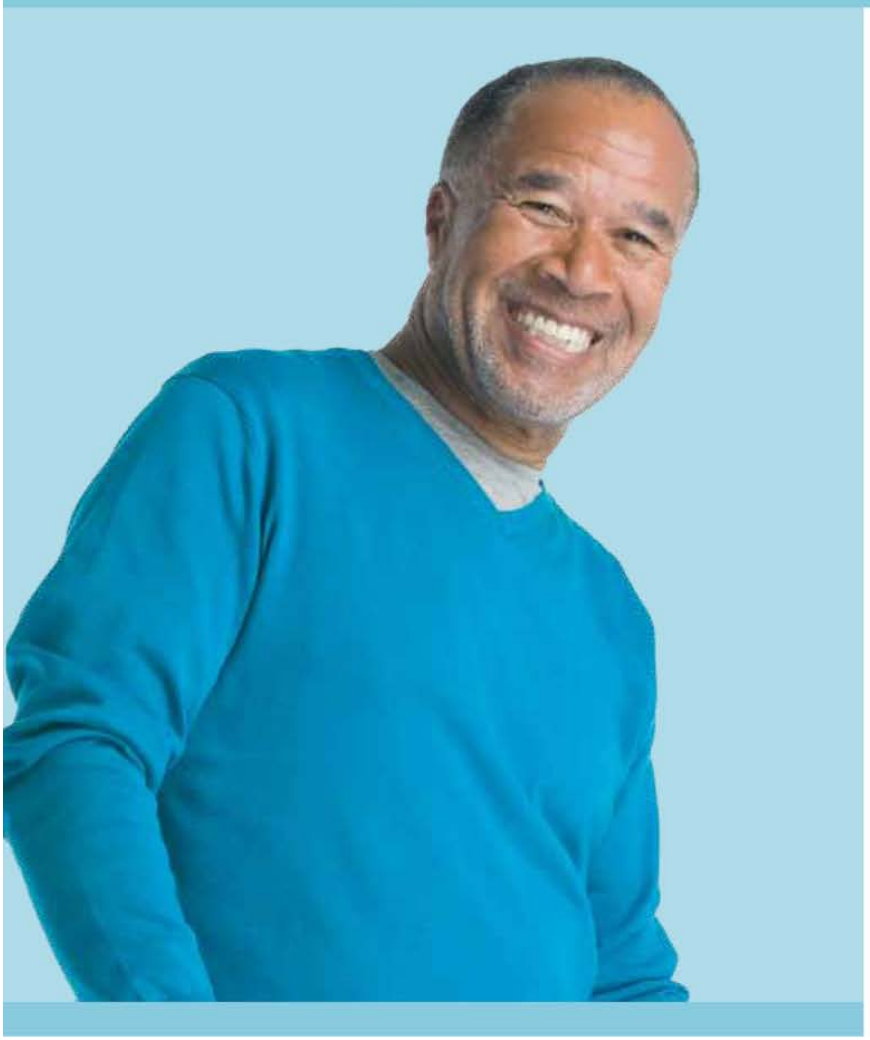
Washington Dental Service



Processing Policies Manual

DELTA DENTAL
Washington Dental Service

Updated April, 2010

Diagnostic: D0120 – D0999 3
Preventive: D1000 – D1999 7
Restorative: D2000 – D2999 9
Endodontics: D3000 – D3999 13
Periodontics: D4000 – D4999 15
Prosthodontics: (removable) D5000 – D5899 19
Maxillofacial Prosthetics: D5900 – D5999 21
Implant Services: D6000 – D6199 22
Prosthodontics (fixed): D6200 – D6999 26
Oral and Maxillofacial Surgery: D7000 – D7999 28
Orthodontics: D8000 – D8999 34
Adjunctive General Services: D9000 – D9999 35

* Please note this is not a comprehensive list of ADA codes.

Approved by Dr. Ronald Inge, VP Dental Director

Processing policies marked with ☑ only apply to groups using DDPA processing policies.

Codes marked with ☆ are new ADA codes effective 1/1/2009.

Policies marked with ↳ are new processing policies effective 5/1/2010.

These are general guidelines. Coverage for all procedures is based on each group's contract.

CLINICAL ORAL EVALUATIONS – GENERAL GUIDELINES

One oral evaluation is covered on the same date of service by the same dentist. If multiple evaluations are billed on the same date by the same dentist the evaluation with the highest filed fee/maximum allowable fee will be paid and all others are disallowed.

Periodontal charting is considered to be part of the oral evaluation and cannot be charged as a separate service. It is disallowed when billed with any oral evaluation.

A fee for an assistant is not a covered benefit.

D0140

A *limited oral evaluation – problem focused* is disallowed if done within 30 days of any surgical procedure by the same provider.

↳ Limited problem focused evaluations (any combination of D0140 and D0170) are covered twice in a benefit period.

D0145

An *oral evaluation for patient under 3 years of age and counseling with primary caregiver* is not a comprehensive oral evaluation, therefore, a comprehensive oral evaluation (D0150) is allowed for the same patient and by the same dentist at a subsequent date.

↳ The time limitation for oral evaluations (any combination of D0120, D0145, D0150, D0160, and D0180) varies with each group contract.

This evaluation includes any caries susceptibility tests (D0425) or oral hygiene instructions (D1330) on the same date. When performed on the same date as D0145, any fees for D0425 and D1330 are disallowed.

D0145 billed on a patient over the age of three is not a covered benefit.

D0150

↳ A *comprehensive oral evaluation – new or established patient* (D0150), detailed and extensive oral evaluation (D0160), or comprehensive periodontal evaluation (D0180) is covered once in the patient's lifetime by the same dentist. All subsequent D0150, D0160, and D0180 by the same dentist are considered as a periodic oral evaluation (D0120) for reimbursement purposes.

↳ The time limitation for oral evaluations (any combination of D0120, D0145, D0150, D0160, and D0180) varies with each group contract.

D0160

↳ A comprehensive oral evaluation (D0150), *detailed and extensive oral evaluation – problem focused, by report* (D0160), or comprehensive periodontal evaluation (D0180) is covered once in the patient's lifetime by the same dentist. All subsequent D0150, D0160, and D0180 by the same dentist are considered as a periodic oral evaluation (D0120) for reimbursement purposes.

↳ The time limitation for oral evaluations (any combination of D0120, D0145, D0150, D0160, and D0180) varies with each group contract.

A *detailed and extensive oral evaluation – problem focused* is disallowed if done within 30 days of any surgical procedure by the same provider.

D0170

A *re-evaluation – limited, problem focused* is disallowed if done within 30 days of any surgical procedure by the same provider.

↳ Limited problem focused evaluations (any combination of D0140 and D0170) are covered twice in a benefit period.

D0180

↳ A comprehensive oral evaluation (D0150), detailed and extensive oral evaluation (D0160), or *comprehensive periodontal evaluation – new or established patient* (D0180) is covered once in the patient's lifetime by the same dentist. All subsequent D0150, D0160, and D0180 by the same dentist are considered as a periodic oral evaluation (D0120) for reimbursement purposes.

↳ The time limitation for oral evaluations (any combination of D0120, D0145, D0150, D0160, and D0180) varies with each group contract.

RADIOGRAPHS/DIAGNOSTIC IMAGING (INCLUDING INTERPRETATION) – GENERAL GUIDELINES

Separate charges submitted for bitewing radiographs and individual periapical radiographs will be considered a full mouth series for reimbursement purposes if the submitted fees equal or exceed the fee for a full mouth series. Any amount charged above the fee for a full mouth series is disallowed.

The time limitation for bitewing radiographs (any combination of D0272, D0273, D0274 and D0277) varies with each group contract.

Duplication of radiographs for insurance purposes is disallowed.

Duplication of radiographs to be transferred to another dentist is denied.

Radiographs for temporomandibular joint diagnosis are not a covered benefit unless the group has elected TMJ benefit coverage.

WDS allows one diagnostic periapical x-ray (D0220) and disallows all additional periapical x-rays (D0230) taken in conjunction with root canal treatment.

D0210

An *intraoral – complete series (including bitewings)* or panoramic film is covered once in three, five or seven years, according to each group's contract.

A complete series of x-rays done for orthodontic or TMJ purposes is paid from that maximum and is denied if the group has not purchased orthodontic or TMJ benefits.

D0220

An *intraoral – periapical first film* is limited to the first periapical film taken on the same date of service. Subsequent periapical films are paid as D0230.

A periapical film done for orthodontic or TMJ purposes is paid from that maximum and is denied if the group has not purchased orthodontic or TMJ benefits.

D0230

Each *intraoral – periapical each additional film* should be billed as a separate line of treatment.

A periapical film done for orthodontic or TMJ purposes is paid from that maximum and is denied if the group has not purchased orthodontic or TMJ benefits.

D0240 – D0260

If these procedures are done for orthodontic or TMJ purposes, they are paid from that maximum and denied if the group has not purchased orthodontic or TMJ benefits.

D0290

A *posterior-anterior or lateral skull and facial bone survey film* is only covered if done for orthodontic or TMJ purposes and the group has purchased Ortho or TMJ benefits. When covered, it is paid from the orthodontic or TMJ maximum.

D0310

Sialography is not a covered benefit unless the group has elected this benefit. Predetermination is recommended.

D0320

TMJ arthrogram, including injection is covered only if done for orthodontic or TMJ purposes and the group has purchased orthodontic or TMJ benefits.

D0321

Other TMJ films, by report are covered only if done for orthodontic or TMJ purposes and the group has purchased orthodontic or TMJ benefits.

D0322

A *tomographic survey* is not a covered benefit unless the group has elected this benefit. Predetermination is recommended.

D0330

A *panoramic film* is covered once in three, five or seven years, according to each group's contract.

A panoramic film done for orthodontic or TMJ purposes is paid from that maximum and is denied if the group has not purchased orthodontic or TMJ benefits.

D0340

A *cephalometric film* done for orthodontic or TMJ purposes is paid from that maximum and is denied if the group has not purchased orthodontic or TMJ benefits.

D0350

Oral/facial photographic images are covered only if done for orthodontic purposes and is paid from the orthodontic maximum. It is denied unless the group has purchased orthodontic benefits.

D0360

Cone beam ct – craniofacial data capture is considered as specialized treatment and is not a covered benefit unless the group has elected this benefit.

D0362

Cone beam – two dimensional image reconstruction using existing data, includes multiple images is considered as specialized treatment and is not a covered benefit unless the group has elected this benefit. Predetermination is recommended.

