

Participating dentists' handbook

DELTA DENTAL OF VIRGINIA • 2026

DELTA DENTAL®

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Forward

This handbook provides information to Virginia dentists and their office staff about Delta Dental of Virginia's (Delta Dental) policies, practices and procedures. It is designed to provide helpful information about document completion and the administration of Delta Dental's programs. Keep a copy of the *Participating dentists' handbook* (Handbook) as a reference for Delta Dental's dental care programs. It has been written with you in mind.

Delta Dental may send a revised Handbook, and/or additional pages to insert into your Handbook, in order to keep this reference material as current as possible. If you have questions or would like more information, contact:

Professional Relations
Delta Dental of Virginia
5415 Airport Road
Roanoke, VA 24012
855.474.5644
ProfessionalRelations@deltadentalva.com

The dentist Handbook is part of your participation agreement. The agreement consists of the participation agreement, dentist Handbook, and any amendments and attachments. All provisions in this dentist Handbook are subject to the terms, conditions and limitations of your participation agreement.

The information in this Handbook is for claims administration and billing purposes only. It does not constitute the rendering of dental services or professional dental advice to any patient by Delta Dental or any director, officer, employee or consultant of Delta Dental.

The Handbook is Delta Dental's sole and exclusive property. It may not be reproduced or shared with anyone other than the dentist(s) and other dental professionals in the practice to which the Handbook is furnished without Delta Dental's prior written consent.

The dentist or other professional to whom Delta Dental furnishes the Handbook must make any other individual with whom they share it aware of Delta Dental's proprietary interest.

A Delta Dental overview

Established by dentists in 1964 as the Virginia Dental Service Plan, Delta Dental of Virginia (Delta Dental) is a not-for-profit service corporation specializing in providing the best dental benefits at an affordable cost. As the Delta Dental member company for Virginia, we are affiliated with the nation's oldest and largest dental insurance provider, Delta Dental Plans Association. Dental prepayment programs were pioneered by Delta Dental, which services more than 78 million Americans,* or 31.2% of the estimated 290.5 million people** with dental insurance in the United States and Puerto Rico. Delta Dental services all 50 states and several U.S. territories, covering people in more than 175,000 groups nationwide.*

DELTA DENTAL NETWORK PARTICIPATION

Delta Dental focuses on getting patients into your office as an essential part of maintaining good oral and overall health. Joining our network gives you exposure to the nation's largest dental insurance* customer base. Three out of four dentists nationwide participate in a Delta Dental network, and for good reason — we help attract and retain patients.

- **National exposure with local support:** Delta Dental is the largest dental carrier in the nation. Our member companies serve more than 78 million Americans* nationwide.
- **Fast payment for services:** Delta Dental's state-of-the-art claims processing systems and expert claims reviewers handled more than 140 million claims* with an average turnaround time of less than three days.
- **Online tools and services:** Dedicated professional relations staff ready to serve you and your office, as well as online and phone features that provide immediate access to eligibility, claims status and more.

DELTA DENTAL OF VIRGINIA MISSION STATEMENT

We create healthy smiles in the community through our people, access to quality oral care and health-related products and services.

DELTA DENTAL PLANS ASSOCIATION MISSION STATEMENT

Delta Dental Plans Association's purpose is to promote an increase in the availability of dental care to the public by encouraging the expansion of dental benefit programs administered through Delta Dental member companies and by providing the means for such service corporations to cooperate in providing multi-state and national group dental coverage.

*Delta Dental Plans Association, 2024. **Delta Dental Plans Association, 2023.

Delta Dental of Virginia information directory

PROFESSIONAL RELATIONS DEPARTMENT

Call 855.474.5644 or email ProfessionalRelations@deltadentalva.com for information on:

- Participation and credentialing
- Practice changes
- Direct Deposit (EFT) enrollment
- Website and portal assistance

BENEFIT SERVICES DEPARTMENT

Call 800.237.6060 or email CustomerService.HelpDesk@deltadentalva.com for help with:

- Claim payment explanation
- Coordination of benefits
- Orthodontic claim inquiries
- Processing policy explanation

DELTADENTALVA.COM

Log in to our dentist portal for:

- Patient benefits, eligibility and limitations
- New claims or to check claims status
- Predeterminations
- Recent payments
- Dentist contracts and forms

AUTOMATED CLAIM INFORMATION SYSTEM (ACIS)

Delta Dental of Virginia's **ACIS** is available at 800.237.6060. Press "2" at the menu for:

- Patient eligibility and benefit fax-back
- Claims status

DELTA DENTAL INDIVIDUAL AND FAMILY™ PLANS

Call 888.899.3734 or go to DeltaDentalCoversMe.com for help with patients covered under individual and family plans:

- Patient benefits, eligibility and limitations
- Claim status and payment explanations
- Predeterminations

Mailing address for claims:
Delta Dental
PO Box 103
Stevens Point, WI 54481
Payor ID: WDENC

DELTA DENTAL MEDICARE ADVANTAGE™

Call 866.327.0597 or go to ToolKitsOnline.com. Login to **DeltaDentalVA.com/dentists** and click on the Documents tab for Medicare Advantage resources.
Mailing address for claims:
Delta Dental
Attn: Medicare Advantage
PO Box 9215
Farmington Hills, MI 48333
Payor ID: VACMS

Delta Dental member companies

Delta Dental Insurance Company — Alabama
(See Delta Dental Insurance Company — Georgia)

Delta Dental of Alaska
Delta Dental of Oregon (Alaska)
P.O. Box 40384
Portland, OR 97240
888.374.8906
DeltaDentalAK.com
Payer #CDOR1

Delta Dental of Arizona
5656 W Talavi Blvd.
Glendale, AZ 85306
602.588.3982
DeltaDentalAZ.com
Payer #86027

Delta Dental of Arkansas
P.O. Box 15965
N. Little Rock, AR 72231
800.462.5410
DeltaDentalAR.com
Payer #CDAR1

Delta Dental of California
P.O. Box 997330
Sacramento, CA 95899
888.335.8227
DeltaDentalIns.com
Payer #77777

Delta Dental of Colorado
P.O. Box 173803
Denver, CO 80217-3803
800.610.0201
DeltaDentalCO.com
Payer #84056

Delta Dental of Connecticut
(See Delta Dental of New Jersey)
Payer #22189

Delta Dental of Delaware (See Delta Dental of Pennsylvania)
Payer #51022

Delta Dental of the District of Columbia
(See Delta Dental of Pennsylvania)
Payer #52147

Delta Dental Insurance Company — Florida
(See Delta Dental Insurance Company — Georgia)

Delta Dental Insurance Company — Georgia
P.O. Box 1809
Alpharetta, GA 30023
800.521.2651
DeltaDentalIns.com
Payer #94276

Hawaii Dental Service
900 Fort Street Mall, Suite 1900
Honolulu, HI 96813-3705
844.379.4325
HawaiiDentalService.com
Payer #99010

Delta Dental of Idaho
P.O. Box 2870
Boise, ID 83701
800.356.7586
DeltaDentalID.com
Payer #82029

Delta Dental of Illinois
Group Plans
P.O. Box 5402
Lisle, IL 60532
800.323.1743
DeltaDentalIL.com
Payer# 05030

IL Individual Plans
P.O. Box 103
Stevens Point, WI 54481
855.335.8267
DeltaDentalIL.com
Payer ID: WDENC

Delta Dental of Indiana
P.O. Box 9085
Farmington Hills, MI 48333
800.524.0149
DeltaDentalIN.com
Payer #DDPIN

Delta Dental of Iowa
P.O. Box 9000
Johnston, IA 50131
800.544.0718
DeltaDentalIA.com
Payer #CDIA1

Delta Dental of Kansas
For claims address, please use:
P.O. Box 70201
London, KY 40742
800.234.3375
DeltaDentalKS.com
Payer #E3960

Delta Dental of Kentucky
P.O. Box 242810
Louisville, KY 40224
800.955.2030
DeltaDentalKY.com
Payer #CDKY1

Delta Dental Insurance Company — Louisiana
(See Delta Dental Insurance Company — Georgia)

Delta Dental of Maryland
(See Delta Dental of Pennsylvania)
Payer #23166

Delta Dental of Massachusetts
P.O. Box 2907
Milwaukee, WI 53201
800.872.0500
DeltaDentalMA.com
Payer #04614

Delta Dental of Michigan
P.O. Box 9085
Farmington Hills, MI 48333
800.524.0149
DeltaDentalMI.com
Payer #DDPMI

Delta Dental of Minnesota
P.O. Box 9120
Farmington Hills, MI 48333
800.448.3815
DeltaDentalMN.org
Payer 07000

Delta Dental Insurance Company — Mississippi
(See Delta Dental Insurance Company — Georgia)

Delta Dental of Missouri
P.O. Box 8690
St. Louis, MO 63126
800.335.8266
DeltaDentalMO.com
Payer #43090

Delta Dental Insurance Company — Montana
(See Delta Dental Insurance Company — Georgia)

Delta Dental of Nebraska
P.O. Box 9120
Farmington Hills, MI 48333
866.524.1134
Payer #07027

Delta Dental Insurance Company — Nevada
(See Delta Dental Insurance Company — Georgia)

Delta Dental of New Jersey
P.O. Box 16354
Little Rock, AR 72231
800.452.9310
DeltaDentalNJ.com
Payer #22189

Delta Dental of New Mexico
100 Sun Avenue NE
Suite 400
Albuquerque, NM 87109
877.395.9420
DeltaDentalNM.com
Payer #85022

Delta Dental of New York
(See Delta Dental of Pennsylvania)
Payer #11198

Delta Dental of North Carolina
P.O. Box 9085
Farmington Hills, MI 48333
DeltaDentalNC.com
800.662.8856
Payer #56101

Delta Dental of North Dakota
P.O. Box 9120
Farmington Hills, MI 48333
800.448.3815
Payer #07000

Northeast Delta Dental (Maine, New Hampshire and Vermont)
P.O. Box 2002
Concord, NH 03302
800.832.5700
NEDelta.com
Payer #02027

Delta Dental of Ohio
P.O. Box 9085
Farmington Hills, MI 48333
800.524.0149
DeltaDentalOH.com
Payer #DDPOH

Delta Dental of Oklahoma
P.O. Box 548809
Oklahoma City, OK 73154
800.990.7337
DeltaDentalOK.org
Payer #22229 and CDOK1

Delta Dental of Oregon
P.O. Box 40384
Portland, OR 97204
888.217.2365
DeltaDentalOR.com
Payer #CDOR1

Delta Dental of Pennsylvania
P.O. Box 2105
Mechanicsburg, PA 17055
800.932.0783
DeltaDentalIns.com
Payer #23166

Delta Dental of Puerto Rico
P.O. Box 9020992
San Juan, PR 00902
939.205.3300
DeltaDentalPR.com
Payer#680652604

Delta Dental of Rhode Island
P.O. Box 1517
Providence, RI 02901
800.843.3582
DeltaDentalRI.com
Payer #05029

Delta Dental of South Carolina
P.O. Box 8690
St. Louis, MO 63126
800.335.8266
DeltaDentalSC.com
Payer #43091

Delta Dental of South Dakota
P.O. Box 1157
Pierre, SD 57501
877.841.1478
DeltaDentalsd.com
Payer #54097

Delta Dental of Tennessee
240 Venture Circle
Nashville, TN 37228
800.223.3104
DeltaDentalTN.com
Payer #CDTN1

Delta Dental Insurance Company — Texas
(See Delta Dental Insurance Company — Georgia)

Delta Dental Insurance Company — Utah
(See Delta Dental Insurance Company — Georgia)

Delta Dental of Virginia
5415 Airport Road
Roanoke, VA 24012
800.237.6060
DeltaDentalVA.com
Payer #54084

Delta Dental of Washington
P.O. Box 75688
Seattle, WA 98175
800.554.1907
DeltaDentalWA.com
Payer #91062

Delta Dental of West Virginia
(See Delta Dental of Pennsylvania)
Payer #31096

Delta Dental of Wisconsin
P.O. Box 828
Stevens Point, WI 54481
800.236.3712
DeltaDentalWI.com
Payer #39069

Delta Dental of Wyoming
P.O. Box 29
Cheyenne, WY 82003
800.735.3379
DeltaDentalWY.org
Payer #CDWY1

AFFILIATED DELTA DENTAL PROGRAMS

AARP Dental Insurance Plan,
administered by Delta Dental Insurance Company
P.O. Box 2059
Mechanicsburg, PA 17055
866.261.4275
DeltaDentalins.com/aarp
Payer #AARP1

DeltaCare® USA
P.O. Box 1810
Alpharetta, GA 30023
866.774.5595
Claims Payer #DDCA2
Encounter Payer #DDCA3

DeltaDentalVA.com

DeltaDentalVA.com helps you streamline your office processes with 24/7 access to:

- Patient benefits
- Claims status
- Claims submission
- Recent payments
- Practice information
- Clinical policies
- Newsletter library
- Forms and documents
- FAQ's and practice resources

READY TO SUBMIT A CLAIM TO ANOTHER DELTA DENTAL MEMBER COMPANY?

To ensure accurate and timely claims processing, use the Delta Dental Claims Submission Information Lookup Tool. This tool provides the correct claims mailing address and Payer ID for each Delta Dental member company.

Access the tool at **DeltaDental.com** in the For Dentists section.

There is a dropdown list to view claims submission details for each state.

HOW TO REGISTER AND CREATE AN ACCOUNT ON DELTADENTALVA.COM:

- First, you must have National Provider Identifier (NPI) number in order to register on our website. Visit **nppes.cms.hhs.gov/NPPES/welcome.do** to obtain your NPI.
- If you do not have an account at **DeltaDentalVA.com,** click "Create an account" at **DeltaDentalVA.com/dentists** to register.
  Note: When creating an account, drop the leading zero in the license number and enter the tax ID number (TIN) without a hyphen. If you need additional assistance, call Professional Relations at 855.474.5644 or email **ProfessionalRelations@deltadentalva.com**.
- To protect account information, all users will be required to enroll in multi-factor authentication. During enrollment, you will be asked to verify your contact details via voice call, email or text message. All users in your practice will need their own unique login.
- There is no limit to how many usernames can be linked to a single email address for MFA.

WHAT IF A PATIENT IS INSURED BY ANOTHER DELTA DENTAL MEMBER COMPANY?

If you have a patient who is covered by another Delta Dental member company, you may access their eligibility, claims and benefits information by signing in at either **DeltaDentalVA.com** or the national website at **DeltaDental.com**. Use your same username and password for **DeltaDental.com** and **DeltaDentalVA.com**.

Dentist participation

DENTIST INFORMATION

All changes relating to a participating dentist, their office and/or contact information must be immediately reported to the Professional Relations department at **ProfessionalRelations@deltadentalva.com**. Such changes can include, but are not limited to:

- Add or remove a dentist
- Change physical address
- Change email address
- Tax ID number (TIN) change
- Electric funds transfers (EFT) change
- Sale of practice
- Retirement

QUARTERLY DIRECTORY ATTESTATION

In order to provide the best service, it is important that Delta Dental of Virginia maintains accurate records. Each quarter, offices will be prompted to review their facility report for accuracy on Delta Dental of Virginia's dentist portal.

How to access your facility report and complete the attestation:

- Log in to the Delta Dental of Virginia portal.
- Click on 'My Profile' found in the upper right-hand corner of the dashboard.
- Select 'View Facility Report' to review your office information.
- Locations with 'To Do' in the drop-down need an attestation submitted.
- If all information is accurate, use the drop-down and select 'Correct' and submit the attestation for your office.
- If all information is not accurate, select 'Incorrect' and use the text box to let us know what needs to be updated. Change requests will automatically be sent to Professional Relations once you submit.

DELTA DENTAL PARTICIPATING DENTIST REQUIREMENTS

To become and remain a Delta Dental participating dentist, you must:

- Be licensed and actively practicing in Virginia;
- Not be under suspension by this corporation, the Virginia Board of Dentistry or any other similar regulatory body;

- File claims for eligible Delta Dental patients and accept payment from Delta Dental, regardless of Delta Dental's benefit determination, based on the maximum plan allowance (MPA) fee concept as described later in this Handbook;
- Agree to abide by the by-laws, processing policies and rules established by Delta Dental Board of Directors;
- As a participating dentist, all entries in treatment records must be completed within 36 hours of the date of service;
- Delta Dental may require the dental office to submit copies of patient records upon request;
- Patient treatment records requested by Delta Dental must be unaltered;
- Edits or corrections are ONLY for clarification and must be clearly indicated with the date of the edit and signed by the dentist;
- Agree to abide by Delta Dental claim processing policies, procedures and this Handbook;
- Sign a participation agreement;
- Agree to participate in quality and utilization management activities;
- When required, allow Delta Dental to examine and copy office records and/or provide information to determine compliance with the terms of the agreement;
- Meet and continue to satisfy all of Delta Dental's credentialing and acceptance requirements; and
- If your office accepts new patients, no Delta Dental patient may be excluded.

A dentist who signs a Participating Dentist Agreement is designated as a participating dentist with Delta Dental of Virginia **as well as** with all Delta Dental member companies nationwide.

The participating dentist agrees to file claims for all Delta Dental patients. This includes patients of all Delta Dental member companies, when Delta Dental is their **primary, secondary, tertiary or quaternary insurance carrier**, and when a predetermination of benefits filing is requested by the patient.

The participating dentist accepts payment directly from Delta Dental on a Maximum Plan Allowance (MPA) basis, as established by Delta Dental of Virginia. Any difference in fees charged and Delta Dental's MPA **cannot** be billed to Delta Dental patients. Amounts that you bill us will not exceed amounts that you typically charge the general public for dental services.

If you discount your fees for dental services, whether as a professional courtesy to the patient or as part of a commercial arrangement that provides for discounted fees, you agree to bill us no more than the discounted fee for the service that you provide to a Delta Dental member.

Participating dentists are held to the current MPA for all Delta Dental covered benefits, **even when the patient has exceeded their maximum annual benefit, contractual frequency limitations, or other plan limitations that may be applied to the covered procedure resulting in no reimbursement such as a waiting period, for example, or in cases when benefit criteria are not met. For all non-covered benefits, participating dentists are not held to the MPA**.

PARTICIPATING DENTIST BENEFITS

As a participating dentist you gain access to a number of benefits for the service you provide your Delta Dental patients. These include:

1. Payment issued directly to you, alleviating collection problems.
2. Access to approximately 78 million Americans in more than 175,000 groups* throughout the United States and its territories. Your name and office location(s) can be found by members who use our Find a Dentist tool at **DeltaDentalVA.com** and on our national website at **DeltaDental.com**.
3. Access to claim status, benefits and eligibility at **DeltaDentalVA.com** or through our fax-back service number for ease. The fax-back number is 800.237.6060; press option two and then option one. You will need your tax ID number (TIN).
4. Getting paid faster! Direct Deposit (EFT) is free and faster than paper check payments. The Direct Deposit (EFT) form is available by clicking on the Forms & Resources section of our dentists page at **DeltaDentalVA.com/dentists**.
5. Participating dentists are listed on our website in the "Find a Dentist" search directory. Network dentist results are listed by network. Delta Dental PPO™ dentists are listed first.
6. Many dentists in our "Find a Dentist" search directory will have a DentaQual® score. DentaQual is a five-star rating system developed by Fluent (formerly P&R Dental Strategies), an independent dental informatics company. It offers an objective, data-driven measure of dental care quality using claims data — not patient reviews. Your DentaQual score is updated monthly based on available data.

CREDENTIALING REQUIREMENTS

As a third-party payer, Delta Dental of Virginia is routinely asked by consultants, brokers and group purchasers to provide assurances that:

- Our network dentists **deliver high-quality dental services.**
- We **monitor changes in our network dentists' credentials.**
- We **address issues as they arise.**

They also inquire about our specific credentialing requirements.

There is a national focus on health and dental issues among groups, individuals and state governments — as well as at the federal level — regarding the quality of care and patient rights. Lawmakers at the state level have implemented credentialing requirements for certain network products.

*Delta Dental Plans Association, 2024.

Delta Dental Plans Association requires that **Delta Dental member companies credential their networks every three years, based on the specific network(s) in which you participate.** The credentialing process provides a baseline from which to build a current database (i.e., the same information from all dentists at the same time). This allows us to:

- Address individual issues that may surface.
- Provide assurances based on the results of this process.
- Ensure that the care available in our network(s) meets or exceeds expectations.

The Virginia Department of Health has also adopted regulations requiring all managed care plans to **credential and recredential** their PPO and DHMO network providers every three years.

Some of the information requested on our facility profile form is not required for credentialing but is helpful and commonly requested by members (e.g., office hours, wheelchair access, languages spoken other than English). All other information is held in the strictest confidence.

Required credentialing documents

When you become a participating dentist, **Delta Dental requires the following forms** to comply with state rules and regulations governing credentialing:

- Completed and signed individual practitioner profile;
- Legible copy of DEA license (Controlled Substance Registration Certificate) or signed statement;
- Proof of professional malpractice insurance;
- Proof of anesthesia education and ACLS certificates, if applicable;
- Signed Delta Dental Premier® participating agreement;
- Signed Delta Dental PPO™ participating agreement;
- Five-year work history;
- National Provider Identifiers (NPIs);
- Facility profile;
- W-9;
- Direct Deposit (EFT) form;
- Specialty documentation; and
- Other forms as indicated.

Delta Dental **recredentials every three years** and is audited for compliance with these standards. Therefore, timely receipt of the requested information is essential. Failure to submit credentialing information will result in **noncompliance** with Delta Dental participating dentist rules and DeltaUSA® standards, and may disrupt claims processing.

We appreciate your prompt response and cooperation with Delta Dental's credentialing requests.

Credential review process

Delta Dental of Virginia reviews network dentist credentials and new dentist applications regularly to ensure that each dentist meets our participation standards. These standards include, but are not limited to:

- Active and unencumbered licensure in the state of Virginia;
- Adequate malpractice insurance coverage for individual instances;
- No outstanding sanctions with the Office of Inspector General of the Department of Health and Human Services; and
- Acceptable malpractice history.

Databases searched to establish licensure and malpractice history include:

- Office of Inspector General (OIG), U.S. Department of Health and Human Services' Exclusions Database, and
- Virginia Board of Dentistry.

Every dentist with listed sanctions will be reviewed by our **Credentialing Committee** for final approval to participate in our network.

Dental office email address

REQUIREMENT FOR CURRENT EMAIL ADDRESS FOR ELECTRONIC DELIVERY OF PROVIDER CONTRACTS AND NOTICES

Insurance carriers, including Delta Dental, are required to deliver dentist contracts, related amendments and notices exclusively in an electronic format.

Effective January 1, 2026, certain claims notices, such as denials for additional information, are required to be delivered electronically.

As a condition of participation, dentists must ensure that their email address is kept current and accurate in order to receive these notices. Failure to provide or update a valid email address may result in Delta Dental delivering notices through an alternative method.

Dentist reimbursement and fee information

MAXIMUM PLAN ALLOWANCE FEES

Maximum Plan Allowance (MPA) is the maximum dollar amount payable (per procedure). Delta Dental has established five geographical MPA regions in Virginia. Our methodology for calculating annual MPAs is based on significant market research, including an independent third-party study.

Recognized specialists are included in both networks, with reimbursement based on the specialty fee schedule for Premier and PPO. This applies to dental anesthesiologists, endodontists, oral surgeons, orthodontists and periodontists.

GUIDELINES FOR COMPLETING THE W-9 FORM CORRECTLY

It is necessary that we have a **current W-9 on file.** Please follow these guidelines to ensure the form is completed accurately:

- **Only one W-9 is needed per EIN/federal tax ID number (TIN).**
- Complete the W-9 form using the **TIN your office uses for IRS tax reporting purposes.**
- The **TIN must also be submitted on claim forms** to Delta Dental.
- On the **NAME** line, enter the name **exactly as it appears on Form 941** filed with the IRS.
- Use the **BUSINESS NAME** line only if you have a **DBA (doing business as) name.**
- Fill in the **address line** with the address where you want your **1099 tax form sent.**
- **Sign the form** and submit it to **Delta Dental of Virginia.**

DIRECT DEPOSIT (EFT)

Delta Dental of Virginia's preferred method of claim payment is Direct Deposit (EFT) because it offers:

- No lost checks;
- No mail delays;
- No fees — it's free; and
- Reliable weekly payments

To enroll, **download the Direct Deposit (EFT) Enrollment Form** from the Forms & Resources section at **DeltaDentalVA.com/dentists**.

Delta Dental networks

Delta Dental is the largest dental benefits provider in the country,* which means many of your patients are likely covered by us. When your patient says, "I have Delta Dental," be sure to ask which networks are covered by their plan (e.g. PPO, Premier). This information is found on their Delta Dental ID card.

DELTA DENTAL PPO

Delta Dental PPO™ is a cost effective fee-for-service program where dentists accept payment based on the lesser of their submitted fee or the PPO fee schedule. Dentists file claims and receive direct payment, regardless of which Delta Dental processes the claim. There is generally a financial incentive for PPO patients to seek services from a participating PPO dentist; however, PPO patients may choose to incur higher out-of-pocket expenses and seek services from a participating Delta Dental Premier®-only dentist **if their group contract allows**. Please check this prior to treatment. Delta Dental PPO, Delta Dental PPO Plus Premier™ and Delta Dental EPO™ are all considered part of the Delta Dental PPO network.

DELTA DENTAL PREMIER

Delta Dental Premier® is our traditional fee-for-service program. You will receive direct payment based on the lesser of your submitted fee or Virginia payment allowance regardless of which Delta Dental processes your claim. Subscribers with Delta Dental Premier coverage generally have financial incentive to seek services from a participating Delta Dental Premier dentist.

DELTA DENTAL MEDICARE ADVANTAGE™ NETWORK**

This network serves Medicare Advantage members, primarily those aged 65 and older. Dentists can join by emailing **ProfessionalRelations@deltadentalva.com** and by signing the participating dentist agreement in the participation packet, located in the Credentialing Forms section at **DeltaDentalVA.com/dentists/resources**. Reimbursement will be based on the dentist's current Delta Dental network participation fee schedule (Delta Dental PPO or Delta Dental Premier).

DELTACARE USA

DeltaCare® USA is a Managed Care program (DHMO), and reimbursement is based on capitation and patient copays. All claims, claim questions, eligibility and complaints must be handled directly by DeltaCare USA by calling 866.774.5595 or sending an email to **PR-DCUSA-East@delta.org**. Visit **deltadentalins.com/dentists** and log into Online Services. The mailing address is P.O. Box 1803 Alpharetta, GA 30023. You must contact DeltaCare USA directly for information about plan benefits.

*Delta Dental Plans Association, 2024. **Recruitment began in December 2023. The Medicare Advantage Network went into effect February 29, 2024 for those who did not opt-out.

DELTA DENTAL NATIONAL COVERAGE

When you sign a Delta Dental participating dentist agreement, your participation is **recognized** across the national Delta Dental system. If your patient is covered under a Delta Dental National Coverage program (Delta Dental Premier®, Delta Dental PPO™, Delta Dental Medicare Advantage™ or DeltaCare), claims must be submitted to the correct Delta Dental member company for processing. You are guaranteed direct payment based on Delta Dental of Virginia's MPAs.

Audits and utilization reviews

CONTRACT COMPLIANCE PROGRAM OVERVIEW

Audits may be conducted on site at the dentist's office or facility or by requesting that dental records be mailed to Delta Dental of Virginia. Two weeks advance written notice is typically provided when an on-site audit will be conducted. The collection of patient documentation to perform the audit will be conducted on-site during regular business hours and with as little disruption to the dental office operations as possible. Collection of patient records may take one to two days. Delta Dental may request to review records for services extending back two years prior to the date of the request. Exceptional circumstances may necessitate a review of records beyond the two-year period (e.g., consistent billing errors, dental material misrepresentation, the potential for fraud, etc.). In addition, certain group accounts or government programs may require longer audit periods.

An audit may seek to verify that:

- The patient was eligible at the time of service;
- The service billed was a covered service and payable under plan criteria;
- Billed services were dentally and/or medically necessary and appropriate;
- Billed tests including radiographs and procedures were in fact ordered, performed and received;
- Charges were not discriminatory — increasing or decreasing a fee for service based on the patient having or not having insurance;
- Coding accurately reflected services performed;
- Coding adhered to recognized guidelines and practices;
- Services billed were supported by necessary and appropriate dentist orders, medical records and other documentation;
- Payment was made at the reimbursement rate or allowed amount established in the dentist contract;

- Incorrect payments (duplicates, over/underpayments) were identified; and
- Overpayments were reimbursed (or refunded) appropriately and patient copayments or coinsurance were satisfied.

Statistically-valid sampling and extrapolation may be used as a component of dentist audits.

As part of our commitment to quality service to both our dentists and members, Delta Dental of Virginia reviews claims activity for our network dentists. Quality assurance is an integral part of our day to day business operations including the identification and tracking of those dentists whose patterns of utilization may be above the average in relation to their peers for one or more procedures.

FOCUSED REVIEW

Delta Dental of Virginia's Focused Review Program is an intensive level of clinical evaluation, in which a provider's claims for a select procedure code or group of procedure codes are manually reviewed to ensure the procedure meets guidelines for necessity and that the code or codes submitted accurately describe the dental services being provided. Based upon patterns of utilization, a small number of providers will be under focused review at any given time.

FINANCIAL INVESTIGATIONS AND DENTIST REVIEW

The Delta Dental of Virginia Contract Compliance Unit (CCU) is responsible for recovery of funds improperly paid, whether resulting from inadvertent billing errors or from fraud, waste and abuse, systemic errors, misrepresentation or concealment of facts.

Cases are often investigated as the result of calls to CCU via our toll-free fraud, waste and abuse hotline, 888.227.6004. The fraud, waste and abuse hotline number is included on explanation of benefit (EOB) forms sent to Delta Dental members.

Dentists should be alert to improper use of identification cards or other practices that defraud Delta Dental, the dentist or other third-party payors. Anyone who becomes aware of a group account, member or dentist who may be engaging in these practices should notify CCU.

CCU staff also performs dentist audits. These audits are often performed when dentists are identified as outliers in comparison to their peers. CCU's procedure for auditing dentists may include the use of statistical sampling and extrapolation. If the audit reveals overpayments issued to the dentist, the dentist will be required to reimburse Delta Dental of Virginia the projected total overpayment. Audit sampling and overpayment extrapolation is described below. Dependent upon the nature of the underlying overpayment, recovery efforts by CCU are often exempted from normal time period limitations for retroactive denials or otherwise adjusting previously paid claims. CCU staff can be contacted through the fraud, waste and abuse hotline, 888.227.6004.

PRE- AND POST-PAYMENT AUDITS

CCU staff periodically performs audits of providers that have been selected based on utilization and billing patterns, relative to peers of dental practice codes for new and established patients. Providers may also be selected for audit based on one or more of the following:

- Calls to our Quality of Care (QOC) department from members,
- Calls from office staff (current or former employees),
- Internal referrals from Delta Dental of Virginia,
- Referral from the FBI, the State Bureau of Investigation (SBI) or other government authority
- Virginia Board of Dentistry investigations, or
- Information from other Delta Dental member companies.

Typically, a registered dental hygienist certified by the National Healthcare Anti-Fraud Association performs the audit. However, external consultants may be contracted to conduct such audits on behalf of Delta Dental. Similarly, CCU staff may on occasion pend and audit a dentist's claims for dental practice codes or other services on a pre-payment basis.

CRITERIA USED IN AUDITS

In the performance of office audits (whether pre- or post-payment), the auditor will use the following criteria to assess adequacy of documentation:

- The applicable CDT codes published by the American Dental Association (ADA) in the *Current Dental Terminology ("CDT")* book.
- Delta Dental's group and individual policies and dentist contract requirement that services be dentally and/or medically necessary.

Each record must support the service billed and the level of care provided on each unique date. Records which contain cloned documentation, conflicting information or other such irregularities may not be billable to the patient. Reimbursement for any record containing any such documentation will be represented in overpayment calculations with zero reimbursement allowed.

DOCUMENTATION OF FINDINGS

To document audit results, CCU auditors use internally created guidelines. Auditors create a summary worksheet which may be supplemented or annotated with written comments. Dentists may wish to analyze the summary worksheets for self-audit to monitor compliance with recognized documentation standards.

SAMPLING AND EXTRAPOLATION

CCU's procedures for auditing dentists may include the use of statistically valid random sampling and extrapolation. The dentist is required to reimburse Delta Dental of Virginia for the projected total overpayment. The auditor will assign an error for any incorrect code submitted by the dentist. The auditor will document determinations of over-coding and under-coding. Once determined, the audit results will then be extrapolated into overpayments and underpayments, as appropriate, using the ratio method. Extrapolation is calculated by determining the percentage of error in the audited results and applying the percentage to the overall payment population, i.e., the dentist's reimbursements over the period of the audit.

REVIEW OF RESULTS WITH DENTISTS

At the conclusion of an audit, the results are submitted in writing to the dentist via certified mail and/or encrypted email. The dentist is afforded the opportunity to rebut audit findings. Copies of the audit worksheets may be made available to the dentist upon written request.

Additionally, the dentist may request a meeting with CCU staff to:

- Ensure the dentist understands the audit process and results;
- Answer any questions regarding correct billing or documentation standards;
- Afford the dentist an opportunity to furnish additional information; and
- Discuss repayment arrangements, if applicable.

RETENTION OF RECORDS

CCU staff will maintain audit worksheets and findings for a period of seven years, in accordance with Delta Dental of Virginia's corporate record retention policy.

Claims

Accurate and complete preparation of claim forms is the first step toward prompt and satisfactory claims processing. Participating dentists agree to submit claims directly to the correct Delta Dental member company on behalf of all Delta Dental patients, **regardless if Delta Dental is their primary, secondary, tertiary or quaternary insurance carrier**.

The claim form provided by Delta Dental of Virginia contains the information to calculate payable benefits and is for your use when filing Delta Dental claims. If it is your office policy to file claims electronically, use standard ADA or computer-generated claim forms. **Claim forms are available for download after you log in at DeltaDentalVA.com and click Documents, where it is posted under Forms.**

The American Dental Association (“ADA”) claims all rights, title, and interest (including all copyrights and other intellectual property rights) to the dental nomenclature and classification entitled in *Current Dental Terminology* and prior editions of that work. Delta Dental uses that dental nomenclature and classification by claim of right. That right has been incorporated into a “Copyright License and Settlement Agreement.”

COMPLETION OF THE DELTA DENTAL CLAIM FORM

Instructions for how to complete the Delta Dental claim form can be found on the ADA website at **ADA.org/en/publications/cdt/ada-dental-claim-form**. All applicable data must be entered to prevent delay in processing the claim. **Completed claims must be submitted to Delta Dental within 12 months of the date of service or will be subject to denial. See the following tips for information on filling out the claim form.**

TIPS FOR COMPLETING THE CLAIM FORM

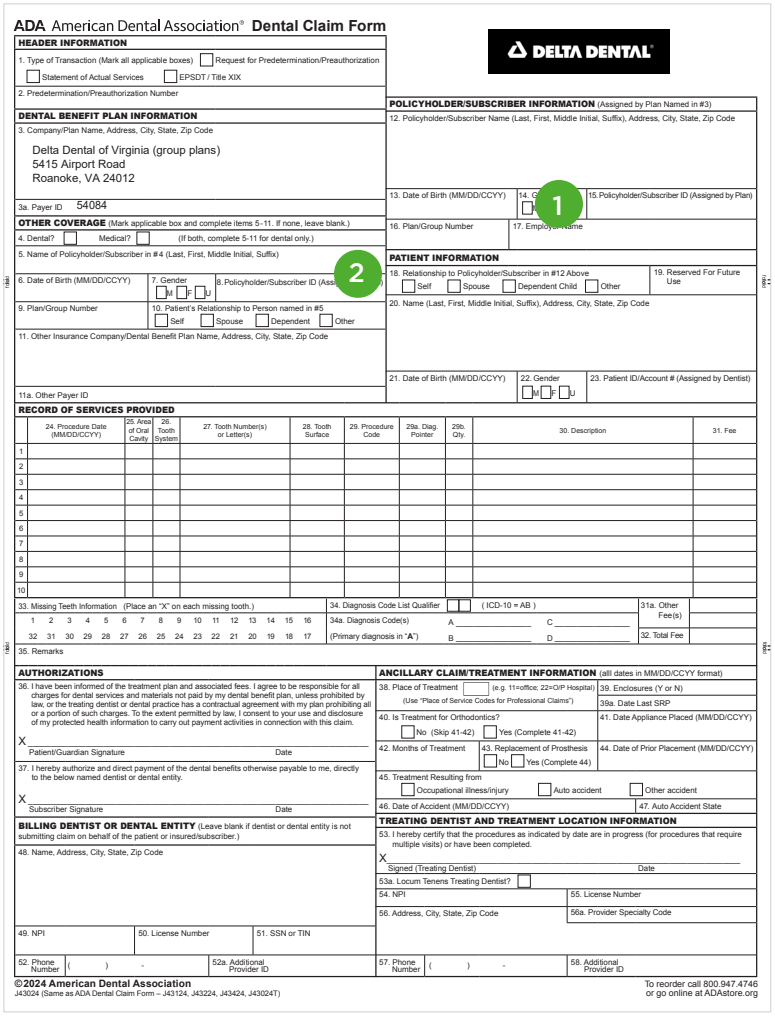
Policyholder/subscriber information

The primary subscriber’s information must include their first name, last name, address, date of birth, and subscriber ID number.

