

2021

CDT GUIDE

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MASSACHUSETTS

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*Blue Cross Blue Shield of Massachusetts refers to Blue Cross and Blue Shield of Massachusetts, Inc., Blue Cross and Blue Shield of Massachusetts HMO Blue®, Inc., and/or Massachusetts Benefit Administrators LLC, based on Product participation

About This Guide

We've designed these administrative guidelines and policies to promote our members' long-term oral health. They are based on scientific research, documented professional standards, and the input of the Interspecialty Dental Advisory Committee (IDAC), which includes representatives of the American Dental Association's (ADA's) recognized clinical specialties and general practitioners from across Massachusetts. IDAC gives input regarding clinical parameters of care and helps to define the community "standard of care" when the ADA or recognized national specialty organizations have not specified national parameters of care. We review our policies on an ongoing basis to determine clinical appropriateness and to reflect significant technical advances.

This guide is organized according to the latest and most current edition of the ADA Current Dental Terminology (CDT) procedure codes. For each code, we note specific guidelines and recommendations with respect to time, age, or other contractual limitations or exclusions. We have also noted:

- When procedures are not covered benefits
- Codes that require radiographic (X-ray) imaging documentation and other supplementary documentation. **Note: Send x-rays and other diagnostic attachments *only* upon request. We will not return any attachments that are not requested or required.**
- Submission requirements for Affordable Care Act-qualifying pediatric dental services. These are available for ACA-qualifying members (small group dental plans with 1-50 eligible employees). These are indicated in red in this document if they differ from the submission requirements for other plans.

We accept only coding that is consistent with the verbal descriptors of CDT. However, the presence of a code in CDT does not mean that a subscriber has coverage available. We determine member benefits on the basis of our administrative policies and the terms of the subscriber's certificate. Also, some employers may customize benefits, so it's always important to check benefits and eligibility before performing services.

Some of the categories of service have introductory sections to explain what information you need to provide to facilitate our claim processing. For a more complete description of procedures, please refer to the *American Dental Association, Current Dental Terminology – 2020*. The 2021 Pediatric Essential Health Benefits CDT Guidelines are also included to comply with the requirements of the Affordable Care Act. These Guidelines are described separately. Please refer to the *Pediatric Essential Health Benefit CDT Guidelines and Submission Requirements* on our Provider Central website.

Please use this guide to determine the most accurate code to describe the service you provided to your patient. For additional information about billing, please refer to the Dental *Blue Book* Administrative Manual or call Dental Provider Service at **1-800-882-1178**.

Utilization Management

This section includes information on our utilization management activities including pre-treatment estimates, treatment review, and claim submission. Our dental utilization management team reviews certain types of procedures for quality of care, necessity, and appropriateness of treatment based on the documentation submitted. The team includes dentists, dental hygienists, and dental assistants.

While we continue to conduct utilization review on submitted claims, we don't routinely require submission of radiographs or periodontal charting from participating Dental Blue and Dental Blue PPO providers. Please refer to the *Submission Requirements for Participating Providers* column for any specific requirements needed when submitting claims for treatment.

What is “necessary and appropriate treatment?”

Our members' subscriber certificates specify that all dental care must be “necessary and appropriate to diagnose or treat your dental condition” and defines dental care as inclusive of services, procedures, supplies and appliances.” The member's subscriber certificates identify the following criteria used to determine whether dental care is necessary and appropriate for the member. The dental care must be:

- Consistent with the prevention and treatment of oral disease or with the diagnosis and treatment of teeth that are decayed or fractured, or where the supporting structure is weakened by disease (including periodontal, endodontic, and related diseases).
- Furnished in accordance with standards of good dental practice.
- Not solely for the member's or dentist's convenience.

How do we determine necessity and appropriateness of treatment?

Based on a review of the submitted procedure documentation, our dental consultants determine available benefits for certain types of procedures, including, but not limited to, cast and milled restorations, periodontal services, oral surgery services, and fixed and removable prosthetics. A dental consultant reviews the treatment plan objectively and determines whether the services are within the scope of benefits, and whether these services appear to be necessary and appropriate for the member. Based on these findings, we may determine that a service is not *necessary and appropriate* for the member, even if a dentist has recommended, approved, prescribed, ordered, or furnished the service.

Utilization Management

Services that are non-covered due to contractual limitations

There are situations in which specific services are not covered regardless of whether the procedure is a covered benefit. These are considered contractual limitations and are outlined in the Subscriber Certificate under “Limitations and Exclusions.” Examples include a service performed for cosmetic purposes rather than for tooth decay or fracture or a service that is exploratory in nature.

Information we need to review a procedure

We review procedures including, but not limited to, cast and milled restorations, periodontal services, oral surgery services, and fixed and removable prosthetics. To thoroughly review a procedure, we may need pertinent documentation supporting your patient’s treatment. This *Guide* identifies the information you must submit for each procedure that requires review. **Where we request a detailed narrative, please supply details about the patient’s condition that will help us evaluate your claim and reimburse you appropriately.**

Individual consideration process

In general, we do not pay for any procedure that is not fully described by a CDT code. However, in some circumstances we will approve the unlisted procedure code or a procedure that does not otherwise meet guidelines for submission under our individual consideration process. To find out if we will apply individual consideration to cover the procedure for your patient, please:

- Submit a pre-treatment estimate request to determine if we will apply individual consideration to cover the non-covered procedure.
- Use a detailed narrative and CDT code D0999, D1999, D2999, D3999, D4999, D5899, D5999, D6199, D6999, D7999, D8999, or D9999 depending on the type of individual consideration being requested for review.

We’ll review the claim and notify you of the outcome through a provider payment advisory (PPA) and provider detail advisory (PDA).

Utilization Management

When documentation is requested

While we continue to conduct utilization review on submitted claims, we don't routinely require submission of radiographs or periodontal charting from participating Dental Blue and Dental Blue PPO providers. Please refer to the *Submission Requirements for Participating Providers* column for any specific requirements needed when submitting claims for treatment.

When we do request documentation, please remember that radiographs must be:

- Preoperative periapical images that are current and dated
- Images labeled "left" or "right" side if they are duplicates
- Mounted if they are a full series
- Diagnostic quality

Please remember to include:

- The member's name and ID
- The dentist's name and address

Refer to the specific code listing to determine what additional documentation is required.

***Massachusetts-contracted participating dentists should ONLY submit radiographs or other diagnostic attachments when requested. We will not return any radiographs or attachments that aren't required or requested**

Diagnostic Services

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|--|--|--|----------------------------------|------------------------|
| | | | BCBSMA-Participating | Out-of-state & Non-par |
| CLINICAL ORAL EVALUATIONS – One evaluation code may be billed per dentist per date of service. Evaluations including diagnosis and treatment planning is the responsibility of the dentist. All evaluations must be completed by a dentist. | | | | |
| D0120 | Periodic oral evaluation – established patient | Two per calendar year. Bill for a periodic oral evaluation only when it is the dentist’s general policy to charge all patients of record for this procedure. Two per calendar year. Not covered with D9110 by dentist/office on same date of service.* | None | None |
| D0140 | Limited oral evaluation – problem-focused | Two in twelve months. Two per calendar year. Not covered with D9110, D0160 by the same dentist/dental office on the same date of service.* | None | None |
| D0145 | Oral evaluation for a patient under three years of age and counseling with primary caregiver | One per member per dentist. Maximum 3 per member, up to age 3. Two per calendar year. Not covered with D9110 by the same dentist/dental office on the same date of service.* | None | None |
| D0150 | Comprehensive oral evaluation - new or established patient | Once in 60 months per dentist or location. | None | None |
| D0160 | Detailed, extensive oral evaluation – problem-focused, by report | Not a covered benefit. Two per 12 months. Not covered with D9110 by same dentist/dental office on same date of service.* | None | None |
| D0170 | Re-evaluation – limited, problem focused (established patient; not post-operative visit) | Two in twelve months. Not to be used as a periodontal reevaluation. | None | None |
| D0171 | Re-evaluation post operative office visit. | Considered to be inclusive of the definitive procedure performed previously. | None | None |
| D0180 | Comprehensive periodontal evaluation – new or established patient | Once per 60 months per dentist or location. Two per member per year when performed by different providers.* | None | None |
| D0190 | Screening of a patient | Not a covered benefit. | None | None |
| D0191 | Assessment of a patient | Not a covered benefit. | None | None |
| DIAGNOSTIC IMAGING - Image capture with interpretation | | | | |
| D0210 | Intraoral - complete series of radiographic images | A full mouth series or a panorex (D0330) is covered once every 60 months and consists of a minimum of 7 or more radiographs, including bitewings. Up to age 19: a full mouth series (including bitewings) or panorex once per three calendar year(s).* | None | None |

* Applies to specific ACA-compliant small group plans only.

Diagnostic Services

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|--------------------------------------|--|--|----------------------------------|------------------------|
| | | | BCBSMA-Participating | Out-of-state & Non-par |
| DIAGNOSTIC IMAGING, continued | | | | |
| D0220 | Intraoral - periapical first radiographic image | A maximum of 6 radiographs per date of service. If reported with endodontic therapy, radiographs are included in the fee for the procedure. <i>One per day per patient per provider or location with a maximum of six radiographs per date of service. Any combination of radiographs that exceed six will be processed as D0210.*</i> | None | None |
| D0230 | Intraoral - periapical each additional radiographic image | A maximum of 6 radiographs per date of service. If reported with endodontic therapy, radiographs are included in the fee for the procedure. <i>Up to age 19: three per day per patient, with a maximum of 12 (D0220 or D0230 combination) per 12 months.*</i> | None | None |
| D0240 | Intraoral - occlusal radiographic image | One film per 6 months per arch. | Arch identification | Arch identification |
| D0250 | Extra-oral – 2D projection radiographic image created using a stationary radiations source and detector. | Not a covered benefit. | None | None |
| D0251 | Extra-oral posterior dental radiographic image | Not a covered benefit. | None | None |
| D0270 | Bitewing - single radiographic image | Two per calendar year. Bitewing radiographs reported within 6 months of D0210 are considered included in this procedure and are non-covered. If reported within 6 months of D0330, we will make an allowance for the difference between the payment of the panoramic and a full series of radiographs. <i>Up to age 19: Two per calendar year per patient. Ages 19+: One per 6 months per patient. May be a combination of any 2 codes D0270, D0272, D0273, D0274.*</i> | None | None |
| D0272 | Bitewings - two radiographic images | | | |
| D0273 | Bitewings - three radiographic images | | | |
| D0274 | Bitewings - four radiographic images | | | |
| D0277 | Vertical bitewings 7-8 radiographical images | One set per 12 month for members age 16 and over. Not covered if reported within six months of other bitewing series. <i>Members age 16: One set per 12 months.*</i> | None | None |
| D0310 | Sialography | Not a covered benefit under BCBSMA dental plans. Please check with patient's medical insurer for possible coverage. | None | None |
| D0320 | Temporomandibular joint arthrogram, including injection | | | |
| D0321 | Other temporomandibular joint radiographic images, by report | | | |

* Applies to specific ACA-compliant small group plans only.

Diagnostic Services

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|---|---|--|----------------------------------|--------------------------|
| | | | BCBSMA-participating | Out-of-state and Non-par |
| IMAGE CAPTURE WITH INTERPRETATION, continued | | | | |
| D0322 | Tomographic survey | Not a covered benefit. | None | None |
| D0330 | Panoramic radiographic image | Panoramic radiograph or full mouth series (D0210) is limited to one per 60 months. Submit bitewing radiographs done in conjunction with a panoramic on a separate line; we will pay for the difference between the panorex and a full mouth series of radiographs. <i>Up to age 19: One per three calendar year(s) per member.*</i> | None | None |
| D0340 | Cephalometric radiographic image | Covered only for members with orthodontic benefits. Limited to twice per lifetime. <i>Up to age 19: Covered for members without orthodontic benefits.*</i> | None | None |
| D0350 | 2D oral/facial photographic images obtained intra-orally or extra orally | Covered only when BCBSMA requests these images to support the claim for another service. | None | None |
| D0351 | 3D photographic image. For dental or maxillofacial diagnostic purposes. Not applicable for a CAD-CAM procedure. | Not a covered benefit. | None | None |
| D0364 | Cone beam CT capture and interpretation with limited field of view-less than one whole jaw | | | |
| D0365 | Cone beam CT capture and interpretation with limited field of one full dental arch-mandible | | | |
| D0366 | Cone beam CT capture and interpretation with field of view of one full dental arch-maxilla, with or without cranium | | | |
| D0367 | Cone beam CT capture and interpretation with field of view of both jaws; with or without cranium | | | |
| D0368 | Cone beam CT capture and interpretation for TMJ series including two or more exposures | | | |
| D0369 | Maxillofacial MRI capture and interpretation | | | |

* Applies to specific ACA-compliant small group plans only.

Diagnostic Services

| CDT Code | Description of Services | Procedure Guidelines | Provider Submission Requirements | |
|---|--|------------------------|----------------------------------|--------------------------|
| | | | BCBSMA-participating | Out-of-state and non-par |
| IMAGE CAPTURE WITH INTERPRETATION, continued | | | | |
| D0370 | Maxillofacial ultrasound capture and interpretation | Not a covered benefit. | None | None |
| D0371 | Sialoendoscopy capture and interpretation | | | |
| IMAGE CAPTURE ONLY - Capture by a practitioner not associated with interpretation and report | | | | |
| D0380 | Cone beam CT image capture with limited field of view – less than one whole jaw | Not a covered benefit. | None | None |
| D0381 | Cone beam CT image capture with field of view of one full dental arch-mandible | | | |
| D0382 | Cone beam CT image capture with field of view of one full dental arch-maxilla, with or without cranium | | | |
| D0383 | Cone beam CT image capture with field of view of both jaws, with or without cranium | | | |
| D0384 | Cone beam CT image capture for TMJ series including two or more exposures | | | |
| D0385 | Maxillofacial MRI image capture | | | |
| D0386 | Maxillofacial ultrasound image capture | | | |
| D0701 | Panoramic radiographic image – image capture only | | | |
| D0702 | 2-D cephalometric radiographic image – image capture only | | | |
| D0703 | 2-D oral/facial photographic image obtained intra-orally or extra-orally– image capture only | | | |
| D0704 | 3-D photographic image – image capture only | | | |

* Applies to specific ACA-compliant small group plans only

Diagnostic Services

| CDT Code | Description of Services | Procedure Guidelines | Provider Submission Requirements | |
|---|---|------------------------|----------------------------------|--------------------------|
| | | | BCBSMA-participating | Out-of-state and non-par |
| IMAGE CAPTURE ONLY - Capture by a practitioner not associated with interpretation and report, continued | | | | |
| 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 not derived from another image. | Not a covered benefit. | None | None |
| D0706 | Intraoral – occlusal radiographic image – image capture only | | | |
| D0707 | Intraoral – periapical radiographic image – image capture only | | | |
| D0708 | Intraoral – bitewing radiographic image – image capture only. Image axis may be horizontal or vertical | | | |
| D0709 | Intraoral – complete series of radiographic images – image capture only. A radiographic survey of the whole mouth, usually consisting of 14-22 images (periapical and posterior bitewing as indicated) intended to display the crowns and roots of all teeth, periapical areas and alveolar bone. | | | |
| INTERPRETATION AND REPORT ONLY – Interpretation and report by a practitioner not associated with image capture | | | | |
| D0391 | Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report | Not a covered benefit. | None | None |
| POST PROCESSING OF IMAGE OR IMAGE SETS | | | | |
| D0393 | Treatment simulation using 3D image volume. The use of 3D image volumes for simulation of treatment including but not limited to, dental implant placement, orthognathic surgery and orthodontic tooth movement. | Not a covered benefit | None | None |

Diagnostic Services

| CDT Code | Description of Services | Procedure Guidelines | Provider Submission Requirements | |
|--|--|---|----------------------------------|------------------------|
| | | | BCBSMA Participating | Out-of-state & Non-par |
| POST PROCESSING OF IMAGE OR IMAGE SETS, continued | | | | |
| D0394 | Digital subtraction of two or more images or image volumes of the same modality. To demonstrate changes that have occurred over time. | Not a covered benefit. | None | None |
| D0395 | Fusion of two or more 3D image volumes of one or more modalities. | | | |
| TESTS AND EXAMINATIONS | | | | |
| D0411 | HbA1c in-office point of service testing | Not a covered benefit. | None | None |
| D0412 | Blood glucose level test — in-office using a glucose meter | | | |
| D0415 | Collection of microorganisms for culture and sensitivity | | | |
| D0414 | Laboratory processing of microbial specimen to include culture and sensitivity studies, preparation and transmission of written report | | | |
| D0416 | Viral culture. A diagnostic test to identify viral organisms, most often herpes virus | Not a covered benefit under BCBSMA dental plans. Please check with patient's medical insurance for possible coverage. | None | None |
| D0417 | Collection and preparation of saliva sample for laboratory diagnostic testing | | | |
| D0418 | Analysis of saliva sample. Chemical or biological analysis of saliva sample for diagnostic purposes | Not a covered benefit under BCBSMA dental plans. Please check with patient's medical insurance for possible coverage. | None | None |
| D0419 | Assessment of salivary flow by measurement | Not a covered benefit. | None | None |
| D0422 | Collection and preparation of genetic sample material for laboratory analysis and report | | | |
| D0423 | Genetic test for susceptibility to diseases – specimen analysis | | | |
| D0425 | Caries susceptibility tests. Not to be used for carious dentin staining. | | | |

