Dental Wellness Plan

DENTIST OFFICE MANUAL July 1, 2017
Thank You
for Being a
Dental Wellness Plan
Participating Dentist

Dental of Iowa is pleased to present you with this Dentist Office Manual. We hope it is a useful source of information for you and your office staff. Please take the opportunity to review the Manual in its entirety. We look forward to serving you in the future and continuing our mutually supportive relationship.
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Dental Wellness Plan Overview
The Dental Wellness Plan (DWP) provides comprehensive dental benefits to adults ages 19 and older. All members are eligible for Full Benefits in the first year. For members who do not complete their Healthy Behaviors, Reduced Benefits may be available in the future years.

New Combined DWP and Adult Fee-for Service (FFS) Program
The movement of all adult Iowa Medicaid members to the DWP will result in a single adult dental plan. A simplified structure will address concerns about a member’s ability to understand and access benefits due to eligibility churn between two programs. The existing dental carriers, Delta Dental of Iowa and MCNA Dental, will be administering the new DWP program.

Benefit Design Modifications:
The DWP tiers (Core, Enhanced, and Enhanced Plus) will be removed from the earned benefits model design effective June 30, 2017.

The new benefit structure will be Full Benefits and Reduced Benefits.

Benefits and Healthy Behaviors:
Members will have access to Full Benefits during the first year of enrollment that include:

- Diagnostic/Preventive Dental Services
- Examinations
- Cleanings
- Radiographs
- Fluoride
- Emergency Services
- Restorative Services
- Surgical and Non-surgical Periodontal Services
- Surgical and Non-surgical Endodontic Services
- Crowns
- Anterior Bridges
- Dentures
- Medically Necessary Orthodontics for 19-20 year olds

NOTE: Please see specific coverage details

To maintain access to the Full Benefits in their second year of enrollment, members must complete the required Healthy Behaviors during their first enrollment year. These Healthy Behaviors include completion of both:
- Oral Health Self-Assessment
- Preventive Service

Members over 50 percent of the Federal Poverty Level (FPL) will have a monthly premium contribution in year two, unless they complete Healthy Behaviors.
Failure to complete the required Healthy Behaviors in this first year may result in a premium obligation of no more than $3 per month. Members who are 19-20 year olds retain their full benefits thru Early Periodic Screening, Diagnosis and Treatment (EPSDT).

Members with a premium obligation who fail to make ongoing monthly premium payments will be eligible for Reduced Benefits only. The Dental Wellness Plan provides an opportunity for a public and private partnership between the State of Iowa, Delta Dental and the dentist community to improve the oral health of Iowans. This Dentist Office Manual will provide you details specific to Delta Dental’s Dental Wellness Plan.

**Important Terms and Definitions**

The following are a list of frequently used terms and definitions to assist you in understanding the information provided in this Manual and to better understand a Covered Enrollee’s dental benefits when corresponding with Delta Dental.

**Agreement**
The document that specifies the contractual obligations of a Participating Dentist.

**Allowed Amount**
Allowed Amount is the total dollar amount allowed for a specific dental service or procedure, under the payment arrangement stipulated by the Dental Wellness Plan Program, determined as specified in the Agreement signed by the Participating Dentist.

**Approved Amount**
The total fee a Participating Dentist agrees to accept as payment in full for a procedure. Participating Dentists agree not to collect from the patient any difference between the Approved Amount and their actual Billed Charge for the procedure.

**Benefit Period**
The Benefit Period is 12 months starting on July 1 and ending June 30.

**Billed Charge**
The Billed Charge is the amount the dentist bills for a specific dental service or procedure.

**Covered Enrollee (also known as member)**
A Covered Enrollee means an individual eligible and enrolled to receive dental services under the Dental Wellness Plan thru Delta Dental.

**Covered Services**
Covered Services means dental services covered under the Dental Wellness Plan provided to a Covered Enrollee by a Participating Dentist (excluding emergency services which may be provided by a Non-Participating Dentist).

**Denied**
If the Billed Charge for a procedure or service is Denied, the procedure or service is not a Covered Service of the Covered Enrollee’s benefit plan and the Billed Charge is collectible from the Covered Enrollee if the appropriate informed consent has been signed prior to the delivery of the service.
Dental Wellness Plan Fee Schedule
Dental Wellness Plan Participating Dentists agree to accept as payment in full the lesser of the Dental Wellness Plan Fee Schedule or the Billed Charge for Covered Services rendered.

Dentally Necessary
Procedures are considered dentally necessary if the diagnosis is proper; the treatment is necessary to address disease or dysfunction of the teeth and the health of the gums, bone, and other tissues, which support the teeth: it is the most appropriate procedure, service or supply for the Covered Enrollee’s individual circumstances; and it is consistent with and meets professionally recognized standards of care, and complies with criteria adopted by Delta Dental of Iowa.

Disallow/Disallowed
If the Billed Charge for a service is Disallowed, reimbursement for the services was either included as part of a payment of a more global service provided and / or the services is still within the time frame for which it should be warranted by the Participating Dentist and / or the Participating Dentist did not follow rules and regulations per the Agreement. Disallowed fees are not collectible from the patient by a Participating Dentist.

Emergency Dental Condition
Emergency Dental Condition means a dental condition of sudden onset and severity which would lead a prudent layperson to conclude that the condition needs immediate dental procedures necessary to control excessive bleeding, relieve severe pain, or eliminate acute infection. The dental procedures will identify the source of the patient’s significant pain, extent of trauma, source of infection, suspicious carcinoma, with palliative measures, or treat a traumatic clinical condition to the teeth and / or supporting structures.

Full Benefits
In the first year, all members have access to all CDT covered codes. Members who complete Healthy Behavior Requirements continue to have access to all CDT covered codes. They are identified by CDT code in the Covered Matrix.

Healthy Behaviors
Dental Wellness Plan enrollees are required to complete Healthy Behaviors. Healthy Behaviors include the completion of an oral health self-assessment and preventive service.

Member Handbook
A document that contains a general explanation of the benefits and related provisions of the Dental Wellness Plan.

Member Pay
Dental Wellness Plan Covered Enrollees may pay services due to frequency limitations, never covered services and / or if the member has agreed to pay for services that are covered and may be required by your provider to sign a patient financial responsibility form.

Non-Participating Dentist
A Non-Participating Dentist is a dentist who has not entered into an Agreement with Delta Dental of Iowa for the Dental Wellness Plan.
**Participating Dentist**
A Participating Dentist is a dentist who holds a current license to practice dentistry, who has completed all credentialing requirements, and who has entered into an Agreement with Delta Dental of Iowa for the Dental Wellness Plan.

**Preventative Service**
The Dental Wellness Plan preventive services required for Healthy Behaviors includes the following codes: D0120, D0140, D0150, D0180, D1110, D4346, D4910.

**Reduced Benefits**
Members who do not complete Healthy Behavior Requirements and don’t pay the monthly premium will have access to Reduced Benefits. Those benefits include only emergency procedures. They are identified by CDT code in the Covered Matrix.

**Uniform Regulations**
Uniform Regulations is a document that specifies the mutual operational rules between the Participating Dentist and Delta Dental of Iowa.
**Dentist Participation**

When a dentist signs an agreement with Delta Dental of Iowa for the Dental Wellness Plan he or she agrees to:

- Abide by the Dental Wellness Plan rules, regulations, Uniform Regulations and this Dentist Office Manual; enroll with Iowa Medicaid Enterprises (IME) as at least and Ordering / Referring Provider;
- Not require Dental Wellness Plan Covered Enrollee’s to prepay a portion of Covered Services, unless the member has agreed to pay for services through the member payment guidelines. See Member Pay Guidelines;
- Accept from Delta Dental as payment in full for Covered Services the lesser of: (i) the applicable amount set forth in the Fee Schedule or (ii) Participating Dentist’s Billed Charges for such Covered Services;
- Furnish Delta Dental of Iowa credentialing information by completing a Professional Application and Credentialing Form when requested;
- File claims for completed services to Delta Dental of Iowa within 90 days of the date-of-service and include all documentation necessary to review, process and finalize the claim. Documentation includes, but is not limited to, clinical rationale / narrative, radiographs, periodontal chart, patient’s treatment record, and coordination of benefits information, as applicable. If the claim is not received and finalized within this time period, the claim may be disallowed as the Participating Dentist’s responsibility and not billable to the Covered Enrollee;
- Follow the Dental Wellness Plan’s processing policies and claim filing guidelines;
- Provide information and patient office records for the purpose of conducting reviews and / or in-office audits, when required;
- Furnish services that meet Dental Wellness Plan’s criteria dental necessity and dental appropriateness of care as defined in the Dental Wellness Plan Uniform Regulations;
- Comply with Occupational Safety and Health Administration (OSHA) requirements and the Centers for Disease Control (CDC) infection control guidelines;
- Conduct business in accordance with the principles and ethics of the American Dental Association (ADA) and Iowa Dental Board (IDB);
- Comply with all applicable state and federal laws and regulations (e. g. Health Insurance Portability and Accountability Act (HIPAA))

Check the program exclusion status of individuals and entities prior to entering into employment or contractual relationships. Provider agrees to check the HHS-OIG website (http://exclusions.oig.hhs.gov or https://oig.hhs.gov/exclusions/index.asp) by the name of any individual or entity for their exclusion status before the Provider hires or enters into any contractual relationship with the person or entity. In addition Provider agrees to check the HHS-OIG website monthly to capture exclusions and reinstatements that have occurred since the last search. Provider must report to Delta Dental of Iowa and Iowa Medicaid Enterprise (IME) any exclusion information discovered through such service.
Delta Dental is generally prohibited from paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities. This payment ban applies to any items or services reimbursable under the Medicaid/Dental Wellness program that are furnished by an excluded individual or entity, and extends to (1) all methods of reimbursement, whether payment results from itemized claims, cost reports, fee schedules, or a prospective payment system, (2) payment for administrative or management services not directly related to patient care, but that are a necessary component of providing items and services to Medicaid/Dental Wellness Plan members, when those payments are reported on a cost report or are otherwise payable by the Medicaid/Dental Wellness Plan program; and (3) payment to cover an excluded individual’s salary, expenses or fringe benefits, regardless of whether they provide direct patient care, when those payments are reported on a cost report or are otherwise payable by the Medicaid/Dental Wellness Plan program. In addition, no Medicaid/Dental Wellness Plan payments can be made for any items or services directed or prescribed by an excluded physician or other authorized person when the individual or entity furnishing the services either knew or should have known of the exclusion. This prohibition applies even when the Medicaid/Dental Wellness Plan payment itself is made to another provider, practitioner or supplier that is not excluded.

42 C. F. R. § 1001.1901(b).

Credentialing

Participating Dentists need to complete credentialing at least every three years.

Dental Wellness Plan Participating Dentists agree to provide the following credentialing elements:

- Accurately and thoroughly complete the Professional Application & Credentialing Form as requested;
- Have an active state issued dental license;
- Provide the Federal DEA license, if applicable;
- Have adequate malpractice liability coverage and provide a copy of the liability declaration page;
- Disclose any licensing board actions, malpractice claims and other adverse personal background information;
- Comply with Centers for Disease Control (CDC) infection control guidelines;
- Provide a copy of certification of specialty training or education, if applicable;
- Provide a professional work history or curriculum vitae with explanation for any gaps in work history;
- Complete and provide the federally mandated ownership control form
- Complete and provide W-9 form with the business name and tax identification number

Network participation will only be backdated 30 days prior to the date that all required credentialing and signed contract information is received.
Separate credentialing or re-credentialing may not be required if you are already a Delta Dental of Iowa Participating Dentist in the Premier® Network.

Notify Professional Relations immediately of any changes in your credentialing elements at 888-472-1205 or e-mail provrelations@deltadentalia.com.

Federally Mandated Ownership Control Form

Centers for the Medicare & Medicaid Services (CMS) and the Iowa Department of Human Services (DHS) require that all Participating Dentists complete and provide a Federally Mandated Ownership & Control Disclosure Form.

What disclosures must be provided?

Participating Dentists must provide the following disclosures:

- The name and address of any person (individual or corporation) with an ownership or control interest in disclosing entity (Participating Dentist practice).
- The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.
- In the case of an individual, date of birth and social security number are required.
- Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has a 5 percent or more interest. Whether the person (individual or corporation) with an ownership of control interest in the disclosing entity is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity has a 5 percent or more interest in the disclosing entity as a spouse, parent, child, or sibling.
- The name of any other disclosing entity in which an owner of the disclosing entity has an ownership or control interest.
- The name, address, date of birth, and social security number of any managing employee of the disclosing entity.

When must disclosures be provided?

**Participating Dentists need to provide disclosure information in regard to the disclosing entity at any of the following times:**

- Upon completed of participating credentialing application and executing of the Participating Dentist agreement.
- Upon request of Department of Human Service during the re-validation of enrollment process.
- Within 35 Days after any change in ownership of the disclosing entity (Participating Dentist’s practice).

**Participating Dentist Must Disclose Information Related to Business Transactions.**

What must a Participating Dentist do to disclose information related to business transactions:
- A Participating Dentist must submit, within 35 days of the date on a request by the Secretary, Department of Human Services or the plan, full and complete information about the ownership of any subcontractor with whom the Participating Dentist has had business transactions totaling more than $25,000 during a 12-month period ending on the date of the request; and
- Any significant business transactions between the Participating Dentist and any wholly owned supplier, or between the Participating Dentist and any subcontractor, during the 5-year period ending on the date of the request.

**Participating Dentists Must Disclose Information On Persons Convicted of Crimes.**

What information must be disclosed?

- Before the plan enters into or renews a Participating Dentist agreement, or at any time upon written request by the Department of Human Services, or the plan:
- The Participating Dentist must disclose to Delta Dental of Iowa and the Department of Human Services the identity of any person who:
  - Has ownership or control interest in the Participating Dentist, or is an agent or managing employee of the Participating Dentist practice; and
  - Has been convicted of a criminal offense related to that person’s involvement in any program under Medicare, Medicaid, or the Title XIX services program since the inception of those programs.

**Locum Tenens**

Locum tenens is a term used to describe a person who temporarily fulfills the duties of another. If you utilize a locum tenens dentist and they treat Dental Wellness Plan Covered Enrollees it is imperative the temporary dentist completes a Professional Application and Credentialing form and signs a Delta Dental Dental Wellness Plan Participating Dentist’s Agreement. If the temporary dentist chooses not to participate with the Dental Wellness Plan, the claim will be disallowed and the Covered Enrollee may not be billed. It is misrepresentation and a form of fraud to submit claims of a treating locum tenens dentist under the name of another dentist. Please contact Professional Relations at 888-472-1205 or e-mail provrelations@deltadentalia.com for participating information for a locum tenens dentist practicing in your office.

**Dentist Terminates Participating Agreement**

A dentist may terminate the Dental Wellness Plan Participating Dentist’s Agreement by giving at least sixty (60) days written notice to Delta Dental by certified mail, return receipt requested. Delta Dental will send a letter of acknowledgement to the dentist confirming the termination effective date. Delta Dental may notify Covered Enrollees of the dentist’s network termination. The dentist must also inform Covered Enrollees when there is a termination of the Delta Dental Dental Wellness Plan Participating Dentist’s Agreement.
Terminating the Delta Dental Dental Wellness Plan Participating Dentist's Agreement does not terminate any other Delta Dental of Iowa Participating Dentist Agreement.

**Delta Dental of Iowa Terminates Participating Agreement**

**Notices of Termination; Other Notices**

Any notice of termination (“Notice of Termination”) required or permitted to be given to a Participating Dentist under the Uniform Regulations shall be in writing and shall be deemed given when delivered personally, placed in the U. S. mail (postage prepaid) and sent certified or registered, return receipt requested, or delivered to a recognized overnight courier service for the next day delivery (delivery charges prepaid), and addressed to the Participating Dentist at the address set forth on the Participating Dentist’s Agreement, or to such other address for Notices of Termination as provided in writing to Delta Dental by the Participating Dentist’s Agreement, or to such other address for Notices of Termination as provided in writing to Delta Dental by the Participating Dentist.

**Termination without Cause**

Delta Dental may terminate a Participating Dentist’s Dental Wellness Plan Agreement without cause at any time by sending a Notice of Termination, which termination will be effective sixty (60) days or more after the date of such Notice of Termination, as designated in the Notice of Termination.

**Termination for Cause**

Delta Dental may terminate a Participating Dentist’s Dental Wellness Plan Agreement for cause if Participating Dentist breaches or violates any of the provisions of the Participating Dentist’s Dental Wellness Plan Agreement or the Uniform Regulations, Participating Dentist’s license to practice dentistry issued by the IDB is suspended or terminate, or Participating Dentist’s conduct is determined to be unprofessional and/or such conduct could be detrimental to Delta Dental, its Contract holders, or Covered Persons.

Any such termination shall be effective on the date designated by Delta Dental in the Notice of Termination (which may be immediate), as determined by Delta Dental. The Notice of Termination will state the reasons for such termination and that the Participating Dentist has a right to request a hearing on the termination.

**Appealing a Termination Notice**

A Participating Dentist may appeal a termination of participation for cause as set forth in the Uniform Regulations.
Interpretation and Translation Services
Delta Dental makes the following services available at no cost to you:

Free language translation services from Language Line Solutions and sign language interpretation services from Life Interpretation, Inc.

Language Line Solutions
Delta Dental of Iowa provides a language translation services to all Delta Dental of Iowa Dental Wellness Plan Participating Dentists at no cost. Charges are billed directly to Delta Dental of Iowa. If you have a language barrier with a patient, Language Line Solutions (LLS) will provide translation. You can either conference LLS or use a speaker phone, if the non-English speaking patient is in your office. Call LLS, request the language needed and an interpreter will promptly assist communication between you and your patient. To learn more about Language Line Solutions go to www.languageline.com.

Follow these steps when using LLS:

1. Dial 800-523-1786
2. Enter on your telephone keypad or provide the representative with the 6 digit Delta Dental Client ID: 749168
3. Press 1 for Spanish or press 2 for all other languages (speak the name of the language at the prompt). Press 0 or stay on the line for assistance.
4. Provide the representative with:
   - Organization Name: Delta Dental of Iowa- DDIA
   - Dentist's 1st initial
   - Dentist's last name
   - City (where the dental office is located)

   {An interpreter will be connected to the call.}
5. Brief the Interpreter: Summarize what you wish to accomplish and provide any special instructions.

Life Interpretation, Inc.
Participating Dentists can receive free sign language interpreting services from Life Interpretation, Inc. This service helps communication with deaf and hard of hearing patients. To learn more go to www.lifeinterpreter.com.

Follow these steps when using Life Interpretation, Inc.:

1. Contact Life Interpretation Inc. at 515-265-5433 or via email at schedule@lifeinterpreter.com to schedule an interpreter. Be sure to contact Life Interpretation, Inc. as possible to schedule an appointment.
2. Identify yourself as a Delta Dental Participating Dentist to schedule an interpreter at no cost.
3. Provide Life Interpretation with the following information:
   - Date, time and duration of the patient’s appointment
   - Address of dentist’s office
   - Name of the deaf or hard of hearing patient
   - Dentist’s name, phone number and name of office contact.

4. If you need to cancel, please contact Life Interpretation, Inc. at least 24 hours before the appointment.

5. You will receive confirmation from Life Interpretation, Inc. for the interpreter.

Please note: Offices filing claims or claim attachments electronically or who use the Internet to verify eligibility or claims status are considered a covered entity under HIPAA Privacy and Security Rules.

If you are a covered entity and are also using Language Line Services (LLS) or Life Interpretation, Inc., Delta Dental of Iowa recommends that you secure a Business Associate agreement with them due to the extent of possible protected Patient Health Information (PHI) being exchanged. For more information regarding HIPAA, refer to the HIPAA section of this Manual.

Send Business Associate Agreements with LLS to:
   Language Line Services
   One Lower Ragsdale Drive, Building Two
   Monterey, CA 93940

Send Business Associate Agreements with Life Interpretation, Inc. to:
   Life Interpretation, Inc.
   P. O. Box 5002
   Des Moines, IA 50305

*This information is for instructional and educational purposes only. It does not constitute legal advice. Recipients are strongly urged to contact their legal counsel for advice with respect to the interpretation of HIPAA and its applicability and the facts and circumstances of the situation at hand.
HIPAA
The Health Insurance Portability and Accountability Act (HIPAA) of 1996 (and implementing regulations) is a federal law intended to provide better access to health insurance, limit fraud and abuse and reduce administrative costs. Since electronic transactions are significantly more cost effective than paper for providers, patients and health plans, HIPAA includes a major provision (Administrative Simplification) that is designed to encourage the use of electronic transactions, while safeguarding patient privacy.

To do so, HIPAA created a universal language or standard for electronic transmissions used in the health care industry. It is also established standards governing the privacy/security of health information, which is an extremely important issue for consumers today. Specific requirements are detailed in rules issued by the federal Department of Health and Human Services (DHHS). Please refer to the end of this section for important HIPAA web sites.

All health plans, health care clearinghouses, and health care providers who maintain or transmit protected health information in electronic form standardized by DHHS are referred to as “Covered Entities”. If you file electronic claims, submit electronic attachments or use the Internet to check benefits, eligibility or claims status, you are considered a Covered Entity.

“Health Information” is any information, whether oral or recorded in any form or medium that:
- Is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university or health care clearinghouse; and
- Relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual.

“Individually Identifiable Health Information (IIHI)” is information that is subset of Health Information, including demographic information collected from an individual, and:
- Is created or received by a health care provider, health plan, employer, or health care clearinghouse;
- Relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for provision of health care to an individual;
- Identifies the individual, or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

“Protected Health Information (PHI)” is Individually Identifiable Health Information maintained or transmitted by electronic media or transmitted or maintained or transmitted by electronic media or transmitted or maintained in any other form or medium by a Covered Entity.

A “Business Associate” is defined as a person or organization that performs a function or activity on behalf of a Covered Entity and has access to PHI, but is not part of the Covered Entity’s work force.

Covered Entities must comply with the HIPAA Transactions and Code Sets Standards. To comply with these standards, you need to ensure that the format you are using for submitting claims electronically is
HIPAA compliant. Covered Entities transferring data electronically have to adopt the use of the Current Dental Terminology (CDT), which is periodically updated by the American Dental Association.

The Privacy Standards are intended to streamline the flow of information integral to the operation of the health care system while protecting confidential health information from inappropriate access, disclosure and use.

The Security Standards are intended to provide safeguards for data storage, protection of information transmission systems and the establishment of chain-of-trust agreements between Covered Entities and their business partners.

Dentists who are Covered Entities are required by law to obtain a **National Provider Identifier (NPI)** number and use a National Provider Identifier under 42 CFR part 435 (Medicaid Managed Care Regulations) which the Dental Wellness Plan must comply with. The NPI is a ten digit unique identifier for health care providers and organizations. There are two basic types of NPIs available; individual and organizational. Individual NPIs, also known as Type 1 NPIs, are for health care providers, such as dentists. Organizational, or Type 2 NPIs are for use by incorporated businesses, such as group practices and clinics.

### NPI Application Process:

1. Visit [https://nppes.cms.hhs.gov](https://nppes.cms.hhs.gov) or call 800-465-3203 to request a paper copy
2. Complete the application and follow instructions to submit either online or by mail. Faxes are not accepted.
3. After confirmation of the receipt of your application, you should receive your NPI via e-mail within one to five business days if you submitted the application online. Mailed applications may require up to 20 days to process.

Access the following web site to learn more about the NPI:


Be sure to notify Delta Dental of your NPI number(s) by contacting Professional Relations at 888-472-1205 or e-mail provrelations@deltadentalia.com.

The **HITECH Act** amends HIPAA and is part of the American Recovery and Reinvestment Act (Federal Stimulus Package). The HITECH Act required the Department of Health and Human Services (HHS) to issue regulations for breach notification by Covered Entities and their Business Associates subject to HIPAA. HITECH rules require Covered Entities (and their Business Associates) to notify affected individuals, the media and the Secretary of HHS following a breach of unsecured PHI. Consequently, Covered Entities must implement security breach detection and notification programs (or alternatively, ensure that PHI is “secured” in accordance with the guidance).

### HIPAA Questions and Answers

**Q** Do dental offices need a Business Associate agreement with Delta Dental?

**A** No. Business Associate agreements are not necessary between Covered Entities for the purpose of treatment, payment and health care operations (TPO).
Q) Is a fax transmission considered an electronic transmission under HIPAA standards?
A) No. DHHS has not adopted a transaction standard for fax transmissions. However, if you are a Covered Entity, you are subject to the Privacy and Security Standards. You need to take appropriate steps to ensure the fax machine is located in a private and secure location to protect PHI that may be on incoming or outgoing documents.

Q) Can I give Delta Dental fees over the phone for procedures I have performed?
A) Yes. Fees are necessary for treatment, payment and health care operations (TPO) and are not considered PHI.