1. Box No. 15: Subscriber ID: Enter the 14-digit Delta Dental of Virginia subscriber ID. Do not include the suffix at the end of the subscriber ID. *Example:* Enter 51000000123456 in box 15, not 51000000123456-01

2. Patient information

Patient information must include their first name, last name and date of birth. This information must be completed even if the primary subscriber is the patient.



ADA American Dental Association® **Dental Claim Form**

DELTA DENTAL

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes) ☐ Request for Predetermination/Preauthorization ☐ Statement of Actual Services ☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

Delta Dental of Virginia (group plans)
5415 Airport Road
Roanoke, VA 24012

3a. Payer ID 54084

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐M ☐F ☐U | 8. Policyholder/Subscriber ID (Assa

9. Plan/Group Number | 10. Patient’s Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

11a. Other Payer ID

POLICYHOLDER/SUBSCRIBER INFORMATION (Assigned by Plan Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. G ☐ | 15. Policyholder/Subscriber ID (Assigned by Plan)

16. Plan/Group Number | 17. Employ Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐M ☐F ☐U | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an “X” on each missing tooth.)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐☐ (ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in “A”) A _____ B _____ C _____ D _____

31a. Other Fee(s)

32. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____ Patient/Guardian Signature _____ Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____ Subscriber Signature _____ Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) - | 52a. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION (all dates in MM/DD/CCYY format)

38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use “Place of Service Codes for Professional Claims”) | 39. Enclosures (Y or N) | 39a. Date Last SRP

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment | 43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) | 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____ Signed (Treating Dentist) _____ Date

53a. Locum Tenens Treating Dentist? ☐

54. NPI | 55. License Number

56. Address, City, State, Zip Code | 56a. Provider Specialty Code

57. Phone Number ( ) - | 58. Additional Provider ID

©2024 American Dental Association
J43024 (Same as ADA Dental Claim Form – J43124, J43224, J43424, J43024T)

To reorder call 800.947.4746 or go online at ADAstore.org

Billing dentist or dental entity

The facility NPI and TIN must match what Delta Dental has on file.

3. Box No. 48: Billing address associated with your TIN.

4. Box No. 49: Facility NPI

- If you do not have a facility NPI, this box should remain blank.
- Please note that many practice management systems auto populate the individual NPI number in the facility NPI box. If there is no facility NPI number, this box should be left blank to avoid claims processing delays/errors.

5. Box No. 51: Tax identification number (TIN)

- The TIN must be digits only. Do not include dashes or spaces.
- The TIN submitted on the claim form must match the TIN on file with Delta Dental.

6. Box No. 52 and No. 52a are not required.

	BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)			
3	48. Name, Address, City, State, Zip Code			
4	49. NPI	50. License Number	5 51. SSN or TIN	
6	52. Phone Number	( ) -	52a. Additional Provider ID	

Treating dentist and treatment location information

The treating dentist's name, license number, individual NPI and address must match what Delta Dental has on file. ***If it doesn't match, the claim will be rejected or denied for more information.***

7. Box No. 53: Treating dentist's name.

8. Box No. 54: Treating dentist's individual NPI.

- Electronic claims must have an individual NPI listed for the treating dentist. If the treating dentist does not have an individual NPI, the claim will need to be mailed.

9. Box No. 55: Treating dentist's license number.

10. Box No. 56: Physical office address at which services were rendered.

- The format of the treating address must match the address on file with Delta Dental.

11. Box No. 57: Phone number for the office where services were rendered.

12. Box No. 56a and No. 58 are not required.

TREATING DENTIST AND TREATMENT LOCATION INFORMATION			
7 53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed. X_____ Signed (Treating Dentist) Date			
53a. Locum Tenens Treating Dentist? ☐			
8 54. NPI		9 55. License Number	
10 56. Address, City, State, Zip Code		12 56a. Provider Specialty Code	
11 57. Phone Number	( ) -	12 58. Additional Provider ID	

CLAIM SUBMISSION TIPS

For dentists, fast claim processing means fast payment. **Claims filled out completely and accurately by dental offices are the key to rapid claim processing.**

When a claim is submitted without the required documentation, a benefit determination cannot be made, therefore the claim will be denied for information. Dental offices can help speed payment by submitting claims with complete and correct information, including all required X-rays, narratives and documentation. See page 25 for a complete list of claim requirements.

The following tips have been developed for dental offices to ensure faster and more accurate processing of claims and correspondence.

1. Use the subscriber and patient's full names and birthdates.

2. Verify patient eligibility **before** providing services using one of these methods:
   - **Online:** Log in to: **DeltaDentalVA.com or DeltaDental.com**
   - **Fax-back Service:** call **Delta Dental of Virginia** at **800.237.6060**
     - Press **option two,** then **option one**
     - Have your **tax ID number** ready
   - **Phone:** Visit the **For Dentists** dropdown menu on **DeltaDental.com**:
     - Click on the **Claims Submission Info Lookup Tool**
     - Select the appropriate state
     - Phone numbers and other relevant information are provided

3. Submit the subscriber's Identification number and birthdate on all claims and correspondence.

4. Submit a separate claim for each patient.

5. Use the universal tooth code where appropriate (1-32 for permanent teeth, A-T for primary teeth).

6. Use valid surface codes for restorations (M, I, D, L, F, B or O).

7. **Do not submit duplicate claims.** Contact Benefit Services or visit **DeltaDentalVA.com** to determine receipt of a claim.

8. Always submit for all services rendered for which there is a charge, **even if the service may not be covered or reimbursement is not expected due to the application of a plan limitation such as a frequency limitation.**

9. **Submit claim forms within 12 months of the date of service.**

10. **Always use the final, completion, delivery or seat date as the date of service for multiple visit procedures. Delta Dental only pays for completed procedures.**

11. Provide documentation for emergency and "by report" procedures. If possible, document only on the claim form.

12. Use the procedure code appropriate to the patient's age when there are different codes for adults and children. If submitting an adult code for a child due to extenuating circumstances, be sure to note this on the claim form. For example, if a child falls under the age limitation for an adult prophy but had all permanent dentition, it is D1110 and that is what should be reported. This may include a narrative stating all adult dentition is present.
13. If you are charging more than your dentist fee for any procedure, document extenuating or unusual circumstances in the remarks section of claim form or submit a narrative.
14. OSHA, infection control and/or sterilization charges are an integral and inseparable part of the general office overhead and should be incorporated into the overall fee schedule. **A separate fee may not be charged by a participating Delta Dental dentist.**
15. File surgical extraction claims with medical insurance first (D7220, D7230, D7240, D7241, D7250 and D7251). Be sure to submit the medical carrier's statement with claim. If surgical extractions are not covered by the medical carrier, indicate this on the claim form.
16. If there is other coverage, indicate the insured's relationship to the patient and the insured's date of birth. Indicate the amount paid by the other carrier by enclosing a copy of the explanation of benefits (EOB) from the primary carrier. Bill the primary carrier first. If the other carrier does not cover the procedure(s), indicate this on the claim.
17. Corrections to an incorrectly-submitted claim can be done by contacting our Benefit Services department. **Do not submit a new claim form. Please see page 39 of this Handbook for more information.**
18. When submitting a **predetermination benefit voucher** for payment, submit only the original predetermination voucher. **Do not submit a new claim or submit a claim form with the predetermination benefit voucher.**
19. Radiographs should be of diagnostic quality; mounted; dated; labeled left to right, or with tooth numbers; and identified with both patient and dentist name.
20. Verify whether pre-operative/post-operative radiographs are required for the procedure and submit with the claim. **If digital radiographs are not available, provide supporting documentation for the necessity of the procedure. Photocopies of radiographs, scanned radiographs or digital radiographs printed on paper are acceptable for benefit determination and will not be returned unless requested.** ***Due to poor diagnostic quality, faxed radiographs will not be accepted.***

CLAIMS SUBMITTED FOLLOWING TERMINATION OF THE PARTICIPATION AGREEMENT

Unless your agreement is terminated for cause, you may continue to provide services to, and submit claims for, Delta Dental eligible individuals with whom you have an existing dentist-patient relationship for 90 days after termination. All policies, procedures and terms of the participation agreement will continue to apply during this period.

ATTACHMENT REQUIREMENTS FOR CLAIMS*

Radiographs (diagnostic quality) specifics:	
Full-mouth series or panoramic	• Partial denture • Bridge
Pre-op periapical	• Crown (D2710-99) • Core buildup (D2950) • Post and core — cast or prefab (D2952-4, D2957) • Root canal — initial (D3310, D3320, D3330) • Root canal —retreat (D3920, D3332, D3346, D3347, D3348) • Surgical extraction (D7210-51)
Bitewings and periapical for quadrant(s) being treated	Periodontal scaling and root planing (D4341, D4342)
Clinical note/narrative*	D3331, D3332, D3333, D4355, D4211, D7320, D7910, D7911, D7912, D9920, D9930 All 'by report' procedures: those with codes ending in DX999 or DXX99
Periodontal charting	D4210, D4211, D4240, D4241, D4245, D4249, D4260, D4261, D4263, D4264, D4266, D4267, D4268, D4270, D4271, D4273, D4274, D4283, D4341, D4342

*Additional clinical documentation is available upon request. Intraoral photos and narratives are encouraged for all procedures.

RADIOGRAPHS

Acceptable radiograph formats for Delta Dental are as follows:

- Digital radiographs: X-rays captured using digital imaging systems.
- Photocopies of radiographs: Physical X-ray films can be photocopied and submitted as long as they maintain adequate diagnostic quality.
- Scanned radiographs: X-ray films that have been scanned into a digital format are acceptable for submission.

Note: Faxed radiographs cannot be accepted due to poor diagnostic quality.

ELECTRONIC CLAIMS

Delta Dental of Virginia's Electronic Claims Payor ID Number is 54084. DeltaDental.com provides electronic claims payor ID numbers for all Delta Dental member companies. Payor IDs are also listed in the member company directory on **pages 6-7**. Electronic claims processing saves your office money by reducing costs associated with generating paper claims, allows for faster processing of claims and enables your staff to spend more time with patients and other duties. To submit claims electronically you will need a computer with a modem, and an agreement with a practice management software vendor or an electronic data interchange (EDI) vendor. There are many vendors to choose from, offering a variety of products and services to suit any budget.

You may submit all claims electronically, including claims for payment, predetermination, coordination of benefits and orthodontic claims. We accept electronic claims for all of our products including Delta Dental Premier® and Delta Dental PPO™.

If you submit claims electronically, do not submit a paper copy of the same claim. This will slow the claims processing. If you are unsure of whether a claim transmitted successfully, call Benefit Services at 800.237.6060 or log into the dentist portal at **DeltaDentalVA.com** to verify receipt of your claim. Your software vendor should also be able to provide a list of claims that were successfully transmitted.

Electronically-submitted claims are typically available by logging in to the dentist portal at **DeltaDentalVA.com** the day after submission. Paper claims are typically available on the portal within three days of receipt. For claims requiring attachments (radiographs, perio charting, etc.), submit the claim and all attachments at the same time, using the same method. If you do not use electronic attachments, submit a paper claim ONLY with the attachment. For your convenience, you may submit electronic claims and attachments for free by logging in to the dentist portal at **DeltaDentalVA.com**.

ELECTRONIC ATTACHMENTS

Electronic attachments (radiographs, perio charting, etc.) allow you to take full advantage of electronic claims filing. Electronic attachments also allow **all** of your claims to be processed electronically, saving on duplication and mailing costs, and allowing for faster claims processing. To submit electronic attachments, you may need a scanner that produces an electronic copy of a document or image. The type of equipment and other requirements depend on which vendor you choose to support this capability. Three notable vendors are ChangeHealthCare, DentalXChange and Vyne Dental. Contact information for these companies is provided in the chart below.

If you are already submitting electronic attachments, note that Delta Dental of Virginia cannot accept an electronic attachment without an electronic claim, or without reference to a Delta Dental of Virginia claim number.

ELECTRONIC CLAIMS AND ATTACHMENTS CONTACT INFORMATION

Company	Website	Phone Number
Change HealthCare	**changehealthcare.com**	866.371.9066
DentalXChange	**dentalxchange.com**	800.576.6412 ext. 455
Vyne Dental	**vynedental.com**	800.782.5150

CLAIM REQUEST FOR INFORMATION

Each day a number of claims submitted for payment or predetermination are delayed and cannot be processed due to missing, incomplete or illegible information. These claims are denied and Delta Dental of Virginia produces a "Request for Information (RFI)," which indicates missing information necessary to process the claim. Review and follow the instructions on the form. If you do not understand the instructions, contact Benefit Services at 800.237.6060. To avoid claim processing delays, read the "Claims submission tips" section starting on page 23.

CLAIM PAYMENT

Payment for care provided to a Delta Dental patient is made directly to you, the participating dentist, thereby improving your cash flow. Because of this direct payment mechanism, we require participating dentists to seek payment from Delta Dental before billing patients for anything other than their applicable coinsurance, copayment, deductible, or other obligations stated under the group contract. If you have collected more than the claim indicates is due from the patient, **a refund to the patient should be given immediately or as soon as possible.**

Delta Dental makes every effort to process claims quickly and fairly. You can help us improve the speed at which we process claims by making sure all the necessary information is provided on the claim form. See the "Claims submission tips" section of this Handbook for valuable information that will speed claims processing.

Delta Dental of Virginia abides by Virginia laws governing the timely processing of claims and language is included in all participating dentist agreements entered into after July 1, 1999, regarding compliance with the Code of Virginia. Please refer to your contract for specifics.

Performance guarantees are included in some group contracts and may include: claim turnaround time, claim processing accuracy, average call wait time and customer satisfaction. Current performance goals for claim turnaround are 90% of claims in 15 calendar days and 99% in 30 calendar days.

CHECK DISBURSEMENTS

If your office is not signed up for Direct Deposit (EFT), Delta Dental of Virginia will mail a check to your office. Checks are sent on a weekly basis and may include payment for more than one patient whose claims were processed during the same payment cycle. A check disbursement [explanation of payment (EOP)] will accompany the check, and it will contain the following information:

- **Business Name**: The business name on file with Delta Dental associated with your tax ID.
- **Tax ID Number (TIN):** The EIN or SSN on file with Delta Dental, used for tax reporting purposes.
- **Check Number:** The check number of the attached check.
- **Amount:** The total amount of the check attached.
- **Subscriber Name:** The policy holder's name under which the claim was processed.
- **Subscriber ID:** The ID number of the subscriber.
- **Provider ID/Loc:** The treating dentist's provider ID and the number of the location where services were performed.
- **Patient Name:** The patient receiving services.
- **Birthdate:** Patient's birthdate.
- **Claim Number:** Claim number assigned by Delta Dental of Virginia.
- **Code:** The CDT code submitted and the CDT code services were processed under.
- **Tooth:** The tooth number services were performed on, if applicable.
- **Date of Service:** The date this service was completed.
- **Submitted:** The amount submitted to Delta Dental for this service.
- **Contract Allowance:** The MPA-based fee participating dentists agree to accept for this service.
- **Plan Allowance:** The amount Delta Dental will consider for this service based on plan design and dentist status.
- **Deduct:** Indicates deductible, if any, applied to the claim.
- **Over Max:** The dollar amount the patient has exceeded for their benefit period designated by their plan maximum.
- **COB:** The amount primary insurance paid, if there was coordination of benefits.
- **Delta Dental of Virginia Payment:** Delta Dental's payment responsibility for this service.
- **Patient Pays:** The amount which the patient is responsible for this service.
- **Provider Adjustment:** The amount to be adjusted for this service by the participating dentist office.

- **Delta Dental of Virginia Copay:** The percentage used to calculate Delta Dental's portion of the benefits based on the group contract.
- **Message Codes:** Processing policies, when needed, are applied for proper benefit allowance according to the group dental contract. If a policy number appears, refer to bottom of the disbursement. If there are multiple pages, refer to the last page for an explanation.
- **Total:** Provides a total of line items for the claim above by column.

If multiple dentists are listed on the check disbursement, the bottom of the disbursement will list each dentist ID and the total (net payment by Delta Dental of Virginia) for that dentist. This is to assist offices who track individual dentist data.

Explanations of any processing policies listed will follow at the end of the disbursement. There may also be a brief informational message from Delta Dental of Virginia that appears on all disbursements.

ORTHODONTIC CLAIMS

Orthodontic claims should be submitted once to Delta Dental of Virginia for payment; no re-submission is necessary. This is the case for treatments involving banding and aligners (e.g., Invisalign®). When an orthodontic claim is initially filed, Delta Dental of Virginia will issue monthly payments over the course of treatment. As a result, there is no need to file claims for monthly orthodontic payments. Furthermore, you do not need to submit a claim at the end of orthodontic treatment. Diagnostic and preparatory services are payable from the patient's orthodontic benefits, and claims submitted for these services should include "for orthodontic purposes" entered in the remarks section on the claim form. Fees for records should be listed with the appropriate CDT codes and the fee charged.

An orthodontic claim should include the following information:

- Date of initial banding or initial aligner delivery,*
- Total case fee,**
- Initial banding fee, and
- Number of months estimated treatment time. If the number of treatment months changes, notify Delta Dental of Virginia, and be sure to include the claim number by:
  Phone: 800.237.6060,
  Email: CustomerService.HelpDesk@deltadentalva.com, or
  Mail: Delta Dental of Virginia
  Attn: Claims Department,
  5415 Airport Road,
  Roanoke VA 24012

*An orthodontic claim should also include if the patient was banded prior to eligibility. If so, please submit the total paid by the prior carrier. **The total case fee may or may not include records, but should include the cost of the retainers.

Orthodontic offices updating their TIN must submit an active patient list that includes the following to ensure timely payment under the new TIN.

- Patient name
- Date of birth
- Patient ID
- Date of service (DOS)
- Old TIN
- New TIN
- Name of previous treating orthodontist
- Name of new treating orthodontist if different

MEDICALLY-NECESSARY ORTHODONTIC CLAIMS

This benefit is different than our standard orthodontic coverage in that the child must meet a certain level of handicapping malocclusion in order to qualify for the coverage. Therefore, it will be necessary to use the HLD or other approved index to assess the severity of the malocclusion. These indices assign weights (point values) from the standpoint of dental health and function. Handicapping esthetic diagnoses are not considered part of the determination. Etiology, diagnosis, planning, complexity of treatment and prognosis are also not factors in this assessment. Rather, it is used only to determine the patient's eligibility for orthodontic benefits.

Medically-necessary orthodontic services means enrollees must have a severe, dysfunctional, handicapping malocclusion. In order to qualify as medically necessary, a minimum score of 25 points using Salzmann Index criteria is required. Handicapping esthetic diagnoses are not considered part of the determination.

Malocclusion is defined as the misalignment of the upper and lower teeth when biting or chewing. Malocclusion can also be defined as a bad bite. This condition may be referred to as an irregular bite, crossbite or overbite. A *handicapping malocclusion* can be defined as one that severely interferes with function. Most handicapping malocclusions require surgery for correction and improved function. Severe cases are typically those where orthodontic services alone cannot solely treat the handicapping malocclusion. Diagnoses include, but are not limited to, cleft palate, severe lateral or anterior open bite deformities; severe class II malocclusion with impingement of the lower incisors into the palatal tissues/mucosa (deep, destructive bite); and class III malocclusions (severe under-bite or lower jaw protrusion).

A Treating Dentist Attestation form is now required for orthodontic treatment costing less than $2,500. This ensures that all orthodontic treatment is being followed by a dentist or orthodontist, particularly in cases where care is self-directed by patients, sometimes called direct-to-consumer orthodontics. These steps are important to confirm that you have evaluated the patient's condition and can certify that they are in a state of good dental and periodontal health and ready for orthodontic treatment. Professional supervision also helps to certify that the orthodontic treatment selected is the correct one for that patient's condition,

and that planned orthodontic appliances fit correctly. The attestation form is now available on the Delta Dental of Virginia website at **DeltaDentalVA.com/dentists/resources**. Failure to include an attestation with planned treatment will result in that claim being denied.

COPAYMENTS/OVERBILLING

Waiving a copayment is called "overbilling." The most common form of overbilling occurs when a dentist accepts a third party carrier's payment as payment in full, and forgives all or part of the patient's copayment portion.

Knowingly overbilling may be considered potentially fraudulent billing practices and is not permitted under the terms of the participating dentist agreement. Overbilling also violates the contract between an employer and his or her employees when the employer pays 100% of the cost of the service, rather than the percentage negotiated.

Coordination of benefits

Coordination of Benefits (COB) is designed to prevent overpayment when an individual is covered by multiple health care plans. It ensures that the total benefits received do not exceed the actual cost of care. COB determines the order in which claims are submitted and processed, as well as the reimbursement amount (financial responsibility) of each plan. It's important to note that the COB rules established by the plan may take precedence over Delta Dental's COB rules. Therefore, always verify the order of benefits with each plan before submitting claims to ensure proper processing, regardless of the COB rules of the other plan. The information below outlines Delta Dental of Virginia's COB guidelines for dependents covered by multiple plans from their parents and/or guardians.

BIRTHDAY RULE

The birthday rule determines primary and secondary insurance coverage when children are covered under both parents' insurance policies. The birthday rule says primary coverage comes from the plan of the parent whose birthday falls first in the year.

CUSTODY CASES

It is important to note that there are two exceptions to the birthday rule:

1. The criteria for identifying the primary carrier for dependent minor children of legally separated or divorced parents will remain as follows:

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

    b. When the parent who has custody has not remarried, that parent's plan will be primary.

    c. When the parent who has custody has remarried, that parent's plan will be primary and the plan of his/her new spouse will be secondary. The parent without custody pays third.

    d. If the custodial parent does not have coverage but the step-parent does, then the step-parent's coverage pays first, and the non-custodial parent's coverage pays second.

2. Where COB occurs between a carrier within your state and one outside of your state, the previous primary/secondary rules will apply if the other state has no birthday rules. A COB form is available to assist you in the Forms & Resources section of our webpage at **DeltaDentalVA.com/dentists**.

DUAL COVERAGE ON PREDETERMINATION CASES

When Delta Dental is the secondary carrier and a claim is submitted for predetermination, Delta Dental of Virginia will advise you of the amount Delta Dental would pay as if there were *no dual coverage*. When Delta Dental's **predetermined benefit voucher** is submitted for *payment*, attach a copy of the primary carrier's payment. Delta Dental will issue its payment subject to contractual limitations. Please do not submit the primary carrier's predetermination when submitting a predetermination to Delta Dental. COB is calculated only on actual payments from the primary carrier and not predetermined benefits.

Note: It is important that all COB information, such as subscriber name and birth date, name of other carrier, etc., be included on the original claim for determination.

COORDINATION OF BENEFITS (COB)

When Delta Dental is the primary carrier, we will process the claim up to our full liability under the patient's group contract. When Delta Dental is the secondary carrier, our obligation is satisfied if the primary carrier pays the same amount or more than Delta Dental would have allowed if benefits had not been coordinated. As secondary carrier, Delta Dental will calculate its payment based on the primary allowed fee or Delta Dental's allowed fee, whichever is lowest. In all cases, any applicable deductible will reduce the amount owed by Delta Dental.

Terms of group contracts vary and will determine the applicable COB method. Policies and examples in this section are models and have not been tailored to reflect specific group contracts. **If there is a conflict, the provisions of the group contract prevails.**

While many scenarios may arise in your practice, the COB scenarios below illustrate common COB rules and how the Delta Dental rules prevail.

Standard COB is when the secondary plan payment is based on the balance left after the primary has paid, but does not exceed the amount it would have paid as primary or the total amount of the claim.

Standard COB example*

Code	Submitted	Delta Dental Allowed	Primary Allowed	Primary Paid	Plan Coinsurance	Delta Dental Payment	Patient Pays
COB: Standard							
D2335	$200	$180	$150	$144	80%	$6	$0
D2332	$200	$150	$180	$144	80%	$6	$0
D5730	$200	$180	$180	$25	10%	$18	$137

When the plan's **COB rule is nonduplication of benefits**, the secondary plan calculates what it would have paid if it were primary and then reduces its payment by the amount paid by the primary plan. In other words, the secondary payment plan is the amount payable by the secondary plan minus the amount paid by the primary. If the primary paid the same or more than what secondary plan would have paid (had it been primary), then secondary carrier is not responsible for any payment at all.

Nonduplication COB example*

Code	Submitted	Delta Dental Allowed	Primary Allowed	Primary Paid	Plan Coinsurance	Delta Dental Payment	Patient Pays
COB: Nonduplication							
D2335	$200	$180	$150	$144	80%	$0	$6
D2332	$200	$150	$180	$144	80%	$0	$6
D5730	$200	$180	$180	$25	10%	$0	$155

*Examples are for illustrative purposes only and may not reflect actual fees or coinsurance.

Primary, Secondary and Tertiary (COB) example (with Delta Dental Medicare Advantage™)*

Mrs. Jones is retired and is covered under her retiree employer group dental plan. Her spouse is actively employed and she is covered as a dependent under her spouse's employer group plan and she has a Medicare Advantage plan. The confirmed order of benefits for this scenario is as follows:

- **Primary:** Spouse's active employed plan covering Mrs. Jones as a dependent
- **Secondary:** Medicare Advantage is secondary
- **Tertiary:** Mrs. Jones' retiree plan

A crown was placed with a fee of $1000. The provider is in-network with all three plans.*

Code	Submitted	Primary Allowed	Secondary Allowed	Tertiary allowed	Patient responsibility
Primary, secondary, tertiary					
D2740	$1,000	$800	$700	$600	$600

Primary paid $275 after a $250 deductible was applied. Secondary paid $300 because this plan calculates COB based on the secondary allowable and a $100 deductible was applied. Tertiary paid $0.00 because of a non-duplication clause.

The calculations are as follows:

- $1,000 — total fee submitted
- $600 patient responsibility — the lowest negotiated fee
- $275 — primary paid
- $300 — secondary paid
- $0 — tertiary paid
- $575 — total paid by all three plans

The patient pays $25 because her total financial responsibility of $600 has not been satisfied by all payments made by the plans. The dentist PPO write off is $400.

Primary, Secondary and Tertiary (COB) example (without Medicare Advantage)**

Mrs. Jones is employed and has dental insurance through her employer. She is also covered as a dependent under her husband's current employer plan. Mrs. Jones also purchased an individual dental plan from the insurance company.

*The confirmed order of benefits is based on the Medicare COB rules from CMS. Example is for illustrative purposes only and may not reflect actual fees or coinsurance. **The order of benefits was confirmed by contacting all plans. The individual plan does not coordinate benefits and each of the employer sponsored plans confirmed they are secondary to a plan that does not coordinate benefit. Then the plans follow the subscriber of the plan primary over the dependent plan.

The confirmed order of benefits for this scenario is as follows:

- **Primary:** Individual plan
- **Secondary:** Mrs. Jones' employer plan
- **Tertiary:** Mr. Jones' employer plan

Multiple restorations were performed. The provider is in-network with the primary and secondary plans.

Code	Submitted	Primary Allowed	Secondary Allowed	Tertiary allowed	Patient responsibility
Primary, secondary, tertiary					
D2391	$400	$250	$300	$350	$250
D2391	$400	$250	$300	$350	$250
D2331	$350	$175	$200	$200	$175
D2392	$500	$325	$350	$400	$325
Total	$1,650	$1,000	$1,150	$1,300	$1,000

Primary paid $240 after a $700 deductible was applied (restorative paid at 80% after deductible is met). Secondary paid $520 after a $500 deductible was applied (restorative paid at 80% after deductible is met). Tertiary paid $330 after a $750 deductible was applied (restorative paid at 60% after deductible is met).* The calculations are as follows:

- $1,650 — total fee submitted
- $1,000 — patient responsibility (the lowest negotiated fee)
- $240 — primary paid
- $520 — secondary paid
- $330 — tertiary paid
- $1,190 — total paid by all three plans

The patient pays nothing because her total financial responsibility of $1,000 has been satisfied by total payments made by the plans. The dentist PPO write off is $560 because the dentist can keep any amount received above the lowest negotiated fee up to the full fee submitted, which reduces the dentist required PPO write off.

COB WITH MEDICAL PLANS

Services performed by a licensed dentist are sometimes covered under a patient's medical benefit plan, as well as his or her dental benefit plan. This occurs most often with oral surgery procedures and services related to dental trauma.

*Examples are for illustrative purposes only and may not reflect actual fees or coinsurance.

Should your office perform services that are covered by the patient's medical benefit plan, the claim should be submitted to the appropriate medical plan administrator/carrier for payment. Once the medical explanation of benefits (EOB) is received, it should be submitted to Delta Dental along with the claim form and pertinent diagnostic materials or other supporting documentation. Delta Dental will provide benefits on a secondary basis for those procedures covered by the patient's medical carrier.

As a reminder, Delta Dental does not provide coverage for hospital expenses.

OVERPAYMENTS

The combined payments by all dental carriers may not exceed your total fee for the services provided. If you receive more than 100% of your fee, the amount in excess must be refunded. When you have collected more than the full fee submitted by all plans involved, always contact all plans involved to confirm the claims were submitted in proper order (COB). Once it is confirmed the claims were submitted in proper order, notify the secondary carrier of a possible overpayment. Follow the refund instructions outlined in this Handbook or as instructed by the Delta Dental representative.

TIPS ON SUBMITTING DUAL DENTAL COVERAGE CLAIMS

If the patient has dental coverage in addition to Delta Dental:

1. File the claim with the carrier who has primary responsibility to pay the claim. Information about the first plan's payment is used by the other plan to determine its payment.
2. If the other carrier has primary responsibility, file the claim with Delta Dental after payment is received from the other carrier.
   a. Complete the other plan information on the claim form in addition to all other items and attach a copy of the primary carrier's Explanation of Benefits (EOB) form.
   Note: If the primary carrier's EOB does not include a breakdown of charges per line of service, please indicate the primary carrier's telephone number.
   b. Mail the claim form to the appropriate Delta Dental member company.

For complex COB situations, a Coordination of Benefits form is provided at **DeltaDentalVA.com/dentists/resources**.

ADDITIONAL TIPS

Never make any insurance adjustments (i.e. PPO write offs) until after all plans have paid.

The order of benefits (primary, secondary, etc.) does not determine the write off when you are in-network with both or more plans.

Predetermination of benefits

Predetermination was pioneered by Delta Dental and has proven to be of such value that it has been incorporated in most group dental care programs. The submission of the treatment plan and pre-operative radiographs to Delta Dental prior to completion of various dental services will allow the patient the opportunity to make proper financial arrangements for their estimated portion of the treatment costs before the actual work is begun. It eliminates confusion on the part of the patient and produces goodwill between the dentist, patient and Delta Dental. **Delta Dental strongly urges the dentist to make predetermination a habit, except in emergency and routine situations.** Participating dentists will not charge a fee to the patient or Delta Dental for submitting predetermination of benefits. A predetermination is recommended for treatment plans over $300, especially those involving prosthetic and orthodontic procedures, implants and oral surgery. **Predetermination of benefits is valid for one year.**

Delta Dental uses the following when reviewing a treatment plan for predetermination:

- It is determined if the patient is eligible for benefits under that particular group's contract. **The fact that the patient is eligible at the time of predetermination, however, does not guarantee eligibility at the time services are actually rendered.**
- It is determined if the proposed services are covered under the group's dental plan.
- Any deductibles are applied and maximum benefits used to date are verified.

Delta Dental will issue a computer-generated **Predetermined Benefit Voucher** to the dentist. This voucher is notification of Delta Dental's estimated liability *and should then be reviewed with your patient.* Once the services have been performed, the dentist fills in the service dates, signs the form, and sends it to Delta Dental of Virginia for payment. Use of this voucher will expedite payment. **Do not submit an additional claim form for services that have been predetermined.**

Delta Dental encourages the treating dentist to discuss any predetermination they do not understand with Benefit Services representatives.

The predetermination of benefits does not guarantee payment. Delta Dental's liability, if any, will depend on the patient's eligibility at the time the work was actually performed and the amount of benefits payable under any other insurance or prepaid dental program. Actual benefits will be subject to eligibility at the time services are rendered, plan limitations, processing policies and coordination of benefits, if applicable, and may reduce or eliminate amount shown as "Estimated Delta Dental Payments". Predetermined benefits and assignment of benefits are subject to change based on the dentist's participating status at the time of treatment and does not guarantee direct payment.

Diagnostic aids

It may be necessary to submit radiographs and/or rationale for treatment when predetermining benefits to establish medical necessity. Indicate all missing teeth and list the teeth to be replaced by proposed appliances. Make mention of teeth which are endodontically involved or fractured and include, when appropriate, a written narrative explaining the circumstances that require a more extensive or costly treatment.

Optional or alternative treatment

The condition of the patient's mouth will usually dictate the course of treatment selected. In some cases, however, you may have a choice of treatment plans. After consulting with the patient, you may select a more expensive covered benefit than the one Delta Dental determines is Delta Dental's MPA for the diagnosis or treatment of the patient's condition.

Payment will be made only for the applicable percentage of the least costly course of adequate treatment. The patient may be responsible for the entire balance of your fee for the more expensive covered benefit.

To qualify as an alternative treatment, the following documentation should be included: the rationale for providing an alternative treatment, documentation that this has been agreed to or requested by the patient along with written consent, what the specific alternative is and why, and that the patient has been advised of the proposed treatment prior to the initiating care.

In all cases in which the primary subscriber or eligible dependent selects a more expensive service or benefit than is deemed necessary, Delta Dental will pay the applicable percentage of the fee for the service or benefit which is needed to restore the tooth or dental arch to contour and function. The primary subscriber or eligible dependent shall be responsible for the remainder of the dentist's fee. This does not require a change to the treatment plan, but it does establish the costs for the service(s) agreed upon by the patient and dentist.

Claims processing

Delta Dental coverage, by necessity, must be limited to dental procedures that can be readily distributed to make a dental program fiscally sound, as comprehensive as possible, and still affordable to the majority. Consequently, although of value to the patient, certain services and procedures exceed the basic premise of the dental benefit plan: to help pay the cost of eliminating disease and restoring teeth to contour and function.

PROFESSIONAL REVIEW

Delta Dental's professional review staff has professional and business experience and/or education and receives extensive training in dental procedures and claims review. Staff members review routine claims and their supporting radiographs and/or narratives when processing claims. Their professional judgment is required to process claims according to DeltaUSA® guidelines and group contracts. More complex claims, those involving review for medical necessity, are reviewed by dental consultants. Dental consultants are licensed dentists who assist the professional review staff in the processing of claims. Delta Dental of Virginia's dental director provides support to the Professional Review department, assists in the review process and handles all quality of care issues in accordance with state Managed Care Health Insurance Plan (MCHIP) laws.

CLAIM CORRECTIONS

A corrected claim may be submitted via USPS or email (**CustomerService.HelpDesk@deltadentalva.com**) in one of these ways:

1. Send the explanation of payment/benefits [EOP or EOB] document with the required changes listed and a notation that it is a "corrected claim."
2. Send a new claim form with a notation that it is a corrected claim.

Chart notes, X-rays, etc., should accompany the corrected claim as needed.

APPEALS

Delta Dental of Virginia allows **two levels of member appeals** for all adverse claim determinations.

First-level appeal

Upon **written authorized request,** Delta Dental of Virginia will re-evaluate initial claim decisions when appropriate. The review is based on the submission of **additional information,**

documentation, or narrative from the treating dentist that may affect the original benefit determination, in accordance with group benefits and utilization review guidelines.

Requirements for claim benefit re-evaluation:

- A **narrative or supporting documentation** addressing the prior decision and explaining why it should be reconsidered
- The **original claim number**
- **Re-submission of all required documentation** per procedural guidelines

Deadline: First-level appeals must be received within **180 days** of the adverse determination.

Second-level appeal

Second-level appeals must be received **within 60 days** of the first-level appeal determination.

Submission instructions

Appeals must be submitted **in writing** to:

- **Email:** AppealsAdmin@DeltaDentalVA.com or
- **Mail:** Appeals Department
  Delta Dental of Virginia
  PO Box 12483
  Roanoke, VA 24026

Dental benefit terminology

DELTA DENTAL OF VIRGINIA PROCESSING POLICY DESCRIPTIONS

The descriptions below are used within Delta Dental of Virginia's claims processing policies, which are detailed in the following section. When a claim is processed and benefit coverage or payment is impacted, the relevant processing policy number will appear on the predetermination of benefits statement, check disbursement, explanation of payment (EOP), electronic remittance advice (ERA) and patient explanation of benefits (EOB) documents.

Allowable fees: The amount of payment for Covered Services, which are provided to covered persons, as determined by the company.

Alternate treatment/benefits: An alternative benefit is a dental plan provision that allows the insurance carrier to determine the benefit based on an alternative procedure that is professionally acceptable and generally less expensive than the one provided or proposed by the treating dentist.

Attending dentist's statement (ADS): The standard uniform claim form, approved by the American Dental Association, is the form supplied by Delta Dental to substantiate any claims and upon which a treatment plan is submitted.

Benefit period: The 12-month period used in determining service limitations and renewals of the individual and family deductibles and maximums is identified as follows:

1. **Subscriber year** — each participant's benefit period begins on their original date of enrollment, in the dental program, and is renewed every 12 months thereafter based on the anniversary of their effective date of Delta Dental of Virginia coverage.
2. **Contract year** — all members of the group have benefits renewed on the same date.
3. **Calendar year** — January 1 to December 31.

By report: An explanation of the need for a specific procedure. This explanation may be included in area 35 of the claim form or on an attached note.

Carrier: The party to the dental plan contract who agrees to pay claims or provide administrative services.