Diagnostic Services

| CDT Code | Description of Services | Procedure Guidelines | Provider Submission Requirements | |
|---|---|---|----------------------------------|------------------------|
| | | | BCBSMA Participating | Out-of-state & Non-par |
| TESTS AND EXAMINATIONS, continued | | | | |
| D0431 | Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures | Not a routinely covered benefit under BCBSMA dental plans. Please check with patient's medical insurance for possible coverage. | None | None |
| D0460 | Pulp vitality tests | Considered to be included in other evaluation services performed on the same day. | None | None |
| D0470 | Diagnostic casts | One complete set per 60 months. | None | None |
| ORAL PATHOLOGY LABORATORY – These procedures do not include collection of the tissue sample, which is documented separately. | | | | |
| D0472 | Accession of tissue, gross examination, preparation and transmission of written report | Not a covered benefit under BCBSMA dental plans. Please check with patient's medical insurer for possible coverage. | None | None |
| D0473 | Accession of tissue, gross and microscopic examination, preparation and transmission of written report | | | |
| D0474 | Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report | | | |
| D0475 | Decalcification procedure | | | |
| D0476 | Special stains for microorganisms | | | |
| D0477 | Special stains, not for microorganisms | | | |
| D0478 | Immunohistochemical stains | | | |
| D0479 | Tissue in-site hybridization, including interpretation | | | |
| D0480 | Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report | | | |
| D0481 | Electron microscopy | | | |
| D0482 | Direct immunofluorescence | | | |

Diagnostic Services

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|---|---|---|----------------------------------|------------------------|
| | | | BCBSMA-Participating | Out-of-state & Non-par |
| ORAL PATHOLOGY LABORATORY, continued | | | | |
| D0483 | Indirect immunofluorescence | Not a covered benefit under BCBSMA dental plans. Please check with patient's medical insurer for possible coverage. | None | None |
| D0484 | Consultation on slides prepared elsewhere | | | |
| D0485 | Consultation, including preparation of slides from biopsy material supplied by referring source | | | |
| D0486 | Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report | | | |
| D0502 | Other oral pathology procedures, by report | | | |
| D0600 | Non ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin and cementum. | Not a covered benefit. | None | None |
| D0601 | Caries risk assessment and documentation, with a finding of low risk | | | |
| D0602 | Caries risk assessment and documentation, with a finding of moderate risk | | | |
| D0603 | Caries risk assessment and documentation, with a finding of high risk | | | |
| D0604 | Antigen testing for a public health related pathogen including coronavirus | Not a covered benefit under BCBSMA dental plans. Please check with patient's medical insurer for possible coverage. | None | None |
| D0605 | Antibody testing for a public health related pathogen including coronavirus | | | |
| D0999 | Unspecified diagnostic procedure, by report | Individual consideration. | Detailed narrative | Detailed narrative |

Preventive Services

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|--|---|--|----------------------------------|------------------------|
| | | | BCBSMA-Participating | Out-of-state & Non-par |
| DENTAL PROPHYLAXIS | | | | |
| D1110 | Prophylaxis - adult | Two per calendar year (any combination of these codes and periodontal maintenance with at least 3 months between visits). <i>Two per calendar year.*</i> | None | None |
| D1120 | Prophylaxis - child | | | |
| TOPICAL FLUORIDE TREATMENT OFFICE PROCEDURE | | | | |
| D1206 | Topical application of fluoride varnish | Two per calendar year through age 18 (up to the 19 th birthday). Benefit will be in place of D1208. <i>Up to age 19: Once per 90 days. Benefit will be in place of D1208.*</i> | None | None |
| D1208 | Topical application of fluoride-excluding varnish | Two per calendar year through age 18 (up to the 19 th birthday). Benefit will be in place of D1206. <i>Up to age 19: Once per 90 days. Benefit will be in place of D1206.*</i> | None | None |
| OTHER PREVENTIVE SERVICES | | | | |
| D1310 | Nutritional counseling for control of dental disease | Not a covered benefit. | None | None |
| D1320 | Tobacco counseling for control and prevention of oral disease | | | |
| 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. | | | |
| D1330 | Oral hygiene instructions | | | |

* Applies to specific ACA-compliant small group plans only.

Preventive Services

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|--|--|--|--|--|
| | | | BCBSMA-participating | Out-of-state & Non-par |
| OTHER PREVENTIVE SERVICES, continued | | | | |
| D1351 | Sealant – per tooth | <p>One per tooth per 48 months, regardless of the number of surfaces, on premolars and permanent first and second molars. Covered through age 13 (up to the 14th birthday.) No coverage for sealants on a restored surface of a tooth. Preventive resin restorations are considered sealants for benefit purposes.</p> <p><i>Under age 9: Covered for primary molars. Reapplication only if process fails within three years.</i></p> <p><i>Under age 19: Covered for permanent non-carious molars for members once every three years per tooth.</i></p> <p><i>Ages 19+: Not covered.*</i></p> | <ul style="list-style-type: none"> • Tooth identification • Surface identification | <ul style="list-style-type: none"> • Tooth identification • Surface identification |
| D1352 | Preventive resin restoration in a moderate to high caries risk patient-permanent tooth | <p>One per tooth per 48 months, regardless of the number of surfaces, on premolars and permanent first and second molars. Covered through age 13 (up to 14th birthday). No coverage for sealants on a restored surface of a tooth. Preventive resin restorations are considered sealants for benefit purposes.</p> <p><i>Up to 14th birthday: Once per tooth per 48 months, on premolars and permanent first and second molars.*</i></p> | <ul style="list-style-type: none"> • Tooth identification • Surface identification | <ul style="list-style-type: none"> • Tooth identification • Surface identification • Narrative indicating risk criteria |
| D1353 | Sealant repair – per tooth | Not a covered benefit. | None | None |
| D1354 | Interim caries arresting medicament application per tooth | <p>Covered once per tooth per lifetime.</p> <p><i>Not a covered benefit.*</i></p> | Tooth identification | Tooth identification |
| D1355 | Caries preventive medicament application – per tooth For primary prevention or remineralization. Medicaments applied do not include topical fluorides. | Not a covered benefit. | | |
| SPACE MAINTENANCE (PASSIVE APPLIANCES) – Passive appliances are designed to prevent tooth movement. | | | | |
| D1510 | Space maintainer – fixed, unilateral – per quadrant | <p>One per arch or quadrant per lifetime for members through age 18 (up to the 19th birthday).</p> <p><i>Up to age 19: Once per arch or quadrant per lifetime</i></p> <p><i>Ages 19+: not covered.*</i></p> | <ul style="list-style-type: none"> • Quadrant identification (D1510 & D1520) • Arch identification (D1516 & D1526) | <ul style="list-style-type: none"> • Quadrant identification (D1510 & D1520) • Arch identification (D1516 & D1526) |
| D1516 | Space maintainer – fixed – bilateral, maxillary | | | |
| D1517 | Space maintainer – fixed – bilateral, mandibular | | | |
| D1520 | Space maintainer – removable, unilateral – per quadrant | | | |

Preventive Services

| CDT Code | Description of Services | Procedure Guidelines | Provider Submission Requirements | |
|--|--|---|--|--|
| | | | BCBSMA-participating | Out-of-state & non-par |
| SPACE MAINTENANCE (PASSIVE APPLIANCES), continued | | | | |
| D1526 | Space maintainer – removable – bilateral, maxillary | One per arch or quadrant per lifetime for members through age 18 (up to the 19th birthday). | <ul style="list-style-type: none"> • Quadrant identification (D1510 & D1520) | <ul style="list-style-type: none"> • Quadrant identification (D1510 & D1520) |
| D1527 | Space maintainer – removable – bilateral, mandibular | Up to age 19: Once per arch or quadrant per lifetime. Ages 19+: not covered.* | <ul style="list-style-type: none"> • Arch identification (D1516 & D1526) | <ul style="list-style-type: none"> • Arch identification (D1516 & D1526) |
| D1551 | Re-cement or rebond bilateral space maintainer, maxillary | One per arch or quadrant per 6 months. Up to age 19: One per arch or quadrant per 6 months Age 19+: Not covered.* | <ul style="list-style-type: none"> • Arch identification • Quadrant identification | <ul style="list-style-type: none"> • Arch identification • Quadrant identification |
| D1552 | Re-cement or re-bond bilateral space maintainer, mandibular | | | |
| D1553 | Re-cement or re-bond unilateral space maintainer, per quadrant | One per quadrant per 6 months. Up to age 19: One per quadrant per 6 months Age 19+: Not covered.* | Quadrant identification | Quadrant identification |
| D1556 | Removal of fixed unilateral space maintainer, per quadrant | Covered only when procedure performed by dentist who did not place original appliance. | Quadrant identification | Quadrant identification |
| D1557 | Removal of fixed bilateral space maintainer, maxillary | Covered only when procedure performed by dentist who did not place original appliance. | Arch identification | Arch identification |
| D1558 | Removal of fixed bilateral space maintainer, mandibular | | | |
| D1575 | Distal shoe space maintainer – fixed unilateral, per quadrant | One per quadrant per lifetime for members through age 18 (up to the 19th birthday). Up to age 19: Once per arch or quadrant per lifetime. Ages 19+: not covered.* | Quadrant identification | Quadrant identification |
| D1999 | Unspecified preventive procedure, by report | Individual consideration. | Detailed narrative | Detailed narrative |

* Applies to specific ACA-compliant small group plans only.

Restorative Services

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|---|---|---|--|--|
| | | | BCBSMA-Participating | Out-of-state & Non-par |
| <p>AMALGAM RESTORATIONS (INCLUDING POLISHING) – Amalgam restorations include tooth preparation, localized tissue removal, base, direct and indirect pulp cap, local anesthesia and all adhesives (including amalgam bonding agents, liners and bases). These are included as part of the restoration. If pins are used, they should be reported separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, or abrasion are not covered benefits.</p> | | | | |
| D2140 | Amalgam – one surface, primary or permanent | <p>One amalgam restoration per tooth surface per 12 months. We consider contiguous surface amalgam restorations as one multiple-surface restoration.</p> <p>One per tooth surface per 12 months.*</p> | <ul style="list-style-type: none"> • Tooth identification • Surface identification | <ul style="list-style-type: none"> • Tooth identification • Surface identification |
| D2150 | Amalgam – two surfaces, primary or permanent | | | |
| D2160 | Amalgam – three surfaces, primary or permanent | | | |
| D2161 | Amalgam – four or more surfaces, primary or permanent | | | |
| <p>RESIN-BASED COMPOSITE RESTORATIONS – Resin refers to a broad category of materials including, but not limited to, composites. May include bonded composite, light-cured composite, etc. Light curing, acid-etching, and adhesives (including resin bonding agents) are included as part of the restoration. Resin restorations include tooth preparation, localized tissue removal, base, direct and indirect pulp cap and local anesthesia. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used, please report them separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, or abrasion are not covered benefits.</p> | | | | |
| D2330 | Resin-based composite – one surface, anterior | <p>One resin restoration per tooth surface per 12 months. Contiguous surface resin restorations are considered one multiple surface restoration.</p> <p>One per tooth surface per 12 months.*</p> | <ul style="list-style-type: none"> • Tooth identification • Surface identification | <ul style="list-style-type: none"> • Tooth identification • Surface identification |
| D2331 | Resin-based composite – two surfaces, anterior | | | |
| D2332 | Resin-based composite – three surfaces, anterior | | | |
| D2335 | Resin-based composite – four or more surfaces or involving incisal angle (anterior) | | | |
| D2390 | Resin-based composite crown, anterior | <p>Once per 12 months – primary anterior teeth. Pays an alternate benefit of procedure code D2930. The remainder is the member’s responsibility.</p> <p>One per tooth surface per 12 months.*</p> | <ul style="list-style-type: none"> • Tooth identification | <ul style="list-style-type: none"> • Tooth identification |

* Applies to specific ACA-compliant small group plans only.

Restorative Services

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|--|--|---|--|--|
| | | | BCBSMA-Participating | Out-of-state & Non-par |
| RESIN-BASED COMPOSITE RESTORATIONS, continued | | | | |
| D2391 | Resin-based composite – one surface, posterior | <p>One resin restoration per tooth surface per 12 months. We consider contiguous surface resin restorations one multiple surface restoration. When a single surface is the only surface being restored by a resin material, the benefit may be paid in full according to the member’s contract, not as an alternate benefit. <i>Posterior composites may pay as an alternate benefit to the corresponding amalgam procedure code. The patient would be responsible for the remainder of the charge. If the employer group has purchased a rider for full benefits on posterior resins, you may not balance bill the patient.</i></p> <p>One per tooth surface per 12 months.*</p> | <ul style="list-style-type: none"> • Tooth identification • Surface identification | <ul style="list-style-type: none"> • Tooth identification • Surface identification |
| D2392 | Resin-based composite – two surfaces, posterior | | | |
| D2393 | Resin-based composite – three surfaces, posterior | | | |
| D2394 | Resin-based composite – four or more surfaces, posterior | | | |
| GOLD FOIL RESTORATIONS | | | | |
| D2410 | Gold foil – one surface | <p>One restoration per tooth surface per 12 months. Restoration includes tooth preparation, localized tissue removal, base direct and indirect pulp cap, and polishing. Gold foil restorations will pay as an alternate benefit, based on the corresponding amalgam procedure code. The patient is responsible for the remainder of the charge.</p> <p>One per tooth surface per 12 months.*</p> | <ul style="list-style-type: none"> • Tooth identification • Surface identification | <ul style="list-style-type: none"> • Tooth identification • Surface identification |
| D2420 | Gold foil – two surfaces | | | |
| D2430 | Gold foil – three surfaces | | | |
| INLAY/ONLAY RESTORATIONS | | | | |
| <p>Inlay: An intra-coronal dental restoration, made outside the oral cavity to conform to the prepared cavity, which does not restore and cusp tips.</p> <p>Onlay: A dental restoration made outside the oral cavity that covers one or more cusp tips and adjoining occlusal surfaces, but not the entire external surface.</p> | | | | |
| D2510 | Inlay – metallic – one surface | <p>One per tooth per 60 months for members ages 16 and older. Alternate benefit of a corresponding amalgam restoration paid for metallic inlays. The patient is responsible for the balance.</p> <p>Ages 16+: One per tooth per 60 months. Alternate benefit of a corresponding amalgam restoration paid for metallic inlays. The patient is responsible for the balance.*</p> | <ul style="list-style-type: none"> • Tooth identification • Surface identification | <ul style="list-style-type: none"> • Tooth identification • Surface identification |
| D2520 | Inlay – metallic – two surfaces | | | |
| D2530 | Inlay – metallic – three or more surfaces | | | |

* Applies to specific ACA-compliant small group plans only.

