HMAA
HAWAII MEDICAL ASSURANCE ASSOCIATION

Dental Procedure Guidelines

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Introduction

The purpose of HMAA's Dental Procedure Guidelines is to provide a comprehensive outline to assist providers in benefit determination and claims processing requirements. This document is intended to be a guideline **only**. Benefits and frequency are determined by the member's individual plan; please refer to the member's Dental Certificate (DC) or Medical Description of Coverage (DOC) for details.

If you have questions or need assistance, please contact our Customer Service Center. Contact information is shown on the front cover of this document.

Legend

● Basic ■ Preventive ▲ Restorative ♦ Major ◙ Orthodontic ★ Refer to DC or DOC

The legend is printed on the bottom of each page of these Guidelines to assist providers in determining coverage for procedures. Please refer to the patient's plan benefits to determine specific percentages of coverage and other information.

Definitions

When used in these Dental Procedure Guidelines:

1) ***Alternate Benefit***. When an alternate method of treatment can be performed, the dental plan allows for the least costly method to be a benefit. Alternate Benefits are not designed to dictate dental care; the provider and patient should decide method of treatment. The Member is responsible for any additional charge up to provider's Usual Customary Rate (UCR). It is the provider's responsibility to inform the patient of any additional cost.
2) ***Deny***. When a procedure is denied due to deductible, frequency limitation, annual maximum met or waiting period, the eligible fee may be collected from the patient.
3) ***Disallowed***. When the fee for a procedure is disallowed, it is not payable by HMAA and cannot be collected from the patient.
4) ***Not a benefit of the plan***. When the benefit guideline indicates procedure is not a benefit of the dental plan, provider may bill patient up to the UCR.
5) ***Payable***. Services upon review are eligible for payment for only tooth #s and/or services listed.
6) ***Submission Requirement***. Additional information that is required in order to make a benefit determination. If a procedure is submitted without the required information, it is disallowed and is not billable to patient.

Submission Requirements

The following defines each type of submission requirement.

1) ***X-ray*** submissions are required to be of diagnostic quality, dated, and identified. To ensure proper return, please indicate the provider's name and address on all submissions. Duplicate or X-ray "prints" are not routinely returned. If the provider requires X-ray duplicate or print to be returned, please indicate on submission. Intraoral photographic images are not accepted in lieu of X-rays; however, they may be sent in addition if X-ray does not clearly indicate area of concern.
2) ***Narratives*** should include a diagnosis and the treatment performed, unless specified otherwise in the Dental Procedure Guidelines. An operative report may be sent in lieu of a narrative; please see HMAA's definition of operative report.
3) ***Periodontal charts*** should indicate current 6-point pocket depth measurements on all teeth present.
4) ***Medical carrier statements*** apply to certain surgical procedures that may be a benefit under the patient's medical plan. Please submit an explanation of benefits from the patient's medical carrier, and HMAA dental will pay as a secondary benefit. If patient has HMAA medical, no additional benefit will be paid from the dental plan and no statement is required.
5) ***Operative reports*** should indicate diagnosis, site of procedure and treatment performed.

6) ***Pathology report*** is a copy of the report issued from pathology laboratory where specimen was submitted. Please submit **copy** only as it will not be returned.
7) ***Tooth chart*** identifies the patient's tooth. Missing teeth should be indicated in "Missing Teeth Information" section 34 of ADA dental claim form. For electronic or EDI submissions, missing teeth may be indicated in narrative form.

By Report Procedure

A "By Report" procedure code (DX999) may be used when the current CDT does not have a code that adequately describes procedure performed. Please include all supporting documentation (e.g. narrative, X-ray, description of procedure, chair-time) to determine appropriate benefit.

Additional Information

HMAA may request additional information to clarify a specific service. Providers are encouraged to submit any additional information to support a claim if required submission does not justify services rendered.

Predetermination

HMAA recommends the plan of treatment proposed be approved by HMAA before treatment begins; however, in cases of emergency or brief routine procedures in which the total fee does not exceed $300, a treatment form need not be submitted before the dental services are performed. HMAA will respond to all pre-determination requests.

Predetermination provides an estimate of payment for the proposed treatment. Monies are **not** held in reserve. Predeterminations are valid for up to 3 months from the date of issue. When services have been rendered, return the document with the dates of service that reflect an actual completion date. Predeterminations do not serve as authorizations or guarantees of benefits because the patient's eligibility and coverage for the exact date of treatment are evaluated when the services are rendered.

Abbreviations

Arches

Upper Arch = UA Lower Arch = LA

Quadrants

Upper Left = UL Upper Right = UR Lower Left = LL Lower Right = LR

Tooth Surfaces

Buccal = B Distal = D Facial/Labial = F Incisal = I

Lingual = L Mesial = M Occusal = O

Tooth Numbers

Primary Dentition - Upper Arch
(commencing in the upper right quadrant and rotating counterclockwise)

Tooth #	A	B	C	D	E	F	G	H	I	J
"Super" #	AS	BS	CS	DS	ES	FS	GS	HS	IS	JS

Primary Dentition - Lower Arch

Tooth #	T	S	R	Q	P	O	N	M	L	K
"Super" #	TS	SS	RS	QS	PS	OS	NS	MS	LS	KS

Permanent Dentition - Upper Arch
commencing in the upper right quadrant and rotating counterclockwise)

Tooth #	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
"Super" #	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66

Permanent Dentition - Lower Arch

Tooth #	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
"Super" #	82	81	80	79	78	77	76	75	74	73	72	71	70	69	68	67

Guidelines

Diagnostic

Clinical Oral Evaluations

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

General Guidelines
Multiple oral evaluations by the same dentist/dental office on the same day will be disallowed.

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D0120 ●	**Periodic oral evaluation - established patient** An evaluation performed on a patient of record to determine any changes in the patient's dental and medical health status since a previous comprehensive or periodic evaluation. This includes an oral cancer evaluation and periodontal screening where indicated, and may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately.	This procedure is applied to the patient's annual exam benefit.	
D0140 ●	**Limited oral evaluation – problem focused** An evaluation limited to a specific oral health problem or complaint. This may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately. Definitive procedures may be required on the same date as the evaluation. Typically, patients receiving this type of evaluation present with a specific problem and/or dental emergencies, trauma, acute infections, etc.	This is a benefit once per patient per dentist, per 12-month period. If this limit is exceeded, the benefit will be denied and the patient is responsible for the eligible fee.	

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D0145 ●	**Oral evaluation for a patient under three years of age and counseling with primary care giver** Diagnostic services performed for a child under the age of three, preferably within the first six months of the eruption of the first primary tooth, including recording the oral and physical health history, evaluation of caries susceptibility, development of an appropriate preventive oral health regimen and communication with and counseling of the child's parent, legal guardian and/or primary caregiver.	This procedure is applied to the patient's annual exam benefit.	
D0150 ●	**Comprehensive oral evaluation – new or established patient** Used by a general dentist and/or a specialist when evaluating a patient comprehensively. This applies to new patients; established patients who have had a significant change in health conditions or other unusual circumstances, by report, or established patients who have been absent from active treatment for three or more years. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. It may require interpretation of information acquired through additional diagnostic procedures. Additional diagnostic procedures should be reported separately. This includes an evaluation for oral cancer where indicated, the evaluation and recording of the patient's dental and medical history and a general health assessment. It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, existing prostheses, occlusal relationships, periodontal conditions (including periodontal screening and/or charting), hard and soft tissue anomalies, etc.	- This procedure is applied to the patient's annual exam benefit. - This procedure is a benefit once per 5 years per patient per dentist/dental office. If procedure is performed by the same dentist/dental office in less than 5 years, the alternate benefit of a Periodic Exam (D0120) is allowed. If the patient has not received any services for 3 years from the same office, a comprehensive evaluation may be a benefit. - Benefits for consultation, diagnosis and routine treatment planning are disallowed as components of the benefits for this evaluation by the same dentist/dental office.	
D0160 ●	**Detailed and extensive oral evaluation – problem focused, by report** A detailed and extensive problem focused evaluation entails extensive diagnostic and cognitive modalities based on the findings of a comprehensive oral evaluation. Integration of more extensive diagnostic modalities to develop a treatment plan for a specific problem is required. The condition requiring this type of evaluation should be described and documented. Examples of conditions requiring this type of evaluation may include dentofacial anomalies, complicated perio-prosthetic conditions, complex temporomandibular dysfunction, facial pain of unknown origin, conditions requiring multi-disciplinary consultation, etc.	The alternate benefit of D0140 is applied, refer to D0140 guidelines for benefit and time limitations.	

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D0170 ●	**Re-evaluation - limited, problem focused (established patient; not post-operative visit)** Assessing the status of a previously existing condition. For example: - a traumatic injury where no treatment was rendered but patient needs follow-up monitoring; - evaluation for undiagnosed continuing pain; - soft tissue lesion requiring follow-up evaluation.	- The alternate benefit of D0140 is applied, refer to D0140 guidelines for benefit and time limitations. - This procedure code is not to be used for a post-operative visit and for follow up to "nonsurgical" definitive care such as root canal treatment or seating of a crown.	
D0180 ●	**Comprehensive periodontal evaluation – new or established patient** This procedure is indicated for patients showing signs or symptoms of periodontal disease and for patients with risk factors such as smoking or diabetes. It includes evaluation of periodontal conditions, probing and charting, evaluation and recording of the patient's dental and medical history, oral cancer evaluation and general health assessment. It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships and oral cancer evaluation.	- This procedure is applied to the patient's annual exam benefit. -This procedure is a benefit once per 5 years per patient per dentist/dental office. If procedure is performed by the same dentist/dental office in less than 5 years, the alternate benefit of a periodic exam (D0120) is allowed. If the patient has not received any services for 3 years from the same dentist/dental office, a comprehensive evaluation may be a benefit. -This procedure should be used primarily by a periodontist for a referred patient from a general dentist and should not be reported in addition to a D0150 by the same dentist/dental office in the same treatment series. - Benefits for consultation, diagnosis and routine treatment planning are disallowed as a component of the benefit for this evaluation by the same dentist/dental office.	

Radiographs/Diagnostic Imaging (Including Interpretation)

Should be taken only for clinical reasons as determined by the patient's dentist. Should be of diagnostic quality and properly identified and dated. Is a part of the patient's clinical record and the original images should be retained by the dentist.

General Guidelines

Any combination of intraoral radiographs (periapical, occlusal, bitewing and/or panoramic films) taken by the same dentist/dental office on the same day with fees that equal or exceed fees for complete series will be processed as D0210. D0210 frequency limitations will be applied.

For oral surgeons, additional radiograph benefits may be allowed for diagnosis of specific condition or injury.

For endodontic treatment, one pre-operative radiograph is allowed. Working and post-operative radiographs are considered part of the complete procedure and disallowed.

Charges for duplication (copying of radiographs) is disallowed.

D0210 ●	**Intraoral - complete series (including bitewings)** A radiographic survey of the whole mouth, usually consisting of 14-22 periapical and posterior bitewing images intended to display the crowns and roots of all teeth, periapical areas and alveolar bone.	Refer to plan benefits for frequency limitations.	

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D0220 **D0230** **D0240** **D0250** **D0260** ★	**Intraoral – periapical first film** **Intraoral – periapical each additional film** **Intraoral – occlusal film** **Extraoral – first film** **Extraoral – each additional film**		
D0270 **D0272** **D0273** **D0274** ★	**Bitewing – single film** **Bitewings – two films** **Bitewings – three films** **Bitewings – four films**	- Refer to plan benefits for frequency limitations. - Each D0270, D0272, D0273, D0274, D0277 when performed, is applied to the patient's annual bitewing benefit.	
D0277 ★	**Vertical bitewings – 7 to 8 films** This does not constitute a full mouth intraoral radiographic series.		
D0290 ■	**Posterior – anterior or lateral skull and facial bone survey film**		
D0310	**Sialography**	Not a benefit of the plan	
D0320	**Temporomandibular joint arthrogram, including injection**	Not a benefit of the plan	
D0321	**Other temporomandibular joint films, by report**	Not a benefit of the plan	
D0330 ●	**Panoramic film**	Refer to plan benefits for frequency limitations.	
D0340 ◙	**Cephalometric film**	- Coverage for this procedure is limited to members who have Orthodontic Plan Benefits. - Benefits for cephalometric film performed with services other than orthodontic treatment are denied.	
D0350 ◙	**Oral/facial photographic images** This includes photographic images, including those obtained by intraoral and extraoral cameras, excluding radiographic images. These photographic images should be part of the patient's clinical record.	- Coverage for this procedure is limited to members who have Orthodontic Plan Benefits. - Benefits for photographic images performed with services other than orthodontic treatment are denied. - Benefit is limited to once per Orthodontic case.	
D0360	**Cone beam CT - craniofacial data capture** Includes axial, coronal and sagittal data.	Not a benefit of the plan	

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D0362	**Cone beam – two-dimensional image reconstruction using existing data, includes multiple images**	Not a benefit of the plan	
D0363	**Cone beam – three-dimensional image reconstruction using existing data, includes multiple images**	Not a benefit of the plan	
D0411	**HbA1c in-office point of service testing**	Not a benefit of the plan	
D0412	**Blood glucose level test – in office using a glucose meter.**	Not a benefit of the plan	
D0415	**Collection of microorganisms for culture and sensitivity**	Not a benefit of the plan	
D0416	**Viral culture** A diagnostic test to identify viral organisms, most often herpes virus.	Not a benefit of the plan	
D0417	**Collection and preparation of saliva sample for laboratory diagnostic testing**	Not a benefit of the plan	
D0418	**Analysis of saliva sample** Chemical or biological analysis of saliva sample for diagnostic purposes.	Not a benefit of the plan	
D0421	**Genetic test for susceptibility to oral diseases** Sample collection for the purpose of certified laboratory analysis to detect specific genetic variations associated with increased susceptibility for oral diseases such as severe periodontal disease.	Not a benefit of the plan	
D0425	**Caries susceptibility tests** Not to be used for carious dentin staining	Not a benefit of the plan	
D0431	**Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures**	Not a benefit of the plan	

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D0460 ●	**Pulp vitality tests** Includes multiple teeth and contra lateral comparison(s), as indicated.	- Pulp tests are payable per visit not per tooth and only for the diagnosis of emergency conditions. - Benefits for this procedure are disallowed as part of any other definitive procedure on the same day, by the same dentist/dental office except D0140 limited oral evaluation-problem focused or D9110 palliative treatment.	
D0470 ◙	**Diagnostic casts** Also known as diagnostic models or study models.	- Coverage for this procedure is limited to members who have Orthodontic Plan benefits. - Diagnostic casts are payable only once per case in conjunction with orthodontic services. - Additional casts taken by the same dentist/dental office during or after orthodontic treatment are included in the fee for orthodontics. - Diagnostic casts are included in the fee for restorations and prosthetic procedures.	

Oral Pathology Laboratory

These are procedures generally performed in a pathology laboratory and do not include the removal of the tissue sample from the patient. For removal of tissue sample, see codes D7285-D7288.

D0472	**Accession of tissue, gross examination, preparation and transmission of written report**	Benefits are limited to one D0472, D0473 or D0474 per site on the same date of service by the same dental office.	
D0473	**Accession of tissue, gross and microscopic examination, preparation and transmission of written report**		
D0474 ●	**Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report** To be used in reporting architecturally intact tissue obtained by invasive means.		
D0475	**Decalcification procedure** Procedure in which hard tissue is processed in order to allow sectioning and subsequent microscopic examination.	Not a benefit of the plan	
D0476	**Special stains for microorganisms** Procedure in which additional stains are applied to biopsy or surgical specimen in order to identify microorganisms.	Not a benefit of the plan	

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D0477	**Special stains, not for microorganisms** Procedure in which additional stains are applied to biopsy or surgical specimen in order to identify such things as melanin, mucin, iron, glycogen, etc.	Not a benefit of the plan	
D0478	**Immunohistochemical stains** A procedure in which specific antibody based reagents are applied to tissue samples in order to facilitate diagnosis.	Not a benefit of the plan	
D0479	**Tissue in-situ hybridization, including interpretation** A procedure which allows for the identification of nucleic acids, DNA and RNA, in the tissue sample in order to aid in the diagnosis of microorganisms and tumors.	Not a benefit of the plan	
D0480 ●	**Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report** To be used in reporting disaggregated, non-transepithelial cell cytology sample via mild scraping of the oral mucosa.		
D0481	**Electron microscopy – diagnostic** An extreme high magnification diagnostic procedure that enables identification of cell components and microorganisms that are otherwise not identifiable under light microscopy.	Not a benefit of the plan	
D0482	**Direct immunofluorescence** A technique used to identify immunoreactants which are localized to the patient's skin or mucous membranes.	Not a benefit of the plan	
D0483	**Indirect immunofluorescence** A technique used to identify circulating immunoreactants.	Not a benefit of the plan	
D0484 ●	**Consultation on slides prepared elsewhere** A service provided in which microscopic slides of a biopsy specimen prepared at another laboratory are evaluated to aid in the diagnosis of a difficult case or to offer a consultative opinion at the patient's request. The findings are delivered by written report.	This benefit is disallowed when billed in conjunction with an evaluation by the same dentist/dental office.	

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D0485 ●	**Consultation, including preparation of slides from biopsy material supplied by referring source** A service that requires the consulting pathologist to prepare the slides as well as render a written report. The slides are evaluated to aid in the diagnosis of a difficult case or to offer a consultative opinion at the patient's request.	Upon review of the pathology report, the alternate benefit of a D0472, D0473, D0474 may be applied.	Pathology Report
D0486	**Laboratory accession of brush biopsy sample, microscopic examination, preparation and transmission of written report** To be used in pathology laboratory reporting transepithelial, disaggregated cell samples by brush biopsy technique.	Not a benefit of the plan	
D0502	**Other oral pathology procedures, by report**	Not a benefit of the plan	
D0999 ●	**Unspecified diagnostic procedure, by report** Used for procedure that is not adequately described by a code. Describe procedure.	Provide a complete description of services/treatment to allow determination of appropriate benefit allowance.	Narrative

Preventive

Dental Prophylaxis

D1110 ■	**Prophylaxis – adult** Removal of plaque, calculus and stains from the tooth structures in the permanent and transitional dentition. It is intended to control local irritational factors.	- A prophylaxis performed on the same date by the same dentist/dental office as a Periodontal Maintenance (D4910) or Scaling and Root Planing (D4341/D4342) is considered to be part of those procedures and the fee is disallowed. - A second prophylaxis treatment will be allowed as a special benefit under the following circumstances: ▪ The two prophylaxis treatments are conducted not more than 21 calendar days apart, and are not performed on the same day. ▪ The patient has not had a prophylaxis performed for at least 24 months. ▪ The patient must be 14 years or older. ▪ The patient has not had periodontal treatment for at least 36 months.	

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D1120 ■	**Prophylaxis – child** Removal of plaque, calculus and stains from the tooth structures in the primary and transitional dentition. It is intended to control local irritational factors.	This is a benefit through age 13.	

Topical Fluoride Treatment (Office Procedure)

Prescription strength fluoride product designed solely for use in the dental office, delivered to the dentition under the direct supervision of a dental professional. Fluoride must be applied separately from prophylaxis paste.

D1203 ■	**Topical application of fluoride – child**	Allowed once per calendar year up to age 17.	
D1204	**Topical application of fluoride – adult**	Not a benefit of the plan	
D1206 ■	**Topical fluoride varnish; therapeutic application for moderate to high caries risk patients** Application of topical fluoride varnish, delivered in a single visit and involving the entire oral cavity. Not to be used for desensitization.	Examples of narratives for benefits of this procedure may include: high rate of decay, history of radiation therapy, root exposure, dry-mouth syndrome (xerostomia, Sjogren's Syndrome).	Narrative

Other Preventive Services

D1310	**Nutritional counseling for control of dental disease** Counseling on food selection and dietary habit as a part of treatment and control of periodontal disease and caries	Not a benefit of the plan	
D1320	**Tobacco counseling for the control and prevention or oral disease** Tobacco prevention and cessation services reduce patient risks of developing tobacco-related oral disease and conditions and improves prognosis for certain dental therapies.	Not a benefit of the plan	
D1330	**Oral hygiene instructions** This may include instructions for home care. Examples include tooth brushing technique, flossing, and use of special oral hygiene aids.	Not a benefit of the plan	

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D1351 ■	**Sealant – per tooth** Mechanically and/or chemically prepared enamel surface sealed to prevent decay.	- Subject to plan coverage. - Sealants are benefits once per tooth on the occlusal surface of all permanent bicuspids and molars. Valid Tooth #'s: 1-5, 12-21, 28-32	
D1510 **D1516** **D1517** ★	**Space maintainer – fixed, unilateral** **Space maintainer – fixed – bilateral, maxillary** **Space maintainer – fixed – bilateral, mandibular**	- Allowed through age 17. - One replacement allowed per tooth. Tooth number/letter must be indicated. Missing Teeth #'s: A-T, 2-15, 18-31	
D1520	**Space maintainer – removable – unilateral**	Not a benefit of the plan	
D1526 **D1527** ★	**Space maintainer – removable – bilateral, maxillary** **Space maintainer – removable – bilateral, mandibular**	- Allowed through age 17. - One replacement allowed per tooth. Tooth number/letter must be indicated. Missing Teeth #'s: A-T, 2-15, 18-31	
D1550 ★	**Re-cementation of space maintainer**	Two re-cementations are allowed per tooth. Missing Teeth #'s: A-T, 2-15, 18-31	
D1555 ★	**Removal of fixed space maintainer** Procedure delivered by dentist who did not originally place the appliance, or by the practice where the appliance was originally delivered to the patient.	Benefits for removal of fixed space maintainer by the same dentist/dental office who placed the appliance are disallowed. D1555 is disallowed when submitted with re-cementation.	

