2023

PEDIATRIC ESSENTIAL HEALTHCARE BENEFITS

DENTAL PROCEDURE GUIDELINES AND SUBMISSION REQUIREMENTS

Updated December 2022

MASSACHUSETTS

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About This Booklet

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 – 2022*.

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 will be administered under the subscriber's medical benefit and considered separate from any other Dental Blue product. 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. Because these benefits have been added **only** 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:

- Use Change Healthcare Dental Connect (available on our website under etools)
- 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. Because these benefits are covered under the member's medical plan, Blue Cross Blue Shield of Massachusetts members who have EHB's through Blue Cross Blue Shield of Massachusetts will have a Blue Cross Blue Shield of Massachusetts medical ID card. Members who have dental benefits covered by Dental Blue will also have a Dental Blue ID card; in this case, both cards will have the same ID number with a different prefix.

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.

Utilization Management

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.**

Diagnostic Services

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
CLINICAL ORAL EVALUATIONS – One evaluation code may be billed per dentist per date of service. Evaluations including diagnosis and treatment planning is the responsibility of the dentist. All evaluations must be completed by a dentist.				
D0120	Periodic oral evaluation – established patient	Two per calendar year of D0145 or D0120. Not a covered benefit when performed on the same day as D9110 by the same dentist/dental office.	Two per calendar year. Not a covered benefit when performed on the same day as D9110 by the same dentist/dental office.	None
D0140	Limited oral evaluation – problem-focused	Two per calendar year. Not a covered benefit when performed on the same day as D9110 or D0160 by the same dentist.	Two per calendar year. Not a covered benefit when performed on the same day as D9110 or D0160 by the same dentist.	
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	Two per calendar year of D0145 or D0120.	Not a covered benefit.	
D0150	Comprehensive oral evaluation - new or established patient	One per member per lifetime.	Once per 60 months per dentist or location.	
D0160	Detailed, extensive oral evaluation – problem-focused, by report	Two per twelve months, by report. Not a covered benefit when performed same day as D9110 by same dentist.	Not a covered benefit.	Detailed narrative
D0170	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.	None
D0171	Re-evaluation – post operative office visit		Not a covered benefit.	
D0180	Comprehensive periodontal evaluation - new or established patient		Once per 60 months per dentist or location.	
D0190	Screening of a patient		Not a covered benefit.	
D0191	Assessment of a patient			
IMAGE CAPTURE WITH INTERPRETATION				
D0210	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

Diagnostic Services

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
IMAGE CAPTURE WITH INTERPRETATION, continued				
D0220	Intraoral - periapical first radiographic image	One per day per patient per (provider or location). Twelve of (D0220, D0230) per 12 months per patient. If reported with endodontic 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 endodontic therapy, radiographs are included in the fee for the procedure.	None
D0230	Intraoral - periapical each additional radiographic image	Three per day per patient per (provider or location). Twelve of (D0220, D0230) per 12 months per patient.	A maximum of 6 radiographs per date of service. Any combination of radiographs that exceed 6 will be processed as D0210. If reported with endodontic therapy, radiographs are included in the fee for the procedure.	
D0240	Intraoral - occlusal radiographic image	Not a covered benefit.	One film per arch per 6 months.	
D0250	Extra-oral – first 2D projection radiographic image created using a stationary radiation source, and detector			
D0270	Bitewing - single radiographic image	Two per calendar year per patient.	One per 6 months per patient.	
D0272	Bitewings - two radiographic images			
D0273	Bitewings - three radiographic images			
D0274	Bitewings - four radiographic images			
D0277	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.	
D0310	Sialography	Not a covered benefit.	Not a covered benefit.	
D0320	Temporomandibular joint arthrogram, including injection			
D0321	Other temporomandibular joint radiographic images, by report			
D0322	Tomographic survey			
D0330	Panoramic radiographic image	One full mouth series (D0210) or panorex (D0330) per three calendar years.	One full mouth series (D0210) or panorex (D0330)per 60 months.	None

Diagnostic Services

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
IMAGE CAPTURE WITH INTERPRETATION, continued				
D0340	2D cephalometric radiographic image – acquisition, measurement and analysis	Individual consideration for non-orthodontic services.	Individual consideration for non-orthodontic services.	None None
D0350	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.	
D0364	Cone beam CT capture and interpretation with limited field of view-less than one whole jaw	Not a covered benefit.	Not a covered benefit.	
D0365	Cone beam CT capture and interpretation with limited field of one full dental arch-mandible			
D0366	Cone beam CT capture and interpretation with field of view of one full dental arch-maxilla, with or without cranium			
D0367	Cone beam CT capture and interpretation with field of view of both jaws; with or without cranium			
D0368	Cone beam CT capture and interpretation for TMJ series including two or more exposures			
D0369	Maxillofacial MRI capture and interpretation			
D0370	Maxillofacial ultrasound capture and interpretation			
D0371	Sialoendoscopy capture and interpretation			
D0372	Intraoral tomosynthesis – comprehensive series of radiographic images			
D0373	Intraoral tomosynthesis – bitewing radiographic image			
D0374	Intraoral tomosynthesis – periapical radiographic image			

Diagnostic Services

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
IMAGE CAPTURE WITH INTERPRETATION, continued				
D0801	3D dental surface scan – direct	Not a covered benefit.	Not a covered benefit.	None
D0802	3D dental surface scan – indirect			
D0803	3D facial surface scan – direct			
D0804	3D facial surface scan – indirect			
IMAGE CAPTURE ONLY - Capture by a practitioner not associated with interpretation and report				
D0380	Cone beam CT image capture with limited field of view – less than one whole jaw	Not a covered benefit.	Not a covered benefit.	None
D0381	Cone beam CT image capture with field of view of one full dental arch-mandible			
D0382	Cone beam CT image capture with field of view of one full dental arch-maxilla, with or without cranium			
D0383	Cone beam CT image capture with field of view of both jaws, with or without cranium			
D0384	Cone beam CT image capture for TMJ series including two or more exposures			
D0385	Maxillofacial MRI image capture			
D0386	Maxillofacial ultrasound image capture			
D0387	Intraoral tomosynthesis – comprehensive series of radiographic images – image capture only			
D0388	Intraoral tomosynthesis – bitewing radiographic image – image capture only			
D0389	Intraoral tomosynthesis – periapical radiographic image – image capture only			

Diagnostic Services

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
IMAGE CAPTURE ONLY - Capture by a practitioner not associated with interpretation and report, *continued*				
D0701	Panoramic radiographic image – image capture only	Not a covered benefit.	Not a covered benefit.	None
D0702	2D cephalometric radiographic image – image capture only			
D0703	2D oral/facial photographic image obtained intra-orally or extra-orally– image capture only			
D0705	Extra-oral posterior dental radiographic image – image capture only			
D0706	Intraoral – occlusal radiographic image – image capture only			
D0707	Intraoral – periapical radiographic image – image capture only			
D0708	Intraoral – bitewing radiographic image – image capture only			
D0709	Intraoral – comprehensive series of radiographic images – image capture only			
INTERPRETATION AND REPORT ONLY - Interpretation and report by a practitioner not associated with image capture				
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report	Not a covered benefit.	Not a covered benefit.	None
POST PROCESSING OF IMAGE OR IMAGE SETS				
D0393	Virtual treatment simulation using 3D image volume or surface scan	Not a covered benefit.	Not a covered benefit.	None
D0394	Digital subtraction of two or more images or image volumes of the same modality to demonstrate changes that occurred over time			
D0395	Fusion of two or more 3D image volumes of one or more modalities			

Diagnostic Services

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
TESTS AND EXAMINATIONS				
D0411	HbA1c in-office point-of-service testing	Not a covered benefit.	Not a covered benefit.	None
D0412	Blood glucose level test – in-office using a glucose meter			
D0415	Collection of microorganisms for culture and sensitivity			
D0416	Viral culture. A diagnostic test to identify viral organisms, most often herpes virus.			
D0417	Collection and preparation of saliva sample for laboratory diagnostic testing			
D0418	Analysis of saliva sample. Chemical or biological analysis of saliva sample for diagnostic purposes.			
D0419	Assessment of salivary flow by measurement			
D0425	Caries susceptibility tests. Not to be used for carious dentin staining.			
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures			
D0460	Pulp vitality tests			
D0470	Diagnostic casts			
D0472	Accession of tissue, gross examination, preparation and transmission of written report			
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report			

Diagnostic Services

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
TESTS AND EXAMINATIONS, continued				
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	Not a covered benefit.	Not a covered benefit.	None
D0475	Decalcification procedure			
D0476	Special stains for microorganisms			
D0477	Special stains, not for microorganisms			
D0478	Immunohistochemical stains			
D0479	Tissue in-site hybridization, including interpretation			
D0480	Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report			
D0481	Electron microscopy			
D0482	Direct immunofluorescence			
D0483	Indirect immunofluorescence			
D0484	Consultation on slides prepared elsewhere			
D0485	Consultation, including preparation of slides from biopsy material supplied by referring source			
D0486	Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report			
D0502	Other oral pathology procedures, by report			
D0601	Caries risk assessment and documentation, with a finding of low risk			

Diagnostic Services

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
TESTS AND EXAMINATIONS, continued				
D0602	Caries risk assessment and documentation, with a finding of moderate risk	Not a covered benefit.	Not a covered benefit.	None
D0603	Caries risk assessment and documentation, with a finding of high risk			
D0604	Antigen testing for a public health related pathogen including coronavirus	Not a covered benefit under BCBSMA dental plans. Please check with patient's medical insurance for possible coverage.	Not a covered benefit under BCBSMA dental plans. Please check with patient's medical insurance for possible coverage.	None
D0605	Antibody testing for a public health related pathogen including coronavirus			
D0606	Molecular testing for a public health related pathogen, including coronavirus			
D0999	Unspecified diagnostic procedure, by report	Individual consideration.	Individual consideration.	Detailed narrative

