Policies listed in this handbook are subject to change.

DELTA DENTAL®

Participating Dentist's Handbook

With Processing Policies & Procedures Reference Guide

Effective January 1, 2024

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What You Need to Know:
A Guide to Delta Dental Participation

Dentist Membership

Membership in Delta Dental of Kansas, Inc. (DDKS) is available to any dentist who is licensed to practice dentistry and is actively engaged in the practice of dentistry in the State of Kansas. The dentist must not be under suspension or other disciplinary action by DDKS, the Kansas Dental Board, Office of Inspector General (OIG) or any other similar regulatory body. The dentist must agree to abide by the policies and procedures as revised from time to time by Delta Dental. Once a dentist has withdrawn or been terminated, membership is at the sole discretion of DDKS (please refer to the sample Participating Dentist Agreement in this guide).

A dentist who signs the Participating Dentist Agreement is designated as a Participating Dentist with Delta Dental of Kansas, as well as with the Delta Dental organization nationwide. They are hereby referred to as Participating Dentists. The Participating Dentist has agreed to allow Delta Dental to list his or her information in paper and/or electronic directories at all locations where the dentist is actively treating patients.

Participating Dentists are provided access to the comprehensive online handbook that lists each CDT procedure code with nomenclature along with its corresponding Delta Dental national processing policy located in the Participating Dentist Handbook. Most questions, such as how a procedure is processed, can be quickly answered with this handbook. Periodic updates to these policies are provided in the Participating Dentist electronic and/or paper newsletters and are considered a component of the handbook. It is the responsibility of the Participating Dentist to read this handbook, newsletters, and additional updates upon notification from Delta Dental.

The Delta Dental Organization

The Delta Dental organization is made up of 39 independent, affiliated member companies that are all members of the Delta Dental Plans Association (DDPA). Together, all member companies offer a nationwide benefits program to over 85 million Americans. As a Delta Dental Participating Dentist of Delta Dental of Kansas, you are a part of a nationwide network of dentists, and will be listed on a nationwide dentist directory.

Patients are able to seek treatment from Delta Dental Participating Dentists throughout the country. This means that there may be times when another Delta Dental member company may administer a patient's benefits. As a general rule, the state in which the patient's employer is headquartered is the Delta Dental member company that will administer benefits for that employer group - the "control plan". No matter what Delta Dental member company administers the benefits for a Delta Dental patient, the DDKS Participating Dentist will still receive payment directly from that Delta Dental member company, and will be reimbursed the same, which is the lesser of the fee that is submitted on a claim form, or the DDKS Maximum Plan Allowance.

If a problem regarding fee discrepancies cannot be resolved between you and another Delta Dental member company, you may contact your local area Professional Relations Representative for assistance.

Maximum Plan Allowance (MPA)

In the case of Participating Dentists, the term "Maximum Plan Allowance" or "MPA" means the lesser of:

1) the fee submitted by the Participating Dentist for the dental procedure, or

2) the maximum amount payable as determined by Delta Dental Participating Dentist MPA.

The Delta Dental Participating Dentist MPA for a covered procedure means the fee established by DDKS. The Delta Dental Participating Dentist MPA is developed from a number of sources, including, but not limited to, the billed charges for the same procedures by dentists in Kansas, and such other information as DDKS, in its sole discretion, deems appropriate.

The Participating Dentist agrees to submit to Delta Dental all treatment rendered, to charge Delta Dental patients the same fee as the provider charges other patients, and to accept payment directly from Delta Dental based on Delta Dental's MPA. Any difference in fees charged by the Participating Dentist and the DDKS MPA cannot be charged to Delta Dental patients for contractually covered services. A covered service is a service which is reimbursable under the dental benefit plan subject to any deductible, coinsurance, waiting period, frequency limitation, annual or lifetime benefit maximum or other contractual limitation contained in the dental benefit plan.

When treatment is provided for services that are not contractually covered, the payment explanation will indicate that the entire submitted fee is the patient's responsibility with no adjustment/write off for any non-covered service.

Provider's Fee

The definition of "Provider's Fee" used by Delta Dental is as follows:

The Provider's Fee is the lowest fee charged or offered for a given service by an individual dentist to any patient or prospective patient. The Provider's Fee shall not be affected by fees accepted for patients covered by programs funded by public or charity funds primarily intended to assist the disadvantaged or those occasional instances where professional courtesy discounts are given or fees are waived or discounted in cases of financial hardship.

Maximum Plan Allowances, which are established by a bona fide arm's length agreement between a Participating Dentist and a third party payer for a group, prepayment, or insurance program, shall not be considered the Provider's Fee with DDKS, and therefore shall not affect a Participating Dentist's Provider's Fee. If so requested by DDKS, it shall be the responsibility of the Participating Dentist to provide documentation of the existence of such agreement between the dentist and such third party payer.

Participating Dentists are prohibited from waiving patient co-payments in accordance with their Participating Dentist Agreement and the laws according to the Kansas Dental Board (K.S.A. 65-1436 (b)(16)). Use of waivers or other verbal or written agreements between a dentist and his or her patient in an effort to collect more than the MPA are prohibited.

Disclaimer: The Dentist Handbook is an extension of the Participating Dentist Agreement. This document is designed to provide important information related to the national processing policies, procedures and guidelines for all ADA CDT procedure codes, along with other helpful information such as definitions, submitting claims, appeals and using electronic services.

No Balance Billing

The Participating Dentist agrees to submit claims on behalf of all Delta Dental patients and also agrees to submit the Provider's Fee for all completed dental procedures whether or not the procedure is covered by the patient's dental plan. **Any difference in fees charged by the dentist and Delta Dental's maximum allowance cannot be charged to any Delta Dental patient for contractually covered services.** This applies to all Delta Dental patients, regardless of the control plan administering the benefits. **Patient waivers do not supersede this policy.**

Discounts

Discounts or coupons provided to non-insured or other non-Delta Dental patients must be provided to Delta Dental patients for the same services. If any discount is offered, that amount should be reflected on the claim form.

Participating Dentists are prohibited from waiving patient co-payments as a method of providing patient discounts in accordance with their Participating Dentist Agreement and the laws according to the Kansas Dental Board (K.S.A. 65-1436 (b)(16)).

The Provider's Fee shall not be affected by fees accepted for patients covered by programs funded by public or charity funds primarily intended to assist the poor or disadvantaged or those occasional instances where professional courtesy discounts are given or fees are waived or discounted in cases of financial hardship.

Credentialing/Re-Credentialing

As part of Delta Dental's overall quality assurance program, secondary source credentialing must be conducted. We are required to credential Participating Dentists in order to comply with the standards of the Delta Dental Plans Association (DDPA).

The credentialing required by DDPA is intended to ensure that enrollees who select Participating Dentists anywhere in the country can be confident that the dentist has met uniform requirements. Credentialing also supports Delta Dental's commitment to quality care, which is a goal we share with the dental profession. It ensures objectivity in the selection process and is completed every three years for all Participating Dentists.

Credentialing is not only about licensing, it is about considering other aspects of a provider's history as well. The credentialing application includes: personal information, education/training, licensure/ tax identification number (TIN) or social security number, malpractice insurance information, dental employment history, professional information and infection control.

Malpractice and Liability Insurance

Malpractice insurance is a requirement of the Kansas Dental Board (K.S.A. 65-1468), DDPA and DDKS' insurance policies. The Participating Dentist agrees to maintain the minimum coverage per the requirements of the Kansas Dental Board to avoid termination of the Participating Dentist Agreement.

The Participating Dentist agrees to carry malpractice and premises liability insurance of a minimum of $100,000 per occurrence and $300,000 aggregate, and provide either a copy of the Declaration policy or the information completed on the Credentialing Application form.

Directory Accuracy

Delta Dental is required to maintain accurate Participating Dentist directories. This ensures that patients can locate active Participating Dentists at listed locations. Please notify DDKS immediately when a Participating Dentist separates from any treatment location by contacting customer service or Professional Relations at pr@deltadentalks.com.

As a method of verification, DDKS conducts periodic audits that include, but are not limited to, personal visits, electronic or print correspondence and/or phone calls to dental offices. For a Participating Dentist's location to be listed in our Participating Dentist directory, the dentist must regularly schedule treatment at that location.

Second Office/Change of Address

Delta Dental strives to keep our directory of Participating Dentists accurate. It is a requirement of Participating Dentists to provide written notification in advance to DDKS if your office location changes. Establishment of an additional location requires completion of a new Participating Dentist Agreement packet signed by each provider working at the additional office location(s) in order for each treating dentist to be paid as a Participating Dentist. Information on the W-9 form provides the business record (TIN, business name and address) for accurate payment to the correct billing address by all Delta Dental Member Companies.

Employee/Associate Dentists

If you have other associate dentists treating patients in your office, they must complete the Participating Dentist Agreement packet with DDKS to be considered a Participating Dentist. Payments are issued based on the TIN information provided on the participation agreement and the W-9 form.

Tax Information

Delta Dental is required by law to report payment information to the IRS each calendar year. We must maintain a current W-9 Form on file indicating accurate/matching TIN information in accordance with the IRS. If a change has not been updated with the IRS or there is a mismatch due to IRS processing, documentation from the IRS can be provided to DDKS as confirmation of change. While DDKS conducts annual audits, it is the responsibility of the Participating Dentist to notify DDKS of changes in the TIN as they occur or by December 31st of each calendar year. Lack of compliance could result in future withholdings as outlined by the IRS https://www.irs.com/.

Dental Consultants

Delta Dental employs dentists to review claims submitted to Delta Dental that require professional judgement for benefit purposes and to objectively evaluate a treatment plan for either predetermination or for treatment pursuant to the terms of the group contract. At DDKS, licensed dentists make decisions requiring professional judgment that would alter requested benefits.

From time to time, DDKS uses the services of regional dental consultants. A regional consultant's job may include the examination of Delta Dental covered patients, specific claims and documentation concerning completed treatment or treatment to be performed. This provides DDKS with information that is vital to fulfilling contractual obligations while assisting the patient in obtaining the best

possible benefits. The regional consultants are essentially acting as the eyes and ears of the in-house consulting staff when a benefit determination cannot be made on the basis of the documentation submitted such as an X-ray and the claim form. However, all determinations of benefits remain the responsibility of our in-house dental consultants.

Procedure Codes & Nomenclature

The listing of a procedure code does not mean that the specific procedure code is a covered or reimbursable benefit under a patient's dental benefits plan. It is the responsibility of the patient, not the dental office, to know what is covered and what is excluded from the group's dental plan. The chosen treatment plan is a decision between the dentist and the patient and should not be determined based upon coverage. Please refer to the Policies and Procedures Reference Guide, located in the Participating Dentist Handbook (as revised from time to time) for complete procedure codes and descriptions. Also, refer to the electronic and/or paper newsletters sent to Participating Dentists from DDKS, which occasionally contains updates to processing policies.

Dental Claim Form

Accurate and complete preparation of the dental claim form is the first step toward prompt and satisfactory claim processing. Participating Dentists agree to submit primary and/or secondary claims directly to Delta Dental on behalf of Delta Dental patients without charge to the patient or to Delta Dental.

The claim form contains all the information necessary to properly adjudicate payable benefits. Claims submitted on forms other than the standard ADA claim form that do not contain all the necessary information may be returned.

Completed claims must be received by Delta Dental within twelve (12) months of the date of service or it will be processed as not billable to the patient. Upon appeal, special consideration may be given for claims older than twelve (12) months.

If another insurance plan is primary and does not pay in a timely manner, it is recommended to submit a claim to the secondary payer within six months of the service date to comply with timely filing requirements. The denial should indicate the need for the primary carrier's remittance advice. Once the primary carrier pays, include a copy of the primary carrier's remittance advice and the secondary carrier's denial (not a new claim) and request reprocessing of the secondary claim.

Guidelines for Submitting Claims

- Use current ADA codes and nomenclature on the claim form. Include teeth numbers, quadrants and service date (if submitting a predetermination, exclude service date).
- Include the Provider's Fee for each service.
- If the patient is offered a discount, include the discounted fee on the claim form.
- Provide the total amount for the services submitted.
- List the treating dentist and treating location on the dental claim form.

Dates of Service

The National Processing policy requires that multi-stage procedures are reported and benefited upon completion. The definition of completion dates are:

- The date the root canal is completed (i.e., sealing the pulp chamber and canal to the apex of the root).
- The date the final prosthesis is seated in the patient's mouth.
- The date of insertion for removable prosthetic appliances.
- The date that the remaining teeth are removed and the denture is inserted for immediate dentures.
- The final cementation date for fixed partial dentures, crowns, onlays and inlays regardless of the type of cement.

Missing Teeth

Indicate all missing teeth for prosthodontics and implants. Use brackets to indicate fixed bridges. Supply a copy of the patient record/clinical chart notes as needed and as required by the code or for further description of services provided.

Treating Dentist

Indicate the name, license number, Type 1 NPI and signature of the dentist who provided the services. This information may be the same or different than the billing entity. A dentist must not submit claims using his or her name as the treating dentist for any service rendered by another dentist except in cases of locum tenens.

Substitute or Fill-In Dentist - Locum Tenens

When a dentist requires coverage for instances of temporary absence from his or her practice (vacation, childbirth, illness, impairment due to injury, etc.), the name and license number of the dentist filling in should be listed in the narrative/remarks portion of the claim along with an indication that the dentist is filling in temporarily. This will allow Delta Dental to process the claim under the Participating Dentist without requiring a Participating Dentist Agreement from the temporary dentist who is providing treatment during any absence.

Electronic Claims Submission (ECS)/Web Claims

Delta Dental readily accepts claims received through electronic clearinghouses. Electronic claims submitted through your practice management system can be processed quickly avoiding multiple entry errors. Contact your practice management vendor for more information on how to submit electronic claims. Please ensure that the treating dentist is accurately listed on both paper and electronic claims. Web claims may be submitted at no cost through your online dentist account at DeltaDentalKS.com. If you need assistance, please contact our Customer Service team at 800.234.3375 or your area Professional Relations Representative.

Rejected Claims

Claims that contain invalid patient data such as misspelled name, incorrect member ID or wrong date of birth are rejected by our system and a new corrected claim must be submitted for processing. You will receive a letter or you can retrieve your notification of rejected claims by accessing Claims Services in your online dentist account by logging in at DeltaDentalKS.com. You or your patient may need to contact Delta Dental to resolve the mismatch.

Submitting Orthodontic Claims

Orthodontic cases may be submitted electronically or by using standard/regular claim forms once the patient is banded or the first aligner is delivered. Please do not submit claims for the patient's monthly follow-up care. Do not send study models or X-rays unless requested by our dental consultants. All claims should include the following information:

- Date appliances were placed or delivered.
- ADA valid procedure code and description of treatment (indicate arch when applicable).
- Total treatment fee.
- Approximate length of treatment (number of months).
- Initial fee/down payment, when applicable.
- Retainer fee, when applicable.
- Primary payer lifetime benefit amount and coinsurance, when applicable and DDKS is secondary.

Once payments are scheduled, the dentist and subscriber will be notified of the amount approved, the patient's maximum, and the monthly payment schedule on the initial Explanation of Payment (EOP), also called an Electronic Remittance Advice (ERA), and on the patient's Explanation of Benefits (EOB). These payments will automatically continue until:

- The case is completed.
- Notification is received in our office that treatment has been interrupted (it is your responsibility to notify Delta Dental if the treatment plan is in any way changed, interrupted or discontinued)
- The eligibility of the patient lapses or changes.
- The maximum benefit for the case or the lifetime maximum benefit has been reached.

If the practice TIN changes or the patient's care is permanently taken over by a different dentist at a different practice, a new/corrected claim form is required. This allows DDKS to move the remaining monthly payment schedule to the correct business record for payment purposes. Delta Dental encourages the predetermination of orthodontic benefits. Payment will not begin on predetermined orthodontic cases until the predetermination of benefits form is returned to Delta Dental with the date the appliances were placed and the dentist's signature.

Orthodontic Takeover

Orthodontic Takeover is the processing method followed when a group is new to DDKS and the member and plan's effective dates are the same, the member was undergoing ortho treatment prior to the group and member's effective date, and payment(s) have been made by the prior carrier towards the treatment.

To determine if a member qualifies for takeover, DDKS will require the information below, as well as: Clarification of the account balance vs. the remaining insurance balance to ensure the patient receives the correct benefit amount.

If the claim is for a patient with a group dental plan providing a takeover option, DDKS requires the following information upon submission of the claim:

- ADA valid procedure code and description of treatment (indicate arch when applicable).
- Remaining treatment fee balance.
- Number of months of treatment remaining.
- Retainer fee if applicable.
- The total amount paid by the previous insurance carrier.

Predetermination of Benefits

A predetermination is the submission of a treatment plan with necessary attachments, such as pre-operative radiographs, prior to completion of dental services. This allows your patients the opportunity to make proper financial arrangements for their portion of the treatment costs before the actual work begins. Some group dental benefit plans may include coverage limitations for extensive or large treatment plans such as a maximum number of crowns, maximum dollar amount, etc. Predeterminations reduce confusion for the patient and promotes goodwill between the dentist, the patient, and Delta Dental.

Requests for predetermination are made by submitting a proposed treatment plan in the same manner as a regular claim, omitting dates of service and the dentist's signature. Delta Dental strongly encourages the dentist to make predeterminations a habit, except in emergency and routine situations. A Participating Dentist agrees not to charge a fee to the patient or Delta Dental for submitting a predetermination of benefits.

Because some procedures are not covered by group contracts, a predetermination is recommended for treatment plans involving implants, TMJ, prosthetic and orthodontic procedures, veneers, crowns, gold restorations, surgical periodontics, endodontics, and oral surgery (except for simple extraction of a single tooth). *For benefit questions, please use your dentist account at DeltaDentalKS.com to verify benefits for specific procedure codes.*

Predetermination Process

When Delta Dental receives an electronic or paper treatment plan for predetermination, the following steps are taken:

- DDKS determines whether or not the patient is eligible for benefits under the group's contract. The fact that the patient is eligible at the time of predetermination does not guarantee eligibility at the time services are actually rendered.

- It is determined if the proposed services are covered under the group's dental plan.

- Any deductibles are applied and maximum benefits used to date are verified. These amounts can differ on the actual claim if other services are submitted prior to completion of the treatment plan.

Delta Dental will issue a predetermination of benefits to the Participating Dentist and the patient. This notification is an estimate of liability. The predetermination should always be reviewed with your patient.

If the services are performed prior to the expiration date, the Participating Dentist can fill in the service dates, sign and return the predetermination form to Delta Dental via email at customerservice@deltadentalks.com for payment. If submitting through a clearinghouse, include the original valid predetermination number in remarks box #35 to reference the approved predetermination, this will expedite payment. Otherwise a new claim (electronic or paper) with no reference to a predetermination number is subject to the normal processing procedures including requests for attachments such as radiographs, chart notes, or a written rationale.

If the treatment plan is altered (i.e. a composite was predetermined but a crown was placed instead), a new claim form should be submitted for the new treatment plan. Be sure to include any necessary documentation such as radiographs. Procedure codes should not be changed on the predetermination form. Any procedures that were predetermined and were completed can still be submitted on the valid predetermination form.

When a predetermination is received with only some of the procedures completed, a new predetermination form will be generated for the services that were not yet completed. If you decide not to perform a procedure, please draw a line through the procedure and it will be deleted.

Predetermination of benefits is not a guarantee of payment. The amounts shown as "patient responsibility" and "plan pays" are always subject to change. They are determined by the patient's eligibility, the amount of benefits available, the dentist's fee, the MPA, any amounts of benefits payable under another dental program and/or if there has been a change in the dentist's participation status at the time of service.

How Long are Predeterminations Valid?

Predeterminations are valid for six (6) months. After six (6) months, the predetermination is purged and a new claim and applicable attachments are required. When groups mandate predeterminations, services must be provided within the "valid to" date. Predeterminations may be extended for an additional six (6) months when requests are received before the predetermination expires by submitting the original predetermination with a request for extension to customerservice@deltadentalks.com or by calling 800.234.3375.

Radiographs and Other Documentation

A Participating Dentist agrees to submit to Delta Dental upon request, any and all available information, including radiographs, chart notes, periodontal charts, missing tooth charts, study models, photographs, etc., which are related to any claim made to Delta Dental or anything related to compliance with the agreement.

It may be necessary to submit radiographs, either mounted (not originals) or electronic copies, and/or rationale before DDKS can determine benefits. Email electronic radiographs to customerservice@deltadentalks.com. Please do not fax or send photocopies of radiographs as it diminishes the diagnostic quality. Be sure to clearly mark mounted copies of radiographs indicating left and right. If you must send original radiographs, include a self-addressed stamped envelope along with a request that your radiographs be returned. Please refer to the Attachment Requirements for details on necessary attachments.

When applicable, please mark all missing teeth on the tooth chart and list the teeth to be replaced by proposed appliances. Make mention of teeth that are endodontically involved or fractured and include, when appropriate, a written narrative explaining circumstances that require a more extensive or costly treatment.

Dental claims and predeterminations may also be sent via your dentist account at DeltaDentalKS.com. The same attachment requirements still apply.

Optional/Alternative Treatment Plans, also known as Least Expensive Professionally Accepted Treatment (LEPAT)

The condition of the patient's mouth will dictate the course of treatment selected. In some cases, however, you may have a choice of treatment plans. The fact that one of the treatment plans is more expensive than another, or that one treatment plan would not be covered by your patient's dental benefit plan should not dictate the type of treatment rendered.

In many cases, payment will be based upon the least costly course of acceptable treatment as determined by the patient's group or individual contract. For example, if teeth are missing in both quadrants of the same arch, benefits are allowed for a bilateral metal-frame partial denture toward the procedure submitted. If a fixed bridge, implant or other more expensive procedure is selected, the difference between Delta Dental's MPA for the alternate benefit and Delta Dental's MPA for the actual treatment rendered is collectable from the patient.

Cosmetic Services

Cosmetic services are those services requested by your patient that do not meet criteria outlined in plan benefits for insurance reimbursement. Examples include anterior crowns or veneers used to "straighten", whiten, close/minimize gaps, or to alter the shape and/or size of teeth with no existing dental decay or fillings. Adding tattoos or jewels are cosmetic and should be reported as a separate miscellaneous procedure. Cosmetic services are processed as non-covered services and your patient is responsible for the full fee charged by the dental office with no insurance adjustment.

If the claim documentation submitted for the cosmetic service is reviewed and determined by our dental consultants that it meets dental necessity due to disease or fracture, then the service is subject to normal plan benefits and limitations, and the Participating Dentist is held to the maximum plan allowance for the procedure code submitted.

Attrition and Wear

When restorations are provided to treat cases of attrition, abrasion, erosion, abfraction or altering occlusion, the restorations are needed because of destructive patient habits rather than a dental disease process and are not covered by most dental benefits plans due to contractual exclusions. This may include treatment where multiple restorations are placed to restore vertical occlusal dimension and/or improve the patients bite position. These types of restorations are processed as non-covered services and your patient is responsible for the full fee charged by the dental office with no insurance adjustment.

Coordination of Benefits

Coordination of Benefits (COB) was developed to eliminate the potential for a patient to profit when a person is covered by more than one group health care plan. It limits the total benefits received so as not to exceed the total amount approved by Delta Dental. Generally, each state has its own coordination of benefits requirements which will be included in the patient's dental benefits policy.

In Kansas, the enrollee's plan through his or her employment is generally primary. For dependent children, the "birthday rule" is used when the parents are married or living together. This ruling states that the dental policy covering children will be considered primary by the plan of the parent whose birthday (month and day) occurs earlier in the calendar year. Therefore, the plan covering the parent whose birthday falls later in the year pays secondary. If the parents' birthdays are identical, the primary carrier will be the one that has covered the children for the longest period of time. If the child is married and has coverage by a parent and a spouse, the plan that has been in effect the longest is primary. It is important to note that there are two exceptions to the birthday rule:

1) Generally, the criteria for identifying the primary carrier for dependent minor children of legally separated or divorced parents is as follows:

    a) When there is a court decree, which places financial responsibility for health care expenses upon one parent, that parent's plan will be primary.

b) When there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

i. The plan covering the custodial parent;

ii. The plan covering the custodial parent's spouse;

iii. The plan covering the non-custodial parent; and then

iv. The plan covering the non-custodial parent's spouse.

2) Where COB occurs between carriers of different states, it is recommended you check with the Delta Dental member company for additional guidance.

For additional COB scenarios, please review the dual coverage processing guidelines flowchart here or you can access it by logging in to your dentist account, under the Documents & Dentist Handbook Section.

Please note that a write-off should only be taken if indicated on the EOP/ERA. Wait until both primary and secondary plans process before determining any write-off. Typically, a write off should not result in a credit balance on your patient's account. **Rarely should the patient receive a credit balance for having dual coverage**.

In the event that combined payments by all carriers exceed 100% of the amount approved by Delta Dental, the amount in excess should typically be refunded to the secondary carrier except when the secondary payer has coverage through a plan that does not coordinate benefits. The patient may be due any overpayment when this occurs. When in doubt, verify with all payers before processing refunds.

Coordination of Benefits on Predeterminations

When a predetermination is submitted and Delta Dental is the secondary carrier, Delta Dental will advise you of the amount we would pay as if there were no dual coverage. When the predetermination is returned for payment, include primary payment information, if available, to avoid delays. Otherwise, an inquiry will be sent to the dental office requesting payment information. Delta Dental will issue its payment, subject to contractual limitation, so that the combined payments do not exceed 100% of the approved amount.

Reimbursement/Patient Expenses

The patient's share in the cost of the dental care services received will depend upon the plan the employer group selects and may involve a copayment, deductible, and/or an annual or lifetime maximum benefit. **The patient cannot be charged upfront for any amount, which is anticipated to be paid by Delta Dental. However, Delta Dental encourages the collection of the patient's share at the time of service.**

Refund Requests

Occasionally, DDKS will request a refund for payment made to a Participating Dentist because of an error in processing or incorrect reporting. DDKS will notify the dentist's business entity in writing that a refund is due, the amount due and the reason for requesting the refund. Per the Participating Dentist Agreement, if the business fails to refund the amount that Delta Dental determines to be properly owed, DDKS will automatically deduct said sums from any future payments due to the business. The refund must arrive at DDKS within 30-days from the initial request to avoid an auto-deduction of the refund due from future payments.

Overpayments

Overpayments are occasionally made because of, but not limited to, an error in processing, duplicate claim submissions, ineligibility of the patient at the time of service, or inaccurate information supplied regarding other insurance coverage.

If you receive an overpayment from DDKS, please notify our office and a refund request will be issued. Please return a copy of the refund request letter with your refund check. Do not refund any excess insurance payments to the patient.

Appeals/Requests for Reconsideration

If you do not agree with Delta Dental's determination of benefits and you have additional information to provide, you may request reevaluation by submitting an appeal request form online or by mail, which includes:

- The reason for requesting reevaluation.

- Radiographs, photos, clinical chart notes and/or comments not initially submitted with the original claim. If additional documentation includes radiographs, send digital radiographs via email (customerservice@deltadentalks.com) or send a duplicate film via mail to DDKS. *__Note:__ Faxed and printed radiographs may provide diminished quality and undiagnostic quality for clinical review.

- The patient's identifying information and original claim number, or an attached copy of the claim detail section of the payment summary or pretreatment estimate.

Send the appeal online, via email to customerservice@deltadentalks.com, fax to 316-462-3392 or mail to DDKS including "Attn: Appeal" on the address attention line.

Do not submit a new claim unless requested to do so as this will likely deny as a duplicate causing unnecessary delays.

How to Initiate an Out-of-State Appeal

Call customer service for the state's Delta Dental member company to which you submitted your patient's claim.

- Follow the instructions provided to you by the Customer Service Representative.

- After following the protocol as requested, if you are still unable to resolve the issue with the other Member Company, contact your local DDKS Professional Relations Representative and request assistance.

Electronic Services

Delta Dental offers several easy-to-use online tools:

Delta Dental Dentist Account

Each Delta Dental Member Company offers an online portal to assist you in finding information on any patient with dental benefits covered by Delta Dental. You can access this portal and create your dentist account at DeltaDentalKS.com. If you need assistance creating your login and password or accessing your account, please contact our Customer Service team.

Eligibility and Benefits

Check the benefits on any Delta Dental patient through your dentist account at DeltaDentalKS.com by selecting "Check benefits of patients covered by Delta Dental in other states" or "Search for One Patient or Search for Multiple Patients" to access detailed benefit information for patients covered by Delta Dental of Kansas.

Claim Verification

Check any claim you have submitted on any of your Delta Dental patients from coast to coast. Other electronic services include Electronic Claims Submission (ECS), web claims, Electronic Funds Transfer (EFT), and Electronic Reminittance Advice (ERA); plus other benefits and services available through your dentist account at DeltaDentalKS.com.

Electronic Claims Submission (ECS)

ECS claims are submitted through a clearinghouse and are set up through your practice management vendor. It is a fast, convenient way to send claims to insurance payers. All claims submitted electronically fall under HIPAA (Health Insurance Portability and Accountability Act). Offices submitting electronically are covered entities under HIPAA and must use a National Provider Identification (NPI) number when submitting electronically. You may wish to contact a legal advisor for more information. To apply for your NPI number, visit https://nppes.cms.hhs.gov/.

Web Claims

Submitting claims via your dentist account at DeltaDentalKS.com is a fast, easy, and free way to send claims, predeterminations and attachments. This simple process allows you to file your claims electronically to DDKS without using a clearinghouse at no cost to you.

Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)

EFT is the safest way to receive your claims payments. We will deposit your payments directly into the bank account of your choice. The funds are available immediately, so there is no more waiting on the mail, worrying about deposits during vacations, or worrying about lost or stolen checks. It is convenient and free to Participating Dentists.

Delta Dental Plans Association offers a National EFT/ERA program through a DentalXChange link, available on the DDKS website for retrieving/accessing all Delta Dental Member Company ERAs.

To sign up for EFT/ERA download the form from your dentist account at DeltaDentalKS.com and follow the enrollment instructions on the form. If you have questions about this program, please contact your area Professional Relations Representative.

Web Report Retrieval – Kansas EOP/ERA

Web Report Retrieval is the most secure way to receive your DDKS EOP/ERA if you are enrolled in EFT. You receive an electronic copy of your EOP/ERA equivalent to the copy you would have received by mail, only faster. Simply log into your dentist account at DeltaDentalKS.com, select the "Payments" link available then print or save your report.

National ERA Retrieval

If you are enrolled in the National EFT/ERA program, you can retrieve electronic remittance advices (ERA) via the "Payments" tab on your dentist account. Select "Check National Electronic Remittance Advice (ERA)", then select "View Delta Dental ERAs". This will redirect you to DentalXChange (DxC) where you will select "Unprocessed ERAs" and can view or print your ERAs.

DentalxChange provides helpful information on their portal and through their customer service. If you have questions, please contact DentalXChange customer service a 800.576.6412 ext. 452. You may also contact DDKS Customer Service or your area Professional Relations Representative.

Daily Claims Payment

Claims submitted electronically or via your dentist account at DeltaDentalKS.com may be eligible for daily claims payment. If your office utilizes either method of claim submission, and is signed up for direct deposit, the business will receive electronic EOPs/ERAs daily.

Contact your Professional Relations Representative for more information on all electronic services.

Value-Added Services Program

To further enhance the service we provide, we have developed a Value Added Services Program for our Participating Dentists. The program includes exclusive cost-effective product discount offerings, additional online services, educational materials, seminars and other business services. Some of these services include:

- Detailed online benefits information with claims history.
- Free online web claims, predeterminations and electronic attachment submission.
- Access to view processed predeterminations.
- Online retrieval of claims payment history.
- Peer-to-peer claim consultation.
- EFT (direct deposit) and daily payments (some restrictions apply).
- Web ERA (electronic remittance advice) retrieval for local and national payments with enrollment.
- Online access to the Dentist Handbook for Processing Policies and Reference Guide.
- Personalized reports available 24/7 on our website.
- Seminars and CEUs.
- Office training and visits from Professional Relations Representatives.
- Electronic newsletters providing educational information and important updates.
- Dental Office Deals—a free program that provides discounts on products and services for the dental office as well as members of your dental office team (access through your dentist account at DeltaDentalKS.com.)

For more information on our Value-Added Services Program, please call our Customer Service department at 800-234-3375 or email Professional Relations at pr@deltadentalks.com.

Delta Dental Network Participation

Delta Dental Premier®

Delta Dental Premier is our traditional fee-for-service program. When signing a Participating Dentist Agreement, a dentist becomes a Participating Dentist in the Premier network. When a dentist participates in the Premier network, they agree to accept payment based on the lesser of their submitted fee or DDKS' MPA.

The Delta Dental Premier network is a nationwide network, with over 95% of dentists in Kansas participating.

Delta Dental PPO™

Delta Dental PPO is our preferred provider, fee-for-service program. To participate in the Delta Dental PPO network, dentists must sign an addendum to the Participating Dentist Agreement. When a dentist participates in the PPO network, they agree to accept payment based on the lesser of their submitted fee or the DDKS PPO fee schedule.

The Delta Dental PPO network is a nationwide network, with over 66% of dentists in Kansas participating.

Delta Dental Patient Plan Types

Delta Dental Premier®

Patients with a Delta Dental Premier plan can visit the dentist of their choice, including a nonparticipating dentist, but will have greater savings when choosing a Premier network dentist.

Delta Dental PPO Plus Premier™

Patients with a Delta Dental PPO Plus Premier plan can visit a PPO or Premier network dentist and will receive the same coverage percentage.

Delta Dental PPO™

Patients with a Delta Dental PPO plan can visit a PPO or Premier network dentist, but will receive higher level of benefits/greater savings when choosing a PPO network dentist.

Delta Dental PPO™ - ONLY

Patients with a Delta Dental PPO - ONLY plan (also called an 'EPO' or exclusive provider option plan) must see a Delta Dental PPO network dentist in order to receive benefits. On these patient's member ID cards you will see "Delta Dental PPO – ONLY" or "DELTA DENTAL PPO Benefits only with PPO providers" in the top right corner.