Routine Restorative

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

A one-surface posterior restoration is one in which the restoration involves only one of the five surface classifications (mesial, distal, occlusal, lingual, or facial, including buccal and labial).

A two-surface posterior restoration is one in which the restoration extends to two of the five surface classifications.

A three-surface posterior restoration is one in which the restoration extends to three of the five surface classifications.

A four-or-more surface posterior restoration is one in which the restoration extends to four or more of the five surface classifications.

A one-surface anterior proximal restoration is one in which neither the lingual nor facial margins of the restoration extend beyond the line angle.

A two-surface anterior proximal restoration is one in which either the lingual or facial margin of the restoration extends beyond the line angle.

A three-surface anterior proximal restoration is one in which both the lingual and facial margins of the restorations extend beyond the line.

A four-or-more surface anterior restoration is one in which both the lingual and facial margins extend beyond the line angle and the incisal angle is involved. This restoration might also involve all four surfaces of an anterior tooth and not involve the incisal angle.

General Guidelines
HMAA plans provide for restoration of tooth structure loss from caries. Restorations provided for cosmetic purposes are non-payable by HMAA. Patient must be informed and agree to assume the cost of non-benefit procedures.

Identify the tooth surface(s) on the claim submission. Please use the following abbreviations: D – distal· F – facial (labial or buccal)· I – incisal· L – lingual· M – mesial· O – occlusal.

Amalgam Restoration (Including Polishing)

Tooth preparation, all adhesives (including amalgam bonding agents), liners and bases are included as part of the restoration. If pins are used, they should be reported separately (see D2951).

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
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

Resin-based composite refers to a broad category of materials including but not limited to composites. May include bonded composite, light-cured composite, etc. Tooth preparation, acid etching, adhesives (including resin bonding agents), liners and bases and curing are included as part of the restoration. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used, they should be reported separately (see D2951).

General Guidelines

Composite restorations in posterior teeth, except for the facial composite on bicuspids, are not a benefit. HMAA will allow the alternate benefit of an amalgam restoration if performed on posterior teeth. The patient should be informed that they are responsible for the cost difference if they elect to have the composite restoration done on a posterior tooth.

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D2330	**Resin-based composite – one surface, anterior**	Valid Tooth #'s: 6-11, 22-27, C-H, M-R	
D2331	**Resin-based composite – two surfaces, anterior**		
D2332	**Resin-based composite – three surfaces, anterior**		
D2335 ▲	**Resin-based composite – four or more surfaces or involving incisal angle (anterior)** Incisal angle to be defined as one of the angles formed by the junction of the incisal and the mesial or distal surface of an anterior tooth.		
D2390 ▲	**Resin-based composite crown, anterior** Full resin-based composite coverage of tooth.	- If D2390 is performed by the same dentist/dental office within 6 months of routine restoration, the routine restoration will be deducted from the approved amount of the D2390. - A D2390 crown placed within 24 months of a routine restorative crown (D2390, D2930, D2932, D2933, D2934) is disallowed by same dentist/dental office and denied by different dentist/dental office Valid Tooth #'s: 6-11, 22-27, C-H, M-R	X-ray
D2391 ▲	**Resin-based composite –one surface, posterior** Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure.	Only facial (buccal) surface on bicuspids are a benefit of the plan. Valid Tooth #'s: 4, 5, 12, 13, 20, 21, 28, 29 Surface: F (facial/buccal) Tooth #'s: 4, 5, 12, 13, 20, 21, 28, 29 Surfaces: M, O, D, L, and 1-3, 14-19, 30-32 (any surface) will be processed as an alternate benefit with amalgam equivalent.	

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D2392	**Resin-based composite – two surfaces, posterior**	Valid Tooth #'s: 1-5, 12-21, 28-32	
D2393	**Resin-based composite – three surfaces, posterior**		
D2394 ▲	**Resin-based composite – four or more surfaces, posterior**		
D2410	**Gold foil – one surface**	The alternate benefit of a posterior amalgam or anterior composite restoration will be applied.	
D2420	**Gold foil – two surfaces**		
D2430 ▲	**Gold foil – three surfaces**		

Inlay/Onlay Restorations

Definitions (Source: CDT 2009/2010, ADA):

Onlay – a restoration that restores one or more cusps and adjoining occlusal surfaces of the entire occlusal surface and is retained by mechanical or adhesive means.

Inlay – a fixed intracoronal restoration; a dental restoration made outside the oral cavity to correspond to the form of the prepared cavity, which is then luted in to the tooth.

General Guidelines

Inlays or Onlays are not a benefit for children under 12 years of age.

The inlay/onlay is a covered benefit only when required for restorative reasons (decay or fracture) and only when the tooth cannot be restored with a more conservative method. When an inlay or onlay is submitted and the tooth can be restored with filling material, the alternate benefit of a routine restoration will be applied.

Multistage procedures are reported and are a benefit upon completion. The completion of onlays and inlays is the cementation date.

Replacement of inlays and onlays may be a benefit for restorations older than 5 years in the presence of fracture, decay or the tooth is otherwise compromised.

D2510	**Inlay – metallic – one surface**		
D2520	**Inlay – metallic – two surfaces**		
D2530 ♦	**Inlay – metallic – three or more surfaces**		
D2542	**Onlay – metallic – two surfaces**	Upon review of X-ray, the alternate benefit of posterior amalgam or anterior composite will be applied if Onlay criteria not met.	X-ray
D2543	**Onlay – metallic – three surfaces**		
D2544 ♦	**Onlay – metallic – four or more surfaces**		

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
	Porcelain/ceramic inlays/onlays include all indirect ceramic and porcelain type inlays/onlays.		
D2610	**Inlay – porcelain/ceramic – one surface**	Posterior Inlays (Tooth #'s:1-5, 12-21, 28-32) will be processed as alternate benefit with metallic equivalent.	
D2620	**Inlay – porcelain/ceramic – two surfaces**		
D2630	**Inlay – porcelain/ceramic – three or more surfaces**		
D2642	**Onlay – porcelain/ceramic – two surfaces**	Upon review of the X-ray, the alternate benefit of a metallic Onlay or a posterior amalgam or anterior composite restoration may be applied if Onlay criteria not met.	X-ray
D2643	**Onlay – porcelain/ceramic – three surfaces**		
D2644 ♦	**Onlay – porcelain/ceramic – four or more surface**		
	Resin-based composite inlays/onlays must utilize indirect technique.		
D2650	**Inlay – resin based composite – one surface**	Posterior Inlays (Tooth #'s:1-5, 12-21, 28-32) will be processed as alternate benefit with metallic equivalent.	
D2651	**Inlay – resin based composite – two surfaces**		
D2652	**Inlay – resin based composite – three or more surfaces**		
D2662	**Onlay – resin based composite – two surfaces**	Upon review of the X-ray, the alternate benefit of a metallic Onlay or a posterior amalgam or anterior composite restoration may be applied if Onlay criteria not met.	X-ray
D2663	**Onlay – resin based composite – three surfaces**		
D2664 ♦	**Onlay – resin based composite – four or more surfaces**		

Crowns – Single Restoration Only

Classification of Metals (Source: ADA Council on Scientific Affairs)
The noble metal classification system has been adopted as a more precise method of reporting various alloys used in dentistry. The alloys are defined on the basis of the percentage of metal content:
high noble - Gold (Au), Palladium (Pd), and/or Platinum (Pt) > 60% (with at least 40% Au); titanium and titanium alloys – Titanium (Ti) > 85%; noble - Gold (Au), Palladium (Pd), and/or Platinum (Pt)> 25%; predominantly base - Gold (Au), Palladium (Pd), and/or Platinum (Pt) < 25%.

Porcelain/Ceramic
Refers to those non-metal, non-resin inorganic refractory compounds processed at high temperatures (600°C/1112°F and above) and pressed, polished or milled – including porcelains, glasses and glass-ceramics.

Resin:
Refers to any resin-based composite, including fiber or ceramic reinforced polymer compounds.

General Guidelines
Porcelain crowns, porcelain-fused to metal or plastic processed to metal type crowns, inlays or onlays are not a benefit for children under 12 years of age.

The fee for a restoration includes services such as, but not limited to, crown removal, tooth preparation, diagnostic wax-up, electro surgery, temporary restorations, cement bases, impressions, laboratory fees, Laser technology, occlusal adjustment within 6 months after the restoration, post-operative visits, local anesthesia, crown lengthening and gingivectomy on the same date of service. These procedures are disallowed when submitted as a separate charge.

A crown (resin, porcelain or metal) is a covered benefit only when required for restorative reasons (decay and fracture) and only when the tooth cannot be restored with a more conservative method. If the tooth can be restored with filling material, the patient must be informed that the crown or cast restoration is an elective procedure. Restorations provided for cosmetic purposes are considered elective services. Patient must be informed and agree to assume the cost of non-benefit procedures. It is recommended that the dentist obtain the patient's written consent on a form that clearly explains the charges that will be incurred.

When a crown is planned for replacement and the x-ray or other submitted attachments do not indicate decay, fracture and or the tooth being otherwise compromised, the provider is requested to provide a narrative to state the reason(s) for replacement. Replacement of cosmetic veneers is denied.

If HMAA has history of endodontic treatment, an X-ray is not required for crowns, buildup or post and core.

Multistage procedures are reported and are a benefit upon completion. The completion date for crowns and veneers is the cementation date. Indicate the cementation date of the crown when submitting for payment. For patients whose dental coverage has been terminated; indicate the preparation date in a narrative. If the preparation was done prior to the patient's termination date, the crown will be a benefit if cemented within 30 days of termination.

Porcelain crowns, porcelain-fused to metal, resin-based or plastic processed to metal type crowns placed posterior to the 2nd bicuspid will be processed as the alternate benefit of the metallic equivalent.

Replacement of gold restorations, veneers, porcelain and composite/resin crowns due to defective marginal integrity, recurrent decay, fracture of tooth structure, or non-repairable fracture of the restoration may be a benefit if older than 5 years.

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D2710 ♦	**Crown – resin-based composite (indirect)** Unfilled or non-reinforced resin crowns should be reported using D2999.	Payable for tooth #'s: 4-13, 20-29 Tooth #'s 1-3, 14-19, 30-32 will be processed as alternate benefit with metallic equivalent.	X-ray
D2712 ♦	**Crown – 3/4 resin based composite (indirect)** This code does not include facial veneers.	Payable for tooth #'s: 4-13, 20-29 Tooth #'s 1-3, 14-19, 30-32 will be processed as alternate benefit with metallic equivalent.	X-ray

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D2720 ♦	**Crown – resin with high noble metal**	Payable for tooth #'s: 4-13, 20-29 Tooth #'s 1-3, 14-19, 30-32 will be processed as alternate benefit with metallic equivalent.	X-ray
D2721 ♦	**Crown – resin with predominantly base metal**		
D2722 ♦	**Crown – resin with noble metal**		
D2740 ♦	**Crown – porcelain/ceramic substrate**	Porcelain margin charges associated with this procedure will be disallowed. Payable for tooth #'s: 4-13, 20-29 Tooth #'s 1-3, 14-19, 30-32 will be processed as alternate benefit with metallic equivalent.	X-ray
D2750 ♦	**Crown – porcelain fused to high noble metal**	The additional lab cost for porcelain gingival margin on anterior and bicuspid crowns may be charged to the patient, submit as code D2999 (Unspecified restorative procedure, by report code) describing the service, including a narrative stating, "service elected by patient for cosmetic reasons". Payable for tooth #'s: 4-13, 20-29 Tooth #'s 1-3, 14-19, 30-32 will be processed as alternate benefit with metallic equivalent.	X-ray
D2751 ♦	**Crown – porcelain fused to predominantly base metal**		
D2752 ♦	**Crown – porcelain fused to noble metal**		
D2780 ♦	**Crown – 3/4 cast high noble metal**		X-ray
D2781 ♦	**Crown – 3/4 cast predominantly base metal**		
D2782 ♦	**Crown – 3/4 cast noble metal**		
D2783 ♦	**Crown – 3/4 porcelain/ceramic** This code does not include facial veneers.	Payable for tooth #'s: 4-13, 20-29 Tooth #'s 1-3, 14-19, 30-32 will be processed as alternate benefit with metallic equivalent.	X-ray
D2790 ♦	**Crown – full cast high noble metal**		X-ray
D2791 ♦	**Crown – full cast predominantly base metal**		
D2792 ♦	**Crown – full cast noble metal**		
D2794 ♦	**Crown – titanium**	Upon review of X-ray, the alternate benefit of a D2790 will be applied.	X-ray

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D2799 ▲	**Provisional crown** Crown utilized as an interim restoration of at least six months duration during restorative treatment to allow adequate time for healing or completion of other procedures. This includes, but is not limited to changing vertical dimension, completing periodontal therapy or cracked-tooth syndrome. This is not to be used as a temporary crown for a routine prosthetic restoration.	Covered as a benefit only in the event of an injury. Narrative must detail the scope of injury.	X-ray Narrative
D2910 **D2915** **D2920** ▲	**Recement inlay, onlay, or partial coverage restoration** **Recement cast or prefabricated post and core** **Recement crown**	- Benefit for recementation within 6 months of the initial placement is disallowed when performed by the same dentist or dental office. - Recementation by a different provider (within 6 months of initial placement) is a benefit once. - Benefits are allowed for one recementation after 6 months have elapsed since initial placement. Subsequent requests for recementation are allowed every 12 months thereafter. - D2920 and D2915 are not benefits on the same tooth on the same service date by the same dentist office. If submitted, D2915 will be disallowed.	
D2930 ▲	**Prefabricated stainless steel crown – primary tooth**	- D2930 performed by same dentist/dental office within 6 months of routine restoration, the routine restoration will be deducted from the approved amount of the D2930. - D2930 placed within 24 months of a routine restorative crown (D2390, D2930, D2932, D2933, D2934) is disallowed by same dentist/dental office and denied by different dentist/dental office.	
D2931 ▲	**Prefabricated stainless steel crown – permanent tooth**	- D2931 performed by same dentist/dental office within 6 months of routine restoration, the routine restoration will be deducted from the approved amount of the D2391. - D2931 placed within 24 months of a routine restorative crown (D2390, D2930, D2932, D2933, D2934) is disallowed by same dentist/dental office and denied by different dentist/dental office.	
D2932 ▲	**Prefabricated resin crown**	- D2392 performed by same dentist/dental office within 6 months of routine restoration, the routine restoration will be deducted from the approved amount of the D2392. - D2392 placed within 24 months of a routine restorative crown (D2390, D2930, D2932, D2933, D2934) is disallowed by same dentist/dental office and denied by different dentist/dental office. - When submitted for a posterior primary tooth or permanent tooth, the alternate benefit allowance of D2930 or D2931 is applied.	

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D2933 ▲	**Prefabricated stainless steel crown with resin window** Open-face stainless steel crown with aesthetic resin facing or veneer.	- D2933 performed by same dentist/dental office within 6 months of routine restoration, the routine restoration will be deducted from the approved amount of the D2393. - D2933 placed within 24 months of a routine restorative crown (D2390, D2930, D2932, D2933, D2934) is disallowed by same dentist/dental office and denied by different dentist/dental office. - When submitted for a posterior primary tooth or a permanent tooth, the alternate benefit D2930 or D2931 is applied.	
D2934 ▲	**Prefabricated esthetic coated stainless steel crown – primary tooth**	- D2934 performed by same dentist/dental office within 6 months of routine restoration, the routine restoration will be deducted from the approved amount of the D2934. - D2934 placed within 24 months of a routine restorative crown (D2390, D2930, D2932, D2933, D2934) is disallowed by same dentist/dental office and denied by different dentist/dental office. - When submitted for a posterior primary tooth, the alternate benefit of D2930 is applied.	
D2940 ▲	**Sedative filling** Temporary restoration intended to relieve pain. Not to be used as a base or liner under a restoration.	- Sedative fillings are covered benefits for emergency relief of pain. - Allowed once per tooth per provider per 24 months. - Benefits for a sedative filling are disallowed when performed in conjunction with a definitive service and/or Palliative treatment (D9110.)	
D2950 ▲	**Core buildup, including any pins** Refers to building up of anatomical crown when restorative crown will be placed, whether or not pins are used. A material is placed in the tooth preparation for a crown when there is insufficient tooth strength and retention for the crown procedure. This should not be reported when the procedure only involves a filler to eliminate any undercut, box form, or concave irregularity in the preparation.	- Core buildups are a benefit only when the tooth being crowned is damaged (over 50% of remaining tooth structure) that there is insufficient tooth structure to support a restorative crown. - Core buildups are disallowed when performed in conjunction with inlay and onlay procedures. - Core buildups are disallowed when radiographs indicate sufficient tooth structure (over 50%) remains to support a crown. - If HMAA has history of endodontic treatment, an X-ray is not required	X-ray
D2951 ▲	**Pin retention – per tooth, in addition to restoration**	- Only allowed for amalgam and composite restorations. A fee for pin retention when billed in conjunction with a buildup is disallowed. - Pin retention is a benefit once per tooth. Fees for additional pins on the same tooth are disallowed.	

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D2952 ♦	**Post and core in addition to crown, indirectly fabricated** Post and core are custom fabricated as a single unit.	- Post and core in addition to crown is payable only on an endodontically treated tooth. - Benefits for post and core are disallowed when radiographs indicate an absence of endodontic treatment, incompletely filled canal space or unresolved pathology associated with the involved tooth. - If HMAA has history of endodontic treatment, an X-ray is not required. - Restorations are not a benefit in conjunction with overdentures and benefits are denied as an elective technique.	X-ray
D2953	**Each additional indirectly fabricated post – same tooth** To be used with D2952	Not a benefit of the plan	
D2954 ▲	**Prefabricated post and core in addition to crown** Core is built around a prefabricated post. This procedure includes the core material.	- Prefabricated post and core in addition to a crown is payable only on an endodontically treated tooth. - Benefits for post and core are disallowed when radiographs indicate an absence of endodontic treatment, incompletely filled canal space or unresolved pathology. - If HMAA has history of endodontic treatment, an X-ray is not required. - Restorations are not a benefit in conjunction with overdentures and benefits are denied as an elective technique.	X-ray
D2955 ▲	**Post removal (not in conjunction with endodontic therapy)** For removal of posts (e.g., fractured posts) not to be used in conjunction with endodontic retreatment (D3346, D3347, D3348).	The narrative should detail the reason for post removal.	Narrative
D2957	**Each additional prefabricated post – same tooth** To be used with D2954	Not a benefit of the plan	
D2960 ▲	**Labial veneer (resin laminate) – chairside** Refers to labial/facial direct resin bonded veneers.	- Veneers to treat caries and incisal fractures are considered covered benefits if the tooth qualifies for a crown and patient payments are limited to copayments of the HMAA eligible amount. - Veneers on permanent anterior teeth and bicuspids for cosmetic purposes are considered non-covered benefits, and the patient may be charged up to the submitted amount. - Benefit limit is 24 months	

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D2961 ♦	**Labial veneer (resin laminate) – laboratory** Refers to labial/facial indirect resin bonded veneers.	- Veneers to treat caries and incisal fractures are considered covered benefits if the tooth qualifies for a crown and patient payments are limited to copayments of the HMAA eligible amount. - Veneers and replacement of veneers on permanent anterior teeth and bicuspids for cosmetic purposes are considered non-covered benefits, and the patient maybe charged up to the submitted amount. - Replacement of veneers must be accompanied by a narrative explaining the need to replace the veneer as well as an X-ray. - Benefit limit is 5 years.	X-ray
D2962 ♦	**Labial veneer (porcelain laminate) – laboratory** Refers also to facial veneers that extend interproximally and/or cover the incisal edge. Porcelain/ceramic veneers presently include all ceramic and porcelain veneers.	- Veneers to treat caries and incisal fractures are considered covered benefits if the tooth qualifies for a crown and patient payments are limited to copayments of the HMAA eligible amount. - Veneers and replacement of veneers on permanent anterior teeth and bicuspids for cosmetic purposes are considered non-covered benefits, and the patient may be charged up to the submitted amount. - Replacement of veneers must be accompanied by a narrative explaining the need to replace the veneer as well as an X-ray. - Benefit limit is 5 years.	X-ray
D2970 ▲	**Temporary crown (fractured tooth)** Usually a preformed artificial crown, which is fitted over a damaged tooth as an immediate protective device. This is not to be used as temporization during crown fabrication.	- Covered as a benefit only in the event of an injury. Narrative must detail the scope of injury. - If used as temporary retainer crown for routine prosthetic fixed partial dentures, benefit will be disallowed.	X-ray Narrative
D2971 ▲	**Additional procedures to construct new crown under existing partial denture framework** To be reported in addition to a crown code.	- This procedure must be submitted with a crown procedure. - Patient history of partial denture (D5213, D5214) is required for benefit of this procedure.	
D2975	**Coping** A thin covering of the remaining portion of a tooth, usually fabricated of metal and devoid of anatomic contour. This is to be used as a definitive restoration.	Not a benefit of the plan	

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D2980	**Crown repair, by report** Includes removal of crown, if necessary.	- Repairs for porcelain on molars are not a benefit. The patient is responsible for the cost. - Repair is a benefit 6 months after cementation and thereafter a benefit once every 12 months - Documentation may include materials used, tooth number, arch, quadrant, or area of the mouth, chair time, X-rays or any other supporting information. - Upon review of documentation, the appropriate benefit allowance will be applied.	Narrative
D2999	**Unspecified restorative procedure, by report** Use for procedure that is not adequately described by a code. Describe procedure.	- Documentation may include materials used, tooth number, chair time, X-rays or any other supporting information. - Upon review of documentation, the appropriate benefit allowance will be applied. - The additional lab cost for porcelain gingival margin on anterior and bicuspid crowns may be charged to the patient, submit as code D2999 (Unspecified restorative procedure, by report code) describing the service, including a narrative stating, “service elected by patient for cosmetic reasons”.	Narrative

Endodontics

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

D3110 ▲	**Pulp cap – direct (excluding final restoration)** Procedure in which the exposed pulp is covered with a dressing or cement that protects the pulp and promotes healing and repair.	Separate benefits for pulp caps by the same dentist/dental office are disallowed as components of a sedative filling.	
D3120 ▲	**Pulp cap – indirect (excluding final restoration)** Procedure in which the nearly exposed pulp is covered with a protective dressing to protect the pulp from additional injury and to promote healing and repair via formation of secondary dentin.	Separate benefits for pulp caps by the same dentist/dental office are disallowed as components of a sedative filling.	
D3220 ▲	**Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament** Pulpotomy is the surgical removal of a portion of the pulp with the aim of maintaining the vitality of the remaining portion by means of an adequate dressing. - To be performed on primary or permanent teeth. - This is not to be construed as the first stage of root canal therapy. - Not to be used for Apexogenesis.	- Therapeutic pulpotomy is only a benefit when performed on primary teeth. The fee for a pulpotomy performed on a permanent tooth is denied and the approved amount is collectable from the patient. - This benefit is allowed once per tooth per lifetime.	

