical procedure necessary for removal.
- GP **The fees for biopsy (D7285, D7286), frenulectomy (D7960), frenuloplasty (D7963) and excision of hard and soft tissue lesions (D7210, D7411, D7450, D7451) are DISALLOWED when the procedure is performed on the same day, same surgical site/area, by the same dentist/dental office as the above referenced codes.** Requests for individual consideration can always be submitted by report for dental consultant review.

**Extractions-includes local anesthesia, suturing if needed, and routine postoperative care**

D7111 Extraction, coronal remnants - deciduous tooth

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

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

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

- D7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
- D7220 Removal of impacted tooth - soft tissue
- D7230 Removal of impacted tooth - partially bony
- D7240 Removal of impacted tooth - completely bony
- D7241 Removal of impacted tooth - completely bony, with unusual surgical complications
- D7250 Surgical removal of residual tooth roots (cutting procedure)

Includes cutting of soft tissue and bone, removal of tooth structure and closure.

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

#### **Other Surgical Procedures**

- D7260 Oroantral fistula closure
- D7261 Primary closure of a sinus perforation
- Dentist Handbook with CDT-2009  
January 2009

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

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

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

The fee for tooth transplantation is DENIED and the approved amount is collectable from the patient.

D7280 Surgical access of an unerupted tooth

D7280 may be considered under orthodontic benefits by dental consultant review.

D7282 Mobilization of erupted or malpositioned teeth to aid eruption

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

D7283 Placement of device to facilitate eruption of impacted tooth

D7285 Biopsy of oral tissue - hard (bone, tooth)

D7286 Biopsy of oral tissue - soft (all others)

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

Biopsy of oral tissue is only benefited for oral structures.

D7287 Exfoliative cytological sample collection

By report and subject to coverage under the medical plan.

D7288 Brush biopsy – transepithelial sample collection

By report and subject to coverage under the medical plan. If covered under dental, the following guidelines should be considered regarding the lesion being biopsied:

1. Erthroplakia (red), leukoplakia (white) or mixed erythroleukoplakia lesion(s) which has not resolved or displayed clinical signs of resolving over a two-week observational period.
2. Ulceration which has not resolved or displayed signs of resolving over a two-week observational period.
3. Tobacco use at a rate of one or more pack(s) of cigarettes per day or an aggregate history of 20 pack years.
4. Use of smoke-less tobacco, pipes or cigars.
5. Alcohol use greater than three drinks per day over a 1 year period.

D7290 Surgical repositioning of teeth

D7291 Transseptal fiberotomy, supra crestal fiberotomy by report

D7292 Surgical placement; temporary anchorage device: screw retained place requiring surgical flap

D7293 Surgical placement: temporary anchorage devise requiring surgical flap

D7294 Surgical placement: temporary anchorage devise without surgical flap

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

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

### **Alveoloplasty-Surgical Preparation of Ridge for Dentures**

GP A quadrant for oral surgery purposes is defined as four or more continuous teeth and/or teeth spaces distal to the midline.

D7310 Alveoloplasty in conjunction with extractions- four or more teeth or tooth spaces per quadrant

**The fee for D7310 performed by the same dentist/dental office in the same surgical area on the same date of service as surgical extractions (D7210-D7230) is DISALLOWED.**

D7311 Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces per quadrant

**The fee for D7311 performed by the same dentist/dental office in the same surgical area on the same date of service as surgical extractions (D7210-D7230) is DISALLOWED.**

Count tooth bounded spaces for D7311 partial quadrant code.

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

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

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

Count tooth bounded spaces for D7321 partial quadrant code.