D0363

Cone beam – three dimensional image reconstruction using existing data, includes multiple images is considered as specialized treatment and is not a covered benefit unless the group has elected this benefit. Predetermination is recommended

TESTS AND EXAMINATIONS

D0415

Collection of microorganisms for culture and sensitivity is not a covered benefit for most groups.

D0416

Viral culture is not a covered benefit.

D0417 ☆

Collection and preparation of saliva sample for laboratory diagnostic testing is not a covered benefit.

D0418 ☆

Analysis of saliva sample is not a covered benefit.

D0421

Genetic test for susceptibility to oral diseases is not a covered benefit.

D0425

Caries susceptibility tests are not a covered benefit for most groups.

D0431

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

D0460

Pulp vitality tests are payable by visit, not by tooth and should be billed as one service.

☑ *Pulp vitality tests* are not a benefit if done on the same date of service as definitive treatment.

D0470

Diagnostic casts are covered only if done for orthodontic or TMJ purposes and the group has purchased orthodontic or TMJ benefits. When covered, they are paid from the orthodontic or TMJ maximum.

☑ When covered, diagnostic casts are covered once in the patient's lifetime.

ORAL PATHOLOGY LABORATORY

WDS will pay for one lab report on the same date of service. The most inclusive code will be paid and all others are disallowed.

Some groups require predetermination in order to pay for lab expenses.

D0472

☑ Accession of tissue, gross examination, preparation and transmission of written report must be submitted with the pathology report.

D0473

Accession of tissue, gross and microscopic examination, preparation and transmission of written report must be submitted with the pathology report.

D0474

Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report must be submitted with the pathology report.

D0475

Decalcification procedures must be submitted with the pathology report.

D0476

Special stains for microorganisms must be submitted with the pathology report.

D0477

Special stains, not for microorganisms must be submitted with the pathology report.

D0478

Immunohistochemical stains must be submitted with the pathology report.

D0479

Tissue in-situ hybridization, including interpretation must be submitted with the pathology report.

D0480

☑ Processing and interpretation of exfoliative cytologic smears, including the preparation and transmission of written report must be submitted with the pathology report.

D0481

Electron microscopy – diagnostic must be submitted with the pathology report.

D0482

Direct immunofluorescence must be submitted with the pathology report.

D0483

Indirect immunofluorescence must be submitted with the pathology report.

D0484

Consultation on slides prepared elsewhere is not a covered benefit unless the group has elected this benefit.

D0485

Consultation, including preparation of slides from biopsy material supplied by referring source is not a covered benefit unless the group has elected this benefit.

D0486

Accession of brush biopsy sample, microscopic examination, preparation and transmission of written report must be submitted with the pathology report.

D0502

☑ *Other oral pathology procedures, by report* must be submitted with the pathology report.

D0999

Unspecified diagnostic procedure, by report requires a narrative to be considered for payment.

Prescription strength home fluoride and anti-microbial mouth rinses may be covered according to each contract if the patient meets periodontal criteria or is pregnant.

Processing policies marked with ☑ only apply to groups using DDPA processing policies.

Codes marked with ☆ are new ADA codes effective 1/1/2009.

Policies marked with ↳ are new processing policies effective 5/1/2010.

These are general guidelines. Coverage for all procedures is based on each group's contract.

DENTAL PROPHYLAXIS

When separate charges are submitted for any combination of adult prophylaxis, periodontal scaling, periodontal maintenance and periodontal surgery on the same day, WDS will allow the most inclusive procedure and disallow all others.

The time limitation for prophylaxis varies with each group contract. It is important to check the time limitation as there are several possibilities, including: once in four months, once in six months, twice in a calendar year, twice in twelve months. The time limitation for prophylaxis includes any combination of prophylaxis (D1110/D1120), full mouth debridement (D4355) and periodontal maintenance (D4910).

For any combination of adult prophylaxis (D1110) and periodontal maintenance (D4910), third and fourth occurrences may be covered if the patient meets periodontal criteria of AAP Case Type III or IV; this coverage varies with each contract.

D1110

A prophylaxis is considered *prophylaxis – adult* on patients age 14 and older. D1110 submitted on a patient under the age of 14 will be considered as a prophylaxis – child (D1120) for reimbursement purposes.

WDS will pay an adult prophylaxis on a child under the age of 14 if that child has his complete adult dentition at the time of service; narrative is required.

A prophylaxis that is performed on two dates of service is considered to be one treatment and should be billed on the completion date.

D1120

A prophylaxis is considered *prophylaxis – child* for patients through the age of 13. D1120 submitted on a patient over the age of 13 will be considered as a prophylaxis – adult (D1110) for reimbursement purposes.

TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)

D1203

Most groups have a maximum age limit for topical application of fluoride – child. The age limit varies according to each group's contract. D1203 billed on a patient exceeding the group's age limit is not a covered benefit.

Some groups cover child fluoride for patients of any age.

D1204

Most groups have a maximum age limit for topical application of fluoride – adult. The age limit varies according to each group's contract. D1204 billed on a patient exceeding the group's age limit is not a covered benefit.

Some groups cover adult fluoride for patients of any age.

D1206

Most groups have a maximum age limit for topical fluoride varnish; therapeutic application for moderate to high caries risk patients. The age limit varies according to each group's contract. D1206 billed on a patient exceeding the group's age limit is not a covered benefit.

Some groups cover topical fluoride varnish for patients of any age.

OTHER PREVENTIVE SERVICES

D1310

Nutritional counseling for control of dental disease is not a covered benefit unless the group has elected this benefit. Predetermination is recommended.

D1320

Tobacco counseling for the control and prevention of oral disease is not a covered benefit unless the group has elected this benefit. Predetermination is recommended.

D1330

Oral hygiene instruction is not a covered benefit unless the group has elected this benefit. Predetermination is recommended.

D1351

Sealant – per tooth is not a covered benefit unless the group elects sealant benefits separately.

When covered, sealants are covered on the unrestored occlusal surface of posterior permanent molars.

Coverage for repair or replacement of a sealant varies with each contract. It may be covered once in two years or once in three years. A repair or replacement done within the specified time by the same dentist is disallowed.

☑ Repair or replacement of a sealant is not a covered benefit. Sealants are allowed once per lifetime on the same tooth. A repair or replacement done within two years of initial placement by the same dentist is disallowed. A repair or replacement done by a different dentist, or done more than two years after initial placement by the same dentist, is not a covered benefit and is the patient's responsibility.

SPACE MAINTENANCE (PASSIVE APPLIANCES)

Space maintainers are covered once per lifetime for the same space.

The age at which coverage for space maintainers varies according to each groups' contract. It is important to check the age limit as there are several possibilities, including: 13, 17, 18, 19 and no age limit.

Space maintainers are a benefit when designed to preserve space created by the premature loss of a primary tooth to enable the proper eruption of permanent teeth or to prevent drifting of teeth.

Space maintainers placed due to missing anterior teeth (permanent or primary) are not a covered benefit.

The same rules apply for removable space maintainers as for fixed space maintainers.

D1550

☑ *Re-cementation of space maintainer* is a covered benefit once per lifetime for the same appliance by the same dentist.

D1555

Removal of fixed space maintainer is not covered if done be the same dentist that placed the space maintainer.

This procedure is paid up to the fee for re-cementation of space maintainer (D1550).

Processing policies marked with ☑ only apply to groups using DDPA processing policies.

Codes marked with ☆ are new ADA codes effective 1/1/2009.

Policies marked with ↳ are new processing policies effective 5/1/2010.

These are general guidelines. Coverage for all procedures is based on each group's contract.

DIRECT RESTORATIONS – GENERAL GUIDELINES

↳ An amalgam, composite, gold foil, or inlay restoration on the same surface(s) of the same tooth is covered once in a two-year period.

↳ An amalgam, composite, gold foil, or inlay restoration placed within 2 years of a buildup on the same tooth is not a covered benefit.

↳ An amalgam, composite, gold foil, or inlay restoration placed after an onlay or crown is denied.

In cases involving two or more separate restorations on the same surface, performed on the same day, the fee for one surface is the benefit. Any remaining restoration billed on the same surface is disallowed. Exceptions can be made in the following situations: On anterior teeth, duplicate surface(s) can be allowed as long as one filling involves the mesial surface, the other filling involves the distal surface, and *neither* filling involves both the mesial and the distal surfaces. On tooth numbers 1, 2, 3, 14, 15, 16, 21, and 28 two occlusal fillings can be allowed *if they are on different areas of the occlusal surface*.

Restorations for altering occlusion, involving vertical dimension, replacing tooth structure lost by attrition, erosion, abrasion (wear), or for periodontal, orthodontic, or other splinting are not a covered benefit.

Area gingivectomy (D4211) or crown lengthening (D4249) in conjunction with any restoration on the same day is disallowed.

RESIN-BASED COMPOSITE RESTORATIONS – DIRECT

Any fee for acid-etch in addition to the fee for restorative procedures is disallowed.

Proximal restorations not involving the incisal angle on an anterior tooth are considered to be one-surface restorations unless a narrative or radiograph(s) show a significant portion of the lingual or labial surfaces are involved.

Composite restorations placed to close diastemas or for esthetics are not a covered benefit.

Unless the group has elected posterior composite benefits, posterior composites are a covered benefit up to the doctor's filed fee for an equal-surface amalgam restoration. Any remaining fee up to the doctor's filed fee for the composite is the patient's responsibility. Any amount submitted above the filed fee for the posterior composite is disallowed.

D2330

Resin-based composite – one surface, anterior

D2331

Resin-based composite – two surfaces, anterior

D2332

Resin-based composite – two surfaces, anterior

D2335

Resin-based composite – two surfaces, anterior

D2390

Resin-based composite crown, anterior

D2391

Resin-based composite – one surface, posterior

D2392

Resin-based composite – two surfaces, posterior

D2393

Resin-based composite – three surfaces, posterior

D2394

Resin-based composite – four or more surfaces, posterior

GOLD FOIL RESTORATIONS

D2410 – D2430

Gold foils are paid as an equal-surface amalgam restoration. Any remaining fee is the patient's responsibility.

INLAY RESTORATIONS

D2510 – D2530, D2610 – D2630, D2650 – D2652

Inlays are paid as an equal-surface amalgam restoration. Any remaining fee up to the maximum allowable fee for the inlay is the patient's responsibility.

Any amount submitted above the maximum allowable fee for the inlay is disallowed.

A sedative filling (D2940), gingivectomy (D4211), or limited occlusal adjustment (D9951) is disallowed if done on the same tooth on the same day as an inlay. The fee for any of these procedures paid prior to processing of the inlay will be deducted from the approved amount for the inlay.