Restorative Services

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|--|--|--|--|---|
| | | | BCBSMA-Participating | Out-of-state & Non-par |
| INLAY/ONLAY RESTORATIONS, continued | | | | |
| D2542 | Onlay – metallic – two surfaces | <p>One per posterior tooth per 60 months for members ages 16 and older. Includes preparation, impression, temporary, and cementation. May be non-covered if certain conditions are present:</p> <ul style="list-style-type: none"> • Untreated bone loss • Tooth has poor-to-hopeless prognosis from a restorative, endodontic or periodontal perspective • Periapical pathology or unresolved, incomplete or failed endodontic therapy • Services meant to treat TMJ, increase vertical dimension, or restore occlusion <p><i>Ages 16+: One per tooth per 60 months.*</i></p> | <ul style="list-style-type: none"> • Tooth identification • Surface identification (must include B or L surface) | <ul style="list-style-type: none"> • Tooth identification • Surface identification (must include B or L surface) • Current mounted and dated pre-operative periapical radiographs • Pre-treatment recommended |
| D2543 | Onlay – metallic – three surfaces | | | |
| D2544 | Onlay – metallic – four or more surfaces | | | |
| D2610 | Inlay – porcelain/ceramic – one surface | <p>One per tooth per 60 months for members ages 16 and older. Alternate benefit of a corresponding amalgam restoration paid for porcelain inlays. The patient is responsible for the balance.</p> <p><i>Ages 16+: One per tooth per 60 months. Alternate benefit of a corresponding amalgam restoration paid for metallic inlays. The patient is responsible for the balance.*</i></p> | <ul style="list-style-type: none"> • Tooth identification • Surface identification | <ul style="list-style-type: none"> • Tooth identification • Surface identification |
| D2620 | Inlay – porcelain/ceramic – two surfaces | | | |
| D2630 | Inlay – porcelain/ceramic – three or more surfaces | | | |
| D2642 | Onlay – porcelain/ceramic – two surfaces | <p>One per posterior tooth per 60 months for members age 16 and older. Includes preparation, impression, temporary restoration and cementation. May be non-covered if certain conditions are present:</p> <ul style="list-style-type: none"> • Untreated bone loss • Tooth has poor-to-hopeless prognosis from a restorative, endodontic, or periodontal perspective • Periapical pathology or unresolved, incomplete or failed endodontic therapy • Services meant to treat TMJ, increase vertical dimension, or restore occlusion. <p><i>Ages 16+: One per tooth per 60 months.*</i></p> | <ul style="list-style-type: none"> • Tooth identification • Surface identification (must include B or L surface) | <ul style="list-style-type: none"> • Tooth identification • Surface identification (must include B or L surface) • Current mounted and dated pre-operative periapical radiographs • Pre-treatment recommended |
| D2643 | Onlay – porcelain/ceramic – three surfaces | | | |
| D2644 | Onlay – porcelain/ceramic – four or more surfaces | | | |

* Applies to specific ACA-compliant small group plans only.

Restorative Services

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|--|--|--|--|---|
| | | | BCBSMA-Participating | Out-of-state & Non-par |
| INLAY/ONLAY RESTORATIONS, continued | | | | |
| D2650 | Inlay – resin-based composite – one surface | <p>One per tooth per 60 months for members ages 16 and older. Alternate benefit of a corresponding amalgam restoration paid for composite inlays. The patient is responsible for the balance.</p> <p>Ages 16+: One per tooth per 60 months. Alternate benefit of a corresponding amalgam restoration paid for metallic inlays. The patient is responsible for the balance.*</p> | <ul style="list-style-type: none"> • Tooth identification • Surface identification | <ul style="list-style-type: none"> • Tooth identification • Surface identification |
| D2651 | Inlay – resin-based composite – two surfaces | | | |
| D2652 | Inlay – resin-based composite – three or more surfaces | | | |
| D2662 | Onlay – resin-based composite – two surfaces | <p>One per posterior tooth per 60 months for members age 16 and older. Includes preparation, impression, temporary restoration, and cementation. May be non-covered if certain conditions are present:</p> <ul style="list-style-type: none"> • Untreated bone loss • Tooth has poor-to-hopeless prognosis from a restorative, endodontic or periodontal perspective • Periapical pathology or unresolved, incomplete or failed endodontic therapy • Services meant to treat TMJ, increase vertical dimension, or restore occlusion. <p>Ages 16+: One per tooth per 60 months.*</p> | <ul style="list-style-type: none"> • Tooth identification • Surface identification (must include B or L surface) | <ul style="list-style-type: none"> • Tooth identification • Surface identification (must include B or L surface) • Current mounted and dated pre-operative periapical radiographs • Pre-treatment recommended |
| D2663 | Onlay – resin-based composite – three surfaces | <p>One per posterior tooth per 60 months for members age 16 and older. Includes preparation, impression, temporary restoration, and cementation. May be non-covered if certain conditions are present:</p> <ul style="list-style-type: none"> • Untreated bone loss • Tooth has poor-to-hopeless prognosis from a restorative, endodontic or periodontal perspective • Periapical pathology or unresolved, incomplete or failed endodontic therapy • Services meant to treat TMJ, increase vertical dimension, or restore occlusion. <p>Ages 16+: One per tooth per 60 months.*</p> | <ul style="list-style-type: none"> • Tooth identification • Surface identification (must include B or L surface) | <ul style="list-style-type: none"> • Tooth identification • Surface identification (must include B or L surface) • Current mounted and dated pre-operative periapical radiographs • Pre-treatment recommended |
| D2664 | Onlay – resin-based composite – four or more surfaces | | | |

* Applies to specific ACA-compliant small group plans only.

Restorative Services

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|--|--|--|----------------------------------|---|
| | | | BCBSMA-Participating | Out-of-state & Non-par |
| CROWNS – SINGLE RESTORATIONS ONLY | | | | |
| D2710 | Crown – resin-based composite (indirect) | <p>One per permanent tooth per 60 months for members age 16 and older. Includes preparation, impression, temporary restoration and insertion. D2710 and D2712 are limited to teeth #6-11 and #22-27. May be non-covered if certain conditions are present:</p> <ul style="list-style-type: none"> • Untreated bone loss • Tooth has poor-to-hopeless prognosis from a restorative, endodontic or periodontal perspective • Periapical pathology or unresolved, incomplete or failed endodontic therapy • Services meant to treat TMJ, increase vertical dimension, or restore occlusion • D2710 one per 60 months all ages. <p>D2712,D2720,D2721, D2722, D2780,D2781, D2782, D2783: Ages 16+: One per permanent tooth per 60 months.</p> <p>D2740, D2750,D2751, D2752, D2790, D2791, D2792, D2794: One per tooth per 60 months.*</p> | Tooth identification | <ul style="list-style-type: none"> • Tooth identification • Current mounted and dated pre-operative periapical radiographs • Pre-treatment recommended |
| D2712 | Crown – ¾ resin-based composite (indirect) (does not include facial veneers) | | | |
| D2720 | Crown – resin with high noble metal | | | |
| D2721 | Crown – resin with predominantly base metal | | | |
| D2722 | Crown – resin with noble metal | | | |
| D2740 | Crown – porcelain/ceramic substrate | | | |
| D2750 | Crown – porcelain fused to high noble metal | | | |
| D2751 | Crown – porcelain fused to predominantly base metal | | | |
| D2752 | Crown – porcelain fused to noble metal | | | |
| D2753 | Crown – Porcelain fused to titanium and titanium alloys | | | |
| D2780 | Crown – ¾ cast high noble metal | | | |
| D2781 | Crown – ¾ cast predominantly base metal | | | |
| D2782 | Crown – ¾ cast noble metal | | | |
| D2783 | Crown – ¾ porcelain/ceramic (does not include facial veneers) | | | |
| D2790 | Crown – full cast, high-noble metal | | | |
| D2791 | Crown – full cast, predominantly base metal | | | |
| D2792 | Crown – full cast, noble metal | | | |
| D2794 | Crown – titanium and titanium alloys | | | |
| D2799 | Provisional crown – further treatment or completion of diagnosis necessary prior to final impression | Not a covered benefit. | None | None |

Restorative Services

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|-----------------------------------|--|--|----------------------------------|------------------------|
| | | | BCBSMA-Participating | Out-of-state & Non-par |
| OTHER RESTORATIVE SERVICES | | | | |
| D2910 | Recement or re-bond inlay, onlay, veneer or partial coverage restoration | One per tooth per 12 months for members age 16 and over. <i>Ages 16+: One per tooth per 12 months.*</i> | Tooth identification | Tooth identification |
| D2915 | Recement or re-bond indirectly fabricated or prefabricated post and core | | | |
| D2920 | Recement or re-bond crown | | | |
| D2921 | Reattachment of tooth fragment, incisal edge or cusp | Not a covered benefit. | None | None |
| D2928 | Prefabricated porcelain/ceramic crown – permanent tooth | | | |
| D2929 | Prefabricated porcelain/ceramic crown – primary tooth | One per primary tooth per 24 months as an alternate benefit to D2932. | Tooth identification | Tooth identification |
| D2930 | Prefabricated stainless steel crown – primary tooth | One per primary tooth per 24 months. Up to four prefabricated ss crowns per date of service. | | |
| D2931 | Prefabricated stainless steel crown – permanent tooth | One per first and second molar per 24 months for members through age 15 (up to the 16 th birthday). <i>Once per primary tooth per 24 months* Up to four prefabricated stainless steel crowns per date of service.*</i> | | |
| D2932 | Prefabricated resin crown | One per permanent anterior tooth per 24 months for members through age 15 (up to the 16 th birthday). One per primary tooth per 24 months. <i>Up to age 19: Four per day per member Ages 19+: Not covered.*</i> | | |
| D2933 | Prefabricated stainless steel crown with resin window | One per 1st molar per 24 months for members up to the 16th birthday. One per primary tooth per 24 months. | | |
| D2934 | Prefabricated esthetic coated stainless steel crown – primary tooth | One per primary tooth per 24 months. <i>Up to age 19: One per tooth per lifetime Ages 19+: One per primary tooth per 24 months.*</i> | | |
| D2940 | Protective restoration | One per tooth per lifetime. Direct placement of a temporary restorative material to protect tooth and/or tissue form. May be used to relieve pain, promote healing or prevent further deterioration. Should not be reported as a base or in conjunction with other restorations. | | |

* Applies to specific ACA-compliant small group plans only.

Restorative Services

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|--|---|---|----------------------------------|------------------------|
| | | | BCBSMA-Participating | Out-of-state & Non-par |
| OTHER RESTORATIVE SERVICES, continued | | | | |
| D2941 | Interim therapeutic restoration – primary dentition | One per tooth per lifetime on primary teeth for members under 3 years of age. Direct placement of a temporary restorative material to protect tooth and/or tissue form. This procedure may be used to relieve pain, promote healing or prevent further deterioration. Should not be reported as a base or in conjunction with other restorations. | Tooth identification | Tooth identification |
| D2949 | Restorative foundation for an indirect restoration | Not a covered benefit. | | |
| D2950 | Core buildup, including any pins when required | One per tooth per 60 months. Not covered if reported with D2952 or D2954. Refers to building up of anatomical crown when restorative crown will be placed, whether or not pins are used. Not intended to be used as a 4-5 surface restoration if crown is not to be considered for a final restoration. <i>One per tooth per 60 months.*</i> | | |
| D2951 | Pin retention – per tooth, in addition to restoration | Once per tooth per lifetime. Not covered if reported with D2950. <i>Up to age 19: Must be billed with two or more surface restorations on a permanent tooth for members.</i> <i>Ages 19+: Once per tooth per lifetime.*</i> | | |
| D2952 | Post and core in addition to crown, indirectly fabricated | One per tooth per 60 months. If reported with a restoration or a core buildup on the same service date, the restoration, amalgam, or composite core build-up is considered part of the post- and core procedure. Cast post and core is separate from crown. <i>One per tooth per 60 months*</i> | | |
| D2953 | Each additional indirectly fabricated post – same tooth | Limited to posterior teeth only (#1-5, 12-16, 17-21 and 28-32). One per tooth per lifetime. Tooth must be badly broken down and missing at least 3 walls. If reported with a restoration or a core build-up on the same service date, the restoration amalgam or composite core build-up is considered part of the post and core procedure. | | |
| D2954 | Prefabricated post and core in addition to crown | One per tooth per 60 months. If reported with a restoration or a core buildup on the same service date, the restoration amalgam or composite core buildup is considered part of the post and core procedure. Cast restorations submitted on same date of service with this procedure will be non-covered. | | |

* Applies to specific ACA-compliant small group plans only.

Restorative Services

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|--|--|---|--|--|
| | | | BCBSMA-Participating | Out-of-state & Non-par |
| OTHER RESTORATIVE SERVICES, continued | | | | |
| D2955 | Post removal | Not a covered benefit. | None | None |
| D2957 | Each additional prefabricated post – same tooth | Limited to posterior teeth only (#1-5, 12-16, 17-21 and 28-32). One per tooth per lifetime. Tooth must be badly broken down and missing at least 3 walls. If reported with a restoration or a core build-up on the same service date, the restoration, amalgam, or composite core build-up is considered part of the post and core procedure. | Tooth identification | Tooth identification |
| D2960 | Labial veneer (resin laminate) – direct | Not a covered benefit. | Tooth identification | <ul style="list-style-type: none"> • Tooth identification • Detailed narrative • Current mounted and dated pre-operative periapical radiographs |
| D2961 | Labial veneer (resin laminate) – indirect | | | |
| D2962 | Labial veneer (porcelain laminate) – indirect | | | |
| D2971 | Additional procedures to construct new crown under existing partial denture framework | Individual consideration. One per tooth per 60 months for members age 16 and older - must be reported with individual crown. <i>Ages 16+: One per tooth per 60 months. Must be reported with individual crown.*</i> | <ul style="list-style-type: none"> • Tooth identification • Detailed narrative | <ul style="list-style-type: none"> • Tooth identification • Detailed narrative |
| 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 | Not a covered benefit. | None | None |
| D2980 | Crown repair necessitated by restorative material failure | One per tooth per 12 months. <i>Up to age 19: no limit.</i> <i>Ages 19+: one per tooth per 12 months.*</i> | Tooth identification | Tooth identification |
| D2981 | Inlay repair necessitated by restorative material failure | One per tooth per 12 months. | | |
| D2982 | Onlay repair necessitated by restorative material failure | One per tooth per 12 months. | | |
| D2983 | Veneer repair necessitated by restorative material failure | Not a covered benefit. | None | None |
| D2990 | Resin infiltration of incipient smooth surface lesions | One per covered tooth surface per 12 months. | <ul style="list-style-type: none"> • Tooth identification • Surface identification (B, L, F surfaces only) | <ul style="list-style-type: none"> • Tooth identification • Surface identification (B, L, F surfaces only) |
| D2999 | Unspecified restorative procedure, by report | Individual consideration. | Detailed narrative | Detailed narrative |

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Endodontic Services

Endodontic procedures include exam, pulp test, pulpotomy, pulpectomy, extirpation of pulp, pre-operative, operative and post-operative radiographs, filling of canals, bacteriologic cultures, and local anesthesia. Endodontic therapy performed specifically for coping or overdenture are not covered benefits.

Claims for multiple-stage procedures should only be billed on date of completion/insertion. Benefits are not available for incomplete care. Payment for endodontic services does not mean that benefits will be available for subsequent restorative services. Coverage for those services is still subject to exclusions listed under major restorative guidelines.