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

### **Vestibuloplasty**

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

D7340 Vestibuloplasty - ridge extension (secondary epithelialization)

D7350 Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)

### **Surgical Excision of Soft Tissue Lesions**

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

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

**GP Pathology laboratory report is required. If no report is submitted, the fee for the procedure are DISALLOWED.**

D7410 Excision of benign lesion up to 1.25 cm

D7411 Excision of benign lesion greater than 1.25 cm

D7412 Excision of benign lesion, complicated

D7413 Excision of malignant lesion up to 1.25 cm

D7414 Excision of malignant lesion greater than 1.25 cm

D7415 Excision of malignant lesion, complicated

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

### **Surgical Excision of Intra-Osseous Lesions**

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

**GP Pathology laboratory report is required. If no report is submitted, the fee for the procedure are DISALLOWED.**

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

D7440 Excision of malignant tumor - lesion diameter up to 1.25 cm

D7441 Excision of malignant tumor - lesion diameter greater than 1.25 cm

D7450 Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm

D7451 Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm

D7460 Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm

D7461 Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm

### **Excision of Bone Tissue**

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

D7471 Removal of lateral exostosis (maxilla or mandible)  
D7471 is benefited based on individual consideration, by report.

D7472 Removal of torus palatinus

D7473 Removal of torus mandibularis

D7485 Surgical reduction of osseous tuberosity

D7490 Radical resection of maxilla or mandible

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

### **Surgical Incision**

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

D7510 Incision and drainage of abscess - intraoral soft tissue

**The fee for surgical incision is DISALLOWED when done on the same date (in the same operative area) and by the same dentist/dental office as endodontics, extractions, palliative treatment or other definitive service.**

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

**The fee for surgical incision is DISALLOWED when done on the same date (in the same operative area) and by the same dentist/dental office as endodontics, extractions, palliative treatment or other definitive service.**

D7520 Incision and drainage of abscess-extraoral soft tissue

D7521 Incision and drainage of abscess-extraoral soft tissue – complicated (includes drainage of multiple fascial spaces)

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

- D7530 Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue
- D7540 Removal of reaction producing foreign bodies, musculoskeletal system
- D7550 Partial ostectomy/sequestrectomy for removal of non-vital bone
- D7560 Maxillary sinusotomy for removal of tooth fragment or foreign body

#### **Treatment of Fractures-Simple**

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

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

- D7610 Maxilla - open reduction (teeth immobilized if present)
- D7620 Maxilla - closed reduction (teeth immobilized if present)
- D7630 Mandible - open reduction (teeth immobilized if present)
- D7640 Mandible - closed reduction (teeth immobilized if present)
- D7650 Malar and/or zygomatic arch - open reduction
- D7660 Malar and/or zygomatic arch - closed reduction
- D7670 Alveolus - closed reduction, may include stabilization of teeth
- D7671 Alveolus - open reduction, may include stabilization of teeth
- D7680 Facial bones - complicated reduction with fixation and multiple surgical approaches

#### **Treatment of Fractures-Compound**

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

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

- D7710 Maxilla - open reduction
- D7720 Maxilla - closed reduction
- D7730 Mandible - open reduction
- D7740 Mandible - closed reduction
- D7750 Malar and/or zygomatic arch - open reduction
- D7760 Malar and/or zygomatic arch - closed reduction
- D7770 Alveolus - open reduction stabilization of teeth
- D7771 Alveolus, closed reduction stabilization of teeth
- D7780 Facial bones - complicated reduction with fixation and multiple surgical approaches

#### **Reduction of Dislocation and Management of Other Temporomandibular Joint Dysfunctions**

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

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

- D7810 Open reduction of dislocation
- D7820 Closed reduction of dislocation

- D7830 Manipulation under anesthesia
- D7840 Condylectomy
- D7850 Surgical discectomy, with/without implant
- D7852 Disc repair
- D7854 Synovectomy
- D7856 Myotomy
- D7858 Joint reconstruction
- D7860 Arthrotomy
- D7865 Arthroplasty
- D7870 Arthrocentesis
- D7871 Non - arthroscopic lysis and lavage
- D7872 Arthroscopy - diagnosis, with or without biopsy
- D7873 Arthroscopy - surgical: lavage and lysis of adhesions
- D7874 Arthroscopy - surgical: disc repositioning and stabilization
- D7875 Arthroscopy - surgical: synovectomy
- D7876 Arthroscopy - surgical: discectomy
- D7877 Arthroscopy - surgical: debridement
- D7880 Occlusal orthotic device, by report
- D7899 Unspecified TMD procedure, by report

**Repair of Traumatic Wounds**

GP Repair of traumatic wounds is limited to oral structures.