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D3221 ▲	**Pulpal debridement, primary and permanent teeth** Pulpal debridement for the relief of acute pain prior to conventional root canal therapy. This procedure is not to be used when endodontic treatment is completed on the same day.	- The benefit for D3221 is disallowed on the same day as D3220 or root canal therapy - This benefit is allowed once per tooth per lifetime.	
D3222 ▲	**Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development** Removal of a portion of the pulp and application of a medicament with the aim of maintaining the vitality of the remaining portion to encourage continued physiological development and formation of the root. This procedure is not to be construed as the first stage of root canal therapy.	The benefit for partial pulpotomy is disallowed when performed in conjunction with root canal therapy or procedures D3351-D3353 on the same tooth by the same dentist/dental office.	

Endodontic Therapy on Primary Teeth

Endodontic therapy on primary teeth with succedaneous teeth and placement of resorbable filling. This includes pulpectomy, cleaning, and filling of canals with resorbable material.

D3230 ▲	**Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)** Primary incisors and cuspids.	- Pulpal therapy is only a benefit when performed on a non-vital primary tooth that has a successor. - For a non-vital primary tooth with no successor, benefit is limited to a D3310 (anterior) root canal. - For a vital primary tooth, benefit is limited to a D3220 (therapeutic pulpotomy).	X-ray
D3240 ▲	**Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)** Primary first and second molars.	- Pulpal therapy is only a benefit when performed on a non-vital primary tooth that has a successor. - For a non-vital primary tooth with no successor, benefit is limited to a D3320 (bicuspid) root canal. - For a vital primary tooth, benefit is limited to a D3220 (therapeutic pulpotomy).	X-ray

Endodontic Therapy (Including Treatment Plan, Clinical Procedures and Follow-Up Care)

Includes primary teeth without succedaneous teeth and permanent teeth. Complete root canal therapy; pulpectomy is part of root canal therapy.

Includes all appointments necessary to complete treatment; also includes intra-operative radiographs. Does not include diagnostic evaluation and necessary radiographs/diagnostic images.

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D3310 **D3320** **D3330** ▲	**Endodontic therapy, anterior tooth (excluding final restoration)** **Endodontic therapy, bicuspid tooth (excluding final restoration)** **Endodontic therapy, molar tooth (excluding final restoration)**	- For a root canal completed and filled with biologically acceptable material on a retained primary tooth with no permanent successor, include a narrative stating that there is no permanent successor. - A separate fee for palliative treatment is disallowed when performed on the same date of service as root canal therapy by the same dentist/dental office.	
D3331 ▲	**Treatment of root canal obstruction; non-surgical access** In lieu of surgery, for the formation of a pathway to achieve an apical seal without surgical intervention because of a non-negotiable root canal blocked by foreign bodies, including but not limited to separated instruments, broken posts or calcification of 50% or more of the length of the tooth root.	Post removal is not included in this procedure.	
D3332 ▲	**Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth** Considerable time is necessary to determine diagnosis and/or provide initial treatment before the fracture makes the tooth unretainable.	- Subsequent endodontic therapy is disallowed when performed by the same dentist/dental office. - Payment is limited to once per tooth.	Narrative
D3333 ▲	**Internal root repair of perforation defects** Non-surgical seal of perforation caused by resorption and/or decay but not iatrogenic by provider filing claim.	- This procedure is only a benefit on permanent teeth with incomplete root development or for repair of a perforation. - This procedure is disallowed on the same day as an apicoectomy (D3410, D3421, D3425, D3426) or retrograde filling (D3430) by the same dentist/dental office.	Narrative Pre-op X-ray

Endodontic Treatment

This procedure 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.

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D3346 **D3347** **D3348** ▲	**Retreatment of previous root canal therapy – anterior** **Retreatment of previous root canal therapy – bicuspid** **Retreatment of previous root canal therapy – molar**	- Retreatment by the same dentist/dental office within 24 months is considered part of the original procedure. - When radiographs indicate obturation of an endodontically treated tooth has been performed without the use of a solid core material, benefits for the endodontic therapy and/or restoration of the tooth are disallowed. - The narrative should state the reason for retreatment.	Narrative Pre-op X-ray Post-op X-ray
D3351 ▲	**Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)** Includes opening tooth, pulpectomy, preparation of canal spaces, first placement of medication and necessary radiographs. (This procedure includes first phase of complete root canal therapy.)	- Apexification is only a benefit on a permanent tooth with incomplete root development or for repair of a perforation. - Subsequent visits are payable as a D3352 (interim) procedure. - Payment is limited to once per tooth.	Pre-op X-ray
D3352 ▲	**Apexification/recalcification interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)** For visits in which the intra-canal medication is replaced with new medication and necessary radiographs. There may be several of these visits.	Apexification is only allowable on a permanent tooth with incomplete root development or for repair of a perforation.	Post-op X-ray
D3353 ▲	**Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)** Includes removal of intra-canal medication and procedures necessary to place final root canal filling material including necessary radiographs. (This procedure includes last phase of complete root canal therapy).	- Apexification is allowable only on a permanent tooth with incomplete root development or for repair of a perforation. - Subsequent submissions are disallowed by same dentist/dental office. - This procedure is disallowed when performed within 24 months of a root canal therapy by the same dentist/dental office. - Payment limited to once per tooth.	Pre-op X-ray

Apicoectomy/Periradicular Services

Periradicular surgery is a term used to describe surgery to the root surface (e.g., apicoectomy), repair of a root perforation or resorptive defect, exploratory curettage to look for root fractures, removal of extruded filling materials or instruments, removal of broken root fragments, sealing of accessory canals, etc. This does not include retrograde filling material placement.

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D3410 ▲	**Apicoectomy/periradicular surgery – anterior** For surgery on root of anterior tooth. Does not include placement of retrograde filling material.	- The benefit for a 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. - Retreatment of apicoectomies/periradicular surgery is disallowed within 24 months of the initial treatment by the same dentist/dental office.	Post-op X-ray
D3421 ▲	**Apicoectomy/periradicular surgery – bicuspid (first root)** For surgery on one root of a bicuspid. Does not include placement of retrograde filling material. If more than one root is treated, see D3426.	- The benefit for a 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. -Retreatment of apicoectomies/periradicular surgery is disallowed within 24 months of the initial treatment by the same dentist/dental office.	Post-op X-ray
D3425 ▲	**Apicoectomy/periradicular surgery – molar (first root)** For surgery on one root of a molar tooth. Does not include placement of retrograde filling material. If more than one root is treated, see D3426.	- The benefit for a 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. - Retreatment of apicoectomies/periradicular surgery is disallowed within 24 months of the initial treatment by the same dentist/dental office.	Post-op X-ray
D3426 ▲	**Apicoectomy/periradicular surgery (each additional root)** Typically used for bicuspids and molar surgeries when more than one root is treated during the same procedure. This does not include retrograde filling material placement.	- The benefit for a 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. - Retreatment of apicoectomies/periradicular surgery is disallowed within 24 months of the initial treatment by the same dentist/dental office.	Post-op X-ray

| CDT Code | CDT Definition | Benefit Guidelines | Submission Requirements |

D3430 ▲	**Retrograde filling – per root** For placement of retrograde filling material during periradicular surgery procedures. If more than one filling is placed in one root - report as D3999 and describe.	- Retrograde filling includes all retrograde procedures per root. - Service is limited to once per 24 months.	Post-op X-ray
D3450 ▲	**Root amputation – per root** Root resection of a multi-rooted tooth while leaving the crown. If the crown is sectioned, see D3920.		Pre-op X-ray
D3460	**Endodontic endosseous implant** Placement of implant material, which extends from a pulpal space into the bone beyond the end of the root.	Not a benefit of the plan	
D3470	**Intentional reimplantation (including necessary splinting)** For the intentional removal, inspection and treatment of the root and replacement of a tooth into its own socket. This does not include necessary retrograde filling material placement.	Not a benefit of the plan	
D3910	**Surgical procedure for isolation of tooth with rubber dam**	Not a benefit of the plan	
D3920 ▲	**Hemisection (including any root removal), not including root canal therapy** Includes separation of a multi-rooted tooth into separate sections containing the root and the overlying portion of the crown. It may also include the removal of one or more of those sections.	No benefit is allowed for the replacement of the missing portion of existing tooth.	Pre-op X-ray
D3950 ▲	**Canal preparation and fitting of preformed dowel or post** Should not be reported in conjunction with D2952, D2953, D2954 o rD2957 by the same practitioner	Not a benefit of the plan	
D3999 ▲	**Unspecified endodontic procedure, by report** Used for procedure that is not adequately described by a code. Describe procedure.	- Provide a complete description of services and treatment including tooth number. - Documentation may include materials used, tooth number, chair time, X-rays or any other supporting information. - Upon review the appropriate benefit allowance will be applied.	Narrative

Periodontics

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

Surgical Services (Including Usual Post-operative Care)

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

- If two contiguous teeth have areas of soft tissue recession, each area of recession is a single site.
- If two contiguous teeth have adjacent but separate osseous defects, each defect is a single site.
- If two contiguous teeth have a communicating interproximal osseous defect, it should be considered a single site.
- All non-communicating osseous defects are single sites.
- All edentulous non-contiguous tooth positions are single sites.
- Depending on the dimensions of the defect, up to two contiguous edentulous tooth positions may be considered a single site.

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

General Guidelines

Periodontal surgical procedures include all necessary post-operative care, finishing procedures, evaluations (D9430, D9110, D0140) for three months as well as any surgical re-entry (except soft tissue grafts) for three years. When a surgical procedure is billed in the same site within three months of the initial procedure, a separate benefit for the surgery is disallowed.

Periodontal services are only a benefit when performed on natural teeth for treatment of periodontal disease. Benefits for these procedures when billed in conjunction with implants, ridge augmentation, extraction sites and/or periradicular surgery are denied and collectable from the patient.

Prophylaxis is not payable as a separate benefit when provided on the same date as periodontal scaling and root planing, or periodontal maintenance.

Once the quadrant fee is paid within the service time limitation, subsequent episodes of same procedure will be disallowed for the same dentist/dental office and denied for a different dentist/dental office. If extraordinary circumstances are present and documented on submission, the benefits will be denied and are the patient's responsibility up to the approved amount for the surgery.

When two or more different 1-3 teeth services are performed in the same quadrant on the same service date, payment of the 1-3 teeth procedures will be made, not to exceed the quadrant fee of the highest service performed.

If periodontal surgery is performed in less than four weeks after scaling and root planing, the benefit for scaling and root planing will be deducted from the surgery.

The benefits for biopsy (D7285, D7286) frenulectomy (D7960) and excision of hard and soft tissue lesions (D7410, D7411, D7450, D7451) are disallowed when the procedures are performed on the same date, same surgical site/area by the same dentist/dental office as the codes D4210 – D4275.
Laser technology is considered a component of the primary procedure and will be disallowed.

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D4210	**Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant**	- Procedure is a benefit if the pocket depth is greater than or equal to 5 mm. - A separate benefit 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. A separate benefit for D4210/4211 will be denied if performed for 'cosmetic reasons'. - Bounded tooth spaces are not counted as the procedure does not require a flap extension. - For D4211, if more than one tooth, indicate additional teeth numbers in narrative. - Gingivectomies, osseous or mucogingival surgery and free soft tissue grafts are covered benefits once every three years.	Perio Chart
D4211 ▲	**Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant** Involves the excision of the soft tissue wall of the periodontal pocket by either an external or an internal bevel. It is performed to eliminate suprabony pocketsafter adequate initial preparation, to allow access for restorative dentistry in the presence of suprabony pockets, or to restore normal architecture when gingival enlargements or asymmetrical or unaesthetic topographyis evident with normal bony configuration.		

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D4212 ▲	**Gingivectomy or gingivoplasty to allow access for restorative procedure per tooth**		
D4230	**Anatomical crown exposure – four or more contiguous teeth or bounded tooth spaces per quadrant.** This procedure is utilized in an otherwise periodontally healthy are to remove enlarged gingival tissue and supporting bone (ostectomy) to provide an anatomically correct gingival relationship.		Perio Chart
D4231	**Anatomical crown exposure – one to three teeth or bounded tooth spaces per quadrant.** This procedure is utilized in an otherwise periodontally healthy are to remove enlarged gingival tissue and supporting bone (ostectomy) to provide an anatomically correct gingival relationship.		
D4240	**Gingival flap procedure, including root planing – four or more contiguous teeth or tooth bounded spaces per quadrant**	- Procedure is a benefit if the pocket is greater than or equal to 5 mm. - Procedure D4240 includes root planing (D4341/4342) and the benefit for root planing will be disallowed when performed in conjunction with D4240/4241. - For D4241, if more than one tooth, indicate additional teeth numbers in narrative. - Procedure is a benefit once every three years.	Perio Chart
D4241 ▲	**Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant** A soft tissue flap is reflected or resected to allow debridement of the root surface and the removal of granulation tissue. Osseous recontouring is not accomplished in conjunction with this procedure. May include open flap curettage, reverse bevel flap surgery, modified Kirkland flap procedure, and modified Widman surgery. This procedure is performed in the presence of moderate to deep probing depths, loss of attachment, need to maintain esthetics, need for increased access to the root surface and alveolar bone, or to determine the presence of a cracked tooth, fractured root, or external root resorption. Other procedures may be required concurrent to D4240 and should be reported separately using their own unique codes.		
D4245	**Apically positioned flap** Procedure is used to preserve keratinized gingiva in conjunction with osseous resection and second stage implant procedure. Procedure may also be used to preserve keratinized/attached gingiva during surgical exposure of labially impacted teeth, and may be used during treatment of peri-implantitis.		

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D4249 ▲	**Clinical crown lengthening – hard tissue** This procedure is employed to allow restorative procedure or crown with little or no tooth structure exposed to the oral cavity. Crown lengthening requires reflection of a flap and is performed in a healthy periodontal environment, as opposed to osseous surgery, which is performed in the presence of periodontal disease. Where there are adjacent teeth, the flap design may involve a larger surgical area.	- Crown lengthening is applied only when bone is removed and sufficient time is allowed for healing. - Benefits for crown lengthening are disallowed when performed on the same day as crown preparations or restorations. - A separate fee for crown lengthening is disallowed when performed in conjunction with osseous surgery on the same teeth. - If more than one tooth, indicate teeth numbers in the narrative. - The fee for multiple crown lengthening sites within a single quadrant will not exceed the benefit for D4260.	X-ray
D4260	**Osseous surgery (including flap entry and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant**	- The fee for osseous surgery includes: ▪ Osseous contouring ▪ Distal or proximal wedge surgery ▪ Scaling and root planing (D4341, D4342) ▪ Gingivectomy (D4210, D4211) ▪ Flap procedures (D4240, D4241) - This procedure is a benefit if the pocket depth is greater than or equal to 5 mm. - Usually only two full quadrants of osseous surgery are allowed on the same date of service. Benefits in excess of two osseous surgeries on the same date of service are denied unless a narrative is supplied to explain exceptional circumstances. - If periodontal surgery is performed less than four weeks after scaling and root planing, the benefit for the scaling and root planing will be deducted from the surgery. - For one to three teeth, when subsequent treatment of the same procedure is required within the same quadrant, the total benefit is limited to the allowance of the quadrant fee. - For D4261, if more than one tooth, indicate teeth numbers in narrative. - Osseous surgery is a benefit on the same tooth once every 3 years. - The following procedures may be a benefit separately on the same day: ▪ Osseous grafts (D4263, D4264) ▪ Exotosis removal (D7471) ▪ Hemisection (D3920) ▪ Extraction (D7140) ▪ Apicoectomy (D3410) ▪ Root Amputations (D3450) ▪ Guided Tissue Regeneration (D4266) ▪ Soft tissue grafts (D4271)	Perio Chart
D4261 ▲	**Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant** This procedure modifies the bony support of the teeth by reshaping the alveolar process to achieve a more physiologic form. This may include the removal of supporting bone (ostectomy) and/or non-supporting bone (osteoplasty). Other procedures may be required concurrent to D4260, D4261 and should be reported using their own unique codes.		