Preventive Services

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
D1110	Prophylaxis – adult	Two per calendar year. D1110: ages 14+ D1120: ages 0 – 13	Two per calendar year. There must be at least three months between a periodontal maintenance cleaning and any other cleanings.	None
D1120	Prophylaxis – child		Not a covered benefit.	
TOPICAL FLUORIDE TREATMENT OFFICE PROCEDURE				
D1206	Topical application of fluoride varnish	Once per 90 day(s) of either code D1206 or D1208	Not a covered benefit.	None
D1208	Topical application of fluoride-excluding varnish	Once per 90 day(s) of either code D1208 or D1206.		
OTHER PREVENTIVE SERVICES				
D1310	Nutritional counseling for control of dental disease	Not a covered benefit.	Not a covered benefit.	None
D1320	Tobacco counseling for control and prevention of oral disease			
D1321	Counseling for control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use			
D1330	Oral hygiene instructions			
D1351	Sealant – per tooth	Once per tooth per 3 years on primary or permanent first, second and third non-carious molars.	Not a covered benefit.	• Tooth identification • Surface identification
D1352	Preventive resin restoration in a moderate to high caries risk patient-permanent tooth	Not a covered benefit.	Not a covered benefit.	None
D1353	Sealant repair – per tooth	Covered for primary molars for members under age nine. Reapplication only if process fails within three years. Covered for permanent non-carious molars for members under age 17 once every three years per tooth.	Not a covered benefit.	• Tooth identification • Surface identification
D1354	Application of caries arresting medicament – per tooth	Not a covered benefit.	Not a covered benefit.	None
D1355	Caries preventive medicament application – per tooth, for primary prevention or remineralization.			

Preventive Services

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
SPACE MAINTENANCE (PASSIVE APPLIANCES) – Passive appliances are designed to prevent tooth movement.				
D1510	Space maintainer – fixed – unilateral – per quadrant	Individual consideration.	Not a covered benefit.	Quadrant identification
D1516	Space maintainer – fixed – bilateral, maxillary	Individual consideration.	Not a covered benefit.	Arch identification
D1517	Space maintainer-fixed-bilateral, mandibular			
D1520	Space maintainer – removable – unilateral – per quadrant	Individual consideration.	Not a covered benefit.	Quadrant identification
D1526	Space maintainer – removable – bilateral, maxillary	Individual consideration.	Not a covered benefit.	Arch identification
D1527	Space maintainer – removable – bilateral, mandibular			
D1551	Re-cement or re-bond bilateral space maintainer – maxillary			
D1552	Re-cement or re-bond bilateral space maintainer – mandibular			
D1553	Re-cement or re-bond unilateral space maintainer – per quadrant	Individual consideration.	Not a covered benefit.	Quadrant identification
D1556	Removal of fixed unilateral space maintainer – per quadrant	Not a covered benefit.	Not a covered benefit.	None
D1557	Removal of fixed bilateral space maintainer – maxillary			
D1558	Removal of fixed bilateral space maintainer – mandibular			
D1575	Distal shoe space maintainer- fixed unilateral – per quadrant	Once per arch or quadrant per lifetime.	Not a covered benefit.	Quadrant or arch identification
D1999	Unspecified preventive procedure, by report	Individual consideration.	Not a covered benefit.	Detailed narrative

Preventive Services

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
VACCINATIONS				
D1701	Pfizer-BioNTech COVID-19 vaccine administration – first dose	Not a covered benefit under BCBSMA dental plans. Please check with patient's medical insurer for possible coverage.	Not a covered benefit under BCBSMA dental plans. Please check with patient's medical insurer for possible coverage.	None
D1702	Pfizer-BioNTech COVID-19 vaccine administration – second dose			
D1703	Moderna COVID-19 vaccine administration – first dose			
D1704	Moderna COVID-19 vaccine administration – second dose			
D1705	AstraZeneca COVID-19 vaccine administration – first dose			
D1706	AstraZeneca COVID-19 vaccine administration – second dose			
D1707	Janssen COVID-19 vaccine administration			
D1708	Pfizer-BioNTech Covid-19 vaccine administration – third dose			
D1709	Pfizer-BioNTech Covid-19 vaccine administration – booster dose			
D1710	Moderna Covid-19 vaccine administration – third dose			
D1711	Moderna Covid-19 vaccine administration – booster dose			
D1712	Janssen Covid-19 vaccine administration - booster dose			
D1713	Pfizer-BioNTech Covid-19 vaccine administration tris-sucrose pediatric – first dose			
D1714	Pfizer-BioNTech Covid-19 vaccine administration tris-sucrose pediatric – second dose			
D1781	Vaccine administration – human papillomavirus – Dose 1			
D1782	Vaccine administration – human papillomavirus – Dose 2			
D1783	Vaccine administration – human papillomavirus – Dose 3			

Restorative Services

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
AMALGAM RESTORATIONS (INCLUDING POLISHING) – Amalgam restorations include tooth preparation, localized tissue removal, base, direct and indirect pulp cap, local anesthesia and all adhesives (including amalgam bonding agents, liners and bases). These are included as part of the restoration. If pins are used, they should be reported separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction, or abrasion are not covered benefits.				
D2140	Amalgam – one surface, primary or permanent	One restoration per tooth surface per 12 months.	One restoration per tooth surface per 24 months.	• Tooth identification • Surface identification
D2150	Amalgam – two surfaces, primary or permanent			
D2160	Amalgam – three surfaces, primary or permanent			
D2161	Amalgam – four or more surfaces, primary or permanent			
RESIN-BASED COMPOSITE RESTORATIONS – Resin refers to a broad category of materials including, but not limited to composites. May include bonded composite, light-cured composite, etc. Light curing, acid-etching, and adhesives (including resin bonding agents) are included as part of the restoration. Resin restorations include tooth preparation, localized tissue removal, base, direct and indirect pulp cap and local anesthesia. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used, please report them separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction, or abrasion are not covered benefits.				
D2330	Resin-based composite – one surface, anterior	One restoration per tooth surface per 12 months.	One restoration per tooth surface per 24 months.	• Tooth identification • Surface identification
D2331	Resin-based composite – two surfaces, anterior			
D2332	Resin-based composite – three surfaces, anterior			
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)			
D2390	Resin-based composite crown, anterior	One per tooth per 12 months.	One per tooth per 24 months.	Tooth identification
D2391	Resin-based composite – one surface, posterior	One per tooth surface per 12 months.	One restoration per tooth surface per 24 months.	• Tooth identification • Surface identification
D2392	Resin-based composite – two surfaces, posterior			
D2393	Resin-based composite – three surfaces, posterior			
D2394	Resin-based composite – four or more surfaces, posterior			

Restorative Services

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
RESIN-BASED COMPOSITE RESTORATIONS, continued				
D2410	Gold foil, one surface	Not a covered benefit.	One restoration per tooth surface per 12 months.	None
D2420	Gold foil, two surfaces			
D2430	Gold foil, three surfaces			
INLAY/ONLAY RESTORATIONS **Inlay: an intra-coronal dental restoration, made outside the oral cavity to conform to the prepared cavity, which does not restore any cusps tips.** **Onlay: A dental restoration made outside the oral cavity that covers one or more cusp tips and adjoining occlusal surfaces, but not the entire external surface.**				
D2510	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 patient is responsible for the balance.	• Tooth identification • Surface identification
D2520	Inlay – metallic, two surfaces			
D2530	Inlay – metallic, three or more surfaces			
D2542	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.	• Tooth identification • Surface identification
D2543	Onlay – metallic, three surfaces			
D2544	Onlay – metallic, four or more surfaces			
D2610	Inlay – porcelain/ceramic, one surface	Not a covered benefit.	One restoration per tooth surface per 84 months.	• Tooth identification • Surface identification
D2620	Inlay – porcelain/ceramic, two surfaces			
D2630	Inlay – porcelain/ceramic, three or more surfaces			
D2642	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.	• Tooth identification • Surface identification
D2643	Onlay – porcelain/ceramic, three surfaces			
D2644	Onlay – porcelain/ceramic, four or more surfaces			
D2650	Inlay – resin-based composite, one surface	Not a covered benefit.	One restoration per tooth surface per 84 months.	• Tooth identification • Surface identification
D2651	Inlay – resin-based composite, two surfaces			
D2652	Inlay – resin-based composite, three or more surfaces			

Restorative Services

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
INLAY/ONLAY RESTORATIONS, continued				
D2662	Onlay – resin-based composite, 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.	• Tooth identification • Surface identification
D2663	Onlay – resin-based composite, three surfaces			
D2664	Onlay – resin-based composite, four or more surfaces			
CROWNS – SINGLE RESTORATIONS ONLY – Subject to 6 month waiting period of member's age 19 and over				
D2710	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
D2712	Crown - ¾ resin-based composite (indirect)	Not a covered benefit.	One crown or cast restoration per permanent tooth per 84 months.	None
D2720	Crown - resin with high noble metal			
D2721	Crown – resin with predominantly base metal			
D2722	Crown – resin with noble metal			
D2740	Crown – porcelain/ceramic substrate	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
D2750	Crown – porcelain fused to high-noble metal			
D2751	Crown – porcelain fused to predominantly base metal			
D2752	Crown – porcelain fused to noble metal			
D2753	Crown – porcelain fused to titanium and titanium alloys	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
D2780	Crown – ¾ cast high noble metal	Not a covered benefit.	One crown or cast restoration per permanent tooth per 84 months.	None
D2781	Crown – ¾ cast predominantly base metal			
D2782	Crown – ¾ cast noble metal			
D2783	Crown – ¾ porcelain/ceramic			