- D7910 Suture of recent small wounds up to 5 cm

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

GP Complicated suturing is limited to oral structures.

- D7911 Complicated suture - up to 5 cm
- D7912 Complicated suture - greater than 5 cm

**Other Repair Procedures**

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

- D7920 Skin grafts (identify defect covered, location and type of graft)
- D7940 Osteoplasty - for orthognathic deformities
- D7941 Ostectomy - mandibular rami
- D7943 Ostectomy - mandibular rami with bone graft; includes obtaining the graft
- D7944 Ostectomy - segmented or subapical - per sextant or quadrant
- D7945 Ostectomy - body of mandible
- D7946 LeFort I (maxilla - total)
- D7947 LeFort I (maxilla - segmented)
- D7948 LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retusion) - without bone graft
- D7949 LeFort II or LeFort III - with bone graft
- D7950 Osseous, osteoperiosteal, or cartilage graft of the mandible - autogenous or nonautogenous, by report
- D7951 Sinus augmentation with bone or bone substitutes
- D7953 Bone replacement graft for ridge preservation – per site

Benefits for osseous autografts and/or osseous allografts are available only when billed for natural teeth for periodontal purposes using periodontal procedure codes (D4263-D4264). Benefits for these procedures when billed in conjunction with implants, ridge augmentation, extraction sites, periradicular surgery etc. are DENIED as an investigational procedure. If the contract covers dental implants this procedure may be a

benefit at the time of extraction.

- D7955 Repair of maxillofacial soft and hard tissue defect
- D7960 Frenulectomy (frenectomy or frenotomy) - separate procedure

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

- D7963 Frenuloplasty

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

- D7970 Excision of hyperplastic tissue - per arch

**The fee for excision of hyperplastic tissue is DISALLOWED when billed in conjunction with other surgical procedure(s) in the same surgical area by the same dentist/dental office.**

- D7971 Excision of pericoronal gingiva

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

- D7972 Surgical reduction of fibrous tuberosity
- D7980 Sialolithotomy
- D7981 Excision of salivary gland, by report
- D7982 Sialodochoplasty
- D7983 Closure of salivary fistula
- D7990 Emergency tracheotomy
- D7991 Coronoidectomy
- D7995 Synthetic graft-mandible or facial bones, by report
- D7996 Implant-mandible for augmentation purposes (excluding alveolar ridge), by report

- D7997 Appliance removal (not by the dentist who placed the appliance), includes removal of archbar

The fee for appliance removal is DENIED as a non-covered procedure unless the contract specifies that the related oral surgery services are a benefit.

- D7998 Intraoral placement of a fixation device not in conjunction with fracture

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

- D7999 Unspecified oral surgery procedure, by report

## **ORTHODONTICS    D8000 - D8999**

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

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

GP      The benefit is based on the approved fee for conventional orthodontics. Any additional fee up to the submitted amount for Invisalign is DENIED and collectible from the patient.

### **Notes**

Limited orthodontic treatment is defined as:

Orthodontic treatment with a limited objective, not 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. Examples of this type of treatment would be treatment in on arch only to correct crowding, partial treatment to open spaces or upright a tooth for a bridge or implant and partial treatment for closure of a space(s).

Interceptive orthodontic treatment is defined as:

Treatment using codes for interceptive treatment are for procedures to lessen the severity or future effects of a malformation and to eliminate its cause. An extension of preventive orthodontics includes localized tooth movement. Such treatment may occur in the primary or transitional dentition and may include such procedures as the redirection of ectopically erupting teeth, correction of isolated dental crossbite, or recovery of recent minor space loss where overall space is adequate. The key to successful interception is intervention in the incipient stages of a developing problem to lessen the severity of the malformation and eliminate its cause. Complicating factors such as skeletal disharmonies, overall space deficiency, or other conditions may require future comprehensive therapy. Early phased of comprehensive therapy may utilize some procedures that might also be used interceptively, but such procedures are not considered in those applications.