ONLAYS AND SINGLE RESTORATION CROWNS – GENERAL GUIDELINES

If a tooth can be restored with a direct filling material such as amalgam or composite, an allowance can be made for such a procedure toward the cost of the onlay or crown.

Some groups require predetermination for onlays and crowns. This is outlined in the patient's benefit book.

Predetermination is recommended for multiple onlays and/or crowns.

Indirect restorations should be billed on the date the restoration is cemented in place, regardless of the type of cement used.

☑ Onlays and crowns are not a covered benefit for children under the age of twelve.

GENERAL CRITERIA TO ALLOW ONLAYS AND CROWNS:

Teeth with dental caries (decay) where a significant amount of tooth structure has been lost and cannot be reasonably restored with an amalgam or composite resin restoration.

Teeth with fractured off or broken off tooth structure, which cannot be reasonably restored with a direct amalgam or composite resin restoration.

Endodontically (root canal) treated posterior teeth.

Posterior teeth diagnosed with Cracked Tooth Syndrome.

GENERAL EXCLUSIONS FOR ONLAYS AND CROWNS:

Onlays and crowns are not a covered benefit for five or seven years after the placement of any prior onlay, crown (on a natural tooth or an implant), porcelain veneer, fixed partial denture unit (on a natural tooth or an implant) on the same tooth or tooth space, depending on each group's contract.

Onlays and crowns are not a covered benefit for two years after the placement of a prior amalgam, composite, gold foil, or inlay restoration on the same tooth without evidence of new pathology. If new pathology is present, a benefit can be allowed or an alternative benefit may be applied by deducting the cost of the prior restoration towards the cost of the indirect restoration.

Onlays and crowns are not a covered benefit for two years after the placement of a prior prefabricated crown.

Onlays and crowns placed with no evidence of carious breakdown or fractured off tooth structure are not a covered benefit.

Onlays and crowns done to alter occlusion or change vertical dimension are not a covered benefit.

Onlays and crowns done to replace tooth structure lost by attrition, erosion or abrasions are not a covered benefit.

Onlays and crowns done for periodontal or orthodontic splinting are not a covered benefit.

Onlays and crowns placed due to enamel cracks or fracture lines (including craze lines), without the displacement of tooth structure or actual failure of the tooth is considered preventive and are not a covered benefit.

Onlays and crowns placed prior to the actual failure of the tooth are considered preventive and are not a contract benefit.

Onlays and crowns placed on endodontically treated anterior teeth with no other contributing factors are not a covered benefit.

Onlays and crowns done for cosmetic or esthetic reasons are not a covered benefit.

Onlays and crowns placed to correct a developmental or congenital defect or anomaly are not a covered benefit.

Onlays and crowns to provide additional retention to a removable partial denture are not a covered benefit.

Onlays and crowns placed on peg laterals are not a covered benefit.

Specialized treatment (e.g. due to allergies) is not covered as a separate benefit from the restoration.

The replacement of an existing onlay or crown with no evidence of pathology is not a covered benefit, regardless of the age of the existing indirect restoration.

ONLAY RESTORATIONS

D2542 – D2544, D2642 – D2644, D2662 – D2664

A buildup is disallowed if done on the same tooth as an onlay. The fee for a buildup paid up to two years prior to

an onlay will be deducted from the approved amount for the onlay.

CROWNS – SINGLE RESTORATIONS ONLY

D2710 – D2712

A resin-based composite crown is a covered benefit up to the filed fee for a four or more surface amalgam restoration (D2161) if billed on a posterior tooth, or a four or more surface resin-based composite restoration (D2335) if billed on an anterior tooth, unless the group has elected resin-based crown benefits separately. Any remaining fee up to the maximum allowable fee for the resin-based crown is the patient's responsibility. Any amount submitted above the maximum allowable fee for the resin-based crown is disallowed.

D2720 – D2794

Permanent crowns on primary teeth are covered only for retained primary teeth with no permanent replacement tooth and only when the tooth meets criteria for crown coverage.

☑ Some groups do not cover porcelain and metal crowns on children under the age of twelve.

OTHER RESTORATIVE SERVICES – GENERAL GUIDELINES

D2799

A long term *provisional crown* requires a narrative to be considered for payment.

D2920

☑ *Recement crown* done within six months of initial placement by the same doctor is disallowed (denied by a different doctor).

D2932, D2934

☑ *Prefabricated resin crown* is paid up to the maximum allowable fee for D2930 or D2931. Any remaining fee up to the maximum allowable fee for the resin crown is the patient's responsibility. Any amount submitted above the resin crown fee is disallowed.

D2940

A *sedative filling* done on the same day as a definitive restoration (direct or indirect) on the same tooth is disallowed.

General criteria to allow core buildups

Build-ups are a covered benefit when 50% or more of the natural coronal structure of the tooth is destroyed by decay or is missing due to fracture (less than 2mm of vertical height remaining).

Buildups are covered on endodontically treated posterior teeth.

Buildups are covered for teeth with existing onlays or crowns having recurrent decay, fractured off restorative material or tooth structure.

General exclusions for core buildups

Build-ups under onlays are considered as part of the procedure and are disallowed.

Any combination of core buildup and post and core (D2950, D2952, D2954, D6970, D6972, and D6973) is covered once in a two, five, or seven year period, depending on each group's contract.

A core buildup or post and core is not a covered benefit for two years after the placement of an amalgam, composite, gold foil, or inlay restoration.

D2950

☑ *Core build up, including any pins* is disallowed if a determination is made that the tooth does not meet clinical criteria.

Some groups require predetermination for core buildups.

If a core buildup is performed on the same tooth as a fixed partial denture retainer, it should be billed as D6973 (*core buildup for retainer, including any pins*)

.

D2952

☑ Evidence of prior root canal therapy must be provided, unless Washington Dental Service has record of the RCT in the patient's history. Without evidence of prior root canal, the procedure is disallowed.

If a *post and core in addition to crown, indirectly fabricated* is performed on the same tooth as a fixed partial denture retainer, it should be billed as D6970 (post and core in addition to fixed partial denture retainer, indirectly fabricated).

D2954

☑ Evidence of prior root canal therapy must be provided, unless Washington Dental Service has record of the RCT in the patient's history. Without evidence of prior root canal, the procedure is disallowed.

If a *prefabricated post and core in addition to crown* is performed on the same tooth as a fixed partial denture retainer, it should be billed as D6972 (prefabricated post and core in addition to fixed partial denture retainer).

D2960-D2961

Resin veneers are a covered benefit up to the doctor's filed fee for a one-surface composite restoration, unless the group has elected resin veneer benefits separately. Any remaining fee up to the maximum allowable fee for the resin veneer is the patient's responsibility. Any amount submitted above the resin veneer fee is disallowed.

D2962

Benefits for *labial veneer (porcelain laminate) – laboratory* are determined using the same guidelines and limitations as full coverage crowns.

D2970

Temporary crown (fractured tooth) placed prior to a permanent indirect restoration is disallowed.

D2980

Crown repair, by report requires a narrative to be considered for payment.

D2999

Unspecified restorative procedure, by report requires a narrative to be considered for payment.

Recontouring restorations or **overhang removal** is not a covered benefit.

Polishing restorations is not a covered benefit

Processing policies marked with ☑ only apply to groups using DDPA processing policies.

Codes marked with ☆ are new ADA codes effective 1/1/2009.

Policies marked with ↳ are new processing policies effective 5/1/2010.

These are general guidelines. Coverage for all procedures is based on each group's contract.

PULP CAPPING – GENERAL GUIDELINES

Direct and indirect pulp caps are considered to be part of the final restoration and are disallowed.

PULPOTOMY – GENERAL GUIDELINES

D3220

A therapeutic pulpotomy, (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament submitted on a permanent tooth is paid as palliative treatment (D9110).

☑ A therapeutic pulpotomy submitted on a permanent tooth is paid as pulpal debridement (D3221).

D3222 ☆

Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development is not a covered benefit.

ENDODONTIC THERAPY ON PRIMARY TEETH – GENERAL GUIDELINES

D3230 – D3240

Pulpal therapy on a primary tooth is a covered benefit up to the maximum allowable fee for a pulpotomy (D3220), unless the group has purchased primary tooth endodontic benefits separately. Any remaining fee up to the maximum allowable fee for the pulpal therapy is the patient's responsibility. Any amount submitted above the maximum allowable fee for the pulpal therapy is disallowed.

ENDODONTIC THERAPY (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES AND FOLLOW-UP CARE) – GENERAL GUIDELINES

A final restoration is a benefit in addition to the charge for the endodontic therapy.

Endodontic therapy submitted on a primary tooth is paid as pulpal therapy (D3230, D3240). An exception can be made for a primary tooth not having a permanent tooth to replace it. A radiograph is required.

One pre-operative radiograph is allowed with endodontic therapy. All other radiographs are considered a component of the endodontic therapy and are disallowed.

D3310 – D3330

Endodontic therapy is a covered benefit once in a lifetime per tooth. Subsequent endodontic therapy is considered as an endodontic re-treatment (D3346 – D3348) for reimbursement purposes.

Endodontic therapy performed in conjunction with an overdenture is paid at the prosthetic co-payment level. Some groups require predetermination for endodontic therapy. This is outlined in the patient's benefit book.

A final restoration is a benefit in addition to the charge for the endodontic therapy.

D3331

Treatment of root canal obstruction; non-surgical access is disallowed as a component of root canal therapy for most groups.

ENDODONTIC RETREATMENT

D3346 – D3348

↳ *Endodontic re-treatment* by the same dentist within 24 months is considered part of the original procedure and is disallowed.

Endodontic re-treatment performed in conjunction with an overdenture is paid at the prosthetic co-payment level.

Some groups require predetermination for endodontic re-treatment.

Removal of post(s) and/or pins(s) is considered to be part of the endodontic re-treatment and is disallowed.

A final restoration is a benefit in addition to the charge for the endodontic re-treatment.

APEXIFICATION/RECALCIFICATION PROCEDURES

D3353

For most groups, *apexification / recalcification – final visit* is covered up to the filed fee for the appropriate endodontic therapy code (D3310 – D3330). Any remaining fee up to the maximum allowable fee for the apexification/recalcification is the patient's responsibility. Any amount submitted above the maximum allowable fee for the D3353 is disallowed.

APICOECTOMY/PERIRADICULAR SERVICES

D3450

☑ *Root amputation – per root* is disallowed when performed on the same day as any other surgical endodontic procedure (D3410 – D3426; D3920).

