2026

PEDIATRIC ESSENTIAL HEALTHCARE BENEFITS

DENTAL PROCEDURE GUIDELINES AND SUBMISSION REQUIREMENTS

January 2026

MASSACHUSETTS

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About This Guide

Under the Patient Protection and Affordable Care Act (ACA), certain plans must cover "essential health benefits" (EHBs). Each state selects an existing health plan as a benchmark of what benefits must be included. Because Massachusetts selected the Child Health Insurance Plan (CHIP) as the benchmark plan, the pediatric dental benefits that were in that plan when it was selected in 2014 are considered Essential Health Benefits (EHB) in Massachusetts.

This guide is designed to provide you with procedure guidelines and submission requirements for the American Dental Association (ADA) Current Dental Terminology (CDT) procedure codes used to bill for pediatric EHBs.

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. As always, we remind you 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 – 2024*.

For each code, we have:

- Provided specific guidelines and recommendations with respect to time, age, or other contractual limitations or exclusions.
- Noted when procedures are not covered benefits.
- Indicated procedure codes that require radiographic (X-ray) imaging documentation and other supplementary documentation.

Please use this guide to determine the correct code to describe the service you provided to your patient. We hope that making our policies and guidelines clear and easily available will enable your office to receive the appropriate compensation for the services provided to our members, your patients.

Administering your patients' pediatric EHBs

These benefits can be administered under the subscriber's medical benefit and considered separate from other stand alone Dental Blue plans. To help you bill for dental EHB's under the member's **medical benefit**, we want you to be aware of the following:

Check eligibility and benefits. These benefits are **only** available to our small group and self-pay plans**,** it is important for you to verify eligibility and benefits before delivering services. To check eligibility and benefits, you can:

- Call Dental Provider Service at **1-800-882-1178**
- Call our **InfoDial** system (available 24 hours a day, seven days a week) at **1-800-882-1178** and follow the prompts for benefits and eligibility

Member benefits. Blue Cross Blue Shield of Massachusetts members who have these benefits covered under their medical plan will have a Blue Cross Blue Shield of Massachusetts medical ID card. Members who have dental benefits covered by a stand-alone Dental Blue plan will have a Dental Blue ID card.

Maximums. The member's dental benefit maximums do not apply for services processed under the member's medical benefit. The provisions of the member's health plan govern coverage for these services. The member will have a separate maximum out of pocket (MOOP) benefit for pediatric dental benefits; after this maximum is met, coverage for pediatric dental benefits will not require a deductible, co-insurance, or a copayment.

Participating Dentists. You must be a participating dentist with Blue Cross Blue Shield of Massachusetts through the **Dental Blue** indemnity network to provide dental EHB's under the member's medical plan.

Reimbursement. We will reimburse Dental Blue participating dentists for pediatric dental EHB's using your submitted fee or the Dental Blue maximum allowable charge, whichever is less, minus the member's dental deductible, copayment, or co-insurance associated with the EHB plan.

Medical cost-share. When you provide services through the member's medical benefit, you must collect the member's cost-sharing (if applicable) to receive your whole reimbursement. The member's appropriate medical cost share may be a copayment (a fixed dollar amount), co-insurance (a percentage of the cost), or deductible (a first-dollar amount).

Utilization management

This section includes information on our utilization management process, 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.

We continue to conduct utilization review on submitted claims but do not routinely require submission of radiographs or periodontal charting from participating Dental Blue and Dental Blue PPO providers. Please refer to the *Submission Requirements* column for any specific requirements needed when submitting claims for treatment, and review the orthodontia section of this booklet for more information on how to submit prior authorization requests for orthodontic services.

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 or 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.

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 appropriately 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. **In cases 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).

When documentation is requested

While we continue to conduct utilization review on submitted claims, we will no longer routinely require submission of radiographic imaging or periodontal charting from participating providers. Please refer to the *Submission Requirements* column for any specific requirements needed when submitting claims for treatment. Please remember that radiographs must be:

- Preoperative periapical radiographic imaging that are current and dated
- Labeled "right" or "left" side
- Mounted if they are a full series
- Of diagnostic quality

Please remember to include the member's name and ID and the dentist's name and address. **If documentation is not requested, any radiographic imaging submitted will not be returned.**

Guidelines for specific services

Diagnostic services

Clinical Oral Evaluations

- Conducting evaluations is the responsibility of the dentist. These evaluations or examinations include an examination of all hard and soft tissues of the oral cavity, periodontal charting/screening, oral cancer screening, diagnosis and treatment planning.
- Post-operative visits are not to be reported as an oral evaluation other than D0171.
- The same evaluation codes are used by both General Practitioners and Specialists.
- Only one oral evaluation is benefited on the same date of service by the same dentist/dental office. If periodontal evaluation and a comprehensive oral evaluation are billed on the same date of service, the fee for the comprehensive oral evaluation (D0150) is a benefit and the fee for the periodontal evaluation (D0180) is inclusive in the comprehensive oral evaluation allowance.

Diagnostic Imaging

- Diagnostic images should only be taken following a patient evaluation in which the dentist determines they are medically necessary based on review of the patient's medical and dental history, any prior imaging, a caries risk assessment of need, and consideration of patient's disease risk and clinical condition. There must be a specific diagnostic purpose for taking images. Patient records need to be documented:
    - Purpose of taking the image. If the necessity and appropriateness for diagnostic radiographic imaging is not evident from the information submitted, no payment will be made for the image and is not billable to the member.
    - Clinical findings.
- Images must be of diagnostic quality, properly oriented, with the date of exposure. If image is not of diagnostic quality, the code for the image should not be submitted for payment and is not billable to the member.
- All covered imaging codes include image capture and interpretation.
- Original images should be part of the patient's clinical record and therefore must be retained by the dentist.
- Fees for duplicating images for insurance purposes cannot be billed to the member. However, a nominal fee may be charged to members requesting a copy of their own images.
- When the fees submitted for any combination of intraoral radiographic images in a single treatment series meet or exceed the fee for a complete intraoral series, Dental Blue considers the radiographic images to be the equivalent fee of a complete series, D0210, and an allowance will be made up to the allowance for procedure D0210 and be considered that the time limit of the D0210 has been met.
- The fee for working images for root canals, surgical and non-surgical procedures, and all post cementation radiographs are included in the allowance of the primary procedure.
- Diagnostic images for temporomandibular joint related services are not a covered benefit.
- Panoramic or bitewing images extracted from a Cone-Beam CT are not a covered benefit and should not be reported under any other imaging codes (ex. D0270-D0274 and D0330) besides the appropriate Cone-Beam CT code.

Preventive services

Prophylaxis and Space Maintenance

- The fee for a prophylaxis is inclusive of the reimbursement for periodontal maintenance, scaling in the presence of gingival inflammation, scaling and root planning or periodontal surgery performed on the same date of service. Therefore, it should not be billed separately to the member.
- The use of prophylaxis pastes containing fluoride is included in the reimbursement for procedures D1110, D1120, D4910, and D4346. It should not be billed separately as a fluoride treatment.
- A space maintainer is considered a temporary appliance that will be used for a specific period prior to the eruption of permanent teeth.
- Removal of a space maintainer is not a covered benefit when performed by same dentist/dental office.
- The fee for a space maintainer includes all of its components, such as teeth, clasps, and rests.

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.

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.

Periodontal Services

Procedure submission 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 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 and subgingival calculus must be evident radiographically for scaling and root planning to be considered for coverage.
- Laser Assisted New Attachment Procedures (LANAP) is not a covered benefit and should not be submitted using Periodontal surgery codes.

When more than one periodontal service (codes D4000-D4999) is completed within the same site or quadrant on the same date of service, BCBSMA 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. To request an exception to the two quadrant limitation of coverage 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 for consideration of coverage.

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.

Prosthodontic services

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. All endodontic retreatments must be completed satisfactorily before prosthetic treatment consideration.
- 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.

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.

Orthodontic services

Benefit administration

Limited Orthodontic Treatment. Use these codes for orthodontic treatment that involves a specific, defined, and limited scope. Treatment may occur in any stage of dental development or dentition. For example: Treatment of a single tooth in crossbite or a tooth that needs guidance during eruption.

Comprehensive Orthodontic Treatment. Use these codes when treatment involves correction of all of the patient's dentofacial issues including any skeletal, muscular, and dental alignment and occlusion issues. For example: 24-month treatment plan to correct crowding and alignment in both arches.

How to submit claims for orthodontic treatment

Limited Treatment. Submit the ADA claim form with the appropriate CDT procedure code based on the patient's stage of dentition when the treatment started, total treatment charge and the date treatment began (date appliance placed). 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 ADA claim form with the appropriate CDT procedure code based on the patient's stage of dentition when the treatment started, total treatment charge, total months of treatment and the date treatment began (date appliance placed).

We will make monthly payments for these comprehensive treatments. The initial monthly payment will be equal to 50% of the patient's orthodontic benefit maximum for covered services less any member cost share. We will pay the rest in monthly installments until the treatment plan is complete, or benefits are exhausted. You do not need to submit for these monthly claims; we will generate the payments automatically.

Refer to **Billing and Reimbursement** under **section 4** of the Blue Book for submission guidelines on any of the following cases:

- **"work in progress"** - comprehensive treatment began before the patient's orthodontic benefits became effective
- **"takeover-case"** - comprehensive treatment began in another office and you are completing the treatment plan for the patient
- **"continuation of treatment"** - comprehensive treatment that requires additional months of treatment than originally reported on the initial treatment plan submission.

Multi-Phase Treatment. There must be a minimum of a six month "rest period" between the completion of phase 1 and the start of phase 2, with all appliances from phase 1 treatment removed prior to the start of phase 2 treatment.

Medically necessary orthodontic services. Require an approved prior authorization (PA). To be eligible, a child must have a severe and handicapping malocclusion or misalignment of teeth. Only orthodontists are allowed to perform Essential Health Benefits (EHB) orthodontic services. Services rendered without obtaining a PA approval will not be covered. If prior authorization has not been requested or approved, the claim will deny. Authorizations will only be given to new cases and not takeover cases.

To request PA for:	Please:
Medically necessary orthodontic services	1. Submit the services requested on a dental claim form with the Pre-Treatment Estimate box checked. 2. Include the appropriate documentation for review of Comprehensive Orthodontics (D8080/D8091) including Pre-Treatment Claim Form, HLD

	Index Form, Orthodontic prior authorization form, cephalometric and panoramic images, and photographic prints showing lateral, occlusal, and frontal views for comprehensive orthodontic cases. 3. Include appropriate documentation for review of Limited Orthodontic (**D8010**, **D8020**) cases Pre-Treatment Claim Form, photographic prints, and the Orthodontic prior authorization form. 4. Send the prior authorization request electronically, if possible. If your Pre-Treatment Estimate has been approved, you can consider this to be your approved prior authorization.
Occlusal guards	1. Submit the services requested on a dental claim form with the Pretreatment Estimate box checked. 2. Submit a narrative stating the necessity and appropriateness of an occlusal guard for prior authorization of this service. Do not enter a date of service on the claim. 3. Remember to: Enter an "X" in Box 1 of the claim form next to "Request for Predetermination/Preauthorization." List the services to be included in the prior authorization. 4. Send the prior authorization request electronically, if possible. If your Pre-Treatment Estimate has been approved, you can consider this to be your approved prior authorization.

Documents required for medically necessary prior authorization requests

Submit the following with the ADA Pre-Treatment Estimate form **(Note: Items 1, 4, and 5 are not required for Limited Orthodontic cases** (D8010/ D8020):

1. **Handicapping Labio-Lingual Deviations form**. Coverage for medically necessary orthodontics is determined by a minimum HLD Score of 22 or by an autoqualifier. Approval is based after consultant review of the appropriate documentation submitted.
2. **Pediatric Essential Health Benefits Prior Authorization form**
3. **Photographic Prints.** Photographic prints should be mounted, indicating the provider and patient names and the date.
   - Facial View: Be sure the patient's face is clearly discernible.
   - Lateral Views: Take views with sufficient soft tissue retraction to expose the buccal dentition, and as close to ninety degrees to the plane of the buccal dentition as possible (use of a mirror may be necessary.) The use of pediatric-size lip retractors facilitates sufficient soft tissue retraction. Photographs should allow evaluation of the antero-posterior relationship.
   - Occlusal Views: Take occlusal views with a mirror and retract so that the soft tissue of the lower lip does not cover the lower incisors. Try to include as many teeth as possible. Please measure the clinical widths of the maxillary and mandibular right central incisors, and enter the measurements on the HLD Recording Form.
4. **Cephalometric radiographic image**
5. **Panoramic radiographic image.** All teeth must be clearly visible.

We cannot prior authorize cases without complete information. We will return orthodontic records to the provider if submitted with a self-addressed, stamped return envelope.

Billing for medically necessary orthodontic treatment

You must have an approved prior authorization before beginning treatment; failure to do so will result in a denial of payment(s). If the case is:

- **Approved:** Submit the ADA claim form in accordance with the approved prior authorization, total treatment charge, total months of treatment and the date treatment began (date appliance placed). Payment (total case allowance – member's cost share) will be made monthly over the course of treatment. The member must be eligible on the date of service. The overall case allowance includes the allowance for the pre-orthodontic records, retention (D8680) and follow-up visits; these are not separately reimbursed. You may not bill members for broken, repaired, or replacement brackets or wires.

- **Denied:** Submit the ADA claim form for CDT procedure code D8660 that includes all components of the orthodontic work-up. We will make payment after receipt of initial claim for treatment.

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
D0120	Diagnostic	Periodic oral evaluation – established patient	Two per calendar year of D0145 or D0120. Considered inclusive when performed on the same day as palliative treatment by the same dentist/dental office. Note: 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.	Two per calendar year. Considered inclusive when performed on the same day as palliative treatment by the same dentist/dental office. Note: 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.	None
D0140	Diagnostic	Limited oral evaluation – problem-focused	Two per calendar year. Considered inclusive when performed on the same day as palliative treatment by the same dentist/dental office. Note: 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.	Two per calendar year. Considered inclusive when performed on the same day as palliative treatment by the same dentist/dental office. Note: 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.	None
D0145	Diagnostic	Oral evaluation for a patient under three years of age and counseling with primary caregiver	Two per calendar year of D0145 or D0120. Note: 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.	Not a covered benefit. Note: 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.	None
D0150	Diagnostic	Comprehensive oral evaluation - new or established patient	One per member per lifetime, per dentist or location. Note: One evaluation code may be billed per dentist per date of service. Evaluations including	Once per 60 months per dentist or location. Considered inclusive when performed on the same day as palliative treatment by the same dentist/dental office	None

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
			diagnosis and treatment planning is the responsibility of the dentist. All evaluations must be completed by a dentist.	Note: 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.	
D0160	Diagnostic	Detailed, extensive oral evaluation – problem-focused, by report	Two per twelve months. Considered inclusive when performed same day as palliative treatment by the same dentist/dental office. Note: 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.	Not a covered benefit.	Detailed narrative
D0170	Diagnostic	Re-evaluation – limited, problem focused (established patient; not post-operative visit)	Not a covered benefit.	Two per twelve months. Not to be used as a periodontal reevaluation. Considered inclusive when performed on the same day as any other definitive service including palliative treatment by the same dentist/dental office. Note: 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.	None
D0171	Diagnostic	Re-evaluation – post operative office visit	Not a covered benefit.	Not a covered benefit.	None
D0180	Diagnostic	Comprehensive periodontal evaluation – new or established patient	Not a covered benefit.	Once per 60 months per dentist or location. Considered inclusive when	None

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
				performed on the same day as palliative treatment by the same dentist/dental office.	
D0190	Diagnostic	Screening of a patient	Not a covered benefit.	Not a covered benefit.	None
D0191	Diagnostic	Assessment of a patient	Not a covered benefit.	Not a covered benefit.	None
D0210	Diagnostic	Intraoral – comprehensive series of radiographic images	One full mouth series (D0210) or panorex (D0330) per three calendar years and consists of a minimum of 7 or more radiographs, including bitewings.	One full mouth series (D0210) or panorex (D0330) per 60 months and consists of a minimum of 7 or more radiographs, including bitewings.	None
D0220	Diagnostic	Intraoral – periapical first radiographic image	One per day per member per (provider or location). Twelve of (D0220, D0230) per 12 months per member. If reported with Endodontics therapy, radiographs are included in the fee for the procedure.	A maximum of 6 radiographs per date of service. Any combination of radiographs that exceed 6 will be processed as D0210. If reported with Endodontics therapy, radiographs are included in the fee for the procedure.	None
D0230	Diagnostic	Intraoral - periapical each additional radiographic image	Three per day per member per (provider or location). Twelve of (D0220, D0230) per 12 months per member. If reported with Endodontics therapy, radiographs are included in the fee for the procedure.	A maximum of 6 radiographs per date of service. Any combination of radiographs that exceed 6 will be processed as D0210. If reported with Endodontics therapy, radiographs are included in the fee for the procedure.	None
D0240	Diagnostic	Intraoral - occlusal radiographic image	Not a covered benefit.	One film per arch per 6 months.	None
D0250	Diagnostic	Extra-oral – first 2D projection radiographic image created using a stationary radiation source, and detector	Not a covered benefit.	Not a covered benefit.	None
D0251	Diagnostic	Extra-oral posterior dental radiographic image	Not a covered benefit.	Not a covered benefit.	None
D0270	Diagnostic	Bitewing - single radiographic image	Two per calendar year per member. Bitewing radiographs reported within 6 months of D0210 are considered inclusive. If reported within 6 months of D0330, we will make an allowance for the difference between the payment of the	One per 6 months per member. Bitewing radiographs reported within 6 months of D0210 are considered inclusive. If reported within 6 months of D0330, we will make an allowance for the difference	None

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
			panoramic and a full series of radiographs.	between the payment of the panoramic and a full series of radiographs.	
D0272	Diagnostic	Bitewings - two radiographic images	Two per calendar year per member. Bitewing radiographs reported within 6 months of D0210 are considered inclusive. 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.	One per 6 months per member. Bitewing radiographs reported within 6 months of D0210 are considered inclusive. 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.	None
D0273	Diagnostic	Bitewings - three radiographic images	Two per calendar year per member. Bitewing radiographs reported within 6 months of D0210 are considered inclusive. 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.	One per 6 months per member. Bitewing radiographs reported within 6 months of D0210 are considered inclusive. 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.	None
D0274	Diagnostic	Bitewings - four radiographic images	Two per calendar year per member. Bitewing radiographs reported within 6 months of D0210 are considered inclusive. 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.	One per 6 months per member. Bitewing radiographs reported within 6 months of D0210 are considered inclusive. 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.	None
D0277	Diagnostic	Vertical bitewings – 7 to 8 radiographic images. This does not constitute a full mouth intraoral radiographic series.	Not a covered benefit.	One set per 12 months.	None
D0310	Diagnostic	Sialography	Not a covered benefit.	Not a covered benefit.	None
D0320	Diagnostic	Temporomandibular joint arthrogram, including injection	Not a covered benefit.	Not a covered benefit.	None
D0321	Diagnostic	Other temporomandibular joint radiographic images, by report	Not a covered benefit.	Not a covered benefit.	None

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
D0322	Diagnostic	Tomographic survey	Not a covered benefit.	Not a covered benefit.	None
D0330	Diagnostic	Panoramic radiographic image	One full mouth series (D0210) or panorex (D0330) per three calendar years. 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.	One full mouth series (D0210) or panorex (D0330) 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.	None
D0340	Diagnostic	2D cephalometric radiographic image – acquisition, measurement, and analysis	Covered benefit for orthodontic services.	Not a covered benefit.	None
D0350	Diagnostic	2D oral/facial photographic image obtained intra-orally or extra-orally	Not a covered benefit.	Covered only when the Plan requests that photos be submitted for utilization review. Otherwise, not covered.	None
D0364	Diagnostic	Cone beam CT capture and interpretation with limited field of view – less than one whole jaw	Not a covered benefit.	Not a covered benefit.	None
D0365	Diagnostic	Cone beam CT capture and interpretation with limited field of one full dental arch – mandible	Not a covered benefit.	Not a covered benefit.	None
D0366	Diagnostic	Cone beam CT capture and interpretation with field of view of one full dental arch – maxilla, with or without cranium	Not a covered benefit.	Not a covered benefit.	None
D0367	Diagnostic	Cone beam CT capture and interpretation with field of view of both jaws; with or without cranium	Not a covered benefit.	Not a covered benefit.	None
D0368	Diagnostic	Cone beam CT capture and interpretation for TMJ series including two or more exposures	Not a covered benefit.	Not a covered benefit.	None
D0369	Diagnostic	Maxillofacial MRI capture and interpretation	Not a covered benefit.	Not a covered benefit.	None
D0370	Diagnostic	Maxillofacial ultrasound capture and interpretation	Not a covered benefit.	Not a covered benefit.	None
D0371	Diagnostic	Sialoendoscopy capture and interpretation	Not a covered benefit.	Not a covered benefit.	None
D0372	Diagnostic	Intraoral tomosynthesis – comprehensive series of radiographic images	Not a covered benefit.	Not a covered benefit.	None
D0373	Diagnostic	Intraoral tomosynthesis – bitewing radiographic image	Not a covered benefit.	Not a covered benefit.	None