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|--|---|---|----------------------------------|------------------------|
| | | | BCBSMA-Participating | Out-of-state & Non-par |
| PULP CAPPING | | | | |
| D3110 | Pulp cap – direct (excluding final restoration) | A separate allowance is not made. Pulp capping is considered part of the final restoration. | None | None |
| D3120 | Pulp cap – indirect (excluding final restoration) | | | |
| PULPOTOMY | | | | |
| D3220 | Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to dentinocemental junction and application of medicament | One per tooth per lifetime. Part of endodontic therapy when performed by the same dentist. | Tooth identification | Tooth identification |
| D3221 | Pulpal debridement, primary and permanent teeth | | | |
| D3222 | Partial pulpotomy for apexogenesis –permanent tooth with incomplete root development. | | | |
| ENDODONTIC THERAPY ON PRIMARY TEETH | | | | |
| D3230 | Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration) | One per tooth per lifetime. | Tooth identification | Tooth identification |
| D3240 | Pulpal therapy (resorbable filling) – posterior primary tooth (excluding final restoration) | | | |

Endodontic Services

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|--|---|--|----------------------------------|--|
| | | | BCBSMA-Participating | Out-of-state & Non-par |
| ENDODONTIC THERAPY (including treatment plan, clinical procedures and follow up care) | | | | |
| D3310 | Endodontic therapy, anterior tooth (excluding final restoration) | One per permanent tooth per lifetime. | Tooth identification | Tooth identification |
| D3320 | Endodontic therapy, premolar tooth (excluding final restoration) | | | |
| D3330 | Endodontic therapy, molar tooth (excluding final restoration) | | | |
| D3331 | Treatment of root canal obstruction; non-surgical access | Individual consideration. Once per tooth per lifetime. | Tooth identification | <ul style="list-style-type: none"> • Tooth identification • Detailed narrative • Current dated pre- and post-operative periapical radiographs |
| D3332 | Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth | Not a covered benefit. | None | None |
| D3333 | Internal root repair of perforation defects | | | |
| ENDODONTIC RETREATMENT | | | | |
| D3346 | Retreatment of previous root canal therapy – anterior | One per tooth per lifetime. Coverage is considered when prior root canal failed and re-treatment is performed by another dentist. | Tooth identification | Tooth identification |
| D3347 | Retreatment of previous root canal therapy – premolar | | | |
| D3348 | Retreatment of previous root canal therapy – molar | | | |
| APEXIFICATION/RECALCIFICATION AND PULPAL REGENERATION PROCEDURES | | | | |
| D3351 | Apexification / recalcification – initial visit (apical closure / calcific repair of perforations, root resorption, etc.) | One per permanent tooth per lifetime. 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). | Tooth identification | Tooth identification |
| D3352 | Apexification / recalcification – interim medication replacement | One per permanent tooth per lifetime. | Tooth identification | Tooth identification |
| D3353 | Apexification/recalcification - final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.) | One per permanent tooth per lifetime. | Tooth identification | Tooth identification |

Endodontic Services

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|--|---|---|--|---|
| | | | BCBSMA Participating | Out-of-state & Non-par |
| APEXIFICATION/RECALCIFICATION AND PULPAL REGENERATION PROCEDURES, continued | | | | |
| D3355 | Pulpal regeneration – initial visit | One per permanent tooth per lifetime. | Tooth identification | Tooth identification |
| D3356 | Pulpal regeneration – interim medication replacement | | | |
| D3357 | Pulpal regeneration – completion of treatment | | | |
| APICOECTOMY/PERIRADICULAR SERVICES | | | | |
| D3410 | Apicoectomy – anterior | One per tooth root per lifetime. | Tooth & root identification | Tooth & root identification |
| D3421 | Apicoectomy – premolar (first root) | | | |
| D3425 | Apicoectomy – molar (first root) | | | |
| D3426 | Apicoectomy – (each additional root) | | | |
| D3428 | Bone graft in conjunction with periradicular surgery – per tooth, single site | Not a covered benefit. | None | None |
| D3429 | Bone graft in conjunction with periradicular surgery – each additional contiguous in the same surgical site | | | |
| D3430 | Retrograde filling – per root | One per tooth root (not canal) per lifetime. Only covered when reported with D3410, D3421, D3425, D3426. Benefit is paid at a maximum of a one-surface amalgam restoration. If more than one filling is placed per tooth, report additional root (not canal) as D3999 and describe. | Tooth & root identification | <ul style="list-style-type: none"> • Tooth & root identification • For additional retrogrades on the same tooth, include either post-operative periapical radiograph or clinical imaging of finished filling at root end of the tooth and report. |
| D3431 | Biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery | Not a covered benefit. | None | None |
| D3432 | Guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery | | | |
| D3450 | Root amputation – per root | One per tooth per lifetime for multi-rooted posterior teeth. | Tooth identification | Tooth identification |
| D3460 | Endodontic endosseous implant | Not a covered benefit. | None | None |
| D3470 | Intentional reimplantation (including necessary splinting) | Individual consideration. | <ul style="list-style-type: none"> • Tooth identification • Detailed narrative | <ul style="list-style-type: none"> • Tooth identification • Detailed narrative |

Endodontic Services

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|------------------------------------|---|---|--|--|
| | | | BCBSMA Participating | Out-of-state & Non-par |
| OTHER ENDODONTIC PROCEDURES | | | | |
| D3471 | Surgical repair of root resorption – anterior | One per tooth root per lifetime. Considered inclusive if submitted with D3410, D3421, D3425, D3426. | Tooth & root identification | Tooth & root identification |
| D3472 | Surgical repair of root resorption – premolar | | | |
| D3473 | Surgical repair of root resorption–molar | | | |
| D3501 | Surgical repair of root surface without apicoectomy or repair of root resorption – anterior | Not a covered benefit. | None | None |
| D3502 | Surgical repair of root surface without apicoectomy or repair of root resorption – premolar | | | |
| D3503 | Surgical repair of root surface without apicoectomy or repair of root resorption – molar | | | |
| D3910 | Surgical procedure for isolation of tooth with rubber dam | | | |
| D3920 | Hemisection (including any root removal), not including root canal therapy | One per posterior tooth per lifetime. | Tooth identification | Tooth identification |
| D3950 | Canal preparation and fitting of preformed dowel or post | Not a covered benefit. | None | None |
| D3999 | Unspecified endodontic procedure, by report | Individual consideration. | <ul style="list-style-type: none"> • Tooth identification • Detailed narrative • Current dated pre- and post-operative periapical radiographs | <ul style="list-style-type: none"> • Tooth identification • Detailed narrative • Current dated pre- and post-operative periapical radiographs |

Periodontal Services

Periodontal procedures billing guidelines

When supporting documentation is requested for periodontal services, please refer to the submission guidelines as outlined in this section.

- A quadrant is defined as four or more contiguous teeth per quadrant.
- A partial quadrant is defined as one to three teeth per quadrant. For billing purposes, a *sextant* is not a recognized designation by the American Dental Association.
- Alveolar crestal bone loss must be evident radiographically for scaling and root planning to be covered.

When more than one periodontal service (codes D4000-D4999) is completed within the same site or quadrant on the same date of service, Blue Cross Blue Shield of Massachusetts will pay for the more extensive treatment as payment for the total service.

Benefits for all periodontal services are limited to two quadrants per date of service. If you want to request an exception to this due to a medical condition that may require your patient to receive extended treatment, please include a detailed narrative including general or intravenous anesthesia record, medical condition and length of appointment time.

Payment for periodontal surgical services

Payment for definitive periodontal service includes follow-up evaluation for both surgical and non-surgical procedures. We provide payment only for one surgical procedure per quadrant, per 36 months. No more than two quadrants of surgical or non-surgical services may be covered when done on the same date of service. Exposure of the cemental surfaces of the root, radiographic evidence of subgingival calculus and bone loss, and excessive pocket depth must be present for coverage availability of scaling and root planning. To request an exception to this due to a medical condition that may require your patient to receive extended periodontal treatment, please submit a detailed narrative including general or intravenous anesthesia record, medical condition, and length of appointment time with the claim form.

When localized procedures are performed in the same quadrant within 36 months, the payment will not exceed the full quadrant allowance. Periodontal services are benefits when performed for the treatment of periodontal disease around natural teeth. There are no benefits for these procedures when billed in conjunction with or in preparation for implants, ridge augmentation, extractions sites, and endodontic surgeries. When localized surgical or presurgical services are performed in the same quadrants within coverage time guidelines, payment for the services will not exceed the full quadrant allowance.

Periodontal Services

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|--|---|--|--|--|
| | | | BCBSMA-Participating | Out-of-state and Non-par |
| SURGICAL SERVICES (INCLUDING USUAL POST-OPERATIVE SERVICES) | | | | |
| D4210 | Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth-bounded spaces, per quadrant | One per quadrant per 36 months. An evaluation period of ≥ 21 days to assess tissue response must be observed following scaling and root planning before benefits become available for soft tissue procedures. A gingivectomy procedure is unusual in the presence of infrabony defects. If reported at any time in preparation and/or temporization phase of teeth for, or in association with restoration/prostheses, D4210 is considered to be included as part of the global restorative/prosthetic procedure. | Quadrant identification | <ul style="list-style-type: none"> • Quadrant identification • Current dated post-Phase I periodontal charting • Current mounted and dated preoperative periapical radiographs. If a current full mouth set of radiographs is not available, submit current (within last year) bitewing and/or periapical radiographs of the treated area) • Pre-treatment recommended |
| D4211 | Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant | One to three teeth per quadrant per 36 months. If reported at any time in preparation and/or temporization phase of tooth for, or in association with restoration/prostheses, D4211 is considered to be included as part of the global restorative/ prosthetic procedure. | Quadrant identification, including teeth numbers | |
| D4212 | Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth | One per tooth per quadrant per 36 months. Not covered on same DOS in association with restoration/ prostheses services. | Quadrant identification, including teeth numbers | |
| D4230 | Anatomical crown exposure - four or more contiguous teeth or tooth bounded spaces per quadrant | Not a covered benefit. | None | None |
| D4231 | Anatomical crown exposure - one to three teeth or tooth bounded spaces per quadrant | | | |
| D4240 | Gingival flap procedure, including root planning – four or more contiguous teeth or tooth-bounded spaces per quadrant | One per quadrant per 36 months. An evaluation period of ≥ 28 days to assess tissue response must be observed following scaling and root planning. If scaling and root planning are performed on the same date and in the same quadrant as periodontal surgery, no payment will be made for D4341/2. | Quadrant identification | <ul style="list-style-type: none"> • Quadrant identification • Current dated post-phase I periodontal charting • Current mounted and dated pre-operative periapical radiographs. If a current full mouth set of radiographs is not available, submit current (within last year) bitewing radiographs and/or periapical radiographs of the treated area • Pre-treatment recommended |
| D4241 | Gingival flap procedure, including root planning – one to three contiguous teeth or tooth bounded spaces per quadrant | One to three teeth per quadrant per 36 months. An evaluation period of ≥ 28 days to assess tissue response must be observed following scaling and root planning. If scaling and root planning are performed on the same date and in the same quadrant as periodontal surgery, no payment will be made for D4341/2. | Quadrant identification, including teeth numbers | |

Periodontal Services

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|---|--|--|--|--|
| | | | BCBSMA Participating | Out-of-state and Non-par |
| SURGICAL SERVICES (INCLUDING USUAL POST-OPERATIVE SERVICES), continued | | | | |
| D4245 | Apically repositioned flap | Not a covered benefit. | None | None |
| 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. | One per tooth per 60 months. Procedure must alter the crown-to-root ratio and be performed in a healthy periodontal environment to be covered. Non-covered when performed on the same day and by the same provider as a crown preparation /insertion or when performed for aesthetic purposes or in conjunction with osseous surgery in the same quadrant. | Tooth identification | Tooth identification |
| D4260 | Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth-bounded spaces per quadrant | One per quadrant per 36 months. A waiting period of ≥ 28 days should follow periodontal scaling and root planning in order to allow healing and observation of tissue response. If scaling and root planning are performed on the same date and in the same quadrant as periodontal surgery, no payment will be made for D4341 or D4342. | Quadrant identification | <ul style="list-style-type: none"> • Quadrant identification • Current dated post phase I periodontal charting • Current mounted and dated pre-operative periapical radiographs. If a current full mouth set of radiographs is not available, submit current (within last year) bitewing and/or periapical radiographs of the treated area • Pre-treatment recommended |
| D4261 | Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant | One to three teeth per quadrant per 36 months. A waiting period of ≥ 28 days should follow periodontal scaling and root planning to allow healing and observation of tissue response. If scaling and root planning are performed on the same date and in the same quadrant as periodontal surgery, no payment will be made for D4341 or D4342. | Quadrant identification, including teeth numbers | |
| D4263 | Bone replacement graft – first site in quadrant | One per tooth per 36 months. An allowance will be made in addition to the surgical procedure to cover the cost of the graft material. Not covered when used in an edentulous space, extraction site or with routine apicoectomy, cystectomy, sinus augmentation, ridge augmentation, mucogingival grafts or implant procedure. | Tooth identification (edentulous spaces do not qualify for this code) | <ul style="list-style-type: none"> • Tooth identification (edentulous spaces do not qualify for this code) • Current mounted and dated pre-operative periapical radiographs Pre-treatment recommended |
| D4264 | Bone replacement graft – each additional site in quadrant | | | |
| D4265 | Biologic materials to aid in soft and osseous tissue regeneration | Not a covered benefit. | None | None |
| D4266 | Guided tissue regeneration - resorbable barrier, per site | One per site per 36 months. An allowance will be made in addition to the surgical procedure to cover the cost of the graft material. Not covered when used in an edentulous space, extraction site, or with routine apicoectomy, cystectomy, ridge augmentation, mucogingival grafts, or implant procedure. | Tooth identification (edentulous spaces do not qualify for use of this code) | <ul style="list-style-type: none"> • Tooth identification (edentulous spaces do not qualify for this code) • Current mounted and dated pre-operative periapical radiographs • Pre-treatment recommended |
| D4267 | Guided tissue regeneration - non-restorable barrier, per site (includes membrane removal) | | | |
| D4268 | Surgical revision procedure, per tooth | Not a covered benefit. | None | None |

Periodontal Services

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|---|---|--|----------------------------------|--|
| | | | BCBSMA Participating | Out-of-state & Non-par |
| SURGICAL SERVICES (INCLUDING USUAL POST-OPERATIVE SERVICES), continued | | | | |
| D4270 | Pedicle soft tissue graft procedure | One per tooth per 36 months. Grafting for cosmetic purposes is non-covered. | Tooth identification | <ul style="list-style-type: none"> • Tooth identification • Current periodontal charting with amount of attached gingiva indicated • Pre-treatment recommended |
| D4273 | Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft | One per site per 36 months on natural tooth only. Limited to three teeth per graft site. | | |
| D4274 | Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures on the same anatomical area) | One per site per 36 months. Must be adjacent to edentulous area. | Tooth identification | <ul style="list-style-type: none"> • Location • Current dated post phase I periodontal charting • Current mounted and dated pre-operative periapical radiographs • Pre-treatment recommended |
| D4275 | Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft | One per site per 36 months on natural tooth only. Limited to three teeth per graft site. | Tooth identification | <ul style="list-style-type: none"> • Tooth identification • Current periodontal charting with amount of attached gingival indicated • Pre-treatment recommended |
| D4276 | Combined connective tissue and double pedicle graft, per tooth | One per tooth per 36 months. Grafting for cosmetic purposes is non-covered. | | |
| D4277 | Free soft tissue graft procedure (including recipient and donor surgical site) first tooth, implant or edentulous tooth position in graft | One per site per 36 months around natural teeth only. Limited to three teeth per graft site. | | |
| D4278 | Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft | | | |
| 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 | Each tooth additional up to three teeth total in graft. | | |
| D4285 | Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site | Each tooth additional up to three teeth total. | | |

Periodontal Services

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|--|--|--|---|---|
| | | | BCBSMA Participating | Out-of-state & Non-par |
| NON-SURGICAL PERIODONTAL SERVICES | | | | |
| D4320 | Provisional splinting – intracoronal | Not a covered benefit | None | None |
| D4321 | Provisional splinting – extracoronal | | | |
| D4341 | Periodontal scaling and root planning – four or more teeth per quadrant | One per quadrant per 24 months. Gross debridement of calculus and polishing of all teeth are considered part of this procedure. | <ul style="list-style-type: none"> • Quadrant identification • For D4342, include teeth numbers | <ul style="list-style-type: none"> • Quadrant identification • For D4342, include teeth numbers |
| D4342 | Periodontal scaling and root planning – one to three teeth per quadrant | | | |
| D4346 | Scaling in the presence of generalized moderate or severe gingival inflammation – full mouth. | Covered interchangeably with D1110. Held to the same frequencies and allowable as D1110. | None | None |
| D4355 | Full mouth debridement to enable comprehensive evaluation and diagnosis | Not a covered benefit. | None | None |
| D4381 | Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth | One treatment per tooth per 24 months. Up to 3 teeth per quadrant with 5-6 mm pocket depths and bleeding on probing, with or subsequent to active and maintained periodontal treatment. Should not be used to treat generalized disease. Not covered for treatment of periodontal abscess. | Detailed narrative | <ul style="list-style-type: none"> • Detailed narrative • Periodontal charting • Tooth/teeth number(s) |
| OTHER PERIODONTAL SERVICES | | | | |
| D4910 | Periodontal maintenance | One per 3 months. Limited to four reportable services during any 12 months. Maximum 4 combined D4910/D1110 in any 12-month period following active therapy. | None | None |
| D4920 | Unscheduled dressing change (by person other than treating dentist or staff) | Not a covered benefit. One per quadrant per 36 months.* | None | None |
| D4921 | Gingival irrigation – per quadrant | Not a covered benefit. | None | None |
| D4999 | Unspecified periodontal procedure, by report | Individual consideration. Adjunctive periodontal diagnostic testing (sulcular temperature; biochemical markers, microbiological tests, etc.) is included in fee for diagnostic evaluation, not covered as a separate procedure. | Detailed narrative | Detailed narrative |

* Applies to specific ACA-compliant small group plans only.

Prosthodontics (Removable)

Bill claims for multiple stage procedures on the date of completion/insertion.

Services may be non-covered for the following conditions:

- Untreated bone loss. An abutment tooth has poor-to-hopeless prognosis from either a restorative or periodontal perspective.
- Periapical pathology or unresolved, incomplete, or failed endodontic therapy.
- Treatment of TMJ to increase vertical dimension or restore occlusion.