Q) What can dental offices expect when calling Delta Dental for patient eligibility, benefits, and claims status?
A) Delta Dental authenticates callers to ensure that customers’ privacy rights are protected under HIPAA. It is necessary for the dental office to provide the following information when requesting disclosure of a patient’s Protected Health Information:

- Caller name
- Dentist or office name
- Dentist tax identification number (TIN)
- Covered Enrollee’s identification number
- Covered Enrollee name
- Covered Enrollee date of birth

This information becomes part of Delta Dental’s call log and is necessary for tracking uses and disclosures of Protected Health Information (PHI) under HIPAA.

Q) Do I need an NPI if I file paper claims?
A) Yes, the Dental Wellness Plan must comply with the Medicaid and Managed Care Regulations 42 CFR part 438. (Medicaid Managed Care Regulations).

Q) Does it cost to apply for an NPI?
A) No. There is no cost to apply for an NPI.

Q) Am I subject to HIPAA requirements if I access the DWP web site to check benefits, eligibility and check status of claims?
A) Yes. If you use the Internet to check patient’s benefits, eligibility and check status of claims, as a Covered Entity, you are required to follow HIPAA provisions, including obtaining an NPI. Be sure to notify Delta Dental of NPI so it can be added to the provider records.

This information is for instructional and educational purposes only. It does not constitute legal advice. Recipients are strongly urged to contact their legal counsel for advice with respect to the interpretation of HIPAA and its applicability to the recipient and the facts and circumstances of the situation at hand.
HIPAA Informational Web Sites

Visit the official HIPAA web site at
www.gov/hipaa/index.html

Access the Office for Civil Rights web site at www.hhs.gov/oc
Customer Service
Delta Dental of Iowa Dental Wellness Plan Customer Service is available from 7:30 a.m. to 5:00 p.m. Monday through Friday.

To contact a Customer Service Representative, use the following number:

888-472-1205 (Toll Free)

All calls disclosing Protected Health Information are authenticated. When calling the Dental Wellness Plan, please be prepared to provide the Customer Service Representative with your name, the dentist office name, the dentist office tax identification number, the Covered Enrollee’s identification number, name and date of birth. For more information regarding HIPAA, refer to the HIPAA Section of this Manual.

Contact Customer Service for information regarding:
- Filing status
- Claim status
- Eligibility
- Benefits
- Claim processing

Dental Wellness Plan Web Site
Confirm patient eligibility, benefits, claim status, submit claims, prior authorizations, benefit estimates, and real time claims, also view patient limits for all Covered Services as well as send and inquiry 24 hours a day, 7 days a week on the secure Dental Wellness Plan Dentist Connection web site at www.dwpiowa.com.

Through the Dental Wellness Plan Dentist Connection, dentist and dental staff can easily look up patient benefits, submit a claim, access claims status, view payments, and submit an inquiry and much more. Fast access to the information you need means less time spent on administration and more time to spend on your patients.

Real time claims submission is a feature on the Dentist Connection which allows you to submit claims and see the result immediately for claims that do not require review and attachment information. Please see the Dental Wellness Plan Dentist Connection User Manual for complete instructions for sending real time claims on the Dental Wellness Plan Dentist Connection and get started today!

To access the Dental Wellness Plan Dentist Connection, you will need a user id and password. Delta Dental has issued your user id and password upon your participation in the Dental Wellness Plan. An e-mail with your user id and password has been sent to you if you provided an e-mail address to us. Otherwise, we have sent the user id and password to you in the mail. The user id and password must be protected and is only used by the individual for whom it was assigned. It is the responsibility of the Participating Dentist to ensure activity on his/her behalf via the Dental Wellness Plan Dentist Connection are accurate and correct. It is the Participating Dentist’s responsibility to inform Professional Relations

Staff when your user id and password need to be inactivated, for example you no longer practice at the location the user name and password were assigned.
Get started today! Go to www.dwpiowa.com
You must change your password from the default assigned to you by Delta Dental of Iowa upon logging onto the Dental Wellness Plan Dentist Connection.

How to change your password:
1) Enter your user id
2) Enter your current password
3) Place a check mark in change password after validation
4) Select log in or press enter on your keyboard.

You will be prompted to enter and confirm your new password.
5) Enter new password
6) Re-enter password at confirm password
7) Select Submit

If you forget your password, call or email Professional Relations at 888-472-1205 or provrelations@deltadentalia.com and we will reset your password.

Professional Relations Staff
Certain questions or information should be directed to the Professional Relations staff. Please contact Professional Relations at 888-472-1205 or e-mail provrelations@deltadentalia.com if you:

- Change your office address or phone number;
- Have a change in your credentialing information;
- Are a new dentist opening an office or have a new associate or locum tenens dentist joining your practice;
- Are leaving a practice due to retirement, relocation, etc.;
- Change your tax identification number (TIN);
- Have questions about your Participating Dentist’s Agreement(s), credentialing, processing policies;
- Would like to schedule an office visit with a Delta Dental of Iowa’s Professional Relations Representative regarding office training needs, network participation, claims processing guidelines, attachment requirements or any other are of concern;
- Need information regarding your participation with Delta Dental;
- Have questions about the Dental Wellness Plan Dentist Connection on the Dental Wellness Plan web site or have questions about registering for the Dentist Connection;
- Need to add additional staff access for the Dentist Connection;
- Forgot your password for the Dentist Corporation.
Claim Filing

The Delta Dental Participating Dentist’s Dental Wellness Plan Agreement requires Participating Dentists to file claims on behalf of all Dental Wellness Plan Covered Enrollees. In addition, Participating Dentists agree to follow Delta Dental’s billing instructions, processing policies and submission requirements and recommendations for specific procedures. This section of the manual provides information on filing paper and electronic claims, services beneficial to your office, and claim filing tips. Refer to the Procedures and Processing Policies Section in this Manual for a list of procedure codes and processing policies.

Electronic Claim Submissions

As a Dental Wellness Plan Participating Dentist you are required to submit claims electronically. There are many benefits to filing claims electronically. The following are some of the advantages:

- Improved accuracy because the claims enter directly into Delta Dental’s claims system.
- Faster payment turnaround time which results in improved cash flow.
- Less paperwork and simpler claims filing.
- Reduced mail costs and mail time.
- More efficient and better for the environment.
- Minimal start-up investment and maximizes your computer’s capability.

You are required to submit claims electronically. Electronic claims consist of claims received electronically via a clearinghouse or electronic claims submitted via the Dentist Connection at www.dwpiowa.com. Electronic claims submitted via the Dentist Connection are easy and are no cost to you. Electronic Claims can be submitted at no cost via the Dentist Connection. For more information about submitting claims electronically via the Dentist Connection please see the DWP Dentist Connection User Manual in the Download Center on the Home page of the Dentist Connection at www.dwpiowa.com. Delta Dental has sent you an email with your user name and password. If you did not supply an e-mail, your user name and password has been mailed to you. You may contact Professional Relations if you are unable to locate your user name and password.

Please contact Delta Dental’s Professional Relations staff at 888-472-1205 if you have questions.

In the event your office does not have the ability to file electronic claims, we are providing you with a mailing address for any claims, attachments, or inquiries.

Dental Wellness Plan address is:
Delta Dental of Iowa-Dental Wellness Plan
PO Box 9030
Johnston, IA 50131-9030

Delta Dental of Iowa accepts all universal claim forms, including the American Dental Association (ADA) claim form, as long as all important information is included to process the claim. Please refrain from using superbills. Superbills are easily detached from the claim and delay the claim preparation and processing.

Some practice management systems require a “payer identification number”. The payer ID number for Delta Dental’s Wellness Plan is CDIAM.
If you system requests a Delta Dental “provider number” use the dentist’s state issued license number. Delta Dental does not issue provider numbers.

Radiograph Return Policy
Delta Dental will not return radiographs or other attachments unless accompanied with a self-addressed, stamped envelope. When radiographs are needed, please send duplicates only – no originals. Be sure to properly identify and date the copy of the image.

Please follow Delta Dental’s attachment guidelines unless Delta Dental of Iowa individually instructs you otherwise. You will find a current list of attachment requirements on the Dental Wellness Plan Dentist Connection at www.dwpiowa.com or you may contact Professional Relations at 888-472-1205 or e-mail provrelations@deltadentalia.com for a copy.

Delta Dental retains the right to request radiographs and/or other documentations for any procedure when necessary to process a claim.

Electronic Attachments
Electronic attachments may be submitted at no cost directly to the secured Dental Wellness Plan Dentist Connection website along with your claim or inquiry. For more information about how to submit electronic attachments, claims and inquiries, see the DWP Dentist Connection User Manual in the Download Center at www.dwpiowa.com.

If you would like information about National Electronic Attachment Inc.’s (NEA) FastAttach™ software, please contact NEA at 800-782-5150 ext.2 or visit www.welcometonea.com to learn more about how this software provides dental offices the capability of sending digitized radiographs and attachments in support of their electronic claims. NEA’s Payer ID number is 080001.

Direct Deposit
Your Dental Wellness Plan Participating Dentist Agreement requires direct deposit of your claim payments directly into your designated bank account—whether you file paper or electronic claims. Choosing Direct Deposit will avoid the hassle of paper check processing and mail time of paper checks.

There are two options available for receiving your Remittance Advice (RA) so you can post payments to your patient accounts:

- You can choose to receive an e-mail which prompts you to access the secure Dentist Connection on the Dental Wellness Plan website to retrieve your RAs; or
- You may opt to have your RAs mailed.

Sign up for Direct Deposit is quick and easy. You may download a Direct Deposit authorization form from the Dentist Connection of the Dental Wellness Plan web site at www.dwpiowa.com. You may also contact Professional Relations for additional information at 888-472-1205 or e-mail provrelations@deltadentalia.com.
Claim Filing Procedures
File claims as soon as the service is completed. Claims must be received within 90 days of the service completion date and include all documents and attachments necessary to review, process and finalize the claim. Documentation includes, but is not limited to, clinical rationale/narrative, radiographs, periodontal chart, patient’s treatment record, coordination of benefits information as applicable. If the claim is not received within this time period, the claim may be disallowed as the Participating Dentist’s responsibility and not billable to the patient.

Filing a Dental Claim
All sections of the claim must be completed to avoid a delay in processing. If you need assistance filing a claim contact a Customer Service Representative at 888-472-1205. Use the following guidelines when completing sections of a claim.

Patient / Subscriber Information
Please use the following guidelines when completing the patient / subscriber section of a claim:

- Use the patient’s full name. Do not submit nicknames.
- It is extremely important to enter the patient’s correct date of birth.
- Be sure to indicate the Patient’s name and identification number which is listed on the Dental Wellness Plan identification card. The identification number for Dental Wellness Plan Covered Enrollee’s is the State assigned number.
- Include the Patient’s address on the claim.
- If applicable, include information about the patient’s other dental insurance so that benefits are coordinated appropriately. Medicaid is always the payer of last resort.

Record of Services
This section of the claim provides detailed information about the services provided.

Please use the following guidelines when completing the record of services section of a claim:

- Indicate if radiographs or other review documents are included with the claim.
- Indicate where the treatment was performed.
- Delta Dental of Iowa uses the standard tooth numbering system. Use letters to identify primary teeth and numbers to identify permanent teeth. Supernumerary teeth in the permanent dentition are identified by the numbers 51-82, beginning with the area of the upper right third molar, following around the upper arch and continuing on the lower arch to the area of the lower right third molar. Supernumerary teeth in the primary dentition are identified by placing an “S” following the tooth letter adjacent to the supernumerary tooth. Refer to the Current Dental Terminology (CDT) Manual for a tooth chart.
- Tooth numbers are required on procedures involving specific teeth. Generalized procedures, such as prophylaxis, fluoride treatments, radiographs, evaluations are excluded from the tooth number requirement.
- The mouth is divided into four quadrants: upper right (UR), upper left (UL), lower right (LR), and lower left (LL). When filing periodontal services, note the tooth number(s) or the quadrant to identify the teeth/area being treated.
- Identify the tooth surfaces when submitting a restoration. The following single letter codes are used to identify surfaces:
**Surface Code**

Buccal    B  
Distal    D  
Facial    F  
Incisal   I  
Lingual  L  
Mesial    M  
Occlusal  O  

- Give complete written description of the service performed.
- When submitting a claim for payment, record the date each procedure was completed. Delta Dental of Iowa does not pay for incomplete procedures. Do not list a date of service if a benefit estimate or prior authorization is being submitted.
- When listing procedure codes, use the most recent version of the American Dental Association’s (ADA) Current Dental Terminology (CDT) manual.
- Enter the Billed Charge for each completed service. Procedures and charges must be listed individually; they cannot be combined. Please verify the fees reflect the correct total of the Billed Charges.
- If a payment has been received from a third party, indicate the amount received in the area that indicates “less third party payments”. A copy of the primary carrier’s claim payment is required in order to coordinate benefits.
- DWP is a Medicaid benefits plan is always the payer of last resort. Therefore, payments from any other dental insurance carrier must be sought after and / or applied before DWP benefits are considered. When submitting claims, identify the other insurance carrier as the primary payer to ensure proper coordination of benefits.
- The treating dentist who performed the services should be listed as the treating dentist in the designated areas; the billing dentist should be listed in the billing dentist area. Include the treating dentist’s license number and National Provider Identifier (NPI) number.

**Dentist Information**

This section of the claim identifies the billing entity and treating dentist.

Please use the following guidelines when completing the dentist information on a claim:
- Please list the billing entity or dentist’s name, address and phone number.
- Include the billing entity or dentist’s tax identifications number (TIN). The number entered should be the TIN recorded with the Internal Revenue Service (IRS). Please contact the dentist’s accountant if you are unsure of the correct TIN.
- Enter the National Provider Identifier (NPI) number. (Please see HIPAA Section of this Manual for more information regarding the NPI number.)
- It is important to input the state issued license number of the dentist who performed services.
- The dentist who performed the treatment needs to sign and date the claim. Also, include the treating dentist’s license number and National Provider Identifier (NPI) number.
Ancillary Claim Information
This area of the claim includes information about occupational injury, accident as well as prosthetic placements dates.

- Be sure to indicate if treatment is a result of occupational injury. If yes, provide a brief description of the injury and the injury date and include a copy of the medical carrier’s claim payment report, if applicable.
- Indicate if treatment is the result of an accident and include a brief description of the accident and the accident date and include a copy of the medical carrier’s claim payment report, if applicable.
- If services include placement of a prosthesis, please indicate if it is the initial placement or if it is a replacement. If it is a replacement, include the date of previous placement, if known, and the reason for the replacement.

Duplicate Claims
Each duplicate claim filed results in additional administrative costs for your office and the Dental Wellness Plan. To help control costs and avoid duplicate claims please be sure to access the claims status on the Dentist Connection at www.dwpiowa.com, and check your electronic submissions to ensure you’re not including claims sent previously. Duplicate filings occur in some dental office practice management systems when claims at the end of a transmission are not deleted and are subsequently resubmitted. If you are unsure whether the claim has been filed, please access the Dental Wellness Plan Dentist Connection on the Dental Wellness Plan web site at www.dwpiowa.com. If your office has a high occurrence of duplicate claims filing, a member of Delta Dental of Iowa’s Professional Relations team may contact your office to assist in determining if there is a claims filing issue or training need.

Infection Control
Delta Dental understands that costs are incurred by the dentist to comply with Centers for the Disease Control (CDC) recommended infection control guidelines. However, infection control is not a unique element of a dental procedure but is a dentist’s professional responsibility. These costs are part of the day-to-day operations and office overhead and should not be billed separately. Participating Dentists may not bill the Covered Enrollee or Delta Dental separately for these charges.

Claim Filing Tips
Review the following filing tips to ensure quick and accurate claims processing:

- If you are approved to submit paper claims, verify the print quality and legibility of your claims.
- Prior Authorizations are required for certain services. For a list of services requiring Prior Authorization refer to the Prior Authorization Section.
- It is very important to submit claims with the Covered Enrollee’s correct date of birth.
- When sending photos or radiographs, indicate the date of the image and identify teeth by labeling “right” (R) or “left” (L). Do not send original photos or radiographs. Delta Dental of Iowa will not return photos or radiographs unless the office includes a self-addressed, stamped envelope with the submission. Be sure to include sufficient postage.
- Submit crowns, onlays, and dentures with seat date, not the preparation date.
- File root canal therapy (RCT) with the completion or fill date.
- When you file periodontal services (i.e. root planning and scaling, osseous surgery, grafting, gingivectomy), include the tooth number or the quadrant (UR, UL, LL< LR) to
identify the teeth/area being treated. Be sure to include the necessary submission requirements for these procedures. (Please refer to the Procedures and Processing Policies section of this Manual for additional details.)

- Be sure to include the tooth number when filing a claim for re-cementing a restoration.
- List tooth numbers on claims for fillings, onlays, crowns.

**Fraud**

Delta Dental of Iowa is dedicated to conducting business in an ethical and legal manner. Delta Dental of Iowa maintains an Anti-Fraud Plan for continuous monitoring of potential fraud, waste, and abuse activity. We are committed to preventing, detecting and reporting fraud, waste, and abuse and overpayments.

**Definitions:**

- **Fraud** is knowing misrepresentation of a fact to obtain benefits whether or not successful.
- **Abuse** refers to overused or unneeded services, which include provider or enrollee actions that result in unneeded costs to the Dental Wellness Plan.
- **Waste** is the misuse of services.
- **Over-payments** refer to any amount paid by DWP that may be a result of improper claims, unacceptable practices, errors, mistakes, fraud, waste and or abuse.

Delta Dental monitors and audits the activities of its providers, enrollees, employees, and vendors. The provider activities monitored and audited may include, but are not limited to both contract and regulatory compliance requirements. Delta Dental may periodically request the completion of a questionnaire, submission of documentation, and/or attestation to applicable policy, procedure, and compliance requirements.

Delta Dental may also perform in office or desk audits, which may include the inspection of the facilities, systems, books, procedures, and or records related to services provided.

Disciplinary actions could result from these monitoring activities including, but not limited to, payment recoupment, education, corrective action plans, and/or contract termination.

If you suspect fraud or an overpayment was made, report it immediately to Delta Dental of Iowa’s Utilization Review Coordinator at 515-261-5638 or 888-472-1205.

Some common types of fraud and abuse include:

- Billing for services not performed
- Keeping over-payments
- Billing for a non-covered services as a covered services
- Misrepresenting dates of services, diagnosis, or procedures performed
- Misrepresenting location of a service
- Misrepresenting provider of a service
- Billing twice for the same service
- Billing for inappropriate or unnecessary services
- Reporting a higher level of dental service than was actually performed
- Falsifying a patient name or their personally identifiable information to obtain payment for services
- Deliberately failing to report the existence of additional dental benefits coverage and billing two or more carries for the full amount
- Kickbacks or bribes
- Lying about degrees and licenses
- Patients who misrepresent themselves as another person to obtain dental benefits

**Recoupment of Overpayment** – In the event Delta Dental makes payments and payments are later determined to have been made in error, or were for dental services not Covered Services because they were cosmetic, elective, not dentally necessary or dental appropriate, or because of dentist’s error, Delta Dental’s error, overpayment by Delta Dental or a patient’s ineligibility for coverage, Delta Dental will deduct from future payments due to the dentist amounts equal to the amount of the incorrect payments. Overpayments need returned within 60 days of discovery.

**Member pay**
Covered enrollees may pay services due to frequency limitations, never covered services and/or if the member has agreed to pay for services that are covered. We strongly encourage you to require the enrollee to sign a patient financial responsibility form.

Note: The Dental Wellness Plan Member Financial Responsibility Consent for Treatment Form can be found on the DWP Dentist Connection in the Download Center under the Forms Section at [www.dwpiowa.com](http://www.dwpiowa.com).

If a member files a complaint in regard to financial responsibility, Delta Dental of Iowa will request that you provide a copy of the signed informed consent form.

**Dental Wellness Plan Benefit Design**
The Dental Wellness Plan focuses on population health with an emphasis on prevention and member accountability. The benefit design includes Full Benefits and Reduced Benefits. All members are eligible for Full Benefits during the first year. Those members who do not complete their Healthy Behaviors during year one, may be subject to Reduced Benefits in future years.

Covered Enrollees ages 19-20 are covered through the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program and are eligible to receive the Full Benefits provided by the plan as long as they meet administrative, clinical and prior authorization criteria for the service. Applicable prior authorizations still apply.
Orthodontics