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
D0374	Diagnostic	Intraoral tomosynthesis – periapical radiographic image	Not a covered benefit.	Not a covered benefit.	None
D0380	Diagnostic	Cone beam CT image capture with limited field of view – less than one whole jaw	Not a covered benefit.	Not a covered benefit.	None
D0381	Diagnostic	Cone beam CT image capture with field of view of one full dental arch – mandible	Not a covered benefit.	Not a covered benefit.	None
D0382	Diagnostic	Cone beam CT image capture with field of view of one full dental arch – maxilla, with or without cranium	Not a covered benefit.	Not a covered benefit.	None
D0383	Diagnostic	Cone beam CT image capture with field of view of both jaws, with or without cranium	Not a covered benefit.	Not a covered benefit.	None
D0384	Diagnostic	Cone beam CT image capture for TMJ series including two or more exposures	Not a covered benefit.	Not a covered benefit.	None
D0385	Diagnostic	Maxillofacial MRI image capture	Not a covered benefit.	Not a covered benefit.	None
D0386	Diagnostic	Maxillofacial ultrasound image capture	Not a covered benefit.	Not a covered benefit.	None
D0387	Diagnostic	Intraoral tomosynthesis – comprehensive series of radiographic images – image capture only	Not a covered benefit.	Not a covered benefit.	None
D0388	Diagnostic	Intraoral tomosynthesis – bitewing radiographic image – image capture only	Not a covered benefit.	Not a covered benefit.	None
D0389	Diagnostic	Intraoral tomosynthesis – periapical radiographic image – image capture only	Not a covered benefit.	Not a covered benefit.	None
D0391	Diagnostic	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report	Not a covered benefit.	Not a covered benefit.	None
D0393	Diagnostic	Virtual treatment simulation using 3D image volume or surface scan	Not a covered benefit.	Not a covered benefit.	None
D0394	Diagnostic	Digital subtraction of two or more images or image volumes of the same modality to demonstrate changes that occurred over time	Not a covered benefit.	Not a covered benefit.	None
D0395	Diagnostic	Fusion of two or more 3D image volumes of one or more modalities	Not a covered benefit.	Not a covered benefit.	None
D0396	Diagnostic	3D printing of a 3D dental surface scan	Not a covered benefit.	Not a covered benefit.	None
D0411	Diagnostic	HbA1c in-office point-of-service testing	Not a covered benefit.	Not a covered benefit.	None
D0412	Diagnostic	Blood glucose level test – in-office using a glucose meter	Not a covered benefit.	Not a covered benefit.	None
D0414	Diagnostic	Laboratory processing of microbial specimen to include culture and sensitivity studies, preparation and transmission of written report	Not a covered benefit.	Not a covered benefit.	None

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
D0415	Diagnostic	Collection of microorganisms for culture and sensitivity	Not a covered benefit.	Not a covered benefit.	None
D0416	Diagnostic	Viral culture. A diagnostic test to identify viral organisms, most often herpes virus.	Not a covered benefit.	Not a covered benefit.	None
D0417	Diagnostic	Collection and preparation of saliva sample for laboratory analysis	Not a covered benefit.	Not a covered benefit.	None
D0418	Diagnostic	Analysis of saliva sample - laboratory	Not a covered benefit.	Not a covered benefit.	None
D0419	Diagnostic	Assessment of salivary flow by measurement	Not a covered benefit.	Not a covered benefit.	None
D0422	Diagnostic	Collection and preparation of genetic sample material for laboratory analysis and report	Not a covered benefit.	Not a covered benefit.	None
D0423	Diagnostic	Genetic test for susceptibility to diseases – specimen analysis	Not a covered benefit.	Not a covered benefit.	None
D0425	Diagnostic	Caries susceptibility tests. Not to be used for carious dentin staining.	Not a covered benefit.	Not a covered benefit.	None
D0426	Diagnostic	Collection, preparation, and analysis of saliva sample – point-of-care	Not a covered benefit.	Not a covered benefit.	None
D0431	Diagnostic	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 covered benefit.	Not a covered benefit.	None
D0460	Diagnostic	Pulp vitality tests	Considered inclusive of other evaluation or endodontic services performed on the same day. Not a covered benefit in any other circumstance.	Considered inclusive of other evaluation or endodontic services performed on the same day. Not a covered benefit in any other circumstance.	None
D0461	Diagnostic	Testing for cracked tooth	Considered inclusive of other evaluation services performed on the same day. Not a covered benefit in any other circumstance.	Considered inclusive of other evaluation services performed on the same day. Not a covered benefit in any other circumstance.	None
D0470	Diagnostic	Diagnostic casts	Not a covered benefit.	Not a covered benefit.	None
D0472	Diagnostic	Accession of tissue, gross examination, preparation and transmission of written report	Not a covered benefit.	Not a covered benefit.	None
D0473	Diagnostic	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	Not a covered benefit.	Not a covered benefit.	None
D0474	Diagnostic	Accession of tissue, gross and microscopic examination, including	Not a covered benefit.	Not a covered benefit.	None

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
		assessment of surgical margins for presence of disease, preparation and transmission of written report			
D0475	Diagnostic	Decalcification procedure	Not a covered benefit.	Not a covered benefit.	None
D0476	Diagnostic	Special stains for microorganisms	Not a covered benefit.	Not a covered benefit.	None
D0477	Diagnostic	Special stains, not for microorganisms	Not a covered benefit.	Not a covered benefit.	None
D0478	Diagnostic	Immunohistochemical stains	Not a covered benefit.	Not a covered benefit.	None
D0479	Diagnostic	Tissue in-site hybridization, including interpretation	Not a covered benefit.	Not a covered benefit.	None
D0480	Diagnostic	Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report	Not a covered benefit.	Not a covered benefit.	None
D0481	Diagnostic	Electron microscopy	Not a covered benefit.	Not a covered benefit.	None
D0482	Diagnostic	Direct immunofluorescence	Not a covered benefit.	Not a covered benefit.	None
D0483	Diagnostic	Indirect immunofluorescence	Not a covered benefit.	Not a covered benefit.	None
D0484	Diagnostic	Consultation on slides prepared elsewhere	Not a covered benefit.	Not a covered benefit.	None
D0485	Diagnostic	Consultation, including preparation of slides from biopsy material supplied by referring source	Not a covered benefit.	Not a covered benefit.	None
D0486	Diagnostic	Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation, and transmission of written report	Not a covered benefit.	Not a covered benefit.	None
D0502	Diagnostic	Other oral pathology procedures, by report	Not a covered benefit.	Not a covered benefit.	None
D0600	Diagnostic	Non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin and cementum	Not a covered benefit.	Not a covered benefit.	None
D0601	Diagnostic	Caries risk assessment and documentation, with a finding of low risk	Not a covered benefit.	Not a covered benefit.	None
D0602	Diagnostic	Caries risk assessment and documentation, with a finding of moderate risk	Not a covered benefit.	Not a covered benefit.	None
D0603	Diagnostic	Caries risk assessment and documentation, with a finding of high risk	Not a covered benefit.	Not a covered benefit.	None
D0604	Diagnostic	Antigen testing for a public health-related pathogen including coronavirus	Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's	Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's	None

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
			medical insurance for possible coverage.	medical insurance for possible coverage.	
D0605	Diagnostic	Antibody testing for a public health-related pathogen including coronavirus	Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurance for possible coverage.	Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurance for possible coverage.	None
D0606	Diagnostic	Molecular testing for a public health-related pathogen, including coronavirus	Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurance for possible coverage.	Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurance for possible coverage.	None
D0701	Diagnostic	Panoramic radiographic image – image capture only	Not a covered benefit.	Not a covered benefit.	None
D0702	Diagnostic	2D cephalometric radiographic image – image capture only	Not a covered benefit.	Not a covered benefit.	None
D0703	Diagnostic	2D oral/facial photographic image obtained intra-orally or extra-orally – image capture only	Not a covered benefit.	Not a covered benefit.	None
D0705	Diagnostic	Extra-oral posterior dental radiographic image – image capture only	Not a covered benefit.	Not a covered benefit.	None
D0706	Diagnostic	Intraoral – occlusal radiographic image – image capture only	Not a covered benefit.	Not a covered benefit.	None
D0707	Diagnostic	Intraoral – periapical radiographic image – image capture only	Not a covered benefit.	Not a covered benefit.	None
D0708	Diagnostic	Intraoral – bitewing radiographic image – image capture only	Not a covered benefit.	Not a covered benefit.	None
D0709	Diagnostic	Intraoral – comprehensive series of radiographic images – image capture only	Not a covered benefit.	Not a covered benefit.	None
D0801	Diagnostic	3D intraoral surface scan – direct	Not a covered benefit.	Not a covered benefit.	None
D0802	Diagnostic	3D dental surface scan – indirect	Not a covered benefit.	Not a covered benefit.	None
D0803	Diagnostic	3D facial surface scan – direct	Not a covered benefit.	Not a covered benefit.	None
D0804	Diagnostic	3D facial surface scan – indirect	Not a covered benefit.	Not a covered benefit.	None
D0999	Diagnostic	Unspecified diagnostic procedure, by report	Individual consideration.	Individual consideration.	Detailed narrative
D1110	Preventive	Prophylaxis – adult	Two per calendar year. Use D1110 for ages 14+	Two per calendar year. There must be at least three months between a periodontal maintenance cleaning and any other cleanings. D1110 and D4346 are considered	None

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
				inclusive of D4341 and D4342 when performed on the same day.	
D1120	Preventive	Prophylaxis – child	Two per calendar year. Use D1120 for ages 0 – 13	Not a covered benefit.	None
D1206	Preventive	Topical application of fluoride varnish	Once per 90 day(s) of either code D1206 or D1208.	Not a covered benefit.	None
D1208	Preventive	Topical application of fluoride-excluding varnish	Once per 90 day(s) of either code D1206 or D1208.	Not a covered benefit.	None
D1301	Preventive	Immunization counseling	Not a covered benefit.	Not a covered benefit.	None
D1310	Preventive	Nutritional counseling for control of dental disease	Not a covered benefit.	Not a covered benefit.	None
D1320	Preventive	Tobacco counseling for control and prevention of oral disease	Not a covered benefit.	Not a covered benefit.	None
D1321	Preventive	Counseling for control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use	Not a covered benefit.	Not a covered benefit.	None
D1330	Preventive	Oral hygiene instructions	Not a covered benefit.	Not a covered benefit.	None
D1351		Sealant – per tooth	Under age 9: Covered for primary and permanent molars. Reapplication only if process fails within three years. Age 9 to under age 19: Covered for permanent non-carious molars for members once every three years per tooth.	Not a covered benefit.	Tooth identification Surface identification
D1353	Preventive	Sealant repair – per tooth	Not a covered benefit.	Not a covered benefit.	None
D1354	Preventive	Application of caries- arresting medicament – per tooth	Not a covered benefit.	Not a covered benefit.	None
D1355	Preventive	Caries preventive medicament application – per tooth, for primary prevention or remineralization.	Not a covered benefit.	Not a covered benefit.	None
D1510	Preventive	Space maintainer – fixed – unilateral – per quadrant	Covered benefit.	Not a covered benefit.	Quadrant identification
D1516	Preventive	Space maintainer – fixed – bilateral, maxillary	Covered benefit.	Not a covered benefit.	Arch identification
D1517	Preventive	Space maintainer-fixed-bilateral, mandibular	Covered benefit.	Not a covered benefit.	Arch identification
D1520	Preventive	Space maintainer – removable – unilateral – per quadrant	Covered benefit.	Not a covered benefit.	Quadrant identification
D1526	Preventive	Space maintainer – removable – bilateral, maxillary	Covered benefit.	Not a covered benefit.	Arch identification

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
D1527	Preventive	Space maintainer – removable – bilateral, mandibular	Covered benefit.	Not a covered benefit.	Arch identification
D1551	Preventive	Re-cement or re-bond bilateral space maintainer – maxillary	Covered benefit.	Not a covered benefit.	Arch identification
D1552	Preventive	Re-cement or re-bond bilateral space maintainer – mandibular	Covered benefit.	Not a covered benefit.	Arch identification
D1553	Preventive	Re-cement or re-bond unilateral space maintainer – per quadrant	Covered benefit.	Not a covered benefit.	Arch identification
D1556	Preventive	Removal of fixed unilateral space maintainer – per quadrant	Not a covered benefit.	Not a covered benefit.	None
D1557	Preventive	Removal of fixed bilateral space maintainer – maxillary	Not a covered benefit.	Not a covered benefit.	None
D1558	Preventive	Removal of fixed bilateral space maintainer – mandibular	Not a covered benefit.	Not a covered benefit.	None
D1575	Preventive	Distal shoe space maintainer- fixed unilateral – per quadrant	Once per arch or quadrant per lifetime.	Not a covered benefit.	Quadrant identification
D1701	Preventive	Pfizer-BioNTech COVID-19 vaccine administration – first dose	Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurer for possible coverage.	Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurer for possible coverage.	None
D1702	Preventive	Pfizer-BioNTech COVID-19 vaccine administration – second dose	Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurer for possible coverage.	Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurer for possible coverage.	None
D1703	Preventive	Moderna COVID-19 vaccine administration – first dose	Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurer for possible coverage.	Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurer for possible coverage.	None
D1704	Preventive	Moderna COVID-19 vaccine administration – second dose	Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurer for possible coverage.	Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurer for possible coverage.	None
D1708	Preventive	Pfizer-BioNTech Covid-19 vaccine administration – third dose	Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's	Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's	None

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
			medical insurer for possible coverage.	medical insurer for possible coverage.	
D1709	Preventive	Pfizer-BioNTech Covid-19 vaccine administration – booster dose	Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurer for possible coverage.	Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurer for possible coverage.	None
D1710	Preventive	Moderna Covid-19 vaccine administration – third dose	Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurer for possible coverage.	Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurer for possible coverage.	None
D1711	Preventive	Moderna Covid-19 vaccine administration – booster dose	Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurer for possible coverage.	Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurer for possible coverage.	None
D1713	Preventive	Pfizer-BioNTech Covid-19 vaccine administration tris-sucrose pediatric – first dose	Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurer for possible coverage.	Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurer for possible coverage.	None
D1714	Preventive	Pfizer-BioNTech Covid-19 vaccine administration tris-sucrose pediatric – second dose	Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurer for possible coverage.	Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurer for possible coverage.	None
D1720	Preventive	Influenza vaccine administration	Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurer for possible coverage.	Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurer for possible coverage.	None
D1781	Preventive	Vaccine administration – human papillomavirus – Dose 1	Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurer for possible coverage.	Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurer for possible coverage.	None

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
D1782	Preventive	Vaccine administration – human papillomavirus – Dose 2	Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurer for possible coverage.	Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurer for possible coverage.	None
D1783	Preventive	Vaccine administration – human papillomavirus – Dose 3	Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurer for possible coverage.	Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurer for possible coverage.	None
D1999	Preventive	Unspecified preventive procedure, by report	Individual consideration.	Individual consideration.	Detailed narrative
D2140	Restorative	Amalgam – one surface, primary or permanent	One restoration per tooth surface per 12 months. Multiple restorations on the same tooth with contiguous or some duplicate surfaces will be adjudicated as a single, more comprehensive restoration. Note: 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). If pins are used, they should be reported separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction, or abrasion are not covered benefits.	One restoration per tooth surface per 24 months. Multiple restorations on the same tooth with contiguous or some duplicate surfaces will be adjudicated as a single, more comprehensive restoration. Note: 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). If pins are used, they should be reported separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction, or abrasion are not covered benefits.	Tooth identification Surface identification
D2150	Restorative	Amalgam – two surfaces, primary or permanent	One restoration per tooth surface per 12 months. Multiple restorations on the same tooth with contiguous or some duplicate surfaces will be	One restoration per tooth surface per 24 months. Multiple restorations on the same tooth with contiguous or some duplicate surfaces	Tooth identification Surface identification

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
			adjudicated as a single, more comprehensive restoration. Note: 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). If pins are used, they should be reported separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction, or abrasion are not covered benefits.	will be adjudicated as a single, more comprehensive restoration. Note: 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). If pins are used, they should be reported separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction, or abrasion are not covered benefits.	
D2160	Restorative	Amalgam – three surfaces, primary or permanent	One restoration per tooth surface per 12 months. Multiple restorations on the same tooth with contiguous or some duplicate surfaces will be adjudicated as a single, more comprehensive restoration. Note: 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). If pins are used, they should be reported separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction, or abrasion are not covered benefits.	One restoration per tooth surface per 24 months. Multiple restorations on the same tooth with contiguous or some duplicate surfaces will be adjudicated as a single, more comprehensive restoration. Note: 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). If pins are used, they should be reported separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction, or	Tooth identification Surface identification

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
				abrasion are not covered benefits.	
D2161	Restorative	Amalgam – four or more surfaces, primary or permanent	One restoration per tooth surface per 12 months. Multiple restorations on the same tooth with contiguous or some duplicate surfaces will be adjudicated as a single, more comprehensive restoration. Note: 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). If pins are used, they should be reported separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction, or abrasion are not covered benefits.	One restoration per tooth surface per 24 months. Multiple restorations on the same tooth with contiguous or some duplicate surfaces will be adjudicated as a single, more comprehensive restoration. Note: 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). If pins are used, they should be reported separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction, or abrasion are not covered benefits.	Tooth identification Surface identification
D2330	Restorative	Resin-based composite – one surface, anterior	One restoration per tooth surface per 12 months. Multiple restorations on the same tooth with contiguous or some duplicate surfaces will be adjudicated as a single, more comprehensive restoration. Note: Resin refers to a broad category of materials including, but not limited to, composites. May include bonded composite, light-cured composite, etc. Tooth preparation, acid-etching, adhesives (including resin bonding agents), liners and bases, localized tissue removal,	One restoration per tooth surface per 24 months. Multiple restorations on the same tooth with contiguous or some duplicate surfaces will be adjudicated as a single, more comprehensive restoration. Note: Resin refers to a broad category of materials including, but not limited to, composites. May include bonded composite, light-cured composite, etc. Tooth preparation, acid-etching, adhesives (including resin	Tooth identification Surface identification

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
			direct and indirect pulp cap, local anesthesia and curing are included as part of the restoration. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used they should be reported separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction or abrasion are not covered benefits.	bonding agents), liners and bases, localized tissue removal, direct and indirect pulp cap, local anesthesia and curing are included as part of the restoration. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used they should be reported separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction or abrasion are not covered benefits.	
D2331	Restorative	Resin-based composite – two surfaces, anterior	One restoration per tooth surface per 12 months. Multiple restorations on the same tooth with contiguous or some duplicate surfaces will be adjudicated as a single, more comprehensive restoration. Note: Resin refers to a broad category of materials including, but not limited to, composites. May include bonded composite, light-cured composite, etc. Tooth preparation, acid-etching, adhesives (including resin bonding agents), liners and bases, localized tissue removal, direct and indirect pulp cap, local anesthesia and curing are included as part of the restoration. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used they should be reported separately (see D2951). Restorations are only allowed for fracture or	One restoration per tooth surface per 24 months. Multiple restorations on the same tooth with contiguous or some duplicate surfaces will be adjudicated as a single, more comprehensive restoration. Note: Resin refers to a broad category of materials including, but not limited to, composites. May include bonded composite, light-cured composite, etc. Tooth preparation, acid-etching, adhesives (including resin bonding agents), liners and bases, localized tissue removal, direct and indirect pulp cap, local anesthesia and curing are included as part of the restoration. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used they should be	Tooth identification Surface identification

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
			decay. Restorations for erosion, attrition, abfraction or abrasion are not covered benefits.	reported separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction or abrasion are not covered benefits.	
D2332	Restorative	Resin-based composite – three surfaces, anterior	One restoration per tooth surface per 12 months. Multiple restorations on the same tooth with contiguous or some duplicate surfaces will be adjudicated as a single, more comprehensive restoration. Note: Resin refers to a broad category of materials including, but not limited to, composites. May include bonded composite, light-cured composite, etc. Tooth preparation, acid-etching, adhesives (including resin bonding agents), liners and bases, localized tissue removal, direct and indirect pulp cap, local anesthesia and curing are included as part of the restoration. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used they should be reported separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction or abrasion are not covered benefits.	One restoration per tooth surface per 24 months. Multiple restorations on the same tooth with contiguous or some duplicate surfaces will be adjudicated as a single, more comprehensive restoration. Note: Resin refers to a broad category of materials including, but not limited to, composites. May include bonded composite, light-cured composite, etc. Tooth preparation, acid-etching, adhesives (including resin bonding agents), liners and bases, localized tissue removal, direct and indirect pulp cap, local anesthesia and curing are included as part of the restoration. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used they should be reported separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction or abrasion are not covered benefits.	Tooth identification Surface identification
D2335	Restorative	Resin-based composite – four or more surfaces (anterior)	One restoration per tooth surface per 12 months. Multiple restorations on the same tooth	One restoration per tooth surface per 24 months. Multiple restorations on the	Tooth identification

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
			with contiguous or some duplicate surfaces will be adjudicated as a single, more comprehensive restoration. Note: Resin refers to a broad category of materials including, but not limited to, composites. May include bonded composite, light-cured composite, etc. Tooth preparation, acid-etching, adhesives (including resin bonding agents), liners and bases, localized tissue removal, direct and indirect pulp cap, local anesthesia and curing are included as part of the restoration. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used they should be reported separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction or abrasion are not covered benefits.	same tooth with contiguous or some duplicate surfaces will be adjudicated as a single, more comprehensive restoration. Note: Resin refers to a broad category of materials including, but not limited to, composites. May include bonded composite, light-cured composite, etc. Tooth preparation, acid-etching, adhesives (including resin bonding agents), liners and bases, localized tissue removal, direct and indirect pulp cap, local anesthesia and curing are included as part of the restoration. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used they should be reported separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction or abrasion are not covered benefits.	Surface identification
D2390	Restorative	Resin-based composite crown, anterior	One per tooth per 12 months. Note: Resin refers to a broad category of materials including, but not limited to, composites. May include bonded composite, light-cured composite, etc. Tooth preparation, acid-etching, adhesives (including resin bonding agents), liners and bases, localized tissue removal, direct and indirect pulp cap, local anesthesia and curing are	One per tooth per 24 months. Note: Resin refers to a broad category of materials including, but not limited to, composites. May include bonded composite, light-cured composite, etc. Tooth preparation, acid-etching, adhesives (including resin bonding agents), liners and bases, localized tissue removal, direct and indirect	Tooth identification