DELTA DENTAL®

Delta Dental Participating Dentist Agreement

WHEREAS, Delta Dental of Kansas, Inc. ("DDKS"), was organized for the purpose of securing the benefit of dental service through the establishment of a dental service program for individuals or groups of individuals; and

WHEREAS, each dentist whose signature appears on this Participating Dentist Agreement ("Agreement") is a person duly licensed to practice dentistry in the State of Kansas, ("Participating Dentist"), and is willing and desires to join in and assist DDKS, and national Delta Dental groups (collectively "Delta Dental") in such dental service programs on the basis hereinafter set forth; and

WHEREAS, Participating Dentist agrees to provide services to persons who are covered by Delta Dental, ("Delta Dental Patient(s)") under the terms and conditions of this Agreement; and

WHEREAS, in all dealings between Delta Dental and Participating Dentist, each agrees to cooperate with the other, and their respective employees and agents, in a professional and courteous manner:

NOW THEREFORE, in order to fix the rights and liabilities of the parties hereto, it is hereby agreed as follows:

1. Participating Dentist authorizes Delta Dental to offer the Participating Dentist's services to Delta Dental Patients, and such authorization includes, but is not limited to, listing Participating Dentist in Delta Dental's directories of Participating Dentists. Participating Dentist shall provide treatment to all Delta Dental Patients requesting service at the same level of service and appointment availability as Participating Dentist provides to non-Delta Dental Patients. Specifically, Participating Dentist agrees to accept new Delta Dental Patients on the same basis that Participating Dentist is accepting new non-Delta Dental Patients.

2. Participating Dentist agrees to accept payment of the DDKS'Maximum Plan Allowance (as defined in DDKS' Participating Dentist Handbook and its Policies and Procedures ReferenceGuide, as revised from time to time, which are collectively referred to as the "Policies") as payment in full for all dental services provided to a Delta Dental Patient, including amounts due from the Delta Dental Patient such as deductibles or copayments. No reductions to any fee submitted to Delta Dental may be charged back to a Delta Dental Patient or to any other source. Participating Dentist further agrees to make no charge to a Delta Dental Patient which is contrary to this Agreement or the Policies of Delta Dental. Participating Dentist agrees not to charge a greater fee for a Delta Dental Patient that is covered under a Delta Dental administered program than the "Provider's Fee" (as defined in the Policies) charged for non-Delta Dental Patients.

3. Since the rendition of a dental service is not always standard or routine, Delta Dental recognizes that billed fees will at times exceed the Maximum Plan Allowance. Special circumstances may arise in a particular case which complicate the treatment. However, only when such unusual circumstances arise and are fully described by the treating dentist in the comments portion of the Attending Dentist's Statement or in an additional attachment will Delta Dental consider an adjustment in compensation for that service.

4. Except as provided in this Agreement, the Delta Dental Patient and Participating Dentist shall have complete freedom of choice in providing or accepting of dental care as long as they comply with all relevant federal and state laws and regulations. Participating Dentist agrees to be familiar with and to abide by all of Delta Dental's policies, rules, and regulations, including but not limited to DDKS' Policies, which are established and revised from time to time, and all relevant federal and state laws and regulations. In addition, Participating Dentist agrees to submit to Delta Dental, upon request, any and all available information which is related to any claim submitted to Delta Dental or anything related to compliance with this Agreement.

5. Participating Dentist agrees to cooperate with preauthorization, quality assurance, and post-treatment review programs established and implemented by Delta Dental.

6. Participating Dentist agrees to maintain adequate and accurate records, whether paper or electronic. Upon request, a representative of Delta Dental will be allowed to examine such records to provide verification that the fees charged are in compliance with this Agreement. To the extent either party deems such action necessary, Participating Dentist shall execute any and all necessary agreements and/or obtain non-Delta Dental Patient authorizations to permit such examination by DDKS. Failure to obtain or to have such authorizations shall not constitute a reason for delay of a scheduled examination.

7. DDKS has established a committee (and may establish additional committees) to handle any inquiries or complaints of Delta Dental Patients or others relating to adequacy of care arising out of or relating to any Delta Dental dental care program or agreement. Participating Dentist hereby waives any and all legal recourse such dentist may have against said committee, DDKS, and DDKS' officers, directors, employees, agents, and representatives regarding the handling of such inquiries or complaints.

8. Participating Dentist agrees to conduct dentist's practice in a legal and ethical manner including being in compliance with the principles established by the Kansas Dental Board. Participating Dentist further consents to the release by Delta Dental of any information relating to such Participating Dentist to the Kansas Dental Board or any investigative, regulatory, or law enforcement group.

Return to Delta Dental of Kansas:
email: PR@deltadentalks.com | mail: P.O. Box 789769 Wichita, KS 67278-9769 | fax: 316.462.3317

800.234.3375 | DeltaDentalKS.com

DELTA DENTAL®

Delta Dental Participating Dentist Agreement

9. Participating Dentist shall not discount any portion of the financial obligation of any Delta Dental Patient to the dentist for services rendered which are benefits under any Delta Dental program.

10. Participating Dentist authorizes Delta Dental to deduct from any payments due to the dentist any sums as Delta Dental determines to be properly due and owing Delta Dental, provided the dentist has been notified by Delta Dental that such sum is due and the dentist has not paid it.

11. Delta Dental may deny all or any portion of the payment of any claim for services which is submitted without prior authorization if prior authorization was required, and such denied amount may not be charged by the Participating Dentist to the Delta Dental Patient.

12. Participating Dentist agrees to provide malpractice history if applicable. Participating Dentist also agrees to notify DDKS in writing of any changes in coverage, including the insurance carrier and policy number, within 30 days of such change.

13. Participating Dentist certifies that his/her license to practice dentistry has not been revoked, suspended, placed on probation or voluntarily relinquished within the past five years, and agrees to notify DDKS in writing within 30 days of any such action occurring.

14. Either Participating Dentist or DDKS may terminate this Agreement for any reason or no reason by giving at least thirty (30) days' written notice to the other. A Participating Dentist whose membership has terminated for any reason, whether voluntarily or involuntarily, may apply to DDKS for reinstatement as a Participating Dentist, but such reinstatement shall be solely at the discretion of, and subject to, such terms and conditions as DDKS deems appropriate.

15. DDKS may amend this Agreement at any time, and from time to time, upon providing at least thirty (30) days' advance written notice of such amendment to Participating Dentist. In such event, and unless Participating Dentist terminates this Agreement as provided above before the effective date of such amendments, Participating Dentist shall be deemed to have agreed to such amendments effective upon the later of i) thirty (30) days following the date of such notice or ii) the effective date specified in such notice.

16. Participating Dentist agrees that the terms of this Agreement and DDKS' Policies supersede any oral or written agreement now existing or hereafter entered into between Participating Dentist and any Delta Dental Patient.

Practice Information

Tax Identification Number (TIN): _____ Type 2 NPI: _____
Note: SSN/IRS Tax ID# reported MUST match the name that you file under which you file with the IRS for payment/refund purposes.

Address: _____ City: _____ ZIP: _____

Dentist Email: _____ Dentist Office Email: _____

Telephone Number: _____ Fax: _____

Second Office *(if applicable)*

Tax Identification Number (TIN): _____ Type 2 NPI: _____

Address: _____ City: _____ ZIP: _____

Dentist Email: _____ Dentist Office Email: _____

Telephone Number: _____ Fax: _____

SIGNATURE

Dentist Signature: _____ License Number: _____ Date: _____

Dentist Name (Print): _____ Type 1 NPI: _____ Gender: _____

FOR INTERNAL USE ONLY: ***The effective date of this agreement shall be upon receipt by Delta Dental of Kansas***

Effective Date: _____ *(To be completed by Delta Dental only. Dentist will be notified in writing by Delta Dental of Effective Date.)*

Completed by Name: _____ Title: _____

Signature: _____ Date: _____

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DELTA DENTAL®

Delta Dental PPO™ Addendum

A supplement to the Delta Dental Participating Dentist Agreement

This Supplement To Participating Dentist Agreement ("Supplement") is entered into between Delta Dental and Participating Dentist to permit Participating Dentist to participate in the Delta Dental PPO ("PPO Program") on the following terms:

- This Supplement modifies the terms of the Agreement only with respect to Participating Dentist's participation in the PPO Program, and all terms defined in the Agreement shall have the same definitions for purposes of this Supplement. Except to the extent expressly provided herein, this Supplement is subject to, and incorporates by reference, all of the terms of the Agreement and the documents referred to therein.
- The term "PPO Program" means a program administered by Delta Dental which contracts with Participating Dentists who agree, pursuant to the terms of this Supplement, to serve as PPO Program Panel Dentists and who provide care at fees that are, on the average, below the fees charged in Delta Dental's conventional fee-for-service programs. In the PPO Program, the Delta Dental Patients may choose a dentist on a treatment-by-treatment basis, although there may be economic incentives for such patient to seek care from a PPO Program Panel Dentist.
- Participating Dentists agrees to provide services to Delta Dental Patients who are enrolled in the PPO Program under the terms and conditions set forth in the Agreement and Policies, except that the fees charged for such shall not exceed the lesser of the Participating Dentist's "provider's fee" (as defined in the Policies) or the fee shown on the enclosed Delta Dental PPO Fee Schedule. *The Delta Dental PPO Fee Schedule shall not affect the fees that Participating Dentist may charge to Delta Dental Patients who are not enrolled in the PPO Program.*
- This Supplement and/or the Delta Dental PPO Fee Schedule may be modified, terminated or revoked from time to time as provided in the Agreement. For a period of one year following termination of this Supplement for any reason, Participating Dentist shall advise Delta Dental Patients who request services from such dentist and who are enrolled in a PPO Program that Participating Dentist is no longer a PPO Program Panel Dentist. If Participating Dentist fails to so advise any PPO Program enrollee who seeks services from such Participating Dentist, Participating Dentist agrees Delta Dental may make such adjustments to the fees to be paid to Participating Dentist as is deemed by Delta Dental, in its discretion, to be reasonable.

This Supplement shall become effective upon Delta Dental of Kansas' written acceptance of it, and applies to all practice locations of Participating Dentist unless otherwise noted.

First Office

Tax Identification Number (TIN): _____ Type 2 NPI: _____
Note: SSN/IRS Tax ID# reported MUST match the name/number under which you file with the IRS for payment/refund purposes.

Address: _____ City: _____ ZIP: _____

Dentist Email: _____ Dentist Office Email: _____

Telephone Number: _____ Fax: _____

Second Office *(if applicable)*

Tax Identification Number (TIN): _____ Type 2 NPI: _____

Address: _____ City: _____ ZIP: _____

Dentist Email: _____ Dentist Office Email: _____

Telephone Number: _____ Fax: _____

SIGNATURE

Dentist Signature: _____ License Number: _____ Date: _____

Dentist Name (Print): _____ Type 1 NPI: _____

FOR INTERNAL USE ONLY: ***The effective date of this agreement shall be upon receipt by Delta Dental of Kansas***

Effective Date: _____ *(To be completed by Delta Dental only. Dentist will be notified in writing by Delta Dental of Effective Date.)*

Completed by Name: _____ Title: _____

Signature: _____ Date: _____

Return to Delta Dental of Kansas:
email: pr@deltadentalks.com | mail: P.O. Box 789769 Wichita, KS 67278-9769 | fax: 316.462.3317

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DELTA DENTAL®

Dentist Handbook 2024

These national processing policies reflect data code set requirements set forth under the Administrative Simplification Provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and related regulations. It is the policy of Delta Dental to comply with all such requirements as well as to require all Delta Dental member companies and their participating dentists to comply with such requirements. Consistent with HIPAA, Delta Dental exercises its right to determine benefits in accordance with applicable policies and plan documents. In determining benefits, Delta Dental adheres to the following national processing policies, except to the extent prohibited under applicable law or specific group and individual contract provisions (described below). Claim submissions shall not be manipulated so as to inflate the charges or otherwise attempt to circumvent the policies or applicable law. Delta Dental member companies shall ensure that their application of these processing policies is consistent with their contractual obligations to groups and individuals.

General Policies

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

Terms of group/individual contracts vary. Policies in this Handbook that address benefits, limitations and exclusions are policies that have not been tailored to reflect the specific terms of applicable group/individual contracts. In all cases, the terms of group/individual contracts take precedence over Dentist Handbook policies. Please contact the member company listed on the patient's identification card for the specific terms of a group/individual contract.

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

Allowance:	The amount of Delta Dental's payment for the procedure benefited.
Alternative Benefit:	In cases where alternative methods of treatment exist, benefits are provided for the least costly, professionally acceptable treatment. This determination is not to recommend which treatment should be provided. It is a determination of benefits under terms of the patient's coverage. The dentist and patient should decide the course of treatment. If the treatment rendered is other than the one benefited, the difference between Delta Dental's allowance and the approved amount for the actual treatment rendered is collectable from the patient.
Approved Amount:	The total fee a participating dentist agrees to accept as payment in full for a procedure. It includes both the Delta Dental allowance and the patient responsibility. Participating dentists agree not to collect from the patient any difference between the approved amount and their actual fee for the procedure.

Denied/Deny:	If the benefit for a procedure or service is denied, the procedure or service is not a benefit of the patient's coverage and the approved amount is collectable from the patient. Specific group/individual contract provisions take precedence over processing policies. It is recommended that the dental office contact the appropriate member company for the group/individual account to determine the specific benefits, limitations, and exclusions.
In Conjunction With:	In conjunction with means as part of another procedure or course of treatment including, but not limited to, being rendered on the same day.
Not billable to the patient:	If the fee for a procedure or service is not billable to the patient, it is not benefited by Delta Dental collectable from the patient by a participating dentist.
Processed as:	When a procedure is processed as a different procedure, participating dentists agree to accept all the limitations, processing policies, and approved amounts that apply to the procedure Delta Dental benefits.
Specialized Procedure	Describes a dental service or procedure that is used when unusual or extraordinary circumstances exist and is not generally used when conventional methods are adequate.

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

- Documentation of extraordinary circumstances can be submitted for review by report.
- Individual consideration may be given if additional supporting documentation is provided (e.g. diagnostic quality radiographs, clinical notes, charting, etc.)
- Fees for completion of claim forms and submission of documentation to Delta Dental to enable benefit determination are not benefits. They are not collectable from the patient by a participating dentist.
- Infection control and OSHA compliance are included in the fee for the dental services provided. Separate fees are not billable to the patient by a participating dentist.
- Multistage procedures are reported and benefited upon completion. The completion date is the date of insertion for removable prosthetic appliances. The completion date for immediate dentures is the date that the remaining teeth are removed and the denture is inserted. The completion date for fixed partial dentures and crowns, onlays and inlays is the cementation date of the final restoration regardless of the type of cement utilized. The completion date for endodontic treatment is the date the canals are permanently filled.

- Charges for procedures determined not to be necessary or not meeting generally accepted standards of care may be denied or not billable to the patient. Many of the processing policies that follow, describe payment procedures that are based on the timing and sequence of inter-related procedures. However, the timing and sequencing of treatment is the responsibility of the dentist rendering care and should always be determined by the treating dentist based on the patient's needs.
- When a procedure is by report and subject to coverage under medical, it should be submitted to the patient's medical carrier first. When submitting to Delta Dental, a copy of the explanation of payment or payment voucher from the medical carrier should be included with the claim, plus a narrative describing the procedure performed, reasons for performing the procedure, pathology report if appropriate, and any other information deemed pertinent. In the absence of such information, Delta Dental will not benefit the procedure.
- The term specialized procedure describes a dental service or procedure that is used when unusual or extraordinary circumstances exist, and is not generally used when conventional methods are adequate.
- Additional supporting documentation may be requested in order to make a benefit determination.
- Narratives are not considered legal documentation. The only acceptable legal written documentation for utilization review are the dental records.
- For payment purposes, local anesthesia is an integral part of the procedure being performed and additional fees are not billable to the patient.

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy

D0100 - D0999 DIAGNOSTIC

Terms of group/individual contracts vary. Policies in this Handbook that address benefits, limitations and exclusions are policies that have not been tailored to reflect the specific terms of applicable group/individual contracts. In all cases, the terms of group/individual contracts take precedence over Dentist Handbook policies. Please contact the member company listed on the patient's identification card for the specific terms of a group/individual contract.

Benefit determinations are subject to individual consideration when accompanied by adequate documentation of extraordinary circumstances.

A. D0100 - D0199 CLINICAL ORAL EVALUATIONS

General Policy - Clinical oral evaluation frequency limitations are determined by group/individual contract.

General Policy – The term specialized procedure describes a dental service or procedure that is used when unusual or extraordinary circumstances exist and is not generally used when conventional methods are adequate.

General Policy - Infection control is included in the fee for the dental services provided. Separate fees are not billable to the patient.

General Policy – Oral evaluations are only a benefit when the elements included in the descriptor are completed.

General Policy - Benefits for oral evaluations (D0120, D0150, D0160, and D0180) performed without an intent to provide dental services to meet the patient's dental needs will be processed as D0190.

General Policy – All services and treatment provided remotely via tele-health modalities, be they synchronous or asynchronous, must be performed by a licensed dentist or their supervised staff, acting within the scope of applicable law. Services and treatment delivered virtually are only a benefit when the elements included in the descriptor of the CDT procedure code are completed and only when they meet generally accepted clinical guidelines.

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, periodontal screening where indicated, and may require interpretation of information acquired through additional diagnostic procedures. The findings are discussed with the patient. Report additional diagnostic procedures separately.	Benefits for D0120 performed without an intent to provide dental service to meet the patient's dental needs will be processed as D0190.

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
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.	a. Limited oral evaluation - problem focused is allowed with definitive treatment. b. Oral evaluations are only a benefit when the elements included in the descriptor are completed.
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	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.	a. D0145 includes any caries susceptibility tests (D0425) or oral hygiene instructions (D1330) on the same date. When performed on the same date as D0145, any fees for D0425 and D1330 are not billable to the patient. b. For patients under the age of three, any other comprehensive evaluation code submitted (D0150, D0160, D0180) is payable as D0145. Any fees in excess of D0145 are not billable to the patient.
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	a. Comprehensive oral evaluation is benefited for the first encounter with the dentist/dental office and subsequent submissions by the same dentist/dental office are benefited as periodic oral evaluations (D0120). b. Benefits for D0150 performed without an intent to provide dental services to meet the patient's dental needs will be processed as D0190.

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
		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, 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.	
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,	Benefit once per dentist/dental office.

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
		conditions requiring multi-disciplinary consultation, etc.	
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 fees for re-evaluation - limited, problem focused are not billable to the patient in conjunction with another procedure by the same dentist/dental office.
D0171	Re-evaluation – post-operative office visit	None	Procedures include all necessary post-operative care and re-evaluations and the fee is not billable to the patient when submitted by the same dentist/dental office who performed the original procedure. Benefits are denied if different dentist/dental office.
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, an evaluation for oral cancer, evaluation and recording of the patient's dental and medical history and general health assessment. It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, and occlusal relationships.	a. If a D0180 is submitted with a D4910 on the same date of service by the same dentist/dental office it is benefited as a D0120 and the difference in the approved amount between the D0120 and the D0180 is not billable to the patient. b. Benefits for D0180 performed without an intent to provide dental services to meet the patient's dental needs will be processed as D0190.
B. D0190-D0191 PRE-DIAGNOSTICS SERVICES General Policy - Benefits are determined by group/individual contract. Fees for pre-diagnostic services are not billable to the patient when reported on the same date of service as another evaluation procedure (D0120 – D0150).			
General Policy - Benefits for oral evaluations (D0120, D0150, D0160, and D0180) performed without an intent to provide dental services to meet the patient's dental needs will be processed as D0190.			

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
D0190	Screening of a patient	A screening including state or federally mandated screenings to determine an individual's need to be seen by a dentist for diagnosis.	When done on the same date as an evaluation/screening (D0120, D0140, D0145, D0150, D0160, D0170, D0171, D0180, D0191 and D9310), the fees for D0190 are not billable to the patient as integral to the evaluation by the same dentist/dental office.
D0191	Assessment of a patient	A limited clinical inspection that is performed to identify possible signs of oral or systemic disease, malformation, or injury, and the potential need for referral for diagnosis and treatment.	When done on the same date as an evaluation/screening (D0120, D0140, D0145, D0150, D0160, D0170, D0171, D0180, D0190 and D9310), the fees for D0191 are not billable to the patient as integral to the evaluation by the same dentist/dental office.
C. D0200 - D0399 DIAGNOSTIC IMAGING			
General Policy - Diagnostic services must be necessary and appropriate relative to an individual dental patient's disease risk and clinical condition. If the necessity and appropriateness for diagnostic radiographic imaging is not evident from the information submitted, or the images have been acquired before such a determination is made, fees for radiographic imaging are not billable to the patient.			
General Policy - Fees for duplication (copying) of diagnostic images for insurance purposes are not billable to the patient.			
General Policy – Images must be of diagnostic quality; properly oriented if submitted for documentation purposes, and with the date of exposure and a patient identifier indicated on all images. If an image is not of diagnostic quality, then the fee for the image is not billable to the patient.			
General Policy - The frequency limitation for an intraoral comprehensive series and panoramic radiographic images are a benefit once every five years. All other imaging frequencies are determined by the group/individual contract.			
General Policy – Limit to two bitewing images for patients under age 10. A D0273 or D0274 submitted for a patient under age 10 will be benefited as D0272 and any fees in excess of the approved amount for D0272 is not billable to the patient.			
D. IMAGE CAPTURE WITH INTERPRETATION **General Policy** – D0210- D0371 include image capture and interpretation. The fee for interpretation of a diagnostic image by a practitioner not associated with the capture of the image is processed according to group/individual contract. In all other instances, interpretation is not billable to the patient.			
D0210	Intraoral - comprehensive series of radiographic images	A radiographic survey of the whole mouth intended to display the crowns and roots of all teeth, periapical areas, interproximal areas and alveolar bone including edentulous areas.	a. Benefits for intraoral complete series of radiographic images are limited to once every five years. b. The fees for additional bitewings (D0270-D0274) within 6 months of D0210 are not

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
			billable to the patient by the same dentist/dental office. Benefits are denied if done by a different dentist/dental office. c. Benefits are limited to either an intraoral complete series radiographic images (D0210) or panoramic radiographic image (D0330) within the five year period. d. When submitted with intraoral complete series image capture only, the fees for D0709 are not billable to the patient by same dentist/dental office. e. The fee for intraoral tomosynthesis – comprehensive series of radiographic images (D0387) capture only is considered part of D0210. f. When submitted with intraoral tomosynthesis – comprehensive series of radiographic images (D0372), benefit intraoral tomosynthesis comprehensive series as a D0210 and the additional fees are chargeable to the patient. The fees for the original D0210 are not billable to the patient.

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TYPE OF ENCOUNTER	PATIENT AGE AND DENTAL DEVELOPMENTAL STAGE				
	Child with Primary Dentition (prior to eruption of first permanent tooth)	Child with Transitional Dentition (after eruption of first permanent tooth)	Adolescent with Permanent Dentition (prior to eruption of third molars)	Adult, Dentate or Partially Edentulous	Adult, Edentulous
New Patient* being evaluated for oral diseases	Individualized radiographic exam consisting of selected periapical/occlusal views and/or posterior bitewings if proximal surfaces cannot be visualized or probed. Patients without evidence of disease and with open proximal contacts may not require a radiographic exam at this time.	Individualized radiographic exam consisting of posterior bitewings with panoramic exam or posterior bitewings and selected periapical images.	Individualized radiographic exam consisting of posterior bitewings with panoramic exam or posterior bitewings and selected periapical images. An intraoral comprehensive intraoral radiographic exam is preferred when the patient has clinical evidence of generalized oral disease or a history of extensive dental treatment.		Individualized radiographic exam, based on clinical signs and symptoms.
Recall Patient* with clinical caries or at increased risk for caries**	Posterior bitewing exam at 6-12 month intervals if proximal surfaces cannot be examined visually or with a probe		Posterior bitewing exam at 6-18 month intervals		Not applicable
Recall Patient* with no clinical caries and not at increased risk for caries**	Posterior bitewing exam at 12-24 month intervals if proximal surfaces cannot be examined visually or with a probe	Posterior bitewing exam at 18-36 month intervals	Posterior bitewing exam at 24-36 month intervals		Not applicable
Recall Patient* with periodontal disease	Clinical judgment as to the need for and type of radiographic images for the evaluation of periodontal disease. Imaging may consist of, but is not limited to, selected bitewing and/or periapical images of areas where periodontal disease (other than nonspecific gingivitis) can be demonstrated clinically.				Not applicable
Patient (New and Recall) for monitoring of dentofacial growth and development, and/or assessment of dental/skeletal relationships	Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development or assessment of dental and skeletal relationships	Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth and development, or assessment of dental and skeletal relationships. Panoramic or periapical exam to assess developing third molars	Usually not indicated for monitoring of growth and development. Clinical judgment as to the need for and type of radiographic image for evaluation of dental and skeletal relationships.		
Patient with other circumstances including, but not limited to, proposed or existing implants, other dental and craniofacial pathoses, restorative/endodontic needs, treated periodontal disease and caries remineralization	Clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of these conditions				

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES. Public Health Service, Food and Drug Administration. AMERICAN DENTAL ASSOCIATION. Council on Dental Benefit Programs, Council on Scientific Affairs, Revised 2012.

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D0220	Intraoral – periapical first radiographic image	None	a. When submitted with intraoral periapical - image capture only, the fees for D0707 are not billable to the patient by same dentist/dental office. b. The fee for intraoral tomosynthesis periapical image – capture only (D0389) is considered part of D0220 and not billable to the patient.
D0230	Intraoral – periapical each additional radiographic image	None	a. Individually listed intraoral radiographic images by the same dentist/dental office are considered a complete series if the fee for individual radiographic images (excluding D0330) equals or exceeds the fee for a complete series done on the same date of service. Any fee in excess of the fee for an intraoral comprehensive series (D0210) is not billable to the patient. b. Routine working and final treatment radiographic images taken for endodontic therapy by the same dentist/dental office are considered a component of the complete treatment procedure and separate fees are not billable to the patient on the same date of service. c. When submitted with intraoral periapical - image capture only, the fees for D0707 are not billable to the patient by same dentist/dental office.
D0240	Intraoral - occlusal radiographic image	None	When submitted with intraoral – occlusal - capture only, the fees for D0706 are not billable to the patient.
D0250	Extra-oral – 2D projection radiographic image created	These images include, but are not limited to: Lateral Skull; Posterior-	Benefits for extra-oral – 2D projection radiographic images created using a

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	using a stationary radiation source, and detector	Anterior Skull; Submentovertex, Waters, Reverse Towns; Oblique Mandibular Body; Lateral Ramus	stationary radiation source, and detector are denied unless covered by group/individual contract.
D0251	Extra-oral posterior dental radiographic image	Image limited to exposure of complete posterior teeth in both dental arches. This is a unique image that is not derived from another image.	a. Extra-oral posterior dental radiographic image is denied unless covered by group/individual contract. b. If there is a history of prior extra-oral radiograph within the frequency limitations for D0330, the fees for D0251 are not billable to the patient. c. When submitted with extra-oral posterior image capture only, the fees for D0705 are not billable to the patient by the same dentist/dental office.
D0270	Bitewing - single radiographic image	None	a. When submitted with intraoral – bitewing image capture only, the fees for D0708 are not billable to the patient by the same dentist/dental office. b. The fee for intraoral tomosynthesis bitewing image - capture only (D0388) is considered part of D0270 and not billable to the patient. c. The fees for additional bitewings (D0270-D0274) within 6 months of D0210 are not billable to the patient by the same dentist/dental office. Benefits are denied if done by a different dentist/dental office.
D0272	Bitewings - two radiographic images	None	a. When submitted with intraoral – bitewing image capture only, the fees for D0708 are not billable to the patient by the same dentist/dental office.

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			b. The fees for additional bitewings (D0270-D0274) within 6 months of D0210 are not billable to the patient by the same dentist/dental office. Benefits are denied if done by a different dentist/dental office. c. The fee for intraoral tomosynthesis bitewing image - capture only (D0388) is considered part of D0272 and not billable to the patient.
D0273	Bitewings - three radiographic images	None	a. When submitted with intraoral – bitewing image capture only, the fees for D0708 are not billable to the patient by the same dentist/dental office. b. The fees for additional bitewings (D0270-D0274) within 6 months of D0210 are not billable to the patient by the same dentist/dental office. Benefits are denied if done by a different dentist/dental office. c. The fee for intraoral tomosynthesis bitewing image - capture only (D0388) is considered part of D0273 and not billable to the patient.
D0274	Bitewings - four radiographic images	None	a. When submitted with intraoral – bitewing image capture only, the fees for D0708 are not billable to the patient by the same dentist/dental office. b. The fees for additional bitewings (D0270-D0274) within 6 months of D0210 are not billable to the patient by the same dentist/dental office. Benefits are denied if done by a different dentist/dental office.

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			c. The fee for intraoral tomosynthesis bitewing image - capture only (D0388) is considered part of D0274 and not billable to the patient.
D0277	Vertical Bitewings – 7 to 8 radiographic images	This does not constitute a full mouth intraoral radiographic series.	a. Vertical bitewings are considered bitewings for benefit purposes and are subject to the frequency limitations for bitewing radiographic images as established by the contract. If the fee for the vertical bitewings is equal to or exceeds the fee for an intraoral comprehensive series, it would be considered an intraoral comprehensive series for payment and benefit purposes and frequency limitations. Any fee in excess of the fee for an intraoral comprehensive series (D0210) is not billable to the patient on the same date of service. b. If the fee for bitewings and occlusal radiographic images is equal to or exceeds the fee for an intraoral comprehensive series, it would be considered an intraoral comprehensive series for payment and benefit purposes and frequency limitations. Any fee in excess of the fee for an intraoral comprehensive series is not billable to the patient. c. The fee for any type of bitewings submitted with an intraoral comprehensive series are considered part of an intraoral comprehensive series (D0210) for payment and benefit purposes. Any fee in excess of an intraoral comprehensive series is not billable to the patient on the same date of service.

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			d. In the absence of contract language for bitewing frequency limitations, the fees for D0277 are not billable to the patient within 12 months of an intraoral comprehensive series.
D0310	Sialography	None	None
D0320	Temporomandibular joint arthrogram, including injection	None	None
D0321	Other temporomandibular joint radiographic images, by report	None	None
D0322	Tomographic survey	None	None
D0330	Panoramic radiographic image	None	a. Benefits for panoramic radiographic image are limited to once every five years. b. Benefits are limited to either a panoramic radiographic image (D0330) or an intraoral complete series (D0210) within the five year period. c. When submitted with panoramic image capture only, the fees for D0701 are not billable to the patient by same dentist/dental office.
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	Image of the head made using a cephalostat to standardize anatomic positioning, and with reproducible x-ray beam geometry.	a. Cephalometric radiographic image is a benefit only in conjunction with orthodontic benefits. b. Benefits for a cephalometric radiographic image not taken in conjunction with orthodontic treatment are denied. c. When submitted with the 2D cephalometric image capture only, the fees

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			for D0702 are not billable to the patient by the same dentist/dental office.
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	None	a. Benefits for 2D oral/facial images may be paid once per case as orthodontic records. b. Benefits for 2D oral/facial images for other procedures are considered elective and therefore are denied. c. When billed with 2-D photographic image – image capture only, D0703, the fees for D0703 are not billable to the patient by the same dentist/dental office.
D0364	Cone beam CT capture and interpretation with limited field of view - less than one whole jaw	None	a. The benefit for cone beam CT capture and interpretation of view restricted to less than one whole jaw is denied unless covered by group/individual contract. When covered, benefit once per 12 months. b. Benefits are denied if D0364, D0365, D0366, D0367 were benefitted in the last 12 months. c. When submitted in conjunction with the capture only procedure D0380, the fee for D0380 is not billable to the patient. d. When submitted in conjunction with the interpretation procedure D0391, the fee for D0391 is not billable to the patient.
D0365	Cone beam CT capture and interpretation with field of view of one full dental arch – mandible	None	a. The benefit for cone beam CT capture and interpretation with field of view of one full arch - mandible is denied unless covered by group/individual contract. When covered, benefit once per 12 months.

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			b. Benefits are denied if D0364, D0365, D0366, D0367 were benefitted in the last 12 months. c. When submitted in conjunction with the capture only procedure D0381, the fee for D0381 is not billable to the patient. d. When submitted in conjunction with the interpretation procedure D0391, the fee for D0391 is not billable to the patient.
D0366	Cone beam CT capture and interpretation with field of view one full dental arch – maxilla, with or without cranium	None	a. Cone beam CT capture and interpretation with field of view one full dental arch – maxilla with or without cranium is denied unless covered by group/individual contract. When covered, benefit once per 12 months. b. Benefits are denied if D0364, D0365, D0366, D0367 were benefitted in the last 12 months. c. When submitted in conjunction with the capture only procedure D0382, the fee for D0382 is not billable to the patient. d. When submitted in conjunction with the interpretation procedure D0391, the fee for D0391 is not billable to the patient.
D0367	Cone beam CT capture and interpretation with field of view of both jaws; with or without cranium	None	a. Cone beam CT capture and interpretation with field of view of both jaws with or without cranium is denied unless covered by group/individual contract. When covered, benefit once per 12 months.

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			b. Benefits are denied if D0364, D0365, D0366, D0367 were benefitted in the last 12 months. c. When submitted in conjunction with the capture only procedure D0383, the fee for D0383 is not billable to the patient. d. When submitted in conjunction with the interpretation procedure D0391, the fee for D0391 is not billable to the patient.
D0368	Cone beam CT capture and interpretation for TMJ series including two or more exposures	None	a. Cone beam CT capture and interpretation for TMJ series including two or more exposures is denied unless the group/individual contract includes TMJ coverage. When covered, benefit once per lifetime. b. When submitted in conjunction with the capture only procedure D0384, the fee for D0384 is not billable to the patient. c. When submitted in conjunction with the interpretation procedure D0391, the fee for D0391 is not billable to the patient.
D0369	Maxillofacial MRI capture and interpretation	None	a. Maxillofacial MRI capture and interpretation is denied. b. When submitted in conjunction with the capture only procedure D0385, the fee for D0385 is not billable to the patient. c. When submitted in conjunction with the interpretation procedure D0391, the fee for D0391 is not billable to the patient.