D3460

Endodontic endosseous implant is not a covered benefit unless the group has elected this benefit.

D3470

Intentional reimplantation (including necessary splinting) is not a covered benefit unless the group has elected this benefit.

OTHER ENDODONTIC PROCEDURES

D3910

Surgical procedure for isolation of tooth with rubber dam is disallowed.

D3950

Canal preparation and fitting of preformed dowel or post is disallowed.

D3999

Unspecified endodontic procedure, by report requires a narrative to be considered for payment.

Processing policies marked with a ☑ only apply to groups using DDPA processing policies.

Codes marked with a ☆ are new ADA codes effective 1/1/2009.

Policies marked with ↳ are new processing policies effective 5/1/2010.

These are general guidelines. Coverage for all procedures is based on each group's contract.

PERIODONTAL PROCEDURES – GENERAL GUIDELINES

WDS uses case type, based on pocket depth readings, recession, and furcation, to determine periodontal benefits. Click *here* for more information on determining case types.

For any combination of the following procedure codes billed on the same date of service, the highest fee procedure that is allowed clinically is paid. All others are disallowed: D1110, D4210, D4211, D4240, D4241, D4260, D4261, D4341, D4342, D4910.

Per quadrant procedure codes should be submitted using UR, UL, LL and LR as the quadrant indicators (versus 10, 20, 30, 40 or I, II, III, IV).

Be sure periodontal charts are legible. Readings written in dark ink are easier to see on our imaging system than readings written in pencil or red ink. Be aware that a dark copy of a periodontal chart will appear as a black page once scanned into our system.

Periodontal charting is considered as part of an exam. If periodontal charting and an exam are billed on the same date of service, the fee for the exam is a benefit. The fee for the periodontal charting is disallowed.

An *occlusal guard, by report* (D9940) done for periodontal reasons is a benefit for many groups, if the patient meets clinical criteria of case type 3 or case type 4. See D9940 in the Adjunctive section for more information.

An *occlusal adjustment – complete* (D9952) done for periodontal reasons is a benefit for many groups, if the patient meets clinical criteria of case type 3 or AAP case type 4. See D9952 in the Adjunctive section for more information.

The use of myomonitor, kineograph or any other such device or equipment is not a covered benefit unless the group has elected this benefit.

SURGICAL SERVICES (INCLUDING USUAL POSTOPERATIVE CARE) – GENERAL GUIDELINES

Surgical periodontal procedures are covered once in three years for most groups.

☑ Surgical periodontal procedures are disallowed within three years of prior periodontal surgery in the same quadrant if done by the same dentist.

Surgical periodontal procedures must be submitted with a periodontal chart dated no more than 12 months prior to the date of service unless otherwise indicated in the following pages.

Some groups do not cover surgical periodontal procedures.

Surgical periodontal procedures are covered for patients classified as case type 3 or case type 4. Benefits are determined based on the number of qualifying teeth in the quadrant. Qualifying teeth have at least one 5mm (or greater) pocket depth reading. For some groups, teeth adjacent to a mesial or distal 5mm(+) pocket depth reading are also considered to be qualifying teeth.

Some groups require that scaling and root planing (D4341/D4342) be performed a minimum of six weeks up to a maximum of six months prior to performing periodontal surgery; or the patient must have been in a sustained program of supportive periodontal therapy (D4910/D1110) following active therapy (D4341/D4342).

Some groups require predetermination of surgical periodontal procedures. This is outlined in the patient's benefit book.

D4210

☑ *Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant* is disallowed if performed within four weeks of periodontal scaling and root planing (D4341/D4342).

D4210 may be prorated if less than four teeth are determined to qualify for coverage.

D4211

Gingivectomy or gingivoplasty- one to three contiguous teeth or tooth bounded spaces per quadrant is disallowed if done on the same day in the same area as any direct or indirect restoration.

D4230

Anatomical crown exposure – four or more contiguous teeth per quadrant is not a covered benefit unless the group has elected this benefit.

D4231

Anatomical crown exposure – one to three teeth per quadrant is not a covered benefit unless the group has elected this benefit.

D4240

☑ *Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant* is disallowed if performed within four weeks of periodontal scaling and root planing (D4341/D4342). This procedure may be prorated if there are less than four qualifying teeth in the quadrant.

This procedure may be prorated if there are less than four qualifying teeth in the quadrant.

D4241

☑ *Gingival flap procedure, including root planing – one to three contiguous teeth or tooth bounded spaces per quadrant* is disallowed if performed within four weeks of periodontal scaling and root planing (D4341/D4342).

D4245

☑ *Apically positioned flap* is disallowed if performed within four weeks of periodontal scaling and root planing (D4341/D4342).

D4249

Clinical Crown Lengthening – hard tissue is covered only if the treated tooth meets clinical criteria for coverage of a restoration and the periodontal environment is healthy. (For more information on clinical criteria for coverage, see Restorative (D2000 – D2999)

Crown lengthening is disallowed if done on the same day in the same area as any direct or indirect restoration.

D4260

☑ *Osseous surgery (including flap entry and closure)- four or more contiguous teeth or tooth bounded spaces per quadrant* is disallowed if performed within four weeks of periodontal scaling and root planing (D4341/D4342).

This procedure may be prorated if there are less than four qualifying teeth in the quadrant.

D4261

☑ *Osseous surgery (including flap entry and closure)- one to three contiguous teeth or tooth bounded spaces per quadrant* is disallowed if performed within four weeks of periodontal scaling and root planing (D4341/D4342).

Bone Grafts – General Guidelines

D4263, D4264, D4265

A bone graft requires *covered* periodontal surgery in order to be a covered benefit.

A bone graft is covered in the same site once in three years for most groups; subsequent grafts in the same site are denied. Additionally, the maximum number of grafts that are covered per quadrant in a three year period is two.

☑ A bone graft is covered in the same site once in three years; subsequent grafts in the same site are disallowed. Additionally, the maximum number of grafts that are covered per quadrant in a three year period is two.

D4263

Bone replacement graft - first site in quadrant is available when the graft is performed for periodontal defects on natural teeth, and implants *for some groups*. When performed in conjunction with ridge augmentations, extractions, root amputations, apicoectomies, and hemisections, in edentulous areas, and implants for most groups, it is not a benefit.

An additional D4263 billed in the same quadrant on the same date of service is paid as bone replacement graft – each additional site in quadrant (D4264).

D4264

Bone replacement graft – each additional site in quadrant is available when the graft is performed for periodontal defects on natural teeth, and implants *for some groups*. When performed in conjunction with ridge augmentations, extractions, root amputations, apicoectomies and hemisections, in edentulous areas, and implants for most groups, it is not a benefit.

D4265

Biologic materials to aid in soft and osseous tissue regeneration is not a covered benefit if it is done on the same day in the same quadrant as a bone graft (D4263, D4264) or guided tissue regeneration (D4266, D4267).

D4266, D4267

Guided tissue regeneration (GTR) requires covered periodontal surgery in order to be a covered benefit.

Guided tissue regeneration (GTR) is available when it is performed for periodontal defects on natural teeth, and implants *for some groups*. When performed in conjunction with ridge augmentations, extractions, root amputations, apicoectomies and hemisections, in edentulous areas, and implants for most groups, it is not a benefit.

Guided tissue regeneration (GTR) is covered in the same site once in three years for most groups; subsequent GTR's in the same site are denied. Additionally, the maximum number of GTR's that are covered per quadrant in a three year period is two.

☑ Guided tissue regeneration (GTR) is covered in the same site once in three years; subsequent GTR's in the same site are disallowed. Additionally, the maximum number of GTR's that are covered per quadrant in a three year period is two.

D4268

Surgical revision procedure, per tooth is not a covered benefit unless the group has elected this benefit.

Soft Tissue Grafts – General Guidelines

D4270, D4271, D4273, D4275, D4276

Periodontal charting is not required for soft tissue grafts.

Soft tissue grafts (D4270, D4271, D4273, D4275, D4276) are a benefit when the graft is performed for periodontal defects on natural teeth, and implants *for some groups*. When performed in conjunction with ridge augmentations, extractions, root amputations, apicoectomies and hemisections, in edentulous areas, and implants for most groups, the graft is not a benefit.

If more than one soft tissue graft is billed in the same site on the same date of service, the highest fee procedure that is allowed clinically is paid. All others are disallowed.

Any combination of soft or connective tissue grafts (D4270, D4271, D4273, D4275, D4276) is covered in the same site once in three years for most groups; subsequent grafts in the same site are denied. Additionally, the maximum number of grafts that are covered per quadrant in a three year period is two.

☑ Any combination of sift or connective tissue grafts (D4270, D4271, D4273, D4275, D4276) is covered in the same site once in three years; subsequent grafts in the same site are disallowed. Additionally, only two grafts are covered per quadrant in a three year period.

D4274

Distal or proximal wedge procedure is only covered when performed on the most distal tooth in the quadrant, and requires a minimum 5mm pocket depth on the distal of the treated tooth in order to be a covered benefit.

Distal or proximal wedge procedure done on the same day in the same quadrant as osseous surgery is disallowed.

NON-SURGICAL PERIODONTAL SERVICES – GENERAL GUIDELINES

Non-surgical periodontal procedures do not require periodontal charting unless otherwise indicated in the following pages.

D4320

Provisional Splinting - intracoronal is not a covered benefit unless the group has elected this benefit.

D4321

Provisional Splinting – extracoronal is not a covered benefit unless it is done as the result of an accident. If done because of an accident, the date and a description of the accident and clinical diagnosis are required.

D4341, D4342

Periodontal scaling and root planing is covered once in one year or once in three years, per quadrant, according to each group's contract.

Periodontal scaling and root planing is not a covered benefit for 12 months following periodontal surgery (D4210, D4240, D4241, D4245, D4260, D4261) in the same quadrant.

D4355

Full mouth debridement to enable comprehensive evaluation and diagnosis is covered as a prophylaxis (D1110) for 12 months following any prior cleaning (D1110, D1120, D4342, D4342, D4355, D4910).

☑ Full mouth debridement is a covered benefit once in a lifetime. All subsequent D4355's are covered as prophylaxis (D1110).

D4381

Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report requires a periodontal chart dated no more than 12 months prior to the date of service. The patient must be an AAP Case Type 3 or AAP Case Type 4 and the treated tooth must have 5mm (or greater) pocket depth readings for the procedure to be a covered benefit.

Localized delivery of chemotherapeutic agents is not a covered benefit if done on the same day as periodontal scaling and root planing.