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|---|--|--|----------------------------------|------------------------|
| | | | BCBSMA Participating | Out-of-state & Non-par |
| COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE) | | | | |
| D5110 | Complete denture – maxillary | One per arch per 60 months. Not covered if D5130, D5211, D5213, D5221, D5223, D5225, or D5281 was reported within 5 years. | Arch identification | Arch identification |
| D5120 | Complete denture – mandibular | One per arch per 60 months. Not covered if D5140, D5212, D5214, D5222, D5224, D5226 or D5281 was reported within 5 years. | | |
| D5130 | Immediate denture – maxillary | One per arch per lifetime. | | |
| D5140 | Immediate denture – mandibular | | | |
| PARTIAL DENTURES – for the following codes, the denture base is presumed to include any conventional clasps, rests, and teeth. | | | | |
| D5211 | Maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth) | One per arch per 60 months for members, age 16+. | Arch identification | Arch identification |
| D5212 | Mandibular partial denture – resin base (including retentive/clasping materials, rests, and teeth) | | | |
| D5213 | Maxillary partial denture – cast metal framework with resin denture bases (including retentive /clasping materials, , rests and teeth) | | | |
| D5214 | Mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) | | | |

Prosthodontics (Removable)

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|------------------------------------|--|--|--|--|
| | | | BCBSMA Participating | Out-of-state & Non-par |
| PARTIAL DENTURES, continued | | | | |
| D5221 | Immediate maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth) | One per arch per 60 months for members, age 16+. | Arch identification | Arch identification |
| D5222 | Immediate mandibular partial denture – resin base (including retentive/clasping materials, rests, and teeth) | | | |
| D5223 | Immediate maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth) | | | |
| D5224 | Immediate mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) | | | |
| D5225 | Maxillary partial denture - flexible base (including retentive/clasping materials, rests and teeth) | | | |
| D5226 | Mandibular partial denture - flexible base (including retentive/clasping materials, rests and teeth) | | | |
| D5282 | Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests and teeth), maxillary | | | |
| D5283 | Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests and teeth), mandibular | One per arch per 60 months for members 16 +. | <ul style="list-style-type: none"> • Arch identification • Quadrant identification | <ul style="list-style-type: none"> • Arch identification • Quadrant identification |
| D5284 | Removal unilateral partial denture – one piece flexible base (including retentive/clasping materials, rests and teeth), per quadrant | | | |
| D5286 | Removal unilateral partial denture – one piece resin (including retentive/clasping materials, rests and teeth), per quadrant | | | |

Prosthodontics (Removable)

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|-------------------------------------|--|---|----------------------------------|------------------------|
| | | | BCBSMA Participating | Out-of-state & Non-par |
| ADJUSTMENTS TO DENTURES | | | | |
| D5410 | Adjust complete denture – maxillary | Considered part of routine post-delivery care for complete and partial denture for the first 90 days. One per arch per 12 months. | None | None |
| D5411 | Adjust complete denture – mandibular | | | |
| D5421 | Adjust partial denture – maxillary | | | |
| D5422 | Adjust partial denture – mandibular | | | |
| REPAIRS TO COMPLETE DENTURES | | | | |
| D5511 | Repair broken complete denture base, mandibular | One per arch per 12 months. | Arch identification | Arch identification |
| D5512 | Repair broken complete denture base, maxillary | | | |
| D5520 | Replace missing or broken teeth – complete denture (each tooth) | One per tooth per 12 months. | Tooth identification | Tooth identification |
| REPAIRS TO PARTIAL DENTURES | | | | |
| D5611 | Repair resin partial denture base, mandibular | One per arch per 12 months. | Arch identification | Arch identification |
| D5612 | Repair resin partial denture base, maxillary | | | |
| D5621 | Repair cast partial framework, mandibular | | | |
| D5622 | Repair cast partial framework, maxillary | | | |
| D5630 | Repair or replace broken retentive clasping materials - per tooth | | | |
| D5640 | Repair broken teeth – per tooth | | | |
| D5650 | Add tooth to existing partial denture | One per tooth per 12 months. | Tooth identification | Tooth identification |
| D5660 | Add clasp to existing partial denture per tooth | | | |
| D5670 | Replace all teeth and acrylic on cast metal framework (maxillary) | One per tooth per partial denture. | | |
| D5671 | Replace all teeth and acrylic on cast metal framework (mandibular) | One per tooth per partial denture. | Arch identification | Arch identification |

Prosthodontics (Removable)

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|--|--|---|----------------------------------|----------------------------|
| | | | BCBSMA Participating | Out-of-state & Non-par |
| DENTURE REBASE PROCEDURES – The process of refitting a denture by replacing the base material. | | | | |
| D5710 | Rebase complete maxillary denture | One per arch per 36 months. Adjustments are considered part of routine post-delivery care for complete and partial denture rebases for the first 90 days. Up to age 19: One per arch per 24 months per patient.* | None | None |
| D5711 | Rebase complete mandibular denture | | | |
| D5720 | Rebase maxillary partial denture | | | |
| D5721 | Rebase mandibular partial denture | | | |
| DENTURE RELINE PROCEDURES – The process of resurfacing the tissue side of a denture with new base material. | | | | |
| D5730 | Reline complete maxillary denture (direct) | One per arch per 24 months for chairside relines. One per arch per 36 months for laboratory relines. Adjustments are considered part of routine post-delivery care for complete and partial denture relines for the first 90 days. D5750, D5751, D5760, D5761: Up to age 19, one per arch per 24 months per patient Ages 19+: one per arch per 36 months* | None | None |
| D5731 | Reline complete mandibular denture (direct) | | | |
| D5740 | Reline maxillary partial denture (direct) | | | |
| D5741 | Reline mandibular partial denture (direct) | | | |
| D5750 | Reline complete maxillary denture (indirect) | | | |
| D5751 | Reline complete mandibular denture (indirect) | | | |
| D5760 | Reline maxillary partial denture (indirect) | | | |
| D5761 | Reline mandibular partial denture (indirect) | | | |
| INTERIM PROSTHESIS | | | | |
| D5810 | Interim complete denture (maxillary) | Not a covered benefit. | None | None |
| D5811 | Interim complete denture (mandibular) | | | |
| D5820 | Interim partial denture (including retentive/clasping materials, rests and teeth), maxillary | One per lifetime per arch. Temporary stay-plate covered when inserted immediately after extraction of anterior tooth (6-11 or 22-27) or loss of anterior tooth due to traumatic injury. | Tooth/teeth being replaced | Tooth/teeth being replaced |

* Applies to specific ACA-compliant small group plans only.

Prosthodontics (Removable)

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|--|--|--|----------------------------------|----------------------------|
| | | | BCBSMA Participating | Out-of-state & Non-par |
| INTERIM PROSTHESIS, continued | | | | |
| D5821 | Interim partial denture (including retentive/clasping materials, rests and teeth), mandibular | One per lifetime per arch. Temporary stay-plate covered when inserted immediately after extraction of anterior tooth (6-11 or 22-27) or loss of anterior tooth due to traumatic injury. | Tooth/teeth being replaced | Tooth/teeth being replaced |
| OTHER REMOVABLE PROSTHETIC SERVICES | | | | |
| D5850 | Tissue conditioning, maxillary | One per denture per 36 months. Not covered if performed within 90 days after the delivery of a full or partial denture, rebase, or reline. | None | None |
| D5851 | Tissue conditioning, mandibular | | | |
| D5862 | Precision attachment, by report | Not a covered benefit. | None | None |
| D5863 | Overdenture – complete maxillary | One per upper arch per 60 months; will reject if history of upper partial or complete denture in prior 60 months. If payable, an alternate benefit of a complete upper denture (D5110) will be made. Member is responsible for the balance. Endodontic therapy or copings placed on remaining teeth are not covered for members age 16+. | Arch identification | Arch identification |
| D5864 | Overdenture – partial maxillary | One per upper arch per 60 months; will reject if history of partial upper denture in prior 60 months. If payable, an alternate benefit of an upper partial denture (D5213) will be made. Member is responsible for the balance. Endodontic therapy or copings placed on remaining teeth are not covered for members ages 16+. | | |
| D5865 | Overdenture – complete mandibular | One per lower arch per 60 months. Will reject if history of upper complete or upper partial denture in 60 months. If payable, an alternate benefit of a complete upper denture (D5110) will be made. Member is responsible for the balance. Endodontic therapy or copings placed on remaining teeth are not covered for members age 16+. | | |
| D5866 | Overdenture – partial mandibular | One per lower arch per 60 months. Will reject if history of complete or partial lower denture in the prior 60 months. If payable, an alternate benefit of a lower partial denture (D5214) will be made. Member is responsible for the balance. Endodontic therapy or copings placed on remaining teeth are not covered for members age 16+. | | |
| D5867 | Replacement of replaceable part of semi-precision or precision attachment (male or female component) | Not a covered benefit. | | |

Prosthodontics (Removable)

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|---|---|--|----------------------------------|------------------------|
| | | | BCBSMA Participating | Out-of-state & Non-par |
| OTHER REMOVABLE PROSTHETIC SERVICES, continued | | | | |
| D5875 | Modification of removable prosthesis following implant surgery. Attachment assemblies are reported using separate codes | Not a covered benefit. | None | None |
| D5876 | Add metal substructure to acrylic full denture (per arch) | | | |
| D5899 | Unspecified removable prosthodontic procedure, by report | Individual consideration. | Detailed narrative | Detailed narrative |
| MAXILLOFACIAL PROSTHETICS | | | | |
| D5911 | Facial moulage (sectional) | Not a covered benefit under BCBSMA dental plans. Please refer to the patient's medical plan for possible benefit coverage. | None | None |
| D5912 | Facial moulage (complete) | | | |
| D5913 | Nasal prosthesis | | | |
| D5914 | Auricula prosthesis | | | |
| D5915 | Orbital prosthesis | | | |
| D5916 | Ocular prosthesis | | | |
| D5919 | Facial prosthesis | | | |
| D5922 | Nasal septal prosthesis | | | |
| D5923 | Ocular prosthesis, interim | | | |
| D5924 | Cranial prosthesis | | | |
| D5925 | Facial augmentation implant prosthesis | | | |
| D5926 | Nasal prosthesis, replacement | | | |
| D5927 | Auricular prosthesis, replacement | | | |
| D5928 | Orbital prosthesis, replacement | | | |
| D5929 | Facial prosthesis, replacement | | | |
| D5931 | Obturator prosthesis, surgical | | | |
| D5932 | Obturator prosthesis, definitive | | | |
| D5933 | Obturator prosthesis, modification | | | |
| D5934 | Mandibular resection prosthesis with guide flange | | | |
| D5935 | Mandibular resection prosthesis without guide flange | | | |

Prosthodontics (Removable)

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|---|--|--|----------------------------------|------------------------|
| | | | BCBSMA Participating | Out-of-state & Non-par |
| MAXILLOFACIAL PROSTHETICS, continued | | | | |
| D5936 | Obturator prosthesis, interim | Not a covered benefit under BCBSMA dental plans. Please refer to the patient's medical plan for possible benefit coverage. | None | None |
| D5937 | Trismus appliance (not for TMD treatment) | | | |
| D5951 | Feeding aid | | | |
| D5958 | Palatal lift prosthesis, interim | | | |
| D5959 | Palatal lift prosthesis, modification | | | |
| D5960 | Speech aid prosthesis, modification | | | |
| D5982 | Surgical stent | | | |
| D5983 | Radiation carrier | | | |
| D5984 | Radiation shield | | | |
| D5985 | Radiation cone locator | | | |
| D5986 | Fluoride gel carrier | | | |
| D5987 | Commissure splint | | | |
| D5988 | Surgical splint | | | |
| D5991 | Vesiculobullous disease medicament carrier | | | |
| D5992 | Adjust maxillofacial prosthetic appliance, by report | | | |
| D5993 | Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral) other than required adjustments, by report | | | |
| D5995 | Periodontal medicament carrier with peripheral seal – laboratory processed – maxillary | Not a covered benefit | None | None |
| D5996 | Periodontal medicament carrier with peripheral seal – laboratory processed – mandibular | | | |
| D5999 | Unspecified maxillofacial prosthesis, by report | Individual consideration. | Detailed narrative | Detailed narrative |

Implant Services

Coverage for Implant Services

Benefits for single tooth endosteal dental implants, single tooth abutments, and single tooth implant/abutment supported crowns are now covered as a group 3 benefit up to the member's annual maximum. The surgical placement of implants to be used in the construction of an implant-supported bridge, or used as a component of an implant-supported overdenture or telescoping bridge is not a covered benefit. Also, the prosthetic abutments and pontics used in the construction of an implant supported fixed partial denture are not covered benefits.

Implant services may also be covered under a **special rider** that employer groups may purchase with their dental insurance policy. Please check the member's benefits to determine eligibility. The implant rider has a maximum lifetime dollar amount.

The rider covers the surgical placement of endosteal implants with a minimum age qualification of 16 for the replacement of teeth 2-15 and teeth 18-31. The implant rider does not cover the following services:

- Special preparatory radiographic or imaging studies (i.e., tomographic, CT, or MRI).
- Routine radiographs (i.e., periapical and panoramic.) May be covered under the member's general dental insurance policy to the same extent and under the same conditions and guidelines as those applied to a natural tooth.
- Adjunctive periodontal (D4000 series) or surgical (D7000 series) procedures in preparation for implant placement, in association with implant placement, or in association with salvage attempts of a failing implant. These services are not covered under the rider, since the intent is to have benefits available for the implants themselves.
- Maxillofacial prosthetic procedure D5982, surgical stent (implant positioning type.) Coverage for this service will be denied, since the intent of the rider is to have benefits available for the implants themselves.
- Frequency limitation: once per tooth (replacement) per 60 months
- Prosthetic crowns for implants are not covered under the implant rider.
- Implant-supported fixed partial dentures.

Implant Services

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|---|--|--|----------------------------------|--|
| | | | BCBSMA Participating | Out-of-state & Non-par |
| IMPLANT SERVICES – Pre-surgical services | | | | |
| D6190 | Radiographic/surgical implant index, by report | Not a covered benefit. | None | None |
| D6191 | Semi-precision abutment – placement This procedure is the initial placement or replacement of a semiprecision abutment on the implant body | | | |
| D6192 | Semi-precision attachment – placement This procedure involves the luting of the initial or replacement semiprecision attachment to the removable prosthesis | | | |
| IMPLANT SERVICES | | | | |
| D6010 | Surgical placement of implant body, endosteal implant | One per tooth per 60 months for members age 16 and over. | Tooth area identification | <ul style="list-style-type: none"> • Tooth area identification • Current dated pre-operative periapical radiograph |
| D6011 | Surgical access to an implant body (Second stage implant surgery) | One per tooth per 60 months for members age 16 and over. <i>Once per 60 months*</i> | Tooth identification | Tooth identification |
| D6012 | Surgical placement of interim implant body for transitional prosthesis, endosteal implant | Not a covered benefit. | None | None |
| D6013 | Surgical placement of mini implant | One per tooth per 60 months for members age 16 and over. Limit two per arch. Allowed in edentulous arch as components of an overdenture. <i>Once per 60 months. Limit two per arch. Allowed in edentulous arch as components of an overdenture for members 16 and over. *</i> | Tooth identification | <ul style="list-style-type: none"> • Tooth area identification • Current dated pre-operative periapical radiograph |
| D6040 | Surgical placement, eposteal implant | Not a covered benefit. | None | None |
| D6050 | Surgical placement, transosteal implant | | | |
| D6051 | Interim abutment | | | |
| 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 | | | |

Implant Services

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|------------------------------------|---|--|----------------------------------|---------------------------|
| | | | BCBSMA Participating | Out-of-state & Non-par |
| IMPLANT SERVICES, continued | | | | |
| D6085 | Provisional implant crown | Not a covered benefit. | None | None |
| D6096 | Remove broken implant retaining screw | Covered under implant rider only. | Tooth area identification | Tooth area identification |
| D6100 | Implant removal, by report | One per tooth per lifetime. | Tooth area identification | Tooth area identification |
| D6101 | Debridement of a peri-implant defect or defects surrounding a single implant and surface cleaning of exposed implant surfaces, including flap entry and closure | Not a covered benefit. | None | None |
| D6102 | Debridement and osseous contouring of a peri-implant defect; or defects surrounding a single implant and includes surface cleaning of exposed implant surfaces including flap entry and closure | | | |
| D6103 | Bone graft for repair of peri-implant defect – does not include flap entry and closure | | | |
| D6104 | Bone graft at time of implant placement | | | |
| D6110 | Implant/abutment supported removable denture for edentulous arch – maxillary | Once per 60 months as an alternative benefit for a complete denture D5110. | Arch identification | Arch identification |
| D6111 | Implant/abutment supported removable denture for edentulous arch – mandibular | Once per 60 months as an alternative benefit for a complete denture D5120. | | |
| D6112 | Implant/abutment supported removable denture for partially edentulous arch – maxillary | Once per 60 months as an alternative benefit for a partial denture D5213. | | |
| D6113 | Implant /abutment supported removable denture for partially edentulous arch – mandibular | Once per 60 months as an alternative benefit for a partial denture D5214. | | |
| D6114 | Implant/abutment supported fixed denture for edentulous arch – maxillary | Covered by rider only. | None | None |
| D6115 | Implant/abutment supported fixed denture for edentulous arch – mandibular | | | |
| D6116 | Implant /abutment supported fixed denture for partially edentulous arch – maxillary | | | |

Implant Services

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|--|---|---|----------------------------------|--|
| | | | BCBSMA Participating | Out-of-state & Non-par |
| IMPLANT SERVICES, continued | | | | |
| D6117 | Implant /abutment supported fixed denture for partially edentulous arch – mandibular | Covered by rider only. | None | None |
| D6118 | Implant/abutment supported interim fixed denture for edentulous arch – mandibular | Not a covered benefit. | Arch identification | Arch identification |
| D6119 | Implant/abutment supported interim fixed denture for edentulous arch – maxillary | | | |
| IMPLANT-SUPPORTED PROSTHETICS - Supporting Structures | | | | |
| D6051 | Interim abutment | Not a covered benefit. | None | None |
| D6055 | Connecting bar – implant supported or abutment supported | Covered by rider only. Not a covered benefit* | Arch identification | <ul style="list-style-type: none"> • Arch identification • Current dated pre-operative periapical radiograph • Detailed narrative |
| D6056 | Prefabricated abutment – includes modification and placement | One per implant per 60 months for members age 16+. Includes preparation, impression, temporary restoration and insertion. | Tooth area identification | <ul style="list-style-type: none"> • Tooth area identification • Current dated pre-operative periapical radiograph • Detailed narrative |
| D6057 | Custom fabricated abutment – includes placement | | | |
| SINGLE CROWNS, ABUTMENT SUPPORTED | | | | |
| D6058 | Abutment supported porcelain/ceramic crown. A single crown restoration that is retained, supported and stabilized by an abutment on an implant | One per implant per 60 months for members age 16+. Includes preparation, impression, temporary restoration and insertion. | Tooth area identification | <ul style="list-style-type: none"> • Tooth area identification • Current mounted and dated pre-operative or post-implant periapical radiographs • Pre-treatment recommended |
| 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 | | | |

* Applies to specific ACA-compliant small group plans only.