Restorative Services

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
CROWNS – SINGLE RESTORATIONS ONLY, continued				
D2790	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.	Tooth identification
D2791	Crown – full cast predominantly base metal	Not a covered benefit.	One crown or cast restoration per permanent tooth per 84 months.	None
D2792	Crown – full cast noble metal			
D2794	Crown – titanium and titanium alloys	Not a covered benefit.	One crown or cast restoration per permanent tooth per 84 months.	
D2799	Interim crown – further treatment or completion of diagnosis necessary prior to final impression	Not a covered benefit.	Not a covered benefit.	
OTHER RESTORATIVE SERVICES				
D2910	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. Not covered within 6 months of initial placement.	Tooth identification
D2915	Recement cast or prefabricated post and core	Not a covered benefit.		
D2920	Recement crown	Once per tooth per 12 months.		
D2921	Reattachment of tooth fragment, incisal edge or cusp	Not a covered benefit.	Not a covered benefit.	None
D2928	Prefabricated porcelain/ceramic crown – permanent tooth			
D2929	Prefabricated porcelain/ceramic crown – primary tooth			
D2930	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	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

Restorative Services

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
OTHER RESTORATIVE SERVICES, continued				
D2932	Prefabricated resin crown	One per tooth per 12 months. Maximum of four crowns per date of service.	Not a covered benefit.	Tooth identification
D2933	Prefabricated stainless steel crown with resin window	Not a covered benefit.	Not a covered benefit.	None
D2934	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	Protective restoration	Not a covered benefit.	One per tooth per lifetime.	None
D2941	Interim therapeutic restoration – primary dentition	Not a covered benefit.	Not a covered benefit.	
D2949	Restorative foundation for an indirect restoration	Not a covered benefit.	Not a covered benefit.	
D2950	Core buildup, including any pins when required	Not a covered benefit.	Once per permanent tooth per 84 months.	
D2951	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	Post and core in addition to crown, indirectly fabricated	Not a covered benefit.	Once per tooth per 84 months.	None
D2953	Each additional indirectly fabricated post – same tooth	Not a covered benefit.	Once per tooth per lifetime.	
D2954	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.	Tooth identification
D2955	Post removal	Not a covered benefit.	Not a covered benefit.	None
D2957	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	None
D2960	Labial veneer (resin laminate) – direct	Not a covered benefit.	Not a covered benefit.	None
D2961	Labial veneer (resin laminate) – indirect			
D2962	Labial veneer (porcelain laminate) – indirect			

Restorative Services

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
OTHER RESTORATIVE SERVICES, continued				
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework	Not a covered benefit.	Individual consideration.	None
D2975	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.	
D2980	Crown repair necessitated by restorative material failure	Individual consideration.	Individual consideration.	Detailed narrative
D2981	Inlay repair necessitated by restorative material failure	Not a covered benefit.	Once per tooth per 12 months.	None
D2982	Onlay repair necessitated by restorative material failure		Once per tooth per 12 months.	
D2983	Veneer repair necessitated by restorative material failure		Not a covered benefit.	
D2990	Resin infiltration of incipient smooth surface lesions		Once per tooth per 12 months.	
D2999	Unspecified restorative procedure, by report	Individual consideration.	Individual consideration.	Detailed narrative

Endodontic Services

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

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

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
PULP CAPPING				
D3110	Pulp cap - direct (excluding final restoration)	Not a covered benefit.	Pulp capping is considered part of the final restoration.	None
D3120	Pulp cap - indirect (excluding final restoration)			
PULPOTOMY				
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	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
D3221	Pulpal debridement, primary & permanent teeth	Not a covered benefit.	Once per tooth per lifetime.	None
D3222	Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development.			
ENDODONTIC THERAPY ON PRIMARY TEETH				
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	Not a covered benefit.	Once per tooth per lifetime.	None
D3240	Pulpal therapy (resorbable filling) – posterior primary tooth (excluding final restoration)			

Endodontic Services

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
ENDODONTIC THERAPY (including treatment plan, clinical procedures and follow-up care)				
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	One per permanent tooth per lifetime.	One per permanent tooth per lifetime.	Tooth identification
D3320	Endodontic therapy, premolar tooth (excluding final restoration)			
D3330	Endodontic therapy, molar (excluding final restoration)			
D3331	Treatment of root canal obstruction; non-surgical access	Not a covered benefit.	Individual consideration.	None
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	Not a covered benefit.	Not a covered benefit.	None
D3333	Internal root repair of perforation defects			
ENDODONTIC RETREATMENT				
D3346	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	Retreatment of previous root canal therapy – premolar			
D3348	Retreatment of previous root canal therapy – molar			
APEXIFICATION/RECALCIFICATION AND PULPAL REGENERATION PROCEDURES				
D3351	Apexification / recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc).	Not a covered benefit.	Once per permanent tooth per lifetime.	None
D3352	Apexification / recalcification – interim medication replacement			
D3353	Apexification/recalcification - final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.)			
D3355	Pulpal regeneration – initial visit			

Endodontic Services

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
APEXIFICATION/RECALCIFICATION AND PULPAL REGENERATION PROCEDURES, continued				
D3356	Pulpal regeneration – interim medication replacement	Not a covered benefit.	Once per permanent tooth per lifetime.	None
D3357	Pulpal regeneration – completion of treatment			
APICOECTOMY/PERIRADICULAR SERVICES				
D3410	Apicoectomy – anterior	One per permanent tooth root per lifetime.	Once per permanent tooth root per lifetime.	Tooth and root identification
D3421	Apicoectomy – premolar (first root)			
D3425	Apicoectomy – molar (first root)			
D3426	Apicoectomy – (each additional			
D3428	Bone graft in conjunction with periradicular surgery – per tooth, single site	Not a covered benefit.	Not a covered benefit.	None
D3429	Bone graft in conjunction with periradicular surgery – each additional contiguous in the same surgical site			
D3430	Retrograde filling – per root	Not a covered benefit.	Once per permanent tooth per lifetime.	Tooth and root identification
D3431	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	Guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery			
D3450	Root amputation – per root	Not a covered benefit.	One per tooth per lifetime for multi-rooted posterior teeth.	Tooth and root identification
D3460	Endodontic endosseous implant	Not a covered benefit.	Not a covered benefit.	None
D3470	Intentional reimplantation (including necessary splinting)	Not a covered benefit.	Individual consideration.	Detailed narrative

Endodontic Services

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
APICOECTOMY/PERIRADICULAR SERVICES, continued				
D3471	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	Surgical repair of root resorption – premolar			
D3473	Surgical repair of root resorption – molar			
D3501	Surgical repair of root surface without apicoectomy or repair of root resorption – anterior	Not a covered benefit.	Not a covered benefit.	None
D3502	Surgical repair of root surface without apicoectomy or repair of root resorption – premolar			
D3503	Surgical repair of root surface without apicoectomy or repair of root resorption – molar			
OTHER ENDODONTIC PROCEDURES				
D3910	Surgical procedure for isolation of tooth with rubber dam	Not a covered benefit.	Not a covered benefit.	None
D3911	Intraorifice barrier	Not a covered benefit.	Not a covered benefit.	
D3920	Hemisection (including any root removal), not including root canal therapy	Not a covered benefit.	One per posterior tooth per lifetime.	
D3921	Decoronation or submergence of an erupted tooth	Not a covered benefit.	One per tooth per lifetime (D3921 or D7251).	
D3950	Canal preparation and fitting of preformed dowel or post	Not a covered benefit.	Not a covered benefit.	
D3999	Unspecified endodontic procedure, by report	Not a covered benefit.	Individual consideration.	

Periodontal Services

Periodontal procedure billing guidelines

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

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

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 this due to a medical condition that may require your patient to receive extended periodontal treatment, please submit a detailed narrative including general or intravenous anesthesia record, medical condition, and length of appointment time with the claim form.

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

Periodontal Services

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
SURGICAL SERVICES (INCLUDING USUAL POST-OPERATIVE SERVICES)				
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth-bounded spaces, per quadrant	One per quadrant per 36 months. Limited to two quadrants on the same date of service.	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.	• Current dated post-Phase I periodontal charting • Quadrant identification, including tooth numbers • Current mounted and dated preoperative periapical radiographs. If a current full mouth set of radiographs is not available, submit current (within last year) bitewing and/or periapical radiographs of the treated area) • Pre-treatment recommended
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant	One 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 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.	
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	Not a covered benefit.	Once per quadrant per 36 months.	None
D4230	Anatomical crown exposure – four or more contiguous teeth or tooth bounded spaces per quadrant	Not a covered benefit.	Not a covered benefit.	
D4231	Anatomical crown exposure – one to three teeth or tooth bounded spaces per quadrant			
D4240	Gingival flap procedure, including root planning – four or more contiguous teeth or tooth-bounded spaces per quadrant	Not a covered benefit.	Once per quadrant per 36 months.	
D4241	Gingival flap procedure, including root planning – one to three			

	contiguous teeth or tooth bounded spaces per quadrant			
D4245	Apically repositioned flap	Not a covered benefit.	Not a covered benefit.	