The Dental Wellness Plan offers a medically necessary orthodontic benefit to Dental Wellness Plan members 19-20 years old. Comprehensive orthodontic treatment can be approved for members with malocclusion scores of 26 or above on the index from “Handicapping Malocclusion Assessment to Establish Treatment Priority”, by J. A. Salzmann, D.D. S. All orthodontic treatment requires a prior authorization before treatment begins. For more information regarding Dental Wellness Plan orthodontic services, please refer to the Dental Wellness Plan Orthodontic Administrative Guide that will be available on the Delta Dental Provider website.
<table>
<thead>
<tr>
<th>CDT Code</th>
<th>Nomenclature</th>
<th>Covered under Reduced Benefits Level</th>
<th>Covered under Full Benefits Level</th>
<th>Prior Authorization Required</th>
<th>Frequency</th>
<th>Claim Submission Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0120 *</td>
<td>periodic oral evaluation - established patient</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>every 6 months</td>
<td>N/A</td>
</tr>
<tr>
<td>D0140*</td>
<td>limited oral evaluation - problem focused</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>2 problem focused / consultation exams (D0140, D0170, and D9310) per benefit year</td>
<td>Narrative</td>
</tr>
<tr>
<td>D0150*</td>
<td>comprehensive oral evaluation - new or established patient</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>once in a 3 year period</td>
<td>N/A</td>
</tr>
<tr>
<td>D0170</td>
<td>re-evaluation - limited, problem focused (established patient; not post-operative visit)</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>2 problem focused / consultation exams (D0140, D0170, and D9310) per benefit year</td>
<td>Narrative</td>
</tr>
<tr>
<td>D0180*</td>
<td>comprehensive periodontal evaluation - new or established patient</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>once in a 3 year period</td>
<td>N/A</td>
</tr>
<tr>
<td>D0210</td>
<td>intraoral - complete series of radiographic images</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>once in 5 year period</td>
<td>N/A</td>
</tr>
<tr>
<td>D0220</td>
<td>intraoral - periapical first radiographic image</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>see full mouth series policies</td>
<td></td>
</tr>
<tr>
<td>D0230</td>
<td>intraoral - periapical each additional radiographic image</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>see full mouth series policies</td>
<td></td>
</tr>
<tr>
<td>D0240</td>
<td>intraoral - occlusal radiographic image</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>see full mouth series policies</td>
<td>N/A</td>
</tr>
<tr>
<td>D0250</td>
<td>extraoral - first radiographic image</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>See full mouth series policies</td>
<td>N/A</td>
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<tr>
<td>D0270</td>
<td>bitewing - single radiographic image</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>once every 12 months</td>
<td>N/A</td>
</tr>
<tr>
<td>D0272</td>
<td>bitewings - two radiographic images</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>once every 12 months</td>
<td>N/A</td>
</tr>
<tr>
<td>D0273</td>
<td>bitewings - three radiographic images</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>once every 12 months</td>
<td>N/A</td>
</tr>
<tr>
<td>D0274</td>
<td>bitewings - four radiographic images</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>once every 12 months</td>
<td>N/A</td>
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<tr>
<td>D0330</td>
<td>panoramic radiographic image</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>once in 5 year period</td>
<td>N/A</td>
</tr>
<tr>
<td>D0340</td>
<td>2D cephalometric radiographic image-acquisition, measurement and analysis</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>once in 1 year period, for covered orthodontics only</td>
<td>Narrative</td>
</tr>
<tr>
<td>D0460</td>
<td>pulp vitality tests</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>by report, included in prosthodontic procedures</td>
<td>Narrative</td>
</tr>
<tr>
<td>D0470</td>
<td>diagnostic casts</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td>Narrative</td>
</tr>
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</tr>
<tr>
<td>D0601**</td>
<td>caries risk assessment and documentation, with finding of low risk</td>
<td>Yes</td>
<td></td>
<td></td>
<td>1 risk assessment is payable per benefit year</td>
<td></td>
</tr>
<tr>
<td>D0602**</td>
<td>caries risk assessment and documentation, with finding of medium risk</td>
<td>Yes</td>
<td></td>
<td></td>
<td>1 risk assessment is payable per benefit year</td>
<td></td>
</tr>
<tr>
<td>D0603**</td>
<td>caries risk assessment and documentation, with finding of high risk</td>
<td>Yes</td>
<td></td>
<td></td>
<td>1 risk assessment is payable per benefit year</td>
<td></td>
</tr>
<tr>
<td>D1110*</td>
<td>prophylaxis - adult</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>once in 6 month period</td>
<td>N/A</td>
</tr>
<tr>
<td>D1206</td>
<td>topical application of fluoride varnish</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>payable every 90 days</td>
<td>N/A</td>
</tr>
<tr>
<td>D1208</td>
<td>topical application of fluoride</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>payable every 90 days</td>
<td>N/A</td>
</tr>
<tr>
<td>D1354</td>
<td>interim caries arresting medicament application</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>twice per tooth per year, see processing policies for limitations</td>
<td></td>
</tr>
<tr>
<td>D2140</td>
<td>amalgam - one surface, primary or permanent</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>payable once per tooth per 24 months</td>
<td></td>
</tr>
<tr>
<td>D2150</td>
<td>amalgam - two surfaces, primary or permanent</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>payable once per tooth per 24 months</td>
<td></td>
</tr>
<tr>
<td>D2160</td>
<td>amalgam - three surfaces, primary or permanent</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>payable once per tooth per 24 months</td>
<td></td>
</tr>
<tr>
<td>D2161</td>
<td>amalgam - four or more surfaces, primary or permanent</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>payable once per tooth per 24 months</td>
<td></td>
</tr>
<tr>
<td>D2330</td>
<td>resin-based composite - one surface, anterior</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>payable once per tooth per 24 months</td>
<td></td>
</tr>
<tr>
<td>D2331</td>
<td>resin-based composite - two surfaces, anterior</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>payable once per tooth per 24 months</td>
<td></td>
</tr>
<tr>
<td>D2332</td>
<td>resin-based composite - three surfaces, anterior</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>payable once per tooth per 24 months</td>
<td></td>
</tr>
<tr>
<td>D2335</td>
<td>resin-based composite - four or more surfaces or involving incisal angle (anterior)</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>payable once per tooth per 24 months</td>
<td>Radiograph, Intraoperative photo if available</td>
</tr>
<tr>
<td>D2390</td>
<td>resin-based composite crown, anterior</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>payable once per tooth per 24 months</td>
<td>Radiograph, Narrative, Intraoperative photo if available</td>
</tr>
<tr>
<td>D2391</td>
<td>resin-based composite - one surface, posterior</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>payable once per tooth per 24 months</td>
<td></td>
</tr>
<tr>
<td>D2392</td>
<td>resin-based composite - two surfaces, posterior</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>payable once per tooth per 24 months</td>
<td></td>
</tr>
<tr>
<td>D2393</td>
<td>resin-based composite - three surfaces, posterior</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Payable once per tooth per 24 months</td>
<td></td>
</tr>
<tr>
<td>D2394</td>
<td>resin-based composite - four or more surfaces, posterior</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>payable once per tooth per 24 months</td>
<td></td>
</tr>
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<tr>
<td>D2710</td>
<td>crown - resin-based composite (indirect)</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>by report only, one crown per tooth per 5 year period</td>
<td>Periapical, Radiograph, Narrative, Intraoperative photo if available.</td>
</tr>
<tr>
<td>D2721</td>
<td>crown - resin with predominantly base metal</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>by report only, one crown per tooth per 5 year period</td>
<td>Periapical, Radiograph, Narrative, Intraoperative photo if available.</td>
</tr>
<tr>
<td>D2740</td>
<td>crown - porcelain/ceramic substrate</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>one crown per tooth per 5 year period</td>
<td>Periapical, Radiograph, Narrative, Intraoperative photo if available.</td>
</tr>
<tr>
<td>D2750</td>
<td>crown - porcelain fused to high noble metal</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>one crown per tooth per 5 year period</td>
<td>Periapical, Radiograph, Narrative, Intraoperative photo if available.</td>
</tr>
<tr>
<td>D2751</td>
<td>crown - porcelain fused to predominantly base metal</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>one crown per tooth per 5 year period</td>
<td>Periapical, Radiograph, Narrative, Intraoperative photo if available.</td>
</tr>
<tr>
<td>D2752</td>
<td>crown - porcelain fused to noble metal</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>one crown per tooth per 5 year period</td>
<td>Periapical, Radiograph, Narrative, Intraoperative photo if available.</td>
</tr>
<tr>
<td>D2781</td>
<td>crown - 3/4 cast predominantly base metal</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>by report only, one crown per tooth per 5 year period</td>
<td>Periapical, Radiograph, Narrative, Intraoperative photo if available.</td>
</tr>
<tr>
<td>D2790</td>
<td>crown - full cast high noble metal</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>one crown per tooth per 5 year period</td>
<td>Periapical, Radiograph, Narrative, Intraoperative photo if available.</td>
</tr>
<tr>
<td>D2791</td>
<td>crown - full cast predominantly base metal</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>one crown per tooth per 5 year period</td>
<td>Periapical, Radiograph, Narrative, Intraoperative photo if available.</td>
</tr>
<tr>
<td>D2792</td>
<td>crown - full cast noble metal</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>one crown per tooth per 5 year period</td>
<td>Periapical, Radiograph, Narrative, Intraoperative photo if available.</td>
</tr>
<tr>
<td>D2910</td>
<td>recement inlay, onlay, or partial coverage restoration</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>one per tooth per 24 months</td>
<td>Radiograph, Narrative.</td>
</tr>
<tr>
<td>D2915</td>
<td>recement cast or prefabricated post and core</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>one per tooth per 24 months</td>
<td>Narrative</td>
</tr>
<tr>
<td>D2920</td>
<td>recement crown</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>one per tooth per 24 months</td>
<td>Narrative</td>
</tr>
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</tr>
<tr>
<td>D2921</td>
<td>reattachment of tooth fragment, incisal edge or cusp</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>one per tooth per 24 months</td>
<td>Narrative</td>
</tr>
<tr>
<td>D2931</td>
<td>prefabricated stainless steel crown - permanent tooth</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>by report only, one per tooth per 24 months</td>
<td>Radiograph, Narrative</td>
</tr>
<tr>
<td>D2932</td>
<td>prefabricated resin crown</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>by report only, one per tooth per 24 months</td>
<td>Radiograph, Narrative</td>
</tr>
<tr>
<td>D2940</td>
<td>protective restoration</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>by report only</td>
<td>Radiograph, Narrative</td>
</tr>
<tr>
<td>D2950</td>
<td>core buildup, including any pins when required</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>payable once on the same restoration in 5 year period</td>
<td>Radiograph, Narrative</td>
</tr>
<tr>
<td>D2951</td>
<td>pin retention – per tooth, in addition to restoration</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td>Narrative</td>
</tr>
<tr>
<td>D2952</td>
<td>post and core in addition to crown, indirectly fabricated</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>payable once on the same restoration in 5 year period</td>
<td>Radiograph, Narrative</td>
</tr>
<tr>
<td>D2954</td>
<td>prefabricated post and core in addition to crown</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>payable once on the same restoration in 5 year period</td>
<td>Radiograph, Narrative</td>
</tr>
<tr>
<td>D2971</td>
<td>additional procedures to construct new crown under existing partial denture framework</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>by report only</td>
<td>Radiograph, Narrative</td>
</tr>
<tr>
<td>D2980</td>
<td>crown repair necessitated by restorative material failure</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>by report only</td>
<td>Radiograph, Narrative</td>
</tr>
<tr>
<td>D3220</td>
<td>therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>once in a life-time per tooth</td>
<td>Radiograph, Narrative</td>
</tr>
<tr>
<td>D3221</td>
<td>pulpal debridement, primary and permanent teeth</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>once in a life-time per tooth</td>
<td>Radiograph, Narrative</td>
</tr>
<tr>
<td>D3310</td>
<td>endodontic therapy, anterior tooth (excluding final restoration)</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>once in a life-time per tooth; by report if more than once</td>
<td>Pre and Post Obturation Radiograph, Narrative</td>
</tr>
<tr>
<td>D3320</td>
<td>Endodontic therapy, anterior tooth (excluding final restoration)</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Once in a lifetime per tooth, by report if more than once</td>
<td>Pre and Post Obturation Radiograph, Narrative</td>
</tr>
<tr>
<td>D3330</td>
<td>endodontic therapy, molar (excluding final restoration)</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>once in a life-time per tooth; by report if more than once</td>
<td>Pre and Post Obturation Radiograph, Narrative</td>
</tr>
<tr>
<td>D3332</td>
<td>incomplete endodontic therapy; inoperable, unrestorable or fractured tooth</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>once in a life-time per tooth</td>
<td>Radiograph, Narrative</td>
</tr>
<tr>
<td>D3346</td>
<td>retreatment of previous root canal therapy - anterior</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>once in a life-time per tooth; by report if more than once</td>
<td>Pre and Post Obturation Radiograph, Narrative</td>
</tr>
<tr>
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</tr>
<tr>
<td>D3347</td>
<td>retreatment of previous root canal therapy - bicuspid</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>once in a life-time per tooth; by report if more than once</td>
<td>Pre and Post Obturation Radiograph, Narrative</td>
</tr>
<tr>
<td>D3348</td>
<td>retreatment of previous root canal therapy - molar</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>once in a life-time per tooth; by report if more than once</td>
<td>Pre and Post Obturation Radiograph, Narrative</td>
</tr>
<tr>
<td>D3351</td>
<td>apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>once in a life-time per tooth; by report if more than once</td>
<td>Radiograph, Narrative</td>
</tr>
<tr>
<td>D3352</td>
<td>apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>once in a life-time per tooth; by report if more than once</td>
<td>Radiograph, Narrative</td>
</tr>
<tr>
<td>D3410</td>
<td>apicoectomy - anterior</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>once in a life-time per tooth; by report if more than once</td>
<td>Radiograph, Narrative</td>
</tr>
<tr>
<td>D3421</td>
<td>apicoectomy - bicuspid (first root)</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>once in a life-time per tooth; by report if more than once</td>
<td>Radiograph, Narrative</td>
</tr>
<tr>
<td>D3425</td>
<td>apicoectomy - molar (first root)</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>once in a life-time per tooth; by report if more than once</td>
<td>Pre and Post Obturation Radiograph, Narrative</td>
</tr>
<tr>
<td>D3426</td>
<td>apicoectomy (each additional root)</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>once in a life-time per tooth; by report if more than once</td>
<td>Pre and Post Obturation Radiograph, Narrative</td>
</tr>
<tr>
<td>D3427</td>
<td>periradicular surgery without apicoectomy</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>once in a life-time per tooth; by report if more than once</td>
<td>Pre and Post Obturation Radiograph, Narrative</td>
</tr>
<tr>
<td>D3430</td>
<td>retrograde filling - per root</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>once in a life-time per tooth; by report if more than once</td>
<td>Radiograph, Narrative</td>
</tr>
<tr>
<td>D3450</td>
<td>root amputation - per root</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>once in a life-time per tooth; by report if more than once</td>
<td>Radiograph, Narrative</td>
</tr>
<tr>
<td>D4210</td>
<td>gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>once per quadrant per 2 years</td>
<td>Narrative, including diagnosis, Periodontal charting, Intraoperative photo if available</td>
</tr>
<tr>
<td>D4211</td>
<td>gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>once per quadrant per 2 years</td>
<td>Narrative, including diagnosis, Periodontal charting, Intraoperative photo if available</td>
</tr>
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<tr>
<td>D4240</td>
<td>gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>once per quadrant per 2 years</td>
<td>Narrative, including diagnosis, Periodontal charting, Intraoperative photo if available, Radiograph</td>
</tr>
<tr>
<td>D4241</td>
<td>gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>once per quadrant per 2 years</td>
<td>Narrative, including diagnosis, Periodontal charting, Intraoperative photo if available, Radiograph</td>
</tr>
<tr>
<td>D4249</td>
<td>clinical crown lengthening - hard tissue</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>once per tooth per 2 years</td>
<td>Narrative, including diagnosis, Periodontal charting, Intraoperative photo if available, Radiograph</td>
</tr>
<tr>
<td>D4260</td>
<td>osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>once per quadrant per 2 years</td>
<td>Narrative, including diagnosis, Periodontal charting, Radiograph</td>
</tr>
<tr>
<td>D4261</td>
<td>osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>once per quadrant per 2 years</td>
<td>Narrative, including diagnosis, Periodontal charting, Radiograph</td>
</tr>
<tr>
<td>D4270</td>
<td>pedicle soft tissue graft procedure</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>once per quadrant per 2 years</td>
<td>Narrative, including diagnosis, Periodontal charting, Intraoperative photo if available</td>
</tr>
<tr>
<td>D4273</td>
<td>subepithelial connective tissue graft procedures, per tooth</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>once per quadrant per 2 years</td>
<td>Narrative, including diagnosis, Periodontal charting, Intraoperative photo if available</td>
</tr>
<tr>
<td>D4275</td>
<td>soft tissue allograft</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>once per quadrant per 2 years</td>
<td>Narrative, including diagnosis, Periodontal charting, Intraoperative photo if available</td>
</tr>
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<tr>
<td>D4277</td>
<td>free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>once per quadrant per 2 years</td>
<td>Narrative, including diagnosis, Periodontal charting, Intraoperative photo if available</td>
</tr>
<tr>
<td>D4278</td>
<td>autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant or edentulous tooth position in graft</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>once per quadrant per 2 years</td>
<td>Narrative, including diagnosis, Periodontal charting, Intraoperative photo if available</td>
</tr>
<tr>
<td>D4283</td>
<td>autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in the same graft site</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>once per quadrant per 2 years</td>
<td>Narrative, including diagnosis, Periodontal charting, Intraoperative photo if available</td>
</tr>
<tr>
<td>D4285</td>
<td>Non-autogenous connective tissue graft procedure (including recipient surgical site and done material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>once per quadrant per 2 years</td>
<td>Narrative, including diagnosis, Periodontal charting, Intraoperative photo if available</td>
</tr>
<tr>
<td>D4341</td>
<td>periodontal scaling and root planing - four or more teeth per quadrant</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>once per quadrant per 24 months</td>
<td>Narrative, Periodontal charting, Radiograph</td>
</tr>
<tr>
<td>D4342</td>
<td>periodontal scaling and root planing - one to three teeth per quadrant</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>once per quadrant per 24 months</td>
<td>Narrative, Periodontal charting, Intraoperative photo if available</td>
</tr>
<tr>
<td>D4346</td>
<td>scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>once in 6 months period</td>
<td>N/A</td>
</tr>
<tr>
<td>D4355</td>
<td>full mouth debridement to enable comprehensive evaluation and diagnosis</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>once every 24 months; no exam charged on date of service</td>
<td>Periodic or Comprehensive exam may not be completed on the same day.</td>
</tr>
<tr>
<td>D4910*</td>
<td>periodontal maintenance</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>One every 3 months following qualifying definitive periodontal procedure.</td>
<td>N/A</td>
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<td>D4999</td>
<td>unspecified periodontal procedure, by report</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>by report</td>
<td>Narrative</td>
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<tr>
<td>D5110</td>
<td>Complete denture-maxillary</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>once every 5 year period; 1 replacement considered by report</td>
<td>Radiograph, Narrative</td>
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<tr>
<td>D5120</td>
<td>complete denture - mandibular</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>once every 5 year period; 1 replacement considered by report</td>
<td>Radiograph, Narrative</td>
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<td>D5130</td>
<td>immediate denture - maxillary</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>once every 5 year period; 1 replacement considered by report</td>
<td>Radiograph, Narrative</td>
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<tr>
<td>D5140</td>
<td>immediate denture - mandibular</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>once every 5 year period; 1 replacement considered by report</td>
<td>Radiograph, Narrative</td>
</tr>
<tr>
<td>D5211</td>
<td>maxillary partial denture - resin base (including any conventional clasps, rests and teeth)</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>once every 5 year period; 1 replacement considered by report</td>
<td>Radiograph, Narrative</td>
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<tr>
<td>D5212</td>
<td>mandibular partial denture - resin base (including any conventional clasps, rests and teeth)</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>once every 5 year period; 1 replacement considered by report</td>
<td>Radiograph, Narrative</td>
</tr>
<tr>
<td>D5213</td>
<td>maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>once every 5 year period; 1 replacement considered by report</td>
<td>Radiograph, Narrative</td>
</tr>
<tr>
<td>D5214</td>
<td>mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>once every 5 year period; 1 replacement considered by report</td>
<td>Radiograph, Narrative</td>
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<tr>
<td>D5225</td>
<td>maxillary partial denture - flexible base (including any clasps, rests and teeth)</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>once every 5 year period; 1 replacement considered by report</td>
<td>Radiograph, Narrative</td>
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<tr>
<td>D5226</td>
<td>mandibular partial denture - flexible base (including any clasps, rests and teeth)</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>once every 5 year period; 1 replacement considered by report</td>
<td>Radiograph, Narrative</td>
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<tr>
<td>D5410</td>
<td>adjust complete denture - maxillary</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>2 repairs/adjustments per arch per year; after 6 months of denture delivery</td>
<td>Narrative</td>
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<tr>
<td>D5411</td>
<td>adjust complete denture - mandibular</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>2 repairs/adjustments per arch per year; after 6 months of denture delivery</td>
<td>Narrative</td>
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<tr>
<td>D5421</td>
<td>adjust partial denture - maxillary</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>2 repairs/adjustments per arch per year; after 6 months of denture delivery</td>
<td>Narrative</td>
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<tr>
<td>D5422</td>
<td>adjust partial denture - mandibular</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>2 repairs/adjustments per arch per year; after 6 months of denture delivery</td>
<td>Narrative</td>
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<tr>
<td>D5510</td>
<td>repair broken complete denture base</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>2 repairs/adjustments per arch per year;</td>
<td>Narrative</td>
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<tr>
<td>D5520</td>
<td>replace missing or broken teeth - complete denture (each tooth)</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>2 repairs/adjustments per arch per year; after 6 months of denture delivery</td>
<td>Narrative</td>
</tr>
<tr>
<td>D5610</td>
<td>repair resin denture base</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>2 repairs/adjustments per arch per year; after 6 months of denture delivery</td>
<td>Narrative</td>
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<tr>
<td>D5620</td>
<td>repair cast framework</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>2 repairs/adjustments per arch per year; after 6 months of denture delivery</td>
<td>Narrative</td>
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<tr>
<td>D5630</td>
<td>repair or replace broken clasp</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>2 repairs/adjustments per arch per year; after 6 months of denture delivery</td>
<td>Narrative</td>
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<tr>
<td>D5640</td>
<td>replace broken teeth - per tooth</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>2 repairs/adjustments per arch per year; after 6 months of denture delivery</td>
<td>Narrative</td>
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<tr>
<td>D5650</td>
<td>add tooth to existing partial denture</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>2 repairs/adjustments per arch per year; after 6 months of denture delivery</td>
<td>Narrative</td>
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<tr>
<td>D5660</td>
<td>add clasp to existing partial denture</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>2 repairs/adjustments per arch per year; after 6 months of denture delivery</td>
<td>Narrative</td>
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<tr>
<td>D5710</td>
<td>rebase complete maxillary denture</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>2 repairs/adjustments per arch per year; after 6 months of denture delivery</td>
<td>Narrative</td>
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<tr>
<td>D5711</td>
<td>rebase complete mandibular denture</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>2 repairs/adjustments per arch per year; after 6 months of denture delivery</td>
<td>Narrative</td>
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<tr>
<td>D5720</td>
<td>rebase maxillary partial denture</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>2 repairs/adjustments per arch per year; after 6 months of denture delivery</td>
<td>Narrative</td>
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<tr>
<td>D5721</td>
<td>rebase mandibular partial denture</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>2 repairs/adjustments per arch per year; after 6 months of denture delivery</td>
<td>Narrative</td>
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<tr>
<td>D5730</td>
<td>reline complete maxillary denture (chairside)</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>one reline per arch every 12 months starting 6 months after denture delivery</td>
<td>Narrative</td>
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<tr>
<td>D5731</td>
<td>reline complete mandibular denture (chairside)</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>one reline per arch every 12 months starting 6 months after denture delivery</td>
<td>Narrative</td>
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<tr>
<td>D5740</td>
<td>reline maxillary partial denture (chairside)</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>one reline per arch every 12 months starting 6 months after denture delivery</td>
<td>Narrative</td>
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<tr>
<td>D5741</td>
<td>reline mandibular partial denture (chairsid)</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>One reline per arch every 12 months starting 6 months after denture delivery</td>
<td>Narrative</td>
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<tr>
<td>D5750</td>
<td>reline complete maxillary denture (laboratory)</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>one reline per arch every 12 months starting 6 months after denture delivery</td>
<td>Narrative</td>
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<tr>
<td>D5751</td>
<td>reline complete mandibular denture (laboratory)</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>one reline per arch every 12 months starting 6 months after denture delivery</td>
<td>Narrative</td>
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<tr>
<td>D5760</td>
<td>reline maxillary partial denture (laboratory)</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>one reline per arch every 12 months starting 6 months after denture delivery</td>
<td>Narrative</td>
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<tr>
<td>D5761</td>
<td>reline mandibular partial denture (laboratory)</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>one reline per arch every 12 months starting 6 months after denture delivery</td>
<td>Narrative</td>
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<tr>
<td>D5850</td>
<td>tissue conditioning, maxillary</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>2 repairs/adjustments per arch per year; after 6 months of denture delivery per clinical</td>
<td>Narrative</td>
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<tr>
<td>D5851</td>
<td>tissue conditioning, mandibular</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>2 repairs/adjustments per arch per year; after 6 months of denture delivery</td>
<td>Narrative</td>
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<td>D5863</td>
<td>overdenture - complete maxillary</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>once every 5 year period; 1 replacement considered by report</td>
<td>Radiograph, Narrative</td>
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<tr>
<td>D5864</td>
<td>overdenture - partial maxillary</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>once every 5 year period; 1 replacement considered by report</td>
<td>Radiograph, Narrative</td>
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<tr>
<td>D5865</td>
<td>overdenture - complete mandibular</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>once every 5 year period; 1 replacement considered by report</td>
<td>Radiograph, Narrative</td>
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<tr>
<td>D5866</td>
<td>overdenture - partial mandibular</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>once every 5 year period; 1 replacement considered by report</td>
<td>Radiograph, Narrative</td>
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<td>D5899</td>
<td>unspecified removable prosthodontic procedure, by report</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>by report</td>
<td>Narrative</td>
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<tr>
<td>D6205</td>
<td>pontic - indirect resin based composite</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>anterior teeth only; one crown/pontic per tooth per 5 year period</td>
<td>Radiograph, Narrative, Chart of Missing/ Present Teeth</td>
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<tr>
<td>D6210</td>
<td>pontic - cast high noble metal</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>anterior teeth only; one crown/pontic per tooth per 5 year period</td>
<td>Radiograph, Narrative, Chart of Missing/ Present Teeth</td>
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<tr>
<td>D6211</td>
<td>pontic - case predominantly base metal</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>anterior teeth only; one crown/pontic per tooth per 5 year period</td>
<td>Radiograph, Narrative, Chart of Missing/ Present Teeth</td>
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<tr>
<td>D6212</td>
<td>pontic - cast noble metal</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>anterior teeth only; one crown/pontic per tooth per 5 year period</td>
<td>Radiograph, Narrative, Chart of Missing/ Present Teeth</td>
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<tr>
<td>D6214</td>
<td>pontic - titanium</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>anterior teeth only; one crown/pontic per tooth per 5 year period</td>
<td>Radiograph, Narrative, Chart of Missing/ Present Teeth</td>
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<tr>
<td>D6240</td>
<td>pontic - porcelain fused to high noble metal</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>anterior teeth only; one crown/pontic per tooth per 5 year period</td>
<td>Radiograph, Narrative, Chart of Missing/ Present Teeth</td>
</tr>
<tr>
<td>D6241</td>
<td>pontic - porcelain fused to predominantly base metal</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>anterior teeth only; one crown/pontic per tooth per 5 year period</td>
<td>Radiograph, Narrative, Chart of Missing/ Present Teeth</td>
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<tr>
<td>D6242</td>
<td>pontic - porcelain fused to noble metal</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>anterior teeth only; one crown/pontic per tooth per 5 year period</td>
<td>Radiograph, Narrative, Chart of Missing/ Present Teeth</td>
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<tr>
<td>D6245</td>
<td>pontic - porcelain/ceramic</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>anterior teeth only; one crown/pontic per tooth per 5 year period</td>
<td>Radiograph, Narrative, Chart of Missing/ Present Teeth</td>
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<tr>
<td>D6545</td>
<td>retainer - cast metal for resin bonded fixed prosthesis</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>by report, anterior teeth only; one crown/pontic per tooth per 5 year period</td>
<td>Radiograph, Narrative, Chart of Missing/ Present Teeth</td>
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<tr>
<td>D6710</td>
<td>retainer crown - indirect resin based composite</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>anterior teeth only; one crown/pontic per tooth per 5 year period</td>
<td>Radiograph, Narrative, Chart of Missing/ Present Teeth</td>
</tr>
<tr>
<td>D6720</td>
<td>retainer crown - resin with high noble metal</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>anterior teeth only; one crown/pontic per tooth per 5 year period</td>
<td>Radiograph, Narrative, Chart of Missing/ Present Teeth</td>
</tr>
<tr>
<td>D6721</td>
<td>retainer crown - resin with predominantly base metal</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>anterior teeth only; one crown/pontic per tooth per 5 year period</td>
<td>Radiograph, Narrative, Chart of Missing/ Present Teeth</td>
</tr>
<tr>
<td>D6722</td>
<td>retainer crown - resin with noble metal</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>anterior teeth only; one crown/pontic per tooth per 5 year period</td>
<td>Radiograph, Narrative, Chart of Missing/ Present Teeth</td>
</tr>
<tr>
<td>D6740</td>
<td>retainer crown - porcelain/ceramic</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>anterior teeth only; one crown/pontic per tooth per 5 year period</td>
<td>Radiograph, Narrative, Chart of Missing/ Present Teeth</td>
</tr>
<tr>
<td>D6750</td>
<td>retainer crown - porcelain fused to high noble metal</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>anterior teeth only; one crown/pontic per tooth per 5 year period</td>
<td>Radiograph, Narrative, Chart of Missing/ Present Teeth</td>
</tr>
<tr>
<td>D6751</td>
<td>retainer crown - porcelain fused to predominantly base metal</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>anterior teeth only; one crown/pontic per tooth per 5 year period</td>
<td>Radiograph, Narrative, Chart of Missing/ Present Teeth</td>
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<tr>
<td>D6752</td>
<td>retainer crown - porcelain fused to noble metal</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>anterior teeth only; one crown/pontic per tooth per 5 year period</td>
<td>Radiograph, Narrative, Chart of Missing/ Present Teeth</td>
</tr>
<tr>
<td>D6930</td>
<td>re-cement or re-bond fixed partial denture</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>one per tooth per 2 years</td>
<td>Narrative</td>
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<tr>
<td>D6980</td>
<td>fixed partial denture repair necessitated by restorative material failure</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>one per tooth per 2 years</td>
<td>Narrative</td>
</tr>
<tr>
<td>D7111</td>
<td>extraction, coronal remnants - deciduous tooth</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Once per lifetime per tooth</td>
<td>N/A</td>
</tr>
<tr>
<td>D7140</td>
<td>extraction, erupted tooth or exposed root (elevation and/or forceps removal)</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Once per lifetime per tooth</td>
<td>N/A</td>
</tr>
<tr>
<td>D7210</td>
<td>extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Once per lifetime per tooth</td>
<td>Radiograph, Clinical Notes</td>
</tr>
<tr>
<td>D7220</td>
<td>removal of impacted tooth - soft tissue</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Once per lifetime per tooth</td>
<td>Radiograph, Clinical Notes</td>
</tr>
<tr>
<td>D7230</td>
<td>removal of impacted tooth - partially bony</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Once per lifetime per tooth</td>
<td>Radiograph, Clinical Notes</td>
</tr>
<tr>
<td>D7240</td>
<td>removal of impacted tooth - completely bony</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Once per lifetime per tooth</td>
<td>Radiograph, Clinical Notes</td>
</tr>
<tr>
<td>D7241</td>
<td>removal of impacted tooth - completely bony, with unusual surgical complications</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Once per lifetime per tooth</td>
<td>Radiograph, Clinical Notes</td>
</tr>
<tr>
<td>D7250</td>
<td>surgical removal of residual tooth roots (cutting procedure)</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Once per lifetime per tooth</td>
<td>Radiograph, Clinical Notes</td>
</tr>
<tr>
<td>D7251</td>
<td>coronectomy - intentional partial tooth removal</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>by report</td>
<td>Radiograph, Clinical Notes</td>
</tr>
<tr>
<td>D7260</td>
<td>oroantral fistula closure</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>D7261</td>
<td>primary closure of a sinus perforation</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>D7270</td>
<td>tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>D7280</td>
<td>surgical access of an unerupted tooth</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>by report, limited to covered orthodontics</td>
<td>Radiograph, Narrative</td>
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<tr>
<td>D7283</td>
<td>placement of device to facilitate eruption of impacted tooth</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>by report, limited to covered orthodontics</td>
<td>Radiograph, Narrative</td>
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<tr>
<td>D7285</td>
<td>biopsy of oral tissue - hard (bone, tooth)</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
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<td>Radiograph, Narrative</td>
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<tr>
<td>D7286</td>
<td>biopsy of oral tissue - soft</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
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<td>Covered under Full Benefits Level</td>
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<td>Frequency</td>
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<td>D7310</td>
<td>alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>once per quadrant per lifetime, see processing policies</td>
<td>Radiograph, Narrative</td>
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<tr>
<td>D7311</td>
<td>alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>once per quadrant per lifetime, see processing policies</td>
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<td>D7320</td>
<td>alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>once per quadrant per lifetime, see processing policies</td>
<td>Radiograph, Narrative</td>
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<tr>
<td>D7321</td>
<td>alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>once per quadrant per lifetime, see processing policies</td>
<td>Radiograph, Narrative</td>
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<tr>
<td>D7450</td>
<td>removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>D7451</td>
<td>removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
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<td>D7460</td>
<td>removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
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<td>D7461</td>
<td>removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
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<td>D7471</td>
<td>removal of lateral exostosis (maxilla or mandible)</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Once per Lifetime</td>
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<td>D7472</td>
<td>removal of torus palatinus</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>D7473</td>
<td>removal of torus mandibularis</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Once per Lifetime</td>
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<td>D7485</td>
<td>surgical reduction of osseous tuberosity</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Once per Lifetime</td>
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<td>D7510</td>
<td>incision and drainage of abscess - intraoral soft tissue</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
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<td>D7530</td>
<td>removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
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<td>D7880</td>
<td>occlusal orthotic device, by report</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>D7960</td>
<td>frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Once per arch, per Lifetime</td>
<td>Radiograph, Narrative</td>
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<tr>
<td>D7963</td>
<td>frenuloplasty</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Once per arch, per Lifetime</td>
<td>Radiograph, Narrative</td>
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<tr>
<td>D7970</td>
<td>excision of hyperplastic tissue - per arch</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Once per arch, per Lifetime</td>
<td>Radiograph, Narrative</td>
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<tr>
<td>D7971</td>
<td>excision of pericoron gingiva</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Once per Lifetime</td>
<td>Radiograph, Narrative</td>
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<tr>
<td>D7972</td>
<td>surgical reduction of fibrous tuberosity</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Once per Lifetime</td>
<td>Radiograph, Narrative</td>
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<tr>
<td>D8080</td>
<td>comprehensive orthodontic treatment of the adolescent dentition</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Medically Necessary: EPSTD</td>
<td>Panoramic, models</td>
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<tr>
<td>D8090</td>
<td>comprehensive orthodontic treatment of the adult dentition</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Medically Necessary: EPSTD</td>
<td>Panoramic, models</td>
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<tr>
<td>D8692</td>
<td>replacement of lost or broken retainer</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>by report only</td>
<td>Narrative</td>
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<tr>
<td>D9110</td>
<td>palliative (emergency) treatment of dental pain - minor procedure</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>D9120</td>
<td>fixed partial denture sectioning</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Once per Lifetime</td>
<td>Radiograph, Narrative</td>
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<tr>
<td>D9223</td>
<td>deep sedation/general anesthesia - each 15 minute increment</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Total of 1 hour for covered oral surgery only</td>
<td>Narrative</td>
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<tr>
<td>D9243</td>
<td>intravenous moderate (conscious) sedation/analgesia - each 15 minute increment</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Total of 1 hour for covered oral surgery only</td>
<td>Narrative</td>
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<tr>
<td>D9248</td>
<td>non-intravenous conscious sedation</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Total of 1 hour for covered oral surgery only</td>
<td>Narrative</td>
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<tr>
<td>D9310</td>
<td>consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>2 problem focused / consultation exams (D0140, D0170, and D9310) per benefit year</td>
<td>Radiograph, Narrative</td>
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<tr>
<td>D9410</td>
<td>house/extended care facility call</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
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<td>Radiograph, Narrative</td>
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<tr>
<td>D9420</td>
<td>hospital or ambulatory surgical center call</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
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<td>Radiograph, Narrative</td>
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<tr>
<td>D9930</td>
<td>treatment of complications (post-surgical) - unusual circumstances, by report</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
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<td>Narrative</td>
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<tr>
<td>D9440</td>
<td>office visit - after regularly scheduled hours</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td>Narrative including time of day, day of week, and clinical condition</td>
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<tr>
<td>D9999</td>
<td>unspecified adjunctive procedure, by report</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>by report</td>
<td>Narrative</td>
</tr>
</tbody>
</table>
*denotes preventative services for Healthy Behaviors
**one risk assessment is payable per benefit year