Child age (Child age limitations): The age to which dependent children are eligible. Eligibility continues to the end of the calendar year in which the child reaches the age limitation unless stated otherwise. Student age extensions are available as long as the child remains enrolled in an accredited educational institution on a full-time basis (12 or more classroom hours per week or the equivalent of 12 or more hours as defined by the institution).

Claim form: A statement listing services rendered, the date of service and itemized costs. Includes a certification signed by the beneficiary and dentist that services have been rendered. The completed form serves the carrier as the basis for payment of benefits.

Check disbursement: A claims payment check which reimburses for the dental services rendered and statement listing the payment information for use in reconciling dental office records.

Copayment/coinsurance: The amount or percentage of the total approved amount that the subscriber is obligated to pay.

Coverage year: A 12-month period of time over which deductibles and maximums apply for each covered person. (This may be a calendar or contract year period.)

Date service performed or date of service: The date that indicates when treatment was completed. Claims for individual crowns, root canal therapy and prosthetic appliances should indicate the date of delivery or final filling.

Deductible amount: That portion of the covered dental care expense that the subscriber must pay before the plan's benefits begin.

DentaQual: DentaQual® is a five-star dentist rating system developed by Fluent (formerly P&R Dental Strategies), an independent dental informatics company.

Dental consultants: Dentists employed by Delta Dental to review claims to determine the covered benefits.

Dental plan: An organization established for the financing of dental care.

Dental prepayment: A system for budgeting the cost of dental services in advance of their receipt.

Dependents: Generally, the spouse and children, as defined in a contract, of a subscriber covered by a dental plan.

Effective date: The date the contract goes into effect and from which benefits are afforded.

Eligible individual: A person entitled to benefits under a dental plan.

Delta Dental EPO™: Exclusive PPO, the member must seek treatment or care from a dentist participating in our Delta Dental PPO™ network. The member can have a coinsurance or a set copay schedule. Contact Professional Relations for EPO copay schedules at 855.474.5644.

Exclusion: Dental services not provided under a dental plan.

Explanation of benefits (EOB): A document provided by Delta Dental to the subscriber detailing the dental services that were processed on a member's behalf and any benefits paid.

Expiration date: The date on which the dental benefits contract terminates.

Fee-for-service plan: A plan providing payment to the dentist for each service rendered rather than on the basis of salary or capitation fee.

Focused review: An intensive level of clinical evaluation, in which a dentist's claims for a select procedure code or group of procedure codes are manually reviewed to ensure the procedure meets guidelines for necessity and that the code or codes submitted accurately describe the dental services being provided. This is a pre-payment review program.

Group contract: A contract between the purchasing group and the dental plan, which provides dental benefits to be extent, described with the contract.

Group purchaser: The employer who buys the dental program, pays the required dues and provides eligibility of subscribers to the carrier.

Limitations: Restriction conditions, such as age and period of time covered, restrictions on covered benefits and waiting periods under which a group or an individual is insured.

Maximum benefit: The maximum dollar amount a dental plan will pay toward the cost of dental care incurred by an individual or family during a coverage year.

Maximum plan allowance (MPA): The fee based on what participating dentists charge in their geographic region. Delta Dental of Virginia has the state divided into five geographical regions for MPA purposes. Delta Dental also factors in the current consumer price index (CPI).

Multi-factor authentication (MFA): Multi-factor authentication is a secure login process that adds a second verification step beyond a password. A one-time code is sent by voice call, email or text message.

Participating dentist: A licensed dentist who has signed a participating agreement and been accepted by Delta Dental, who agrees to those rules and regulations promulgated by Delta Dental's Board of Directors and applicable state laws.

Predetermination of benefits: A review of the dentist's recommended treatment plans submitted to verify eligibility and to identify covered benefits, plan allowances, limitations and exclusions prior to dental treatment.

Predetermination benefit voucher: This voucher is notification of Delta Dental's estimated liability to be reviewed with the patient. Once the services have been performed, the dentist fills in the service dates, signs the form, and sends it to Delta Dental of Virginia for payment.

Primary payer: The plan responsible for being the first to consider reimbursement.

Post-treatment review: The examination by dental consultants of covered patients, on a random sample basis, to assure that the treatment listed on the claim form has been provided, and has been accurately and completely reported.

Provider: The dentist providing the dental services.

Rolling month: The time frame rolls based on history. For example, if a patient's benefits are two in a contract year and the contract year is 7/1 through 6/30 then the patient is eligible for two in that time frame. It is the same for the calendar year; the patient would have two between 1/1 and 12/31. Two in 12 months would be considered a rolling month frequency because it would be contingent on what happened in the past 12 months for future eligibility. If a patient had a service done in March 2022 and August 2022 they would not be eligible until March 2023 and then August 2023.

Scheduled allowances: A list of specified amounts which will be paid toward the cost of dental services rendered; the patient pays the difference between the allowance and the actual cost of service, up to the, maximum plan allowance.

Secondary payer: The plan that considers benefit reimbursement second in order of benefits.

Student age (student age limitations): See CHILD AGE definition.

Subscriber: The employee or retiree who represents the family unit in relation to the pre-payment plan.

Tertiary plan: The plan that considers benefit reimbursement third in order of benefits.

Processing policies

The following is a list of Delta Dental of Virginia's claims processing policies. Each description is preceded by a processing policy number, which will appear on the following documents when a claim is processed and benefit coverage or payment is affected: the predetermination of benefits statement, check disbursement, explanation of payment (EOP), electronic remittance advice (ERA) and patient explanation of benefits (EOB).

Services provided by the treating dentist to an immediate family member, including the dentist's parent, spouse or child, are not covered. Additionally, services provided by a treating dentist to themself are not covered. In cases where plan requirements are broader (for instance including siblings), the plan provisions prevail.

2. Service(s) performed before/or after the subscriber's/patient's eligibility period. Refer to the exclusion section of your dental plan document for more information.

4. Dependents are not covered under this plan. Refer to the eligibility section of your dental plan document for more information.

5. The dependent is over eligible contract age for dependent children and is not eligible for benefits under this plan. Refer to the eligibility section of your dental plan document for more information.

6. The patient/dependent did not meet full-time student eligibility requirements per this plan at the time services were rendered. Refer to the eligibility section of your dental plan document for more information.

7. Patient not eligible for service due to limitations specified in this dental plan. Patient may refer to the limitations section of the dental plan document for more information.

9. Porcelain crowns or porcelain fused to metal crowns are not a benefit due to the patient's age. Please advise the patient of responsibility for fee. Refer to the limitations section of your dental plan document for more information.

11. Per this plan, this procedure is not a covered benefit. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

13. Per this plan the procedure is only covered once every three years. Please advise patient of responsibility for fee. Refer to the limitations section of your dental plan document for more information.

17. An automated matching process in our payment system determined that this claim is an exact match of a claim that we previously processed. Please do not resubmit this claim, as it will only result in another denial. Refer to the limitations section of your dental plan document for more information.

18. Payment denied because of late submission. Refer to the claims, appeals and grievances section of your dental plan document for more information.

19. Due to additional information, an adjustment has been made to a previous claim payment or denial which may result in additional co-pay responsibility. Please refer to Patient Pays.

21. Procedures to correct congenital or developmental malformations are excluded under this plan. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

22. Procedures, appliances or restorations performed mainly for aesthetic or cosmetic reasons are excluded under this plan. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

23. Procedures rendered for treatment of complications of wear, attrition, erosion or abfraction do not meet criteria for reimbursement and are excluded under this plan. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

24. Realignment of teeth is not a covered benefit. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

25. Periodontal splinting is excluded under this plan. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

26. Gnathological recordings are excluded under this plan. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

27. Equilibration is excluded under this plan. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

28. Appliances, restorations or services for the diagnosis and/or treatment of disturbances of the temporomandibular joint are not a covered benefit. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

29. Increasing vertical dimension and alteration of the occlusion are excluded under this plan. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

30. Prescription drugs, nonprescription drugs, premedications and relative analgesia are excluded under this plan. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

31. General anesthesia is excluded under this plan. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

32. Charges for hospitalization, including hospital visits are excluded under this plan. Please submit the charges to the medical carrier. Refer to the exclusion section of your dental plan document for more information.

34. Special control programs such as plaque control, oral hygiene and dietary instruction are excluded under this plan. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

35. Payment is made for one tooth surface per visit regardless of the number or combination of restorations placed. Participating dentists have agreed to charge the patient only the amount indicated as Patient Pays. Refer to the limitations section of your dental plan document for more information.

36. An allowance has been made for two or more surfaces which are normally joined together. Refer to the limitations section of your dental plan document for more information.

38. This procedure is a component of the completed procedure and may not be billed separately. Participating dentists have agreed to charge the patient only the amount indicated as Patient Pays. Refer to the exclusion section of your dental plan document for more information.

39. Composite resin or acrylic restorations in posterior teeth are not benefits of this plan, and if provided are considered optional. Allowance has been made for an amalgam restoration and the patient is responsible for the additional fee.

40. Placement of a fixed bridge does not eliminate the need for further tooth replacement in this arch. All missing or hopeless teeth can be replaced simultaneously with a removable partial denture. Participating providers have agreed to charge the patient only the amount indicated Patient Pays.

41. Clinical information does not meet the criteria for benefit payment (i.e., 4 mm or greater pocket depths). Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

42. Regardless of the number of pins placed to retain a restoration, pin retention is a benefit once per tooth. Participating dentists have agreed to charge the patient only the amount indicated as Patient Pays. Refer to the exclusion section of your dental plan document for more information.

43. Buildups are considered part of the preparation except when due to extensive loss of tooth structure. Participating dentists have agreed to charge the patient only the amount indicated as Patient Pays. Refer to the exclusion section of your dental plan document for more information.

44. Predeterminations have been issued for multiple courses of treatment. Please select one treatment plan and submit for payment when services are completed.

45. General anesthesia is a covered benefit with this plan only when provided in conjunction with oral surgery, surgical periodontics and surgical endodontics. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

46. Edentulous spaces that have closed by the drifting of adjacent teeth are not eligible for prosthetic benefits. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

47. Claim history indicates a crown, buildup, fixed bridge, denture, partial, inlay, onlay, cast or prefabricated post and core has been placed on this tooth. Refer to the limitations section of your dental plan document for more information.

48. Retreatment of a root canal tooth or apical surgery performed by the same dentist/dental office within 24 months is considered part of the original procedure and additional payment is not allowed. Refer to the exclusions section of your dental plan document for more information.

49. Routine pre- and post-operative visits including local anesthesia are considered inclusive of the surgical procedure. Participating dentists have agreed to charge the patient only the amount indicated as Patient Pays. Refer to the exclusion section of your dental plan document for more information.

50. Oral surgery provides for extractions and other oral surgery, including local anesthesia and routine pre- and post-operative care. Refer to the exclusion section of your dental plan document for more information.

51. Specialized techniques including but not limited to those involving gold, precision partial attachments, over-dentures, implants, precision bridge attachments and personalization or characterization are not covered. Refer to the exclusion section of your dental plan document for more information.

52. Based on consultant review of the submitted procedure, an amalgam or composite restoration can satisfactorily restore tooth function. Please advise patient of responsibility for fee. Refer to the limitations section of your dental plan document for more information.

54. Replacement of a restoration on the same tooth and by the same dentist/dental office within 24 months is not allowed. Participating dentists have agreed to charge the patient only the amount indicated as Patient Pays. Refer to the exclusions section of your dental plan document for more information.

55. Stainless steel crowns are not a benefit due to the patient's age. Please advise patient of responsibility for fee. Refer to the limitations section of your dental plan document for more information.

58. Service(s) previously performed and the plan contractual time limitations exceeded. Please advise patient of responsibility for fee. Refer to the limitations section of your dental plan document for more information.

59. Allowance made for temporary procedure(s) will be deducted from allowance for permanent procedure(s) submitted for payment.

60. Fixed bridgework or removable cast partials are not a benefit due to patient's age. Refer to the limitations section of your dental plan document for more information.

61. Preparation of gingival tissues for placing a crown or other restoration is inclusive of the restorative procedure. Participating dentists have agreed to charge the patient only the amount indicated as Patient Pays. Refer to the exclusion section of your dental plan document for more information.

63. Procedure classification modified for processing only.

64. Allowance based on consultant evaluation. Refer to the exclusion section of your dental plan document for more information.

65. Bases are considered components of the completed restoration. Participating dentists have agreed to charge the patient only the amount indicated as Patient Pays. Refer to the exclusion section of your dental plan document for more information.

67. A sedative filling is a covered benefit for emergency relief of pain, otherwise it is considered part of the completed procedure. Participating dentists have agreed to charge the patient only the amount indicated as Patient Pays. Refer to the exclusion section of your dental plan document.

68. Direct or indirect pulp caps provided on the same date as the final restoration are considered part of a single complete restorative procedure and benefits are not allowed. Refer to the exclusion section of your dental plan document for more information.

69. In the absence of a surgical report, no allowance is being made. Claim will be reopened when requested information is received.

70. Payment for root canal includes all pre- and post-operative radiographs exclusive of initial diagnostic film. Participating dentists have agreed to charge the patient only the amount indicated as Patient Pays. Refer to the exclusion section of your dental plan document for more information.

71. Tooth number corrected by dental consultant as indicated by the radiograph or prior tooth history.

72. Benefits for this procedure have been denied as claim history indicates this tooth was previously extracted. Participating dentists have agreed to charge the patient only the amount indicated as Patient Pays. Refer to the exclusions section of your dental plan document for more information.

73. This is Delta Dental's initial orthodontic payment for this case. Payments will be generated monthly as long as the patient remains eligible or until the orthodontic lifetime maximum has been met.

74. Orthodontic treatment started prior to the patient's eligibility and benefits are prorated according to the months eligible with Delta Dental, up to the lifetime maximum available. Refer to the other payment rules that affect my coverage section of your dental plan document for more information.

76. Submitted procedure(s) is included in the fee for the more inclusive periodontal procedure when performed in the same quadrant (area). Participating dentists have agreed to charge the patient only the amount indicated in Patient Pays. Refer to the exclusion section of your dental plan document.

77. Subgingival curettage and or periodontal scaling and root planing are limited to once every 24 months per quadrant under this plan. Please advise the patient of responsibility for fee. Refer to the limitations section of your dental plan document for more information.

79. Periodontal maintenance and/or a prophy are not covered when provided on the same day as another periodontal service. Participating dentist have agreed to charge the patient only the amount indicated as Patient Pays. Refer to the exclusion section of your dental plan document.

80. Periodontal root planing performed within three years following periodontal surgery requires documentation of extraordinary circumstances. Otherwise, allowance is included in periodontal prophylaxis. Refer to the exclusion section of your dental plan document.

82. Patient Responsibility and Plan Pays columns reflect coordination of benefits (COB) with another carrier where this plan is the secondary payor. Refer to the COB section of your dental plan document for more information.

83. Sealants are covered benefits on permanent first and second molars without decay or restorations. Refer to the limitations section of your dental plan document for more information.

84. Prophys and fluoride treatments are limited by this plan to two in any 24 consecutive month period. Please advise patient of responsibility for fee. Refer to the limitations section of your dental plan document for more information.

87. Assignment of benefits was honored on this claim.

91. When more bridge abutments or pontics are provided than normally required to restore the case, the additional abutments or pontics are considered optional services. Please advise patient of responsibility for fee.

93. Lab fees are not a separate benefit. Participating dentists have agreed to charge the patient only the amount indicated as Patient Pays. Refer to the exclusion of your dental plan document for more information.

94. The tooth/oral cavity submitted for the service line is missing, invalid or is not valid based on the description of the code. Please submit a new claim with the correct tooth/oral cavity or code.

95. Pre-determinations with more than four units of anesthesia must be submitted with the completion date and anesthesia records. Benefits will be reconsidered when treatment has been performed. Refer to the Claims Review and Appeals Procedures section of your dental plan document for more information.

96. Group run-out period is exceeded.

97. Procedure(s) is limited to a time period of one month following definitive periodontal therapy. Participating dentists have agreed to charge the patient only the amount indicated as Patient Pays. Refer to the exclusion section of your dental plan document for more information.

98. Submitted procedure(s) cannot be performed on the same date as other surgical procedures. Participating dentists have agreed to charge the patient only the amount indicated in Patient Pays. Refer to the exclusion section of your dental plan document.

99. Patient history indicates Delta Dental has previously processed the claim as primary. No further payments are due.

107. Prophylactic removal of impacted third molars (asymptomatic nonpathological) is not a benefit of this plan. Refer to the exclusion section of your dental plan document for more information.

109. Treatment in progress at inception of eligibility is not a covered benefit of this plan. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

121. Periodontal procedure(s) are a benefit for treatment of periodontal disease and/or defects around natural teeth only. Refer to the exclusion section of your dental plan document for more information.

123. The procedure code for this extraction has been reclassified based on the consultant's evaluation of the information submitted. Participating dentists have agreed to charge the patient only the amount indicated in Patient Pays.

124. Recementation within six months of initial placement is included in the original fee. Participating dentists have agreed to charge the patient only the amount indicated as Patient Pays. Refer to the exclusion section of your dental plan document for more information.

125. Replacement of stainless steel crowns on the same tooth is not allowed if performed by the same dentist/dental office. Participating dentists have agreed to charge the patient only the amount indicated as Patient Pays. Refer to the exclusion section of your dental plan document for more information.

126. Cast or pre-fabricated post and cores are a benefit in anterior teeth only when there is insufficient tooth structure to support a cast restoration. Participating dentists have agreed to charge the patient only the amount indicated as Patient Pays.

127. Periodontal procedures include all necessary post-operative care for three months, as well as any surgical reentry for three years. Participating dentists have agreed to charge the patient only the amount indicated as Patient Pays. Refer to the exclusion section of your dental plan document.

128. Gingival curettage, surgical gingivectomy/gingivoplasty, grafts, osseous or mucogingival surgery includes surgical reentry for three years. Participating dentists have agreed to charge the patient only the amount indicated as Patient Pays. Refer to the exclusion section of your dental plan document.

130. Clinical information does not meet the criteria for benefit payment (i.e., sufficient loss of attachment and bone loss). Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

134. The consultation is included in the fee for the exam. Participating dentists have agreed to charge the patient only the amount indicated as Patient Pays. Refer to the exclusion section of your dental plan document for more information.

135. Partial or incomplete endodontic procedure is not a covered benefit. Please advise the patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

136. Root recovery or alveoloplasty is considered inclusive of the extraction. Participating dentists have agreed to charge the patient only the amount indicated as Patient Pays. Refer to the exclusion section of your dental plan document for more information.

137. Surgical incision and drainage is included in the surgical fee for endo, extractions and palliative or other definitive treatment done on the same date by the same dentist/dental office. Refer to the exclusion section of your dental plan document for more information.

138. Frenectomy is included in the fee when performed in the same site with other mucogingival surgery. Participating dentists have agreed to charge the patient only the amount indicated in Patient Pays. Refer to the exclusion section of your dental plan document for more information.

139. Partial or incomplete crown procedure is not a covered benefit. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

140. Allowance for dentures and partial dentures include relines and rebases for six months. Participating dentists have agreed to charge the patient only the amount indicated as Patient Pays. Refer to the exclusion section of your dental plan document for more information.

141. Allowance for dentures, partial dentures, relines and rebases include all adjustments for six months. Participating dentists have agreed to charge the patient only the amount indicated as Patient Pays. Refer to the exclusion section of your dental plan document for more information.

142. Periodontal prophylaxis is a benefit only when the patient has completed active periodontal therapy. As our records do not show history of such services, allowance has been made for prophylaxis. Patient may refer to the exclusion section of the dental plan document for more information.

143. Agents applied for desensitization or microbial control are not a benefit of this plan. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

144. Repair or replacement of orthodontic appliances, occlusal guards or space maintainers are not benefits of this plan. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

145. Orthodontic services, including tooth guidance appliances, are not covered benefits of this plan. Please advise patient of responsibility for fee. Refer to the exclusions section of your dental plan document for more information.

148. An implant is a benefit of this plan once in a three year period. Our records indicate this service was previously performed within this period. Please advise patient of responsibility for fee. Refer to the limitations section of your dental plan document for more information.

149. Post removal is not a benefit of this plan. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

150. Benefits for these services cannot be determined without supporting documentation. Please provide financial ledger, radiographs and all clinical documentation describing dental necessity and rational for all treatment rendered. Please submit a new claim for processing.

151. Our dental consultant has reevaluated this procedure. The original decision is upheld.

152. The waiting period was not met for the submitted procedure. Please advise patient of responsibility for fee. Refer to the covered benefits, deductible and benefit waiting period section of your dental plan document for more information.

153. This procedure is covered only in conjunction with orthodontics. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

154. Endodontics including, but not limited to, castings performed primarily to facilitate the placement of overdentures, is not a benefit. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document.

155. Implants and any related implant procedures are not benefits under this plan. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

157. Exams and cleanings are limited by this plan. Please advise patient of responsibility for fee. Refer to the limitations section of your dental plan document for more information.

158. Exams and cleanings are limited by this plan to two in 12 consecutive months. Please advise patient of responsibility for fee. Refer to the limitations section of your dental plan document for more information.

160. This plan covers one fluoride treatment in a calendar year. Please advise patient of responsibility for fee. Refer to the limitations section of your dental plan document for more information.

161. This plan covers one fluoride treatment in any consecutive 12 month period. Please advise patient of responsibility for fee. Refer to the limitations section of your dental plan document for more information.

162. Only one space maintainer is provided per space. Please advise patient of responsibility for fee. Refer to the limitations section of your dental plan document for more information.

164. Code D0220 is for an intraoral periapical first film. Additional single films on the same day are coded D0230. Code modified to match description.

165. Procedure is not a benefit as submitted. See additional line for alternate benefit procedure and allowance.

166. Benefit allowance for scaling and root planing is subject to change based on the date of completion. If both root planing and periodontal surgery procedures are performed within a four week period, the root planing will be included as part of the surgery.

167. Charges for duplicating radiographs are excluded under this plan. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

168. An osseous graft placed in an extraction site is indicative of ridge augmentation and is therefore considered a specialized technique. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

169. Charges for infection control and instrument tray setup are considered part of the dental services provided. Participating dentists have agreed to charge the patient only the amount indicated as Patient Pays. Refer to the exclusion section of your dental plan document for more information.

170. The information provided to the dental consultants does not indicate a medical necessity as required by this plan. An allowance has been made for a removable partial denture. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

171. When performed on the same date of service as a cast or prefabricated post and core or buildup, an amalgam or composite restoration is included in the fee. Refer to the exclusion section of your dental plan document for more information.

172. Clinical information does not indicate the need for periodontal surgical procedure (i.e. 5 mm or greater pocket depths). Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

173. Appliances indicated for harmful habits are not covered benefits. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

179. Bitewings are covered once annually for adults and twice annually for children under age 18. Refer to the limitations section of your dental plan document for more information.

180. Service(s) denied as our records indicate that this dentist holds an inactive Virginia State License. Refer to the exclusion section of your dental plan document for more information.

182. Porcelain crowns or porcelain fused to metal crowns are not a benefit due to patient's age. Refer to the limitations section of your dental plan document.

184. The contract maximum has been exceeded for the specified time period. Refer to the limitations section of your dental plan document for more information.

185. Procedure is not a benefit as submitted. See additional line for alternate benefit procedure and allowance.

186. All predeterminations for procedures that require pathology reports must be submitted with the completion date and pathology report attached. Benefits will be reconsidered when treatment has been performed. Refer to the claims and appeal procedures of your dental plan document for more information.

187. Based on a recent audit, this claim has been reprocessed resulting in an additional payment.

188. Inlay or gold foil restorations are always considered optional. An alternate benefit will be allowed for an amalgam or resin restoration. The fee in excess of the allowed procedure is the patient's responsibility. Refer to the exclusion section of your dental plan document for more information.

190. Periodontal appliance (occlusal guard) is a benefit only in conjunction with documented need in the treatment of periodontal disease, per this plan. Not a benefit for treatment of TMJ or bruxism. Refer to the exclusion section of your dental plan document for more information.

192. Benefits for sealants include repair or replacement within two years. Participating dentists have agreed to charge the patient only the amount indicated as Patient Pays. Refer to the exclusion section of your dental plan document for more information.

193. Sealants are covered once in a lifetime. Patient is responsible for fee. Refer to the limitations section of your dental plan document for more information.

194. Periodontal maintenance procedures are not a benefit in the absence of prior definitive perio therapy. An allowance has been made for a prophy and the patient is responsible for the additional fee. Refer to the exclusion section of your dental plan document for more information.

196. This procedure is only covered once every five years. Please advise patient of responsibility for fee. Refer to the limitation section of your dental plan document for more information.

197. Delta Dental has not received a reply to our request for required information, and a benefit determination could not be made. Please submit a new claim for processing with required information. Refer to the claims and appeal procedures of your dental plan document for more information.

198. The ortho maximum has been exceeded for the specified time period. Refer to the limitations section of your dental plan document for more information.

199. Payment plan is created at the time the initial ortho claim was received. Payments will be generated monthly as long as the patient remains eligible or until the orthodontic lifetime maximum has been met. Monthly billing for orthodontic cases is not necessary.

201. Delta Dental's obligation for processing of claims has ceased. Please contact your benefits administrator.

204. Procedure D0150 is for new patients or established patients who have had a significant change in health condition or have been absent from active treatment for three or more years. Refer to the limitation section of your dental plan document for more information.

205. Procedure is denied under the dental plan and can only be considered under the dental plan after proof is received indicating that the member's medical plan will not consider expenses.

206. Procedure is a pre-estimate only and will require clinical documentation (radiographs, charting, narratives) prior to final determination of benefits. Actual payment amount and/or patient responsibility is subject to change when the payment is generated.

208. Procedures with missing or invalid info cannot be processed. Please submit a new claim with required data [current CDT code, surface, tooth/cavity]. The following procedures require a narrative, radiographs and/or perio charting: crowns, onlays, prosthodontics, implants, surgical extractions, perio.

209. Service(s) denied for this dentist pending confirmation of renewal of Virginia State License. Refer to the exclusion section of your dental plan document for more information.

210. Service(s) denied as our records indicate that this dentist holds a suspended license. Refer to the exclusion section of your dental plan document.

211. Temporary crowns are considered components of, and included in the fees for, the permanent crown or cast restoration. Participating dentist(s) have agreed to charge the patient only the amount indicated as Patient Pays. Refer to the exclusions section of your dental plan document for more information.

212. Crown repairs are subject to the limitation specified in the limitations section of your dental plan document. Please advise patient of responsibility for fee.

213. Bleaching is covered once in a lifetime. Patient is responsible for fee. Refer to limitation section of your dental plan document for more information.

214. History indicates that an apicoectomy and/or retrograde amalgam were benefited within 30 days. No benefits are available for retreatment of a root canal and the patient is responsible for the fee. Refer to limitation section of your dental plan document for more information.

215. Prophylaxis is considered an integral part of and is included in the fee for periodontal maintenance procedure. Participating dentist(s) have agreed to charge the patient only the amount indicated as Patient Pays. Refer to the exclusion section of your dental plan document.

216. Benefit allowance for flap, or osseous surgery is limited to two quadrants on the same date of service. To reconsider, please submit perio charting, full mouth or panoramic radiographs and length of time surgery was performed. Please advise patient of responsibility for fee.

218. According to the plan contract, the replacement of tooth/teeth extracted prior to eligibility is/are not a benefit. Please advise patient of responsibility for fee. Refer to the exclusions and exclusions section of your dental plan document for more information.

219. This claim has been reviewed by a licensed dental consultant.

220. Replacement of amalgam or composite restorations on the same tooth is not allowed if performed by the same dentist/dental office. Participating dentists have agreed to charge the patient only the amount indicated as Patient Pays. Refer to exclusions section of your dental plan document for more information.

226. Full porcelain/resin or porcelain/resin substrate crowns, onlays, abutment crowns and pontics on posterior teeth are optional treatment. Please refer to the alternate treatment section of your dental plan document.

227. Brush biopsy procedures are limited by this plan contract to two in 24 months. Please advise patient of responsibility for fee. Refer to the limitations section of your dental plan document for more information.

228. Payment reflects allowance for only those surfaces that have not been previously duplicated during the plan's contractual time period.

230. This cleaning is allowed through enrollment in the Healthy Smile, Healthy You® pregnancy benefit.

231. This cleaning is allowed through enrollment in the Healthy Smile, Healthy You diabetes benefit.

232. This cleaning is allowed through enrollment in the Healthy Smile, Healthy You high-risk cardiac conditions benefit.

243. The procedure code(s) was modified based on the information submitted.

258. Benefits are payable only when services are provided by a licensed dentist. Please refer to the exclusion section of your dental plan document for more information.

259. When treatment is completed, submit the surgical procedures to the medical carrier first and return a copy of the medical carrier's Explanation of Benefits (EOB) with this form. Refer to the Coordination of Benefits (COB) section of your dental plan document for more information.

260. Fixed bridges, dentures, partials, inlays, onlays, cast or prefabricated post and cores, buildups and crowns have a seven-year replacement limitation under this plan. Patient is responsible for fee. Refer to the limitations section of your dental plan document.

268. This cleaning is allowed through enrollment in the Healthy Smile, Healthy You cancer therapy benefit.

269. This fluoride application is allowed through enrollment in the Healthy Smile, Healthy You cancer therapy benefit.

270. This exam is allowed through enrollment in the Healthy Smile, Healthy You® pregnancy benefit.

271. This exam is allowed through enrollment in the Healthy Smile, Healthy You diabetes benefit.

272. This exam is allowed through enrollment in the Healthy Smile, Healthy You high-risk cardiac conditions benefit.

273. This exam is allowed through enrollment in the Healthy Smile, Healthy You cancer therapy benefit.

274. Based upon review of the requested clinical documentation by a licensed dental consultant a determination has been made that the procedure/s submitted cannot be verified as having been performed. Please provide supplemental information as to where, when and for whom the services were provided.

275. Based on consultant review, the provided radiographs indicate the tooth has an apparent poor long term prognosis due to significant periodontal bone loss. Patient is responsible for fee. Please refer to the exclusion section of your dental plan document for more information.

276. According to the plan, this procedure is not a benefit. The specific procedure/CDT code used relates either to cosmetic and/or investigational services. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

277. This procedure is a benefit once per lifetime. Please refer to the limitations section of your dental plan document for more information.

278. This procedure is a benefit once in calendar year. Please refer to the limitations section of your plan document for more information.

279. Pulp testing is a benefit per visit, not per tooth. Refer to the limitations section of your dental plan document for more information.

280. Benefits for a full mouth radiograph include periapical radiographs and may not be billed separately. Please refer to the exclusion section of your dental plan document for more information.

281. Orthodontic benefits and related services are limited to once in a lifetime per patient. Patient is responsible for fee. Please refer to the limitations section of your dental plan document for more information.

282. Consultations are considered a regular exam and subject to the benefit limitation for a regular exam.

283. Pulp tests are payable per visit and are subject to the limitation specified in the limitation section of your dental plan document for more information.

284. Services have been denied to reflect reasonable and customary dental practices. Participating dentist(s) have agreed to charge the patient only the amount indicated as Patient Pays. Please refer to the exclusion section of your dental plan document for more information.

286. Patient history indicates the tooth has been extracted and an implant placed. Please submit a new claim with the appropriate CDT implant supported prosthetic procedure code.

287. Procedure(s) performed does not meet CDT definition or criteria for this code. Participating dentist have agreed to charge the patient only the amount indicated as Patient Pays.

288. An allowance for an alternate benefit was made based on the terms of the group contract. Refer to the alternate treatment section of your dental plan document for more information.

289. The monthly reimbursement has been increased based on additional information received for this active treatment case.

290. The procedure code for the submitted service line was missing, invalid or inactive. A miscellaneous code was entered to allow for notification to your office. Please resubmit with an active CDT code for consideration.

291. The clinical documentation does not support the required minimum Salzmann Index score for medical necessity; therefore, the orthodontic case is denied.

292. The maximum out of pocket amount has been met for the current benefit year. Please refer to your plan document for more information.

293. This service is covered under a separate benefit. You will receive another explanation of benefits (EOB) for this service.

294. Sealants are covered benefits on permanent molars without decay or restorations. Refer to the limitations section of your dental plan document for more information.

295. Benefits are provided only for definitive treatment. Please refer to the “Other Payment Rules that Affect My Coverage” section of your dental plan document for more information.

296. The restoration appears to have a poor long term prognosis. Please advise the patient of responsibility for fee. Please refer to the exclusion section of your dental plan document.

297. Procedure(s) does not meet criteria for treatment. In the absence of extraordinary circumstances soft tissue grafting requires a minimum of 2 mm of recession and absence of attached gingiva. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document.

298. Soft tissue and osseous grafting is limited to two teeth per quadrant per date of service. Grafts performed on subsequent teeth will be denied. Please advise patient of responsibility for fee.

299. Procedure(s) is limited to a time period of six weeks up to six months following definitive periodontal therapy, two sites per quadrant per date of service and is limited to natural teeth only with pocket depths of at least 5 mm and less than 10 mm. Please advise patient of responsibility for fee.

300. Procedure(s) performed does not meet CDT definition or criteria for this code, benefit(s) is denied. Please advise patient of responsibility for fee.

301. Implant placement for second molars will be considered if the implant is occlusally functional, and if the implant is necessary to prevent passive eruption of the opposing molar(s). Please advise patient of responsibility for fee. Please refer to the exclusion section of your dental plan document.

302. Implant placement is limited to four implants per arch and two implants per quadrant. Please advise patient of responsibility for fee. Refer to the limitations section of your dental plan document for more information.

303. Exploratory surgery and partial or incomplete procedures are excluded under this contract. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

304. Procedure(s) requires submission of pathology report(s) in order to make a final benefit determination. Please advise patient of responsibility for fee.

305. Nondiagnostic radiographs are not allowed. Participating dentist have agreed to charge the patient only the amount indicated as Patient Pays. Please refer to the exclusion section of your dental plan document for more information.

309. Periodontal scaling and root planing procedures require administration of intramucosal injection of local anesthetic. An allowance has been made for a prophylaxis.

310. Radiographs do not appear to meet medical necessity guidelines. Participating dentist have agreed to charge the patient only the amount indicated as Patient Pays. Please refer to exclusion section of your dental plan document for more information.

311. Procedure(s) do not indicate dental necessity for more than one hour of anesthesia. Participating dentists have agreed to charge the patient only the amount indicated as Patient Pays. Please refer to exclusion section of your dental plan document.

312. Individually listed radiographs are considered a complete series. Allowance has been made for a full mouth series (D0210).

314. Implant(s) and implant related services are benefited once in a lifetime per site. Please advise patient of responsibility for fee. Refer to the limitations section of your dental plan document for more information.

315. Patient history indicates that an initial root canal has been performed on this tooth. Please submit a new claim with the appropriate CDT code for retreatment of a previous root canal. Please refer to the exclusion section of your dental plan document for more information.

316. Services provided in a foreign country are not covered unless required as an emergency. Please advise patient of responsibility for fee. Please refer to the exclusion section of your dental plan document for more information.

319. Treatment rendered does not indicate medical necessity for the number of anesthesia units submitted. Any anesthesia in excess may not be billed separately. Participating dentist have agreed to charge the patient only the amount indicated as Patient Pays.

320. Patient not eligible for service due to age limitations specified in this plan. Please advise patient of responsibility for fee. Refer to the limitations of your dental plan document for more information.

321. Predetermined services submitted without a date of service have been processed with a billed amount of $0.00. When the service has been completed, please submit a new claim.

323. Procedure performed does not meet CDT definition or criteria for this code based on patient's history. Please resubmit with correct code.

325. Services rendered by non-PPO dentists are excluded under this benefit plan. Refer to How Delta Dental Pays for Covered Benefits section of your dental plan document for more information.

326. Services rendered by non-VCU dentists are excluded under this benefit plan. Refer to How Delta Dental Pays for Covered Benefits section of your dental plan document for more information.

332. Infiltration of sustained release therapeutic drug is only a benefit when submitted with surgical extractions.

333. Benefits for caries arresting medicament application are not allowed on the same tooth and date of service as a restoration. Participating dentist(s) have agreed to charge the patient only the amount indicated as Patient Pays. Please refer to the exclusion section of your dental plan document.

334. Three or four bitewing radiographs are not a benefit for patients under the age of 10. An allowance has been made for two bitewing radiographs. Participating dentists have agreed to charge the patient only the amount indicated as Patient Pays.

335. This predetermination was issued for multiple services and has been finalized based on the completion of one or more service(s). If the other services are completed at a later date, please submit a new claim.

336. Benefits for three or more quadrants of periodontal scaling and root planing cannot be determined without supporting documentation. Please provide periodontal charting, full mouth or panoramic radiographs and the length of time therapy was performed for each quadrant.

337. Interim partial dentures are benefited only on permanent anterior teeth for members under the age of 16. Please advise patient of responsibility for fee.

338. Tissue regeneration and bone replacement graft procedures are a benefit for treatment of natural teeth. Refer to the exclusion section of your dental plan document for more information.

339. Periodontal maintenance procedures are not a benefit in the absence of prior definitive periodontal therapy.

340. Procedure performed does not meet the criteria for this code based on patient's history. Benefit is denied.

341. D0180 is for comprehensive periodontal oral evaluation for new patients showing signs of periodontal disease; established patients who have had a significant change in periodontal health conditions, by report, or established patients who have been absent from active periodontal treatment.

342. Benefits for this procedure cannot be determined based on the patient's claim history. Please review the code, tooth number and/or date of service and resubmit for consideration. Participating dentists have agreed to charge the patient only the amount indicated as Patient Pays.