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
			included as part of the restoration. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used they should be reported separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction or abrasion are not covered benefits.	pulp cap, local anesthesia and curing are included as part of the restoration. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used they should be reported separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction or abrasion are not covered benefits.	
D2391	Restorative	Resin-based composite – one surface, posterior	One restoration per tooth surface per 12 months. Multiple restorations on the same tooth with contiguous or some duplicate surfaces will be adjudicated as a single, more comprehensive restoration. Note: Resin refers to a broad category of materials including, but not limited to, composites. May include bonded composite, light-cured composite, etc. Tooth preparation, acid-etching, adhesives (including resin bonding agents), liners and bases, localized tissue removal, direct and indirect pulp cap, local anesthesia and curing are included as part of the restoration. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used they should be reported separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction or abrasion are not covered benefits.	One restoration per tooth surface per 24 months. Multiple restorations on the same tooth with contiguous or some duplicate surfaces will be adjudicated as a single, more comprehensive restoration. Note: Resin refers to a broad category of materials including, but not limited to, composites. May include bonded composite, light-cured composite, etc. Tooth preparation, acid-etching, adhesives (including resin bonding agents), liners and bases, localized tissue removal, direct and indirect pulp cap, local anesthesia and curing are included as part of the restoration. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used they should be reported separately (see D2951). Restorations are only allowed for fracture or	Tooth identification Surface identification

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				decay. Restorations for erosion, attrition, abfraction or abrasion are not covered benefits.	
D2392	Restorative	Resin-based composite – two surfaces, posterior	One restoration per tooth surface per 12 months. Multiple restorations on the same tooth with contiguous or some duplicate surfaces will be adjudicated as a single, more comprehensive restoration. Note: Resin refers to a broad category of materials including, but not limited to, composites. May include bonded composite, light-cured composite, etc. Tooth preparation, acid-etching, adhesives (including resin bonding agents), liners and bases, localized tissue removal, direct and indirect pulp cap, local anesthesia and curing are included as part of the restoration. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used they should be reported separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction or abrasion are not covered benefits.	One restoration per tooth surface per 24 months. Multiple restorations on the same tooth with contiguous or some duplicate surfaces will be adjudicated as a single, more comprehensive restoration. Note: Resin refers to a broad category of materials including, but not limited to, composites. May include bonded composite, light-cured composite, etc. Tooth preparation, acid-etching, adhesives (including resin bonding agents), liners and bases, localized tissue removal, direct and indirect pulp cap, local anesthesia and curing are included as part of the restoration. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used they should be reported separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction or abrasion are not covered benefits.	Tooth identification Surface identification
D2393	Restorative	Resin-based composite – three surfaces, posterior	One restoration per tooth surface per 12 months. Multiple restorations on the same tooth with contiguous or some duplicate surfaces will be	One restoration per tooth surface per 24 months. Multiple restorations on the same tooth with contiguous or some duplicate surfaces will be adjudicated as a	Tooth identification Surface identification

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
			adjudicated as a single, more comprehensive restoration. Note: Resin refers to a broad category of materials including, but not limited to, composites. May include bonded composite, light-cured composite, etc. Tooth preparation, acid-etching, adhesives (including resin bonding agents), liners and bases, localized tissue removal, direct and indirect pulp cap, local anesthesia and curing are included as part of the restoration. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used they should be reported separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction or abrasion are not covered benefits.	single, more comprehensive restoration. Note: Resin refers to a broad category of materials including, but not limited to, composites. May include bonded composite, light-cured composite, etc. Tooth preparation, acid-etching, adhesives (including resin bonding agents), liners and bases, localized tissue removal, direct and indirect pulp cap, local anesthesia and curing are included as part of the restoration. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used they should be reported separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction or abrasion are not covered benefits.	
D2394	Restorative	Resin-based composite – four or more surfaces, posterior	One restoration per tooth surface per 12 months. Multiple restorations on the same tooth with contiguous or some duplicate surfaces will be adjudicated as a single, more comprehensive restoration. Note: Resin refers to a broad category of materials including, but not limited to, composites. May include bonded composite, light-cured composite, etc. Tooth preparation, acid-etching, adhesives (including resin bonding agents), liners and	One restoration per tooth surface per 24 months. Multiple restorations on the same tooth with contiguous or some duplicate surfaces will be adjudicated as a single, more comprehensive restoration. Note: Resin refers to a broad category of materials including, but not limited to, composites. May include bonded composite, light-cured composite, etc. Tooth preparation, acid-etching,	Tooth identification Surface identification

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
			bases, localized tissue removal, direct and indirect pulp cap, local anesthesia and curing are included as part of the restoration. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used they should be reported separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction or abrasion are not covered benefits.	adhesives (including resin bonding agents), liners and bases, localized tissue removal, direct and indirect pulp cap, local anesthesia and curing are included as part of the restoration. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used they should be reported separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction or abrasion are not covered benefits.	
D2410	Restorative	Gold foil, one surface	Not a covered benefit.	One restoration per tooth surface per 24 months. Multiple restorations on the same tooth with contiguous or some duplicate surfaces will be adjudicated as a single, more comprehensive restoration. 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 member is responsible for the remainder of the charge.	Tooth identification Surface identification
D2420	Restorative	Gold foil, two surfaces	Not a covered benefit.	One restoration per tooth surface per 24 months. Multiple restorations on the same tooth with contiguous or some duplicate surfaces will be adjudicated as a single, more comprehensive restoration. Restoration	Tooth identification Surface identification

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
				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 member is responsible for the remainder of the charge.	
D2430	Restorative	Gold foil, three surfaces	Not a covered benefit.	One restoration per tooth surface per 24 months. Multiple restorations on the same tooth with contiguous or some duplicate surfaces will be adjudicated as a single, more comprehensive restoration. 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 member is responsible for the remainder of the charge.	Tooth identification Surface identification
D2510	Restorative	Inlay – metallic, one surface	Not a covered benefit.	One restoration per tooth surface per 84 months. Alternate benefit of a corresponding amalgam restoration paid for metallic inlays. The member is responsible for the balance. Note: an inlay is considered to be an intra-coronal dental restoration, made outside the oral cavity to conform to the prepared cavity, which does not restore any cusps tips.	Tooth identification Surface identification

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
D2520	Restorative	Inlay – metallic, two surfaces	Not a covered benefit.	One restoration per tooth surface per 84 months. Alternate benefit of a corresponding amalgam restoration paid for metallic inlays. The member is responsible for the balance. Note: an inlay is considered to be an intra-coronal dental restoration, made outside the oral cavity to conform to the prepared cavity, which does not restore any cusps tips.	Tooth identification Surface identification
D2530	Restorative	Inlay – metallic, three or more surfaces	Not a covered benefit.	One restoration per tooth surface per 84 months. Alternate benefit of a corresponding amalgam restoration paid for metallic inlays. The member is responsible for the balance. Note: an inlay is considered to be an intra-coronal dental restoration, made outside the oral cavity to conform to the prepared cavity, which does not restore any cusps tips.	Tooth identification Surface identification
D2542	Restorative	Onlay – metallic, two surfaces	Not a covered benefit.	One restoration per tooth surface per 84 months. Limited to permanent posterior teeth 1-5, 12-21, 28-32. Note: An onlay is considered to be 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.	Tooth identification Surface identification

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
D2543	Restorative	Onlay – metallic, three surfaces	Not a covered benefit.	One restoration per tooth surface per 84 months. Limited to permanent posterior teeth 1-5, 12-21, 28-32. Note: An onlay is considered to be 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.	Tooth identification Surface identification
D2544	Restorative	Onlay – metallic, four or more surfaces	Not a covered benefit.	One restoration per tooth surface per 84 months. Limited to permanent posterior teeth 1-5, 12-21, 28-32. Note: An onlay is considered to be 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.	Tooth identification Surface identification
D2610	Restorative	Inlay – porcelain/ceramic, one surface	Not a covered benefit.	One restoration per tooth surface per 84 months. Note: an inlay is considered to be an intra-coronal dental restoration, made outside the oral cavity to conform to the prepared cavity, which does not restore any cusps tips.	Tooth identification Surface identification
D2620	Restorative	Inlay – porcelain/ceramic, two surfaces	Not a covered benefit.	One restoration per tooth surface per 84 months. Note: an inlay is considered to be an intra-coronal dental restoration, made outside the oral cavity to conform to the prepared cavity, which	Tooth identification Surface identification

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
				does not restore any cusps tips.	
D2630	Restorative	Inlay – porcelain/ceramic, three or more surfaces	Not a covered benefit.	One restoration per tooth surface per 84 months. Note: an inlay is considered to be an intra-coronal dental restoration, made outside the oral cavity to conform to the prepared cavity, which does not restore any cusps tips.	Tooth identification Surface identification
D2642	Restorative	Onlay – porcelain/ceramic, two surfaces	Not a covered benefit.	One restoration per tooth surface per 84 months. Limited to permanent posterior teeth 1-5, 12-21, 28-32. Note: An onlay is considered to be 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.	Tooth identification Surface identification
D2643	Restorative	Onlay – porcelain/ceramic, three surfaces	Not a covered benefit.	One restoration per tooth surface per 84 months. Limited to permanent posterior teeth 1-5, 12-21, 28-32. Note: An onlay is considered to be 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.	Tooth identification Surface identification
D2644	Restorative	Onlay – porcelain/ceramic, four or more surfaces	Not a covered benefit.	One restoration per tooth surface per 84 months.	Tooth identification Surface identification

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
				Limited to permanent posterior teeth 1-5, 12-21, 28-32. Note: An onlay is considered to be 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.	
D2650	Restorative	Inlay – resin-based composite, one surface	Not a covered benefit.	One restoration per tooth surface per 84 months. Note: an inlay is considered to be an intra-coronal dental restoration, made outside the oral cavity to conform to the prepared cavity, which does not restore any cusps tips.	Tooth identification Surface identification
D2651	Restorative	Inlay – resin-based composite, two surfaces	Not a covered benefit.	One restoration per tooth surface per 84 months. Note: an inlay is considered to be an intra-coronal dental restoration, made outside the oral cavity to conform to the prepared cavity, which does not restore any cusps tips.	Tooth identification Surface identification
D2652	Restorative	Inlay – resin-based composite, three or more surfaces	Not a covered benefit.	One restoration per tooth surface per 84 months. Note: an inlay is considered to be an intra-coronal dental restoration, made outside the oral cavity to conform to the prepared cavity, which does not restore any cusps tips.	Tooth identification Surface identification
D2662	Restorative	Onlay – resin-based composite, two surfaces	Not a covered benefit.	One restoration per tooth surface per 84 months.	Tooth identification

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
				Limited to permanent posterior teeth 1-5, 12-21, 28-32. Note: An onlay is considered to be 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.	Surface identification
D2663	Restorative	Onlay – resin-based composite, three surfaces	Not a covered benefit.	One restoration per tooth surface per 84 months. Limited to permanent posterior teeth 1-5, 12-21, 28-32. Note: An onlay is considered to be 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.	Tooth identification Surface identification
D2664	Restorative	Onlay – resin-based composite, four or more surfaces	Not a covered benefit.	One restoration per tooth surface per 84 months. Limited to permanent posterior teeth 1-5, 12-21, 28-32. Note: An onlay is considered to be 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.	Tooth identification Surface identification
D2710	Restorative	Crown – resin-based composite (indirect)	Once per permanent tooth per 60 months for teeth numbers 3-14 and 19-30.	Once per permanent tooth per 84 months for teeth numbers 3-14 and 19-30.	Tooth identification

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
				Note: Subject to a six-month waiting period for members age 19 and over	
D2712	Restorative	Crown - ¾ resin-based composite (indirect)	Not a covered benefit.	One crown or cast restoration per permanent tooth per 84 months. Note: Subject to a six-month waiting period for members age 19 and over	Tooth identification
D2720	Restorative	Crown - resin with high noble metal	Not a covered benefit.	One crown or cast restoration per permanent tooth per 84 months. Note: Subject to a six-month waiting period for members age 19 and over	Tooth identification
D2721	Restorative	Crown – resin with predominantly base metal	Not a covered benefit.	One crown or cast restoration per permanent tooth per 84 months. Note: Subject to a six-month waiting period for members age 19 and over	Tooth identification
D2722	Restorative	Crown – resin with noble metal	Not a covered benefit.	One crown or cast restoration per permanent tooth per 84 months. Note: Subject to a six-month waiting period for members age 19 and over	Tooth identification
D2740	Restorative	Crown – porcelain/ceramic substrate	Once per tooth per 60 months for teeth numbers 2-15 and 18-31.	One crown or cast restoration per permanent tooth per 84 months. Note: Subject to a six-month waiting period for members age 19 and over	Tooth identification
D2750	Restorative	Crown – porcelain fused to high-noble metal	Once per tooth per 60 months for teeth numbers 2-15 and 18-31.	One crown or cast restoration per permanent tooth per 84 months.	Tooth identification

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
				Note: Subject to a six-month waiting period for members age 19 and over	
D2751	Restorative	Crown – porcelain fused to predominantly base metal	Once per tooth per 60 months for teeth numbers 2-15 and 18-31.	One crown or cast restoration per permanent tooth per 84 months. Note: Subject to a six-month waiting period for members age 19 and over	Tooth identification
D2752	Restorative	Crown – porcelain fused to noble metal	Once per tooth per 60 months for teeth numbers 2-15 and 18-31.	One crown or cast restoration per permanent tooth per 84 months. Note: Subject to a six-month waiting period for members age 19 and over	Tooth identification
D2753	Restorative	Crown – porcelain fused to titanium and titanium alloys	Once per tooth per 60 months for teeth numbers 2-15 and 18-31.	One crown or cast restoration per permanent tooth per 84 months. Note: Subject to a six-month waiting period for members age 19 and over	Tooth identification
D2780	Restorative	Crown – ¾ cast high noble metal	Not a covered benefit.	One crown or cast restoration per permanent tooth per 84 months. Note: Subject to a six-month waiting period for members age 19 and over	Tooth identification
D2781	Restorative	Crown – ¾ cast predominantly base metal	Not a covered benefit.	One crown or cast restoration per permanent tooth per 84 months. Note: Subject to a six-month waiting period for members age 19 and over	Tooth identification
D2782	Restorative	Crown – ¾ cast noble metal	Not a covered benefit.	One crown or cast restoration per permanent tooth per 84 months.	Tooth identification

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				Note: Subject to a six-month waiting period for members age 19 and over	
D2783	Restorative	Crown – ¾ porcelain/ceramic	Not a covered benefit.	One crown or cast restoration per permanent tooth per 84 months. Note: Subject to a six-month waiting period for members age 19 and over	Tooth identification
D2790	Restorative	Crown – full cast high-noble metal	Once per tooth per 60 months for teeth numbers 2-15 and 18-31.	One crown or cast restoration per permanent tooth per 84 months. Note: Subject to a six-month waiting period for members age 19 and over	Tooth identification
D2791	Restorative	Crown – full cast predominantly base metal	Not a covered benefit.	One crown or cast restoration per permanent tooth per 84 months. Note: Subject to a six-month waiting period for members age 19 and over	Tooth identification
D2792	Restorative	Crown – full cast noble metal	Not a covered benefit.	One crown or cast restoration per permanent tooth per 84 months. Note: Subject to a six-month waiting period for members age 19 and over	Tooth identification
D2794	Restorative	Crown – titanium and titanium alloys	Not a covered benefit.	One crown or cast restoration per permanent tooth per 84 months. Note: Subject to a six-month waiting period for members age 19 and over	Tooth identification
D2799	Restorative	Interim crown – further treatment or completion of diagnosis necessary prior to final impression	Not a covered benefit.	Not a covered benefit.	None
D2910	Restorative	Recement inlay, onlay, or partial coverage restoration	One per tooth per 12 months. Not covered within 6 months of initial placement.	One per tooth per 12 months.	Tooth identification

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
				Not covered within 6 months of initial placement.	
D2915	Restorative	Recement cast or prefabricated post and core	Not a covered benefit.	One per tooth per 12 months. Not covered within 6 months of initial placement.	Tooth identification
D2920	Restorative	Recement crown	Once per tooth per 12 months.	Not covered within 6 months of initial placement.	Tooth identification
D2921	Restorative	Reattachment of tooth fragment, incisal edge, or cusp	Not a covered benefit.	Not a covered benefit.	None
D2928	Restorative	Prefabricated porcelain/ceramic crown – permanent tooth	Not a covered benefit.	Not a covered benefit.	None
D2929	Restorative	Prefabricated porcelain/ceramic crown – primary tooth	Not a covered benefit.	Not a covered benefit.	None
D2930	Restorative	Prefabricated stainless steel crown – primary tooth	One per tooth per 12 months. Maximum of four crowns per date of service.	One per tooth per 24 months.	Tooth identification
D2931	Restorative	Prefabricated stainless steel crown – permanent tooth	One per tooth per 12 months. Maximum of four crowns per date of service. Limited to permanent posterior teeth (#2-5, 12-15, 18-21 and 28-31.	Not a covered benefit.	Tooth identification
D2932	Restorative	Prefabricated resin crown	One per tooth per 12 months. Maximum of four crowns per date of service.	Not a covered benefit.	Tooth identification
D2933	Restorative	Prefabricated stainless steel crown with resin window	Not a covered benefit.	Not a covered benefit.	None
D2934	Restorative	Prefabricated esthetic coated stainless steel crown – primary tooth	One per tooth per 12 months. Maximum of four crowns per date of service.	One per tooth per 24 months.	Tooth identification
D2940	Restorative	Placement of interim direct restoration	Not a covered benefit.	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.	Tooth identification

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D2949	Restorative	Restorative foundation for an indirect restoration	Not a covered benefit.	Not a covered benefit.	None
D2950	Restorative	Core buildup, including any pins when required	Not a covered benefit.	Once per permanent tooth per 84 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.	Tooth identification
D2951	Restorative	Pin retention – per tooth, in addition to restoration	Covered when billed with a two or more surface restoration on a permanent tooth only.	Limited to three pins per tooth per lifetime.	Tooth identification
D2952	Restorative	Post and core in addition to crown, indirectly fabricated	Not a covered benefit.	Once per tooth per 84 months (Either D2952 or D2954). If reported with a restoration or a core buildup on the same service date, the restoration or core build-up is considered part of the post-and core procedure.	Tooth identification
D2953	Restorative	Each additional indirectly fabricated post – same tooth	Not a covered benefit.	Once per tooth per lifetime.	Tooth identification
D2954	Restorative	Prefabricated post and core in addition to crown	Once per tooth per 60 months for teeth numbers 2-15 and 18-31.	Once per tooth per 84 months (Either D2952 or D2954). If reported with a restoration or a core buildup on the same service date, the restoration or 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.	Tooth identification
D2955	Restorative	Post removal	Not a covered benefit.	Not a covered benefit.	None
D2956	Restorative	Removal of an indirect restoration on a natural tooth	Not a covered benefit.	Not a covered benefit.	None

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D2957	Restorative	Each additional prefabricated post – same tooth	Not a covered benefit.	Once per tooth per lifetime. Limited to teeth 1-5, 12-21 and 28-32	Tooth identification
D2960	Restorative	Labial veneer (resin laminate) – direct	Not a covered benefit.	Not a covered benefit.	None
D2961	Restorative	Labial veneer (resin laminate) – indirect	Not a covered benefit.	Not a covered benefit.	None
D2962	Restorative	Labial veneer (porcelain laminate) – indirect	Not a covered benefit.	Not a covered benefit.	None
D2971	Restorative	Additional procedures to customize a crown to fit under an existing partial denture framework	Not a covered benefit.	Individual consideration.	Tooth identification Detailed narrative
D2975	Restorative	Coping a thin covering of the coronal portion of the tooth. Usually devoid of anatomic contour that can be used as a definitive restoration	Not a covered benefit.	Not a covered benefit.	None
D2976	Restorative	Band stabilization – per tooth	Not a covered benefit.	Not a covered benefit.	None
D2980	Restorative	Crown repair necessitated by restorative material failure	Covered benefit.	One per tooth per 12 months.	Tooth identification Detailed narrative
D2981	Restorative	Inlay repair necessitated by restorative material failure	Not a covered benefit.	Once per tooth per 12 months.	Tooth identification
D2982	Restorative	Onlay repair necessitated by restorative material failure	Not a covered benefit.	Once per tooth per 12 months.	Tooth identification
D2983	Restorative	Veneer repair necessitated by restorative material failure	Not a covered benefit.	Not a covered benefit.	None
D2989	Restorative	Excavation of a tooth resulting in the determination of non-restorability	Not a covered benefit.	Not a covered benefit.	None
D2990	Restorative	Resin infiltration of incipient smooth surface lesions	Not a covered benefit.	Once per tooth per 12 months.	Tooth identification
D2991	Restorative	Application of hydroxyapatite regeneration medicament – per tooth	Not a covered benefit.	Not a covered benefit.	None
D2999	Restorative	Unspecified restorative procedure, by report	Individual consideration.	Individual consideration.	Detailed narrative
D3110	Endodontics	Pulp cap – direct (excluding final restoration)	Considered inclusive of the final restoration. Not a covered benefit in any other circumstance.	Considered inclusive of the final restoration. Not a covered benefit in any other circumstance.	Tooth identification
D3120	Endodontics	Pulp cap – indirect (excluding final restoration)	Considered inclusive of the final restoration. Not a covered benefit in any other circumstance.	Considered inclusive of the final restoration. Not a covered benefit in any other circumstance.	Tooth identification
D3220	Endodontics	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	One per tooth per lifetime. Part of endodontic therapy when performed by the same dentist.	One per tooth per lifetime. Part of endodontic therapy when performed by the same dentist.	Tooth identification