Some groups require that scaling and root planing (D4341/D4342) be performed a minimum of six weeks up to a maximum of six months prior to this treatment; or the patient must have been in a sustained program of supportive periodontal therapy (D4910/D1110) following active therapy (D4341/D4342).

Localized delivery of chemotherapeutic agents is covered twice in a benefit period per tooth, up to a maximum of two treated teeth per quadrant.

Localized delivery of chemotherapeutic agents is disallowed if done on the same day as periodontal surgery.

Localized delivery of chemotherapeutic agents is not a covered benefit when used for the purpose of maintaining non-covered dental procedures or implants.

The chemotherapeutic agent must be approved by the Federal Drug Administration.

OTHER PERIODONTAL SERVICES – GENERAL GUIDELINES

D4910

The time limitation for *periodontal maintenance* varies with each group contract. It is important to check the time limitation as there are several possibilities, including: once in four months, once in six months, twice in a calendar year, once in a benefit period, twice in a benefit period and four times in a benefit period. The time limitation for periodontal maintenance includes any combination of prophylaxis (D1110/D1120), full mouth debridement (D4355) and periodontal maintenance (D4910).

Periodontal maintenance is not a covered benefit unless the patient has had prior active periodontal treatment. Qualifying periodontal procedures are gingival flap procedure (D4240, D4241), apically positioned flap (D4245), osseous surgery (D4260, D4261), soft tissue flap (D4270, D4271, D4273, D4275, D4276), distal wedge (D4274), and root planing and scaling (D4341, D4342).

For any combination of adult prophylaxis (D1110) and periodontal maintenance (D4910), third and fourth occurrences may be covered if the patient meets periodontal criteria of AAP Case Type III or IV; this coverage varies with each contract.

D4999

Unspecified periodontal procedure, by report requires a narrative to be considered for payment.

Case Type	Characteristics	Pocket Depths	Furcation Grade	Gum Recession	Attachment Loss
0 Clinically Healthy	Pink, firm, resilient without inflammation	1 to 3 mm	None	None	None
1 Chronic Marginal Gingivitis	Reddish blue with inflammation, bleeds with gentle probing	< 4 mm	None	None	None
2 Early Periodontitis	Progression of inflammation, early bone loss with moderate bleeding	4 to 5 mm	May have Grade I furcation	May exhibit signs of early recession	Ranges from 1 to 5 mm
3 Moderate Periodontitis	Increased destruction of tissues	5 to 7 mm	Grade II furcation	Advancing recession	5 to 7 mm
4 Advanced Periodontitis	Further progression with severe destruction of periodontal structures	> 7 mm	Grade II to Grade III furcation	Advancing recession	6+ mm

Prosthodontics: (removable) D5000 – D5899

Processing policies marked with ☑ only apply to groups using DDPA processing policies.

Codes marked with ☆ are new ADA codes effective 1/1/2009.

Policies marked with ↳ are new processing policies effective 5/1/2010.

These are general guidelines. Coverage for all procedures is based on each group's contract.

PROSTHODONTICS – GENERAL GUIDELINES

Some groups have a six or 12 month waiting period for prosthodontic procedures.

Most groups cover removable prosthetics once in five or seven years in the same arch.

Washington Dental Service has no missing tooth clause.

PARTIAL DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE) – GENERAL GUIDELINES

D5211 – D5281

☑ Partial dentures are not a covered benefit for children under the age of 16.

ADJUSTMENTS TO DENTURES – GENERAL GUIDELINES

D5410 – D5422

☑ Adjustments are covered twice in a twelve month period.

Adjustments are disallowed if done within six months of initial delivery of the denture by the same doctor (denied by a different doctor).

Adjustments are disallowed if done within six months of a rebase by the same doctor (denied by a different doctor .

REPAIRS TO COMPLETE DENTURES – GENERAL GUIDELINES

D5510 – D5520

Repairs are disallowed if done within six months of initial delivery of the complete denture by the same doctor (denied by a different doctor).

REPAIRS TO PARTIAL DENTURES – GENERAL GUIDELINES

D5610 – D5671

Repairs are disallowed if done within six months of initial delivery of the partial denture by the same doctor (denied by a different doctor).

DENTURE REBASE PROCEDURES – GENERAL GUIDELINES

D5710 – D5721

For most groups, rebases are covered once in a twelve month period.

Rebases are disallowed if done within six months of initial delivery of the denture by the same doctor (denied by a different doctor).

DENTURE RELINE PROCEDURES – GENERAL GUIDELINES

D5730 – D5761

For most groups, denture relines are covered once in a twelve month period.

Relines are disallowed if done within six months of initial delivery of the denture by the same doctor (denied by a different doctor).

Relines are disallowed if done within six months of a rebase by the same doctor (denied by a different doctor).

INTERIM PROSTHESIS – GENERAL GUIDELINES

D5810 – D5811

☑ *Interim complete dentures* are not a covered benefit unless the group has elected this benefit.

For some groups, interim prostheses are a covered benefit once in a lifetime per arch.

For some groups, interim complete dentures are a covered benefit up to the filed fee for a reline. Any remaining fee up to the maximum allowable fee for the interim complete denture is the patient's responsibility. Any amount submitted above the interim complete denture fee is disallowed.

D5820 – D5821

Interim partial dentures are covered once in a lifetime per arch. For some groups, interim partial dentures are a covered benefit up to the filed fee for a reline. Any remaining fee up to the filed fee for the interim partial denture is the patient's responsibility. Any amount submitted above the interim partial denture fee is disallowed.

☑ Interim partial dentures are not a covered benefit to replace primary teeth.

☑ Interim partial dentures are not a covered benefit to replace posterior teeth.

☑ For patients 16 and younger, interim partials are covered to replace permanent anterior teeth.

☑ For patients over the age of 16, interim partial dentures are not a benefit unless a permanent anterior tooth was extracted or lost within the past six months. Narrative is required.

OTHER REMOVABLE PROSTHETIC SERVICES – GENERAL GUIDELINES

D5850 – D5851

For most groups, *tissue conditioning* is a covered benefit twice in a three year period.

Tissue conditioning is disallowed if done on the same day as initial delivery, rebase or reline of the permanent prosthesis.

D5860 – D5861

☑ *Overdenture – complete, by report* and *overdenture – partial, by report* are covered up to the filed fee for a complete or partial denture. Any fee remaining fee up to the maximum allowable fee for an overdenture is the patient's responsibility. Any amount submitted above the overdenture fee is disallowed.

For most groups, fillings and root canals done in conjunction with overdentures are limited to two teeth per arch and are paid at the prosthetic co-payment level.

☑ Fillings and root canals done in conjunction with overdentures are not a covered benefit unless the group has elected this benefit.

D5862

Precision attachment – by report is not a covered benefit unless the group has elected this benefit.

D5867

Replacement of replaceable part of semi-precision or precision attachment (male or female component) is not a covered benefit unless the group has elected this benefit.

D5875

Modification of removable prosthesis following implant surgery is a covered benefit for most groups.

D5899

Unspecified removable prosthodontics procedure, by report requires a narrative to be considered for payment.

Processing policies marked with ☑ only apply to groups using DDPA processing policies.

Codes marked with ☆ are new ADA codes effective 1/1/2009.

Policies marked with ↳ are new processing policies effective 5/1/2010.

These are general guidelines. Coverage for all procedures is based on each group's contract.

MAXILLOFACIAL PROSTHETICS – GENERAL GUIDELINES

For most groups, maxillofacial prosthetics are not a covered benefit.

For groups that do cover maxillofacial prosthetics, they are paid from the patient's regular annual maximum and there are no review requirements, with the exception of D5999. Check the group contract to verify coverage

Predetermination is highly recommended.

D5991 ☆

Topical medicament carrier is not a covered benefit.

D5999

Unspecified maxillofacial prosthesis, by report requires a narrative to be considered for payment.

Processing policies marked with ☑ only apply to groups using DDPA processing policies.

Codes marked with ☆ are new ADA codes effective 1/1/2009.

Policies marked with ↳ are new processing policies effective 5/1/2010.

These are general guidelines. Coverage for all procedures is based on each group's contract.

IMPLANT SERVICES – GENERAL GUIDELINES

Surgical implants and supporting structures are not a covered benefit unless the group has elected this benefit.

Implant supported prosthetics may be covered as submitted, covered as an alternate benefit (elective) or denied. If the procedure is paid as an alternate benefit, the balance up to the filed fee or maximum allowable fee for the actual service provided is the patient's responsibility. Any amount submitted above the implant supported prosthetic's filed fee is disallowed. Alternate benefits are described at the procedure code level.

Many WDS groups have implant coverage as a standard benefit. For these groups, implant benefits are paid from the group's annual maximum.

Some groups have a separate lifetime maximum for implant and implant related procedures.

Covered surgical implant and related procedures have a five or seven year time limitation depending on the group's contract.

Covered implant crowns are covered

Implants and implant related procedures are paid as Class III benefits unless otherwise indicated in the group's contract.

Some groups require predetermination on implants and/or implant related procedures. This is outlined in the patient's benefit book. Predetermination is recommended for all groups.

Soft Tissue Grafts (D4270, D4271, D4273, D4275, D4276) done in conjunction with implants are not a covered benefit for some groups.

Area gingivectomy (D4211) done in conjunction with any implant procedure is not a covered benefit.

Washington Dental Service has no missing tooth clause for implants.

PRE-SURGICAL SERVICES

D6190

Radiographic/surgical implant index, by report is covered or denied based on each group's contract. Narrative is not required.

SURGICAL SERVICES

D6010

Surgical placement of implant body; endosteal implant is covered or denied based on each group's contract.

D6012

Surgical placement of interim implant body for transitional prosthesis: endosteal implant is not a covered benefit unless the group has elected this benefit.

D6040

Surgical placement: eposteal implant is covered or denied based on each group's contract.

D6050

Surgical placement: transosteal implant is covered or denied based on each group's contract.

D6100

Implant removal, by report is covered or denied based on each group's contract. Narrative is not required.

IMPLANT SUPPORTED PROSTHETICS

SUPPORTING STRUCTURES

D6055

Dental implant supported connecting bar is covered or denied based on each group's contract.

D6056

Prefabricated abutment – includes placement is covered or denied based on each group's contract.

D6057

Custom abutment – includes placement is covered or denied based on each group's contract.

IMPLANT/ABUTMENT SUPPORTED REMOVABLE DENTURES

D6053

Implant/abutment supported removable denture for completely edentulous arch is covered or denied based on each group's contract. If paid as an alternate benefit, the alternate procedure is D5110 or D5120 (based on the treated arch) and the time limitations for the alternate procedure apply.