343. Benefits for bone, cartilage grafts or augmentation, when billed with implants, implant removal, ridge augmentation, extraction sites, mucogingival/soft tissue grafts, periradicular surgery, sinus elevation, defects from cyst removal, hemisections etc. are denied as a specialized technique.

344. Services rendered by dental hygienists are limited under this benefit plan. Refer to the "Covered Benefits, Deductible and Benefit Waiting Period" section of your dental plan document for more information.

345. Removal of an implant body is considered inclusive when performed within six months of the implant placement. Refer to the exclusion section of your dental plan document for more information.

346. Removal of a non-resorbable barrier membrane, whether for natural teeth, an implant or an edentulous area, is considered inclusive of the initial placement. Refer to the exclusion section of your dental plan document for more information.

347. Reline of an appliance is considered inclusive when performed within six months of insertion of the initial appliance. Refer to the exclusion section of your dental plan document for more information.

348. Based on current clinical evidence the restoration appears to have a poor long term prognosis. Please advise the patient of responsibility for fee.

349. Crowns and buildups require a diagnostic quality pre-treatment periapical X-ray within one year of treatment of the tooth/teeth undergoing treatment. Please submit a new claim with the required X-ray(s).

350. Crowns and buildups require a diagnostic quality periapical X-ray(s) within one year of treatment of the tooth/teeth undergoing treatment. Please submit a new claim with the required X-ray(s).

351. Crowns and buildups require a diagnostic quality periapical X-ray within one year of treatment of the tooth or teeth undergoing treatment that is of sufficient image resolution, is not blurry and includes sufficient contrast, is not grainy. Please submit a new claim with the required X-ray(s).

352. Crowns and buildups require a diagnostic quality periapical X-ray within one year of care of the treated tooth/ teeth that is without angulation, cone cutting, artifacts blocking areas requiring review, and/or is not pre-cropped. Please submit a new claim with the required X-ray(s).

353. Crowns and buildups require a diagnostic quality pre-treatment X-ray within one year of treatment of the tooth or teeth undergoing treatment. Please submit a new claim with the required X-ray(s).

354. Crowns and buildups require a diagnostic quality periapical X-ray within one year of treatment showing the entirety of the tooth or teeth undergoing treatment, including the root tip. Please submit a new claim with the required X-ray(s).

355. Submitted periodontal code requires a full-mouth series or periapical and bitewing X-rays of the treated area that is of sufficient image resolution, is not blurry and includes sufficient contrast, is not grainy. Please submit a new claim with the required X-ray(s).

356. Procedures, appliances or restorations performed mainly for aesthetic or cosmetic reasons are excluded under this plan. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

357. Clinical information does not meet the criteria for benefit payment (i.e., 4mm or greater pocket depths). Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

358. Based on consultant review, the provided X-rays indicate the tooth has an apparent poor long term prognosis due to significant periodontal bone loss. Patient is responsible for fee. Please refer to the exclusion section of your dental plan document for more information.

359. The restoration appears to have a poor long term prognosis. Please advise the patient of responsibility for fee. Please refer to the exclusion section of your dental plan document.

360. Based on consultant review of the submitted procedure, an amalgam or composite restoration can satisfactorily restore tooth function. Please advise patient of responsibility for fee. Refer to the limitations section of your dental plan document for more information.

361. Procedures rendered for treatment of complications of wear, attrition, erosion or abfraction do not meet criteria for treatment and are excluded under this plan. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

362. Allowance based on consultant evaluation. Refer to the exclusion section of your dental plan document for more information.

363. Submitted periodontal code requires a full-mouth series or periapical and bitewing X-rays of the treated area that is undergoing treatment that is without angulation or cone cutting, does not include artifacts blocking areas requiring review, and/or is not pre-cropped. Please submit a new claim with the required X-ray(s).

364. Submitted periodontal code requires a diagnostic quality pre-treatment full-mouth series or periapical and bitewing X-rays of the tooth or teeth undergoing treatment. Please submit a new claim with the required X-ray(s).

365. Submitted periodontal code requires a diagnostic quality full-mouth series or periapical and bitewing X-rays of the treated area showing the entirety of the tooth or teeth undergoing treatment, including the bone levels. Please submit a new claim with the required X-ray(s).

366. Our dental consultant has reevaluated this procedure. The original decision is upheld.

366. Procedures with missing or invalid info cannot be processed. Please submit a new claim with the required data [correct quadrant].

367. Submitted periodontal code requires pocket charting within 12 months, a full-mouth series or periapical and bitewing X-rays of the treated area. If more than two quadrants, chart notes including length of time surgery was performed. Please submit a new claim with all documentation.

372. Procedure is a pre-estimate only and will require post-treatment periapical X-rays for endodontic procedures. Actual payment amount and/or patient responsibility is subject to change when the payment is generated.

373. Primary closure of sinus perforation is not covered when performed on the same day as a completely bony surgical extraction with unusual complications. Patient may refer to the exclusion section of the dental plan document for more information.

373. Procedure classification modified by consultant evaluation.

374. Benefits cannot be determined. Procedure does not meet the CDT definition or criteria for this code due to lack of history of surgical removal of teeth or implant treatment. Patient may refer to the exclusion section of the dental plan document for more information.

375. A completed treating dentist attestation form is required. The attestation form is available for download at **DeltaDentalVA.com/dentists/resources**. Search ‘attestation’ to find the form. Please submit a new claim with the completed attestation form.

376. General anesthesia is a covered benefit with this plan only when provided with six or more extractions. Please advise patient of responsibility for fee. Refer to the exclusion section of your dental plan document for more information.

377. Gingival curettage, surgical gingivectomy/gingivoplasty, grafts, osseous or mucogingival surgery includes surgical reentry for three years. Participating dentists agree to charge only the amount listed under Patient Pays. Refer to the limitation section of your dental plan document.

378. Periodontal procedures include all post-operative care for three months, as well as surgical reentry for three years. Participating dentists agree to charge only the amount listed under Patient Pays. Patient may refer to the Exclusions section of the dental plan document for more information.

390. The fee for bitewings and periapicals is included in the allowance for a full mouth series if done on the same day. An adjustment has been made for the previously allowed X-ray cost. Patient may refer to the Exclusions section of the dental plan document for more information.

391. When individual intraoral radiographic images submitted by the same dentist/dental office exceed the cost of a full-mouth X-ray, reimbursement will be limited to the equivalent fee for a full-mouth X-ray. Participating dentists have agreed to charge the amount indicated as Patient Pay.

National processing policies

INTRODUCTORY NOTE

These national processing policies have been revised to reflect data code set requirements set forth under the Administrative Simplification Provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and related regulations. It is the policy of Delta Dental to comply with all such requirements as well as to require all Delta Dental member companies and their participating dentists to comply with such requirements. However, consistent with HIPAA, Delta Dental exercises its right to determine claims reimbursement procedures and requires the processing of such codes in accordance with the following policies, unless prohibited under other applicable law or specific group contract provisions (described below). Notwithstanding, treatment of procedures under the national processing policies, dentists are required to utilize those procedure codes reflective of services rendered and in accordance with HIPAA. Amounts charged under any procedure shall not be inflated or manipulated in light of the processing policies. Delta Dental member companies shall ensure that their application of these processing policies is consistent with their contractual obligations to groups and enrollees.

GENERAL POLICIES

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

Terms of group contracts vary. Policies in this Handbook that address benefits, limitations and exclusions are "model" policies that have not been tailored to reflect the specific terms of applicable group contracts. This Handbook may not fully or accurately reflect the terms of applicable group contracts and may be inconsistent with such terms. In all cases, the terms of group contracts take precedence over the Handbook policies. Contact the member company listed on the patient's identification card for the specific terms of a group contract.

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

Allowance: The amount of Delta Dental's payment for the procedure benefited.

Approved amount: The total fee a participating dentist agrees to accept as payment in full for a procedure. It includes both the Delta Dental allowance and the patient responsibility. Participating dentists agree not to collect from the patient any difference between the approved amount and their actual fee for the procedure.

Denied/deny: If the fee for a procedure or service is denied, the procedure or service is not a benefit of the patient's coverage and the approved amount is collectable from the patient. As previously stated, specific group contract provisions take precedence over processing policies.

It is recommended that the dental office contact the appropriate member company for the group account to determine the specific benefits, limitations and exclusions for each group.

Not billable to the patient: If the fee for a procedure or service is not billable to the patient, it is neither benefited by Delta Dental nor collectable from the patient by a participating dentist.

Alternative benefit: In cases where alternative methods of treatment exist, benefits are provided for the least costly, professionally acceptable treatment. This determination is not to recommend which treatment should be provided. It is a determination of benefits under terms of the patient's coverage. The dentist and patient should decide the course of treatment. If the treatment rendered is other than the one benefited, the difference between Delta Dental's allowance and the approved amount for the actual treatment rendered is collectable from the patient.

In conjunction with: In conjunction with means as part of another procedure or course of treatment including, but not limited to, being rendered on the same day.

Processed as: When a procedure is processed as a different procedure, participating dentists agree to accept all the limitations, processing policies and approved amounts that apply to the procedure Delta Dental benefits.

ALL SERVICES PROVIDED TO DELTA DENTAL MEMBERS ARE SUBJECT TO THE FOLLOWING GENERAL POLICIES:

- **Documentation of extraordinary circumstances** can be submitted for review by report.
- **Fees for completion of claim forms and submission of documentation** to Delta Dental to enable benefit determination are not benefits. They are not collectable from the patient by a participating dentist.
- **Infection control and OSHA compliance** are included in the fee for the dental services provided. Separate fees are not billable to the patient and not collectable separately from the patient by a participating dentist.
- **Multistage procedures** are reported and benefited upon completion. The completion date is the date of insertion for removable prosthetic appliances. The completion date for immediate dentures is the date that the remaining teeth are removed and the denture is inserted. The completion date for fixed partial dentures and crowns, onlays and inlays is the cementation date regardless of the type of cement utilized. The completion date for endodontic treatment is the date the canals are permanently filled. The completion date for implant supported restorations and tooth replacement is when these are permanently placed and includes temporary appliances.*
- **Charges for procedures determined not to be necessary** or not meeting generally accepted standards of care may be denied or not billable to the patient. Many of the processing policies that follow detail payment procedures that are based on the timing and sequence of inter-related procedures.
- However, the **timing and sequencing of treatment is the responsibility of the dentist** rendering care and should always be determined by the treating dentist based on the patient's needs.
- **When a procedure is by report and subject to coverage under medical,** it should be submitted to the patient's medical carrier first. When submitting to Delta Dental, a copy of the explanation of payment or payment voucher from the medical carrier should be included with the claim, plus a narrative describing the procedure performed, reasons for performing the procedure, pathology report if appropriate, and any other information deemed pertinent. In the absence of such information, Delta Dental will not benefit the procedure.
- **The term specialized procedure** describes a dental service or procedure that is used when unusual or extraordinary circumstances exist, and is not generally used when conventional methods are adequate.

*Multiple-visit procedures are paid in the order claims are received.

- All services and treatment provided remotely via tele-health modalities, be they synchronous or asynchronous, must be performed by a licensed dentist or their supervised staff, acting within the scope of applicable law. Services and treatment delivered virtually are only a benefit when the elements included in the descriptor of the CDT procedure code are completed and only when they meet generally accepted clinical guidelines. This general policy provides an overarching guidance as to our approach to benefiting treatment done virtually. Additional policies may be considered at procedure code levels as they emerge.

CDT codes

DIAGNOSTIC (D0100-D0999)

Terms of group contracts vary. Policies in this Handbook that address benefits, limitations and exclusions are "model" policies that have not been tailored to reflect the specific terms of applicable group contracts. This Handbook may not fully or accurately reflect the terms of applicable group contracts, and may be inconsistent with such terms. In all cases, the terms of group contracts take precedence over the *Handbook* policies. Contact the member company listed on the patient's identification card for the specific terms of a group contract.

Clinical oral evaluations

GP Clinical oral evaluation frequency limitations are determined by group/ individual contract.

GP Comprehensive, periodic and periodontal evaluations include but are not limited to a thorough evaluation and recording of the extra-oral and intraoral hard and soft tissues. This would include the evaluation and recording of the patient's dental and medical history and general health assessment. It may typically include the evaluation and recording of dental caries, missing or un-erupted teeth, restorations, existing prostheses, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, oral cancer evaluation, consultations, diagnosis, treatment planing, screening and assessment of a patient or other procedures typically part of a patient evaluation.

GP Oral evaluations are only a benefit when the elements included in the descriptor are completed.

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

GP All oral evaluations should meet the current best practices regardless if done in person or virtually which includes presenting the patient with clinical findings and a treatment plan.

D0120 **Periodic oral evaluation — established patient.** Time limitations for evaluations are established by group/individual contract and should count towards contractual evaluation limitations. Benefits for D0120 performed without an intent to provide dental services to meet the patient's dental needs will be processed as D0190.

D0140 **Limited oral evaluation — problem focused is allowed with definitive treatment specific to the problem or complaint.** The time limitation for evaluations is established by group/individual contract and counts toward contractual evaluation limitations. Oral evaluations are only a benefit when the elements included in the descriptor are completed.

D0145 **Diagnostic services performed for a child under the age of three, preferably within the first six months of the eruption of the first primary tooth, including recording the oral and physical health history, evaluation of caries susceptibility, development of an appropriate preventive oral health regimen and communication with and counseling of the child's parent, legal guardian and/or primary caregiver.** The time limitation for oral evaluations is determined by group/individual contract and should count towards contractual oral evaluation limitations. D0145 includes any caries susceptibility tests (D0425) or oral hygiene instructions (D1330) on the same date. When performed on the same date as D0145, any fees for D0425 and D1330 are not billable to the patient. For patients under the age of three, any other comprehensive evaluation code submitted (D0150, D0160, D0180) is payable as D0145. Any fees in excess of D0145 are not billable to the patient. Benefits for D0145 for a child over three years of age are considered miscoded, and the correct code should be applied.

D0150 **Comprehensive oral evaluation — new or established patient.** Comprehensive oral evaluation is benefited for the first encounter with the dentist/dental office and subsequent submissions by the same dentist/dental office are benefited as periodic oral evaluations (D0120) determined by the contractual/frequency limitations or level of benefit. If the patient has not received any dental services for three years from the same dentist/dental office, a comprehensive evaluation may be benefited. Benefits for D0150 performed without an intent to provide dental services to meet the patient's dental needs will be processed as D0190.

D0160 **Detailed and extensive oral evaluation — problem focused — by report.** Benefit is once per dentist/dental office; D0160 counts toward the contractual evaluation limitations.

D0170 **Re-evaluation — limited, problem focused.** The fees for re-evaluation — limited, problem focused are not billable to the patient in conjunction with another procedure by the same dentist/dental office.

D0171 **Re-evaluation — post operative office visit.** Procedures include all necessary postoperative care and re-evaluations. Not billable to the patient when submitted by the same dentist/dental office who performed the original procedure. DENIED if different dentist/dental office.

D0180 **Comprehensive periodontal evaluation — new or established patient.** Frequency limitations are determined by group/individual contract and should count towards contractual evaluation limitations. If a D0180 is submitted with D4910 by the same dentist/dental office it is benefited as a D0120 and the difference in the approved amount between D0120 and D0180 is not billable to the patient. Benefits for D0180 performed without an intent to provide dental services to meet the patient's dental needs will be processed as D0190. Fees for D0180 are not billable to the patient when done on the same date of service as D4355 by the same dentist/dental office.

Pre-diagnostic services

GP Benefits are determined by group contract.

GP When reported individually, pre-diagnostic services are considered incomplete and DENIED.

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

D0190 **Screening of a patient.** When reported in conjunction with an evaluation/screening (D0120, D0140, D0145, D0150, D0160, D0170, D0171, D0180, D0191 and D9310), the fees for D0190 are not billable to the patient as integral to the evaluation by the same dentist/dental office/dental office on the same date of service. When covered by group/individual contract and reported individually, benefit once per 12 months. Subsequent submissions within 12 months are DENIED. When a benefit, D0190 does not count towards the evaluation frequency limits and should cross check against D0191.

D0191 **Assessment of a patient.** When reported in conjunction with an evaluation/screening (D0120, D0140, D0145, D0150, D0160, D0170, D0171, D0180, D0190 and D9310) the fees for D0191 are not billable to the patient as integral to the evaluation by the same dentist/dental office on the same date of service. When covered by group/individual contract and reported individually, benefit once per 12 months. Subsequent submissions within 12 months are DENIED. When a benefit, D0191 does not count towards the evaluation frequency limits and should cross check against D0190.

Diagnostic imaging

GP Diagnostic imaging services must be necessary and appropriate relative to an individual dental patient's disease risk and clinical condition. If the need is not evident from the information submitted, fees for radiographic images are not billable to the patient.

GP Fees for duplication (copying) of diagnostic images for insurance purposes are not billable to the patient.

GP Fees for non-diagnostic images, as determined by consultant review, are not billable to the patient.

GP Individually listed intraoral radiographic images by the same dentist/dental office are considered a complete series if the fee for individual radiographic images equals or exceeds the fee for a complete series. Any amount charged in excess of the allowance for a complete series (D0210) is not billable to the patient.

GP Limit two bitewing images for patients under age 10. A D0273 or D0274 submitted for a patient under age 10 will be benefited as D0272 and any fees in excess of the approved amount for D0272 is not billable to the patient.

GP When image capture only procedures are submitted with capture and interpretation procedures, the fee for the image capture only procedure will be not billable to the patient.

GP When interpretation of a diagnostic image procedure (D0391) is submitted with the capture and interpretation procedures, the fee for the interpretation of a diagnostic image (D0391) will be not billable to the patient.

GP The frequency limitation for full mouth and panoramic radiographic images are a benefit once every five years. All other imaging frequencies are determined by the group/individual contract.

GP Fees for final orthodontic records (images, photos, and models) are included in the treatment and not billable to the patient.

GP The fees for radiographs taken during the procedures and post-operative radiographs are included in the fees for root canals, surgical and non-surgical procedures, and all indirect restorations (crowns, onlays, bridges, inlays, and implants) and are not billable to the patient.

D0210 **Intraoral — complete series radiographic images.** Benefits for intraoral complete series of radiographic images are limited to once every five years unless determined by group/individual contract. The fee for any type of bitewings submitted with a full mouth series are considered part of the full mouth series for payment and benefit purposes. Any fee in excess of a full mouth series is not billable to the patient. Benefits are limited to either an intraoral complete series radiographic images (D0210) or panoramic radiographic image (D0330) within the five-year period. Any additional benefits are DENIED. When submitted with intraoral complete series image capture only, the fees for D0709 are not billable to the patient by same dentist/dental office. The fees for additional bitewings (D0270-D0274) within six months of D0210 are not billable to the patient by the same dentist/dental office. The fee for intraoral tomosynthesis — comprehensive series of radiographic images (D0387) capture

only is considered part of D0210. When submitted with intraoral tomosynthesis — comprehensive series of radiographic images, benefit intraoral tomosythesis comprehensive series as a D0210 and the additional fees are chargeable to the patient. The separate D0210 is not billable to the patient.

D0220 Intraoral — periapical — first radiographic image. When submitted with intraoral periapical image capture only, the fees for D0707 are not billable to the patient by same dentist/dental office. The fee for intraoral tomosynthesis periapical image — capture only (D0389) is considered part of D0220 and not billable to the patient.

D0230 Intraoral — periapical — each additional radiographic image. Individually listed intraoral radiographic images by the same dentist/dental office are considered a complete series if the there are more than eight periapicals and/or bitewings, or fee for individual radiographic images equals or exceeds the fee for a complete series done on the same date of service (excluding D0330). Any more than eight periapicals and/or bitewings or fee in excess of the fee for a full mouth series (D0210) is not billable to the patient. Routine working and final treatment radiographic images taken by the same dentist/dental office for endodontic therapy are considered a component of the complete treatment procedure. Separate fees for these images are not billable to the patient. When submitted with intraoral periapical image capture only, the fees for D0707 are not billable to the patient by same dentist/dental office.

D0240 Intraoral — occlusal radiographic image. When submitted with intraoral–occlusal — capture only, the fees for D0706 are not billable to the patient.

D0250 Extra-oral — first radiographic image. Benefits for extra-oral — 2D projection radiographic images created using a stationary radiation source and detector are DENIED unless covered by group/individual contract. When submitted with intra-occlusal radiographic image capture only, the fees for D0706 are not billable to the patient by same dentist/dental office.

D0251 Extra-oral posterior dental radiographic image. Extra-oral posterior dental radiographic image is DENIED unless covered by group/individual contract. If there is a history of prior extra-oral radiograph within the frequency limitation for D0330, the fees for D0251 are not billable to the patient. When submitted with extra-oral posterior radiographic image capture only, the fees for D0705 are not billable to the patient by same dentist/dental office. Under extenuating circumstances or for special health care needs, benefits may be limited to a bitewing (D0270).

D0270 Bitewing — single radiographic image. When submitted with intraoral — bitewing image capture only, the fees for D0708 are not billable to the patient by the same dentist/dental office. The fee for intraoral tomosynthesis bitewing image — capture only (D0388) is considered part of D0270 and not billable to the patient. The fees for additional bitewings (D0270-D0274) within six months of D0210 are not billable to the patient by the same dentist/dental office. Benefits are DENIED if done by a different dentist/dental office.

D0272 **Bitewings — two radiographic images.** When submitted with intraoral — bitewing image capture only, the fees for D0708 are not billable to the patient by the same dentist/dental office. The fee for intraoral tomosynthesis bitewing image — capture only (D0388) is considered part of D0272 and not billable to the patient. The fees for additional bitewings (D0270-D0274) within six months of D0210 are not billable to the patient by the same dentist/dental office. Benefits are DENIED if done by a different dentist/dental office.

D0273 **Bitewings — three radiographic images.** When submitted with intraoral — bitewing image capture only, the fees for D0708 are not billable to the patient by the same dentist/dental office. The fee for intraoral tomosynthesis bitewing image — capture only (D0388) is considered part of D0273 and not billable to the patient. The fees for additional bitewings (D0270-D0274) within six months of D0210 are not billable to the patient by the same dentist/dental office. Benefits are DENIED if done by a different dentist/dental office.

D0274 **Bitewings — four radiographic images.** When submitted with intraoral — bitewing image capture only, the fees for D0708 are not billable to the patient by the same dentist/dental office. The fee for intraoral tomosynthesis bitewing — image capture only (D0388) is considered part of D0274 and not billable to the patient. The fees for additional bitewings (D0270-D0274) within six months of D0210 are not billable to the patient by the same dentist/dental office. Benefits are DENIED if done by a different dentist/dental office.

D0277 **Vertical bitewings — seven to eight radiographic images.** Vertical bitewings are considered bitewings for benefit purposes. If there are more than eight bitewings and/or periapicals or if the fee for the vertical bitewings with or without additional radiographic images equals or exceeds the fee for a complete series, it would be considered a complete series for payment, benefit and time limitation purposes. The fee in excess of the fee for a complete series of radiographic images is not billable to the patient. In the absence of contract language for bitewing frequency limitations, the fees for D0277 are not billable to the patient within 12 months of a full mouth series.

D0310 **Sialography.**

D0320 **Temporomandibular joint arthrogram including injection.**

D0321 **Other temporomandibular joint radiographic images — by report.**

D0322 **Tomographic survey.**

D0330 **Panoramic radiographic image.** Benefits for panoramic radiographic image are limited to once every five years. Benefits are limited to either a panoramic radiographic image (D0330) or an intraoral complete series radiographic images (D0210) within the five year period. Any additional benefits are DENIED. When submitted with panoramic image capture only, the fees for D0701 are not billable to the patient by same dentist/dental office.

D0340 2D Cephalometric radiographic image. A cephalometric radiographic image is payable only in conjunction with orthodontic benefits. The fee for a cephalometric radiographic image taken in conjunction with services other than orthodontic treatment is DENIED and the approved amount is collectable from the patient. When submitted with 2D cephalometric radiographic image capture only, the fees for D0702 are not billable to the patient by same dentist/dental office.

D0350 2D oral/facial photographic image obtained intraorally or extra-orally. Oral/facial images are benefited only once per case in conjunction with orthodontic services. The fees for additional images taken during or after orthodontic treatment by the same dentist/dental office are included in the fee for orthodontics and not billable to the patient. The fees for oral/facial images taken in conjunction with any other procedure are DENIED, and the approved amount is collectable from the patient. When submitted with 2D oral-facial photographic image capture only, the fees for D0703 are not billable to the patient by same dentist/dental office.

GP When image capture only procedures are submitted with capture and interpretation procedures, the fee for the image capture only procedure will be not billable to the patient.

GP When interpretation of a diagnostic image procedure (D0391) is submitted with the capture and interpretation procedures, the fee for the interpretation of a diagnostic image (D0391) will be not billable to the patient.

D0364 Cone beam CT capture and interpretation with limited field of view. The benefit for cone beam CT capture and interpretation of view restricted to less than one whole jaw is DENIED unless covered by group individual contract. When covered, benefit once per 12 months. Benefits are DENIED if D0364, D0365, D0366, D0367 were benefited in the last 12 months. When submitted in conjunction with the capture only procedure D0380, the fee for D0380 is not billable to the patient. When submitted in conjunction with the interpretation procedure D0391, the fee for D0391 is not billable to the patient.

D0365 Cone beam CT capture and interpretation with field of view of one full dental arch — mandible. Cone beam CT codes are DENIED, unless covered by group/individual contract. When covered, benefit once per 12 months. Benefits are DENIED if D0364-D0367 were benefited in the last 12 months. When submitted in conjunction with the capture only procedure D0381, the fee for D0381 is not billable to the patient. When submitted in conjunction with the interpretation procedure D0391, the fee for D0391 is not billable to the patient.

D0366 Cone beam CT capture and interpretation with field of view one full dental arch — maxilla with or without cranium is DENIED unless covered by group/individual contract. When covered, benefit once per 12 months. Benefits are DENIED if D0364, D0365, D0366, D0367 were benefited in the last 12 months. When submitted in

conjunction with the capture only procedure D0382, the fee for D0382 is not billable to the patient. When submitted in conjunction with the interpretation procedure D0391, the fee for D0391 is not billable to the patient.

D0367 **Cone beam CT capture and interpretation with field of view of both jaws with or without cranium is DENIED unless covered by group/individual contract.** When covered, benefit once per 12 months. Benefits are DENIED if D0364, D0365, D0366, D0367 were benefited in the last 12 months When submitted in conjunction with the capture only procedure D0383, the fee for D0383 is not billable to the patient. When submitted in conjunction with the interpretation procedure D0391, the fee for D0391 is not billable to the patient.

D0368 **Cone beam CT capture and interpretation for TMJ series including two or more exposures is DENIED unless the group/individual contract includes TMJ coverage.** When covered, benefit once per lifetime. When submitted in conjunction with the capture only procedure D0384, the fee for D0384 is not billable to the patient. When submitted in conjunction with the interpretation procedure D0391, the fee for D0391 is not billable to the patient.

D0369 **Maxillofacial MRI capture and interpretation.** The fee for maxillofacial MRI capture and interpretation is DENIED. When submitted in conjunction with the capture only procedure D0385, the fee for D0385 is not billable to the patient. When submitted in conjunction with the interpretation procedure D0391, the fee for D0391 is not billable to the patient.

D0370 **Maxillofacial ultrasound capture and interpretation.** The fee for maxillofacial ultrasound, capture and interpretation is DENIED. When submitted in conjunction with the capture only procedure D0386, the fee for D0386 is not billable to the patient. When submitted in conjunction with the interpretation procedure D0391, the fee for D0391 is not billable to the patient.

D0371 **Sialoendoscopy capture and interpretation.** The fee for sialoendoscopy capture and interpretation is DENIED.

D0372 **Intraoral tomosynthesis — comprehensive series of radiographic images.** Benefits for intraoral tomosynthesis comprehensive series are DENIED, unless covered by group/individual contract. When covered, intraoral tomosynthesis radiographic images are included in the frequency limitations for radiographs. When billed with intraoral — complete series of radiographic images (D0210) by the same dentist/dental office, the D0210 is not billable to the patient. When billed with intraoral tomosynthesis — comprehensive series — capture only (D0387) by the same dentist/dental office, the D00387 (capture only) is not billable to the patient. When billed with intraoral — complete series of radiographic images — image capture only (D0709) by the same dentist/dental office, the D0709 is not billable to the patient.

D0373 Intraoral tomosynthesis — bitewing — radiographic image. Benefits for intraoral tomosynthesis comprehensive series are DENIED, unless covered by group/individual contract. When covered, intraoral tomosynthesis radiographic images are included in the frequency limitations for radiographs. When billed with bitewings (D0270, D0271, D0272, D0273, D0274, D0277) by the same dentist/dental office, the (D0270, D0271, D0272, D0273, D0274, D0277) are not billable to the patient. When billed with intraoral tomosynthesis bitewing — radiographic image — capture only (D0388) by the same dentist/dental office, the D00388 (capture only) is not billable to the patient. When billed with intraoral — bitewing radiographic image — image capture only (D0708) by the same dentist/dental office, the D0708 is not billable to the patient.

D0374 Intraoral tomosynthesis — periapical radiographic image. Benefits for intraoral tomosynthesis periapical image are DENIED, unless covered by group/individual contract. When covered, intraoral tomosynthesis radiographic images are included in the frequency limitations for radiographs. When billed with intraoral — periapical first radiograph image (D0220) and intraoral periapical each additional radiographic image (D0230) by the same dentist/dental office, the D0220 and D0230 are not billable to the patient. When billed with intraoral tomosynthesis — periapical radiographic image — capture only (D0389) by the same dentist/dental office, the D0389 (capture only) is not billable to the patient. When billed with intraoral — periapical radiographic image — image capture only (D0707) by the same dentist/dental office, the D0707 is not billable to the patient.

Diagnostic imaging — image capture only

GP When image capture only procedures are submitted with capture and interpretation procedures, the fee for the image capture only procedure will be not billable to the patient.

D0380 Cone beam CT image capture with limited field of view — less than one whole jaw. The fee for cone beam CT image capture with limited field of view — less than one whole jaw is DENIED. When submitted in conjunction with the capture and interpretation procedure D0364, the fee for D0380 is not billable to the patient. When submitted by the same dentist/dental office in conjunction with the interpretation procedure D0391, it is reprocessed as D0364 and the fees for D0380 and D0391 are not billable to the patient. The fee for the interpretation of a diagnostic image D0391, when submitted by a different dentist/dental office than that who submitted the capture only procedure D0380-D0386, is processed according to group/individual contract.

D0381 Cone beam CT image capture with field of view one full dental arch — mandible. Cone beam CT image capture with field of view of one full dental arch — mandible is DENIED. When submitted in conjunction with the capture and interpretation

procedure D0365, the fee for D0381 is not billable to the patient. When submitted by the same dentist/dental office in conjunction with the interpretation procedure D0391, it is reprocessed as D0365 and the fees for D0381 and D0391 are not billable to the patient. The fee for the interpretation of a diagnostic image D0391, when submitted by a different dentist/dental office than that who submitted the capture only procedure D0380-D0386, is processed according to group/individual contract.

D0382 **Cone beam CT image capture with field of view one full dental arch — maxilla, with and without cranium.** Cone beam CT image capture with field of view one full dental arch — maxilla, with or without cranium is DENIED. When submitted in conjunction with the capture and interpretation procedure D0366, the fee for D0382 is not billable to the patient. When submitted by the same dentist/dental office in conjunction with the interpretation procedure D0391, it is reprocessed as D0366 and the fees for D0382 and D0391 are not billable to the patient. The fee for the interpretation of a diagnostic image D0391, when submitted by a different dentist/dental office than that who submitted the capture only procedure D0380-D0386, is processed according to group/individual contract.

D0383 **Cone beam CT image capture field of view both jaws, with or without cranium.** The fee for cone beam CT image capture field of view both jaws, with or without cranium is DENIED. When submitted in conjunction with the capture and interpretation procedure D0367, the fee for D0383 is not billable to the patient. When submitted by the same dentist/dental office in conjunction with the interpretation procedure D0391, it is reprocessed as D0368 and the fees for D0383 and D0391 are not billable to the patient. The fee for the interpretation of a diagnostic image D0391, when submitted by a different dentist/dental office than that who submitted the capture only procedure D0380-D0386, is processed according to group/individual contract.

D0384 **Cone beam CT image capture for TMJ series including two or more exposures.** The fee for cone beam CT image capture for TMJ series including two or more exposures is DENIED. When submitted in conjunction with the capture and interpretation procedure D0368, the fee for D0384 is not billable to the patient. When submitted by the same dentist/dental office in conjunction with the interpretation procedure D0391, it is reprocessed as D0368 and the fees for D0384 and D0391 are not billable to the patient. The fee for the interpretation of a diagnostic image D0391, when submitted by a different dentist/dental office than that who submitted the capture only procedure D0380-D0386, is processed according to group/individual contract.

D0385 **Maxillofacial MRI image capture.** The fee for maxillofacial MRI image capture is DENIED. When submitted in conjunction with the capture and interpretation procedure D0369, the fee for D0385 is not billable to the patient. When submitted by the same dentist/dental office in conjunction with the interpretation procedure D0391, it is reprocessed as D0369 and the fees for D0385 and D0391 are not billable to the patient. The fee for the interpretation of a diagnostic image D0391, when submitted by

a different dentist/dental office than that who submitted the capture only procedure D0380-D0386, is processed according to group/individual contract.

D0386 Maxillofacial ultrasound image capture. The fee for maxillofacial ultrasound image capture is DENIED. When submitted in conjunction with the capture and interpretation procedure D0370, the fee for D0386 is not billable to the patient. When submitted by the same dentist/dental office in conjunction with the interpretation procedure D0391, it is reprocessed as D0370 and the fees for D0386 and D0391 are not billable to the patient. The fee for the interpretation of a diagnostic image D0391, when submitted by a different dentist than who submitted the capture only procedure D0380-D0386, is processed according to group/individual contract.

D0387 Intraoral tomosynthesis — comprehensive series of radiographic images — capture only. The fee for intraoral tomosynthesis — comprehensive series of radiographic images (D0387) capture only is considered part of D0372 and not billable to the patient.

D0388 Intraoral tomosynthesis bitewing — radiographic image — capture only. When billed with intraoral tomosynthesis — bitewing — radiographic image (D0373) by the same dentist/dental office, the D0388 (capture only) is not billable to the patient.

D0389 Intraoral tomosynthesis — periapical radiographic image — capture only. When billed with intraoral tomosynthesis — periapical image (D0374) by the same dentist/dental office, the D0389 (capture only) is not billable to the patient.

Interpretation and report only

D0391 Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report. The fee for interpretation of diagnostic image by a practitioner not associated with capture of the image, including report is DENIED. The fee for the interpretation of diagnostic image D0391 when submitted by the same dentist/dental office as the capture only procedures D0380-D0386 are not billable to the patient. The fee for the interpretation of a diagnostic image D0391, when submitted by a different dentist/dental office than who submitted the capture only procedure D0380–D0386, is processed according to group/individual contract.

D0393 Virtual treatment simulation using 3D image volume or surface scan. Benefits for D0393 are DENIED as a specialized procedure.

D0394 Digital subtraction of two or more images or image volumes of the same modality.

D0395 Fusion of two or more 3D image volumes of one or more modalities.

D0396 3D printing of a 3D dental surface scan — 3D printing of a 3D dental surface scan to obtain a physical model. 3D printing of a surface scan is inclusive of other procedures and is not billable to the patient.

Tests and examinations

D0411 **HbA1c in-office point of service testing.** Benefits are DENIED unless covered by group/individual contract. When covered by group/individual contract, limited to one test per benefit year. When D0411 is submitted on the same date/same dentist/dental office as D0412 (blood level glucose level test), D0412 is not billable to the patient. This code is to be used when drawing a blood sample and performing point of service analysis of the sample by a dentist. When a covered procedure, benefit for patients with risk factors for Type II diabetes who have not been previously diagnosed. Must be performed by a properly licensed provider who is acting in compliance with applicable local, state and federal requirements.

D0412 **Blood glucose level test, in office using a glucose meter.** Benefits are DENIED unless covered by group/individual contract. D0412 is not billable to the patient on the same day as D0411.

D0414 **Laboratory processing of microbial specimen to include culture and sensitivity studies, preparation and transmission of written report.** Benefits for laboratory processing of microbial specimens are DENIED unless covered by the group/individual contract.

D0415 **Collection of microorganisms for culture and sensitivity.** Bacteriologic studies for determination of sensitivity of pathologic agents to antibiotics are DENIED as a specialized procedure.

D0416 **Viral culture.** Studies for determining pathologic agents are specialized procedures and the fees are DENIED.

D0417 **Collection and preparation of saliva sample for laboratory diagnostic testing.** Benefits for collection and preparation of a saliva sample for laboratory analysis are DENIED unless covered by group/individual contract.

D0418 **Analysis of saliva sample — laboratory.** Benefits for analysis of a saliva sample are DENIED unless covered by group/individual contract.

D0419 **Assessment of salivary flow by measurement.** Limited to one assessment every three years. Subsequent submissions are not billable to the patient within 12 months and DENIED between 12 and 36 months.

D0422 **Collection and preparation of genetic sample material for lab analysis and report.** Genetic tests for susceptibility to oral diseases are DENIED unless covered by group/individual contract.

D0423 **Genetic test for susceptibility to disease — specimen analysis.** Genetic tests for susceptibility to oral diseases are DENIED unless covered by group/individual contract.

