Access Dental Plan Family Dental HMO
Schedule Of Benefits

This Schedule of Benefits lists the services available to you under your Access Dental Individual Plan, as well as the Copayments associated with each procedure. Please review the Benefits Description and Limitations & Exclusions Section below for a detailed description and additional information about how your Plan works.

The following Copayments apply when services are performed by your assigned Primary Care Dentist (PCD) or a Contracted Specialty Provider (with prior approval from Access Dental, also referred to as "the Plan"). If Specialty Services are recommended by your PCD, the treatment plan must be preauthorized in writing by the Plan prior to treatment in order for the services to be eligible for coverage.

The benefits shown below are performed as deemed appropriate by the assigned Primary Care Dentist subject to the limitations and exclusions of the program. You should discuss all treatment options with your PCD prior to services being rendered.

Specialty services require prior authorization from the Plan. A referral must be submitted to the Plan by your Primary Care Dentist for approval.

Procedure Category	Child-ONLY* Copay Range	Adult-Only** Copay Range
Diagnostic and Preventive Oral Exam, Preventive-Cleaning, Topical Fluoride Application, Sealants per Tooth, Preventive - X-rays and Space maintainers - Fixed	$0	$0
Basic Services Restorative Procedures, Periodontal Maintenance Services, Adult Periodontics (other than maintenance) Adult Endodontics (Group Dental Plans only)	$0-$25	$0-$25
Major Services Crowns & Casts, Prosthodontics, Endodontics, Periodontics (other than maintenance), and Oral Surgery	$0-$350	$0-$400
Orthodontia (Only for pre-authorized Medically Necessary Orthodontia)	$0-$350	N/A
Individual Deductible (Waived for Diagnostic and Preventive)	$0	N/A
Family Deductible (Waived for Diagnostic and Preventive)	$0	N/A
Out of Pocket Maximum (OOP) (per person)	$350	N/A
Out of Pocket Maximum (OOP) (2+ children)	$700	N/A
Annual Maximum	None	N/A
Ortho Lifetime Maximum	None	N/A
Office Visit (Per Visit)	$0	$0
Waiting Period	None	N/A

*This plan is available for individuals up to age 19
**This plan is available for individuals ages 19 and over.

ADP_SOB_HMO_FAM_CA_17

		Pediatric Dental EHB	Adult Dental
ADA Code	**ADA Code Description**	**In-network Member Cost Share**	**In-Network Member Cost Share**
(D0100-D999)	**Diagnostic**		
D0120	Periodic oral evaluation - established patient	No Charge	No Charge
D0140	Limited oral evaluation – problem focused	No Charge	No Charge
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Charge	Not Covered
D0150	Comprehensive oral evaluation – new or established patient	No Charge	No Charge
D0160	Detailed and extensive oral evaluation – problem focused, by report	No Charge	No Charge
D0170	Re-evaluation - limited, problem focused (established patient not post-operative visit)	No Charge	No Charge
D0180	Comprehensive periodontal evaluation – new or established patient	No Charge	No Charge
D0190	Screening of a patient	Not Covered	No Charge
D0191	Assessment of a patient	Not Covered	No Charge
D0210	Intraoral - complete series of radiographic images	No Charge	No Charge
D0220	Intraoral - periapical first radiographic image	No Charge	No Charge
D0230	Intraoral - periapical each additional radiographic image	No Charge	No Charge
D0240	Intraoral - occlusal radiographic image	No Charge	No Charge
D0250	Extraoral - first radiographic image	No Charge	No Charge
D0270	Bitewing - single radiographic image	No Charge	No Charge
D0272	Bitewings - two radiographic images	No Charge	No Charge
D0273	Bitewings - three radiographic images	No Charge	No Charge
D0274	Bitewings - four radiographic images	No Charge	No Charge
D0277	Vertical bitewings – 7 to 8 radiographic images	No Charge	No Charge
D0290	Posterior – anterior or lateral skull and facial bone survey radiographic image	No Charge	Not Covered
D0310	Sialography	No Charge	Not Covered
D0320	Temporomandibular joint arthrogram, including injection	No Charge	Not Covered
D0322	Tomographic survey	No Charge	Not Covered
D0330	Panoramic film	No Charge	No Charge
D0340	Cephalometric radiographic image	No Charge	Not Covered
D0350	Oral/Facial photographic images	No Charge	Not Covered
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	Not Covered	No Charge
D0460	Pulp vitality tests	No Charge	No Charge
D0470	Diagnostic casts	No Charge	No Charge
D0502	Other oral pathology procedures, by report	No Charge	Not Covered
D0601	caries risk assessment and documentation, with a finding of low risk	No Charge	Not Covered
D0602	caries risk assessment and documentation, with a finding of moderate risk	No Charge	Not Covered
D0603	caries risk assessment and documentation, with a finding of high risk	No Charge	Not Covered
D0999	Unspecified diagnostic procedure, by report	No Charge	Not Covered
(D1000-D1999)	**Preventive**		
D1110	Prophylaxis – adult	No Charge	No Charge
D1120	Prophylaxis – child	No Charge	Not Covered
D1206	Topical application of fluoride varnish – child 0 to 5	No Charge	Not Covered
D1208	Topical application of flouride varnish – child 6 to 20	No Charge	Not Covered
D1310	Nutritional counseling for control of dental disease	No Charge	Not Covered
D1320	Tobacco counseling for the control and prevention of oral disease	No Charge	Not Covered

D1330	Oral hygiene instructions	No Charge	No Charge
D1351	Sealant - per tooth	No Charge	Not Covered
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	No Charge	Not Covered
D1510	Space maintainer - fixed – unilateral	No Charge	Not Covered
D1515	Space maintainer - fixed – bilateral	No Charge	Not Covered
D1520	Space maintainer - removable - unilateral	No Charge	Not Covered
D1525	Space maintainer - removable - bilateral	No Charge	Not Covered
D1550	Recementation of space maintainer	No Charge	Not Covered
D1555	Removal of fixed space maintainer	No Charge	Not Covered
(D2000-D2999)	**Restorative**		
D2140	Amalgam - one surface, primary or permanent	$25	$25
D2150	Amalgam - two surfaces, primary or permanent	$30	$30
D2160	Amalgam - three surfaces, primary or permanent	$40	$40
D2161	Amalgam - four or more surfaces, primary or permanent	$45	$45
D2330	Resin-based composite - one surface, anterior	$30	$30
D2331	Resin-based composite - two surfaces, anterior	$45	$45
D2332	Resin-based composite - three surfaces, anterior	$55	$55
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$60	$60
D2390	Resin-based composite crown, anterior	$50	$50
D2391	Resin-based composite – one surface, posterior	$30	$30
D2392	Resin-based composite – two surfaces, posterior	$40	$40
D2393	Resin-based composite – three surfaces, posterior	$50	$50
D2394	Resin-based composite – four or more surfaces, posterior	$70	$70
D2542	Onlay – metallic - two surfaces	Not Covered	$185
D2543	Onlay - metallic – three surfaces	Not Covered	$200
D2544	Onlay – metallic – four or more surfaces	Not Covered	$215
D2642	Onlay – porcelain/ceramic – two surfaces	Not Covered	$250
D2643	Onlay – porcelain/ceramic – three surfaces	Not Covered	$275
D2644	Onlay – porcelain/ceramic – four or more surfaces	Not Covered	$300
D2662	Onlay - resin-based composite - two surfaces	Not Covered	$160
D2663	Onlay - resin-based composite - three surfaces	Not Covered	$180
D2664	Onlay - resin-based composite - four or more surfaces	Not Covered	$200
D2710	Crown – resin-based composite (indirect)	$140	$140
D2712	Crown - 3/4 resin-based composite (indirect)	$190	Not Covered
D2720	Crown – resin with high noble metal	Not Covered	$300
D2721	Crown – resin with predominantly base metal	$300	$300
D2722	Crown – resin with noble metal	Not Covered	$300
D2740	Crown – porcelain/ceramic substrate	$300	$300
D2750	Crown - porcelain fused to high noble metal	Not Covered	$300
D2751	Crown - porcelain fused to predominantly base metal	$300	$300
D2752	Crown - porcelain fused to noble metal	Not Covered	$300
D2780	Crown - 3/4 cast high noble metal	Not Covered	$300
D2781	Crown - 3/4 cast predominantly base metal	$300	$300
D2782	Crown - 3/4 cast noble metal	Not Covered	$300
D2783	Crown – ¾ porcelain/ceramic	$310	Not Covered
D2790	Crown - full cast high noble metal	Not Covered	$300
D2791	Crown - full cast predominantly base metal	$300	$300
D2792	Crown - full cast noble metal	Not Covered	$300
D2910	Recement inlay, onlay, or partial coverage restoration	$25	$25
D2915	Recement cast or prefabricated post and core	$25	$25
D2920	Recement crown	$25	$15
D2929	Prefabricated porcelain/ceramic crown - primary tooth	$95	Not Covered

D2930	Prefabricated stainless steel crown - primary tooth	$65	Not Covered
D2931	Prefabricated stainless steel crown - permanent tooth	$75	$75
D2932	Prefabricated resin crown	$75	Not Covered
D2933	Prefabricated stainless steel crown with resin window	$80	Not Covered
D2940	protective restoration	$25	$20
D2950	Core buildup, involving any pins	$20	$20
D2951	Pin retention - per tooth, in addition to restoration	$25	$20
D2952	Post and core in addition to crown, indirectly fabricated	$100	$60
D2953	Each additional indirectly fabricated post, same tooth	$30	$30
D2954	Prefabricated post and core in addition to crown	$90	$60
D2955	Post removal	$60	Not Covered
D2957	Each additional prefabricated post – same tooth	$35	$35
D2971	Additional procedures to construct new crown under existing partial denture framework	$35	Not Covered
D2980	Crown repair, by report	$50	$50
D2999	Unspecified restorative procedure, by report	$40	Not Covered
(D3000-D3999)	**Endodontics**		
D3110	Pulp cap - direct (excluding final restoration)	$20	$20
D3120	Pulp cap – indirect (excluding final restoration)	$25	$25
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction application of medicament	$40	$35
D3221	Pulpal debridement, primary and permanent teeth	$40	Not Covered
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$60	Not Covered
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	$55	Not Covered
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	$55	Not Covered
D3310	Root canal therapy Anterior (excluding final restoration)	$195	$200
D3320	Root canal therapy, Bicuspid tooth(excluding final restoration)	$235	$235
D3330	Root canal therapy, Molar (excluding final restoration)	$300	$300
D3331	Treatment of root canal obstruction; non-surgical access	$50	$50
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$45	$85
D3333	Internal root repair of perforation defects	$80	Not Covered
D3346	Retreatment of previous root canal therapy – anterior	$240	$245
D3347	Retreatment of previous root canal therapy – bicuspid	$295	$295
D3348	Retreatment of previous root canal therapy - molar	$365	$365
D3351	Apexification/recalcificaion – initial visit	$85	Not Covered
D3352	Apexification/recalcification – interim	$45	Not Covered
D3353	Apexification/recalcification – final visit	Not Covered	Not Covered
D3410	Apicoectomy/periradicular surgery – anterior	$240	$240
D3421	Apicoectomy/periradicular surgery – bicuspid (first root)	$250	$250
D3425	Apicoectomy/periradicular surgery – molar (first root)	$275	$275
D3426	Apicoectomy/periradicular surgery molar (each additional root)	$110	$110
D3430	Retrograde filling – per root	$90	$90
D3450	Root amputation – per root	Not Covered	$110
D3910	Surgical procedure for isolation of tooth with rubber dam	$30	Not Covered
D3920	Hemisection (including any root removal; not including root canal therapy)	Not Covered	$120
D3950	Canal prepartion and fitting of preformed dowel or post	Not Covered	$60
D3999	Unspecified endodontic procedure, by report	$100	Not Covered
(D4000-D4999)	**Periodontics**		
D4210	Gingivectomy or gingivoplasty - per quadrant - - four or more contiguous teeth or tooth bound	$150	$150

	spaces		
D4211	gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per tooth	$50	$50
D4240	Gingival flap procedure including root planing four or more teeth per quadrant	Not Covered	$135
D4241	Gingival flap procedure including root planing one to three teeth per quadrant	Not Covered	$70
D4249	Clinical crown lengthening – hard tissue	$165	Not Covered
D4260	Osseous – muco- gingival surgery per quadrant	$265	$265
D4261	Osseous surgery (including flap entry and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	$140	$140
D4263	Bone replacement graft - first site in quadrant	Not Covered	$105
D4264	Bone replacement graft - each additional site in quadrant	Not Covered	$75
D4265	Biologic materials to aid in soft and osseous tissue regeneration	$80	Not covered
D4266	Guided tissue regeneration - resorbable barrier - per site	Not Covered	$145
D4267	Guided tissue regeneration - non-resorbable barrier - per site (includes membrane removal)	Not Covered	$175
D4270	Pedicle soft tissue graft procedure	Not Covered	$155
D4273	Subepithelial connective tissue graft procedure - per tooth	Not Covered	$220
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	$55	$55
D4342	Periodontal scaling and root planing – one to three teeth per quadrant	$30	$25
D4355	full mouth debridement to enable comprehensive evaluation and diagnosis	$40	$40
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$10	Not Covered
D4910	Periodontal maintenance	$30	$30
D4920	Unscheduled dressing change (by someone other than treating dentist)	$15	Not Covered
D4999	Unspecified periodontal procedure, by report	$350	Not Covered
(D5000-D5899)	**Removable Prosthodontics**		
D5110	Complete denture –maxillary	$300	$400
D5120	Complete denture – mandibular	$300	$400
D5130	Immediate denture – maxillary	$300	$400
D5140	Immediate denture – mandibular	$300	$400
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$300	$325
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$300	$325
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including. any conventional clasps, rests and teeth)	$335	$375
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$335	$375
D5225	Maxillary partial denture – flexible base (including any clasps, rests and teeth)	Not Covered	$375
D5226	Mandibular partial denture – flexible base (including any clasps, rests and teeth)	Not Covered	$375
D5281	Removable unilateral partial denture – one piece cast metal (including clasps and teeth)	Not Covered	$250
D5410	Adjust complete denture – maxillary	$20	$20
D5411	Adjust complete denture – mandibular	$20	$20
D5421	Adjust partial denture – maxillary	$20	$20
D5422	Adjust partial denture – mandibular	$20	$20
D5510	Repair broken complete denture base	$40	$30
D5520	Replace missing or broken teeth - complete denture (each tooth)	$40	$30
D5610	Repair resin denture base	$40	$30
D5620	Repair cast framework	$40	$35

D5630	Repair or replace broken clasp	$50	$30
D5640	Replace broken teeth - per tooth	$35	$30
D5650	Add tooth to existing partial denture	$35	$35
D5660	Add clasp to existing partial denture	$60	$45
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	Not Covered	$195
D5671	Replace all teeth an acrylic on cast metal framework (mandibular)	Not Covered	$195
D5710	Rebase complete maxillary denture	Not Covered	$155
D5711	Rebase complete mandibular denture	Not Covered	$155
D5720	Rebase maxillary partial denture	Not Covered	$150
D5721	Rebase mandibular partial denture	Not Covered	$150
D5730	Reline complete maxillary denture (chairside)	$60	$80
D5731	Reline complete mandibular denture (chairside)	$60	$80
D5740	Reline maxillary partial denture (chairside)	$60	$75
D5741	Reline mandibular partial denture (chairside)	$60	$75
D5750	Reline complete maxillary denture (laboratory)	$90	$120
D5751	Reline complete mandibular denture (laboratory)	$90	$120
D5760	Reline maxillary partial denture (laboratory)	$80	$110
D5761	Reline mandibular partial denture (laboratory)	$80	$110
D5850	Tissue conditioning, maxillary	$30	$35
D5851	Tissue conditioning, mandibular	$30	$35
D5862	Precision attachment, by report	$90	Not Covered
D5863	Overdenture – complete maxillary	$300	Not Covered
D5865	Overdenture – complete mandibular	$300	Not Covered
D5899	Unspecified removable prosthodontic procedure, by report	$350	Not Covered
D5911	Facial moulage (sectional)	$285	Not Covered
D5912	Facial moulage (complete)	$350	Not Covered
D5913	Nasal prosthesis	$350	Not Covered
D5914	Auricular prosthesis	$350	Not Covered
D5915	Orbital prosthesis	$350	Not Covered
D5916	Ocular prosthesis	$350	Not Covered
D5919	Facial prosthesis	$350	Not Covered
D5922	Nasal septal prosthesis	$350	Not Covered
D5923	Ocular prosthesis, interim	$350	Not Covered
D5924	Cranial prosthesis	$350	Not Covered
D5925	Facial augmentation implant prosthesis	$200	Not Covered
D5926	Nasal prosthesis, replacement	$200	Not Covered
D5927	Auricular prosthesis, replacement	$200	Not Covered
D5928	Orbital prosthesis, replacement	$200	Not Covered
D5929	Facial prosthesis, replacement	$200	Not Covered
D5931	Obturator prosthesis, surgical	$350	Not Covered
D5932	Obturator prosthesis, definitive	$350	Not Covered
D5933	Obturator prosthesis, modification	$150	Not Covered
D5934	Mandibular resection prosthesis with guide flange	$350	Not Covered
D5935	Mandibular resection prosthesis without guide flange	$350	Not Covered
D5936	Obturator prosthesis, interim	$350	Not Covered
D5937	Trismus appliance (not for TMD treatment)	$85	Not Covered
D5951	Feeding aid	$135	Not Covered
D5952	Speech aid prosthesis, pediatric	$350	Not Covered
D5953	Speech aid prosthesis, adult	$350	Not Covered
D5954	Palatal augmentation prosthesis	$135	Not Covered
D5955	Palatal lift prosthesis, definitive	$350	Not Covered
D5958	Palatal lift prosthesis, interim	$350	Not Covered
D5959	Palatal lift prosthesis, modification	$145	Not Covered
D5960	Speech aid prosthesis, modification	$145	Not Covered

D5982	Surgical stent	$70	Not Covered
D5983	Radiation carrier	$55	Not Covered
D5984	Radiation shield	$85	Not Covered
D5985	Radiation cone locator	$135	Not Covered
D5986	Fluoride gel carrier	$35	Not Covered
D5987	Commissure splint	$85	Not Covered
D5988	Surgical splint	$95	Not Covered
D5991	Topical Medicament Carrier	$70	Not Covered
D5999	Unspecified maxillofacial prosthesis, by report	$350	Not Covered
(D6000-D6199)	**Implant Services**		
D6010	Surgical placement of implant body: endosteal implant	$350	Not Covered
D6040	Surgical placement: eposteal implant	$350	Not Covered
D6050	Surgical placement: transosteal implant	$350	Not Covered
D6055	Connecting bar - implant supported or abutment supported	$350	Not Covered
D6056	Prefabricated abutment - includes modification and placement	$135	Not Covered
D6057	Custom fabricated abutment - includes placement	$180	Not Covered
D6058	Abutment supported porcelain/ceramic crown	$320	Not Covered
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$315	Not Covered
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$295	Not Covered
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$300	Not Covered
D6062	Abutment supported cast metal crown (high noble metal)	$315	Not Covered
D6063	Abutment supported cast metal crown (predominantly base metal)	$300	Not Covered
D6064	Abutment supported cast metal crown (noble metal)	$315	Not Covered
D6065	Implant supported porcelain/ceramic crown	$340	Not Covered
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	$335	Not Covered
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	$340	Not Covered
D6068	Abutment supported retainer for porcelain/ceramic FPD	$320	Not Covered
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$315	Not Covered
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$290	Not Covered
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$300	Not Covered
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$315	Not Covered
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$290	Not Covered
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$320	Not Covered
D6075	Implant supported retainer for ceramic FPD	$335	Not Covered
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	$330	Not Covered
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	$350	Not Covered
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis	$30	Not Covered
D6090	Repair implant supported prosthesis, by report	$65	Not Covered
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment	$40	Not Covered
D6092	Recement implant/abutment supported crown	$25	Not Covered
D6093	Recement implant/abutment supported fixed partial denture	$35	Not Covered
D6094	Abutment supported crown (titanium)	$295	Not Covered
D6095	Repair implant abutment, by report	$65	Not Covered
D6100	Implant removal, by report	$110	Not Covered

D6110	Implant/abutment supported removable denture for edentulous arch - maxillary	$350	Not Covered
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular	$350	Not Covered
D6112	Implant/abutment supported removable denture for partically edentulous arch - maxillary	$350	Not Covered
D6113	Implant/abutment supported removable denture for partically edentulous arch - mandibular	$350	Not Covered
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary	$350	Not Covered
D6115	Implant/abutment supported fixed denture for edentulous arch - mandibular	$350	Not Covered
D6116	Implant/abutment supported fixed denture for partically edentulous arch - maxillary	$350	Not Covered
D6117	Implant/abutment supported fixed denture for partically edentulous arch - mandibular	$350	Not Covered
D6190	Radiographic/Surgical implant index, by report	$75	Not Covered
D6194	Abutment supported retainer crown for FPD (titanium)	$265	Not Covered
D6199	Unspecified implant procedure, by report	$350	Not Covered
D6205	Pontic - indirect resin based composite	Not Covered	$165
D6210	Pontic - cast high noble metal	Not Covered	$300
D6211	Pontic - cast predominantly base metal	$300	$300
D6212	Pontic - cast noble metal	Not Covered	$300
D6214	Pontic - cast titanium metal	Not Covered	$300
D6240	Pontic - porcelain fused to high noble metal	Not Covered	$300
D6241	Pontic - porcelain fused to predominantly base metal	$300	$300
D6242	Pontic - porcelain fused to noble metal	Not Covered	$300
D6245	Pontic - porcelain/ceramic	$300	$300
D6250	Pontic – resin with high noble metal	Not Covered	$300
D6251	Pontic – resin with predominantly base metal	$300	$300
D6252	Pontic – resin with noble metal	Not Covered	$300
D6545	retainer - cast metal for resin bonded fixed prosthesis	Not Covered	$130
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	Not Covered	$145
D6608	Onlay - porcelain/ceramic - two surfaces	Not Covered	$200
D6609	Onlay - porcelain/ceramic - three or more surfaces	Not Covered	$200
D6610	Onlay - cast high noble metal - two surfaces	Not Covered	$200
D6611	Onlay - cast high noble metal - three or more surfaces	Not Covered	$200
D6612	Onlay - cast predominantly base metal - two surfaces	Not Covered	$200
D6613	Onlay - cast predominantly base metal - three or more surfaces	Not Covered	$200
D6614	Onlay - cast noble metal- two surfaces	Not Covered	$200
D6615	Onlay - cast noble metal - three or more surfaces	Not Covered	$200
D6634	Onlay - titanium	Not Covered	$200
D6710	Crown - indirect resin based composite	Not Covered	$200
D6720	Crown – resin with high noble metal	Not Covered	$300
D6721	Crown – resin with predominantly base metal	$300	$300
D6722	Crown – resin with noble metal	Not Covered	$300
D6740	crown - porcelain/ceramic	$300	$300
D6751	Crown – porcelain fused to predominantly base metal	$300	$300
D6781	crown - 3/4 cast predominantly base metal	$300	$300
D6782	crown - 3/4 cast noble metal	Not Covered	$300
D6783	crown - 3/4 porcelain/ceramic	$300	$300
D6791	Crown – full cast predominantly base metal	$300	$300
D6930	Re-cement or re-bond fixed partial denture	$40	$40
D6980	Fixed partial denture repair necessitated by restorative material failure	$95	$95