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D0370	Maxillofacial ultrasound capture and interpretation	None	a. Maxillofacial ultrasound capture interpretation is denied. b. When submitted in conjunction with the capture only procedure D0386, the fee for D0386 is not billable to the patient. c. When submitted in conjunction with the interpretation procedure D0391, the fee for D0391 is not billable to the patient.
D0371	Sialoendoscopy capture and interpretation	None	Sialoendoscopy capture and interpretation is denied.
D0372	Intraoral tomosynthesis – comprehensive series of radiographic images	A radiographic survey of the whole mouth intended to display the crowns and roots of all teeth, periapical areas, interproximal areas and alveolar bone including edentulous areas.	Benefits for intraoral tomosynthesis comprehensive series are denied, unless covered by group/individual contract. When covered: a. When billed with intraoral – complete series of radiographic images (D0210) by the same dentist/dental office, the fee for D0210 is not billable to the patient. b. When billed with intraoral tomosynthesis – comprehensive series – capture only (D0387) by the same dentist/dental office, the fee for D0387 is not billable to the patient. c. When billed with intraoral – complete series of radiographic images – image capture only (D0709) by the same dentist/dental office, the fee for D0709 is not billable to the patient.
D0373	Intraoral tomosynthesis - bitewing radiographic image	None	Benefits for intraoral tomosynthesis bitewing image are denied, unless covered by group/individual contract.

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			When covered: a. When billed with bitewings (D0270, D0272, D0273, D0274, D0277) by the same dentist/dental office, the fees for D0270, D0272, D0273, D0274, and D0277 are not billable to the patient. b. When billed with intraoral tomosynthesis bitewing – radiographic image - capture only (D0388) by the same dentist/dental office, the fee for D0388 is not billable to the patient. c. When billed with intraoral – bitewing radiographic image – image capture only (D0708) by the same dentist/dental office, the fee for D0708 is not billable to the patient.
D0374	Intraoral tomosynthesis - periapical radiographic image	None	Benefits for intraoral tomosynthesis periapical image are denied, unless covered by group/individual contract. When covered: a. When billed with intraoral – periapical first radiograph image (D0220) and intraoral periapical each additional radiographic image (D0230) by the same dentist/dental office, the fees for D0220 and D0230 are not billable to the patient. b. When billed with intraoral tomosynthesis - periapical radiographic image – capture only (D0389) by the same dentist/dental office, the fee for D0389 is not billable to the patient.

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			c. When billed with intraoral – periapical radiographic image – image capture only (D0707) by the same dentist/dental office, the fee for D0707 is not billable to the patient.
E. IMAGE CAPTURE ONLY			
D0380	Cone beam CT image capture with limited field of view – less than one whole jaw	None	a. Cone beam CT image capture with limited field of view – less than one whole jaw is denied. b. When submitted in conjunction with the capture and interpretation procedure D0364, the fee for D0380 is not billable to the patient. c. When submitted by the same dentist/dental office in conjunction with the interpretation procedure D0391, it is re-processed as D0364 and the fees for D0380 and D0391 are not billable to the patient. d. The fee for the interpretation of a diagnostic image D0391, when submitted by a different dentist/dental office than that who submitted the capture only procedure D0380 – D0386, is processed according to group/individual contract.
D0381	Cone beam CT image capture with field of view of one full dental arch – mandible	None	a. Cone beam CT image capture with field of view of one full dental arch – mandible is denied. b. When submitted in conjunction with the capture and interpretation procedure D0365, the fee for D0381 is not billable to the patient.

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			c. When submitted by the same dentist/dental office in conjunction with the interpretation procedure D0391, it is re-processed as D0365 and the fees for D0381 and D0391 are not billable to the patient. d. The fee for the interpretation of a diagnostic image D0391, when submitted by a different dentist/dental office than that who submitted the capture only procedure D0380 – D0386, is processed according to group/individual contract.
D0382	Cone beam CT image capture with field of view one full dental arch – maxilla, with or without cranium	None	a. Cone beam CT image capture with field of view one full dental arch – maxilla, with or without cranium is denied. b. When submitted in conjunction with the capture and interpretation procedure D0366, the fee for D0382 is not billable to the patient. c. When submitted by the same dentist/dental office in conjunction with the interpretation procedure D0391, it is reprocessed as D0366 and the fees for D0382 and D0391 are not billable to the patient. d. The fee for the interpretation of a diagnostic image D0391, when submitted by a different dentist/dental office than that who submitted the capture only procedure D0380 – D0386, is processed according to group/individual contract.

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D0383	Cone beam CT image capture with field of view of both jaws; with or without cranium	None	a. Cone beam CT image capture with field of view of both jaws, with or without cranium is denied. b. When submitted in conjunction with the capture and interpretation procedure D0367, the fee for D0383 is not billable to the patient. c. When submitted by the same dentist/dental office in conjunction with the interpretation procedure D0391, it is re-processed as D0367 and the fees for D0383 and D0391 are not billable to the patient. d. The fee for the interpretation of a diagnostic image D0391, when submitted by a different dentist/dental office than that who submitted the capture only procedure D0380 – D0386, is processed according to group/individual contract.
D0384	Cone beam CT capture image for TMJ series including two or more exposures	None	a. Cone beam CT capture image for TMJ series including two or more exposures is denied. b. When submitted by in conjunction with the capture and interpretation procedure D0368, the fee for D0384 is not billable to the patient. c. When submitted by the same dentist/dental office in conjunction with the interpretation procedure D0391, it is re-processed as D0368 and the fees for D0384 and D0391 are not billable to the patient.

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			d. The fee for the interpretation of a diagnostic image D0391, when submitted by a different dentist/dental office than that who submitted the capture only procedure D0380 – D0386, is processed according to group/individual contract.
D0385	Maxillofacial MRI image capture	None	a. Maxillofacial MRI image capture is denied. b. When submitted in conjunction with the capture and interpretation procedure D0369, the fee for D0385 is not billable to the patient. c. When submitted by the same dentist/dental office in conjunction with the interpretation procedure D0391, it is re-processed as D0369 and the fees for D0385 and D0391 are not billable to the patient. d. The fee for the interpretation of a diagnostic image D0391, when submitted by a different dentist/dental office than that who submitted the capture only procedure D0380 – D0386, is processed according to group/individual contract.
D0386	Maxillofacial ultrasound image capture	None	a. Maxillofacial ultrasound image capture is denied. b. When submitted in conjunction with the capture and interpretation procedure D0370, the fee for D0386 is not billable to the patient. c. When submitted by the same dentist/dental office in conjunction with the interpretation procedure D0391, it is re-

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			processed as D0370 and the fees for D0386 and D0391 are not billable to the patient. d. The fee for the interpretation of a diagnostic image D0391, when submitted by a different dentist/dental office than who submitted the capture only procedure D0380 – D0386, is processed according to group/individual contract.
D0387	Intraoral tomosynthesis – comprehensive series of radiographic images – capture only	A radiographic survey of the whole mouth, intended to display the crowns and roots of all teeth, periapical areas and alveolar bone.	The fee for D0387 intraoral tomosynthesis – comprehensive series of radiographic images capture only is considered part of D0372 and is not billable to the patient by the same dentist/dental office.
D0388	Intraoral tomosynthesis bitewing –radiographic image - capture only	None	The fee for D0388 intraoral tomosynthesis bitewing capture only is considered part of (D0373) and is not billable to the patient by the same dentist/dental office.
D0389	Intraoral tomosynthesis - periapical radiographic image – capture only	None	The fee for D0389 intraoral tomosynthesis - periapical capture only is part of D0374 and is not billable to the patient.
F. INTERPRETATION AND REPORT ONLY			
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report	None	a. The fee for interpretation of a diagnostic image by the practitioner not associated with the capture only procedures D0380 – D0386 is denied. b. The fee for the interpretation of diagnostic image D0391 when submitted by the same dentist/dental office as the capture only procedures D0380-D0386 are not billable to the patient. c. The fee for the interpretation of a diagnostic image D0391, when submitted by

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			a different dentist/dental office than who submitted the capture only procedure D0380 – D0386, is processed according to group/individual contract.
G. POST PROCESSING OF IMAGE OR IMAGE SETS			
General Policy – Benefits for post processing of image or image sets are denied as specialized procedures.			
D0393	Virtual treatment simulation using 3D image volume or surface scan	Virtual simulation of treatment including, but not limited to, dental implant placement, prosthetic reconstruction, orthognathic surgery and orthodontic tooth movement.	Benefits for D0393 are denied as a specialized procedure.
D0394	Digital subtraction of two or more images or image volumes of the same modality	To demonstrate changes that have occurred over time.	None
D0395	Fusion of two or more 3D image volumes of one or more modalities	None	None
D0396	3D printing of a 3D dental surface scan	3D printing of a 3D dental surface scan to obtain a physical model.	3D printing of a surface scan is inclusive of other procedures and is not billable to the patient.
H. D0400 – D0999 TESTS AND EXAMINATIONS			
D0411	HbA1c in-office point of service testing	None	a. Benefits are denied unless covered by group/individual contract. b. When covered by group/individual contract, limited to one test per benefit year. c. When D0411 is submitted on the same date/same dentist/dental office as D0412 (blood level glucose level test), the fee for D0412 is not billable to the patient.
D0412	Blood glucose level test – in-office using a glucose meter	This procedure provides an immediate finding of a patient's blood glucose level at the time of	a. Benefits are denied unless covered by group/individual contract.

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		sample collection for the point-of-service analysis.	b. The fee for D0412 is not billable to the patient on the same date of service as D0411.
D0414	Laboratory processing of microbial specimen to include culture and sensitivity studies, preparation and transmission of written report	None	Benefits for laboratory processing of microbial specimens are denied unless covered by the group/individual contract.
D0415	Collection of microorganisms for culture and sensitivity	None	Bacteriologic studies for determination of sensitivity of pathologic agents to antibiotics are denied as a specialized procedure.
D0416	Viral culture	A diagnostic test to identify viral organisms, most often herpes virus.	Studies for determining pathologic agents are a specialized procedure and the benefits are denied.
D0417	Collection and preparation of saliva sample for laboratory diagnostic testing	None	Collection and preparation of a saliva sample for laboratory diagnostic testing is considered experimental and the benefits are denied.
D0418	Analysis of saliva sample	Chemical or biological analysis of saliva sample for diagnostic purposes.	The benefits for analysis of saliva sample are denied.
D0419	Assessment of salivary flow by measurement	This procedure is for identification of low salivary flow in patients at risk for hyposalivation and xerostomia, as well as effectiveness of pharmacological agents used to stimulate saliva production.	Benefits are limited to one assessment every three years. Subsequent submissions not billable to the patient within 12 months and denied between 12 and 36 months.
D0422	Collection and preparation of genetic sample material for laboratory analysis and report	None	Genetic tests for susceptibility to oral diseases are denied unless covered by group/individual contract.
D0423	Genetic test for susceptibility to diseases – specimen analysis	Certified laboratory analysis to detect specific genetic variations associated with increased susceptibility for diseases.	Genetic tests for susceptibility to oral diseases are denied unless covered by group/individual contract.

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D0425	Caries susceptibility tests	Not to be used for carious dentin staining.	Caries susceptibility tests are not a benefit, and the fees are denied as a specialized procedure.
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant, malignant lesions not to include cytology or biopsy procedures	None	Benefits for adjunctive pre-diagnostic tests that aid in the detection of mucosal abnormalities are denied as investigational.
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. Therefore, fees for pulp tests are not billable to the patient as part of any other definitive procedure on the same date of service, by the same dentist/dental office except D0140 limited oral evaluation - problem focused, D9110 palliative treatment, radiographic images (D0210-D0391), consultation (D9310) and sedative filling (D2940).
D0470	Diagnostic casts	Also known as diagnostic models or study models	a. Diagnostic casts are payable only once when performed 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 and separate fees are not billable to the patient. Benefit once per lifetime. b. Benefits for diagnostic casts taken in conjunction with any other procedure are denied.
I. ORAL PATHOLOGY LABORATORY			

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D0472	Accession of tissue, gross examination, preparation and transmission of written report	To be used in reporting architecturally intact tissue obtained by invasive means.	See D0472-D0480 below
D0473	Accession of tissue, gross and microscopic examination preparation and transmission of written report	To be used in reporting architecturally intact tissue obtained by invasive means	See D0472-D0480 below
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	See D0472-D0480 below
D0475	Decalcification procedure	Procedure in which hard tissue is processed in order to allow sectioning and subsequent microscopic examination	See D0472-D0480 below
D0476	Special stains for microorganisms	Procedure in which additional stains are applied to biopsy or surgical specimen in order to identify microorganisms.	See D0472-D0480 below
D0477	Special stains, not for microorganisms	Procedure in which additional stains are applied to a biopsy or surgical specimen in order to identify such things as melanin, mucin, iron, glycogen, etc.	See D0472-D0480 below
D0478	Immunohistochemical stains	A procedure in which specific antibody based reagents are applied to tissue samples in order to facilitate diagnosis.	See D0472-D0480 below
D0479	Tissue in-situ hybridization, including interpretation	A procedure which allows for the identification of nucleic acids, DNA	See D0472-D0480 below

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		and RNA, in the tissue sample in order to aid in the diagnosis of microorganisms and tumors.	
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. *accession = preparation of tissue (sectioning, staining, etc.)	See D0472-D0480 below
D0472-D0480, D0486	D0472-D0480, D0486 policy: a. These procedures must be accompanied by a pathology report. If the procedure is not accompanied by a pathology report the fee for the procedure is not billable to the patient. b. If more than one of these procedures is submitted on the same date of service, same site by the same dentist/dental office, benefits are allowed for the most inclusive procedure and the less inclusive procedure is not billable to the patient.		
D0481	Electron microscopy	None	See D0481-D0483 below
D0482	Direct immunofluorescence	A technique used to identify immunoreactants which are localized to the patient's skin or mucous membranes.	See D0481-D0483 below
D0483	Indirect immunofluorescence	A technique used to identify circulating immunoreactants	See D0481-D0483 below
D0481-D0483	D0481-D0483 policy: Pathology reports, procedures D0472, D0473, D0474 and D0480 include preparation of tissue (sectioning, staining, etc.) and gross and microscopic evaluation. The fees for D0475 through D0483 are not billable to the patient being a component of the pathology procedures.		
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.	D0484 is benefited as D9310 (diagnostic service provided by dentist or physician other than practitioner providing treatment).

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
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.	a. D0485 must be accompanied by a pathology report. If the procedure is not accompanied by a pathology report the fee for the procedure is not billable to the patient. b. When billed on the same date of service, same site by the same dentist/dental office, benefits are allowed for the most inclusive procedure and the less inclusive procedure is not billable to the patient. c. When multiple procedures are submitted in the same area of the mouth, the more complex would be a benefit. The fees for subsequent procedure codes would be not billable to the patient.
D0486	Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report	Analysis, and written report of findings, of cytologic sample of disaggregated transepithelial cells.	None
D0502	Other oral pathology procedures, by report	None	Other oral pathology procedures must be accompanied by a pathology report. Fee for D0502 submitted without the report are not billable to the patient
J. TEST AND EXAMINATIONS			
General Policy- recognized risk assessment tools include: PreViser, Cambra, CAT, ADA, Cariogram			
D0600	Non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin and cementum	None	a. The fees for D0600 are not billable to the patient when submitted with an evaluation. b. When submitted separately from an evaluation, diagnostic monitoring benefits are denied.

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
D0601	Caries risk assessment and documentation, with a finding of low risk	Using recognized assessment tools	a. The fee for D0601 is not billable to the patient when submitted for children under the age of three. b. Benefits are limited to one risk assessment every 12 months. Subsequent risk assessment codes submissions are not billable to the patient within 12 months. c. The fee for D0601 is not billable to the patient when submitted with other risk assessment codes on the same date of service by the same dentist/dental office.
D0602	Caries risk assessment and documentation, with a finding of moderate risk	Using recognized assessment tools	a. The fee for D0602 is not billable to the patient when submitted for children under the age of three. b. Benefits are limited to one risk assessment every 12 months. Subsequent risk assessment codes submissions are not billable to the patient within 12 months. c. The fee for D0602 is not billable to the patient when submitted with other risk assessment codes on the same date of service by the same dentist/dental office.
D0603	Caries risk assessment and documentation, with a finding of high risk	Using recognized assessment tools	a. The fee for D603 is not billable to the patient when submitted for children under the age of three. b. Benefits are limited to one risk assessment every 12 months. Subsequent risk assessment codes submissions are not billable to the patient within 12 months.

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
			c. The fee for D603 is not billable to the patient when submitted with other risk assessment codes on the same date of service by the same dentist/dental office.
D0604	Antigen testing for a public health related pathogen includes coronavirus	None	Benefits are denied unless covered by group/individual contract.
D0605	Antibody testing for a public health related pathogen includes coronavirus	None	Benefits are denied unless covered by group/individual contract.
D0606	Molecular testing for a public health related pathogen, including coronavirus	None	Benefits are denied unless covered by group/individual contract.
D0701	Panoramic radiographic image – image capture only	None	The fee for a panoramic image capture only is considered part of D0330 and is not billable to the patient.
D0702	2-D cephalometric radiographic image – image capture only	None	The fee for a 2D cephalometric image capture only is considered part of D0340 and is not billable to the patient.
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally – image capture only	None	The fee for 2-D oral/facial photographic image capture only is considered part of D0350 and is not billable to the patient.
D0705	Extra-oral posterior dental radiographic image – image capture only	Image limited to exposure of complete posterior teeth in both dental arches. This is a unique image that is not derived from another image.	The fee for the extra-oral posterior- image capture only is considered part of D0251 and is not billable to the patient.
D0706	Intraoral – occlusal radiographic image – image capture only	None	The fee for the intraoral – occlusal image capture only is considered part of D0240 and is not billable to the patient.

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
D0707	Intraoral – periapical radiographic image – image capture only	None	The fee for the intraoral – periapical image-capture only is considered part of D0220/D0230 and is not billable to the patient.
D0708	Intraoral – bitewing radiographic image – image capture only	Image axis may be horizontal or vertical.	The fee for the intraoral – bitewing image capture only is considered part of D0270, D0272, D0273, D0274 and is not billable to the patient.
D0709	Intraoral – comprehensive series of radiographic images – image capture only	A radiographic survey of the whole mouth, intended to display the crowns and roots of all teeth, periapical areas, interproximal areas and alveolar bone including edentulous areas.	The fee for intraoral complete series image - capture only is considered part of D0210 and is not billable to the patient.
D0801	3D dental surface scan – direct	None	3D scans are denied as a specialized procedure.
D0802	3D dental surface scan – indirect	A surface scan of a diagnostic cast.	3D scans are denied as a specialized procedure
D0803	3D facial surface scan – direct	None	3D scans are denied as a specialized procedure.
D0804	3D facial surface scan – indirect	A surface scan of constructed facial features.	3D scans are denied as a specialized procedure.
D0999	Unspecified diagnostic procedure, by report	Used for procedure that is not adequately described by a code. Describe the procedure.	Unless covered by group/individual contact, benefits for medical procedures such as, but not limited to, urine analysis, blood studies and skin tests are denied, and the approved amount is chargeable to the patient.

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy

D1000 – D1999 PREVENTIVE

Terms of group/individual contracts vary. Policies in this Handbook that address benefits, limitations and exclusions are policies that have not been tailored to reflect the specific terms of applicable group/individual contracts. In all cases, the terms of group/individual contracts take precedence over Dentist Handbook policies. Please contact the member company listed on the patient's identification card for the specific terms of a group/individual contract.

Benefit determinations are subject to individual consideration when accompanied by adequate documentation of extraordinary circumstances.

A. D1000 - D1199 DENTAL PROPHYLAXIS

General Policy - In the absence of group/individual contract language regarding age, a person age 14 and older is considered an adult for benefit determination purposes of a prophylaxis-adult.

General Policy - A prophylaxis done on the same date of service by the same dentist/dental office as a periodontal maintenance, scaling in the presence of generalized moderate or severe gingival inflammation, scaling and root planing, or periodontal surgery is considered to be part of and included in those procedures and the fee is not billable to the patient.

General Policy - The time limitation for prophylaxis is determined by group/individual contract. Additional prophylaxes are optional and may be charged to the patient. D4910 is counted toward the contract limitation for prophylaxis. In the absence of contract limitations, D4346 and D4355 should be counted toward the contractual limitation for prophylaxis.

General Policy - Infection control is included in the fee for the dental services provided. Separate fees are not billable to the patient.

General Policy – All services and treatment provided remotely via tele-health modalities, be they synchronous or asynchronous, must be performed by a licensed dentist or their supervised staff, acting within the scope of applicable law. Services and treatment delivered virtually are only a benefit when the elements included in the descriptor of the CDT procedure code are completed and only when they meet generally accepted clinical guidelines.

D1110	Prophylaxis-adult	Removal of plaque, calculus and stains from the tooth structures and implants in the permanent and transitional dentition. It is intended to control local irritational factors.	a. For benefit purposes, the distinction between the adult and child dentition is determined by group/individual contract. Any fee in excess is not billable to the patient. b. When submitted with D4346, fees for D1110 by the same dentist/dental office are not billable to the patient.
D1120	Prophylaxis - child	Removal of plaque, calculus and stains from the tooth structures and implants in the primary and	a. For benefit purposes, the distinction between the adult and child dentition is determined by contract. In the absence of group/individual contract language

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
		transitional dentition. It is intended to control local irritational factors.	regarding age, a person under age 14 is considered a child for benefit determination purposes of a prophylaxis - child. Any fee in excess is not billable to the patient. b. When submitted with D4346, fees for D1120 by the same dentist/dental office are not billable to the patient.
B. D1200 – D1299 TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)			
General Policy - Benefits for fluoride treatments are determined by the group/individual contract.			
General Policy - Using prophylaxis paste containing fluoride or a fluoride rinse or swish in conjunction with a prophylaxis is considered a prophylaxis only. A separate fee for this type of topical fluoride application is not billable to the patient.			
General Policy - Fluoride gels, rinses, tablets, or other preparations intended for home application are denied unless covered by group/individual contract.			
General Policy - The age limitation for topical fluoride gel or varnish treatments is determined by group/individual contract. Professionally applied prescription strength, topical fluoride applications should be a benefit up to age 19.			
D1206	Topical application of fluoride varnish	None	Benefits for topical fluoride varnish when used for desensitization or as cavity liner are denied.
D1208	Topical application of fluoride – excluding varnish	None	Fluoride gels, rinses, tablets, or other preparations intended for home application are denied.
C. D1300 – D1499 OTHER PREVENTIVE SERVICES			
General Policy -Age limitations for sealants are subject to group/individual contract.			
General Policy Sealants are a benefit once per tooth on the occlusal surface of permanent molars.			
D1301	Immunization counseling	A review of a patient's vaccine and medical history, and discussion of the vaccine benefits, risks, and consequences of not obtaining the vaccine. Counseling also includes a discussion of questions and concerns the patient, family, or caregiver may have and suggestions on where the patient can obtain the vaccine.	Benefits for immunization counseling are denied unless covered by group/individual contract.
D1310	Nutritional counseling for control of dental disease	Counseling on food selection and dietary habits as a part of treatment	Benefits for nutritional counseling are denied, unless covered by group/individual contract.

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
		and control of periodontal disease and caries.	
D1320	Tobacco counseling for the control and prevention of oral disease	Tobacco prevention and cessation services reduce patient risks of developing tobacco-related oral diseases and conditions and improves prognosis for certain dental therapies.	Benefits for tobacco counseling are denied, unless covered by group/individual contract.
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use	Counseling services may include patient education about adverse oral, behavioral, and systemic effects associated with high-risk substance use and administration routes. This includes ingesting, injecting, inhaling and vaping. Substances used in a high-risk manner may include but are not limited to alcohol, opioids, nicotine, cannabis, methamphetamine and other pharmaceuticals or chemicals.	Benefits are denied unless covered by group/individual contract.
D1330	Oral hygiene instructions	This may include instructions for home care. Examples include tooth brushing technique, flossing, use of special oral hygiene aids.	Benefits for oral hygiene instruction are denied, unless covered by group/individual contract.
D1351	Sealant - per tooth	Mechanically and/or chemically prepared enamel surface sealed to prevent decay.	a. Fees for sealants completed on the same date of service and on the same surface as a restoration by the same dentist/dental office are not billable to the patient as a component of the restoration. b. Benefits for sealants are denied when the patient's claims history indicates a restoration on the occlusal surface of the same tooth. c. Benefits for sealants include repair or replacement within 24 months by the same

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
			dentist/dental office. Fees for repair or replacement of a sealant are not billable to the patient if performed within 24 months of initial placement by the same dentist/dental office. d. Benefits for sealants requested more than 24 months following the initial placement are DENIED unless covered by group/individual contract.
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	Conservative restoration of an active cavitated lesion in a pit or fissure that does not extend into dentin; includes placement of a sealant in any radiating non-carious fissures or pits.	a. Fees for preventive resin restoration completed on the same date of service and on the same surface as a restoration by the same dentist/dental office are considered a component of the restoration and are not billable to the patient. b. Benefits for preventive resin restorations are denied when submitted documentation or the patient's claim history indicates a restoration on the occlusal surface of the same tooth. c. Preventive resins restorations are a benefit once per tooth on the occlusal surface of permanent molars for patients through age 15. The teeth must be free from overt dentinal caries. d. Benefits for preventive resin restorations or sealants include repair or replacement within 24 months by the same dentist/dental office. Fees for repair or replacement of a preventive resin restoration are not billable to the patient if performed within 24 months of initial placement by the same dentist/dental office.

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
			e. Benefits for preventive resin restorations requested after 24 months are denied or covered based on group/individual contract.
D1353	Sealant repair - per tooth	None	a. Fees for repairing sealants completed on the same date of service and on the same surface as a restoration by the same dentist/dental office are considered a component of the restoration and are not billable to the patient. b. Benefits to repair sealants are denied when submitted documentation or the patient's claims history indicates a restoration on the occlusal surface of the same tooth. c. Fees for repair or replacement of a sealant are not billable to the patient if performed within 24 months of initial placement by the same dentist/dental office. d. Benefits for repairing sealants requested 24 months or more following the initial placement are denied or covered based on group/individual contract.
D1354	Application of caries arresting medicament – per tooth	Conservative treatment of an active, non-symptomatic carious lesion by topical application of a caries arresting or inhibiting medicament and without mechanical removal of sound tooth structure.	a. Benefits are limited to twice per tooth per benefit year. b. Benefits for more than twice per tooth per benefit year are denied. c. Fees for D1354 on the same date of service as a restoration are not billable to the patient. d. Benefits for restorations placed within 2 months of D1354 are denied.

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
			e. D1354 does not count against fluoride frequency.
D1355	Caries preventive medicament application – per tooth	For primary prevention or remineralization. Medicaments applied do not include topical fluorides.	Benefits are denied unless covered by group/individual contract.
D. D1500 – D1999 SPACE MAINTAINERS (PASSIVE APPLIANCES)			
General Policy – Benefits for the repair or replacement of a space maintainer are denied.			
General Policy - Only one space maintainer is benefited per arch, per lifetime except under unusual circumstances. Otherwise, benefits are denied.			
General Policy - Space maintainers for missing primary anterior teeth or missing permanent teeth or for persons age 14 or older are not covered benefits and are denied.			
General Policy – only one unilateral space maintainer is benefited per quadrant, per lifetime except under unusual circumstances. Otherwise, benefits are denied.			
D1510	Space maintainer – fixed, unilateral – per quadrant	Excludes distal shoe space maintainer.	None
D1516	Space maintainer – fixed – bilateral, maxillary	None	None
D1517	Space maintainer – fixed – bilateral, mandibular	None	None
D1520	Space maintainer – removable – unilateral – per quadrant	None	None
D1526	Space maintainer – removable – bilateral, maxillary	None	None
D1527	Space maintainer – removable – bilateral, mandibular	None	None
D1551	Re-cement or re-bond bilateral space maintainer – maxillary	None	a. One recementation or re-bonding is allowed per space maintainer per arch. b. Benefits for subsequent requests for recementation or re-bonding are denied.

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
D1552	Re-cement or re-bond bilateral space maintainer – mandibular	None	a. One recementation or re-bonding is allowed per space maintainer per arch. b. Benefits for subsequent requests for recementation or re-bonding are denied.
D1553	Re-cement or re-bond unilateral space maintainer – per quadrant	None	a. One recementation or re-bonding is allowed per space maintainer, per quadrant. b. Benefits for subsequent requests for recementation or re-bonding are denied.
D1556	Removal of fixed unilateral space maintainer – per quadrant	None	a. Fees for removal of fixed space maintainer by the same dentist/dental office who placed appliance are not billable to the patient anytime following placement of space maintainer. b. Fees for D1556 are not billable to the patient when submitted with recementation done on the same date of service. c. Fees for removal of a fixed space maintainer by a different dentist/dental office than who placed the appliance are denied.
D1557	Removal of fixed bilateral space maintainer – maxillary	None	a. Fees for removal of fixed space maintainer by the same dentist/dental office who placed the appliance are not billable to the patient anytime following placement of space maintainer. b. Fees for D1557 are not billable to the patient when submitted with recementation done on the same date of service. c. Fees for removal of a fixed space maintainer by a different dentist/dental

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
			office than who placed the appliance are denied.
D1558	Removal of fixed bilateral space maintainer – mandibular	None	a. Fees for removal of fixed space maintainer by the same dentist/dental office who placed the appliance are not billable to the patient anytime following placement of space maintainer. b. Fees for D1558 are not billable to the patient when submitted with recementation done on the same date of service. c. Fees for removal of a fixed space maintainer by a different dentist/dental office than who placed the appliance are denied.
D1575	Distal shoe space maintainer – fixed, unilateral – per quadrant	Fabrication and delivery of fixed appliance extending subgingivally and distally to guide the eruption of the first permanent molar. Does not include ongoing follow-up or adjustments, or replacement appliances, once the tooth has erupted.	a. Benefits for D1575 for children age 9 and over are denied. b. Fees for repairs and adjustments by same dentist/dental office are not billable to the patient.
D1701	Pfizer-BioNTech Covid-19 vaccine administration – first dose	SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 1	Benefits are denied unless covered by group/individual contract.
D1702	Pfizer-BioNTech Covid-19 vaccine administration – second dose	SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 2	Benefits are denied unless covered by group/individual contract.
D1703	Moderna Covid-19 vaccine administration – first dose	SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 1	Benefits are denied unless covered by group/individual contract.
D1704	Moderna Covid-19 vaccine administration – second dose	SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 2	Benefits are denied unless covered by group/individual contract.
D1705	AstraZeneca Covid-19 vaccine administration – first dose	SARSCOV2 COVID-19 VAC rS-ChAdOx1 5x1010 VP/.5mL IM DOSE 1	Benefits are denied unless covered by group/individual contract.

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
D1706	AstraZeneca Covid-19 vaccine administration – second dose	SARSCOV2 COVID-19 VAC rS-ChAdOx1 5x1010 VP/.5mL IM DOSE 2	Benefits are denied unless covered by group/individual contract.
D1707	Janssen Covid-19 vaccine administration	SARSCOV2 COVID-19 VAC Ad26 5x1010 VP/.5mL IM SINGLE DOSE	Benefits are denied unless covered by group/individual contract.
D1708	Pfizer-BioNTech Covid-19 vaccine administration – third dose	SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 3	Benefits are denied unless covered by group/individual contract.
D1709	Pfizer-BioNTech Covid-19 vaccine administration – booster dose	SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE BOOSTER	Benefits are denied unless covered by group/individual contract.
D1710	Moderna Covid-19 vaccine administration – third dose	SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 3	Benefits are denied unless covered by group/individual contract.
D1711	Moderna Covid-19 vaccine administration – booster dose	SARSCOV2 COVID-19 VAC mRNA 50mcg/0.25mL IM DOSE BOOSTER	Benefits are denied unless covered by group/individual contract.
D1712	Janssen Covid-19 Vaccine Administration - booster dose	SARSCOV2 COVID-19 VAC Ad26 5x1010 VP/.5mL IM DOSE BOOSTER	Benefits are denied unless covered by group/individual contract.
D1713	Pfizer-BioNTech Covid-19 vaccine administration tris-sucrose pediatric - first dose	SARSCOV2 COVID-19 VAC mRNA 10mcg/0.2mL tris-sucrose IM DOSE 1	Benefits are denied unless covered by group/individual contract.
D1714	Pfizer-BioNTech Covid-19 vaccine administration tris-sucrose pediatric - second dose	SARSCOV2 COVID-19 VAC mRNA 10mcg/0.2mL tris-sucrose IM DOSE 2	Benefits are denied unless covered by group/individual contract.
D1781	Vaccine administration – human papillomavirus - Dose 1	Gardasil 9 0.5mL intramuscular vaccine injection.	Benefits are denied unless covered by group/individual contract.
D1782	Vaccine administration – human papillomavirus - Dose 2	Gardasil 9 0.5mL intramuscular vaccine injection.	Benefits are denied unless covered by group/individual contract.
D1783	Vaccine administration – human papillomavirus - Dose 3	Gardasil 9 0.5mL intramuscular vaccine injection.	Benefits are denied unless covered by group/individual contract.

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
D1999	Unspecified preventive procedure, by report	Used for procedure that is not adequately described by a code. Describe the procedure.	None

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy

D2000 - D2999 RESTORATIVE

Terms of group/individual contracts vary. Policies in this Handbook that address benefits, limitations and exclusions are policies that have not been tailored to reflect the specific terms of applicable group/individual contracts. In all cases, the terms of group/individual contracts take precedence over Dentist Handbook policies. Please contact the member company listed on the patient's identification card for the specific terms of a group/individual contract.

Benefit determinations are subject to individual consideration when accompanied by adequate documentation of extraordinary circumstances.

Benefits for multi-stage procedures are only available for completed services as determined by the date of insertion.

General Policy – The term specialized procedure describes a dental service or procedure that is used when unusual or extraordinary circumstances exist and is not generally used when conventional methods are adequate.

General Policy - Infection control is included in the fee for the dental services provided. Separate fees are not billable to the patient.

General Policy - Benefits for restorations for altering occlusion, adjusting vertical dimension, replacing tooth structure lost by attrition, erosion, abrasion, abfraction, corrosion, TMD or for periodontal, orthodontic or other splinting are denied.

General Policy – Benefits for biomimetic restorations (e.g. Biodentine) are denied as investigational.

General Policy - Restorations or surgical procedures to correct congenital or developmental malformations are benefited unless done solely for cosmetic reasons.

Definitions

Attrition

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

Abrasion

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

Erosion

1. The wasting away or loss of substance of a tooth by a chemical process that does not involve known bacterial action. (Treatment Planning in Dentistry; Mosby 2006).