Periodontal Services

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
SURGICAL SERVICES (INCLUDING USUAL POST-OPERATIVE SERVICES), continued				
D4249	Clinical crown lengthening – hard tissue. This procedure is employed to allow a restorative procedure on a tooth with little or no tooth structure exposed to the oral cavity.	Not a covered benefit.	One per tooth per 60 months.	None
D4260	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.	• Quadrant identification • Current dated post phase I periodontal charting • Current mounted and dated pre-operative periapical radiographs. If a current full mouth set of radiographs is not available, submit current (within last year) bitewing and/or periapical radiographs of the treated area • Pre-treatment recommended
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant			
D4263	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.	• Tooth identification (edentulous spaces do not qualify for this code) • Current mounted and dated pre-operative periapical radiographs
D4264	Bone replacement graft – each additional site in quadrant			

				• Pre-treatment recommended
D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site	Not a covered benefit.	Not a covered benefit.	None

Periodontal Services

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
SURGICAL SERVICES (INCLUDING USUAL POST-OPERATIVE SERVICES), continued				
D4266	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 the cost of the graft material. Not covered when used in an edentulous space, extraction site, or with routine apicoectomy, cystectomy, ridge augmentation, mucogingival grafts, or implant procedure.	• Tooth identification (edentulous spaces do not qualify for this code) • Current mounted and dated pre-operative periapical radiographs • Pre-treatment recommended
D4267	Guided tissue regeneration, natural teeth – non-restorable barrier, per site			
D7956	Guided tissue regeneration, edentulous area – resorbable barrier, per site	Not a covered benefit.	Not a covered benefit.	None
D7957	Guided tissue regeneration, edentulous area – non-resorbable barrier, per site			
D4268	Surgical revision procedure, per tooth	Not a covered benefit.	Not a covered benefit.	None
SURGICAL SERVICES (INCLUDING USUAL POST-OPERATIVE SERVICES)				
D4270	Pedicle soft tissue graft procedure	Not a covered benefit.	Once per tooth per 36 months. **Grafting for cosmetic purposes is non-covered.**	Tooth identification
D4273	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.	
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	Not a covered benefit.	One per site per 36 months. Must be adjacent to edentulous area.	
D4275	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.	
D4276	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.**	

D4277	Free soft tissue graft procedure (including recipient and donor surgica 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.	

Periodontal Services

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
SURGICAL SERVICES (INCLUDING USUAL POST-OPERATIVE SERVICES), *continued*				
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites), each additional contiguous tooth, implant or edentulous tooth position in same graft site	Not a covered benefit.	One per site per 36 months on natural teeth only. Limited to three teeth per graft site.	Tooth identification
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites), each additional contiguous tooth, implant or edentulous tooth position in same graft site	Not a covered benefit.	Each additional tooth, up to three teeth total in graft..	Tooth identification
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	Not a covered benefit.	Each additional tooth, up to three teeth total in graft.	Tooth identification
D4286	Removal of non-resorbable barrier	Not a covered benefit.	Considered inclusive of D4267, not a covered benefit in any other circumstance.	Tooth identification
NON SURGICAL PERIODONTAL SERVICES				
D4322	Splint – intra-coronal; natural teeth or prosthetic crowns	Not a covered benefit.	Not a covered benefit.	None
D4323	Splint – extra-coronal; natural teeth or prosthetic crowns			

D4341	Periodontal scaling and root planning – four or more teeth per quadrant	One per 36 months per quadrant.	Once per quadrant per 24 months.	• Quadrant identification • For D4342, include teeth numbers
D4342	Periodontal scaling and root planning, one to three teeth per quadrant			
D4346	Scaling in the presence of generalized moderate or severe gingival inflammation – full mouth	Covered interchangeably with D1110. Held to the same frequencies and allowable as D1110.	Covered interchangeably with D1110. Held to the same frequencies and allowable as D1110.	None
D4355	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	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth		Individual consideration.	

Periodontal Services

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
OTHER PERIODONTAL SERVICES				
D4910	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.	None
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	Not a covered benefit	Not a covered benefit.	None
D4921	Gingival irrigation with a medicinal agent – per quadrant			
D4999	Unspecified periodontal procedure, by report	Individual consideration.	Individual consideration.	Detailed narrative

Prosthodontics (Removable)

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

Services may be non-covered for the following conditions:

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

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)				
D5110	Complete denture – maxillary	One per arch per 84 months.	One per arch per 84 months; not covered if D5130, D5211, D5213, D5221, D5223, D5225, or D5227 was done within 84 months.	Arch identification
D5120	Complete denture – mandibular	One per arch per 84 months.	One per arch per 84 months; not covered if D5140, D5212, D5214, D5222, D5224, D5226, or D5228 was done within 84 months.	
D5130	Immediate denture – maxillary	One per arch per lifetime.	One per arch per lifetime.	
D5140	Immediate denture – mandibular			
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	One per 84 months.	One per 84 months.	
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)			
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)			
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)			
D5221	Immediate maxillary partial denture – resin base (including retentive/ clasping materials, rests, and teeth)	One per arch per 84 months for members age 16 and older.	One per arch per 84 months.	Arch identification

Prosthodontics (Removable)

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE), continued				
D5222	Immediate mandibular partial denture – resin base (including retentive/clasping materials, rests, and teeth)	One per arch per 84 months for members age 16 and older.	One per arch per 84 months.	Arch identification
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)			
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)			
D5225	Maxillary partial denture – flexible base (including retentive/clasping materials, rests, and teeth)	One per arch per 84 months.	One per arch per 84 months.	Arch identification
D5226	Mandibular partial denture – flexible base (including retentive/clasping materials, rests, and teeth)			
D5227	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	One per arch per 84 months for members age 16 and older.	One per arch per 84 months.	
D5228	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)			
D5282	Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary	Not a covered benefit.	One per arch per 84 months.	
D5283	Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular			

Prosthodontics (Removable)

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE), continued				
D5284	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.	Arch identification
D5286	Removable unilateral partial denture – one piece resin (including retentive/clasping materials, rests, and teeth), per quadrant			
ADJUSTMENTS TO DENTURES				
D5410	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.	None
D5411	Adjust complete denture – mandibular			
D5421	Adjust partial denture – maxillary			
D5422	Adjust partial denture – mandibular			
REPAIRS TO COMPLETE DENTURES				
D5511	Repair broken complete denture base, mandibular	Not covered if D5110, D5120, D5130 and D5140 have paid within the prior 6 months.	Once per arch 12 months.	Arch identification
D5512	Repair broken complete denture base, maxillary			
D5520	Replace missing or broken teeth - complete denture (each tooth)	Not covered if D5110, D5120, D5130 and D5140 have paid within the prior 6 months.	Once per arch 12 months.	Tooth identification
REPAIRS TO PARTIAL DENTURES				
D5611	Repair resin partial denture base, mandibular	Not covered if D5110, D5120, D5130, D5140, D5211, D5212, D5213 or D5214 have paid within the prior 6 months.	Once per arch 12 months.	Arch identification
D5612	Repair resin partial denture base, maxillary			
D5621	Repair cast partial framework, mandibular			
D5622	Repair cast partial framework, maxillary			

Prosthodontics (Removable)

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
REPAIRS TO PARTIAL DENTURES, continued				
D5630	Repair or replace broken retentive clasping materials, per tooth	Not covered if D5110, D5120, D5130, D5140, D5211, D5212, D5213 or D5214 have paid within the prior 6 months.	Once per tooth per 12 months.	Tooth identification
D5640	Repair broken teeth, per tooth	Not covered if D5110, D5120, D5130, D5140, D5211, D5212, D5213 or D5214 have paid within the prior 6 months.	Once per tooth per 12 months.	Tooth identification
D5650	Add tooth to existing partial denture			
D5660	Add clasp to existing partial denture			
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	Not a covered benefit.	Once per arch per partial denture.	Archidentification
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)			
DENTURE REBASE PROCEDURES – The process of refitting a denture by replacing the base material.				
D5710	Rebase complete maxillary denture	One 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.	One 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.	None
D5711	Rebase complete mandibular denture			
D5720	Rebase maxillary partial denture			
D5721	Rebase mandibular partial denture			
D5725	Rebase hybrid prosthesis	Once per arch per 24 months.	Once per arch per 36 months.	Arch identification
DENTURE RELINE PROCEDURES – The process of resurfacing the tissue side of a denture with new base material.				
D5730	Reline complete maxillary denture – direct	Once 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.	One 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.	Arch identification
D5731	Reline complete mandibular denture – direct			
D5740	Reline maxillary partial denture – direct			
D5741	Reline mandibular partial denture – direct			
D5750	Reline complete maxillary denture – indirect	Once 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.	One 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.	Arch identification
D5751	Reline complete mandibular denture – indirect			

Prosthodontics (Removable)

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
DENTURE RELINE PROCEDURES, continued				
D5760	Reline maxillary partial denture – indirect	Once 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.	One 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.	Arch identification
D5761	Reline mandibular partial denture – indirect			
INTERIM PROSTHESIS				
D5810	Interim complete denture (maxillary)	Not a covered benefit.	Not a covered benefit.	None
D5811	Interim complete denture (mandibular)			
D5820	Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary	Not a covered benefit.	One per upper arch per lifetime.	
D5821	Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular	Not a covered benefit.	One per lower arch per lifetime.	
OTHER REMOVABLE PROSTHETIC SERVICES				
D5765	Soft liner for complete or partial removable denture – indirect	Once per arch per 24 months.	Once per arch per 36 months.	Arch identification
D5850	Tissue conditioning, maxillary	Not a covered benefit.	One per denture per 36 months.	None
D5851	Tissue conditioning, mandibular			
D5862	Precision attachment, by report	Not a covered benefit.	Not a covered benefit.	
D5863	Overdenture – complete maxillary	Not a covered benefit.	One per arch per 84 months.	
D5864	Overdenture – partial maxillary			
D5865	Overdenture – complete mandibular			
D5866	Overdenture – partial mandibular			
D5867	Replacement of replaceable part of semi-precision or precision attachment, per attachment	Not a covered benefit.	Not a covered benefit.	
D5875	Modification of removable prosthesis following implant surgery			
D5876	Add metal substructure to acrylic full denture (per arch)	Not a covered benefit.	Not a covered benefit.	