D6999	Unspecified fixed prosthodontic procedure, by report	$350	Not Covered
(D7000-D7999)	**Oral and Maxillofacial Surgery**		
D7111	Extraction, coronal remnants – deciduous tooth	$40	$40
D7140	Extraction, erupted tooth or exposed root	$65	$65
D7210	Surgical removal of erupted tooth requiring elevation of mucoperisteal flap and removal of bone and/or section of tooth	$120	$115
D7220	Removal of impacted tooth - soft tissue	$95	$85
D7230	Removal of impacted tooth - partially bony	$145	$145
D7240	Removal of impacted tooth - completely bony	$160	$160
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$175	$175
D7250	Surgical removal of residual tooth roots (cutting procedure)	$80	$75
D7260	Oral Antral Fistula closure	$280	$280
D7261	Primary closure of a sinus perforation	$285	Not Covered
D7270	tooth reimplantation / stabilization	$185	Not Covered
D7280	Surgical access of an unerupted tooth	$220	Not Covered
D7283	Placement of device to facilitate eruption of impacted tooth	$85	Not Covered
D7285	Biopsy of oral tissue – hard (bone, tooth)	$180	Not Covered
D7286	Biopsy of oral tissue – soft	$110	$110
D7287	Exfoliative cytological sample collection	Not Covered	$35
D7288	Brush biopsy transepithelial sample collection	Not Covered	$35
D7290	Surgical repositioning of teeth	$185	Not Covered
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$80	Not Covered
D7310	alveoloplasty in conjunction with extractions – per quadrant	$85	$85
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per	$50	$50
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	$120	$120
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	$65	$65
D7340	Vestibuloplasty – ridge extension (secondary epithelialization)	$350	Not Covered
D7350	Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	$350	Not Covered
D7410	excision of benign lesion up to 1.25 cm	$75	Not Covered
D7411	excision of benign lesion greater than 1.25 cm	$115	Not Covered
D7412	Excision of benign lesion, complicated	$175	Not Covered
D7413	Excision of malignant lesion up to 1.25 cm	$95	Not Covered
D7414	Excision of malignant lesion greater than 1.25 cm	$120	Not Covered
D7415	Excision of malignant lesion, complicated	$255	Not Covered
D7440	Excision of malignant tumor – lesion diameter up to 1.25 cm	$105	Not Covered
D7441	Excision of malignant tumor – lesion diameter greater than 1.25 cm	$185	Not Covered
D7450	removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	$180	Not Covered
D7451	removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$330	Not Covered
D7460	removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	$155	Not Covered

D7461	removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$250	Not Covered
D7465	Destruction of lesion(s) by physical or chemical method, by report	$40	Not Covered
D7471	Removal of lateral exostosis (maxilla or mandible)	$140	$140
D7472	Removal of torus palatinus	$145	$140
D7473	Removal of torus mandibularis	$140	$140
D7485	Surgical reduction of osseous tuberosity	$105	Not Covered
D7490	Radical resection of maxilla or mandible	$350	Not Covered
D7510	Incision and drainage of abscess – intraoral soft tissue	$70	$55
D7511	Incision and drainage of abscess – intraoral soft tissue – complicated	$70	$69
D7520	incision and drainage of abscess - extraoral soft tissue	$70	Not Covered
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple facial spaces)	$80	Not Covered
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	$45	Not Covered
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	$75	Not Covered
D7550	Partial ostectomy /sequestrectomy for removal of non-vital bone	$125	$125
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	$235	Not Covered
D7610	Maxilla – open reduction (teeth immobilized, if present)	$140	Not Covered
D7620	Maxilla – closed reduction (teeth immobilized, if present)	$250	Not Covered
D7630	Mandible – open reduction (teeth immobilized, if present)	$350	Not Covered
D7640	Mandible – closed reduction (teeth immobilized, if present)	$350	Not Covered
D7650	Malar and/or zygomatic arch – open reduction	$350	Not Covered
D7660	Malar and/or zygomatic arch – closed reduction	$350	Not Covered
D7670	Alveolus – closed reduction, may include stabilization of teeth	$170	Not Covered
D7671	Alveolus – open reduction, may include stabilization of teeth	$230	Not Covered
D7680	Facial bones – complicated reduction with fixation and multiple surgical approaches	$350	Not Covered
D7710	Maxilla – open reduction	$110	Not Covered
D7720	Maxilla – closed reduction	$180	Not Covered
D7730	Mandible – open reduction	$350	Not Covered
D7740	Mandible – closed reduction	$290	Not Covered
D7750	Malar and/or zygomatic arch – open reduction	$220	Not Covered
D7760	Malar and/or zygomatic arch – closed reduction	$350	Not Covered
D7770	Alveolus – open reduction stabilization of teeth	$135	Not Covered
D7771	Alveolus, closed reduction stabilization of teeth	$160	Not Covered
D7780	Facial bones – complicated reduction with fixation and multiple surgical approaches	$350	Not Covered
D7810	Open reduction of dislocation	$350	Not Covered
D7820	Closed reduction of dislocation	$80	Not Covered
D7830	Manipulation under anesthesia	$85	Not Covered
D7840	Condylectomy	$350	Not Covered
D7850	Surgical discectomy, with/without implant	$350	Not Covered
D7852	Disc repair	$350	Not Covered

D7854	Synovectomy	$350	Not Covered
D7856	Myotomy	$350	Not Covered
D7858	Joint reconstruction	$350	Not Covered
D7860	Arthrostomy	$350	Not Covered
D7865	Arthroplasty	$350	Not Covered
D7870	Arthrocentesis	$90	Not Covered
D7871	Non-arthroscopic lysis and lavage	$150	Not Covered
D7872	Arthroscopy – diagnosis, with or without biopsy	$350	Not Covered
D7873	Arthroscopy – surgical: lavage and lysis of adhesions	$350	Not Covered
D7874	Arthroscopy – surgical: disc repositioning and stabilization	$350	Not Covered
D7875	Arthroscopy – surgical: synovectomy	$350	Not Covered
D7876	Arthroscopy – surgical: discectomy	$350	Not Covered
D7877	Arthroscopy – surgical: debridement	$350	Not Covered
D7880	Occlusal orthotic device, by report	$120	Not Covered
D7899	Unspecified TMD therapy, by report	$350	Not Covered
D7910	Suture of recent small wounds up to 5 cm	$35	Not Covered
D7911	Complicated suture – up to 5 cm	$55	Not Covered
D7912	Complicated suture – greater than 5 cm	$130	Not Covered
D7920	Skin graft (identify defect covered, location and type of graft)	$120	Not Covered
D7940	Osteoplasty – for orthognathic deformities	$160	Not Covered
D7941	Osteotomy – mandibular rami	$350	Not Covered
D7943	Osteotomy – mandibular rami with bone graft; includes obtaining the graft	$350	Not Covered
D7944	Osteotomy – segmented or subapical	$275	Not Covered
D7945	Osteotomy – body of mandible	$350	Not Covered
D7946	LeFort I (maxilla – total)	$350	Not Covered
D7947	LeFort I (maxilla – segmented)	$350	Not Covered
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) – without bone graft	$350	Not Covered
D7949	LeFort II or LeFort III – with bone graft	$350	Not Covered
D7950	Osseous, osteoperiosteal, or cartilage graft of mandible or facial bones – autogenous or nonautogenous, by report	$190	Not Covered
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	$290	Not Covered
D7952	Sinus augmentation with bone or bone substitute via a vertical approach	$175	Not Covered
D7955	Repair of maxillofacial soft and/or hard tissue defect	$200	Not Covered
D7960	Frenulectomy – also known as frenectomy or frenotomy – separate procedure	$120	$120
D7963	Frenuloplasty	$120	$120
D7970	Excision of hyperplastic tissue - per arch	$175	$176
D7971	Excision of pericoronal gingival	$80	$80
D7972	Surgical reduction of fibrous tuberosity	$100	Not Covered
D7980	Sialolithotomy	$155	Not Covered
D7981	Excision of salivary gland, by report	$120	Not Covered

D7982	Sialodochoplasty	$215	Not Covered
D7983	Closure of salivary fistula	$140	Not Covered
D7990	Emergency tracheotomy	$350	Not Covered
D7991	Coronoidectomy	$345	Not Covered
D7995	Synthetic graft – mandible or facial bones, by report	$150	Not Covered
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	$60	Not Covered
D7999	Unspecified oral surgery procedure, by report	$350	Not Covered
(D8000-D8999)	**Orthodontics**		
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$350	Not Covered
D8210	Removable appliance therapy		Not Covered
D8220	Fixed appliance therapy		Not Covered
D8660	Pre-orthodontic treatment visit		Not Covered
D8670	Periodic orthodontic treatment visit (as part of contract)		Not Covered
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))		Not Covered
D8691	Repair of orthodontic appliance		Not Covered
D8692	Replacement of lost or broken retainer		Not Covered
D8693	Rebonding or recementing: and/or repair, as required, of fixed retainers		Not Covered
D8999	Unspecified orthodontic procedure, by report		Not Covered
(D9000-D9999)	**Adjunctive General Services**		
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$30	$28
D9120	Fixed partial denture sectioning	$95	$95
D9210	Local anesthesia not in conjunction with outpatient surgical procedures	$10	$10
D9211	Regional block anesthesia	$20	$20
D9212	Trigeminal division block anesthesia	$60	$60
D9215	Local anesthesia in conjunction with operative or surgical procedures	$15	$15
D9223	Deep sedation/general anesthesia - each 15 minute increment	$45	$45
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	$15	Not Covered
D9241	Intravenous conscious sedation/analgesia – first 30 minutes	$165	Not Covered
D9243	Intraveneous conscious sedation/analgesia - each 15 minute increment	$60	$45
D9248	Non-intravenous conscious sedation	$65	Not Covered
D9310	Consultation **- (**diagnostic service provided by dentist or physician other than requesting dentist or physician)	$50	$45
D9410	House/Extended care facility call	$50	Not Covered
D9420	Hospital or ambulatory surgical center call	$135	Not Covered
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed	$20	$12
D9440	Office visit - after regularly scheduled hours	$45	$40
D9450	Case presentation, detailed and extensive treatment planning	Not Covered	$0
D9610	Therapeutic parenteral drug, single administration	$30	Not Covered
D9612	Therapeutic parenteral drug, two or more administrations, different medications	$40	Not Covered
D9910	Application of desensitizing medicament	$20	$22
D9930	treatment of complications (post-surgical) - unusual circumstances, by report	$35	Not Covered
D9940	Occlusal guards, by report	Not Covered	$115
D9942	Repair and/or reline of occlusal guard	Not Covered	$35
D9950	Occlusion analysis – mounted case	$120	Not Covered

D9951	Occlusal adjustment - limited	$45	$45
D9952	Occlusal adjustment - complete	$210	$210
D9999	unspecified adjunctive procedure, by report	$0	Not Covered

If services for a listed procedure are performed by the assigned PCD, the member pays the specified co-payment.

Benefits are provided if the plan determines the services to be medically necessary.

You may be charged for missed appointments if you do not give the dental office at least 24 hours notice of cancellation.

Listed procedures, which require a dentist to provide specialized services, and are referred by the assigned PCD, must be preauthorized in writing by the Plan. The member pays the co-payment specified for such services. Procedures not listed above are not covered, however may be available at the PCD's contracted fees. "Contracted fees" means the PCD's fees on file with the Plan.

Minimum coverage plan benefits are covered at 100% by the plan after the member meets the medical plan deductible and Annual Out-of-Pocket maximum. Members are responsible for the total cost of the benefit until the deductible is met. Covered preventive and diagnostic services are covered at 100% regardless of deductible and Annual Out of Pocket.

Benefits Description

Diagnostic General Policies (D0100-D0999)

1. **Radiographs (D0210-D0340):**
   - **a)** According to accepted standards of dental practice, the lowest number of radiographs needed to provide the diagnosis shall be taken.
   - b) Original radiographs shall be a part of the patient's clinical record and shall be retained by the provider at all times.
   - c) Radiographs shall be considered current as follows:
     - i) radiographs for treatment of primary teeth within the last eight months.
     - ii) radiographs for treatment of permanent teeth (as well as over-retained primary teeth where the permanent tooth is congenitally missing or impacted) within the last 14 months.
     - iii) radiographs to establish arch integrity within the last 36 months.
   - d) All treatment and post treatment radiographs are included in the fee for the associated procedure and are not payable separately.
2. **Photographs (D0350):**
   - a) Photographs are a part of the patient's clinical record and the provider shall retain original photographs at all times.
   - b) Photographs shall be made available for review upon the request.
3. **Prior authorization is not required for examinations, radiographs or photographs.**

Diagnostic Procedures (D0100-D0999)

PROCEDURE D0120
PERIODIC ORAL EVALUATION - ESTABLISHED PATIENT

A benefit:

a. for patients under the age of 19.

b. once every six months, per provider.

PROCEDURE D0140
LIMITED ORAL EVALUATION - PROBLEM FOCUSED

A benefit:

a. for patients under the age of 19.
b. once per patient per provider.

PROCEDURE D0145
ORAL EVALUATION FOR A PATIENT UNDER THREE YEARS OF AGE AND COUNSELING WITH PRIMARY CAREGIVER

PROCEDURE D0150
COMPREHENSIVE ORAL EVALUATION - NEW OR ESTABLISHED PATIENT

1. A benefit once per patient per provider for the initial evaluation.
2. This procedure is not a benefit when provided on the same date of service with procedures:
   a. limited oral evaluation (D0140),
   b. detailed and extensive oral evaluation- problem focused, by report (D0160),
   c. re-evaluation-limited, problem focused (established patient; not post-operative visit) (D0170).
3. The following procedures are not a benefit when provided on the same date of service with D0150:
   a. periodic oral evaluation (D0120),
   b. office visit for observation (during regularly scheduled hours)-no other services performed (D9430).

PROCEDURE D0160
DETAILED AND EXTENSIVE ORAL EVALUATION - PROBLEM FOCUSED, BY REPORT

1. A benefit once per patient per provider.
   a. The following procedures are not a benefit when provided on the same date of service with D0160: periodic oral evaluation (D0120),
   b. limited oral evaluation-problem focused (D0140),
   c. comprehensive oral evaluation- new or established patient (D0150),
   d. re-evaluation-limited, problem focused (established patient; not post- operative visit) (D0170), office visit for observation (during regularly scheduled hours-no other services performed (D9430).

PROCEDURE D0170
RE-EVALUATION – LIMITED, PROBLEM FOCUSED (ESTABLISHED PATIENT; NOT POST-OPERATIVE VISIT)

1. A benefit for the ongoing symptomatic care of temporomandibular joint dysfunction:
   a. up to six times in a three month period.
   b. up to a maximum of 12 in a 12-month period.

PROCEDURE D0180
COMPREHENSIVE PERIODONTAL EVALUATION - NEW OR ESTABLISHED PATIENT

PROCEDURE D0210
INTRAORAL - COMPLETE SERIES OF RADIOGRAPHIC IMAGES

A benefit once per provider every 36 months.

PROCEDURE D0220
INTRAORAL - PERIAPICAL FIRST RADIOGRAPHIC IMAGE

PROCEDURE D0230
PROCEDURE INTRAORAL - PERIAPICAL EACH ADDITIONAL RADIOGRAPHIC IMAGE

A benefit to a maximum of 20 periapicals in a 12- month period to the same provider, in any combination of the following: intraoral- periapical first radiographic image (D0220) and intraoral- periapical each additional radiographic image (D0230). Periapicals taken as part of an intraoral complete series of radiographic images (D0210) are not considered against the maximum of 20 periapical films in a 12 month period.

PROCEDURE D0240

INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE

A benefit up to a maximum of two in a six-month period per provider.

PROCEDURE D0250 EXTRAORAL - FIRST RADIOGRAPHIC IMAGE

A benefit once per date of service.

PROCEDURE D0270 BITEWING - SINGLE RADIOGRAPHIC IMAGE

1. A benefit once per date of service.
2. Not a benefit for a totally edentulous area.

PROCEDURE D0272 BITEWINGS - TWO RADIOGRAPHIC IMAGES

1. A benefit once every six months per provider.
2. Not a benefit:
   a. within six months of intraoral-complete series of radiographic images (D0210), same provider.
   b. for a totally edentulous area.

PROCEDURE D0273 BITEWINGS - THREE RADIOGRAPHIC IMAGES

PROCEDURE D0274 BITEWINGS - FOUR RADIOGRAPHIC IMAGES

1. A benefit once every six months per provider.
2. Not a benefit:
   a. within six months of intraoral-complete series of radiographic images (D0210), same provider.
   b. for patients under the age of 10
   c. for a totally edentulous area.

PROCEDURE D0277 VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC IMAGES

This procedure can only be billed as bitewings-four radiographic images (D0274). The maximum payment is for four bitewings.

PROCEDURE D0290 POSTERIOR - ANTERIOR OR LATERAL SKULL AND FACIAL BONE SURVEY RADIOGRAPHIC IMAGE

A benefit:

a. for the survey of trauma or pathology.

b. for a maximum of three per date of service.

PROCEDURE D0310 SIALOGRAPHY

PROCEDURE D0320 TEMPOROMANDIBULAR JOINT ARTHROGRAM, INCLUDING INJECTION

A benefit:

a. for the survey of trauma or pathology.

b. for a maximum of three per date of service.

PROCEDURE D0322 TOMOGRAPHIC SURVEY

A benefit twice in a 12 month period per provider.

PROCEDURE D0330 PANORAMIC RADIOGRAPHIC IMAGE

1. A benefit once in a 36-month period per provider, except when documented as essential for a follow-up/ post-operative exam (such as after oral surgery).
2. Not a benefit, for the same provider, on the same date of service as an intraoral- complete series of radiographic images (D0210).
3. This procedure shall be considered part of an intraoral- complete series of radiographic images (D0210) when taken on the same date of service with bitewings (D0272 or D0274) and a minimum of two (2) intraoral-periapicals each additional radiographic image (D0230).

PROCEDURE D0340 CEPHALOMETRIC RADIOGRAPHIC IMAGE

A benefit twice in a 12-month period per provider.

PROCEDURE D0350 ORAL/FACIAL PHOTOGRAPHIC IMAGES

A benefit up to a maximum of four per date of service.

PROCEDURE D0460 PULP VITALITY TESTS

PROCEDURE D0470 DIAGNOSTIC CASTS

1. Diagnostic casts are for the evaluation of orthodontic benefits only.
2. Diagnostic casts are required to be submitted for orthodontic evaluation and are payable only upon authorized orthodontic treatment. Do not send original casts, as casts will not be returned.
3. A benefit:
   a. once per provider

unless special circumstances are documented (such as trauma or pathology which has affected the course of orthodontic treatment).

b. for patients under the age of 19.

c. for permanent dentition (unless over the age of 13 with primary teeth still present or has a cleft palate or craniofacial anomaly).

d. only when provided by a Specialty Care orthodontist.

PROCEDURE D0502 OTHER ORAL PATHOLOGY PROCEDURES BY REPORT

PROCEDURE D0601 CARIES RISK ASSESSMENT AND DOCUMENTATION< WITH A FINDING OF LOW RISK

PROCEDURE D0602 CARIES RISK ASSESSMENT AND DOCUMENTATION< WITH A FINDING OF MODERATE RISK

PROCEDURE D0603 CARIES RISK ASSESSMENT AND DOCUMENTATION< WITH A FINDING OF HIGH RISK

PROCEDURE D0999 UNSPECIFIED DIAGNOSTIC PROCEDURE, BY REPORT

Preventive General Policies (D1000-D1999)

1. **Dental Prophylaxis and Fluoride Treatment (D1110-D1208):**

   a. Dental prophylaxis (D1110 and D1120) is defined as the preventive dental procedure of coronal scaling and polishing which includes the complete removal of calculus, soft deposits, plaque, stains and smoothing of unattached tooth surfaces.

   b. Fluoride treatment (D1206 and D1208) is a benefit only for prescription strength fluoride products.

   c. Fluoride treatments do not include treatments that incorporate fluoride with prophylaxis paste, topical application of fluoride to the prepared portion of a tooth prior to restoration and applications of aqueous sodium fluoride.

   d. The application of fluoride is only a benefit for caries control and as a full mouth treatment regardless of the number of teeth treated.

   e. Prophylaxis and fluoride procedures (D1120, D1206 and D1208) are a benefit once in a six-month period without prior authorization under the age of 19

   f. Prophylaxis and fluoride procedures (D1110, D1206 and D1208) are a benefit once in a 12-month period without prior authorization for age 19 or older.

   g. Additional requests, beyond the stated frequency limitations, for prophylaxis and fluoride procedures (D1110, D1120, D1206 and D1208) shall be considered for prior authorization when documented medical necessity is justified due to a physical limitation and/or an oral condition that prevents daily oral hygiene.