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
2. The process and the results of loss of dental hard tissue that is chemically etched away from the tooth surface, by acid and/or chelation, without bacterial involvement. (ten Cate & Imfeld, Eur J Oral Sci 1996; 104:241). Abfraction Wedge-shaped lesions occurring in the cervical enamel. Can result from occlusal loading and flexure in the area. (Dorland's Illustrated Medical Dictionary, 25th edition 1975).			
General Policy – For benefit purposes, local anesthesia is an integral part of the procedure being performed and additional fees are not billable to the patient.			
General Policy - The fee for a restoration includes services such as, but not limited to, adhesives, etching, liners, bases, direct and indirect pulp caps, local anesthesia, polishing, occlusal adjustment, caries removal and gingivectomy on the same date of service. Fees for the procedures noted above, when performed in conjunction with a restoration, by the same dentist/dental office are not billable to the patient on the same date of service.			
General Policy - If an indirectly fabricated restoration is performed, by the same dentist/dental office within 24 months of the placement of an amalgam or composite restoration, the benefit and patient co-payment allowance for the amalgam or composite restorations will be deducted from an indirectly fabricated restoration benefit.			
General Policy - Fees for the replacement of amalgam or composite restorations within 24 months are not billable to the patient if done by the same dentist/dental office. Benefits may be allowed if done by a different dentist. Special consideration may be given by report.			
General Policy- When multiple restorations involving the proximal and occlusal surfaces of the same tooth are requested or performed, benefits will be limited to that of a multi-surface restoration. A separate benefit may be allowed for a non-contiguous restoration on the buccal or lingual surface(s) of the same tooth.			
General Policy – Benefits are allowed only once per surface in a 24 month interval, irrespective of the number or combination of procedures requested or performed.			
General Policy – Narratives are not considered legal documentation. The only acceptable legal written documentation for utilization review are the dental records.			
General Policy - When restorations not involving the occlusal surface are requested or performed on posterior teeth on the same date of service by the same dentist/dental office, the level of benefits will be limited to that of a one surface restoration. Any fee in excess of the one surface restoration will be not billable to the patient on the same date of service.			
General Policy – If a root canal is performed after crown insertion, benefit a one surface restoration for endodontic access closure of the natural tooth.			
General Policy – All services and treatment provided remotely via tele-health modalities, be they synchronous or asynchronous, must be performed by a licensed dentist or their supervised staff, acting within the scope of applicable law. Services and treatment delivered virtually are only a benefit when the elements included in the descriptor of the CDT procedure code are completed and only when they meet generally accepted clinical guidelines.			
A. D2100 - D2199 AMALGAM RESTORATIONS			
D2140	Amalgam - one surface, primary or permanent	None	None

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
D2150	Amalgam - two surfaces, primary or permanent	None	None
D2160	Amalgam - three surfaces, primary or permanent	None	None
D2161	Amalgam - four or more surfaces, primary or permanent	None	None
B. D2330 - D2399 RESIN – BASED COMPOSITE RESTORATIONS – DIRECT			
General Policy - Fees for the replacement of amalgam or composite restorations within 24 months are not billable to the patient if done by the same dentist/dental office. Benefits may be allowed if done by a different dentist/dental office. Special consideration may be given by report.			
General Policy - In the event an anterior proximal restoration involves a significant portion of the labial or lingual surface, it may be reported as D2331 or D2332, as appropriate, otherwise treat as D2330.			
General Policy - In a pit and fissure area, if the resin is limited to the enamel it is considered a sealant or preventive resin restoration. If the resin extends into the dentin, the appropriate composite resin codes should be reported.			
D2330	Resin-based composite – one surface, anterior	None	None
D2331	Resin-based composite - two surfaces, anterior	None	None
D2332	Resin-based composite - three surfaces, anterior	None	None
D2335	Resin-based composite - four or more surfaces (anterior)	None	None
D2390	Resin-based composite crown, anterior	Full resin-based composite coverage of tooth.	None
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.	Benefits are determined by group/individual contract.
D2392	Resin-based composite - two surfaces, posterior	None	Benefits are determined by group/individual contract.
D2393	Resin-based composite - three surfaces, posterior	None	Benefits are determined by group/individual contract.
D2394	Resin-based composite - four or more surfaces, posterior	None	Benefits are determined by group/individual contract.
C. D2400 - D2499 GOLD FOIL RESTORATIONS			

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
General Policy - An alternate benefit will be allowed for an amalgam or resin restoration, according to the policies for amalgam and resin restorations. The additional fee up to the approved amount for the gold foil restoration is chargeable to the patient.			
D2410	Gold foil - one surface	None	None
D2420	Gold foil - two surfaces	None	None
D2430	Gold foil - three surfaces	None	None
D. D2500 – D2699 INLAY/ ONLAY RESTORATIONS			
General Policy - Multistage procedures are reported and benefited upon completion. The completion date is the date of insertion for removable prosthetic appliances. The completion date for immediate dentures is the date that the remaining teeth are removed and the denture is inserted. The completion date for fixed partial dentures, crowns, onlays and inlays is the cementation date, regardless of the type of cement utilized.			
General Policy - For inlay restorations, an alternate benefit will be allowed for an amalgam or resin restoration, according to the policies for amalgam and resin restorations. Any additional fee up to the approved amount for the inlay is chargeable to the patient.			
General Policy – Crowns and onlays are not a benefit for children under 12 years of age. Benefits for patient under age 12 are denied.			
General Policy – Crowns, onlays and indirectly fabricated restorations are considered to be an optional benefit unless the tooth is damaged by decay or fracture to the point that it cannot be restored with amalgam or resin.			
General Policy - Restorative benefits are made for the least expensive professionally accepted treatment procedure (LEPAT). Any difference in the fee is denied.			
General Policy - If the deciduous tooth is an "extra tooth" in addition to the normal complement of teeth, an inlay/onlay is not a benefit. Benefits are denied and the approved amount is chargeable to the patient.			
General Policy - If an inlay/onlay is being proposed or has been done where periodontal bone support appears to be inadequate, benefits are denied due to the unfavorable prognosis for the tooth.			
General Policy - Indirectly fabricated restorations include all models, temporaries and other associated procedures. Separate fees for models, temporaries, and other associated procedures by the same dentist/dental office are not billable to the patient.			
D2510	Inlay – metallic – one surface	None	None
D2520	Inlay - metallic - two surfaces	None	None
D2530	Inlay - metallic - three or more surfaces	None	None
D2542	Onlay - metallic - two surfaces	None	None
D2543	Onlay - metallic - three surfaces	None	None
D2544	Onlay - metallic - four or more surfaces	None	None
D2610	Inlay - porcelain/ceramic - one surface	None	None

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
D2620	Inlay - porcelain/ceramic - two surfaces	None	None
D2630	Inlay - porcelain/ceramic - three or more surfaces	None	None
D2642	Onlay - porcelain/ceramic - two surfaces	None	None
D2643	Onlay - porcelain/ceramic - three surfaces	None	None
D2644	Onlay - porcelain/ceramic - four or more surfaces	None	None
D2650	Inlay - resin-based composite - one surface	None	None
D2651	Inlay - resin-based composite - two surfaces	None	None
D2652	Inlay - resin-based composite - three or more surfaces	None	None
D2662	Onlay - resin-based composite - two surfaces	None	None
D2663	Onlay - resin-based composite - three surfaces	None	None
D2664	Onlay - resin-based composite - four or more surfaces	None	The fee for models, temporaries and other associated procedures by the same dentist/dental office are not billable to the patient.

E. D2700 – D2899 CROWNS- SINGLE RESTORATION ONLY

General Policy - Crowns and indirectly fabricated restorations are considered to be an optional benefit unless the tooth is damaged by decay or fracture to the point that it cannot be restored with amalgam or resin.

General Policy - Restorative benefits are made for the least expensive professionally accepted treatment procedure (LEPAT). Any difference in the fee is denied.

General Policy - If the deciduous tooth is an “extra tooth” in addition to the normal complement of teeth, a crown is not a benefit. Benefits are denied and the approved amount is chargeable to the patient.

General Policy - If a crown is being proposed or has been done where periodontal bone support appears to be inadequate, benefits are DENIED due to the unfavorable prognosis for the tooth.

General Policy – Narratives are not considered legal documentation. The only acceptable legal written documentation for utilization review are the dental records.

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
General Policy - Tooth preparation, temporary restorations, laboratory fees and material, cement bases, impressions, occlusal adjustment, gingivectomies (on the same date of service) and local anesthesia are considered to be included in the fee for a crown restoration. Separate fees for these procedures by the same dentist/dental office are not billable to the patient on the same date of service.			
General Policy - Crowns and onlays are not a benefit for children under 12 years of age. Benefits for patient under age 12 are denied.			
General Policy - Restorations for altering occlusion, involving vertical dimension, replacing tooth structure lost by attrition, erosion, abrasion (wear), abfraction or for periodontal, orthodontic or TMD therapy, or other splinting are not a benefit. Benefits are denied.			
General Policy – Indirectly fabricated restorations include all models, temporaries and other associated procedures. Fees for models, temporaries, and other associated procedures by the same dentist/dental office are not billable to the patient.			
D2710	Crown – resin-based composite (indirect)	None	None
D2712	Crown - ¾ resin-based composite (indirect)	This procedure does not include facial veneers.	None
D2720	Crown - resin with high noble metal	None	None
D2721	Crown - resin with predominantly base metal	None	None
D2722	Crown - resin with noble metal	None	None
D2740	Crown - porcelain/ceramic	None	None
D2750	Crown - porcelain fused to high noble metal	None	None
D2751	Crown - porcelain fused to predominantly base metal	None	None
D2752	Crown - porcelain fused to noble metal	None	None
D2753	Crown - porcelain fused to titanium or titanium alloys	None	None
D2780	Crown- ¾ cast high noble metal	None	None
D2781	Crown- ¾ cast predominantly base metal	None	None
D2782	Crown- ¾ cast noble metal	None	None

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
D2783	Crown - ¾ porcelain/ceramic	This procedure does not include facial veneers.	
D2790	Crown - full cast high noble metal	None	None
D2791	Crown - full cast predominantly base metal	None	None
D2792	Crown - full cast noble metal	None	None
D2794	Crown – titanium and titanium alloys	None	None
D2799	Interim crown - further treatment or completion of diagnosis necessary prior to final impression	Not to be used as a temporary crown for a routine prosthetic restoration.	a. Temporary, interim or provisional restorations are not separate benefits and should be included in the fee for the permanent restoration. Fees for provisional crown are not billable to the patient. b. When a temporary, interim, or provisional crown is billed as a therapeutic measure for a fractured tooth, benefits are subject to individual consideration. c. Temporary, interim, or provisional fixed prostheses by the same dentist/dental office are not separate benefits and should be included in the fee for the permanent prosthesis. Fees for provisional crown are not billable to the patient.
F. D2900 – D2999 OTHER RESTORATIVE SERVICES			
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	None	a. Fees for the recementation or rebonding by the same dentist/dental office of covered restorations within six months of initial placement are considered part of the fee for the original procedure and are not billable to the patient.

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
			b. Benefit for one recementation or rebonding after six months have elapsed since initial placement. Benefits for recementations or rebonding in excess of one recementation or rebonding by the same dentist/dental office are denied.
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	None	a. Fees for the recementation or rebonding by the same dentist/dental office of an indirectly fabricated or prefabricated post and core within six months of initial placement are considered part of the fee for the original procedure and are not billable to the patient. b. Benefits for recementation or rebonding after six months have elapsed since initial placement, but only once, to the same dentist/ dental office. Benefits for recementations or rebonding in excess of one recementation or rebonding by the same dentist/dental office are denied. c. Post recementation or rebonding (D2915) and crown recementation or rebonding (D2920) are not allowed on the same tooth on the same date of service by the same dentist/dental office. The allowance will be made only for D2920 when D2915 and D2920 are submitted together. The fee for D2915 (recement or rebonding indirectly fabricated or prefabricated post and core) is not billable to the patient.
D2920	Re-cement or re-bond crown	None	a. Fees for the recementation or rebonding by the same dentist/dental office of covered restorations within six months of initial placement are considered part of the fee for

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
			the original procedure and are not billable to the patient. b. Benefits may be paid for recementation or rebonding after six months have elapsed since initial placement, but only once. Benefits for recementations or rebonding in excess of one recementation or rebonding by the same dentist/dental office are denied.
D2921	Reattachment of tooth fragment, incisal edge or cusp	None	The fee for reattachment by the same dentist/dental office within 24 months is included in the initial reattachment or restoration and is not billable to the patient.
D2928	Prefabricated porcelain/ceramic crown – permanent tooth	None	a. The fee for the replacement of a prefabricated porcelain/ceramic crown by the same dentist/dental office within 24 months is included in the initial crown placement and is not billable to the patient. b. Benefits for D2928 are denied if done by different dentist/dental office within 24 months.
D2929	Prefabricated porcelain/ceramic crown – primary tooth	None	a. D2929 is benefitted once per lifetime. b. The fee for replacement of a porcelain/ceramic crown by the same dentist/dental office within 24 months is included in the initial crown placement and is not billable to the patient. Benefits are denied if done by a different dentist/dental office
D2930	Prefabricated stainless steel crown - primary tooth	None	a. D2930 is benefitted once per lifetime. b. The fee for replacement of a stainless steel crown by the same dentist/dental office

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
			within 24 months is not billable to the patient.
D2931	Prefabricated stainless steel crown - permanent tooth	None	The fee for the replacement of a stainless steel crown within 24 months is included in the initial crown placement and is not billable to the patient. Benefits are denied if done by a different dentist/dental office.
D2932	Prefabricated resin crown	None	The resin crown is an esthetic restoration benefited only for primary anterior teeth.
D2933	Prefabricated stainless steel crown with resin window	Open-face stainless steel crown with aesthetic resin facing or veneer.	a. A prefabricated stainless steel crown with resin window is a benefit only on anterior primary teeth. If submitted for a posterior primary tooth or for a permanent tooth, an alternate benefit allowance for prefabricated stainless steel crown - primary tooth (D2930) or prefabricated stainless steel crown - permanent tooth (D2931) is made. The difference between the allowance for the D2930 or D2931 and the approved amount for the D2933 is denied and chargeable to the patient. b. A fee for replacement of a stainless steel crown on a primary or permanent tooth within 24 months is included in the initial crown placement and is not billable to the patient. c. Replacement within 24 months of initial placement by a different dentist/dental office is denied and the approved amount is chargeable to the patient.
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	Stainless steel primary crown with exterior esthetic coating.	a. A prefabricated esthetic coated stainless steel crown is a benefit only on anterior primary teeth. If submitted for a posterior primary tooth or for a permanent tooth, an

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
			alternate benefit allowance for prefabricated stainless steel crown - primary tooth (D2930) or prefabricated stainless steel crown - permanent tooth (D2931) is made. The difference between the allowance for the D2930 or D2931 and the approved amount for the D2934 is denied and chargeable to the patient. b. A fee for replacement of a stainless steel crown on a primary or permanent tooth by the same dentist/dental office within 24 months is included in the initial crown placement and is not billable to the patient. c. Benefits for replacement within 24 months of initial placement by a different dentist/dental office are denied and the approved amount is collectable from the patient.
	General Policy – The fees for buildups are not billable to the patient when buildups are performed in conjunction with inlays, ¾ crowns or onlays.		
D2940	Protective restoration	Direct placement of a restorative material to protect tooth and/or tissue form. This procedure may be used to relieve pain, promote healing, or prevent further deterioration. Not to be used for endodontic access closure, or as a base or liner under a restoration.	a. Protective restorations are covered benefits for emergency relief of pain. The fee for a protective restoration filling is not billable to the patient when performed in conjunction with a definitive restoration by same dentist/dental office on same date of service. b. Pulp cap - direct (excluding final restoration) (D3110) or pulp cap - indirect (excluding final restoration) (D3120) are not billable to the patient when billed in conjunction with D2940.

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
			c. Fees for D2940 are not billable to the patient when performed in conjunction with any restorative codes D2000-D2999, bridge codes (D6200-D6699), D3220-D3330, D3346-D3353, D3410-D3450.
D2941	Interim therapeutic restoration – primary dentition	Placement of an adhesive restorative material following caries debridement by hand or other method for the management of early childhood caries. Not considered a definitive restoration.	a. Allow one per primary tooth. b. Fees for D2941 are not billable to the patient in conjunction with definitive restorations (D2000-D2999) within 24 months.
D2949	Restorative foundation for an indirect restoration	Placement of restorative material to yield a more ideal form, including elimination of undercuts	D2949 is a component of the definitive indirect restoration and the fees are not billable to the patient.
D2950	Core buildup, including any pins when required	Refers to building up of coronal structure when there is insufficient retention for a separate extracoronal restorative procedure. A core buildup is not a filler to eliminate any undercut, box form, or concave irregularity in a preparation.	Substructures are only a benefit when necessary to retain an indirectly fabricated restoration due to extensive loss of tooth structure from caries or fracture. A material is placed in the tooth preparation for a crown when there is insufficient tooth strength and retention for the crown procedure. Otherwise, fees are not billable to the patient. The procedure should not be reported when the procedure only involves a filler to eliminate any undercut, box form or concave irregularity in the preparation.
D2951	Pin retention - per tooth, in addition to restoration	None	a. Pin retention is a benefit once per tooth when necessary on a permanent tooth when completed at the same appointment. Fees for additional pins by the same dentist/dental office on the same tooth are not billable to the patient as a component of the initial pin placement. b. Fees for pin retention when billed on the same date of service with a core buildup by

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
			the same dentist/dental office are not billable to the patient as a component of the buildup.
D2952	Post and core in addition to crown, indirectly fabricated	Post and core are custom fabricated as a single unit.	a. An indirectly fabricated post and core in addition to crown is a benefit only on an endodontically treated tooth. Fees for post and cores are not billable to the patient when radiographs indicate an absence of endodontic treatment, or an incompletely filled canal space. Unresolved radiolucencies may be a reason to not billable to the patient but should be evaluated based on the time since the completion of the endodontic services and co-joint signs and symptoms. b. An indirectly fabricated post and core is a benefit in anterior teeth only when there is insufficient tooth structure to support a cast restoration. c. If reported with a restoration or a core buildup, the amalgam or composite core buildup is considered part of the post and core procedure. d. When radiographs indicate more than half of the coronal tooth structure remains, fees for post and cores are denied.
D2953	Each additional indirectly fabricated post - same tooth	To be used with D2952	Individual consideration may be given by report.
D2954	Prefabricated post and core in addition to crown	Core is built around a prefabricated post. This procedure includes the core material	a. A prefabricated post and core in addition to crown is a benefit only on an endodontically treated tooth. Fees for post and core are not billable to the patient when radiographs indicate an absence of endodontic treatment, or an incompletely filled canal space, or unresolved pathology

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
			associated with the involved tooth. Unresolved radiolucencies may be a reason to not billable to the patient but should be evaluated based on the time since the completion of the endodontic services and co-joint signs and symptoms. b. A prefabricated post and core is a benefit in anterior teeth only when there is insufficient tooth structure to support a cast restoration. c. When radiographs indicate more than half of the coronal tooth structure remains, fees for post and cores are denied.
D2955	Post removal	None	The fee for post removal is a component of the fee for the retreatment of a previous root canal therapy and is not billable to the patient
D2957	Each additional prefabricated post - same tooth	To be used with D2954	None
D2960	Labial veneer (resin laminate) - direct	Refers to labial/facial direct resin bonded veneers	D2960 is considered cosmetic and benefits are determined by to group/individual contract.
D2961	Labial veneer (resin laminate) - indirect	Refers to labial/facial indirect resin bonded veneers	D2961 is considered cosmetic and benefits are determined group/individual contract.
D2962	Labial veneer (porcelain laminate) - indirect	Refers also to facial veneers that extend interproximally and/or cover the incisal edge. Porcelain/ceramic veneers presently include all ceramic and porcelain veneers.	D2962 is considered cosmetic and benefits are determined to group/individual contract.
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework	This procedure is in addition to the separate crown procedure documented with its own code.	None

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
D2975	Coping	A thin covering of the coronal portion of a tooth, usually devoid of anatomic contour, that can be used as a definitive restoration.	Copings are considered a specialized procedure and benefits are denied.
	General Policy – Fees for repairs are not billable to the patient within 24 months of the original restoration by the same dentist/dental office. Benefits are denied if done by a different dentist/dental office.		
D2976	Band stabilization - per tooth	A band, typically cemented around a molar tooth after a multi-surface restoration has been placed, to add support and resistance to fracture until a patient is ready for a full cuspal coverage restoration.	a. Benefits are limited to posterior permanent teeth only. b. Benefit once per tooth per lifetime.
D2980	Crown repair necessitated by restorative material failure	None	a. Fees for a crown repair completed on the same date of service as a new crown are not billable to the patient. b. Fees for crown repair are not billable to the patient within 24 months of the original restoration by the same dentist/dental office. c. Benefits for D2980 are denied within 24 months of the original restoration by different dentist/dental office.
D2981	Inlay repair necessitated by restorative material failure	None	a. Fees for inlay repairs completed on the same date of service as a new inlay are not billable to the patient. b. Fees for inlay repairs are not billable to the patient within 24 months of the original restoration. c. Benefits for D2981 are denied within 24 months of the original restoration by different dentist/dental office.

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
D2982	Onlay repair necessitated by restorative material failure	None	a. Fees for onlay repairs completed on the same date of service as a new onlay are not billable to the patient. b. Fees for onlay repairs are not billable to the patient within 24 months of the original restoration. c. Benefits for D2982 are denied within 24 months of the original restoration by different dentist/dental office.
D2983	Veneer repair necessitated by restorative material failure	None	a. Fees for veneer repairs completed on the same date of service as a new veneer are not billable to the patient. b. Fees for veneer repairs are not billable to the patient within 24 months of the original restoration. c. Benefits for D2983 are denied within 24 months of the original restoration by different dentist/dental office.
D2989	Excavation of a tooth resulting in the determination of non-restorability	None	D2989 is considered an incomplete service and the fees are not billable to the patient.
D2990	Resin infiltration of incipient smooth surface lesions	Placement of an infiltrating resin restoration for strengthening, stabilizing and/or limiting the progression of the lesion.	Benefits for resin infiltration of incipient smooth surface lesions are denied as investigational.
D2991	Application of hydroxyapatite regeneration medicament – per tooth	Preparation of tooth surfaces and topical application of a scaffold to guide hydroxyapatite regeneration.	Benefits are denied unless covered by group/individual contract. When covered: a. Benefits are limited to twice per tooth per benefit year.

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
			b. Benefits for more than twice per tooth per benefit year are denied. c. Fees for D2991 on the same tooth and on the same date of service as a restoration [D2000-D2999] are not billable to the patient by the same dentist/dental office. d. Fees for restorations placed within 6 months of D2991 are not billable to the patient by the same dentist/dental office. e. Fees for D1354 on the same tooth and on the same date of service as D2991 are not billable to the patient.
D2999	Unspecified restorative procedure, by report	Used for a procedure that is not adequately described by a code. Describe the procedure.	None

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy

D3000 – D3999 ENDODONTICS

Terms of group/individual contracts vary. Policies in this Handbook that address benefits, limitations and exclusions are policies that have not been tailored to reflect the specific terms of applicable group/individual contracts. In all cases, the terms of group/individual contracts take precedence over Dentist Handbook policies. Please contact the member company listed on the patient's identification card for the specific terms of a group/individual contract.

Benefit determinations are subject to individual consideration when accompanied by adequate documentation of extraordinary circumstances.

General Policy - For benefit purposes, anesthesia is an integral part of the procedures being performed and additional fees are not billable to the patient.

General Policy – The term specialized procedure describes a dental service or procedure that is used when unusual or extraordinary circumstances exist and is not generally used when conventional methods are adequate.

General Policy - Infection control is included in the fee for the dental services provided. Separate fees are not billable to the patient.

General Policy – All services and treatment provided remotely via tele-health modalities, be they synchronous or asynchronous, must be performed by a licensed dentist or their supervised staff, acting within the scope of applicable law. Services and treatment delivered virtually are only a benefit when the elements included in the descriptor of the CDT procedure code are completed and only when they meet generally accepted clinical guidelines.

A. D3100 – D3199 PULP CAPPING

General Policy - Direct or indirect pulp caps provided on the same date of service as the final restoration by the same dentist/dental office are considered part of a single complete restorative procedure and fees are not billable to the patient.

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.	Fees for a pulp cap performed in conjunction with a restoration by the same dentist/dental office are not billable to the patient.
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. This code is not to be used for bases and	Fees for an indirect pulp cap performed in conjunction with a restoration by the same dentist/dental office are not billable to the patient.

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
		liners when all caries has been removed.	
B. D3200 – D3229 PULPOTOMY			
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	a. If provided on permanent teeth, process as palliative treatment (D9110) and any fees in excess of D9110 are not billable to the patient. b. When done in conjunction with a root canal procedure (D3310-D3330) the fees for D3220 are not billable to the patient.
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.	a. The relief of acute pain is benefited as gross pulpal debridement (D3221). b. It is not considered a separate procedure when performed by the same dentist/dental office on the same date of service as endodontic therapy (D3230–D3333) and the fees for D3221 are not billable to the patient. c. The fees for D9110 in conjunction with D3221 are not billable to the patient by the same dentist/dental office.
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.	a. Fees for D3222 are not billable to the patient when performed within 30 days on same tooth by the same dentist/dental office as root canal therapy (D3230–D3333) or codes D3351-D3353. b. The fees for D9110 in conjunction with D3222 are not billable to the patient by the same dentist/dental office.
C. D3230 – D3299 ENDODONTIC THERAPY ON PRIMARY TEETH			

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	Primary incisors and cuspids	a. The benefit for root canal therapy is denied when the radiographs reveal insufficient root structure, internal resorption, furcal perforation, or extensive periapical pathosis. b. Fees for D3221 and D3222 are not billable to the patient when performed within 30 days on same tooth by the same dentist/dental office as root canal therapy (D3230–D3333) or codes D3351-D3353. c. The fees for D9110 in conjunction with D3230 are not billable to the patient by the same dentist/dental office.
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	Primary first and second molars	a. The benefit for root canal therapy is denied when the radiographs reveal insufficient root structure, internal resorption, furcal perforation, or extensive periapical pathosis. b. Fees for D3221 and D3222 are not billable to the patient when performed by the same dentist/dental office on the same date of service as endodontic therapy (D3230 – D3333). c. The fees for D9110 in conjunction with D3240 are not billable to the patient by the same dentist/dental office.
D. D3300 – D3399 ENDODONTIC THERAPY (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES, AND FOLLOW-UP CARE)			
General Policy – Benefits for techniques, e.g., ultrasonic cleaning, or instrumentation are considered to be part of the procedure and not billable to the patient.			
General Policy - The fee for a root canal includes treatment, working and final fill radiographic images, and temporary restorations. Fees for radiographic images and temporary restorations in the course of endodontic treatment are not billable to the patient.			

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
General Policy - When radiograph indicates obturation of an endodontically treated tooth has been performed without the use of a solid core material, fees for the endodontic therapy and/or restoration of the tooth are not billable to the patient.			
General Policy - A diagnostic film taken to ascertain the presence of pathology is a separate benefit. The initial opening into the canal and routine postoperative visits are considered part of and included in the fee for completed endodontic treatment. Separate fees are not billable to the patient.			
General Policy - Incompletely filled root canals are not a benefit. Fees for the endodontic therapy are not billable to the patient.			
General Policy - Root canal therapy is not a benefit in conjunction with overdentures(D5863-D5866) and benefits are denied.			
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	None	a. Fees for a pulp test (D0460), palliative treatment (D9110) and pulpal debridement (D3221) are not billable to the patient when done on the same date of service as the root canal therapy by the same dentist/dental office are included in the fee for root canal. b. Benefit determination for incomplete endodontic therapy is subject to individual consideration if a report indicates the patient failed to complete treatment. c. Fees for D3221 and D3222 are not billable to the patient when performed by the same dentist/dental office on the same date of service as endodontic therapy (D3230 – D3333).
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	None	a. Fees for a pulp test (D0460), palliative treatment(D9110) and pulpal debridement (D3221) are not billable to the patient when done on the same date of service as root canal therapy by the same dentist/dental office are included in the fee for root canal. b. Benefit determination for incomplete endodontic therapy is subject to individual consideration if a report indicates the patient failed to complete treatment.

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
			c. Fees for D3221 and D3222 are not billable to the patient when performed by the same dentist/dental office on the same date of service as endodontic therapy (D3230–D3333).
D3330	Endodontic therapy, molar tooth (excluding final restoration)	None	a. Fees for a pulp test (D0460), palliative treatment (D9110) and pulpal debridement (D3221) done on the same date of service as the root canal therapy by the same dentist/dental office is included in the fee for the root canal and fees are not billable to the patient. b. Benefit determination for incomplete endodontic therapy is subject to individual consideration if a report indicates the patient failed to complete treatment. c. Fees for D3221 and D3222 are not billable to the patient when performed by the same dentist/dental office on the same date of service as endodontic therapy (D3230–D3333).
	Working radiographic images and post-operative radiographic images on final fill date are considered part of a root canal treatment and the fees are not billable to the patient.		
D3331	Treatment of root canal obstruction, non-surgical access	In lieu of surgery, 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.	a. This procedure is considered a component of a root canal. A separate fee for the procedure by the same dentist/dental office is not billable to the patient on same date of service as the root canal therapy. b. The fee for D2955, post removal, is not included as part of treatment of root canal obstruction. c. Fees for D3221 and D3222 are not billable to the patient when performed within 30 days on same tooth by the same dentist/dental office

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			as root canal therapy (D3230–D3333) or codes D3351-D3353.
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.	Fees for D3222 are not billable to the patient when performed within 30 days on same tooth by the same dentist/dental office as root canal therapy (D3230–D3333) or codes D3351-D3353.
D3333	Internal root repair of perforation defects	Non-surgical seal of perforation caused by resorption and/or decay but not iatrogenic by same provider.	a. Internal root repair is only a benefit on permanent teeth with incomplete root development or for repair of a perforation. b. If submitted on a primary tooth, benefits for D3333 are denied. c. If submitted on a permanent tooth, fees for D3333 are not billable to the patient when submitted with apicoectomy on the same date of service. d. The procedure is accomplished by recalcification of the defect. In the event surgical intervention is performed by the same dentist/dental office, the fee for the procedure is not billable to the patient in addition to apicoectomy and/or retrograde filling. Also, if reported on a primary tooth the benefits for internal root repair of perforation defects are denied as investigational. e. The fees for D3333 are not billable to the patient if perforation is iatrogenic by the same dentist/dental office submitting the claim. f. Fees for D3222 are not billable to the patient when performed within 30 days on same tooth by the same dentist/dental office as root canal therapy (D3230–D3333) or codes D3351-D3353.

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E. D3340 – D3349 ENDODONTIC RETREATMENT			
General Policy - When a radiograph indicates obturation of an endodontically treated tooth has been performed without the use of a solid core material, fees for the endodontic therapy, and/or restoration of the tooth are not billable to the patient.			
General Policy - Retreatment of root canal therapy or retreatment of apical surgery by the same dentist/dental office within 24 months is considered part of the original procedure. Fees for the retreatment by the same office are not billable to the patient. Benefits by a different dentist/dental office are denied.			
General Policy - 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 and separate fees for these procedures by the same dentist/dental office are not billable to the patient 30 days prior to retreatment as included in the fees for the retreatment. Separate fees for these procedures by a different dentist/dental office are denied.			
D3346	Retreatment of previous root canal therapy - anterior	None	None
D3347	Retreatment of previous root canal therapy - premolar	None	None
D3348	Retreatment of previous root canal therapy - molar	None	None
F. D3350 – D3354 APEXIFICATION/RECALCIFICATION			
D3351	Apexification/recalcification – initial visit (apical closure/ calcific repair of perforations, root resorption, etc.)	Includes opening tooth, preparation of canal spaces, first placement of medication and necessary radiographs. (This procedure may include first phase of complete root canal therapy.)	a. Apexification is only benefited on permanent teeth with incomplete root development or for repair of a perforation. b. Closure of the apex results in a better fill of the canal. If the apex is fully developed, this treatment is not indicated and benefits are denied. c. Fees for D3222 are not billable to the patient when performed within 30 days on same tooth by the same dentist/dental office as root canal therapy (D3230–D3333) or codes D3351-D3353.
D3352	Apexification/recalcification - interim medication replacement	For visits in which the intra-canal medication is replaced with new medication. Includes any necessary radiographs.	Fees for D3222 are not billable to the patient when performed within 30 days on same tooth by the same dentist/dental office as root canal therapy (D3230–D3333) or codes D3351-D3353.

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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.)	Fees for D3222 are not billable to the patient when performed within 30 days on same tooth by the same dentist/dental office as root canal therapy (D3230–D3333) or codes D3351-D3353.
G. D3355 – D3359 PULPAL REGENERATION			
D3355	Pulpal regeneration – initial visit	Includes opening tooth, preparation of canal spaces, placement of medication.	Includes opening in tooth, preparation of canal spaces, and placement of medication. This procedure is considered experimental and benefits are denied.
D3356	Pulpal regeneration – interim medication replacement	None	This procedure is considered experimental and benefits are denied.
D3357	Pulpal regeneration – completion of treatment	Does not include final restoration.	This procedure is considered experimental and benefits are denied.
H. D3400 – D3499 APICOECTOMY/PERIRADICULAR SERVICES (D3410-D3470, D3920)			
General Policy - The fees for biopsy (D7285, D7286), frenectomy (D7961 and D7962) and excision of hard and soft tissue lesions (D7410, D7411, D7450, D7451) are not billable to the patient when the procedures are performed on the same date of service, same surgical site/area, by the same dentist/dental office as the above referenced codes. Requests for individual consideration may always be submitted by report for dental consultant review.			
D3410	Apicoectomy - anterior	For surgery on root of anterior tooth. Does not include placement of retrograde filling material	None
D3421	Apicoectomy - premolar (first root)	For surgery on one root of a premolar. Does not include placement of retrograde filling material. If more than one root is treated, see D3426.	None
D3425	Apicoectomy - 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.	None
D3426	Apicoectomy (each additional root)	Typically used for premolar and molar surgeries when more than one root is treated during the same	None

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		procedure. This does not include retrograde filling material placement.	
D3428	Bone graft in conjunction with periradicular surgery - per tooth; single site	Includes non-autogenous graft material	None
D3429	Bone graft in conjunction with periradicular surgery - each additional contiguous tooth in same surgical site.	Includes non-autogenous graft material	None
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	a. Retrograde filling includes all retrograde procedures per root. A maximum allowance is one retrograde filling per root (not per canal). Any excess of the allowance is not billable to the patient. b. The fee for biopsy of oral tissue, when performed in the same location and on the same date of service by the same dentist/dental office, is not billable to the patient as included in the fee for surgical procedures (e.g. apicoectomy).
D3431	Biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery	None	Benefits are available only when billed for natural teeth. Benefits for these procedures, when billed in conjunction with periradicular surgery, etc. are denied as a specialized technique.
D3432	Guided tissue regeneration, resorbable barrier, per site in conjunction with periradicular surgery	None	Benefits are available only when billed for natural teeth. Benefits for these procedures, when billed in conjunction with periradicular surgery are denied as a specialized technique.
D3450	Root amputation - per root	Root resection of a multi-rooted tooth while leaving the crown. If the crown is sectioned, see D3920.	The fee for root amputation performed on the same date of service as an apicoectomy by the same dentist/dental office is not billable to the patient.
D3460	Endodontic endosseous implant	Placement of implant material, which extends from a pulpal space into the bone beyond the end of the root	Benefits are denied.