D0425 **Caries susceptibility tests are not a benefit and the benefits are DENIED as a specialized procedure.**

D0426 Collection, preparation and analysis of a saliva sample — point-of-care. Benefits for preparation, collection, and analysis of a saliva sample (point of care) are DENIED unless covered by group/individual contract.

D0431 Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures. Code D0431 is considered experimental and/or investigational and fees are DENIED.

D0460 Pulp vitality tests are payable per visit, not per tooth, and only for the diagnosis of emergency conditions. Fees for pulp tests are not billable to the patient when performed on the same date by the same dentist/dental office as any other definitive procedure except radiographic images, limited oral evaluation — problem focused (D0140), protective restoration (D2940) or palliative treatment (D9110).

D0461 Testing for cracked tooth. Testing for cracked tooth is included as part of the definitive procedure and the fees are not billable to the patient.

D0470 Diagnostic casts are a benefit once per case in conjunction with orthodontic services. The fees for additional casts taken during or after orthodontic treatment by the same dentist/dental office are included in the fee for orthodontics and are not billable to the patient. The fees for cast restorations and prosthetic procedures include diagnostic casts. Any fees charged for diagnostic casts in excess of the approved amount for these procedures by the same dentist/dental office are not billable to the patient. The fees for diagnostic casts taken in conjunction with any other procedure are DENIED and the approved amount is collectable from the patient.

D0600 Non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin and cementum. The fees for D0600 are not billable to the patient when submitted with an evaluation. When submitted separately from an evaluation benefits are DENIED unless covered by group.

D0601 Caries risk assessment and documentation with a finding of low risk not billable to the patient when submitted for children under the age of three. Limited to one risk assessment every 12 months. Subsequent risk assessment codes submissions are not billable to the patient within 12 months. The fee for D0601 is not billable to the patient when submitted with other risk assessment codes on the same date of service by the same dentist/dental office.

D0602 Caries risk assessment and documentation with a finding of moderate risk not billable to the patient when submitted for children under the age of three. Limited to one risk assessment every 12 months. Subsequent risk assessment codes submissions are not billable to the patient within 12 months. The fee for D0601 is not billable to the patient when submitted with other risk assessment codes on the same date of service by the same dentist/dental office.

D0603 Caries risk assessment and documentation with a finding of high risk not billable to the patient when submitted for children under the age of three. Limited to one risk assessment every 12 months. Subsequent risk assessment codes submissions are not billable to the patient within 12 months. Not billable to the patient when submitted with other risk assessment codes on the same date of service by the same dentist/dental office.

D0604 Antigen testing for a public health-related pathogen includes coronavirus. Benefits are DENIED unless covered by group/individual contract. Subject to coverage under the medical plan.

D0605 Antibodies testing for a public health-related pathogen includes coronavirus. Benefits are DENIED unless covered by group/individual contract. Subject to coverage under medical plan.

ORAL PATHOLOGY LABORATORY (USE CODES D0472-D0483)

Terms of group contracts vary. Policies in this Handbook that address benefits, limitations and exclusions are "model" policies that have not been tailored to reflect the specific terms of applicable group contracts. This Handbook may not fully or accurately reflect the terms of applicable group contracts and may be inconsistent with such terms. In all cases, the terms of group contracts take precedence over Handbook policies. Please contact the member company listed on the patient's identification card for the specific terms of a group contract.

GP All oral pathologic procedures must be accompanied by a pathology report to be considered for payment. The fee for an oral pathologic procedure not accompanied by a pathology report is not billable to the patient.

GP The fees for pathology reports submitted by anyone other than a licensed dentist are DENIED, and the approved amount is collectable from the patient.

GP If more than one of these procedures is submitted on the same day, same site, by the same dentist/dental office benefits are allowed for the most inclusive procedure and the less inclusive procedure is not billable to the patient.

GP Fees for the included procedures are not billable to the patient and not billable to the patient by a participating dentist. These inter-related procedures include, but are not limited to, the following hierarchy: D0474, most inclusive D0473, D0472.

GP All oral pathology procedures are by report and subject to medical coverage. Pathology reports, procedures D0472, D0473 and D0474 include preparation of tissue (sectioning, staining, etc.) and gross and microscopic examination. The fees for D0475, D0480, D0482 and D0483 are not billable to the patient as being a component of the pathology reports.

GP All oral pathology procedures must be accompanied by a pathology report to be considered for payment. A fee for pathology procedure not accompanied by a pathology report is not billable to the patient.

D0472 Accession of tissue, gross examination, preparation and transmission of written report.

D0473 Accession of tissue, gross and microscopic examination, preparation and transmission of written report.

D0474 Accession of tissue, gross and microscopic examination including assessment of surgical margins for presence of disease, preparation and transmission of written report.

D0475 Decalcification procedure.

D0476 Special stains, for microorganisms.

D0477 Special stains, not for microorganisms.

D0478 Immunohistochemical stains.

D0479 Tissue in-site hybridization, including interpretation.

D0480 Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report.

D0481 Electron microscopy.

D0482 Direct immunoflourescence.

D0483 Indirect immunofluorescence.

D0484 Consultation on slides prepared elsewhere is paid as D9310 — Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment).

D0485 Consultation, including preparation of slides from biopsy material supplied by referring source. D0485 must be accompanied by a pathology report. If the procedure is not accompanied by a pathology report the fee for the procedure is not billable to the patient. When billed on the same date of service, same site by the same dentist/dental office, benefits are allowed for the most inclusive procedure and the less inclusive procedure is not billable to the patient. When multiple procedures are submitted in the same area of the mouth, the more complex would be a benefit. The fees for subsequent procedure codes would be not billable to the patient.

D0486 Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report.

D0502 Other oral pathology procedures — by report. Other oral pathology procedures must be accompanied by a pathology report. Fee for D0502 submitted without the report are not billable to the patient. Benefits for D0502 are DENIED.

D0606 Molecular testing for a public health related pathogen, including coronavirus. Benefits are DENIED unless covered by group/individual contract.

IMAGE CAPTURE (D0701-D0709)

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GP Diagnostic services must be necessary and appropriate relative to an individual dental patient's disease risk and clinical condition. If the necessity and appropriateness for diagnostic radiographic imaging is not evident from the information submitted, or the images have been acquired before such a determination is made, fees for radiographic imaging are not billable to the patient.

GP Fees for duplication (copying) of diagnostic images for insurance purposes are not billable to the patient.

GP Images must be of diagnostic quality; properly oriented if submitted for documentation purposes, and with the date of exposure and a patient identifier indicated on all images. If an image is not of diagnostic quality, then the fee for the image is not billable to the patient.

GP Benefits for an intraoral comprehensive series and panoramic radiographic images are limited to once every five years. All other imaging frequencies are determined by the group/individual contract

GP The fees for radiographs taken during the procedures and post-operative radiographs are included in the fees for root canals, surgical and non-surgical procedures, and all indirect restorations (crowns, onlays, bridges, inlays, and implants) and are not billable to the patient.

D0701 Panoramic radiographic image — image capture only. The fee for a panoramic image capture only is considered part of D0330 and is not billable to the patient.

D0702 2D cephalometric radiographic image — image capture only. The fee for a 2D cephalometric radiographic image capture only is considered part of D0340 and is not billable to the patient.

D0703 2D oral/facial photographic image obtained intraorally or extra-orally — image capture only. The fee for a 2D oral/facial photographic image obtained intraorally or extra-orally only is considered part of D0350 and is not billable to the patient.

D0705 Extra-oral posterior dental radiographic image — image capture only. The fee for extra-oral posterior dental radiographic image capture only is considered part of D0251 and is not billable to the patient.

D0706 Intraoral — occlusal radiographic image — image capture only. The fee for an intraoral occlusal radiographic image capture only is considered part of D0240 and is not billable to the patient.

D0707 Intraoral — periapical radiographic image — image capture only. The fee for the intraoral periapical image capture only is considered part of D0220/D0230 and is not billable to the patient.

D0708 Intraoral — bitewing radiographic image — image capture only. The fee for the intraoral periapical image capture only is considered part of D0220/D0230 and is not billable to the patient.

D0709 Intraoral — comprehensive series of radiographic images — image capture only. The fee for intraoral complete series image — capture only is considered part of D0210 and is not billable to the patient.

D0801 3D dental surface scan — direct. 3D scans are included as part of the definitive procedure and the fees are not billable to the patient.

D0802 3D dental surface scan — indirect. A surface scan of a diagnostic cast. 3D scans are included as part of the definitive procedure and the fees are not billable to the patient.

D0803 3D facial surface scan — direct. 3D scans are DENIED as a specialized procedure.

D0804 3D facial surface scan — indirect. A surface scan of constructed facial features. 3D scans are DENIED as a specialized procedure.

D0999 Unspecified diagnostic procedure — by report. Benefits for medical procedures such as but not limited to urine analysis, blood studies and skin tests are DENIED and the approved amount is collectable from the patient.

PREVENTIVE (D1000-D1999)

Terms of group contracts vary. Policies in this Handbook that address benefits, limitations and exclusions are “model” policies that have not been tailored to reflect the specific terms of applicable group contracts. This Handbook may not fully or accurately reflect the terms of applicable group contracts and may be inconsistent with such terms. In all cases, the terms of group contracts take precedence over Handbook policies. Please contact the member company listed on the patient’s identification card for the specific terms of a group contract.

GP A fee for a prophylaxis done during the same episode of treatment by the same dentist/dental office as a periodontal maintenance, scaling and root planing or periodontal surgery is considered to be part of those procedures and is not billable to the patient.

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

Dental prophylaxis

GP For payment purposes, the distinction between the adult and child dentition may be determined by contract. In the absence of group/individual contract language regarding age, a person age 14 and older is considered an adult for benefit determination purposes of a prophylaxis — adult. Any fee, for persons less than age 14 in excess of the approved amount for D1120 is not billable to the patient and not chargeable to the patient.

D1110 **Prophylaxis — adult.** For benefit purposes, the age for adult prophylaxis is determined by group/individual contract. Any fee in excess is not billable to the patient. In the absence of group/individual contract language regarding age, a person age 14 and older is considered an adult. When submitted with D4346, fees for D1110 by the same dentist/dental office are not billable to the patient

D1120 **Prophylaxis — child.** For payment purposes, the distinction between the adult and child dentition is determined by contract. In the absence of group/individual contract language regarding age, a person under age 14 is considered a child for benefit determination purposes of a prophylaxis — child. Any fee in excess is not billable to the patient. When submitted with D4346, fees for D1120 by the same dentist/dental office are not billable to the patient.

Topical fluoride treatment — office procedure

GP Using prophylaxis paste containing fluoride, a fluoride rinse, or fluoride swish in conjunction with a prophylaxis is considered a prophylaxis only and a separate fee for topical fluoride application is not billable to the patient.

GP The age limitation for topical fluoride gel or varnish treatments is determined by group/individual contract. Professionally applied, prescription-strength topical fluoride applications should be a benefit up to age 19. Professionally applied fluoride as a distinct and separate procedure is a benefit in accordance with contractual provisions regardless of the vehicle.

GP Fluoride gels, rinses, tablets or other preparations intended for home application are DENIED unless covered by group/individual contract.

D1206 **Topical fluoride varnish.** The application of topical fluoride varnish, delivered on a single visit and involving the entire oral cavity. Benefits for topical fluoride varnish when used for desensitization or as cavity liner are DENIED. Benefits for topical fluoride treatments are determined by the group contract.

D1208 **Topical application of fluoride — excluding varnish.** Fluoride gels, rinses, tablets, or other preparations intended for home application are DENIED.

Other preventive services

GP Age limitations for sealants are subject to group/individual contract.

GP Sealants are a benefit once per tooth on the occlusal surface of permanent molars.

D1301 **Immunization counseling.** Benefits for immunization counseling are DENIED unless covered by group/individual contract.

D1310 **Nutritional counseling for the control of dental disease.** The fee for nutritional counseling is DENIED unless covered by group or individual contract.

D1320 **Tobacco counseling for the control and prevention of oral disease.** The fee for tobacco counseling is DENIED and the approved amount is collectable from the patient.

D1321 **Counseling for the control and prevention of adverse oral, behavioral and systemic health effects associated with high-risk substance use.** Benefits are DENIED unless covered by group/individual contract.

D1330 **Oral hygiene instructions.** The fee for oral hygiene instruction is DENIED unless covered by group or individual contract.

D1351 **Sealant — per tooth.** Sealants are payable once per tooth on the occlusal surface of permanent first and second molars for patients through age 15. The teeth must be free from overt dentinal caries (incipient caries sealing is preferred) or restorations on the occlusal surface. Special consideration for late eruption can be given by report. A separate fee for sealant done on the same date of service and on the same surface as a restoration by the same dentist/dental office is considered a component of the restoration and is not billable to the patient. Benefits for sealants are DENIED when the patient's claims history indicates a restoration on the occlusal surface of the same tooth. The fee for repair or replacement of a sealant or preventive resin restoration by the same dentist within two years of initial placement is included in the fee for the initial placement and is not billable to the patient. The fee for repair or replacement of a sealant by a different dentist within two years of initial placement is DENIED and the approved amount is collectable from the patient. Benefits for sealants requested more than 24 months following the initial placement are DENIED unless covered by group/individual contract.

D1353 **Sealant repair — per tooth.** Benefits for sealants include repair or replacement within 24 months by the same dentist/dental office. Fees for repair or replacement of a sealant are not billable to the patient if performed within 24 months of initial placement by same dentist/dental office. Benefits to repair sealants are DENIED when submitted documentation or the patient's claims history indicates a restoration on the occlusal surface of the same tooth. Preventive resins restorations are a benefit once per tooth on the occlusal surface of permanent molars for patients through age 15. The teeth must be free from overt dentinal caries.

D1354 **Application of caries arresting medicament — per tooth.** Benefits are limited to twice per tooth per benefit year. Benefits for more than twice per tooth per benefit year are DENIED. Fees for D1354 on the same date of service as a restoration are not billable to the patient. Benefits for restorations placed within two months of D1354 are DENIED. D1354 does not count against fluoride frequency.

D1355 **Caries preventive medicament application — per tooth.** Benefits are DENIED unless covered by group/individual contract.

Space maintenance — passive appliances

GP The fee for repair or replacement of a space maintainer is DENIED and the approved amount is collectable from the patient.

GP Only one space maintainer is provided for a space. Additional appliances are DENIED and the approved amount is collectable from the patient.

GP Only one unilateral space maintainer is benefited per quadrant, per lifetime except under unusual circumstances. Otherwise, benefits are DENIED.

GP Space maintainers for missing primary anterior teeth, missing permanent teeth or for persons age 14 or older are DENIED and the approved amount is collectable from the patient.

GP Space maintainer fees include all teeth, clasps and rests. Any fee charged in excess of the approved amount for the appliance by the same dentist/dental office is not billable to the patient.

D1510 **Space maintainer — fixed, unilateral — per quadrant.**

D1516 **Space maintainer — fixed, bilateral — maxillary.**

D1517 **Space maintainer — fixed, bilateral — mandibular.**

D1520 **Space maintainer — removable, unilateral — per quadrant.**

D1526 **Space maintainer — removable, bilateral — maxillary.**

D1527 **Space maintainer — removable, bilateral — mandibular.**

D1551 **Recement or rebond bilateral space maintainer — maxillary.** One recementation or rebonding is allowed per space maintainer per arch. Benefits for subsequent requests for recementation or rebonding are DENIED.

D1552 **Recement or rebond bilateral space maintainer — mandibular.** One recementation or rebonding is allowed per space maintainer per arch. Benefits for subsequent requests for recementation or rebonding are DENIED.

D1553 **Recement or rebond unilateral space maintainer — per quadrant.** One recementation or rebonding is allowed per space maintainer, per quadrant. Benefits for subsequent requests for recementation or rebonding are DENIED.

D1556 **Removal of fixed unilateral space maintainer — per quadrant.** Fees for removal of fixed space maintainer by the same dentist/dental office who placed appliance are not billable to the patient anytime following placement of space maintainer. Fees for D1556 is not billable to the patient when submitted with recementation done on the same date of service.

D1557 **Removal of fixed bilateral space maintainer — maxillary.** Fees for removal of fixed space maintainer by the same dentist/dental office who placed the appliance are not billable to the patient anytime following placement of space maintainer. D1557 is not billable to the patient when submitted with recementation done on the same date of service. Fees for removal of a fixed space maintainer by a different dentist/office than who placed the appliance are DENIED.

D1558 **Removal of fixed bilateral space maintainer — mandibular.** Fees for removal of fixed space maintainer by the same dentist/dental office who placed the appliance are not billable to the patient anytime following placement of space maintainer. D1558 is not billable to the patient when submitted with recementation done on the same date of service. Fees for removal of a fixed space maintainer by a different dentist/office than who placed the appliance are DENIED.

D1575 **Distal shoe space maintainer — fixed, unilateral — per quadrant.** Limited to children up to age eight. Fees for repairs and adjustments by the same dentist/dental office are not billable to the patient.

D1701 **Pfizer BioNtech COVID 19 vaccine — first dose SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM dose one.** Benefits are DENIED unless covered by group/individual contract.

D1702 **Pfizer BioNtech COVID 19 vaccine — second dose SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM dose two.** Benefits are DENIED unless covered by group/individual contract.

D1703 **Moderna COVID 19 vaccine administration — first dose SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM dose one.** Benefits are DENIED unless covered by group/individual contract.

D1704 **Moderna COVID 19 vaccine administration — second SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM dose two.** Benefits are DENIED unless covered by group/individual contract.

D1708 **Pfizer-BioNTech COVID-19 vaccine administration — third dose. SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM dose three.** Benefits are DENIED unless covered by group/individual contract.

D1709 **Pfizer-BioNTech COVID-19 vaccine administration — booster dose. SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM dose booster.** Benefits are DENIED unless covered by group/individual contract.

D1710 **Moderna COVID-19 vaccine administration — third dose. SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM dose three.** Benefits are DENIED unless covered by group/individual contract.

D1711 **Moderna COVID-19 vaccine administration — booster dose. SARSCOV2 COVID-19 VAC mRNA 50mcg/0.25mL IM dose booster.** Benefits are DENIED unless covered by group/individual contract.

D1713 **Pfizer-BioNTech COVID-19 vaccine administration tris-sucrose pediatric — first dose.** SARSCOV2 COVID-19 VAC mRNA 10mcg/0.2mL tris-sucrose IM dose one. Benefits are DENIED unless covered by group/individual contract.

D1714 **Pfizer-BioNTech COVID-19 vaccine administration tris-sucrose pediatric — second dose.** SARSCOV2 COVID-19 VAC mRNA 10mcg/0.2mL tris-sucrose IM dose two. Benefits are DENIED unless covered by group/individual contract.

D1720 **Influenza vaccine administration.** Benefits are DENIED unless covered by group/individual contract.

D1781 **Implant — Gardasil 9 0.5mL intramuscularly vaccine injection dose one.** Benefits are DENIED unless covered by group/individual contract.

D1782 **Vaccine administration — human papillomavirus — Gardasil 9 0.5mL intramuscularly vaccine injection dose two.** Benefits are DENIED unless covered by group/individual contract.

D1783 **Vaccine administration — human papillomavirus — Gardasil 9 0.5mL intramuscularly vaccine injection dose three.** Benefits are DENIED unless covered by group/individual contract.

D1999 **Unspecified preventive procedure — by report.**

RESTORATIVE (D2000-D2999)

Terms of group contracts vary. Policies in this Handbook that address benefits, limitations and exclusions are "model" policies that have not been tailored to reflect the specific terms of applicable group contracts. This Handbook may not fully or accurately reflect the terms of applicable group contracts and may be inconsistent with such terms. In all cases, the terms of group contracts take precedence over *Handbook* policies. Please contact the member company listed on the patient's identification card for the specific terms of a group contract.

GP The fee for a restoration includes services such as, but not limited to, adhesives, etching, liners, bases, direct and indirect pulp caps, local anesthesia, polishing, occlusal adjustment, caries removal and gingivectomy done on the same date of service as the restoration. A separate fee for any of these procedures by the same dentist/dental office is not billable to the patient.

GP A fee for the replacement of amalgam or composite restorations, same tooth and same surface(s), is not billable to the patient if done by the same dentist within 24 months of the initial restoration. Benefits may be DENIED and the approved amount for the restoration collectable from the patient if done by a different dentist/dental office.

GP When multiple restorations involving the proximal and occlusal surfaces of the same tooth are requested or performed, the allowance is limited to that of a multi-surface restoration. Any fee charged in excess of the allowance for the multi-surface restoration by the same dentist/dental office is not billable to the patient. A separate benefit may be allowed for a noncontiguous restoration on the buccal or lingual surface(s) of the same tooth.

GP Any restoration involving two or more contiguous surfaces should be reported using the appropriate multiple surface restoration code.

GP Benefits are allowed only once per surface in a 24-month interval, irrespective of the number or combination of procedures requested or performed. A fee for restoration of a surface within 24 months of previous treatment is not billable to the patient if done by the same dentist/dental office and DENIED and the approved amount is collectable from the patient if done by a different dentist/dental office.

GP Multistage procedures are reported and benefited upon completion. The completion date is the date of insertion for removable prosthetic appliances. The completion date for fixed partial dentures and crowns, onlays, and inlays is the cementation date regardless of the type of cement utilized.

GP If an indirectly fabricated restoration is performed by the same dentist within 24 months of the placement of an amalgam or composite restoration the Delta Dental payment and patient copayment allowance for the amalgam or composite restorations will be deducted from the indirectly fabricated restoration benefit.

GP Tooth preparation, temporary restorations, cement bases, impressions, laboratory fees and material, occlusal adjustment, gingivectomies (on the same date of service) and local anesthesia are considered to be included in the fee for all restorations, and a separate fee for any of these procedures by the same dentist/dental office is not billable to the patient. Fees for buildups, not required for retention are not billable to the patient.

GP The fees for restorations for altering occlusion, involving vertical dimension, replacing tooth structure lost by attrition, erosion, abrasion, abfraction, corrosion, TMD or for periodontal, orthodontic or other splinting are DENIED and the approved amount is collectable from the patient, unless covered by group/individual contract.

GP Biomimetic restorations (e.g. Biodentine) are DENIED as experimental and/or investigational.

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

GP Infection control is included in the fee for the dental services provided. Separate fees are not billable to the patient. Infection control is considered a component of all dental procedures performed.

GP Restorations or surgical procedures to correct congenital or developmental malformations for functional purposes are benefited unless for cosmetic reasons.

GP The fees for radiographs taken during the procedures and post-operative radiographs are included in the fees for root canals, surgical and non-surgical procedures, and all indirect restorations (crowns, onlays, bridges, inlays, and implants) and are not billable to the patient.

Definitions

Attrition

1. The frictional wearing of the teeth over time. Severe attrition, due to bruxing may be evident.(Treatment Planing in Dentistry; Mosby 2006).

2. The loss of tooth structure from tooth to tooth contact (Lee, Eakle. J Prosthet Dent 1996; 75:487).

Abrasion

1. Wearing away or notching of the teeth by a mechanical means, such as tooth brushing (Treatment Planing in Dentistry; Mosby 2006).

2. The grinding or wearing away of tooth substance by mastication, incorrect brushing methods, bruxism or similar causes (Mosby's Dental Dictionary).

3. The abnormal wearing away of a substance or tissue by a mechanical process. (Mosby's Dental Dictionary).

4. The loss of tooth structure from the mechanical rubbing of teeth by some object or objects (no source).

5. The act or result of the grinding or wearing away of a substance, such as a tooth worn by mastication, bruxing or tooth brushing (The Glossary of Operative Dentistry Terms).

Erosion

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

2. The process and the results of loss of dental hard tissue that is chemically etched away from the tooth surface, by acid and/or chelation, without bacterial involvement (ten Cate and Imfeld, Eur J Oral Sci 1996; 104:241).

Abfraction

Wedge-shaped lesions occurring in the cervical enamel. Can result from occlusal loading and flexure in the area. (Dorland's Illustrated Medical Dictionary, 25th edition 1975). For classification of metals see the ADA CDT Manual.

Amalgam restorations — including polishing

D2140 Amalgam — one surface, primary or permanent.

D2150 Amalgam — two surfaces, primary or permanent.

D2160 Amalgam — three surfaces, primary or permanent.

D2161 Amalgam — four or more surfaces, primary or permanent.

Resin–based composite restorations — direct

GP Fees for the replacement of amalgam or composite restorations within 24 months are not billable to the patient if done by the same dentist/dental office. Benefits may be allowed if done by a different dentist/dental office. Special consideration may be given by report.

GP In the event an anterior proximal restoration involves a significant portion of the labial or lingual surface, it may be reported as D2331 or D2332, as appropriate.

GP In a pit and fissure area, if the resin is limited to the enamel it is considered a sealant or preventive resin restoration. If the resin extends into the dentin, the appropriate composite resin codes should be reported.

D2330 Resin-based composite — one surface — anterior.

D2331 Resin-based composite — two surfaces — anterior.

D2332 Resin-based composite — three surfaces — anterior.

D2335 Resin-based composite — four or more surfaces — anterior.

D2390 Resin-based composite — crown — anterior.

D2391 Resin-based composite — one surface — posterior. Benefits are determined by group/individual contract. D2391 will be used as a replacement to D1352 — preventive resin restoration in a moderate to high caries risk patient — permanent tooth, since it was deleted in CDT 2026.

D2392 Resin-based composite — two surfaces — posterior. Benefits are determined by group/individual contract.

D2393 Resin-based composite — three or more surfaces — posterior. Benefits are determined by group/individual contract.

D2394 Resin-based composite — four or more surfaces — posterior. Benefits are determined by group/individual contract.

GP Resin restorations on posterior teeth are a benefit only on the buccal surfaces of bicuspids. If done on posterior teeth, an alternate benefit allowance up to that for amalgam is made and any fee charged in excess of the allowance is DENIED and is collectable from the patient up to the approved amount for the resin-based posterior composite restoration. Benefits are determined by group/individual contract.

Gold foil restorations

GP An alternate benefit allowance is made for an amalgam or resin restoration, according to the policies for amalgam or resin restorations. The difference between the allowance for the amalgam or resin restoration and the approved amount for the gold foil restoration is DENIED and collectable from the patient.

D2410 Gold foil — one surface.

D2420 Gold foil — two surfaces.

D2430 Gold foil — three surfaces.

Inlay/onlay restorations

GP When the retentive quality of a tooth qualifies for an onlay, benefits are based on the submitted procedure. If an alternate benefit allowance is applied, the difference between the allowance for the alternative benefit and the approved amount for the inlay/onlay restoration is DENIED and collectable from the patient.

GP For inlay restorations, an alternate benefit allowance is made for an amalgam or resin restoration, according to the policies for amalgam and resin restorations. The difference between the allowance for the amalgam or resin restoration and the approved amount for the inlay restoration is DENIED and collectable from the patient.

GP Crowns and indirectly fabricated restorations are optional benefits unless the tooth is damaged by decay or fracture to the point it cannot be restored by an amalgam or resin restoration. If the fee for a cast crown or indirectly fabricated restoration is not allowed, an alternate benefit allowance for an amalgam or resin restoration is made according to the policies for those restorations and the difference between the allowance for the amalgam or resin restoration and the approved amount for the cast crown or indirectly fabricated restoration is DENIED and collectable from the patient.

GP The fees for crowns and onlays are DENIED and the approved amount is collectable from the patient for children under 12 years of age.

GP Onlays are considered to cover one or more cusps and include the inlay. Onlays are only benefited when the tooth would otherwise qualify for a crown based on degree of breakdown.

GP Tooth preparation, temporary restorations, laboratory fees and material cement bases, impressions, occlusal adjustment, gingivectomies (on the same date of service) and local anesthesia are considered to be included in the fee for an onlay or crown restoration. Separate fees for these procedures by the same dentist/dental office are not billable to the patient on the same date of service.

GP Restorative benefits are made for the least expensive professionally accepted treatment procedure (LEPAT). Any difference in the fee is DENIED.

GP If the deciduous tooth is an “extra tooth” in addition to the normal complement of teeth, an inlay/onlay is not a benefit. Benefits are DENIED and the approved amount is chargeable to the patient.

GP If an inlay/onlay is being proposed or has been done where periodontal bone support appears to be inadequate, benefits are DENIED due to the unfavorable prognosis for the tooth.

D2510 Inlay — metallic — one surface.

D2520 Inlay — metallic — two surfaces.

D2530 Inlay — metallic — three or more surfaces.

D2542 Onlay — metallic — two surfaces.

D2543 Onlay — metallic — three surfaces.

D2544 Onlay — metallic — four or more surfaces.

D2610 Inlay — porcelain/ceramic — one surface.

D2620 Inlay — porcelain/ceramic — two surfaces.

D2630 Inlay — porcelain/ceramic — three or more surfaces.

D2642 Onlay — porcelain/ceramic — two surfaces.

D2643 Onlay — porcelain/ceramic — three surface.

D2644 Onlay — porcelain/ceramic — four or more surfaces.

D2650 Inlay — resin-based composite — one surface.

D2651 Inlay — resin-based composite — two surfaces.

D2652 Inlay — resin-based composite — three or more surfaces.

D2662 Onlay — resin-based composite — two surfaces.

D2663 Onlay — resin-based composite — three surfaces.

D2664 Onlay — resin-based composite — four or more surfaces.

The fee for models, temporaries and other associated procedures by the same dentist/dental office are not billable to the patient. Applies to D2510-D2664.

Crowns* — single restorations only

GP Crowns and indirectly fabricated restorations are optional benefits unless the tooth is damaged by decay or fracture to the point it cannot be restored by an amalgam or resin restoration. If the fee for a crown or indirectly fabricated restoration is not allowed, an alternate benefit allowance for an amalgam or resin restoration is made according to the policies for those restorations.

GP The fees for crowns and onlays are DENIED and the approved amount is collectable from the patient for children under 12 years of age.

GP Tooth preparation, temporary restorations, laboratory fees and material cement bases, impressions, occlusal adjustment, gingivectomies (on the same date of service) and local anesthesia are considered to be included in the fee for an onlay or crown restoration. Separate fees for these procedures by the same dentist/dental office are not billable to the patient on the same date of service.

*For classification of metals see the ADA CDT Manual.

GP Restorations for altering occlusion, involving vertical dimension, replacing tooth structure lost by attrition, erosion, abrasion (wear), abfraction or for periodontal, orthodontic or TMD therapy or other splinting are not a benefit. Benefits are DENIED.

GP Restorative benefits are made for the least expensive professionally accepted treatment procedure (LEPAT). Any difference in the fee is DENIED.

GP If the deciduous tooth is an "extra tooth" in addition to the normal complement of teeth, a crown is not a benefit. Benefits are DENIED and the approved amount is chargeable to the patient.

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

GP Narratives as documentation are not considered legal entities nor are they contemporaneous in nature. The patient record/clinical notes are considered a legal document and are contemporaneous. The only acceptable legal written documentation for utilization review are the contemporaneous treatment notes.

GP The time limitation for replacement of crowns or onlays will be determined by the group/individual contract.

D2710 Crown — resin-based composite — indirect.

D2712 Crown — ¾ resin-based composite — indirect.

D2720 Crown — resin with high noble metal.

D2721 Crown — resin with predominantly base metal.

D2722 Crown — resin with noble metal.

D2740 Crown — porcelain/ceramic.

D2750 Crown — porcelain fused to high noble metal.

D2751 Crown — porcelain fused to predominantly base metal.

D2752 Crown — porcelain fused to noble metal.

D2753 Crown — fused to titanium and titanium alloys.

D2780 Crown — ¾ cast high noble metal.

D2781 Crown — ¾ cast predominantly base metal.

D2782 Crown — ¾ cast noble metal.

D2783 Crown — ¾ porcelain/ceramic.

D2790 Crown — full cast high noble metal.

D2791 Crown — full cast predominantly base metal.

D2792 Crown — full cast noble metal.

D2794 Crown — titanium/titanium alloy.

D2799 Interim crown. Temporary (interim) or provisional restorations are not separate benefits and should be included in the fee for the permanent restoration. Fees for provisional crown are not billable to the patient. When a temporary, interim or provisional crown is billed as a therapeutic measure for a fractured tooth, benefits are subject to individual consideration. Temporary, interim, or provisional fixed prostheses by the same dentist/dental office are not separate benefits and should be included in the fee for the permanent prosthesis. Fees for provisional crown are not billable to the patient.

Other restorative services

GP Delta Dental member companies consider the cementation date to be that date upon which the completed or indirectly fabricated post, prefabricated post and core, inlay, onlay, crown or fixed partial denture is first delivered to the mouth. The type of cement used is not a determining factor (whether permanent or temporary).

GP Fees for recementation of indirectly fabricated or prefabricated post and cores, inlays, onlays, crowns and fixed partial dentures are not billable to the patient if done within six months of the initial seating date by the same dentist or dental office.

GP Benefits may be paid for one recementation after six months have elapsed since initial placement. Subsequent requests for recementation by the same provider are DENIED and the approved amount is collectable from the patient. Benefits may be paid when billed by a dentist other than the one who seated the bridge or performed the previous recementation.

GP D2915 (post recementation) and D2920 (crown recementation) are not allowed on the same tooth on the same day by the same dentist/dental office. The allowance will be made only for D2920 when D2915 and D2920 are submitted together. The fee for D2915 will be not billable to the patient.

D2910 Recement or rebond inlay, onlay, veneer, or partial coverage restoration. Fees for the recementation or rebonding by the same dentist/dental office of covered restorations within six months of initial placement are considered part of the fee for the original procedure and are not billable to the patient. Benefit for one recementation or rebonding after six months have elapsed since initial placement. Benefits for recementations or rebonding in excess of one recementation or rebonding by the same dentist/dental office are DENIED.

D2915 **Recement or rebond indirectly fabricated or pre-fabricated post and core.** Fees for the recementation or rebonding by the same dentist/dental office of an indirectly fabricated or prefabricated post and core within six months of initial placement are considered part of the fee for the original procedure and are not billable to the patient.

Benefits for recementation or rebonding after six months have elapsed since initial placement, but only once, to the same dentist/dental office. Benefits for recementations or rebonding in excess of one recementation or rebonding by the same dentist/dental office are DENIED. Post recementation or rebonding (D2915) and crown recementation or rebonding (D2920) are not allowed on the same tooth on the same date of service by the same dentist/dental office. The allowance will be made only for D2920 when D2915 and D2920 are submitted together. The fee for D2915 (recement or rebonding indirectly fabricated or prefabricated post and core) is not billable to the patient.

D2920 **Recement or rebond crown.** Fees for the recementation or rebonding by the same dentist/dental office of covered restorations within six months of initial placement are considered part of the fee for the original procedure and are not billable to the patient. Benefits may be paid for recementation or rebonding after six months have elapsed since initial placement, but only once. Benefits for recementations or rebonding in excess of one recementation or rebonding by the same dentist/dental office are DENIED.

D2921 **Reattachment of tooth fragment — incisal edge or cusp.** The fee for reattachment by the same dentist/dental office within 24 months is included in the initial reattachment or restoration and is not billable to the patient.

D2928 **Prefabricated porcelain/ceramic crown — permanent tooth — prefabricated porcelain/ceramic crown — permanent tooth.** The fee for the replacement of a prefabricated porcelain/ceramic crown by the same dentist/dental office within 24 months is included in the initial crown placement and is not billable to the patient. Benefits for D2928 are DENIED if work is completed by different dentist/dental office within 24 months.

D2929 **Prefabricated porcelain/ceramic crown — primary tooth.** The fee for replacement of a porcelain/ceramic crown by the same dentist/dental office within 24 months is included in the initial crown placement and is not billable to the patient. Benefits are DENIED if done by a different dentist/dental office. Benefit once per lifetime per tooth.

D2930 **Prefabricated stainless steel crown — primary tooth.** A fee for replacement of a stainless steel crown on a primary tooth by the same dentist/dental office within 24 months is included in the initial crown placement and is not billable to the patient. Benefit once per lifetime per tooth.

D2931 **Prefabricated stainless steel crown — permanent tooth.** A fee for replacement of a stainless steel crown on a permanent tooth by the same dentist/dental office within 24 months is included in the initial crown placement and is not billable to the patient. Benefits are DENIED if done by a different dentist/dental office.

D2932 **Prefabricated resin crown.** A prefabricated resin crown is a benefit only on anterior primary teeth.

D2933 **Prefabricated stainless steel crown with resin window.** A prefabricated stainless steel crown with resin window is a benefit only on anterior primary teeth. If submitted for a posterior primary tooth or for a permanent tooth, an alternate benefit allowance for D2930 or D2931 is made. The difference between the allowance for the D2930 or D2931 and the approved amount for the D2933 is DENIED and collectable from the patient. A fee for replacement of a stainless steel crown by the same dentist/dental office within 24 months is included in the initial crown placement and is not billable to the patient. Benefits are DENIED if done by a different dentist/dental office.

D2934 **Prefabricated esthetic coated stainless steel crown — primary tooth.** A prefabricated aesthetic coated stainless steel crown is a benefit only on anterior primary teeth. If submitted for a posterior primary tooth or for a permanent tooth, an alternate benefit allowance for D2930 or D2931 is made. The difference between the allowance for the D2930 or D2931 and the approved amount for the D2934 is DENIED and collectable from the patient. A fee for replacement of a stainless steel crown by the same dentist/dental office within 24 months is included in the initial crown placement and is not billable to the patient. Benefits are DENIED if done by a different dentist/dental office. Benefits may be allowed with the same processing policies and edits as a D2933 if performed on permanent teeth and subject to individual consideration.