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D4263	**Bone replacement graft - first site in quadrant**	- This procedure is a benefit if the pocket depth is greater than or equal to 5 mm. Benefits for bone grafting are available only when billed for natural teeth and performed for periodontal purposes. - The benefit for bone grafting is denied as a specialized or elective technique when billed in conjunction with implants, ridge augmentation, extraction sites, periradicular surgery, etc. – refer to D7950, D7951 and D7953. - This procedure must be submitted with a gingival flap (D4240/D4241) or osseous surgery (D4260/D4261) entry procedure. - Maximum benefit for bone replacement grafts is two sites per quadrant. Bone graft for the second site in the same quadrant will be processed as D4264.	Perio Chart
D4264 ▲	**Bone replacement graft – each additional site in quadrant** This procedure involves the use of osseous autografts, osseous allografts, or non-osseous grafts to stimulate periodontal regeneration when the disease process has led to a deformity of the bone. This procedure does not include flap entry and closure, wound debridement, osseous contouring, or the placement of biologic materials to aid in osseous tissue regeneration or barrier membranes. Other separate procedures may be required concurrent to D4263 and should be reported using their own unique codes. Definition for the term “site” precedes code D4210.		
D4265 ▲	**Biologic materials to aid in soft and osseous tissue regeneration** Biologic materials may be used alone or with other regenerative substrates such as bone and barrier membranes, depending upon their formulation and the presentation of the periodontal defect. This procedure does not include surgical entry and closure, wound debridement, osseous contouring, or the placement of graft materials and /or barrier membranes. Other separate procedures may be required concurrent to D4265 and should be reported using their own unique codes.	- Benefits are available only when billed for natural teeth. Benefits are denied when billed in conjunction with implants, ridge augmentation, extraction sites and periradicular surgery as a specialized or elective technique. - Benefits are available when reported with periodontal flap surgery (D4240, D4241, D4260, D4261). - Benefits are denied when done on the same day as bone grafts (D4263, D4264), guided tissue regeneration (D4266, D4267) or tissue grafts (D4271, D4273, D4275).	
D4266 ▲	**Guided tissue regeneration – resorbable barrier, per site** A membrane is placed over the root surfaces or defect area following surgical exposure and debridement. The mucoperiosteal flaps are then adapted over the membrane and sutured. The membrane is placed to exclude epithelium and gingival connective tissue from the healing wound. This procedure may require subsequent surgical procedures to correct the gingival contours. Guided tissue regeneration may also be carried out in conjunction with bone replacement grafts or to correct deformities resulting from inadequate faciolingual bone width in an edentulous area. When guided tissue regeneration is used in association with a tooth, each site on a specific tooth should be reported separately with this code. When no tooth is present, each site should be reported separately. Definition for the term "site" precedes code D4210.	- 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 as a specialized or elective technique. - Benefits for guided tissue regeneration are denied in conjunction with soft tissue grafts (D4271, D4273, D4275) in the same surgical area. - A bone graft is required in order to benefit the guided tissue regeneration. - Maximum benefit for guided tissue regeneration is two sites per quadrant. GTR for more than two sites will be denied to the eligible fee.	Perio Chart

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D4267 ▲	**Guided tissue generation nonresorbable barrier, per site (includes membrane removal)** This procedure is used to regenerate lost or injured periodontal tissue by directing differential tissue responses. A membrane is placed over the root surfaces or defect area following surgical exposure and debridement. The mucoperiosteal flaps are then adapted over the membrane and sutured. The membrane is placed to exclude epithelium and gingival connective tissue from the healing wound. This procedure requires subsequent surgical procedures to remove the membranes and/or to correct the gingival contours. Guided tissue regeneration may be used in conjunction with bone replacement grafts or to correct deformities resulting from inadequate faciolingual bone width in an edentulous area. When guided tissue regeneration is used in association with a tooth, each site on a specific tooth should be reported separately with this code. When no tooth is present, each site should be reported separately. Definition for the term "site" precedes code D4210.	- 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 as a specialized or elective technique. - Upon review of the documentation, the alternate benefit of a D4266 (guided tissue regeneration) may be applied. - A bone graft is required in order to benefit the guided tissue regeneration. - Benefits for guided tissue regeneration are denied in conjunction with soft tissue grafts (D4271, D4273, and D4275) in the same surgical area. - Maximum benefit for guided tissue regeneration is two sites per quadrant. GTR for more than two sites within a quadrant will be denied to the eligible fee.	Perio Chart
D4271 ▲	**Free soft tissue graft procedure (including donor site surgery)** Gingival or masticatory mucosa is grafted to create or augment the gingiva at another site, with or without root coverage. This graft may also be used to eliminate the pull of frena and muscle attachments, to extend the vestibular fornix, and to correct localized gingival recession.	- Narrative should specify donor site and if one of the following conditions applies: ▪ Active recession ▪ No attached gingival ▪ No keratinized gingival ▪ Mucogingiva defect ▪ Progressive perio disease - Not a benefit when performed for cosmetic purposes. - Benefits for guided tissue regeneration (D4266,D4267) are denied in conjunction with soft tissue grafts in the same surgical area. - Benefits for Frenulectomy (D7960) or Frenuloplasty (D7963) are disallowed in conjunction with soft tissue grafts (D4271, D4275). - Extraoral grafts are not covered benefits. - Maximum benefit for free soft tissue graft is two sites per quadrant. Free soft tissue graft for more than two sites within a quadrant will be denied to the eligible fee. - Benefit allowance will be made per graft site, once every three years.	Narrative

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D4273 ▲	**Subepithelial connective tissue graft procedures, per tooth** This procedure is performed to create or augment gingiva, to obtain root coverage to eliminate sensitivity and to prevent root caries, to eliminate frenum pull, to extend the vestibular fornix, to augment collapsed ridges, to provide an adequate gingival interface with a restoration or to cover bone or ridge regeneration sites when adequate gingival tissues are not available for effective closure. There are two surgical sites. The recipient site utilizes a split thickness incision, retaining the overlying flap of gingiva and/or mucosa. The connective tissue is dissected from the donor site leaving an epithelialized flap for closure.	- Narrative should specify donor site and one of the following conditions: ▪ Active recession ▪ No attached gingiva ▪ No keratinized gingiva ▪ Mucogingiva defect ▪ Progressive perio disease - Not a benefit when performed for cosmetic purposes. - Benefits for guided tissue regeneration (D4266) are denied in conjunction with soft tissue grafts in the same surgical area. - Maximum benefit for subepithelial connective tissue graft is two sites per quadrant. Subepithelial connective tissue graft for more than two sites within a quadrant will be denied to the eligible fee.	Narrative
D4274	**Distal or proximal wedge procedure (when not performed in conjunction)** This procedure is performed in an edentulous area adjacent to a periodontally involved tooth. Gingival incisions are utilized to allow removal of tissue wedge to gain access and correct the underlying osseous defect and to permit close flap adaptation.	Not a benefit of the plan	
D4275 ▲	**Soft tissue allograft** Procedure is performed to create or augment the gingiva,with or without root coverage. This may be used to eliminate the pull of the frena and muscle attachments, to extend the vestibular fornix, and correct localized gingival recession. There is no donor site.	- Narrative should specify if one of the following conditions applies:· Active recession ▪ No attached gingival ▪ No keratinized gingival ▪ Mucogingiva defect ▪ Progressive perio disease - Not a benefit when performed for cosmetic purposes. - Upon review, the alternate benefit of free soft tissuegraft (D4271) may be applied. - Benefits for guided tissue regeneration (D4266) are denied in conjunction with soft tissue grafts in the same surgical area. - Benefits for Frenulectomy (D7960) or Frenuloplasty (D7963) are disallowed in conjunction with soft tissue grafts (D4271, D4275). - Maximum benefit for free soft tissue graft is two sites per quadrant. Free soft tissue graft for more than two sites within a quadrant will be denied to the eligible fee.	Narrative
D4276	**Combined connective tissue and double pedicle graft, per tooth** Advanced gingival recession often cannot be corrected with a single procedure. Combined tissue grafting procedures are needed to achieve the desired outcome.	Not a benefit of the plan	

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D4320	**Provisional splinting – intracoronal**	Not a benefit of the plan	
D4321	**Provisional splinting - extracoronal** This is an interim stabilization of mobile teeth. A variety of methods and appliances may be employed for this purpose.		
D4341	**Periodontal scaling and root planing - four or more teeth per quadrant**	- Scaling and root planing is a benefit if pocket depths are greater than or equal to 4 mm. - In the absence of 4 mm pockets, a benefit allowance for a prophylaxis (D1110) is made and any fee in excess of the approved amount for D1110 is disallowed and not chargeable to the patient. - If periodontal surgery is performed less than four weeks after scaling and root planing, the benefit for the scaling and root planing will be deducted from the surgery. - Prophylaxis (D1110) is disallowed if performed on the same day as D4341 or D4342. - D4341 or D4342 performed in conjunction with periodontal surgery is disallowed on the same teeth. - For D4342, if more than one tooth, indicate teeth numbers in narrative. - Periodontal scaling and root planing per quadrant are covered benefits once every 2 years.	Perio Chart
D4342 ▲	**Periodontal scaling and root planing – one to three teeth per quadrant** This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. It is indicated for patients with periodontal disease and is therapeutic, not prophylactic, in nature. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and/or as a part of pre-surgical procedures in others.		
D4355 ▲	**Full mouth debridement to enable comprehensive evaluation and diagnosis** The gross removal of plaque and calculus that interfere with the ability of the dentist to perform a comprehensive oral evaluation. This preliminary procedure does not preclude the need for additional procedures.	- This procedure is allowed as a benefit under the following circumstances: ▪ The patient has not had a prophylaxis or debridement for at least 24 months. ▪ The patient must be 14 years or older. ▪ The patient has not had periodontal treatment for at least 36 months. - A D4355 may be a benefit 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. -This procedure is applied to the prophylaxis benefit. - When benefit criteria are not met, this procedure is limited to and processed as a prophylaxis (D1110).	

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D4381	**Localized delivery of antimicrobial agents via a controlled release vehicle into disease crevicular tissue, per tooth, by report** FDA approved subgingival delivery devices containing antimicrobial medications(s) are inserted into periodontal pockets to suppress the pathogenic microbiota. These devices slowly release the pharmacological agents so they can remain at the intended site of action in a therapeutic concentration for a sufficient length of time.	Not a benefit of the plan	
D4910 ▲	**Periodontal maintenance** This procedure is instituted following periodontal therapy and continues at varying intervals, determined by the clinical evaluation of the dentist, for the life of the dentition or any implant replacements. It includes removal of the bacterial plaque and calculus from supragingival and subgingival regions, site specific scaling and root planing where indicated, and polishing the teeth. If new or recurring periodontal disease appears, additional diagnostic and treatment procedures must be considered.	- D4910 is a benefit (up to 4 times) per calendar year starting three months following active periodontal treatment (D4210, D4211, D4240, D4241, D4260, D4261, D4341, and D4342) for the next 18 months, D4910 is disallowed when performed within 3 months of periodontal treatment. An extension of this benefit will be made for as long as the member remains on the same HMAA dental plan. A current periodontal chart (recorded within 6 months of the date of service) must be submitted with D4910. - Benefits for D4910 are denied when the documentation submitted does not indicate active periodontal disease.	
D4920 ▲	**Unscheduled dressing change (by someone other than treating dentist)**	- This benefit is limited to once per dentist/dental office per patient and subsequent treatment is disallowed when performed by same dentist/dental office. - Unscheduled dressing changes by the treating dentist are disallowed.	

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D4999 ▲	**Unspecified periodontal procedure, by report** Use of this procedure that is not adequately described by a code. Describe procedure.	- Please provide complete description of services/treatment to allow determination of appropriate benefit allowance. - Indicate tooth number as needed. - When submitting for laser-assisted new attachment procedure (LANAP): ▪ Maintain an appropriate Patient Consent Form on file documenting that the LANAP procedure was explained to the patient and alternatives to the LANAP procedure were also explained. Inform the patient of the cost difference if they elect LANAP. Patient will be responsible for the difference between the HMAA payment and the submitted fee for the LANAP. ▪ Submit CDT procedure code D4999 (unspecified periodontal procedure) Indicate the quadrant or tooth number. For one to three teeth, indicate the additional teeth in the narrative. ▪ Submit a copy of the patient's periodontal chart. Indicate "LANAP" in the narrative. HMAA will process the submission as an alternate benefit of a gingival flap procedure, D4240/D4241. ▪ The alternate benefit will be allowed if the pocket depth is greater than or equal to 5 mm.	Narrative

Prosthodontics (Removable)

Local anesthesia is usually considered part of Removable Prosthodontic procedures.

General Guidelines
Removable cast partials are not a benefit for patients under age 16.

The fees for prosthetic procedures includes services such as, but not limited to, tooth preparation, impressions, all models, guide planes, diagnostic wax-up, laboratory fees, occlusal adjustment within 6 months after the insertion and other associated procedures. Treatment involving specialized techniques, precious metals for removable appliances, precision attachments for partial dentures or bridges, implants and related procedures along with any associated appliances are optional and any additional fee is the patient's responsibility.

Replacement of Removable Prosthodontic appliances (complete dentures, immediate dentures or partial dentures) one per edentulous space, may be a benefit for appliances older than 5 years.

Complete or partial dentures, except in the case of immediate dentures, include any reline/rebase, adjustment or repair required within 6 months of delivery; reline/rebase is denied if performed after 6 months and prior to two years following delivery. Thereafter, reline/rebase is allowed once every two years.

In the case of immediate dentures, reline is allowed any time following the insertion and there after once every two years. The rebase allowance includes the allowance for reline and a separate charge cannot be made to the patient.

Restorations for altering occlusion, involving change in vertical dimension, replacing tooth structure lost by attrition, erosion, abrasion (wear) or for periodontal or orthodontic are not a benefit. Benefits are denied.

Restorations and associated services are not a benefit for overdentures and benefits are denied.

Precision attachments for partial dentures are not a benefit.

Multistage procedures are reported and a benefit upon completion. The completion date for removable prosthesis is the delivery date. Indicate the delivery date when submitting for payment. For patients whose dental coverage has been terminated; indicate the preparation date in a narrative.

If a new denture is placed within 24 months of a rebase, HMAA payment for the rebase will be deducted from the allowance for the new denture.

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D5110	**Complete denture – maxillary**		
D5120 ♦	**Complete denture – mandibular**		
D5130	**Immediate denture – maxillary**		
D5140 ♦	**Immediate denture – mandibular** Includes limited follow-up care only; does not include required future rebasing/relining procedure(s) or a complete new denture.		
D5211	**Maxillary partial denture – resin base (including any conventional clasps, rests and teeth)**		Tooth Chart
D5212 ♦	**Mandibular partial denture – resin base (including any conventional clasps, rests and teeth)** Includes acrylic resin base denture with resin or wrought wire clasps.		

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D5213	**Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)**		Tooth Chart
D5214 ♦	**Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)**		
D5225	**Maxillary partial denture – flexible base (including any clasps, rests and teeth)**		Tooth Chart
D5226 ♦	**Mandibular partial denture – flexible base (including any clasps, rests and teeth)**		
D5282 ♦	**Removable unilateral partial denture – one piece cast metal (including clasps and teeth), maxillar**y		Tooth Chart
D5283 ♦	**Removable unilateral partial denture – one piece cast metal (including clasps and teeth), mandibular**		Tooth Chart
D5410 **D5411** **D5421** **D5422** ♦	**Adjust complete denture – maxillary** **Adjust complete denture – mandibular** **Adjust partial denture – maxillary** **Adjust partial denture – mandibular**	Adjustments to complete or partial dentures are limited to once every 6 months (after 6 months have elapsed since initial placement).	
D5511 **D5512** **D5520** **D5611** **D5612** **D5621** **D5622** **D5630** **D5640** **D5650** **D5660** ♦	**Repair broken complete denture base, mandibular** **Repair broken complete denture base, maxillary** **Repair missing or broken teeth – complete denture (each tooth)** **Repair resin partial denture base, mandibular** **Repair cast partial framework, maxillary** **Repair or replace broken clasp** **Repair cast partial framework, mandibular** **Repair cast partial framework, maxillary** **Repair broken teeth – per tooth** **Replace broken teeth – per tooth** **Add tooth to existing partial denture** **Add clasp to existing partial denture**	- The benefit for combined repairs, rebase and reline will not exceed the allowable benefit of a removable prosthesis. - Fees for repairs of complete or partial dentures if performed within 6 months of initial placement by the same dentist/dental office are disallowed. - Benefits for this service is limited to once every 6 months.	

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D5670 **D5671** ♦	**Replace all teeth and acrylic on cast metal framework (maxillary)** **Replace all teeth and acrylic on cast metal framework (mandibular)**	- The allowance for this benefit includes reline and rebase and a separate charge cannot be made to the patient. - These procedures only apply to partials with four or more teeth. For situations involving fewer than four teeth, the per tooth repair codes (D5640/D5650) should be used. - Benefit is allowed two years following date of partial denture insertion. - Benefit is allowed once per partial denture.	Tooth Chart
D5710 **D5711** **D5720** **D5721** ♦	**Rebase complete maxillary denture** **Rebase complete mandibular denture** **Rebase maxillary partial denture** **Rebase mandibular partial denture**		
D5730 **D5731** **D5740** **D5741** ♦	**Reline complete maxillary denture (chairside)** **Reline complete mandibular denture (chairside**) **Reline maxillary partial denture (chairside)** **Reline mandibular partial denture (chairside**)	If a new denture is placed within 6 months of a chairside reline, the HMAA payment will be deducted from the allowance for the new denture.	
D5750 **D5751** **D5760** **D5761** ♦	**Reline complete maxillary denture (laboratory)** **Reline complete mandibular denture (laboratory)** **Reline maxillary partial denture (laboratory)** **Reline mandibular partial denture (laboratory)**	If a new denture is placed within 12 months of a laboratory reline, the HMAA payment will be deducted from the allowance for the new denture.	

Interim Prosthesis

A provisional prosthesis designed for use over a limited period of time, after which it is to be replaced by a more definitive restoration.

D5810 **D5811**	**Interim complete denture (maxillary)** **Interim complete denture (mandibular)**	Not a benefit of the plan	
D5820 **D5821** ♦	**Interim partial denture (maxillary)** **Interim partial denture (mandibular)** Includes any necessary clasps and rests.	- Patients are allowed one interim partial denture to replace an extracted or lost permanent anterior tooth if provided within 21 days of the extraction or when the tooth was lost. Interim partial denture is denied and chargeable to the patient if submitted for other than replacement of a recently extracted or lost tooth. - Indicate recently extracted tooth number and date of extraction. Valid Tooth #'s : 5-12 and 22-27	Narrative

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D5850 **D5851** ♦	**Tissue conditioning, maxillary** **Tissue conditioning, mandibular** Treatment reline using materials designed to heal unhealthy ridges prior to more definitive final restoration.	- A maximum of two tissue conditioning treatments per denture is allowed prior to impressions for reline, rebase or denture prostheses. The patient is responsible for the cost of additional treatments. - Tissue conditioning is a benefit if done prior to insertion, but not on the same day as insertion.	
D5860 ♦	**Overdenture – complete, by report** Describe and document procedures as performed. Other separate procedures may be required concurrent to D5860.	- Benefit is limited to the allowance of a complete denture (D5110/D5120) and processed to the limitations of a complete denture. - Restorations and associated services are not a benefit for overdentures and benefits are denied.	
D5861 ♦	**Overdenture – partial, by report** Describe and document procedures as performed. Other separate procedures may be required concurrent to D5861.	- The benefit is limited to the allowance of a partial denture (D5213/D5214) and processed to the limitations of a partial denture. - Restorations and associated services are not a benefit for overdentures and benefits are denied.	
D5862	**Precision attachment, by report** Each set of male and female componets should be reported as one precision attachment.	Not a benefit of the plan	
D5867	**Replacement of replaceable part of semi-precision or precision attachment (male or female component)**	Not a benefit of the plan	
D5875	**Modification of removable prosthesis following implant surgery** The modification of existing removable prosthesis is sometimes necessary at the time of implant placement and bone graft surgery and is always necessary at the time of the placement of the healing caps. This code could also be used to report the modification of an existing prosthesis when the abutments are placed and retentive elements are placed into the removable prosthesis, thereby reducing the need for a new prosthesis.	Not a benefit of the plan	
D5876	**Add metal substructure to acrylic full denture (per arch)**	Not a benefit of the plan	

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D5899 ♦	**Unspecified removable prosthodontic procedure, by report** Use for a procedure that is not adequately described by a code. Describe procedure.	- Documentation may include materials used, tooth number, arch, quadrant, or area of the mouth, chair time, X-rays or any other supporting information. - Restorations and associated services are not a benefit for overdentures and benefits are denied. - Upon review of documentation, the appropriate benefit allowance will be applied.	Narrative
D5911	**Facial moulage (sectional)** A sectional facial moulage impression is a procedure used to record the soft tissue contours of a portion of the face. Occasionally several separate sectional impressions are made, and then reassembled to provide a full facial contour cast. The impression is utilized to create a partial facial moulage and generally is not reusable.	Not a benefit of the plan	
D5912	**Facial moulage (complete)** Synonymous terminology: facial impression, face mask impression. A complete facial moulage impression is a procedure used to record the soft tissue contours of the whole face. The impression is utilized to create a facial moulage and generally not reusable.	Not a benefit of the plan	
D5913	**Nasal prosthesis** Synonymous terminology: artificial nose A removable prosthesis attached to the skin, which artificially restores part or all of the nose. Fabrication of a nasal prosthesis requires creation of an original mold. Additional prostheses usually can be made from the same mold, and assuming no further tissue changes occur, the same mold can be utilized for extended periods of time. When a new prosthesis is made from the existing mold, this procedure is termed a nasal prosthesis replacement.	Not a benefit of the plan	
D5914	**Auricular prosthesis** Synonymous terminology: artificial ear, ear prosthesis. A removable prosthesis, which artificially restore part of all of the natural ear. Usually, replacement prosthesis can be made from the original mold if tissue bed changes have not occurred. Creation of an auricular prosthesis requires fabrication of a mold, from which additional prostheses usually can be made, as needed later (auricular prosthesis, replacement).	Not a benefit of the plan	

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D5915	**Orbital prosthesis** A prosthesis, which artificially restores the eye, eyelids, and adjacent hard and soft tissue, lost as a result of trauma or surgery. Fabrication of an orbital prosthesis requires creation of an original mold. Additional prostheses usually can be made from the same mold, and assuming no further tissue changes occur, the same mold can be utilized for extended periods of time. When a new prosthesis is made from the existing mold, this procedure is termed an orbital prosthesis replacement.	Not a benefit of the plan	
D5916	**Ocular prosthesis** Synonymous terminology: artificial eye, glass eye A prosthesis, which artificially replaces an eye missing as a result of trauma, surgery or congenital absence. The prosthesis does not replace missing eyelids or adjacent skin, mucosa or muscle. Ocular prosthesis require semiannual or annual cleaning and polishing. Also, occasional revisions to re-adapt the prosthesis to the tissue bed may be necessary. Glass eyes are rarely made and cannot be re-adapted.	Not a benefit of the plan	
D5919	**Facial prosthesis** Synonymous terminology: prosthetic dressing A removable prosthesis, which artificially replaces a portion of the face, lost due to surgery, trauma or congenital absence. Flexion of natural tissues may preclude adaption and movement of the prosthesis to match the adjacent skin. Salivary leakage, when communicating with the oral cavity, adversely affects retention.	Not a benefit of the plan	
D5922	**Nasal septal prosthesis** Synonymous terminology: Septal plug, septal button. Removable prosthesis to occlude (obdurate) a hole within the nasal septal wall. Adverse chemical degradation in this moist environment may require frequent replacement. Silicone prostheses are occasionally subject to fungal invasion.	Not a benefit of the plan	