NOTE- Only the PreViser risk assessment can be used for reimbursement and this must be submitted in the online PreViser tool. Payments will be recouped if the assessment is not submitted into the online PreViser tool.

The Fee for caries risk assessment is DISALLOWED when submitted with other risk assessment codes on the same date of service by the same dentist/dental office.
# NON-COVERED CDT Procedure Codes - Effective July 1, 2017

## NOMENCLATURE

<table>
<thead>
<tr>
<th>CDT Code</th>
<th>CDT Nomenclature</th>
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<tbody>
<tr>
<td>D0145</td>
<td>oral evaluation for a patient under three years of age and counseling with primary caregiver</td>
</tr>
<tr>
<td>D0160</td>
<td>detailed and extensive oral evaluation - problem focused, by report</td>
</tr>
<tr>
<td>D0171</td>
<td>re-evaluation- post- operative office visit</td>
</tr>
<tr>
<td>D0190</td>
<td>screening of a patient</td>
</tr>
<tr>
<td>D0191</td>
<td>assessment of a patient</td>
</tr>
<tr>
<td>D0251</td>
<td>extra-oral 2 D projection radiographic image created using a stationary radiation source, and detector</td>
</tr>
<tr>
<td>D0277</td>
<td>vertical bitewings - 7 to 8 radiographic images</td>
</tr>
<tr>
<td>D0310</td>
<td>sialography</td>
</tr>
<tr>
<td>D0320</td>
<td>temporomandibular joint arthrogram, including injection</td>
</tr>
<tr>
<td>D0321</td>
<td>other temporomandibular joint radiographic images, by report</td>
</tr>
<tr>
<td>D0322</td>
<td>tomographic survey</td>
</tr>
<tr>
<td>D0350</td>
<td>2 D cephalometric radiographic image - acquisition, measurement and analysis</td>
</tr>
<tr>
<td>D0351</td>
<td>3D photographic image</td>
</tr>
<tr>
<td>D0364</td>
<td>cone beam CT capture and interpretation with limited field of view - less than one whole jaw</td>
</tr>
<tr>
<td>D0365</td>
<td>cone beam CT capture and interpretation with field of view of one full dental arch - mandible</td>
</tr>
<tr>
<td>D0366</td>
<td>cone beam CT capture and interpretation with field of view of one full dental arch - maxilla, with or without cranium</td>
</tr>
<tr>
<td>D0367</td>
<td>cone beam CT capture and interpretation with field of view of both jaws: with or without cranium</td>
</tr>
<tr>
<td>D0368</td>
<td>cone bean CT capture and interpretation for TMJ series including two or more exposures</td>
</tr>
<tr>
<td>D0369</td>
<td>maxillofacial MRI capture and interpretation</td>
</tr>
<tr>
<td>D0370</td>
<td>maxillofacial ultrasound capture and interpretation</td>
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<tr>
<td>D0371</td>
<td>sialoendoscopy capture and interpretation</td>
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<tr>
<td>D0380</td>
<td>cone beam CT image capture with limited field of view - less than one whole jaw</td>
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<tr>
<td>Non Covered D0381</td>
<td>cone beam CT image capture with field of view of one full dental arch- mandible</td>
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<tr>
<td>Non Covered D0382</td>
<td>cone beam CT image capture with field of view of one full dental arch- maxilla, with or without cranium</td>
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<tr>
<td>Non Covered D0383</td>
<td>cone beam CT image capture with field of view of both jaws, with or without cranium</td>
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<td>Non Covered D0384</td>
<td>cone beam CT image capture for TMJ series including two or more exposures</td>
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<td>Non Covered D0385</td>
<td>maxillofacial MRI image capture</td>
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<tr>
<td>Non Covered D0386</td>
<td>maxillofacial ultrasound image capture</td>
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<tr>
<td>Non Covered D0391</td>
<td>interpretation of diagnostic image by a practitioner not associated with capture of the image, including report</td>
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<tr>
<td>Non Covered D0393</td>
<td>treatment simulation using 3D image volume</td>
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<tr>
<td>Non Covered D0394</td>
<td>digital subtraction of two or more images or image volumes of the same modality</td>
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<tr>
<td>Non Covered D0395</td>
<td>fusion of two or more 3D image volumes of one or more modalities</td>
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<td>Non Covered D0414</td>
<td>laboratory processing of microbial specimen to include culture and sensitivity studies, preparation and transmission of written report</td>
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<tr>
<td>Non Covered D0415</td>
<td>collection of microorganisms for culture and sensitivity</td>
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<tr>
<td>Non Covered D0416</td>
<td>viral culture</td>
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<tr>
<td>Non Covered D0417</td>
<td>collection and preparation of saliva sample for laboratory diagnostic testing</td>
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<tr>
<td>Non Covered D0418</td>
<td>analysis of saliva sample</td>
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<tr>
<td>Non Covered D0422</td>
<td>collection and preparation of genetic sample material for laboratory analysis and report</td>
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<tr>
<td>Non Covered D0423</td>
<td>genetic test for susceptibility to diseases- specimen analysis</td>
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<tr>
<td>Non Covered D0425</td>
<td>caries susceptibility tests</td>
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<tr>
<td>Non Covered D0431</td>
<td>adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures</td>
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<tr>
<td>Non Covered D0600</td>
<td>non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin, and cementum</td>
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<tr>
<td>Non Covered D0472</td>
<td>accession of tissue, gross examination, preparation and transmission of written report</td>
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<tr>
<td>Non Covered D0473</td>
<td>accession of tissue, gross and microscopic examination, preparation and transmission of written report</td>
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<tr>
<td>Non Covered D0474</td>
<td>accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report</td>
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<tr>
<td>Non Covered D0486</td>
<td>laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report</td>
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<tr>
<td>Non Covered D0475</td>
<td>decalcification procedure</td>
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<tr>
<td>Non Covered D0476</td>
<td>special stains for microorganisms</td>
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<tr>
<td>Non Covered D0477</td>
<td>special stains, not for microorganisms</td>
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<tr>
<td>Non Covered D0478</td>
<td>immunohistochemical stains</td>
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<td>Non Covered D0479</td>
<td>tissue in-situ hybridization, including interpretation</td>
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<tr>
<td>Non Covered D0480</td>
<td>accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report</td>
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<td>Non Covered D0481</td>
<td>electron microscopy - diagnostic</td>
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<tr>
<td>Non Covered D0482</td>
<td>direct immunofluorescence</td>
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<td>Non Covered D0484</td>
<td>consultation on slides prepared elsewhere</td>
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<tr>
<td>Non Covered D0485</td>
<td>consultation, including preparation of slides from biopsy material supplied by referring source</td>
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<tr>
<td>Non Covered D0502</td>
<td>other oral pathology procedures, by report</td>
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<td>Non Covered D1120</td>
<td>prophylaxis - child</td>
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<td>nutritional counseling for control of dental disease</td>
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<td>tobacco counseling for the control and prevention of oral disease</td>
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<td>oral hygiene instructions</td>
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<td>sealant - per tooth</td>
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<td>preventive resin restoration in a moderate to high caries risk patient – permanent tooth</td>
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<td>Non Covered D1353</td>
<td>sealant repair - per tooth</td>
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<td>space maintainer - fixed - unilateral</td>
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<td>space maintainer - removable - unilateral</td>
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<tr>
<td>Non Covered D1525</td>
<td>space maintainer - removable - bilateral</td>
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<td>Non Covered D1550</td>
<td>re-cement or re-bond space maintainer</td>
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<td>Non Covered D1555</td>
<td>removal of fixed space maintainer</td>
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<tr>
<td>Non Covered D1575</td>
<td>distal shoe space maintainer-fixed-unilateral</td>
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<td>Non Covered D1999</td>
<td>unspecified preventive procedure, by report</td>
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<td>Non Covered D2410</td>
<td>gold foil - one surface</td>
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<tr>
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<td>gold foil - two surfaces</td>
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<td>Non Covered D2430</td>
<td>gold foil - three surfaces</td>
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<td>inlay - metallic - one surface</td>
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<td>inlay - metallic - two surfaces</td>
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<td>inlay - metallic - three or more surfaces</td>
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<td>Non Covered D2542</td>
<td>onlay- metallic - two surfaces</td>
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<td>onlay- metallic - three surfaces</td>
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<td>Non Covered D2620</td>
<td>inlay - porcelain/ceramic - two surfaces</td>
</tr>
<tr>
<td>Non Covered D2630</td>
<td>inlay - porcelain/ceramic - three or more surfaces</td>
</tr>
<tr>
<td>Non Covered D2642</td>
<td>onlay- porcelain/ceramic- two surfaces</td>
</tr>
<tr>
<td>Non Covered D2643</td>
<td>onlay-porcelain/ceramic - three surfaces</td>
</tr>
<tr>
<td>Non Covered D2644</td>
<td>onlay-porcelain/ceramic - four or more surfaces</td>
</tr>
<tr>
<td>Non Covered D2650</td>
<td>inlay - resin-based composite - one surface</td>
</tr>
<tr>
<td>Non Covered D2651</td>
<td>inlay - resin-based composite - two surfaces</td>
</tr>
<tr>
<td>Non Covered D2652</td>
<td>inlay - resin-based composite - three surfaces</td>
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<td>CDT Code</td>
<td>CDT Nomenclature</td>
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<tr>
<td>Non Covered D2662</td>
<td>onlay- resin- based composite- two surfaces</td>
</tr>
<tr>
<td>Non Covered D2663</td>
<td>onlay- resin-based composite - three or more surfaces</td>
</tr>
<tr>
<td>Non Covered D2664</td>
<td>onlay- resin- based composite- four or more surfaces</td>
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<tr>
<td>Non Covered D2712</td>
<td>crown- 3/4 resin - based composite (indirect)</td>
</tr>
<tr>
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<td>crown - resin- based composite (indirect)</td>
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<tr>
<td>Non Covered D2722</td>
<td>crown- resin with noble metal</td>
</tr>
<tr>
<td>Non Covered D2780</td>
<td>crown- 3/4 cast high noble metal</td>
</tr>
<tr>
<td>Non Covered D2782</td>
<td>crown - 3/7 cast noble metal</td>
</tr>
<tr>
<td>Non Covered D2783</td>
<td>crown - 3/4 porcelain/ceramic</td>
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<tr>
<td>Non Covered D2794</td>
<td>crown- titanium</td>
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<tr>
<td>Non Covered D2799</td>
<td>provisional crown-- further treatment or completion of diagnosis necessary prior to final impression</td>
</tr>
<tr>
<td>Non Covered D2990</td>
<td>resin infiltration of incipient smooth surface lesions</td>
</tr>
<tr>
<td>Non Covered D2929</td>
<td>prefabricated porcelain/ceramic crown – primary tooth</td>
</tr>
<tr>
<td>Non Covered D2930</td>
<td>prefabricated stainless steel crown - primary tooth</td>
</tr>
<tr>
<td>Non Covered D2933</td>
<td>prefabricated stainless steel crown with resin window</td>
</tr>
<tr>
<td>Non Covered D2934</td>
<td>prefabricated esthetic coated stainless steel crown - primary tooth</td>
</tr>
<tr>
<td>Non Covered D2941</td>
<td>interim therapeutic restoration – primary dentition</td>
</tr>
<tr>
<td>Non Covered D2949</td>
<td>restorative foundation for an indirect restoration</td>
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<tr>
<td>Non Covered D2953</td>
<td>each additional indirectly fabricated post - same tooth</td>
</tr>
<tr>
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<td>post removal</td>
</tr>
<tr>
<td>Non Covered D2957</td>
<td>each additional prefabricated post- same tooth</td>
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<td>labial veneer (resin laminate) - chairside</td>
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<tr>
<td>Non Covered D2961</td>
<td>labial veneer (resin laminate) - laboratory</td>
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<td>labial veneer (porcelain laminate) - laboratory</td>
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<td>Non Covered D2975</td>
<td>coping</td>
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<tr>
<td>Non Covered D2981</td>
<td>inlay repair necessitated by restorative material failure</td>
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<tr>
<td>Non Covered D2982</td>
<td>onlay repair necessitated by restorative material failure</td>
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<td>veneer repair necessitated by restorative material failure</td>
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<tr>
<td>Non Covered D2999</td>
<td>unspecified restorative procedure, by report</td>
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<tr>
<td>Non Covered D3110</td>
<td>pulp cap - direct (excluding final restoration)</td>
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<tr>
<td>Non Covered D3120</td>
<td>pulp cap - indirect (excluding final restoration)</td>
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<td>Non Covered D3222</td>
<td>partial pulpotomy for apexogenesis - permanent tooth with incomplete root development</td>
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<tr>
<td>Non Covered D3230</td>
<td>pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)</td>
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<tr>
<td>Non Covered D3240</td>
<td>pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)</td>
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<td>Non Covered D3311</td>
<td>treatment of root canal obstruction; non-surgical access</td>
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<tr>
<td>Non Covered D3333</td>
<td>internal root repair of perforation defects</td>
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<tr>
<td>Non Covered D3353</td>
<td>incomplete endodontic therapy; inoperable, unrestorable or fractured tooth</td>
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<td>Non Covered D3355</td>
<td>pulpal regeneration - initial visit</td>
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<tr>
<td>Non Covered D3356</td>
<td>pulpal regeneration - interim medication replacement</td>
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<tr>
<td>Non Covered D3357</td>
<td>pulpal regeneration - completion of treatment</td>
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<tr>
<td>Non Covered D3428</td>
<td>bone graft in conjunction with periradicular surgery – per tooth, single site</td>
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<tr>
<td>Non Covered D3429</td>
<td>bone graft in conjunction with periradicular surgery– each additional contiguous tooth in the same surgical site</td>
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<tr>
<td>Non Covered D3431</td>
<td>biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery</td>
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<tr>
<td>Non Covered D3432</td>
<td>guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery</td>
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<td>Non Covered D3460</td>
<td>endodontic endosseous implant</td>
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<td>Non Covered D3470</td>
<td>intentional re-implantation (including necessary splinting)</td>
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<td>surgical procedure for isolation of tooth with rubber dam</td>
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<td>hemisection (including any root removal), not including root canal therapy</td>
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<td>canal preparation and fitting of preformed dowel or post</td>
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<td>unspecified endodontic procedure, by report</td>
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<tr>
<td>D4212</td>
<td>gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth</td>
</tr>
<tr>
<td>D4230</td>
<td>anatomical crown exposure - four or more contiguous teeth per quadrant</td>
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<tr>
<td>D4231</td>
<td>anatomical crown exposure - one to three teeth per quadrant</td>
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<tr>
<td>D4245</td>
<td>apically positioned flap</td>
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<tr>
<td>D4263</td>
<td>bone replacement graft - retained natural tooth - first site in quadrant</td>
</tr>
<tr>
<td>D4264</td>
<td>bone replacement graft - retained natural tooth - each additional site in quadrant</td>
</tr>
<tr>
<td>D4265</td>
<td>biologic materials to aid in soft and osseous tissue regeneration</td>
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<tr>
<td>D4266</td>
<td>guided tissue regeneration - resorbable barrier, per site</td>
</tr>
<tr>
<td>D4267</td>
<td>guided tissue regeneration - non-resorbable barrier, per site (includes membrane removal)</td>
</tr>
<tr>
<td>D4268</td>
<td>surgical revision procedure, per tooth</td>
</tr>
<tr>
<td>D4274</td>
<td>mesial / distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)</td>
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<tr>
<td>D4276</td>
<td>combined connective tissue and double pedicle graft, per tooth</td>
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<td>D4320</td>
<td>provisional splinting - intracoronar</td>
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<tr>
<td>D4321</td>
<td>provisional splinting - extracoronar</td>
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<tr>
<td>D4381</td>
<td>localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth</td>
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<td>D4920</td>
<td>unscheduled dressing change (by someone other than treating dentist or their staff)</td>
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<tr>
<td>D4921</td>
<td>gingival irrigation – per quadrant</td>
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<tr>
<td>D5221</td>
<td>immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)</td>
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<tr>
<td>D5222</td>
<td>immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)</td>
</tr>
<tr>
<td>D5223</td>
<td>immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)</td>
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<tr>
<td>D5224</td>
<td>immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)</td>
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<td>D5281</td>
<td>removable unilateral partial denture- one piece cast metal (including clasps and teeth)</td>
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<td>D5670</td>
<td>replace all teeth and acrylic on cast metal framework (maxillary)</td>
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<tr>
<td>D5671</td>
<td>replace all teeth and acrylic on cast metal framework (mandibular)</td>
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<td>D5810</td>
<td>interim complete denture (maxillary)</td>
</tr>
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<td>D5811</td>
<td>interim complete denture (mandibular)</td>
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<tr>
<td>D5820</td>
<td>interim partial denture (maxillary)</td>
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<td>D5821</td>
<td>interim partial denture (mandibular)</td>
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<td>D5862</td>
<td>precision attachment, by report</td>
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<tr>
<td>D5867</td>
<td>replacement of replaceable part of semi-precision or precision attachment (male or female component)</td>
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<tr>
<td>D5875</td>
<td>modification of removable prosthesis following implant surgery</td>
</tr>
<tr>
<td>D5912</td>
<td>facial moulage (complete)</td>
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<tr>
<td>D5911</td>
<td>facial moulage (sectional)</td>
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<tr>
<td>D5913</td>
<td>nasal prosthesis</td>
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<td>auricular prosthesis</td>
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<td>orbital prosthesis</td>
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<td>D5916</td>
<td>ocular prosthesis</td>
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<td>facial prosthesis</td>
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<td>nasal septal prosthesis</td>
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<td>D5923</td>
<td>ocular prosthesis, interim</td>
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<td>D5924</td>
<td>cranial prosthesis</td>
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<td>D5925</td>
<td>facial augmentation implant prosthesis</td>
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<td>D5926</td>
<td>nasal prosthesis, replacement</td>
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<td>D5927</td>
<td>auricular prosthesis, replacement</td>
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<td>D5928</td>
<td>orbital prosthesis, replacement</td>
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<td>D5929</td>
<td>facial prosthesis, replacement</td>
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<td>D5931</td>
<td>obturator prosthesis, surgical</td>
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<td>D5932</td>
<td>obturator prosthesis, definitive</td>
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<tr>
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<td>CDT Nomenclature</td>
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<td>D5933</td>
<td>obturator prosthesis, modification</td>
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<tr>
<td>D5934</td>
<td>mandibular resection prosthesis with guide flange</td>
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<tr>
<td>D5935</td>
<td>mandibular resection prosthesis without guide flange</td>
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<td>D5936</td>
<td>obturator prosthesis, interim</td>
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<tr>
<td>D5937</td>
<td>trismus appliance (not for TMD treatment)</td>
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<tr>
<td>D5951</td>
<td>feeding aid</td>
</tr>
<tr>
<td>D5952</td>
<td>speech aid prosthesis, pediatric</td>
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<tr>
<td>D5953</td>
<td>speech aid prosthesis, adult</td>
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<td>D5954</td>
<td>palatal augmentation prosthesis</td>
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<tr>
<td>D5955</td>
<td>palatal lift prosthesis, definitive</td>
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<tr>
<td>D5958</td>
<td>palatal lift prosthesis, interim</td>
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<td>D5959</td>
<td>palatal lift prosthesis, modification</td>
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<td>D5960</td>
<td>speech aid prosthesis, modification</td>
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<td>D5982</td>
<td>surgical stent</td>
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<td>D5984</td>
<td>radiation shield</td>
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<td>D5985</td>
<td>radiation cone locator</td>
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<td>commissure splint</td>
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<td>D5988</td>
<td>surgical splint</td>
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<tr>
<td>D5992</td>
<td>adjust maxillofacial prosthetic appliance, by report</td>
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<tr>
<td>D5993</td>
<td>maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral) other than required adjustments, by report</td>
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<tr>
<td>D5983</td>
<td>radiation carrier</td>
</tr>
<tr>
<td>D5986</td>
<td>fluoride gel carrier</td>
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<tr>
<td>D5991</td>
<td>vesiculobullous disease medicament carrier</td>
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<tr>
<td>D5994</td>
<td>periodontal medicament carrier with peripheral seal – laboratory processed</td>
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<td>CDT Nomenclature</td>
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<tr>
<td>D5999</td>
<td>unspecified maxillofacial prosthesis, by report</td>
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<tr>
<td>D6190</td>
<td>radiographic/surgical implant index, by report</td>
</tr>
<tr>
<td>D6010</td>
<td>surgical placement of implant body: endosteal implant</td>
</tr>
<tr>
<td>D6011</td>
<td>second stage implant surgery</td>
</tr>
<tr>
<td>D6012</td>
<td>surgical placement of interim implant body for transitional prosthesis: endosteal implant</td>
</tr>
<tr>
<td>D6013</td>
<td>surgical placement of mini implant</td>
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<tr>
<td>D6014</td>
<td>surgical placement: eposteal implant</td>
</tr>
<tr>
<td>D6050</td>
<td>surgical placement: transosteal implant</td>
</tr>
<tr>
<td>D6081</td>
<td>scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure</td>
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<tr>
<td>D6085</td>
<td>provisional implant crown</td>
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<tr>
<td>D6100</td>
<td>implant removal, by report</td>
</tr>
<tr>
<td>D6101</td>
<td>debridement of a periimplant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure</td>
</tr>
<tr>
<td>D6102</td>
<td>debridement and osseous contouring of a periimplant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure</td>
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<tr>
<td>D6103</td>
<td>bone graft for repair of periimplant defect– does not include flap entry and closure.</td>
</tr>
<tr>
<td>D6104</td>
<td>bone graft at time of implant placement</td>
</tr>
<tr>
<td>D6110</td>
<td>implant / abutment supported removable denture for edentulous arch - maxillary</td>
</tr>
<tr>
<td>D6111</td>
<td>implant / abutment supported removable denture for edentulous arch - mandibular</td>
</tr>
<tr>
<td>D6112</td>
<td>implant / abutment supported removable denture for partially edentulous arch - maxillary</td>
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<tr>
<td>D6113</td>
<td>implant / abutment supported removable denture for partially edentulous arch - mandibular</td>
</tr>
<tr>
<td>D6114</td>
<td>implant / abutment supported fixed denture for edentulous arch - maxillary</td>
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<td>D6115</td>
<td>implant / abutment supported fixed denture for edentulous arch - mandibular</td>
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<td>D6116</td>
<td>implant / abutment supported fixed denture for partially edentulous arch - maxillary</td>
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<td>D6117</td>
<td>Non Covered implant / abutment supported fixed denture for partially edentulous arch - mandibular</td>
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<td>D6055</td>
<td>Non Covered connecting bar– implant supported or abutment supported</td>
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<td>D6056</td>
<td>Non Covered prefabricated abutment– includes modification and placement</td>
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<td>D6057</td>
<td>Non Covered custom fabricated abutment– includes placement</td>
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<td>D6051</td>
<td>Non Covered interim abutment</td>
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<td>Non Covered semi-precision attachment abutment</td>
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<td>D6058</td>
<td>Non Covered abutment supported porcelain/ceramic crown</td>
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<tr>
<td>D6060</td>
<td>Non Covered abutment supported porcelain fused to metal crown (predominantly base metal)</td>
</tr>
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<td>D6061</td>
<td>Non Covered abutment supported porcelain fused to metal crown (noble metal)</td>
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<td>D6062</td>
<td>Non Covered abutment supported cast metal crown (high noble metal)</td>
</tr>
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<td>D6063</td>
<td>Non Covered abutment supported cast metal crown (predominantly base metal)</td>
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<td>D6064</td>
<td>Non Covered abutment supported cast metal crown (noble metal)</td>
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<tr>
<td>D6065</td>
<td>Non Covered implant supported porcelain/ceramic crown</td>
</tr>
<tr>
<td>D6066</td>
<td>Non Covered implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)</td>
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<td>D6067</td>
<td>Non Covered implant supported metal crown (titanium, titanium alloy, high noble metal)</td>
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<td>D6068</td>
<td>Non Covered abutment supported retainer for porcelain/ceramic FPD</td>
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<td>Non Covered abutment supported retainer for porcelain fused to metal FPD (high noble metal)</td>
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<td>Non Covered abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)</td>
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<td>Non Covered abutment supported retainer for porcelain fused to metal FPD (noble metal)</td>
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<td>Non Covered abutment supported retainer for cast metal FPD (high noble metal)</td>
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<td>Non Covered abutment supported retainer for cast metal FPD (predominantly base metal)</td>
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<td>Non Covered abutment supported retainer for cast metal FPD (noble metal)</td>
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<td>D6194</td>
<td>Non Covered abutment supported retainer crown for FPD (titanium)</td>
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<td>CDT Nomenclature</td>
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<td>brush biopsy - transepithelial sample collection</td>
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<td>transseptal fiberotomy/ supra crestal fiberotomy, by report</td>
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<td>placement of temporary anchorage device [screw retained plate] requiring flap; includes device removal</td>
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<td>placement of temporary anchorage device requiring flap; includes device removal</td>
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<td>surgical placement of temporary anchorage device without flap; includes device removal</td>
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<td>harvest of bone for use in autogenous grafting procedure</td>
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<td>vestibuloplasty - ridge extension (secondary epithelialization)</td>
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<td>vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)</td>
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<td>Non Covered D7410</td>
<td>excision of benign lesion up to 1.25 cm</td>
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<td>excision of benign lesion greater than 1.25 cm</td>
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<td>excision of benign lesion, complicated</td>
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<td>excision of malignant lesion up to 1.25 cm</td>
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<td>excision of malignant lesion, complicated</td>
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<td>destruction of lesion(s) by physical or chemical method, by report</td>
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<td>excision of malignant tumor - lesion diameter up to 1.25 cm</td>
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<td>excision of malignant tumor - lesion diameter greater than 1.25 cm</td>
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<td>radical resection of maxilla or mandible</td>
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<td>incision and drainage of abscess - extraoral soft tissue</td>
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<td>incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)</td>
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<td>removal of reaction producing foreign bodies, musculoskeletal system</td>
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<td>partial ostectomy/sequestrectomy for removal of non-vital bone</td>
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<td>maxillary sinusotomy for removal of tooth fragment or foreign body</td>
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<td>maxilla - open reduction (teeth immobilized, if present)</td>
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<td>maxilla - closed reduction (teeth immobilized, if present)</td>
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<td>facial bones - complicated reduction with fixation and multiple surgical approaches</td>
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<td>arthroscopy - lavage and lysis of adhesions</td>
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<td>arthroscopy - disc repositioning and stabilization</td>
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<td>suture of recent small wounds up to 5 cm</td>
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<td>skin graft (identify defect covered, location and type of graft)</td>
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<td>osteotomy - mandibular rami with bone graft; includes obtaining the graft</td>
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<td>LeFort I (maxilla - total)</td>
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<td>LeFort I (maxilla - segmented)</td>
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<td>implant-mandible for augmentation purposes (excluding alveolar ridge), by report</td>
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<td>appliance removal (not by dentist who placed appliance), includes removal of archbar</td>
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<td>pre-orthodontic treatment examination to monitor growth and development</td>
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<td>periodic orthodontic treatment visit (as part of contract)</td>
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<td>removable orthodontic retainer adjustment</td>
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<td>re-cement or re-bond fixed retainer</td>
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<td>repair of fixed retainers, includes reattachment</td>
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<td>local anesthesia not in conjunction with operative or surgical procedures</td>
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<td>regional block anesthesia</td>
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<td>local anesthesia in conjunction with operative or surgical procedures</td>
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<td>evaluation for deep sedation or general anesthesia</td>
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<td>inhalation of nitrous oxide / anxiolysis, analgesia</td>
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<td>consultation with medical health care professional</td>
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<td>office visit for observation (during regularly scheduled hours) - no other services performed</td>
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<td>case presentation, detailed and extensive treatment planning</td>
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<td>therapeutic parenteral drug, single administration</td>
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<td>therapeutic parenteral drugs, two or more administrations, different medications</td>
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<td>drugs or medicaments dispensed in the office for home use</td>
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<td>application of desensitizing medicament</td>
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<td>application of desensitizing resin for cervical and/or root surface, per tooth</td>
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<td>behavior management, by report</td>
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<td>cleaning and inspection of removable complete denture, maxillary</td>
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<td>cleaning and inspection of removable complete denture, mandibular</td>
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<td>repair and/or reline of occlusal guard</td>
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<td>occlusal guard adjustment</td>
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<td>Non Covered D9950</td>
<td>occlusion analysis - mounted case</td>
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<td>occlusal adjustment - limited</td>
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<td>Non Covered D9952</td>
<td>occlusal adjustment - complete</td>
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<td>enamel microabrasion</td>
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<td>odontoplasty 1 - 2 teeth; includes removal of enamel projections</td>
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<td>external bleaching - per arch - performed in office</td>
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<td>external bleaching - per tooth</td>
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<td>internal bleaching - per tooth</td>
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<td>external bleaching for home application, per arch; includes materials and fabrication of custom trays</td>
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<td>sales tax</td>
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<td>Non Covered D9986</td>
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<tr>
<td>Non Covered D9987</td>
<td>cancelled appointment</td>
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<tr>
<td>Non Covered D9991</td>
<td>dental case management-addressing appointment compliance barriers</td>
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<tr>
<td>Non Covered D9992</td>
<td>dental case management-care coordination</td>
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<tr>
<td>Non Covered D9993</td>
<td>dental case management - motivation interviewing</td>
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<tr>
<td>Non Covered D9994</td>
<td>dental case management - patient education to improve oral health literacy</td>
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Eligibility