Implant Services

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|---|--|---|----------------------------------|--|
| | | | BCBSMA Participating | Out-of-state & Non-par |
| SINGLE CROWNS, ABUTMENT SUPPORTED, continued | | | | |
| 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. | One per implant per 60 months for members age 16+. Includes preparation, impression, temporary restoration and insertion. | Tooth area identification | <ul style="list-style-type: none"> • Tooth area identification • Current mounted and dated pre-operative or post-implant periapical radiographs • Pre-treatment recommended |
| 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. | | | |
| D6062 | Abutment-supported cast-metal crown (high noble metal). A single metal-ceramic crown restoration that is retained, supported, and stabilized by an abutment on an implant. | | | |
| D6063 | Abutment-supported cast-metal crown (predominantly base metal). A single metal-ceramic crown restoration that is retained, supported, and stabilized by an abutment on an implant. | | | |
| D6064 | Abutment-supported cast-metal crown (noble metal) A single metal-ceramic crown restoration that is retained, supported, and stabilized by an abutment on an implant. | | | |
| D6094 | Abutment supported crown, titanium and titanium alloy | | | |
| D6097 | Abutment supported crown, porcelain fused to titanium or titanium alloys | | | |

Implant Services

| CDT Code | Description of Services | Procedure Guidelines | Provider Submission Requirements | |
|---|--|---|----------------------------------|---|
| | | | BCBSMA Participating | Out-of-State and Non-par |
| SINGLE CROWNS, IMPLANT SUPPORTED | | | | |
| D6065 | Implant-supported porcelain/ ceramic crown. A single crown restoration that is retained, supported, and stabilized by an implant. | One per implant per 60 months for members age 16+. Includes preparation, impression, temporary restoration and insertion. | Tooth area identification | <ul style="list-style-type: none"> • Tooth area identification • Current mounted and dated pre-operative or post-implant periapical radiographs • Pre-treatment recommended • Consultant review |
| 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. | | | |
| D6067 | Implant supported crown – high noble alloys. A single cast metal or milled crown restoration that is retained, supported, and stabilized by an implant | | | |
| D6082 | Implant supported crown – porcelain fused to predominately base alloys. A single crown restoration that is retained, supported, and stabilized by an implant. | One per implant per 60 months for members 16 +. | | |
| D6083 | Implant supported crown – porcelain fused to noble alloys. A single crown restoration that is retained, supported, and stabilized by an implant. | | | |
| D6084 | Implant supported crown – porcelain fused to titanium and titanium alloys. A single crown restoration that is retained, supported, and stabilized by an implant. | | | |
| D6086 | Implant supported crown – predominately base alloys. A single crown restoration that is retained, supported, and stabilized by an implant | | | |
| D6087 | Implant supported crown – noble alloys. A single crown restoration that is retained, supported, and stabilized by an implant. | | | |

Implant Services

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|--|---|--|----------------------------------|--|
| | | | BCBSMA Participating | Out-of-state & Non-par |
| SINGLE CROWNS, IMPLANT SUPPORTED, continued | | | | |
| D6088 | Implant supported crown – titanium and titanium alloys. A single crown restoration that is retained, supported, and stabilized by an implant. | One per implant per 60 months for members 16 +. | Tooth identification | <ul style="list-style-type: none"> • Tooth identification • Current mounted and dated pre-operative or post-implant periapical radiographs • Pre-treatment recommended • Consultant review |
| FIXED PARTIAL DENTURE, ABUTMENT SUPPORTED | | | | |
| 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. | Not a covered benefit, either with or without a rider. | Tooth area identification | Tooth area identification |
| 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. | | | |
| D6070 | Abutment-supported retainer for porcelain fused to metal FPD (predominately base metal)) A metal-ceramic retainer for a fixed partial denture that gains retention, support, and stability from an abutment on an implant. | | | |
| D6071 | Abutment-supported retainer for porcelain fused to metal FPD (noble metal) | | | |
| D6072 | Abutment-supported retainer for cast metal FPD (high noble metal) | | | |
| D6073 | Abutment-supported retainer for cast metal FPD (predominately base metal) | | | |
| D6074 | Abutment-supported retainer for cast metal FPD (noble metal) | | | |
| D6194 | Abutment supported retainer crown for FPD - titanium and titanium alloys | Not a covered benefit. | None | None |

Implant Services

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|---|--|-----------------------------|----------------------------------|--|
| | | | BCBSMA Participating | Out-of-state and Non-par |
| FIXED PARTIAL DENTURE, ABUTMENT SUPPORTED, continued | | | | |
| D6195 | Abutment supported retainer – porcelain fused to titanium and titanium alloys | Not a covered benefit. | None | None |
| FIXED PARTIAL DENTURE, IMPLANT SUPPORTED | | | | |
| D6075 | Implant-supported retainer for ceramic FPD | Not a covered benefit. | Tooth area identification | Tooth area identification |
| D6076 | Implant-supported retainer for FPD-porcelain fused to high noble alloys | | | |
| D6077 | Implant-supported retainer for metal FPD – high noble alloys | | | |
| D6098 | Implant supported retainer – porcelain fused to predominately base alloys | | | |
| D6099 | Implant supported retainer for FPD – porcelain fused to noble alloys | | | |
| D6120 | Implant supported retainer for FPD-porcelain fused to titanium and titanium alloys | | | |
| D6121 | Implant supported retainer for metal FPD – predominately based alloys | | | |
| D6122 | Implant supported retainer for metal FPD – noble alloys | | | |
| D6123 | Implant supported retainer for metal FPD – titanium and titanium alloys | | | |
| OTHER IMPLANT SERVICES | | | | |
| D6080 | Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments | Covered by rider only. | Arch identification | <ul style="list-style-type: none"> • Arch identification • Current dated pre-operative periapical radiograph • Detailed narrative |
| D6090 | Repair implant supported prosthesis, by report | One per arch per 6 months. | | |
| D6095 | Repair implant abutment, by report | One per tooth per 6 months. | Tooth area identification | Tooth area identification |

Implant Services

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|--|---|--|----------------------------------|--------------------------|
| | | | BCBSMA Participating | Out-of-state and Non-par |
| OTHER IMPLANT SERVICES, continued | | | | |
| D6091 | Replacement of replaceable part of semi-precision or precision attachment (male or female component) of implant/abutment-supported prosthesis, per attachment | Not a covered benefit. | Tooth identification | Tooth identification |
| D6092 | Recement or re-bond implant/abutment-supported crown | One per tooth per 12 months for members age 16 and older. | | |
| D6093 | Recement or re-bond implant/abutment-supported fixed partial denture | One per bridge per 12 months for members age 16 and older. | | |
| D6199 | Unspecified implant procedure, by report | Individual consideration. Not a covered benefit* | Detailed narrative | Detailed narrative |

* Applies to specific ACA-compliant small group plans only.

Prosthodontics, Fixed

Benefits for fixed prosthodontics

Bill claims for multiple stage procedures on the date of completion/insertion of the final restoration. Treatments must be generally accepted dental practice and must be necessary and appropriate for the dental condition. The foundation of generally accepted dental practice continues to be:

- Establishing periodontal health prior to final phase restoration prosthetic dentistry.
- Avoiding incomplete or technically deficient endodontic treatment which is detrimental to the long-term prognosis of the tooth and subsequent oral health.
- Cantilever pontic in the natural dentition is only covered for the replacement of a missing lateral incisor with a natural canine, or canine and bicuspid.

When services are non-covered

Fixed prosthodontics will not be covered if certain conditions are present:

- Untreated bone loss
- An abutment tooth has poor-to-hopeless prognosis from either a restorative or periodontal perspective
- Periapical pathology or unresolved, incomplete, or failed endodontic therapy
- Service meant to treat TMJ, increase vertical dimension, or restore occlusion
- A bridge where one or more of the abutments is an implant.

Prosthodontics, Fixed

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|--------------------------------------|---|---|----------------------------------|---|
| | | | BCBSMA Participating | Out-of-state & Non-par |
| FIXED PARTIAL DENTURE PONTICS | | | | |
| D6205 | Pontic – indirect resin-based composite | Not a covered benefit. | None | None |
| D6210 | Pontic – cast high noble | One per absent tooth per 60 months for members age 16 and over. Pontics to replace an impacted tooth or a space beyond the normal complement of teeth due to a diastema or drifting are not covered. Cast restorations are covered only once within 60 months regardless of the type of restoration placed. Our current clinical standard of care indicating the utilization of a cantilever pontic in the natural dentition is for the replacement of a missing lateral incisor supported by a natural canine, or canine and premolar. Not covered when part of an implant-supported fixed prosthesis. D6241: Once per 60 months per patient for all ages* D6242,D6245,D6250, D6251,D6252: One per absent tooth per 60 months for members age 16+ | Tooth identification | <ul style="list-style-type: none"> • Tooth identification • Current mounted and dated pre-operative periapical radiographs • Pre-treatment recommended |
| D6211 | Pontic – cast predominantly base metal | | | |
| D6212 | Pontic – cast noble metal | | | |
| D6214 | Pontic – titanium and titanium alloys | | | |
| D6240 | Pontic – porcelain fused to high noble metal | | | |
| D6241 | Pontic – porcelain fused to predominantly base metal | | | |
| D6242 | Pontic – porcelain fused to noble metal | | | |
| D6243 | Pontic -porcelain fused to titanium and titanium alloys | | | |
| D6245 | Pontic – porcelain/ceramic | | | |
| D6250 | Pontic – resin with high noble metal | | | |
| D6251 | Pontic – resin with predominantly base metal | | | |
| D6252 | Pontic – resin with noble metal | | | |
| D6253 | Provisional pontic | Individual consideration. Not to be used as a temporary crown/bridge for routine fixed partial denture restorations. Not a covered benefit* | Tooth identification | <ul style="list-style-type: none"> • Tooth identification • Current mounted and dated pre-operative periapical radiographs • Pre-treatment recommended • Detailed narrative |

* Applies to specific ACA-compliant small group plans only.

Prosthodontics, Fixed

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|--|--|---|---|---|
| | | | BCBSMA Participating | Out-of-state & Non-par |
| FIXED PARTIAL DENTURE RETAINERS – INLAYS/ONLAYS | | | | |
| D6545 | Retainer – cast metal for resin-bonded fixed prosthesis | One per tooth per 60 months for members age 16+. Cast restorations are covered only once within 60 months regardless of the type of restoration placed. | Tooth identification | <ul style="list-style-type: none"> • Tooth identification • Current mounted and dated pre-operative periapical radiographs • Pre-treatment recommended |
| D6548 | Retainer – porcelain/ ceramic for resin-bonded fixed prosthesis | | | |
| D6549 | Resin retainer – for resin bonded fixed prosthesis | | | |
| D6600 | Retainer inlay –porcelain/ ceramic, two surfaces | One per tooth per 60 months for members age 16 and older. | <ul style="list-style-type: none"> • Tooth identification • Surface identification | <ul style="list-style-type: none"> • Tooth identification • Current mounted and dated pre-operative periapical radiographs • Pre-treatment recommended |
| D6601 | Retainer inlay – porcelain/ ceramic, three or more surfaces | | | |
| D6602 | Retainer inlay – cast high noble, two surfaces | | | |
| D6603 | Retainer inlay – cast high noble metal, three or more surfaces | | | |
| D6604 | Retainer inlay – cast predominantly base metal, two surfaces | One per tooth per 60 months for members age 16 and over. Inlays pay as an alternate benefit to the corresponding amalgam restoration. | <ul style="list-style-type: none"> • Tooth identification • Current mounted and dated pre-operative periapical radiographs • Pre-treatment recommended | |
| D6605 | Retainer inlay – cast predominantly base metal, three or more surfaces | | | |
| D6606 | Retainer inlay – cast noble metal, 2 surfaces | | | |
| D6607 | Retainer inlay – cast noble metal, three or more surfaces | | | |
| D6624 | Inlay – titanium | | | |
| D6608 | Retainer onlay – porcelain/ceramic, two surfaces | One per tooth per 60 months for members 16 and over. Cast restorations are covered only once within 60 months regardless of the type of restoration placed. | <ul style="list-style-type: none"> • Tooth identification • Surface identification –must include B or L surface | |
| D6609 | Retainer onlay – porcelain/ ceramic, three or more surfaces | | | |
| D6610 | Retainer onlay – cast high-noble metal, two surfaces | | | |
| D6611 | Retainer onlay – cast high-noble metal, three or more surfaces | | | |

Prosthodontics, Fixed

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|---|--|---|---|--|
| | | | BCBSMA Participating | Out-of-state & Non-par |
| FIXED PARTIAL DENTURE RETAINERS – INLAYS/ONLAYS, continued | | | | |
| D6612 | Retainer onlay – cast predominantly base metal, two surfaces | One per tooth per 60 months for members 16 and over. Cast restorations are covered only once within 60 months regardless of the type of restoration placed. | <ul style="list-style-type: none"> • Tooth identification • Surface identification –must include B or L surface | <ul style="list-style-type: none"> • Tooth identification • Surface identification –must include B or L surface • Current mounted and dated pre-operative periapical radiographs • Pre-treatment recommended |
| D6613 | Retainer onlay – cast predominantly base metal, three or more surfaces | | | |
| D6614 | Retainer onlay – cast noble metal, two surfaces | | | |
| D6615 | Retainer onlay – cast noble metal, three or more surfaces | | | |
| D6634 | Retainer onlay - titanium | | | |
| FIXED PARTIAL DENTURE RETAINERS – CROWNS | | | | |
| D6710 | Retainer crown – indirect resin-based composite | Not a covered benefit. | None | None |
| D6720 | Retainer crown – resin with high noble metal | One per tooth per 60 months for members age 16 and over. Cast restorations are covered only once within 60 months regardless of the type of restoration placed. | Tooth identification | <ul style="list-style-type: none"> • Tooth identification • Current mounted and dated pre-operative periapical radiographs • Pre-treatment recommended |
| D6721 | Retainer crown – resin with predominantly base metal | | | |
| D6722 | Retainer crown – resin with noble metal | Individual consideration required for double abutting of teeth. Appropriate only for prosthetic considerations in specific circumstances, not for periodontal splinting. | | |
| D6740 | Retainer crown – porcelain/ceramic | D6751(ONLY): One per tooth per 60 months for members all ages. | | |
| D6750 | Retainer crown – porcelain fused to high noble | | | |
| D6751 | Retainer crown – porcelain fused to predominantly base metal | | | |
| D6752 | Retainer crown – porcelain fused to noble metal | | | |
| D6753 | Retainer crown – porcelain fused to titanium and titanium alloys | | | |
| D6780 | Retainer crown – ¾ cast high noble metal | | | |
| D6781 | Retainer crown – ¾ cast predominately base metal | | | |
| D6782 | Retainer crown – ¾ cast noble metal | | | |

Prosthodontics, Fixed

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|--|---|---|----------------------------------|---|
| | | | BCBSMA Participating | Out-of-state & Non-par |
| FIXED PARTIAL DENTURE RETAINERS – CROWNS, continued | | | | |
| D6783 | Retainer crown – ¾ porcelain/ceramic | One per tooth per 60 months for members age 16 and over. Cast restorations are covered only once within 60 months regardless of the type of restoration placed. Individual consideration required for double abutting of teeth. Appropriate only for prosthetic considerations in specific circumstances, not for periodontal splinting. | Tooth identification | <ul style="list-style-type: none"> • Tooth identification • Current mounted and dated pre-operative periapical radiographs • Pre-treatment recommended |
| D6784 | Retainer crown ¾ titanium and titanium alloys | | | |
| D6790 | Retainer crown – full cast high noble metal | | | |
| D6791 | Retainer crown – full cast predominantly base metal | | | |
| D6792 | Retainer crown – full cast noble metal | | | |
| D6794 | Retainer crown – titanium and titanium alloys | | | |
| D6793 | Provisional retainer crown – further treatment or completion of diagnosis necessary prior to final impression | Not a covered benefit. | None | None |
| OTHER FIXED PARTIAL DENTURE SERVICES | | | | |
| D6920 | Connector bar | Not a covered benefit. | None | None |
| D6930 | Recement or rebond fixed partial denture | One re-cementation per 12 months. Up to age 19: Not payable within 6 months of the placement of the fixed partial denture. Ages 19+: One re-cementation per 12 months* | Tooth identification | Tooth identification |
| D6940 | Stress breaker | Not a covered benefit. | None | None |
| D6950 | Precision attachments | Not a covered benefit. | None | None |
| D6980 | Fixed partial denture repair necessitated by restorative material failure | One repair per 12 months. Up to age 19: No limits Ages 19+: One repair per 12 months* | Tooth identification | Tooth identification |
| D6985 | Pediatric partial denture, fixed | One per arch per lifetime for members through the age 18 (up to the 19 th birthday). | Arch identification | Arch identification |
| D6999 | Unspecified fixed prosthodontic procedure, by report | Individual consideration. | Detailed narrative | Detailed narrative |

* Applies to specific ACA-compliant small group plans only.