Comprehensive orthodontic treatment is defined as:

This code should be used when there are multiple phases of treatment provide at different states of dentofacial development. For example, the use of an activator is generally stage one of a two-stage treatment. In this situation, placement of fixed appliances will generally be state two of a two-stage treatment. Both phases should be listed as comprehensive treatment modified by the appropriate stage of dental development. This is used to report coordinated diagnosis and treatment leading to the improvement of the patient's craniofacial dysfunction and/or dentofacial deformity including anatomical, functional, aesthetic relationships. Treatment usually, but not necessarily, utilizes fixed orthodontic appliances. Adjunctive procedures, such as extractions, maxillofacial surgery, nasopharyngeal surgery, myofunctional or speech therapy and restorative or periodontal care, may be coordinated disciplines. Optimal care requires long-term consideration of patient's need and periodic reevaluation. Treatment may incorporate several phases with specific objectives at various stages of dentofacial development.

### **Limited Orthodontic Treatment**

- D8010 Limited orthodontic treatment of the primary dentition
- D8020 Limited orthodontic treatment of the transitional dentition
- D8030 Limited orthodontic treatment of the adolescent dentition

D8040 Limited orthodontic treatment of the adult dentition

#### **Interceptive Orthodontic Treatment**

D8050 Interceptive orthodontic treatment of the primary dentition

D8060 Interceptive orthodontic treatment of the transitional dentition

#### **Comprehensive Orthodontic Treatment**

D8070 Comprehensive orthodontic treatment of the transitional dentition

D8080 Comprehensive orthodontic treatment of the adolescent dentition

D8090 Comprehensive orthodontic treatment of the adult dentition

#### **Minor Treatment to Control Harmful Habits**

D8210 Removable appliance therapy

D8220 Fixed appliance therapy

#### **Other Orthodontic Services**

D8660 Pre-orthodontic treatment visit

D8670 Periodic orthodontic treatment visit (as part of contract)

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

**A separate fee for orthodontic retention is DISALLOWED unless performed by a different dentist and the lifetime orthodontic maximum has not been reached.**

D8690 Orthodontic treatment (alternative billing to a contract fee)

D8691 Repair of orthodontic appliance

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

D8692 Replacement of lost or broken retainer

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

D8693 Rebonding or recementing: and/or repair, as required of fixed retainers

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

D8999 Unspecified Orthodontic procedure, by report

## ADJUNCTIVE GENERAL SERVICES D9000 - D9999

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

### Unclassified Treatment

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

**The fee for palliative treatment is DISALLOWED when any other definitive treatment is performed on the same date by the same dentist/dental office. Limited radiographs and tests necessary to diagnose the emergency condition are considered separately.**

Palliative treatment is a benefit on a per visit basis, once on the same date, and includes all procedures necessary for the relief of pain. Examination is not considered as the relief of pain.

**A separate fee for palliative treatment is DISALLOWED when billed on the same date as root canal therapy by the same dentist/dental office.**

D9120 Fixed partial denture sectioning

This procedure is only a benefit if a portion of the fixed prosthesis is to remain intact and serviceable following sectioning and extraction or other treatment.

**If this code is part of the process of removing and replacing a fixed prosthesis, it is considered integral to the fabrication of the fixed prosthesis and a separate fee for this code is DISALLOWED**

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

### Anesthesia

D9210 Local anesthesia not in conjunction with operative or surgical procedures

D9211 Regional block anesthesia

D9212 Trigeminal division block anesthesia

D9215 Local anesthesia

**A separate fee for local anesthesia is DISALLOWED when performed in conjunction with any other procedure.**

D9220 Deep sedation/General anesthesia-first thirty (30) minutes

D9221 Deep sedation/General anesthesia-each additional fifteen (15) minutes

General anesthesia is a benefit only when administered by a properly licensed dentist in a dental office in conjunction with specific oral surgery procedures (D7000-D7999) when covered or when necessary due to concurrent medical conditions. Otherwise, the fee for general anesthesia is DENIED and the approved amount is collectable from the patient.