D2940 **Placement of interim direct restoration.** Interim direct restorations are covered benefits for emergency relief of pain once per tooth. The fee for an interim direct filling is not billable to the patient when performed in conjunction with a definitive restoration dental treatment by same dentist/dental office on same date of service. Fees for D2940 are not billable to the patient when performed in conjunction with any restorative codes D2000-D2999, bridge codes (D6200-D6699). Fees for D2940 are not billable to the patient when performed in conjunction with any endodontic code D3220-D3950. When a D2940 is benefited, the fees for D3110 (pulp cap — direct) and D3120 (pulp cap — indirect) are not billable to the patient.

D2949 **Restorative foundation for an indirect restoration.** This procedure is a component of the definitive indirect restoration. Fees are not billable to the patient.

02950 **Core buildup, including any pins.** Substructures are a benefit only when necessary to retain an indirectly fabricated restoration due to extensive loss of tooth structure from caries or fracture. The procedure should not be reported when the procedure only involves a filler to eliminate any undercut, box form, or concave irregularity in the

preparation. A material is placed in the tooth preparation for a crown when there is insufficient tooth strength and retention for the crown procedure. Otherwise, fees are not billable to the patient. A separate fee for a buildup is not billable to the patient when radiographs indicate sufficient tooth structure remains to support a cast or indirectly fabricated restoration.

D2951 **Pin retention — per tooth, in addition to restoration.** Pin retention is a benefit once per tooth when necessary on a permanent tooth and when completed at the same appointment. Fees for additional pins on the same tooth by the same dentist/dental office are not billable to the patient as a component of the initial pin placement. A fee for pin retention when billed in conjunction with a buildup by the same dentist/dental office is not billable to the patient as a component of the buildup procedure.

D2952 **Post and core in addition to crown — indirectly fabricated.** An indirectly fabricated post and core in addition to crown is a benefit only on a successful endodontically treated tooth. The fee for an indirectly fabricated post and core is not billable to the patient when radiographs indicate an absence of endodontic treatment, incompletely filled canal space or unresolved pathology associated with the involved tooth.

An indirectly fabricated post and core in anterior teeth is a benefit only when there is insufficient tooth structure to support a cast or indirectly fabricated restoration. If sufficient tooth structure remains, a fee for a post and core is not billable to the patient. If reported with a restoration or a core buildup, the amalgam or composite core buildup is considered part of the post and core procedure.

D2953 **Each additional indirectly fabricated post — same tooth.** Each additional indirectly fabricated post is considered a component of an indirectly fabricated post.

D2954 **A prefabricated post and core in addition to crown is a benefit only on an endodontically treated tooth.** Fees for post and core are not billable to the patient when radiographs indicate an absence of endodontic treatment, or an incompletely filled canal space, or unresolved pathology associated with the involved tooth. Unresolved radiolucencies may be a reason to not billable to the patient but should be evaluated based on the time since the completion of the endodontic services and co-joint signs and symptoms. A prefabricated post and core is a benefit in anterior teeth only when there is insufficient tooth structure to support a cast restoration. When radiographs indicate more than half of the coronal tooth structure remains, fees for post and cores are DENIED.

D2955 **Post removal.** The fee for post removal when the procedure is rendered by the same dentist/office rendering retreatment is not billable to the patient as a component of the fee for the retreatment.

D2956 **Removal of an indirect restoration on a natural tooth.** The removal of an indirect restoration is included in the definitive treatment and the fees are not billable to the patient.

D2957 Each additional prefabricated post in the same tooth. Benefits are determined by group/individual contract.

D2960 Labial veneer — resin laminate — chairside. D2960 is considered cosmetic and benefits are determined by to group/individual contract.

D2961 Labial veneer — resin laminate — laboratory. D2961 is considered cosmetic and benefits are determined by to group/individual contract.

D2962 Labial veneer — porcelain laminate — laboratory. D2962 is considered cosmetic and benefits are determined by to group/individual contract.

D2971 Additional procedures to customize a crown to fit under an existing partial denture framework — Allow this procedure as another form of partial denture repair.

D2975 Coping. Copings are considered a specialized procedure and DENIED.

D2976 Band stabilization — per tooth. Benefits are limited to posterior permanent teeth only. Benefit once per tooth per lifetime.

D2980 Crown repair — necessitated by restorative material failure. Fees for a crown repair completed on the same date of service as a new crown are not billable to the patient. Fees for crown repair are not billable to the patient within 24 months of the original restoration by the same dentist/dental office. Benefits for D2980 are DENIED within 24 months of the original restoration by different dentist/dental office.

D2981 Inlay repair — necessitated by restorative material failure. Fees for inlay repairs completed on the same date of service as a new inlay are not billable to the patient. Fees for inlay repairs are not billable to the patient within 24 months of the original restoration. Benefits for D2981 are DENIED within 24 months of the original restoration by different dentist/dental office.

D2982 Onlay repair — necessitated by restorative material failure. Fees for onlay repairs completed on the same date of service as a new onlay are not billable to the patient. Fees for onlay repairs are not billable to the patient within 24 months of the original restoration. Benefits for D2982 are DENIED within 24 months of the original restoration by different dentist/dental office.

D2983 Veneer repair — necessitated by restorative material failure. Fees for veneer repairs completed on the same date of service as a new veneer are not billable to the patient. Fees for veneer repairs are not billable to the patient within 24 months of the original restoration. Benefits for D2983 are DENIED within 24 months of the original restoration by different dentist/dental office.

D2989 Excavation of a tooth resulting in the determination of non-restorability. D2989 is considered an incomplete service and the fees are not billable to the patient (restorability should be determined prior to the procedure).

D2990 Resin infiltration of incipient smooth surface lesions. Fees for resin infiltration of incipient smooth surface lesions are DENIED as investigational.

D2991 Application of hydroxyapatite regeneration medicament — per tooth. Benefits are DENIED as investigational.

D2999 Unspecified restorative procedure — by report.

ENDODONTICS (D3000-D3999)

Terms of group contracts vary. Policies in this Handbook that address benefits, limitations and exclusions are "model" policies that have not been tailored to reflect the specific terms of applicable group contracts. This Handbook may not fully or accurately reflect the terms of applicable group contracts and may be inconsistent with such terms. In all cases, the terms of group contracts take precedence over Handbook policies. Please contact the member company listed on the patient's identification card for the specific terms of a group contract.

GP Endodontic retreatment may include the removal of a post, pin(s), old root canal filling material, and the procedures necessary to prepare the canals and place the canal filling. This includes complete root canal therapy. Separate fees for these procedures by the same dentist/dental office are not billable to the patient as included in the fees for the retreatment.

GP Benefits for techniques, e.g. ultrasonic cleaning, or instrumentation are considered to be part of the procedure and not billable to the patient.

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

GP Infection control is included in the fee for the dental services provided. Separate fees are not billable to the patient. Infection control is considered a component of all dental procedures performed.

Pulp capping

GP A separate fee for a pulp cap by the same dentist/dental office is not billable to the patient when submitted in conjunction with protective resin restoration or with final restoration on the same tooth.

GP Fees for direct or indirect pulp caps are not billable to the patient when provided by the same dentist/dental office in conjunction with the final restoration for the same tooth.

GP The fees for root canal therapy done in conjunction with an overdenture are DENIED and the approved amount is collectable from the patient.

D3110 **Pulp cap — direct — excluding final restoration.** Fees for a pulp cap performed in conjunction with a restoration by the same dentist/dental office are not billable to the patient.

D3120 **Pulp cap — indirect — excluding final restoration.** Fees for an indirect pulp cap performed in conjunction with a restoration by the same dentist/dental office are not billable to the patient.

Pulpotomy

D3220 **Therapeutic pulpotomy — excluding final restoration — removal of pulp coronal to the dentinocemental junction and application of medicament.** If provided on permanent teeth, process as palliative treatment (D9110) and any fees in excess of D9110 are not billable to the patient. When done in conjunction with a root canal procedure (D3310-D3330) the fees for D3220 are not billable to the patient.

D3221 **Pulpal debridement — primary and permanent teeth.** The relief of acute pain is benefited as gross pulpal debridement (D3221). It is not considered a separate procedure when performed by the same dentist/dental office on the same date of service as endodontic therapy (D3230-D3333) and the fees for D3221 are not billable to the patient. The fees for D9110 in conjunction with D3221 are not billable to the patient by the same dentist/dental office.

D3222 **Partial pulpotomy for apexogenesis — permanent tooth with incomplete root development.** Benefits are determined by group/individual contract. Fees for D3222 are not billable to the patient when performed within 30 days on same tooth by the same dentist/dental office as root canal therapy (D3230-D3333) or codes D3351-D3353. The fees for D9110 in conjunction with D3222 are not billable to the patient by the same dentist/dental office.

Endodontic therapy on primary teeth

D3230 **Pulpal therapy — resorbable filling — anterior, primary tooth — excluding final restoration.** The benefit for root canal therapy is DENIED when the radiographs reveal insufficient root structure, internal resorption, furcal perforation, or extensive periapical pathosis. Fees for D3221 and D3222 are not billable to the patient when performed within 30 days on same tooth by the same dentist/dental office as root canal therapy (D3230-D3333) or codes D3351-D3353. The fees for D9110 in conjunction with D3230 are not billable to the patient by the same dentist/dental office.

D3240 **Pulpal therapy — resorbable filling — posterior, primary tooth — excluding final restoration.** The benefit for root canal therapy is DENIED when the radiographs reveal insufficient root structure, internal resorption, furcal perforation, or extensive periapical pathosis. Fees for D3221 and D3222 are not billable to the patient when

performed within 30 days on same tooth by the same dentist/dental office as root canal therapy (D3230-D3333). The fees for D9110 in conjunction with D3240 are not billable to the patient by the same dentist/dental office.

Endodontic therapy — including treatment plan, clinical procedures and follow-up care

GP The fee for a root canal includes treatment radiographs and temporary restorations. Any additional fee charged by the same dentist/dental office is not billable to the patient.

GP When a radiograph indicates obturation of an endodontically treated tooth has been performed without the use of a biologically acceptable nonresorbable semisolid or solid core material, fees for the endodontic therapy and/or restoration of the tooth are not billable to the patient.

GP The completion date for endodontic therapy is the date that the canals are permanently filled.

D3310 Endodontic therapy — anterior — excluding final restoration. Fees for a pulp test (D0460), palliative treatment (D9110) and pulpal debridement (D3221) are not billable to the patient when done on the same date of service as the root canal therapy by the same dentist/dental office are included in the fee for root canal. Benefit determination for incomplete endodontic therapy is subject to individual consideration if a report indicates the patient failed to complete treatment. Fees for D3221 and D3222 are not billable to the patient when performed by the same dentist/dental office on the same date of service as endodontic therapy (D3230-D3333). Working radiographic images and post-obturation radiographic images are considered part of a root canal treatment and the fees are not billable to the patient.

D3320 Endodontic therapy — premolar — excluding final restorations. Fees for a pulp test (D0460), palliative treatment(D9110) and pulpal debridement (D3221) are not billable to the patient when done on the same date of service as root canal therapy by the same dentist/dental office are included in the fee for root canal. Benefit determination for incomplete endodontic therapy is subject to individual consideration if a report indicates the patient failed to complete treatment. Fees for D3221 and D3222 are not billable to the patient when performed by the same dentist/dental office on the same date of service as endodontic therapy (D3230-D3333). Working radiographic images and post-obturation radiographic images are considered part of a root canal treatment and the fees are not billable to the patient.

D3330 Endodontic therapy — molar tooth — excluding final restorations. Fees for a pulp test (D0460), palliative treatment (D9110) and pulpal debridement (D3221) done on the same date of service as the root canal therapy by the same dentist/dental office is included in the fee for the root canal and fees are not billable to the patient.

Benefit determination is subject to individual consideration if a report indicates the patient failed to complete treatment. Fees for D3221 and D3222 are not billable to the patient when performed by the same dentist/dental office on the same date of service as endodontic therapy (D3230-D3333). Working radiographic images and post-obturation radiographic images are considered part of a root canal treatment and the fees are not billable to the patient.

D3331 **Treatment of root canal obstruction — nonsurgical access.** D3331 is considered a component of a root canal. The fee for the procedure by the same dentist/dental office is not billable to the patient on same date of service as the root canal therapy. The fee for D2955, post removal, is not included in this procedure. Fees for D3221 and D3222 are not billable to the patient when performed within 30 days on same tooth by the same dentist/dental office as root canal therapy (D3230-D3333) or codes D3351-D3353.

D3332 **Incomplete endodontic therapy — inoperable, unrestorable or fractured tooth.** Under individual consideration, the consultant may allow up to 50% of the fees for a completed root canal therapy. Fees for D3222 are not billable to the patient when performed within 30 days on same tooth by the same dentist/dental office as root canal therapy (D3230-D3333) or codes D3351-D3353. Benefit determination is subject to individual consideration unless a report indicates the patient failed to complete treatment. If instrumentation is complete and the patient does not return, then benefit to the equivalent root canal up to 50% of that fee.

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

Endodontic retreatment

GP Endodontic retreatment may include the removal of a post, pin(s), old root canal filling material, and the procedures necessary to prepare the canals and place the canal filling. This includes complete root canal therapy. Separate fees for these procedures

by the same dentist/dental office are not billable to the patient as included in the fees for the retreatment.

GP The fee for retreatment of root canal therapy or retreatment of apical surgery by the same dentist/dental office within 24 months of initial treatment is not billable to the patient as a component of the fee for the original procedure.

D3346 Retreatment of previous root canal therapy — anterior. Fees for retreatment of root canal therapy within 24 months by the same dentist/dental office are not billable to the patient. Benefits by a different dentist/dental office are DENIED.

D3347 Retreatment of previous root canal therapy — premolar. Fees for retreatment of root canal therapy within 24 months by the same dentist/dental office are not billable to the patient. Benefits by a different dentist/dental office are DENIED.

D3348 Retreatment of previous root canal therapy — molar. Fees for retreatment of root canal therapy within 24 months by the same dentist/dental office are not billable to the patient. Benefits by a different dentist/dental office are DENIED.

Apexification/recalcification and pulpal regeneration procedures

D3351 Apexification/recalcification — initial visit — apical closure/calcific repair of perforations, root resorption, etc. Apexification is eligible for benefits on permanent teeth with incomplete root development or for repair of a perforation. Closure of the apex results in a better fill of the canal. If the apex is fully developed, this treatment is not indicated and benefits are DENIED. Fees for D3222 are not billable to the patient when performed within 30 days on same tooth by the same dentist/dental office as root canal therapy (D3230-D3333) or codes D3351-D3353.

D3352 Apexification/recalcification/pulpal regeneration — interim medication replacement — apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc. Benefits should be administered with the same processing policies, system edits as code D3351 or benefited as submitted. Fees for D3222 are not billable to the patient when performed within 30 days on same tooth by the same dentist/dental office as root canal therapy (D3230-D3333) or codes D3351-D3353.

D3353 Apexification/recalcification — final visit — includes completed root canal therapy — apical closure/calcific repair of perforations, root resorption, etc. Apexification/recalcification — final visit benefits are administered as the same processing policies as D3310, D3320 or D3330 (depending on tooth type) and any fee charged in excess of the approved amount for the D3310, D3320, or D3330 (depending on the tooth type) is not billable to the patient. Fees for D3222 are not billable to the patient when performed within 30 days on same tooth by the same dentist/dental office as root canal therapy (D3230-D3333) or codes D3351-D3353.

D3355 **Pulpal regeneration — initial visit.** Includes opening in tooth, preparation of canal spaces, and placement of medication. This procedure is considered experimental and benefits are DENIED.

D3356 **Pulpal regeneration — interim medication replacement.** This procedure is considered experimental and benefits are DENIED.

D3357 **Pulpal regeneration — completion of treatment.** This procedure is considered experimental and benefits are DENIED.

Apicoectomy/periradicular services

GP The fee for biopsy of oral tissue is not billable to the patient as included in the fee for a surgical procedure (e.g. apicoectomy) when performed in the same location and on the same date of service by the same dentist/dental office.

D3410 **Apicoectomy/periradicular surgery — anterior.**

D3421 **Apicoectomy/periradicular surgery — premolar — first root.**

D3425 **Apicoectomy/periradicular surgery — molar — first root.**

D3426 **Apicoectomy/periradicular surgery — each additional root.**

D3428 **Bone graft in conjunction with periradicular surgery — per tooth single site.**

D3429 **Bone graft in conjunction with periradicular surgery — additional contiguous tooth in the same surgical site.**

D3430 **Retrograde filling — per root.** Retrograde filling includes all retrograde procedures per root. A maximum allowance is one retrograde filling per root (not per canal). Any fee charged in excess of the allowance for a retrograde filling by the same dentist/dental office is not billable to the patient. The fee for biopsy of oral tissue, when performed in the same location and on the same date of service by the same dentist/dental office, is not billable to the patient as included in the fee for surgical procedures (e.g. apicoectomy).

D3431 **Biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery.** Benefits are available only when billed for natural teeth. Benefits for these procedures, when billed in conjunction with periradicular surgery are DENIED as a specialized technique.

D3432 **Guided tissue regeneration — resorbable barrier per site — in conjunction with periradicular surgery.** Benefits are available only when billed for natural teeth. Benefits for these procedures, when billed in conjunction with periradicular surgery are DENIED as a specialized technique.

D3450 Root amputation — per root. A separate fee for root amputation is not billable to the patient when performed in conjunction with an apicoectomy by the same dentist/dental office.

D3460 Endodontic endosseous implant. Benefits are DENIED.

D3470 Intentional re-implantation — including necessary splinting. Intentional reimplantation is considered a specialized procedure. The fees are DENIED and the approved amount is collectable from the patient.

D3471 Surgical repair of root resorption — anterior. Fees for surgical repair of root resorption are not billable to the patient when performed on the same tooth by the same dentist/dental office on the same date of service as D3333 D3410-D3426, D3430, D3450, D4210-D4212, D4231, D4240, D4241, D4245, D4249, D4260, D4261, D4268, D4270, D4273-D4278, D4283, and D4285. When performed on the same tooth by the same dentist/dental office as D4341 or D4342, the fees for scaling and root planing are not billable to the patient.

D3472 Surgical repair of root resorption — premolar. Fees surgical repair of root resorption are not billable to the patient when performed on the same tooth by the same dentist/dental office on the same date of service as D3333 D3410-D3426, D3430, D3450, D4210-D4212, D4231, D4240, D4241, D4245, D4249, D4260, D4261, D4268, D4270, D4273-D4278, D4283, and D4285. When performed on the same tooth by the same dentist/dental office as D4341 or D4342, the fees for scaling and root planing are not billable to the patient.

D3473 Surgical repair of root resorption — molar. Fees for surgical repair of root resorption are not billable to the patient when performed on the same tooth by the same dentist/dental office on the same date as D3333, D3410-D3426, D3430, D3450, D3503, D4210-D4212, D4231, D4240, D4241, D4245, D4249, D4260, D4261, D4268, D4270, D4273-D4278, D4283 and D4285. When performed on the same tooth by the same dentist/dental office as D4341 or D4342, the fees for scaling and root planing are not billable to the patient.

D3501 (Anterior), D3502 (premolar), D3503 (molar). Surgical exposure of root surface without apicoectomy or repair of root resorption. Not to be used for or in conjunction with apicoectomy or repair of root resorption. Fees for surgical exposure of root surface are not billable to the patient when performed on the same tooth by the same dentist/dental office on the same date as D3333 D3410-D3426, D3430, D3450, D3471, D4210-D4212, D4231, D4240, D4241, D4245, D4249, D4260, D4261, D4268, D4270, D4273-D4278, D4283 and D4285. When performed on the same tooth by the same dentist/dental office as D4341 or D4342 the fees for SRP are not billable to the patient.

D3502 Surgical exposure of root surface without apicoectomy or repair of root resorption — premolar. Fees for surgical exposure of root surface are not billable to the patient when performed on the same tooth by the same dentist/dental office on the same date as D3333 D3410-D3426, D3430, D3450, D3472, D4210-D4212, D4231, D4240, D4241, D4245, D4249, D4260, D4261, D4268, D4270, D4273-D4278, D4283, D4285. When performed on the same tooth by the same dentist/dental office as D4341 or D4342 the fees for SRP are not billable to the patient.

D3503 Surgical exposure of root surface without apicoectomy or repair of root resorption — molar. Fees for surgical exposure of root surface are not billable to the patient when performed on the same tooth by the same dentist/dental office on the same date as D3333 D3410-D3426, D3430, D3450, D3473, D4210-D4212, D4231, D4240, D4241, D4245, D4249, D4260, D4261, D4268, D4270, D4273-D4278, D4283, and D4285. When performed on the same tooth by the same dentist/dental office as D4341 or D4342 the fees for SRP are not billable to the patient.

Other endodontic procedures

D3910 Surgical procedure for isolation of tooth with rubber dam. A separate fee for isolation of a tooth with a rubber dam by the same dentist/dental office is not billable to the patient as a component of the fee for the procedure performed.

D3911 Intra-orifice barrier. An intra-orifice barrier is considered part of the root canal procedure (D3310-D3348) and the fees are not billable to the patient.

D3920 Hemisection — including any root removal, not including root canal therapy. Benefits for bone replacement grafts (D4263 and D4264) are DENIED when submitted with D3920.

D3921 Decoronation or submergence of an erupted tooth. Benefited under individual consideration.

D3950 Canal preparation and fitting of preformed dowel or post. Canal preparation and fitting of preformed dowel or post 30 days prior to post or root canal therapy by the same dentist/dental office is included in the fee for the post or root canal. Separate fees are not billable to the patient.

D3999 Unspecified endodontic procedure — by report.

PERIODONTICS (D4000-D4999)

Terms of group contracts vary. Policies in this Handbook that address benefits, limitations and exclusions are "model" policies that have not been tailored to reflect the specific terms of applicable group contracts. This Handbook may not fully or accurately reflect the terms of applicable group contracts and may be inconsistent with such terms. In all cases, the terms of group contracts take precedence over Handbook policies. Please contact the member company listed on the patient's identification card for the specific terms of a group contract.

GP When more than one surgical procedure is provided on the same teeth on the same day, benefits are based upon, but not limited to, the most inclusive procedure.

GP The fee for the following services: D1110, D1120, D4355, and/or D4910 will be not billable to the patient if the services are rendered by the same dentist/dental office within 30 days after the most recent scaling and root planing (D4341, D4342) or other periodontal therapy.

GP Fees for the included procedures are not billable to the patient and not billable to the patient by a participating dentist/dental office. These inter-related services include, but are not limited to, the following hierarchy: D4260 (most inclusive), D4261, D6102, D4249, D4245, D4268, D4240, D4241, D6101, D4274, D4230, D4231, 4210, D4211, D4212, D4341, D4342, D4355, D4910, D1110, D1120 (least inclusive).

GP Periodontal services are only benefited when performed on natural teeth for treatment of periodontal disease. Unless otherwise specified by contract, benefits for these procedures when billed in conjunction with implants, ridge augmentation, extraction sites (teeth) and/or periradicular surgery are DENIED and the approved amount is collectable from the patient.

GP The fee for biopsy (D7285, D7286), frenulectomy (D7961-D7963) and excision of hard and soft tissue lesions (D7410, D7411, D7450, D7451) are not billable to the patient when the procedures are by the same dentist/dental office performed on the same date, same surgical site/area, and any other surgical procedure. Request for individual consideration can always be submitted by report for the dental consultant for review.

GP Laser disinfection is a technique, not a procedure. Fees for laser disinfection are not billable to the patient. If done as a standalone procedure, the fee for laser disinfection is DENIED and the approved amount is collectable from the patient.

GP The fees for low level laser therapy when performed as part of another procedure are not billable to the patient. When billed as a standalone procedure, the fees for low level laser therapy are DENIED as experimental and/or investigational.

GP Periodontal therapy includes the following: previous periodontal surgery, osseous flap, scaling and root planing.

GP The following categorizes procedures for reporting and adjudicating by quadrant, site or individual tooth in order to enhance standard benefit determinations and expedite claim processing.

GP Infection control is included in the fee for the dental services provided. Separate fees are not billable to the patient. Infection control is considered a component of all dental procedures performed.

GP Benefits for restorations for altering occlusion, adjusting vertical dimension, replacing tooth structure lost by attrition, erosion, abrasion, abfraction, corrosion, TMD or for periodontal, orthodontic, or other splinting are DENIED, unless covered by group/ individual contract.

Diseased teeth/periodontium definition:

For processing purposes, periodontally involved teeth that would qualify for surgical pocket reduction benefits under procedure codes D4210, D4211, D4240, D4241, D4260, D4261, D6101 and D6102 must be documented to have at least 5 mm pocket depths. If pocket depths are less than 5 mm, the surgical procedure is DENIED and the approved amount collectable from the patient.

In the case of procedure codes D4341 and D4342, there must be documentation of at least 4 mm pockets on the diseased teeth/periodontium involved. In the absence of 4 mm pockets, a benefit allowance for a prophylaxis (D1110) is made and any fee in excess of the approved amount for D1110 is not billable to the patient and not chargeable to the patient.

Quadrant:

D4210, D4230, and D4341: Four or more diseased teeth/periodontium distal to the midline are considered a quadrant. Tooth bounded spaces are not counted in making this determination. When these periodontal procedures do not meet all of these criteria use codes D4211, D4231 and D4342 respectively.

D4240, D4260: Four or more diseased teeth/periodontium or bounded tooth spaces distal to the midline are considered a quadrant. A tooth bounded space counts as one space irrespective of the number of teeth that would normally exist in the space. When these procedures do not meet all of these criteria use codes D4241 and D4261 respectively.

Site: A site is defined by the current ADA CDT manual.

Site: D4245, D4249, D4263, D4264, D4265, D4266, D4267, D4270, D4274 and D4275.

One to three diseased teeth/periodontium per quadrant: D4211, D4231 D4241, D4261, D4342.

Per tooth: D4212, D4268, D4273, D4276, D4277, D4278, D4381, D6101, D6102, D6103.

Per implant: D6101, D6102, D6103.

GP If surgery is performed less than four weeks after scaling and root planing, the fee for the surgical procedure or the scaling and root planning by the same dentist/dental office are not billable to the patient following consultant review.

Surgical services — including usual postoperative care

GP A separate fee for all necessary postoperative care, finishing procedures (D1110, D1120, D4341, D4342, D4355, D4910), evaluations or other surgical procedures (except soft tissue grafts) on the same date of service or for three months following the initial periodontal surgery by the same dentist/dental office is not billable to the patient.

In the absence of documentation of extraordinary circumstances, the fee for additional surgery or for any surgical re-entry (except soft tissue grafts) by the same dentist/dental office for three years is not billable to the patient.

If extraordinary circumstances are present the benefits will be DENIED and are the patient's responsibility up to the approved amount for the surgery.

GP If periodontal surgery is performed less than six weeks after scaling and root planing, the fee for the surgical procedure or the scaling and root planing may be not billable to the patient following consultant review.

GP Benefits for periodontal surgical services are available only when billed for natural teeth. Benefits for these procedures when billed in conjunction with implants, ridge augmentation, extraction sites (teeth), peradicular surgery, etc., are DENIED as a specialized or elective procedure.

GP Providing more than two D4245, D4265, D4266, D4267, D4268, D4270, D4273, D4275, D4276, D4277, D4278, D6101, D6102 or osseous grafts (D4263,D4264, D6103) within any given quadrant should be highly unusual and additional submissions will only be considered on a by-report basis. Requested fees for more than two sites (teeth) in a quadrant may be not billable to the patient. When documentation of exceptional circumstances is submitted, benefits may be DENIED, unless covered, dependent on group contract language.

D4210 Gingivectomy or gingivoplasty — four or more contiguous teeth or tooth bounded spaces per quadrant. Count tooth bounded spaces for pocket reduction surgery that includes a flap procedure (D4240, D4260). Do not count tooth bounded spaces for D4210, D4211, D4341,D4342. Benefit once per quadrant per 36 months. Fees for D4210 are not billable to the patient when performed within 36 months by the same dentist/dental office. If done by a different dentist, the benefits are DENIED.

D4211 Gingivectomy or gingivoplasty — one to three contiguous teeth or tooth bounded spaces per quadrant. A separate fee for gingivectomy or gingivoplasty — per tooth is not billable to the patient when performed in conjunction with the preparation of a crown or other restoration by the same dentist/dental office. Only diseased

teeth/periodontium, (see definition starting on page 110) are eligible for benefit consideration. Count tooth bounded spaces for pocket reduction surgery that includes a flap procedure (D4240, D4260). Do not count tooth bounded spaces for D4210, D4211, D4341, D4342. Benefit once per quadrant per 36 months. Benefit one D4210 or D4211 per quadrant per 36 months. Fees for D4211 are not billable to the patient when performed within 36 months by the same dentist/dental office. If done by a different dentist, the benefits are DENIED. Fee for D4211 done on the same date/same quadrant as D4210 are not billable to the patient.

D4212 **Gingivectomy or gingivoplasty — to allow access for restorative procedures — per tooth.** The fee for D4212 in conjunction with a direct or indirect restoration is not billable to the patient.

D4230 **Anatomical crown exposure — four or more contiguous teeth or bounded tooth spaces per quadrant.** Benefits are DENIED unless covered by group/ individual contract.

D4231 **Anatomical crown exposure — one to three teeth or bounded tooth spaces per quadrant.** Anatomical crown exposure is considered cosmetic in nature and therefore DENIED by group contracts that exclude cosmetic services.

D4240 **Gingival flap procedure, including root planing — four or more contiguous teeth or tooth bounded spaces per quadrant.** Count teeth bounded spaces for pocket reduction surgery that includes a flap procedure (D4240, D4241, D4260, D4261). D4342/D4341 are part of D4240 and the fees for scaling root planing on the same date of service in same quadrant are not billable to the patient.

D4241 **Gingival flap procedure, including root planing — one to three contiguous teeth, or tooth bounded spaces per quadrant.** Count teeth bounded spaces for pocket reduction surgery that includes a flap procedure (D4240, D4241, D4260, D4261). D4342/D4341 are part of D4241 and the fees for scaling root planning on the same date of service in same quadrant are not billable to the patient.

D4245 **Apically positioned flap.**

D4249 **Clinical crown lengthening — hard tissue.** When performed in conjunction with osseous surgery, fees for crown lengthening are not billable to the patient. Crown lengthening is a benefit per site and not per tooth when adjacent teeth are included. If D4249 is performed on the same date of service as restoration placement, fees for D4249 are not billable to the patient.

D4260 **Osseous surgery — including elevation of a full thickness flap and closure — four or more contiguous teeth or tooth bounded spaces per quadrant.** Benefits for osseous surgery in excess of two quadrants per date of service are DENIED in the absence of a narrative explaining the exceptional circumstances. For sulcular debridement, biostimulation, reduction of bacterial levels or curettage — claims for gingival

curettage as standalone procedures are not billable to the patient. If done in conjunction with D4341/D4342, fees are not billable to the patient as part of the procedure.

D4261 **Osseous surgery — including elevation of a full thickness flap and closure — one to three contiguous teeth, or tooth bounded spaces per quadrant.** Benefits for osseous surgery in excess of two quadrants per date of service are DENIED in the absence of a narrative explaining the exceptional circumstances. For sulcular debridement, biostimulation, reduction of bacterial levels or curettage — claims for gingival curettage as standalone procedures are not billable to the patient. If done in conjunction with D4341/D4342, fees are not billable to the patient as part of the procedure.

D4263 **Bone replacement graft — retained natural tooth — first site in quadrant.** Benefit bone replacement grafts once per tooth per 36 months on natural teeth only. Only benefit up to two teeth per quadrant per 36 months. Benefits for bone replacement grafts are DENIED when submitted with apicoectomy sites, implants, mucogingival/soft tissue grafts, periradicular surgery, ridge augmentation or preservation procedures, sinus elevation, defects from cyst removal, hemi-sections or with extractions.

D4264 **Bone replacement graft — retained natural tooth — each additional site in quadrant.** Benefits for bone grafting are available only when billed for natural teeth and performed for periodontal purposes. Only benefit up to two teeth per quadrant per 36 months. Benefits for bone replacement grafts are DENIED when submitted with apicoectomy sites, implants, mucogingival/soft tissue grafts, periradicular surgery, ridge augmentation or preservation procedures, sinus elevation, defects from cyst removal, hemisections or with extractions.

D4265 **Biologic materials to aid in soft and osseous tissue regeneration per site.** Benefits are available only when billed for natural teeth. Biologic materials may be a benefit when reported with periodontal flap surgery (D4240, D4241, D4245, D4260 and D4261). Benefit one D4265 per site, per 36 months. When submitted with a D4263, D4264, D4266, D4267, D4270, D4273, D4275, D4276, D4277, D4283, D4285, D4341, D4342 in the same surgical site, the benefit for the D4265 is DENIED. Benefit for these procedures when billed in conjunction with implants, or other oral surgical procedures are DENIED as a specialized procedure.

D4266 **Guided tissue regeneration — resorbable barrier, per site.** Benefits for GTR when billed in conjunction with implants, ridge augmentation, ridge preservation/extraction sites, periradicular surgery, apicoectomy sites, hemisections, etc. are DENIED as a specialized procedure. Benefits for GTR, in conjunction with mucogingival/soft tissue grafts in the same surgical area, are DENIED.

D4267 **Guided tissue regeneration — natural teeth — nonresorbable barrier, per site — includes membrane removal.** Benefits for GTR when billed in conjunction with implants, ridge augmentation, ridge preservation/extraction sites, periradicular

surgery, apicoectomy sites, hemisections, etc., are DENIED as a specialized procedure. Benefits for GTR, in conjunction with mucogingival/soft tissue grafts in the same surgical area, are DENIED. Fees for re-entry for removal of the barrier material are not billable to the patient by the same dentist/dental office.

D4268 **Surgical revision procedure, per tooth.** The fee for D4268 is considered a component of the surgical procedure (D4240, D4241, D4260, and D4261) and is not billable to the patient. If D4268 is performed by the same dentist/dental office within 36 months of previous periodontal surgery, the fee for the procedure is not billable to the patient. It may be eligible for consideration under dentist consultant review. If D4268 is performed within the specified time limits by a different office/dentist, the contractual time limits would apply and benefits for the procedure would be DENIED.

D4270 **Pedicle soft tissue graft procedure.** When multiple grafts are provided within a single quadrant, a maximum of two sites (teeth) are benefited. Benefits for more than two sites (teeth) are DENIED.

D4273 **Autogenous connective tissue graft procedure — including donor and recipient surgical site — first tooth, implant or endentualous tooth position.** Benefits for GTR, in conjunction with soft tissue grafts in the same surgical area, are DENIED. Benefits for D4273 are DENIED if membrane is used as opposed to autografts. Allow up to two teeth or soft tissue grafts per quadrant. Benefits for more than two teeth are DENIED.

D4274 **Mesial/distal wedge procedure, single tooth — when not performed in conjunction with surgical procedures in the same anatomical area.** Based on pocket depths, benefits will be allowed as submitted for a D4274.

D4275 **Non-autogenous connective tissue graft — including recipient site and donor material — first tooth, implant or endentulous tooth position in graft.** When multiple sites (teeth) are provided within a single quadrant, a maximum of two sites (teeth) are benefited. Benefits for more than two teeth are DENIED. Benefits for frenulectomy (D7960) or frenuloplasty (D7963) are not billable to the patient when performed in conjunction with D4275, D4276 or D4285.

D4276 **Combined connective tissue and pedicle graft.** Fees for a frenulectomy (D7960) or frenuloplasty (D7963) are not billable to the patient when performed in conjunction with D4270, D4273, D4275, D4276, D4277, D4278, D4283 or D4285. Allow up to two teeth or soft tissue grafts per quadrant.

D4277 **Free soft tissue graft procedure — including donor site surgery — first tooth or edentulous tooth site in graft.** Allow up to two teeth or soft tissue grafts per quadrant. Benefits for more than two teeth are DENIED. Benefits for D4263, D4264, D4266 and D4267 in conjunction with soft tissue grafts in the same surgical area, are DENIED. Fees for a frenectomy (D7961 and D7962) or frenuplasty (D7963) are not billable to the patient when performed in conjunction with soft tissue grafts.

D4278 **Free soft tissue graft procedure — including donor site surgery — each additional contiguous tooth position in same graft site.** When multiple grafts are provided within a single quadrant, a maximum of two teeth are benefited. The fee for more than two sites (teeth) is DENIED. Allow up to two teeth per quadrant. Benefits for more than two teeth are DENIED. Benefits for GTR and or bone grafts, in conjunction with soft tissue grafts in the same surgical area, are DENIED. Fees for a frenectomy (D7961 and D7962) or frenuplasty (D7963) are not billable to the patient when performed in conjunction with soft tissue grafts.

D4283 **Autogenous connective tissue graft procedure — including donor and recipient surgical sites — each additional contiguous tooth, implant or endentulous tooth position in same graft site.** Allow up to two or teeth soft tissue grafts per quadrant. Benefits for more than two teeth are DENIED. Benefits for GTR and or bone grafts, in conjunction with soft tissue grafts in the same surgical area, are DENIED. Fees for a frenectomy (D7961 and D7962) or frenuplasty (D7963) are not billable to the patient when performed in conjunction with soft tissue grafts.

D4285 **Nonautogenous connective tissue graft procedure — including recipient surgical site and donor material — each additional contiguous tooth, implant or edentualous tooth position in same graft site.** Allow up to two or teeth soft tissue grafts per quadrant. Benefits for GTR and or bone grafts, in conjunction with soft tissue grafts in the same surgical area, are DENIED. Fees for a frenectomy (D7961 and D7962) or frenuplasty (D7963) are not billable to the patient when performed in conjunction with soft tissue grafts contiguous tooth position in same graft site.