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D5923	**Ocular prosthesis, interim** Synonymous terminology: Eye shell, shell, ocular conformer, conformer. A temporary replacement generally made of clear acrylic resin for an eye lost due to surgery or trauma. No attempt is made to re-establish esthetics. Fabrication of an interim ocular prosthesis generally implies subsequent fabrication of an aesthetic ocular prosthesis.	Not a benefit of the plan	
D5924	**Cranial prosthesis** Synonymous terminology: Skull plate, cranioplasty prosthesis, cranial implant. A biocompatible, permanently implanted replacement of a portion of the skull bones; an artificial replacement for a portion of the skull bone.	Not a benefit of the plan	
D5925	**Facial augmentation implant prosthesis** Synonymous terminology: facial implant. An implantable biocompatible material generally onlayed upon an existing bony area beneath the skin tissue to fill in or collectively raise portions of the overlaying facial skin tissues to create acceptable contours.	Not a benefit of the plan	
D5926	**Nasal prosthesis, replacement** Synonymous terminology: replacement nose. An artificial nose produced from a previously made mold. A replacement prosthesis does not require fabrication of a new mold. Generally, several prostheses can be made from the same mold assuming no changes occur in the tissue bed due to surgery or age related topographical variations.	Not a benefit of the plan	
D5927	**Auricular prosthesis, replacement** Synonymous terminology: replacement ear. An artificial ear produced from a previously made mold. A replacement prosthesis does not require fabrication of a new mold. Generally, several prostheses can be made from the same mold assuming no changes occur in the tissue bed due to surgery or age related topographical variations.	Not a benefit of the plan	

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D5928	**Orbital prosthesis, replacement** A replacement for a previously made orbital prosthesis. A replacement prosthesis does not require fabrication of a new mold. Generally, several prostheses can be made from the same mold assuming no changes occur in the tissue bed due to surgery or age related topographical variations.	Not a benefit of the plan	
D5929	**Facial prosthesis, replacement** A replacement facial prosthesis made from original mold. A replacement prosthesis does not require fabrication of a new mold. Generally, several prostheses can be made from the same mold assuming no changes occur in the tissue bed due to surgery or age related topographical variations.	Not a benefit of the plan	
D5931	**Obturator prosthesis, surgical** Synonymous terminology: Obturator, surgical stayplate, immediate temporary obturator. A temporary prosthesis inserted during or immediately following surgical or traumatic loss of a portion or all of one or both maxillary bones and contiguous alveolar structures (e.g., gingival tissue, teeth). Frequent revisions of surgical obturators are necessary during the ensuing healing phase (approximately six months). Some dentist prefer to replace many or all teeth removed by the surgical procedure in the surgical obturator while other do not replace any teeth. Further surgical revisions may require fabrication of another surgical obturator (e.g., an initially planned small defect may be revised and greatly enlarged after the final pathology report indicates margins are not fee of tumor).	Not a benefit of the plan	
D5932	**Obturator prosthesis, definitive** Synonymous terminology: obturator. A prosthesis, which artificially replaces part or all of the maxilla and associated teeth, lost due to surgery, trauma or congenital defects. A definitive obturator is made when it is deemed that further tissue changes or recurrence of tumor are unlikely and a more permanent prosthetic rehabilitation can be achieved; it is intended for long-term use.	Not a benefit of the plan	

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D5933	**Obturator prosthesis, modification** Synonymous terminology: adjustment, denture adjustment, temporary or office reline. Revision or alteration of an existing obturator (surgical, interim, or definitive); possible modifications include relief of the denture base due to tissue compression, augmentation of the seal or peripheral areas to effect adequate sealing or separation between the nasal and oral cavities.	Not a benefit of the plan	
D5934	**Mandibular resection prosthesis with guide flange** Synonymous terminology: resection device, resection appliance. A prosthesis which guides the remaining portion of the mandible, left after a partial resection, into a more normal relationship with the maxilla. This allows for some tooth-to-tooth or an improved tooth contact. It may also artificially replace missing teeth and thereby increase masticatory efficiency.	Not a benefit of the plan	
D5935	**Mandibular resection prostheis without guide flange** A prosthesis which helps guide the partially resected mandible to more normal relation with the maxilla allowing for increased tooth contract. It does not have a flange or ramp, however, to assist in directional closure. It may replace missing teeth and thereby increase masticatory efficiency. Dentists who treat mandibulectomy patients may refer to replace some, all or none of the teeth in the defect area. Frequently, the defect's margins preclude even partial replacement. Use of a guide (a mandibular resection prosthesis with a guide flange) may not be possible due to anatomical limitation or poor patient tolerance. Ramps, extended occulsal arrangements and irregular occlusal positioning relative to the denture foundation frequently preclude stability of the prostheses, and thus some prostheses are poorly tolerated under such adverse circumstances.	Not a benefit of the plan	

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D5936	**Obturator prosthesis, interim** Synonymous terminology: immediate post-operative obturator. A prosthesis which is made following completion of the initial healing after a surgical resection of a portion or all of one or both the maxillae; frequently many or all teeth in the defect area are replaced by this prosthesis. This prosthesis replaces the surgical obturator, which is usually inserted at, or immediately following the resection. Generally, in interim obturator is made to facilitate closure of the resultant defect after initial healing has been completed. Unlike the surgical obturator, which usually is made prior to surgery and frequently revised in the operating room during surgery, the interim obturator is made when the defect margins are clearly defined and further surgical revisions are not planned. It is a provisional prosthesis, which may replace some or all lost teeth, and other lost bone and soft tissue structures. Also, it frequently must be revised (termed an obturator prosthesis modification) during subsequent dental procedures (e.g., restorations, gingival surgery) as well as to compensate for further tissue shrinkage before a definitive obturator prosthesis is made.	Not a benefit of the plan	
D5937	**Trismus appliance (not for TMD treatment)** Synonymous terminology: occlusal device for mandibular trismus, dynamic bite opener. A prosthesis, which assists the patient in increasing their oral aperture width in order to eat as well as maintain oral hygiene. Several version and designs are possible, all intending to ease the sever lack of oral opening experienced by many patient immediately following extensive intraoral surgical procedure.	Not a benefit of the plan	
D5951	**Feeding aid** Synonymous terminology: feeding prosthesis. A prosthesis, which maintains the right and left maxillary segments of the infant cleft palate patient in their proper orientation until surgery is performed to repair the cleft. It closes the oral-nasal cavity defect, thus enhancing sucking and swallowing. Used on an interim basis, this prosthesis achieves separation of the oral and nasal cavities in infants born with wide clefts necessitating delay closure. It is eliminated if surgical closure can be effected or, alternatively, with eruption of the deciduous dentition a pediatric speech aid may be made to facilitate closure of the defect.	Not a benefit of the plan	

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D5952	**Speech aid prosthesis, pediatric** Synonymous terminology: nasopharyngeal obturator, speech appliance, obturator, cleft palate appliance, prosthetic speech aid, speech bulb. A temporary or interim prosthesis used to close a defect in the hard and/or soft palate. It may replace tissue lost due to developmental or surgical alterations. It is necessary for the production of intelligible speech. Normal lateral growth of the palatal bones necessitates occasional replacement of this prosthesis. Intermittent revisions of the obturator section can assist in maintenance of the palatalpharyngeal closure (termed a speech aid prosthesis modification). Frequently, such prostheses are not fabricated before the deciduous dentition is fully erupted since clasp retention is often essential.	Not a benefit of the plan	
D5953	**Speech aid prosthesis, adult** Synonymous terminology: prosthetic speech appliance, speech aid, speech bulb. A definitive prosthesis, which can improve speech in adult cleft palate patients either by obturating (sealing off) a palatal cleft or fistula, or occasionally by assisting an incompetent soft palate. Both mechanisms are necessary to achieve velopharyngeal competency. Generally, this prosthesis is fabricated when no further growth is anticipated and the objective is to achieve long-term use. Hence, more precise materials and techniques are utilized. Occasionally such procedures are accomplished in conjunction with precision attachments in crown work undertaken on some or all maxillary teeth to achieve improved aesthetics.	Not a benefit of the plan	
D5954	**Palatal augmentation prosthesis** Synonymous terminology: superimposed prosthesis, maxillary glossectomy prosthesis, maxillary speech prosthesis, palatal drop prosthesis. A removable prosthesis which alters the hard and/or soft tissue palate's topographical form adjacent to the tongue.	Not a benefit of the plan	
D5955	**Palatal lift prosthesis, definitive** A prosthesis which elevates the soft palate superiorly and aids in restoration of soft palate functions which may be lost due to an acquired, congenital or developmental defect. A definitive palatal lift is usually made for patients whose experience with an interim palatal lift has been successful, especially if surgical alterations are deemed unwarranted.	Not a benefit of the plan	

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D5958	**Palatal lift prosthesis, interim** Synonymous terminology: diagnostic palatal lift A prosthesis which elevates and assists in restoring soft palate function which may be lost due to clefting, surgery, trauma or unknown paralysis. It is intended for interim use to determine its usefulness in achieving palatapharyngeal competency or enhance swallowing reflexes. This prosthesis is intended for interim use as diagnostic aid to asses the level of possible improvement in speech intelligibility. Some clinicians believe use of a palatal lift on an interim basis may stimulate an otherwise flaccid soft palate to increase functional activity, subsequently lessening its need.	Not a benefit of the plan	
D5959	**Palatal lift prosthesis, modification** Synonymous terminology: revision of lift, adjustment. Alterations in the adaptation, contour, form or function of an existing palatal lift necessitated due to tissue impingement, lack of function, poor clasp adaptation or the like.	Not a benefit of the plan	
D5960	**Speech aid prosthesis, modification** Synonymous terminology: adjustment, repair, revision. Any revision of a pediatric or adult speech aid not necessitating its replacement. Frequently, revisions of the obturating sections of any speech aid are required to facilitate enhanced speech intelligibility. Such revisions or repairs do not require complete remaking of the prosthesis, thus extending its longevity.	Not a benefit of the plan	
D5982	**Surgical stent** Synonymous terminology: periodontal stent, skin graft stent, columellar stent. Stents are utilized to apply pressure to soft tissue to facilitate healing and prevent cicatrization of collapse. A surgical stent maybe required in surgical and post-surgical revisions to achieve close approximation of tissues. Usually such materials as temporary or interim soft denture liners, gutta percha, or dental modeling impression compound may be used.	Not a benefit of the plan	

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D5983	**Radiation carrier** Synonymous terminology: radiotherapy prosthesis, carrier prosthesis, radiation applicator, radium carrier, intracavity carrier, intracavity applicator. A device used to administer radiation to confined areas by means of capsules, beads or needles of radiation emitting materials such as radium or cesium. Its function is to hold the radiation source securely in the same location during the entire period of treatment. Radiation oncologist occasionally request these devices to achieve close approximation and controlled application of the radiation to a tumor deemed amiable to eradication.	Not a benefit of the plan	
D5984	**Radiation shield** Synonymous terminology: radiation stent, tongue protector, lead shield. An intraoral prosthesis designed to shield adjacent tissues from radiation during orthovoltage treatment of malignant lesions of the head and neck region.	Not a benefit of the plan	
D5985	**Radiation cone locator** Synonymous terminology: docking device, cone locator. A prosthesis utilized to direct and reduplicate the path of radiation to an oral tumor during a split course of irradiation.	Not a benefit of the plan	
D5986	**Fluoride gel carrier** Synonymous terminology: fluoride applicator A prosthesis, which covers the teeth in either dental arch and is used to apply topical fluoride in close proximity to tooth enamel and dentin for several minutes daily.	Not a benefit of the plan	
D5987	**Commissure splint** Synonymous terminology: lip splint A device placed between the lips, which assists in achieving increase opening between the lips. Use of such devices enhances opening where surgical, chemical or electrical alterations of the lips has resulted in severe restriction or contractures.	Not a benefit of the plan	

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D5988	**Surgical splint** Synonymous terminology: Gunning splint, modified Gunning splint, labiolingual splint, fenestrated splint, Kingsley splint, cast metal splint Splints are designed to utilize existing teeth and/or alveolar processes as points of anchorage to assist in stabilization and immobilization of broken bones during healing. They are used to re-establish, as much as possible, normal occlusal relationships during the process of immobilization. Frequently, existing prostheses (e.g., a patient's complete dentures) can be modified to serve as surgical splints. Frequently, surgical splint have arch bars added to facilitate intermaxillary fixation. Rubber elastics may be used to assist in this process. Circummandubular eyelet hooks can be utilized for enhanced stabilization with wiring to adjacent bone.	Not a benefit of the plan	
D5991	**Topical medicament carrier** A custom fabricated carrier that covers the teeth and alveolar mucosa, or alveolar mucosa alone, and is used to deliver topical corticosteroids and similar effective medicaments for maximum sustained contact with the alveolar ridge and/or attached gingival tissues for the control and management of immunologically medicated vesiculobullous mucosal, chronic recurrent ulcerative, and other desquamative diseases of the gingival and oral mucosa.	Not a benefit of the plan	
D5999	**Unspecified maxillofacial prosthesis, by report** Used for a procedure that is not adequately described by a code. Describe procedure.	- Documentation should include materials used, tooth number, arch, quadrant, or area of the mouth, chair time, X-rays or any other supporting information. - Upon review of documentation, the appropriate benefit allowance will be applied.	Narrative

Implant Services

Local anesthesia is usually considered to be part of Implant Services procedures. Report surgical implant procedure using codes in this section.

Report surgical implant procedure using codes in this section; prosthetic devices should be reported using existing fixed or removable prosthetic codes.

General Guidelines
Implant bodies are not covered by all HMAA benefit plans. Please refer to current group benefit information for specific coverage. The following guidelines apply only to those group plans with the implant rider:

Implants are limited to endosteal implants submitted as ADA procedure code D6010.

An implant is allowed as an alternate benefit only if replacing a missing permanent tooth between two natural teeth.

The implant will not be payable for use as an abutment for a bridge or removable prosthesis.

Implant maintenance procedures, including but not limited to; removal of prosthesis, cleaning of prosthesis and abutments, reinsertion of prosthesis, repair implant supported prosthesis, repair implant abutment and implant removal are denied.

Implants are denied for patients under age 16.

Implant procedures will be paid as an alternate benefit equivalent to the payment for two retainers of a 3-unit fixed partial denture. Therefore, the adjacent teeth are subject to treatment limitations for existing inlays, onlays, crowns, veneers and fixed and removable prosthodontics. Appropriate processing policies will be applied. As an example, for plans that have a 5-year limitation on crowns: a crown placed on a tooth adjacent to an implant is not a benefit for 5 years following implant placement.

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D6010 ♦	**Surgical placement of implant body; endosteal implant** Includes second stage surgery and placement of healing cap.	Valid Tooth #'s: 2-15, 18-31	X-ray
D6012	**Surgical placement of interim implant body for transitional prosthesis: endosteal implant** Includes removal during later therapy to accommodate the definitive restoration, which may include placement of other implants.	Not a benefit of the plan	
D6040	**Surgical placement: eposteal implant** An eposteal (subperiosteal) framework of a biocompatible material designed and fabricated to fit on the surface of the bone of the mandible or maxilla with permucosal extensions which provide support and attachment of a peosthesis. This may be a complete arch or unilateral appliance. Eposteal implants rest upon the bone and under the periosteum.	Not a benefit of the plan	

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D6050	**Surgical placement: transosteal implant** A transosteal (transossesous) biocompatible device with threaded posts penetrating both the superior and inferior cortical bone plates of the mandibular symphysis and exiting through the permucosa provider support and attachment for a dental prosthesis. Transosteal implants are placed completely through the bone and into the oral cavity from extraoral or intraoral.	Not a benefit of the plan	
D6100	**Implant removal, by report** This procedure involves the surgical removal of an implant.	Not a benefit of the plan	

Implant/Abutment Supported Prosthetics

Porcelain/ceramic crowns include all ceramic, porcelain, polymer-reinforced porcelain and porcelain fused to metal crowns. Resin crowns and resin metal crown include all reinforced heat and/or pressure-cured resin materials.

General Guidelines
Anterior Teeth: Replacing 1 to 4 missing teeth with an implant supported prosthesis will be payable as the alternate benefit up to 4 pontics in the anterior segment, only when there are teeth present anterior and posterior to the implants.

Posterior Teeth: Replacing 1 to 3 missing teeth with an implant supported prosthesis will be paid as the alternate benefit up to 3 pontics in the posterior segment, only when there are teeth present anterior and posterior to the implants.

The X-ray should be post-operative and show the implant body. When submitting for preauthorization, attach the most current X-ray for tentative approval. The post-operative X-ray is required for payment on preauthorization.

When a distal extension edentulous space is involved, the appropriate alternate benefit will be applied as follows: If the implant crown is for one tooth, and it is adjacent to a natural tooth, the alternate benefit of one pontic will be applied. This benefit is allowed twice per arch (once on the left side and once on the right side) within a 5-year period. If adjacent implant crowns are for more than one tooth, the alternate benefit of a removable partial denture will be applied. This benefit is allowed once per arch per 5-year period on the left or right side. If an implant crown is placed on the opposite side within the time limitation, the combined benefit (of the implant crowns on both sides) will not exceed the benefit of two pontics.

A bridge between an implant tooth and a natural tooth is denied.