The fee for general anesthesia is DENIED and the approved amount is collectable from the patient when billed by anyone other than a properly licensed dentist.

D9230 Analgesia, anxiolysis, inhalation of nitrous oxide

The fee for analgesia is DENIED and the approved amount is collectable from the patient.

D9241 Intravenous conscious sedation/analgesia - first 30 minutes

D9242 Intravenous conscious sedation/analgesia each additional 15 minutes

Intravenous sedation/analgesia is a benefit only when administered by a properly licensed dentist in a dental office in conjunction with specific oral surgery procedures (codes D7000-D7999) when covered or when necessary due to concurrent medical conditions. Otherwise the fee for intravenous conscious sedation/analgesia is DENIED and the approved amount is collectable from the patient.

Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of a trained personnel and the doctor may safely leave the room to attend to other patients or duties.

The fee for intravenous sedation/analgesia is DENIED and the approved amount is collectable from the patient when billed by anyone other than a licensed dentist.

D9248 Non-intravenous conscious sedation

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

### **Professional Consultation**

D9310 Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)

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

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

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

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

### **Professional Visits**

GP The fees for all procedures are DENIED and the approved amount is collectable from the patient.

D9410 House/extended care facility call

D9420 Hospital call

D9430 Office visit for observation (during regularly scheduled hours) - no other services performed

D9440 Office visit - after regularly scheduled hours

D9450 Case presentation, detailed and extensive treatment planning

The fee for extensive treatment planning is DENIED and the approved amount is collectable from the patient.

**The fees for routine treatment planning and case presentation are considered inclusive in an evaluation and are DISALLOWED.**

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

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

### **Drugs**

GP The fees for all procedures are DENIED and the approved amount is collectable from the patient.

D9610 Therapeutic drug injection, by report

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

D9630 Other drugs and/or medicaments, by report

### **Miscellaneous Services**

D9910 Application of desensitizing medicament

The fee for application of desensitizing medicaments is DENIED and the approved amount is collectable from the patient.

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

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

D9920 Behavior management, by report

The fee for behavior management is DENIED and the approved amount is collectable from the patient.

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

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

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

D9940 Occlusal guard, by report

D9941 Fabrication of athletic mouthguard

D9942 Repair or relining of occlusal guard

Occlusal guard and related repair and/or relining is not a covered benefit unless it is contract specific. The fee is DENIED.

**If covered contractually, the fee for the occlusal guard includes any adjustment or repair required with six months of delivery. Fees for the adjustment or repair of the occlusal guard are DISALLOWED if performed by the same dentist/dental office within six months of initial placement.**

**General Policy- If covered contractually, the fee for repair of an occlusal guard cannot exceed one-half of the fee for a new appliance, and any excess fee is DISALLOWED**

- D9950 Occlusion analysis - mounted case
- D9951 Occlusal adjustment - limited
- D9952 Occlusal adjustment - complete
- D9970 Enamel microabrasion

The fees for procedure codes D9940-D9970 are DENIED and the approved amount is collectable from the patient.

- D9971 Odontoplasty 1-2 teeth includes removal of enamel projections

The fee for odontoplasty is DENIED and the approved amount is collectable from the patient.

- D9972 External bleaching per arch

The fee for bleaching is DENIED, and the approved amount is collectable from the patient.

- D9973 External bleaching per tooth

The fee for bleaching is DENIED, and the approved amount is collectable from the patient.

- D9974 Internal bleaching per tooth

The fee for bleaching is DENIED, and the approved amount is collectable from the patient.

- D9999 Unspecified adjunctive procedure, by report