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D3221	Endodontics	Pulpal debridement, primary & permanent teeth	Not a covered benefit.	Once per tooth per lifetime.	Tooth identification
D3222	Endodontics	Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development.	Not a covered benefit.	Once per tooth per lifetime.	None
D3230	Endodontics	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	Not a covered benefit.	Once per tooth per lifetime.	None
D3240	Endodontics	Pulpal therapy (resorbable filling) – posterior primary tooth (excluding final restoration)	Not a covered benefit.	Once per tooth per lifetime.	None
D3310	Endodontics	Endodontic therapy, anterior tooth (excluding final restoration)	One per permanent tooth per lifetime. Note: includes treatment plan, clinical procedures and follow-up care	One per permanent tooth per lifetime. Note: includes treatment plan, clinical procedures and follow-up care	Tooth identification
D3320	Endodontics	Endodontic therapy, premolar tooth (excluding final restoration)	One per permanent tooth per lifetime excluding third molars. Note: includes treatment plan, clinical procedures and follow-up care	One per permanent tooth per lifetime excluding third molars. Note: includes treatment plan, clinical procedures and follow-up care	Tooth identification
D3330	Endodontics	Endodontic therapy, molar (excluding final restoration)	One per permanent tooth per lifetime excluding third molars. Note: includes treatment plan, clinical procedures and follow-up care	One per permanent tooth per lifetime excluding third molars. Note: includes treatment plan, clinical procedures and follow-up care	Tooth identification
D3331	Endodontics	Treatment of root canal obstruction; non-surgical access	Not a covered benefit.	Individual consideration.	Tooth identification Detailed narrative Current dated pre- and post-operative periapical radiographs
D3332	Endodontics	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	Not a covered benefit.	Not a covered benefit.	None
D3333	Endodontics	Internal root repair of perforation defects	Not a covered benefit.	Not a covered benefit.	None

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D3346	Endodontics	Retreatment of previous root canal therapy – anterior	One per permanent tooth per lifetime excluding third molars. Coverage is considered when prior root canal failed and re-treatment is performed by another dentist or within 24 months.	One per permanent tooth per lifetime excluding third molars. Coverage is considered when prior root canal failed and re-treatment is performed by another dentist or within 24 months.	Tooth identification
D3347	Endodontics	Retreatment of previous root canal therapy – premolar	One per permanent tooth per lifetime excluding third molars. Coverage is considered when prior root canal failed and re-treatment is performed by another dentist or within 24 months.	One per permanent tooth per lifetime excluding third molars. Coverage is considered when prior root canal failed and re-treatment is performed by another dentist or within 24 months.	Tooth identification
D3348	Endodontics	Retreatment of previous root canal therapy – molar	One per permanent tooth per lifetime excluding third molars. Coverage is considered when prior root canal failed and re-treatment is performed by another dentist or within 24 months.	One per permanent tooth per lifetime excluding third molars. Coverage is considered when prior root canal failed and re-treatment is performed by another dentist or within 24 months.	Tooth identification
D3351	Endodontics	Apexification / recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc).	Not a covered benefit.	Once per permanent tooth per lifetime.	Tooth identification
D3352	Endodontics	Apexification / recalcification – interim medication replacement	Not a covered benefit.	Once per permanent tooth per lifetime.	Tooth identification
D3353	Endodontics	Apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.)	Not a covered benefit.	Once per permanent tooth per lifetime.	Tooth identification
D3355	Endodontics	Pulpal regeneration – initial visit	Not a covered benefit.	Once per permanent tooth per lifetime.	Tooth identification
D3356	Endodontics	Pulpal regeneration – interim medication replacement	Not a covered benefit.	Once per permanent tooth per lifetime.	Tooth identification
D3357	Endodontics	Pulpal regeneration – completion of treatment	Not a covered benefit.	Once per permanent tooth per lifetime.	Tooth identification
D3410	Endodontics	Apicoectomy – anterior	One per permanent tooth root per lifetime.	Once per permanent tooth root per lifetime.	Tooth and root identification
D3421	Endodontics	Apicoectomy – premolar (first root)	One per permanent tooth root per lifetime.	Once per permanent tooth root per lifetime.	Tooth and root identification
D3425	Endodontics	Apicoectomy – molar (first root)	One per permanent tooth root per lifetime.	Once per permanent tooth root per lifetime.	Tooth and root identification

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
D3426	Endodontics	Apicoectomy – each additional	One per permanent tooth root per lifetime.	Once per permanent tooth root per lifetime.	Tooth and root identification
D3428	Endodontics	Bone graft in conjunction with periradicular surgery – per tooth, single site	Not a covered benefit.	Not a covered benefit.	None
D3429	Endodontics	Bone graft in conjunction with periradicular surgery – each additional contiguous in the same surgical site	Not a covered benefit.	Not a covered benefit.	None
D3430	Endodontics	Retrograde filling – per root	Not a covered benefit.	Once per permanent tooth per lifetime.	Tooth and root identification
D3431	Endodontics	Biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery	Not a covered benefit.	Not a covered benefit.	None
D3432	Endodontics	Guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery	Not a covered benefit.	Not a covered benefit.	None
D3450	Endodontics	Root amputation – per root	Not a covered benefit.	One per tooth per lifetime for multi-rooted posterior teeth.	Tooth and root identification
D3460	Endodontics	Endodontic endosseous implant	Not a covered benefit.	Not a covered benefit.	None
D3470	Endodontics	Intentional reimplantation (including necessary splinting)	Not a covered benefit.	Individual consideration.	Detailed narrative
D3471	Endodontics	Surgical repair of root resorption – anterior	Not a covered benefit.	One per tooth root per lifetime. Considered inclusive if submitted with D3410, D3421, D3425, D3426.	Tooth and root identification
D3472	Endodontics	Surgical repair of root resorption – premolar	Not a covered benefit.	One per tooth root per lifetime. Considered inclusive if submitted with D3410, D3421, D3425, D3426.	Tooth and root identification
D3473	Endodontics	Surgical repair of root resorption – molar	Not a covered benefit.	One per tooth root per lifetime. Considered inclusive if submitted with D3410, D3421, D3425, D3426.	Tooth and root identification
D3501	Endodontics	Surgical repair of root surface without apicoectomy or repair of root resorption – anterior	Not a covered benefit.	Not a covered benefit.	None
D3502	Endodontics	Surgical repair of root surface without apicoectomy or repair of root resorption – premolar	Not a covered benefit.	Not a covered benefit.	None
D3503	Endodontics	Surgical repair of root surface without apicoectomy or repair of root resorption – molar	Not a covered benefit.	Not a covered benefit.	None

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
D3910	Endodontics	Surgical procedure for isolation of tooth with rubber dam	Not a covered benefit.	Not a covered benefit.	None
D3911	Endodontics	Intraorifice barrier	Not a covered benefit.	Not a covered benefit.	None
D3920	Endodontics	Hemisection (including any root removal), not including root canal therapy	Not a covered benefit.	One per posterior tooth per lifetime.	Tooth identification
D3921	Endodontics	Decoronation or submergence of an erupted tooth	Not a covered benefit.	One per tooth per lifetime (D3921 or D7251).	Tooth identification
D3950	Endodontics	Canal preparation and fitting of preformed dowel or post	Not a covered benefit.	Not a covered benefit.	None
D3999	Endodontics	Unspecified endodontic procedure, by report	Not a covered benefit.	Individual consideration.	Tooth identification Detailed narrative Current dated pre- and post-operative periapical radiographs
D4210	Periodontics	Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth-bounded spaces, per quadrant	One per quadrant per 36 months. Limited to two quadrants on the same date of service. Note: Includes usual post-operative services	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. Note: Includes usual post-operative services	Current dated post-Phase I periodontal charting Quadrant identification 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	Periodontics	Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant	One per quadrant per 36 months. Limited to two quadrants on the same date of service.	One to three teeth per quadrant per 36 months. If reported at any time in	Quadrant identification

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
			Note: Includes usual post-operative services	preparation and/or temporization phase of tooth for, or in association with restoration/ prostheses, the D4211 is considered to be included as part of the global restorative/ prosthetic procedure. Note: Includes usual post-operative services	
D4212	Periodontics	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	Not a covered benefit.	Once per quadrant per 36 months. Note: Includes usual post-operative services	Tooth identification
D4230	Periodontics	Anatomical crown exposure – four or more contiguous teeth or tooth-bounded spaces per quadrant	Not a covered benefit.	Not a covered benefit.	None
D4231	Periodontics	Anatomical crown exposure – one to three teeth or tooth-bounded spaces per quadrant	Not a covered benefit.	Not a covered benefit.	None
D4240	Periodontics	Gingival flap procedure, including root planning – four or more contiguous teeth or tooth-bounded spaces per quadrant	Not a covered benefit.	Once per quadrant per 36 months. Note: Includes usual post-operative services. Laser Assisted New Attachment Procedures (LANAP) is not a covered benefit and should not be submitted using Periodontal surgery codes.	Quadrant identification
D4241	Periodontics	Gingival flap procedure, including root planning – one to three contiguous teeth or tooth-bounded spaces per quadrant	Not a covered benefit.	Once per quadrant per 36 months. Note: Includes usual post-operative services. Laser Assisted New Attachment Procedures (LANAP) is not a covered benefit and should not be submitted using Periodontal surgery codes.	Quadrant identification
D4245	Periodontics	Apically repositioned flap	Not a covered benefit.	Not a covered benefit.	None

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D4249	Periodontics	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.	Not a covered benefit.	One per tooth per 60 months. Note: Includes usual post-operative services	Tooth identification
D4260	Periodontics	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth-bounded spaces per quadrant	Not a covered benefit.	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. Laser Assisted New Attachment Procedures (LANAP) is not a covered benefit and should not be submitted using Osseous surgery codes.	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	Periodontics	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	Not a covered benefit.	One 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. Laser Assisted New Attachment Procedures (LANAP) is not a covered benefit and should not be	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

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
				submitted using Osseous surgery codes.	(within last year) bitewing and/or periapical radiographs of the treated area Pre-treatment recommended
D4263	Periodontics	Bone replacement graft – first site in quadrant	Not a covered benefit.	One per site/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. Note: Includes usual post-operative services	Tooth identification (edentulous spaces do not qualify for this code) Current mounted and dated pre-operative periapical radiographs Pre-treatment recommended
D4264	Periodontics	Bone replacement graft – each additional site in quadrant	Not a covered benefit.	One per site/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. Note: Includes usual post-operative services	Tooth identification (edentulous spaces do not qualify for this code) Current mounted and dated pre-operative periapical radiographs Pre-treatment recommended
D4265	Periodontics	Biologic materials to aid in soft and osseous tissue regeneration, per site	Not a covered benefit.	Not a covered benefit.	None
D4266	Periodontics	Guided tissue regeneration, natural teeth – resorbable barrier, per site	Not a covered benefit.	One per site/tooth per 36 months. An allowance will be made in addition to the surgical procedure to cover	Tooth identification (edentulous spaces

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
				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. Note: Includes usual post-operative services	do not qualify for this code) Current mounted and dated pre-operative periapical radiographs Pre-treatment recommended
D4267	Periodontics	Guided tissue regeneration, natural teeth – non-restorable barrier, per site	Not a covered benefit.	One per site/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, ridge augmentation, mucogingival grafts, or implant procedure. Note: Includes usual post-operative services	Tooth identification (edentulous spaces do not qualify for this code) Current mounted and dated pre-operative periapical radiographs Pre-treatment recommended
D4268	Periodontics	Surgical revision procedure, per tooth	Not a covered benefit.	Not a covered benefit.	None
D4270	Periodontics	Pedicle soft tissue graft procedure	Not a covered benefit.	Once per tooth per 36 months. Grafting for cosmetic purposes is non-covered. Note: Includes usual post-operative services	Tooth identification
D4273	Periodontics	Autogenous connective tissue graft procedures (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	Not a covered benefit.	One per site per 36 months on natural teeth only. Limited to three teeth per graft site. Note: Includes usual post-operative services	Tooth identification
D4274	Periodontics	Mesial/distal wedge procedure, single tooth (when not performed in	Not a covered benefit.	One per site per 36 months. Must be adjacent to edentulous area.	Tooth identification

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
		conjunction with surgical procedures in the same anatomical area)		Note: Includes usual post-operative services	
D4275	Periodontics	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	Not a covered benefit.	One per site per 36 months on natural teeth only. Limited to three teeth per graft site. Note: Includes usual post-operative services	Tooth identification
D4276	Periodontics	Combined connective tissue and pedicle graft, per tooth	Not a covered benefit.	One per tooth per 36 months. Grafting for cosmetic purposes is non-covered. Note: Includes usual post-operative services	Tooth identification
D4277	Periodontics	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft	Not a covered benefit.	One per site per 36 months on natural teeth only. Limited to three teeth per graft site. Note: Includes usual post-operative services	Tooth identification
D4278	Periodontics	Free soft tissue graft procedure (including recipient and donor surgical sites), each additional contiguous tooth, implant or edentulous tooth position in same graft site	Not a covered benefit.	One per site per 36 months on natural teeth only. Limited to three teeth per graft site. Note: Includes usual post-operative services	Tooth identification
D4283	Periodontics	Autogenous connective tissue graft procedure (including donor and recipient surgical sites), each additional contiguous tooth, implant or edentulous tooth position in same graft site	Not a covered benefit.	Each additional tooth, up to three teeth total in graft. Note: Includes usual post-operative services	Tooth identification
D4285	Periodontics	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	Not a covered benefit.	Each additional tooth, up to three teeth total in graft. Note: Includes usual post-operative services	Tooth identification
D4286	Periodontics	Removal of non-resorbable barrier	Not a covered benefit.	Considered inclusive of D4267, not a covered benefit in any other circumstance.	Tooth identification

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
				Note: Includes usual post-operative services	
D4322	Periodontics	Splint – intra-coronal; natural teeth or prosthetic crowns	Not a covered benefit.	Not a covered benefit.	None
D4323	Periodontics	Splint – extra-coronal; natural teeth or prosthetic crowns	Not a covered benefit.	Not a covered benefit.	None
D4341	Periodontics	Periodontal scaling and root planning – four or more teeth per quadrant	One per quadrant per 36 months.	One per quadrant per 24 months.	Quadrant identification
D4342	Periodontics	Periodontal scaling and root planning, one to three teeth per quadrant	One per quadrant per 36 months.	One per quadrant per 24 months.	Quadrant identification
D4346	Periodontics	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.	Covered interchangeably with D1110. Held to the same frequencies and allowable as D1110.	None
D4355	Periodontics	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	Not a covered benefit.	Not a covered benefit.	None
D4381	Periodontics	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	Not a covered benefit.	One treatment per tooth per 24 months, up to 2 teeth per quadrant. Must present as 5-6 mm pocket depths and bleeding on probing, subsequent to active and maintained non surgical periodontal treatment. Should not be used to treat generalized disease. Not covered for treatment of periodontal abscess.	Detailed narrative Periodontal charting Tooth identification
D4910	Periodontics	Periodontal maintenance	Not a covered benefit.	One per 3 months following active periodontal treatment. There must be at least three months between a periodontal maintenance cleaning and any other cleanings. D4910 is considered inclusive of D4341 and D4342 when performed on the same day.	None

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D4920	Periodontics	Unscheduled dressing change (by someone other than treating dentist or their staff)	Not a covered benefit	Not a covered benefit.	None
D4921	Periodontics	Gingival irrigation with a medicinal agent – per quadrant	Not a covered benefit	Not a covered benefit.	None
D4999	Periodontics	Unspecified periodontal procedure, by report	Individual consideration.	Individual consideration.	Detailed narrative
D5110	Prosthodontics (removable)	Complete denture – maxillary	One per arch per 84 months. Note: Includes routine post-delivery care	One per arch per 84 months; not covered if D5130, D5211, D5213, D5221, D5223, D5225, or D5227 was done within 84 months. Note: Includes routine post-delivery care	Arch identification
D5120	Prosthodontics (removable)	Complete denture – mandibular	One per arch per 84 months. Note: Includes routine post-delivery care	One per arch per 84 months; not covered if D5140, D5212, D5214, D5222, D5224, D5226, or D5228 was done within 84 months. Note: Includes routine post-delivery care	Arch identification
D5130	Prosthodontics (removable)	Immediate denture – maxillary	One per arch per lifetime. Note: Includes routine post-delivery care	One per arch per lifetime. Note: Includes routine post-delivery care	Arch identification
D5140	Prosthodontics (removable)	Immediate denture – mandibular	One per arch per lifetime. Note: Includes routine post-delivery care	One per arch per lifetime. Note: Includes routine post-delivery care	Arch identification
D5211	Prosthodontics (removable)	Maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)	One per 84 months. Note: Includes routine post-delivery care	One per 84 months. Note: Includes routine post-delivery care	Arch identification
D5212	Prosthodontics (removable)	Mandibular partial denture – resin base (including retentive/clasping materials, rests, and teeth)	One per 84 months. Note: Includes routine post-delivery care	One per 84 months. Note: Includes routine post-delivery care	Arch identification
D5213	Prosthodontics (removable)	Maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	One per 84 months. Note: Includes routine post-delivery care	One per 84 months. Note: Includes routine post-delivery care	Arch identification

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D5214	Prosthodontics (removable)	Mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	One per 84 months. Note: Includes routine post-delivery care	One per 84 months. Note: Includes routine post-delivery care	Arch identification
D5221	Prosthodontics (removable)	Immediate maxillary partial denture – resin base (including retentive/ clasping materials, rests, and teeth)	One per arch per 84 months for members age 16+. Note: Includes routine post-delivery care	One per arch per 84 months. Note: Includes routine post-delivery care	Arch identification
D5222	Prosthodontics (removable)	Immediate mandibular partial denture – resin base (including retentive/clasping materials, rests, and teeth)	One per arch per 84 months for members age 16+. Note: Includes routine post-delivery care	One per arch per 84 months. Note: Includes routine post-delivery care	Arch identification
D5223	Prosthodontics (removable)	Immediate maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	One per arch per 84 months for members age 16+. Note: Includes routine post-delivery care	One per arch per 84 months. Note: Includes routine post-delivery care	Arch identification
D5224	Prosthodontics (removable)	Immediate mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	One per arch per 84 months for members age 16+. Note: Includes routine post-delivery care	One per arch per 84 months. Note: Includes routine post-delivery care	Arch identification
D5225	Prosthodontics (removable)	Maxillary partial denture – flexible base (including retentive/clasping materials, rests, and teeth)	One per arch per 84 months. Note: Includes routine post-delivery care	One per arch per 84 months. Note: Includes routine post-delivery care	Arch identification
D5226	Prosthodontics (removable)	Mandibular partial denture – flexible base (including retentive/clasping materials, rests, and teeth)	One per arch per 84 months. Note: Includes routine post-delivery care	One per arch per 84 months. Note: Includes routine post-delivery care	Arch identification
D5227	Prosthodontics (removable)	Immediate maxillary partial denture – flexible base (including any clasps, rests and teeth)	One per arch per 84 months for members age 16+. Note: Includes routine post-delivery care	One per arch per 84 months. Note: Includes routine post-delivery care	Arch identification
D5228	Prosthodontics (removable)	Immediate mandibular partial denture – flexible base (including any clasps, rests and teeth)	One per arch per 84 months for members age 16+. Note: Includes routine post-delivery care	One per arch per 84 months. Note: Includes routine post-delivery care	Arch identification
D5282	Prosthodontics (removable)	Removable unilateral partial denture – one piece cast metal	Not a covered benefit.	One per arch per 84 months.	Arch identification

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		(including retentive/clasping materials, rests, and teeth), maxillary		Note: Includes routine post-delivery care	
D5283	Prosthodontics (removable)	Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular	Not a covered benefit.	One per arch per 84 months. Note: Includes routine post-delivery care	Arch identification
D5284	Prosthodontics (removable)	Removable unilateral partial denture – one piece flexible base (including retentive/clasping materials, rests, and teeth), per quadrant	Not a covered benefit.	One per arch per 84 months. Note: Includes routine post-delivery care	Arch identification
D5286	Prosthodontics (removable)	Removable unilateral partial denture – one piece resin (including retentive/clasping materials, rests, and teeth), per quadrant	Not a covered benefit.	One per arch per 84 months. Note: Includes routine post-delivery care	Arch identification
D5410	Prosthodontics (removable)	Adjust complete denture – maxillary	Not a covered benefit.	Considered part of routine post-delivery care for complete and partial denture for the first 90 days. Once per arch 12 months.	Arch identification
D5411	Prosthodontics (removable)	Adjust complete denture – mandibular	Not a covered benefit.	Considered part of routine post-delivery care for complete and partial denture for the first 90 days. Once per arch 12 months.	Arch identification
D5421	Prosthodontics (removable)	Adjust partial denture – maxillary	Not a covered benefit.	Considered part of routine post-delivery care for complete and partial denture for the first 90 days. Once per arch 12 months.	Arch identification
D5422	Prosthodontics (removable)	Adjust partial denture – mandibular	Not a covered benefit.	Considered part of routine post-delivery care for complete and partial denture for the first 90 days. Once per arch 12 months.	Arch identification
D5511	Prosthodontics (removable)	Repair broken complete denture base, mandibular	Not covered if initial placement was done within the prior 6 months.	Once per arch 12 months.	Arch identification
D5512	Prosthodontics (removable)	Repair broken complete denture base, maxillary	Not covered if initial placement was done within the prior 6 months.	Once per arch 12 months.	Arch identification
D5520	Prosthodontics (removable)	Replace missing or broken teeth - complete denture - per tooth	Not covered if initial placement was done within the prior 6 months.	Once per tooth per 12 months.	Tooth identification