Oral and Maxillofacial Surgery

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|---|---|--|--|--|
| | | | BCBSMA Participating | Out-of-state & Non-par |
| EXTRACTIONS (Includes local anesthesia, suturing, if needed, and routine post-operative care). Bone grafts (D4263, D4264, D4265) and GTR membranes (D4266, D4267) are not covered in conjunction with oral surgery codes (D7000-D7999) | | | | |
| D7111 | Extraction – coronal remnants, deciduous tooth | One per tooth per lifetime. | Tooth identification | Tooth identification |
| D7140 | Extraction – erupted tooth or exposed root (elevation and/or forcep removal) | | | |
| D7210 | Surgical removal of an erupted tooth requiring removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated | | | |
| D7220 | Removal of impacted tooth – soft tissue | | | |
| D7230 | Removal of impacted tooth – partially bony | | | |
| D7240 | Removal of impacted tooth – completely bony | | | |
| D7241 | Removal of impacted tooth – completely bony, with unusual surgical complications | | | |
| D7250 | Surgical removal of residual tooth roots (cutting procedure) | | | |
| D7251 | Coronectomy – intentional partial tooth removal | | | |
| OTHER SURGICAL PROCEDURES | | | | |
| D7260 | Oroantral fistula closure | Individual consideration. | <ul style="list-style-type: none"> • Periapical or panoramic radiograph • Detailed narrative | <ul style="list-style-type: none"> • Periapical or panoramic radiograph • Detailed narrative |
| D7261 | Primary closure of a sinus perforation | | | |
| D7270 | Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth | One per tooth per lifetime. Up to age 19: No limit Ages 19+: One tooth per lifetime* | Tooth identification | Tooth identification |

* Applies to specific ACA-compliant small group plans only.

Oral and Maxillofacial Surgery

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|---|---|--|---|---|
| | | | BCBSMA Participating | Out-of-state & Non-par |
| OTHER SURGICAL PROCEDURES, continued | | | | |
| D7272 | Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization) | Not a covered benefit. | None | None |
| D7280 | Surgical access of unerupted tooth | One per tooth per lifetime. | Tooth identification | Tooth identification |
| D7282 | Mobilization of erupted or mal-positioned tooth to aid eruption | | | |
| D7283 | Placement of a device to facilitate eruption of impacted tooth | Only covered in conjunction with D7280. One per tooth per lifetime. Report the surgical exposure separately using D7280. | Tooth identification | Tooth identification |
| D7285 | Incisional biopsy of oral tissue – hard (bone, tooth) | Individual consideration. | Pathology report | Pathology report |
| D7286 | Incisional biopsy of oral tissue – soft | | | |
| D7287 | Cytology exfoliative sample collection | Individual consideration. | Detailed narrative | Detailed narrative |
| D7288 | Brush biopsy – transepithelial sample collection | | | |
| D7290 | Surgical repositioning of teeth – grafting procedures are additional | Individual consideration. | <ul style="list-style-type: none"> • Tooth identification • Detailed narrative | <ul style="list-style-type: none"> • Tooth identification • Detailed narrative |
| D7291 | Transseptal fiberotomy/supra crestal fiberotomy, by report | Individual consideration. | <ul style="list-style-type: none"> • Tooth identification • Detailed narrative incl orthodontic history | <ul style="list-style-type: none"> • Tooth identification • Detailed narrative incl orthodontic history |
| D7292 | Surgical placement of temporary anchorage device (screw retained plate) requiring flap; includes device removal | Not a covered benefit. | None | None |
| D7293 | Surgical placement of temporary anchorage device requiring flap; includes device removal | | | |
| D7294 | Surgical placement of temporary anchorage device without flap; includes device removal | | | |
| D7295 | Harvest of bone for use in autogenous grafting procedures | | | |
| D7296 | Corticotomy one to three teeth | | | |
| D7297 | Corticotomy four or more teeth | | | |

Oral and Maxillofacial Surgery

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|---|--|--|--|--|
| | | | BCBSMA Participating | Out-of-state & Non-par |
| ALVEOLOPLASTY – SURGICAL PREPARATION OF RIDGE FOR DENTURES | | | | |
| D7310 | Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant | One per quadrant per lifetime. Inclusive when used in conjunction with surgical extractions. | <ul style="list-style-type: none"> • Quadrant identification • Include tooth spaces identification for D7311, D7321. | <ul style="list-style-type: none"> • Quadrant identification • Include tooth spaces identification for D7311, D7321. |
| D7311 | Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant | | | |
| D7320 | Alveoloplasty not in conjunction with extractions –four or more teeth or tooth spaces, per quadrant | | | |
| D7321 | Alveoloplasty, not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant | | | |
| VESTIBULOPLASTY | | | | |
| D7340 | Vestibuloplasty – ridge extension (secondary epithelialization) | Individual consideration. Not covered in conjunction with implants. | <ul style="list-style-type: none"> • Arch identification • Operative reports | <ul style="list-style-type: none"> • Arch identification • Operative reports |
| D7350 | Vestibuloplasty – ridge extension (incl. soft tissue grafts, muscle re-attachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue) | | | |
| INCLUDES NON-ODONTOGENIC CYSTS | | | | |
| D7410 | Excision of benign lesion, up to 1.25 cm | Individual consideration. | Pathology report | Pathology report |
| D7411 | Excision of benign lesion greater than 1.25 cm | | | |
| D7412 | Excision of benign lesion, complicated | | | |

Oral and Maxillofacial Surgery

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|---|---|---|----------------------------------|-------------------------|
| | | | BCBSMA Participating | Out-of-state & Non-par |
| INCLUDES NON-ODONTOGENIC CYSTS, continued | | | | |
| D7413 | Excision of malignant lesion up to 1.25 cm | Individual consideration. | Pathology report | Pathology report |
| D7414 | Excision of malignant lesion greater than 1.25 cm | | | |
| D7415 | Excision of malignant lesion, complicated | | | |
| D7465 | Destruction of lesion(s) by physical or chemical methods, by report | | | |
| SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS | | | | |
| D7440 | Excision of malignant tumor – lesion diameter up to 1.25 cm | Individual consideration. | Pathology report | Pathology report |
| D7441 | Excision of malignant tumor – lesion diameter greater than 1.25 cm | | | |
| D7450 | Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm | | | |
| D7451 | Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm | | | |
| D7460 | Removal of benign non-odontogenic cyst or tumor – lesion diameter up to 1.25 cm | | | |
| D7461 | Removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm | | | |
| D7471 | Removal of lateral exostosis (maxilla or mandible) | One per arch per lifetime. | Arch identification | Arch identification |
| D7472 | Removal of torus palatinus | One per lifetime. | | |
| D7473 | Removal of torus mandibularis | One per quadrant per lifetime. | Quadrant identification | Quadrant identification |
| D7485 | Surgical reduction of osseous tuberosity | One per upper quadrant(s) per lifetime. | | |

Oral and Maxillofacial Surgery

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|--|---|---|---|---|
| | | | BCBSMA Participating | Out-of-state & Non-par |
| SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS, continued | | | | |
| D7490 | Radical resection of maxilla or mandible | Not a covered benefit under BCBSMA dental plans. Refer to patient's medical plan for possible benefit coverage. | None | None |
| SURGICAL INCISION | | | | |
| D7510 | Incision and drainage of abscess – intraoral soft tissue | Individual consideration. | <ul style="list-style-type: none"> • Tooth identification • Detailed narrative | <ul style="list-style-type: none"> • Tooth identification • Detailed narrative |
| D7511 | Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces) | | | |
| D7520 | Incision and drainage of abscess – extraoral soft tissue | Individual consideration. | Detailed narrative | Detailed narrative |
| D7521 | Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces) | | | |
| D7530 | Removal of foreign body, mucosa, skin, or subcutaneous alveolar tissue | Individual consideration. | <ul style="list-style-type: none"> • Pathology report • Operative report | <ul style="list-style-type: none"> • Pathology report • Operative report |
| D7540 | Removal of reaction-producing foreign bodies, musculoskeletal system | | | |
| D7550 | Partial ostectomy/sequestrectomy for removal of non-vital bone | | | |
| D7560 | Maxillary sinusotomy for removal of tooth fragment or foreign body | | | |
| D7610 | Maxilla – open reduction (teeth immobilized, if present) | Individual consideration. | <ul style="list-style-type: none"> • Panoramic radiograph • Operative report • Include arch identification for D7670 and D7671 | <ul style="list-style-type: none"> • Panoramic radiograph • Operative report • Include arch identification for D7670 and D7671 |
| D7620 | Maxilla – closed reduction (teeth immobilized, if present) | | | |

Oral and Maxillofacial Surgery

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|--|---|---------------------------|---|---|
| | | | BCBSMA Participating | Out-of-state & Non-par |
| TREATMENT OF FRACTURES – SIMPLE | | | | |
| D7630 | Mandible – open reduction (teeth immobilized, if present) | Individual consideration. | <ul style="list-style-type: none"> • Panoramic radiograph • Operative report • Include arch identification for D7670 and D7671 | <ul style="list-style-type: none"> • Panoramic radiograph • Operative report • Include arch identification for D7670 and D7671 |
| D7640 | Mandible – closed reduction (teeth immobilized, if present) | | | |
| D7650 | Malar and/or zygomatic arch – open reduction | | | |
| D7660 | Malar and/or zygomatic arch – closed reduction | | | |
| D7670 | Alveolus – closed reduction, may include stabilization of teeth | | | |
| D7671 | Alveolus – open reduction, may include stabilization of teeth | | | |
| D7680 | Facial bones – complicated reduction with fixation and multiple surgical approaches | | | |
| TREATMENT OF FRACTURES – COMPOUND | | | | |
| D7710 | Maxilla – open reduction, stabilization of teeth | Individual consideration. | <ul style="list-style-type: none"> • Panoramic radiograph • Operative report • Include arch identification for D7770 and D7771 | <ul style="list-style-type: none"> • Panoramic radiograph • Operative report • Include arch identification for D7770 and D7771 |
| D7720 | Maxilla – closed reduction | | | |
| D7730 | Mandible – open reduction | | | |
| D7740 | Mandible – closed reduction | | | |
| D7750 | Malar and/or zygomatic arch – open reduction | | | |
| D7760 | Malar and/or zygomatic arch – closed reduction | | | |
| D7770 | Alveolus – open reduction stabilization of teeth | | | |
| D7771 | Alveolus – closed reduction, stabilization of teeth | | | |
| D7780 | Facial bones – complicated reduction with fixation and multiple surgical approaches | | | |

Oral and Maxillofacial Surgery

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|--|--|---|----------------------------------|------------------------|
| | | | BCBSMA Participating | Out-of-state & Non-par |
| REDUCTION OF DISLOCATION AND MANAGEMENT OF OTHER TEMPOROMANDIBULAR JOINT DYSFUNCTIONS – Procedures that are integral part of primary procedure should not be reported separately. | | | | |
| D7810 | Open reduction of dislocation | Not covered under BCBSMA dental plans. Please refer to your patient's medical plan for possible benefit coverage. | None | None |
| D7820 | Closed reduction of dislocation | | | |
| D7830 | Manipulation under anesthesia | | | |
| D7840 | Condylectomy | | | |
| D7850 | Surgical disectomy; with or without implant | | | |
| D7852 | Disc repair | | | |
| D7854 | Synovectomy | | | |
| D7856 | Myotomy | | | |
| D7858 | Joint reconstruction | | | |
| D7860 | Arthrotomy | | | |
| D7865 | Arthroplasty | | | |
| D7870 | Arthrocentesis | | | |
| D7871 | Non-arthroscopic lysis and lavage | | | |
| D7872 | Arthroscopy – diagnosis, with or without biopsy | | | |
| D7873 | Arthroscopy – surgical, lavage and lysis of adhesions | | | |
| D7874 | Arthroscopy – surgical, disc repositioning and stabilization | | | |
| D7875 | Arthroscopy – surgical, synovectomy | | | |
| D7876 | Arthroscopy – surgical, disectomy | | | |
| D7877 | Arthroscopy – surgical, debridement | | | |
| D7880 | Occlusal orthotic device, by report | Not a covered benefit. | | |
| D7881 | Occlusal orthotic device adjustment | | | |
| D7899 | Unspecified TMD therapy, by report | Not covered under BCBSMA dental plans. Please refer to your patient's medical plan for possible benefit coverage. | | |

Oral and Maxillofacial Surgery

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|-----------------------------------|--|---|----------------------------------|------------------------|
| | | | BCBSMA Participating | Out-of-state & Non-par |
| REPAIR OF TRAUMATIC WOUNDS | | | | |
| D7910 | Suture of recent small wounds up to 5 cm | Not covered under BCBSMA dental plans. Please refer to your patient's medical plan for possible benefit coverage. | None | None |
| D7911 | Complicated suture – up to 5 cm | | | |
| D7912 | Complicated suture – greater than 5 cm | | | |
| OTHER REPAIR PROCEDURES | | | | |
| D7920 | Skin grafts (identify defect covered, location, and type of graft) | Not covered under BCBSMA dental plans. Please refer to your patient's medical plan for possible benefit coverage. | None | None |
| D7921 | Collection and application of autologous blood concentrate product | | | |
| D7922 | Placement on intra-socket biological dressing to aid in hemostasis or clot stabilization, per site | | | |
| D7940 | Osteoplasty – for orthognathic deformities | | | |
| D7941 | Osteotomy – mandibular rami | | | |
| D7943 | Osteotomy – mandibular rami with bone graft; includes obtaining the graft | | | |
| D7944 | Osteotomy – segmented or sub-apical per sextant or quadrant | | | |
| D7945 | Osteotomy – body of mandible | | | |
| D7946 | LeFort I (maxilla – total) | | | |
| D7947 | LeFort I (maxilla – segmented) | | | |
| D7948 | LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) – without bone graft | | | |
| D7949 | LeFort II or LeFort II – with bone graft | | | |