D6053 ♦	**Implant/abutment supported removable denture for completely edentulous arch**	Upon review, the alternate benefit of D5110/D5120 will be applied.	Post-op X-ray
D6054 ♦	**Implant/abutment supported removable denture for partially edentulous arch**	Upon review, the alternate benefit of D5213/D5214 will be applied.	Post-op X-ray

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D6055	**Dental implant supported connecting bar** A device attached to transmucosal abutments to stabilize and anchor a removable overdenture prosthesis.	Not a benefit of the plan	
D6056	**Prefabricated abutment – includes placement** A connection to an implant that is a manufactured component usually made of machine high noble metal, titanium, titanium alloy or ceramic. Modification of a prefabricated abutment may be necessary, and is accomplished by altering its shape using dental burrs/diamonds.	Not a benefit of the plan	
D6057	**Custom abutment – includes placement** A connection to an implant that is a fabricated component, usually by a laboratory, specific for an individual application. A custom abutment is typically fabricated using a casting process and usually is made of noble or high noble metal. A 'UCLA abutment' is an example of this type abutment.	Not a benefit of the plan	
D6058 ♦	**Abutment supported porcelain/ceramic crown** A single crown restoration that is retained, supported and stabilized by an abutment on an implant; may be screw retained or cemented.	Upon review, the alternate benefit of D6210/D6240 will be applied.	Post-op X-ray
D6059 ♦	**Abutment supported porcelain fused to metal crown (high noble metal)** A single metal-ceramic crown restoration that is retained, supported and stabilized by an abutment on an implant; may be screw retained or cemented.	Upon review, the alternate benefit D6210/D6240 will be applied.	Post-op X-ray
D6060 ♦	**Abutment supported porcelain fused to metal crown (predominantly base metal)** A single metal-ceramic crown restoration that is retained, supported and stabilized by an abutment on an implant; may be screw retained or cemented.	Upon review, the alternate benefit D6211/D6241 will be applied.	Post-op X-ray

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D6061 ♦	**Abutment supported porcelain fused to metal crown (noble metal)** A single metal-ceramic crown restoration that is retained, supported and stabilized by an abutment on an implant; may be screw retained or cemented.	Upon review, the alternate benefit D6212/D6242 will be applied.	Post-op X-ray
D6062 ♦	**Abutment supported cast metal crown (high noble metal)** A single cast metal crown restoration that is retained, supported and stabilized by an abutment on an implant; may be screw retained or cemented.	Upon review, the alternate benefit D6210 will be applied.	Post-op X-ray
D6063 ♦	**Abutment supported cast metal crown (predominantly base metal)** A single cast metal crown restoration that is retained, supported and stabilized by an abutment on an implant; may be screw retained or cemented**.**	Upon review, the alternate benefit D6211 will be applied	Post-Op X-ray
D6064 ♦	**Abutment supported cast metal crown (noble metal)** A single cast metal crown restoration that is retained, supported and stabilized by an abutment on an implant; may be screw retained or cemented.	Upon review, the alternate benefit D6212 will be applied.	Post-Op X-ray
D6065 ♦	**Implant supported porcelain/ceramic crown** A single crown restoration that is retained, supported and stabilized by an implant; may be screw retained or cemented.	Upon review, the alternate benefit of D6210, D6240 may be applied.	Post-Op X-ray
D6066 ♦	**Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)** A single metal-ceramic crown restoration that is retained, supported and stabilized by an implant; may be screw retained or cemented.	Upon review, the alternate benefit D6210/D6240 will be applied.	Post-Op X-ray

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D6067 ♦	**Implant supported metal crown (titanium, titanium alloy, high noble metal)** A single cast or milled metal crown restoration that is retained, supported and stabilized on an implant; may be screw retained or cemented.	Upon review, the alternate benefit D6210 will be applied.	Post-Op X-ray
D6068 ♦	**Abutment supported retainer for porcelain/ceramic FPD** A ceramic retainer for a fixed partial denture that gains retention, support and stability from an abutment on an implant; may be screw retained or cemented.	Upon review, the alternate benefit D6210/D6240 will be applied.	Post-Op X-ray
D6069 ♦	**Abutment supported retainer for porcelain fused to metal FPD (high noble metal)** A metal-ceramic retainer for a fixed partial denture that gains retention, support and stability from an abutment on an implant; may screw retained or cemented.	Upon review, the alternate benefit D6210/D6240 will be applied.	Post-Op X-ray
D6070 ♦	**Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)** A metal-ceramic retainer for a fixed partial denture that gains retention, support and stability from an abutment on an implant; may be screw retained or cemented.	Upon review, the alternate benefit of D6211/D6241 will be applied.	Post-Op X-ray
D6071 ♦	**Abutment supported retainer for porcelain fused to metal FPD (noble metal)** A metal-ceramic retainer for a fixed partial denture that gains retention, support and stability from an abutment on an implant; may be screw retained or cemented.	Upon review, the alternate benefit of D6212/D6242 will be applied.	Post-Op X-ray
D6072 ♦	**Abutment supported retainer for cast metal FPD (high noble metal)** A cast metal retainer for a fixed partial denture that gains retention, support and stability from an abutment on an implant; may be screw retained or cemented.	Upon review, the alternate benefit of D6210 will be applied.	Post-Op X-ray

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D6073 ♦	**Abutment supported retainer for cast metal FPD (predominantly base metal)** A cast metal retainer for a fixed partial denture that gains retention, support and stability from an abutment on an implant; may be screw retained or cemented.	Upon review, the alternate benefit of D6211 will be applied.	Post-Op X-ray
D6074 ♦	**Abutment supported retainer for cast metal FPD (noble metal)** A cast metal retainer for a fixed partial denture that gains retention, support and stability from an abutment on an implant; may be screw retained or cemented.	Upon review, the alternate benefit of D6212 will be applied.	Post-Op X-ray
D6075 ♦	**Implant supported retainer for ceramic FPD** A ceramic retainer for a fixed partial denture that gains retention, support and stability from an implant; may be screw retained or cemented.	Upon review, the alternate benefit of D6240 will be applied.	Post-Op X-ray
D6076 ♦	**Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)** A metal-ceramic retainer for a fixed partial denture that gains retention, support and stability from an implant; may be screw retained or cemented.	Upon review, the alternate benefit of D6210/D6240 will be applied.	Post-Op X-ray
D6077 ♦	**Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)** A cast metal retainer for a fixed partial denture that gains retention, support and stability from an implant; may be screw retained or cemented.	Upon review, the alternate benefit of D6210 will be applied.	Post-Op X-ray
D6078 ♦	**Implant/abutment supported fixed denture for completely edentulous arch** A prosthesis that is retained, supported and stabilized by implants or abutments placed on implants but does not have specific relationships between implant positions and replacement teeth; may be screw retained or cemented; commonly referred to as a "hybrid prosthesis."	Upon review, the alternate benefit of D5110/D5120 will be applied.	Post-Op X-ray

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D6079 ♦	**Implant/abutment supported fixed denture for partially edentulous arch** A prosthesis that is retained, supported and stabilized by implants or abutments placed on implants but does not have specific relationship between implant positions and replacement teeth; may be screw retained or cemented; commonly referred to as a "hybrid prosthesis" will be applied.	Upon review, the alternate benefit of D5213/D5214 will be applied.	Post-Op X-ray
D6080	**Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis** This procedure includes a prophylaxis to provide active debriding of the implant and examination of all aspects of the implant system, including the occlusion and stability of the superstructure. The patient is also instructed in thorough daily cleansing of the implant.	Not a benefit of the plan	
D6090	**Repair implant support prosthesis, by report** This procedure involves the repair or replacement of any part of the implant supported prosthesis.	Not a benefit of the plan	
D6091	**Replacement of semi-precision or precision attachment (male or female component) of the implant/abutment supported prosthesis per attachment** This procedure applies to the replaceable male or female component of the attachment.	Not a benefit of the plan	
D6092 **D6093** ♦	**Recement implant/abutment supported crown** **Recement implant/abutment supported fixed partial denture**	- Benefit for recementation within 6 months of the initial placement is disallowed if performed by the same dentist or dental office. - Recementation by a different dentist (within 6 months of initial placement) is a benefit once. - Benefits are allowed for one recementation after 6 months have elapsed since initial placement. - Subsequent requests for recementation are allowed every 12 months thereafter.	

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D6094 ♦	**Abutment supported crown - titanium**	Upon review, the alternate benefit of D6210 will be applied.	Post-Op X-ray
D6095	**Repair implant abutment, by report** This procedure involves the repair or replacement of any part of the implant abutment.	Not a benefit of the plan	
D6096	**Remove broken implant retaining screw**	Not a benefit of the plan	
D6118	**Implant/abutment supported interim fixed denture for edentulous arch – mandibular** Used when a period of healing is necessary prior to fabrication and placement of a permanent prosthetic		Tooth Chart
D6119	**Implant/abutment supported interim fixed denture for edentulous arch – maxillary** Used when a period of healing is necessary prior to fabrication and placement of a permanent prosthetic		Tooth Chart
D6190 ♦	**Radiographic/surgical implant index, by report** An appliance, designed to relate to osteotomy of fixture position to existing anatomic structures, to be utilized during radiographic exposure for treatment planning and or during osteotomy creation for fixture installation.		Pre-op x ray Op report
D6194 ♦	**Abutment supported retainer crown for FPD – titanium**	Upon review, the alternate benefit of D6790 will be applied.	Post-op X-ray
D6199 ♦	**Unspecified implant procedure, by report** Use for procedure that is not adequately described by a code. Describe procedure.		Narrative

Prosthodontics, Fixed

Each retainer and each pontic constitutes a unit in a fixed partial denture. Local anesthesia is usually considered to be part of Fixed Prosthodontic procedures. The words “bridge” and “bridgework” are synonymous with the term “fixed partial denture.

Classification of Metals – The noble metal classification system has been adopted as a more precise method of reporting various alloys used in dentistry. The alloys are defined on the basis of the percentage of noble metal content: high noble – Gold (Au), Palladium (Pd), and/or Platinum (Pt) > 60%(with at least 40% Au), noble – Gold (Au), Palladium (Pd), and/or Platinum (Pt) > 25%; predominantly base – Gold (Au), Palladium (Pd), and/or Platinum (Pt) < 25%.

General Guidelines

Separate charges are not allowed for crown/fixed partial denture removal, tooth preparation, models, electro surgery, temporary restorations, cement bases, impressions, laboratory fees, laser technology, local anesthesia, occlusal adjustments within six months after the insertion, and other associated procedures as these services are components of a complete procedure for which a single charge is made. If submitted as a separate charge(s) the fees for these procedures will be disallowed.

If porcelain/resin to metal bridgework is placed posterior to the 2nd bicuspid, it will be processed as the alternate benefit of the metallic equivalent.

Fixed bridges and removable cast partials are not benefits for patients under age 16.

If any unit or tooth within a new bridge has had a restoration still subject to the time limitations, that unit of the bridge will be denied and the patient is responsible for the cost.

Cantilever bridges are limited to the allowed fee of one pontic.

When a retainer or bridge is planned for replacement and the x-rays and other submitted attachments do not indicate decay, fracture and/or the tooth being otherwise compromised, the provider is requested to provide a narrative to state the reason(s) for replacement.

The following are optional procedures and require the agreement of the patient to assume cost:
▪ Treatment involving specialized techniques
▪ Precision attachments for dentures, bridges or implants (related procedures along with any associated appliances)

A posterior fixed bridge and removable partial denture are not a benefit in the same arch in the same treatment plan. An anterior fixed bridge with not more than 4 pontics is allowed in the same arch with a posterior removable partial denture.

Anterior bridges spanning more than 4 pontics or posterior bridges spanning more than 3 pontics will be processed as the alternate benefit of a removable partial denture and held to the benefit of a partial denture.

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

The following conditions are not covered benefits and if performed, patients must be informed that they are responsible for cost:
▪ Additional abutments needed because of abnormal conditions.
▪ Additional pontics needed to restore a space beyond the normal complement of natural teeth.

Porcelain/ceramic/resin retainers and pontics will be processed as the conventional fixed prosthetics with the patient responsible for the difference to the submitted amount.

Please indicate the insertion date of the appliance when submitting for payment. For patients whose coverage has terminated, also indicate the date of preparation.

Replacement of prosthodontic appliances (complete dentures, partial dentures or bridges) may be payable for prosthodontic appliances older than 5-years.

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D6205 ♦	**Pontic – indirect resin based composite**	Upon review the alternate benefit of D6251 or D6211 will be applied.	X-ray
D6210	**Pontic – cast high noble metal**		X-ray
D6211	**Pontic – cast predominantly base metal**		
D6212	**Pontic – cast noble metal**		
D6214 ♦	**Pontic – titanium**		
D6240	**Pontic – porcelain fused to high noble metal**	Payable for tooth #'s: 4-13, 20-29	X-ray
D6241	**Pontic – porcelain fused to predominantly base metal**	Tooth #'s 1-3, 14-19, 30-32 will be processed as alternate benefit with metallic equivalent.	
D6242 ♦	**Pontic – porcelain fused to noble metal**		
D6245	**Pontic – porcelain/ceramic**	Upon review the alternate benefit of D6240 will be applied.	X-ray
D6250	**Pontic – resin with high base metal**	Payable for tooth #'s: 4-13, 20-29	
D6251	**Pontic – resin with predominantly base metal**	Tooth #'s 1-3, 14-19, 30-32 will be processed as alternate benefit with metallic equivalent.	
D6252 ♦	**Pontic – resin with noble metal**		
D6253 ♦	**Provisional pontic** Pontic utilized as an interim of at least six months duration during restorative treatment to allow adequate time for healing or completion of other procedures. This is not to be used as a temporary retainer crown for routine prosthetic fixed partial dentures.	- Covered as a benefit only in the event of an injury. - Narrative must detail the scope of the injury. - If used as a temporary pontic for routine prosthetic fixed partial denture, benefit will be disallowed.	X-ray Narrative
D6545	**Retainer – cast metal for resin bonded fixed prosthesis**	- Limited to two retainers, one on each side of space. - Upon review the alternate benefit of a D6545 will be applied. - Generally used for Maryland Bridge retainer.	X-ray
D6548 ♦	**Retainer – porcelain/ceramic for resin bonded fixed prosthesis**		
D6600	**Inlay – porcelain/ceramic, two surfaces**	Upon review, the alternate benefit of D6602 (2 surface) or D6603 (3 surface) will be applied.	X-ray
D6601 ♦	**Inlay – porcelain/ceramic, three or more surfaces**		

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D6602	**Inlay – cast high noble metal, two surfaces**		X-ray
D6603	**Inlay – cast high noble metal, three or more surfaces**		
D6604	**Inlay – cast predominantly base metal, two surfaces**		
D6605	**Inlay – cast predominantly base metal, three or more surfaces**		
D6606	**Inlay – cast noble metal, two surfaces**		
D6607 ♦	**Inlay – cast noble metal, three or more surfaces**		
D6608 ♦	**Onlay – porcelain/ceramic, two surfaces**	Upon review, the alternate benefit of D6610 will be applied.	X-ray
D6609 ♦	**Onlay – porcelain/ceramic, three or more surfaces**	Upon review, the alternate benefit of D6611 will be applied.	X-ray
D6610	**Onlay – cast high noble metal, two surfaces**		X-ray
D6611	**Onlay – cast high noble metal, three or more surfaces**		
D6612	**Onlay – cast predominantly base metal, two surfaces**		
D6613	**Onlay – cast predominantly base metal, three or more surfaces**		
D6614	**Onlay – cast noble metal, two surfaces**		
D6615 ♦	**Onlay – cast noble metal, three or more surfaces**		
D6624 ♦	**Inlay – titanium**	Upon review of the X-ray, the alternate benefit of a posterior amalgam or anterior composite restoration will be applied.	X-ray
D6634 ♦	**Onlay – titanium**	Upon review, the alternate benefit of D6610/D6611 will be applied.	X-ray

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D6710 ♦	**Crown – indirect resin based composite**	Upon review, the alternate benefit of D6721/D6791 will be applied. Payable for tooth #'s: 4-13, 20-29 Tooth #'s 1-3, 14-19, 30-32 will be processed as alternate benefit with metallic equivalent.	X-ray
D6720 **D6721** **D6722** ♦	**Crown – resin with high noble metal** **Crown – resin with predominantly base metal** **Crown – resin with noble metal**	Payable for tooth #'s: 4-13, 20-29 Tooth #'s 1-3, 14-19, 30-32 will be processed as alternate benefit with metallic equivalent.	X-ray
D6740 **D6750** **D6751** **D6752** ♦	**Crown – porcelain/ceramic** **Crown – porcelain fused to high noble metal** **Crown – porcelain fused to predominantly base metal** **Crown – porcelain fused to noble metal**	Upon review, the alternate benefit of D6750 will be applied. Payable for tooth #'s: 4-13, 20-29 Tooth #'s 1-3, 14-19, 30-32 will be processed as alternate benefit with metallic equivalent.	X-ray
D6780 **D6781** **D6782** ♦	**Crown – 3/4 cast high noble metal** **Crown – 3/4 cast predominantly base metal** **Crown – 3/4 cast noble metal**		X-ray
D6783 ♦	**Crown – 3/4 porcelain/ceramic**	Upon review, the alternate benefit of D6780 will be applied. Payable for tooth #'s: 4-13, 20-29 Tooth #'s 1-3, 14-19, 30-32 will be processed as alternate benefit with metallic equivalent.	X-ray

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D6790 ♦	**Crown – full cast high noble metal**		X-ray
D6791 ♦	**Crown – full cast predominantly base metal**		
D6792 ♦	**Crown – full cast noble metal**		
D6793 ♦	**Provisional retainer crown** Retainer crown utilized as an interim of at least six months duration during restorative treatment to allow adequate time for healing or completion of other procedures. This is not to be used as a temporary retainer crown for routine prosthetic fixed partial dentures.	- Covered as a benefit only in the event of an injury. - Narrative must detail the scope of the injury - If used as temporary retainer crown for routine prosthetic fixed partial denture, benefit will be disallowed.	X-ray Narrative
D6794 ♦	**Crown – titanium**	Upon review, the alternate benefit of D6790 will be applied.	X-ray
D6920 ♦	**Connector bar** A device attached to fixed partial denture retainer or coping which serves to stabilize and anchor a removable overdenture prosthesis.	Not a benefit of the plan	
D6930 ♦	**Recement fixed partial denture**	- Benefit is limited to once every 12 months beginning 6 months after the bridge is inserted. - Fees for recementation of bridges are disallowed if done within 6 months of the initial seating date by the same dentist or dental office.	
D6940 ♦	**Stress breaker** A non-rigid connector.	- Coverage is limited to once every 5 years. - Procedure D6940 includes: ▪ Rest for bridge (in lieu of abutment). ▪ Misaligned bridge abutments.	X-ray
D6950	**Precision attachment** Report attachment separately from crown; a male and female pair constitutes one precision attachment.	Not a benefit of the plan	

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D6970 ♦	**Post and core in addition to fixed partial denture retainer, indirectly fabricated**	- Post and core in addition to bridge retainer is a benefit only on an endodontically treated tooth and only when necessary to retain a cast restoration due to extensive loss (over 50%) of tooth structure from caries or fracture and subject of the same time limitations as cast restorations. - Benefits for post and core are disallowed when radiographs indicate an absence of endodontic therapy, incompletely filled canal space or unresolved pathology. - Benefits for post and core are disallowed when radiographs indicate an absence of sufficient tooth structure (over 50%) present to retain a bridge retainer - If HMAA has history of endodontic treatment, an X-ray is not required.	X-ray
D6972 ♦	**Prefabricated post and core in addition to fixed partial denture retainer**	- Prefabricated post and core in addition to bridge retainer is a benefit only on an endodontically treated tooth. - Benefits for post and core are disallowed when radiographs indicate an absence of endodontic therapy, incompletely filled canal space or unresolved pathology. - Benefits for post and core are disallowed when radiographs indicate an absence of sufficient tooth structure (over 50%) present to retain a bridge retainer - If HMAA has history of endodontic treatment, an X-ray is not required.	X-ray
D6973 ♦	**Core build up for retainer, including any pins**	- Substructures are only a benefit when necessary to retain a cast restoration due to extensive loss (over 50%) of tooth structure from caries or fracture. - Benefits for a buildup are disallowed when radiographs indicate sufficient tooth structure (over 50%) remains to support a retainer. - If HMAA has history of endodontic treatment, an X-ray is not required.	X-ray
D6975	**Coping – metal** To be used as a definitive restoration when coping is an integral part of a fixed prosthesis.	Not a benefit of the plan	

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D6976	**Each additional indirectly fabricated post – same tooth** To be used with D6970.	Not a benefit of the plan	
D6977	**Each additional prefabricated post – same tooth** To be used with D6972.	Not a benefit of the plan	
D6980 ♦	**Fixed partial denture repair, by report**	- Coverage is limited to once every 12 months. - Repairs are allowed 6 months following the insertion date. - Documentation should include materials used, chair time, X-rays or any other supporting information. - Includes removal of bridge, if necessary. - Repairs of porcelain on molars are not a benefit. Patient is responsible for cost. - Upon review of documentation, the appropriate benefit allowance will be applied.	Narrative
D6985	**Pediatric partial denture, fixed** This prosthesis is used primarily for aesthetic purposes.	Not a benefit of the plan	
D6999 ♦	**Unspecified, fixed prosthodontic procedure, by report** Used for procedure that is not adequately described by a code.	- Documentation should include materials used, tooth number, arch, quadrant, or area of the mouth, chair time, X-rays or any other supporting information. - Upon review of documentation, the appropriate benefit allowance will be applied.	Narrative

Oral and Maxillofacial Surgery

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

General Guidelines
The fee for all oral and maxillofacial surgery includes local anesthesia, suturing if needed, and routine post-operative care. Separate fees for these procedures when performed in conjunction with oral and maxillofacial surgery are disallowed when done by the same dentist/dental office and are denied and the approved amount is collectible from the patient when done by another dentist/dental office.

Some oral surgical procedures are considered medical benefits; if the patient has HMAA medical coverage, then the procedure will be processed under the patient's medical plan benefits only. The HMAA dental plan will not act as secondary coverage. The provider may continue to use appropriate dental code(s) and submit the claim using a Dental Claim form. If the patient does not have HMAA medical coverage and a medical carrier statement is required, the claim should be submitted to the patient's medical carrier first.

Exploratory surgery is not a benefit of the plan.

Unsuccessful attempts at extractions are disallowed.

Bone grafts in new extraction sites, with or without an implant, are denied as a specialized technique.

Biopsy of oral tissue – soft (D7286) and Removal of benign odontogenic cyst or tumor up to 1.25 cm (D7450) may be disallowed in conjunction with extraction procedures.

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D7111 ▲	**Extraction, coronal remnants - deciduous tooth** Removal of soft tissue-retained coronal remnants.	Valid Tooth #'s A-T	
D7140 ▲	**Extraction, erupted tooth or exposed root (elevation and/or forceps removal)** Includes routine removal of tooth structure, minor smoothing of socket bone and closure, as necessary.		
D7210 ▲	**Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth** Includes cutting of gingiva and bone, removal of tooth structure, minor smoothing of socket bone and closure.		
D7220 ▲	**Removal of impacted tooth – soft tissue** Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation.		