Preventive Procedures (D1000-D1999)

PROCEDURE D1110
PROPHYLAXIS - ADULT

A benefit once in a 12- month period for patients age 19 or older. Frequency limitations shall apply toward prophylaxis procedure D1120.

PROCEDURE D1120
PROPHYLAXIS - CHILD

A benefit once in a six- month period for patients under the age of 19.

PROCEDURE D1206
TOPICAL APPLICATION OF FLUORIDE VARNISH

A benefit:

a. once in a six month period for patients under the age of 19. Frequency limitations shall apply toward topical application of fluoride(D1208).

b. once in a 12 month period for patients age 19 or older. Frequency limitations shall apply toward topical application of fluoride(D1208).

PROCEDURE D1208
TOPICAL APPLICATION OF FLUORIDE

A benefit:

a. once in a six month period for patients under the age of 19. Frequency limitations shall apply toward topical application of fluoride varnish (D1206).

b. once in a 12 month period for patients age 19 or older. Frequency limitations shall apply toward topical application of fluoride varnish (D1206).

PROCEDURE D1310
NUTRITIONAL COUNSELING FOR CONTROL OF DENTAL DISEASE

PROCEDURE D1320
TOBACCO COUNSELING FOR THE CONTROL AND PREVENTION OF ORAL DISEASE

PROCEDURE D1330
ORAL HYGIENE INSTRUCTIONS

PROCEDURE D1351
SEALANT - PER TOOTH

A benefit:

a. for first, second and third permanent molars that occupy the second molar position.

b. only on the occlusal surfaces that are free of decay and/or restorations.

c. for patients under the age of 19.

d. once per tooth every 36 months per provider regardless of surfaces sealed.

PROCEDURE D1352
PREVENTIVE RESIN RESTORATIONIN A MODERATE TO HIGH CARIES RISK PATIENT-PERMANENT TOOTH

A benefit:

a. for first, second and third permanent molars that occupy the second molar position.

b. only for an active cavitated lesion in a pit or fissure that does not cross the DEJ.

c. for patients under the age of 19.

d. once per tooth every 36 months per provider regardless of surfaces sealed.

2. **PROCEDURE D1510**
3. **SPACE MAINTAINER - FIXED UNILATERAL**

1. A benefit:

   a. once per quadrant per patient.

   b. for patients under the age of 18.

   c. only to maintain the space for a single tooth.

2. Not a benefit:

   a. when the permanent tooth is near eruption or is missing.

   b. for upper and lower anterior teeth.

   c. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.

PROCEDURE D1515
SPACE MAINTAINER - FIXED - BILATERAL

A benefit:

once per arch when there is a missing primary molar in both quadrants or when there are two missing primary molars in the same quadrant for patients under the age of 18.

Not a benefit:

a. when the permanent tooth is near eruption or is missing.

b. for upper and lower anterior teeth.

c. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.

PROCEDURE D1520 SPACE MAINTAINER - REMOVABLE - UNILATERAL

1. A benefit:
   a. once per quadrant per patient.
   b. for patients under the age of 18.
   c. only to maintain the space for a single tooth.
2. Not a benefit:
   a. when the permanent tooth is near eruption or is missing.
   b. for upper and lower anterior teeth.
   c. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.

PROCEDURE D1525 SPACE MAINTAINER - REMOVABLE - BILATERAL

1. A benefit:
   a. once per arch when there is a missing primary molar in both quadrants or when there are two missing primary molars in the same quadrant.
   b. for patients under the age of 18.
2. Not a benefit:

a. when the permanent tooth is near eruption or is missing.

b. for upper and lower anterior teeth.

c. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.

PROCEDURE D1550 RECEMENTATION OF SPACE MAINTAINER

1. A benefit:
   a. once per provider, per applicable quadrant or arch.
   b. for patients under the age of 18.

PROCEDURE D1555 REMOVAL OF FIXED SPACE MAINTAINER

Restorative General Policies (D2000-D2999)

1. **Amalgam and Resin-Based Composite Restorations (D2140-D2394):**

   a) Restorative services shall be a benefit when medically necessary, when carious activity or fractures have extended through the dentinoenamel junction (DEJ) and when the tooth demonstrates a reasonable longevity.

   b) Anterior proximal restorations (amalgam/composite) submitted as a two or three surface restoration shall be clearly demonstrated on radiographs that the tooth structure is involved to a point one-third the mesial–distal width of the tooth.

   c) Restorative services provided solely to replace tooth structure lost due to attrition, abrasion, erosion or for cosmetic purposes are not a benefit.

   d) Restorative services are not a benefit when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement.

   e) Restorations for primary teeth near exfoliation are not a benefit.

   f) The five valid tooth surface classifications are mesial, distal, occlusal/incisal, lingual and facial (including buccal and labial).

   g) Each separate non-connecting restoration on the same tooth for the same date of service shall be submitted on separate Claim Service Lines (CSLs). All surfaces on a single tooth restored with the same restorative material shall be considered connected, for payment purposes, if performed on the same date of service.

   h) Tooth and soft tissue preparation, crown lengthening, cement bases, direct and indirect pulp capping, bonding agents, lining agents, occlusal adjustments (D9951), polishing, local anesthesia and any other associated procedures are included in the fee for a completed restorative service.

   i) The original provider is responsible for any replacement restorations necessary in primary teeth within the first 12 months and permanent teeth within the first 36 months, except when failure or breakage results from circumstances beyond the control of the provider (such as due to a patient's oral habits).

   j) Replacement of otherwise satisfactory amalgam restorations with resin-based composite restorations is not a benefit unless a specific allergy has been documented by a medical specialist (allergist) on their professional letterhead or prescription and submitted for payment.

2. **Prefabricated Crowns (D2929-D2933):**

   A) Primary Teeth:

      a) Prefabricated crowns (D2929, D2930, D2932 and D2933) are a benefit only once in a 12-month period.

      b) Primary teeth do not require prior authorization. At least one of the following criteria shall be met for coverage:

         i. decay, fracture or other damage involving three or more tooth surfaces,

         ii. decay, fracture or other damage involving one interproximal surface when the damage has extended extensively buccolingually or mesiodistally,

      c) Prefabricated crowns for primary teeth near exfoliation are not a benefit.

   B) Permanent Teeth:

      a) Prefabricated crowns (D2931, D2932 and D2933) are a benefit only once in a 36-month period.

      b) Permanent teeth do not require prior authorization. At least one of the following

criteria shall be met for coverage:

i. Anterior teeth shall show traumatic or pathological destruction of the crown of the tooth which involves four or more tooth surfaces including at least the loss of one incisal angle,

ii. bicuspids (premolars) shall show traumatic or pathological destruction of the crown of the tooth which involves three or more tooth surfaces including at least one cusp,

iii. molars shall show traumatic or pathological destruction of the crown of the tooth which involves four or more tooth surfaces including at least two cusps,

iv. the prefabricated crown shall restore an endodontically treated bicuspid or molar tooth.

v. Arch integrity and the overall condition of the mouth, including the patient's ability to maintain oral health, shall be considered based upon a supportable 36-month prognosis for the permanent tooth to be crowned.

vi. Indirectly fabricated or prefabricated posts (D2952 and D2954) are benefits when medically necessary for the retention of prefabricated crowns on root canal treated permanent teeth.

vii. Prefabricated crowns on root canal treated teeth shall be considered for payment only after satisfactory completion of root canal therapy.

viii. Prefabricated crowns are not a benefit for abutment teeth for cast metal framework partial dentures (D5213 and D5214).

C) Primary and Permanent Teeth:

i. Prefabricated crowns provided solely to replace tooth structure lost due to attrition, abrasion, erosion or for cosmetic purposes are not a benefit.

ii. Prefabricated crowns are not a benefit when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement.

iii. Prefabricated crowns are not a benefit when a tooth can be restored with an amalgam or resin-based composite restoration.

iv. Tooth and soft tissue preparation, crown lengthening, cement bases, direct and indirect pulp capping, amalgam or acrylic buildups, pins (D2951), bonding agents, occlusal adjustments (D9951), local anesthesia (D9210) and any other associated procedures are included in the fee for a prefabricated crown.

3. Laboratory Processed Crowns (D2710-D2792):

a) Laboratory processed crowns on permanent teeth (or over-retained primary teeth with no permanent successor) are a benefit only once in a 5 year period except when failure or breakage results from circumstances beyond the control of the provider (such as due to a patient's oral habits).

b) A benefit for patients age 13 or older when a lesser service will not suffice because of extensive coronal destruction.

i) Anterior teeth shall show traumatic or pathological destruction to the crown of the tooth, which involves at least one of the following:

a. the involvement of four or more surfaces including at least one incisal angle. The facial or lingual surface shall not be considered involved for a mesial or proximal restoration unless the proximal restoration wraps around the tooth to at least the midline,

b. the loss of an incisal angle which involves a minimum area of both half the incisal width and half the height of the anatomical crown,

c. an incisal angle is not involved but more than 50% of the anatomical crown is

involved

ii) Bicuspids (premolars) shall show traumatic or pathological destruction of the crown of the tooth, which involves three or more tooth surfaces including one cusp.

iii) Molars shall show traumatic or pathological destruction of the crown of the tooth, which involves four or more tooth surfaces including two or more cusps.

iv) Posterior crowns for patients age 19 or older are a benefit only when they act as an abutment for a removable partial denture with cast clasps or rests (D5213 and D5214) or for a fixed partial denture which meets current criteria.

c) Restorative services provided solely to replace tooth structure lost due to attrition, abrasion, erosion or for cosmetic purposes are not a benefit.

d) Laboratory crowns are not a benefit when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement.

e) Laboratory processed crowns are not a benefit when the tooth can be restored with an amalgam or resin-based composite.

f) Tooth and soft tissue preparation, crown lengthening, cement bases, direct and indirect pulp capping, amalgam or acrylic buildups, pins (D2951), bonding agents, lining agents, impressions, temporary crowns, occlusal adjustments (D9951), polishing, local anesthesia (D9210) and any other associated procedures are included in the fee for a completed laboratory processed crown.

g) Indirectly fabricated or prefabricated posts (D2952 and D2954) are a benefit when medically necessary for the retention of allowable laboratory processed crowns on root canal treated permanent teeth.

h) Partial payment will not be made for an undelivered laboratory processed crown. Payment shall be made only upon final cementation

Restorative Procedures (D2000-D2999)

PROCEDURE D2140
AMALGAM - ONE SURFACE, PRIMARY OR PERMANENT

Primary teeth:

A benefit once in a 12- month period.

Permanent teeth:

A benefit once in a 36- month period.

PROCEDURE D2150
AMALGAM - TWO SURFACES, PRIMARY OR PERMANENT

See the criteria under Procedure D2140.

PROCEDURE D2160
AMALGAM - THREE SURFACES, PRIMARY OR PERMANENT

See the criteria under Procedure D2140.

PROCEDURE D2161
AMALGAM - FOUR OR MORE SURFACES, PRIMARY OR PERMANENT

See the criteria under Procedure D2140

PROCEDURE D2330
RESIN-BASED COMPOSITE - ONE SURFACE, ANTERIOR

Primary teeth:
A benefit once in a 12-month period.

Permanent teeth:
A benefit once in a 36-month period.

PROCEDURE D2331
RESIN-BASED COMPOSITE - TWO SURFACES, ANTERIOR

Primary teeth:

A benefit once in a 12- month period.

Permanent teeth:

A benefit once in a 36-month period

PROCEDURE D2332
RESIN-BASED COMPOSITE - THREE SURFACES, ANTERIOR

See the criteria under Procedure D2331.

PROCEDURE D2335
RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES OR INVOLVING INCISAL ANGLE (ANTERIOR)

See the criteria under Procedure D2331.

PROCEDURE D2390
RESIN-BASED COMPOSITE CROWN, ANTERIOR

Primary teeth:

A benefit once in a 12- month period.

Permanent teeth:

A benefit once in a 36 month period.

PROCEDURE D2391
RESIN-BASED COMPOSITE - ONE SURFACE, POSTERIOR

Primary teeth:

A benefit once in a 12- month period.

Permanent teeth:

A benefit once in a 36- month period.

PROCEDURE D2392
RESIN-BASED COMPOSITE - TWO SURFACES, POSTERIOR

See the criteria under Procedure D2391.

PROCEDURE D2393
RESIN-BASED COMPOSITE - THREE SURFACES, POSTERIOR

See the criteria under Procedure D2391.

A benefit once in a 36- month period.

PROCEDURE D2394
RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES, POSTERIOR

See the criteria under Procedure D2391.

PROCEDURE D2710
CROWN – RESIN– BASED COMPOSITE (INDIRECT)

Permanent anterior teeth (age 13 or older) and permanent posterior teeth (ages 13 through 19):

1. A benefit:
   a. once in a five-year period.
   b. for any resin based composite crown that is indirectly fabricated.
2. Not a benefit:
   a. for patients under the age of 13.
   b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
3. for use as a temporary crown.

Permanent posterior teeth (age 19 or older):

A benefit:

a. once in a five-year

period.

b. for any resin based composite crown that is indirectly fabricated.

c. only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests (D5213 and D5214), or

d. when the treatment plan includes an abutment crown and removable partial denture (D5213 or D5214).

Not a benefit:

e. for 3rd molars, unless the 3rd molar is an abutment for an existing removable partial denture with cast clasps or rests.

f. for use as a temporary crown.

PROCEDURE D2712 CROWN – 3/4 RESIN- BASED COMPOSITE (INDIRECT)

Permanent anterior teeth (age 13 or older) and permanent posterior teeth (ages 13 through 19):

1. A benefit:

   a. once in a five-year period.

   b. for any resin based composite crown that is indirectly fabricated.

2. Not a benefit:

   a. for patients under the age of 13.

   b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.

   c. for use as a temporary crown.

Permanent posterior teeth (age 19 or older):

1. A benefit:

   a. once in a five-year period.

   b. for any resin based composite crown that is indirectly fabricated.

   c. only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests (D5213 and D5214), or

2. Not a benefit:

   a. for 3rd molars, unless the 3rd molar is an abutment for an existing removable partial denture with cast clasps or rests.

   b. for use as a temporary crown.

PROCEDURE D2721 CROWN - RESIN WITH PREDOMINANTLY BASE METAL

Permanent anterior teeth (age 13 or older) and permanent posterior teeth (ages 13 through 19):

1. A benefit once in a five- year period.

2. Not a benefit:

   a. for patients under the age of 13.

   b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.

Permanent posterior teeth (age 21 or older):

1. A benefit:

   a. once in a five-year period.

   b. only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests (D5213 and D5214), or

2. Not a benefit for 3rd molars, unless the 3rd molar is an abutment for an existing removable partial denture with cast clasps or rests.

PROCEDURE D2740 CROWN - PORCELAIN/CERAMIC SUBSTRATE

Permanent anterior teeth

(age 13 or older) and permanent posterior teeth

(ages 13 through 19):

1. A benefit once in a five- year period.

2. Not a benefit:

   a. for patients under the age of 13.

   b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.

Permanent posterior teeth (age 19 or older):

1. A benefit:

a. once in a five-year period.

b. only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests (D5213 and D5214), or

2. Not a benefit for 3rd molars, unless the 3rd molar is an abutment for an existing removable partial denture with cast clasps or rests.

PROCEDURE D2751 CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL

Permanent anterior teeth (age 13 or older) and permanent posterior teeth (ages 13 through 19):

1. A benefit once in a five- year period.
2. Not a benefit:

a. for beneficiaries under the age of 13.

b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.

Permanent posterior teeth (age 19 or older):

1. A benefit:

a. once in a five-year period.

b. only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests (D5213 and D5214), or

c. when the treatment plan includes an abutment crown and removable partial denture (D5213 or D5214).

2. Not a benefit for 3rd molars, unless the 3rd molar is an abutment for an existing removable partial denture with cast clasps or rests.

PROCEDURE D2781 CROWN - 3/4 CAST PREDOMINANTLY BASE METAL

Permanent anterior teeth (age 13 or older) and permanent posterior teeth (ages 13 through 19):

1. A benefit once in a five- year period.
2. Not a benefit:

a. for patients under the age of 13.

b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.

Permanent posterior teeth (age 21 or older):

1. A benefit:

a. once in a five- year period.

b. only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests (D5213 and D5214), or

2. Not a benefit for 3rd molars, unless the 3rd molar is an abutment for an existing removable partial denture with cast clasps or rests.

PROCEDURE D2783 CROWN - 3/4 PORCELAIN / CERAMIC

Permanent anterior teeth (age 13 or older) and permanent posterior teeth (ages 13 through 19):

1. A benefit once in a five-year period.
2. Not a benefit:

a. for patients under the age of 13.

b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.

Permanent posterior teeth (age 19 or older):

1. A benefit:

a. once in a five- year period.

b. only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests (D5213 and D5214), or

2. Not a benefit for 3rd molars, unless the 3rd molar is an abutment for an existing removable

partial denture with cast clasps or rests.

PROCEDURE D2791 CROWN - FULL CAST PREDOMINANTLY BASE METAL

Permanent anterior teeth (age 13 or older) and permanent posterior teeth (ages 13 through 19):

1. A benefit once in a five- year period.
2. Not a benefit:
   a. for patients under the age of 13.
   b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.

Permanent posterior teeth (age 19 or older):

1. A benefit:
   a. once in a five-year period.
2. Not a benefit for 3rd molars, unless the 3rd molar is an abutment for an existing removable partial denture with cast clasps or rests.

PROCEDURE D2910 RECEMENT INLAY, ONLAY, OR PARTIAL COVERAGE RESTORATION

A benefit once in a 12-month period, per provider.

PROCEDURE D2915 RECEMENT CAST OR PREFABRICATED POST AND CORE

PROCEDURE D2920 RECEMENT CROWN

Not a benefit within 12 months of a previous re-cementation by the same provider.

PROCEDURE D2929 PREFABRICATED PORCELAIN/ CERAMIC CROWN - PRIMARY TOOTH

A benefit once in a 12- month period.

PROCEDURE D2930 PREFABRICATED STAINLESS STEEL CROWN - PRIMARY TOOTH

A benefit once in a 12- month period.

PROCEDURE D2931 PREFABRICATED STAINLESS STEEL CROWN - PERMANENT TOOTH

1. A benefit once in a 36-month period.
2. Not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.

PROCEDURE D2932 PREFABRICATED RESIN CROWN

Primary teeth:

1. A benefit once in a 12- month period.

Permanent teeth:

2. A benefit once in a 36- month period.
3. Not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.

PROCEDURE D2933 PREFABRICATED STAINLESS STEEL CROWN WITH RESIN WINDOW

Primary teeth:

1. A benefit once in a 12-month period.
2. This procedure includes the placement of a resin-based composite.

Permanent teeth:

1. A benefit once in a 36-month period.
2. Not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.
3. This procedure includes the placement of a resin-based composite.

PROCEDURE D2940 PROTECTIVE RESTORATION

1. A benefit once per tooth in a six-month period, per provider.
2. Not a benefit:
   a. when performed on the same date of service with a permanent restoration or crown, for same tooth.
   b. on root canal treated teeth.

PROCEDURE D2950 CORE BUILDUP, INCLUDING ANY PINS

This procedure is included in the fee for restorative procedures and is not payable separately.

PROCEDURE D2951 PIN RETENTION - PER TOOTH, IN ADDITION TO RESTORATION

A benefit:

a. for permanent teeth only.
b. when billed with an amalgam or composite

restoration on the same date of service.

c. once per tooth regardless of the number of pins placed.

d. for a posterior restoration when the destruction involves three or more connected surfaces and at least one cusp, or

e. for an anterior restoration when extensive coronal destruction involves the incisal angle.

PROCEDURE D2952 POST AND CORE IN ADDITION TO CROWN, INDIRECTLY FABRICATED

1. A benefit:

   a. once per tooth regardless of number of posts placed.

   b. only in conjunction with allowable crowns (prefabricated or laboratory processed) on root canal treated permanent teeth.

PROCEDURE D2953 EACH ADDITIONAL INDIRECTLY FABRICATED POST - SAME TOOTH

This procedure is to be performed in conjunction with D2952

PROCEDURE D2954 PREFABRICATED POST AND CORE IN ADDITION TO CROWN

A benefit:

a. once per tooth regardless of number of posts placed.

b. only in conjunction with allowable crowns (prefabricated or laboratory processed) on root canal treated permanent teeth.

PROCEDURE D2955 POST REMOVAL

This procedure is included in the fee for endodontic and restorative procedures and is not payable separately.

PROCEDURE D2957 EACH ADDITIONAL PREFABRICATED POST - SAME TOOTH

This procedure is to be performed in conjunction with D2954 and is not payable separately.

PROCEDURE D2971 ADDITIONAL PROCEDURES TO CONSTRUCT NEW CROWN UNDER EXISTING PARTIAL DENTURE FRAMEWORK

This procedure is included in the fee for laboratory processed crowns and is not payable separately.

PROCEDURE D2980 CROWN REPAIR NECESSITATED BY RESTORATIVE MATERIAL FAILURE

Not a benefit within 12 months of initial crown placement or previous repair for the same provider.

PROCEDURE D2999 UNSPECIFIED RESTORATIVE PROCEDURE, BY REPORT

1. This procedure does not require prior authorization.

2. Procedure D2999 shall be used:

   a. for a procedure which is not adequately described by a CDT code, or

   b. for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the medical condition and the specific CDT code associated with the treatment.

Endodontic General Policies (D3000-D3999)

a) Prior authorization with current periapical radiographs is required for initial root canal therapy (D3310, D3320 and D3330), root canal retreatment (D3346, D3347 and D3348), partial pulpotomy for apexogenesis (D3222), apexification/recalcification (D3351) and apicoectomy/periradicular surgery (D3410, D3421, D3425 and D3426) on permanent teeth.

b) Root canal therapy (D3310, D3320, D3330, D3346, D3347 and D3348) is a benefit for permanent teeth and over-retained primary teeth with no permanent successor, if medically necessary. It is medically necessary when the tooth is non-vital (due to necrosis, gangrene or death of the pulp) or if the pulp has been compromised by caries, trauma or accident that may lead to the death of the pulp.

c) Endodontic procedures are not a benefit when the prognosis of the tooth is questionable (due to non- restorability or periodontal involvement).

d) Endodontic procedures are not a benefit when extraction is appropriate for a tooth due to non-restorability, periodontal involvement or for a tooth that is easily replaced by an addition to an existing or proposed prosthesis in the same arch.

e) Endodontic procedures are not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar positions or is an abutment for an existing fixed or removable partial denture with cast clasps or rests.

f) The fee for endodontic procedures includes all treatment and post treatment radiographs, any temporary restorations and/or occlusal seals, medicated treatments, bacteriologic studies, pulp vitality tests, removal of root canal obstructions (such as posts, silver points, old root canal filling material, broken root canal files and broaches and calcifications), internal root repairs of perforation defects and routine postoperative care within 30 days.

g) Endodontic procedures shall be completed prior to payment. The date of service on the payment request shall reflect the final treatment date.

h) Satisfactory completion of endodontic procedures is required prior to requesting the final restoration.