Prosthodontics (Removable)

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
OTHER REMOVABLE PROSTHETIC SERVICES, continued				
D5899	Unspecified removable prosthodontic procedure, by report	Individual consideration.	Individual consideration.	Detailed narrative
MAXILLOFACIAL PROSTHETICS				
D5911	Facial moulage (sectional)	Not a covered benefit.	Not a covered benefit.	None
D5912	Facial moulage (complete)			
D5913	Nasal prosthesis			
D5914	Auricula prosthesis			
D5915	Orbital prosthesis			
D5916	Ocular prosthesis			
D5919	Facial prosthesis			
D5922	Nasal septal prosthesis			
D5923	Ocular prosthesis, interim			
D5924	Cranial prosthesis			
D5925	Facial augmentation implant prosthesis			
D5926	Nasal prosthesis, replacement			
D5927	Auricular prosthesis, replacement			
D5928	Orbital prosthesis, replacement			
D5929	Facial prosthesis, replacement			
D5931	Obturator prosthesis, surgical			
D5932	Obturator prosthesis, definitive			
D5933	Obturator prosthesis, modification			
D5934	Mandibular resection prosthesis with guide flange			
D5935	Mandibular resection prosthesis without guide flange			
D5936	Obturator prosthesis, interim			
D5937	Trismus appliance (not for TMD treatment)			
D5951	Feeding aid			
D5952	Speech aid prosthesis, pediatric			

Prosthodontics (Removable)

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
MAXILLOFACIAL PROSTHETICS, continued				
D5953	Speech aid prosthesis, adult	Not a covered benefit.	Not a covered benefit.	None
D5954	Palatal augmentation prosthesis			
D5955	Palatal lift prosthesis, definitive			
D5958	Palatal lift prosthesis, interim			
D5959	Palatal lift prosthesis, modification			
D5960	Speech aid prosthesis, modification			
D5982	Surgical stent			
D5983	Radiation carrier			
D5984	Radiation shield			
D5985	Radiation cone locator			
D5986	Fluoride gel carrier			
D5987	Commissure splint			
D5988	Surgical splint			
D5991	Vesiculobullous disease medicament carrier			
D5992	Adjust maxillofacial prosthetic appliance, by report			
D5993	Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral) other than required adjustments, by report			
D5995	Periodontal medicament carrier with peripheral seal – laboratory processed – maxillary			
D5996	Periodontal medicament carrier with peripheral seal – laboratory processed - mandibular			
D5999	Unspecified maxillofacial prosthesis, by report			

Implant Services

Implant services are not covered under the Essential Health Benefits

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
IMPLANT SERVICES – Pre-surgical services				
D6190	Radiographic/surgical implant index, by report	Not a covered benefit	Not a covered benefit	None
D6010	Surgical placement of implant body, endosteal implant			
D6011	Surgical access to an implant body (Second stage implant surgery)			
D6012	Surgical placement of interim implant body for transitional prosthesis: endosteal implant			
D6013	Surgical placement of mini implant			
D6040	Surgical placement: eposteal implant			
D6050	Surgical placement: transosteal implant			
D6100	Surgical removal of implant body			
D6101	Debridement of a peri-implant defect and surface cleaning of exposed implant surfaces, including flap entry and closure			
D6102	Debridement and osseous contouring of a peri-implant defect; includes surface cleaning of exposed implant surfaces and flap entry			
D6103	Bone graft for repair of peri-implant defect – not including flap entry and closure			
D6104	Bone graft at time of implant placement			
D6105	Removal of implant body not requiring bone removal nor flap elevation			
D6106	Guided tissue regeneration – resorbable barrier, per implant			
D6107	Guided tissue regeneration – non-resorbable barrier, per implant			

Implant Services

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
IMPLANT SERVICES, continued				
D6110	Implant /abutment supported removable denture for edentulous arch – maxillary	Once per 60 months.	Once per 60 months.	None
D6111	Implant /abutment supported removable denture for edentulous arch – mandibular			
D6112	Implant /abutment supported removable denture for partially edentulous arch – maxillary			
D6113	Implant /abutment supported removable denture for partially edentulous arch – mandibular			
D6114	Implant /abutment supported fixed denture for edentulous arch – maxillary	Covered by rider only.	Covered by rider only.	None
D6115	Implant /abutment supported fixed denture for edentulous arch – mandibular			
D6116	Implant /abutment supported fixed denture for partially edentulous arch – maxillary			
D6117	Implant /abutment supported fixed denture for partially edentulous arch – mandibular			
D6118	Implant/abutment supported interim fixed denture for edentulous arch – mandibular			
D6119	Implant/abutment supported interim fixed denture for edentulous arch – maxillary			
IMPLANT-SUPPORTED PROSTHETICS - Supporting structures				
D6051	Interim implant abutment placement	Not a covered benefit.	Not a covered benefit.	None
D6055	Connecting bar – implant-supported or abutment-supported			

Implant Services

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
IMPLANT-SUPPORTED PROSTHETICS - Supporting structures, continued				
D6056	Prefabricated abutment – includes modification and placement	Not a covered benefit.	Not a covered benefit.	None
D6057	Custom fabricated abutment – includes placement			
IMPLANT SERVICES - Implant/abutment-supported removable dentures				
D6078	Implant/abutment-supported fixed denture, completely edentulous arch	Not a covered benefit.	Not a covered benefit.	None
D6079	Implant/abutment-supported fixed denture, partially edentulous arch			
SINGLE CROWNS, ABUTMENT SUPPORTED				
D6058	Abutment-supported porcelain/ ceramic crown. A single crown restoration that is retained, supported and stabilized by an abutment on an implant	Not a covered benefit.	Not a covered benefit.	None
D6059	Abutment-supported porcelain fused to metal crown (high noble metal) A single metal-ceramic crown restoration that is retained, supported and stabilized by an abutment on an implant			
SINGLE CROWNS, ABUTMENT SUPPORTED				
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal). A single metal-ceramic crown restoration that is retained, supported, and stabilized by an abutment on an implant.	Not a covered benefit.	Not a covered benefit.	None
D6061	Abutment-supported porcelain fused to metal crown (noble metal). A single metal-ceramic crown restoration that is retained, supported, and stabilized by an abutment on an implant.			

Implant Services

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
SINGLE CROWNS, ABUTMENT SUPPORTED, continued				
D6062	Abutment-supported cast metal crown (high noble metal). A single metal-ceramic crown restoration that is retained, supported, and stabilized by an abutment on an implant.	Not a covered benefit.	Not a covered benefit.	None
D6063	Abutment-supported cast metal crown (predominantly base metal). A single metal-ceramic crown restoration that is retained, supported, and stabilized by an abutment on an implant.			
D6064	Abutment-supported cast metal crown (noble metal). A single metal-ceramic crown restoration that is retained, supported, and stabilized by an abutment on an implant.			
D6094	Abutment-supported crown titanium and titanium alloys			
D6097	Abutment-supported crown – porcelain fused to titanium and titanium alloys			
SINGLE CROWNS, IMPLANT SUPPORTED				
D6065	Implant-supported porcelain/ceramic crown	Not a covered benefit.	Not a covered benefit.	None
D6066	Implant supported crown – porcelain fused to high noble alloys			
D6067	Implant supported crown – high noble alloys			
D6082	Implant supported crown – porcelain fused to predominately base alloys			
D6083	Implant supported crown – porcelain fused to noble alloys			

Implant Services

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
SINGLE CROWNS, IMPLANT SUPPORTED, continued				
D6084	Implant supported crown – porcelain fused to titanium and titanium alloys	Not a covered benefit.	Not a covered benefit.	None
D6085	Provisional implant crown			
D6086	Implant supported crown – predominantly base alloys			
D6087	Implant supported crown – noble alloys			
D6088	Implant supported crown – titanium and titanium alloys			
FIXED PARTIAL DENTURE, ABUTMENT SUPPORTED				
D6068	Abutment supported retainer for porcelain/ceramic FPD. A ceramic retainer for a fixed partial denture that gains retention, support and stability from an abutment on an implant.	Not a covered benefit.	Not a covered benefit.	None
D6069	Abutment-supported retainer for porcelain fused to metal FPD (high noble metal). A metal-ceramic retainer for a fixed partial denture that gains retention, support and stability from an abutment on an implant.			
D6070	Abutment-supported retainer for porcelain fused to metal FPD (predominately base metal) A metal-ceramic retainer for a fixed partial denture that gains retention, support and stability from an abutment on an implant.			
D6071	Abutment-supported retainer for porcelain fused to metal FPD (noble metal)			

Implant Services

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
FIXED PARTIAL DENTURE, ABUTMENT SUPPORTED, continued				
D6072	Abutment-supported retainer for cast metal FPD (high noble metal)	Not a covered benefit.	Not a covered benefit.	None
D6073	Abutment-supported retainer for cast metal FPD (predominately base metal)			
D6074	Abutment-supported retainer for cast metal FPD (noble metal)			
D6191	Semi-precision abutment – placement			
D6192	Semi-precision attachment – placement			
D6194	Abutment supported retainer crown for FPD – titanium and titanium alloys			
D6195	Abutment supported retainer – porcelain fused to titanium and titanium alloys			
FIXED PARTIAL DENTURE, IMPLANT SUPPORTED				
D6075	Implant-supported retainer for ceramic FPD	Not a covered benefit.	Not a covered benefit.	None
D6076	Implant-supported retainer for FPD – porcelain fused to high noble alloys)			
D6077	Implant-supported retainer for cast metal FPD – high noble alloys)			
D6098	Implant supported retainer – porcelain fused to predominantly base alloys			
D6099	Implant supported retainer for FPD – porcelain fused to noble alloys			
D6099	Implant supported retainer for FPD – porcelain fused to noble alloys			