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D7230 ▲	**Removal of impacted tooth – partially bony** Part of crown covered by bone; requires mucoperiosteal flap elevation and bone removal.		
D7240 ▲	**Removal of impacted tooth – completely bony** Most or all of crown covered by bone; requires mucoperiosteal flap elevation and bone removal.		
D7241 ▲	**Removal of impacted tooth – completely bony, with unusual surgical complication** Most or all of crown covered by bone; unusually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required or aberrant tooth position.		
D7250 ▲	**Surgical removal of residual tooth roots (cutting procedure)** Includes cutting of soft tissue and bone, removal of tooth structure, and closure.		
D7260 ▲	**Oroantral fistula closure** Excision of fistulous tract between maxillary sinus and oral cavity and closure by advancement flap.	Valid Tooth #'s 1-16, UR, UL	Operative Report
D7261 ▲	**Primary closure of a sinus perforation** Subsequent to surgical removal of tooth, exposure of sinus requiring repair, or immediate closure of oroantral or oralnasal communication in absence of fistulus tract.		Operative Report
D7270 ▲	**Tooth reimplantation and or stabilization of accidentally evulsed or displaced tooth** Includes splinting and/or stabilization.	- Includes post-operative care and removal of splint by the same dentist/dental office. - Narrative should indicate all teeth involved and describe the method of stabilization.	X-ray Narrative
D7272	**Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)**	Not a benefit of the plan	

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D7280 ▲	**Surgical access of an unerupted tooth** An incision is made and the tissue is reflected and bone removed as necessary to expose the crown of an impacted tooth not intended to be extracted.		X-ray
D7282 ▲	**Mobilization of erupted or malpositioned tooth to aid eruption** Procedure is by report	When performed in conjunction with other surgery in this immediate area, the benefit is disallowed.	X-ray
D7283 ◙	**Placement of device to facilitate eruption of impacted tooth** Placement of an orthodontic bracket, band or other device on an unerupted tooth, after its exposure, to aid in its eruption. Report the surgical exposure separately using D7280.	Coverage for this procedure is limited to members who have Orthodontic plan benefits.	X-ray
D7285 ▲	**Biopsy of oral tissue – hard (bone, tooth)** For removal of specimen only. This code involves biopsy of osseous lesions and is not used for apicoectomy/periradicular surgery.	- This service is disallowed when performed in conjunction with an apicoectomy (D3410, D3421, D3425 or D3426), or surgical extraction (D7210), by the same dentist/dental office in the same surgical area and on the same date of service. - This service may be processed under patient's medical benefits.	Pathology Report
D7286 ▲	**Biopsy of oral tissue – soft** For surgical removal of an architecturally intact specimen only. This code is not used at the same time as codes for apicoectomy/periradicular curettage.	- This service is disallowed when performed in conjunction with an apicoectomy (D3410, D3421, D3425 or D3426), or surgical extraction (D7210), by the same dentist/dental office in the same surgical area and on the same date of service. - This service may be processed under patient's medical benefits.	Pathology Report
D7287	**Exfoliative cytological sample collection** For collection of non-transepithelial cytology sample via mild scraping of the oral mucosa.	Not a benefit of the plan	
D7288	**Brush biopsy – transepithelial sample collection** For collection of oral disaggregated transepithelial cells via rotational brushing of the oral mucosa.	Not a benefit of the plan	

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D7290 ◙	**Surgical repositioning of teeth** Grafting procedure(s) is/are additional.	Coverage for this procedure is limited to members who have Orthodontic Plan Benefits	Operative Report
D7291 ◙	**Transseptal fiberotomy/supra crestal fiberotomy, by report** The supraosseous connective tissue attachment is surgically severed around the involved teeth. Where there are adjacent teeth, the transseptal fiberotomy of a single tooth will involve a minimum of three teeth. Since the incisions are within the gingival sulcus and tissue and the root surface is not instrumented, this procedure heals by the reunion of connective tissue with the root surface on which viable periodontal tissue is present (reattachment).	Coverage for this procedure is limited to members who have Orthodontic plan benefits.	Operative Report
D7292	**Surgical placement: temporary anchorage device [screw retained plate] requiring surgical flap** Insertion of a temporary skeletal anchorage device that is attached to the bone by screws and requires a surgical flap. Includes device removal.	Not a benefit of the plan	
D7293	**Surgical placement: temporary anchorage device requiring surgical flap** Insertion of a device for temporary skeletal anchorage when a surgical flap is required. Includes device removal.	Not a benefit of the plan	
D7294	**Surgical placement: temporary anchorage device without surgical flap** Insertion of a device for temporary skeletal anchorage when a surgical flap is not required. Includes device removal.	Not a benefit of the plan	
D7296	**Corticotomy - one to three teeth or tooth spaces, per quadrant** This procedure involves creating multiple cuts, perforations, or removal of cortical, alveolar or basal bone of the jaw for the purpose of facilitatiing orthodontic repositioning of the dentition. This procedure includes flap entry and closure. Graft material and membrane, if used, should be reported separately.	Not a benefit of the plan	

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D7297	**Corticotomy – four or more teeth or tooth spaces, per quadrant** This procedure involves creating multiple cuts, perforations, or removal of cortical, alveolar or basal bone of the jaw for the purpose of facilitatiing orthodontic repositioning of the dentition. This procedure includes flap entry and closure. Graft material and membrane, if used, should be reported separately.	Not a benefit of the plan	
D7310	**Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant**	- Alveoloplasty is included in the fee for surgical extractions (D7210-D7250), and is disallowed if performed by the same dentist/dental office in the same surgical area on the same date of service. - Allowed with simple extraction in same quadrant, when periodontal disease is present. - If more than one tooth, indicate additional teeth number in narrative.	
D7311 ▲	**Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant** The alveoloplasty is distinct (separate procedure) from extractions and/or surgical extractions. Usually in preparation for a prosthesis or other treatment such as radiation therapy and transplant surgery.		
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** No extractions performed in an edentulous area. See D7310/D7311 if teeth are being extracted concurrently with the alveoloplasty. Usually in preparation for a prosthesis or other treatments such as radiation therapy and transplant surgery.	Indicate additional teeth numbers in narrative.	
D7340	**Vestibuloplasty – ridge extension (secondary epithelialization)**	Not a benefit of the plan	
D7350	**Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)**	Not a benefit of the plan	

Surgical Excision of Soft Tissue Lesions

General Guidelines
Pathology Report should include site and size of growth.

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D7410	**Excision of benign lesion up to 1.25 cm**	- The benefit for D7410/D7411 is subject to the review of the pathology report and may be included in the benefit for another surgery when performed on the same date of service. - This service may be processed under patient's medical benefits.	Medical Carrier Statement, Pathology Report
D7411 ▲	**Excision of benign lesion greater than 1.25 cm**		
D7412	**Excision of benign lesion, complicated** Requires extensive undermining with advancement of rotational flap closure.	Not a benefit of the plan	
D7413	**Excision of malignant lesion up to 1.25 cm**	This service may be processed under patient's medical benefits.	Medical Carrier Statement, Operative Report, Pathology Report
D7414 ▲	**Excision of malignant lesion greater than 1.25 cm**		
D7415	**Excision of malignant lesion, complicated** Requires extensive undermining with advancement of rotational flap closure.	Not a benefit of the plan	

Surgical Excision of Intra-Osseous Lesions

All procedures are subject to coverage under medical plan.

Pathology Report should include site and size of growth.

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D7440	**Excision of malignant tumor - lesion diameter up to 1.25 cm**	This service may be processed under patient's medical benefits.	Medical Carrier Statement, Operative Report, Pathology Report
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**	- The benefit for D7450/D7451 is subject to the review of the pathology report and may be including the benefit for another surgery when performed on the same date of service. - This service may be processed under patient's medical benefits.	Medical Carrier Statement, Operative Report, Pathology Report
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**	This service may be processed under patient's medical benefits.	Medical Carrier Statement, Operative Report, Pathology Report
D7461 ▲	**Removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm**		
D7465 ▲	**Destruction of lesion(s), by physical or chemical method, by report** Examples include using cryo, laser or electro surgery.	- Narrative should describe lesion and method of destruction. - This service may be processed under patient's medical benefits.	Narrative
D7471 ▲	**Removal of lateral exostosis (maxilla or mandible)**		Operative Report
D7472 ▲	**Removal of torus palatinus**	Valid Quad: UA	Operative Report
D7473 ▲	**Removal of torus mandibularis**	Valid Quad: LL, LR	Operative Report
D7485 ▲	**Surgical reduction of osseous tuberosity**	Valid Quad: UL, UR	Operative Report

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D7490 ▲	**Radical resection of maxilla or mandible** Partial resection of maxilla or mandible; removal of lesion and defect with margin of normal appearing bone. Reconstruction and bone grafts should be reported separately.	This service may be processed under patient's medical benefits. Valid Quad: LL, LR	Medical Carrier Statement, Operative Report, Pathology Report

Surgical Incision

General Guidelines
Operative report should include Diagnosis, Operation: site of incision, instrument used and method of drainage.

D7510 ▲	**Incision and drainage of abscess – intraoral soft tissue** Involves incision through mucosa, including periodontal origins.	- The benefit for D7510 is subject to the review of the operative report and may be included in the benefit for another procedure when performed on the same date of service by the same dentist/dentist office. - This service may be processed under patient's medical benefits.	Operative Report
D7511 ▲	**Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)** Incision is made intraorally and dissection is extended into adjacent fascial space(s) to provide adequate drainage of abscess/cellulitis.	- The benefit for D7511 is subject to the review of the operative report and may be included in the benefit for another procedure when performed on the same date of service. - This service may be processed under patient's medical benefits.	Medical Carrier Statement, Operative Report
D7520 ▲	**Incision and drainage of abscess – extraoral soft tissue** Involves incision through skin.	- Incision and drainage of abscess - extraoral soft tissue is a benefit only if dental related infection is present. - This service may be processed under patient's medical benefits.	Operative Report
D7521 ▲	**Incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces)** Incision is made extraorally and dissection is extended into adjacent fascial space(s) to provide adequate drainage of abscess/cellulitis.	- Incision and drainage of abscess-extraoral soft tissue is a benefit only if dentally-related infection is present. - Upon review of documentation, the appropriate benefit allowance will be applied. - This service may be processed under patient's medical benefits.	Medical Carrier Statement, Operative Report
D7530 ▲	**Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue**	- This service may be processed under patient's medical benefits.	Medical Carrier Statement, Operative Report
D7540 ▲	**Removal of reaction producing foreign bodies, musculoskeletal system** May include, but is not limited to, removal of splinters, pieces of wire, etc., from muscle and/or bone.	- This service may be processed under patient's medical benefits.	Operative Report

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D7550 ▲	**Partial ostectomy/sequestrectomy for removal of non-vital bone** Removal of loose or sloughed-off dead bone caused by infection or reduced blood supply.	- This service may be processed under patient's medical benefits.	Operative Report
D7560 ▲	**Maxillary sinusotomy for removal of tooth fragment or foreign body**		Operative Report

Treatment of Fractures – Simple

General Guidelines
All procedures are subject to coverage under medical plan.

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)** Teeth may be wired, banded or splinted together to prevent movement. Surgical incision required for interosseous fixation.	This service may be processed under patient's medical benefits.	Medical Carrier Statement, Operative Report
D7620 ▲	**Maxilla – closed reduction (teeth immobilized, if present)** No incision required to reduce fracture. See D7610 if interosseous fixation is applied.	This service may be processed under patient's medical benefits.	Medical Carrier Statement, Operative Report
D7630 ▲	**Mandible – open reduction (teeth immobilized, if present)** Teeth may be wired, banded or splinted together to prevent movement.	This service may be processed under patient's medical benefits.	Medical Carrier Statement, Operative Report
D7640 ▲	**Mandible – closed reduction (teeth immobilized, if present)** No incision required to reduce fracture. See D7630 if interosseous fixation is applied.	This service may be processed under patient's medical benefits.	Medical Carrier Statement, Operative Report
D7650 ▲	**Malar and or zygomatic arch – open reduction**	This service may be processed under patient's medical benefits.	Medical Carrier Statement, Operative Report
D7660 ▲	**Malar and or zygomatic arch – closed reduction**	This service may be processed under patient's medical benefits.	Medical Carrier Statement, Operative Report

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D7670 ▲	**Alveolus – closed reduction, may include stabilization of teeth** Teeth may be wired, banded or splinted together to prevent movement.	This service may be processed under patient's medical benefits.	Medical Carrier Statement Operative Report
D7671 ▲	**Alveolus – open reduction, may include stabilization of teeth** Teeth may be wired, banded or splinted together to prevent movement.	This service may be processed under patient's medical benefits.	Medical Carrier Statement Operative Report X-ray
D7680	**Facial bones – complicated reduction with fixation and multiple surgical approaches** Facial bones include upper and lower jaw, cheek, and bones around eyes, nose and ears.	Not a benefit of the plan	

Treatment of Fractures – Compound

General Guidelines
All procedures are subject to coverage under medical plan.

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** Surgical incision required to reduce fracture.	This service may be processed under patient's medical benefits.	Medical Carrier Statement, Operative Report
D7720 ▲	**Maxilla – closed reduction**	This service may be processed under patient's medical benefits.	Medical Carrier Statement, Operative Report
D7730 ▲	**Mandible – open reduction** Surgical incision required to reduce fracture.	This service may be processed under patient's medical benefits.	Medical Carrier Statement, Operative Report
D7740 ▲	**Mandible – closed reduction**	This service may be processed under patient's medical benefits.	Medical Carrier Statement, Operative Report
D7750 ▲	**Malar and/or zygomatic arch – open reduction** Surgical incision required to reduce fracture.	This service may be processed under patient's medical benefits.	Medical Carrier Statement, Operative Report
D7760 ▲	**Malar and/or zygomatic arch – closed reduction**	This service may be processed under patient's medical benefits.	Medical Carrier Statement, Operative Report

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D7770 ▲	**Alveolus – open reduction stabilization of teeth** Fractured bone(s) are exposed to mouth or outside the face. Surgical incision required to reduce facture.	This service may be processed under patient's medical benefits.	Medical Carrier Statement, Operative Report
D7771 ▲	**Alveolus, closed reduction stabilization of teeth** Fractured bone(s) are exposed to mouth or outside the face.	This service may be processed under patient's medical benefits.	Medical Carrier Statement Operative Report
D7780	**Facial bones – complicated reduction with fixation and multiple surgical approaches** Surgical incision required to reduce fracture. Facial bones include upper and lower jaw, cheek, and bones around eyes, nose and ears.	Not a benefit of the plan	
D7810	**Open reduction of dislocation** Access to TMJ via surgical opening	Not a benefit of the plan	
D7820	**Closed reduction of dislocation** Joint manipulated into place; no surgical exposure.	Not a benefit of the plan	
D7830	**Manipulation under anesthesia** Usually done under general anesthesia or intravenous sedation.	Not a benefit of the plan	
D7840	**Condylectomy** Surgical removal of all or portion of the mandibular condyle (separate procedure)	Not a benefit of the plan	
D7850	**Surgical discectomy, with/without implant** Excision of the intra-articular disc of a joint.	Not a benefit of the plan	

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D7852	**Disc repair** Repositioning and/or sculpting of disc; repair of perforated posterior attachment.	Not a benefit of the plan	
D7854	**Synovectomy** Excision of a portion or all of the synovial membrane of a joint.	Not a benefit of the plan	
D7856	**Myotomy** Cutting of muscle for therapeutic purposes (separate procedure).	Not a benefit of the plan	
D7858	**Joint reconstruction** Reconstruction of osseous components including or excluding soft tissues of the joint with autogenous, homologous, or alloplastic materials.	Not a benefit of the plan	
D7860	**Arthrotomy** Cutting into joint (separate procedure).	Not a benefit of the plan	
D7865	**Arthroplasty** Reduction of osseous components of the joint to create a pseudoarthrosis or eliminate an irregular remodeling pattern (osteophytes).	Not a benefit of the plan	
D7870	**Arthrocentesis** Withdrawal of fluid from a joint space by aspiration.	Not a benefit of the plan	
D7871	**Non-arthroscopic lysis and lavage** Inflow and outflow catheters are placed into the joint space. The joint is lavaged and manipulated as indicated in an effort to release minor adhesions and synovial vacuum phenomenon as well as to remove inflammation products from the joint space.	Not a benefit of the plan	
D7872	**Arthroscopy – diagnosis, with or without biopsy**	Not a benefit of the plan	

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D7873	**Arthroscopy – surgical: lavage and lysis of adhesions** Removal of adhesions using the arthroscope and lavage of the joint cavities.	Not a benefit of the plan	
D7874	**Arthroscopy – surgical: disc repositioning and stabilization** Repositioning and stabilization of disc using arthroscopic techniques.	Not a benefit of the plan	
D7875	**Arthroscopy – surgical: synovectomy** Removal of inflamed and hyperplastic synovium (partial/complete) via an arthroscopic technique.	Not a benefit of the plan	
D7876	**Arthroscopy – surgical: discectomy** Removal of disc and remodeled posterior attachment via the arthroscope.	Not a benefit of the plan	
D7877	**Arthroscopy – surgical: debridement** Removal of pathologic hard and/or soft tissue using the arthroscope.	Not a benefit of the plan	
D7880	**Occlusal orthotic device, by report** Presently includes splints provided for treatment of temporomandibular joint dysfunction.	Not a benefit of the plan	
D7899	**Unspecified TMD therapy, by report** Used for procedure that is not adequately described by a code. Describe procedure.	Not a benefit of the plan	
D7910 ▲	**Suture of recent small wounds up to 5 cm**	- Specify site in operative report. - This service may be processed under patient's medical benefits.	Medical Carrier Statement, Operative Report
D7911	**Complicated suture – up to 5 cm**	Not a benefit of the plan	
D7912	**Complicated suture – greater than 5 cm**		

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D7920	**Skin graft (identify defect covered, location and type of graft)**	Not a benefit of the plan	
D7940	**Osteoplasty – for orthognathic deformities** Reconstruction of jaws for correction of congenital, developmental or acquired traumatic or surgical deformity.	Not a benefit of the plan	
D7941	**Osteotomy – mandibular rami**	Not a benefit of the plan	
D7943	**Osteotomy – mandibular rami with bone graft; includes obtaining the graft**	Not a benefit of the plan	
D7944	**Osteotomy – segmented or subapical** Reports by range of tooth numbers with segment.	Not a benefit of the plan	
D7945	**Osteotomy – body of mandible** Surgical section of lower jaw. This includes the surgical exposure, bone cut, fixation, routine wound closure and normal post-operative follow-up care.	Not a benefit of the plan	
D7946	**LeFort I (maxilla – total)** Surgical section of the upper jaw. This includes the surgical exposure, bone cuts, downfracture, repositioning, fixation, routine wound closure and normal post-operative follow-up care.	Not a benefit of the plan	
D7947	**LeFort I (maxilla – segmented)** When reporting a surgically assisted palatal expansion without downfracture, this code would entail a reduced service and should be “by report.”	Not a benefit of the plan	

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D7948	**LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) – without bone graft** Surgical section of the upper jaw. This includes the surgical exposure, bone cuts, downfracture, segmentation of maxilla, repositioning, fixation, routine wound closure and normal post-operative follow-up care.	Not a benefit of the plan	
D7949	**LeFort II or LeFort III – with bone grafts** Includes obtaining autografts.	Not a benefit of the plan	
D7950	**Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla – autogenous or nonautogenous, by report** This code may be used for ridge augmentation or reconstruction to increase height, width and/or volume of residual alveolar ridge. It includes obtaining autograft and/or allograft material. Placement of a barrier membrane, if used, should be reported separately.	Not a benefit of the plan	
D7951	**Sinus augmentation with bone or bone substitutes** The augmentation of the sinus cavity to increase alveolar height for reconstruction of edentulous portions of the maxilla. This includes obtaining the bone or bone substitutes. Placement of a barrier membrane, if used, should be reported separately.	Not a benefit of the plan	
D7953	**Bone replacement graft for ridge preservation – per site** Osseous autograft, allograft or non-osseous graft is placed in an extraction site at the time of extraction to preserve ridge integrity (e.g. clinically indicated in preparation for implant reconstruction or where alveolar contour is critical to planned prosthetic reconstruction). Membrane, if used should be reported separately.	Not a benefit of the plan	

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D7955	**Repair of maxillofacial soft and/or hard tissue defect** Reconstruction of surgical, traumatic, or congenital defects of the facial bones, including the mandible, may utilize autograft, allograft, or alloplastic materials in conjunction with soft tissue procedure to repair and restore the facial bones to form and function. This does not include obtaining the graft and these procedures may require multiple surgical approaches. This procedure does not include edentulous maxilla and mandibular reconstruction for prosthetic considerations. See code D7950.	Not a benefit of the plan	
D7960 ▲	**Frenulectomy (frenectomy or frenotomy) – separate procedure** The frenum may be excised when the tongue has limited mobility; for large diastemas between teeth; or when the frenum interferes with a prosthetic appliance; or when it is the etiology of periodontal tissue disease.	- Narrative should include diagnosis. - Frenulectomy is disallowed when performed on the same day as any periodontal or surgical procedure by the same dentist/dental office. - This service may be processed under patient's medical benefits.	Narrative
D7963 ▲	**Frenuloplasty** Excision of the frenum with accompanying excision or repositioning of aberrant muscle and z-plasty or other local flap closure.	- Narrative should include diagnosis. - Frenuloplasty is disallowed when billed in conjunction with another surgical or periodontal procedure(s) in the same surgical site, by the same dentist/ dental office. -This service may be processed under patient's medical benefits. Valid Arch/Tooth #'s: UA, LA, 6-11, 22-27	Narrative
D7970 ▲	**Excision of hyperplastic tissue – per arch**	- The benefit 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 - Limited to edentulous areas. Valid Arch: UA, LA	Narrative
D7971 ▲	**Excision pericoronal gingiva** Surgical removal of inflammatory or hypertrophied tissues surrounding partially erupted/impacted teeth.	- The benefit 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. - This applies to excision distal of 2nd or 3rd molars. Valid Tooth #'s: 1, 2, 15, 16, 17, 18, 31, 32	Narrative