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D3470	Intentional re-implantation (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	Intentional reimplantation is a specialized technique and the benefit is denied and the approved amount is chargeable to the patient.
D3471	Surgical repair of root resorption - anterior	For surgery on root of anterior tooth. Does not include placement of restoration.	a. Fees for surgical repair of root resorption are not billable to the patient when performed on the same tooth by the same dentist/dental office on the same date of service as D3333 D3410-D3426, D3430, D3450, D4210- D4212, D4231, D4240, D4241, D4245, D4249, D4260, D4261, D4268, D4270, D4273 - D4278, D4283, and D4285. b. When performed on the same tooth by the same dentist/dental office as D4341 or D4342, the fees for scaling and root planing are not billable to the patient.
D3472	Surgical repair of root resorption – premolar	For surgery on root of premolar tooth. Does not include placement of restoration.	a. Fees surgical repair of root resorption are not billable to the patient when performed on the same tooth by the same dentist/dental office on the same date of service as D3333 D3410-D3426, D3430, D3450, D4210- D4212, D4231, D4240, D4241, D4245, D4249, D4260, D4261, D4268, D4270, D4273 - D4278, D4283, and D4285. b. When performed on the same tooth by the same dentist/dental office as D4341 or D4342, the fees for scaling and root planing are not billable to the patient.
D3473	Surgical repair of root resorption – molar	For surgery on root of molar tooth. Does not include placement of restoration.	a. Fees surgical repair of root resorption are not billable to the patient when performed on the same tooth by the same dentist/dental office on the same date of service as D3333 D3410-D3426, D3430, D3450, D3503, D4210-

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			D4212, D4231, D4240, D4241, D4245, D4249, D4260, D4261, D4268, D4270, D4273 - D4278, D4283, and D4285. b. When performed on the same tooth by the same dentist/dental office as D4341 or D4342, the fees for scaling and root planing are not billable to the patient.
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption – anterior	Exposure of root surface followed by observation and surgical closure of the exposed area. Not to be used for or in conjunction with apicoectomy or repair of root resorption.	a. Fees for surgical exposure of root surface are not billable to the patient when performed on the same tooth by the same dentist/dental office on the same date of service as D3333 D3410-D3426, D3430, D3450, D3471, D4210-D4212, D4231, D4240, D4241, D4245, D4249, D4260, D4261, D4268, D4270, D4273 - D4278, D4283, and D4285. b. When performed on the same tooth by the same dentist/dental office as D4341 or D4342 the fees for scaling and root planing are not billable to the patient.
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption – premolar	Exposure of root surface followed by observation and surgical closure of the exposed area. Not to be used for or in conjunction with apicoectomy or repair of root resorption.	a. Fees for surgical exposure of root surface are not billable to the patient when performed on the same tooth by the same dentist/dental office on the same date of service as D3333 D3410-D3426, D3430, D3450, D3472, D4210-D4212, D4231, D4240, D4241, D4245, D4249, D4260, D4261, D4268, D4270, D4273 - D4278, D4283, and D4285. b. When performed on the same tooth by the same dentist/dental office as D4341 or D4342 the fees for scaling and root planing are not billable to the patient.
D3503	Surgical exposure of root surface without apicoectomy	Exposure of root surface followed by observation and surgical closure of the exposed area. Not to be used for	a. Fees surgical exposure of root surface are not billable to the patient when performed on the same tooth by the same dentist/dental

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	or repair of root resorption – molar	or in conjunction with apicoectomy or repair of root resorption	office on the same date of service as D3333 D3410-D3426, D3430, D3450, D3473, D4210-D4212, D4231, D4240, D4241, D4245, D4249, D4260, D4261, D4268, D4270, D4273 - D4278, D4283, and D4285. b. When performed on the same tooth by the same dentist/dental office as D4341 or D4342 the fees for scaling and root planing are not billable to the patient.
I. D3900 - D3999 OTHER ENDODONTIC PROCEDURES			
D3910	Surgical procedure for isolation of tooth with rubber dam	None	The fee for isolation of tooth with rubber dam should be included in the procedure performed on the same date of service and are not billable to the patient to the same dentist/dental office.
D3911	Intraorifice barrier	Not to be used as a final restoration.	An intraorifice barrier is considered part of the root canal procedure (D3310-D3348) and the fees are not billable to the patient.
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.	Benefits for bone replacement grafts (D4263 and D4264) are denied when submitted with D3920.
D3921	Decoronation or submergence of an erupted tooth	Intentional removal of the coronal tooth structure for preservation of the root and surrounding bone.	
D3950	Canal preparation and fitting of preformed dowel or post	Should not be reported in conjunction with D2952, D2953, D2954 or D2957 by the same practitioner	Canal preparation and fitting of preformed dowel or post 30 days prior to post or root canal therapy by the same dentist/dental office is included in the fee for the post or root canal. Separate fees are not billable to the patient.

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D3999	Unspecified endodontic procedure, by report	Used for procedure that is not adequately described by a code. Describe the procedure	None

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D4000 – D4999 PERIODONTICS

Terms of group/individual contracts vary. Policies in this Handbook that address benefits, limitations and exclusions are policies that have not been tailored to reflect the specific terms of applicable group/individual contracts. In all cases, the terms of group/individual contracts take precedence over Dentist Handbook policies. Please contact the member company listed on the patient's identification card for the specific terms of a group/individual contract.

Benefit determinations are subject to individual consideration when accompanied by adequate documentation of extraordinary circumstances.

General Policy – The term specialized procedure describes a dental service or procedure that is used when unusual or extraordinary circumstances exist and is not generally used when conventional methods are adequate.

General Policy - Infection control is included in the fee for the dental services provided. Separate fees are not billable to the patient.

General Policy - For benefit purposes, local anesthesia is an integral part of the periodontal procedures being performed and additional charges are not billable to the patient.

General Policy - When more than one surgical procedure involves the same teeth or area on the same date of service, benefits will be based on the most inclusive procedure. Additional procedures may be benefited.

General Policy - Unless otherwise stipulated by the group/individual contract, periodontal services are only benefits for the treatment of natural teeth.

General Policy - Laser disinfection is a technique, not a procedure. Fees for laser disinfection are not billable to the patient.

General Policy – Benefits for laser disinfection as a standalone procedure are denied as investigational.

General Policy – Benefits for laser biostimulation as a standalone procedure are denied as investigational.

General Policy – Fees for low level laser therapy are not billable to the patient when performed as part of another procedure. When billed as a standalone procedure, low level laser therapy is denied as investigational.

General Policy – Narratives are not considered legal documentation. The only acceptable legal written documentation for utilization review are the dental records.

General Policy - Periodontal charting is considered as part of an oral evaluation (D0120, D0150, D0160, D0180). If periodontal evaluation and an oral evaluation are billed on the same date of service, the fee for the oral evaluation (D0120, D0150, D0160) is a benefit and the fee for the periodontal evaluation (D0180) is not billable to the patient.

General Policy – When periodontal charting is requested for surgical and non-surgical procedures it must be submitted with a periodontal chart dated no more than 12 months prior to the date of service.

General Policy - Perioscopy is a technique not a procedure. Fees for Perioscope are not billable to the patient.

General Policy – All services and treatment provided remotely via tele-health modalities, be they synchronous or asynchronous, must be performed by a licensed dentist or their supervised staff, acting within the scope of applicable law. Services and

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treatment delivered virtually are only a benefit when the elements included in the descriptor of the CDT procedure code are completed and only when they meet generally accepted clinical guidelines.

A. D4100 - D4299 SURGICAL SERVICES (INCLUDING USUAL POSTOPERATIVE SERVICES)

General Policy - Periodontal surgical procedures include all necessary postoperative care, finishing procedures, oral evaluations for three months. Soft tissue grafts may be allowed on the same teeth/sites within 36 months with supporting documentation. When a surgical procedure is billed within three months of the initial surgical procedure in relation to both natural teeth and implants by the same dentist/dental office, the fee for the surgery is not billable to the patient. In the absence of documentation of extraordinary circumstances, the fee for additional surgery by the same dentist/dental office for three years is not billable to the patient. If extraordinary circumstances are present, the benefits will be denied and is chargeable to the patient up to the approved amount for the surgery.

General Policy - Periodontally involved teeth which would qualify for surgical pocket reduction benefits under these procedure codes must be documented to have at least 5 mm pocket depths and bone loss beyond 1-1.5 millimeters. If pocket depths are under 5 mm, then benefits are denied.

D4210	D4241	D4211
D4260	D4240	D4261

General Policy - If surgery is performed less than four weeks after scaling and root planing, the fee for the surgical procedure or the scaling and root planning by the same dentist/dental office may NOT BE BILLABLE TO THE PATIENT following consultant review.

General Policy - Partial quadrant benefits will be considered on a prorated basis when three or less qualified diseased teeth/periodontium are documented anywhere within the quadrant.

General Policy - Categorizing procedures for reporting and adjudication by quadrant, site or individual tooth will also enhance the standardization of benefits determination.

1. Quadrant - D4210, D4260, D4240, D4341
2. One to three teeth, per quadrant- D4211, D4241, D4261, D4342
3. Per tooth: D4212, D4268, D4273, D4276, D4277, D4278, D4283, D4285, D6081, D6101, D6102, D6103
4. Sites:

D4249	D4266	D4273	D4278	D6101
D4263	D4267	D4275	D4283	D6102
D4264	D4268	D4276	D4285	D6103
D4265	D4270	D4277	D6081	

D4210	Gingivectomy or gingivoplasty - four or more	It is performed to eliminate suprabony pockets or to restore	a. Count tooth bounded spaces for pocket reduction surgery that includes a flap

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	contiguous teeth or tooth bounded spaces per quadrant	normal architecture when gingival enlargements or asymmetrical or unaesthetic topography is evident with normal bony configuration.	procedure (D4240, D4260). Do not count tooth bounded spaces for D4210, D4211, D4341, D4342. b. Benefit once per quadrant per 36 months.
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	It is performed to eliminate suprabony pockets or to restore normal architecture when gingival enlargements or asymmetrical or unaesthetic topography is evident with normal bony configuration.	Gingivectomy or gingivoplasty (D4211) performed on the same date of service as the preparation of a crown or other restoration is included in the fee for the restoration, and separate fees from the same dentist/dental office are not billable to the patient.
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	None	The fee for D4212 in conjunction with a direct or indirect restoration is not billable to the patient.
D4230	Anatomical crown exposure - four or more contiguous teeth or tooth bounded spaces per quadrant	This procedure is utilized in an otherwise periodontally healthy area to remove enlarged gingival tissue and supporting bone (ostectomy) to provide an anatomically correct gingival relationship.	Benefits are denied unless covered by group/individual contract.
D4231	Anatomical crown exposure - one to three teeth or tooth bounded spaces per quadrant	This procedure is utilized in an otherwise periodontally healthy area to remove enlarged gingival tissue and supporting bone (ostectomy) to provide an anatomically correct gingival relationship.	Benefits are denied unless covered by group/individual contract.
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or teeth 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	a. Count teeth bounded spaces for pocket reduction surgery that includes a flap procedure (D4240, D4241, D4260, D4261). b. D4342/D4341 are part of D4240 and the fees for scaling and root planing done on the same date of service in the same quadrant are not billable to the patient.

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		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 or fractured root. Other procedures may be required concurrent to D4240 and should be reported separately using their own unique codes.	
D4241	Gingival flap procedure, including root planning – one to three 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, or fractured root. Other procedures may be required concurrent to D4241 and should be reported separately using their own unique codes.	a. Count teeth bounded spaces for pocket reduction surgery that includes a flap procedure (D4240, D4241, D4260, D4261). b. D4342/D4341 are part of D4241 and the fees for scaling and root planing done on the same date of service in the same quadrant are not billable to the patient.
D4245	Apically positioned flap	Procedure is used to preserve keratinized gingiva in conjunction with osseous resection and second	None

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		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.	
D4249	Clinical crown lengthening - hard tissue	This procedure is employed to allow a restorative procedure on a tooth with little or no tooth structure exposed to the oral cavity. Crown lengthening requires reflection of a full thickness flap and removal of bone, altering the crown to root ratio. It is performed in a healthy periodontal environment, as opposed to osseous surgery, which is performed in the presence of periodontal disease.	a. When performed in conjunction with osseous surgery, fees for crown lengthening are not billable to the patient. b. Crown lengthening is a benefit per site and not per tooth when adjacent teeth are included. If D4249 is performed on the same date of service as restoration placement, fees for D4249 are not billable to the patient.
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more 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 during the surgical procedure. This must include the removal of supporting bone (ostectomy) and/or non-supporting bone (osteoplasty). Other procedures may be required concurrent to D4260 and should be reported using their own unique codes.	a. Benefits for osseous surgery in excess of two quadrants per date of service are denied in the absence of a narrative explaining the exceptional circumstances. b. For sulcular debridement, biostimulation, reduction of bacterial levels or curettage – Claims for gingival curettage as standalone procedures are not billable to the patient. If done in conjunction with D4341/D4342, fees are not billable to the patient as part of the procedure.
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bonded spaces per quadrant	This procedure modifies the bony support of the teeth by reshaping the alveolar process to achieve a more physiologic form during the surgical procedure. This must include the removal of supporting	a. Benefits for osseous surgery in excess of two quadrants per date of service are denied in the absence of a narrative explaining the exceptional circumstances.

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		bone (ostectomy) and/or non-supporting bone (osteoplasty). Other procedures may be required concurrent to D4261 and should be reported using their own unique codes.	b. For sulcular debridement, biostimulation, reduction of bacterial levels or curettage – Claims for gingival curettage as standalone procedures are not billable to the patient. If done in conjunction with D4341/D4342, fees are not billable to the patient as part of the procedure.
D4263	Bone replacement graft – retained natural tooth - first site in quadrant	This procedure involves the use of 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 delivered concurrently are documented with their own codes. Not to be reported for an edentulous space or an extraction site.	a. Benefit bone replacement grafts once per tooth per 36 months on natural teeth only. b. Benefits for bone replacement grafts are denied when submitted with apicoectomy sites, implants, mucogingival/soft tissue grafts, periradicular surgery, ridge augmentation or preservation procedures, sinus elevation, defects from cyst removal, hemisections or with extractions.
D4264	Bone replacement graft – retained natural tooth - each additional site in quadrant	This procedure involves the use of 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. This procedure is performed concurrently with one or more bone replacement grafts to document the number of sites	a. Benefit bone replacement grafts once per tooth per 36 months on natural teeth only. b. Benefits for bone replacement grafts are denied when submitted with apicoectomy sites, implants, mucogingival/soft tissue grafts, periradicular surgery, ridge augmentation or preservation procedures, sinus elevation, defects from cyst removal, hemisections or with extractions.

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		involved. Not to be reported for an edentulous space or an extraction site.	
D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site	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.	a. Benefits are available only when billed for natural teeth. b. Biologic materials may be a benefit when reported with periodontal flap surgery (D4240, D4241, D4245, D4260, and D4261). c. Benefits for the D4265 are denied when submitted in the same surgical site as D4263, D4264, D4266, D4267, D4270, D4273, D4275, D4276, D4277, D4283, D4285, D4341, or D4342. d. Benefits for D4265 when billed in conjunction with implants, or other oral surgical procedures are denied as a specialized procedure.
D4266	Guided tissue regeneration, natural teeth - resorbable barrier, per site	This procedure does not include flap entry and closure, or, when indicated, wound debridement, osseous contouring, bone replacement grafts, and placement of biologic materials to aid in osseous regeneration. This procedure can be used for periodontal defects around natural teeth.	a. Benefits for D4266 when billed in conjunction with implants, ridge augmentation, ridge preservation/extraction sites, periradicular surgery, apicoectomy sites, hemisections, etc. are denied as a specialized procedure. b. Benefits for D4266, in conjunction with mucogingival/soft tissue grafts in the same surgical area, are denied.
D4267	Guided tissue regeneration, natural teeth – non-resorbable barrier, per site	This procedure does not include flap entry and closure, or, when indicated, wound debridement, osseous contouring, bone replacement grafts, and placement of biologic materials to aid in osseous regeneration. This	a. Benefits for D4267 when billed in conjunctiowith implants, ridge augmentation, ridge preservation/extraction sites, periradicular surgery, apicoectomy sites, hemisections, etc. are denied as a specialized procedure.

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		procedure can be used for periodontal defects around natural teeth.	b. Benefits for D4267, in conjunction with mucogingival/soft tissue grafts in the same surgical area, are denied. c. Fees for re-entry for removal of the barrier material are not billable to the patient by the same dentist/dental office.
D4268	Surgical revision procedure, per tooth	This procedure is to refine the results of a previously provided surgical procedure. This may require a surgical procedure to modify the irregular contours of hard or soft tissue. A mucoperiosteal flap may be elevated to allow access to reshape alveolar bone. The flaps are replaced or repositioned and sutured.	a. This procedure is considered a component of the surgical procedure and a separate fee is not billable to the patient. b. If retreatment is performed by the same dentist/dental office within 36 months separate fee for the procedure is not billable to the patient. It may be eligible for consideration under consultant review. c. If retreatment is performed within the specified time limits by different dentist/dental office the contractual limits apply and benefits for the procedure would be denied.
	General Policy - Periodontal surgical procedures include all necessary postoperative care, finishing procedures, oral evaluations for three months, as well as any surgical re-entry for three years. When a surgical procedure is billed within three months of the initial surgical procedure by the same dentist/dental office, the fee for the surgery is not billable to the patient. In the absence of documentation of extraordinary circumstances, fees for additional surgery are not billable to the patient for three years.		
B. D4270 – D4285 MUCOGOGINIVAL GRAFTS			
D4270	Pedicle soft tissue graft procedure	A pedicle flap of gingiva can be raised from an edentulous ridge, adjacent teeth, or from the existing gingiva on the tooth and moved laterally or coronally to replace alveolar mucosa as marginal tissue. The procedure can be used to cover an exposed root or to eliminate a	Benefits for more than two teeth per quadrant are denied.

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		gingival defect if the root is not too prominent in the arch.	
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	There are two surgical sites. The recipient site utilizes a split thickness incision, retaining the overlapping flap of gingiva and/or mucosa. The connective tissue is dissected from a separate donor site leaving an epithelialized flap for closure.	a. Benefits for D4266 and D4267, in conjunction with soft tissue grafts in the same surgical area, are denied. b. Benefits for D4273 are denied if membrane is used as opposed to autografts. c. Benefits for more than two teeth per quadrant are denied.
	General Policy – Narratives are not considered legal documentation. The only acceptable legal written documentation for utilization review are the dental records.		
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	This procedure is performed in an edentulous area adjacent to a tooth allowing removal of a tissue wedge to gain access for debridement, and to permit close flap adaptation, and reduce pocket depths.	None
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	There is only a recipient surgical site utilizing split thickness incision, retaining the overlaying flap of gingiva and/or mucosa. A donor surgical site is not present.	a. Fees for a frenectomy (D7961 and D7962) or frenuloplasty (D7963) are not billable to the patient when performed in conjunction with D4275, D4276 or D4285. b. Benefits for more than two teeth per quadrant are denied.
D4276	Combined connective tissue and 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.	Fees for a frenectomy (D7961 and D7962) or frenuloplasty (D7963) are not billable to the patient when performed in conjunction with D4270, D4273, D4275, D4276, D4277, D4278, D4283 or D4285.
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or	None	a. Benefits for more than two teeth per quadrant are denied.

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	edentulous tooth position in graft		b. Benefits for D4263, D4264, D4266 and D4267 in conjunction with soft tissue grafts in the same surgical area, are denied. c. Fees for a frenectomy (D7961 and D7962) or frenuloplasty (D7963) are not billable to the patient when performed in conjunction with soft tissue grafts.
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site	Used in conjunction with D4277.	a. Benefits for more than two teeth per quadrant are denied. b. Benefits for GTR and or bone grafts, in conjunction with soft tissue grafts in the same surgical area, are denied. c. Fees for a frenectomy (D7961 and D7962) or frenuloplasty (D7963) are not billable to the patient when performed in conjunction with soft tissue grafts.
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	Used in conjunction with D4273.	a. Benefits for more than two teeth per quadrant are denied. b. Benefits for GTR and or bone grafts, in conjunction with soft tissue grafts in the same surgical area, are denied. c. Fees for a frenectomy (D7961 and D7962) or frenuloplasty (D7963) are not billable to the patient when performed in conjunction with soft tissue grafts.
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous	Used in conjunction with D4275.	a. Benefits for GTR and or bone grafts, in conjunction with soft tissue grafts in the same surgical area, are denied. b. Fees for a frenectomy (D7961 and D7962) or frenuloplasty (D7963) are not billable to the patient when performed in conjunction with

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	tooth position in same graft site		soft tissue grafts contiguous tooth position in same graft site.
D4286	Removal of non-resorbable barrier	none	a. Fees for removal of barrier membrane (D4286) by the same dentist/dental office who placed the barrier (D4267) are not billable to the patient. b. Benefits for removal of a barrier membrane (D4286) by a different dentist/dental office than who placed the barrier are denied.
C. D4300 - D4399 NON-SURGICAL PERIODONTAL SERVICES			
D4322	Splint – intra-coronal; natural teeth or prosthetic crowns	Additional procedure that physically links individual teeth or prosthetic crowns to provide stabilization and additional strength.	a. When submitted as a standalone procedure, benefits are denied unless covered by group/individual contract. b. The fees for Intra-coronal splints submitted in conjunction with prosthetic crowns (D2700-D2799), implant prosthetics crowns (D6058-D6067, D6082-D6085, D6086-D6088, D6094, D6097), fixed partial dentures (D6205-D6794) and implant fixed partial denture retainers (D6068-D6077, D6098, D6099, D6120-D6123, D6194, D6195) are not billable to the patient.
D4323	Splint – extra-coronal; natural teeth or prosthetic crowns	Additional procedure that physically links individual teeth or prosthetic crowns to provide stabilization and additional strength.	a. When submitted as a standalone procedure, benefits are denied unless covered by group/individual contract. b. The fees for extra-coronal splints submitted in conjunction with prosthetic crowns (D2700-D2799), implant prosthetics crowns (D6058-D6067, D6082-D6085, D6086-D6088, D6094, D6097), fixed partial dentures (D6205-D6794) and implant fixed partial denture retainers (D6068-D6077, D6098, D6099, D6120-D6123, D6194, D6195) are not billable to the patient.

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D4341	Periodontal scaling and root planing – four or more 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.	a. Fees are not billable to the patient in the absence of radiographic documentation of bone loss and documentation of clinical attachment loss. Limit the benefits to that of a prophylaxis (D1110) or scaling in the presence of generalized moderate to severe gingival inflammation (D4346). b. Fees for D4341 are not billable to the patient within 24 months when done by the same dentist/dental office. If treatment is done by a different dentist/dental office within 24 months, benefits are denied. c. Adult prophylaxis procedures (D1110), full mouth scaling in the presence of generalized moderate to severe inflammation (D4346) or full mouth debridement (D4355) are considered a component when submitted on the same date of service as D4341. This time limitation, like all other contractual time limitations, should be defined in the group/individual contract. Fees for the prophylaxis procedure by the same dentist/dental office are not billable to the patient. d. Fees for scaling and root planing (D4341 or D4342) are not billable to the patient when billed by the same dentist/dental office as D4210, D4211, D4212, D4240, D4241, D4245, D4260, D4261 e. Fees for scaling and root planing (D4341) are not billable to the patient when done on the same date of service and same tooth as a

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			surgical repair of root resorption (D3471-D3473).
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.	a. Fees are not billable to the patient in the absence of radiographic documentation of bone loss and documentation of clinical attachment loss. Limit benefits to that of a prophylaxis (D1110) or scaling in the presence of generalized moderate to severe gingival inflammation (D4346). b. Fees for scaling and root planing (D4341 or D4342) are not billable to the patient on the same date of services and same tooth as D3471-D3473. c. Fees for scaling and root planing (D4341 or D4342) are not billable to the patient when billed by the same dentist/dental office as D4210, D4211, D4212, D4240, D4241, D4245, D4260, D4261.
D4346	Scaling in the presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	The removal of plaque, calculus and stains from supra- and sub-gingival tooth surfaces when there is generalized moderate or severe gingival inflammation in the absence of periodontitis. It is indicated for patients who have swollen, inflamed gingiva, generalized suprabony pockets, and moderate to severe bleeding on probing. Should not be reported in conjunction with prophylaxis, scaling and root planning, or debridement procedures.	a. D4346 includes prophylaxis, therefore fees for D1110, D1120 or D4355 are not billable to the patient when submitted with D4346 by the same dentist/dental office. b. Fees for D4346 are not billable to the patient when submitted with D4910 by the same dentist/dental office.
D4355	Full mouth debridement to enable comprehensive periodontal evaluation and	None	a. Benefit once per lifetime unless defined by group/individual contract.

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	diagnosis on subsequent visit		b. The fee for D4355 is not billable to the patient when performed by the same dentist/dental office on the same date of service as D0180.
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	FDA approved subgingival delivery devices containing antimicrobial medication(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.	Benefits are denied.
D. D4900 - D4999 OTHER PERIODONTAL SERVICES			
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.	a. Benefits for D4910 include prophylaxis and scaling and root planing procedures. Fees for these procedures by the same dentist/dental office are not billable to the patient when billed on the same date of service as the periodontal maintenance. b. Fees for D4910 when billed within 30 days of periodontal therapy by the same dentist/dental office are not billable to the patient. c. If a D0180 is submitted with a D4910 by the same dentist/dental office it is benefited as a D0120 and the difference in the approved amount between the D0120 and the D0180 is not billable to the patient on the same date of service unless the D0180 is the initial evaluation by the dentist rendering the D4910. d. Benefits for D4910 are denied if no history of periodontal therapy. Benefit as D1110 in cases

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			of bone loss without periodontitis (iatrogenic or idiopathic). D4910 should be performed at an interval judged appropriate by the clinician based on clinical parameters.
D4920	Unscheduled dressing change (by someone other than the treating dentist or their staff)	None	The fee for dressing change performed by the same dentist/dental office is not billable to the patient within 30 days following the surgical procedure.
D4921	Gingival irrigation with medicinal agent – per quadrant	None	a. When gingival irrigation is submitted as a standalone procedure, medicaments and solutions used for gingival irrigation are not covered benefits and the benefits are denied. b. Fees for gingival irrigation are not billable to the patient when performed with any periodontal service.
D4999	Unspecified periodontal procedure, by report	Use for procedure that is not adequately described by a code. Describe the procedure.	None
	General policy - Perioscopy is a technique not a procedure. Fees for Perioscope are not billable to the patient. Benefits for Perioscopy as a standalone procedure are denied as investigational.		

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D5000 – D5899 PROSTHODONTICS

Terms of group/individual contracts vary. Policies in this Handbook that address benefits, limitations and exclusions are policies that have not been tailored to reflect the specific terms of applicable group/individual contracts. In all cases, the terms of group/individual contracts take precedence over Dentist Handbook policies. Please contact the member company listed on the patient's identification card for the specific terms of a group/individual contract.

Benefit determinations are subject to individual consideration when accompanied by adequate documentation of extraordinary circumstances.

General Policy - For benefit purposes, anesthesia is an integral part of the procedures being performed and additional fees are not billable to the patient.

General Policy – The term specialized procedure describes a dental service or procedure that is used when unusual or extraordinary circumstances exist and is not generally used when conventional methods are adequate.

General Policy - Infection control is included in the fee for the dental services provided. Separate fees are not billable to the patient.

General Policy - For benefit purposes, local anesthesia is an integral part of the procedure being performed and additional charges are not billable to the patient.

General Policy – Full or partial dentures include any reline/rebase, adjustment or repair required within six months of delivery; Benefits may be denied if repair or replacement within the contractual time limitation is the patient's fault.

General policy - The fee for an immediate denture includes any adjustments, relines, or tissue conditioning within 3 months of delivery. Laboratory relines are benefited 3 months after delivery of an immediate denture to allow adequate time for healing.

General Policy - Any characterization, staining, overdentures or metal bases are specialized techniques or procedures and an allowance will be made for conventional dentures. Any additional fee is the patient's responsibility.

General Policy - The fees for cast restorations and prosthetic procedures include all models, temporaries and other associated procedures. Any fees charged for these procedures in excess of the approved amounts for the indirectly fabricated restorations or prosthetic procedures by the same dentist/dental office are not billable to the patient on the same date of service.

General Policy - Full or partial dentures include any reline/rebase, adjustment or repair required within six months of delivery; except in the case of immediate dentures. Benefits may be denied if repair or replacement within the contractual time limitation is the patient's fault.

General Policy – Benefits for restorations for altering occlusion, adjusting vertical dimension, replacing tooth structure lost by attrition, erosion, abfraction, abrasion (wear) or for periodontal, orthodontic or TMD therapy or other splinting procedures are denied.

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

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General Policy - Fees for denture repairs, relines or rebases cannot exceed one-half of the fee for a new appliance, and any excess fee by the same dentist/dental office is not billable to the patient on the same date of service.			
General Policy – All services and treatment provided remotely via tele-health modalities, be they synchronous or asynchronous, must be performed by a licensed dentist or their supervised staff, acting within the scope of applicable law. Services and treatment delivered virtually are only a benefit when the elements included in the descriptor of the CDT procedure code are completed and only when they meet generally accepted clinical guidelines.			
A. D5000 - D5199 COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)			
D5110	Complete denture - maxillary	None	None
D5120	Complete denture - mandibular	None	None
D5130	Immediate denture - maxillary	Includes limited follow-up care only; does not include required future rebasing/relining procedure(s)	None
D5140	Immediate denture - mandibular	Includes limited follow-up care only; does not include required future rebasing/relining procedure(s)	None
B. D5200 - D5399 PARTIAL DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)			
General Policy - A posterior fixed partial denture and a removable partial denture are not benefits in the same dental arch. The benefit is limited to the allowance for the partial removable denture.			
General Policy - Fixed bridges or removable cast partials are not a benefit for patients under age 16.			
D5211	Maxillary partial denture - resin base (including, retentive/clasping materials, rests, and teeth)	None	None
D5212	Mandibular partial denture - resin base (including, retentive/clasping materials, rests, and teeth)	None	None
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	None	None

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D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	None	None
D5221	Immediate maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth)	Includes limited follow-up care only; does not include future rebasing/relining procedure(s).	None
D5222	Immediate mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth)	Includes limited follow-up care only; does not include future rebasing/relining procedure(s).	None
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	Includes limited follow-up care only; does not include future rebasing/relining procedure(s).	None
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	Includes limited follow-up care only; does not include future rebasing/relining procedure(s).	None
D5225	Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	None	None
D5226	Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth)	None	None
D5227	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	None	None

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D5228	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	None	None
D5282	Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary	None	None
D5283	Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular	None	None
D5284	Removable unilateral partial denture – one piece flexible base (including retentive/clasping materials, rests, and teeth)- per quadrant	None	None
D5286	Removable unilateral partial denture – one piece resin (including retentive/clasping materials, rests, and teeth) - per quadrant	None	None
C. D5400 - D5499 ADJUSTMENTS TO DENTURES			
General Policy - Full or partial dentures include any adjustment or repair required within six months of delivery. Fees for the adjustment or repair of dentures are not billable to the patient if performed by the same dentist/dental office within six months of initial placement.			
General Policy - Adjustments to complete or partial dentures are limited to two adjustments per denture per 12 months (after six months has elapsed since initial placement). Benefits are denied after two adjustments.			
D5410	Adjust complete denture - maxillary	None	None
D5411	Adjust complete denture - mandibular	None	None

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D5421	Adjust partial denture - maxillary	None	None
D5422	Adjust partial denture - mandibular	None	None
D. D5500 - D5599 REPAIRS TO COMPLETE DENTURES			
General Policy - Fees for repair of a complete denture cannot exceed half the fees for a new appliance, and any excess fee billed by the same dentist/dental office is not billable to the patient on the same date of service.			
D5511	Repair broken complete denture base, mandibular	None	Fees for repairs of complete dentures, if performed within six months of initial placement by the same dentist/dental office are not billable to the patient.
D5512	Repair broken complete denture base, maxillary	None	Fees for repairs of complete dentures, if performed within six months of initial placement by the same dentist/dental office are not billable to the patient.
D5520	Replace missing or broken teeth - complete denture (each tooth)	None	Fees for repairs of complete or partial dentures if performed within six months of initial placement by the same dentist/dental office are not billable to the patient.
E. D5600 - D5699 REPAIRS TO PARTIAL DENTURES			
General Policy - Fee for repair of a partial denture cannot exceed one-half of the fee for a new appliance, and any excess fee by the same dentist/dental office is not billable to the patient on the same date of service.			
D5611	Repair resin partial denture base, mandibular	None	Fees for repairs of resin partial dentures, if performed within six months of initial placement by the same dentist/dental office are not billable to the patient.
D5612	Repair resin partial denture base, maxillary	None	Fees for repairs of complete dentures, if performed within six months of initial placement by the same dentist/dental office are not billable to the patient.
D5621	Repair cast partial framework, mandibular	None	Fees for repairs of cast partial dentures, if performed within six months of initial placement by the same dentist/dental office are not billable to the patient.
D5622	Repair cast partial framework, maxillary	None	Fees for repairs of cast partial dentures, if performed within six months of initial

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			placement by the same dentist/dental office are not billable to the patient.
D5630	Repair or replace broken retentive clasping materials – per tooth	None	Fees for repair of a partial denture cannot exceed one-half of the fee for a new appliance, and any excess fee by the same dentist/dental office is not billable to the patient on the same date of service.
D5640	Replace broken teeth - per tooth	None	None
D5650	Add tooth to existing partial denture	None	None
D5660	Add clasp to existing partial denture – per tooth	None	Fees for repair of a partial denture cannot exceed one-half of the fee for a new appliance, and any excess fee by the same dentist/dental office is not billable to the patient on the same date of service.
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	None	Fees for denture repairs, relines or rebases cannot exceed one-half of the fee for a new appliance, and any excess fee by the same dentist/dental office is not billable to the patient on the same date of service.
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	None	Fees for denture repairs, relines or rebases cannot exceed one-half of the fee for a new appliance, and any excess fee by the same dentist/dental office is not billable to the patient on the same date of service.
F. D5700 - D5729 DENTURE REBASE PROCEDURES			
General Policy - Fee for rebase of a denture cannot exceed one-half of the fee for a new appliance, and any excess fee by the same dentist/dental office is not billable to the patient on the same date of service.			
General Policy - Rebase includes the fee for relining. When a reline is billed in conjunction with a rebase within six months by the same dentist/dental office fees for the reline are not billable to the patient.			
General Policy - Rebase includes adjustments required within six months of delivery. When an adjustment is billed within six months of a reline or rebase by the same dentist/dental office, fees for the adjustment are not billable to the patient. Benefits for adjustments beyond two in a 12-month interval are denied and chargeable to the patient.			
D5710	Rebase complete maxillary denture	None	None

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D5711	Rebase complete mandibular denture	None	None
D5720	Rebase maxillary partial denture	None	None
D5721	Rebase mandibular partial denture	None	None
D5725	Rebase hybrid prosthesis	replacing the base material connected to the framework	None
G. D5730 - D5799 DENTURE RELINE PROCEDURES			
General Policy - Fee for relines cannot exceed one-half of the fee for a new appliance, and any excess fee by the same dentist/dental office is not billable to the patient on the same date of service.			
General Policy - Relines include adjustments required within six months of delivery. Fees for adjustments by the same dentist/dental office are not billable to the patient if done within six months of initial placement.			
General Policy – Benefits for adjustments beyond two in a 12 month interval are denied and chargeable to the patient.			
D5730	Reline complete maxillary denture (direct)	None	None
D5731	Reline complete mandibular denture (direct)	None	None
D5740	Reline maxillary partial denture (direct)	None	None
D5741	Reline mandibular partial denture (direct)	None	None
D5750	Reline complete maxillary denture (indirect)	None	None
D5751	Reline complete mandibular denture (indirect)	None	None
D5760	Reline maxillary partial denture (indirect)	None	None
D5761	Reline mandibular partial denture (indirect)	None	None
D5765	Soft liner for complete or partial removable denture – indirect	A discrete procedure provided when the dentist determines placement of the soft liner is clinically indicated.	None
H. D5800 - D5899 INTERIM PROSTHESIS			
D5810	Interim complete denture (maxillary)	None	Benefits for temporary complete denture are denied.