Implant Services

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
FIXED PARTIAL DENTURE, IMPLANT SUPPORTED, continued				
D6120	Implant supported retainer – porcelain fused to titanium and titanium alloys	Not a covered benefit.	Not a covered benefit.	None
D6121	Implant supported retainer for metal FPD – predominantly base alloys			
D6122	Implant supported retainer for metal FPD – noble alloys			
D6123	Implant supported retainer for metal FPD – titanium and titanium alloys			
OTHER IMPLANT SERVICES				
D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments	Not a covered benefit.	Not a covered benefit.	None
D6090	Repair implant supported prosthesis, by report	Not a covered benefit.	Covered by rider only.	Arch identification
D6091	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	Recement or re-bond implant/abutment-supported crown			
D6093	Recement or re-bond implant/abutment-supported fixed partial denture			
D6095	Repair implant abutment, by report	Not a covered benefit.	Covered by rider only.	Tooth identification
D6096	Remove broken implant retaining screw			

Implant Services

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
OTHER IMPLANT SERVICES, continued				
D6197	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	Not a covered benefit.	One per tooth per 6 months when done within 3 months of an implant repair (D6095 or D6096) on the same tooth.	Tooth identification
D6198	Remove interim implant component	Not a covered benefit.	Not a covered benefit.	None
D6199	Unspecified implant procedure, by report			

Prosthodontics, Fixed

Benefits for fixed prosthodontics

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

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

When services are non-covered

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

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

Prosthodontics, Fixed

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
FIXED PARTIAL DENTURE PONTICS				
D6205	Pontic – indirect resin-based composite	Not a covered benefit.	Not a covered benefit.	None
D6210	Pontic – cast high noble	Not a covered benefit	One pontic per permanent tooth per 84 months.	
D6211	Pontic – cast predominantly base metal			
D6212	Pontic – cast noble metal			
D6214	Pontic – titanium and titanium alloys			
D6240	Pontic – porcelain fused to high noble metal			
D6241	Pontic – porcelain fused to predominantly base metal	Once per 60 months per tooth.	One pontic per permanent tooth per 84 months.	Tooth identification
D6242	Pontic – porcelain fused to noble metal	Not a covered benefit.	One pontic per permanent tooth per 84 months.	None
D6243	Pontic – porcelain fused to titanium and titanium alloys			
D6245	Pontic – porcelain/ceramic			
D6250	Pontic – resin with high noble metal			
D6251	Pontic – resin with predominantly base metal			
D6252	Pontic – resin with noble metal			
D6253	Interim pontic – further treatment or completion of diagnosis necessary prior to final impression	Not a covered benefit.	Individual consideration.	Tooth identification
FIXED PARTIAL DENTURE RETAINERS – INLAYS/ONLAYS				
D6545	Retainer – cast metal for resin-bonded fixed prosthesis	Not a covered benefit.	One restoration per permanent tooth per 84 months.	Tooth identification
D6548	Retainer – porcelain/ ceramic for resin-bonded fixed prosthesis			
D6549	Resin retainer – for resin bonded fixed prosthesis			

Prosthodontics, Fixed

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
FIXED PARTIAL DENTURE RETAINERS – INLAYS/ONLAYS, continued				
D6600	Retainer inlay – porcelain/ceramic, two surfaces	Not a covered benefit.	One restoration per tooth surface per 84 months.	None
D6601	Retainer Inlay – porcelain/ceramic, three or more surfaces			
D6602	Retainer Inlay – cast high noble metal, two surfaces			
D6603	Retainer inlay – cast high noble metal, three or more surfaces			
D6604	Retainer inlay – cast predominantly base metal, two surfaces			
D6605	Retainer inlay – cast predominantly base metal, three or more surfaces			
D6606	Retainer inlay – cast noble metal, two surfaces			
D6607	Retainer inlay – cast noble metal, three or more surfaces			
D6608	Retainer onlay – porcelain/ceramic, two surfaces	Not a covered benefit.	Once per tooth per 84 months.	None
D6609	Retainer onlay – porcelain/ ceramic, three or more surfaces			
D6610	Retainer onlay – cast high noble metal, two surfaces			
D6611	Retainer onlay – cast high noble metal, three or more surfaces			
D6612	Retainer onlay – cast predominantly base metal, two surfaces			
D6613	Retainer onlay – cast predominantly base metal, three or more surfaces			

Prosthodontics, Fixed

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
FIXED PARTIAL DENTURE RETAINERS – INLAYS/ONLAYS, continued				
D6614	Retainer onlay – cast noble metal, two surfaces	Not a covered benefit.	Once per tooth per 84 months.	None
D6615	Retainer onlay – cast noble metal, three or more surfaces			
D6624	Retainer Inlay – titanium	Not a covered benefit.	Not a covered benefit.	
D6634	Retainer onlay – titanium	Not a covered benefit.	Once per tooth per 84 months.	
D6710	Retainer crown – indirect resin-based composite	Not a covered benefit.	Not a covered benefit.	
D6720	Retainer crown – resin with high noble metal	Not a covered benefit.	One retainer crown or cast restoration per permanent tooth per 84 months.	
D6721	Retainer crown – resin with predominantly base metal			
D6722	Retainer crown – resin with noble metal			
D6740	Retainer crown – porcelain/ceramic			
D6750	Retainer crown – porcelain fused to high noble			
D6751	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	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	Retainer crown – porcelain fused to titanium and titanium alloys			
D6780	Retainer crown – ¾ cast high noble metal			
D6781	Retainer crown – ¾ cast predominately base metal			
D6782	Retainer crown – ¾ cast noble metal			

Prosthodontics, Fixed

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
FIXED PARTIAL DENTURE RETAINERS – INLAYS/ONLAYS, continued				
D6783	Retainer crown – ¾ porcelain/ceramic	Not a covered benefit.	One retainer crown or cast restoration per permanent tooth per 84 months.	Tooth identification
D6784	Retainer crown ¾ – titanium and titanium alloys			
D6790	Retainer crown – full cast high noble metal			
D6791	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	Retainer crown – full cast noble metal			
D6793	Interim retainer crown – further treatment or completion of diagnosis necessary prior to final impression		Not a covered benefit.	
D6794	Retainer crown – titanium and titanium alloys		One crown or cast restoration per permanent tooth per 84 months.	
OTHER FIXED PARTIAL DENTURE SERVICES				
D6920	Connector bar	Not a covered benefit.	Not a covered benefit.	None
D6930	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	Stress breaker	Not a covered benefit.	Not a covered benefit.	None
D6950	Precision attachment			
D6980	Fixed partial denture repair necessitated by restorative material failure	Covered.	One repair per 12 months.	• Quadrant identification • Detailed narrative
D6985	Pediatric partial denture, fixed	Not a covered benefit.	Not a covered benefit.	None
D6999	Unspecified fixed prosthodontic procedure, by report	Individual consideration.	Individual consideration.	Detailed narrative

Oral and Maxillofacial Surgery

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
EXTRACTIONS (Includes local anesthesia, suturing, if needed, and routine post-operative care). Bone grafts (D4263, D4264, D4265) and GTR membranes (D4266, D4267) are not covered in conjunction with oral surgery codes (D7000-D7999)				
D7111	Extraction – coronal remnants, deciduous tooth	One per tooth per lifetime.	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
D7140	Extraction – erupted tooth or exposed root (elevation and/or forcep removal)			
D7210	Surgical removal of an erupted tooth requiring removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated			
D7220	Removal of impacted tooth – soft tissue			
D7230	Removal of impacted tooth – partially bony			
D7240	Removal of impacted tooth – completely bony			
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	Not a covered benefit.		
D7250	Surgical removal of residual tooth roots (cutting procedure)	Only covered for teeth that are symptomatic, carious or pathologic.		
D7251	Coronectomy – intentional partial tooth removal, impacted teeth only	Not a covered benefit.	Once per tooth per lifetime (D3921 or D7251).	None
OTHER SURGICAL PROCEDURES				
D7260	Oroantral fistula closure	Not a covered benefit.	Individual consideration.	• Periapical or panoramic radiograph • Operative note
D7261	Primary closure of a sinus perforation			
D7270	Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth	Individual consideration.	Once per permanent tooth per lifetime.	Tooth identification

Oral and Maxillofacial Surgery

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
OTHER SURGICAL PROCEDURES, continued				
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)	Not a covered benefit.	Not a covered benefit.	None
D7280	Surgical access of unerupted tooth	Not a covered benefit.	Once per permanent tooth (1 through 32) per lifetime.	None
D7282	Mobilization of erupted or mal-positioned tooth to aid eruption			
D7283	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
D7285	Incisional biopsy of oral tissue – hard (bone, tooth)	Not a covered benefit.	Individual consideration.	Pathology report
D7286	Incisional biopsy of oral tissue – soft			
D7287	Cytology exfoliative sample collection	Not a covered benefit.	Individual consideration.	Detailed narrative
D7288	Brush biopsy – transepithelial sample collection			
D7290	Surgical repositioning of teeth – grafting procedures are additional	Not a covered benefit.	Individual consideration.	• Tooth identification • Detailed narrative
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	Not a covered benefit.	Individual consideration.	• Tooth identification • Detailed narrative • Include orthodontic history
D7292	Placement of temporary anchorage device [screw retained plate] requiring flap	Not a covered benefit.	Not a covered benefit.	None
D7293	Placement of temporary anchorage device requiring flap			
D7294	Placement of temporary anchorage device without flap			
D7295	Harvest of bone for use in autogenous grafting procedures			