D6054

Implant/abutment supported removable denture for partially edentulous arch is covered or denied based on each group's contract. If paid as an alternate benefit, the alternate procedure is D5213 or D5214 (based on the treated arch) and the time limitations for the alternate procedure apply.

IMPLANT/ABUTMENT SUPPORTED FIXED DENTURES (HYBRID PROSTHESIS)

D6078

Implant/abutment supported fixed denture for completely edentulous arch is covered or denied based on each group's contract. If paid as an alternate benefit, the alternate procedure is D5110 or D5120 (based on treated arch) and the time limitations for the alternate procedure apply.

D6079

Implant/abutment supported fixed denture for partially edentulous arch is covered or denied based on each group's contract. If paid as an alternate benefit, the alternate procedure is D5213 or D5214 (based on treated arch) and the time limitations for the alternate procedure apply.

SINGLE CROWNS, ABUTMENT SUPPORTED

Abutment supported single crowns should be billed on the date the crown is cemented in place, regardless of the type of cement used.

Abutment supported single crowns are covered based on each group's contract. The crown may be covered as submitted, covered as an alternate benefit, or not covered.

↳ When covered as submitted, abutment supported single crowns are not a covered benefit for five or seven years after the placement of any prior onlay, crown (on a natural tooth or an implant), porcelain veneer, fixed partial denture unit (on a natural tooth or an implant) on the same tooth, depending on each group's contract.

When covered as an alternate benefit, the time limitations for the alternate procedure apply.

D6058

If abutment supported porcelain/ceramic crown is covered as an alternate benefit, the allowed procedure is either D2740 or D5213, depending on each group's contract.

D6059

If *abutment supported porcelain fused to metal crown (high noble metal)* is covered as an alternate benefit, the allowed procedure is either D2750 or D5213, depending on each group's contract.

D6060

If *abutment supported porcelain fused to metal crown (predominantly noble metal)* is covered as an alternate benefit, the allowed procedure is D2751, D5213, or D5214, depending on each group's contract

D6061

If *abutment supported porcelain fused to metal crown (noble metal)* is covered as an alternate benefit, the allowed procedure is D2752, D5213, or D5214, depending on each group's contract.

D6062

If *abutment supported cast metal crown (high noble metal)* is covered as an alternate benefit, the allowed procedure is either D2790, D5213, or D5214, depending on each group's contract and the time limitations for the alternate procedure apply.

D6063

If *abutment supported cast metal crown (predominantly noble metal)* is covered as an alternate benefit, the allowed procedure is D2791, D5213, or D5214, depending on each group's contract.

D6064

If *abutment supported cast metal crown (noble metal)* is covered as an alternate benefit, the allowed procedure is D2792, D5213, or D5214, depending on each group's contract.

D6094

If *abutment supported crown (titanium)* is covered as an alternate benefit, the allowed procedure is D2794, D5213, or D5214, depending on each group's contract.

SINGLE CROWNS, IMPLANT SUPPORTED

Implant supported single crowns should be billed on the date the crown is cemented in place, regardless of the type of cement used.

Implant supported single crowns are covered based on each group's contract. The crown may be covered as submitted, covered as an alternate benefit, or not covered.

↳ When covered as submitted, implant supported single crowns are not a covered benefit for five or seven years after the placement of any prior onlay, crown (on a natural tooth or an implant), porcelain veneer, fixed partial denture unit (on a natural tooth or an implant) on the same tooth, depending on each group's contract.

When covered as an alternate benefit, the time limitations for the alternate procedure apply.D6065

If *implant supported porcelain/ceramic crown* is covered as an alternate benefit, the allowed procedure is D2740, D5213, or D5214, depending on each group's contract.

D6066

If *implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)* is covered as an alternate benefit, the allowed procedure is D2750, D5213, or D5214, depending on each group's contract.

D6067

If *implant supported metal crown (titanium, titanium alloy, high noble metal)* is covered an alternate benefit, the allowed procedure is D2790, D5213, or D5214, depending on each group's contract.

FIXED PARTIAL DENTURE, ABUTMENT SUPPORTED

Abutment supported fixed partial dentures (fpd) should be billed on the date the fpd is cemented in place, regardless of the type of cement used.

Abutment supported fixed partial dentures are covered based on each group's contract. The fixed partial denture may be covered as submitted, covered as an alternate benefit, or not covered.

When covered as an alternate benefit, the time limitations for the alternate procedure apply.

D6068

If an *abutment supported retainer for porcelain/ceramic FPD* is covered as an alternate benefit, the allowed procedure is D6740, D5213, or D5214, depending on each group's contract and the treated arch.

D6069

If an *abutment supported retainer for porcelain fused to metal FPD (high noble metal)* is covered as an alternate benefit, the allowed procedure is D6750, D5213, or D5214, depending on each group's contract and the treated arch.

D6070

If *abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)* is covered as an alternate benefit, the allowed procedure is D6751, D5213, or D5214, depending on each group's contract and the treated arch.

D6071

If *abutment supported retainer for porcelain fused to metal FPD (noble metal)* is covered as an alternate benefit, the allowed procedure is D6752, D5213, or D5214, depending on each group's contract and the treated arch.

D6072

If *abutment supported retainer for cast metal FPD (high noble metal)* is covered as an alternate benefit, the allowed procedure is D6790, D5213, or D5214, depending on each group's contract and the treated arch.

D6073

If *abutment supported retainer for cast metal FPD (predominantly base metal)* is covered as an alternate benefit, the allowed procedure is D6791, D5213, or D5214, depending on each group's contract and the treated arch.

D6074

If *abutment supported retainer for cast metal FPD (noble metal)* is covered as an alternate benefit, the allowed procedure D6792, D5213, or D5214, depending on each group's contract and the treated arch.

FIXED PARTIAL DENTURE, IMPLANT SUPPORTED

Implant supported fixed partial dentures (fpd) should be billed on the date the fpd is cemented in place, regardless of the type of cement used.

Implant supported fixed partial dentures are covered based on each group's contract. The fixed partial denture may be covered as submitted, covered as an alternate benefit, or not covered.

When covered as an alternate benefit, the time limitations for the alternate procedure apply.

D6075

If *implant supported retainer for ceramic FPD* is covered as an alternate benefit, the allowed procedure D6740, D5213, or D5214, depending on each group's contract and the treated arch.

D6076

If *implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)* is covered as an alternate benefit, the allowed procedure is D6750, D5213, or D5214, depending on each group's contract and the treated arch.

D6077

If *implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)* is covered as an alternate benefit, the allowed procedure is D6792, D5213, or D5214, depending on each group's contract and the treated arch.

OTHER IMPLANT SERVICES

D6080

Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis is not a covered benefit for most groups.

D6090

Repair implant supported prosthesis, by report is covered or denied based on each group's contract. Narrative is not required.

D6091

Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment is covered or denied based on each group's contract.

D6092

Recement implant/abutment supported crown is covered or denied based on each group's contract.

D6093

Recement implant/abutment supported fixed partial denture is covered or denied based on each group's contract.

D6095

Repair implant abutment, by report is covered or denied based on each group's contract. Narrative is not required.

D6194

Abutment supported retainer crown for FPD (titanium) is covered or denied based on each group's contract. If paid as an alternate benefit, the alternate procedure is one of the following codes, depending on each group's contract: D6794, D5213

D6199

Unspecified implant procedure, by report is covered or denied based on each group's contract. Narrative is required.

Below are some common procedures performed in conjunction with implants:

An **interim partial** provided with an implant is a covered benefit if the implant is a covered benefit.

A **provisional crown** done with an implant is a covered benefit if the implant is a covered benefit.

An **implant retainer** is a covered benefit if the implant is a covered benefit.

Bone harvesting is not a covered benefit, regardless of the implant benefit.

A **sinus lift** is not a covered benefit. Please refer to ADA code D7951.

A **surgical guide** coded as D6199 is not a covered benefit. Please refer to ADA code D6190.

A **surgical stent** coded as D6199 is not a covered benefit. Please refer to ADA code D5982

Processing policies marked with ☑ only apply to groups using DDPA processing policies.

Codes marked with ☆ are new ADA codes effective 1/1/2009.

Policies marked with ↳ are new processing policies effective 5/1/2010.

These are general guidelines. Coverage for all procedures is based on each group's contract.

FIXED PROSTHODONTICS – GENERAL GUIDELINES

Fixed partial dentures (fpd) are not a covered benefit for five or seven years after the placement of a prior fpd, depending on each group's contract.

Some groups require predetermination on fixed partial dentures. This is outlined in the patient's benefit book.

A fixed partial denture replacing primary teeth on a child is not a covered benefit.

A double retainer is not a covered benefit unless the additional retainer tooth meets crown criteria. See the Restorative section of this manual for more information on benefiting crowns.

Washington Dental Service has no missing tooth clause.

☑ Fixed partial dentures are not a covered benefit for children under the age of 16.

D6253

A *provisional pontic* placed prior to a permanent fixed partial denture as part of a temporary fpd is disallowed.

Narrative is required for a long-term provisional pontic.

D6793

A *provisional retainer crown* placed prior to a permanent fixed partial denture as part of a temporary fpd is disallowed.

Narrative is required for a long-term provisional retainer crown.

D6920

A *connector bar* is not a covered benefit unless the group has elected this benefit.

D6930

Recement fixed partial denture is covered once in a 12 month period.

An FPD re-cement is disallowed within six months of initial placement if done by the same doctor (denied by a different doctor).

D6940

A *stress breaker* is not a covered benefit unless the group has elected this benefit.

D6950

A *precision attachment* is not a covered benefit unless the group has elected this benefit.

D6970

☑ Evidence of prior root canal therapy must be provided, unless Washington Dental Service has record of the RCT in the patient's history. Without evidence of prior root canal, *post and core in addition of fixed partial denture retainer, indirectly fabricated* is disallowed.

Any combination of core buildup and post and core (D2950, D2952, D2954, D6970, D6972, and D6973) is covered once in a two, five, or seven year period, depending on each group's contract.

A post and core is not a covered benefit for two years after the placement of an amalgam, composite, gold foil, or inlay restoration.

D6972

☑ Evidence of prior root canal therapy must be provided, unless Washington Dental Service has record of the RCT in the patient's history. Without evidence of prior root canal, *prefabricated post and core in addition to fixed partial denture retainer* is disallowed.

Any combination of core buildup and post and core (D2950, D2952, D2954, D6970, D6972, and D6973) is covered once in a two, five, or seven year period, depending on each group's contract.