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D5811	Interim complete denture (mandibular)	None	Benefits for temporary complete denture are denied.
D5820	Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary	None	Temporary partial-stayplate denture is only a benefit for children 16 years of age or under for missing anterior permanent teeth.
D5821	Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular	None	Temporary partial-stayplate denture is only a benefit for children 16 years of age or under for missing anterior permanent teeth.
I. D5850 - D5899 OTHER REMOVABLE PROSTHETIC SERVICES			
D5850	Tissue conditioning, maxillary	Treatment reline using materials designed to heal unhealthy ridges prior to more definitive final restoration	The fee for tissue conditioning done on the same date of service the denture is delivered or a reline/rebase is provided by the same dentist/dental office and is not billable to the patient.
D5851	Tissue conditioning, mandibular	Treatment reline using materials designed to heal unhealthy ridges prior to more definitive final restoration	The fee for tissue conditioning done on the same date of service the denture is delivered or a reline/rebase is provided by the same dentist/dental office and is not billable to the patient.
D5862	Precision attachment, by report	Each pair of components is one precision attachment. Describe the type of attachment used.	Benefits for precision attachment are denied as a specialized procedure.
General Policy - Complete and partial overdentures are considered specialized techniques and the benefits for an overdenture procedure are denied. An allowance may be made for a conventional denture, and any excess fee is chargeable to the patient.			
D5863	Overdenture – complete maxillary	None	None
D5864	Overdenture – partial maxillary	None	None
D5865	Overdenture – complete mandibular	None	None
D5866	Overdenture – partial mandibular	None	None
D5867	Replacement of replaceable part of semi-precision or	None	Benefits for precision attachments are denied unless covered by group/individual contract.

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
	precision attachment, per attachment		
D5875	Modification of removable prosthesis following implant surgery	Attachment assemblies are reported using separate codes	If implant services are covered, benefits for D5875 are denied, as a specialized procedure.
D5876	Add metal substructure to acrylic full denture (per arch)	Use of metal substructure in removable complete dentures without a framework.	Benefits are denied as a specialized procedure.
D5899	Unspecified removable prosthodontic procedure, by report	Use for a procedure that is not adequately described by a code. Describe the procedure.	None

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
D5900 – D5999 MAXILLOFACIAL PROSTHETICS			
Terms of group/individual contracts vary. Policies in this Handbook that address benefits, limitations and exclusions are policies that have not been tailored to reflect the specific terms of applicable group/individual contracts. In all cases, the terms of group/individual contracts take precedence over Dentist Handbook policies. Please contact the member company listed on the patient's identification card for the specific terms of a group/individual contract. Benefit determinations are subject to individual consideration when accompanied by adequate documentation of extraordinary circumstances.			
General Policy – The term specialized procedure describes a dental service or procedure that is used when unusual or extraordinary circumstances exist and is not generally used when conventional methods are adequate.			
General Policy - Infection control is included in the fee for the dental services provided. Separate fees are not billable to the patient.			
General Policy - For benefit purposes, anesthesia is an integral part of the procedures being performed and additional fees are not billable to the patient.			
General Policy - Benefits are denied, unless the group/individual contract specifies that maxillofacial prosthetics are a benefit.			
General Policy – All services and treatment provided remotely via tele-health modalities, be they synchronous or asynchronous, must be performed by a licensed dentist or their supervised staff, acting within the scope of applicable law. Services and treatment delivered virtually are only a benefit when the elements included in the descriptor of the CDT procedure code are completed and only when they meet generally accepted clinical guidelines.			
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, then reassembled to provide a full facial contour cast. The impression is utilized to create a partial facial moulage and generally is not reusable.	None
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	None

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
		face. The impression is utilized to create a facial moulage and generally is not reusable.	
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.	None
D5914	Auricular prosthesis	Synonymous terminology: artificial ear, ear prosthesis. A removable prosthesis, which artificially restores part or all of the natural ear. Usually, replacement prostheses 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).	None
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.	None

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
		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.	
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 prostheses 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.	None
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 adaptation and movement of the prosthesis to match the adjacent skin. Salivary leakage, when communicating with the oral cavity, adversely affects retention.	None
D5922	Nasal septal prosthesis	Synonymous terminology: Septal plug, septal button. Removable	None

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
		prosthesis to occlude (obturate) 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.	
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.	None
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.	None
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. Although some forms of pre-made surgical implants are commercially available, the facial augmentation is usually custom made for surgical	None

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
		implantation for each individual patient due to the irregular or extensive nature of the facial deficit.	
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.	None
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.	None
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.	None
D5929	Facial prosthesis, replacement	A replacement facial prosthesis made from the original mold. A replacement prosthesis does not require fabrication of a new mold.	None

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
		Generally, several prostheses can be made from the same mold assuming no changes occur in the tissue bed due to further surgery or age-related topographical variations.	
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 dentists prefer to replace many, or all teeth removed by the surgical procedure in the surgical obturator, while others 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 free of tumor).	None
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	None

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
		unlikely and a more permanent prosthetic rehabilitation can be achieved; it is intended for long-term use.	
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 affect adequate sealing or separation between the nasal and oral cavities.	None
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.	None
D5935	Mandibular resection prosthesis without guide flange	A prosthesis which helps guide the partially resected mandible to a more normal relation with the maxilla allowing for increased tooth contact. 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 prefer	None

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
		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 limitations or poor patient tolerance. Ramps, extended occlusal 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.	
D5936	Obturator prosthesis, interim	Synonymous terminology: immediate postoperative 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, an 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	None

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
		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.	
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 versions and designs are possible, all intending to ease the severe lack of oral opening experienced by many patients immediately following extensive intraoral surgical procedures	None
D5951	Feeding aid	Synonymous terminology: feeding prosthesis. A prosthesis, which maintains the right and left maxillary segments of an 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	None

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
		separation of the oral and nasal cavities in infants born with wide clefts necessitating delayed closure. It is eliminated if surgical closure can be affected or, alternatively, with eruption of the deciduous dentition a pediatric speech aid may be made to facilitate closure of the defect	
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 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.	None
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	None

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
		(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.	
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 palate's topographical form adjacent to the tongue.	None
D5955	Palatal life 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	None

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
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 palatalpharyngeal competency or enhance swallowing reflexes. This prosthesis is intended for interim use as a diagnostic aid to assess 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.	None
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.	None
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 section of any speech aid is required to facilitate enhanced speech intelligibility. Such revisions or repairs do not require	None

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
		complete remaking of the prosthesis, thus extending its longevity.	
D5982	Surgical stent	Synonymous terminology: periodontal stent, skin graft stent, columellar stent. Stents are utilized to apply pressure to soft tissues to facilitate healing and prevent cicatrization or collapse. A surgical stent may be 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.	None
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 oncologists occasionally request these devices to achieve close approximation and controlled application of radiation to a tumor deemed amiable to eradication.	None
D5984	Radiation shield	Synonymous terminology: radiation stent, tongue protector, lead shield. An intraoral prosthesis designed to	None

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
		shield adjacent tissues from radiation during orthovoltage treatment of malignant lesions of the head and neck region.	
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.	None
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	None
D5987	Commissure splint	Synonymous terminology: lip splint. A device placed between the lips, which assists in achieving increased 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.	None
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.	None

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
		Frequently, existing prostheses (e.g., a patient's complete dentures) can be modified to serve as surgical splints. Frequently, surgical splints have arch bars added to facilitate intermaxillary fixation. Rubber elastics may be used to assist in this process. Circummandibular eyelet hooks can be utilized for enhanced stabilization with wiring to adjacent bone.	
D5991	Vesiculobullous disease medicament carrier	A custom fabricated carrier that covers the teeth and alveolar mucosa, or alveolar mucosa alone, and is used to deliver prescription medicaments for treatment of immunologically mediated vesiculobullous disease.	Benefits are denied unless the group/individual contract specifies that maxillofacial prosthetics are a benefit.
D5992	Adjust maxillofacial prosthetic appliance	None	None
D5993	Maintenance and cleaning of a maxillofacial prosthesis (extra- and intra-oral) other than required adjustments, by report	None	Maxillofacial prosthesis maintenance and cleaning (D5993) is not a covered benefit and is denied unless covered by group/individual contract.
D5995	Periodontal medicament carrier with peripheral seal – laboratory processed - maxillary	A custom fabricated, laboratory processed carrier for the maxillary arch that covers the teeth and alveolar mucosa. Used as a vehicle to deliver prescribed medicaments for sustained contact with the gingiva, alveolar mucosa, and into the periodontal sulcus or pocket.	Benefits are denied unless covered by group/individual contract.
D5996	Periodontal medicament carrier with peripheral seal -	A custom fabricated, laboratory processed carrier for the mandibular arch that covers the teeth and	Benefits are denied unless covered by group/individual contract.

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
	laboratory processed - mandibular	alveolar mucosa. Used as a vehicle to deliver prescribed medicaments for sustained contact with the gingiva, alveolar mucosa, and into the periodontal sulcus or pocket.	
D5999	Unspecified maxillofacial prosthesis, by report	Used for procedure that is not adequately described by a code. Describe the procedure	None

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy

D6000 – D6199 IMPLANT SERVICES

Terms of group/individual contracts vary. Policies in this Handbook that address benefits, limitations and exclusions are policies that have not been tailored to reflect the specific terms of applicable group/individual contracts. In all cases, the terms of group/individual contracts take precedence over Dentist Handbook policies. Please contact the member company listed on the patient's identification card for the specific terms of a group/individual contract.

Benefit determinations are subject to individual consideration when accompanied by adequate documentation of extraordinary circumstances.

General Policy - For benefit purposes, anesthesia is an integral part of the procedures being performed and additional fees are not billable to the patient.

General Policy – The term specialized procedure describes a dental service or procedure that is used when unusual or extraordinary circumstances exist and is not generally used when conventional methods are adequate.

General Policy - Infection control is included in the fee for the dental services provided. Separate fees are not billable to the patient.

General Policy - Implants are not a benefit for patients under 19 years of age.

General Policy – All services and treatment provided remotely via tele-health modalities, be they synchronous or asynchronous, must be performed by a licensed dentist or their supervised staff, acting within the scope of applicable law. Services and treatment delivered virtually are only a benefit when the elements included in the descriptor of the CDT procedure code are completed and only when they meet generally accepted clinical guidelines.

D6010	Surgical placement of implant body: endosteal implant	None	None
D6011	Surgical access to an implant body (second stage implant surgery)	This procedure, also known as second stage implant surgery, involves removal of tissue that covers the implant body so that a fixture of any type can be placed, or an existing fixture be replaced with another. Examples of fixtures include but are not limited to healing caps, abutments shaped to help contour the gingival margins or the final restorative prosthesis.	a. D6011 is considered part of D6010/D6012/D6013 and fees are not billable to the patient. b. Benefits for D6011 are denied if done by a different dentist/dental office.
D6012	Surgical placement of interim implant body for	None	Benefits are denied, and the approved amount is chargeable to the patient.

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
	transitional prosthesis: endosteal implant		
D6013	Surgical placement of mini implant	None	Fees for more than one D6013 per tooth/tooth bounded site are not billable to the patient.
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 prosthesis. This may be a complete arch or unilateral appliance. Eposteal implants rest upon the bone and under the periosteum.	None
D6050	Surgical placement: transosteal implant	A transosteal (transosseous) biocompatible device with threaded posts penetrating both the superior and inferior cortical bone plates of the mandibular symphysis and exiting through the permucosa providing support and attachment for a dental prosthesis. Transosteal implants are placed completely through the bone and into the oral cavity from extraoral or intraoral.	None
IMPLANT SUPPORTED PROSTHETICS			
General Policy - Where covered by group/individual contract, benefits for the placement of an implant to natural tooth bridge are denied. Special consideration may be given by report particularly where there is documentation of semi-rigid fixation between the tooth and implant and where other risk factors are not present.			
D6051	Interim implant abutment placement	A healing cap is not an interim abutment.	Benefits are denied, and the approved amount is chargeable to the patient.
D6055	Connecting bar - implant supported or abutment supported	Utilized to stabilize and anchor a prosthesis.	Benefits are denied unless covered by the group/individual contract.

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
D6056	Prefabricated abutment – includes modification and placement	Modification of a prefabricated abutment may be necessary.	None
D6057	Custom fabricated abutment – includes placement	Created by a laboratory process, specific for an individual application.	None
D6058	Abutment supported porcelain/ceramic crown	A single crown restoration that is retained, supported and stabilized by an abutment on an implant.	None
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.	None
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.	None
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.	None
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.	None
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.	None
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.	None
D6065	Implant supported porcelain/ceramic crown	A single crown restoration that is retained, supported and stabilized by an implant.	None

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
D6066	Implant supported crown - porcelain fused to high noble alloys	A single metal-ceramic crown restoration that is retained, supported and stabilized by an implant.	None
D6067	Implant supported crown - high noble alloys	A single cast metal crown restoration that is retained, supported, and stabilized by an implant.	None
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.	None
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	None
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	None
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	None
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	None
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	None
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	None
D6075	Implant supported retainer for ceramic FPD	A ceramic retainer for a fixed partial denture that gains retention, support and stability from an implant	None

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
D6076	Implant supported retainer for FPD - porcelain fused to high noble alloys	A metal-ceramic retainer for a fixed partial denture that gains retention, support and stability from an implant	None
D6077	Implant supported retainer for metal FPD - high noble alloys	A metal retainer for a fixed partial denture that gains retention, support and stability from an implant	None
OTHER IMPLANT SUPPORTED PROSTHETICS			
D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments	This procedure includes active debriding of the implant(s) and examination of all aspects of the implant system(s), including the occlusion and stability of the superstructure. The patient is also instructed in thorough daily cleansing of the implant(s). This is not a per implant code, and is indicated for implant supported fixed prostheses.	Benefits for D6080 are denied unless covered by group/individual contract. When covered: Benefits are limited to once every 36 months.
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure.	This procedure is not performed in conjunction with D1110, D4910 or D4346.	a. Benefits for D6081 are denied unless implants are covered by the group/individual contract. b. Fees for D6081 are not billable to the patient when performed in the same quadrant by the same dentist/dental office as D4341/D4342 or D4240/D4241, D4260/D4261 or D6101/D6102. c. When covered, benefits are limited to once per tooth per 24 months. d. Fees for retreatment by the same dentist/dental office within 24 months of initial therapy are not billable to the patient, if different dentist/dental office then benefits are denied.

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
			e. Fees for D6081 are not billable to the patient when performed within 12 months of restoration (D6058-D6077, D6085, D6094, D6118, D6119, D6194) placement by same dentist/dental office. f. Fees for D6081 are not billable to the patient when performed in conjunction with D1110, D4346 or D4910.
D6082	Implant supported crown - porcelain fused to predominantly base alloys	A single metal-ceramic crown restoration that is retained, supported and stabilized by an implant.	None
D6083	Implant supported crown - porcelain fused to noble alloys	A single noble metal-ceramic crown restoration that is retained, supported and stabilized by an implant.	None
D6084	Implant supported crown - porcelain fused to titanium and titanium alloys	A single metal-ceramic crown restoration that is retained, supported and stabilized by an implant.	None
D6085	Interim implant crown	Placed when a period of healing is necessary prior to fabrication and placement of the definitive prosthesis.	Benefits for interim implant crowns are denied unless covered by group/individual contract.
D6086	Implant supported crown - predominantly base alloys	A single metal crown restoration that is retained, supported and stabilized by an implant.	None
D6087	Implant supported crown - noble alloys	A single metal crown restoration that is retained, supported and stabilized by an implant.	None
D6088	Implant supported crown – titanium and titanium alloys	A single metal crown restoration that is retained, supported and stabilized by an implant.	None
D6089	Accessing and retorquing loose implant screw - per screw	None	Benefits are denied unless covered by group/individual contract. When covered:

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
			a. Benefits are limited to once every 24 months. b. Fees for D6089 are not billable to the patient on the same date of service by same dentist/dental office as D6080 or D6090.
D6090	Repair implant supported prosthesis, by report	This procedure involves the repair or replacement of any part of the implant supported prosthesis.	None
D6091	Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment	None	a. Benefits for D6091 are denied as a specialized procedure unless covered by the group/individual. b. If covered, benefits are limited to once per 24 months. Benefits are denied less than 24 months.
D6092	Re-cement or re-bond implant/abutment supported crown	None	a. Fees for recementation or rebonding of crowns are not billable to the patient if done within six months of the initial seating date by the same dentist/dental office. b. Benefit one recementation or rebonding after six months have elapsed since the initial placement. Subsequent requests for recementation or rebonding by the same dentist/dental office are denied. c. Benefit when billed by a dentist/dental office other than the one who seated the crown or performed the previous recementation or rebonding.
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture	None	a. Fees for recementation or rebonding of fixed partial dentures are not billable to the patient if done within six months of the initial seating date by the same dentist/dental office. b. Benefit one recementation or rebonding after six months have elapsed since the initial

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
			placement. Subsequent requests for recementation or rebonding by the same dentist/dental office are denied. c. Benefit when billed by a dentist/dentist office other than the one who seated the crown or performed the previous recementation or rebonding
D6094	Abutment supported crown – titanium or titanium alloys	A single crown restoration that is retained, supported and stabilized by an abutment on an implant.	None
D6095	Repair implant abutment, by report	This procedure involves the repair or replacement of any part of the implant abutment.	None
D6096	Remove broken implant retaining screw	None	Benefits are denied unless implants are covered by group/individual contract.
D6097	Abutment supported crown - porcelain fused to titanium and titanium alloys	A single metal-ceramic crown restoration that is retained, supported, and stabilized by an abutment on an implant.	None
D6098	Implant supported retainer - porcelain fused to predominantly base alloys	A metal-ceramic retainer for a fixed partial denture that gains retention, support, and stability from an implant.	None
D6099	Implant supported retainer for FPD - porcelain fused to noble alloys	A metal-ceramic retainer for a fixed partial denture that gains retention, support, and stability from an implant.	None
D6100	Surgical removal of implant body	None	When implants are covered by the group/individual contract, the fee for D6100 when performed within 3 months of D6010/ D6013 on the same tooth by the same dentist/dental office is not billable to the patient. After 3 months, benefit once per tooth per frequency limitation for implants/prosthetics.

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
D6101	Debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure	None	a. Benefits are denied if implants are not covered by group/individual contract. b. Fees for D6101 are not billable to the patient when performed in the same surgical site by the same dentist/dental office on the same date of service as D6102. c. Fees for D6101 are not billable to the patient when billed in conjunction with D4260 or D4261.
D6102	Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure	None	a. Unless covered by group/individual contract, benefits are denied. b. Any items in the nomenclature listed separately should be not billable to the patient in conjunction with this procedure. c. Fees for D6102 are not billable to the patient when billed in conjunction with D4260 or D4261.
D6103	Bone graft for repair of peri-implant defect – does not include flap entry and closure.	Placement of a barrier membrane or biologic materials to aid in osseous regeneration, are reported separately.	Benefits for these procedures when billed in conjunction with implants, implant removal, ridge augmentation or preservation, in extraction sites, periradicular surgery, etc. are denied.
D6104	Bone graft at time of implant placement	Placement of a barrier membrane, or biologic materials to aid in osseous regeneration are reported separately.	Benefits for these procedures when billed in conjunction with implants, implant removal, ridge augmentation or preservation, in extraction sites, periradicular surgery, etc. are denied.
D6105	Removal of implant body not requiring bone removal nor flap elevation	None.	a. When implants are covered by the group/individual contract, the fee for D6105 when performed within 6 months of D6010/D6013 on the same tooth by the same dentist/dental office is NOT BILLABLE TO THE PATIENT. Benefits are denied if done by a different dentist/dental office.

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
			b. After 6 months, benefit once per implant within the frequency limitation for implants/prosthetics.
D6106	Guided tissue regeneration – resorbable barrier, per implant	This procedure does not include flap entry and closure, or, when indicated, wound debridement, osseous contouring, bone replacement grafts, and placement of biologic materials to aid in osseous regeneration. This procedure is used for peri-implant defects and during implant placement.	a. Unless covered by group/individual contract, benefits for GTR when billed in conjunction with implants, soft tissue grafts on implants, ridge augmentation, or ridge preservation/extraction sites, are denied as a specialized procedure. b. Benefits for GTR, in conjunction with mucogingival/soft tissue grafts in the same surgical area, are denied.
D6107	Guided tissue regeneration – non-resorbable barrier, per implant	This procedure does not include flap entry and closure, or, when indicated wound debridement, osseous contouring, bone replacement grafts, and placement of biologic materials to aid in osseous regeneration. This procedure is used for peri-implant defects and during implant placement.	a. When covered by group/individual contract, benefits for GTR when billed in conjunction with mucogingival/soft tissue grafts on implants, ridge augmentation, ridge preservation/extraction sites, periradicular surgery, apicoectomy sites, hemisections etc. are denied as a specialized procedure. b. Fees for re-entry for removal of the barrier material are not billable to the patient by the same dentist/dental office.
D6110	Implant /abutment supported removable denture for edentulous arch – maxillary	None	None
D6111	Implant /abutment supported removable denture for edentulous arch – mandibular	None	None
D6112	Implant /abutment supported removable denture for partially edentulous arch – maxillary	None	

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
D6113	Implant /abutment supported removable denture for partially edentulous arch – mandibular	None	
D6114	Implant /abutment supported fixed denture for edentulous arch – maxillary	None	
D6115	Implant /abutment supported fixed denture for edentulous arch – mandibular	None	
D6116	Implant /abutment supported fixed denture for partially edentulous arch – maxillary	None	
D6117	Implant /abutment supported fixed denture for partially edentulous arch – mandibular	None	
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	Benefits for implant/abutment supported interim fixed denture for edentulous arch – mandibular are denied.
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	Benefits for implant/abutment supported interim fixed denture for edentulous arch – maxillary are denied.
D6120	Implant supported retainer - porcelain fused to titanium and titanium alloy	A metal-ceramic retainer for a fixed partial denture that gains retention, support, and stability from an implant.	None
D6121	Implant supported retainer for metal FPD - predominantly base alloys	A metal retainer for a fixed partial denture that gains retention, support, and stability from an implant.	None
D6122	Implant supported retainer for metal FPD - noble alloys	A metal retainer for a fixed partial denture that gains retention, support, and stability from an implant.	None

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
D6123	Implant supported retainer for metal FPD- titanium and titanium alloy	A metal retainer for a fixed partial denture that gains retention, support, and stability from an implant.	None
D6190	Radiographic/surgical implant index, by report	None	Benefits are denied, unless covered by group/individual contract.
D6191	Semi-precision abutment – placement	This procedure is the initial placement, or replacement, of a semi-precision abutment on the implant body.	Benefits are denied as a specialized technique/procedure unless covered by the group/individual contract.
D6192	Semi-precision attachment – placement	This procedure involves the luting of the initial, or replacement, semi-precision attachment to the removable prosthesis.	Benefits are denied as a specialized technique/procedure unless covered by the group/individual contract.
D6194	Abutment supported retainer crown for FPD – titanium and titanium alloys	A retainer for a fixed partial denture that gains retention, support and stability from an abutment on an implant.	Add this code to the list of other abutment supported retainer crowns and benefit as determined by contract.
D6195	Abutment supported retainer - porcelain fused to titanium and titanium alloys	A metal-ceramic retainer for a fixed partial denture that gains retention, support, and stability from an abutment on an implant.	None
D6197	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	None	Benefits are denied unless covered by group/individual contract. When covered: a. Fees for replacement of restorative material to close an access opening of a screw retained implant supported prosthesis when performed by the same dentist/dental office within 6 months placement of the implant prosthesis are not billable to the patient. b. Benefits are limited to once every 24 months c. Fees for D6197 are not billable to the patient on the same date of service by same dentist/dental office as D6080 or D6090.

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
D6198	Remove interim implant component	Removal of implant component (e.g., interim abutment; provisional implant crown) originally placed for a specific clinical purpose and period of time determined by the dentist.	a. Fees for removal of an interim implant component by the same dentist/dental office who placed the implant component are considered part of the interim abutment placement procedure and are not billable to the patient. b. Benefits for removal of an interim implant abutment by a different dentist/dental office than who placed the abutment are denied.
D6199	Unspecified implant procedure, by report	Use for procedure that is not adequately described by a code. Describe the procedure.	None

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy

D6200 – D6999 PROSTHODONTICS, FIXED

Each abutment and each pontic constitutes a unit in a fixed partial bridge

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Benefit determinations are subject to individual consideration when accompanied by adequate documentation of extraordinary circumstances.

General Policy - Fixed partial denture prosthetic procedures include the routine use of temporary prosthetics during the time for normal laboratory fabrication of the completed prosthesis. Participating dentists have agreed that these temporary prostheses are part of the fee for the fixed prosthetic device. Fees for interim or provisional appliances are not billable to the patient when reported less than six months prior to placement of the permanent prosthesis.

General Policy - For benefit purposes, anesthesia is an integral part of the procedures being performed and additional fees are not billable to the patient.

General Policy - Benefits will be based on the number of pontics necessary for the space, not to exceed the normal complement of teeth.

General Policy - A posterior fixed bridge and partial denture are not benefits in the same arch within the frequency limitations. Benefit is limited to the allowance for the partial denture.

General Policy - Fixed prosthodontics are not a benefit for children under 16 years of age. Benefits for children under age 16 are denied.

General Policy – Benefits for porcelain and resin inlay bridges are denied.

General Policy - The fees for indirectly fabricated restorations and prosthetic procedures include all models, temporaries, laboratory charges and materials, and other associated procedures. Any fees charged for these procedures by the same dentist/dental office in excess of the approved amounts for the indirectly fabricated restorations or prosthetic procedures are not billable to the patient on same date of service.

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

General Policy – Infection control is included in the fee for the dental services provided. Separate fees are not billable to the patient.

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy

General Policy – All services and treatment provided remotely via tele-health modalities, be they synchronous or asynchronous, must be performed by a licensed dentist or their supervised staff, acting within the scope of applicable law. Services and treatment delivered virtually are only a benefit when the elements included in the descriptor of the CDT procedure code are completed and only when they meet generally accepted clinical guidelines.

D6200 - D6499 FIXED PARTIAL DENTURE PONTICS			
D6205	Pontic - indirect resin based composite	Not to be used as a temporary or provisional prosthesis.	None
D6210	Pontic - cast high noble metal	None	None
D6211	Pontic - cast predominantly base metal	None	None
D6212	Pontic - cast noble metal	None	None
D6214	Pontic – titanium and titanium alloys	None	None
D6240	Pontic - porcelain fused to high noble metal	None	None
D6241	Pontic - porcelain fused to predominantly base metal	None	None
D6242	Pontic - porcelain fused to noble metal	None	None
D6243	Pontic - porcelain fused to titanium and titanium alloys	None	None
D6245	Pontic - porcelain/ceramic	None	None
D6250	Pontic - resin with high noble metal	None	None
D6251	Pontic - resin with predominantly base metal	None	None
D6252	Pontic - resin with noble metal	None	None
D6253	Interim pontic- further treatment or completion of diagnosis necessary prior to final impression	Not to be used as a temporary pontic for a routine prosthetic restoration.	Temporary, interim or provisional fixed prostheses are not separate benefits and should be included in the fee for the permanent prostheses. Fees for D6253 are not billable to the patient by the same dentist/dental office as the permanent prostheses.

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
D6500 - D6699 FIXED PARTIAL DENTURE RETAINERS – INLAYS/ ONLAYS			
General Policy - Any extra abutments needed in excess of what is customary or due to a special condition of that patient's mouth (such as periodontal splinting) are denied and the fees up to the approved amount for the additional abutment is chargeable to the patient.			
D6545	Retainer - cast metal for resin bonded fixed prosthesis	None	None
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	None	None
D6549	Resin retainer – for resin bonded fixed prosthesis	None	None
D6600	Retainer inlay - porcelain/ceramic, two surfaces	None	None
D6601	Retainer inlay - porcelain/ ceramic, three or more surfaces	None	None
D6602	Retainer inlay - cast high noble metal, two surfaces	None	Benefits for D6602 are denied unless covered by group/individual contract.
D6603	Retainer inlay - cast high noble metal, three or more surfaces	None	Benefits for D6603 are denied unless covered by group/individual contract.
D6604	Retainer inlay – cast predominantly base metal, two surfaces	None	Benefits for D6604 are denied unless covered by group/individual contract.
D6605	Retainer inlay – cast predominantly base metal, three or more surfaces	None	Benefits for D6605 are denied unless covered by group/individual contract.
D6606	Retainer inlay – cast noble metal, two surfaces	None	Benefits for D6606 are denied unless covered by group/individual contract.
D6607	Retainer inlay – cast noble metal – three or more surfaces	None	Benefits for D6607 are denied unless covered by group/individual contract.
D6608	Retainer onlay - porcelain/ ceramic, two surfaces	None	None

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
D6609	Retainer onlay porcelain/ ceramic, three or more surfaces	None	None
D6610	Retainer onlay – cast high noble metal, two surfaces	None	Benefits for D6610 are denied unless covered by group/individual contract.
D6611	Retainer onlay – cast high noble metal, three or more surfaces	None	Benefits for D6611 are denied unless covered by group/individual contract.
D6612	Retainer onlay - cast predominantly base metal, two surfaces	None	Benefits for D6612 are denied unless covered by group/individual contract.
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	None	Benefits for D6613 are denied unless covered by group/individual contract.
D6614	Retainer onlay – cast noble metal, two surfaces	None	Benefits for D6614 are denied unless covered by group/individual contract.
D6615	Retainer onlay - cast noble metal, three or more surfaces	None	Benefits for D6615 are denied unless covered by group/individual contract.
D6624	Retainer inlay – titanium	None	Benefits for D6624 are denied unless covered by group/individual contract.
D6634	Retainer onlay - titanium	None	Benefits for D6634 are denied unless covered by group/individual contract.
C. D6700 - D6799 FIXED PARTIAL DENTURE RETAINERS – CROWN			
D6710	Retainer crown – indirect resin based composite	Not to be used as a temporary or provisional prosthesis.	None
D6720	Retainer crown - resin fused to high noble metal	None	None
D6721	Retainer crown - resin with predominantly base metal	None	None
D6722	Retainer crown - resin with noble metal	None	None
D6740	Retainer crown - porcelain/ ceramic	None	None

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
D6750	Retainer crown - porcelain fused to high noble metal	None	None
D6751	Retainer crown - porcelain fused to predominantly base metal	None	None
D6752	Retainer crown - porcelain fused to noble metal	None	None
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	None	None
D6780	Retainer crown - 3/4 - cast high noble metal	None	None
D6781	Retainer crown - 3/4 - cast predominantly base metal	None	None
D6782	Retainer crown - 3/4 - cast noble metal	None	None
D6783	Retainer crown - 3/4 porcelain/ceramic	None	None
D6784	Retainer crown ¾ - titanium and titanium alloys	None	None
D6790	Retainer crown - full cast high noble metal	None	None
D6791	Retainer crown - full cast predominantly base metal	None	None
D6792	Retainer crown - full cast noble metal	None	None
D6793	Interim retainer crown - further treatment or completion of diagnosis necessary prior to final impression	Not to be used as a temporary retainer crown for a routine prosthetic restoration.	Temporary, interim, or provisional fixed prostheses are not separate benefits and should be included in the fee for the permanent prostheses. Separate fees to the same dentist/dental office are not billable to the patient.
D6794	Retainer crown – titanium and titanium alloys	None	None

D. D6900 - D6999 OTHER FIXED PARTIAL DENTURE SERVICES

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
D6920	Connector bar	A device attached to fixed partial denture retainer or coping which serves to stabilize and anchor a removable overdenture prosthesis.	Benefits are denied as a specialized technique unless covered by the group/individual contract.
D6930	Re-cement or re-bond fixed partial denture	None	The fee for recementation or rebonding of a fixed partial denture by the same dentist/dental office within six months of the seating date is a component of the fee for the original procedure and is not billable to the patient.
D6940	Stress breaker	A non-rigid connector	Benefits are denied as a specialized procedure, unless covered by the group/individual contract.
D6950	Precision attachment	A pair of components constitutes one precision attachment that is separate from the prosthesis	Benefits are denied as a specialized procedure, unless covered by the group/individual contract.
D6980	Fixed partial denture repair necessitated by restorative material failure	None	The fee for repair of a fixed partial denture cannot exceed one-half of the fee for a new appliance and any fee in excess of the allowance by the same dentist/dental office is not billable to the patient on the same date of service.
D6985	Pediatric partial denture, fixed	This prosthesis is used primarily for aesthetic purposes	Benefits are denied unless covered by the group/individual contract.
D6999	Unspecified fixed prosthodontic procedure, by report	Used for procedure that is not adequately described by a code. Describe procedure.	None

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy

D7000 – D7999 ORAL AND MAXILLOFACIAL SURGERY

Terms of group/individual contracts vary. Policies in this Handbook that address benefits, limitations and exclusions are policies that have not been tailored to reflect the specific terms of applicable group/individual contracts. In all cases, the terms of group/individual contracts take precedence over Dentist Handbook policies. Please contact the member company listed on the patient's identification card for the specific terms of a group/individual contract.