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D7972 ▲	**Surgical reduction of fibrous tuberosity**	- The benefit for surgical reduction of fibrous tuberosity is disallowed when billed in conjunction with other surgical procedure(s) in the same surgical area by the same dentist/dental office. - This service may be processed under patient's medical benefits. Valid Quad/Arch: UA, UR, UL	Medical Carrier Statement, Operative Report
D7979	**Non-surgical Sialolithotomy** A sialolith is removed from the gland or ductal portion of the gland without surgical incision into the gland or the duct of the gland; for example via manual manipulation, ductal dilation, or any other non-surgical method.	Not a benefit of the plan	
D7980 ▲	**Sialolithotomy** Surgical procedure by which a stone within a salivary gland or its duct is removed either intraorally or extraorally.	This service may be processed under patient's medical benefits. Valid Quad/Arch: LA, LL, LR	Medical Carrier Statement, Operative Report
D7981	**Excision of salivary gland, by report**	Not a benefit of the plan	
D7982	**Sialodochoplasty** Surgical procedure for the repair of a defect and/or restoration of a portion of a salivary gland duct.	Not a benefit of the plan	
D7983 ▲	**Closure of salivary fistula** Surgical closure of an opening between a salivary duct and/or gland and the cutaneous surface or an opening into the oral cavity through other than the normal anatomic pathway.	This service may be processed under patient's medical benefits.	Medical Carrier Statement, Operative Report
D7990	**Emergency tracheotomy** Surgical formation of a tracheal opening usually below the cricoid cartilage to allow for respiratory exchange.	Not a benefit of the plan	
D7991	**Coronoidectomy** Surgical removal of the coronoid process of the mandible.	Not a benefit of the plan	
D7995	**Synthetic graft – mandible or facial bones by report** Includes allogenic material.	Not a benefit of the plan	

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D7996	**Implant – mandible for augmentation purposes (excluding alveolar ridge), by report**	Not a benefit of the plan	
D7997	**Appliance removal (not by dentist who placed appliance), includes removal of archbar**	Not a benefit of the plan	
D7998	**Intraoral placement of a fixation device not in conjunction with a fracture** The placement of intermaxillary fixation appliance for documented medically accepted treatments not in association with fractures.	Not a benefit of the plan	
D7999 ▲	**Unspecified oral surgery procedure, by report** Used for procedure that is not adequately described by a code. Describe procedure.	- Documentation should include materials used, tooth number, arch, quadrant, or area of the mouth, chair time, X-rays or any other supporting information. - Upon review of documentation, the appropriate benefit allowance will be applied.	Operative Report

Orthodontics

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

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

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

Adult Dentition: The dentition that is present after the cessation of growth that would affect orthodontic treatment. All of these codes may be used more than once for the treatment of a particular patient depending on the particular circumstance. A patient may require more than one interceptive procedure or more than one limited procedure depending on their particular problem.

General Guidelines

Orthodontic services are not benefits of all HMAA Plans. Please refer to current group benefit information for specific coverage.

Allowances include all appliances, adjustments, insertion and removal (and associated office visits). HMAA Plans do not provide for repair or replacement of any appliance. All cases assume time frame for active course of treatment, and includes the cost of any post-treatment retention.

▪ Services that are related to orthodontic treatment are benefits of a patient's diagnostic or basic coverage, whether or not the plan provides orthodontic coverage. Such procedures may include routine X-rays and extractions.

▪ Services listed with the description of "Coverage limited to members who have Orthodontic Plan Benefits" are only covered under those plans that have Orthodontic coverage and are payable as part of the diagnostic or basic benefits.

The HMAA orthodontic plans allow one retainer per arch per lifetime. Retainer adjustments are included in the fee for "Comprehensive Orthodontic Treatment" and are disallowed if performed by the same dentist/dental office, denied if performed by a different dentist/dental office.

Payments are scheduled according to the plan's contractual agreement and the payment schedule is designated in the current Group Schedule of Benefits.

A Comprehensive Orthodontic treatment is a benefit once per lifetime.

For two phase treatment plans, submit a narrative for each phase. Phase I may be a benefit as Limited or Interceptive treatment instead of Comprehensive. Phase II will be a benefit as Comprehensive treatment.

Separate laboratory fees for clear aligners, such as Invisalign, are considered cosmetic and chargeable to the patient; on claim the form use a separate line for the clear aligner dental laboratory charges as procedure code D8999 and include a narrative stating "clear aligner". Maintain a patient consent form on file.

When a service is elected by the patient for cosmetic reasons, the dentist must explain to the patient that it is not a covered benefit and the dental insurance will not pay for the services. HMAA recommends the dental office to obtain the patient's written consent, prior to rendering the service on a form that clearly discloses to the patient the financial charge that will be incurred for cosmetic services.

Limited Orthodontic Treatment

Orthodontic treatment with a limited objective, not involving the entire dentition. It may be directed at the only existing problem or at only one aspect of a larger problem in which a decision is made to defer or forego more comprehensive therapy. Examples of this type of treatment would be treatment in one arch only to correct crowding, partial treatment to open spaces or upright a tooth for a bridge or implant and partial treatment for closure of space(s.)

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D8010	**Limited orthodontic treatment of the primary dentition**	Not a benefit of the plan	
D8020	**Limited orthodontic treatment of the transitional dentition**	Not a benefit of the plan	
D8030	**Limited orthodontic treatment of the adolescent dentition**	Not a benefit of the plan	
D8040 ◙	**Limited orthodontic treatment of the adult dentition**	Not a benefit of the plan	

Interceptive Orthodontic Treatment

Treatment using codes for interceptive orthodontic treatment are for procedures to lessen the severity or future effects of a malformation and to eliminate its cause.

An extension of preventive orthodontics that may include localized tooth movement. Such treatment may occur in the primary or transitional dentition and may include such procedures as the redirection of ectopically erupting teeth, correction of isolated dental crossbite or recovery of recent minor space loss where overall space is adequate.

The key to successful interception is intervention in the incipient stages of a developing problem to lessen the severity of the malformation and eliminate its cause. Complicating factors such as skeletal disharmonies, overall space deficiency, or other conditions may require future comprehensive therapy.

Early phases of comprehensive therapy may utilize some procedures that might also be used interceptively, but such procedures are not considered interceptive in those applications.

D8050	**Interceptive orthodontic treatment of the primary dentition**	Not a benefit of the plan	
D8060 ◙	**Interceptive orthodontic treatment of the transitional dentition**	Not a benefit of the plan	

Comprehensive Orthodontic Treatment

These codes should be used when there are multiple phases of treatment provided at different stages of dentofacial development.

For example, the use of an activator is generally stage one of a two-stage treatment. In this situation, placement of fixed appliances will generally be stage two of a two-stage treatment. Both phases should be listed as comprehensive treatment modified by the appropriate stage of dental development.

This is used to report the coordinated diagnosis and treatment leading to the improvement of a patient's craniofacial dysfunction and/or dentofacial deformity including anatomical, functional and aesthetic relationships. Treatment usually, but not necessarily, utilizes fixed orthodontic appliances. Adjunctive procedures, such as extractions, maxillofacial surgery, nasopharyngeal surgery, myofunctional or speech therapy and restorative or periodontal care, may be coordinated disciplines. Optimal care requires long-term consideration of patient's needs and periodic re-evaluation. Treatment may incorporate several phases with specific objectives at various stages of dental facial development.

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D8070 ◙	**Comprehensive orthodontic treatment of the transitional dentition**	- Narrative should include class of malocclusion (Class I, II, III); extent of crowding, overbite, spacing, rotation, arch discrepancy; extraction/expansion; fixed/removable appliance and duration of treatment. - Due to the contract limitation of one Comprehensive treatment per lifetime, for two phase treatment plans, submit narrative for each phase. Phase I may be beneficial as Limited or Interceptive treatment, instead of Comprehensive. Phase II will be a benefit as Comprehensive treatment.	Narrative
D8080 ◙	**Comprehensive orthodontic treatment of the adolescent dentition**	Not a benefit of the plan	
D8090 ◙	**Comprehensive orthodontic treatment of the adult dentition**	Not a benefit of the plan	
D8210 ◙	**Removable appliance** Removable indicates patient can remove; includes appliances for thumb sucking and tongue thrusting.	Limited to one appliance per arch	
D8220 ◙	**Fixed appliance therapy** Fixed indicates patient cannot remove appliance; includes appliances for thumb sucking and tongue thrusting.	Limited to one appliance per arch	
D8660 ◙	**Pre-orthodontic treatment visit**	Not a benefit of the plan	
D8670 ◙	**Periodic orthodontic treatment visit (as part of contract)**	Not a benefit of the plan	

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D8680 ◙	**Orthodontic retention (removal of appliances, construction and placement of retainer(s))**	- Limited to the removal of appliances. - Upon review, the appropriate benefit allowance will be applied. - This procedure is disallowed unless performed by a dentist other than the original dentist/dental office.	Narrative
D8690 ◙	**Orthodontic treatment (alternative billing to a contract fee)** Services provided by dentist other than original treating dentist. A method of payment between the provider and responsible party for services that reflect an open-ended fee arrangement.	Not a benefit of the plan	
D8691 ◙	**Repair of orthodontic appliance** Does not include bracket and standard fixed orthodontic appliances. It does include functional appliances and palatal expanders.	Not a benefit of the plan	
D8692 ◙	**Replacement of lost or broken retainer**	Limited to one replacement.	
D8693 ◙	**Rebonding or recementing; and/or repair, as required, of fixed retainers**	- This procedure is included in the Ortho Case Fee. - A separate fee is disallowed to the same dentist. - In the case where a different dentist is repairing/recementing/rebonding the fixed retainer, a separate benefit may be given once in a lifetime; then it becomes the patient responsibility due to lack of compliance.	
D8695	**Removal of fixed orthodontic appliance for reasons other than completion of treatment**	Not a benefit of the plan	

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D8999 ◙	**Unspecified orthodontic procedure, by report** Used for procedure that is not adequately described by the code. Describe the procedure.	- Documentation should include materials used, tooth number, arch, quadrant, or area of the mouth, chair time, X-rays or any other supporting information. Upon review of documentation, the appropriate benefit allowance will be applied. - The additional laboratory fee for clear aligners, such as Invisalign, may be charged to the patient when the following conditions are met on the claim submission: ▪ Enter the orthodontic procedure code and charge amount. ▪ Enter a separate line for the clear aligner dental laboratory charges as procedure code D8999 and include a narrative stating “clear aligner”. ▪ Maintain a patient consent form on file.	Narrative

Adjunctive General Services

Unclassified Treatment

D9110 ▲	**Palliative (emergency) treatment of dental pain – minor procedure** This is typically reported on a “per visit” basis for emergency treatment of dental pain.	- All procedures necessary for the relief of pain are included in the allowance for D9110. - This service is payable per visit, not per tooth. - The narrative must include the diagnosis and treatment performed to relieve pain. If the narrative indicates definitive treatment has been performed, the service will be processed as that definitive procedure.	Narrative
D9120 ▲	**Fixed partial denture sectioning** Separation of one or more connections between abutments and/or pontics when some portion of a fixed prosthesis is to remain intact and serviceable following sectioning and extraction or other treatment. Includes all recontouring and polishing of retained portions.		Narrative
D9130	**Temporomandibular joint dysfunction – non-invasive physical therapies** Therapy including but not limited to massage, diathermy, ultrasound, or cold application to provide relief from muscle spasms, inflammation or pain, intending to improve freedom of motion and joint function. This should be reported on a per session basis.	Not a benefit of the plan	

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D9210	**Local anesthesia not in conjunction with operative or surgical procedures**	Not a benefit of the plan	
D9211	**Regional block anesthesia**	Not a benefit of the plan	
D9212	**Trigeminal division block anesthesia**	Not a benefit of the plan	
D9215	**Local anesthesia**	Not a benefit of the plan	
D9220 ▲	**Deep sedation/general anesthesia – first 30 minutes** Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties. The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetic's effects upon the central nervous system and not dependent upon the route of administration.	General anesthesia is only a benefit when provided in conjunction with a covered oral surgery procedure.	
D9221	**Deep sedation/general anesthesia – each additional 15 minutes** Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties. The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetic's effects upon the central nervous system and not dependent upon the route of administration.	Not a benefit of the plan	
D9222	**Deep sedation/general anesthesia - first 15 minutes** Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of the trained personnel and the doctor may safely leave the room to attend to other patient duties. The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetic effects upon the central nervous system and not dependent upon the route of the administration		

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D9230	**Analgesia, anxiolysis, inhalation of nitrous oxide**	Not a benefit of the plan	
D9241 ▲	**Intravenous conscious sedation/analgesia – first 30 minutes** Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties. The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetic's effects upon the central nervous system and not dependent upon the route of administration.	Intravenous sedation is a benefit only when provided in conjunction with a covered oral surgery procedure.	
D9242	**Intravenous conscious sedation/analgesia – each additional 15 minutes** Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties. The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetic's effects upon the central nervous system and not dependent upon the route of administration.	Not a benefit of the plan	
D9248	**Non-intravenous conscious sedation** A medically controlled state of depressed consciousness while maintaining the patient's airway, protective reflexes and the ability to respond to stimulation or verbal commands. It includes non-intravenous administration of sedative and/or analgesic agent(s) and appropriate monitoring. The level of anesthesia is determined by the anesthesia provider's documentation of the anesthetic's effects upon the central nervous system and not dependent upon the route of administration.	Not a benefit of the plan	

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D9310 ▲	**Consultation diagnostic service provided by dentist or physician other than requesting dentist or physician** A patient encounter with a practitioner whose opinion or advice regarding evaluation and/or management of a specific problem; may be requested by another practitioner or appropriate source. The consultation includes an oral evaluation. The consulted practitioner may initiate diagnostic and/or therapeutic services.	- The benefit for consultation is disallowed when performed in conjunction with an examination /evaluation by the same dentist/dental office. - This procedure is a benefit once per patient per dentist per 12 month period. - Narrative should indicate referring dentist and the reason for consultation. - In absence of noting the referring dentist or reason for the consultation, the consultation is processed to the limitations of a D0140 (problem focused) evaluation and fees in excess of a D0140 are disallowed.	Narrative
D9410	**House/extended care facility call** Includes visits to nursing homes, long-term care facilities, hospice sites, institutions, etc. Report in addition to reporting appropriate code numbers for actual services performed.	Not a benefit of the plan	
D9420	**Hospital call** May be reported when providing treatment in hospital or ambulatory surgical center, in addition to reporting appropriate code numbers for actual services performed.	Not a benefit of the plan	
D9430 ▲	**Office visit for observation (during regularly scheduled hours) – no other services performed**	- This is not an evaluation procedure. It is allowable only when the visit is for observing injuries. - This procedure will be disallowed when related to a prior service that has a post-operative period. - Office visits for reasons other than injury or post-operative observation will be denied. The patient will be responsible up to the allowed amount. - An office visit performed in conjunction with a procedure (other than X-rays), is disallowed as included in the allowance for the procedure. - Narrative should include the nature of the injury. - In absence of the required narrative, the office visit is processed to the limitations of a D0140 problem focused evaluation and fees in excess of a D0140 are disallowed.	Narrative
D9440 ▲	**Office visit – after regularly scheduled hours**	The narrative should include the nature of the visit, documentation of regular scheduled hours, and the time of day.	Narrative
D9450	**Case presentation, detailed and extensive treatment planning** Established patient. Not performed on same day as evaluation.	Not a benefit of the plan	

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D9610	**Therapeutic parenteral drug, single administration** Includes single administration of antibiotics, steroids, anti-inflammatory drugs, or other therapeutic medications. This code should not be used to report administration of sedative, anesthetic or reversal agents.	Not a benefit of the plan	
D9612	**Therapeutic parenteral drug, two or more administrations, different medications** Includes multiple administrations of antibiotics, steroids, anti-inflammatory drugs, or other therapeutic medications. This code should not be used to report administration of sedative, anesthetic or reversal agents. This code should be reported when two or more different medications are necessary and should not be reported in addition to code D9610 on the same date.	Not a benefit of the plan	
D9613	**Infiltration of sustained release therapeutic drug – single or multiple sites** Infiltration of a sustained release pharmacologic agent for long acting surgical site plan control. Not for local anesthesia purposes.	Not a benefit of the plan	
D9630	**Other drugs and/or medicaments, by report** Includes, but is not limited to oral antibiotics, oral analgesics, and topical fluoride dispensed in the office for home use; does not include writing prescriptions.	Not a benefit of the plan	
D9910	**Application of desensitizing medicament** Includes in-office treatment for root sensitivity. Typically reported on a “per visit” basis for application of topical fluoride. This code is not to be used for bases, liners or adhesives used under restorations.	Not a benefit of the plan	
D9911	**Application of desensitizing resin for cervical and/or root surface, per tooth** Typically reported on a “per visit” basis for application of adhesive resins. This code is not to be used for bases, liners or adhesives used under restorations.	Not a benefit of the plan	

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D9920	**Behavior management by report** May be reported in addition to treatment provided. Should be reported in 15-minute increments.	Not a benefit of the plan	
D9930 ▲	**Treatment of complications (postsurgical) - unusual circumstances, by report**	- Covered only if performed by a dentist other than the treating dentist. - Narrative should detail the complication and treatment rendered. - Benefit is limited to once per dentist/dental office.	Narrative
D9940	**Occlusal guard, by report** Removable dental appliances, which are designed to minimize effects of bruxism (grinding) and other occusal factors.	Not a benefit of the plan	
D9941	**Fabrication of athletic mouthguard**	Not a benefit of the plan	
D9942	**Repair and/or reline of occlusal guard**	Not a benefit of the plan	
D9944	**Occlusal guard – hard appliance, full arch** Removable dental appliance designed to minimize the effects of bruxism or other occlusal factors. Not to be reported for.	Not a benefit of the plan	
D9945	**Occlusal guard – soft appliance, full arch** Removable dental appliance designed to minimize the effects of bruxism or other occlusal factors. Not to be reported for any type of sleep apnea, snoring or TMD appliances.	Not a benefit of the plan	
D9946	**Occlusal guard – hard appliance, partial arch** Removable dental appliance designed to minimize the effects of bruxism or other occlusal factors. Provides only partial occlusal coverage such as anterior deprogrammer. Not to be reported for any type of sleep apnea, snoring or TMD appliances.	Not a benefit of the plan	
D9950	**Occlusal analysis – mounted case** Includes, but is not limited to, facebow, interocclusal records tracings, and diagnostic wax-up; for diagnostic casts, see D0470.	Not a benefit of the plan	

CDT Code	CDT Definition	Benefit Guidelines	Submission Requirements
D9951	**Occlusal adjustment – limited** May also be known as equilibration; reshaping the occlusal surfaces of teeth to create harmonious contact relationships between the maxillary and mandibular teeth. Presently includes discing/odontoplasty/ enamoplasty. Typically reported on a "per visit" basis. This should not be reported when the procedure only involves bite adjustment in the routing post-delivery care for a direct/indirect restoration or fixed/removable prosthodontics.	Not a benefit of the plan	
D9952	**Occlusal adjustment – complete** Occlusal adjustment may require several appointments of varying length, and sedation may be necessary to attain adequate relaxation of the musculature. Study cases mounted on an articulating instrument may be utilized for analysis of occlusal disharmony. It is designed to achieve functional relationships and masticatory efficiency in conjunction with restorative treatment, orthodontics, orthognathic surgery, or jaw trauma when indicated. Occlusal adjustment enhances the healing potential of tissues affected by the lesions of occlusal trauma.	Not a benefit of the plan	
D9961	**Duplicate/copy patient's records**	Not a benefit of the plan	
D9970	**Enamel microabrasion** The removal of discolored surface enamel defects resulting from altered mineralization or decalcification of the superficial enamel layer. Submit per treatment visit.	Not a benefit of the plan	
D9971	**Odontoplasty 1 – 2 teeth; includes removal of enamel projections**	Not a benefit of the plan	
D9972	**External bleaching – per arch**	Not a benefit of the plan	
D9973	**External bleaching – per tooth**	Not a benefit of the plan	
D9974 ▲	**Internal bleaching – per tooth**	- Allowed once per year on Teeth: 4-13 and 20-29 only. - Tooth must have history of endodontic treatment and no full coverage crown.	X-ray
D9990	**Certified translation or sign-language services – per visit**	Not a benefit of the plan	
D9999 ▲	**Unspecified adjunctive procedure, by report** Used for procedure that is not adequately described by a code.	- Describe procedure. - Provide complete description of services/treatment to allow determination of appropriate benefit allowance. -Include tooth number, quadrant or arch.	Narrative