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D5611	Prosthodontics (removable)	Repair resin partial denture base, mandibular	Not covered if initial placement was done within the prior 6 months.	Once per arch 12 months.	Arch identification
D5612	Prosthodontics (removable)	Repair resin partial denture base, maxillary	Not covered if initial placement was done within the prior 6 months.	Once per arch 12 months.	Arch identification
D5621	Prosthodontics (removable)	Repair cast partial framework, mandibular	Not covered if initial placement was done within the prior 6 months.	Once per arch 12 months.	Arch identification
D5622	Prosthodontics (removable)	Repair cast partial framework, maxillary	Not covered if initial placement was done within the prior 6 months.	Once per arch 12 months.	Arch identification
D5630	Prosthodontics (removable)	Repair or replace broken retentive clasping materials, per tooth	Not covered if initial placement was done within the prior 6 months.	Once per tooth per 12 months.	Tooth identification
D5640	Prosthodontics (removable)	Replace missing or broken teeth - partial denture - per tooth	Not covered if initial placement was done within the prior 6 months.	Once per tooth per 12 months.	Tooth identification
D5650	Prosthodontics (removable)	Add tooth to existing partial denture – per tooth	Not covered if initial placement was done within the prior 6 months.	Once per tooth per 12 months.	Tooth identification
D5660	Prosthodontics (removable)	Add clasp to existing partial denture	Not covered if initial placement was done within the prior 6 months.	Once per tooth per 12 months.	Tooth identification
D5670	Prosthodontics (removable)	Replace all teeth and acrylic on cast metal framework (maxillary)	Not a covered benefit.	Once per arch per lifetime.	Arch identification
D5671	Prosthodontics (removable)	Replace all teeth and acrylic on cast metal framework (mandibular)	Not a covered benefit.	Once per arch per lifetime.	Arch identification
D5710	Prosthodontics (removable)	Rebase complete maxillary denture	One per arch per 24 months; adjustments are considered part of routine post-delivery care for complete and partial denture rebases within 6 months of dispensing date of denture. Note: Dental rebase procedures are considered to be the process of refitting a denture by replacing the base material.	One per arch per 36 months; adjustments are considered part of routine post-delivery care for complete and partial denture rebases within 6 months of dispensing date of denture. Note: Dental rebase procedures are considered to be the process of refitting a denture by replacing the base material.	Arch identification
D5711	Prosthodontics (removable)	Rebase complete mandibular denture	One per arch per 24 months; adjustments are considered part of routine post-delivery care for	One per arch per 36 months; adjustments are considered part of routine post-delivery	Arch identification

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
			complete and partial denture rebases within 6 months of dispensing date of denture. Note: Dental rebase procedures are considered to be the process of refitting a denture by replacing the base material.	care for complete and partial denture rebases within 6 months of dispensing date of denture. Note: Dental rebase procedures are considered to be the process of refitting a denture by replacing the base material.	
D5720	Prosthodontics (removable)	Rebase maxillary partial denture	One per arch per 24 months; adjustments are considered part of routine post-delivery care for complete and partial denture rebases within 6 months of dispensing date of denture. Note: Dental rebase procedures are considered to be the process of refitting a denture by replacing the base material.	One per arch per 36 months; adjustments are considered part of routine post-delivery care for complete and partial denture rebases within 6 months of dispensing date of denture. Note: Dental rebase procedures are considered to be the process of refitting a denture by replacing the base material.	Arch identification
D5721	Prosthodontics (removable)	Rebase mandibular partial denture	One per arch per 24 months; adjustments are considered part of routine post-delivery care for complete and partial denture rebases within 6 months of dispensing date of denture. Note: Dental rebase procedures are considered to be the process of refitting a denture by replacing the base material.	One per arch per 36 months; adjustments are considered part of routine post-delivery care for complete and partial denture rebases within 6 months of dispensing date of denture. Note: Dental rebase procedures are considered to be the process of refitting a denture by replacing the base material.	Arch identification
D5725	Prosthodontics (removable)	Rebase hybrid prosthesis	Once per arch per 24 months. Note: Dental rebase procedures are considered to be the process of refitting a denture by replacing the base material.	Once per arch per 36 months. Note: Dental rebase procedures are considered to be the process of refitting a denture by replacing the base material.	Arch identification

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
D5730	Prosthodontics (removable)	Reline complete maxillary denture – direct	One per arch per 24 months; adjustments are considered part of routine post-delivery care for complete and partial denture rebases within 6 months of dispensing date of denture. Note: Denture reline procedures are considered to be the process of resurfacing the tissue side of a denture with new base material.	One per arch per 24 months; adjustments are considered part of routine post-delivery care for complete and partial denture rebases within 6 months of dispensing date of denture. Note: Denture reline procedures are considered to be the process of resurfacing the tissue side of a denture with new base material.	Arch identification
D5731	Prosthodontics (removable)	Reline complete mandibular denture – direct	One per arch per 24 months; adjustments are considered part of routine post-delivery care for complete and partial denture rebases within 6 months of dispensing date of denture. Note: Denture reline procedures are considered to be the process of resurfacing the tissue side of a denture with new base material.	One per arch per 24 months; adjustments are considered part of routine post-delivery care for complete and partial denture rebases within 6 months of dispensing date of denture. Note: Denture reline procedures are considered to be the process of resurfacing the tissue side of a denture with new base material.	Arch identification
D5740	Prosthodontics (removable)	Reline maxillary partial denture –direct	One per arch per 24 months; adjustments are considered part of routine post-delivery care for complete and partial denture rebases within 6 months of dispensing date of denture. Note: Denture reline procedures are considered to be the process of resurfacing the tissue side of a denture with new base material.	One per arch per 24 months; adjustments are considered part of routine post-delivery care for complete and partial denture rebases within 6 months of dispensing date of denture. Note: Denture reline procedures are considered to be the process of resurfacing the tissue side of a denture with new base material.	Arch identification
D5741	Prosthodontics (removable)	Reline mandibular partial denture – direct	One per arch per 24 months; adjustments are considered part of routine post-delivery care for complete and partial denture	One per arch per 24 months; adjustments are considered part of routine post-delivery care for complete and partial denture rebases within 6	Arch identification

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
			rebases within 6 months of dispensing date of denture. Note: Denture reline procedures are considered to be the process of resurfacing the tissue side of a denture with new base material.	months of dispensing date of denture. Note: Denture reline procedures are considered to be the process of resurfacing the tissue side of a denture with new base material.	
D5750	Prosthodontics (removable)	Reline complete maxillary denture – indirect	One per arch per 24 months; adjustments are considered part of routine post-delivery care for complete and partial denture rebases within 6 months of dispensing date of denture. Note: Denture reline procedures are considered to be the process of resurfacing the tissue side of a denture with new base material.	One per arch per 36 months; adjustments are considered part of routine post-delivery care for complete and partial denture rebases within 6 months of dispensing date of denture. Note: Denture reline procedures are considered to be the process of resurfacing the tissue side of a denture with new base material.	Arch identification
D5751	Prosthodontics (removable)	Reline complete mandibular denture – indirect	One per arch per 24 months; adjustments are considered part of routine post-delivery care for complete and partial denture rebases within 6 months of dispensing date of denture. Note: Denture reline procedures are considered to be the process of resurfacing the tissue side of a denture with new base material.	One per arch per 36 months; adjustments are considered part of routine post-delivery care for complete and partial denture rebases within 6 months of dispensing date of denture. Note: Denture reline procedures are considered to be the process of resurfacing the tissue side of a denture with new base material.	Arch identification
D5760	Prosthodontics (removable)	Reline maxillary partial denture – indirect	One per arch per 24 months; adjustments are considered part of routine post-delivery care for complete and partial denture rebases within 6 months of dispensing date of denture. Note: Denture reline procedures are considered to be the process	One per arch per 36 months; adjustments are considered part of routine post-delivery care for complete and partial denture rebases within 6 months of dispensing date of denture. Note: Denture reline procedures are considered to	Arch identification

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
			of resurfacing the tissue side of a denture with new base material.	be the process of resurfacing the tissue side of a denture with new base material.	
D5761	Prosthodontics (removable)	Reline mandibular partial denture – indirect	One per arch per 24 months; adjustments are considered part of routine post-delivery care for complete and partial denture rebases within 6 months of dispensing date of denture. Note: Denture reline procedures are considered to be the process of resurfacing the tissue side of a denture with new base material.	One per arch per 36 months; adjustments are considered part of routine post-delivery care for complete and partial denture rebases within 6 months of dispensing date of denture. Note: Denture reline procedures are considered to be the process of resurfacing the tissue side of a denture with new base material.	Arch identification
D5765	Prosthodontics (removable)	Soft liner for complete or partial removable denture – indirect	Once per arch per 24 months.	Once per arch per 36 months.	Arch identification
D5810	Prosthodontics (removable)	Interim complete denture (maxillary)	Not a covered benefit.	Not a covered benefit.	None
D5811	Prosthodontics (removable)	Interim complete denture (mandibular)	Not a covered benefit.	Not a covered benefit.	None
D5820	Prosthodontics (removable)	Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary	Not a covered benefit.	One per arch per lifetime.	Arch identification
D5821	Prosthodontics (removable)	Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular	Not a covered benefit.	One per arch per lifetime.	Arch identification
D5850	Prosthodontics (removable)	Tissue conditioning, maxillary	Not a covered benefit.	One per arch per 36 months.	Arch identification
D5851	Prosthodontics (removable)	Tissue conditioning, mandibular	Not a covered benefit.	One per arch per 36 months.	Arch identification
D5862	Prosthodontics (removable)	Precision attachment, by report	Not a covered benefit.	Not a covered benefit.	None
D5863	Prosthodontics (removable)	Overdenture – complete maxillary - natural tooth borne	Not a covered benefit.	One per arch per 84 months.	Arch identification
D5864	Prosthodontics (removable)	Overdenture – partial maxillary - natural tooth borne	Not a covered benefit.	One per arch per 84 months.	Arch identification
D5865	Prosthodontics (removable)	Overdenture – complete mandibular - natural tooth borne	Not a covered benefit.	One per arch per 84 months.	Arch identification
D5866	Prosthodontics (removable)	Overdenture – partial mandibular - natural tooth borne	Not a covered benefit.	One per arch per 84 months.	Arch identification
D5867	Prosthodontics (removable)	Replacement of replaceable part of semi-precision or precision attachment of	Not a covered benefit.	Not a covered benefit.	None

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		natural tooth borne prosthesis, per attachment			
D5875	Prosthodontics (removable)	Modification of removable prosthesis following implant surgery	Not a covered benefit.	Not a covered benefit.	None
D5876	Prosthodontics (removable)	Add metal substructure to acrylic complete denture - per arch	Not a covered benefit.	Not a covered benefit.	None
D5877	Prosthodontics (removable)	Duplication of complete denture – maxillary	Not a covered benefit.	Not a covered benefit.	None
D5878	Prosthodontics (removable)	Duplication of complete denture – mandibular	Not a covered benefit.	Not a covered benefit.	None
D5899	Prosthodontics (removable)	Unspecified removable prosthodontic procedure, by report	Individual consideration.	Individual consideration.	Detailed narrative
D5909	Maxillofacial prosthetics	Maxillary guidance prosthesis with guide flange	Not a covered benefit.	Not a covered benefit.	None
D5911	Maxillofacial prosthetics	Facial moulage (sectional)	Not a covered benefit.	Not a covered benefit.	None
D5912	Maxillofacial prosthetics	Facial moulage (complete)	Not a covered benefit.	Not a covered benefit.	None
D5913	Maxillofacial prosthetics	Nasal prosthesis	Not a covered benefit.	Not a covered benefit.	None
D5914	Maxillofacial prosthetics	Auricula prosthesis	Not a covered benefit.	Not a covered benefit.	None
D5915	Maxillofacial prosthetics	Orbital prosthesis	Not a covered benefit.	Not a covered benefit.	None
D5916	Maxillofacial prosthetics	Ocular prosthesis	Not a covered benefit.	Not a covered benefit.	None
D5919	Maxillofacial prosthetics	Facial prosthesis	Not a covered benefit.	Not a covered benefit.	None
D5922	Maxillofacial prosthetics	Nasal septal prosthesis	Not a covered benefit.	Not a covered benefit.	None
D5923	Maxillofacial prosthetics	Ocular prosthesis, interim	Not a covered benefit.	Not a covered benefit.	None
D5924	Maxillofacial prosthetics	Cranial prosthesis	Not a covered benefit.	Not a covered benefit.	None
D5925	Maxillofacial prosthetics	Facial augmentation implant prosthesis	Not a covered benefit.	Not a covered benefit.	None
D5926	Maxillofacial prosthetics	Nasal prosthesis, replacement	Not a covered benefit.	Not a covered benefit.	None
D5927	Maxillofacial prosthetics	Auricular prosthesis, replacement	Not a covered benefit.	Not a covered benefit.	None
D5928	Maxillofacial prosthetics	Orbital prosthesis, replacement	Not a covered benefit.	Not a covered benefit.	None

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D5929	Maxillofacial prosthetics	Facial prosthesis, replacement	Not a covered benefit.	Not a covered benefit.	None
D5930	Maxillofacial prosthetics	Maxillary guidance prosthesis without guide flange	Not a covered benefit.	Not a covered benefit.	None
D5931	Maxillofacial prosthetics	Obturator prosthesis, surgical	Not a covered benefit.	Not a covered benefit.	None
D5932	Maxillofacial prosthetics	Obturator prosthesis, definitive	Not a covered benefit.	Not a covered benefit.	None
D5933	Maxillofacial prosthetics	Obturator prosthesis, modification	Not a covered benefit.	Not a covered benefit.	None
D5934	Maxillofacial prosthetics	Mandibular guidance prosthesis with guide flange	Not a covered benefit.	Not a covered benefit.	None
D5935	Maxillofacial prosthetics	Mandibular guidance prosthesis without guide flange	Not a covered benefit.	Not a covered benefit.	None
D5936	Maxillofacial prosthetics	Obturator prosthesis, interim	Not a covered benefit.	Not a covered benefit.	None
D5937	Maxillofacial prosthetics	Trismus appliance (not for TMD treatment)	Not a covered benefit.	Not a covered benefit.	None
D5938	Maxillofacial prosthetics	Resection prosthesis, maxillary complete removable	Not a covered benefit.	Not a covered benefit.	None
D5939	Maxillofacial prosthetics	Resection prosthesis, mandibular complete removable	Not a covered benefit.	Not a covered benefit.	None
D5940	Maxillofacial prosthetics	Resection prosthesis, maxillary partial removable	Not a covered benefit.	Not a covered benefit.	None
D5941	Maxillofacial prosthetics	Resection prosthesis, mandibular partial removable	Not a covered benefit.	Not a covered benefit.	None
D5942	Maxillofacial prosthetics	Resection prosthesis, maxillary implant/abutment supported removable prosthesis for edentulous arch	Not a covered benefit.	Not a covered benefit.	None
D5943	Maxillofacial prosthetics	Resection prosthesis, mandibular implant/abutment supported removable prosthesis for edentulous arch	Not a covered benefit.	Not a covered benefit.	None
D5944	Maxillofacial prosthetics	Resection prosthesis, maxillary implant/abutment supported removable prosthesis for the partial edentulous arch	Not a covered benefit.	Not a covered benefit.	None
D5945	Maxillofacial prosthetics	Resection prosthesis, mandibular implant/abutment supported removable prosthesis for the partial edentulous arch	Not a covered benefit.	Not a covered benefit.	None
D5946	Maxillofacial prosthetics	Resection prosthesis, maxillary implant/abutment supported fixed prosthesis for edentulous arch	Not a covered benefit.	Not a covered benefit.	None
D5947	Maxillofacial prosthetics	Resection prosthesis, mandibular implant/abutment supported fixed prosthesis for edentulous arch	Not a covered benefit.	Not a covered benefit.	None

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D5948	Maxillofacial prosthetics	Resection prosthesis, maxillary implant/abutment supported fixed prosthesis for the partial edentulous arch	Not a covered benefit.	Not a covered benefit.	None
D5949	Maxillofacial prosthetics	Resection prosthesis, mandibular implant/abutment supported fixed prosthesis for the partial edentulous arch	Not a covered benefit.	Not a covered benefit.	None
D5951	Maxillofacial prosthetics	Feeding aid	Not a covered benefit.	Not a covered benefit.	None
D5952	Maxillofacial prosthetics	Speech aid prosthesis, pediatric	Not a covered benefit.	Not a covered benefit.	None
D5953	Maxillofacial prosthetics	Speech aid prosthesis, adult	Not a covered benefit.	Not a covered benefit.	None
D5954	Maxillofacial prosthetics	Palatal augmentation prosthesis	Not a covered benefit.	Not a covered benefit.	None
D5955	Maxillofacial prosthetics	Palatal lift prosthesis, definitive	Not a covered benefit.	Not a covered benefit.	None
D5958	Maxillofacial prosthetics	Palatal lift prosthesis, interim	Not a covered benefit.	Not a covered benefit.	None
D5959	Maxillofacial prosthetics	Palatal lift prosthesis, modification	Not a covered benefit.	Not a covered benefit.	None
D5960	Maxillofacial prosthetics	Speech aid prosthesis, modification	Not a covered benefit.	Not a covered benefit.	None
D5982	Maxillofacial prosthetics	Surgical stent for soft tissue healing	Not a covered benefit.	Not a covered benefit.	None
D5983	Maxillofacial prosthetics	Radiation carrier	Not a covered benefit.	Not a covered benefit.	None
D5984	Maxillofacial prosthetics	Radiation shield	Not a covered benefit.	Not a covered benefit.	None
D5985	Maxillofacial prosthetics	Radiation cone locator	Not a covered benefit.	Not a covered benefit.	None
D5986	Maxillofacial prosthetics	Fluoride gel carrier	Not a covered benefit.	Not a covered benefit.	None
D5987	Maxillofacial prosthetics	Commissure splint	Not a covered benefit.	Not a covered benefit.	None
D5988	Maxillofacial prosthetics	Surgical splint	Not a covered benefit.	Not a covered benefit.	None
D5991	Maxillofacial prosthetics	Vesiculobullous disease medicament carrier	Not a covered benefit.	Not a covered benefit.	None
D5992	Maxillofacial prosthetics	Adjust maxillofacial prosthetic appliance, by report	Not a covered benefit.	Not a covered benefit.	None
D5993	Maxillofacial prosthetics	Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral) other than required adjustments, by report	Not a covered benefit.	Not a covered benefit.	None

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D5995	Maxillofacial prosthetics	Periodontal medicament carrier with peripheral seal – laboratory processed – maxillary	Not a covered benefit.	Not a covered benefit.	None
D5996	Maxillofacial prosthetics	Periodontal medicament carrier with peripheral seal – laboratory processed - mandibular	Not a covered benefit.	Not a covered benefit.	None
D5999	Maxillofacial prosthetics	Unspecified maxillofacial prosthesis, by report	Individual consideration.	Individual consideration.	Detailed narrative
D6010	Implant	Surgical placement of implant body, endosteal implant	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per permanent tooth (excluding third molars) per 60 months for members age 16+.	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per permanent tooth (excluding third molars) per 60 months.	Tooth identification Current mounted and dated post-implant periapical radiographs
D6011	Implant	Surgical access to an implant body (Second stage implant surgery)	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per tooth per 60 months for members age 16+.	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per tooth per 60 months.	Tooth identification
D6012	Implant	Surgical placement of interim implant body for transitional prosthesis: endosteal implant	Not a covered benefit	Not a covered benefit	None
D6013	Implant	Surgical placement of mini implant	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per tooth per 60 months for members age 16+. Limit two per arch. Allowed in edentulous arch as components of an overdenture.	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per tooth per 60 months. Limit two per arch. Allowed in edentulous arch as components of an overdenture.	Tooth identification Current mounted and dated post-implant periapical radiographs
D6040	Implant	Surgical placement: eposteal implant	Not a covered benefit	Not a covered benefit	None
D6049	Implant	Scaling and debridement of a single implant in the presence of peri-implantitis inflammation, bleeding upon probing and increased pocket depths, including cleaning of the implant surfaces, without flap entry and closure	Not a covered benefit	Not a covered benefit	None
D6050	Implant	Surgical placement: transosteal implant	Not a covered benefit	Not a covered benefit	None
D6051	Implant	Placement of interim implant abutment	Not a covered benefit.	Not a covered benefit.	None
D6055	Implant	Connecting bar – implant- supported or abutment-supported	Not a covered benefit.	Not a covered benefit.	None

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D6056	Implant	Prefabricated abutment – includes modification and placement	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per implant per 60 months for members age 16+. Includes preparation, impression, temporary restoration and insertion.	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per implant per 60 months. Includes preparation, impression, temporary restoration and insertion.	Tooth identification Current mounted and dated post-implant periapical radiographs Detailed narrative
D6057	Implant	Custom fabricated abutment – includes placement	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per implant per 60 months for members age 16+. Includes preparation, impression, temporary restoration and insertion.	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per implant per 60 months. Includes preparation, impression, temporary restoration and insertion.	Tooth identification Current mounted and dated post-implant periapical radiographs Detailed narrative
D6058	Implant	Abutment-supported porcelain/ ceramic crown. A single crown restoration that is retained, supported, and stabilized by an abutment on an implant	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per implant per 60 months for members age 16+. Includes preparation, impression, temporary restoration and insertion.	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per implant per 60 months. Includes preparation, impression, temporary restoration and insertion.	Tooth identification Current mounted and dated post-implant periapical radiographs Pre-treatment recommended
D6059	Implant	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	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per implant per 60 months for members age 16+. Includes preparation, impression, temporary restoration and insertion.	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per implant per 60 months. Includes preparation, impression, temporary restoration and insertion.	Tooth identification Current mounted and dated post-implant periapical radiographs Pre-treatment recommended
D6060	Implant	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.	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per implant per 60 months for members age 16+. Includes preparation, impression,	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per implant per 60 months. Includes preparation, impression,	Tooth identification Current mounted and dated post-implant periapical radiographs Pre-treatment

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			temporary restoration and insertion.	temporary restoration and insertion.	recommended
D6061	Implant	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.	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per implant per 60 months for members age 16+. Includes preparation, impression, temporary restoration and insertion.	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per implant per 60 months. Includes preparation, impression, temporary restoration and insertion.	Tooth identification Current mounted and dated post-implant periapical radiographs Pre-treatment recommended
D6062	Implant	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.	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per implant per 60 months for members age 16+. Includes preparation, impression, temporary restoration and insertion.	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per implant per 60 months. Includes preparation, impression, temporary restoration and insertion.	Tooth identification Current mounted and dated post-implant periapical radiographs Pre-treatment recommended
D6063	Implant	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.	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per implant per 60 months for members age 16+. Includes preparation, impression, temporary restoration and insertion.	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per implant per 60 months. Includes preparation, impression, temporary restoration and insertion.	Tooth identification Current mounted and dated post-implant periapical radiographs Pre-treatment recommended
D6064	Implant	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.	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per implant per 60 months for members age 16+. Includes preparation, impression, temporary restoration and insertion.	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per implant per 60 months. Includes preparation, impression, temporary restoration and insertion.	Tooth identification Current mounted and dated post-implant periapical radiographs Pre-treatment recommended
D6065	Implant	Implant-supported porcelain/ceramic crown	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per implant per 60 months for members age 16+. Includes	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per implant per 60 months. Includes	Tooth identification Current mounted and dated post-implant periapical radiographs