Oral and Maxillofacial Surgery

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
OTHER SURGICAL PROCEDURES, continued				
D7298	Removal of temporary anchorage device [screw retained plate], requiring flap	Not a covered benefit.	Not a covered benefit.	None
D7299	Removal of temporary anchorage device, requiring flap			
D7300	Removal of temporary anchorage device without flap			
ALVEOPLASTY – SURGICAL PREPARATION OF RIDGE FOR DENTURES				
D7310	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 • Include tooth spaces identification for D7311, D7321. • Detailed narrative or progress notes • Pre-operative radiographs
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant			
D7320	Alveoloplasty not in conjunction with extractions –four or more teeth or tooth spaces, per quadrant			
D7321	Alveoloplasty, not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant			
VESTIBULOPLASTY				
D7340	Vestibuloplasty – ridge extension (secondary epithelialization)	Individual consideration. 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	Vestibuloplasty – ridge extension (incl. soft tissue grafts, muscle re-attachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)			
INCLUDES NON-ODONTOGENIC CYSTS				
D7410	Excision of benign lesion, up to 1.25 cm	Individual consideration.	Individual consideration.	Detailed narrative
D7411	Excision of benign lesion greater than 1.25 cm			

Oral and Maxillofacial Surgery

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
INCLUDES NON-ODONTOGENIC CYSTS, continued				
D7412	Excision of benign lesion, complicated	Not a covered benefit.	Individual consideration.	Pathology report
D7413	Excision of malignant lesion up to 1.25 cm			
D7414	Excision of malignant lesion greater than 1.25 cm			
D7415	Excision of malignant lesion, complicated	Not a covered benefit.	Individual consideration.	None
SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS				
D7440	Excision of malignant tumor – lesion diameter up to 1.25 cm	Not a covered benefit.	Individual consideration.	Pathology report
D7441	Excision of malignant tumor – lesion diameter greater than 1.25 cm			
D7450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm	Individual consideration; services must be rendered by an oral surgeon for benefit coverage.		
D7451	Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm			
D7460	Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm			
D7461	Removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm			
D7465	Destruction of lesion(s) by physical or chemical methods, by report	Not a covered benefit.		
D7471	Removal of lateral exostosis (maxilla or mandible)	Individual consideration. Services must be rendered by an oral surgeon for benefit coverage.	Once per arch per lifetime.	Arch identification
D7472	Removal of torus palatinus	Not a covered benefit.	Once per arch per lifetime	Arch identification
D7473	Removal of torus mandibularis		Once per quadrant per lifetime.	Quadrant identification

Oral and Maxillofacial Surgery

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS, *continued*				
D7485	Surgical reduction of osseous tuberosity	Not a covered benefit.	Once per upper quadrant per lifetime.	Quadrant identification
D7490	Radical resection of maxilla or mandible	Not a covered benefit.	Not a covered benefit.	None
SURGICAL INCISION				
D7509	Marsupialization of odontogenic cyst	Not a covered benefit.	Individual consideration.	• Tooth identification • Detailed narrative or operative report
D7510	Incision and drainage of abscess – intraoral soft tissue	Not a covered benefit.	Individual consideration.	• Tooth identification • Detailed narrative
D7511	Incision and drainage of abscess intraoral soft tissue, complicated (includes drainage of multiple fascial spaces)			
D7520	Incision and drainage of abscess – extraoral soft tissue	Not a covered benefit.	Individual consideration.	Detailed narrative
D7521	Incision and drainage of abscess – extraoral soft tissue, complicated (includes drainage of multiple fascial spaces)			
D7530	Removal of foreign body, mucosa, skin, or subcutaneous alveolar tissue	Not a covered benefit.	Individual consideration.	• Pathology report • Operative report
D7540	Removal of reaction-producing foreign bodies, musculoskeletal system			
D7550	Partial ostectomy/ sequestrectomy for removal of non-vital bone			
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body			
D7610	Maxilla – open reduction (teeth immobilized, if present)	Not a covered benefit.	Individual consideration.	• Panoramic radiograph • Operative report
D7620	Maxilla – closed reduction (teeth immobilized, if present)			

Oral and Maxillofacial Surgery

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
SURGICAL INCISION, continued				
D7630	Mandible – open reduction (teeth immobilized, if present)	Not a covered benefit.	Individual consideration.	• Panoramic radiograph • Operative report • Include arch identification for D7670 and D7671
D7640	Mandible – closed reduction (teeth immobilized, if present)			
D7650	Malar and/or zygomatic arch – open reduction			
D7660	Malar and/or zygomatic arch – closed reduction			
D7670	Alveolus - closed reduction, may include stabilization of teeth			
D7671	Alveolus - open reduction, may include stabilization of teeth			
D7680	Facial bones – complicated reduction with fixation and multiple surgical approaches			
TREATMENT OF FRACTURES – COMPOUND				
D7710	Maxilla – open reduction, stabilization of teeth	Not a covered benefit.	Individual consideration.	None
D7720	Maxilla – closed reduction			
D7730	Mandible – open reduction			
D7740	Mandible – closed reduction			
D7750	Malar and/or zygomatic arch – open reduction			
D7760	Malar and/or zygomatic arch – closed reduction			
D7770	Alveolus – open reduction stabilization of teeth			
D7771	Alveolus – closed reduction, stabilization of teeth			
D7780	Facial bones – complicated reduction with fixation and multiple surgical approaches			

Oral and Maxillofacial Surgery

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
REDUCTION OF DISLOCATION AND MANAGEMENT OF OTHER TEMPOROMANDIBULAR JOINT DYSFUNCTIONS – Procedures that are integral part of primary procedure should not be reported separately				
D7810	Open reduction of dislocation	Not a covered benefit.	Not a covered benefit.	None
D7820	Closed reduction of dislocation			
D7830	Manipulation under anesthesia			
D7840	Condylectomy			
D7850	Surgical disectomy; with or without implant			
D7852	Disc repair			
D7854	Synovectomy			
D7856	Myotomy			
D7858	Joint reconstruction			
D7860	Arthrotomy			
D7865	Arthroplasty			
D7870	Arthrocentesis			
D7871	Non-anthroscopic lysis and lavage			
D7872	Arthroscopy – diagnosis, with or without biopsy			
D7873	Arthroscopy – surgical, lavage and lysis of adhesions			
D7874	Arthroscopy – surgical, disc repositioning and stabilization			
D7875	Arthroscopy – surgical, synovectomy			
D7876	Arthroscopy – surgical, disectomy			
D7877	Arthroscopy – surgical, debridement			
D7880	Occlusal orthotic device, by report			
D7881	Occlusal orthotic device adjustment			
D7899	Unspecified TMD therapy, by report			

Oral and Maxillofacial Surgery

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
REPAIR OF TRAUMATIC WOUNDS				
D7910	Suture of recent small wounds up to 5 cm	Not a covered benefit.	Not a covered benefit.	None
D7911	Complicated suture – up to 5 cm			
D7912	Complicated suture – greater than 5 cm			
OTHER REPAIR PROCEDURES				
D7920	Skin grafts (identify defect covered, location, and type of graft)	Not a covered benefit.	Not a covered benefit.	None
D7921	Collection and application of autologous blood concentrate product			
D7922	Placement on intra-socket biological dressing to aid in hemostasis or clot stabilization, per site			
D7940	Osteoplasty – for orthognathic deformities			
D7941	Osteotomy – mandibular rami			
D7943	Osteotomy – mandibular rami with bone graft; includes obtaining the graft			
D7944	Osteotomy – segmented or sub-apical, per sextant or quadrant			
D7945	Osteotomy – body of mandible			
D7946	LeFort I (maxilla – total)			
D7947	LeFort I (maxilla – segmented)			
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) – without bone graft			
D7949	LeFort II or LeFort II – with bone graft			

Oral and Maxillofacial Surgery

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
OTHER REPAIR PROCEDURES, continued				
D7950	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	Sinus augmentation with bone or bone substitutes via a lateral open approach			
D7952	Sinus augmentation via a vertical approach			
D7953	Bone replacement graft for ridge preservation – per site			
D7955	Repair of maxillofacial soft and/or hard tissue defect			
D7961	Buccal / labial 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 or D7962 covered once per site per lifetime. Covered for members 6 years and older. Not allowed when performed in conjunction with soft tissue graft; same site and same date of service.	• Tooth identification • Detailed narrative
D7962	Lingual frenectomy (frenulectomy)			
D7963	Frenuloplasty		Individual consideration.	• Tooth identification • Detailed narrative
D7970	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	Excision of pericoronal gingiva	Not a covered benefit.	Once per upper quadrant per lifetime.	None
D7972	Surgical reduction of fibrous tuberosity			
D7979	Non-surgical sailolithotomy	Not a covered benefit.	Not a covered benefit.	None
D7980	Sialolithotomy	Not a covered benefit.	Individual consideration.	Detailed narrative
D7981	Excision of salivary gland, by report			
D7982	Sialodochoplasty			

Oral and Maxillofacial Surgery

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
OTHER REPAIR PROCEDURES, continued				
D7983	Closure of salivary fistula	Not a covered benefit.	Individual consideration.	Detailed narrative
D7990	Emergency tracheotomy	Not a covered benefit.	Not a covered benefit.	None
D7991	Coronoidectomy			
D7993	Surgical placement of craniofacial implant – extra oral			
D7994	Surgical placement: zygomatic implant			
D7995	Synthetic graft - mandible or facial bones, by report			
D7996	Implant – mandible for aumentation purposes (excluding alveolar ridge), by report	Not a covered benefit.	Not a covered benefit.	None
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	Not a covered benefit.	Individual consideration.	Detailed narrative
D7998	Intraoral placement of a fixation device not in conjunction with a fracture	Not a covered benefit.	Not a covered benefit.	None
D7999	Unspecified oral surgery procedure, by report	Individual consideration.	Individual consideration.	• Tooth identification • Detailed narrative • Operative report

Orthodontic Services

Orthodontic Benefit Administration

For medically necessary orthodontia services, prior authorization (PA) is required, and supporting documentation is be required. 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. Claims will not be approved for payment unless they have received PA approval; if authorization has not been requested or approved, the claim will deny. Authorizations will only be given to new cases and not takeover cases.