Endodontic Procedures (D3000-D3999)

PROCEDURE D3110 PULP CAP - DIRECT (EXCLUDING FINAL RESTORATION)

PROCEDURE D3120 PULP CAP - INDIRECT (EXCLUDING FINAL RESTORATION)

PROCEDURE D3220 THERAPEUTIC PULPOTOMY (EXCLUDING FINAL RESTORATION) - REMOVAL OF PULP CORONAL TO THE DENTINOCEMENTAL JUNCTION AND APPLICATION OF MEDICAMENT

1. A benefit once per primary tooth.
2. Not a benefit:
   a. for a primary tooth near exfoliation.
   b. for a primary tooth with a necrotic pulp or a periapical lesion.
   c. for a primary tooth that is non-restorable.
   d. for a permanent tooth.

PROCEDURE D3221 PULPAL DEBRIDEMENT, PRIMARY AND PERMANENT TEETH

1. A benefit:
   a. for permanent teeth.
   b. for over-retained primary teeth with no permanent successor.
   c. once per tooth.

PROCEDURE D3222 PARTIAL PULPOTOMY FOR APEXOGENESIS- PERMANENT TOOTH WITH INCOMPLETE ROOT DEVELOPMENT

1. A benefit:
   a. once per permanent tooth.
   b. for patients under the age of 19.
2. Not a benefit:
   a. for primary teeth.
   b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.

PROCEDURE D3230 PULPAL THERAPY (RESORBABLE FILLING) - ANTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION)

1. A benefit once per primary tooth.
2. Not a benefit:
   a. for a primary tooth near exfoliation.
   b. with a therapeutic pulpotomy (excluding final restoration) (D3220), same date of service, same tooth.
   c. with pulpal debridement, primary and permanent teeth (D3221), same date of service, same tooth.

PROCEDURE D3240 PULPAL THERAPY (RESORBABLE FILLING) - POSTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION)

1. A benefit once per primary tooth.
2. Not a benefit:
   a. for a primary tooth near exfoliation.
   b. with a therapeutic pulpotomy (excluding final restoration) (D3220), same date of service, same tooth.
   c. with pulpal debridement, primary and permanent teeth (D3221), same date of service, same tooth.

PROCEDURE D3310 ENDODONTIC THERAPY, ANTERIOR TOOTH (EXCLUDING FINAL RESTORATION)

1. A benefit once per tooth for initial root canal therapy treatment. For root canal therapy retreatment use retreatment of previous root canal therapy-anterior (D3346).
2. The fee for this procedure includes all treatment and post treatment radiographs, any temporary restoration and/or occlusal seal.

PROCEDURE D3320 ENDODONTIC THERAPY, BICUSPID TOOTH (EXCLUDING FINAL RESTORATION)

1. A benefit once per tooth for initial root canal therapy

treatment. For root canal therapy retreatment use retreatment of previous root canal therapy-bicuspid (D3347).

The fee for this procedure includes all treatment and post treatment radiographs, any temporary restoration and/or occlusal seal.

PROCEDURE D3330 ENDODONTIC THERAPY, MOLAR TOOTH (EXCLUDING FINAL RESTORATION)

1. A benefit once per tooth for initial root canal therapy treatment.
2. Not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
3. The fee for this procedure includes all treatment and post treatment radiographs, any temporary restoration and/or occlusal seal.

PROCEDURE D3331 TREATMENT OF ROOT CANAL OBSTRUCTION; NON-SURGICAL ACCESS

This procedure is to be performed in conjunction with endodontic procedures and is not payable separately.

PROCEDURE D3332 INCOMPLETE ENDODONTIC THERAPY; INOPERABLE, UNRESTORABLE OR FRACTURED TOOTH

Endodontic treatment is only payable upon successful completion of endodontic therapy.

PROCEDURE D3333 INTERNAL ROOT REPAIR OF PERFORATION DEFECTS

This procedure is to be performed in conjunction with endodontic procedures and is not payable separately.

PROCEDURE D3346 RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - ANTERIOR

1. Not a benefit to the original provider within 12 months of initial treatment.
2. The fee for this procedure includes all treatment and post treatment radiographs, any temporary restoration and/or occlusal seal.

PROCEDURE D3347 RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - BICUSPID

1. Not a benefit to the original provider within 12 months of initial treatment.
2. The fee for this procedure includes all treatment and post treatment radiographs, any temporary restoration and/or occlusal seal.

PROCEDURE D3348 RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - MOLAR

1. Not a benefit:
   a. to the original provider within 12 months of initial treatment.
   b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
2. The fee for this procedure includes all treatment and post treatment radiographs, any temporary restoration and/or occlusal seal.

PROCEDURE D3351 APEXIFICATION/ RECALCIFICATION/PULPAL REGENERATION - INITIAL VISIT (APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, PULP SPACE DISINFECTION ETC.)

1. A benefit:
   a. once per permanent tooth.
   b. for patients under the age of 19.
2. Not a benefit:
   a. for primary teeth.
   b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
   c. on the same date of service as any other endodontic procedures for the

same tooth.

3. This procedure includes initial opening of the tooth, performing a pulpectomy, preparation of canal spaces, placement of medications and all treatment and post treatment radiographs.

PROCEDURE D3352 APEXIFICATION/ RECALCIFICATION/PULPAL REGENERATION - INTERIM MEDICATION REPLACEMENT

1. A benefit:
   a. only following apexification/ recalcification- initial visit (apical closure/ calcific repair of perforations, root resorption, etc.) (D3351).
   b. once per permanent tooth.
   c. for patients under the age of 19.
2. Not a benefit:
   a. for primary teeth.
   b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
   c. on the same date of service as any other endodontic procedures for the same tooth.
3. This procedure includes reopening the tooth, placement of medications and all treatment and post treatment radiographs.

PROCEDURE D3353 APEXIFICATION/ RECALCIFICATION - FINAL VISIT (INCLUDES COMPLETED ROOT CANAL THERAPY - APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, ETC.)

This procedure is not a benefit.

PROCEDURE D3410 APICOECTOMY/ PERIRADICULAR SURGERY - ANTERIOR

1. A benefit for permanent anterior teeth only.
2. Not a benefit:
   a. to the original provider within 90 days of root canal therapy except when a medical necessity is documented.
   b. to the original provider within 24 months of a prior apicoectomy/ periradicular surgery.

PROCEDURE D3421 APICOECTOMY/ PERIRADICULAR SURGERY - BICUSPID (FIRST ROOT)

1. A benefit for permanent bicuspid teeth only.
2. Not a benefit:
   a. to the original provider within 90 days of root canal therapy except when a medical necessity is documented.
   b. to the original provider within 24 months of a prior apicoectomy/ periradicular surgery, same root.

PROCEDURE D3425 APICOECTOMY/ PERIRADICULAR SURGERY - MOLAR (FIRST ROOT)

1. Requires a tooth code.
2. A benefit for permanent 1st and 2nd molar teeth only.
3. Not a benefit:
   a. to the original provider within 90 days of root canal therapy except when a medical necessity is documented.
   b. to the original provider within 24 months of a prior apicoectomy/ periradicular surgery, same root.
   c. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.

PROCEDURE D3426 APICOECTOMY/ PERIRADICULAR SURGERY (EACH ADDITIONAL ROOT)

1. A benefit for permanent teeth only.
2. Not a benefit:
   a. to the original provider within 90 days of root canal therapy except when a medical necessity is documented.
   b. to the original provider within 24 months of a prior apicoectomy/

periradicular surgery, same root.

c. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.

PROCEDURE D3430 RETROGRADE FILLING - PER ROOT

This procedure is to be performed in conjunction with endodontic procedures and is not payable separately.

PROCEDURE D3910 ISOLATION OF TOOTH WITH RUBBER DAM

This procedure is included in the fees for restorative and endodontic procedures and is not payable separately.

PROCEDURE D3999 UNSPECIFIED ENDODONTIC PROCEDURE, BY REPORT

1. Procedure D3999 shall be used:

a. for a procedure which is not adequately described by a CDT code, or

b. for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the medical condition and the specific CDT code associated with the treatment.

Periodontal General Policies (D4000-D4999)

a. Periodontal procedures shall be a benefit for patients age 13 or older. Periodontal procedures shall be considered for patients under the age of 13 when unusual circumstances exist such as aggressive periodontitis and drug-induced hyperplasia and the medical necessity has been fully documented.

b. Prior authorization is required for all periodontal procedures except for unscheduled dressing change (by someone other than the treating dentist) (D4290) and periodontal maintenance (D4910).

c. Only teeth that qualify as diseased are to be considered in the count for the number of teeth to be treated in a particular quadrant. A qualifying tooth shall have a significant amount of bone loss, presence of calculus deposits, be restorable and have arch integrity. Qualifying teeth include implants. Teeth shall not be counted as qualifying when they are indicated to be extracted. Full or partial quadrants are defined as follows:

   i) a full quadrant is considered to have four or more qualifying diseased teeth,

   ii) a partial quadrant is considered to have one, two, or three diseased teeth,

   iii) third molars shall not be counted unless the third molar occupies the first or second molar position or is an abutment for an existing fixed or removable partial denture with cast clasps or rests.

d. Tooth bounded spaces shall only be counted in conjunction with osseous surgeries (D4260 and D4261) that require a surgical flap. Each tooth bounded space shall only count as one tooth space regardless of the number of missing natural teeth in the space.

e. Scaling and root planing (D4341 and D4342) are a benefit once per quadrant in a 24 month period. Patients shall exhibit connective tissue attachment loss and radiographic evidence of bone loss and/or subgingival calculus deposits on root surfaces.

f. Gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261) are a benefit once per quadrant in a 36 month period and shall not be authorized until 30 days following scaling and root planing (D4341 and D4342) in the same quadrant. Patients shall exhibit radiographic evidence of moderate to severe bone loss to qualify for osseous surgery.

g. Gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261) includes three months of post-operative care and any surgical re-entry for 36 months. Documentation of extraordinary circumstances and/or medical conditions will be given consideration on a case-by- case basis.

h. Scaling and root planing (D4341 and D4342) can be authorized in conjunction with prophylaxis procedures (D1110 and D1120). However, payment shall not be made for any prophylaxis procedure if the prophylaxis is performed on the same date of service as the scaling and root planing.

i. Gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261) includes frenulectomy (frenectomy or frenotomy) (D7960), frenuloplasty (D7963) and/or distal wedge performed in the same area on the same date of service.

j. Procedures involved in acquiring graft tissues (hard or soft) from extra-oral donor sites are considered part of the fee for osseous surgery (D4260 and D4261) and are not payable separately.

k. Gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261) performed in conjunction with a laboratory crown, prefabricated crown, amalgam or resin-based composite restoration or endodontic therapy is included in the fee for the final restoration or endodontic therapy and is not payable separately.

Periodontal Procedures (D4000-D4999)

PROCEDURE D4210 GINGIVECTOMY OR GINGIVOPLASTY- FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT

1. If three or fewer diseased teeth are present in the quadrant, use gingivectomy or gingivoplasty (D4211).
2. A benefit:
   a. for patients age 13 or older.
   b. once per quadrant every 36 months.

PROCEDURE D4211 GINGIVECTOMY OR GINGIVOPLASTY - ONE TO THREE CONTIGUOUS TEETH, OR TOOTH BOUNDED SPACES PER QUADRANT

1. If four or more diseased teeth are present in the quadrant, use gingivectomy or gingivoplasty (D4210).
2. A benefit:
   a. for patients age 13 or older.
   b. once per quadrant every 36 months.

PROCEDURE D4249 CLINICAL CROWN LENGTHENING – HARD TISSUE

This procedure is included in the fee for a completed restorative service.

PROCEDURE D4260 OSSEOUS SURGERY (INCLUDING FLAP ENTRY AND CLOSURE)- FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT

1. Prior authorization is required.
2. Requires a quadrant code.
3. If three or fewer diseased teeth are present in the quadrant, use osseous surgery (D4261).
4. A benefit:
   a. for patients age 13 or older.
   b. once per quadrant every 36 months.

PROCEDURE D4261 OSSEOUS SURGERY (INCLUDING FLAP ENTRY AND CLOSURE) - ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES, PER QUADRANT

1. Prior authorization is required.
2. Requires a quadrant code.
3. If four or more diseased teeth are present in the quadrant, use osseous surgery (D4260).
4. A benefit:
   a. for patients age 13 or older.
   b. once per quadrant every 36 months.

PROCEDURE D4265 BIOLOGIC MATERIALS TO AID IN SOFT AND OSSEOUS TISSUE REGENERATION

1. This procedure is included in the fees for other periodontal procedures and is not payable separately.

PROCEDURE D4341 PERIODONTAL SCALING AND ROOT PLANING - FOUR OR MORE TEETH PER QUADRANT

A benefit:

a. for patients age 13 or older.
b. once per quadrant every 24 months.

PROCEDURE D4342 PERIODONTAL SCALING AND ROOT PLANING - ONE TO THREE TEETH PER QUADRANT

A benefit:

a. for patients age 13 or older.
b. once per quadrant every 24 months.

PROCEDURE D4355 FULL MOUTH DEBRIDEMENT TO ENABLE COMPREHENSIVE EVALUATION AND DIAGNOSIS

This procedure is included in the fees for other periodontal procedures and is not payable separately.

PROCEDURE D4381 LOCALIZED DELIVERY OF ANTIMICROBIAL AGENTS VIA A CONTROLLED RELEASE VEHICLE INTO DISEASED CREVICULAR TISSUE, PER TOOTH

This procedure is included in the fees for other

periodontal procedures and is not payable separately.

PROCEDURE D4910 PERIODONTAL MAINTENANCE

1. This procedure does not require prior authorization.
2. A benefit:
   a. only for patients residing in a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF).
   b. only when preceded by a periodontal scaling and root planing (D4341-D4342).
   c. only after completion of all necessary scaling and root planings.
   d. once in a calendar quarter.
   e. only in the 24 month period following the last scaling and root planing.
3. This procedure is considered a full mouth treatment.

PROCEDURE D4920 UNSCHEDULED DRESSING CHANGE (BY SOMEONE OTHER THAN TREATING DENTIST)

1. This procedure cannot be prior authorized.
2. A benefit:
   a. for patients age 13 or older.
   b. once per patient per provider.
   c. within 30 days of the date of service of gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261).
3. Unscheduled dressing changes by the same provider are considered part of, and included in the fee for gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261).

PROCEDURE D4999 PROCEDURE, BY REPORT

1. A benefit for patients age 13 or older.
2. Procedure D4999 shall be used:
   a. for a procedure which is not adequately described by a CDT code, or
   b. for a procedure that has a CDT code that is not a benefit but the patient has an condition to justify the medical necessity. Documentation shall include the exceptional medical medical condition and the specific CDT code associated with the treatment.

Prosthodontics (Removable) General Policies (D5000-D5899)

1. **Complete and Partial Dentures (D5110-D5214 and D5860):**

   a) Prior authorization is required for removable prostheses except for immediate dentures (D5130 and D5140).

   b) Prior authorization shall be considered for a new prosthesis only when it is clearly evident that the existing prosthesis cannot be made serviceable by repair, replacement of broken and missing teeth or reline.

   c) Complete and partial dentures are prior authorized only as full treatment plans. Payment shall be made only when the full treatment has been completed.

   d) New complete or partial dentures shall not be prior authorized when it would be highly improbable for a patient to utilize, care for or adapt to a new prosthesis due to psychological and/or motor deficiencies as determined by a clinical screening dentist (see "g" below).

   e) All endodontic, restorative and surgical procedures for teeth that impact the design of a removable partial denture (D5211, D5212, D5213 and D5214) shall be addressed before prior authorization is considered.

   f) The need for new or replacement prosthesis may be evaluated by a clinical screening dentist.

   g) A removable prosthesis is a benefit only once in a five year period. When adequately documented, the following exceptions shall apply:

      i) Catastrophic loss beyond the control of the patient. Documentation must include a copy of the official public service agency report (fire or police), or

      ii) A need for a new prosthesis due to surgical or traumatic loss of oral-facial anatomic structure, or

      iii) The removable prosthesis is no longer serviceable as determined by a clinical screening dentist.

   h) Prosthodontic services provided solely for cosmetic purposes are not a benefit.

   i) Temporary or interim dentures to be used while a permanent denture is being constructed are not a benefit.

   j) Spare or backup dentures are not a benefit.

   k) Evaluation of a denture on a maintenance basis is not a benefit.

   l) The fee for any removable prosthesis, reline, tissue conditioning or repair includes all adjustments necessary for six months after the date of service by the same provider.

   m) Immediate dentures should only be considered for a patient when one or more of the following conditions exist:

      i) extensive or rampant caries are exhibited in the radiographs,

      ii) severe periodontal involvement is indicated in the radiographs,

      iii) numerous teeth are missing resulting in diminished masticating ability adversely affecting the patient's health.

   n) There is no insertion fee payable to an oral surgeon who seats an immediate denture.

   o) Preventative, endodontic or restorative procedures are not a benefit for teeth to be retained for overdentures. Only extractions for the retained teeth will be a benefit.

   p) Partial dentures are not a benefit to replace missing 3rd molars.

2. Relines and Tissue Conditioning (D5730-D5761, D5850 and D5851):

a) Laboratory relines (D5750, D5751, D5760 and D5761) are a benefit six months after the date of service for immediate dentures (D5130 and D5140), an immediate overdenture (D5860) and cast metal partial dentures (D5213 and D5214) that required extractions.

b) Laboratory relines (D5750, D5751, D5760 and D5761) are a benefit 12 months after the date of service for complete (remote) dentures (D5110 and D5120), a complete (remote) overdenture (D5860) and cast metal partial dentures (D5213 and D5214) that did not require extractions.

c) Laboratory relines (D5760 and D5761) are not a benefit for resin based partial dentures (D5211and D5212).

d) Laboratory relines (D5750, D5751, D5760 and D5761) are not a benefit within 12 months of chairside relines (D5730, D5731, D5740 and D5741).

e) Chairside relines (D5730, D5731, D5740 and D5741) are a benefit six months after the date of service for immediate dentures (D5130 and D5140), an immediate overdenture (D5860), resin based partial dentures (D5211 and D5212) and cast metal partial dentures (D5213 and D5214) that required extractions.

f) Chairside relines (D5730, D5731, D5740 and D5741) are a benefit 12 months after the date of service for complete (remote) dentures (D5110 and D5120), a complete (remote) overdenture (D5860), resin based partial dentures (D5211 and D5212) and cast metal partial dentures (D5213 and D5214) that did not require extractions.

g) Chairside relines (D5730, D5731, D5740 and D5741) are not a benefit within 12 months of laboratory relines (D5750, D5751, D5760 and D5761).

h) Tissue conditioning (D5850 and D5851) is only a benefit to heal unhealthy ridges prior to a definitive prosthodontic treatment.

i) Tissue conditioning (D5850 and D5851) is a benefit the same date of service as an immediate prosthesis that required extractions.

Prosthodontic (Removable) Procedures (D5000-D5899)

PROCEDURE D5110 COMPLETE DENTURE – MAXILLARY

1. Prior authorization is required.
2. A benefit once in a five year period from a previous complete, immediate or overdenture- complete denture.
3. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
4. A laboratory reline (D5750) or chairside reline (D5730) is a benefit 12 months after the date of service for this procedure.

PROCEDURE D5120 COMPLETE DENTURE – MANDIBULAR

1. Prior authorization is required.

   A benefit once in a five year period from a previous complete, immediate or overdenture- complete denture.
2. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
3. A laboratory reline (D5751) or chairside reline (D5731) is a benefit 12 months after the date of service for this procedure.

PROCEDURE D5130 IMMEDIATE DENTURE – MAXILLARY

1. A benefit once per patient.
2. Not a benefit as a temporary denture. Subsequent complete dentures are not a benefit within a five-year period of an immediate denture.
3. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
4. A laboratory reline (D5750) or chairside reline (D5730) is a benefit six months after the date of service for this procedure.

PROCEDURE D5140 IMMEDIATE DENTURE – MANDIBULAR

1. A benefit once per patient.
2. Not a benefit as a temporary denture. Subsequent complete dentures are not a benefit within a five-year period of an immediate denture.
3. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
4. A laboratory reline (D5751) or chairside reline (D5731) is a benefit six months after the date of service for this procedure.

PROCEDURE D5211 MAXILLARY PARTIAL DENTURE – RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)

1. Prior authorization is required.
2. A benefit once in a five-year period.
3. A benefit when replacing a permanent anterior tooth/teeth and/or the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows:
   a. five posterior permanent teeth are missing, (excluding 3rd molars), or
   b. all four 1st and 2nd permanent molars are missing, or
   c. the 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side.
4. Not a benefit for replacing missing 3rd molars.
5. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
6. Laboratory reline (D5760) is not a benefit for this procedure.
7. Chairside reline (D5740) is a benefit:
   a. once in a 12-month period.
   b. six months after the date of service for a partial

denture that required extractions, or

c. 12 months after the date of service for a partial denture that did not require extractions.

PROCEDURE D5212 MANDIBULAR PARTIAL DENTURE – RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)

1. Prior authorization is required.
2. A benefit once in a five-year period.
3. A benefit when replacing a permanent anterior tooth/ teeth and/or the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows:
   a. five posterior permanent teeth are missing, (excluding 3rd molars), or
   b. all four 1st and 2nd permanent molars are missing, or
   c. the 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side.
4. Not a benefit for replacing missing 3rd molars.
5. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
6. Laboratory reline (D5761) is not a benefit for this procedure.
7. Chairside reline (D5741) is a benefit:
   a. once in a 12-month period.
   b. six months after the date of service for a partial denture that required extractions, or
   c. 12 months after the date of service for a partial denture that did not require extractions.