Iowa Medicaid Enterprise (IME) determines eligibility.

The Dental Wellness Plan provides benefits for adults 19 years and older who are enrolled in Medicaid and the Iowa Health and Wellness Plan.

Iowa Medicaid Enterprise (IME) provides Delta Dental with an eligibility file daily.

Once a person applies for Medicaid or Iowa Health and Wellness Plan, that individual will be covered for both medical and dental benefits through Iowa Medicaid Fee for Service (FFS) for the first 30 days after eligibility approval.

Example of how a member’s DWP eligibility could change:

1) Member applies July 5, 2017.
2) Iowa Medicaid Enterprise notifies member of eligibility for Medicaid Plan on July 20, 2017.
3) Member is eligible for starting July 1 through July 31, 2017 with Iowa Medicaid Enterprise Fee for Service.
4) Dental Wellness Plan is effective for member on August 1, 2017.

All covered enrollees have access to Full Benefits the first year.
The following services require prior authorization:

- Crowns
- Fixed Partial Dentures (Bridges); Note: only anterior bridges are covered and all teeth in the bridge must be anterior teeth
- Overdentures and Partial Dentures
- Surgical Periodontal Services
- Surgical Endodontics Services
- Scaling and Root Planing for members under age 30

When submitting a prior authorization, be sure to include all required documentation. See the claim attachment requirements as a part of the CDT Covered Services Grid.

You are strongly encouraged to file a prior authorization for other high cost services.

Filing a prior authorization will assist you in determining if you will be reimbursed for the service based upon the clinical criteria required as well as the benefits available for a Covered Enrollee.

All services submitted for prior authorization will be adjudicated similar to a claim with a date of service. The submitted services will be checked for frequency limitations, age limitations, processing policies, review requirements, etc. If a service requires a review of clinical documentations or radiographs, the prior authorization will be suspended for clinical review prior to a decision being determined.

Submit Prior Authorizations on the Dentist Connection

Prior authorizations can be submitted via the Dentist Connection on the Dental Wellness Plan website or through other methods of claims submission such as electronic / clearinghouse claims. When submitting a prior authorization claim via a clearinghouse do not enter a date of service.

Extend, Void, Pay and Submit a Prior Authorization

Approved services, once completed, must be submitted for payment online. Retrieve the patient’s eligibility, and click on Prior Authorizations. Select the Prior Authorization that you wish to utilize. You will be presented four buttons:

- Extend Prior Authorization
- Void
- Pay on Authorization
- Submit Prior Authorization

Select one of the actions by clicking the appropriate button.

**Extend Prior Authorization** – this link will extend the prior authorization another 3 months from today’s date.

**Void** – this link will immediately void the selected prior authorization.

**Pay on Authorization** – this link will allow you to submit for payment on a previously approved prior authorization. This is the preferred method of claim submission on a previously approved
prior authorization. If you are unable to submit through the Dentist Connection and are submitting for payment via a paper claim, you must include a copy of the prior authorization with the paper claim. Any claim submitted through a clearinghouse or by paper must include a comment referencing the prior authorization number. If the prior authorization number is not included, the claim will be rejected. To avoid rejection, submit through this Pay on Auth option.

Submit Prior Authorization – this link will take you to the Claim Submission screen where you may request a prior authorization.

To learn more about submitting prior authorizations on the Dentist Connection follow the steps on page 11 in the Dental Wellness Plan Dentist Connection User Manual located on the Dentist Connection.

**Benefit Estimate**

A benefit estimate is different from a prior authorization. Dentist can use the Benefit Estimator tool on the Dentist Connection to quickly determine how a planned service may be adjudicated. Similar to a prior authorization, services submitted using the Benefit Estimator will be checked for frequency limitations, age limitations, and processing polices.

Unlike a prior authorization, services submitted using the Benefit Estimator tool assumes any clinical criteria required to be submitted and reviewed when submitting an actual claim for services is met. The Benefit Estimator tool provides immediate, real time results and is **not a guarantee for payment and does not satisfy the requirement for prior authorization**.

To submit a benefit estimate you must use the Benefit Estimate tool on the Dentist Connection. If you submit a benefit estimate via paper or electronic/clearinghouse method the benefit estimate will become a prior authorization.

For detailed information on how to use the Benefit Estimator Tool see the Dental Wellness Plan Dentist Connection User Manual available on the Dentist Connection at **www.dwpiowa.com**.
PreViser- Oral Health Self-Assessment

Healthy Behaviors includes the completion of an oral health self-assessment annually. The member must complete this self-assessment. The Dentist is not responsible or required to submit on behalf of the member. Providers should encourage members to complete the self-assessment. Though not required, a provider can submit a PreViser risk assessment and this will count towards the member's Healthy Behavior.

Delta Dental will be using the PreViser Oral Health Self-Assessment tool, My Dental Score, to help aid DWP members in completing the self-assessment component of Healthy Behaviors. My Dental Score is an easy to use online tool that accurately describes the risk of caries, cancer, and periodontal disease. The self-assessment needs information from the member only, and no input from the dental office is required.

Members can locate My Dental Score

To access the self-assessment, members should go to www.dwpiowa.com and create a member account.

Members can select “Oral Health Self-Assessment” and complete the assessment. Members will be able to complete the oral health self-assessment, print results, and bring in with them to their dental appointment to discuss and use as an aid for treatment planning. Members may also complete their self-assessment while they are in for a dental visit if a device with Internet connection is available for them to use while in the dental office.

Members can contact our Customer Service center at 888-472-2793 and a customer service representative will assist them in completing the Self-Assessment.

Communication

It is important to stay connected. Delta Dental of Iowa provides the following ongoing communications:

**Dental Office Manual**

Have a question on how to file a claim, how to contact Delta Dental or information on the Dental Wellness Plan Benefits? Access the current version of the Dental Wellness Plan Dentist Office Manual to get everything you need to know about the Dental Wellness Plan Benefits and working with Delta Dental.

**Dental Wellness Plan Dental Connection**

Through the Dental Wellness Plan Dentist Connection, dentists and dental office staff can easily look up patient benefits, submit a claim, submit a prior authorization, pay on a prior authorization, benefit estimate, check claims status, submit inquiries, view payments and have access to much more valuable information. Login today at [www.dwpiowa.com](http://www.dwpiowa.com).

**Monthly Newsletter**

A monthly Dental Wellness Plan newsletter is sent via e-mail to participating Dental Wellness plan offices. This publication includes important information and facts about the plan. Current and past issues are posted on the DWP Dentist Connection at [www.dwpiowa.com](http://www.dwpiowa.com).

If you are not receiving the Dental Wellness Plan monthly e-mail publication make sure you have checked your spam folder and have added us to your address book.

Delta Dental would like to communicate with you electronically and having your current email is key in the age of electronic communications. Contact Professional Relations at 888-472-1205 and provide your email address.
Programs and Helpful Items Available for Dental Wellness Enrollees

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program

EPSDT is a federally mandated program for children through 20 years old which emphasizes the importance of prevention, early detection of dental conditions and timely dental treatment of conditions detected as a result of screening. EPSDT services should be provided routinely beginning at 12 months of age. For DWP EPSDT applies to members 19-20 years old.

Prior Authorizations requirements still apply to members in this age group. Prior authorizations will not be honored if the service is completed after the member has reached 21 years old AND has access to only Reduced Benefits.

Iowa Medicaid Enterprise Smoking Quit Line

The Dental Wellness Plan does not cover smoking counseling or cessation programs. Any patient that require these programs can contact the Iowa Medicaid Enterprises Smoking Quit Line at 800-QUITNOW (800-784-8669). www.quitnow.net/iowa or www.betobaccofree.gov

Nutritional Counseling

All Dental Wellness Plan patients that require nutritional counseling should access these benefits through their Medical Benefits by seeing their Medical Home Physician.

Federally Qualified Health Center- Wrap Payments

If you are a Federally Qualified Health Center and have questions about wrap payments, please contact Iowa Medicaid Enterprise.
Member Care Facilitation

Definitions:

**Outreach:** to “reach out” with a goal to generate awareness and educate the public.

**Education:** to provide public education on the value of oral health care through providing direct education, materials, advertising and promotion, social marketing, social media and other mechanisms.

**Referral:** to provide information to assist an individual with finding a Dental Wellness Plan Participating Dentist.

**Care Coordination:** the complex organization of services and health care provided by a team approach to assist an individual in receiving needed services, it is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient’s care to facilitate the appropriate delivery of health care services.

Community partnerships, beginning at the state level, with organizations will enhance and support the infrastructure but will also be critical at the local level. A wide breadth of safety net, public health and human service partners will be engaged to assist with outreach and education to low-income adults about the availability of oral health services and how to access those services. Media approaches, including social media, will also play a key role.

Immediately after enrollment, the Dental Wellness Plan Covered Enrollees receives a member welcome/enrollment packet. This packet includes an informational letter and benefit certificate to explain available benefits and dental referrals and resources for obtaining assistance in arranging dental visits.

A toll-free number will be answered by customer services representatives (CSRs) specifically trained to provide enhanced education and referrals for the adult Medicaid population. These specially trained CSRs will:

- Provide information on the importance of routine dental care
- Answer dental benefit questions
- Assist in finding a general dentist or dental specialist.

As the Dental Wellness Plan matures, additional strategies to engage community based partners to support outreach and referral will be created to further enhance this process.

**“No Show” Patients**
We strongly encourage you to use reminder tools for Dental Wellness Plan Covered Enrollee’s to keep their appointments. The population is transient, so obtaining patients’ cell phone numbers for texting reminders may be the best mechanism for communication.

**Transportation**
Transportation to dental appointments may be available depending on a member’s Iowa Medicaid Coverage. Most IA Health Link Members have transportation covered by their Managed Care Organization (MCO). Transportation is not a covered service for members in the Iowa Health and Wellness Plan, unless they are medically exempt. For more information contact the member’s MCO.
Procedures and Processing Policies

This section provides in depth details about Delta Dental’s standardized processing policies used by the Delta Dental of Iowa Dental Wellness Plan.

Delta Dental of Iowa’s Responsibility

It is Delta Dental of Iowa’s responsibility to the Department of Human Services to oversee utilization and billing patterns of the Participating Dentist network. Utilization review is performed to determine if a dentist’s practice patterns are beyond the Iowa norm of like dentists with similar education and practice experience. If unusual patterns are detected, Delta Dental of Iowa will review all factors that could establish reasons why a dentist would demonstrate differing results than peers.

In-Office Audit and Desk Audit

As indicated in the Dental Wellness Plan Uniform Regulations, Delta Dental and its representatives may make periodic examinations of a Participating Dentist’s office and records (including, without limitation, the records required to be maintained under Section 6 of the Uniform Regulations) during regular office hours to determine Participating Dentist’s compliance with the Agreement. Without limiting the generality of the foregoing, Delta Dental may request, and Participating Dentist shall provide at no cost to Delta Dental, de-identified data regarding fees charged to other patients not enrolled in Medicaid or the Dental Wellness Plan. Participating Dentist understands and agrees that governmental agencies with regulatory authority over the Dental Wellness Plan product shall also have access to Participating Dentist’s office and records as required or permitted under applicable law.

Dental Necessity

Delta Dental will provide a decision within 10 days of the request.

As outlined in the Dental Wellness Plan Uniform Regulations section 12 and in addition to the further terms and conditions of the Agreement, including the incorporated documents, Participating Dentist shall furnish and will receive payment only for dental services that are Dentally Necessary. Delta Dental shall not be responsible to pay for dental services that are not Dentally Necessary. Prior to providing a Covered Enrollee with dental services that are not Dentally Necessary, a Participating Dentist shall inform the Covered Enrollee of Delta Dental’s payment policies and obtain a written acknowledgement from the Covered Enrollee that he/she has been information that the dental services may not be paid by a third party. In the event a payment is made to Participating Dentist by Delta Dental for dental services that are later determined not to be Dentally Necessary, Delta Dental (or the applicable regulatory agency) may recoup payment pursuant to Section 9 of the Dental Wellness Plan Uniform Regulations.

A procedure, service or supply shall be considered “Dentally Necessary” if and only if Delta Dental determines that each of the following statements is true with respect to such procedure, service or supply:

- The diagnosis is proper;
The treatment is necessary to address disease or basic function of the teeth and the health of the gums, bone and other tissues, which support the teeth;
It is the most appropriate procedure, service or supply for the Covered Enrollee’s individual circumstances; and
It is consistent with and meets professionally recognized standards of dental care, and complies with criteria adopted by Delta Dental.