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			preparation, impression, temporary restoration and insertion.	preparation, impression, temporary restoration and insertion.	Pre-treatment recommended
D6066	Implant	Implant supported crown – porcelain fused to high noble alloys	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per implant per 60 months for members age 16+. Includes preparation, impression, temporary restoration and insertion.	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per implant per 60 months. Includes preparation, impression, temporary restoration and insertion.	Tooth identification Current mounted and dated post-implant periapical radiographs Pre-treatment recommended
D6067	Implant	Implant-supported crown – high noble alloys	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per implant per 60 months for members age 16+. Includes preparation, impression, temporary restoration and insertion.	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per implant per 60 months. Includes preparation, impression, temporary restoration and insertion.	Tooth identification Current mounted and dated post-implant periapical radiographs Pre-treatment recommended
D6068	Implant	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.	Not a covered benefit.	None
D6069	Implant	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.	Not a covered benefit.	Not a covered benefit.	None
D6070	Implant	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.	Not a covered benefit.	Not a covered benefit.	None
D6071	Implant	Abutment-supported retainer for porcelain fused to metal FPD (noble metal)	Not a covered benefit.	Not a covered benefit.	None
D6072	Implant	Abutment-supported retainer for cast metal FPD (high noble metal)	Not a covered benefit.	Not a covered benefit.	None

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D6073	Implant	Abutment-supported retainer for cast metal FPD (predominately base metal)	Not a covered benefit.	Not a covered benefit.	None
D6074	Implant	Abutment-supported retainer for cast metal FPD (noble metal)	Not a covered benefit.	Not a covered benefit.	None
D6075	Implant	Implant-supported retainer for ceramic FPD	Not a covered benefit.	Not a covered benefit.	None
D6076	Implant	Implant-supported retainer for FPD – porcelain fused to high noble alloys)	Not a covered benefit.	Not a covered benefit.	None
D6077	Implant	Implant-supported retainer for cast metal FPD – high noble alloys)	Not a covered benefit.	Not a covered benefit.	None
D6080	Implant	Implant maintenance procedures when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments	Not a covered benefit.	Not a covered benefit.	None
D6081	Implant	Scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths; includes cleaning of the implant surfaces, without flap entry and closure	Not a covered benefit.	Not a covered benefit.	None
D6082	Implant	Implant-supported crown – porcelain fused to predominately base alloys	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per implant per 60 months for members age 16+.	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per implant per 60 months.	Tooth identification Current mounted and dated post-implant periapical radiographs Pre-treatment recommended
D6083	Implant	Implant-supported crown –porcelain fused to noble alloys	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per implant per 60 months for members age 16+.	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per implant per 60 months.	Tooth identification Current mounted and dated post-implant periapical radiographs Pre-treatment recommended
D6084	Implant	Implant-supported crown – porcelain fused to titanium and titanium alloys	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per implant per 60 months for members age 16+.	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per implant per 60 months.	Tooth identification Current mounted and dated post-implant periapical radiographs

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
					Pre-treatment recommended
D6085	Implant	Provisional implant crown	Not a covered benefit.	Not a covered benefit.	None
D6086	Implant	Implant supported crown – predominantly base alloys	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per implant per 60 months for members age 16+.	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per implant per 60 months.	Tooth identification Current mounted and dated post-implant periapical radiographs Pre-treatment recommended
D6087	Implant	Implant supported crown – noble alloys	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per implant per 60 months for members age 16+.	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per implant per 60 months.	Tooth identification Current mounted and dated post-implant periapical radiographs Pre-treatment recommended
D6088	Implant	Implant-supported crown – titanium and titanium alloys	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per implant per 60 months for members age 16+.	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per implant per 60 months.	Tooth identification Current mounted and dated post-implant periapical radiographs Pre-treatment recommended
D6089	Implant	Accessing and retorquing loose implant screw – per screw	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per permanent tooth area (excluding third molars) per 12 months for members age 16+.	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per permanent tooth area (excluding third molars) per 12 months.	Tooth identification
D6090	Implant	Repair of implant/abutment supported prosthesis	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per arch per 6 months for members age 16+.	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per arch per 6 months.	Arch identification Detailed narrative

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
D6091	Implant	Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment	Not a covered benefit.	Not a covered benefit.	None
D6092	Implant	Recement or re-bond implant/abutment-supported crown	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per tooth per 12 months for members age 16+.	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per tooth per 12 months.	Tooth identification
D6093	Implant	Recement or re-bond implant/abutment-supported fixed partial denture	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per bridge per 12 months for members age 16+.	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per bridge per 12 months.	Tooth identification
D6094	Implant	Abutment-supported crown – titanium and titanium alloys	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per implant per 60 months for members age 16+. Includes preparation, impression, temporary restoration, and insertion.	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per implant per 60 months. Includes preparation, impression, temporary restoration, and insertion.	Tooth identification Current mounted and dated post-implant periapical radiographs Pre-treatment recommended
D6096	Implant	Remove broken implant retaining screw	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per permanent tooth area (excluding third molars) per 12 months for members age 16+.	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per permanent tooth area (excluding third molars) per 12 months.	Tooth identification Current mounted and dated post-implant periapical radiographs Pre-treatment recommended
D6097	Implant	Abutment-supported crown – porcelain fused to titanium and titanium alloys	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per implant per 60 months for members age 16+. Includes preparation, impression, temporary restoration, and insertion.	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per implant per 60 months. Includes preparation, impression, temporary restoration, and insertion.	Tooth identification Current mounted and dated post-implant periapical radiographs Pre-treatment recommended

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
D6098	Implant	Implant supported retainer – porcelain fused to predominantly base alloys	Not a covered benefit.	Not a covered benefit.	None
D6099	Implant	Implant supported retainer for FPD – porcelain fused to noble alloys	Not a covered benefit.	Not a covered benefit.	None
D6100	Implant	Surgical removal of implant body	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per permanent tooth (excluding third molars) per lifetime for members age 16+ (either D6100 or D6105).	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per permanent tooth (excluding third molars) per lifetime (either D6100 or D6105).	Tooth identification
D6101	Implant	Debridement of a peri-implant defect and surface cleaning of exposed implant surfaces, including flap entry and closure	Not a covered benefit.	Not a covered benefit.	None
D6102	Implant	Debridement and osseous contouring of a peri-implant defect; includes surface cleaning of exposed implant surfaces and flap entry	Not a covered benefit.	Not a covered benefit.	None
D6103	Implant	Bone graft for repair of peri-implant defect – not including flap entry and closure	Not a covered benefit.	Not a covered benefit.	None
D6104	Implant	Bone graft at time of implant placement	Not a covered benefit.	Not a covered benefit.	None
D6105	Implant	Removal of implant body not requiring bone removal or flap elevation	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per permanent tooth (excluding third molars) per lifetime for members age 16+ (either D6100 or D6105).	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per permanent tooth (excluding third molars) per lifetime (either D6100 or D6105).	Tooth identification
D6106	Implant	Guided tissue regeneration – resorbable barrier, per implant	Not a covered benefit.	Not a covered benefit.	None
D6107	Implant	Guided tissue regeneration – non-resorbable barrier, per implant	Not a covered benefit.	Not a covered benefit.	None
D6110	Implant	Implant /abutment supported removable denture for edentulous arch – maxillary	Verify if the member's plan has implant coverage. If the plan has implant coverage: Once per 60 months for members age 16+. Based on the member's benefits, Implant/abutment supported removable dentures may pay as	Verify if the member's plan has implant coverage. If the plan has implant coverage: Once per 60 months. Based on the member's benefits, Implant/abutment supported removable dentures may pay as an alternate benefit to the	Arch identification

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
			an alternate benefit to the corresponding Denture procedure code. The member would be responsible for the remainder of the charge. If the member's plan provides full benefits on Implant/abutment supported removable dentures; you may not balance bill the member.	corresponding Denture procedure code. The member would be responsible for the remainder of the charge. If the member's plan provides full benefits on Implant/abutment supported removable dentures; you may not balance bill the member.	
D6111	Implant	Implant /abutment supported removable denture for edentulous arch – mandibular	Verify if the member's plan has implant coverage. If the plan has implant coverage: Once per 60 months for members age 16+. Based on the member's benefits, Implant/abutment supported removable dentures may pay as an alternate benefit to the corresponding Denture procedure code. The member would be responsible for the remainder of the charge. If the member's plan provides full benefits on Implant/abutment supported removable dentures; you may not balance bill the member.	Verify if the member's plan has implant coverage. If the plan has implant coverage: Once per 60 months. Based on the member's benefits, Implant/abutment supported removable dentures may pay as an alternate benefit to the corresponding Denture procedure code. The member would be responsible for the remainder of the charge. If the member's plan provides full benefits on Implant/abutment supported removable dentures; you may not balance bill the member.	Arch identification
D6112	Implant	Implant /abutment supported removable denture for partially edentulous arch – maxillary	Verify if the member's plan has implant coverage. If the plan has implant coverage: Once per 60 months for members age 16+. Based on the member's benefits, Implant/abutment supported removable dentures may pay as an alternate benefit to the corresponding Denture procedure code. The member would be responsible for the remainder of the charge. If the member's plan provides full	Verify if the member's plan has implant coverage. If the plan has implant coverage: Once per 60 months. Based on the member's benefits, Implant/abutment supported removable dentures may pay as an alternate benefit to the corresponding Denture procedure code. The member would be responsible for the remainder of the charge. If the member's plan provides full benefits on	Arch identification

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
			benefits on Implant/abutment supported removable dentures; you may not balance bill the member.	Implant/abutment supported removable dentures; you may not balance bill the member.	
D6113	Implant	Implant /abutment supported removable denture for partially edentulous arch – mandibular	Verify if the member's plan has implant coverage. If the plan has implant coverage: Once per 60 months for members age 16+. Based on the member's benefits, Implant/abutment supported removable dentures may pay as an alternate benefit to the corresponding Denture procedure code. The member would be responsible for the remainder of the charge. If the member's plan provides full benefits on Implant/abutment supported removable dentures; you may not balance bill the member.	Verify if the member's plan has implant coverage. If the plan has implant coverage: Once per 60 months. Based on the member's benefits, Implant/abutment supported removable dentures may pay as an alternate benefit to the corresponding Denture procedure code. The member would be responsible for the remainder of the charge. If the member's plan provides full benefits on Implant/abutment supported removable dentures; you may not balance bill the member.	Arch identification
D6114	Implant	Implant /abutment supported fixed denture for edentulous arch – maxillary	Not a covered benefit.	Not a covered benefit.	None
D6115	Implant	Implant /abutment supported fixed denture for edentulous arch – mandibular	Not a covered benefit.	Not a covered benefit.	None
D6116	Implant	Implant /abutment supported fixed denture for partially edentulous arch – maxillary	Not a covered benefit.	Not a covered benefit.	None
D6117	Implant	Implant /abutment supported fixed denture for partially edentulous arch – mandibular	Not a covered benefit.	Not a covered benefit.	None
D6118	Implant	Implant/abutment supported interim fixed denture for edentulous arch – mandibular	Not a covered benefit.	Not a covered benefit.	None
D6119	Implant	Implant/abutment supported interim fixed denture for edentulous arch – maxillary	Not a covered benefit.	Not a covered benefit.	None
D6120	Implant	Implant supported retainer – porcelain fused to titanium and titanium alloys	Not a covered benefit.	Not a covered benefit.	None
D6121	Implant	Implant-supported retainer for metal FPD – predominantly base alloys	Not a covered benefit.	Not a covered benefit.	None

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
D6122	Implant	Implant-supported retainer for metal FPD – noble alloys	Not a covered benefit.	Not a covered benefit.	None
D6123	Implant	Implant-supported retainer for metal FPD – titanium and titanium alloys	Not a covered benefit.	Not a covered benefit.	None
D6180	Implant	Implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments	Not a covered benefit.	Not a covered benefit.	None
D6190	Implant	Radiographic/surgical implant index, by report	Not a covered benefit.	Not a covered benefit.	None
D6191	Implant	Semi-precision abutment – placement	Not a covered benefit.	Not a covered benefit.	None
D6192	Implant	Semi-precision attachment – placement	Not a covered benefit.	Not a covered benefit.	None
D6193	Implant	Replacement of an implant screw	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per permanent tooth area (excluding third molars) per 12 months for members age 16+.	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per permanent tooth area (excluding third molars) per 12 months.	Tooth identification
D6194	Implant	Abutment supported retainer crown for FPD – titanium and titanium alloys	Not a covered benefit.	Not a covered benefit.	None
D6195	Implant	Abutment supported retainer – porcelain fused to titanium and titanium alloys	Not a covered benefit.	Not a covered benefit.	None
D6196	Implant	Removal of an indirect restoration on an implant retained abutment	Not a covered benefit.	Not a covered benefit.	None
D6197	Implant	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per tooth per 12 months for members age 16+. Considered part of routine post-delivery care for abutment/implant supported crowns for the first 90 days.	Verify if the member's plan has implant coverage. If the plan has implant coverage: One per tooth per 12 months. Considered part of routine post-delivery care for abutment/implant supported crowns for the first 90 days.	Tooth identification
D6198	Implant	Remove interim implant component	Not a covered benefit.	Not a covered benefit.	None
D6199	Implant	Unspecified implant procedure, by report	Verify if the member's plan has implant coverage. If the plan has implant coverage: Individual consideration.	Verify if the member's plan has implant coverage. If the plan has implant coverage: Individual consideration.	Detailed narrative
D6205	Prosthodontics (fixed)	Pontic – indirect resin-based composite	Not a covered benefit.	Not a covered benefit.	None
D6210	Prosthodontics (fixed)	Pontic – cast high noble	Not a covered benefit.	One pontic per permanent tooth per 84 months.	Tooth identification

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
D6211	Prosthodontics (fixed)	Pontic – cast predominantly base metal	Not a covered benefit.	One pontic per permanent tooth per 84 months.	Tooth identification
D6212	Prosthodontics (fixed)	Pontic – cast noble metal	Not a covered benefit.	One pontic per permanent tooth per 84 months.	Tooth identification
D6214	Prosthodontics (fixed)	Pontic – titanium and titanium alloys	Not a covered benefit.	One pontic per permanent tooth per 84 months.	Tooth identification
D6240	Prosthodontics (fixed)	Pontic – porcelain fused to high noble metal	Not a covered benefit.	One pontic per permanent tooth per 84 months.	Tooth identification
D6241	Prosthodontics (fixed)	Pontic – porcelain fused to predominantly base metal	Once per 60 months per tooth.	One pontic per permanent tooth per 84 months.	Tooth identification
D6242	Prosthodontics (fixed)	Pontic – porcelain fused to noble metal	Not a covered benefit.	One pontic per permanent tooth per 84 months.	Tooth identification
D6243	Prosthodontics (fixed)	Pontic – porcelain fused to titanium and titanium alloys	Not a covered benefit.	One pontic per permanent tooth per 84 months.	Tooth identification
D6245	Prosthodontics (fixed)	Pontic – porcelain/ceramic	Not a covered benefit.	One pontic per permanent tooth per 84 months.	Tooth identification
D6250	Prosthodontics (fixed)	Pontic – resin with high noble metal	Not a covered benefit.	One pontic per permanent tooth per 84 months.	Tooth identification
D6251	Prosthodontics (fixed)	Pontic – resin with predominantly base metal	Not a covered benefit.	One pontic per permanent tooth per 84 months.	Tooth identification
D6252	Prosthodontics (fixed)	Pontic – resin with noble metal	Not a covered benefit.	One pontic per permanent tooth per 84 months.	Tooth identification
D6253	Prosthodontics (fixed)	Interim pontic – further treatment or completion of diagnosis necessary prior to final impression	Not a covered benefit.	Not a covered benefit.	None
D6280	Implant	Implant maintenance procedures when a full arch removable implant/abutment supported denture is removed and reinserted, including cleansing of prosthesis and abutments – per arch	Not a covered benefit.	Not a covered benefit.	None
D6545	Prosthodontics (fixed)	Retainer – cast metal for resin-bonded fixed prosthesis	Not a covered benefit.	One restoration per permanent tooth per 84 months.	Tooth identification
D6548	Prosthodontics (fixed)	Retainer – porcelain/ ceramic for resin-bonded fixed prosthesis	Not a covered benefit.	One restoration per permanent tooth per 84 months.	Tooth identification
D6549	Prosthodontics (fixed)	Resin retainer – for resin bonded fixed prosthesis	Not a covered benefit.	One restoration per permanent tooth per 84 months.	Tooth identification
D6600	Prosthodontics (fixed)	Retainer inlay – porcelain/ceramic, two surfaces	Not a covered benefit.	One restoration per tooth surface per 84 months.	Tooth identification Surface identification
D6601	Prosthodontics (fixed)	Retainer inlay – porcelain/ceramic, three or more surfaces	Not a covered benefit.	One restoration per tooth surface per 84 months.	Tooth identification

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
					Surface identification
D6602	Prosthodontics (fixed)	Retainer inlay – cast high noble metal, two surfaces	Not a covered benefit.	One restoration per tooth surface per 84 months.	Tooth identification Surface identification
D6603	Prosthodontics (fixed)	Retainer inlay – cast high noble metal, three or more surfaces	Not a covered benefit.	One restoration per tooth surface per 84 months.	Tooth identification Surface identification
D6604	Prosthodontics (fixed)	Retainer inlay – cast predominantly base metal, two surfaces	Not a covered benefit.	One restoration per tooth surface per 84 months.	Tooth identification Surface identification
D6605	Prosthodontics (fixed)	Retainer inlay – cast predominantly base metal, three or more surfaces	Not a covered benefit.	One restoration per tooth surface per 84 months.	Tooth identification Surface identification
D6606	Prosthodontics (fixed)	Retainer inlay – cast noble metal, two surfaces	Not a covered benefit.	One restoration per tooth surface per 84 months.	Tooth identification Surface identification
D6607	Prosthodontics (fixed)	Retainer inlay – cast noble metal, three or more surfaces	Not a covered benefit.	One restoration per tooth surface per 84 months.	Tooth identification Surface identification
D6608	Prosthodontics (fixed)	Retainer onlay –porcelain/ceramic, two surfaces	Not a covered benefit.	Once per tooth per 84 months.	Tooth identification Surface identification –must include B or L surface
D6609	Prosthodontics (fixed)	Retainer onlay – porcelain/ ceramic, three or more surfaces	Not a covered benefit.	Once per tooth per 84 months.	Tooth identification Surface identification –must include B or L surface
D6610	Prosthodontics (fixed)	Retainer onlay – cast high noble metal, two surfaces	Not a covered benefit.	Once per tooth per 84 months.	Tooth identification Surface identification –must include B or L surface
D6611	Prosthodontics (fixed)	Retainer onlay – cast high noble metal, three or more surfaces	Not a covered benefit.	Once per tooth per 84 months.	Tooth identification Surface identification –must include B or L surface

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
D6612	Prosthodontics (fixed)	Retainer onlay – cast predominantly base metal, two surfaces	Not a covered benefit.	Once per tooth per 84 months.	Tooth identification Surface identification –must include B or L surface
D6613	Prosthodontics (fixed)	Retainer onlay – cast predominantly base metal, three or more surfaces	Not a covered benefit.	Once per tooth per 84 months.	Tooth identification Surface identification –must include B or L surface
D6614	Prosthodontics (fixed)	Retainer onlay – cast noble metal, two surfaces	Not a covered benefit.	Once per tooth per 84 months.	Tooth identification Surface identification –must include B or L surface
D6615	Prosthodontics (fixed)	Retainer onlay – cast noble metal, three or more surfaces	Not a covered benefit.	Once per tooth per 84 months.	Tooth identification Surface identification –must include B or L surface
D6624	Prosthodontics (fixed)	Retainer inlay – titanium	Not a covered benefit.	Not a covered benefit.	None
D6634	Prosthodontics (fixed)	Retainer onlay – titanium	Not a covered benefit.	Once per tooth per 84 months.	Tooth identification Surface identification –must include B or L surface
D6710	Prosthodontics (fixed)	Retainer crown – indirect resin-based composite	Not a covered benefit.	Not a covered benefit.	None
D6720	Prosthodontics (fixed)	Retainer crown – resin with high noble metal	Not a covered benefit.	One retainer crown or cast restoration per permanent tooth per 84 months.	Tooth identification
D6721	Prosthodontics (fixed)	Retainer crown – resin with predominantly base metal	Not a covered benefit.	One retainer crown or cast restoration per permanent tooth per 84 months.	Tooth identification
D6722	Prosthodontics (fixed)	Retainer crown – resin with noble metal	Not a covered benefit.	One retainer crown or cast restoration per permanent tooth per 84 months.	Tooth identification