PROCEDURE D5213 MAXILLARY PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)

1. Prior authorization is required.
2. A benefit once in a five- year period.
3. A benefit when opposing a full denture and the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows:
   a. five posterior permanent teeth are missing, (excluding 3rd molars), or
   b. all four 1st and 2nd permanent molars are missing, or
   c. the 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side.
4. Not a benefit for replacing missing 3rd molars.
5. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
6. Laboratory reline (D5760) is a benefit:
   a. once in a 12-month period.
   b. six months after the date of service for a cast partial denture that required extractions, or
   c. 12 months after the date of service for a cast partial denture that did not require extractions.
7. Chairside reline (D5740) is a benefit:
   a. once in a 12 month period.
   b. six months after the date of service for a partial denture that required extractions, or
   c. 12 months after the date of service for a partial denture that did not require extractions.

PROCEDURE D5214 MANDIBULAR PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)

1. Prior authorization is required.
2. A benefit once in a five- year period.
3. A benefit when opposing a full denture and the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows:
   a. five posterior permanent teeth are missing, (excluding 3rd molars), or
   b. all four 1st and 2nd permanent molars are missing, or
   c. the 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side.
4. Not a benefit for replacing missing 3rd molars.
5. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
6. Laboratory reline (D5761) is a benefit:
   a. once in a 12-month period.
   b. six months after the date of service for a cast partial denture that required extractions, or
   c. 12 months after the date of service for a cast partial denture that did not require extractions.
7. Chairside reline (D5741) is a benefit:
   a. once in a 12-month period.
   b. six months after the date of service for a partial denture that required extractions, or
   c. 12 months after the date of service for a partial denture that did not require extractions.

PROCEDURE D5410 ADJUST COMPLETE DENTURE - MAXILLARY

1. A benefit:
   a. once per date of service per provider.
   b. twice in a 12-month period per provider.
2. Not a benefit:
   a. same date of service or within six months of the date of service of a complete denture-maxillary (D5110), immediate denture- maxillary (D5130)or overdenture-complete (D5860).
   b. same date of service or within six months of the date of service of a reline complete maxillary denture (chairside) (D5730), reline complete maxillary denture (laboratory) (D5750) and tissue conditioning, maxillary (D5850).
   c. same date of service or within six months of the date of service of repair broken complete denture base (D5510) and replace missing or broken teeth-complete denture (D5520).

PROCEDURE D5411 ADJUST COMPLETE DENTURE – MANDIBULAR

1. A benefit:
   a. once per date of service per provider.
   b. twice in a 12-month period per provider.
2. Not a benefit:
   a. same date of service or within six months of the date of service of a complete denture-mandibular (D5120), immediate denture-

mandibular (D5140) or overdenture-complete (D5860).

b. same date of service or within six months of the date of service of a reline complete mandibular denture (chairside) (D5731), reline complete mandibular denture (laboratory) (D5751) and tissue conditioning, mandibular (D5851).

c. same date of service or within six months of the date of service of repair broken complete denture base (D5510) and replace missing or broken teeth-complete denture (D5520).

PROCEDURE D5421 ADJUST PARTIAL DENTURE MAXILLARY

1. A benefit:

   a. once per date of service per provider.

   b. twice in a 12-month period per provider.

2. Not a benefit:

   a. same date of service or within six months of the date of service of a maxillary partial- resin base (D5211) or maxillary partial denture- cast metal framework with resin denture bases (D5213).

   b. same date of service or within six months of the date of service of a reline maxillary partial denture (chairside) (D5740), reline maxillary partial denture (laboratory) (D5760) and tissue conditioning, maxillary (D5850).

   c. same date of service or within six months of the date of service of repair resin denture base (D5610), repair cast framework (D5620), repair or replace broken clasp (D5630), replace broken teeth-per tooth (D5640), add tooth to existing partial denture (D5650) and add clasp to existing partial denture (D5660).

A PROCEDURE D5422 ADJUST PARTIAL DENTURE - MANDIBULAR

1. A benefit:

   a. once per date of service per provider.

   b. twice in a 12 month period per provider.

2. Not a benefit:

   a. same date of service or within six months of the date of service of a mandibular partial- resin base (D5212) or mandibular partial denture- cast metal framework with resin denture bases (D5214).

   b. same date of service or within six months of the date of service of a reline mandibular partial denture (chairside) (D5741), reline mandibular partial denture (laboratory) (D5761) and tissue conditioning, mandibular (D5851).

   c. same date of service or within six months of the date of service of repair resin denture base (D5610), repair cast framework (D5620), repair or replace broken clasp (D5630), replace broken teeth- per tooth (D5640), add tooth to existing partial denture (D5650) and add clasp to existing partial denture (D5660).

PROCEDURE D5510 REPAIR BROKEN COMPLETE DENTURE BASE

1. A benefit:

   a. once per arch, per date of service per provider.

   b. twice in a 12-month period per provider.

2. Not a benefit on the

same date of service as reline complete maxillary denture (chairside) (D5730), reline complete mandibular denture (chairside) (D5731), reline complete maxillary denture (laboratory) (D5750) and reline complete mandibular denture (laboratory) (D5751).

3. All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.

PROCEDURE D5520 REPLACE MISSING OR BROKEN TEETH – COMPLETE DENTURE (EACH TOOTH)

1. A benefit:
   a. up to a maximum of four, per arch, per date of service per provider.
   b. twice per arch, in a12- month period per provider.
2. All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.

PROCEDURE D5610 REPAIR RESIN DENTURE BASE

1. A benefit:
   a. once per arch, per date of service per provider.
   b. twice per arch, in a 12-month period per provider.
   c. for partial dentures only.
2. Not a benefit same date of service as reline maxillary partial denture (chairside) (D5740), reline mandibular partial denture (chairside) (D5741), reline maxillary partial denture (laboratory) (D5760) and reline mandibular partial denture (laboratory) (D5761).
3. All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.

PROCEDURE D5620 REPAIR CAST FRAMEWORK

1. A benefit:
   a. once per arch, per date of service per provider.
   b. twice per arch, in a 12-month period per provider.
2. All adjustments made for six months after the date of

repair, by the same provider and same arch, are included in the fee for this procedure.

PROCEDURE D5630 REPAIR OR REPLACE BROKEN CLASP

1. A benefit:
   a. up to a maximum of three, per date of service per provider.
   b. twice per arch, in a 12- month period per provider.
2. All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.

PROCEDURE D5640 REPLACE BROKEN TEETH – PER TOOTH

1. A benefit:
   a. up to a maximum of four, per arch, per date of service per provider.
   b. twice per arch, in a 12- month period per provider.
   c. for partial dentures only.
2. All adjustments made for

   six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.

PROCEDURE D5650 ADD TOOTH TO EXISTING PARTIAL DENTURE

1. A benefit:
   a. for up to a maximum of three, per date of service per provider.
   b. once per tooth.
2. Not a benefit for adding 3rd molars.
3. All adjustments made for six months after the date of repair, by the same provider and same arch, are included

in the fee for this procedure.

PROCEDURE D5660 ADD CLASP TO EXISTING PARTIAL DENTURE

1. A benefit:
   a. for up to a maximum of three, per date of service per provider.
   b. twice per arch, in a 12-month period per provider.
2. All adjustments made for six months after the date of repair, by the same provider

   and same arch, are included in the fee for this procedure.

PROCEDURE D5730 RELINE COMPLETE MAXILLARY DENTURE (CHAIRSIDE)

1. A benefit:
   a. once in a 12-month period.
   b. six months after the date of service for a immediate denture-maxillary (D5130) or immediate overdenture-complete (D5860) that required extractions, or
   c. 12 months after the date of service for a complete (remote) denture-maxillary (D5110) or overdenture(remote)-complete (D5860) that did not require extractions.
2. Not a benefit within 12 months of a reline complete maxillary denture (laboratory) (D5750).
3. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

PROCEDURE D5731 RELINE COMPLETE MANDIBULAR DENTURE (CHAIRSIDE)

1. A benefit:
   a. once in a 12-month period.
   b. six months after the date of service for a immediate denture-mandibular (D5140) or immediate overdenture-complete (D5860) that required extractions, or
   c. 12 months after the date of service for a complete (remote) denture-mandibular (D5120) or overdenture (remote)-complete (D5860) that did not require extractions.
2. Not a benefit within 12 months of a reline complete mandibular denture (laboratory) (D5751).
3. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

PROCEDURE D5740 RELINE MAXILLARY PARTIAL DENTURE (CHAIRSIDE)

1. A benefit:
   a. once in a 12-month period.
   b. six months after the date of service for maxillary partial denture- resin base (D5211) or maxillary partial denture- cast metal framework with resin denture bases (D5213) that required extractions, or
   c. 12 months after the date of service for maxillary partial denture- resin base (D5211) or maxillary partial denture- cast metal framework with resin denture bases (D5213) that did not require extractions.
2. Not a benefit within 12 months of a reline maxillary partial denture (laboratory)

(D5760).

3. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

PROCEDURE D5741 RELINE MANDIBULAR PARTIAL DENTURE (CHAIRSIDE)

1. A benefit:
   a. once in a 12-month

period.

b. six months after the date of service for mandibular partial denture-resin base (D5212) or mandibular partial denture-cast metal framework with resin denture bases (D5214) that required extractions, or

c. 12 months after the date of service for mandibular partial denture-resin base (D5212) or mandibular partial denture-cast metal framework with resin denture bases (D5214) that did not require extractions.

2. Not a benefit within 12 months of a reline mandibular partial denture (laboratory) (D5761).

3. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

PROCEDURE D5750 RELINE COMPLETE MAXILLARY DENTURE (LABORATORY)

1. A benefit:

a. once in a 12-month period.

b. six months after the date of service for a immediate denture-maxillary (D5130) or immediate overdenture-complete (D5860) that required extractions, or

c. 12 months after the date of service for a complete (remote) denture- maxillary (D5110) or overdenture (remote)-complete (D5860) that did not require extractions.

2. Not a benefit within 12 months of a reline complete maxillary denture (chairside) (D5730).

3. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

PROCEDURE D5751 RELINE COMPLETE MANDIBULAR DENTURE (LABORATORY)

1. A benefit:

a. once in a 12-month period.

b. six months after the date of service for a immediate denture-mandibular (D5140) or immediate overdenture-complete (D5860) that required extractions, or

c. 12 months after the date of service for a complete (remote) denture - mandibular (D5120) or overdenture (remote) - complete (D5860) that did not require extractions.

2. Not a benefit within 12 months of a reline complete mandibular denture (chairside) (D5731).

3. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

PROCEDURE D5760 RELINE MAXILLARY PARTIAL DENTURE (LABORATORY)

1. A benefit:

a. once in a 12-month period.

b. six months after the date of service for maxillary partial denture-cast metal framework with resin denture bases (D5213) that required extractions, or

c. 12 months after the date of service for maxillary partial denture- cast metal framework with resin denture bases (D5213) that did not require extractions.

2. Not a benefit:

a. within 12 months of a reline maxillary partial denture (chairside) (D5740).

b. for a maxillary partial denture-resin base (D5211).

3. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

PROCEDURE D5761
RELINE MANDIBULAR PARTIAL DENTURE (LABORATORY)

A benefit:

a. once in a 12-month period.
b. six months after the date of service for mandibular partial denture- cast metal framework with resin denture bases (D5214) that required extractions, or
c. 12 months after the date of service for mandibular partial denture- cast metal framework with resin denture bases (D5214) that did not require extractions.

3. Not a benefit:

a. within 12 months of a reline mandibular partial denture (chairside) (D5741).

b. for a mandibular partial denture- resin base (D5212).

4. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

PROCEDURE D5850
TISSUE CONDITIONING, MAXILLARY

1. A benefit twice per prosthesis in a 36-month period.

2. Not a benefit:

a. same date of service as reline complete maxillary denture (chairside) (D5730), reline maxillary partial denture (chairside) (D5740), reline complete maxillary denture (laboratory) (D5750) and reline maxillary partial denture (laboratory) (D5760).

b. same date of service as a prosthesis that did not require extractions.

3. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

4. Tissue conditioning is designed to heal unhealthy ridges prior to a more definitive treatment.

PROCEDURE D5851
TISSUE CONDITIONING, MANDIBULAR

1. A benefit twice per prosthesis in a 36-month period.

2. Not a benefit:

a. same date of service as reline complete mandibular denture (chairside) (D5731), reline mandibular partial denture (chairside) (D5741), reline complete mandibular denture (laboratory) (D5751) and reline mandibular partial denture (laboratory) (D5761).

b. same date of service as a prosthesis that did not require extractions.

3. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

4. Tissue conditioning is designed to heal unhealthy ridges prior to a more definitive treatment.

PROCEDURE D5862
PRECISION ATTACHMENT, BY REPORT

This procedure is included in the fee for prosthetic and restorative procedures and is not payable separately.

PROCEDURE D5899
UNSPECIFIED REMOVABLE PROSTHODONTIC PROCEDURE, BY REPORT

1. Procedure D5899 shall be used:

a. for a procedure which is not adequately described by a CDT code, or

b. for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the medical condition and the specific CDT code associated with the treatment.

Maxillofacial Prosthetics General Policies (D5900-D5999)

a. Maxillofacial prosthetic services are for the anatomic and functional reconstruction of those regions of the maxilla and mandible and associated structures that are missing or defective because of surgical intervention, trauma (other than simple or compound fractures), pathology, developmental or congenital malformations.

b. Prior authorization is required for the following procedures:

   i) trismus appliance (D5937),

   ii) palatal lift prosthesis, interim (D5958),

   iii) fluoride gel carrier (D5986),

   iv) surgical splint (D5988).

c. All maxillofacial prosthetic procedures include routine postoperative care, revisions and adjustments for 90 days after the date of delivery.

Maxillofacial Prosthetic Procedures (D5900-D5999)

PROCEDURE D5911
FACIAL MOULAGE (SECTIONAL)

PROCEDURE D5912
FACIAL MOULAGE (COMPLETE)

PROCEDURE D5913
NASAL PROSTHESIS

PROCEDURE D5914
AURICULAR PROSTHESIS

PROCEDURE D5915
ORBITAL PROSTHESIS

PROCEDURE D5916
OCULAR PROSTHESIS

Not a benefit on the same date of service as ocular prosthesis, interim (D5923).

PROCEDURE D5919
FACIAL PROSTHESIS

PROCEDURE D5922
NASAL SEPTAL PROSTHESIS

PROCEDURE D5923
OCULAR PROSTHESIS, INTERIM

Not a benefit on the same date of service with an ocular prosthesis (D5916).

PROCEDURE D5924
CRANIAL PROSTHESIS

PROCEDURE D5925
FACIAL AUGMENTATION IMPLANT PROSTHESIS

PROCEDURE D5926
NASAL PROSTHESIS, REPLACEMENT

PROCEDURE D5927
AURICULAR PROSTHESIS, REPLACEMENT

PROCEDURE D5928
ORBITAL PROSTHESIS, REPLACEMENT

PROCEDURE D5929
FACIAL PROSTHESIS, REPLACEMENT

PROCEDURE D5931
OBTURATOR PROSTHESIS, SURGICAL

1. Not a benefit on the same date of service as obturator prosthesis, definitive (D5932) and obturator prosthesis, interim (D5936).
2. **PROCEDURE D5932**
3. **OBTURATOR PROSTHESIS, DEFINITIVE**

Not a benefit on the same date of service as obturator prosthesis, surgical (D5931) and obturator prosthesis, interim (D5936).

PROCEDURE D5933
OBTURATOR PROSTHESIS, MODIFICATION

1. A benefit twice in a 12 month period.
2. Not a benefit on the same date of service as obturator prosthesis, surgical (D5931), obturator prosthesis, definitive (D5932) and obturator prosthesis, interim (D5936).

PROCEDURE D5934
MANDIBULAR RESECTION PROSTHESIS WITH GUIDE FLANGE

PROCEDURE D5935
MANDIBULAR RESECTION PROSTHESIS WITHOUT GUIDE FLANGE

PROCEDURE D5936
OBTURATOR PROSTHESIS, INTERIM

Not a benefit on the same date of service as obturator prosthesis, surgical (D5931) and obturator prosthesis, definitive (D5932).

PROCEDURE D5937
TRISMUS APPLIANCE (NOT FOR TMD TREATMENT)

PROCEDURE D5951
FEEDING AID

A benefit for patients under the age of 18.

PROCEDURE D5952
SPEECH AID PROSTHESIS, PEDIATRIC

A benefit for patients under the age of 18.

PROCEDURE D5953
SPEECH AID PROSTHESIS, ADULT

A benefit for patients age 18 or older.

PROCEDURE D5954
PALATAL AUGMENTATION PROSTHESIS

PROCEDURE D5955
PALATAL LIFT PROSTHESIS, DEFINITIVE

Not a benefit on the same date of service as palatal lift prosthesis, interim (D5958).'

PROCEDURE D5958
PALATAL LIFT PROSTHESIS, INTERIM

Not a benefit on the same date of service with palatal lift prosthesis, definitive (D5955).

PROCEDURE D5959
PALATAL LIFT PROSTHESIS, MODIFICATION

1. A benefit twice in a 12- month period.
2. Not a benefit on the

same date of service as palatal lift prosthesis, definitive (D5955) and palatal lift prosthesis, interim (D5958).

PROCEDURE D5960 SPEECH AID PROSTHESIS, MODIFICATION

1. A benefit twice in a 12- month period.
2. Not a benefit on the same date of service as speech aid prosthesis, pediatric (D5952) and speech aid prosthesis, adult (D5953).

PROCEDURE D5982 SURGICAL STENT

PROCEDURE D5983 RADIATION CARRIER

PROCEDURE D5984 RADIATION SHIELD

PROCEDURE D5985 RADIATION CONE LOCATOR

PROCEDURE D5986 FLUORIDE GEL CARRIER

A benefit only in conjunction with radiation therapy directed at the teeth, jaws or salivary glands.

PROCEDURE D5987 COMMISSURE SPLINT

PROCEDURE D5988 SURGICAL SPLINT

PROCEDURE D5991 TOPICAL MEDICAMENT CARRIER

PROCEDURE D5992 ADJUST MAXILLOFACIAL PROSTHETIC APPLIANCE, BY REPORT

This procedure is not a benefit.

PROCEDURE D5993 MAINTENANCE AND CLEANING OF A MAXILLOFACIAL PROSTHESIS (EXTRA OR INTRAORAL) OTHER THAN REQUIRED ADJUSTMENTS, BY REPORT

This procedure is not a benefit.

PROCEDURE D5999 UNSPECIFIED MAXILLOFACIAL PROSTHESIS, BY REPORT

1. Procedure D5999 shall be used:

a. for a procedure which is not adequately described by a CDT code, or
b. for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the medical condition and the specific CDT code associated with the treatment.

Implant Services General Policies (D6000-D6199)

a. Implant services are a benefit only when exceptional medical conditions. Exceptional medical conditions include, but are not limited to:

   i) cancer of the oral cavity requiring ablative surgery and/or radiation leading to destruction of alveolar bone, where the remaining osseous structures are unable to support conventional dental prostheses.

   ii) severe atrophy of the mandible and/or maxilla that cannot be corrected with vestibular extension procedures or osseous augmentation procedures, and the patient is unable to function with conventional prostheses.

   iii) skeletal deformities that preclude the use of conventional prostheses (such as arthrogryposis, ectodermal dysplasia, partial anaodontia and cleidocranial dysplasia).

   iv) traumatic destruction of jaw, face or head where the remaining osseous structures are unable to support conventional dental prostheses.

b) Providers shall submit complete case documentation (such as radiographs, scans, operative reports, craniofacial panel reports, diagnostic casts, intraoral/extraoral photographs and tracings) necessary to demonstrate the medical necessity of the requested implant services.

c) Single tooth implants are not a benefit of the plan.

d) Implant removal, by report (D6100) is a benefit. Refer to the procedure for specific requirements.

Implant Service Procedures (D6000-D6199)

PROCEDURE D6010 SURGICAL PLACEMENT OF IMPLANT BODY: ENDOSTEAL IMPLANT

Implant services are a benefit only when exceptional medical conditions are documented and shall be reviewed for medical necessity. Refer to Implant Services General policies for specific requirements.

PROCEDURE D6040 SURGICAL PLACEMENT: EPOSTEAL IMPLANT

See the criteria for Procedure D6010.

PROCEDURE D6050 SURGICAL PLACEMENT: TRANSOSTEAL IMPLANT

See the criteria for Procedure D6010.

PROCEDURE D6051 INTERIM ABUTMENT

This procedure is not a benefit.

PROCEDURE D6055 CONNECTING BAR – IMPLANT SUPPORTED OR ABUTMENT SUPPORTED

See the criteria for Procedure D6010.

PROCEDURE D6056 PREFABRICATED ABUTMENT - INCLUDES MODIFICATION AND PLACEMENT

See the criteria for Procedure D6010.

PROCEDURE D6057 CUSTOM FABRICATED ABUTMENT - INCLUDES PLACEMENT

See the criteria for Procedure D6010.

PROCEDURE D6058 ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN

See the criteria for Procedure D6010.

PROCEDURE D6059 ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (HIGH NOBLE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6060 ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINANTLY BASE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6061 ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (NOBLE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6062 ABUTMENT SUPPORTED CAST METAL CROWN (HIGH NOBLE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6063 ABUTMENT SUPPORTED CAST METAL CROWN (PREDOMINANTLY BASE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6064 ABUTMENT SUPPORTED CAST METAL CROWN (NOBLE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6065 IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN

See the criteria for Procedure D6010.

PROCEDURE D6066
IMPLANT SUPPORTED PORCELAIN FUSED TO METAL CROWN (TITANIUM, TITANIUM ALLOY, HIGH NOBLE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6067
IMPLANT SUPPORTED METAL CROWN (TITANIUM, TITANIUM ALLOY, HIGH NOBLE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6068
ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/ CERAMIC FPD

See the criteria for Procedure D6010.