Notwithstanding the foregoing and in all events Participating Dentist shall exercise his or her independent professional judgment in providing dental services. Nothing herein shall be construed to (a) interfere with or otherwise affect the rendering of dental services by Participating Dentist in accordance with Participating Dentist's independent professional judgment, or (b) prohibit or otherwise restrict Participating Dentist acting within the lawful scope of his or her profession, from discussing with a Covered Enrollee the Covered Enrollee’s health status and dental care or treatment options.

Patient Record Keeping

At times it may be necessary for Delta Dental of Iowa to request a copy of a Covered Enrollee’s treatment notes, tooth chart and/or ledge for further clarification of a claim. It is important that the Covered Enrollee’s records are complete and legible. The following lists patient record keeping requirements as outlined by the Iowa Dental Board (IDB):

650 -27.11 (153,272C) Record keeping. Dentists shall maintain patient records in a manner consistent with the protection of the welfare of the patient. Records shall be permanent, timely, accurate, legible, and easily understandable.

27.11 (1) Dental records. Dentists shall maintain dental records for each patient. The records shall contain all of the following:

a. Personal data
   1) Name, date of birth, address and, if a minor, name of parent or guardian. Name and telephone number of person to contact in case of emergency.

b. Dental and medical history. Dental records shall include information from the patient’s parent or guardian regarding the patient’s dental and medical history. The information shall include sufficient data to support the recommended treatment plan.

c. Patient’s reason for visit. When a patient presents with a chief complaint, dental records shall include the patient’s stated oral health care reasons for visiting the dentist.

d. Clinical examination progress notes. Dental records shall include chronological dates and descriptions of the following:
   1) Clinical examination findings, tests conducted, and a summary of all pertinent diagnoses;
   2) Plan of intended treatment and treatment sequence;
   3) Services rendered and any treatment complications;
   4) All radiographs, study models, and periodontal charting, if applicable;
   5) Name, quantity, and strength of all drugs dispensed, administered, or prescribed; and
6) Name of dentist, dental hygienist, or any other auxiliary, who performs any treatment or service or who may have contact with a patient regarding the patient’s dental health. Is this right?

e. Informed consent. Dental records shall include, at a minimum, documentation of informed consent that includes discussion of procedure(s), treatment options, potential complications and known risks, and patient’s consent to proceed with treatment.

27.11 (2) Retention of records. A dentist shall maintain a patient’s dental record for a minimum of seven years after the date of last examination, prescription, or treatment. Records for minors shall be maintained for a minimum of either (a) one year after the patient reaches the age of majority (18), or (b) seven years, whichever is longer. Proper safeguards shall be maintained to ensure safety of records from destructive elements.

27.11 (3) Electronic record keeping. The requirements of this rule apply to electronic records as well as to records kept by any other means. When electronic records are kept, a dentist shall keep either a duplicate hard copy record or use an unalterable electronic record.

27.11 (4) Correction of records. Notations shall be legible, written in ink, and contain no erasures or white outs. If incorrect information is placed in the record, it must be crossed out with a single, non-deleting line and be initialed by a dental health care worker.

27.11 (5) Confidentiality and transfer of records. Dentists shall preserve the confidentiality of patient records in a manner consistent with the protection of the welfare of the patient. Upon request of the patient or patient’s legal guardian, the dentist shall furnish the dental records or copies or summaries of the records, including dental radiographs or copies of the radiographs that are of diagnostic quality, as will be beneficial for the future treatment of that patient. The dentist may charge a nominal fee for duplication of records, but may not refuse to transfer records for nonpayment of any fees. (IDB Code 650, Chapter 27 - Standards of Practice and Principles of Professional Ethics)

Request a Review / Reconsideration of a Denied or Disallowed Claim or Prior Authorization

If Delta Dental of Iowa does not pay all or part of a patient’s claim or a submitted prior authorization was Denied, a Participating Dentist can ask for a review / reconsideration. A review, also called a reconsideration, can be requested when a Participating Dentist provides additional information.

Request a Review / Reconsideration of a Denied or Disallowed Claim or Prior Authorization

To request a Review/Reconsideration of a claim or prior authorization a dentist must:

- Send an inquiry requesting review or reconsideration of the Denied or Disallowed claim or prior authorization. You may use the Inquiry feature on the Dentist Connection.
- Document the reasons why Delta Dental of Iowa should reconsider the original decision and outline what new information is being submitted.
- Provide all appropriate review documentation (e.g. narrative, patient treatment record, radiographs, etc.)
Include your name, patient’s name and the patient identification number on all documents. This information will be reviewed and a determination will be provided to the Participating Dentist within 30 business days.

You may send the Review / Reconsideration request and supporting documents via the following:

Fax Number: 888-264-0195

Dentist Connection: Inquiry Feature (See the DWP Dentist Connection User Manual in the Download center on the Dentist Connection at www.dwpiowa.com)

Email Address: dwpmembers@deltadentalia.com (Be sure to secure the email since Protected Health Information is included.) Please put “Reconsideration Request” in the e-mail subject line.

Mailing Address: Delta Dental of Iowa
Attn: DWP Reconsideration Request
P O Box 9030
Johnston, IA 50131

Dental Wellness Plan Grievance System

Covered Enrollees, and Participating Dentists acting on the behalf of a Covered Enrollee, have access to the Grievance System.

This system includes and Appeal and Complaint Process and access to the Iowa Department of Human Service’s state fair hearing system. Delta Dental of Iowa is available to provide assistance to members when filing a complaint or an appeal.

Dental Wellness Plan Appeal Process

An Appeal is a request for review of an adverse benefit determination, which is defined as follows:

- The denial or limited authorization of a requested service, including the type of level of service.
- The reduction, suspension or termination of a previously authorized service.
- The denial, in whole or in part, of payment for a service.
- The failure to provide services in a timely manner, as defined by the State.
- The failure of Delta Dental of Iowa Dental Wellness Plan to act within the required time frames for the standard resolution of appeals.
- Denial of a rural area resident’s request to obtain services outside the provider network.
- The denial of enrollee’s request to dispute financial liability.

Any action outlined above can be appealed by a Covered Enrollee or Participating Dentist with Covered Enrollee’s written consent.

A Participating Dentist must have the Covered Enrollee’s written authorization to act upon their behalf in an Appeal.

To request an Appeal on behalf of a Covered Enrollee, a dentist must:
Obtain written consent from the Covered Enrollee. The Covered Enrollee must complete the Personal Representative Appointment and Authorization to Release Protected Health Information (PHI) Form.

Submit a completed Appeal Request Form and Personal Representative Appointment and Authorization to Release PHI Form within 60 days of the adverse benefit determination.

The appeal request must include the appeal reason. The appeal request must be signed by the Participating Dentist.

Provide all appropriate documentation (narrative, patient treatment record, radiograph, photo, etc.)

Include the Participating Dentist’s name, the Covered Enrollee’s name, and the Covered Enrollee’s identification number on all documents submitted.

Upon receipt of both the Appeal Form and Personal Appointment and Authorization Release PHI Form (both forms can be found in the Forms section of the Download Center on the Dentist Connection), Delta Dental will:

- Respond in writing with the final disposition of the appeal within 30 days of the appeal receipt date.
- The written response will include information about how to request a State Fair Hearing in the event the original decision is upheld in the appeal.
- All appeals will be reviewed by the Appeals Committee.

How to Request an Appeal

Your request may be sent via the following options:

Fax Number: 888-264-0195

Email Address: dwpmembers@deltadentalia.com (Be sure to secure the email since Protected Health Information is included.) (Please put “DWP Appeal” in the email subject line)

Mailing Address: Delta Dental of Iowa
Attn: DWP Appeals and Grievances
PO Box 9040
Johnston, IA 50131

Expedited Appeal

A participating Dentist may request an Expedited Appeal on behalf of a Covered Enrollee. An Expedited Appeal can be written or verbal. An Expedited Appeal can be requested if taking the time for the standard appeal could seriously jeopardize the Covered Enrollee’s life, health or ability to regain maximum function. Delta Dental of Iowa will provide a decision within 72 hours of the request.

Delta Dental of Iowa may extend the time to process a standard or expedited appeal by up to 14 days of the request, if the Covered Enrollee requests an extension or if Delta Dental shows...
there is a need for additional information and a delay would be in the Covered Enrollee’s best interest.

Continuation of Benefits

A Participating Dentist must have the Covered Enrollee’s written authorization to request a Continuation of Benefits while an Appeal or State Fair Hearing is pending. To request a Continuation of Benefits on behalf of a Covered Enrollee use the Appeal Form and Personal Representative Appointment and Authorization to Release PHI Form. Both forms can be found in the Forms section of the Download Center on the Dentist Connection at www.dwpiowa.com. A Continuation of Benefits may be requested if all of the following are true:

- The Appeal is filed timely, meaning on or before the later of the following:
  - Within 60 days of the adverse benefit determination (Remittance Advice).
- The Appeal involves the termination, suspension, or reduction of a previously authorized service.
- The services were ordered by an authorized provider.
- The authorization period has not expired, if applicable.
- The request of continuation of benefits is filed on or before the later of:
  - Within 10 days of the adverse benefit determination, or
  - The intended effective date of the processed adverse benefit determination

Dental Wellness Plan Grievance Process

A grievance is an expression of dissatisfaction about any matter other than an adverse benefit determination. The grievance can be about the Dental Wellness Plan, Delta Dental of Iowa, a provider, or services received including the quality. Grievance can also be in regards to the failure to respect a Covered Enrollee’s rights. A Participating Dentist must have the Covered Enrollee’s written authorization to submit a grievance.

To submit a grievance on behalf of a Covered Enrollee a dentist must:

- Obtain a written consent from the Covered Enrollee. The Covered Enrollee must complete the Personal Representative Appointment and Authorization to Release PHI Form.
- Submit a completed Grievance Form and the Personal Representative Appointment and Authorization to Release PHI Form. The forms are available in the Forms section of the Download Center on the Dentist Connection at www.dwpiowa.com.
- Provide all appropriate documentation.
- Include the Participating Dentist’s name, the Covered Enrollee’s name, and the Covered Enrollee’s identification number on all documents submitted.
Upon receipt of both the Grievance Form and Personal Representative Appointment and Authorization to Release PHI Form, Delta Dental will respond in writing within 30 days.

Your request may be sent via the following options:

Fax Number: 888-264-0195

Email Address: dwpmembers@deltadentalia.com (Be sure to secure the email since Protected Health Information is included.) Please put “DWP Grievance” in the email subject line.

Mailing Address: Delta Dental of Iowa
Attn: DWP Grievance
P O Box 9040
Johnston, IA 50131

State Fair Hearing

If the Covered Enrollee is not satisfied with our Appeal decision, they may have the right to request State Fair Hearing. A Participating Dentist may request the hearing if the State permits the Participating Dentist to act as the Covered Enrollee’s authorized representative.

The hearing must be requested within 120 days of the Appeal resolution notice letter. The State will typically reach a decision within 90 days of the hearing request date or Appeal request date.

Participating Dentists do not have the right to a State Fair Hearing for the purpose of resolving payment disputes with Delta Dental or the Covered Enrollee.

To request a State Fair Hearing, send the request to:
Iowa Department of Human Services
Attn: Iowa Medicaid Appeals Liaison
1305 E. Walnut Street, 5th Floor
Des Moines, IA 50309
Dental Wellness Plan Processing Policies

Delta Dental’s processing policies reflect the data code set requirements set forth under the Administrative Simplification Provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and related regulations.

However, consistent with HIPAA, Delta Dental exercises its right to determine claims reimbursement procedures and requires the processing of such codes in accordance with the following policies, unless prohibited under other applicable law or specific contract provisions.

Notwithstanding treatment of procedures under Delta Dental’s processing policies, dentists are required to utilize those procedure codes reflective of services rendered and in accordance with HIPAA. Amounts charged under any procedure shall not be inflated or manipulated in light of Delta Dental’s processing policies. Please refer to the HIPAA section of this Manual for further information regarding HIPAA.
Dentist Handbook Preamble

The following handbook provides the Dental Wellness Plan processing policies for all CDT codes. These policies are standards of payment and should not be misconstrued as standards of care. Please refer to the covered services grid for covered procedures.

Dental Wellness Plan Processing Policies

Introductory Note
These processing policies reflect data code set requirements set forth under the Administrative Simplification Provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and related regulations. It is the policy of Delta Dental to comply with all such requirements as well as to require participating dentists to comply with such requirements. However, consistent with HIPAA, Delta Dental exercises its right to determine claims reimbursement procedures and requires the processing of such codes in accordance with the following policies, unless prohibited under applicable law. Dentists are required to utilize those procedure codes reflective of services rendered and in accordance with HIPAA. Amounts charged under any procedure shall not be inflated or manipulated in light of the processing policies.

General Policies

All services provided to Dental Wellness Plan Covered Enrollees are subject to the following general policies:

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

- When a radiograph is required, the most current radiograph must be provided. Please date and label radiographs. If you are sending radiographs via mail, do not send original radiographs. Send a copy. If you would like the radiograph returned, you must include a postage paid envelope. Delta Dental does not return radiographs unless a postage paid envelope is included.

- Most procedures associated with orthodontic care can be member pay if you have the member sign the Dental Wellness Plan Member Financial Responsibility Consent for Treatment Form prior to the services being performed. For complete details regarding Member Pay guidelines, see Section 6 page 28 of this Dentist Office Manual.

- Frequency limitations apply for all procedures including care delivered under Iowa Medicaid and any additional Dental Wellness Plan Benefit Administrators.

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

- Reasonable fee is the fee charged by a dentist for a specific dental procedure which has been modified by the nature and severity of the condition being treated and by any medical or dental complications or unusual circumstances, and therefore may differ from the dentist’s “usual” fee or the benefit administrator’s “customary” fee.

- Documentation of extraordinary circumstances can be submitted for review by report.

- Fees for completion of claim forms and submission of documentation to Delta Dental to enable benefit determination are not benefits. They are not collectable from the patient by a participating dentist.

- Multistage procedures are reported and benefitted upon completion.
  - The completion date is the date of insertion for removable prosthetic appliances.
  - The completion date for immediate dentures is the date that the remaining teeth are removed and the denture is inserted.
  - The completion date for fixed partial dentures and crowns, onlays and inlays is the cementation date of the final restoration regardless of the type of cement utilized.
  - The completion date for endodontic treatment is the date the canals are permanently filled.

- Charges for procedures determined not to be necessary or not meeting generally accepted standards of care may be denied or disallowed. Many of the processing policies that follow, detail payment procedures that are based on the timing and sequence of inter-related procedures. However, the timing and sequencing of treatment is the responsibility of the dentist rendering care and should always be determined by the treating dentist based on the patient’s needs.

- When a procedure is by report and subject to coverage under medical, it should be submitted to the patient’s medical carrier first. When submitting to Delta Dental, a copy of the explanation of payment or payment voucher from the medical carrier should be included with the claim, plus a narrative describing the procedure performed, reasons for performing the procedure, pathology report if appropriate, and any other information
deemed pertinent. In the absence of such information, Delta Dental will not benefit the procedure.

- The term specialized procedure describes a dental service or procedure that is used when unusual or extraordinary circumstances exist, and is not generally used when conventional methods are adequate.
- Note: this is a comprehensive list of CDT codes, please see the benefits grid for procedures covered under this plan.

**DIAGNOSTIC  D0100 - D0999**

**Clinical Oral Evaluations**

*There is a maximum of two periodic/comprehensive evaluations per benefit year.*

- One (1) comprehensive (D0150 or D0180) and one (1) recall evaluation (D0120) per member per year.

- A D0150 and a D0180 are payable once (1) per three (3) years per member

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

**D0120** Periodic oral evaluation – established patient, 1 per 6 months

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

**D0140** Limited oral evaluation - problem focused

Maximum of 2 problem focused / consultation exams (D0140, D0170, and D9310) per benefit year

**D0150** Comprehensive oral evaluation – new or established patient
The fees for consultation, diagnosis, and routine treatment planning are DISALLOWED as components of the fee for the evaluation, by the same dentist/dental office.

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

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

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

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

Maximum of 2 problem focused / consultation exams (D0140, D0170, and D9310) per benefit year

D0171 Re-evaluation – post operative office visit

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

D0180 Comprehensive periodontal evaluation – new or established patient

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

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

Pre-Diagnostic Services

D0190 Screening of a patient

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

D0191 Assessment of a patient
When reported in conjunction with an evaluation, the fee for the assessment of a patient is DISALLOWED.

**Diagnostic Imaging**

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

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

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

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

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

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

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

D0210  Intraoral-complete series radiographic images.

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

Bitewings, of any type, are DISALLOWED within 12 months of a full mouth series. A separate fee for a panoramic radiographic image (D0330) in conjunction with D0210 by the same dentist/dental office is DISALLOWED as a component part of D0210.

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

D0220  Intraoral-periapical-first radiographic image

D0230  Intraoral-periapical-each additional radiographic image

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

D0240  Intraoral-occlusal radiographic image

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

D0251  Extraoral posterior dental radiographic image

D0270  Bitewing-single radiographic image

D0272  Bitewings-two radiographic images

D0273  Bitewings- three radiographic images

D0274  Bitewings-four radiographic images
D0277  Vertical bitewings - 7 to 8 radiographic images

D0310  Sialography

D0320  Temporomandibular joint arthrogram including injection

D0321  Other temporomandibular joint radiographic images, by report

D0322  Tomographic survey

D0330  Panoramic radiographic image

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

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

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

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

D0350  2D oral/facial photographic images obtained intraorally or extra orally

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

Benefits for oral/facial images taken in conjunction with any other procedure are DENIED.

D0351  3D photographic image

3D photographic image is DENIED.
D0364 Cone beam CT capture and interpretation with limited field of view – less than one whole jaw

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

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

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

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

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

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

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

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

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

D0369 Maxillofacial MRI capture and interpretation

The fee for maxillofacial MRI capture and interpretation is DENIED.

D0370 Maxillofacial ultrasound capture and interpretation

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

D0371 Sialoendoscopy capture and interpretation

The fee for sialoendoscopy capture and interpretation is DENIED.

Diagnostic Imaging – Image Capture Only
When image capture only procedures are submitted with capture and interpretation procedures, the fee for the image capture only procedure will be DISALLOWED.

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

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

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

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

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

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

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

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

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

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

D0385 Maxillofacial MRI image capture

The fee for maxillofacial MRI image capture is DENIED.

D0386 Maxillofacial ultrasound image capture

The fee for maxillofacial ultrasound image capture is DENIED.

Interpretation and Report Only

D0391 Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report
The fee for interpretation of diagnostic image by a practitioner not associated with capture of the image, including report is DENIED. In all other instances the interpretation is DISALLOWED.

Post Processing of Image or Image Sets

D0393 Treatment simulation using 3-D image volume

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

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

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

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

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

Tests and Examinations

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

D0415 Collection of microorganisms for culture and sensitivity

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

D0416 Viral culture

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

D0417 Collection and preparation of saliva sample for laboratory diagnostic testing

Benefits for the collection and preparation of a saliva sample are DENIED.

D0418 Analysis of saliva sample
Benefits for the analysis of a saliva sample are DENIED.

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

D0423 Genetic test for susceptibility to diseases – specimen analysis

D0425 Caries susceptibility tests

Benefits for caries susceptibility tests are DENIED.

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

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

D0460 Pulp vitality tests

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

D0470 Diagnostic casts

The fees for cast restorations and prosthetic procedures include diagnostic casts. Any fees charged for diagnostic casts in excess of the approved amount for these procedures by the same dentist/dental office are DISALLOWED.

**Oral Pathology Laboratory**

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

GP The benefits for pathology reports submitted by anyone other than a licensed dentist are DENIED.
When more than two procedures are performed on the same area of the mouth on the same day, benefits are based upon, but not limited to, the most inclusive procedure.

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

Most inclusive: D0474, D0473, D0472

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

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

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

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

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

Decalcification procedure

Special stains for microorganisms

Special stains, not for microorganisms

Immunohistochemical stains

Tissue in-site hybridization, including interpretation

Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report
D0481  Electron microscopy

D0482  Direct immunofluorescence

D0483  Indirect immunofluorescence

D0484  Consultation on slides prepared elsewhere

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

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

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

D0502  Other oral pathology procedures, by report

Benefits for other oral pathology procedures for routine surgical procedures are DENIED.

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

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

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

The fees for D0601 are DISALLOWED if 1) a non-PreViser risk assessment is utilized and 2) the risk assessment is not submitted to the PreViser database.

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

The fees for D0602 are DISALLOWED if 1) a non-PreViser risk assessment is utilized and 2) the risk assessment is not submitted to the PreViser database.

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

The fees for D0602 are DISALLOWED if 1) a non-PreViser risk assessment is utilized and 2) the risk assessment is not submitted to the PreViser database.
D0999 Unspecified diagnostic procedure, by report

Benefits for medical procedures such as but not limited to urine analysis, blood studies and skin tests are DENIED.

PREVENTIVE D1000 - D1999

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

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

Dental Prophylaxis

D1110 Prophylaxis-adult

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

D1120 Prophylaxis-child

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

Topical Fluoride Treatment (office procedure)

GP Using prophylaxis paste containing fluoride, a fluoride rinse, or fluoride swish in conjunction with a prophylaxis is considered a prophylaxis only and a separate fee for this type of topical fluoride application is DISALLOWED.

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

D1206 Topical fluoride varnish

The application of topical fluoride varnish, delivered on a single visit and involving the entire oral cavity. Benefits for topical fluoride varnish when used for desensitization or as cavity liner are DENIED.
D1208  Topical application of fluoride - excluding varnish

**Other Preventive Services**

D1310  Nutritional counseling for the control of dental disease

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

D1320  Tobacco counseling for the control and prevention of oral disease

D1330  Oral hygiene instructions

The benefit for oral hygiene instruction is DENIED

D1351  Sealant-per tooth

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

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

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

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

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

D1353  Sealant repair – per tooth
Fees for repairing sealants completed on the same date of service and on the same surface as a restoration by the same dentist/dental office are DISALLOWED as a component of the restoration.

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

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

Benefits for repairing sealants requested 24 months or more following the initial placement are DENIED.

D1354 Interim caries arresting medicament application

This is used to arrest dentinal and cervical caries. There is no limit on the number of teeth treated per date of service, but the payment is capped at 4 teeth per date of service. Fees for greater than 4 teeth will be DISALLOWED. Each tooth is eligible for payment twice a year. A restoration is DENIED if placed within 3 months of this treatment. This does not count against the frequency of other fluorides.

**Space Maintenance (passive appliances)**

**GP** The benefits for repair or replacement of a space maintainer are DENIED.

**GP** Only one space maintainer is provided for a space. Additional appliances are DENIED.

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

D1510 Space maintainer-fixed unilateral

D1515 Space maintainer-fixed bilateral

D1520 Space maintainer-removable unilateral

D1525 Space maintainer-removable bilateral

D1550 Re-cement or rebond space maintainer
One recementation or rebonding of a space maintainer is allowed per dental office. Benefits for subsequent requests for recementation or rebonding by the same office are DENIED.

D1555 Removal of fixed space maintainer

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

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

D1575 Distal shoe space maintainer - fixed – unilateral

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

D1999 Unspecified preventive procedure, by report

**RESTORATIVE D2000 - D2999**

GP The fee for a restoration includes services such as, but not limited to, adhesives, etching, liners, bases, direct and indirect pulp caps, local anesthesia, polishing, occlusal adjustment, caries removal, and gingivectomy done on the same date of service as the restoration. A separate fee for any of these procedures by the same dentist/dental office is DISALLOWED.

GP A fee for the replacement of amalgam or composite restorations, same tooth and same surface(s), is DISALLOWED if done by the same dentist/dental office within 24 months of the initial restoration.

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

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

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

GP Benefits are allowed only once per surface in a 24 month interval, irrespective of the number or combination of procedures requested or performed. A fee for restoration of a surface within 24 months of previous treatment is DISALLOWED.

GP Multistage procedures are reported and benefitted upon completion. The completion date is the date of insertion for removable prosthetic appliances. The completion date for fixed partial dentures and crowns, onlays, and inlays is the cementation date regardless of the type of cement utilized.

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

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

GP Benefits for restorations for altering occlusion, involving vertical dimension, replacing tooth structure lost by attrition, erosion, abrasion, abfraction, corrosion, TMD or for periodontal, orthodontic, or other splinting are DENIED.

GP Biomimetic restorations (e.g. Biodentine) are DENIED.

Definitions

Attrition
1. The frictional wearing of the teeth over time. Severe attrition, due to bruxing may be evident. (Treatment Planning in Dentistry; Mosby 2006).