Benefit determinations are subject to individual consideration when accompanied by adequate documentation of extraordinary circumstances.

General Policy - The fee for all oral and maxillofacial surgery includes local anesthesia and suturing on the same date of service as the oral and maxillofacial surgery, and routine postoperative care 30 days following surgery. Separate fees for these procedures by the same dentist/dental office are not billable to the patient and are denied to another dentist/dental office.

General Policy – The term specialized procedure describes a dental service or procedure that is used when unusual or extraordinary circumstances exist and is not generally used when conventional methods are adequate.

General Policy - Infection control is included in the fee for the dental services provided. Separate fees are not billable to the patient.

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

General Policy - The fees for exploratory surgery or unsuccessful attempts at extractions are not billable to the patient.

General Policy - Restorations or surgical procedures to correct congenital or developmental malformations are benefited unless done solely for cosmetic reasons.

General Policy - Impaction codes are based on anatomical position rather than the surgical procedure necessary for removal.

General Policy – All services and treatment provided remotely via tele-health modalities, be they synchronous or asynchronous, must be performed by a licensed dentist or their supervised staff, acting within the scope of applicable law. Services and treatment delivered virtually are only a benefit when the elements included in the descriptor of the CDT procedure code are completed and only when they meet generally accepted clinical guidelines.

A. D7000 – D7199 EXTRACTIONS (Includes local anesthesia, suturing if needed, and routine postoperative care)

General Policy - The fees for biopsy (D7285, D7286), frenectomy (D7961, 7962) and excision of hard and soft tissue lesions (D7410, D7411, D7450, D7451) are not billable to the patient when the procedures are performed on the same date of service, same surgical site/area, by the same dentist/dental office as the above referenced codes. Requests for individual consideration can always be submitted by report for dental consultant review.

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
D7111	Extraction, coronal remnants – primary tooth	Removal of soft tissue-retained coronal remnants	D7111 is considered part of any other (more comprehensive) surgery in same surgical area, same date of service by the same dentist/dental office and the fees are not billable to the patient.
D7140	Extraction, erupted tooth or exposed root (elevation and/ or forceps removal)	Includes removal of tooth structure, minor smoothing of socket bone, and closure, as necessary	None
B. D7200 – D7259 SURGICAL EXTRACTIONS (Includes local anesthesia, suturing if needed, and routine postoperative care)			
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	Includes related cutting of gingiva and bone, removal of tooth structure, minor smoothing of socket bone and closure	None
D7220	Removal of impacted tooth - soft tissue	Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation	None
D7230	Removal of impacted tooth - partially bony	Part of crown covered by bone; requires mucoperiosteal flap elevation and bone removal	None
D7240	Removal of impacted tooth - completely bony	Most or all of crown covered by bone; requires mucoperiosteal flap elevation and bone removal	None
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	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	None
D7250	Removal of residual tooth roots (cutting procedure)	Includes cutting of soft tissue and bone, removal of tooth structure, and closure	Fees for removal of residual tooth roots on same date of service as the extraction of the same tooth by the same dentist/dental office are not billable to the patient.

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
D7251	Coronectomy – intentional partial tooth removal, impacted teeth only	Intentional partial tooth removal is performed when a neurovascular complication is likely if the entire impacted tooth is removed	None
C. D7260 – D7299 OTHER SURGICAL PROCEDURES			
General Policy - The fee for all oral and maxillofacial surgery includes local anesthesia, and suturing if needed on the same date of service, and routine postoperative care 30 days following surgery. A separate fee for these procedures in conjunction with oral and maxillofacial surgery by the same dentist/dental office is not billable to the patient and are denied to another dentist/dental office.			
D7260	Oroantral fistula closure	Excision of fistulous tract between maxillary sinus and oral cavity and closure by advancement flap	None
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 fistulous tract.	The fee for D7261 is not billable to the patient when submitted with D7241.
D7270	Tooth re-implantation and/or stabilization of accidentally avulsed or displaced tooth	Includes splinting and/or stabilization	Includes local anesthesia, suturing, postoperative care and removal of splint by the same dentist/dental office 30 days following the surgical procedure. The fees for these procedures in conjunction with D7270 are not billable to the patient by the same dentist/dental office and are denied to another dentist/dental office.
D7272	Tooth transplantation (includes re-implantation from one site to another and splinting and/or stabilization)	None	Benefits for D7272 are denied as a specialized procedure.
D7280	Exposure 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	Benefits are denied in the absence of orthodontic benefits.

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	To move/luxate teeth to eliminate ankylosis; not in conjunction with an extraction.	None
D7283	Placement of device to facilitate eruption of impacted tooth	Placement of an attachment on an unerupted tooth, after its exposure, to aid in its eruption. Report the surgical exposure separately using D7280.	Benefits are denied unless covered by group/individual contract.
D7284	Excisional biopsy of minor salivary glands	None	a. A pathology report must be included. b. The fee for biopsy of oral tissue is included in the fee for a surgical procedure (e.g., apicoectomy, extractions, etc.) and is not billable to the patient when performed by the same dentist/dental office in the same surgical area and on the same date of service.
D7285	Incisional biopsy of oral tissue – hard (bone, tooth)	For partial removal of specimen only. This procedure involves biopsy of osseous lesions and is not used for apicoectomy/periradicular surgery. This procedure does not entail an excision.	None
D7286	Incisional Biopsy of oral tissue – soft	For partial removal of an architecturally intact specimen only. This procedure is not used at the same time as codes for apicoectomy/periradicular curettage. This procedure does not entail an excision.	a. A pathology report must be included. b. The fee for biopsy of oral tissue is included in the fee for a surgical procedure (e.g. apicoectomy, extractions, etc.) and is not billable to the patient when performed by the same dentist/dental office in the same surgical area and on the same date of service. c. Biopsy is only a benefit for oral structures.
D7287	Exfoliative cytology sample collection	For collection of non-transepithelial cytology sample via mild scraping of the oral mucosa.	None

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
D7288	Brush biopsy- transepithelial sample collection	For collection of oral disaggregated transepithelial cells via rotational brushing of the oral mucosa	Benefits for brush biopsy are denied unless covered by group/ individual contract. When covered: A pathology report must be included.
D7290	Surgical repositioning of teeth	Grafting procedure(s) is/are additional	Benefit surgical repositioning including grafting procedures when covered by group/individual contract.
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).	Benefits for transseptal fiberotomy are denied unless covered by group/individual contract.
D7292	Placement of temporary anchorage device [screw retained plate] requiring flap	None	Benefits are denied as a specialized procedure.
D7293	Placement of temporary anchorage device requiring flap	None	Benefits are denied as a specialized procedure.
D7294	Placement of temporary anchorage device without flap	None	Benefits are denied as a specialized procedure, unless covered by group/individual contract.
D7295	Harvest of bone for use in autogenous grafting procedure	Reported in addition to those autogenous graft placement procedures that do not include harvesting of bone	a. Benefits are denied unless covered by group/individual contract. b. Benefit if the companion oral surgery procedures (D7953 and D7955) are covered under the group/individual contract.

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
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 facilitating orthodontic repositioning of the dentition. This procedure includes flap entry and closure. Graft material and membrane, if used, should be reported separately.	Benefits for corticotomy procedures are denied as a specialized procedure.
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 facilitating orthodontic repositioning of the dentition. This procedure includes flap entry and closure. Graft material and membrane, if used, should be reported separately.	Benefits for corticotomy procedures are denied as a specialized procedure.
D7298	Removal of temporary anchorage device [screw retained plate], requiring flap	None	a. Benefits are denied as a specialized procedure. b. The fee for D7298 is included in the surgery and is not billable to the patient when done by the same dentist/dental office as D7292. Benefits are denied when done by a different dentist/dental office.
D7299	Removal of temporary anchorage device, requiring flap	None	a. Benefits are denied as a specialized procedure. b. The fee for D7299 is included in the surgery and is not billable to the patient when done by the same dentist/dental office as D7292. Benefits are denied when done by a different dentist/dental office.

D. D7300 – D7339 ALVEOLOPLASTY- PREPARATION OF RIDGE FOR DENTURES

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
D7300	Removal of temporary anchorage device without flap	None	a. Benefits are denied as a specialized procedure. unless covered by group/individual contract. b. The fee for D7300 is included in the surgery and is not billable to the patient when done by the same dentist/dental office as D7292. Benefits are denied when done by a different dentist/dental office.
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	The alveoloplasty is distinct (separate procedure) from extractions. Usually in preparation for a prosthesis or other treatments such as radiation therapy and transplant surgery.	a. Alveoloplasty is included in the fee for extractions (D7140, D7210-D7250). Fees for D7310 are not billable to the patient if performed by the same dentist/dental office, in the same surgical area on the same date of service. b. Fees are not billable to the patient no matter how many extractions are performed in the quadrant.
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	The alveoloplasty is distinct (separate procedure) from extractions. Usually in preparation for a prosthesis or other treatments such as radiation therapy and transplant surgery.	Alveoloplasty is included in the fee for extractions (D7140, D7210-D7250). Fees for D7311 are not billable to the patient if performed by the same dentist/dental office, in the same surgical area on the same date of service.
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	No extractions performed in an edentulous area. See D7310 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.	None
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	No extractions performed in an edentulous area. See D7311 if teeth are being extracted concurrently with the alveoloplasty. Usually in preparation for a prosthesis or other	None

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
		treatments such as radiation therapy and transplant surgery.	
E. D7340 - D7399 VESTIBULOPLASTY			
General Policy - All procedures are by report and subject to coverage available under the medical plan.			
D7340	Vestibuloplasty - ridge extension (secondary epithelialization)	None	None
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachments, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	None	None
F. D7400 - D7429 EXCISION OF SOFT TISSUE LESIONS (Includes non-odontogenic cysts)			
General Policy - All procedures are by report and subject to coverage available under the medical plan.			
General policy - If considered under dental, pathology report required. If no report is submitted, then the fee for the procedure is not billable to the patient.			
D7410	Excision of benign lesion up to 1.25 cm	None	The fee for D7410 is not billable to the patient as included in the fee for another surgery in the same area of the mouth on the same date of service by the same dentist/dental office.
D7411	Excision of benign lesion greater than 1.25 cm	None	The fee for D7411 is not billable to the patient as included in the fee for another surgery in the same area of the mouth on the same date of service by the same dentist/dental office.
D7412	Excision of benign lesion, complicated	Requires extensive undermining with advancement or rotational flap closure	The fee for D7412 is not billable to the patient as included in the fee for another surgery in the same area of the mouth on the same date of service by the same dentist/dental office.
D7413	Excision of malignant lesion up to 1.25 cm	None	The fee for D7413 is not billable to the patient as included in the fee for another surgery in the same area of the mouth on the same date of service by the same dentist/dental office.

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
D7414	Excision of malignant lesion greater than 1.25 cm	None	The fee for D7414 is not billable to the patient as included in the fee for another surgery in the same area of the mouth on the same date of service by the same dentist/dental office.
D7415	Excision of malignant lesion, complicated	Requires extensive undermining with advancement or rotational flap closure	The fee for D7415 is not billable to the patient as included in the fee for another surgery in the same area of the mouth on the same date of service by the same dentist/dental office.
G.	**D7430 - D7469 EXCISION OF INTRA-OSSEOUS LESIONS**		
General Policy - All procedures are by report and are subject to coverage available under the medical plan.			
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm	None	None
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm	None	None
D7450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm	None	The fee for D7450 is not billable to the patient as included in the fee for another surgery in the same area of the mouth on the same date of service by the same dentist/dental office.
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	None	The fee for D7451 is not billable to the patient as included in the fee for another surgery in the same area of the mouth on the same date of service by the same dentist/dental office.
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	None	None
D7461	Removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm	None	None
D7465	Destruction of lesion(s) by physical or chemical method, by report	Examples include using cryo, laser or electro surgery	None

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
H. D7470 - D7599 EXCISION OF BONE TISSUE			
General Policy - All procedures are by report and are subject to coverage available under the medical plan.			
D7471	Removal of lateral exostosis - (maxilla or mandible)	None	None
D7472	Removal of torus palatinus	None	None
D7473	Removal of torus mandibularis	None	None
D7485	Reduction of osseous tuberosity	None	None
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	If considered under dental by group/individual contract, pathology report required.
I. D7500 - D7599 SURGICAL INCISION			
General Policy - All procedures are not a benefit unless specifically covered by group/individual contract and are subject to coverage available under the medical plan. When covered, all procedures are by report and subject to coverage under medical. The fees for procedures that are an integral part of a primary procedure in the same surgical area by the same dentist/dental office should not be reported separately and are not billable to the patient.			
General Policy - All procedures are by report and are subject to coverage available under the medical plan.			
D7509	Marsupialization of odontogenic cyst	Surgical decompression of a large cystic lesion by creating a long-term open pocket or pouch.	None
D7510	Incision and drainage of abscess - intraoral soft tissue	Involves incision through mucosa, including periodontal origins	Fees for D7510 are not billable to the patient when submitted on the same date of service with all surgery (D7000-D7999), endodontic codes (D3000-D3999), and surgical periodontal procedures (D4210-D4278).
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	Fees for D7511 are not billable to the patient when submitted on the same date of service with all oral surgery (D7000-D7999), endodontic codes (D3000-D3999), and surgical periodontal procedures (D4210-D4285).

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
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.
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.	Benefits are subject to coverage available under the medical plan.
D7530	Removal of foreign body from mucosa, skin or subcutaneous alveolar tissue	None	When covered by group/individual contract, pathology report is required.
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.	When covered by group/individual contract, pathology report is required.
D7550	Partial ostectomy/ sequestretomy for removal of non-vital bone	Removal of loose or sloughed-off dead bone caused by infection or reduced blood supply	When covered by group/individual contract, pathology report is required.
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	None	When covered by group/individual contract, pathology report is required.
J. D7600 - D7699 TREATMENT OF CLOSED FRACTURES			
General Policy - All procedures are by report and are subject to coverage available under the medical plan.			
General Policy –A separate fee for splinting, wiring or banding is not billable to the patient when performed on the same date of service 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. Incision required for interosseous fixation	None
D7620	Maxilla - closed reduction (teeth immobilized, if present)	No incision required to reduce fracture. See D7610 if interosseous fixation is applied	None
D7630	Mandible - open reduction (teeth immobilized, if present)	Teeth may be wired, banded or splinted together to prevent movement. Incision required to reduce fracture	None

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
D7640	Mandible - closed reduction (teeth immobilized, if present)	No incision required to reduce fracture. See D7630 if interosseous fixation is applied	None
D7650	Malar and/or zygomatic arch - open reduction	None	None
D7660	Malar and/or zygomatic arch - closed reduction	None	None
D7670	Alveolus - closed reduction, may include stabilization of teeth	Teeth may be wired, banded or splinted together to prevent movement	None
D7671	Alveolus, open reduction, may include stabilization of teeth	Teeth may be wired, banded or splinted together to prevent movement	None
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	None
K. D7700 - D7799 TREATMENT OF OPEN FRACTURES			
General Policy - All procedures are by report and are subject to coverage available under the medical plan.			
General Policy - A separate fee for splinting, wiring or banding is not billable to the patient when performed on the same date of service by the same dentist/dental office rendering the primary procedure.			
D7710	Maxilla - open reduction	Incision required to reduce fracture	None
D7720	Maxilla - closed reduction	None	None
D7730	Mandible - open reduction	Incision required to reduce fracture	None
D7740	Mandible - closed reduction	None	None
D7750	Malar and/or zygomatic arch - open reduction	Incision required to reduce fracture	None
D7760	Malar and/or zygomatic arch - closed reduction	None	None
D7770	Alveolus - open reduction stabilization of teeth	Fractured bone(s) are exposed to mouth or outside the face. Incision required to reduce fracture	None
D7771	Alveolus, closed reduction stabilization of teeth	Fractured bone(s) are exposed to mouth or outside the face	None
D7780	Facial bones - complicated reduction with fixation and multiple approaches	Incision required to reduce fracture. Facial bones include upper and lower	None

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
		jaw, cheek, and bones around eyes, nose, and ears	
L. D7800 - D7899 REDUCTION OF DISLOCATION AND MANAGEMENT OF OTHER TEMPOROMANDIBULAR JOINT DYSFUNCTIONS. PROCEDURES WHICH ARE AN INTEGRAL PART OF A PRIMARY PROCEDURE SHOULD NOT BE REPORTED SEPARATELY			
General Policy - All procedures are not a benefit unless specifically covered by group/individual contract and are subject to coverage available under the medical plan. When covered, all procedures are by report and subject to coverage under medical. The fees for procedures that are an integral part of a primary procedure in the same surgical area by the same dentist/dental office should not be reported separately and are not billable to the patient.			
D7810	Open reduction of dislocation	Access to TMJ via surgical opening.	None
D7820	Closed reduction of dislocation	Joint manipulated into place; no surgical exposure	None
D7830	Manipulation under anesthesia	Usually done under general anesthesia or intravenous sedation.	None
D7840	Condylectomy	Removal of all or portion of the mandibular condyle (separate procedure).	None
D7850	Surgical discectomy, with/without implant	Excision of the intra-articular disc of a joint.	None
D7852	Disc repair	Repositioning and/or sculpting of disc; repair of perforated posterior attachment	None
D7854	Synovectomy	Excision of a portion or all of the synovial membrane of a joint.	None
D7856	Myotomy	Cutting of muscle for therapeutic purposes (separate procedure).	None
D7858	Joint reconstruction	Reconstruction of osseous components including or excluding soft tissues of the joint with autogenous, homologous, or alloplastic materials	None
D7860	Arthrotomy	Cutting into joint (separate procedure).	None
D7865	Arthoplasty	Reduction of osseous components of the joint to create a pseudoarthrosis	None

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
		or eliminate an irregular remodeling pattern (osteophytes).	
D7870	Arthrocentesis	Withdrawal of fluid from a joint space by aspiration	None
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.	The benefits for these services are denied unless the related TMJ services are covered under the group/individual contract.
D7872	Arthroscopy - diagnosis, with or without biopsy	None	None
D7873	Arthroscopy: lavage and lysis of adhesions	Removal of adhesions using the arthroscope and lavage of the joint cavities.	None
D7874	Arthroscopy: disc repositioning and stabilization	Repositioning and stabilization of disc using arthroscopic techniques	None
D7875	Arthroscopy: synovectomy	Removal of inflamed and hyperplastic synovium (partial/complete) via an arthroscopic technique.	None
D7876	Arthroscopy: discectomy	Removal of disc and remodeled posterior attachment via the arthroscope	None
D7877	Arthroscopy: debridement	Removal of pathologic hard and/or soft tissue using the arthroscope	None
D7880	Occlusal orthotic device, by report	Presently includes splints provided for treatment of temporomandibular joint dysfunction.	None
D7881	Occlusal orthotic device adjustment	None	a. Benefits for occlusal orthotic device adjustments are denied unless covered by group/individual contract.

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
			b. When covered by group/individual contract, fees for all adjustments within six months are not billable to the patient. c. Benefit one per year following six months from initial placement.
D7899	Unspecified TMJ therapy, by report	Used for procedure that is not adequately described by a code. Describe procedure.	None
M. D7900 - D7910 REPAIR OF TRAUMATIC WOUNDS			
General Policy - Repair of traumatic wounds is limited to oral structures.			
D7910	Suture of recent small wounds up to 5 cm	None	None
N. D7911 - D7919 COMPLICATED SUTURING (RECONSTRUCTION REQUIRING DELICATE HANDLING OF TISSUES AND WIDE UNDERMINING FOR METICULOUS CLOSURE)			
General Policy - Complicated suturing is limited to oral structures.			
D7911	Complicated suture - up to 5 cm	None	None
D7912	Complicated suture - greater than 5 cm	None	None
O. D7920 - D7999 OTHER REPAIR PROCEDURES			
General Policy - All procedures except D7961, D7962, D7963, D7970 and D7971 are by report and are subject to coverage available under the medical plan.			
D7920	Skin graft (identify defect covered, location and type of graft)	None	None
D7921	Collection and application of autologous blood concentrate product	None	Benefits are denied as investigational.
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	This procedure can be performed at time and/or after extraction to aid in hemostasis. The socket is packed with hemostatic agent to aid in hemostasis and or clot stabilization.	a. Placement of an intra-socket biological dressing to aid in hemostasis or clot stabilization is considered part of the extraction and/or post-operative procedure.

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
			b. A separate fee is not billable to the patient.
D7939	Indexing for osteotomy using dynamic robotic assisted or dynamic navigation	A guide is stabilized to the teeth and/or the bone to allow for virtual guidance of osteotomy.	Benefits are denied as specialized technique.
D7940	Osteoplasty - for orthognathic deformities	Reconstruction of jaws for correction of congenital, developmental or acquired traumatic or surgical deformity	None
D7941	Osteotomy – mandibular rami	None	None
D7943	Osteotomy – mandibular rami with bone graft; includes obtaining the graft	None	None
D7944	Osteotomy - segmented or subapical	Report by range of tooth numbers within segment.	None
D7945	Osteotomy - body of mandible	Sectioning of lower jaw. This includes the exposure, bone cut, fixation, routine wound closure and normal post-operative follow-up care.	None
D7946	LeFort I (maxilla - total)	Sectioning of the upper jaw. This includes the exposure, bone cuts, downfracture, repositioning, fixation, routine wound closure and normal post-operative follow-up care.	None
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”.	None
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft	Sectioning of upper jaw. This includes the exposure, bone cuts, downfracture, segmentation of maxilla, repositioning, fixation, routine wound closure and normal post-operative follow-up care.	None

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
D7949	LeFort II or LeFort III - with bone graft	Includes obtaining autografts	None
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report	This procedure is for ridge augmentation or reconstruction to increase height, width and/or volume of residual alveolar ridge. It includes obtaining graft material. Placement of a barrier membrane, if used, should be reported separately	a. When billed in conjunction with implants, ridge augmentation, extraction sites, periradicular surgery, etc., benefits for D7950 are denied as a specialized procedure. b. Benefits for platelets are denied as investigational.
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	The augmentation of the sinus cavity to increase alveolar height for reconstruction of edentulous portions of the maxilla. This procedure is performed via a lateral open approach. This includes obtaining the bone or bone substitutes. Placement of a barrier membrane if used should be reported separately.	a. When billed in conjunction with implants, ridge augmentation, extraction sites, periradicular surgery, etc., benefits for D7951 are denied as a specialized procedure. b. Benefits for platelets are denied as investigational.
D7952	Sinus augmentation via a vertical approach	The augmentation of the sinus to increase alveolar height by vertical access through the ridge crest by raising the floor of the sinus and grafting as necessary. This includes obtaining the bone or bone substitutes.	When billed in conjunction with implants, ridge augmentation, extraction sites, periradicular surgery, etc., benefits for D7952 are denied as a specialized procedure.
D7953	Bone replacement graft for ridge preservation - per site	Graft is placed in an extraction or implant removal site at the time of the extraction or removal to preserve ridge integrity (e.g., clinically indicated in preparation for implant reconstruction or where alveolar contour is critical to planned prosthetic reconstruction). Does not include obtaining graft material. Membrane, if used should be reported separately.	A site is equal to one tooth (extraction or implant removal site). a. Benefits when billed in conjunction with implants, implant removal, ridge augmentation, extraction sites, periradicular surgery etc. are denied as an investigational procedure. b. Bone replacement grafts for natural teeth are denied.

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
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 graft materials in conjunction with soft tissue procedures 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.	None
	General Policy - Repair is by report and subject to coverage available under the medical plan.		
D7956	Guided tissue regeneration, edentulous area – resorbable barrier, per site	This procedure does not include flap entry and closure, or, when indicated, wound debridement, osseous contouring, bone replacement grafts, and placement of biologic materials to aid in osseous regeneration. This procedure may be used for ridge augmentation, sinus lift procedures, and after tooth extraction.	Benefits for GTR when billed in conjunction with implants, soft tissue grafts on implants, ridge augmentation, ridge preservation/extraction sites, periradicular surgery, apicoectomy sites, hemisections etc. are denied as a specialized procedure.
D7957	Guided tissue regeneration, edentulous area – non-resorbable barrier, per site	This procedure does not include flap entry and closure, or, when indicated wound debridement, osseous contouring, bone replacement grafts, and placement of biologic materials to aid in osseous regeneration. This procedure may be used for ridge augmentation, sinus lift procedures, and after tooth extraction.	a. Benefits for GTR when billed in conjunction with implants, mucogingival/soft tissue grafts on implants, ridge augmentation, ridge preservation/extraction sites, periradicular surgery, apicoectomy sites, hemisections etc. are denied as a specialized procedure. b. Benefits for GTR, in conjunction with mucogingival/soft tissue grafts in the same surgical area, are denied. c Fees for re-entry for removal of the barrier material are not billable to the patient by the same dentist/dental office.

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
D7961	Buccal/labial frenectomy (frenulectomy)	None	The fee for frenectomy is not billable to the patient when billed on the same date of service as any other surgical procedure(s) in the same surgical area by the same dentist/dental office.
D7962	Lingual frenectomy (frenulectomy)	None	The fee for frenectomy is not billable to the patient when billed on the same date of service as any other surgical procedure(s) in the same surgical area by the same dentist/dental office.
D7963	Frenuloplasty	Excision of frenum with accompanying excision or repositioning of aberrant muscle and z-plasty or other local flap closure	The fee for frenuloplasty is not billable to the patient on the same date of service as any other surgical procedure(s) in the same surgical site.
D7970	Excision of hyperplastic tissue - per arch	None	The fee for excision of hyperplastic tissue performed on the same date of service as another surgical procedure in the same surgical area by the same dentist/dental offices is not billable to the patient.
D7971	Excision of pericoronal gingiva	Removal of inflammatory or hypertrophied tissues surrounding partially erupted/impacted teeth.	The fee for excision of pericoronal gingiva performed on the same date of service as another surgical procedure in the same surgical area by the same dentist/dental office is not billable to the patient.
D7972	Surgical reduction of fibrous tuberosity	None	None
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.	None
D7980	Surgical sialolithotomy	Procedure by which a stone within a salivary gland or its duct is removed, either intraorally or extraorally.	None

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
D7981	Excision of salivary gland, by report	None	None
D7982	Sialodochoplasty	Procedure for the repair of a defect and/or restoration of a portion of a salivary gland duct.	None
D7983	Closure of salivary fistula	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.	None
D7990	Emergency tracheotomy	Formation of a tracheal opening usually below the cricoid cartilage to allow for respiratory exchange.	None
D7991	Coronoidectomy	Removal of the coronoid process of the mandible.	None
D7993	Surgical placement of craniofacial implant – extra oral	Surgical placement of a craniofacial implant to aid in retention of an auricular, nasal, or orbital prosthesis.	Benefits are denied unless covered by group/individual contract.
D7994	Surgical placement: zygomatic implant	An implant placed in the zygomatic bone and exiting though the maxillary mucosal tissue providing support and attachment of a maxillary dental prosthesis.	Benefits are denied unless covered by group/individual contract.
D7995	Synthetic graft - mandible or facial bones, by report	Includes allogenic material.	None
D7996	Implant-mandible for augmentation purposes (excluding alveolar ridge), by report	None	None
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	None	The fee for D7997 is denied unless the group/individual contract specifies that the related oral surgery services are a benefit. If covered, the fees are not billable to the patient 45 days following appliance placement.

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
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.	None
	General Policy - All procedures are by report and are subject to coverage under medical. This procedure is not billable to the patient by the same dentist/dental office when billed in conjunction with any surgical procedure not in conjunction with fractures for which splinting, wiring or banding is considered part of the complete procedure (e.g., D7270, D7272).		
D7999	Unspecified oral surgery procedure, by report	Used for procedure that is not adequately described by a code. Describe the procedure	None

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy

D8000 – D8999 ORTHODONTICS

Terms of group/individual contracts vary. Policies in this Handbook that address benefits, limitations and exclusions are policies that have not been tailored to reflect the specific terms of applicable group/individual contracts. In all cases, the terms of group/individual contracts take precedence over Dentist Handbook policies. Please contact the member company listed on the patient's identification card for the specific terms of a group/individual contract.

General Policy – The term specialized procedure describes a dental service or procedure that is used when unusual or extraordinary circumstances exist and is not generally used when conventional methods are adequate.

General Policy - Infection control is included in the fee for the dental services provided. Separate fees are not billable to the patient.

General Policy - Orthodontics, including clinical oral evaluations and all treatment, must be performed by a licensed dentist or his or her supervised staff, acting within the scope of applicable law. The dentist of record must perform a clinical oral evaluation of the patient, regardless if done in person or virtually, to establish the need for orthodontic treatment, and have adequate diagnostic information and appropriate radiographic imaging, to develop a treatment plan.

General Policy – treating dentists must have arrangements for patients to seek emergency care**.**

General Policy –orthodontic services are only a benefit when they meet generally accepted clinical guidelines.

General Policy – All services and treatment provided remotely via tele-health modalities, be they synchronous or asynchronous, must be performed by a licensed dentist or their supervised staff, acting within the scope of applicable law. Services and treatment delivered virtually are only a benefit when the elements included in the descriptor of the CDT procedure code are completed and only when they meet generally accepted clinical guidelines.

General Policy: Direct to consumer orthodontic treatment requires an attestation by treating dentist.

LIMITED ORTHODONTIC TREATMENT

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

The objective may be limited by:
- not involving the entire dentition.
- not attempting to address the full scope of the existing or developing orthodontic problem.
- mitigating an aspect of a greater malocclusion (i.e., crossbite, overjet, overbite, arch length, anterior alignment, one phase of multi-phase treatment, treatment prior to the permanent dentition, etc.).
- a decision to defer or forego comprehensive treatment

D8010	Limited orthodontic treatment of the primary dentition	None	None

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
D8020	Limited orthodontic treatment of the transitional dentition	None	None
D8030	Limited orthodontic treatment of the adolescent dentition	None	None
D8040	Limited orthodontic treatment of the adult dentition	None	None
COMPREHENSIVE ORTHODONTIC TREATMENT Comprehensive orthodontic care includes a coordinated diagnosis and treatment leading to the improvement of a patient's craniofacial dysfunction and/or dentofacial deformity which may include anatomical, functional and/or esthetic relationships. Treatment may utilize fixed and/or removable orthodontic appliances and may also include functional and/or orthopedic appliances in growing and non-growing patients. Adjunctive procedures to facilitate care may be required. Comprehensive orthodontics may incorporate treatment phases focusing on specific objectives at various stages of dentofacial development.			
D8070	Comprehensive orthodontic treatment of the transitional dentition	None	Benefits are denied when the supporting documentation does not meet the criteria for coverage.
D8080	Comprehensive orthodontic treatment of the adolescent dentition	None	Benefits are denied when the supporting documentation does not meet the criteria for coverage.
D8090	Comprehensive orthodontic treatment of the adult dentition	None	Benefits are denied when the supporting documentation does not meet the criteria for coverage.
MINOR TREATMENT TO CONTROL HARMFUL HABITS			
D8210	Removable appliance therapy	Removable indicates patient can remove; includes appliances for thumb sucking and tongue thrusting	None
D8220	Fixed appliance therapy	Fixed indicates patient cannot remove appliance; includes appliances for thumb sucking and tongue thrusting	None
OTHER ORTHODONTIC SERVICES			

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D8660	Pre-orthodontic treatment examination to monitor growth and development	Periodic observation of patient dentition, at intervals established by the dentist, to determine when orthodontic treatment should begin. Diagnostic procedures are documented separately	a Fees for D8660 are not billable to the patient with any other oral evaluation (D0120 – D0180). D8660 is included in the oral evaluation frequency limits. b. Fees for D8660 are not billable to the patient when submitted with D8070, D8080, D8090.
D8670	Periodic orthodontic treatment visit	None	None
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	None	a. The fee for orthodontic retention is not billable to the patient within 24 months of placement by same dentist/dental office. b. Benefits are denied if performed by different dentist/dental office. c. Benefits for D8680 submitted after 24 months is denied.
D8681	Removable orthodontic retainer adjustment	None	Fees for removable orthodontic retainer adjustments are not billable to the patient if performed by the same dentist/dental office providing orthodontic treatment. Benefits are denied if performed by a different dentist/dental office.
D8695	Removal of fixed orthodontic appliances for reasons other than at completion of treatment	None	Benefits for patient requested removal of fixed orthodontic appliance(s) are denied.
D8696	Repair of orthodontic appliance – maxillary	Does not include bracket and standard fixed orthodontic appliances. It does include functional appliances and palatal expanders.	None

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
D8697	Repair of orthodontic appliance – mandibular	Does not include bracket and standard fixed orthodontic appliances. It does include functional appliances and palatal expanders.	None
D8698	Re-cement or re-bond fixed retainer – maxillary	None	This procedure is included in the orthodontic case fee. A separate fee is not billable to the patient anytime following placement of the fixed retainer by the same dentist/dental office.
D8699	Re-cement or re-bond fixed retainer – mandibular	None	This procedure is included in the orthodontic case fee. A separate fee is not billable to the patient anytime following placement of the fixed retainer by the same dentist/dental office.
D8701	Repair of fixed retainer, includes reattachment – maxillary	None	a. The fee for D8701 is not billable to the patient within 24 months following placement of the fixed retainer by the same dentist/dental office. In cases where there are excessive or continuous repairs, individual consideration can always be given. b. Benefits for D8701 submitted after 24 months of placement are denied.
D8702	Repair of fixed retainer, includes reattachment – mandibular	None	a. The fee for D8702 is not billable to the patient within 24 months following placement of the fixed retainer by the same dentist/dental office. In cases where there are excessive or continuous repairs, individual consideration can always be given. b. Benefits for D8702 submitted after 24 months of placement are denied.
D8703	Replacement of lost or broken retainer – maxillary	None	Benefits subject to orthodontic coverage. If covered:

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			Benefits are denied within 12 months of completion of orthodontic treatment. After 12 months, benefit once per lifetime.
D8704	Replacement of lost or broken retainer – mandibular	None	Benefits subject to orthodontic coverage. If covered: Benefits are denied within 12 months of completion of orthodontic treatment. After 12 months, benefit once per lifetime.
D8999	Unspecified orthodontic procedure, by report	Used for procedure that is not adequately described by a code. Describe procedure.	None

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D9000 – D9999 ADJUNCTIVE GENERAL SERVICES

Terms of group/individual contracts vary. Policies in this Handbook that address benefits, limitations and exclusions are policies that have not been tailored to reflect the specific terms of applicable group/individual contracts. In all cases, the terms of group/individual contracts take precedence over Dentist Handbook policies. Please contact the member company listed on the patient's identification card for the specific terms of a group/individual contract.