Oral and Maxillofacial Surgery

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|---|--|---|---|---|
| | | | BCBSMA Participating | Out-of-state & Non-par |
| OTHER REPAIR PROCEDURES, continued | | | | |
| D7950 | Osseous, osteoperiosteal, or cartilage graft of the mandible or facial bones, autogenous or nonautogenous, by report | Not covered under BCBSMA dental plans. Please refer to your patient's medical plan for possible benefit coverage. | None | None |
| D7951 | Sinus augmentation with bone or bone substitutes via a lateral open approach | | | |
| D7952 | Sinus augmentation via a vertical approach | | | |
| D7953 | Bone replacement graft for ridge preservation – per site | | | |
| D7955 | Repair of maxillofacial soft and/or hard tissue defect | Not covered under BCBSMA dental plans. Please refer to your patient's medical plan for possible benefit coverage. | <ul style="list-style-type: none"> • Pretreatment recommended • Operative report • Appropriate radiographs | <ul style="list-style-type: none"> • Pretreatment recommended • Operative report • Appropriate radiographs |
| D7961 | Buccal / labial frenectomy (frenulectomy) | D7961 or D7962 covered once per site per lifetime. Covered for members 6 years and older. Not allowed when performed in conjunction with soft tissue graft; same site and same date of service. | <ul style="list-style-type: none"> • Tooth identification • Detailed narrative | <ul style="list-style-type: none"> • Tooth identification • Detailed narrative |
| D7962 | Lingual frenectomy (frenulectomy) | | | |
| D7963 | Frenuloplasty | | | |
| D7970 | Excision of hyperplastic tissue – per arch | Individual consideration. | <ul style="list-style-type: none"> • Arch identification • Operative report | <ul style="list-style-type: none"> • Arch identification • Operative report |
| D7971 | Excision of pericoronal gingiva | Individual consideration. | <ul style="list-style-type: none"> • Tooth identification • Operative report | <ul style="list-style-type: none"> • Tooth identification • Operative report |
| D7972 | Surgical reduction of fibrous tuberosity | One per upper quadrant(s) per lifetime. | Quadrant identification | Quadrant identification |
| D7979 | Non-surgical sialolithotomy | Not a covered benefit. | None | None |
| D7980 | Sialolithotomy | Individual consideration. | Operative report | Operative report |
| D7981 | Excision of salivary gland, by report | | | |

Oral and Maxillofacial Surgery

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|---|--|---|--|--|
| | | | BCBSMA Participating | Out-of-state & Non-par |
| OTHER REPAIR PROCEDURES, continued | | | | |
| D7982 | Sialodochoplasty | Individual consideration. | Operative report | Operative report |
| D7983 | Closure of salivary fistula | | | |
| D7990 | Emergency tracheotomy | Not covered under BCBSMA dental plans. Please refer to your patient's medical plan for possible benefit coverage. | None | None |
| D7991 | Coronoidectomy | | | |
| 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. | | | |
| D7994 | Surgical placement: zygomatic implant. An implant placed in the zygomatic bone and exiting through the maxillary mucosal tissue providing support and attachment of a maxillary dental prosthesis. | | | |
| D7995 | Synthetic graft - mandible or facial bones, by report | | | |
| D7996 | Implant – mandible for augmentation purposes (excluding alveolar ridge), by report | | | |
| D7997 | Appliance removal (not by dentist who placed appliance), includes removal of archbar | Individual consideration. Not covered* | Detailed narrative | Detailed narrative |
| D7998 | Intraoral placement of a fixation device not in conjunction with a fracture | Not a covered benefit. | None | None |
| D7999 | Unspecified oral surgery procedure, by report | Individual consideration. | <ul style="list-style-type: none"> • Tooth identification • Detailed narrative • Operative report | <ul style="list-style-type: none"> • Tooth identification • Detailed narrative • Operative report |

* Applies to specific ACA-compliant small group plans only.

Orthodontic Services

Orthodontic Benefit Administration

Limited Orthodontic Treatment. Use these codes for treatment with a limited objective, not involving the entire dentition. For example: Treatment in one arch only to correct crowding, partial treatment to open spaces or upright a tooth for a bridge, implant, and partial treatment for closure of a space.

Interceptive Orthodontic Treatment. Use these codes for procedures to lessen the severity or future effects of a malformation and to eliminate its cause. For example: The redirection of ectopically erupted tooth, correction of isolated dental cross-bite, or recovery of recent minor space loss where overall space is adequate.

Comprehensive Orthodontic Treatment. Use these codes when there are multiple phases of treatment provided at different stages of dentofacial development. For example: The use of an activator is generally stage one of a two-stage treatment. In this situation, placement of fixed appliances will generally be stage two of a two-stage treatment. List both treatment phases as comprehensive treatment modified by the stage of dental development.

How to submit claims for orthodontic treatment

Limited, Interceptive and Minor Treatment. Submit a claim with the appropriate CDT procedure code, including the total treatment fee and the placement date of the appliance. We will make payment after receipt of initial claim for treatment.

Comprehensive Treatment. For patients whose comprehensive treatment started after their orthodontic benefits became effective, submit the claim with the appropriate CDT procedure code, including the treatment charge and the date treatment began.

We will make monthly payments for comprehensive treatments. Initial monthly payment to you will be equal to 50% of the patients orthodontic benefit maximum for covered services less any member cost share. We will pay the rest in monthly installments until treatment plan is complete, or benefits exhausted. You do not need to submit a second claim; we will generate the payments automatically.

If comprehensive treatment began before the patient's orthodontic benefits became effective, submit the monthly visits and your monthly fee using the appropriate CDT procedure code. When submitting claims for the services included in orthodontic records, be sure to itemize listing the appropriate CDT procedure code for each service (e.g., radiographs, evaluation, study models) with your usual fee.

If you have questions regarding a patient's coverage, effective dates, or benefits, please call Dental Provider Service at **1-800-882-1178**.

Orthodontic Services

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|---|---|---|--|--|
| | | | BCBSMA Participating | Out-of-state & Non-par |
| ORTHODONTICS - Limited orthodontic treatment | | | | |
| D8010 | Limited orthodontic treatment of the primary dentition | Available as rider and subject to lifetime maximum and copayment. | None | None |
| D8020 | Limited orthodontic treatment of the transitional dentition | Not covered under the Essential Health Benefit , but may be covered with traditional orthodontics rider* | None | None |
| D8030 | Limited orthodontic treatment of the adolescent dentition | | | |
| D8040 | Limited orthodontic treatment of the adult dentition | | | |
| INTERCEPTIVE ORTHODONTIC TREATMENT | | | | |
| D8050 | Interceptive orthodontic treatment of the primary dentition | Available as rider and subject to lifetime maximum and copayment. | None | None |
| D8060 | Interceptive orthodontic treatment of the transitional dentition | May be covered under traditional orthodontics plan with a rider* | None | None |
| COMPREHENSIVE ORTHODONTIC TREATMENT | | | | |
| D8070 | Comprehensive orthodontic treatment of the transitional dentition | Available as rider and subject to lifetime maximum and copayment. Not covered* | <ul style="list-style-type: none"> • First date in treatment series • Total treatment charge | <ul style="list-style-type: none"> • First date in treatment series • Total treatment charge |
| D8080 | Comprehensive orthodontic treatment of the adolescent dentition | Available as rider and subject to lifetime maximum and copayment. May be covered under traditional orthodontics plan with a rider* | <ul style="list-style-type: none"> • First date in treatment series • Total treatment charge | <ul style="list-style-type: none"> • First date in treatment series • Total treatment charge |
| D8090 | Comprehensive orthodontic treatment of the adult dentition | Available as rider and subject to lifetime maximum and copayment. Not covered* | <ul style="list-style-type: none"> • First date in treatment series • Total treatment charge | <ul style="list-style-type: none"> • First date in treatment series • Total treatment charge |
| MINOR TREATMENT TO CONTROL HARMFUL HABITS | | | | |
| D8210 | Removable appliance therapy | Available as rider and subject to lifetime maximum and copayment. Not covered* | None | None |
| D8220 | Fixed appliance therapy | | | |
| OTHER ORTHODONTIC SERVICES | | | | |
| D8660 | Pre-orthodontic treatment examination to monitor growth and development | Not a covered benefit. Once per six months. Payable only to a dental provider who is a specialist in orthodontics* | None | None |

* Applies to specific ACA-compliant small group plans only.

Orthodontic Services

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|--|--|---|--|--|
| | | | BCBSMA Participating | Out-of-state & Non-par |
| OTHER ORTHODONTIC SERVICES, continued | | | | |
| D8670 | Periodic orthodontic treatment visit | Use for payment of monthly benefit when a dentist started a case prior to insurance coverage and is now providing services to patient who has become covered. | Submit monthly charge; not fee for whole case. | Submit monthly charge; not fee for whole case. |
| D8680 | Orthodontic retention (removal of appliances, construction and placement of retainer(s)) | Part of the global fee for the orthodontic outcome. | None | None |
| D8681 | Occlusal orthotic device adjustment | Not a covered benefit. | None | None |
| D8690 | Orthodontic treatment, (alternative billing to a contract fee) | Use for payment of monthly benefit for services provided by dentist other than original treating dentist. A method of payment between the provider and responsible party for services that reflect an open-ended fee arrangement. | Submit monthly charge; not fee for whole case. | Submit monthly charge; not fee for whole case. |
| D8695 | Removal of fixed orthodontic appliances for reasons other than completion of treatment | Not a covered benefit. | None | None |
| D8696 | Repair of orthodontic appliance – maxillary | | | |
| D8697 | Repair of orthodontic appliance – mandibular | | | |
| D8698 | Re-cement or re-bond fixed retainer – maxillary | | | |
| D8699 | Re-cement or re-bond retainer – mandibular | | | |
| D8701 | Repair of fixed retainer, includes reattachment - maxillary | | | |
| D8702 | Repair of fixed retainer, includes reattachment – mandibular | | | |
| D8703 | Replacement of lost or broken retainer – maxillary | | | |
| D8704 | Replacement of lost or broken retainer – mandibular | | | |
| D8999 | Unspecified orthodontic procedure, by report. Used for procedures not adequately described by a code | Individual consideration. May be covered under traditional ortho with rider. | Detailed narrative | Detailed narrative |

Unclassified Treatment

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|-------------------------------|--|--|----------------------------------|------------------------|
| | | | BCBSMA Participating | Out-of-state & Non-par |
| UNCLASSIFIED TREATMENT | | | | |
| D9110 | Palliative (emergency) treatment of dental pain – minor procedure | Not covered when reported with other definitive services on same treatment date. Up to age 19: Other non emergency medically necessary treatment may be provided during the same visit. Ages 19+: Not covered when reported on same day as definitive services.* | None | None |
| D9120 | Fixed partial denture sectioning | Not a covered benefit. | None | None |
| D9130 | Temporomandibular joint dysfunction – non-invasive physical therapies | | | |
| ANESTHESIA | | | | |
| D9210 | Local anesthesia not in conjunction with operative or surgical procedures | Not a covered benefit. | None | None |
| D9211 | Regional block anesthesia | | | |
| D9212 | Trigeminal division block anesthesia | | | |
| D9215 | Local anesthesia in conjunction with operative or surgical procedures | Included in the total fee for non-surgical or surgical services. | | |
| D9219 | Evaluation for moderate sedation, deep sedation or general anesthesia | Not a covered benefit. | | |
| D9222 | Deep sedation / general anesthesia first 15 minutes | Covered when provided with covered surgical procedures. Up to age 19: no limit* | | |
| D9223 | Deep sedation/general anesthesia – each 15 minute increment | Covered when provided with covered surgical procedures. Up to age 19: no limit* | | |
| D9230 | Administration of nitrous oxide/ analgesia, anxiolysis | Not a covered benefit. Up to age 19: One per day per patient * | | |
| D9239 | Intravenous moderate (conscious) sedation/analgesia – first 15 minutes | Covered when provided with covered surgical procedures. Up to age 19: no limit* | | |
| D9243 | Intravenous moderate (conscious) sedation/analgesia – each 15 minute increment | Covered when provided with covered surgical procedures. Up to age 19: no limit* | | |
| D9248 | Non-intravenous (conscious) sedation | Not a covered benefit. Up to age 19: No limit* | | |

* Applies to specific ACA-compliant small group plans only.

Adjunctive General Services

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|----------------------------------|---|--|--|--|
| | | | BCBSMA Participating | Out-of-state & Non-par |
| PROFESSIONAL CONSULTATION | | | | |
| D9310 | Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician | Covered benefit only when a dentist who is not providing treatment is the consultant. Benefits reconsidered on an individual basis. | <ul style="list-style-type: none"> Detailed narrative including the treating dentist's name Submit with code D9999 | <ul style="list-style-type: none"> Detailed narrative including the treating dentist's name Submit with code D9999 |
| D9311 | Consultation with a medical health care professional | Not a covered benefit. | None | None |
| PROFESSIONAL VISITS | | | | |
| D9410 | House call/extended care facility call | Not a covered benefit. | None | None |
| D9420 | Hospital or ambulatory surgical center call | D9410: Up to age 19: One per facility per date of service. Claim must include place of service codes 03,04,12,13,14,31,32,33,34 or 99 * | | |
| D9430 | Office visit for observation during regular office hours – no other services performed | | | |
| D9440 | Office visit-after regular office hours | | | |
| D9450 | Case presentation, detailed and extensive treatment planning | | | |
| DRUGS | | | | |
| D9610 | Therapeutic parenteral drug, single administration | Not a covered benefit. | None | None |
| D9612 | Therapeutic parenteral drugs, two or more administrations, different meds | | | |
| D9613 | Infiltration of sustained-release therapeutic drug, single or multiple site | | | |
| D9630 | Other drugs/medicaments, by report | | | |
| MISCELLANEOUS SERVICES | | | | |
| D9910 | Application of desensitizing medicament | Once within a 12-month period. | None | None |
| D9911 | Application of desensitizing resin for cervical and/or root surface, per tooth | Once per tooth per 48 months. Limited to age 16 and older. | Tooth identification | Tooth identification |
| D9920 | Behavior management, by report | Not a covered benefit. Up to age 19: One per day per provider or location* | None | None |

* Applies to specific ACA-compliant small group plans only.

Adjunctive General Services

| CDT Code | Description of Service | Procedure Guidelines | Provider Submission Requirements | |
|--|---|---|----------------------------------|-------------------------|
| | | | BCBSMA Participating | Out-of-state & Non-par |
| MISCELLANEOUS SERVICES, continued | | | | |
| D9930 | Treatment of complications (post-surgical) – unusual circumstances, by report | Individual consideration. | Detailed narrative | Detailed narrative |
| D9932 | Cleaning and inspection of removable complete denture, maxillary | Not a covered benefit. | None | None |
| D9933 | Cleaning and inspection of removable complete denture, mandibular | | | |
| D9934 | Cleaning and inspection of removable partial denture, maxillary | | | |
| D9935 | Cleaning and inspection of removable partial denture, mandibular | | | |
| D9941 | Fabrication of athletic mouthguard | | | |
| D9942 | Repair and/ or relines of occlusal guard | Not a covered benefit. | None | None |
| D9943 | Occlusal guard adjustment | | | |
| D9944 | Occlusal guard hard appliance, full arch | | | |
| D9945 | Occlusal guard – soft appliance, full arch | | | |
| D9946 | Occlusal guard – hard appliance, partial arch | | | |
| D9950 | Occlusion analysis-mounted case | Not a covered benefit (inclusive of rehabilitative services being performed). | | |
| D9951 | Occlusal adjustment-limited | One per 24 months, per quadrant. | Quadrant identification | Quadrant identification |
| D9952 | Occlusal adjustment-complete | Once per 24 months. | None | None |
| D9961 | Duplicate/copy patient’s records | Not a covered benefit. | | |
| D9970 | Enamel microabrasion | | | |
| D9971 | Odontoplasty - per tooth | | | |
| D9972 | External bleaching – per arch – in office | | | |
| D9973 | External bleaching – per tooth | | | |
| D9974 | Internal bleaching – per tooth | | | |
| D9975 | External bleaching – in home – per arch; includes materials & fabrication of custom trays | | | |
| D9985 | Sales tax | | | |
| D9986 | Missed appointment | | | |
| D9987 | Cancelled appointment | | | |

* Applies to specific ACA-compliant small group plans only.

Adjunctive General Services

| CDT Code | Description of Services | Procedure Guidelines | Provider Submission Requirements | |
|--|---|---------------------------|----------------------------------|--------------------------|
| | | | BCBSMA-participating | Out-of-state and Non-par |
| MISCELLANEOUS SERVICES, continued | | | | |
| D9990 | Certified translation or sign – language services, per visit | Not a covered benefit. | None | None |
| D9991 | Dental case management – addressing appointment compliance barriers | | | |
| D9992 | Dental case management – care coordination | | | |
| D9993 | Dental case management – motivational interviewing | | | |
| D9994 | Dental case management – patient education | | | |
| D9995 | Teledentistry synchronous | Not a covered benefit. | | |
| D9996 | Teledentistry nonsynchronous | | | |
| D9997 | Dental case management – patients with special health care needs | | | |
| D9999 | Unspecified adjunctive procedure by report | Individual consideration. | Detailed narrative | Detailed narrative |