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

**Erosion**

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

**Abfraction**

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

**Amalgam Restorations (including polishing)**

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

**Resin-Based Composite Restorations-Direct**

GP  In the event an anterior proximal restoration involves a significant portion of the labial or lingual surface, it may be reported as D2331 or D2332, as appropriate.
D2330  Resin-based composite - one surface, anterior
D2331  Resin-based composite - two surfaces, anterior
D2332  Resin-based composite - three surfaces, anterior

D2335  Resin-based composite - four or more surfaces or involving the incisal angle (anterior)

D2390  Resin-based composite crown, anterior

D2391  Resin-based composite - one surface, posterior

D2392  Resin-based composite - two surfaces, posterior

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

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

**Inlay/Onlay Restorations**

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

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

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

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

D2510  Inlay - metallic - one surface

D2520  Inlay - metallic - two surfaces

D2530  Inlay - metallic - three or more surfaces
D2542 Onlay - metallic - two surfaces

D2543 Onlay - metallic - three surfaces

D2544 Onlay - metallic - four or more surfaces

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

D2610 Inlay - porcelain/ceramic - one surface

D2620 Inlay - porcelain/ceramic - two surfaces

D2630 Inlay - porcelain/ceramic - three or more surfaces

D2642 Onlay - porcelain/ceramic - two surfaces

D2643 Onlay - porcelain/ceramic - three surfaces

D2644 Onlay - porcelain/ceramic - four or more surfaces

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

D2650 Inlay - resin - based composite - one surface

D2651 Inlay - resin - based composite - two surfaces

D2652 Inlay - resin - based composite - three or more surfaces

D2662 Onlay - resin - based composite - two surfaces

D2663 Onlay - resin - based composite - three surfaces

D2664 Onlay - resin - based composite - four or more surfaces

**Crowns - Single Restorations Only**

**GP** Crowns and indirectly fabricated restorations are optional benefits unless the tooth is damaged by decay or fracture to the point it cannot be restored by an amalgam or resin restoration.

Requests for crowns are considered as stated below:

**Crowns / Veneers For Anterior Teeth**
• Moderate peripheral tooth structure loss with \( \frac{1}{2} \) or more of the incisal edge structure lost, (including at least one incisal angle).

• Severe damage to the peripheral tooth structure where both the mesial and distal proximal area structure loss extends beyond 3mm from the outer tooth surface.

• Severe damage affecting more than 50% of central tooth structure.

**Crowns / Veneers For Anterior Teeth Are Not Benefited When:**

• There is minimal damage to the peripheral tooth structure with small proximal or Class V lesions.

• Moderate damage to peripheral tooth structure with one incisal angle involved and less than \( \frac{1}{2} \) of the incisal edge structure is lost.

• The tooth is treated endodontically and the access is conservative and there are small proximal lesions.

• The primary purpose is: cosmetic, alteration of tooth color, alteration of tooth shape and size, or closure of diastema spacing.

**Crowns / Onlays for Posterior Teeth**

• Moderate to severe damage to the central core tooth structure, peripheral tooth structure loss is greater than 50% of the tooth surface, with at least one cusp with either no supporting dentin, or the cusp is lost (fractured).

• Severe damage where central destruction extends into core of tooth. The structure loss is either:
  - Both mesial and distal proximal area structure losses are greater than 3 mm from the outer tooth surface.
  - Either of the proximal areas structure loss is greater than 3 mm and the occlusal structure loss is \( \frac{1}{2} \) the distance from the occlusal surface to the pulp chamber.

• Endodontically treated teeth.

• Cracked tooth syndrome with documented duration of symptoms, differential diagnosis, identification of the cusp involved and the diagnostic tool used to identify the cracked tooth.

**Crowns / Onlays For Posterior Teeth Are Not Benefited When:**

• Minimal damage with small occlusal, proximal and / or facial lesions, or combined occlusal and proximal lesions

• Moderate damage where occlusal or proximal lesions extend 1mm past the dentino-enamel junction.

• Periodontally compromised teeth with poor prognosis or for molars with significant furcation involvement.

**Crowns, Onlays, Veneers**
• Crowns / Onlays / Veneers are not benefited that are preventative in nature (i.e., to prevent unpredictable or possible anticipated future fractures or to eliminate crack or craze lines in the absence of pathology).

• Crowns / Onlays / Veneers are not benefited for primarily cosmetic purposes.

• Crowns / Onlays / Veneers are not benefited when the primary purpose is for splinting

• Crowns / Onlays / Veneers are not benefited to replace tooth structure lost due to wear, attrition, abfraction, abrasion, or erosion.

D2710 Crown - resin-based composite (indirect)

D2712 Crown – ¾ resin-based composite (indirect)

D2720 Crown - resin with high noble metal

D2721 Crown - resin with predominantly base metal

D2722 Crown - resin with noble metal

D2740 Crown - porcelain/ceramic substrate

D2750 Crown - porcelain fused to high noble metal

D2751 Crown - porcelain fused to predominantly base metal

D2752 Crown - porcelain fused to noble metal

D2780 Crown - ¾ cast high noble metal

D2781 Crown - ¾ cast predominantly base metal

D2782 Crown - ¾ cast noble metal

D2783 Crown - ¾ porcelain/ceramic

D2790 Crown - full cast high noble metal

D2791 Crown - full cast predominantly base metal

D2792 Crown - full cast noble metal

D2794 Crown - titanium
The fee for a provisional crown by the same dentist/dental office is DISALLOWED as a component of the fee for a permanent crown.

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

Other Restorative Services

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

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

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

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

Fees for crown, inlay, onlay and veneer repairs are DISALLOWED within 24 months of the original restoration.
Fees for the replacement of amalgam or composite restorations or attachment of tooth fragment within 24 months are DISALLOWED if done by the same dentist/dental office. Benefits may be allowed if done by a different dentist.

D2929 Prefabricated porcelain/ceramic crown – primary tooth

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

D2930 Prefabricated stainless steel crown - primary tooth

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

D2931 Prefabricated stainless steel crown - permanent tooth

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

D2932 Prefabricated resin crown

D2933 Prefabricated stainless steel crown with resin window

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

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

D2934 Prefabricated esthetic coated stainless steel crown – primary tooth

A prefabricated esthetic coated stainless steel crown is a benefit only on anterior primary teeth. If submitted for a posterior primary tooth or for a permanent tooth, an alternate benefit allowance for D2930 or D2931 is made. The difference between the allowance for the D2930 or D2931 and the approved amount for the D2934 is DENIED and collectable from the patient
A fee for replacement of a stainless steel crown on a primary or permanent tooth by the same dentist/dental office within 24 months is included in the initial crown placement and is DISALLOWED.

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

D2940  Protective restoration

Protective restorations are a benefit for emergency relief of pain.

A fee for a replacement of a protective restoration by the same dentist/dental office within 24 months, same tooth, is DISALLOWED.

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

This procedure is DISALLOWED when submitted with any restorative codes D2000-D2999, bridge codes D6200-D6699, or endodontic codes D3220-D3330, D3346-D3353, D3410-D3450 and extraction codes D7111-D7251.

D2941  Interim therapeutic restoration – primary dentition

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

D2949  Restorative foundation for an indirect restoration

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

D2950  Core buildup, including any pins when required

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

A separate fee for a buildup is DISALLOWED when radiographs indicate sufficient tooth structure remains to support an indirectly fabricated restoration.
D2951  Pin retention-per tooth, in addition to restoration

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

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

D2952  Post and core in addition to crown, indirectly fabricated

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

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

D2953  Each additional indirectly fabricated post- same tooth

D2954  Prefabricated post and core in addition to crown

A prefabricated post and core in addition to crown is a benefit only on an endodontically treated tooth. The fee for a prefabricated post and core is DISALLOWED when radiographs indicate an absence of endodontic treatment and incompletely filled canal space.

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

D2955  Post removal

The fee for post removal when the procedure is submitted by the same dentist/office rendering retreatment is DISALLOWED within 30 days prior to endodontic retreatment as a component of the fee for the retreatment.

D2957  Each additional prefabricated post in the same tooth

The fee for this procedure is considered a component of a prefabricated post.
D2960 Labial veneer (resin laminate) – chairside

D2961 Labial veneer (resin laminate) - laboratory

D2962 Labial veneer (porcelain laminate) – laboratory

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

D2975 Coping

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

D2980 Crown repair, necessitated by restorative material failure

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

D2981 Inlay repair, necessitated by restorative material failure

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

D2982 Onlay repair, necessitated by restorative material failure

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

Fees for crown, inlay, and onlay repair within 24 months of the original restoration are DISALLOWED.

D2983 Veneer repair, necessitated by restorative material failure

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

D2990 Resin infiltration of incipient smooth surface lesions

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

D2999 Unspecified restorative procedure, by report
All endodontic procedures require a pre and post obturation radiograph and narrative explaining the clinical need for the service.

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

Pulp Capping

GP  A separate fee for a pulp cap by the same dentist/dental office is DISALLOWED when submitted in conjunction with protective resin restoration or with final restoration on the same tooth.

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

D3110  Pulp cap-direct (excluding final restoration)

D3120  Pulp cap-indirect (excluding final restoration)

Pulpotomy

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

D3221  Pulpal debridement, primary and permanent teeth

The fee for gross pulpal debridement is DISALLOWED when endodontic treatment is completed on the same tooth on the same day by the same dentist/dental office.

D3222  Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development
DISALLOW the fee for D3222 when performed within 30 days/same tooth/same dentist/same dental office as root canal therapy or codes D3351-D3353.

The fee for partial pulpotomy for apexogenesis is DISALLOWED when endodontic treatment is completed on the same tooth on the same day by the same dentist/dental office.

**Endodontic Therapy on Primary Teeth**

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

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

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

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

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

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

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

D3310  Endodontic therapy - anterior (excluding final restoration)

D3320  Endodontic therapy - bicuspid (excluding final restoration)

D3330  Endodontic therapy - molar (excluding final restoration)

A separate fee for palliative treatment is DISALLOWED when done in conjunction with root canal therapy by the same dentist/dental office on the same date of service.
Incompletely filled root canals are not a benefit and the fee for the endodontic therapy is DISALLOWED.

D3331 Treatment of root canal obstruction; non-surgical access

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

Post removal is not included in this procedure.

D3332 Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth

D3332 is subject to individual consideration, by report.

D3333 Internal root repair of perforation defects

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

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

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

*Endodontic Retreatment*

**GP**

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

**GP**

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

D3346 Retreatment of previous root canal therapy – anterior

D3347 Retreatment of previous root canal therapy - bicuspid

D3348 Retreatment of previous root canal therapy – molar
Apexification/Recalcification

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

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

D3352 Apexification / recalcification - interim medication replacement

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

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

Pulpal Regeneration

D3355 Pulpal Regeneration - initial visit

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

D3356 Pulpal regeneration – interim medication replacement

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

D3357 Pulpal regeneration – completion of treatment

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

Apicoectomy/Periradicular Services

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

D3410 Apicoectomy - anterior
D3421 Apicoectomy - bicuspid (first root)
D3425 Apicoectomy - molar (first root)
D3426 Apicoectomy (each additional root)
D3427 Periradicular surgery without apicoectomy

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

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

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

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

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

D3430 Retrograde filling - per root

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

D3431 Biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery

Benefits are available only when billed for natural teeth. Benefits for these procedures when billed in conjunction with periradicular surgery, etc. are DENIED as a specialized or elective technique.

D3432 Guided tissue regeneration, resorbable barrier, per site in conjunction with periradicular surgery

Benefits are available only when billed for natural teeth. Benefits for these procedures when billed in conjunction with periradicular surgery are DENIED as a specialized or elective technique.

D3450 Root amputation - per root

A separate fee for root amputation is DISALLOWED when performed in conjunction with an apicoectomy by the same dentist/dental office.
D3460 Endodontic endosseous implant

D3470 Intentional reimplantation (including necessary splinting)

Intentional reimplantation is considered a specialized procedure. Benefits are DENIED.

Other Endodontic Procedures

D3910 Surgical procedure for isolation of tooth with rubber dam

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

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

D3950 Canal preparation and fitting of preformed dowel or post

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

D3999 Unspecified endodontic procedure, by report

PERIODONTICS D4000 - D4999

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

GP The fee for the following services: D1110, D1120, D4346, D4355, and/or D4910 may be DISALLOWED if the services are rendered by the same dentist/dental office within 30 days of the most recent scaling and root planing (D4341, D4342) or other periodontal therapy.

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

D4260 (most inclusive), D4261, D4249, D4245, D4268, D4240, D4241, D4274, 4210, D4211, D4341, D4342, D4346, D4910, D1110 D4355 (least inclusive)

GP Periodontal services are only benefitted when performed on natural teeth for treatment of periodontal disease.

GP The fee for biopsy (D7285, D7286), frenulectomy (D7960) and excision of hard and soft tissue lesions (D7410, D7411, D7450, D7451) are DISALLOWED.
when the procedures are by the same dentist/dental office performed on the same date, same surgical site/area, and any other surgical procedure.

GP Laser disinfection is a technique, not a procedure. Fees for laser disinfection are DISALLOWED.

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

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

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

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

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

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

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

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

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

Site: D4245, D4249, D4263, D4264, D4265, D4266, D4267, D4270, D4274, and D4275

One to three diseased teeth/periodontium per quadrant: D4211, D4231, D4241, D4261, D4342
Per tooth: D4212, D4268, D4273, D4276, D4277, D4278, D4381, D6101, D6102, D6103
Per implant: D6101, D6102, D6103

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

**GP** A separate fee for all necessary postoperative care, finishing procedures (D1110, D1120, D4341, D4342, D4346, D4355, D4910), evaluations, or other surgical procedures (except soft tissue grafts) on the same date of service or for three months following the initial periodontal surgery in relation to both natural teeth and implants by the same dentist/dental office is **DISALLOWED**.

In the absence of documentation of extraordinary circumstances, the fee for additional surgery or for any surgical re-entry (except soft tissue grafts) by the same dentist/dental office for three years is **DISALLOWED**.

If extraordinary circumstances are present the benefits could be considered for coverage.

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

**GP** Periodontally involved teeth which would qualify for surgical pocket reduction benefits under these procedure codes (D4210, D4211, D4240, D4241, D4260, D4261) must be documented to have at least 5 mm pocket depths. If pocket depths are under 5 mm, then benefits are **DENIED**.

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

**GP** Providing more than two D4245, D4265, D4266, D4267, D4268, D4270, D4273, D4275, D4276, D4277, D4278, D6101, D6102, or osseous grafts (D4263, D4264, D6103) within any given quadrant should be highly unusual and additional submissions will only be considered on a by report basis. Requested fees for more than two sites in a quadrant may be **DISALLOWED**. When documentation of exceptional circumstances is submitted, benefits may be considered.

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

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

A separate fee for gingivectomy or gingivoplasty - per tooth is **DISALLOWED** when performed in conjunction with the preparation of a crown or other restoration by the same dentist/dental office.
Only diseased teeth/periodontium are eligible for benefit consideration. Bounded tooth spaces are not counted as the procedure does not require a flap extension.

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

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

**D4230** Anatomical crown exposure – four or more contiguous teeth per quadrant

**D4231** Anatomical crown exposure – one to three teeth per quadrant

Anatomical crown exposure is considered cosmetic in nature and therefore DENIED

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

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

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

**D4245** Apically positioned flap

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

**D4249** Clinical crown lengthening - hard tissue

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

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

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

**D4260** Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.
D4261 Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth, or tooth bounded spaces per quadrant.

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

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

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

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

Up to two teeth per quadrant may be benefitted.

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

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

Up to two teeth per quadrant may be benefitted.

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

D4265 Biologic materials to aid in soft and osseous tissue regeneration

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

When submitted with a D4263, D4264, D4267, D4270, D4273, D4275, D4276, or D6103 in the same surgical site, the fee for the D4265 is DENIED. When a D4265 is submitted with an extraction or periradicular surgery, the D4265 is DENIED and the approved amount is collectable from the patient.

D4266 Guided tissue regeneration (GTR)- resorbable barrier, per site

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

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

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

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

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

D4268 Surgical revision procedure, per tooth

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

If D4268 is performed by the same dentist/dental office within 36 months of previous periodontal surgery, the fee for the procedure is DISALLOWED.

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

D4270 Pedicle soft tissue graft procedure

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

D4273 Autogenous connective tissue graft procedures, (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft
Benefits for GTR, in conjunction with soft tissue grafts in the same surgical area, are DISALLOWED.

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

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

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

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

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

D4276 Combined connective tissue and double pedicle graft per tooth

This procedure may be eligible for consideration in lieu of D4265, D4266, D4267, D4270, D4273, D4275, D4277 or D4278 under dentist consultant review based upon documentation of clinical conditions (Miller Class III). When multiple teeth are grafted within a single quadrant, a maximum of two natural teeth are benefitted unless extraordinary circumstances are documented.

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

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

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

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

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

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

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

Benefits for GTR and or bone grafts, in conjunction with soft tissue grafts in the same surgical area, are DENIED.
Fees for a frenulectomy D7960 or frenuplasty D7963 are disallowed when performed in conjunction with soft tissue grafts contiguous tooth position in same graft site.

**D4283** Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site

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

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

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

**D4285** Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site

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

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

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

**Non-surgical periodontal services**

**D4320** Provisional splinting - intracoronal

**D4321** Provisional splinting - extracoronal

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

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

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

Adult prophylaxis procedures (D1110, D4910), full mouth scaling (D4346) or debridement (D4355) are considered a component when submitted on the
same date of service as D4341. Fees for the prophylaxis procedure by the same dentist/dental office are DISALLOWED.

Fees for D4341, when billed in conjunction with periodontal surgery procedures by the same dentist/dental office are DISALLOWED as a component of the surgical procedure. Any fee for retreatment performed by the same dentist within 24 months of initial therapy is DISALLOWED.

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

The fee for retreatment within 24 months of initial therapy is DISALLOWED. A fee reduction will apply to D4341 when performed within 24 months in the same quadrant, by the same dentist/office as D4342. If performed by a different dentist/office, the once in 24 month frequency will apply.

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

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

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

There must be documentation of alveolar bone and clinical attachment loss and at least 4mm pocket depths on the diseased teeth/periodontium involved. In the absence of 4mm pocket and alveolar bone and clinical attachment loss, D4342 is processed as prophylaxis (D1110) and any fee in excess of the approved amount for D1110 is DISALLOWED.

Adult prophylaxis procedures (D1110, D4910), full mouth scaling (D4346) or debridement (D4355) are considered a component when submitted on the same date of service as D4342. Fees for the prophylaxis procedure by the same dentist/dental office are DISALLOWED.

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

D4346 Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation
Benefits for D4346 include prophylaxis, fees for D1110, D1120 or D4355 are DISALLOWED when submitted with D4346 by the same dentist/dental office.

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

D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis

The procedure can be benefitted once every two years if there are no D1110, D4341, D4342, D4346, D4910 during the previous 24 months. A D4355 may be benefitted in order to do a proper evaluation and diagnosis if the patient has not been to the dentist in several years, and the dentist is unable to accomplish an effective prophylaxis under normal conditions.

D4355 is DISALLOWED if completed on the same day as an exam

D4355 is DISALLOWED in conjunction with a prophylaxis or any periodontal treatment.

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

Localized delivery of chemotherapeutic agents is DENIED.

Other Periodontal Services

D4910 Periodontal maintenance

One D1110, D4346, or D4910 is payable every six (6) months. Periodontal maintenance procedure is available once (1) every three (3) months following qualifying definitive periodontal procedures (scaling and root planing, flap surgery, osseous surgery).

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

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

A separate fee for all necessary postoperative care, finishing procedures (D1110, D1120, D4341, D4342, D4355, D4910), evaluations, or other surgical procedures (except soft tissue grafts) on the same date of service or for three months following the initial periodontal surgery by the same dentist/dental office is DISALLOWED.
D4920 Unscheduled dressing change (by someone other than the treating dentist)

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

D4921 Gingival irrigation – per quadrant

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

D4999 Unspecified periodontal procedure, by report

**PROSTHODONTICS (REMOVABLE) D5000 - D5899**

GP Characterizations, staining, overdentures, or metal bases are considered specialized techniques or procedures are DISALLOWED.

GP The fees for full or partial dentures include any reline/rebase, adjustment or repair required within six months of delivery by any provider.

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

GP The benefits for restorations for altering occlusion, involving vertical dimension, treating TMD, replacing tooth structure lost by attrition, erosion, abrasion (wear), abfraction, corrosion or for periodontal, orthodontic or other splinting are DENIED.

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

GP Multistage procedures are reported and benefitted upon completion. The completion date is the date of insertion for removable prosthetic appliances. The completion date for immediate dentures is the date that the remaining teeth are removed and the denture is inserted. The completion date for fixed partial dentures and crowns, onlays, and inlays is the cementation date regardless of the type of cement utilized.

GP If replacement is required please include narrative.

GP Denture benefits, (fixed or removable) are limited to one (1) denture per arch, every five (5) years. Example: If a member receives a removable partial
denture in an arch, DWP cannot pay for a full denture in that arch for 5 years. One replacement in the five (5) year period can be requested.

GP If a partial denture is completed in an arch and later the dentist/member wants a complete denture in that same arch, the replacement policy does not apply. The denture replacement policy only applies for like denture to like denture (full denture to full denture OR partial denture to partial denture).

GP Partial denture benefits are available for the replacement of anterior teeth.

GP Partial denture benefits are also available for the replacement of posterior teeth when there are fewer than eight posterior teeth in occlusion or when required to balance the posterior occlusion.

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

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

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

- D5211 Maxillary partial denture-resin base (including any conventional clasps, rests, and teeth)
- D5212 Mandibular partial denture-resin base (including any conventional clasps, rests, and teeth)
- D5213 Maxillary partial denture-cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)
- D5214 Mandibular partial denture-cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)
- D5221 Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)
- D5222 Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)
- D5223 Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
- D5224 Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
- D5225 Maxillary partial denture – flexible base (including any clasps, rests, and teeth)
D5226 Mandibular partial denture – flexible base (including any clasps, rests, and teeth)

D5281 Removable unilateral partial denture-one piece cast metal (including clasps and teeth)

Adjustments to Dentures

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

GP The fees for adjustments to complete or partial dentures are limited to two adjustments per denture per twelve months (after six months has elapsed since initial placement).

D5410 Adjust complete denture - maxillary

D5411 Adjust complete denture - mandibular

D5421 Adjust partial denture – maxillary

D5422 Adjust partial denture - mandibular

Repairs to Complete Dentures

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

GP The fees for full or partial dentures include any adjustments or repairs required within six months of delivery.

D5510 Repair broken complete denture base

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

Repairs to Partial Dentures

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

GP The fees for full or partial dentures include any adjustments or repairs required within six months of delivery.

D5610 Repair resin denture base

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

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

Denture Rebase Procedures

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

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

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

Denture Reline Procedures

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

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

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

**Interim Prosthesis**

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

The benefits for interim complete dentures are DENIED.

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

**Other Removable Prosthetic Services**

D5850  Tissue conditioning, maxillary
D5851  Tissue conditioning, mandibular

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

Tissue conditioning is not a benefit more than twice per denture unit per 2 years, and the benefit for tissue conditioning is DENIED.

D5862  Precision attachment, by report

The benefit for a precision attachment is DENIED.

D5863  Overdenture – complete maxillary
D5864  Overdenture – partial maxillary

D5865  Overdenture - complete mandibular

D5866  Overdenture – partial mandibular

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

The benefit for this procedure (D5867) is DENIED.
D5875  Modification of a removable prosthesis following implant surgery
       The benefits for implant services are DENIED.
D5899  Unspecified removable prosthodontic procedure, by report

MAXILLOFACIAL PROSTHETICS  D5900 - D5999

D5911  Facial moulage (sectional)
D5912  Facial moulage (complete)
D5913  Nasal prosthesis
D5914  Auricular prosthesis
D5915  Orbital prosthesis
D5916  Ocular prosthesis
D5919  Facial prosthesis
D5922  Nasal septal prosthesis
D5923  Ocular prosthesis, interim
D5924  Cranial prosthesis
D5925  Facial augmentation implant prosthesis
D5926  Nasal prosthesis, replacement
D5927  Auricular prosthesis, replacement
D5928  Orbital prosthesis, replacement
D5929  Facial prosthesis, replacement
D5931  Obturator prosthesis, surgical
D5932  Obturator prosthesis, definitive
D5933  Obturator prosthesis, modification
D5934  Mandibular resection prosthesis with guide flange
D5935  Mandibular resection prosthesis without guide flange
D5936  Obturator prosthesis, interim
D5937  Trismus appliance (not for TMD treatment)
D5951  Feeding aid
D5952  Speech aid prosthesis, pediatric
D5953  Speech aid prosthesis, adult
D5954  Palatal augmentation prosthesis
D5955  Palatal lift prosthesis, definitive
D5958  Palatal lift prosthesis, interim
D5959  Palatal lift prosthesis, modification
D5960  Speech aid prosthesis, modification
D5982  Surgical stent
D5984  Radiation shield
D5985  Radiation cone locator
D5987  Commissure splint
D5988  Surgical splint
D5992  Adjust maxillofacial prosthetic appliance, by report
D5993  Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral) other than required adjustments, by report

**Carriers**

D5983  Radiation carrier
D5986  Fluoride gel carrier
D5991  Vesiculobullous disease medicament carrier
D5994  Periodontal medicament carrier with peripheral seal – laboratory processed
D5999  Unspecified maxillofacial prosthesis, by report

**IMPLANT SERVICES**

D6000 - D6199 IMPLANT SERVICES
GP  Implants are not covered, the benefits for implant services are DENIED.