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
D6740	Prosthodontics (fixed)	Retainer crown – porcelain/ceramic	Not a covered benefit.	One retainer crown or cast restoration per permanent tooth per 84 months.	Tooth identification
D6750	Prosthodontics (fixed)	Retainer crown – porcelain fused to high noble	Not a covered benefit.	One retainer crown or cast restoration per permanent tooth per 84 months.	Tooth identification
D6751	Prosthodontics (fixed)	Retainer crown – porcelain fused to predominantly base metal	Once per 60 months per tooth.	One retainer crown or cast restoration per permanent tooth per 84 months.	Tooth identification
D6752	Prosthodontics (fixed)	Retainer crown – porcelain fused to noble metal	Not a covered benefit.	One retainer crown or cast restoration per permanent tooth per 84 months.	Tooth identification
D6753	Prosthodontics (fixed)	Retainer crown – porcelain fused to titanium and titanium alloys	Not a covered benefit.	One retainer crown or cast restoration per permanent tooth per 84 months.	Tooth identification
D6780	Prosthodontics (fixed)	Retainer crown – ¾ cast high noble metal	Not a covered benefit.	One retainer crown or cast restoration per permanent tooth per 84 months.	Tooth identification
D6781	Prosthodontics (fixed)	Retainer crown – ¾ cast predominately base metal	Not a covered benefit.	One retainer crown or cast restoration per permanent tooth per 84 months.	Tooth identification
D6782	Prosthodontics (fixed)	Retainer crown – ¾ cast noble metal	Not a covered benefit.	One retainer crown or cast restoration per permanent tooth per 84 months.	Tooth identification
D6783	Prosthodontics (fixed)	Retainer crown – ¾ porcelain/ceramic	Not a covered benefit.	One retainer crown or cast restoration per permanent tooth per 84 months.	Tooth identification
D6784	Prosthodontics (fixed)	Retainer crown ¾ – titanium and titanium alloys	Not a covered benefit.	One retainer crown or cast restoration per permanent tooth per 84 months.	Tooth identification
D6790	Prosthodontics (fixed)	Retainer crown – full cast high noble metal	Not a covered benefit.	One retainer crown or cast restoration per permanent tooth per 84 months.	Tooth identification
D6791	Prosthodontics (fixed)	Retainer crown – full cast predominantly base metal	Not a covered benefit.	One crown or cast restoration per permanent tooth per 84 months.	Tooth identification
D6792	Prosthodontics (fixed)	Retainer crown – full cast noble metal	Not a covered benefit.	One crown or cast restoration per permanent tooth per 84 months.	Tooth identification
D6793	Prosthodontics (fixed)	Interim retainer crown – further treatment or completion of diagnosis necessary prior to final impression	Not a covered benefit.	Not a covered benefit.	Tooth identification

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D6794	Prosthodontics (fixed)	Retainer crown – titanium and titanium alloys	Not a covered benefit.	One crown or cast restoration per permanent tooth per 84 months.	Tooth identification
D6920	Prosthodontics (fixed)	Connector bar	Not a covered benefit.	Not a covered benefit.	None
D6930	Prosthodontics (fixed)	Recement or re-bond fixed partial denture	Not payable within 6 months of the placement of the fixed partial denture.	One re-cementation per 12 months.	Tooth identification
D6940	Prosthodontics (fixed)	Stress breaker	Not a covered benefit.	Not a covered benefit.	None
D6950	Prosthodontics (fixed)	Precision attachment	Not a covered benefit.	Not a covered benefit.	None
D6980	Prosthodontics (fixed)	Fixed partial denture repair necessitated by restorative material failure	Covered.	One repair per 12 months.	Quadrant identification Detailed narrative
D6985	Prosthodontics (fixed)	Pediatric partial denture, fixed	Not a covered benefit.	Not a covered benefit.	None
D6999	Prosthodontics (fixed)	Unspecified fixed prosthodontic procedure, by report	Individual consideration.	Individual consideration.	Detailed narrative
D7111	Oral & maxillofacial surgery	Extraction – coronal remnants, deciduous tooth	One per tooth per lifetime. Note: 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)	One per tooth per lifetime. Note: 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)	Tooth identification
D7140	Oral & maxillofacial surgery	Extraction – erupted tooth or exposed root (elevation and/or forcep removal)	One per tooth per lifetime. Note: 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)	One per tooth per lifetime. If D7140, D7210, or D7250 is performed within 90 days after a D3921, payment for the extraction will be reduced by the payment of D3921. Note: 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	Tooth identification

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
				conjunction with oral surgery codes (D7000-D7999)	
D7210	Oral & maxillofacial surgery	Surgical removal of an erupted tooth requiring removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated	One per tooth per lifetime. Note: 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)	One per tooth per lifetime. If D7140, D7210 or D7250 is performed within 90 days after a D3921, payment for the extraction will be reduced by the payment of D3921. Note: 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)	Tooth identification
D7220	Oral & maxillofacial surgery	Removal of impacted tooth – soft tissue	One per tooth per lifetime.	One per tooth per lifetime.	Tooth identification
D7230	Oral & maxillofacial surgery	Removal of impacted tooth – partially bony	One per tooth per lifetime.	One per tooth per lifetime.	Tooth identification
D7240	Oral & maxillofacial surgery	Removal of impacted tooth – completely bony	One per tooth per lifetime.	One per tooth per lifetime.	Tooth identification
D7241	Oral & maxillofacial surgery	Removal of impacted tooth – completely bony, with unusual surgical complications	Not a covered benefit.	One per tooth per lifetime.	Tooth identification
D7250	Oral & maxillofacial surgery	Surgical removal of residual tooth roots (cutting procedure)	Only covered for teeth that are symptomatic, carious or pathologic.	One per tooth per lifetime. If D7140, D7210 or D7250 is performed within 90 days after a D3921, payment for the extraction will be reduced by the payment of D3921.	Tooth identification
D7251	Oral & maxillofacial surgery	Coronectomy – intentional partial tooth removal, impacted teeth only	Not a covered benefit.	Once per tooth per lifetime (D3921 or D7251).	Tooth identification
D7252	Oral & maxillofacial surgery	Partial extraction for immediate implant placement	Once per permanent canine or incisor tooth per lifetime for members age 16+ when done in conjunction with implant placement on same date of service.	Once per permanent canine or incisor tooth per lifetime for members age 16+ when done in conjunction with implant placement on same date of service.	Tooth identification

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
D7259	Oral & maxillofacial surgery	Nerve dissection	Not a covered benefit.	Not a covered benefit.	None
D7260	Oral & maxillofacial surgery	Oroantral fistula closure	Not a covered benefit.	Individual consideration.	Periapical or panoramic radiograph Operative note Tooth identification
D7261	Oral & maxillofacial surgery	Primary closure of a sinus perforation	Not a covered benefit.	Individual consideration.	Periapical or panoramic radiograph Operative note Tooth identification
D7270	Oral & maxillofacial surgery	Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth	Covered for permanent teeth.	Once per permanent tooth per lifetime.	Tooth identification
D7272	Oral & maxillofacial surgery	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)	Not a covered benefit.	Not a covered benefit.	None
D7280	Oral & maxillofacial surgery	Surgical access of unerupted tooth	Not a covered benefit.	Once per permanent tooth (1 through 32) per lifetime.	Tooth identification
D7282	Oral & maxillofacial surgery	Mobilization of erupted or mal-positioned tooth to aid eruption	Not a covered benefit.	Once per permanent tooth (1 through 32) per lifetime.	Tooth identification
D7283	Oral & maxillofacial surgery	Placement of a device to facilitate eruption of impacted tooth	Once per tooth per lifetime and covered only with approved medically necessary orthodontics.	Once per tooth per lifetime.	Tooth identification
D7284	Oral & maxillofacial surgery	Excisional biopsy of minor salivary glands	Individual consideration.	Individual consideration.	Pathology report
D7285	Oral & maxillofacial surgery	Incisional biopsy of oral tissue – hard (bone, tooth)	Not a covered benefit.	Individual consideration.	Pathology report
D7286	Oral & maxillofacial surgery	Incisional biopsy of oral tissue – soft	Not a covered benefit.	Individual consideration.	Pathology report
D7287	Oral & maxillofacial surgery	Cytology exfoliative sample collection	Not a covered benefit.	Individual consideration.	Pathology report
D7288	Oral & maxillofacial surgery	Brush biopsy – transepithelial sample collection	Not a covered benefit.	Individual consideration.	Pathology report
D7290	Oral & maxillofacial surgery	Surgical repositioning of teeth – grafting procedures are additional	Not a covered benefit.	Individual consideration.	Tooth identification Detailed narrative

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
D7291	Oral & maxillofacial surgery	Transseptal fiberotomy/supra crestal fiberotomy, by report	Not a covered benefit.	Individual consideration.	Tooth identification Detailed narrative Include orthodontic history
D7292	Oral & maxillofacial surgery	Placement of temporary anchorage device [screw retained plate] requiring flap	Not a covered benefit.	Not a covered benefit.	None
D7293	Oral & maxillofacial surgery	Placement of temporary anchorage device requiring flap	Not a covered benefit.	Not a covered benefit.	None
D7294	Oral & maxillofacial surgery	Placement of temporary anchorage device without flap	Not a covered benefit.	Not a covered benefit.	None
D7295	Oral & maxillofacial surgery	Harvest of bone for use in autogenous grafting procedures	Not a covered benefit.	Not a covered benefit.	None
D7296	Oral & maxillofacial surgery	Corticotomy one to three teeth	Not a covered benefit.	Not a covered benefit.	None
D7297	Oral & maxillofacial surgery	Corticotomy four or more teeth	Not a covered benefit.	Not a covered benefit.	None
D7298	Oral & maxillofacial surgery	Removal of temporary anchorage device [screw retained plate], requiring flap	Not a covered benefit.	Not a covered benefit.	None
D7299	Oral & maxillofacial surgery	Removal of temporary anchorage device, requiring flap	Not a covered benefit.	Not a covered benefit.	None
D7300	Oral & maxillofacial surgery	Removal of temporary anchorage device without flap	Not a covered benefit.	Not a covered benefit.	None
D7310	Oral & maxillofacial surgery	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	Once per quadrant per lifetime.	Once per quadrant per lifetime.	Quadrant Identification Detailed narrative or progress notes Pre-operative radiographs
D7311	Oral & maxillofacial surgery	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	Once per quadrant per lifetime.	Once per quadrant per lifetime.	Quadrant Identification Detailed narrative or progress notes Pre-operative radiographs

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
D7320	Oral & maxillofacial surgery	Alveoloplasty not in conjunction with extractions –four or more teeth or tooth spaces, per quadrant	Once per quadrant per lifetime.	Once per quadrant per lifetime.	Quadrant Identification Detailed narrative or progress notes Pre-operative radiographs
D7321	Oral & maxillofacial surgery	Alveoloplasty, not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	Once per quadrant per lifetime.	Once per quadrant per lifetime.	Quadrant Identification Tooth spaces identification Detailed narrative or progress notes Pre-operative radiographs
D7340	Oral & maxillofacial surgery	Vestibuloplasty – ridge extension (secondary epithelialization)	Individual consideration. Services must be rendered by an oral surgeon for benefit coverage.	Individual consideration. Services must be rendered by an oral surgeon for benefit coverage.	Arch identification
D7350	Oral & maxillofacial surgery	Vestibuloplasty – ridge extension (incl. soft tissue grafts, muscle re-attachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	Individual consideration. Services must be rendered by an oral surgeon for benefit coverage.	Individual consideration. Services must be rendered by an oral surgeon for benefit coverage.	Arch identification
D7410	Oral & maxillofacial surgery	Excision of benign lesion, up to 1.25 cm	Individual consideration.	Individual consideration.	Pathology report
D7411	Oral & maxillofacial surgery	Excision of benign lesion greater than 1.25 cm	Individual consideration.	Individual consideration.	Pathology report
D7412	Oral & maxillofacial surgery	Excision of benign lesion, complicated	Not a covered benefit.	Individual consideration.	Pathology report
D7413	Oral & maxillofacial surgery	Excision of malignant lesion up to 1.25 cm	Not a covered benefit.	Individual consideration.	Pathology report
D7414	Oral & maxillofacial surgery	Excision of malignant lesion greater than 1.25 cm	Not a covered benefit.	Individual consideration.	Pathology report
D7415	Oral & maxillofacial surgery	Excision of malignant lesion, complicated	Not a covered benefit.	Individual consideration.	Pathology report
D7440	Oral & maxillofacial surgery	Excision of malignant tumor – lesion diameter up to 1.25 cm	Not a covered benefit.	Individual consideration.	Pathology report

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D7441	Oral & maxillofacial surgery	Excision of malignant tumor – lesion diameter greater than 1.25 cm	Not a covered benefit.	Individual consideration.	Pathology report
D7450	Oral & maxillofacial surgery	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm	Individual consideration; services must be rendered by an oral surgeon for benefit coverage.	Individual consideration.	Pathology report
D7451	Oral & maxillofacial surgery	Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm	Individual consideration; services must be rendered by an oral surgeon for benefit coverage.	Individual consideration.	Pathology report
D7460	Oral & maxillofacial surgery	Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm	Individual consideration; services must be rendered by an oral surgeon for benefit coverage.	Individual consideration.	Pathology report
D7461	Oral & maxillofacial surgery	Removal of benign nonodontogenic cyst or tumor– lesion diameter greater than 1.25 cm	Individual consideration; services must be rendered by an oral surgeon for benefit coverage.	Individual consideration.	Pathology report
D7465	Oral & maxillofacial surgery	Destruction of lesion(s) by physical or chemical methods, by report	Not a covered benefit.	Not a covered benefit.	None
D7471	Oral & maxillofacial surgery	Removal of lateral exostosis (maxilla or mandible)	Services must be rendered by an oral surgeon for benefit coverage.	Once per arch per lifetime.	Arch identification
D7472	Oral & maxillofacial surgery	Removal of torus palatinus	Not a covered benefit.	Once per arch per lifetime	Arch identification
D7473	Oral & maxillofacial surgery	Removal of torus mandibularis	Not a covered benefit.	Once per quadrant per lifetime.	Quadrant identification
D7485	Oral & maxillofacial surgery	Reduction of osseous tuberosity	Not a covered benefit.	Once per upper quadrant per lifetime.	Quadrant identification
D7490	Oral & maxillofacial surgery	Radical resection of maxilla or mandible	Not a covered benefit.	Not a covered benefit.	None
D7509	Oral & maxillofacial surgery	Marsupialization of odontogenic cyst	Not a covered benefit.	Individual consideration.	Tooth identification Detailed narrative or operative report
D7510	Oral & maxillofacial surgery	Incision and drainage of abscess – intraoral soft tissue	Not a covered benefit.	Individual consideration.	Tooth identification Detailed narrative
D7511	Oral & maxillofacial surgery	Incision and drainage of abscess – intraoral soft tissue, complicated (includes drainage of multiple fascial spaces)	Not a covered benefit.	Individual consideration.	Tooth identification Detailed narrative
D7520	Oral & maxillofacial surgery	Incision and drainage of abscess – extraoral soft tissue	Not a covered benefit.	Individual consideration.	Detailed narrative

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D7521	Oral & maxillofacial surgery	Incision and drainage of abscess – extraoral soft tissue, complicated (includes drainage of multiple fascial spaces)	Not a covered benefit.	Individual consideration.	Detailed narrative
D7530	Oral & maxillofacial surgery	Removal of foreign body, mucosa, skin, or subcutaneous alveolar tissue	Not a covered benefit.	Individual consideration.	Pathology report Operative report
D7540	Oral & maxillofacial surgery	Removal of reaction-producing foreign bodies, musculoskeletal system	Not a covered benefit.	Individual consideration.	Pathology report Operative report
D7550	Oral & maxillofacial surgery	Partial ostectomy/ sequestrectomy for removal of non-vital bone	Not a covered benefit.	Individual consideration.	Pathology report Operative report
D7560	Oral & maxillofacial surgery	Maxillary sinusotomy for removal of tooth fragment or foreign body	Not a covered benefit.	Individual consideration.	Operative report Arch identification
D7610	Oral & maxillofacial surgery	Maxilla – open reduction (teeth immobilized, if present)	Not a covered benefit.	Individual consideration.	Panoramic radiograph Operative report Arch identification
D7620	Oral & maxillofacial surgery	Maxilla – closed reduction (teeth immobilized, if present)	Not a covered benefit.	Individual consideration.	Panoramic radiograph Operative report Arch identification
D7630	Oral & maxillofacial surgery	Mandible – open reduction (teeth immobilized, if present)	Not a covered benefit.	Individual consideration.	Panoramic radiograph Operative report Arch identification
D7640	Oral & maxillofacial surgery	Mandible – closed reduction (teeth immobilized, if present)	Not a covered benefit.	Individual consideration.	Panoramic radiograph Operative report Arch identification
D7650	Oral & maxillofacial surgery	Malar and/or zygomatic arch – open reduction	Not a covered benefit.	Individual consideration.	Panoramic radiograph Operative report

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
					Arch identification
D7660	Oral & maxillofacial surgery	Malar and/or zygomatic arch – closed reduction	Not a covered benefit.	Individual consideration.	Panoramic radiograph Operative report Arch identification
D7670	Oral & maxillofacial surgery	Alveolus – closed reduction, may include stabilization of teeth	Not a covered benefit.	Individual consideration.	Panoramic radiograph Operative report Arch identification
D7671	Oral & maxillofacial surgery	Alveolus – open reduction, may include stabilization of teeth	Not a covered benefit.	Individual consideration.	Panoramic radiograph Operative report Arch identification
D7680	Oral & maxillofacial surgery	Facial bones – complicated reduction with fixation and multiple surgical approaches	Not a covered benefit.	Individual consideration.	Panoramic radiograph Operative report
D7710	Oral & maxillofacial surgery	Maxilla – open reduction, stabilization of teeth	Not a covered benefit.	Individual consideration.	Panoramic radiograph Operative report Arch identification
D7720	Oral & maxillofacial surgery	Maxilla – closed reduction	Not a covered benefit.	Individual consideration.	Panoramic radiograph Operative report Arch identification
D7730	Oral & maxillofacial surgery	Mandible – open reduction	Not a covered benefit.	Individual consideration.	Panoramic radiograph Operative report Arch identification
D7740	Oral & maxillofacial surgery	Mandible – closed reduction	Not a covered benefit.	Individual consideration.	Panoramic radiograph

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
					Operative report Arch identification
D7750	Oral & maxillofacial surgery	Malar and/or zygomatic arch – open reduction	Not a covered benefit.	Individual consideration.	Panoramic radiograph Operative report Arch identification
D7760	Oral & maxillofacial surgery	Malar and/or zygomatic arch – closed reduction	Not a covered benefit.	Individual consideration.	Panoramic radiograph Operative report Arch identification
D7770	Oral & maxillofacial surgery	Alveolus – open reduction stabilization of teeth	Not a covered benefit.	Individual consideration.	Panoramic radiograph Operative report Arch identification
D7771	Oral & maxillofacial surgery	Alveolus – closed reduction, stabilization of teeth	Not a covered benefit.	Individual consideration.	Panoramic radiograph Operative report Arch identification
D7780	Oral & maxillofacial surgery	Facial bones – complicated reduction with fixation and multiple surgical approaches	Not a covered benefit.	Individual consideration.	None
D7810	Oral & maxillofacial surgery	Open reduction of dislocation	Not a covered benefit.	Not a covered benefit.	None
D7820	Oral & maxillofacial surgery	Closed reduction of dislocation	Not a covered benefit.	Not a covered benefit.	None
D7830	Oral & maxillofacial surgery	Manipulation under anesthesia	Not a covered benefit.	Not a covered benefit.	None
D7840	Oral & maxillofacial surgery	Condylectomy	Not a covered benefit.	Not a covered benefit.	None
D7850	Oral & maxillofacial surgery	Surgical disectomy; with or without implant	Not a covered benefit.	Not a covered benefit.	None
D7852	Oral & maxillofacial surgery	Disc repair	Not a covered benefit.	Not a covered benefit.	None

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D7854	Oral & maxillofacial surgery	Synovectomy	Not a covered benefit.	Not a covered benefit.	None
D7856	Oral & maxillofacial surgery	Myotomy	Not a covered benefit.	Not a covered benefit.	None
D7858	Oral & maxillofacial surgery	Joint reconstruction	Not a covered benefit.	Not a covered benefit.	None
D7860	Oral & maxillofacial surgery	Arthrotomy	Not a covered benefit.	Not a covered benefit.	None
D7865	Oral & maxillofacial surgery	Arthroplasty	Not a covered benefit.	Not a covered benefit.	None
D7870	Oral & maxillofacial surgery	Arthrocentesis	Not a covered benefit.	Not a covered benefit.	None
D7871	Oral & maxillofacial surgery	Non-anthroscopic lysis and lavage	Not a covered benefit.	Not a covered benefit.	None
D7872	Oral & maxillofacial surgery	Arthroscopy – diagnosis, with or without biopsy	Not a covered benefit.	Not a covered benefit.	None
D7873	Oral & maxillofacial surgery	Arthroscopy – surgical, lavage and lysis of adhesions	Not a covered benefit.	Not a covered benefit.	None
D7874	Oral & maxillofacial surgery	Arthroscopy – surgical, disc repositioning and stabilization	Not a covered benefit.	Not a covered benefit.	None
D7875	Oral & maxillofacial surgery	Arthroscopy – surgical, synovectomy	Not a covered benefit.	Not a covered benefit.	None
D7876	Oral & maxillofacial surgery	Arthroscopy – surgical, disectomy	Not a covered benefit.	Not a covered benefit.	None
D7877	Oral & maxillofacial surgery	Arthroscopy – surgical, debridement	Not a covered benefit.	Not a covered benefit.	None
D7880	Oral & maxillofacial surgery	Occlusal orthotic device, by report	Not a covered benefit.	Not a covered benefit.	None
D7881	Oral & maxillofacial surgery	Occlusal orthotic device adjustment	Not a covered benefit.	Not a covered benefit.	None
D7899	Oral & maxillofacial surgery	Unspecified TMD therapy, by report	Not a covered benefit.	Not a covered benefit.	None
D7910	Oral & maxillofacial surgery	Suture of recent small wounds up to 5 cm	Not a covered benefit.	Not a covered benefit.	None
D7911	Oral & maxillofacial surgery	Complicated suture – up to 5 cm	Not a covered benefit.	Not a covered benefit.	None
D7912	Oral & maxillofacial surgery	Complicated suture – greater than 5 cm	Not a covered benefit.	Not a covered benefit.	None
D7920	Oral & maxillofacial surgery	Skin grafts (identify defect covered, location, and type of graft)	Not a covered benefit.	Not a covered benefit.	None
D7921	Oral & maxillofacial surgery	Collection and application of autologous blood concentrate product	Not a covered benefit.	Not a covered benefit.	None