PROCEDURE D6069
ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6070
ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (PREDOMINANTLY BASE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6071
ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (NOBLE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6072
ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (HIGH NOBLE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6073
ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (PREDOMINANTLY BASE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6074
ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (NOBLE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6075
IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD

See the criteria for Procedure D6010.

PROCEDURE D6076
IMPLANT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (TITANIUM, TITANIUM ALLOY, OR HIGH NOBLE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6077
IMPLANT SUPPORTED RETAINER FOR CAST METAL FPD (TITANIUM, TITANIUM ALLOY, OR HIGH NOBLE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6080
IMPLANT MAINTENANCE PROCEDURES, INCLUDING REMOVAL OF PROSTHESIS, CLEANSING OF PROSTHESIS AND ABUTMENTS AND REINSERTION OF PROSTHESIS

See the criteria for Procedure D6010.

PROCEDURE D6090
REPAIR IMPLANT SUPPORTED PROSTHESIS, BY REPORT

See the criteria for Procedure D6010.

PROCEDURE D6091
REPLACEMENT OF SEMI-PRECISION OR PRECISION ATTACHMENT (MALE OR FEMALE COMPONENT) OF IMPLANT/ABUTMENT SUPPORTED PROSTHESIS, PER ATTACHMENT

See the criteria for Procedure D6010.

PROCEDURE D6092
RECEMENT IMPLANT/ ABUTMENT SUPPORTED CROWN

Not a benefit within 12 months of a previous re-cementation by the same provider.

PROCEDURE D6093
RECEMENT IMPLANT/ ABUTMENT SUPPORTED FIXED PARTIAL DENTURE

Not a benefit within 12 months of a previous re-cementation by the same provider.

PROCEDURE D6094
ABUTMENT SUPPORTED CROWN (TITANIUM)

See the criteria for Procedure D6010.

PROCEDURE D6095
REPAIR IMPLANT ABUTMENT, BY REPORT

See the criteria for Procedure D6010.

PROCEDURE D6100
IMPLANT REMOVAL, BY REPORT

PROCEDURE D6101
DEBRIDEMENT OF A PERIIMPLANT DEFECT AND SURFACE CLEANING OF EXPOSED IMPLANT SERVICES, INCLUDING FLAP ENTRY AND CLOSURE

This procedure is not a benefit.

PROCEDURE D6102

DEBRIDEMENT AND OSSEOUS CONTOURING OF A PERIIMPLANT DEFECT; INCLUDES SURFACE CLEANING OF EXPOSED IMPLANT SURFACES AND FLAP ENTRY AND CLOSURE

This procedure is not a benefit.

PROCEDURE D6103 BONE GRAFT FOR REPAIR OF PERIIMPLANT DEFECT - NOT INCLUDING FLAP ENTRY AND CLOSURE OR, WHEN INDICATED, PLACEMENT OF A BARRIER MEMBRANE OR BIOLOGIC MATERIALS TO AID IN OSSEOUS REGENERATION

This procedure is not a benefit.

PROCEDURE D6104 BONE GRAFT AT TIME OF IMPLANT PLACEMENT

This procedure is not a benefit.

PROCEDURE D6190 RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY REPORT

This procedure is included in the fee for surgical placement of implant body: endosteal implant (D6010).

PROCEDURE D6194 ABUTMENT SUPPORTED RETAINER CROWN FOR FPD (TITANIUM)

See the criteria for Procedure D6010.

PROCEDURE D6199 UNSPECIFIED IMPLANT PROCEDURE, BY REPORT

1. Implant services are a benefit only when exceptional medical conditions are documented and shall be reviewed for medical necessity.
2. radiographs.

Fixed Prosthodontic General Policies (D6200-D6999)

a. Fixed partial dentures (bridgework) are considered beyond the scope of the plan. However, the fabrication of a fixed partial denture shall be considered for prior authorization only when medical conditions or employment preclude the use of a removable partial denture. Most importantly, the patient shall first meet the criteria for a removable partial denture before a fixed partial denture will be considered.

b. Medical conditions, which preclude the use of a removable partial denture, include:

   i) the epileptic patient where a removable partial denture could be injurious to their health during an uncontrolled seizure,

   ii) the paraplegia patient who utilizes a mouth wand to function to any degree and where a mouth wand is inoperative because of missing natural teeth,

   iii) patients with neurological disorders whose manual dexterity precludes proper care and maintenance of a removable partial denture.

c. Fixed partial dentures are a benefit once in a five-year period only on permanent teeth when the above criteria are met.

d. Fixed partial dentures are not a benefit when the prognosis of the retainer (abutment) teeth is questionable due to non-restorability or periodontal involvement.

e. Posterior fixed partial dentures are not a benefit when the number of missing teeth requested to be replaced in the quadrant does not significantly impact the patient's masticatory ability.

f. Tooth and soft tissue preparation, crown lengthening, cement bases, direct and indirect pulp capping, amalgam or acrylic buildups, pins (D2951), bonding agents, lining agents, impressions, temporary crowns, adjustments (D9951), polishing, local anesthesia (D9210) and any other associated procedures are included in the fee for a completed fixed partial denture.

g. Fixed partial denture inlay/onlay retainers (abutments) (D6545-D6634) are not a benefit.

h. Cast resin bonded fixed partial dentures (Maryland Bridges) are not a benefit.

Fixed Prosthodontic Procedures (D6200-D6999)

PROCEDURE D6211 PONTIC – CAST PREDOMINANTLY BASE METAL

1. A benefit:
   a. once in a five year period.
   b. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).
   c. only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791).
2. Not a benefit for patients under the age of 13.

PROCEDURE D6241 PONTIC – PORCELAIN FUSED TO PREDOMINANTLY BASE METAL

1. A benefit:
   a. once in a five year period.
   b. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).
   c. only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791).
2. Not a benefit for patients under the age of 13.

PROCEDURE D6242 PONTIC – PORCELAIN FUSED TO NOBLE METAL

This procedure is not a benefit.

PROCEDURE D6245 PONTIC – PORCELAIN/CERAMIC

1. A benefit:
   a. once in a five year period.
   b. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).
   c. only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791).
2. Not a benefit for patients under the age of 13.

PROCEDURE D6251 PONTIC – RESIN WITH PREDOMINANTLY BASE METAL

1. A benefit:
   a. once in a five year period.
   b. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).
   c. only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791).
2. Not a benefit for patients under the age of 13.

PROCEDURE D6721 CROWN – RESIN WITH PREDOMINANTLY BASE METAL

1. A benefit:
   a. once in a five year period.
   b. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).
2. Not a benefit for patients under the age of 13.

PROCEDURE D6740 CROWN – PORCELAIN/CERAMIC

1. A benefit:
   a. once in a five year period.
   b. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).
2. Not a benefit for patients under the age of 13.

PROCEDURE D6751 CROWN – PORCELAIN FUSED TO PREDOMINANTLY BASE METAL

1. A benefit:
   a. once in a five year period.
   a. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).
2. Not a benefit for patients under the age of 13.

PROCEDURE D6781 CROWN – ¾ CAST PREDOMINANTLY BASE METAL

1. A benefit:
   a. once in a five year period.
   b. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).
2. Not a benefit for patients under the age of 13.

PROCEDURE D6783 CROWN – ¾ PORCELAIN/ CERAMIC

1. Requires a tooth code.
2. A benefit:
   a. once in a five year period.
   b. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).
3. Not a benefit for patients under the age of 13.

PROCEDURE D6791 CROWN – FULL CAST PREDOMINANTLY BASE METAL

1. A benefit:
   a. once in a five year period.
   b. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).
2. Not a benefit for patients under the age of 13.

PROCEDURE D6930 RECEMENT

FIXED PARTIAL DENTURE

The original provider is responsible for all re-cementations

PROCEDURE D6980 FIXED PARTIAL DENTURE REPAIR NECESSITATED BY RESTORATIVE MATERIAL FAILURE

Not a benefit within 12 months of initial placement or previous repair, same provider.

PROCEDURE D6999 UNSPECIFIED, FIXED PROSTHODONTIC PROCEDURE, BY REPORT

1. Not a benefit within 12 months of initial placement, same provider.
2. Procedure D6999 shall be used:

a. for a procedure which is not adequately described by a CDT code, or

b. for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the medical condition and the specific CDT code associated with the treatment.

Oral and Maxillofacial Surgery General Policies (D7000-D7999)

a) Local anesthetic, sutures and routine postoperative care within 30 days following an extraction procedure (D7111-D7250) are considered part of, and included in, the fee for the procedure. All other oral and maxillofacial surgery procedures include routine postoperative care for 90 days.

b) The level of payment for multiple surgical procedures performed on the same date of service shall be modified to the most inclusive procedure.

1. Extractions (D7111-D7250):

a) The following conditions shall be considered medically necessary and shall be a benefit:

i) full bony impacted supernumerary teeth or mesiodens that interfere with the alignment of other teeth,

ii) teeth which are involved with a cyst, tumor or other neoplasm,

iii) unerupted teeth which are severely distorting the normal alignment of erupted teeth or causing the resorption of the roots of other teeth,

iv) the extraction of all remaining teeth in preparation for a full prosthesis,

v) extraction of third molars that are causing repeated or chronic pericoronitis

vi) extraction of primary teeth required to minimize malocclusion or malalignment when there is adequate space to allow normal eruption of succedaneous teeth,

vii) perceptible radiologic pathology that fails to elicit symptoms,

viii) extractions that are required to complete orthodontic dental services excluding prophylactic removal of third molars,

ix) when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement.

b. The prophylactic extraction of 3rd molars is not a benefit.

c) The fee for surgical extractions includes the removal of bone and/or sectioning of tooth, and elevation of mucoperiosteal flap, if indicated.

d) Classification of surgical extractions and impactions shall be based on the anatomical position of the tooth rather than the surgical technique employed in the removal.

2. Fractures (D7610-D7780):

a) The placement and removal of wires, bands or splints is included in the fee for the associated procedure.

b) Routine postoperative care within 90 days is included in the fee for the associated procedure.

c) When extensive multiple or bilateral procedures are performed at the same operative session, each procedure shall be valued as follows:

i) 100% (full value) for the first or major procedure, and

ii) 50% for the second procedure, and

iii) 25% for the third procedure, and

iv) 10% for the fourth procedure, and

v) 5% for the fifth procedure, and

vi) over five procedures, by report.

3. **Temporomandibular Joint Dysfunctions (D7810-D7899):**

   a) TMJ dysfunction procedures are limited to differential diagnosis and symptomatic care. Not included as a benefit are those TMJ treatment modalities that involve prosthodontia, orthodontia and full or partial occlusal rehabilitation.

   b) Most TMJ dysfunction procedures require prior authorization. Submission of sufficient diagnostic information to establish the presence of the dysfunction is required. Refer to the individual procedures for specific submission requirements.

   c) TMJ dysfunction procedures solely for the treatment of bruxism is not a benefit.

4. **Repair Procedures (D7910-D7998):**

   Suture procedures (D7910, D7911 and D7912) are not a benefit for the closure of surgical incisions.

Oral and Maxillofacial Surgery Procedures (D7000-D7999)

PROCEDURE D7111 EXTRACTION, CORONAL REMNANTS – DECIDUOUS TOOTH

Not a benefit for asymptomatic teeth.

PROCEDURE D7140 EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND/OR FORCEPS REMOVAL)

Not a benefit to the same provider who performed the initial tooth extraction.

PROCEDURE D7210 SURGICAL REMOVAL OF ERUPTED TOOTH REQUIRING REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF MUCOPERIOSTEAL FLAP IF INDICATED

A benefit when the removal of any erupted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone or sectioning of the tooth.

PROCEDURE D7220 REMOVAL OF IMPACTED TOOTH - SOFT TISSUE

A benefit when the major portion or the entire occlusal surface is covered by mucogingival soft tissue.

PROCEDURE D7230 REMOVAL OF IMPACTED TOOTH – PARTIALLY BONY

A benefit when the removal of any impacted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone. One of the proximal heights of contour of the crown shall be covered by bone.

PROCEDURE D7240 REMOVAL OF IMPACTED TOOTH – COMPLETELY BONY

A benefit when the removal of any impacted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone covering most or all of the crown.

PROCEDURE D7241 REMOVAL OF IMPACTED TOOTH – COMPLETELY BONY, WITH UNUSUAL SURGICAL COMPLICATIONS

A benefit when the removal of any impacted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone covering most or all of the crown. Difficulty or complication shall be due to factors such as nerve dissection or aberrant tooth position.

PROCEDURE D7250 SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)

A benefit when the root is completely covered by alveolar bone.

Not a benefit to the same provider who performed the initial tooth extraction.

PROCEDURE D7251 CORONECTOMY- INTENTIONAL PARTIAL TOOTH REMOVAL

This procedure is not a benefit.

PROCEDURE D7260 ORAL ANTRAL FISTULA CLOSURE

1. A benefit for the excision of a fistulous tract between the maxillary sinus and oral cavity.
2. Not a benefit in conjunction with extraction procedures (D7111 – D7250).

PROCEDURE D7261 PRIMARY CLOSURE OF A SINUS PERFORATION

A benefit in the absence of a fistulous tract requiring the repair or immediate closure of the oroantral or oralnasal communication, subsequent to the removal of a tooth.

PROCEDURE D7270 TOOTH REIMPLANTATION AND/ OR STABILIZATION OF ACCIDENTALLY EVULSED OR DISPLACED TOOTH

1. A benefit:
   a. once per arch regardless of the number of teeth involved, and
   b. for permanent anterior teeth only.
2. The procedure includes splinting and/or stabilization,

postoperative care and the removal of the splint or stabilization, by the same provider.

PROCEDURE D7272 TOOTH TRANSPLANTATION (INCLUDES REIMPLANTATION FROM ONE SITE TO ANOTHER AND SPLINTING AND/OR STABILIZATION)

This procedure is not a benefit.

PROCEDURE D7280 SURGICAL ACCESS OF AN UNERUPTED TOOTH

1. Requires a tooth code.
2. Not a benefit:
   a. for patients age 19 or older.
   b. for 3rd molars.

PROCEDURE D7282 MOBILIZATION OF ERUPTED OR MALPOSITIONED TOOTH TO AID ERUPTION

This procedure is not a benefit.

PROCEDURE D7283 PLACEMENT OF DEVICE TO FACILITATE ERUPTION OF IMPACTED TOOTH

1. A benefit only for patients in active orthodontic treatment.
2. Not a benefit:
   a. for patients age 19 years or older.
   b. for 3rd molars unless the 3rd molar occupies the 1st or 2nd molar position.

PROCEDURE D7285 BIOPSY OF ORAL TISSUE – HARD (BONE, TOOTH)

1. A benefit:
   a. for the removal of the specimen only.
   b. once per arch, per date of service regardless of the areas involved.
2. Not a benefit with an apicoectomy/periradicular surgery (D3410-D3426), an extraction (D7111-D7250) and an excision of any soft tissues or intraosseous lesions (D7410-D7461) in the same area or region on the same date of service.

PROCEDURE D7286 BIOPSY OF ORAL TISSUE – SOFT

1. A benefit:
   a. for the removal of the specimen only.
   b. up to a maximum of three per date of service.
2. Not a benefit with an apicoectomy/periradicular surgery (D3410-D3426), an extraction (D7111-D7250) and an excision of any soft tissues or intraosseouslesions (D7410-D7461) in the same area or region on the same date of service.

PROCEDURE D7290 SURGICAL REPOSITIONING OF TEETH

1. Requires an arch code.
2. A benefit:
   a. for permanent teeth only.
   b. once per arch.
   c. only for patients in active orthodontic treatment.
3. Not a benefit:
   a. for patients age 19 years or older.
   b. for 3rd molars unless the 3rd molar occupies the 1st or 2nd molar position.

PROCEDURE D7291 TRANSSEPTAL FIBEROTOMY/ SUPRA CRESTAL FIBEROTOMY, BY REPORT

1. A benefit:
   a. once per arch.
   b. only for patients in active orthodontic treatment.
2. Not a benefit for patients age 19 or older.

PROCEDURE D7310 ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS – FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT

1. A benefit on the same date of service with two or more extractions (D7140-D7250) in the same quadrant.
2. Not a benefit when only one tooth is extracted in the same quadrant on the same date of service.

PROCEDURE D7311 ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS – ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT

This procedure can only in conjunction with extractions-four or more teeth or tooth spaces, per quadrant (D7310).

PROCEDURE D7320 ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS – FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT

1. A benefit regardless of the number of teeth or tooth spaces.
2. Not a benefit within six months following extractions (D7140-D7250) in the same quadrant, for the same provider.

PROCEDURE D7321 ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS – ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT

This procedure can only be billed as alveoloplasty not in conjunction with extractions- four or more teeth or tooth spaces, per quadrant (D7320).

PROCEDURE D7340 VESTIBULOPLASTY-RIDGE EXTENSION (SECONDARY EPITHELIALIZATION)

1. A benefit once in a five year period per arch.
2. Not a benefit:
   a. on the same date of service with a vestibuloplasty – ridge extension (D7350) same arch.
   b. on the same date of service with extractions (D7111-D7250) same arch.

PROCEDURE D7350 VESTIBULOPLASTY – RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT AND MANAGEMENT OF HYPERTROPHIED AND HYPERPLASTIC TISSUE)

1. A benefit once per arch.
2. Not a benefit:
   a. on the same date of service with a vestibuloplasty – ridge extension (D7340) same arch.
   b. on the same date of service with extractions (D7111-D7250) same arch.

PROCEDURE D7410 EXCISION OF BENIGN LESION UP TO 1.25 CM

A pathology report from a certified pathology laboratory is required.

PROCEDURE D7411 EXCISION OF BENIGN LESION GREATER THAN 1.25 CM

1. A pathology report from a certified pathology laboratory is required.

PROCEDURE D7412 EXCISION OF BENIGN LESION, COMPLICATED

1. A pathology report from a certified pathology laboratory is required.
2. A benefit when there is extensive undermining with advancement or rotational flap closure.

PROCEDURE D7413 EXCISION OF MALIGNANT LESION UP TO 1.25 CM

1. A pathology report from a certified pathology laboratory is required.

PROCEDURE D7414 EXCISION OF MALIGNANT LESION GREATER THAN 1.25 CM

A pathology report from a certified pathology laboratory is required.

PROCEDURE D7415 EXCISION OF MALIGNANT LESION, COMPLICATED

1. A pathology report from a certified pathology laboratory is required.
2. A benefit when there is extensive undermining with advancement or rotational flap closure.

PROCEDURE D7440 EXCISION OF MALIGNANT TUMOR – LESION DIAMETER UP TO 1.25 CM

A pathology report from a certified pathology laboratory is required.

PROCEDURE D7441 EXCISION OF MALIGNANT TUMOR – LESION DIAMETER GREATER THAN 1.25 CM

A pathology report from a certified pathology laboratory is required.

PROCEDURE D7450 REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR – LESION DIAMETER UP TO 1.25 CM

A pathology report from a certified pathology laboratory is required.

PROCEDURE D7451 REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR – LESION DIAMETER GREATER THAN 1.25 CM

A pathology report from a certified pathology laboratory is required.

PROCEDURE D7460 REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR – LESION DIAMETER UP TO 1.25 CM

1. A pathology report from a certified pathology laboratory is required.

PROCEDURE D7461
REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR – LESION DIAMETER GREATER THAN 1.25 CM

A pathology report from a certified pathology laboratory is required.

PROCEDURE D7465
DESTRUCTION OF LESION(S) BY PHYSICAL OR CHEMICAL METHOD, BY REPORT

PROCEDURE D7471
REMOVAL OF LATERAL EXOSTOSIS (MAXILLA OR MANDIBLE)

1. A benefit:
   a. once per quadrant.
   b. for the removal of buccal or facial exostosis only.

PROCEDURE D7472
REMOVAL OF TORUS PALATINUS

1. A benefit once in the patient's lifetime.

PROCEDURE D7473
REMOVAL OF TORUS MANDIBULARIS

1. A benefit once per quadrant.

PROCEDURE D7485
SURGICAL REDUCTION OF OSSEOUS TUBEROSITY

1. A benefit once per quadrant.

PROCEDURE D7490
RADICAL RESECTION OF MAXILLA OR MANDIBLE

PROCEDURE D7510
INCISION AND DRAINAGE OF ABSCESS – INTRAORAL SOFT TISSUE

1. A benefit once per quadrant, same date of service.
2. Not a benefit when any other definitive treatment is performed in the same quadrant on the same date of service, except necessary radiographs and/or photographs.

This procedure includes the incision, placement and removal of a surgical draining device.

PROCEDURE D7511
INCISION AND DRAINAGE OF ABSCESS – INTRAORAL SOFT TISSUE- COMPLICATED (INCLUDES DRAINAGE OF MULTIPLE FASCIAL SPACES)

1. A benefit once per quadrant, same date of service.
2. Not a benefit when any other definitive treatment is performed in the same quadrant on the same date of service, except necessary radiographs and/or photographs.
3. This procedure includes the incision, placement and removal of a surgical draining device.

PROCEDURE D7520
INCISION AND DRAINAGE OF ABSCESS – EXTRAORAL SOFT TISSUE

1. This procedure includes the incision, placement and removal of a surgical draining device.

PROCEDURE D7521
INCISION AND DRAINAGE OF ABSCESS – EXTRAORAL SOFT TISSUE- COMPLICATED (INCLUDES DRAINAGE OF MULTIPLE FASCIAL SPACES)

1. This procedure includes the incision, placement and removal of a surgical draining device.

PROCEDURE D7530
REMOVAL OF FOREIGN BODY FROM MUCOSA, SKIN, OR SUBCUTANEOUS ALVEOLAR TISSUE

1. A benefit once per date of service.
2. Not a benefit when associated with the removal of a tumor, cyst (D7440- D7461) or tooth (D7111- D7250).

PROCEDURE D7540
REMOVAL OF REACTION PRODUCING FOREIGN BODIES, MUSCULOSKELETAL SYSTEM

1. A benefit once per date of service.
2. Not a benefit when associated with the removal of a tumor, cyst (D7440- D7461) or tooth (D7111- D7250).