A post and core is not a covered benefit for two years after the placement of an amalgam, composite, gold foil, or inlay restoration.

General criteria to allow core buildups

Build-ups are a covered benefit when 50% or more of the natural coronal structure of the tooth is destroyed by decay or is missing due to fracture (less than 2mm of vertical height remaining)

Buildups are covered on endodontically treated posterior teeth.

Buildups are covered for teeth with existing onlays or crowns having recurrent decay, fractured off restorative material or tooth structure.

General exclusions for core buildups

Build-ups under onlays are considered as part of the procedure and are disallowed unless the tooth has been endodontically treated.

D6973

☑ *Core build up for retainer, including any pins* is disallowed if a determination is made that the tooth does not meet clinical criteria.

Some groups require predetermination for core buildups.

Any combination of core buildup and post and core (D2950, D2952, D2954, D6970, D6972, and D6973) is covered once in a two, five, or seven year period, depending on each group's contract.

A core buildup is not a covered benefit for two years after the placement of an amalgam, composite, gold foil, or inlay restoration.

D6975

Coping – metal is not a covered benefit under most group contracts.

D6976 – D6977

Each additional indirectly fabricated post – same tooth and each additional prefabricated post – same tooth are disallowed as a component of the post and core.

D6980

Fixed partial denture repair, by report does not require a narrative.

D6985

Pediatric partial denture, fixed is not a covered benefit.

D6999

Unspecified fixed prosthodontics procedure, by report requires a narrative to be considered for payment.

Processing policies marked with ☑ only apply to groups using DDPA processing policies.

Codes marked with ☆ are new ADA codes effective 1/1/2009.

Policies marked with ↳ are new processing policies effective 5/1/2010.

These are general guidelines. Coverage for all procedures is based on each group's contract.

ORAL and MAXILLOFACIAL SURGERY – GENERAL GUIDELINES

An x-ray is not required with Oral and Maxillofacial surgery procedures unless indicated in this section. WDS reserves the right to request x-rays when needed.

Coverage of surgical procedures varies by group contract.

Some groups require predetermination for oral surgery procedures. This is outlined in the patient's benefit book.

Supernumerary teeth should be billed as tooth numbers 33, 34, etc… and a narrative provided indicating the specific location of the supernumerary.

Some group contracts specify a six or 12 month waiting period before eligible individuals are covered for oral and maxillofacial surgery procedures.

D7111

Extraction, coronal remnants – deciduous tooth is not a covered benefit if billed on a permanent tooth.

D7220

Removal of impacted tooth - soft tissue should be used when the tooth is not erupted to the occlusal plane and has soft tissue covering any portion of the crown above the height of contour.

D7230

Removal of impacted tooth - partially bony should be used when some portion of the coronal part of the tooth is covered by bone above the height of contour and the tooth is clearly below the occlusal plane.

D7240

Removal of impacted tooth - completely bony should be used when more than one-half of the coronal part of the tooth is covered by bone above the height of contour and the tooth is clearly below the occlusal plane.

D7241

Removal of impacted tooth - completely bony, with unusual surgical complications should be used when the tooth meets all of the criteria for D7240 and has additional complications such as the examples here, and requires an x-ray and narrative.

The patient has an extensively compromised medical condition

Meets ASA-3 criteria

The tooth is in a significantly aberrant position

Horizontal impaction facing buccal/lingual (more than 45° from the arch form)

More than one-fourth of the roots and/or the crown of the tooth below the inferior alveolar nerve

Distoangular impaction with dilacerated roots curving distally

Vertical impaction with the occlusal surface of the tooth at the level of the apical one-third or higher of the adjacent tooth

The tooth is ankylosed

D7250

Surgical removal of residual tooth root (cutting procedure) is disallowed if done on the same day as an extraction on the same tooth by the same provider.

D7272

Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization is not a covered benefit for most groups.

D7280

Surgical access of an unerupted tooth is covered once in a lifetime per tooth.

D7283

Placement of device to facilitate eruption of impacted tooth is not a covered benefit for most groups.

D7285

Biopsy of oral tissue – hard (bone, tooth) must be submitted with a pathology report.

☑ Biopsies are disallowed when done on the same day in the same site as any other surgical procedure(s).

D7286

Biopsy of oral tissue – soft must be submitted with a pathology report.

☑ Biopsies are disallowed when done on the same day in the same site as any other surgical procedure(s).

D7288

Brush biopsy – transepithelial sample collection must be submitted with a pathology report.

☑ Biopsies are disallowed when done on the same day in the same site as any other surgical procedure(s).

D7290

Surgical repositioning of teeth is a covered benefit only if the group contract covers orthodontics. It is paid from the orthodontic maximum.

D7291

Transseptal fiberotomy/supra crestal fiberotomy, by report is a covered benefit only if the group contract covers orthodontics. It is paid from the orthodontic maximum.

D7292

Surgical placement: temporary anchorage device [screw retained plate] requiring surgical flap is not a covered benefit unless the group has elected orthognathic benefits.

D7293

Surgical placement: temporary anchorage device requiring surgical flap is not a covered benefit unless the group has elected orthognathic benefits.

D7294

Surgical placement: temporary anchorage device without surgical flap is not a covered benefit unless the group has elected orthognathic benefits.

D7310

Alveoloplasty in conjunction with extractions – per quadrant is a covered benefit when done on the same day in the same quadrant as three or more simple extractions (D7140 in the same quadrant.

If there are not at least three simple extractions (D7140) done on the same day, alveoloplasty is disallowed.

☑ Alveoloplasty is disallowed if done on the same day as any surgical extraction(s) in the same quadrant.

D7311

Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant is a covered benefit.

☑ Alveoloplasty is disallowed if done on the same day as any surgical extraction(s) in the same quadrant.

D7320

Alveoloplasty not in conjunction with extractions – per quadrant is a covered benefit.

If done on the same day as any extraction(s) in the same quadrant, D7320 is paid as D7310.

D7321

Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant is a covered benefit.

If done on the same day as any extraction(s) in the same quadrant, D7321 is paid as D7311.

D7340

Vestibuloplasty – ridge extension (secondary epithelialization) is not a covered benefit.

D7350

Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue) is not a covered benefit.

D7410

☑ *Excision of benign lesion up to 1.25 cm* is disallowed if done on the same day in the same site as any other oral surgery procedure(s).

D7411

☑ Excision of benign lesion greater than 1.25 cm must be submitted with a pathology report.

☑ This procedure is disallowed if done on the same day in the same site as any other oral surgery procedure(s).

D7412

☑ *Excision of benign lesion, complicated* must be submitted with a pathology report.

D7413

☑ *Excision of malignant lesion up to 1.25 cm* must be submitted with a pathology report.

D7414

☑ Excision of malignant lesion greater than 1.25 cm must be submitted with a pathology report.

D7415

☑ *Excision of malignant lesion, complicated* must be submitted with a pathology report.

D7440

Excision of malignant tumor – lesion diameter up to 1.25 cm must be submitted with a pathology report.

D7441

☑ Excision of malignant tumor – lesion diameter greater than 1.25 cm must be submitted with a pathology report.

D7450

☑ Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm must be submitted with a pathology report.

☑ This procedure is disallowed if done on the same day in the same site as any other oral surgery procedure(s).

D7451

☑ Removal of benign odontogenic cyst or tumor – lesion diameter greater than .25 cm must be submitted with a pathology report.

☑ This procedure is disallowed if done on the same day in the same site as any other oral surgery procedure(s).

D7460

☑ Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm must be submitted with a pathology report.

D7461

☑ Removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm must be submitted with a pathology report.

D7465

☑ Destruction of lesion(s) by physical or chemical method, by report does not require a narrative.

D7490

Radical resection of maxilla or mandible is not a covered benefit for most groups.

D7510

☑ *Incision and drainage of abscess – intraoral soft tissue* is disallowed if performed on the same date of service in the same area as a root canal treatment (D3310 – D3347).

D7511

☑ *Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)* is disallowed if performed on the same date of service in the same area as a root canal treatment (D3310 – D3347).

TREATMENT OF FRACTURES – SIMPLE; TREATMENT OF FRACTURES – COMPOUND

The following procedures are not a covered benefit unless the group has elected major oral surgery benefits.

There are exceptions where a group has chosen to cover these procedures under regular oral surgery benefits.

D7560

Maxillary Sinusotomy for removal of tooth fragment or foreign body

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.

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 DYSFUNCITONS

The procedures in this section are not a covered benefit unless the group has elected temporomandibular joint dysfunction benefits.

For procedures marked with a ✓, the group must have elected surgical temporomandibular joint dysfunction benefits.

D7810 ✓

Open reduction of dislocation

D7820 ✓

Closed reduction of dislocation

D7830

Manipulation under anesthesia

D7840 ✓

Condylectomy

D7850 ✓

Surgical disectomy, 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 does not require narrative.

D7899

Unspecified TMD therapy, by report requires a narrative to be considered for payment.

OTHER REPAIR PROCEDURES

The following procedures may be covered as orthognathic, major oral surgery or standard oral surgery benefits. (OG, MOS and OS behind each code indicate the possible coverage levels for that code.)

Orthognathic and Major Oral Surgery are not standard benefits and must be elected separately by the group.

Coverage for these codes varies greatly and predetermination is highly recommended.

D7920 – MOS/OS

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

D7940 – OG/MOS

Osteoplasty – for orthognathic deformities

D7941 – OG/MOS

Osteotomy – mandibular rami

D7943 – OG/MOS

Osteotomy – mandibular rami with bone graft; includes obtaining the graft

D7944 – OG/MOS

Osteotomy – segmented or subapical

D7945 – OG/MOS

Osteotomy – body of mandible

7946 – OG/MOS

LeFort I (maxilla – total)

D7947 – OG/MOS

LeFort I (maxilla – segmented)

D7948 – OG/MOS

LeFort II or LeFort III (Osteoplasty of facial bones for mid-face hypoplasia or retrusion) – without bone graft

D7949 – OG/MOS

LeFort II or LeFort III – with bone graft

D7950 – MOS/OS

Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla – autogenous or nonautogenous, by report does not require a narrative.

This procedure is disallowed if performed on the same date of service as an apicoectomy, the placement of an implant, or an extraction.

D7951 - MOS

Sinus augmentation with bone or bone substitutes

D7953 - OS

Bone replacement graft for ridge preservation – per site is not a covered benefit unless the group has elected it as a separate benefit.

D7955 – MOS/OS

Repair of maxillofacial soft and/or hard tissue defect is disallowed if performed on the same date of service as an apicoectomy, the placement of an implant, or an extraction.