Benefit determinations are subject to individual consideration when accompanied by adequate documentation of extraordinary circumstances

General Policy – The term specialized procedure describes a dental service or procedure that is used when unusual or extraordinary circumstances exist and is not generally used when conventional methods are adequate.

General Policy - Infection control is included in the fee for the dental services provided. Separate fees are not billable to the patient.

General Policy - General anesthesia and intravenous sedation are limited to one hour. Any additional minutes are not billable to the patient unless clinical documentation supports more than an hour was necessary. For example, special health care needs patients may require additional units of anesthesia and may be a benefit according to group/individual contract.

General Policy – All services and treatment provided remotely via tele-health modalities, be they synchronous or asynchronous, must be performed by a licensed dentist or their supervised staff, acting within the scope of applicable law. Services and treatment delivered virtually are only a benefit when the elements included in the descriptor of the CDT procedure code are completed and only when they meet generally accepted clinical guidelines.

A. D9000 - D9199 UNCLASSIFIED TREATMENT

D9110	Palliative treatment of dental pain - per visit	Treatment that relieves pain but is not curative; services provided do not have distinct procedure codes.	The fee for palliative treatment is not billable to the patient when submitted with all CDT procedures except radiographic images (D0210-D0340) and diagnostic procedure codes (D0120- D0180 and D0460) and is performed by the same dentist/dental office on the same date of service.
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.	a. This procedure is only a benefit if a portion of a fixed prosthesis is to remain intact and serviceable following sectioning and extraction or other treatment. b. If D9120 is part of the process of removing and replacing a fixed prosthesis, it is

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		Includes all recontouring and polishing of retained portions.	considered integral to the fabrication of the new fixed prosthesis and fees are not billable to the patient. c. Fees for polishing and recontouring of the retained portion of the prosthesis are not billable to the patient.
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.	a. Benefits for non-invasive TMD physical therapies are denied unless covered by group/individual contract. b. If covered by group/individual contract, benefit is limited to once every 12 months.
B. D9200 - D9299 ANESTHESIA			
General Policy - General anesthesia and intravenous sedation are limited to one hour. Any additional minutes are not billable to the patient unless clinical documentation (e.g., anesthesia record) supports more than an hour was necessary.			
D9210	Local anesthesia not in conjunction with operative or surgical procedures	None	None
D9211	Regional block anesthesia	None	None
D9212	Trigeminal division block anesthesia	None	None
D9215	Local anesthesia in conjunction with operative or surgical procedures	None	a. The fee for local anesthesia is not billable to the patient when performed on the same date of service as any other procedure. b. The fee for D9215 is not billable to the patient when performed, whether standalone or in conjunction with, any other procedure, unless covered by the group/individual contract.
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	None	Fees for evaluation for moderate sedation, deep sedation or general anesthesia are not

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
			billable to the patient with moderate, deep sedation or general anesthesia.
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 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 effects upon the central nervous system and not dependent upon the route of administration.	a. Benefit in conjunction with oral surgical procedures (D7000-D7999) when covered, or when necessary due to concurrent medical conditions. Otherwise, the benefit for deep sedation/general anesthesia is denied. Unless specifically covered by group/individual contract. b Benefits for more than one hour of deep sedation are not billable to the patient unless clinical documentation supports more than an hour was necessary. For example, special health care needs patients may require additional units of anesthesia and more than one hour of anesthesia may be a benefit according to group/individual contract. c. The benefit for deep sedation/general anesthesia is denied when billed by anyone other than an appropriately licensed and qualified provider.
D9223	Deep sedation/general anesthesia – each subsequent 15 minute increment	None	a. Benefit in conjunction with oral surgical procedures (D7000-D7999) when covered, or when necessary due to concurrent medical conditions. Otherwise, the benefit for deep sedation/general anesthesia is denied, unless specifically covered by group/individual contract. b Benefits for more than one hour of deep sedation are not billable to the patient unless clinical documentation supports more than an hour was necessary. For example, special health care needs patients may require additional units of anesthesia and more than

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
			one hour of anesthesia may be a benefit according to group/individual contract. c. The benefit for deep sedation/general anesthesia is denied when billed by anyone other than an appropriately licensed and qualified provider.
D9230	Inhalation of nitrous oxide/anxiolysis, analgesia	None	Benefits for analgesia are denied unless covered by the group/individual contract. If covered: a. Fees for multiple D9230 are not billable to the patient on the same date of service. b. Fees for D9230 are not billable to the patient in conjunction with IV sedation (D9239 and D9243) and general anesthesia (D9222 and D9223).
D9239	Intravenous moderate (conscious) sedation/analgesia – 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 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 effects upon the central nervous system and not dependent upon the route of administration.	a. Intravenous moderate (conscious) sedation/analgesia is a benefit only when administered; (1) in a dental office with appropriate monitoring by an appropriately licensed and qualified dentist who is acting in compliance with applicable rules and regulations, and (2) in conjunction with oral surgical procedures (D7000-D7999) when covered, or when necessary due to concurrent medical conditions. Otherwise, the benefit for intravenous moderate (conscious) sedation/analgesia is denied. b. Benefits for more than one hour of sedation is not billable to the patient unless clinical documentation (e.g., anesthesia record) supports more than an hour was necessary.

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
			c. The benefit for intravenous moderate (conscious) sedation/analgesia is denied when billed by anyone other than an appropriately licensed and qualified dentist.
D9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment	None	a. Intravenous moderate (conscious) sedation/analgesia is a benefit only when administered; (1) in a dental office with appropriate monitoring by an appropriately licensed and qualified dentist who is acting in compliance with applicable rules and regulations, and (2) in conjunction with oral surgical procedures (D7000-D7999) when covered, or when necessary due to concurrent medical conditions. Otherwise, the benefit for intravenous moderate (conscious) sedation/analgesia is denied. b. Benefits for more than one hour of sedation are not billable to the patient unless clinical documentation (e.g., anesthesia record) supports more than an hour was necessary. c. The benefit for intravenous moderate (conscious) sedation/analgesia is denied when billed by anyone other than an appropriately licensed and qualified dentist.
D9248	Non-intravenous conscious sedation	This includes non-IV minimal and moderate 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	a. Benefits for non-intravenous conscious sedation are denied, unless the group/individual contract specifies that services are a covered benefit. b. Fees for D9248 are not billable to the patient in conjunction with IV sedation (D9239 and D9243) and general anesthesia (D9222 and D9223).

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
		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.	
C. D9300 - D9399 PROFESSIONAL CONSULTATION			
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.	a. Consultation should be included in the evaluation fee. The fee for the consultation is not billable to the patient when billed in conjunction with an evaluation by the same dentist/dental office. b. May be considered for benefits when submitted with definitive treatment. c. Consultation (D9310) may be benefited when the service is provided by a dentist or dental specialist whose opinion or advice regarding an evaluation and/or management of a specific problem may be requested by another dentist, physician or appropriate service. The dentist performing the consultation may initiate diagnostic or therapeutic services. d. When covered, the consultations count against the contractual oral evaluation frequency limitations.
D9311	Consultation with a medical health care professional	Treating dentist consults with a medical health care professional concerning medical issues that may	The fees for the consultation with a health care professional concerning medical issues is not billable to the patient.

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		affect patient's planned dental treatment.	
D. D9400 - D9599 PROFESSIONAL VISITS			
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.	Benefits for house calls or extended care facility calls are denied unless covered by group/individual contract.
D9420	Hospital or ambulatory surgical center call	Care provided outside the dentist's office to a patient who is in a hospital or ambulatory surgical center. Services delivered to the patient on the date of service are documented separately using the applicable procedure codes.	Benefits for hospital or ambulatory call are denied unless covered by group/individual contract.
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	None	a. Benefits for office visit for observation are denied. b. Fees for an office visit for observation are not billable to the patient when billed with other procedures.
D9440	Office visit - after regularly scheduled hours	None	Benefits for an office visit-after regularly scheduled hours are denied.
D9450	Case presentation, subsequent to detailed and extensive treatment planning	None	a. Benefits for extensive treatment planning are denied. b. The fee for D9450 may be benefited for complex treatment planning cases involving multiple treatment disciplines and multiple providers of care by report. c. When covered, the D9450 is subject to the same frequency limitations and processing policies as a comprehensive evaluation (D0150).

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E. D9600 - D9899 DRUGS			
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.	None
D9612	Therapeutic parenteral drugs, 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 sedatives, 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.	None
D9613	Infiltration of sustained release therapeutic drug, per quadrant	Infiltration of a sustained release pharmacologic agent for long-acting surgical site pain control. Not for local anesthesia purposes.	Benefits for infiltration of sustained release therapeutic drug are denied unless covered by group/individual contract. When covered, benefit D9613 once per date of service when submitted with extractions (D7220-D7241) and any additional D9613 submitted on the same date of service are not billable to the patient.
D9630	Drugs or medicaments dispensed in the office for home use	Includes, but is not limited to oral antibiotics, oral analgesics, and topical fluoride; does not include writing prescriptions.	Benefits for therapeutic drug injection (D9610) or other drugs and/or medicaments (D9630) are denied.
F. D9900 - D9999 MISCELLANEOUS SERVICES			
General Policy – all teledentistry claims should include either procedure code D9995 or D9996.			

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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.	Benefits for application of desensitizing medicaments are denied.
D9911	Application of desensitizing resin for cervical and/or root surface, per tooth	Typically reported on a "per tooth" basis for application of adhesive resins. This code is not to be used for bases, liners, or adhesives used under restorations.	Benefits for application of desensitizing medicaments are denied.
D9912	Pre-visit patient screening	Capture and documentation of a patient's health status prior to or on the scheduled date of service to evaluate risk of infectious disease transmission if the patient is to be treated within the dental practice.	The fee for a pre-visit patient screening is not billable to the patient.
D9920	Behavior management, by report	May be reported in addition to treatment provided. Should be reported in 15-minute increments.	Benefits for behavior management are denied.
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	For example, treatment of a dry socket following extraction or removal of bony sequestrum.	a. The fee for dry socket palliation is not billable to the patient within 30 days following the extraction and included in the fee for the extraction by the same dentist/dental office. b. Benefit treatment of routine complications if done by a different dentist/dental office.
D9932	Cleaning and inspection of removable complete denture, maxillary	This procedure does not include any adjustments.	Fees for cleaning and inspection of a removable complete denture are not billable to the patient when done with a reline or rebase procedure. In all other instances, benefits for cleaning and inspection of a removable complete denture are denied unless covered by group/individual contract.

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
			When covered: a. Benefits are limited to fully edentulous patients. b. Benefits are included in prophylaxis frequency. c. The fee for D9932 is included in D1110 and is not billable to the patient on the same date of service.
D9933	Cleaning and inspection of removable complete denture, mandibular	This procedure does not include any adjustments.	Fees for cleaning and inspection of a removable complete denture are not billable to the patient when done with a reline or rebase procedure. In all other instances, benefits for cleaning and inspection of a removable complete denture are denied unless covered by group/individual contract. When covered: a. Benefits are limited to fully edentulous patients. b The fee for D9933 is included in D1110 and is not billable to the patient on the same date of service.
D9934	Cleaning and inspection of removable partial denture, maxillary	This procedure does not include any adjustments.	Fees for cleaning and inspection of a removable partial denture are not billable to the patient when done with a reline or rebase procedure. In all other instances, benefits for cleaning and inspection of a removable partial denture are denied.
D9935	Cleaning and inspection of removable partial denture, mandibular	This procedure does not include any adjustments.	Fees for cleaning and inspection of a removable partial denture are not billable to the patient when done with a reline or rebase procedure. In all other instances, benefits for cleaning and inspection of a removable partial denture are denied.

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D9938	Fabrication of a custom removable clear plastic temporary aesthetic appliance	None	Benefits are denied unless covered by group/individual contract.
D9939	Placement of a custom removable clear plastic temporary aesthetic appliance	None	Benefits are denied unless covered by group/individual contract.
D9941	Fabrication of athletic mouthguard	None	Benefit are limited once every 24 months for patients 18 and younger.
D9942	Repair and/or reline of occlusal guard	None	a. Benefits for occlusal guard are denied unless covered by group/individual contract specific. b. If covered, the fee for the occlusal guard includes any adjustment or repair required within six months of delivery. Fees for the adjustment or repair of the occlusal guard are not billable to the patient if performed by the same dentist/dental office within six months of initial placement. c. If covered, the fee for repair of an occlusal guard cannot exceed one-half of the fee for a new appliance, and any excess fee is not billable to the patient.
D9943	Occlusal guard adjustment	None	a. Benefits for occlusal guard adjustments are denied unless covered by group/individual contract. b. When covered by group/individual contract, all adjustments within six months are not billable to the patient.
D9944	Occlusal guard – hard appliance, full arch	Removable dental appliance designed to minimize the effects of bruxism or other occlusal factors.	Benefits for occlusal guard are denied unless covered by group/individual contract.

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		Not to be reported for any type of sleep apnea, snoring or TMD appliances	
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.	Benefits for occlusal guard are denied unless covered by group/individual contract.
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.	Benefits for occlusal guard are denied unless covered by group/individual contract.
D9947	Custom sleep apnea appliance fabrication and placement	None	Benefits are denied unless covered by group/individual contract.
	Note: subject to coverage under medical plan.		
D9948	Adjustment of custom sleep apnea appliance	None	a. Benefits denied unless covered by group/individual contract. b. If covered, the fees for adjustments custom sleep apnea appliance, if performed within six months of initial placement by the same dentist/dental office are not billable to the patient. b. Benefits for an adjustment if performed within six months of initial placement by a different dentist/dental office are denied.
D9949	Repair of a custom sleep apnea appliance	None	a. Benefits denied unless covered by group/individual contract.

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
			b. Fees for repair of custom sleep apnea appliance, if performed within six months of initial placement by the same dentist/dental office are not billable to the patient. c. Benefits for an adjustment if performed within six months of initial placement by a different dentist/dental office are denied.
D9950	Occlusion analysis - mounted case	Includes, but is not limited to, facebow, interocclusal records tracings, and diagnostic wax-up; for diagnostic casts, see D0470.	Benefits for occlusion analysis are denied.
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 routine post-delivery care for a direct/indirect restoration or fixed/removable prosthodontics.	Benefits for occlusal adjustment-limited are denied unless covered by group/individual contract.
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 casts 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,	Benefits for occlusal adjustment - complete are denied unless covered by group/individual contract.

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		orthognathic surgery, or jaw trauma when indicated. Occlusal adjustment enhances the healing potential of tissues affected by the lesions of occlusal trauma.	
D9953	Reline custom sleep apnea appliance (indirect)	Resurface dentition side of appliance with new soft or hard base material as required to restore original form and function.	a. Benefits are denied unless covered by group/individual contract. b. Fees for reline of custom sleep apnea appliance, if performed within six months of initial placement by the same dentist/dental office are not billable to the patient. c. Benefits for reline, if performed within six months of initial placement by a different dentist/dental office are denied
D9954	Fabrication and delivery of oral appliance therapy (OAT) morning repositioning device	Device for use immediately after removing a mandibular advancement device to aid in relieving muscle/jaw pain and occlusal changes.	Benefits are denied unless covered by group/individual contract.
D9955	Oral appliance therapy (OAT) titration visit	Post-delivery visit for titration of a mandibular advancement device and to subsequently evaluate the patient's response to treatment, integrity of the device, and management of side effects.	Benefits are denied unless covered by group/individual contract.
D9956	Administration of a home sleep apnea test	Sleep apnea test, for patients who are at risk for sleep related breathing disorders and appropriate candidates, as allowed by applicable laws. Also, to help the dentist in defining the optimal position of the mandible.	Benefits are denied unless covered by group/individual contract.
	Note: this is not the original diagnosis		
D9957	Screening for sleep related breathing disorders	Screening activities, performed alone or in conjunction with another evaluation, to identify signs and	Benefits are denied unless covered by group/individual contract.

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		symptoms of sleep-related breathing disorders.	When covered: a. Benefits are limited to twice per benefit year. b. Benefits for more than twice per benefit year are denied.
D9961	Duplicate/copy patient's records	None	Benefits for patient record duplication are denied.
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.	Benefits for enamel microabrasion are denied.
D9971	Odontoplasty per tooth	Removal/reshaping of enamel surfaces or projections	Benefits for D9971 when performed with restorations for altering occlusion, involving vertical dimension, replacing tooth structure lost by attrition, erosion, abrasion (wear) or for periodontal, orthodontic or other splinting are denied.
D9972	External bleaching per arch-performed in office	None	Benefits for bleaching of teeth are denied, unless covered by group/individual contract.
D9973	External bleaching - per tooth	None	a. Benefits for bleaching of teeth are denied, unless covered by group/individual contract. b. If covered, Benefit once per 12 months per tooth. Benefits are denied within 12 months of D9972.
D9974	Internal bleaching - per tooth	None	Benefits for bleaching of teeth are denied, unless covered by group/individual contract.
D9975	External bleaching for home applications, per arch; includes materials and fabrication of custom trays	None	Benefits for bleaching of teeth are denied unless covered by group/individual contract.
D9985	Sales Tax	None	Sales/service charges are not a benefit of dental plans and are denied.

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
D9986	Missed appointment	None	A missed appointment is not a procedure therefore the benefit is denied.
D9987	Cancelled appointment	None	A cancelled appointment is not a procedure therefore the benefit is denied.
D9990	certified translation or sign language services- per visit	None	The fees for translation services are considered inclusive in overall patient management and are not billable to the patient unless covered by group/individual contract.
D9991	Dental case management – addressing appointment compliance barriers	Individualized efforts to assist a patient to maintain scheduled appointments by solving transportation challenges or other barriers.	Fees for action taken to schedule and assure compliance with patient appointments are inclusive with office operations and are not billable to the patient.
D9992	Dental case management – care coordination	Assisting in a patient's decisions regarding the coordination of oral health care services across multiple providers, provider types, specialty areas of treatment, health care settings, health care organizations and payment systems. This is the additional time and resources expended to provide experience or expertise beyond that possessed by the patient.	The fees for care coordination are considered inclusive in overall patient management and are not billable to the patient.
D9993	Dental case management – motivational interviewing	Patient-centered, personalized counseling using methods such as Motivational Interviewing (MI) to identify and modify behaviors interfering with positive oral health outcomes. This is a separate service from traditional nutritional or tobacco counseling.	a. Benefits for personalized counseling are denied. b. Fees for motivational interviewing are not billable to the patient when submitted on same date of service as D1310, D1320, D1330.
D9994	Dental case management-patient education to improve oral health literacy	Individual, customized communication of information to assist the patient in making appropriate health decisions	a. Benefits for patient education are denied. b. Fees for patient education to improve oral health literacy are not billable to the patient

CDT Code	ADA CDT Nomenclature	ADA CDT Descriptor	Delta Dental Policy
		designed to improve oral health literacy, explained in a manner acknowledging economic circumstances and different cultural beliefs, values, attitudes, traditions and language preferences, and adopting information and services to these differences, which require the expenditure of time and resources beyond that of an oral evaluation or case presentation.	when submitted on same date of service as D1310, D1320, D1330.
D9995	Teledentistry – synchronous; real-time encounter	Reported in addition to other procedures (e.g., diagnostic) delivered to the patient on the date of service.	The fees for teledentistry - synchronous are considered inclusive in overall patient management and are not billable to the patient.
D9996	Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	Reported in addition to other procedures (e.g., diagnostic) delivered to the patient on the date of service	The fees for teledentistry - asynchronous are considered inclusive in overall patient management and are not billable to the patient.
D9997	Dental case management – patients with special health care needs	Special treatment considerations for patients/individuals with physical, medical, developmental or cognitive conditions resulting in substantial functional limitations or incapacitation, which require that modifications be made to delivery of treatment to provide customized or comprehensive oral health care services.	The fees for patients with special health care needs are considered administrative and used to identify services provided to a particular type of patient and are not billable to the patient.
D9999	Unspecified adjunctive procedure, by report	Used for procedure that is not adequately described by a code. Describe procedure	None

Attachment 1

DELTA DENTAL

Attachment Requirements

Delta Dental of Kansas continues to try to limit the amount of requests for attachments to make your experience as smooth as possible. To assist you in your claim submission, please see the list of general guidelines below for procedure codes that require attachments or other documentation, such as tooth numbers, quadrants, narratives or pre-determinations. Delta Dental reserves the right to request any documentation necessary to properly adjudicate claims.

KEY
Periapical (PA)
Bitewings (BW)
Periodontal Charting (PC)
Chart Notes (CN)
Full Mouth X-Ray (FMX)
Panoramic (PANO)
Predetermination (PD)
Missing Tooth Chart (MTC)

/ = or
+ = and

Multi-stage procedures are reported and benefitted upon completion. The completion date is the date of insertion (delivery to the patient including initial adjustments) for **removable prosthetic devices such as full and partial dentures, TMJ splints, and bruxism guards**.

The completion date for **crowns, bridges (fixed partial dentures), onlays and inlays** is the permanent cementation date.

The completion date for **endodontic treatment** is the date the canals are permanently filled.

Submit claims for **orthodontic treatment** using the date that brackets are cemented or the first aligners are delivered.

***Predeterminations (PD)** are recommended to help reduce confusion and promote goodwill between your office, your patient and Delta Dental.

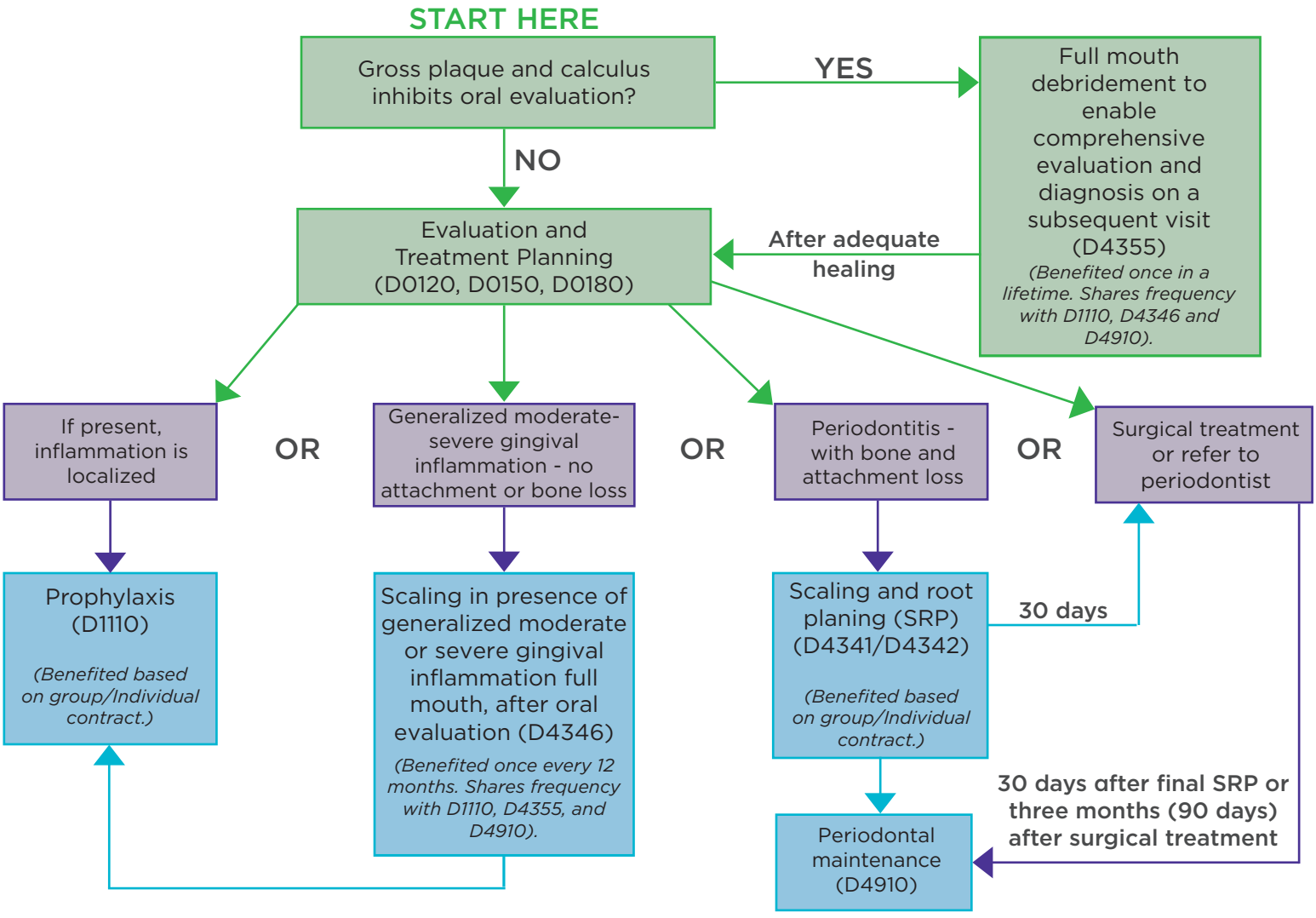
Restorative Dentistry*		
D2543 - D2544	Metallic onlays	PA/BW
D2643 - D2644	Porcelain/ceramic onlays	PA/BW
D2710 - D2794	Crowns	PA/BW
D2950	Core buildup	PA/BW
D2960 - D2962	Veneers	PA
Endodontics*		
D3346 - D3348	Root canal retreatment	PA
D3410 - D3426	Apicoectomy/periradicular surgery	PA
D3921	Decoronation or submergence of an erupted tooth	CN
Periodontics* (include quadrant and/or tooth #)		
D4210 - D4211	Gingivectomy/Gingivoplasty	PC
D4240 - D4241	Gingival flap procedure	PC
D4249	Crown lengthening	PA + CN
D4260 - D4261	Osseous surgery	PA + PC
D4263 - D4264	Bone replacement graft	PA + PC
D4273 - D4285	Tissue grafts	PC
D4341 - D4342	Scaling & root planing	FMX + PC
Implants* (full arch x-rays required)		
D6010, D6013, D6040, D6050	Surgical placement of implant body	PANO/FMX + MTC
D6052 - D6057	Abutments	PANO/FMX + MTC
D6058 - D6094	Implant crowns	PANO/FMX + MTC
Prosthodontics* (full arch x-rays required)		
D6205 - D6252	Pontics	PANO/FMX + MTC
D6545 - D6792	Fixed partial denture (bridge) retainers	PANO/FMX + MTC
Oral Surgery*		
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated	PA/PANO/FMX
D7220 - D7241	Removal of impacted tooth	PA/PANO/FMX
D7250	Removal of residual tooth roots	PA/PANO/FMX
D7961	Buccal/labial frenectomy	CN
D7962	Lingual frenectomy (frenulectomy)	CN
TMJ & Bruxism*		
D7880	Occlusal orthotic device (TMJ/TMD)	CN
D9944	Occlusal guard - hard appliance, full arch	CN
D9945	Occlusal guard - soft appliance, full arch	CN
D9946	Occlusal guard - hard appliance, partial arch	CN

Decision Tree

PROPHYLAXIS VS. THERAPEUTIC TREATMENT

Patient records include:

- Comprehensive oral or periodontal evaluation
- Periodontal chart indicating pocket depths, clinical attachment loss and areas of bleeding on probing
- Diagnostic images to document the gingival conditions
  - To visualize localized vs. generalized inflammation
  - Type and frequency determined by the dentist



.Periodontal Procedures are normally covered at 40-80% with the patient responsible for the co-payment and subject to deductible.

Periodontal maintenance (D4910) and scaling in presence of generalized moderate or severe gingival inflammation (D4346) are generally covered at the periodontal co-pay, and shares frequency with D1110, D4355 D4346 and D4910. The patient is financially responsible up to the Maximum Plan Allowance for additional cleanings beyond the group's contractual frequency limitations.

It is recommended to schedule any periodontal therapy procedures 14 days after initial prophylaxis.

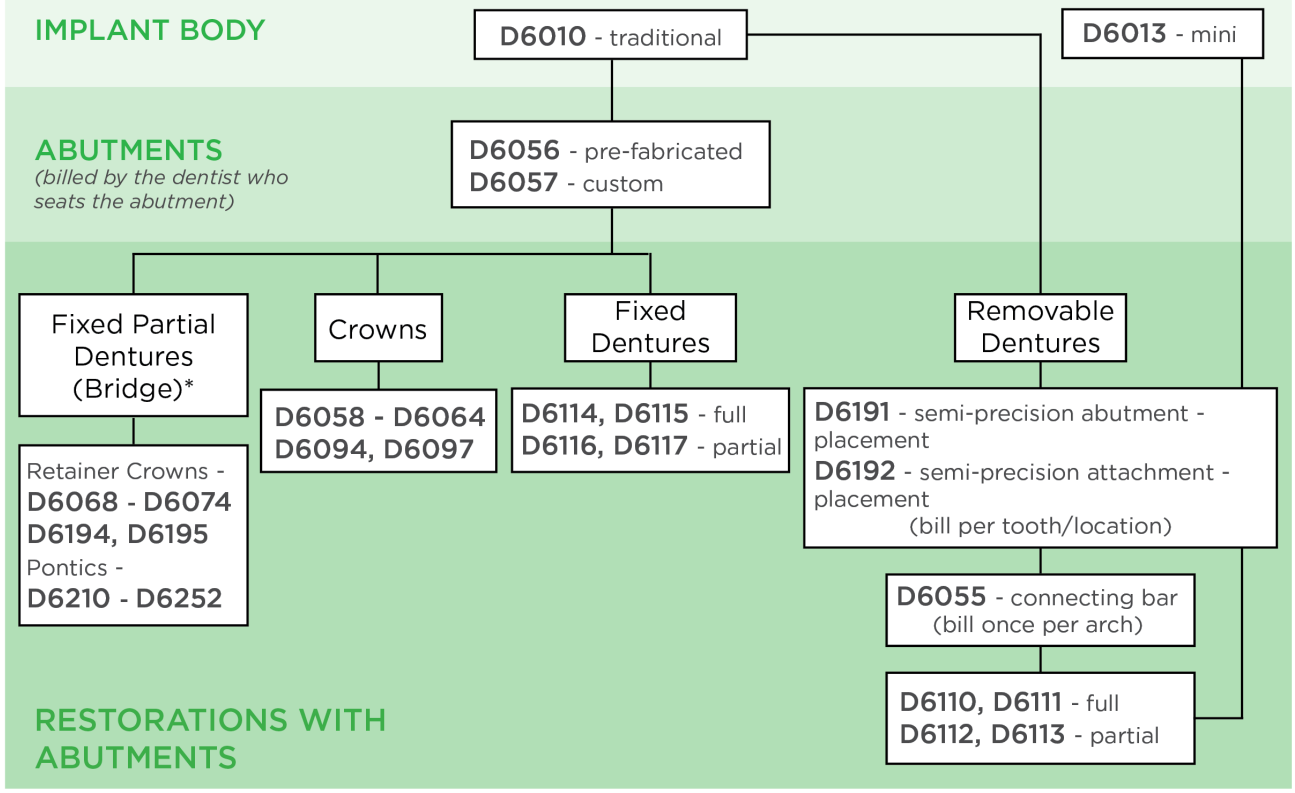
Please note: The employer contract dictates the frequencies, limitations and co-payments. Our guidelines are standards of payment and not to be interpreted as standards of care.

Attachment 3

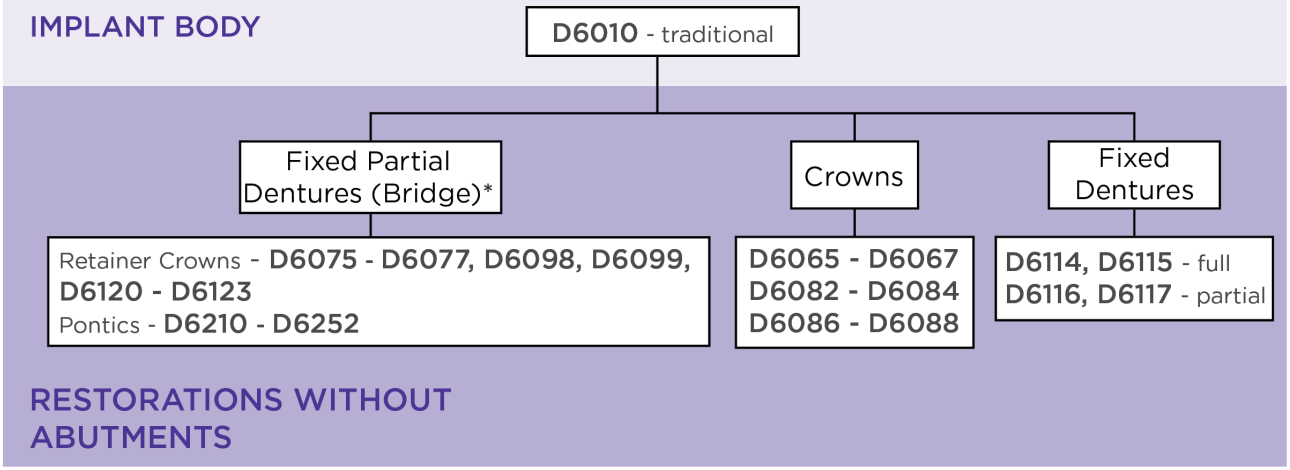
DELTA DENTAL

Implant Flowchart

Abutment Supported Prosthetics



Implant Supported Prosthetics (Non-Abutment Supported)



*Include corresponding pontic code(s).