Limited Orthodontic Treatment. Use these codes for treatment utilizing any therapeutic modality with a limited objective or scale of treatment. Treatment may occur in any stage of dental development or dentition. For example: Treatment in one arch only to correct crowding, partial treatment to open spaces or upright a tooth for a bridge, implant, and partial treatment for closure of a space.

Comprehensive Orthodontic Treatment. Use these codes when there are multiple phases of treatment provided at different stages of dento-facial development. For example: The use of an activator is generally stage one of a two-stage treatment. In this situation, placement of fixed appliances will generally be stage two of a two-stage treatment. List both treatment phases as comprehensive treatment modified by the stage of dental development. For comprehensive orthodontic treatment, the member should present with a fully erupted set of permanent teeth before the components of a pre-orthodontic work-up is done. At least three-fourths of the clinical crown should be exposed, unless the tooth is impacted or congenitally missing.

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) 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..

Orthodontic Services

Required documents 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 orthodontic treatment

Use code D8660 (pre-orthodontic records) to submit claims for the services included for orthodontic records when a prior authorization if medically necessary orthodontics has been denied. 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:** The patient is authorized for initiation (24-36 months) of orthodontic treatment (D8080) and active follow-up treatment. Submit the ADA claim form indicating the date of service (banding date). Upon completion of banding, submit a claim for code D8080. 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:** We will notify both the provider and the member, and pay the provider an allowance for an orthodontic work-up under code D8660 that includes all components of the orthodontic work-up.

Orthodontic Services

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
LIMITED ORTHODONTIC TREATMENT				
D8010	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	Limited orthodontic treatment of the transitional dentition			
D8030	Limited orthodontic treatment of the adolescent dentition	Not a covered benefit.	Not a covered benefit.	None
D8040	Limited orthodontic treatment of the adult dentition			
COMPREHENSIVE ORTHODONTIC TREATMENT				
D8070	Comprehensive orthodontic treatment of transitional dentition	Not a covered benefit.	Not a covered benefit.	None
D8080	Comprehensive orthodontic treatment of adolescent dentition	Once per child per lifetime; services must be provided by an orthodontist.		Prior authorization.
D8090	Comprehensive orthodontic treatment of the adult dentition	Not a covered benefit.		None
MINOR TREATMENT TO CONTROL HARMFUL HABITS				
D8210	Removable appliance therapy	Not a covered benefit.	Not a covered benefit.	None
D8220	Fixed appliance therapy			
OTHER ORTHODONTIC SERVICES				
D8660	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	Periodic orthodontic treatment visit	Included in the allowance for the comprehensive treatment. Also covered for previously approved EHB take over cases.	Not a covered benefit.	None

Orthodontic Services

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
OTHER ORTHODONTIC SERVICES, continued				
D8680	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	Removable orthodontic retainer adjustment	Not a covered benefit.		
D8696	Repair of orthodontic appliance – maxillary	Not a covered benefit.	Not a covered benefit.	None
D8697	Repair of orthodontic appliance – mandibular			
D8698	Re-cement or re-bond fixed retainer – maxillary			
D8699	Re-cement or re-bond retainer – mandibular			
D8701	Repair of fixed retainer, includes reattachment – maxillary			
D8702	Repair of fixed retainer, includes reattachment – mandibular			
D8703	Replacement of lost or broken retainer – maxillary	Individual consideration.	Not a covered benefit.	• Prior authorization • Detailed narrative
D8704	Replacement of lost or broken retainer – mandibular			
D8999	Unspecified orthodontic procedure, by report. Use for procedures not adequately described by a code			

Unclassified Treatment

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
UNCLASSIFIED TREATMENT				
D9110	Palliative treatment of dental pain – per visit	Not covered in conjunction with D0140 on the same date of service.	Not a covered benefit.	None
D9120	Fixed partial denture sectioning	Not a covered benefit.		
D9130	Temporomandibular joint dysfunction – non-invasive physical therapies			
ANESTHESIA				
D9210	Local anesthesia not in conjunction with operative or surgical procedures	Not a covered benefit.	Not a covered benefit.	None
D9211	Regional block anesthesia			
D9212	Trigeminal division block anesthesia			
D9215	Local anesthesia in conjunction with operative or surgical procedures			
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia			
D9222	Deep sedation/general anesthesia – first 15 minutes Anesthesia time route of administration	Covered when provided with covered surgical procedures.	Covered when provided with covered surgical procedures.	
D9223	Deep sedation/general anesthesia – each 15 minute increment			
D9230	Administration of nitrous oxide/ analgesia, anxiolysis	Not a covered benefit.	Not a covered benefit.	
D9239	Intravenous moderate (conscious) sedation/analgesia- first 15 minutes	Once per child per date of service.	Not a covered benefit.	
D9243	Intravenous moderate (conscious) sedation/analgesia – each 15 minute increment			
D9248	Non−intravenous (conscious) sedation. This includes non-IV minimal and moderate sedation			

Adjunctive General Treatment

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
PROFESSIONAL CONSULTATION				
D9219	Evaluation for deep sedation or general anesthesia	Not a covered benefit.	Not a covered benefit.	None
D9310	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: D9310 at the charge amount and D9999 at no charge on the same claim.
PROFESSIONAL VISITS				
D9410	House call/extended care facility call	Individual consideration.	Not a covered benefit.	Detailed narrative
D9420	Hospital or ambulatory surgical center call	Not a covered benefit.	Not a covered benefit.	None
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed			
D9440	Office visit-after regularly scheduled hours			
D9450	Case presentation, subsequent to detailed and extensive treatment planning			
DRUGS				
D9610	Therapeutic parenteral drug, single administration	Not a covered benefit.	Not a covered benefit.	None
D9612	Therapeutic parenteral drugs, two or more administrations, different medications			
D9613	Infiltration of sustained release therapeutic drug, per quadrant			

Adjunctive General Treatment

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
DRUGS, continued				
D9630	Other drugs and/or medicaments, by report	Not a covered benefit.	Not a covered benefit	None
MISCELLANEOUS SERVICES				
D9910	Application of desensitizing medicament	Not a covered benefit.	Once per 12 months.	None
D9911	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	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
D9920	Behavior management, by report	Individual consideration.	Not a covered benefit.	Detailed narrative
D9930	Treatment of complications (post-surgical) – unusual circumstances, by report	Individual consideration.	Individual consideration.	
D9932	Cleaning and inspection of removable complete denture, maxillary	Not a covered benefit.	Not a covered benefit.	None
D9933	Cleaning and inspection of removable complete denture, mandibular			
D9934	Cleaning and inspection of removable partial denture, maxillary			
D9935	Cleaning and inspection of removable partial denture, mandibular			
D9941	Fabrication of athletic mouthguard	Covered for ACA plans.	Not a covered benefit.	
D9942	Repair and/or reline of occlusal guard	Not a covered benefit.	Not a covered benefit.	
D9943	Occlusal guard adjustment			
D9944	Occlusal guard – hard appliance, full arch	One D9944, D9945 or D9946 covered once per calendar year.	Not a covered benefit	

Adjunctive General Treatment

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
MISCELLANEOUS SERVICES, continued				
D9945	Occlusal guard – soft appliance, full arch			
D9946	Occlusal guard – hard appliance, partial arch	One D9944, D9945 or D9946 covered once per calendar year.	Not a covered benefit	None
D9947	Custom sleep apnea appliance fabrication and placement	Not a covered benefit under BCBSMA dental plans. Please check with patient's medical insurer for possible coverage.	Not a covered benefit under BCBSMA dental plans. Please check with patient's medical insurer for possible coverage.	
D9948	Adjustment of custom sleep apnea appliance			
D9949	Repair of custom sleep apnea appliance			
D9950	Occlusion analysis – mounted case	Not a covered benefit	Not a covered benefit	
D9951	Occlusal adjustment – limited	Not a covered benefit	Once per quadrant per 24 months	Quadrant identification
D9952	Occlusal adjustment – complete	Not a covered benefit	Once per arch 24 months	Arch identification
D9953	Reline custom sleep apnea appliance (indirect)	Not a covered benefit	Not a covered benefit	None
D9961	Duplicate/copy patient's records			
D9970	Enamel microabrasion			
D9971	Odontoplasty – per tooth			
D9972	External bleaching – per arch – in office			
D9973	External bleaching – per tooth			
D9974	Internal bleaching – per tooth			
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays			
D9985	Sales tax			
D9986	Missed appointment			
D9987	Cancelled appointment			
D9990	Certified translation or sign language services – per visit	Not a covered benefit	Not a covered benefit	None

Adjunctive General Treatment

CDT Code	Description of Service	Pediatric EHB Procedure Guidelines *Ages 0-19*	Adult EHB Procedure Guidelines *Ages 19 & older*	Submission Requirements
MISCELLANEOUS SERVICES, continued				
D9997	Dental case management – patients with special health care needs	Not a covered benefit	Not a covered benefit	None
D9999	Unspecified adjunctive procedure by report	Individual consideration	Individual consideration	Detailed narrative