D7960 – OS

☑ *Frenulectomy (frenectomy or frenotomy) – separate procedure* is disallowed if done on the same day in the same site as any other surgical procedure from the D3000, D4000, D6000, or D7000 series.

D7963 – OS

☑ *Frenuloplasty* is disallowed if done on the same day in the same site as any other D3000, D4000, D6000 or D7000 series surgical procedure.

D7970 – OS

☑ *Excision of hyperplastic tissue – per arch* is disallowed if done on the same day in the same site as any other D3000, D4000, D6000 or D7000 series surgical procedure.

D7971 – OS

☑ *Excision of pericoronal gingiva* is disallowed if done on the same day in the same site as any other D3000, D4000, D6000 or D7000 series surgical procedure.

D7972 – OS

Surgical reduction of fibrous tuberosity

D7980 – OS

Sialolithotomy

D7981 – OS

Excision of salivary gland, by report does not require a narrative.

D7982 – OS

Sialodochoplasty

D7983 – OS

Closure of salivary fistula

D7990 – OS

Emergency tracheotomy

D7991 – MOS/OS

Coronoidectomy

D7995 – MOS/OS

Synthetic graft – mandible or facial bones, by report does not require a narrative.

D7996 – MOS

Implant – mandible for augmentation purposes (excluding alveolar ridge), by report does not require a narrative.

D7997 – OS

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

D7998 – OS

Intraoral placement of a fixation device not in conjunction with a fracture is not a covered benefit.

D7999

Unspecified oral surgery procedure, by report requires a narrative to be considered for payment

Processing policies marked with ☑ only apply to groups using DDPA processing policies.

Codes marked with ☆ are new ADA codes effective 1/1/2009.

Policies marked with ↳ are new processing policies effective 5/1/2010.

These are general guidelines. Coverage for all procedures is based on each group's contract.

ORTHODONTICS – GENERAL GUIDELINES

Unless the group has purchased orthodontic benefits separately, orthodontics are not a covered benefit.

When purchased separately by the group, orthodontic coverage may be limited to dependent children only or may include adults and dependent children, according to the group's contract.

When submitting a full orthodontic case, the banding date, total case fee, initial fee (down payment), number of treatment months, the monthly fee, and the appropriate valid CDT code are all required to process the ortho claim.

All full case fees are paid in monthly installments, unless otherwise specified in the group's contract.

Orthodontic records are paid from the ortho maximum.

Harmful habit appliances are not a covered benefit.

D8210

Removable appliance therapy is not a covered benefit, regardless of orthodontic benefits.

D8220

Fixed appliance therapy is not a covered benefit, regardless of orthodontic benefits.

D8691

Repair of orthodontic appliance is not a covered benefit for most groups, regardless of orthodontic benefits.

D8692

Replacement of lost or broken retainer is not a covered benefit for most groups, regardless of orthodontic coverage.

D8396

Rebonding or recementing; and/or repair, as required, of fixed retainers is considered part of the total orthodontic case fee and is disallowed if billed by the dentist providing the orthodontic care.

Rebonding or recementing done by a dentist other than the one providing the orthodontic care may be covered once per lifetime. Any additional rebonding or recementing services are not a covered benefit.

D8999

Unspecified orthodontic procedure, by report requires a narrative to be considered for payment

.

Processing policies marked with ☑ only apply to groups using DDPA processing policies.

Codes marked with ☆ are new ADA codes effective 1/1/2009.

Policies marked with ↳ are new processing policies effective 5/1/2010.

These are general guidelines. Coverage for all procedures is based on each group's contract.

GENERAL SERVICES – GENERAL GUIDELINES

D9110

Palliative (emergency) treatment of dental pain - minor procedure is disallowed for some groups if submitted within 30 days of any oral surgery procedure if the palliative treatment is performed in the same area as the extraction by the same dentist.

☑ Palliative care is disallowed if done on the same day as any definitive care in the same treatment area.

D9120

Fixed partial denture sectioning is a covered benefit only if some portion of the fixed prosthesis is to remain intact and serviceable following the sectioning and extraction or other treatment.

Fixed partial denture sectioning is disallowed if done as part of the process of removing and replacing an existing fixed prosthesis.

A separate fee for polishing and recontouring the retained portion of the fixed partial denture is disallowed.

D9210

Local anesthetic not in conjunction with operative or surgical procedures is disallowed.

D9211

Regional block anesthesia is disallowed.

D9212

Trigeminal division block anesthesia is disallowed.

D9215

Local anesthesia is disallowed.

D9220

Deep sedation/general anesthesia - first 30 minutes is disallowed unless Washington Dental Service has a current general anesthesia permit or medical license on file.

For all groups, general anesthesia is a covered benefit for children under the age of seven, in accordance with RCW 48.43.185, regardless of group contract.

For all groups, general anesthesia is a covered benefit for patients who are physically or developmentally disabled, in accordance with RCW 48.43.185, regardless of group contract.

Some groups don't cover this procedure except as previously noted.

In all other circumstances, general anesthesia is not a covered benefit unless there is qualifying surgical treatment billed on the same date of service. What constitutes qualifying treatment varies with each group's contract.

D9221

Deep sedation/general anesthesia - each additional 15 minutes is disallowed unless Washington Dental Service has a current general anesthesia permit or medical license on file.

For all groups, general anesthesia is a covered benefit for children under the age of seven, in accordance with RCW 48.43.185, regardless of group contract.

For all groups, general anesthesia is a covered benefit for patients who are physically or developmentally disabled, in accordance with RCW 48.43.185, regardless of group contract.

Some groups don't cover this procedure except as previously noted.

In all other circumstances, general anesthesia is not a covered benefit unless there is qualifying surgical treatment billed on the same date of service. What constitutes qualifying treatment varies with each group's contract.

D9230

Analgesia, anxiolysis, inhalation of nitrous oxide is not a covered benefit for most groups.

D9241

Intravenous conscious sedation/analgesia - first 30 minutes is disallowed unless Washington Dental Service has a current conscious sedation permit, general anesthesia permit or medical license on file.

IV sedation is not a covered benefit unless there is qualifying surgical treatment billed on the same date of service. What constitutes qualifying treatment varies with each group's contract.

Some groups don't cover this procedure.

D9242

Intravenous conscious sedation/analgesia - each additional 15 minutes is disallowed unless Washington Dental Service has a current conscious sedation permit, general anesthesia permit or medical license on file.

IV sedation is not a covered benefit unless there is qualifying surgical treatment billed on the same date of service. What constitutes qualifying treatment varies with each group's contract.

Some groups don't cover this procedure.

D9248

Non-intravenous conscious sedation is not a covered benefit for most groups.

For groups that cover this procedure, it is covered with any definitive treatment.

D9310

Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician is not a covered benefit for most groups.

☑ A consultation is disallowed if done on the same day as any clinical oral evaluation.

D9410

House call is not a covered benefit for most groups.

☑ A house call is disallowed if done on the same day as any clinical oral evaluation.

D9420

Hospital call is not a covered benefit for most groups.

D9430

Office visit for observation (during regularly scheduled hours) - no other services performed is not a covered benefit for most groups.

D9440

Office visit - after regularly schedules hours is not a covered benefit for most groups.

D9450

Case presentation, detailed and extensive treatment planning is not a covered benefit.

D9610

Therapeutic parenteral drug, single administration is not a covered benefit for most groups.

D9612

Therapeutic parenteral drugs, two or more administrations, different medications is not a covered benefit.

D9630

Other drugs and/or medicaments, by report is not a covered benefit for some groups. For groups that cover this procedure, a description of the drug(s) prescribed is required.

D9910

Application of desensitizing medicament is not a covered benefit for most groups.

D9911

Application of desensitizing resin for cervical and/or root surface, per tooth is not a covered benefit for most groups.

D9920

Behavior management, by report is not a covered benefit for most groups.

D9930

Treatment of complications (postsurgical) - unusual circumstances, by report requires a narrative to be considered for payment.

☑ This procedure is disallowed if done within 30 days of any surgical procedure by the same provider

D9940

Coverage for *occlusal guard, by report* varies with each group contract. It is important to check the patient's plan to determine coverage for this procedure. It is also important to provide a narrative identifying the reason for the occlusal guard.

Some groups cover occlusal guards only if done for periodontal purposes and only if the patient is an AAP Case Type III or IV. If WDS doesn't have a case type on file, be sure to include the patient's AAP Case Type when submitting the claim.

Some groups cover occlusal guards done for any clinical condition.

Some groups do not cover occlusal guards.

Occlusal guards done for TMJ purposes should be coded as D7880 (Occlusal Orthotic Device, by report).

D9941

Fabrication of athletic mouthguard is not a covered benefit for most groups.

D9942

Coverage for *repair and/or reline of occlusal guard* varies with each group contract. It is important to check the patient's plan to determine coverage for this procedure.

For groups that cover this procedure, a repair or reline done within six months of the initial placement is disallowed if done by the same doctor.

D9950

Occlusion analysis - mounted case is not a covered benefit for most groups.

D9951

Occlusal adjustment - limited is a covered benefit once in 12 months for most groups.

Claims for occlusal adjustment must include the tooth numbers that were adjusted.

Do not submit multiple occurrences of D9951 on the same date of service. Submit one occurrence of D9951 with the total fee and indicate the teeth adjusted. If the adjustment involved more than eight teeth, submit as D9952 (occlusal adjustment - complete).

A limited occlusal adjustment done on the same day and same or opposing tooth as any restoration is disallowed.

An occlusal adjustment done for TMJ purposes is a covered benefit only if the group has elected TMJ benefits separately.

D9952

Occlusal adjustment - complete is a covered benefit once in a lifetime for most groups that cover it.

Most groups that cover complete occlusal adjustment do so only if done for periodontal purposes and only if the patient is an AAP Case Type III or IV. If WDS doesn't have a case type on file, be sure to include the patient's AAP Case Type when submitting the claim.

An occlusal adjustment done for TMJ purposes is a covered benefit only if the group has elected TMJ benefits separately.

D9970

Enamel microabrasion is not a covered benefit.

D9971

Odontoplasty1 - 2 teeth; includes removal of enamel projections is not a covered benefit for most groups.

D9972

External bleaching - per arch is not a covered benefit.

D9973

External bleaching - per tooth is not a covered benefit.

D9974

Internal bleaching - per tooth is not a covered benefit for most groups.

D9999

Unspecified adjunctive procedure, by report requires a narrative to be considered for payment.

A fee for an assistant is not a covered benefit.

A fee for infection control is disallowed.