D4286 **Removal of nonresorbable barrier.** Fees for removal of barrier membrane by the same dentist/dental office who placed the barrier are not billable to the patient. Fee for removal of D4267, D6107, D7957 barrier membrane by a different dentist/office than who placed the barrier are denied.

Nonsurgical periodontal services

D4322 **Splint — intra-coronal; natural teeth or prosthetic crowns.** When submitted as a standalone procedure, benefits are DENIED unless covered by group/individual contract. The fees for intra-coronal splints submitted in conjunction with prosthetic crowns (D2700-D2799), implant prosthetics crowns (D6058-D6067, D6082-D6085, D6086-D6088, D6094, D6097), fixed partial dentures (D6205-D6794) and implant fixed partial denture retainers (D6068-D6077, D6098, D6099, D6120-D6123, D6194, D6195) are not billable to the patient.

D4323 **Splint — extra-coronal; natural teeth or prosthetic crowns.** When submitted as a standalone procedure, benefits are DENIED unless covered by group/individual contract. The fees for extra-coronal splints submitted in conjunction with prosthetic crowns (D2700-D2799), implant prosthetics crowns (D6058-D6067, D6082-D6085,

D6086-D6088, D6094, D6097), fixed partial dentures (D6205-D6794) and implant fixed partial denture retainers (D6068-D6077, D6098, D6099, D6120-D6123, D6194, D6195) are not billable to the patient.

D4341 **Periodontal scaling and root planing — four or more sites (teeth) or spaces per quadrant.** Fees are not billable to the patient in the absence of radiographic documentation of bone loss and documentation of clinical attachment loss. Limit the benefits to that of a prophylaxis (D1110) or scaling in the presence of generalized moderate to severe gingival inflammation (D4346). A tooth bounded space does not count for benefit consideration as the procedure does not require flap extension. Only diseased teeth/periodontium are eligible for benefit consideration. Fees for retreatment of D4341, D4342 performed by the same dentist within 24 months of initial therapy are not billable to the patient. Retreatment done by a different dentist within 24 months is DENIED. Adult prophylaxis procedures (D1110), full mouth scaling in the presence of generalized moderate to severe inflammation (D4346) or full mouth debridement (D4355) are considered a component when submitted on the same date of service as D4341. This time limitation, like all other contractual time limitations, should be defined in the group/individual contract. A separate fee for prophylaxis (D1110) is not billable to the patient when done during the same episode of treatment as D4341 by the same dentist/dental office. For interim root planing, see D4910. A separate fee for D4341 billed in conjunction with (30 days prior or 90 days following) periodontal surgery (D4210, D4211, D4212, D4240, D4241, D4245, D4260, D4261) procedures by the same dentist/dental office is not billable to the patient as a component of the surgical procedure. Fees for scaling and root planing (D4341) are not billable to the patient when done on the same date of service and same tooth as a surgical repair of root resorption (D3471-D3473).

D4342 **Periodontal scaling and root planing — one to three sites (teeth), per quadrant.** Fees are not billable to the patient in the absence of radiographic documentation of bone loss and documentation of clinical attachment loss. Limit the benefits to that of a prophylaxis (D1110) or scaling in the presence of generalized moderate to severe gingival inflammation (D4346). A tooth bounded space does not count for benefit consideration as the procedure does not require flap extension. Only diseased teeth/periodontium are eligible for benefit consideration. Fees for retreatment of D4341, D4342 performed by the same dentist within 24 months of initial therapy are not billable to the patient. Retreatment done by a different dentist within 24 months is DENIED and the approved amount is collectable from the patient. A separate fee for D4341 billed in conjunction with (30 days prior or 90 days following) periodontal surgery (D4210, D4211, D4212, D4240, D4241, D4245, D4260, D4261) procedures by the same dentist/dental office is not billable to the patient as a component of the surgical procedure.

Fees for scaling and root planing (D4341) are not billable to the patient when done on the same date of service and same tooth as a surgical repair of root resorption (D3471-D3473).

D4346 Scaling in presence of generalized moderate or severe gingival inflammation-full mouth, after oral evaluation. D4346 is included in frequency for D1110, D1120 or D4910. Benefits for D4346 include prophylaxis, fees for D1110, D1120 or D4355 are not billable to the patient when submitted with the D4346 by the same dentist/dental office. Fees for D4346 are not billable to the patient when submitted with D4910 by the same dentist/dental office.

D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis on subsequent visit. Count D4355 against prophylaxis frequency limitations. In absence of group contract language, the procedure is benefited once in a lifetime. A D4355 may be benefited in order to do a proper evaluation and diagnosis if the patient has not been to the dentist in several years, and the dentist is unable to accomplish an effective prophylaxis under normal conditions. The fee for D0180 is not billable to the patient when performed by the same dentist/dental office on the same day as D4355.

D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue — per tooth. Localized delivery of chemotherapeutic agents is DENIED and the approved amount is collectable from the patient. A D4381 may be a contractual benefit, for refractory cases by individual consideration.

When covered contractually, D4381 is subject to the following processing policies:

1. A D4381 may be benefited, subject to dental consultant review if the following conditions exist:
   a. It is being performed six weeks to six months following initial therapy (scaling and root planing or periodontal surgery).
   b. It is being performed for a patient of record on periodontal maintenance following initial therapy (scaling and root planing or periodontal surgery).
   c. It is indicated for refractory cases for patients of record post planning or where refractory with no more than two sites per quadrant.
   d. If either a or b are met, benefits are available for no more than two refractory sites (teeth) per quadrant with pocket depths of at least 5 mm and less than 10 mm.
2. If different sites (teeth) are treated in the quadrant, within 12 months, benefits are DENIED and the approved amount is collectable from the patient.
3. If the same sites (teeth) are re-treated within 24 months, benefits are DENIED and the approved amount is collectable from the patient.

4. Teeth must have 5 mm to 10 mm pocketing to be eligible for benefits. If less than 5 mm pocketing, benefits are DENIED and the approved amount is collectable from the patient.
5. Benefits are provided for up to two sites (teeth) per quadrant. If three or more sites (teeth) are submitted, the entire case may be DENIED and the approved amount is collectable from the patient.
6. When submissions are requested outside time parameters, benefits are DENIED and the approved amount is collectable from the patient.

Other periodontal services

D4910 Periodontal maintenance. Benefits for D4910 include prophylaxis and site specific scaling and root planing procedures. Separate fees for these procedures by the same dentist/dental office are not billable to the patient when billed in conjunction with periodontal maintenance (D4910). The fee for a separate evaluation is eligible for benefit consideration based on group contract. If an oral evaluation (D0120) is submitted and benefited on same date of service as D4910, the evaluation counts toward evaluation frequency limits. If a D0180 is submitted with a D4910 it is benefited as a D0120 and the difference in the approved amount between the D0120 and the D0180 is not billable to the patient unless the D0180 is the initial evaluation by the dentist rendering the D4910. A separate fee for all necessary postoperative care, finishing procedures (D1110, D1120, D4341, D4342, D4355, D4910), evaluations, or other surgical procedures (except soft tissue grafts) on the same date of service or within 30 days of periodontal therapy by the same dentist/dental office is not billable to the patient. Count towards frequency limits for prophylaxis (D1110, D1120 and D4346).

D4920 Unscheduled dressing change — by someone other than the treating dentist. A fee for dressing change submitted by a doctor of the same office is not billable to the patient within 30 days following the surgical procedure.

D4921 Gingival irrigation with medicinal agent — per quadrant. When gingival irrigation is submitted as a standalone procedure, medicaments and solutions used for gingival irrigation are not covered benefits and the benefits are DENIED. Fees for gingival irrigation are not billable to the patient when performed with any periodontal service.

D4999 Unspecified periodontal procedure — by report.

PROSTHODONTICS — REMOVABLE (D5000-D5899)

Terms of group contracts vary. Policies in this Handbook that address benefits, limitations and exclusions are "model" policies that have not been tailored to reflect the specific terms of applicable group contracts. This Handbook may not fully or accurately reflect the terms of applicable group contracts and may be inconsistent with such terms. In all cases, the terms of group contracts take precedence over Handbook policies. Please contact the member company listed on the patient's identification card for the specific terms of a group contract.

GP Characterizations, staining, overdentures or metal bases are considered customization and not a benefit. An allowance is made for a conventional denture. Any fee charged in excess of the allowance for conventional denture is DENIED and the difference between the allowance for the conventional denture and the approved amount for the procedure performed is collectable from the patient.

GP The fees for full or partial dentures include any reline/rebase, adjustment or repair required within six months of delivery by the same dentist/dental office, except in the case of immediate dentures. Except in the case of immediate dentures, the fees for these services by the same dentist/dental office are not billable to the patient.

GP Benefits may be DENIED and the approved amount is collectable from the patient if repair or replacement within contractual time limitations is the patient's fault.

GP The fees for restorations for altering occlusion, involving vertical dimension, treating TMD, replacing tooth structure lost by attrition, erosion, abrasion (wear), abfraction, corrosion or for periodontal, orthodontic or other splinting are DENIED unless covered by group or individual contract and the approved amount is collectable from the patient.

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

GP Multistage procedures are reported and benefited upon completion. The completion date is the date of insertion for removable prosthetic appliances.

The completion date for immediate dentures is the date that the remaining teeth are removed and the denture is inserted. The completion date for fixed partial dentures and crowns, onlays, and inlays is the cementation date regardless of the type of cement utilized.

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

GP Infection control is included in the fee for the dental services provided. Separate fees are not billable to the patient. Infection control is considered a component of all dental procedures performed.

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

GP Adjustments to complete or partial dentures are limited to two adjustments per denture per 12 months (after six months has elapsed since initial placement). Benefits are DENIED after two adjustments.

GP Benefits for restorations for altering occlusion, adjusting vertical dimension, replacing tooth structure lost by attrition, erosion, abrasion, abfraction, corrosion, TMD or for periodontal, orthodontic, or other splinting are DENIED, unless covered by group/individual contract.

Complete dentures — including routine post-delivery care

D5110 Complete denture — maxillary.

D5120 Complete denture — mandibular.

D5130 Immediate denture — maxillary.

D5140 Immediate denture — mandibular.

Partial dentures — including routine post-delivery care

GP A posterior fixed bridge and a removable partial denture are not a benefit in the same arch within a five year period. An allowance for a removable partial denture is made and any fee charged in excess of the allowance is DENIED and the approved amount is collectable from the patient.

GP The fees for fixed bridges or removable cast partials are DENIED and the approved amount is collectable from the patient, for patients under age 16.

D5211 Maxillary partial denture — resin base — including, retentive/clasping materials, rests and teeth.

D5212 Mandibular partial denture — resin base — including, retentive/clasping materials, rests and teeth.

D5213 Maxillary partial denture — cast metal framework with resin denture bases — including any retentive/clasping materials, rests and teeth.

D5214 Mandibular partial denture — cast metal framework with resin denture bases — including any retentive/clasping materials, rests and teeth.

D5221 Immediate maxillary partial denture — resin base — including retentive/clasping materials, rests and teeth.

D5222 Immediate mandibular partial denture — resin base — including retentive/clasping materials, rests and teeth.

D5223 Immediate maxillary partial denture — cast metal framework with resin denture base — including retentive/clasping materials, rests and teeth.

D5224 Immediate mandibular partial denture — cast metal framework with resin denture base — including retentive/clasping materials, rests and pins.

D5225 Maxillary partial denture — flexible base — including retentive/clasping materials, rests and teeth.

D5226 Mandibular partial denture — flexible base — including retentive/clasping materials, rests and teeth.

D5227 Immediate maxillary partial denture — flexible base — including any clasps, rests and teeth.

D5228 Immediate mandibular partial denture — flexible base — including any clasps, rests and teeth.

D5282 Removable unilateral partial denture — one piece cast metal — including retentive/clasping materials, rests and teeth — maxillary.

D5283 Removable unilateral partial denture — one piece cast metal — including retentive/clasping materials, rests and teeth — mandibular.

D5284 Removable unilateral partial denture — one piece flexible base — including retentive/clasping materials, rests and teeth — per quadrant.

D5286 Removable unilateral partial denture — one piece resin — including retentive/clasping materials, rests and teeth — per quadrant.

Adjustments to dentures

GP The fees for full or partial dentures include any adjustments or repairs required within six months of delivery, except in the case of immediate dentures. If performed by the same dentist/dental office within six months of initial placement, fees for adjustments or repairs are not billable to the patient.

GP The fees for adjustments to complete or partial dentures are limited to two adjustments per denture per 12 months (after six months has elapsed since initial placement). More frequent adjustments are DENIED and the approved amount is collectable from the patient.

D5410 Adjust complete denture — maxillary.

D5411 Adjust complete denture — mandibular.

D5421 Adjust partial denture — maxillary.

D5422 Adjust partial denture — mandibular repairs to complete denture.

GP The fee for the repair of a complete denture cannot exceed one-half of the fee for a new appliance, and any excess fee by the same dentist/dental office is not billable to the patient.

GP The fees for full or partial dentures include any adjustments or repairs required within six months of delivery, except in the case of immediate dentures. If performed by the same dentist/dental office within six months of initial placement, fees for adjustments or repairs are not billable to the patient.

D5511 Repair broken complete denture base — mandibular. Fees for repairs of complete dentures, if performed within six months of initial placement by the same dentist/dental office are not billable to the patient.

D5512 Repair broken complete denture base — maxillary. Fees for repairs of complete dentures, if performed within six months of initial placement by the same dentist/dental office are not billable to the patient.

D5520 Replace missing or broken teeth — complete denture — per tooth. Fees for repairs of complete or partial dentures if performed within six months of initial placement by the same dentist/dental office are not billable to the patient. Benefits are DENIED if done by a different dentist/dental office.

Repairs to partial dentures

GP The fee for the repair of a partial denture cannot exceed one-half of the fee for a new appliance, and any excess fee by the same dentist/dental office is not billable to the patient.

GP The fees for full or partial dentures include any adjustments or repairs required within six months of delivery, except in the case of immediate dentures. If performed by the same dentist/dental office within six months of initial placement, fees for the adjustments or repairs are not billable to the patient.

D5611 Repair resin partial denture base — mandibular. Fees for repairs of resin partial dentures, if performed within six months of initial placement by the same dentist/dental office are not billable to the patient.

D5612 Repair resin partial denture base — maxillary. Fees for repairs of complete dentures, if performed within six months of initial placement by the same dentist/dental office are not billable to the patient.

D5621 **Repair cast partial framework — mandibular.** Fees for repairs of cast partial dentures, if performed within six months of initial placement by the same dentist/dental office are not billable to the patient.

D5622 **Repair cast partial framework — maxillary.** Fees for repairs of cast partial dentures, if performed within six months of initial placement by the same dentist/dental office are not billable to the patient.

D5630 **Repair or replace broken retentive clasping materials — per tooth.** Fees for repair of a partial denture cannot exceed one-half of the fee for a new appliance, and any excess fee by the same dentist/dental office is not billable to the patient on the same date of service.

D5640 **Replace missing or broken teeth — partial denture — per tooth.**

D5650 **Add tooth to existing partial denture — per tooth.**

D5660 **Add clasp to existing partial denture — per tooth.** Fees for repair of a partial denture cannot exceed one-half of the fee for a new appliance, and any excess fee by the same dentist/dental office is not billable to the patient on the same date of service.

D5670 **Replace all teeth and acrylic on cast metal framework — maxillary.** Fees for denture repairs, relines or rebases cannot exceed one-half of the fee for a new appliance, and any excess fee by the same dentist/dental office is not billable to the patient on the same date of service.

D5671 **Replace all teeth and acrylic on cast metal framework — mandibular.** The fee for a D5670 or D5671 cannot exceed one-half of the fee for a new appliance, and any excess fee by the same dentist/dental office is not billable to the patient.

Denture rebase procedures

GP The fee for the rebase includes the fee for relining. When the fee for a reline performed in conjunction with rebase (within six months of) by the same dentist/dental office the fee for the reline is not billable to the patient.

GP The fee for a rebase includes adjustments required within six months of delivery. A fee for an adjustment performed within six months of a reline or rebase by the same dentist/dental office is not billable to the patient.

D5710 **Rebase complete maxillary denture.**

D5711 **Rebase complete mandibular denture.**

D5720 **Rebase maxillary partial denture.**

D5721 **Rebase mandibular partial denture.**

D5725 **Rebase hybrid prosthesis.**

Denture reline procedures

GP The fee for a reline includes adjustments required within six months of delivery. A fee for an adjustment billed within six months of a reline by the same dentist/dental office is not billable to the patient.

GP The fee for the rebase includes the fee for relining. The fee for a reline performed in conjunction with (within six months of) a rebase by the same dentist/dental office is not billable to the patient.

D5730 Reline complete maxillary denture — chairside.

D5731 Reline complete mandibular denture — chairside.

D5740 Reline maxillary partial denture — chairside.

D5741 Reline mandibular partial denture — chairside.

D5750 Reline complete maxillary denture — laboratory.

D5751 Reline complete mandibular denture — laboratory.

D5760 Reline maxillary partial denture — laboratory.

D5761 Reline mandibular partial denture — laboratory.

D5765 Soft liner for complete or partial removable denture — indirect.

Interim prosthesis

D5810 Interim complete denture — maxillary. The fees for interim complete dentures are DENIED.

D5811 Interim complete denture — mandibular. The fees for interim complete dentures are DENIED.

D5820 Interim partial denture — including retentive/clasping materials, rests and teeth — maxillary. An interim partial denture is a benefit only in children age 16 or under for missing anterior permanent teeth.

D5821 Interim partial denture — including retentive/clasping materials, rests and teeth — mandibular. An interim partial denture is a benefit only in children age 16 or under for missing anterior permanent teeth.

Other removable prosthetic services

D5850 Tissue conditioning — maxillary. A separate fee for tissue conditioning is not billable to the patient if performed by the same dentist/dental office on the same day the denture is delivered or a reline/rebase is provided. Tissue conditioning is not a benefit more than twice per denture unit per 36 months, and the fee for tissue conditioning is DENIED and the approved amount is collectable from the patient if done more frequently.

D5851 Tissue conditioning — mandibular. A separate fee for tissue conditioning is not billable to the patient if performed by the same dentist/dental office on the same day the denture is delivered or a reline/rebase is provided. Tissue conditioning is not a benefit more than twice per denture unit per 36 months, and the fee for tissue conditioning is DENIED and the approved amount is collectable from the patient if done more frequently.

D5862 Precision attachment — by report. Benefits for precision attachment are DENIED as a specialized procedure.

D5863 Overdenture — complete maxillary — natural tooth borne.

D5864 Overdenture — complete mandibular — natural tooth borne.

D5865 Overdenture — partial maxillary — natural tooth borne.

D5866 Overdenture — partial mandibular — natural tooth borne.

D5867 Replacement of replaceable part of semi-precision or precision attachment, natural tooth borne prosthesis — per attachment. Benefits for precision attachments are DENIED unless covered by group/individual contract.

D5875 Modification of a removable prosthesis following implant surgery. If implant services are covered, benefits for D5875 are DENIED, as a specialized procedure.

D5876 Add metal substructure to acrylic complete denture — per arch. Use of metal substructure in removable complete dentures without a framework. Benefits are DENIED unless covered by group/individual contract.

D5877 Duplication of complete denture — maxillary. Benefits are DENIED unless covered by group/individual contract.

D5878 Duplication of complete denture — mandibular. Benefits are DENIED unless covered by group/individual contract.

D5880-D5999

GP Any characterization, staining, overdentures, or metal bases are considered customization and not a benefit. An allowance may be made for conventional dentures. Any additional fee is the patient's responsibility.

D5899 Unspecified removable prosthodontic procedure — by report.

MAXILLOFACIAL PROSTHETICS (D5900-D5999)

Terms of group contracts vary. Policies in this Handbook that address benefits, limitations and exclusions are "model" policies that have not been tailored to reflect the specific terms of applicable group contracts. This Handbook may not fully or accurately reflect the terms of applicable group contracts and may be inconsistent with such terms. In all cases, the terms of group contracts take precedence over Handbook policies. Please contact the member company listed on the patient's identification card for the specific terms of a group contract.

GP The fees for maxillofacial prosthetics are DENIED and the approved amount is collectable from the patient unless the group contract specifies that maxillofacial prosthetics are a benefit.

D5909 Maxillary guidance prosthesis with guide flange.

D5911 Facial moulage — sectional.

D5912 Facial moulage — complete.

D5913 Nasal prosthesis.

D5914 Auricular prosthesis.

D5915 Orbital prosthesis.

D5916 Ocular prosthesis.

D5919 Facial prosthesis.

D5922 Nasal septal prosthesis.

D5923 Ocular prosthesis — interim.

D5924 Cranial prosthesis.

D5925 Facial augmentation implant prosthesis.

D5926 Nasal prosthesis — replacement.

D5927 Auricular prosthesis — replacement.

D5928 Orbital prosthesis — replacement.

D5929 Facial prosthesis — replacement.

D5930 Maxillary guidance prosthesis without guide flange.

D5931 Obturator prosthesis — surgical.

D5932 Obturator prosthesis — definitive.

D5933 Obturator prosthesis — modification.

D5934 Mandibular guidance prosthesis with guide flange. Prior to 1990, a mandible was resected without reconstruction. The term guidance is used for prosthesis when there is no reconstruction. After 1990, reconstruction became more common and thus a resection appliance is when the mandible/maxilla is resected and then reconstructed.

D5935 **Mandibular guidance prosthesis without guide flange.** Prior to 1990, a mandible was resected without reconstruction. The term guidance is used for the prosthesis when there is no reconstruction. After 1990, reconstruction became more common and thus a resection appliance is when the mandible/maxilla is resected and then reconstructed.

D5936 **Obturator prosthesis — interim.**

D5937 **Trismus appliance (not for TMD treatment).**

D5939 **Resection prosthesis, mandibular complete removable.**

D5940 **Resection prosthesis, maxillary partial removable.**

D5941 **Resection prosthesis, mandibular partial removable.**

D5942 **Resection prosthesis, maxillary implant/abutment supported removable prosthesis for edentulous arch.**

D5943 **Resection prosthesis, mandibular implant/abutment supported removable prosthesis for edentulous arch.**

D5944 **Resection prosthesis, maxillary implant/abutment supported removable prosthesis for the partial edentulous arch.**

D5945 **Resection prosthesis, mandibular implant/abutment supported removable prosthesis for the partial edentulous arch.**

D5946 **Resection prosthesis, maxillary implant/abutment supported fixed prosthesis for edentulous arch**

D5947 **Resection prosthesis, mandibular implant/abutment supported fixed prosthesis for edentulous arch.**

D5948 **Resection prosthesis, maxillary implant/abutment supported fixed prosthesis for the partial edentulous arch.**

D5949 **Resection prosthesis, mandibular implant/abutment supported fixed prosthesis for the partial edentulous arch.**

D5951 **Feeding aid.**

D5952 **Speech aid prosthesis — pediatric.**

D5953 **Speech aid prosthesis — adult.**

D5954 **Palatal augmentation prosthesis.**

D5955 **Palatal lift prosthesis — definitive.**

D5958 **Palatal lift prosthesis — interim.**

D5959 **Palatal lift prosthesis — modification.**

D5960 **Speech aid prosthesis — modification.**

D5982 Surgical stent for soft tissue healing.

D5983 Radiation carrier.

D5984 Radiation shield.

D5985 Radiation cone locator.

D5986 Fluoride gel carrier.

D5987 Commissure splint.

D5988 Surgical splint.

D5991 Topical medicament carrier. Benefits are DENIED unless the group/individual contract specifies that maxillofacial prosthetics are a benefit.

D5992 Adjust maxillofacial prosthetic appliance — by report.

D5993 Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral) other than required adjustments. Maxillofacial prosthesis maintenance and cleaning (D5993) is not a covered benefit and is DENIED unless covered by group/individual contract.

D5995 Periodontal medicament carrier with peripheral seal — laboratory processed — maxillary.

D5996 Periodontal medicament carrier with peripheral seal — laboratory processed — mandibular. Benefits are DENIED unless covered by group/individual contract.

D5999 Unspecified maxillofacial prosthesis — by report.

IMPLANT SERVICES (D6000-D6199)

Terms of group contracts vary. Policies in this Handbook that address benefits, limitations and exclusions are "model" policies that have not been tailored to reflect the specific terms of applicable group contracts. This Handbook may not fully or accurately reflect the terms of applicable group contracts and may be inconsistent with such terms. In all cases, the terms of group contracts take precedence over Handbook policies. Please contact the member company listed on the patient's identification card for the specific terms of a group contract.

GP Unless the group contract specifies implants are covered, the fees for implant services are DENIED and the approved amount is collectable from the patient.

GP When benefited, implant time limitations are established by contract.

GP When benefited, the surgical procedure includes the dental implant.

GP If implant services are covered benefits, include the implant and surgical procedures. The term specialized procedure describes a dental service or procedure that is used when unusual or extraordinary circumstances exist and is not generally used when conventional methods are adequate.

GP Infection control is included in the fee for the dental services provided. Separate fees are not billable to the patient. Infection control is considered a component of all dental procedures performed.

GP Fees for repairs to implant prosthesis cannot exceed one-half of the fee for a new appliance, and any excess fee by the same dentist/dental office is not billable to the patient.

D6010 Surgical placement of implant body: endosteal implant.

D6011 Surgical access to an implant body — second stage of implant surgery. D6011 is considered part of D6010/D6012/D6013 and fees are not billable to the patient. Benefits for D6011 are DENIED if done by a different dentist/dental office.

D6012 Surgical placements of interim implant body for transitional prosthesis: endosteal implant. Benefits are DENIED, and the approved amount is chargeable to the patient.

D6013 Surgical placement of mini implant. Benefits are DENIED unless covered by group or individual contract. If covered by group/individual contract, allow one per tooth/tooth-bounded site. Fees for more than one D6013 per tooth/tooth-bounded site are not billable to the patient.

D6049 Scaling and debridement of a single implant in the presence of peri-implantitis inflammation, bleeding upon probing and increased pocket depths, including cleaning of the implant surfaces, without flap entry and closure. Benefits for D6049 are DENIED unless implants are covered by the group/individual contract. When covered, fees for D6049 are not billable to the patient when performed in the same quadrant by the same dentist/dental office as D4341/D4342 or D4240/D4241, D4260/D4261 or D6101/D6102. When covered, allow once per tooth per 24 months. Fees for retreatment by the same dentist/dental office within 24 months of initial therapy is not billable to the patient, if different dentist/dental office then benefits are DENIED. Fees for D6049 are not billable to the patient when performed within 12 months of restoration (D6058-D6077, D6085, D6094,6118, D6119, D6194).

D6040 Surgical placement — eposteal implant.

D6050 Surgical placement — transosteal implant.

Implant supported prosthetics

GP Where benefited by contract, fees for the placement of an implant to natural tooth bridge are not billable to the patient. Special consideration may be given by report particularly where there is documentation of semi-ridged fixation between the tooth and implant and where other risk factors are not present.

D6051 **Placement of interim implant abutment.** Benefits are DENIED, and the approved amount is chargeable to the patient.

D6055 **Connecting bar — implant supported or abutment supported includes modification and placement.** Benefits for a D6055 are DENIED as a specialized procedure and the approved amount is collectable from the patient unless implants are covered by contract.

D6066 **Implant supported porcelain fused to metal crown — high noble alloys.**

D6067 **Implant supported metal crown — high noble alloys.**

D6068 **Abutment supported retainer for porcelain/ceramic FPD.**

D6069 **Abutment supported retainer for porcelain fused to metal FPD — high noble metal.**

D6070 **Abutment supported retainer for porcelain fused to metal FPD — predominantly base metal.**

D6071 **Abutment supported retainer for porcelain fused to metal FPD — noble metal.**

D6072 **Abutment supported retainer for cast metal FPD — high noble metal.**

D6073 **Abutment supported retainer for cast metal FPD — predominantly base metal.**

D6074 **Abutment supported retainer for cast metal FPD — noble metal.**

D6075 **Implant supported retainer for ceramic FPD.**

D6076 **Implant supported retainer for porcelain fused to metal FPD — high noble alloys.**

D6077 **Implant supported retainer for cast metal FPD — high noble alloys.**

Other implant services

D6080 **Implant maintenance procedures, when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesises and abutments.** Benefits for D6080 are DENIED unless covered by group/individual contract. If implant services and D6114 and D6115 are covered. Benefits are limited to once every 36 months. Benefits for D6080 and D6180 are DENIED if done more frequently. Fees for D6080 are not billable to the patient if done within 12 months of D6114 and D6115. Dental consultant criteria/notes: This procedure is not routine maintenance and generally done to address an abutment issue.

D6081 **Scaling and debridement of a single implant in the presence of mucositis including inflammation, bleeding upon probing and increased pocket depths, includes cleaning of the implant surfaces, without flap entry and closure.** Benefits for D6081 are DENIED unless implants are covered by the group/individual contract. When covered, fees for D6081 are not billable to the patient when performed in the same quadrant by the same dentist/dental office as D4341/D4342 or D4240/D4241, D4260/D4261, D6049 or D6101/D6102. When covered, allow once per tooth per 24 months. Fees for

retreatment by the same dentist/dental office within 24 months of initial therapy are not billable to the patient, if different dentist/dental office then benefits are DENIED. Fees for D6081 are not billable to the patient when performed within 12 months of restoration (D6058-D6094, D6118, D6119, D6194) placement by same dentist/dental office. Fees for D6081 are not billable to the patient when performed in conjunction with D1110, D4346 or D4910.

D6084 Implant supported crown — porcelain fused to titanium and titanium alloys.

D6085 Interim implant crown. Benefits for provisional interim implant crowns are DENIED unless covered by group/individual contract.

D6086 Implant supported crown — predominantly base alloys.

D6087 Implant supported crown — noble alloys.

D6088 Implant supported crown — titanium and titanium alloys.

D6089 Accessing and retorquing loose implant screw — per screw. Benefits are DENIED unless covered by group/individual contract. When covered, benefit once every 24 months. Fees for D6089 are not billable to the patient on the same date of service by same dentist/dental office as D6080 or D6090. When done on the same date of service as D6193, fees for D6089 are not billable to the patient.

D6090 Repair implant/abutment supported prosthesis. Benefits are DENIED unless implants are covered by group/individual contract. When covered, fees for repair of implant/abutment supported prosthesis, performed within six months of the initial placement of the prosthesis, by the same dentist/dental office, are not billable to the patient. Benefits are limited to once in 24 months, per prosthesis.

D6091 Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis — per attachment. Benefits for D6091 are DENIED unless covered by the group/individual. If covered, benefit once per 24 months. Benefits are DENIED less than 24 months.

D6092 Recement or rebond implant/abutment supported crown. Fee for the recementation of crowns are not billable to the patient if done within six months of the initial seating date by the same dentist/dental office. Benefits may be paid for one recementation after six months have elapsed since the initial placement. Subsequent requests for recementation by the same dentist are DENIED. Benefits may be paid when billed by a dentist other than the one who seated the crown or performed the previous recementation.

D6093 Recement or rebond implant/abutment supported fixed partial denture. Fee for recementation for fixed partial dentures are not billable to the patient if done within six months of the initial seating date by the same dentist/dental office. Benefits may be paid for one recementation after six months have elapsed since the initial placement. Subsequent requests for recementation by the same dentist are DENIED.

Benefits may be paid when billed by a dentist other than the one who seated the crown or performed the previous recementation.

D6094 Abutment supported crown — titanium alloys.

D6095 Repair implant abutment — by report.

D6096 Remove broken implant retaining screw. Benefits are DENIED unless implants are covered by group/individual contract. When covered, benefit once at the same frequency as implants.

D6097 Abutment supported crown — porcelain fused to titanium and titanium alloys.

D6098 Implant supported retainer — porcelain fused to predominantly base alloys.

D6099 Implant supported retainer for FPD — porcelain fused to noble alloys.

D6100 Surgical removal of implant body. When implants are covered by the group/individual contract, the fee for D6100 when performed within three months of D6010/D6013 on the same tooth by the same dentist/dental office is not billable to the patient. After three months, benefit once per tooth per frequency limitation for implants/prosthetics.

D6101 Debridement of a peri-implant defect or defects surrounding a single implant and surface cleaning of the exposed implant surfaces — including flap and closure. Benefits are DENIED if implants are not covered by group/individual contract. Fees for D6101 are not billable to the patient when billed in conjunction with D4260 or D4261. This procedure is not billable to the patient when performed in the same surgical site by the same dentist/dental office on the same day as D6102.

D6102 Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces — including flap entry and closure. Benefits are DENIED if implants are not covered by group/individual contract. Benefit for these procedures when billed in conjunction with implants, implant removal, ridge augmentation or preservation, in extraction site, periradicular surgery, etc. are DENIED. In conjunction with D4260 or D4261, this procedure is not billable to the patient when billed separately. Fees for D6101 are not billable to the patient in conjunction with this procedure.

D6103 Bone graft for repair of peri-implant defect — does not include flap entry and closure. Placement of a barrier membrane or biologic materials to aid in osseous regeneration are reported separately. Benefits for these procedures when billed in conjunction with implants, implant removal, ridge augmentation or preservation in extraction sites, periradicular surgery are DENIED. Sufficient longitudinal study data on outcomes is not available.

D6104 Bone graft at time of implant placement. Benefits for these procedures when billed in conjunction with implants, implant removal, ridge augmentation or preservation in extraction sites, periradicular surgery are DENIED.

D6105 **Removal of implant body not requiring bone removal nor flap elevation.** When implants are covered by the group/individual contract, the fee for D6105 when performed within six months of D6010/D6013 on the same tooth by the same dentist/dental office is not billable to the patient. Benefits are DENIED if done by a different dentist/dental office. After six months, benefit once per implant within the frequency limitation for implants/prosthetics.

D6106 **Guided tissue regeneration — resorbable barrier — per implant.** Unless covered by group or individual contract, benefits for GTR are DENIED. Benefits for GTR in conjunction with mucogingival/soft tissue grafts in the same surgical area are DENIED.

D6107 **Guided tissue regeneration — nonresorbable barrier — per implant.** When covered by group/individual contract, benefits for GTR are DENIED. Fees for re-entry for removal of the barrier material are not billable to the patient by the same dentist/dental office.

D6110 **Implant/abutment supported removable denture for edentulous arch — maxillary.** Benefit according to group/individual contract. Allow an alternate benefit of a conventional complete mandibular denture (D5110). Any additional fee up to the approved amount for the D6110 is DENIED.

D6111 **Implant/abutment supported removable denture for edentulous arch — mandibular.** Benefit according to group/individual contract. Allow an alternate benefit of a conventional complete mandibular denture (D5120). Any additional fee up to the approved amount for the D6111 is DENIED.

D6112 **Implant/abutment supported removable denture for partially edentulous arch — maxillary.** Benefit according to group/individual contract. Allow an alternate benefit of a conventional partial maxillary denture (D5213). Any additional fee up to the approved amount for the D6112 is DENIED.

D6113 **Implant/abutment supported removable denture for partially edentulous arch — mandibular.** Benefit according to group/individual contract. Allow an alternate benefit of a conventional partial mandibular denture (D5214). Any additional fee up to the approved amount for the D6113 is DENIED.

D6114 **Implant/abutment supported fixed denture for edentulous arch — maxillary.** Benefit according to group/individual contract. Allow an alternate benefit of a conventional complete maxillary denture (D5110). Any additional fee up to the approved amount for the D6114 is DENIED.

D6115 **Implant/abutment supported fixed denture for edentulous arch — mandibular.** Benefit according to group/individual contract. Allow an alternate benefit of a conventional complete mandibular denture (D5120). Any additional fee up to the approved amount for the D6115 is DENIED.

D6116 **Implant/abutment supported fixed denture for partially edentulous arch — maxillary.** Benefit according to group/individual contract. Allow an alternate benefit of a conventional partial maxillary denture (D5213). Any additional fee up to the approved amount for the D6116 is DENIED.

D6117 **Implant/abutment supported fixed denture for partially edentulous arch — mandibular.** Allow an alternate benefit of a conventional partial mandibular denture (D5214). Any additional fee up to the approved amount for the D6117 is DENIED.

D6118 **Implant/abutment supported interim fixed denture for edentulous arch — mandibular.** Benefits for implant/abutment supported interim fixed denture for edentulous arch — mandibular are DENIED.

D6119 **Implant/abutment supported interim fixed denture for edentulous arch — maxillary.** Benefits for implant/abutment supported interim fixed denture for edentulous arch — maxillary are DENIED.

D6120 **Implant supported retainer — porcelain fused to titanium and titanium alloys.**

D6121 **Implant supported retainer for metal FPD — porcelain fused to predominantly base metal alloys.**

D6122 **Implant supported retainer for metal FPD — noble alloys.**

D6123 **Implant supported retainer for metal FPD — porcelain fused to titanium and titanium alloys.**

D6180 **Implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutment.** Benefits for D6180 are DENIED unless covered by group/individual contract. If implant services and D6114 and D6115 are covered, Benefits are limited to once every 36 months. Benefits for D6080 and D6180 are DENIED if done more frequently. Fees for D6180 are not billable to the patient if done within 12 months of D6114 and D6115.

D6190 **Radiographic/surgical implant index — by report.** Benefits are DENIED, unless covered by group/individual contract.

D6191 **Semi-precision abutment — placement.** Benefits are DENIED unless covered by the group/individual contract.

D6192 **Semi-precision attachment — placement.** Benefits are DENIED unless covered by the group/individual contract.