PROCEDURE D7550
PARTIAL OSTECTOMY/ SEQUESTRECTOMY FOR REMOVAL OF NON-VITAL BONE

1. A benefit:
   a. once per quadrant per date of service.
   b. only for the removal of loose or sloughed off dead bone caused by infection or reduced blood supply.
2. Not a benefit within 30 days of an associated extraction (D7111-D7250).

PROCEDURE D7560 MAXILLARY SINUSOTOMY FOR REMOVAL OF TOOTH FRAGMENT OR FOREIGN BODY

1. Not a benefit when a tooth fragment or foreign body is retrieved from the tooth socket.

PROCEDURE D7610 MAXILLA – OPEN REDUCTION (TEETH IMMOBILIZED, IF PRESENT)

1. This procedure includes the placement and removal of wires, bands, splints and arch bars.
2. Anesthesia procedure (D9248) is a separate benefit when necessary for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7620 MAXILLA – CLOSED REDUCTION (TEETH IMMOBILIZED, IF PRESENT)

2. This procedure includes the placement and removal of wires, bands, splints and arch bars.
1. Anesthesia procedure (D9248) is a separate benefit when necessary for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7630 MANDIBLE – OPEN REDUCTION (TEETH IMMOBILIZED, IF PRESENT)

1. This procedure includes the placement and removal of wires, bands, splints and arch bars.
2. Anesthesia procedure (D9248) is a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7640 MANDIBLE – CLOSED REDUCTION (TEETH IMMOBILIZED, IF PRESENT)

1. This procedure includes the placement and removal of wires, bands, splints and arch bars.
2. Anesthesia procedure (D9248) is a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7650 MALAR AND/OR ZYGOMATIC ARCH – OPEN REDUCTION

1. This procedure includes the placement and removal of wires, bands, splints and arch bars.
2. Anesthesia procedure (-D9248) is a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7660 MALAR AND/OR ZYGOMATIC ARCH – CLOSED REDUCTION

This procedure includes the placement and removal of wires, bands, splints and arch bars.

1. Anesthesia procedures (D9220-D9248) are a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7670 ALVEOLUS – CLOSED REDUCTION, MAY INCLUDE STABILIZATION OF TEETH

1. This procedure includes the placement and removal of wires, bands, splints and arch bars.
2. Anesthesia procedure (D9248) is a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7671 ALVEOLUS – OPEN REDUCTION, MAY INCLUDE STABILIZATION OF TEETH

1. This procedure includes the placement and removal of wires, bands, splints and arch bars.
2. Anesthesia procedure (D9248) is a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7680 FACIAL BONES – COMPLICATED REDUCTION WITH FIXATION AND MULTIPLE SURGICAL APPROACHES

1. A benefit for the treatment of simple fractures.
2. This procedure includes the placement and removal of wires, bands, splints and arch bars.
3. Anesthesia procedure (D9248) is a separate benefit, when necessary, for the surgical

removal of wires, bands, splints or arch bars.

PROCEDURE D7710 MAXILLA – OPEN REDUCTION

1. This procedure includes the placement and removal of wires, bands, splints and arch bars.
2. Anesthesia procedure (D9248) is a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7720 MAXILLA – CLOSED REDUCTION

1. This procedure includes the placement and removal of wires, bands, splints and arch bars.
2. Anesthesia procedure (D9248) is a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7730 MANDIBLE – OPEN REDUCTION

1. This procedure includes the placement and removal of wires, bands, splints and arch bars.
2. Anesthesia procedure (D9248) is a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7740 MANDIBLE – CLOSED REDUCTION

1. This procedure includes the placement and removal of wires, bands, splints and arch bars.
2. Anesthesia procedure (D9248) is a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7750 MALAR AND/OR ZYGOMATIC ARCH – OPEN REDUCTION

1. This procedure includes the placement and removal of wires, bands, splints and arch bars.
2. Anesthesia procedure (D9248) is a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7760 MALAR AND/OR ZYGOMATIC ARCH – CLOSED REDUCTION

1. This procedure includes the placement and removal of wires, bands, splints and arch bars.
2. Anesthesia procedure (D9248) is a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7770 ALVEOLUS – OPEN REDUCTION STABILIZATION OF TEETH

1. This procedure includes the placement and removal of wires, bands, splints and arch bars.
2. Anesthesia procedure (D9248) is a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7771 ALVEOLUS – CLOSED REDUCTION STABILIZATION OF TEETH

1. This procedure includes the placement and removal of wires, bands, splints and arch bars.
2. Anesthesia procedure (D9248) is a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7780 FACIAL BONES – COMPLICATED REDUCTION WITH FIXATION AND MULTIPLE SURGICAL APPROACHES

1. A benefit for the treatment of compound fractures.
2. This procedure includes the placement and removal of wires, bands, splints and arch bars.
3. Anesthesia procedure (D9248) is a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7810 OPEN REDUCTION OF DISLOCATION

PROCEDURE D7820 CLOSED REDUCTION OF DISLOCATION

PROCEDURE D7830 MANIPULATION UNDER

ANESTHESIA

1. Anesthesia procedures (D9248) are a separate benefit, when necessary.

PROCEDURE D7840 CONDYLECTOMY

PROCEDURE D7850 SURGICAL DISCECTOMY, WITH/ WITHOUT IMPLANT

PROCEDURE D7852 DISC REPAIR

PROCEDURE D7854 SYNOVECTOMY

PROCEDURE D7856 MYOTOMY

PROCEDURE D7858 JOINT RECONSTRUCTION

PROCEDURE D7860 ARTHROTOMY

PROCEDURE D7865 ARTHROPLASTY

PROCEDURE D7870 ARTHROCENTESIS

PROCEDURE D7871 NON-ARTHROSCOPIC LYSIS AND LAVAGE

This procedure is included in the fee for other procedures and is not payable separately.

PROCEDURE D7872 ARTHROSCOPY – DIAGNOSIS, WITH OR WITHOUT BIOPSY

PROCEDURE D7873 ARTHROSCOPY – SURGICAL: LAVAGE AND LYSIS OF ADHESIONS

PROCEDURE D7874 ARTHROSCOPY – SURGICAL: DISC REPOSITIONING AND STABILIZATION

PROCEDURE D7875 ARTHROSCOPY – SURGICAL: SYNOVECTOMY

PROCEDURE D7876 ARTHROSCOPY – SURGICAL: DISCECTOMY

PROCEDURE D7877 ARTHROSCOPY – SURGICAL: DEBRIDEMENT

PROCEDURE D7880 OCCLUSAL ORTHOTIC DEVICE, BY REPORT

1. A benefit for diagnosed TMJ dysfunction.
2. Not a benefit for the treatment of bruxism.

PROCEDURE D7899 UNSPECIFIED TMD THERAPY, BY REPORT

Not a benefit for procedures such as acupuncture, acupressure, biofeedback and hypnosis.

PROCEDURE D7910 SUTURE OF RECENT SMALL WOUNDS UP TO 5 CM

Not a benefit for the closure of surgical incisions.

PROCEDURE D7911 COMPLICATED SUTURE – UP TO 5 CM

Not a benefit for the closure of surgical incisions.

PROCEDURE D7912 COMPLICATED SUTURE – GREATER THAN 5 CM

Not a benefit for the closure of surgical incisions.

PROCEDURE D7920 SKIN GRAFT (IDENTIFY DEFECT COVERED, LOCATION AND TYPE OF GRAFT)

Not a benefit for periodontal grafting.

PROCEDURE D7940 OSTEOPLASTY – FOR ORTHOGNATHIC DEFORMITIES

PROCEDURE D7941 OSTEOTOMY – MANDIBULAR RAMI

PROCEDURE D7943 OSTEOTOMY – MANDIBULAR RAMI WITH BONE GRAFT; INCLUDES OBTAINING THE GRAFT

PROCEDURE D7944 OSTEOTOMY – SEGMENTED OR SUBAPICAL

PROCEDURE D7945 OSTEOTOMY – BODY OF MANDIBLE

PROCEDURE D7946 LEFORT I (MAXILLA – TOTAL)

PROCEDURE D7947 LEFORT I (MAXILLA – SEGMENTED)

PROCEDURE D7948 LEFORT II OR LEFORT III (OSTEOPLASTY OF FACIAL BONES FOR MIDFACE HYPOPLASIA OR RETRUSION) – WITHOUT BONE GRAFT

PROCEDURE D7949 LEFORT II OR LEFORT III – WITH BONE GRAFT

PROCEDURE D7950 OSSEOUS, OSTEOPERIOSTEAL, OR CARTILAGE GRAFT OF THE MANDIBLE OR FACIAL BONES – AUTOGENOUS OR NONAUTOGENOUS, BY REPORT

Not a benefit for periodontal grafting.

PROCEDURE D7951 SINUS AUGMENTATION WITH BONE OR BONE SUBSTITUTES VIA A LATERAL OPEN APPROACH

A benefit only for patients with authorized implant services.

PROCEDURE D7952 SINUS AUGMENTATION WITH BONE OR BONE SUBSTITUTE VIA A VERTICAL APPROACH

A benefit only for patients with authorized implant services.

PROCEDURE D7953 BONE REPLACEMENT GRAFT FOR RIDGE PRESERVATION- PER SITE

This procedure is not a benefit.

PROCEDURE D7955 REPAIR OF MAXILLOFACIAL SOFT AND/OR HARD TISSUE DEFECT

Not a benefit for periodontal grafting.

PROCEDURE D7960 FRENULECTOMY ALSO KNOWN AS FRENECTOMY OR FRENOTOMY – SEPARATE PROCEDURE NOT IDENTICAL TO ANOTHER

1. A benefit
   a. once per arch per date of service
   b. only when the permanent incisors and cuspids have erupted.

PROCEDURE D7963 FRENULOPLASTY

1. A benefit
   a. once per arch per date of service.

   only when the permanent incisors and cuspids have erupted.

PROCEDURE D7970 EXCISION OF HYPERPLASTIC TISSUE – PER ARCH

1. A benefit once per arch per date of service.
2. Not a benefit for drug induced hyperplasia or where removal of tissue requires extensive gingival recontouring.
3. This procedure is included in the fees for other surgical procedures that are performed in the same area on the same date of service.

PROCEDURE D7971 EXCISION OF PERICORONAL GINGIVA

This procedure is included in the fee for other associated procedures that are performed on the same tooth on the same date of service.

PROCEDURE D7972 SURGICAL REDUCTION OF FIBROUS TUBEROSITY

1. A benefit once per quadrant per date of service.
2. This procedure is included in the fees for other surgical procedures that are performed in the same quadrant on the same date of service.

PROCEDURE D7980 SIALOLITHOTOMY

PROCEDURE D7981 EXCISION OF SALIVARY GLAND, BY REPORT

PROCEDURE D7982 SIALODOCHOPLASTY

PROCEDURE D7983 CLOSURE OF SALIVARY FISTULA

PROCEDURE D7990 EMERGENCY TRACHEOTOMY

PROCEDURE D7991 CORONOIDECTOMY

PROCEDURE D7995 SYNTHETIC GRAFT – MANDIBLE OR FACIAL BONES, BY REPORT

Not a benefit for periodontal grafting.

PROCEDURE D7996 IMPLANT – MANDIBLE FOR AUGMENTATION PURPOSES (EXCLUDING ALVEOLAR RIDGE), BY REPORT

This procedure is not a benefit.

PROCEDURE D7997 APPLIANCE REMOVAL (NOT BY DENTIST WHO PLACED APPLIANCE), INCLUDES REMOVAL OF ARCH BAR

1. A benefit:
   a. once per arch per date of service.
   b. for the removal of appliances related to

surgical procedures only.

2. Not a benefit for the removal of orthodontic appliances and space maintainers.

PROCEDURE D7998 INTRAORAL PLACEMENT OF A FIXATION DEVICE NOT IN CONJUNCTION WITH A FRACTURE

This procedure is not a benefit.

PROCEDURE D7999 UNSPECIFIED ORAL SURGERY PROCEDURE, BY REPORT

1. Procedure D7999 shall be used:

   a. for a procedure which is not adequately described by a CDT code, or

   b. for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the medical condition and the specific CDT code associated with the treatment.

Orthodontic General Policies (D8000-D8999)

1. **Orthodontic Procedures (D8080, D8660, D8670 and D8680)**

   a. Orthodontic procedures shall only be performed by dentists who qualify as orthodontists under the California Code of Regulations, Title 22, Section 51223(c).

   b. Orthodontic procedures are benefits for medically necessary handicapping malocclusion, cleft palate and facial growth management cases for patients under the age of 19 and shall be prior authorized.

   c. Only those cases with permanent dentition shall be considered for medically necessary handicapping malocclusion, unless the patient is age 13 or older with primary teeth remaining. Cleft palate and craniofacial anomaly cases are a benefit for primary, mixed and permanent dentitions. Craniofacial anomalies are treated using facial growth management.

   d. All necessary procedures that may affect orthodontic treatment shall be completed before orthodontic treatment is considered.

   e. Orthodontic procedures are a benefit only when the diagnostic casts verify a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (06/09) or one of the six automatic qualifying conditions below exist or when there is written documentation of a craniofacial anomaly from a credentialed specialist on their professional letterhead.

   f. The automatic qualifying conditions are:

      i) cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,

      ii) craniofacial anomaly. Written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,

      iii) a deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,

      iv) a crossbite of individual anterior teeth causing destruction of soft tissue,

      v) an overjet greater than 9 mm or reverse overjet greater than 3.5 mm,

      vi) a severe traumatic deviation (such as loss of a premaxilla segment by burns, accident or osteomyelitis or other gross pathology). Written documentation of the trauma or pathology shall be submitted with the prior authorization request.

   g. When a patient transfers from one orthodontist to another orthodontist, prior authorization shall be submitted:

      i) when the patient has already qualified and has been receiving treatment, the balance of the originally authorized treatment shall be authorized to the new orthodontist to complete the case. Diagnostic casts, Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (06/09), and photographs are not required for a transfer case that has already been approved, or

      ii) when a patient has been receiving orthodontic treatment that has not been previously approved, pre-treatment diagnostic casts and current photographs are required. If pre-treatment diagnostic casts are not available then current diagnostic casts shall be submitted. Prior authorization for the balance of the orthodontic treatment shall be allowed or denied based on plan's evaluation of the diagnostic casts and photographs.

h. When additional periodic orthodontic treatment visit(s) (D8670) are necessary beyond the maximum allowed to complete the case, prior authorization is required. Current photographs are required to justify the medical necessity.

i. If the patient's orthodontic treatment extends beyond the month of their 19th birthday or they become ineligible during treatment, then it is the patient's responsibility to pay for their continued treatment.

j. If the patient's orthodontic treatment is interrupted and orthodontic bands are prematurely removed, then the patient no longer qualifies for continued orthodontic treatment.

k. If the patient's orthodontic bands have to be temporarily removed and then replaced due to a medical necessity, a claim for comprehensive orthodontic treatment of the adolescent dentition (D8080) for rebanding shall be submitted along with a letter from the treating physician or radiologist, on their professional letterhead, stating the reason why the bands needed to be temporarily removed.

Orthodontic Procedures (D8000-D8999)

PROCEDURE D8080
COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION

1. Prior authorization is required. The following shall be submitted together for prior authorization:
   a. comprehensive orthodontic treatment of the adolescent dentition (D8080), and
   b. periodic orthodontic treatment visit(s) (D8670), and
   c. orthodontic retention (D8680), and
   d. the diagnostic casts (D0470), and
   e. a completed Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (06/09).
2. No treatment will be authorized after the month of the patient's 19th birthday.
3. Written documentation for prior authorization for cleft palate and facial growth management cases shall be submitted:
   a. cleft palate cases require documentation from a credentialed specialist, on their professional letterhead, if the cleft palate is not visible on the diagnostic casts, or facial growth management cases require documentation from a credentialed specialist, on their professional letterhead, of the craniofacial anomaly.
4. A benefit:
   a. for handicapping malocclusion, cleft palate and facial growth management cases.
   b. for patients under the age of 19.
   c. for permanent dentition (unless the patient is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly).
   d. once per patient per phase of treatment.
5. All appliances (such as bands, arch wires, headgear and palatal expanders) are included in the fee for this procedure. No additional charge to the patient is permitted.
6. This procedure includes the replacement, repair and removal of brackets, bands and arch wires by the original provider.

PROCEDURE D8210
REMOVABLE APPLIANCE THERAPY

1. Prior authorization is required.
2. Radiographs for prior authorization –submit current periapical radiographs of the maxillary anterior teeth.
3. Written documentation for prior authorization –shall justify the medical necessity for the appliance and the presence of a harmful oral habit such as thumb sucking and/or tongue thrusting.
4. A benefit:
   a. for patients ages 6 through 12.
   b. once per patient.
5. Not a benefit:
   a. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.
   b. for space maintainers in the upper or lower anterior region.
6. This procedure includes all adjustments to the appliance.

PROCEDURE D8220
FIXED APPLIANCE THERAPY

1. Prior authorization is required.
2. Radiographs for prior authorization –submit current periapical radiographs of the maxillary anterior teeth.
3. Written documentation for

prior authorization –shall justify the medical necessity for the appliance and the presence of a

harmful oral habit such as thumb sucking and/or tongue thrusting.

4. A benefit:
   a. for patients ages 6 through 12.
   b. once per patient.
5. Not a benefit:
   a. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.
   b. for space maintainers in the upper or lower anterior region.
6. This procedure includes all adjustments to the appliance.

PROCEDURE D8660 PRE-ORTHODONTIC TREATMENT VISIT

1. This procedure is for the observation of the patient's oral and/or facial growth for craniofacial anomalies prior to starting orthodontic treatment for facial growth management cases.
2. Prior authorization is required. The following shall be submitted together for authorization:
   a. comprehensive orthodontic treatment of the adolescent dentition (D8080), and
   b. pre-orthodontic treatment visit(s) (D8660) indicating the quantity of treatment visits required up to a maximum of six during the patient's lifetime, and
   c. periodic orthodontic treatment visit(s) (D8670), and

   orthodontic retention (D8680), and
   d. a completed Handicapping Labio- Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (06/09).
3. Written documentation for prior authorization- shall include a letter from a credentialed specialist, on their professional letterhead, confirming a craniofacial anomaly.
4. A benefit:
   a. prior to comprehensive orthodontic treatment of the adolescent dentition (D8080) for the initial treatment phase for facial growth management cases regardless of how many dentition phases are required.
   b. once every three months.
   c. for patients under the age of 19.
   d. for a maximum of six.

PROCEDURE D8670 PERIODIC ORTHODONTIC TREATMENT VISIT (AS PART OF CONTRACT)

1. Prior authorization is required. Refer to Orthodontic General Policies for specific authorization requirements.
2. The start of payments for this procedure shall be the next calendar month following the date of service for comprehensive orthodontic treatment of the adolescent dentition (D8080).
3. A benefit:
   a. for patients under the age of 19.
   b. for permanent dentition (unless the patient is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly).
   c. once per calendar quarter.
4. The maximum quantity of monthly treatment visits for the following phases are:
   a. Malocclusion- up to a maximum of 8 quarterly visits. (4 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity), or
   b. Cleft Palate:
      i) Primary dentition – up to a maximum of 4 quarterly visits. (2 additional quarterly visits shall be authorized when documentation and

photographs justify the medical necessity).

ii) Mixed dentition - up to a maximum of 5 quarterly visits. (3 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).

iii) Permanent dentition- up to a maximum of 10 quarterly visits. (5 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity), or

c. Facial Growth Management:

i) Primary dentition- up to a maximum of 4 quarterly visits. (2 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).

ii) Mixed dentition- up to a maximum of 5 quarterly visits. (3 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).

iii) Permanent dentition- up to a maximum of 8 quarterly visits. (4 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).

PROCEDURE D8680 ORTHODONTIC RETENTION (REMOVAL OF APPLIANCES, CONSTRUCTION AND PLACEMENT OF RETAINER(S))

1. Prior authorization is required. Refer to Orthodontic General Policies for specific authorization requirements.
2. This procedure shall be paid only following the completion of periodic orthodontic treatment visit(s) (D8670) which is considered to be the active phase of orthodontic treatment.
3. Requires an arch code.
4. A benefit:
   a. for patients under the age of 19.
   b. for permanent dentition (unless the patient is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly).
   c. once per arch for each authorized phase of orthodontic treatment.
5. Not a benefit until the active phase of orthodontic treatment (D8670) is completed. If fewer than the authorized number of periodic orthodontic treatment visit(s) (D8670) are necessary because the active phase of treatment has been completed early, then this shall be documented on the claim for orthodontic retention (D8680).
6. The removal of appliances, construction and placement of retainers, all observations and necessary adjustments are included in the fee for this procedure.

PROCEDURE D8691 REPAIR OF ORTHODONTIC APPLIANCE

1. This procedure does not require prior authorization.
2. Written documentation for payment – indicate the type of orthodontic appliance and a description of the repair.
3. Requires an arch code.
4. A benefit:
   a. for patients under the age of 19.
   b. once per appliance.
5. Not a benefit to the original provider for the replacement and/or repair of brackets, bands, or arch wires.

PROCEDURE D8692 REPLACEMENT OF LOST OR BROKEN RETAINER

1. This procedure does not require prior authorization.
2. Written documentation for payment – indicate how the retainer was lost or why it is no longer serviceable.
3. Requires an arch code.
4. A benefit:
   a. for patients under the age of 19.
   b. once per arch.

c. only within 24 months following the date ofservice of orthodontic retention (D8680).

5. This procedure is only payable when orthodontic retention (D8680) has been previously paid by the program.

PROCEDURE D8693 REBONDING OR RECEMENTING: AND/OR REPAIR, AS REQUIRED, OF FIXED RETAINERS

1. This procedure does not require prior authorization.
2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
3. Requires an arch code.
4. A benefit:
   a. for patients under the age of 19.
   b. once per provider.
5. Additional requests beyond the stated frequency limitations shall be considered for payment when the medical necessity is documented and identifies an unusual condition (such as displacement due to a sticky food item).