D6010 Surgical placement of implant body: endosteal implant

D6011 Second stage implant surgery

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

   Benefits are DENIED

D6013 Surgical placement of mini implant

D6040 Surgical placement: eposteal implant

D6050 Surgical placement: transosteal implant

**Implant Supported Prosthetics**

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

D6051 Interim abutment

D6052 Semi-precision attachment abutment

   Benefits are DENIED

D6055 Connecting bar – implant supported or abutment supported

D6056 Prefabricated abutment – includes modification and placement

   Benefits for a prefabricated abutment are DENIED

D6057 Custom fabricated abutment - includes placement

   Benefits for a custom fabricated abutment are DENIED

D6058 Abutment supported porcelain/ceramic crown

D6059 Abutment supported porcelain fused to metal crown (high noble metal)

D6060 Abutment supported porcelain fused to metal crown (predominantly base metal)

D6061 Abutment supported porcelain fused to metal crown (noble metal)
D6062  Abutment supported cast metal crown (high noble metal)
D6063  Abutment supported cast metal crown (predominantly base metal)
D6064  Abutment supported cast metal crown (noble metal)
D6094  Abutment supported crown (titanium)
D6065  Implant supported porcelain/ceramic crown
D6066  Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)
D6067  Implant supported metal crown (titanium, titanium alloy, high noble metal)
D6068  Abutment supported retainer for porcelain/ceramic FPD
D6069  Abutment supported retainer for porcelain fused to metal FPD (high noble metal)
D6070  Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)
D6071  Abutment supported retainer for porcelain fused to metal FPD (noble metal)
D6072  Abutment supported retainer for cast metal FPD (high noble metal)
D6073  Abutment supported retainer for cast metal FPD (predominantly base metal)
D6074  Abutment supported retainer for cast metal FPD (noble metal)
D6194  Abutment supported retainer for cast metal FPD (titanium)
D6075  Implant supported retainer for ceramic FPD
D6076  Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy or high noble metal)
D6077  Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal)

Other Implant Services

D6080  Implant maintenance procedures, including: removal of prosthesis, cleansing of prosthesis and abutments, reinsertion of prosthesis
D6081  Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure
Fees for D6081 are DISALLOWED when performed in the same quadrant by the same dentist/dental office as D4341/D4342 or D4240/4241, D4260/D4261 or D6101/D6102.

Fees for retreatment by the same dentist/dental office within 24 months of initial therapy are DISALLOWED.

DISALLOW when performed within 12 months of restoration (D6058-D6094) placement by same dentist/dental office.

Fees for D6081 are DISALLOWED when performed in conjunction with D1110 or D4910.

**D6085** Provisional implant crown

Fees for provisional implant crown are DISALLOWED when billed by the same dentist/dental office who provided the permanent prosthesis.

**D6090** Repair implant supported prosthesis, by report

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

Benefits are DENIED as a specialized procedure.

**D6092** Recement or rebond implant/abutment supported crown

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

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

**D6093** Recement or rebond implant/abutment supported fixed partial denture

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

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

**D6095** Repair implant abutment, by report

**D6100** Implant removal, by report
D6101 Debridement of a periimplant defect or defects surrounding a single implant and surface cleaning of exposed implant surfaces, including flap entry and closure

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

GP Benefit for these procedures when billed in conjunction with implants, implant removal, ridge augmentation or preservation, in extraction site, periradicular surgery, etc. are DENIED.

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

D6104 Bone graft at time of implant placement

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

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

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

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

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

D6115 Implant /abutment supported fixed denture for edentulous arch – mandibular

D6116 Implant /abutment supported fixed denture for partially edentulous arch – maxillary

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

D6190 Radiographic/surgical implant index, by report

Benefits for implant index are DENIED as a specialized procedure.

D6199 Unspecified implant procedure, by report

**PROSTHODONTICS, FIXED D6200 - D6999**

GP Benefits will be based on the number of pontics necessary for the space, not to exceed the normal complement of teeth.
The fees for cast or indirectly fabricated restorations and prosthetic procedures include all models, temporaries, laboratory charges and materials, and other associated procedures. Any fees charged for these procedures by the same dentist/dental office in excess of the approved amounts for the cast or indirectly fabricated restorations or prosthetic procedures are DISALLOWED.

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

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

Multistage procedures are reported and benefitted upon completion. The completion date is the date of insertion for removable prosthetic appliances. The completion date for immediate dentures is the date that the remaining teeth are removed and the denture is inserted. The completion date for fixed partial dentures and crowns, onlays, and inlays is the cementation date regardless of the type of cement utilized.

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

NOTE: The Dental Wellness Plan covers anterior bridges ONLY. All teeth that are a component of the bridge must be anterior teeth.

**Fixed Partial Denture Pontics**

- D6205 Pontic-indirect resin-based composite
- D6210 Pontic-cast high noble metal
- D6211 Pontic-cast predominantly base metal
- D6212 Pontic-cast noble metal
- D6214 Pontic-titanium
- D6240 Pontic-porcelain fused to high noble metal
- D6241 Pontic-porcelain fused to predominantly base metal
- D6242 Pontic-porcelain fused to noble metal
- D6245 Pontic-porcelain/ceramic
- D6250 Pontic-resin with high noble metal
D6251 Pontic-resin with predominantly base metal
D6252 Pontic-resin with noble metal
D6253 Provisional pontic

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

Fixed Partial Denture Retainers – Inlays/Onlays

D6545 Retainer-cast metal for resin bonded fixed prosthesis
D6548 Retainer- porcelain/ceramic for resin bonded fixed prosthesis
D6549 Resin retainer – for resin bonded fixed prosthesis
D6600 Retainer inlay - porcelain/ceramic, two surfaces
D6601 Retainer inlay - porcelain/ceramic, three or more surfaces
D6602 Retainer inlay - cast high noble metal, two surfaces
D6603 Retainer inlay - cast high noble metal, three or more surfaces
D6604 Retainer inlay - cast predominantly base metal, two surfaces
D6605 Retainer inlay - cast predominantly base metal, three or more surfaces
D6606 Retainer inlay - cast noble metal, two surfaces
D6607 Retainer inlay - cast noble metal, three or more surfaces
D6608 Retainer onlay - porcelain/ceramic, two surfaces
D6609 Retainer onlay - porcelain/ceramic, three or more surfaces
D6610 Retainer onlay - cast high noble metal, two surfaces
D6611 Retainer onlay - cast high noble metal, three or more surfaces
D6612 Retainer onlay - cast predominantly base metal, two surfaces
D6613 Retainer onlay - cast predominantly base metal, three or more surfaces
D6614 Retainer onlay - cast noble metal, two surfaces
D6615 Retainer onlay - cast noble metal, three or more surfaces
D6624  Retainer inlay - titanium
D6634  Retainer onlay - titanium

**Fixed Partial Denture Retainers-Crowns**

D6710  Retainer crown – indirect resin based composite
D6720  Retainer crown - resin with high noble metal
D6721  Retainer crown - resin with predominantly base metal
D6722  Retainer crown - resin with noble metal
D6740  Retainer crown- porcelain/ceramic
D6750  Retainer crown-porcelain fused to high noble metal
D6751  Retainer crown-porcelain fused to predominantly base metal
D6752  Retainer crown-porcelain fused to noble metal
D6780  Retainer crown-¾ cast high noble metal
D6781  Retainer crown- ¾ cast predominantly base metal
D6782  Retainer crown- ¾ cast noble metal
D6783  Retainer crown- ¾ porcelain/ceramic
D6790  Retainer crown-full cast high noble metal
D6791  Retainer crown-full cast predominantly base metal
D6792  Retainer crown-full cast noble metal
D6793  Provisional retainer crown

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

D6794  Retainer crown-titanium

**Other Fixed Partial Denture Services**

D6920  Connector bar

The fee for a connector bar is DENIED

D6930  Recement or rebond fixed partial denture
Delta Dental considers the cementation date to be that date upon which the completed bridge is first delivered to the mouth. The type of cement used is not a determining factor (whether permanent or temporary).

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

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

D6940 Stress breaker

The benefit for a stress breaker is DENIED

D6950 Precision attachment

The benefit for a precision attachment is DENIED

D6980 Fixed partial denture repair necessitated by restorative material failure

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

D6985 Pediatric partial denture, fixed

The fee for a pediatric partial denture, fixed is DENIED

D6999 Unspecified fixed prosthodontic procedure, by report

ORAL AND MAXILLOFACIAL SURGERY D7000 - D7999

GP The fee for all oral and maxillofacial surgery includes local anesthesia, suturing if needed, and routine postoperative care, including treatment of dry sockets. Separate fees for these procedures when performed in conjunction with oral and maxillofacial surgery are DISALLOWED. If performed by another dentist these procedures are DENIED.

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

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

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

D7111  Extraction, coronal remnants - deciduous tooth

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

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

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

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

D7220  Removal of impacted tooth - soft tissue
D7230  Removal of impacted tooth - partially bony

D7240  Removal of impacted tooth - completely bony

D7241  Removal of impacted tooth - completely bony, with unusual surgical complications

D7250  Removal of residual tooth roots (cutting procedure)

Includes cutting of soft tissue and bone, removal of tooth structure and closure. The fee for root recovery is DISALLOWED if submitted in conjunction with a surgical extraction (in the same surgical area) by the same dentist/dental office.

D7251  Coronectomy – intentional partial tooth removal

A coronectomy may be benefitted under individual consideration and only for documented probable neurovascular complications as proximity to mental foramen, inferior alveolar nerve, sinus, etc.

Other Surgical Procedures

D7260  Oroantral fistula closure

D7261  Primary closure of a sinus perforation
D7270  Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth

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

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

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

D7280  Exposure of an unerupted tooth

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

D7282  Mobilization of erupted or malpositioned teeth to aid eruption

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

D7283  Placement of device to facilitate eruption of impacted tooth

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

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

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

Biopsy of oral tissue is only benefitted for oral structures.

D7287  Exfoliative cytological sample collection

D7288  Brush biopsy – transepithelial sample collection

D7290  Surgical repositioning of teeth

D7291  Transseptal fiberotomy, supra crestal fiberotomy by report

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

**Placement: temporary anchorage device without surgical flap**

**Harvest of bone for use in autogenous grafting procedure**

**Alveoloplasty-Preparation of Ridge for Dentures**

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

**Note**: Extractions, by CDT definition, include smoothing of bone.

**Note**: The reimbursement for surgical extraction includes alveoloplasty.

Claim Submission Requirement: Include a panoramic radiograph and a narrative explaining why the alveoloplasty is required and why it is more than normal bone smoothing as part of an extraction.

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

The fee for D7310 performed by the same dentist/dental office in the same surgical area on the same date of service as surgical extractions (D7210-D7250) is DISALLOWED.

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

The fee for D7311 performed by the same dentist/dental office in the same surgical area on the same date of service as surgical extractions (D7210-D7250) is DISALLOWED.

Count tooth bounded spaces for D7311 partial quadrant code.

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

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

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

Count tooth bounded spaces for D7321 partial quadrant code.

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

D7340 Vestibuloplasty - ridge extension (secondary epithelialization)

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

**Excision of Soft Tissue Lesions**

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

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

D7410 Excision of benign lesion up to 1.25 cm

D7411 Excision of benign lesion greater than 1.25 cm

D7412 Excision of benign lesion, complicated

D7413 Excision of malignant lesion up to 1.25 cm

D7414 Excision of malignant lesion greater than 1.25 cm

D7415 Excision of malignant lesion, complicated

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

**Excision of Intra-Osseous Lesions**

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

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

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

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

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

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

D7460 Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm
D7461  Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm

**Excision of Bone Tissue**

D7471  Removal of lateral exostosis (maxilla or mandible)

D7472  Removal of torus palatinus

D7473  Removal of torus mandibularis

D7485  Reduction of osseous tuberosity

D7490  Radical resection of maxilla or mandible

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

**Surgical Incision**

GP  Procedures D7530-D7560 require a pathology report.

D7510  Incision and drainage of abscess - intraoral soft tissue

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

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

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

D7520  Incision and drainage of abscess-extraoral soft tissue

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

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

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

D7540  Removal of reaction producing foreign bodies, musculoskeletal system

D7550  Partial ostectomy/sequestrectomy for removal of non-vital bone
D7560 Maxillary sinusotomy for removal of tooth fragment or foreign body

**Treatment of Closed Fractures**

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

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

**Treatment of Open Fractures**

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

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

**Reduction of Dislocation and Management of Other Temporomandibular Joint Dysfunctions**
D7810 Open reduction of dislocation
D7820 Closed reduction of dislocation
D7830 Manipulation under anesthesia
D7840 Condylectomy
D7850 Surgical discectomy, with/without implant
D7852 Disc repair
D7854 Synovectomy
D7856 Myotomy
D7858 Joint reconstruction
D7860 Arthrotomy
D7865 Arthroplasty
D7870 Arthrocentesis
D7871 Non - arthroscopic lysis and lavage
D7872 Arthroscopy - diagnosis, with or without biopsy
D7873 Arthroscopy - lavage and lysis of adhesions
D7874 Arthroscopy - disc repositioning and stabilization
D7875 Arthroscopy - synovectomy
D7876 Arthroscopy - discectomy
D7877 Arthroscopy - debridement
D7880 Occlusal orthotic device, by report. The fee for 7880 is DENIED when submitted for Sleep Apnea.
D7881 Occlusal orthotic device adjustment
D7899 Unspecified TMD therapy, by report

**Repair of Traumatic Wounds**

GP Repair of traumatic wounds is limited to oral structures.
D7910 Suture of recent small wounds up to 5 cm
Complicated Suturing (reconstruction requiring delicate handling of tissues and wide undermining for meticulous closure)

GP Complicated suturing is limited to oral structures.

D7911 Complicated suture - up to 5 cm

D7912 Complicated suture - greater than 5 cm

Other Repair Procedures

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

D7921 Collection and application of autologous blood concentrate product

D7940 Osteoplasty - for orthognathic deformities

D7941 Ostectomy - mandibular rami

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

D7944 Ostectomy - segmented or subapical - per sextant or quadrant

D7945 Ostectomy - body of mandible

D7946 LeFort I (maxilla - total)

D7947 LeFort I (maxilla - segmented)

D7948 LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retusion) - without bone graft

D7949 LeFort II or LeFort III - with bone graft

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

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

D7952 Sinus augmentation via vertical approach

D7953 Bone replacement graft for ridge preservation – per site

Benefits for osseous autografts and/or osseous allografts are available only when billed for natural teeth for periodontal purposes using periodontal procedure codes (D4263-D4264). Benefits for these procedures when billed in conjunction with implants, implant removal, ridge augmentation, extraction sites, periradicular surgery etc. are DENIED.

D7955 Repair of maxillofacial soft and hard tissue defect
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7960</td>
<td>Frenulectomy - also known as frenectomy or frenotomy - separate procedure</td>
<td>A separate fee for frenulectomy is DISALLOWED when billed in conjunction with any other surgical procedure(s) in the same surgical area, by the same dentist/dental office.</td>
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<tr>
<td></td>
<td>not incidental to another procedure</td>
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<tr>
<td>D7963</td>
<td>Frenuloplasty</td>
<td>A separate fee for frenuloplasty is DISALLOWED when billed in conjunction with any other surgical procedure(s) in the same surgical area by the same dentist/dental office.</td>
</tr>
<tr>
<td>D7970</td>
<td>Excision of hyperplastic tissue - per arch</td>
<td>The fee for excision of hyperplastic tissue is DISALLOWED when billed in conjunction with other surgical procedure(s) in the same surgical area by the same dentist/dental office.</td>
</tr>
<tr>
<td>D7971</td>
<td>Excision of pericoronal gingiva</td>
<td>The fee for excision of pericoronal gingiva is DISALLOWED when billed in conjunction with other surgical procedure(s) in the same surgical area by the same dentist/dental office.</td>
</tr>
<tr>
<td>D7972</td>
<td>Surgical reduction of fibrous tuberosity</td>
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<tr>
<td>D7980</td>
<td>Sialolithotomy</td>
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<tr>
<td>D7981</td>
<td>Excision of salivary gland, by report</td>
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<tr>
<td>D7982</td>
<td>Sialodochoplasty</td>
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<tr>
<td>D7983</td>
<td>Closure of salivary fistula</td>
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<tr>
<td>D7990</td>
<td>Emergency tracheotomy</td>
<td></td>
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<tr>
<td>D7991</td>
<td>Coronoidectomy</td>
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<tr>
<td>D7995</td>
<td>Synthetic graft-mandible or facial bones, by report</td>
<td></td>
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<tr>
<td>D7996</td>
<td>Implant-mandible for augmentation purposes (excluding alveolar ridge), by</td>
<td></td>
</tr>
<tr>
<td></td>
<td>report</td>
<td></td>
</tr>
<tr>
<td>D7997</td>
<td>Appliance removal (not by dentist who placed appliance), includes removal of</td>
<td>The benefit for appliance removal is DENIED as a non-covered procedure.</td>
</tr>
<tr>
<td></td>
<td>archbar</td>
<td></td>
</tr>
<tr>
<td>D7998</td>
<td>Intraoral placement of a fixation devise not in conjunction with fracture</td>
<td></td>
</tr>
</tbody>
</table>
This procedure is DISALLOWED by the same dentist/dental office when billed in conjunction with any surgical procedure not in conjunction with fractures for which splinting, wiring or banding is considered part of the complete procedure (e.g., D7270, D7272).

D7999 Unspecified oral surgery procedure, by report

ORTHODONTICS D8000 - D8999

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

Orthodontic services are an extremely limited benefit for members 19-20 years of age. Orthodontic services require prior authorization.

A request for prior approval must be accompanied by:

- An interpreted cephalometric radiograph and either a full series of radiographs or panography film.
- Study models trimmed so that the models simulate centric occlusion of the member when the models are placed on their heels.
- A written plan of treatment.

A one-time lump sum payment is allowed for dentist who have signed form 470-3174, Addendum to Dental Provider Agreement for Orthodontia.

Limited orthodontic treatment should be used with:

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

Interceptive orthodontic treatment should be used with:

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

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

**Limited Orthodontic Treatment**

- **D8010** Limited orthodontic treatment of the primary dentition
- **D8020** Limited orthodontic treatment of the transitional dentition
- **D8030** Limited orthodontic treatment of the adolescent dentition
- **D8040** Limited orthodontic treatment of the adult dentition

**Interceptive Orthodontic Treatment**

- **D8050** Interceptive orthodontic treatment of the primary dentition
- **D8060** Interceptive orthodontic treatment of the transitional dentition

**Comprehensive Orthodontic Treatment**

- **D8070** Comprehensive orthodontic treatment of the transitional dentition
- **D8080** Comprehensive orthodontic treatment of the adolescent dentition
- **D8090** Comprehensive orthodontic treatment of the adult dentition

**Minor Treatment to Control Harmful Habits**

- **D8210** Removable appliance therapy
- **Fixed appliance therapy**

**Other Orthodontic Services**

- **D8660** Pre-orthodontic treatment examination to monitor growth and development
- **D8670** Periodic orthodontic treatment visit
- **D8680** Orthodontic retention (removal of appliances, construction and placement of retainer(s))
- **D8681** Removable orthodontic retainer adjustment
Fees for removable orthodontic retainer adjustments are DISALLOWED if performed by the same dentist/dental office providing orthodontic treatment. Benefits are DENIED if performed by a different dentist/dental office.

D8690 Orthodontic treatment
D8691 Repair of orthodontic appliance
D8692 Replacement of lost or broken retainer
D8693 Rebond or recement fixed retainer

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

D8694 Repair of fixed retainers, includes reattachment

This procedure is included in the orthodontic case fee. A separate fee is DISALLOWED anytime following placement of the fixed retainer by the same dentist/dental office.

D8999 Unspecified Orthodontic procedure, by report

**ADJUNCTIVE GENERAL SERVICES D9000 - D9999**

**Unclassified Treatment**

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

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

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

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

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

D9120 Fixed partial denture sectioning

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

If this code is part of the process or removing and replacing a fixed prosthesis, it is considered integral to the fabrication of the fixed prosthesis and a separate fee for this code is DISALLOWED.
Polishing and recontouring are considered an integral part of the fixed partial denture sectioning. Additional fees are DISALLOWED.

**Anesthesia**

D9210 Local anesthesia not in conjunction with operative or surgical procedures

D9211 Regional block anesthesia

D9212 Trigeminal division block anesthesia

D9215 Local anesthesia in conjunction with operative or surgical procedures

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

D9219 Evaluation for deep sedation or general anesthesia

A separate fee for evaluation for deep sedation or general anesthesia is DISALLOWED.

Fees for D9219 are DISALLOWED with deep sedation/general anesthesia.

D9223 Deep sedation/general anesthesia – each 15 minute increment

A maximum of 1 hour of anesthesia (CDT D9223, D9243) will be benefited on one date of service. Additional increments beyond 1 hour will only be considered on a “by report” basis with documentation of exceptional circumstances.

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

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

D9230 Inhalation of nitrous oxide/anxiolysis, analgesia

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

D9243 Intravenous moderate (conscious) sedation/analgesia – each 15 minute increment
A maximum of 1 hour anesthesia (CDT 9223, D9243) will be benefited on one date of service. Additional increments beyond 1 hour will only be considered on a “by report” basis with documentation of exceptional circumstances.

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

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

D9248 Non-intravenous conscious sedation

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

Professional Consultation

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

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

The benefit for a consultation in connection with non-covered services is DENIED.

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

Maximum of 2 problem focused / consultation exams (D0140, D0170, and D9310) per benefit year

D9311 Consultation with medical health care professional

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

Professional Visits

D9410 House/extended care facility call
D9420 Hospital or ambulatory surgical center call
D9430 Office visit for observation (during regularly scheduled hours) - no other services performed
Fees for an office visit for observation are DISALLOWED when billed with other procedures.
D9440 Office visit - after regularly scheduled hours
D9450 Case presentation, detailed and extensive treatment planning
The benefit for detailed and extensive treatment planning is DENIED.
The fees for routine treatment planning and case presentation are considered inclusive in an evaluation and are DISALLOWED.
The fee for extensive treatment planning may be benefitted for complex treatment planning cases involving multiple treatment disciplines and multiple providers of care.

Drugs
D9610 Therapeutic drug injection, by report
D9612 Therapeutic parenteral drugs, two or more administrations, different medications
D9630 Drugs or medicaments dispensed in the office for home use

Miscellaneous Services
D9910 Application of desensitizing medicament
The benefit for application of desensitizing medicaments is DENIED.
D9911 Application of desensitizing resin for cervical and/or root surface, per tooth
The benefit for application of a desensitizing resin is DENIED.
D9920 Behavior management, by report
The benefit for behavior management is DENIED.
D9930 Treatment of complications (postsurgical)-unusual circumstances, by report
The fee for treatment of routine postsurgical complications is DISALLOWED when done by the first treating dentist.
Benefits for dry socket are DISALLOWED and are included in the fee for the extraction by the same dentist/dental office.
D9932 Cleaning and inspection of removable complete denture, maxillary
Fees for cleaning and inspection of a removable complete denture are DISALLOWED when done with a reline or rebase procedure. In all other instances, benefits for cleaning and inspection of a removable complete denture are DENIED.

D9933 Cleaning and inspection of removable complete denture, mandibular

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

D9934 Cleaning and inspection of removable partial denture, maxillary

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

D9935 Cleaning and inspection of removable partial denture, mandibular

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

D9940 Occlusal guard, by report

D9941 Fabrication of athletic mouth guard

D9942 Repair or reline of occlusal guard

D9943 Occlusal guard adjustment

D9950 Occlusion analysis - mounted case

D9951 Occlusal adjustment - limited

D9952 Occlusal adjustment - complete

D9970 Enamel microabrasion

The benefits for enamel microabrasion are DENIED.

D9971 Odontoplasty 1-2 teeth includes removal of enamel projections

The benefit for odontoplasty is DENIED.

D9972 External bleaching per arch – performed in office
The benefit for bleaching is DENIED.

D9973 External bleaching per tooth

The benefit for bleaching is DENIED.

D9974 Internal bleaching per tooth

The benefit for bleaching is DENIED.

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

D9985 Sales tax

Sales/service fee are DENIED.

D9986 Missed appointment

Missed appointments are DENIED.

D9987 Cancelled appointment

Cancelled appointments are DENIED.

D9991 Dental case management – addressing appointment compliance barriers

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

D9992 Dental case management – care coordination

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

D9993 Dental case management – motivational interviewing

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

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

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

D9999 Unspecified adjunctive procedure, by report