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D7922	Oral & maxillofacial surgery	Placement on intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	Not a covered benefit.	Not a covered benefit.	None
D7939	Oral & maxillofacial surgery	Indexing for osteotomy using dynamic robotic assisted or dynamic navigation	Not a covered benefit.	Not a covered benefit.	None
D7940	Oral & maxillofacial surgery	Osteoplasty – for orthognathic deformities	Not a covered benefit.	Not a covered benefit.	None
D7941	Oral & maxillofacial surgery	Osteotomy – mandibular rami	Not a covered benefit.	Not a covered benefit.	None
D7943	Oral & maxillofacial surgery	Osteotomy – mandibular rami with bone graft; includes obtaining the graft	Not a covered benefit.	Not a covered benefit.	None
D7944	Oral & maxillofacial surgery	Osteotomy – segmented or sub-apical, per sextant or quadrant	Not a covered benefit.	Not a covered benefit.	None
D7945	Oral & maxillofacial surgery	Osteotomy – body of mandible	Not a covered benefit.	Not a covered benefit.	None
D7946	Oral & maxillofacial surgery	LeFort I (maxilla – total)	Not a covered benefit.	Not a covered benefit.	None
D7947	Oral & maxillofacial surgery	LeFort I (maxilla – segmented)	Not a covered benefit.	Not a covered benefit.	None
D7948	Oral & maxillofacial surgery	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) – without bone graft	Not a covered benefit.	Not a covered benefit.	None
D7949	Oral & maxillofacial surgery	LeFort II or LeFort II – with bone graft	Not a covered benefit.	Not a covered benefit.	None
D7950	Oral & maxillofacial surgery	Osseous, osteoperiosteal, or cartilage graft of the mandible or facial bones, autogenous or nonautogenous, by report	Not a covered benefit.	Not a covered benefit.	None
D7951	Oral & maxillofacial surgery	Sinus augmentation with bone or bone substitutes via a lateral open approach	Not a covered benefit.	Not a covered benefit.	None
D7952	Oral & maxillofacial surgery	Sinus augmentation via a vertical approach	Not a covered benefit.	Not a covered benefit.	None
D7953	Oral & maxillofacial surgery	Bone replacement graft for ridge preservation – per site	Not a covered benefit.	Not a covered benefit.	None
D7955	Oral & maxillofacial surgery	Repair of maxillofacial soft and/or hard tissue defect	Not a covered benefit.	Not a covered benefit.	None
D7956	Oral & maxillofacial surgery	Guided tissue regeneration, edentulous area – resorbable barrier, per site	Not a covered benefit.	Not a covered benefit.	None
D7957	Oral & maxillofacial surgery	Guided tissue regeneration, edentulous area – non-resorbable barrier, per site	Not a covered benefit.	Not a covered benefit.	None
D7961	Oral & maxillofacial surgery	Buccal/labial frenectomy (frenulectomy)	D7961, D7962 or D7963 covered once per site per lifetime. Not allowed when performed in conjunction with	D7961, D7962 or D7963 covered once per site per lifetime. Not allowed when performed in conjunction	Tooth identification Detailed narrative

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			soft tissue graft; same site and same date of service.	with soft tissue graft; same site and same date of service.	
D7962	Oral & maxillofacial surgery	Lingual frenectomy (frenulectomy)	D7961, D7962 or D7963 covered once per site per lifetime. Not allowed when performed in conjunction with soft tissue graft; same site and same date of service.	D7961, D7962 or D7963 covered once per site per lifetime. Not allowed when performed in conjunction with soft tissue graft; same site and same date of service.	Tooth identification Detailed narrative
D7963	Oral & maxillofacial surgery	Frenuloplasty	D7961, D7962 or D7963 covered once per site per lifetime. Not allowed when performed in conjunction with soft tissue graft; same site and same date of service.	D7961, D7962 or D7963 covered once per site per lifetime. Not allowed when performed in conjunction with soft tissue graft; same site and same date of service.	Tooth identification Detailed narrative
D7970	Oral & maxillofacial surgery	Excision of hyperplastic tissue – per arch	Not payable on the same date of service as an extraction in the same area.	Individual consideration.	Arch identification
D7971	Oral & maxillofacial surgery	Excision of pericoronal gingiva	Not a covered benefit.	Individual consideration.	Tooth identification
D7972	Oral & maxillofacial surgery	Surgical reduction of fibrous tuberosity	Not a covered benefit.	Once per upper quadrant per lifetime.	Quadrant identification
D7979	Oral & maxillofacial surgery	Non-surgical sailolithotomy	Not a covered benefit.	Not a covered benefit.	None
D7980	Oral & maxillofacial surgery	Sialolithotomy	Not a covered benefit.	Individual consideration.	Detailed narrative
D7981	Oral & maxillofacial surgery	Excision of salivary gland, by report	Not a covered benefit.	Individual consideration.	Detailed narrative
D7982	Oral & maxillofacial surgery	Sialodochoplasty	Not a covered benefit.	Individual consideration.	Detailed narrative
D7983	Oral & maxillofacial surgery	Closure of salivary fistula	Not a covered benefit.	Individual consideration.	Detailed narrative
D7990	Oral & maxillofacial surgery	Emergency tracheotomy	Not a covered benefit.	Not a covered benefit.	None
D7991	Oral & maxillofacial surgery	Coronoidectomy	Not a covered benefit.	Not a covered benefit.	None
D7993	Oral & maxillofacial surgery	Surgical placement of craniofacial implant – extra oral	Not a covered benefit.	Not a covered benefit.	None
D7994	Oral & maxillofacial surgery	Surgical placement: zygomatic implant	Not a covered benefit.	Not a covered benefit.	None
D7995	Oral & maxillofacial surgery	Synthetic graft – mandible or facial bones, by report	Not a covered benefit.	Not a covered benefit.	None
D7996	Oral & maxillofacial surgery	Implant – mandible for augmentation purposes (excluding alveolar ridge), by report	Not a covered benefit.	Not a covered benefit.	None

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D7997	Oral & maxillofacial surgery	Appliance removal (not by dentist who placed appliance), includes removal of archbar	Not a covered benefit.	Individual consideration.	Detailed narrative
D7998	Oral & maxillofacial surgery	Intraoral placement of a fixation device not in conjunction with a fracture	Not a covered benefit.	Not a covered benefit.	None
D7999	Oral & maxillofacial surgery	Unspecified oral surgery procedure, by report	Individual consideration.	Individual consideration.	Tooth identification Detailed narrative Operative report
D8010	Orthodontics	Limited orthodontic treatment of the primary dentition	Once per child per lifetime; services must be provided by an orthodontist.	Not a covered benefit.	Prior authorization
D8020	Orthodontics	Limited orthodontic treatment of the transitional dentition	Once per child per lifetime; services must be provided by an orthodontist.	Not a covered benefit.	Prior authorization
D8030	Orthodontics	Limited orthodontic treatment of the adolescent dentition	Not a covered benefit.	Not a covered benefit.	None
D8040	Orthodontics	Limited orthodontic treatment of the adult dentition	Not a covered benefit.	Not a covered benefit.	None
D8070	Orthodontics	Comprehensive orthodontic treatment of transitional dentition	Not a covered benefit.	Not a covered benefit.	None
D8080	Orthodontics	Comprehensive orthodontic treatment of adolescent dentition	Once per child per lifetime; services must be provided by an orthodontist.	Not a covered benefit.	Prior authorization.
D8090	Orthodontics	Comprehensive orthodontic treatment of the adult dentition	Not a covered benefit.	Not a covered benefit.	None
D8091	Orthodontics	Comprehensive orthodontic treatment with orthognathic surgery	Once per child per lifetime; services must be provided by an orthodontist.	Not a covered benefit.	Prior authorization.
D8210	Orthodontics	Removable appliance therapy	Not a covered benefit.	Not a covered benefit.	None
D8220	Orthodontics	Fixed appliance therapy	Not a covered benefit.	Not a covered benefit.	None
D8660	Orthodontics	Pre-orthodontic treatment examination to monitor growth and development	Use for orthodontic work-up. Services must be rendered by orthodontist. Covered when prior auth for codes D8010, D8020 and D8080 is denied. Not covered and considered inclusive of D8010, D8020 and D8080 when prior auth for orthodontics is approved.	Not a covered benefit.	None
D8670	Orthodontics	Periodic orthodontic treatment visit	Included in the allowance for the comprehensive treatment. Also	Not a covered benefit.	None

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			covered for previously approved EHB take-over cases.		
D8671	Orthodontics	Periodic orthodontic treatment visit associated with orthognathic surgery	Included in the allowance for the comprehensive treatment. Also covered for previously approved EHB take-over cases.	Not a covered benefit.	None
D8680	Orthodontics	Orthodontic retention (removal of appliances, construction and placement of retainer(s)	Included in the allowance for the comprehensive treatment.	Not a covered benefit.	None
D8681	Orthodontics	Removable orthodontic retainer adjustment	Not a covered benefit.	Not a covered benefit.	None
D8695	Orthodontics	Removal of fixed orthodontic appliances for reasons other than completion of treatment	Not a covered benefit.	Not a covered benefit.	None
D8696	Orthodontics	Repair of orthodontic appliance – maxillary	Not a covered benefit.	Not a covered benefit.	None
D8697	Orthodontics	Repair of orthodontic appliance – mandibular	Not a covered benefit.	Not a covered benefit.	None
D8698	Orthodontics	Re-cement or re-bond fixed retainer – maxillary	Not a covered benefit.	Not a covered benefit.	None
D8699	Orthodontics	Re-cement or re-bond retainer – mandibular	Not a covered benefit.	Not a covered benefit.	None
D8701	Orthodontics	Repair of fixed retainer, includes reattachment – maxillary	Not a covered benefit.	Not a covered benefit.	None
D8702	Orthodontics	Repair of fixed retainer, includes reattachment – mandibular	Not a covered benefit.	Not a covered benefit.	None
D8703	Orthodontics	Replacement of lost or broken retainer – maxillary	Not a covered benefit.	Not a covered benefit.	None
D8704	Orthodontics	Replacement of lost or broken retainer – mandibular	Not a covered benefit.	Not a covered benefit.	None
D8999	Orthodontics	Unspecified orthodontic procedure, by report. Use for procedures not adequately described by a code	Individual consideration.	Not a covered benefit.	Prior authorization Detailed narrative
D9110	Adjunctive general	Palliative treatment of dental pain – per visit	Other definitive medically necessary services may be provided during the same visit.	Considered inclusive when performed on the same day as other definitive services by same dentist/dental office, other than appropriate radiographs.	None
D9120	Adjunctive general	Fixed partial denture sectioning	Not a covered benefit.	Not a covered benefit.	None
D9128	Adjunctive General	Photobiomodulation therapy - first 15 minute increment, or any portion thereof	Not a covered benefit.	Not a covered benefit.	None

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D9129	Adjunctive General	Photobiomodulation therapy - each subsequent 15 minute increment, or any portion thereof	Not a covered benefit.	Not a covered benefit.	None
D9130	Adjunctive general	Temporomandibular joint dysfunction – non-invasive physical therapies	Not a covered benefit.	Not a covered benefit.	None
D9210	Adjunctive general	Local anesthesia not in conjunction with operative or surgical procedures	Not a covered benefit.	Not a covered benefit.	None
D9211	Adjunctive general	Regional block anesthesia	Not a covered benefit.	Not a covered benefit.	None
D9212	Adjunctive general	Trigeminal division block anesthesia	Not a covered benefit.	Not a covered benefit.	None
D9215	Adjunctive general	Local anesthesia in conjunction with operative or surgical procedures	Included in the total fee for non-surgical or surgical services.	Included in the total fee for non-surgical or surgical services.	None
D9219	Adjunctive general	Evaluation for moderate sedation, deep sedation or general anesthesia	Not a covered benefit.	Not a covered benefit.	None
D9222	Adjunctive general	Administration of deep sedation/general anesthesia – first 15 minute increment, or any portion thereof	Covered when provided with covered surgical procedures.	Covered when provided with covered surgical procedures.	None
D9223	Adjunctive general	Administration of deep sedation/general anesthesia – each subsequent 15 minute increment, or any portion thereof	Covered when provided with covered surgical procedures.	Covered when provided with covered surgical procedures.	None
D9224	Adjunctive General	Administration of general anesthesia with advanced airway – first 15 minute increment, or any portion thereof	Covered when provided with covered surgical procedures.	Covered when provided with covered surgical procedures.	None
D9225	Adjunctive General	Administration of general anesthesia with advanced airway – each subsequent 15 minute increment, or any portion thereof	Covered when provided with covered surgical procedures.	Covered when provided with covered surgical procedures.	None
D9230	Adjunctive general	Administration of nitrous oxide	Not a covered benefit.	Not a covered benefit.	None
D9239	Adjunctive general	Administration of moderate sedation - intravenous - first 15 minute increment, or any portion thereof	Covered when provided with covered surgical procedures.	Covered when provided with covered surgical procedures.	None
D9243	Adjunctive general	Administration of moderate sedation – intravenous - each subsequent 15 minute increment, or any portion thereof	Covered when provided with covered surgical procedures.	Covered when provided with covered surgical procedures.	None
D9244	Adjunctive General	in-office administration of minimal sedation – single drug – enteral	Not a covered benefit.	Not a covered benefit.	None
D9245	Adjunctive General	administration of moderate sedation – enteral	Not a covered benefit.	Not a covered benefit.	None
D9246	Adjunctive General	administration of moderate sedation – non-intravenous parenteral – first 15 minute increment, or any portion thereof	Not a covered benefit.	Not a covered benefit.	None
D9247	Adjunctive General	administration of moderate sedation – non-intravenous parenteral – each	Not a covered benefit.	Not a covered benefit.	None

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
		subsequent 15 minute increment, or any portion thereof			
D9310	Adjunctive general	Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	Not a covered benefit.	Covered benefit only when documented as used for a second opinion.	Detailed narrative including the referring dentist's name Submit with both codes on the same claim: D9310 at the charge amount and D9999 at no charge.
D9311	Adjunctive general	Consultation with a medical health care professional	Not a covered benefit.	Not a covered benefit.	None
D9410	Adjunctive general	House call/extended care facility call	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.	Not a covered benefit.	Detailed narrative
D9420	Adjunctive general	Hospital or ambulatory surgical center call	Not a covered benefit.	Not a covered benefit.	None
D9430	Adjunctive general	Office visit for observation (during regularly scheduled hours) – no other services performed	Not a covered benefit.	Not a covered benefit.	None
D9440	Adjunctive general	Office visit-after regularly scheduled hours	Not a covered benefit.	Not a covered benefit.	None
D9450	Adjunctive general	Case presentation, subsequent to detailed and extensive treatment planning	Not a covered benefit.	Not a covered benefit.	None
D9610	Adjunctive general	Therapeutic parenteral drug, single administration	Not a covered benefit.	Not a covered benefit.	None
D9612	Adjunctive general	Therapeutic parenteral drugs, two or more administrations, different medications	Not a covered benefit.	Not a covered benefit.	None
D9613	Adjunctive general	Infiltration of sustained release therapeutic drug, per quadrant	Not a covered benefit.	Not a covered benefit.	None
D9630	Adjunctive general	Other drugs and/or medicaments, by report	Not a covered benefit.	Not a covered benefit	None
D9910	Adjunctive general	Application of desensitizing medicament	Not a covered benefit.	Once per 12 months.	None
D9911	Adjunctive general	Application of desensitizing resin for cervical and/or root surface, per tooth	Not a covered benefit.	Once per permanent tooth (1 through 32) per 48 months.	Tooth identification
D9912	Adjunctive general	Pre-visit patient screening	Not a covered benefit (included in the primary service that is being rendered).	Not a covered benefit (included in the primary service that is being rendered).	None

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D9913	Adjunctive general	Administration of neuromodulators	Not a covered benefit.	Not a covered benefit.	None
D9914	Adjunctive general	Administration of dermal fillers	Not a covered benefit.	Not a covered benefit.	None
D9920	Adjunctive general	Behavior management, by report	One per day per provider or location.	Not a covered benefit.	Detailed narrative
D9930	Adjunctive general	Treatment of complications (post-surgical) – unusual circumstances, by report	Individual consideration.	Individual consideration.	Detailed narrative
D9932	Adjunctive general	Cleaning and inspection of removable complete denture, maxillary	Not a covered benefit.	Not a covered benefit.	None
D9933	Adjunctive general	Cleaning and inspection of removable complete denture, mandibular	Not a covered benefit.	Not a covered benefit.	None
D9934	Adjunctive general	Cleaning and inspection of removable partial denture, maxillary	Not a covered benefit.	Not a covered benefit.	None
D9935	Adjunctive general	Cleaning and inspection of removable partial denture, mandibular	Not a covered benefit.	Not a covered benefit.	None
D9936	Adjunctive General	Cleaning and inspection of occlusal guard – per appliance	Not a covered benefit.	Not a covered benefit.	None
D9938	Adjunctive general	Fabrication of a custom removable clear plastic temporary aesthetic appliance	Not a covered benefit.	Not a covered benefit.	None
D9939	Adjunctive general	Placement of a custom removable clear plastic temporary aesthetic appliance	Not a covered benefit.	Not a covered benefit.	None
D9941	Adjunctive general	Fabrication of athletic mouthguard	Covered benefit.	Not a covered benefit.	None
D9942	Adjunctive general	Repair and/or reline of occlusal guard	Not a covered benefit.	Not a covered benefit.	None
D9943	Adjunctive general	Occlusal guard adjustment	Not a covered benefit.	Not a covered benefit.	None
D9944	Adjunctive general	Occlusal guard – hard appliance, full arch	One D9944, D9945, or D9946 covered once per calendar year.	Not a covered benefit	None
D9945	Adjunctive general	Occlusal guard – soft appliance, full arch	One D9944, D9945, or D9946 covered once per calendar year.	Not a covered benefit	None
D9946	Adjunctive general	Occlusal guard – hard appliance, partial arch	One D9944, D9945, or D9946 covered once per calendar year.	Not a covered benefit	None
D9947	Sleep Related Breathing Disorders and Airway Management Services	Custom sleep apnea appliance fabrication and placement	Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurer for possible coverage.	Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurer for possible coverage.	None
D9948	Sleep Related Breathing Disorders and Airway Management Services	Adjustment of custom sleep apnea appliance	Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Check with patient's medical insurer for possible coverage.	Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurer for possible coverage.	None
D9949	Sleep Related Breathing Disorders	Repair of custom sleep apnea appliance	Not a covered benefit under Blue Cross Blue Shield of	Not a covered benefit under Blue Cross Blue Shield of	None

CDT Code	ADA Category	Description of Service	Pediatric EHB Procedure Guidelines Ages 0-19	Adult EHB Procedure Guidelines Ages 19 & older	Submission Requirements
	and Airway Management Services		Massachusetts dental plans. Check with patient's medical insurer for possible coverage.	Massachusetts dental plans. Please check with patient's medical insurer for possible coverage.	
D9950	Adjunctive general	Occlusion analysis – mounted case	Considered inclusive of rehabilitative services. Not a covered benefit in any other circumstances.	Considered inclusive of rehabilitative services. Not a covered benefit in any other circumstances.	None
D9951	Adjunctive general	Occlusal adjustment – limited	Not a covered benefit	Once per quadrant per 24 months	Quadrant identification
D9952	Adjunctive general	Occlusal adjustment – complete	Not a covered benefit	Once per 24 months	None
D9953	Sleep Related Breathing Disorders and Airway Management Services	Reline custom sleep apnea appliance (indirect)	Not a covered benefit	Not a covered benefit	None
D9954	Sleep Related Breathing Disorders and Airway Management Services	Fabrication and delivery of oral appliance therapy (OAT) morning repositioning device	Not a covered benefit	Not a covered benefit	None
D9955	Sleep Related Breathing Disorders and Airway Management Services	Oral appliance therapy (OAT) titration visit	Not a covered benefit	Not a covered benefit	None
D9956	Sleep Related Breathing Disorders and Airway Management Services	Administration of home sleep apnea test	Not a covered benefit	Not a covered benefit	None
D9957	Sleep Related Breathing Disorders and Airway Management Services	Screening for sleep related breathing disorders	Not a covered benefit	Not a covered benefit	None
D9959	Sleep Related Breathing Disorders and Airway Management Services	Unspecified sleep apnea services procedure, by report	Not a covered benefit	Not a covered benefit	None
D9961	Adjunctive general	Duplicate/copy patient's records	Not a covered benefit	Not a covered benefit	None
D9970	Adjunctive general	Enamel microabrasion	Not a covered benefit	Not a covered benefit	None
D9971	Adjunctive general	Odontoplasty – per tooth	Not a covered benefit	Not a covered benefit	None
D9972	Adjunctive general	External bleaching – per arch – in office	Not a covered benefit	Not a covered benefit	None
D9973	Adjunctive general	External bleaching – per tooth	Not a covered benefit	Not a covered benefit	None
D9974	Adjunctive general	Internal bleaching – per tooth	Not a covered benefit	Not a covered benefit	None
D9975	Adjunctive general	External bleaching for home application, per arch; includes materials and fabrication of custom trays	Not a covered benefit	Not a covered benefit	None

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D9985	Adjunctive general	Sales tax	Not a covered benefit	Not a covered benefit	None
D9986	Adjunctive general	Missed appointment	Not a covered benefit	Not a covered benefit	None
D9987	Adjunctive general	Cancelled appointment	Not a covered benefit	Not a covered benefit	None
D9990	Adjunctive general	Certified translation or sign language services – per visit	Not a covered benefit	Not a covered benefit	None
D9991	Adjunctive general	Dental case management – addressing appointment compliance barriers	Not a covered benefit	Not a covered benefit	None
D9992	Adjunctive general	Dental case management – care coordination	Not a covered benefit	Not a covered benefit	None
D9993	Adjunctive general	Dental case management – motivational interviewing	Not a covered benefit	Not a covered benefit	None
D9994	Adjunctive general	Dental case management – patient education	Not a covered benefit	Not a covered benefit	None
D9995	Adjunctive general	Teledentistry synchronous	Not a covered benefit	Not a covered benefit	None
D9996	Adjunctive general	Teledentistry nonsynchronous	Not a covered benefit	Not a covered benefit	None
D9997	Adjunctive general	Dental case management – patients with special health care needs	Not a covered benefit	Not a covered benefit	None
D9999	Adjunctive general	Unspecified adjunctive procedure by report	Individual consideration	Individual consideration	Detailed narrative