PROCEDURE D8999 UNSPECIFIED ORTHODONTIC PROCEDURE, BY REPORT

1. Prior authorization is required for non-emergency procedures.
2. Radiographs for prior authorization - submit radiographs if applicable for the type of procedure.
3. Photographs for prior authorization - submit photographs if applicable for the type of procedure.
4. Written documentation for prior authorization or payment – describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed or actual treatment.
5. A benefit for patients under the age of 19.
6. Not a benefit to the original provider for the adjustment, repair, replacement or removal of brackets, bands or arch wires.
7. Procedure D8999 shall be used:
   a. for a procedure which is not adequately described by a CDT code, or
   b. for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the medical condition and the specific CDT code associated with the treatment.

Adjunctive General Policies (D9000-D9999)

Anesthesia (D9210-D9248)

a) General anesthesia (D9223) is defined as a controlled state of unconsciousness, accompanied by a partial or complete loss of protective reflexes, including the loss of the ability to independently maintain an airway and respond purposefully to physical stimulation or verbal command, produced by a pharmacologic or non-pharmacologic method or combination thereof.

b) Intravenous sedation/analgesia (D9241 and D9243) is a medically controlled state of depressed consciousness while maintaining the patient's airway, protective reflexes and the ability to respond to stimulation or verbal commands. It includes intravenous (IV) administration of sedative and/or analgesic agent(s) and appropriate monitoring.

c) Non-intravenous conscious sedation (D9248) is a medically controlled state of depressed consciousness while maintaining the patient's airway, protective reflexes and the ability to respond to stimulation or verbal commands. It includes administration of sedative and/or analgesic agent(s) by a route other than IV (oral, patch, intramuscular or subcutaneous) and appropriate monitoring.

d) Deep sedation/general anesthesia (D9223) and intravenous conscious sedation/ analgesia (D9241 and D9243) shall be considered for payment when it is documented why local anesthesia is contraindicated. Such contraindications shall include the following:

   i) a severe mental or physical handicap,

   ii) extensive surgical procedures,

   iii) an uncooperative child,

   iv) an acute infection at an injection site,

   v) a failure of a local anesthetic to control pain.

e) The administration of deep sedation/general anesthesia (D9223), nitrous oxide (D9230), intravenous conscious sedation/analgesia (D9241 and D9243) and therapeutic parenteral drug (D9610) is a benefit in conjunction with payable associated procedures.

f) Only one anesthesia procedure is payable per date of service regardless of the methods of administration or drugs used. When one or more anesthesia procedures are performed only the most profound procedure will be allowed. The following anesthesia procedures are listed in order from most profound to least profound:

   i) Procedure D9223 (Deep Sedation/General Anesthesia),

   ii) Procedure D9241/D9243 (Intravenous Conscious Sedation/Analgesia),

   iii) Procedure D9248 (Non-Intravenous Conscious Sedation),

   iv) Procedure D9230 (Inhalation Of Nitrous Oxide/Analgesia, Anxiolysis).

g) Providers who administer general anesthesia (D9223) and/or intravenous conscious sedation/analgesia (D9241 and D9243) shall have valid anesthesia permits with the California Dental Board.

h) The cost of analgesic and anesthetic agents and supplies are included in the fee for the analgesic/ anesthetic procedure.

I) Anesthesia time for general anesthesia and intravenous conscious sedation is defined as the period between the beginning of the administration of the anesthetic agent and the time that the anesthetist is no longer in personal attendance.

J) Sedation is a benefit in conjunction with the surgical removal of wires, bands, splints and arch bars.

Adjunctive Service Procedures (D9000-D9999)

PROCEDURE D9110 PALLIATIVE (EMERGENCY) TREATMENT OF DENTAL PAIN – MINOR

1. A benefit once per date of service per provider regardless of the number of teeth and/or areas treated.
2. Not a benefit when any other treatment is performed on the same date of service, except when radiographs/ photographs are needed of the affected area to diagnose and document the emergency condition.

PROCEDURE D9120 FIXED PARTIAL DENTURE SECTIONING

1. Requires a tooth code for the retained tooth.
2. A benefit when at least one of the abutment teeth is to be retained.

PROCEDURE D9210 LOCAL ANESTHESIA NOT IN CONJUNCTION WITH OPERATIVE OR SURGICAL PROCEDURES

A benefit:

a. once per date of service per provider.

b. only for use in order to perform a differential diagnosis or as a therapeutic injection to eliminate or control a disease or abnormal state.

2. Not a benefit when any other treatment is performed on the same date of service, except when radiographs/ photographs are needed of the affected area to diagnose and document the emergency condition.

PROCEDURE D9211 REGIONAL BLOCK ANESTHESIA

This procedure is included in the fee for other procedures and is not payable separately.

PROCEDURE D9212 TRIGEMINAL DIVISION BLOCK ANESTHESIA

This procedure is included in the fee for other procedures and is not payable separately.

PROCEDURE D9215 LOCAL ANESTHESIA IN CONJUNCTION WITH OPERATIVE OR SURGICAL PROCEDURES

This procedure is included in the fee for other procedures and is not payable separately.

PROCEDURE D9230 INHALATION OF NITROUS OXIDE/ANXIOLYSIS, ANALGESIA

1. Written documentation for patients age 13 or older- shall indicate the physical, behavioral, developmental or emotional condition that prohibits the patient from responding to the provider's attempts to perform treatment.
2. A benefit:

   a. for uncooperative patients under the age of 13, or

   b. for patients age 13 or older when documentation specifically identifies the physical, behavioral, developmental or emotional condition that prohibits the patient from responding to the provider's attempts to perform treatment.

3. Not a benefit:

   a. on the same date of service as deep sedation/general anesthesia (D9223), intravenous conscious sedation/ analgesia (D9241 and D9243) or non-intravenous conscious sedation (D9248).

   b. when all associated procedures on the same date of service by the same provider are denied.

PROCEDURE D9241 INTRAVENOUS CONSCIOUS SEDATION/ANALGESIA – FIRST 30 MINUTES

1. Written documentation–shall justify the medical necessity based on a mental or physical limitation or contraindication to a local anesthetic agent.
2. Not a benefit:

   on the same date of service as deep sedation/general anesthesia (D9223), analgesia, anxiolysis, inhalation of nitrous oxide (D9230) or non- intravenous conscious sedation (D9248).

   a. when all associated procedures on the same date of service by the same provider are denied.

PROCEDURE D9248 NON-INTRAVENOUS CONSCIOUS SEDATION

1. Written documentation for patients age 13 or older- shall indicate the physical,

behavioral, developmental or emotional condition that prohibits the patient from responding to the provider's attempts to perform treatment.

2. A benefit:
   a. for uncooperative patients under the age of 13, or
   b. for patients age 13 or older when documentation specifically identifies the physical, behavioral, developmental or emotional condition that prohibits the patient from responding to the provider's attempts to perform treatment.
   c. for oral, patch, intramuscular or subcutaneous routes of administration.
   d. once per date of service.
3. Not a benefit:

   on the same date of service as deep sedation/general anesthesia (D9223), analgesia, anxiolysis, inhalation of nitrous oxide (D9230) or intravenous conscious sedation/ analgesia (D9241 and D9243).

   a. when all associated procedures on the same date of service by the same provider are denied.

PROCEDURE D9310 CONSULTATION - (DIAGNOSTIC SERVICE PROVIDED BY DENTIST OR PHYSICIAN OTHER THAN REQUESTING DENTIST OR PHYSICIAN

PROCEDURE D9410 HOUSE/EXTENDED CARE FACILITY CALL

1. A benefit:
   a. once per patient per date of service.

   only in conjunction with procedures that are payable.

PROCEDURE D9420 HOSPITAL OR AMBULATORY SURGICAL CENTER CALL

1. Not a benefit:
   a. for an assistant surgeon.
   b. for time spent compiling the patient history, writing reports or for post- operative or follow up visits.

PROCEDURE D9430 OFFICE VISIT FOR OBSERVATION (DURING REGULARLY SCHEDULED HOURS) – NO OTHER SERVICES PERFORMED

1. Not a benefit:
   a. when procedures other than necessary radiographs and/or photographs are provided on the same date of service.
   b. for visits to patients residing in a house/ extended care facility.

PROCEDURE D9440 OFFICE VISIT – AFTER REGULARLY SCHEDULED HOURS

1. A benefit
   a. once per date of service per provider.
   b. only with treatment that is a benefit.
2. This procedure is to compensate providers for travel time back to the office for emergencies outside of regular office hours.

PROCEDURE D9610 THERAPEUTIC PARENTERAL DRUG, SINGLE ADMINISTRATION

1. A benefit for up to a maximum of four injections per date of service.
2. Not a benefit:
   a. for the administration of an analgesic or sedative when used in conjunction with deep sedation/general anesthesia (D9223), analgesia, anxiolysis, inhalation of nitrous oxide (D9230), intravenous conscious sedation/ analgesia (D9241 and D9243) or non- intravenous conscious sedation (D9248).
   b. when all associated procedures on the same date of service by the same provider are denied.

PROCEDURE D9612 THERAPEUTIC PARENTERAL DRUG, TWO OR MORE ADMINISTRATIONS, DIFFERENT MEDICATIONS

PROCEDURE D9910 APPLICATION OF DESENSITIZING MEDICAMENT

1. A benefit:
   a. once in a 12-month period per provider.
   b. for permanent teeth only.
2. Not a benefit:
   a. when used as a base, liner or adhesive under a restoration.
   b. the same date of

service as fluoride (D1206 and D1208).

PROCEDURE D9930 TREATMENT OF COMPLICATIONS (POST-SURGICAL) – UNUSUAL CIRCUMSTANCES, BY REPORT

1. A benefit:
   a. once per date of service per provider.
   b. for the treatment of a dry socket or excessive bleeding within 30 days of the date of service of an extraction.
   c. for the removal of bony fragments within 30 days of the date of service of an extraction.
2. Not a benefit:
   a. for the removal of bony fragments on the same date of service as an extraction.
   b. for routine post-operative visits.

PROCEDURE D9950 OCCLUSION ANALYSIS – MOUNTED CASE

1. A benefit:
   a. once in a 12-month period.
   b. for patients age 13 or older.
   c. for diagnosed TMJ dysfunction only.
   d. for permanent dentition.
2. Not a benefit for bruxism only.

PROCEDURE D9951 PROCEDURE OCCLUSAL ADJUSTMENT - LIMITED

1. A benefit:
   a. once in a 12-month period per quadrant per provider.
   b. for patients age 13 or older.
   c. for natural teeth only.
2. Not a benefit within 30 days following definitive restorative, endodontic, removable and fixed prosthodontic treatment in the same or opposing quadrant.

PROCEDURE D9952 OCCLUSAL ADJUSTMENT - COMPLETE

1. A benefit:
   a. once in a 12-month period following occlusion analysis-mounted case (D9950).
   b. for patients age 13 or older.
   c. for diagnosed TMJ dysfunction only.
   d. for permanent dentition.
2. Not a benefit in conjunction with an occlusal orthotic device (D7880).

PROCEDURE D9999 UNSPECIFIED ADJUNCTIVE PROCEDURE, BY REPORT

1. Procedure D9999 shall be used:
   a. for a procedure which is not adequately described by a CDT code, or
   b. for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the medical condition and the specific CDT code associated with the treatment.

Adult Only Benefits Description

This section lists the dental benefits and services you **(Individuals Ages 19 and over)** are allowed to obtain through the Plan when the services are necessary for your dental health consistent with professionally recognized standards of practice, subject to the exceptions and limitations and exclusions listed here.

Diagnostic and Preventive Benefits

Description

Benefit includes:

- Initial and periodic oral examinations (*Limited to two (2) in a twelve (12) month period*)
- Consultations, including specialist consultations
- Preventive dental education and oral hygiene instruction
- X-ray films
- Panoramic film
- Prophylaxis services (cleanings) (*Limited to two (2) in a twelve (12) month period*)
- Space maintainer – removable - bilateral

Limitations

X-rays are limited as follows:

- Bitewing x-rays in conjunction with periodic examinations are limited to two series of four films in any twelve (12) month period. Isolated bitewing or periapical films are allowed on an emergency or episodic basis.
- Full mouth x-rays in conjunction with periodic examinations are limited to once every twenty (24) consecutive months
- Panoramic film x-rays are limited to once every twenty-four (24) consecutive months

Restorative Dentistry

Description

Restorations include:

- Amalgam, composite resin, acrylic, synthetic or plastic restorations for the treatment of caries
- Micro filled resin restorations which are non-cosmetic.
- Replacement of a restoration
- Use of pins and pin build-up in conjunction with a restoration
- Sedative base and sedative fillings

Limitations

Restorations are limited to the following:

- For the treatment of caries, if the tooth can be restored with amalgam, composite resin, acrylic, synthetic or plastic restorations; any other restoration such as a crown or jacket is considered optional.
- Composite resin or acrylic restorations in posterior teeth are optional.
- Replacement of a restoration is covered only when it is defective, as evidenced by conditions such as recurrent caries or fracture, and replacement is dentally necessary
- Frequency limitations are calculated to the exact date.
- Fillings: Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners, and acid etch procedures.
- Crowns: There is an additional copayment of $125 per unit for treatment plans of 7 or more units. There is an additional copayment for $75 per unit for porcelain on molars. Actual metal fees will apply for any procedure involving noble, high noble, or titanium metals.
- The replacement of crowns requires the existing restoration to be 5+ years old.

Oral Surgery

Description

Oral surgery includes:

- Extractions, including surgical extractions
- Removal of impacted teeth
- Biopsy of oral tissues
- Alveolectomies
- Excision of cysts and neoplasms
- Treatment of palatal torus
- Treatment of mandibular torus
- Frenectomy
- Incision and drainage of abscesses
- Post-operative services, including exams, suture removal and treatment of complications
- Root recovery (separate procedure)

Limitation

- The surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists.
- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.
- Removal of pathology-free 3rd molars is not covered.
- Biopsy of oral tissue does not include pathology laboratory services.

Endodontics

Description

Endodontic benefits include:

- Direct pulp capping
- Pulpotomy and vital pulpotomy
- Apexification filling with calcium hydroxide
- Root amputation
- Root canal therapy, including culture canal and limited retreatment of previous root canal therapy as specified below
- Apicoectomy
- Vitality tests

Limitations

Root canal therapy, including culture canal, is limited as follows:

- Retreatment of root canals is a covered benefit only if clinical or radiographic signs of abscess formation are present and/or the patient is experiencing symptoms.
- Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology, is not a covered benefit.
- Including all pre-operative and post-operative x-rays, bacteriologic cultures, diagnostic tests, local anesthesia, all irrigants, obstruction of root canals and routine follow-up care.
- Retreatment of a root canal, within a twenty-four (24) month period, is not payable to the same provider that did the original root canal.

Periodontics

Description

Periodontics benefits include:

- Emergency treatment, including treatment for periodontal abscess and acute periodontitis
- Periodontal scaling and root planing, and subgingival curettage
- Gingivectomy
- Osseous or muco-gingival surgery

Limitation

- Periodontal scaling and root planing, and subgingival curettage are limited to five (5) quadrant treatments in any twelve (12) consecutive months.
- Includes pre-operative and post-operative evaluations and treatment of natural teeth under a local anesthetic.

Crown and Fixed Bridge

Description

Crown and fixed bridge benefits include:

- Crowns, including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold onlay or three quarter crown, and stainless steel
- Related dowel pins and pin build-up
- Fixed bridges, which are cast, porcelain baked with metal, or plastic processed to gold
- Recementation of crowns, bridges, inlays and onlays

- Cast post and core, including cast retention under crowns
- Repair or replacement of crowns, abutments or pontics

Limitation

The crown benefit is limited as follows:

- Replacement of each unit is limited to once every sixty (60) consecutive months, except when the crown is no longer functional as determined by the Plan.
- Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. For example, if the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling.
- Veneers posterior to the second bicuspid are considered optional. An allowance will be made for a cast full crown.

The fixed bridge benefit is limited as follows:

- Fixed bridges will be used only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered optional treatment.
- A fixed bridge is covered when it is necessary to replace a missing permanent anterior tooth in a person sixteen (16) years of age or older and the patient's oral health and general dental condition permits.
- Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic.
- Fixed bridges are optional when provided in connection with a partial denture on the same arch.
- Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair.
- Frequency limitations are calculated to the exact date.
- Prosthodontics fixed (each retainer and each pontic constitutes a unit in a fixed partial denture (bridge)).
- There is an additional co-payment of $125 per unit for treatment plans of seven (7) or more units.
- There is an additional co-payment of $75 per unit for porcelain on molars.
- Actual fees will apply for any procedure involving noble, high noble, or titanium metals.
- Implants and implant-related procedures are not covered.

The program allows up to five units of crown or bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction, which is optional treatment.

Removable Prosthetics

Description

The removable prosthetics benefit includes:

- Dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers
- Office or laboratory relines or rebases
- Denture repair

- Denture adjustment
- Tissue conditioning
- Denture duplication
- Stayplates

Limitations

The removable prosthetics benefit is limited as follows:

- Partial dentures will not be replaced within sixty (60) consecutive months, unless:
  1. It is necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible, or
  2. The denture is unsatisfactory and cannot be made satisfactory.
- The covered dental benefit for partial dentures will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. If a more elaborate or precision appliance is chosen by the patient and the dentist, and is not necessary to satisfactorily restore an arch, the patient will be responsible for all additional charges.
- A removable partial denture is considered an adequate restoration of a case when teeth are missing on both sides of the dental arch. Other treatments of such cases are considered optional.
- Full upper and/or lower dentures are not to be replaced within sixty (60) consecutive months unless the existing denture is unsatisfactory and cannot be made satisfactory by reline or repair.
- The covered dental benefit for complete dentures will be limited to the benefit level for a standard procedure. If a more personalized or specialized treatment is chosen by the patient and the dentist, the patient will be responsible for all additional charges.
- Office or laboratory relines or rebases are limited to one (1) per arch in any twelve (12) consecutive months.
- Tissue conditioning is limited to two per denture
- Implants are considered an optional benefit
- Frequency limitations are calculated to the exact date.
- Prosthodontics fixed (each retainer and each Pontic constitutes a unit in a fixed partial denture (bridge)).
- There is an additional copayment of $125 per unit for treatment plans of seven (7) or more units.
- There is an additional copayment of $75 per unit for porcelain on molars. Actual metal fees will apply for any procedure involving noble, high noble, or titanium metals.
- The replacement of retainers and pontics requires the existing bridge to be 5+ years old.

Other Benefits

Description

Other dental benefits include:

- Local anesthetics
- Oral sedatives when dispensed in a dental office by a practitioner acting within the scope of their licensure
- Nitrous oxide when dispensed in a dental office by a practitioner acting within the scope of their licensure
- Emergency treatment, palliative treatment

- Occlusual guard, by report
- External bleaching – per arch
- Coordination of benefits with member's health plan in the event hospitalization or outpatient surgery setting is medically appropriate for dental services

Orthodontic Benefits

Orthodontic treatment includes medically-necessary orthodontia only and is limited to individuals up to age 19.

Adult Only Exclusions

The following dental benefits are excluded under the plan for **Individuals Ages 19 and over**:

1. Any service that is not specifically listed as a covered benefit.
2. Services, which in the opinion of the attending dentist are not necessary to the member's dental health.
3. Experimental or investigational services, including any treatment, therapy, procedure or drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supply which is not recognized as being in accordance with generally accepted professional standards or for which the safety and efficacy have not been determined for use in the treatment for which the item or service in question is recommended or prescribed.
4. Services, which were provided without cost to the member by State government or an agency thereof, or any municipality, county or other subdivisions.
5. Additional treatment costs incurred because a dental procedure is unable to be performed in the dentist's office due to the general health and physical limitations of the member.
6. Dental Services that are received in an emergency care setting for conditions that are not emergencies if the subscriber reasonably should have known that an emergency care situation did not exist.
7. Dental expenses incurred in connection with any dental procedures started after termination of coverage or prior to the date the member became eligible for such services.
8. Procedures, appliances, or restorations to correct congenital or developmental malformations, unless specifically listed in the Benefits section above.
9. Hospital charges of any kind.
10. Dispensing of drugs not normally supplied in a dental office
11. Major surgery for fractures and dislocations
12. Loss or theft of dentures or bridgework without appropriate documentation (i.e. police report or natural disaster).
13. Malignancies.
14. The cost of precious metals used in any form of dental benefits.
15. Implants and implant-related services
16. Placement and replacement of Cantilever and Maryland/Resin-bonded bridges
17. Extraction of pathology-free teeth, including supernumerary teeth (unless for medically necessary orthodontics)

18. Cosmetic dental care
19. Services of a pedodontist/pediatric dentist, except when the member is unable to be treated by his or her PCD, or treatment by a pedodontist/pediatric dentist is medically necessary, or his or her PCD is a pedodontist/pediatric dentist.

Endnotes to 2017 Dental Standard Benefit Plan Designs
Pediatric Dental EHB Notes (only applicable to the pediatric portion of the Children's Dental Plan, Family Dental Plan or Group Dental Plan)

1) Deductible is waived for Diagnostic and Preventive Services.
2) Cost sharing payments made by each individual child for in-network covered services accrue to the child's out-of-pocket maximum. Once the child's individual out of-pocket maximum has been reached, the plan pays all costs for covered services for that child.
3) In a plan with two or more children, cost sharing payments made by each individual child for in-network services contribute to the family out-of-pocket maximum.
4) In a plan with two or more children, cost sharing payments made by each individual child for out-of-network covered services contribute to the family out-of-network deductible, if applicable, and do not accumulate to the family out-of-pocket maximum.
5) Administration of these plan designs must comply with requirements of the pediatric dental EHB benchmark plan, including coverage of services in circumstances of medical necessity as defined in the Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.
6) The requirements set forth in 10 CCR 6522 (a)(4)(A) and (a)(5)(A) shall apply to the Group Dental Plan design.
7) Member cost share for Medically Necessary Orthodontia services applies to course of treatment, not individual benefit years within a multi-year course of treatment. This member cost share applies to the course of treatment as long as the member remains enrolled in the plan.

Adult Dental Benefit Notes (only applicable to the Family Dental Plan and Group Dental Plan)

1) Each adult is responsible for an individual deductible.
2) Deductible is waived for Diagnostic and Preventive Services.
3) The requirements set forth in 10 CCR 6522 (a)(4)(A) and (a)(5)(A) shall apply to the Group Dental Plan design.
4) Tooth whitening, adult orthodontia and implants are not covered services.

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