D6193 **Replacement of an implant screw. Benefits are DENIED unless implants are covered by group/individual contract.** When covered, fees for replacement of an implant screw, if performed within six months of the initial placement of the prosthesis, by the same dentist/dental office, are not billable to the patient. Benefits are limited to once per implant every 24 months. Fees for D6089 are not billable to the patient on the same date of services as D6193.

D6194 **Abutment supported retainer crown for FPD — titanium alloys.** Benefits are DENIED unless covered by group/individual contract.

D6195 **Abutment supported retainer — porcelain fused to titanium and titanium alloys.**

D6196 **Removal of an indirect restoration on an implant retained abutment.** The removal of an indirect restoration is included in the definitive treatment and the fees are not billable to the patient.

D6197 **Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis — per implant.** Benefits are DENIED unless covered by group/individual contract. When covered, fees for replacement of restorative material to close an access opening of a screw retained implant supported prosthesis when performed by the same dentist/dental office within six months placement of the implant prosthesis are not billable to the patient. Benefit once every 24 months. Fees for D6197 are not billable on the same date of service by same dentist/dental office as D6080 or D6090.

D6198 **Remove interim implant component.** Fees for removal of an interim implant component by the same dentist/dental office who placed the implant component are considered part of the interim abutment placement procedure and are not billable to the patient. Benefits for removal of an interim implant abutment by a different dentist/office than who placed the abutment are DENIED.

D6199 **Unspecified implant procedure — by report.**

PROSTHODONTICS — FIXED (D6200-D6999)

Terms of group contracts vary. Policies in this Handbook that address benefits, limitations and exclusions are "model" policies that have not been tailored to reflect the specific terms of applicable group contracts. This Handbook may not fully or accurately reflect the terms of applicable group contracts and may be inconsistent with such terms. In all cases, the terms of group contracts take precedence over Handbook policies. Please contact the member company listed on the patient's identification card for the specific terms of a group contract.

GP Fixed prosthodontics are subject to contractual time limits for replacement.

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

GP A posterior fixed bridge and a removable partial denture are not benefits in the same arch within the group contract limitation. An allowance for a removable partial denture is made and any fee charged in excess of the allowance is DENIED and the approved amount is collectable from the patient.

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

GP Fixed prosthodontics are not a benefit for children under 16 years of age. Benefits for children under age 16 are DENIED.

GP Cementation date is the delivery date. The type of cement used is not a determining factor (whether permanent or temporary).

GP The fees for restorations for altering occlusion, involving vertical dimension, treating TMD, replacing tooth structure lost by attrition, erosion, abrasion (wear), abfraction, corrosion or for periodontal, orthodontic or other splinting are DENIED and the approved amount is collectable from the patient.

GP Multistage procedures are reported and benefited upon completion. The completion date is the date of insertion for removable prosthetic appliances.

The completion date for fixed partial dentures and crowns, onlays, and inlays is the cementation date regardless of the type of cement utilized.

GP An allowance of a conventional fixed prosthesis is provided for porcelain/ceramic or resin bridges. The difference between the allowance for the conventional fixed prosthesis and the approved amount for the porcelain/ceramic or resin bridge is collectable from the patient.

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

GP Infection control is included in the fee for the dental services provided. Separate fees are not billable to the patient. Infection control is considered a component of all dental procedures performed.

Fixed partial denture pontics

D6205 Pontic — indirect resin-based composite — not to be used as a temporary or provisional prosthesis.

D6210 Pontic — cast high noble metal.

D6211 Pontic — cast predominantly base metal.

D6212 Pontic — cast noble metal.

D6214 Pontic — titanium or titanium alloys.

D6240 Pontic — porcelain fused to high noble metal.

D6241 Pontic — porcelain fused to predominantly base metal.

D6242 Pontic — porcelain fused to noble metal.

D6243 Pontic — porcelain fused to titanium and titanium alloys.

D6245 Pontic — porcelain/ceramic.

D6250 Pontic — resin with high noble metal.

D6251 Pontic — resin with predominantly base metal.

D6252 Pontic — resin with noble metal.

D6253 Interim pontic. Temporary interim or provisional fixed prostheses are not separate benefits and are included in the fee for the permanent prostheses. The fees for the temporary fixed prostheses by the same dentist/dental office are not billable to the patient.

D6280 Implant maintenance procedure when a full arch removable implant/abutment supported denture is removed and reinserted, including cleansing of the prosthesis and abutments — per arch. Benefits for D6280 are DENIED unless covered by group/individual contract. If implant services D6110 and D6111 are covered, benefits are limited to once every 36 months. Benefits for D6280 are DENIED if done more frequently. Fees for D6280 are not billable to the patient if done within 12 months of D6110 and D6111. This procedure is not routine maintenance and generally done to address an abutment issue.

Fixed partial denture retainers — inlays/onlays

D6545 Retainer — cast metal for resin bonded fixed prosthesis.

D6548 Retainer — porcelain/ceramic for resin bonded fixed prosthesis.

D6549 Resin retainer — for resin bonded fixed prosthesis.

D6600 Inlay — porcelain/ceramic — two surfaces.

D6601 Inlay — porcelain/ceramic — three or more surfaces.

D6602 Inlay — cast high noble metal — two surfaces. Benefits are DENIED unless covered by group/individual contract.

D6603 Inlay — cast high noble metal — three or more surfaces. Benefits are DENIED unless covered by group/individual contract.

D6604 Inlay — cast predominantly base metal — two surfaces. Benefits are DENIED unless covered by group/individual contract.

D6605 Inlay — cast predominantly base metal — three or more surfaces. Benefits are DENIED unless covered by group/individual contract.

D6606 Inlay — cast noble metal — two surfaces. Benefits are DENIED unless covered by group/individual contract.

D6607 Inlay — cast noble metal — three or more surfaces. Benefits are DENIED unless covered by group/individual contract.

D6608 Onlay — porcelain/ceramic — two surfaces.

D6609 Onlay — porcelain/ceramic — three or more surfaces.

D6610 Onlay — cast high noble metal — two surfaces. Benefits are DENIED unless covered by group/individual contract.

D6611 Onlay — cast high noble metal — three or more surfaces. Benefits are DENIED unless covered by group/individual contract.

D6612 Onlay — cast predominantly base metal — two surfaces. Benefits are DENIED unless covered by group/individual contract.

D6613 Onlay — cast predominantly base metal — three or more surfaces. Benefits are DENIED unless covered by group/individual contract.

D6614 Onlay — cast noble metal — two surfaces. Benefits are DENIED unless covered by group/individual contract.

D6615 Onlay — cast noble metal — three or more surfaces. Benefits are DENIED unless covered by group/individual contract.

D6624 Inlay — titanium. Benefits are DENIED unless covered by group/individual contract.

D6634 Onlay — titanium. Benefits are DENIED unless covered by group/individual contract.

Fixed partial denture retainers — crowns

D6710 Crown — indirect resin based composite.

D6720 Crown — resin with high noble metal.

D6721 Crown — resin with predominantly base metal.

D6722 Crown — resin with noble metal.

D6740 Crown — porcelain/ceramic.

D6750 Crown — porcelain fused to high noble metal.

D6751 Crown — porcelain fused to predominantly base metal.

D6752 Crown — porcelain fused to noble metal.

D6753 Retainer crown — porcelain fused to titanium and titanium alloys.

D6780 Crown — ¾ cast high noble metal.

D6781 Crown — ¾ cast predominantly base metal.

D6782 Crown — ¾ cast noble metal.

D6783 Crown — ¾ porcelain/ceramic.

D6784 Retainer crown — ¾ titanium and titanium alloys.

D6790 Crown — full cast high-noble metal.

D6791 Crown — full cast predominantly base metal.

D6792 Crown — full cast noble metal.

D6793 Interim retainer crown. Temporary, interim or provisional fixed prostheses are not separate benefits and are included in the fee for the permanent prostheses. The fees for the temporary fixed prostheses by the same dentist/dental office are not billable to the patient.

D6794 Crown — titanium or titanium alloys.

Other fixed partial denture services

D6920 Connector bar. The fee for a connector bar is DENIED unless covered by group/individual contract and the approved amount is collectable from the patient.

D6930 Recement or rebond fixed partial denture. Delta Dental member companies consider the cementation date to be that date upon which the completed bridge is first delivered to the mouth. The type of cement used is not a determining factor (whether permanent or temporary). Fees for recementation of inlays, onlays, crowns and fixed partial dentures are not billable to the patient if done within six months of the initial seating date by the same dentist or dental office. Benefits may be paid for one recementation after six months have elapsed since initial placement. Subsequent requests for recementation by the same provider are DENIED and the approved amount is collectable from the patient. Benefits may be paid when billed by a provider other than the one who seated the bridge or performed the previous recementation.

D6940 Stress breaker. The fee for a stress breaker is DENIED as a specialized technique and the approved amount for the stress breaker is collectable from the patient.

D6950 Precision attachment. Benefits are DENIED unless covered by the group/individual contract.

D6980 Fixed partial denture repair necessitated by restorative material failure. The fee for the repair of a fixed partial denture cannot exceed one-half of the fee for a new appliance, and any fee charged in excess of the allowance by the same dentist/dental office is not billable to the patient.

D6985 Pediatric partial denture — fixed. Benefits are DENIED unless covered by the group/individual contract.

D6999 Unspecified fixed prosthodontic procedure — by report.

ORAL AND MAXILLOFACIAL SURGERY (D7000-D7999)

Terms of group contracts vary. Policies in this Handbook that address benefits, limitations and exclusions are "model" policies that have not been tailored to reflect the specific terms of applicable group contracts. This Handbook may not fully or accurately reflect the terms of applicable group contracts and may be inconsistent with such terms. In all cases, the terms of group contracts take precedence over Handbook policies. Please contact the member company listed on the patient's identification card for the specific terms of a group contract.

GP The fee for all oral and maxillofacial surgery includes local anesthesia, suturing if needed and routine postoperative care, including treatment of dry sockets. Separate fees for these procedures when performed in conjunction with oral and maxillofacial surgery are not billable to the patient. If performed by another dentist these procedures are DENIED and the approved amount is collectable from the patient.

GP Fees for exploratory surgery or unsuccessful attempts at extractions are not billable to the patient. Benefits are generally only available for completed services.

GP Impaction codes are based on the anatomical position of the tooth, rather than the surgical procedure necessary for removal.

GP The fees for biopsy (D7285, D7286), frenulectomy (D7960), frenuloplasty (D7963) and excision of hard and soft tissue lesions (D7210, D7411, D7450, D7451) are not billable to the patient when the procedure is performed on the same day, same surgical site/area, by the same dentist/dental office and any other surgical procedure. Requests for individual consideration can always be submitted by report for dental consultant review.

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

GP Restorations or surgical procedures to correct congenital or developmental malformations are benefited unless for cosmetic reasons.

Extractions — includes local anesthesia, suturing if needed, and routine postoperative care

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

GP Infection control is included in the fee for the dental services provided. Separate fees are not billable to the patient. Infection control is considered a component of all dental procedures performed.

D7111 Extraction, coronal remnants — primary tooth. D7111 is considered part of any other primary surgery in the same surgical area on the same date and the fee is not billable to the patient if performed by the same dentist/dental office.

D7140 Extraction, erupted tooth or exposed root — elevation and/or forceps removal.

Surgical extractions — includes local anesthesia, suturing if needed and routine postoperative care.

GP Biopsies are done to obtain a sample of diseased tissue for laboratory examination. The pathology report is sufficient evidence that a biopsy has been done and submitted for examination. A separate laboratory fee is not a benefit.

D7210 Extraction — erupted tooth requiring removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated.

D7220 Removal of impacted tooth — soft tissue.

D7230 Removal of impacted tooth — partially bony.

D7240 Removal of impacted tooth — completely bony.

D7241 Removal of impacted tooth — completely bony, with unusual surgical complications.

D7250 Removal of residual tooth roots — cutting procedure. The fee for root recovery is not billable to the patient if submitted in conjunction with a surgical extraction (in the same surgical area) by the same dentist/dental office.

D7251 Coronectomy — intentional partial tooth removal — impacted teeth only. Depending on the group coverage, coronectomy may be benefited under individual consideration and only for documented probable neurovascular complications as proximity to mental foramen, inferior alveolar nerve, sinus, etc. Benefit only under group/individual contracts that cover removal of impacted teeth. Note: Enhanced complexity due to angulation of the cuts to remove the crown and not disturb the roots (mobilize). Non-impacted tooth should be coded as a D3921.

D7252 Partial extraction for immediate implant placement. Benefits are DENIED unless covered by group/individual contract. If implant services are covered, benefits are limited to once per tooth, in conjunction with immediate implant placement.

Other surgical procedures

D7259 **Nerve dissection.** Benefits for nerve dissection are DENIED as a specialized procedure. Nerve dissection is part of D7241 and the fees are not billable to the patient when done on the same date of service.

D7260 **Oroantral fistula closure.**

D7261 **Primary closure of a sinus perforation.** When submitted with D7241, the fees for D7261 are not billable to the patient.

D7270 **Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.** Includes local anesthesia, suturing, postoperative care and removal of splint by the same dentist/dental office 30 days following the surgical procedure. The fees for these procedures in conjunction with D7270 are not billable to the patient by the same dentist/dental office and are DENIED to another dentist/dental office.

D7272 **Tooth transplantation — includes reimplantation from one site to another and splinting and/or stabilization.** The fee for tooth transplantation is DENIED.

D7280 **Exposure of an unerupted tooth.** Benefits are determined by group/individual contract. Benefits are DENIED in the absence of orthodontic benefits.

D7282 **Mobilization of erupted or malpositioned teeth to aid eruption.**

D7283 **Placement of device to facilitate eruption of impacted tooth.** Recommend as part of the orthodontic benefit. Benefits are DENIED unless covered by group/individual contract.

D7284 **Excisional biopsy of minor salivary glands.** If the pathology report is not included, the fees are not billable to the patient. The fee for biopsy of oral tissue is included in the fee for a surgical procedure (e.g., apicoectomy, extractions, etc.) and is not billable to the patient when performed by the same dentist/dental office in the same surgical area and on the same date of service.

D7285 **Incisional biopsy of oral tissue — hard (bone, tooth).** If the pathology report is not included, the fees are not billable to the patient. The fee for biopsy of oral tissue is included in the fee for a surgical procedure (for example apicoectomy, periodontal surgery and extractions) and is not billable to the patient when performed by the same dentist/dental office in the same surgical area and on the same date of service.

D7286 **Biopsy of oral tissue — soft (all others).** A fee for biopsy of oral tissue is not billable to the patient if not submitted with a pathology report. The fee for biopsy of oral tissue is not billable to the patient as included in the fee for a surgical procedure (e.g. apicoectomy, periodontal surgery, extractions) when performed by the same dentist/dental office in the same surgical area and on the same date of service.

D7287 **Exfoliative cytological sample collection.** By report and subject to coverage under the medical plan.

D7288 **Brush biopsy.** Benefits for brush biopsy are DENIED unless covered by group/individual contract. When covered:

a. D7288 is an appropriate adjunctive diagnostic procedure for a patient(s) with unexplained red or white oral lesions or a patient with an oral lesion who has significant risk factors.

b. A pathology report must be included.

D7290 **Surgical repositioning of teeth.** Benefit surgical repositioning including grafting procedures when covered by group/individual contract.

D7291 **Transseptal fiberotomy, supra crestal fiberotomy — by report.** Benefits for transseptal fiberotomy are DENIED unless covered by group/individual contract.

D7292 **Placement of temporary anchorage device; (screw retained plate) requiring flap.** Benefits are DENIED as a specialized technique.

D7293 **Placement of temporary anchorage device requiring flap.** Benefits are DENIED as a specialized technique.

D7294 **Placement of temporary anchorage device without flap.** Benefits are DENIED as a specialized technique.

D7295 **Harvest of bone for use in autogenous grafting procedure.** Benefits are DENIED unless covered by group/individual contract. Benefit if the companion oral surgery procedures (D7953 and D7955) are covered under the group/individual contract.

D7296 **Corticotomy — one to three teeth or tooth spaces — per quadrant.** Benefits for corticotomy procedures are DENIED as a specialized procedure.

D7297 **Corticotomy — four or more teeth or tooth spaces — per quadrant.** Benefits for corticotomy procedures are DENIED as a specialized procedure.

D7298 **Removal of temporary anchorage device [screw retained plate], requiring flap. Benefits are DENIED as a specialized procedure.** The fee for D7298 is included in the surgery and is not billable to the patient when done by the same dentist/dental office as D7292. Benefits are DENIED when done by a different dentist/dental office.

D7299 **Removal of temporary anchorage device, requiring flap.** Benefits are DENIED as a specialized procedure. The fee for D7299 is included in the surgery and is not billable to the patient when done by the same dentist/dental office as D7292. Benefits are DENIED when done by a different dentist/dental office.

D7300 **Removal of temporary anchorage device without flap.** Benefits are DENIED as a specialized procedure unless covered by group/individual contract. The fee for D7300

is included in the surgery and is not billable to the patient when done by the same dentist/dental office as D7292. Benefits are DENIED when done by a different dentist/dental office.

Alveoloplasty — Surgical preparation of ridge for dentures

GP A quadrant for oral surgery purposes is defined as four or more contiguous teeth and/or teeth spaces distal to the midline.

D7310 Alveoloplasty in conjunction with extractions — four or more teeth or tooth spaces — per quadrant. The fee for D7310 performed by the same dentist/dental office in the same surgical area on the same date of service as surgical extractions (D7210-D7230) is not billable to the patient. Fees are not billable to the patient no matter how many extractions are performed in the quadrant.

D7311 Alveoloplasty in conjunction with extractions — one to three teeth or tooth spaces — per quadrant. The fee for D7311 performed by the same dentist/dental office in the same surgical area on the same date of service as surgical extractions (D7210-D7230) is not billable to the patient.

D7320 Alveoloplasty not in conjunction with extractions — four or more teeth or tooth spaces per quadrant.

D7321 Alveoloplasty not in conjunction with extractions — one to three teeth or tooth spaces — per quadrant. Count tooth bounded spaces for D7321 partial quadrant code.

Vestibuloplasty

GP All procedures are by report and subject to coverage under the medical plan.

D7340 Vestibuloplasty — ridge extension — secondary epithelialization.

D7350 Vestibuloplasty — ridge extension — including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue.

Surgical excision of soft tissue lesions

GP All procedures are subject to coverage under the medical plan.

GP The fee for D7410 and D7411 is not billable to the patient as included in the fee for another surgery performed in the same area of the mouth on the same day by the same dentist/dental office.

GP Pathology laboratory report is required. If no report is submitted, the fee for the procedure is not billable to the patient.

D7410 **Excision of benign lesion up to 1.25 cm.** The fee for D7410 is not billable to the patient as included in the fee for another surgery in the same area of the mouth on the same day by the same dentist/dental office.

D7411 **Excision of benign lesion greater than 1.25 cm.** The fee for D7411 is not billable to the patient as included in the fee for another surgery in the same area of the mouth on the same day by the same dentist/dental office.

D7412 **Excision of benign lesion — complicated.** The fee for D7412 is not billable to the patient as included in the fee for another surgery in the same area of the mouth on the same date of service by the same dentist/dental office.

D7413 **Excision of malignant lesion up to 1.25 cm.** The fee for D7413 is not billable to the patient as included in the fee for another surgery in the same area of the mouth on the same date of service by the same dentist/dental office.

D7414 **Excision of malignant lesion greater than 1.25 cm.** The fee for D7414 is not billable to the patient as included in the fee for another surgery in the same area of the mouth on the same date of service by the same dentist/dental office.

D7415 **Excision of malignant lesion — complicated.** The fee for D7415 is not billable to the patient as included in the fee for another surgery in the same area of the mouth on the same day by the same dentist/dental office.

Surgical excision of intra-osseous lesions

GP All procedures are by report and subject to coverage under the medical plan.

GP Pathology laboratory report is required. If no report is submitted, the fee for the procedure is not billable to the patient.

GP The fee for D7450 and D7451 is not billable to the patient as included in the fee for another surgery performed in the same area of the mouth on the same day by the same dentist/dental office.

D7440 **Excision of malignant tumor — lesion diameter up to 1.25 cm.**

D7441 **Excision of malignant tumor — lesion diameter greater than 1.25 cm.**

D7450 **Removal of benign odontogenic cyst or tumor — lesion diameter up to 1.25 cm.** The fee for D7450 is not billable to the patient as included in the fee for another surgery in the same area of the mouth on the same date of service by the same dentist/dental office.

D7451 **Removal of benign odontogenic cyst or tumor — lesion diameter greater than 1.25 cm.** The fee for D7451 is not billable to the patient as included in the fee for another surgery in the same area of the mouth on the same date of service by the same dentist/dental office.

D7460 Removal of benign nonodontogenic cyst or tumor — lesion diameter up to 1.25 cm.

D7461 Removal of benign nonodontogenic cyst or tumor — lesion diameter greater than 1.25 cm.

D7465 Destruction of lesion(s) by physical or chemical method — by report.

Excision of bone tissue

GP All procedures are by report and subject to coverage under the medical plan.

D7471 Removal of lateral exostosis — maxilla or mandible. May be considered under the medical plan. D7471 is benefited based on individual consideration, by report.

D7472 Removal of torus palatinus. May be considered under the medical plan. Individual consideration by report.

D7473 Removal of torus mandibularis. May be considered under the medical plan. Individual consideration by report.

D7485 Reduction of osseous tuberosity.

D7490 Radical resection of maxilla or mandible. If considered under dental, the fee for D7490 is not billable to the patient unless pathology laboratory report is submitted.

Surgical incision

GP All procedures are not a benefit unless specifically covered by group/individual contract and are subject to coverage available under the medical plan. When covered, all procedures are by report and subject to coverage under medical. The fees for procedures that are an integral part of a primary procedure in the same surgical area by the same dentist/dental office should not be reported separately and are not billable to the patient.

D7509 Marsupialization of odontogenic cyst.

D7510 Incision and drainage of abscess — intraoral soft tissue. Fees for D7510 for incision and drainage of abscess are not billable to the patient when submitted on the same date of service with all surgery (D7000-D7999), and endodontic codes (D3000 D3999), and surgical periodontal procedures (D4210-D4285).

D7511 Incision and drainage of abscess-intraoral soft tissue — complicated — includes drainage of multiple fascial spaces. Fees for D7511 are not billable to the patient when submitted on the same date of service with all oral surgery (D7000-D7999), endodontic codes (D3000-D3999), and surgical periodontal procedures (D4210-D4285).

D7520 Incision and drainage of abscess — extra-oral soft tissue. Incision and drainage of abscess — extraoral soft tissue is a benefit only if dental-related infection is present.

D7521 **Incision and drainage of abscess — extra-oral soft tissue — complicated — includes drainage of multiple fascial spaces.** If it is not related to a dental infection, the fee for treatment is DENIED and the approved amount is collectable from the patient. All procedures are by report and are subject to coverage available under the medical plan.

D7530 **Removal of foreign body from mucosa, skin or subcutaneous alveolar tissue.** When covered by group/individual contract, pathology report is required.

D7540 **Removal of reaction producing foreign bodies — musculoskeletal system.** When covered by group/individual contract, pathology report is required.

D7550 **Partial ostectomy/sequestrectomy for removal of non-vital bone.** When covered by group/individual contract, pathology report is required.

D7560 **Maxillary sinusotomy for removal of tooth fragment or foreign body.** When covered by group/individual contract, pathology report is required.

Treatment of fractures — simple

GP All procedures are by report and are subject to coverage under the medical plan.

GP A separate fee for splinting, wiring or banding is not billable to the patient when performed by the same dentist/dental office rendering the primary procedure.

D7610 **Maxilla — open reduction — teeth immobilized if present.**

D7620 **Maxilla — closed reduction — teeth immobilized if present.**

D7630 **Mandible — open reduction — teeth immobilized if present.**

D7640 **Mandible — closed reduction — teeth immobilized if present.**

D7650 **Malar and/or zygomatic arch — open reduction.**

D7660 **Malar and/or zygomatic arch — closed reduction.**

D7670 **Alveolus — closed reduction, may include stabilization of teeth.**

D7671 **Alveolus — open reduction, may include stabilization of teeth.**

D7680 **Facial bones — complicated reduction with fixation and multiple surgical approaches.**

Treatment of fractures — compound

GP A separate fee for splinting, wiring or banding is not billable to the patient when performed by the same dentist/dental office rendering the primary procedure.

D7710 **Maxilla — open reduction.**

D7720 **Maxilla — closed reduction.**

D7730 **Mandible — open reduction.**

D7740 Mandible — closed reduction.

D7750 Malar and/or zygomatic arch — open reduction.

D7760 Malar and/or zygomatic arch — closed reduction.

D7770 Alveolus — open reduction stabilization of teeth.

D7771 Alveolus — closed reduction stabilization of teeth.

D7780 Facial bones — complicated reduction with fixation and multiple approaches.

Reduction of dislocation and management of other temporomandibular joint dysfunctions

GP All procedures are DENIED and the approved amount is collectable from the patient unless covered by the subscriber's group contract and are subject to coverage under the medical plan.

GP When covered by the subscriber's group contract all procedures are by report and subject to coverage under the medical plan. The fees for procedures that are an integral part of a primary procedure should not be reported separately and are not billable to the patient.

D7810 Open reduction of dislocation.

D7820 Closed reduction of dislocation.

D7830 Manipulation under anesthesia.

D7840 Condylectomy.

D7850 Surgical discectomy — with/without implant.

D7852 Disc repair.

D7854 Synovectomy.

D7856 Myotomy.

D7858 Joint reconstruction.

D7860 Arthrotomy.

D7865 Arthroplasty.

D7870 Arthrocentesis.

D7871 Non-arthroscopic lysis and lavage. The benefits for these services are DENIED unless the related TMJ services are covered under the group/individual contract.

D7872 Arthroscopy — diagnosis, with or without biopsy.

D7873 Arthroscopy — lavage and lysis of adhesions.

D7874 Arthroscopy — disc repositioning and stabilization.

D7875 Arthroscopy — synovectomy.

D7876 Arthroscopy — discectomy.

D7877 Arthroscopy — debridement.

D7880 Occlusal orthotic device — by report. All procedures are not a benefit unless specifically covered by group/individual contract and are subject to coverage available under the medical plan.

D7881 Occlusal orthotic device adjustment. Benefits for occlusal orthotic device adjustments are DENIED unless covered by group/individual contract. When covered by group/individual contract, fees for all adjustments within six months are not billable to the patient. Benefit one per year following six months from initial placement.

D7899 Unspecified TMD therapy — by report.

Repair of traumatic wounds

GP Repair of traumatic wounds is limited to oral structures.

Complicated suturing — reconstruction requiring delicate handling of tissues and wide undermining for meticulous closure

GP Complicated suturing is limited to oral structures.

D7910 Suture of small recent wounds — up to 5 cm.

D7911 Complicated suture — up to 5 cm.

D7912 Complicated suture — greater than 5 cm.

Other repair procedures

GP All procedures except D7961, D7962, D7963, D7970 and D7971 are by report and subject to coverage under medical plan.

D7920 Skin grafts — identify defect covered, location and type of graft.

D7921 Collection and application of autologous blood concentrate product. The fee for collection and application of autologous blood concentrate product is DENIED as investigational and is not a covered benefit.

D7922 Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization — per site. Placement of an intra-socket biological dressing to aid in hemostasis or clot stabilization is considered part of the extraction and/or post-operative procedure. A separate fee is not billable to the patient.

D7939 Indexing for osteotomy using dynamic robotic assisted or dynamic navigation. Benefits are DENIED as specialized technique.

GP All procedures are by report and are subject to coverage available under the medical plan.

D7940 Osteoplasty — for orthognathic deformities.

D7941 Ostectomy — mandibular rami.

D7943 Ostectomy — mandibular rami with bone graft; includes obtaining the graft.

D7944 Ostectomy — segmented or subapical — per sextant or quadrant.

D7945 Ostectomy — body of mandible.

D7946 LeFort I — maxilla — total.

D7947 LeFort I — maxilla — segmented.

D7948 LeFort II or LeFort III — osteoplasty of facial bones for midface hypoplasia or retusion — without bone graft.

D7949 LeFort II or LeFort III — with bone graft.

D7950 Osseous, osteoperiosteal, or cartilage graft of the mandible — autogenous or nonautogenous — by report. Subject to coverage available under the medical plan and are DENIED unless covered by group/individual contract. When covered, obtaining grafting material is part of D7950 and the fees are not billable to the patient.

D7951 Sinus augmentation with bone or bone substitutes via lateral open approach. Subject to coverage available under the medical plan. When billed in conjunction with implants, ridge augmentation, extraction sites, periradicular surgery, benefits are DENIED as a specialized procedure. Benefits for platelets are DENIED as investigational.

D7952 Sinus augmentation via vertical approach. Subject to coverage available under the medical plan. When billed in conjunction with implants, ridge augmentation, extraction sites, periradicular surgery, benefits are DENIED as a specialized procedure. Benefits for platelets are DENIED as investigational.

D7953 Bone replacement graft for ridge preservation — per site. A site is equal to one tooth (extraction or implant removal site). Benefits are by report and subject to coverage available under the medical plan and are DENIED, unless covered by group/individual contract. When covered, fees for D7953 are not billable to the patient on an edentulous ridge or on the same date of service as implant placement. Benefits are limited to one per extraction site. D7953 is only a benefit when done on the same site and on the same date of service as an extraction (D7140, D7210, D7220, D7230, D7240, D7241, D7250) or removal of an implant (D6100 and D6105). Benefits for D7953 are DENIED when performed on third molars.

D7955 Repair of maxillofacial soft and hard tissue defect.

D7956 Guided tissue regeneration, edentulous area — resorbable barrier — per site. Benefits for GTR when billed in conjunction with implants, soft tissue grafts on implants, ridge augmentation, ridge preservation/extraction sites, periradicular surgery, apicoectomy sites, hemisections, etc. are DENIED as a specialized procedure.

D7957 Guided tissue regeneration, edentulous area — nonresorbable barrier — per site. Benefits for GTR when billed in conjunction with implants, mucogingival/soft tissue grafts on implants, ridge augmentation, ridge preservation/extraction sites, periradicular surgery, apicoectomy sites, hemisections, etc. are DENIED as a specialized procedure. Benefits for GTR, in conjunction with mucogingival/soft tissue grafts in the same surgical area, are DENIED. Fees for re-entry for removal of the barrier material are not billable to the patient by the same dentist/dental office.

D7961 Buccal/labial frenectomy (frenulectomy). The fee for frenectomy is not billable to the patient when billed on the same date of service as any other surgical procedure(s) in the same surgical area by the same dentist/dental office.

D7962 Lingual frenectomy (frenulectomy). The fee for frenulectomy is not billable to the patient when billed on the same date as any other surgical procedure(s) in the same surgical area by the same dentist/dental office.

D7963 Frenuloplasty. A separate fee for frenuloplasty is not billable to the patient when billed in conjunction with any other surgical procedure(s) in the same surgical area by the same dentist/dental office.

D7970 Excision of hyperplastic tissue, per arch. The fee for excision of hyperplastic tissue is not billable to the patient when billed in conjunction with other surgical procedure(s) in the same surgical area by the same dentist/dental office.

D7971 Excision of pericoronal gingiva. The fee for excision of pericoronal gingiva is not billable to the patient when billed in conjunction with other surgical procedure(s) in the same surgical area by the same dentist/dental office.

D7972 Surgical reduction of fibrous tuberosity.

D7979 Nonsurgical sialolithotomy.

D7980 Surgical sialolithotomy.

D7981 Excision of salivary gland — by report.

D7982 Sialodochoplasty.

D7983 Closure of salivary fistula.

D7990 Emergency tracheotomy.

D7991 Coronoidectomy.

D7993 **Surgical placement of craniofacial implant — extra oral.** Subject to coverage available under the medical plan. Benefits are DENIED unless covered by group/individual contract.

D7994 **Surgical placement — zygomatic implant.** Medical coverage may include this procedure. Benefits are DENIED unless covered by group/individual contract. Subject to coverage available under the medical plan.

D7995 **Synthetic graft — mandible or facial bones — by report.**

D7996 **Implant — mandible for augmentation purposes — excluding alveolar ridge — by report.**

D7997 **Appliance removal (not by dentist who placed appliance) — includes removal of archbar.** The fee for appliance removal is DENIED as a noncovered procedure unless the contract specifies that the related oral surgery services are a benefit. If covered, not billable to the patient 45 days following appliance placement.

D7998 **Intraoral placement of a fixation device not in conjunction with fracture.** This procedure is by report and subject to coverage under the medical plan. This procedure is not billable to the patient by the same dentist/dental office when billed in conjunction with any surgical procedure not in conjunction with fractures for which splinting, wiring or banding is considered part of the complete procedure (e.g., D7270, D7272).

D7999 **Unspecified oral surgery procedure — by report.**

ORTHODONTICS (D8000-D8999)

Terms of group contracts vary. Policies in this Handbook that address benefits, limitations and exclusions are "model" policies that have not been tailored to reflect the specific terms of applicable group contracts. This Handbook may not fully or accurately reflect the terms of applicable group contracts and may be inconsistent with such terms. In all cases, the terms of group contracts take precedence over Handbook policies. Please contact the member company listed on the patient's identification card for the specific terms of a group contract.

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

GP Treating dentists must have arrangements for patients to seek emergency care.

GP Orthodontic services are only a benefit when they meet generally accepted clinical guidelines.

Dental consultant criteria/notes:

1. A comprehensive clinical evaluation should meet the current best practices, regardless if done in person or virtually, which includes presenting the patient with a treatment plan.
2. AAO states that a comprehensive clinical examination should include the following, with all findings documented in the patient's record:
   - An extra-oral facial assessment to determine the facial form, symmetry, soft-tissue harmony and status of the perioral musculature. This determines the patient's deviations from normal sagittal, vertical and transverse maxillofacial relationships and to assess the relationship of the dentition to the facial structures.
   - An intraoral examination to assess the condition of the hard and soft tissues of the mouth, (including the periodontium) and the static and functional status of the patient's occlusion.
   - An evaluation of the temporomandibular joint and associated musculature to assess function and disease.
   - Verification of the presence of any oral parafunctional habits.
3. Diagnostic records, along with a comprehensive examination and history, form the foundation upon which a diagnosis and treatment plan with options are built, and are a standard of orthodontic care.
4. Pretreatment unaltered diagnostic records for comprehensive orthodontic treatment should include the following to establish a baseline for documenting pre-existing conditions, treatment and/or growth changes:
   - Extra-oral and intraoral images (may include digital or video images) to supplement the clinical findings.
   - Dental casts (or digital models) to assess the inter-arch and intra-arch relationship of the teeth, to help determine arch length and width requirements and to assess arch symmetry.
   - Intraoral and/or panoramic radiographs to assess the condition and developmental status of the teeth and hard tissue supporting structures, and to identify any dental anomalies or pathology.
   - Radiographic imaging to permit relative evaluation of the size, shape and positions of the relevant hard and soft tissue craniofacial structures including the dentition, and to aid in the identification of skeletal anomalies and/or pathology. Three-dimensional cone-beam computed tomography (CBCT) may be used as an imaging source to obtain this information.

GP Surgical procedures should be reported separately under the appropriate procedure codes.

GP The benefit is based on the approved fee for conventional orthodontics. Any additional fee up to the submitted amount for Invisalign® is DENIED and collectable from the patient.

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

GP Infection control is included in the fee for the dental services provided. Separate fees are not billable to the patient. Infection control is considered a component of all dental procedures performed.

GP Direct to consumer orthodontic treatment requires an attestation by treating dentist (See Attestation Form).

GP Fees for final orthodontic records (images, photos, and models) are included in the treatment and not billable to the patient.

GP Benefits for restorations for altering occlusion, adjusting vertical dimension, replacing tooth structure lost by attrition, erosion, abrasion, abfraction, corrosion, TMD or for periodontal, orthodontic, or other splinting are DENIED, unless covered by group/individual contract.

Dentition

Primary dentition: Teeth developed and erupted first in order of time.

Transitional dentition: The final phase of the transition from primary to adult teeth, in which the deciduous molars and canines are in the process of shedding and the permanent successors are emerging.

Adolescent dentition: The dentition that is present after the normal loss of primary teeth and prior to cessation of growth that would affect orthodontic treatment.

Adult dentition: The dentition that is present after the cessation of growth that would affect orthodontic treatment.

All of the following orthodontic treatment codes may be used more than once for the treatment of a particular patient depending on the particular circumstance. A patient may require more than one limited or comprehensive procedure depending on their problems.

Limited orthodontic treatment should be used with:

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

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

Examples of this type of treatment would be treatment in an arch only to correct crowding, partial treatment to open spaces or upright a tooth for a bridge or implant and partial treatment for closure of a space(s).

Comprehensive orthodontic treatment should be used with:

There are multiple phases of orthodontic treatment provided at different states of dentofacial development. For example, the use of an activator is generally stage one of a two-stage treatment.

In this situation, placement of fixed appliances will generally be stage two of a two-stage treatment. Both phases should be listed as comprehensive treatment modified by the appropriate stage of dental development. This is used to report coordinated diagnosis and treatment leading to the improvement of the patient's craniofacial dysfunction and/or dentofacial deformity including anatomical, functional, aesthetic relationships. Treatment usually, but not necessarily, utilizes fixed orthodontic appliances. Adjunctive procedures, such as extractions, maxillofacial surgery, nasopharyngeal surgery, myofunctional or speech therapy and restorative or periodontal care may be coordinated disciplines. Optimal care requires long-term consideration of patient's need and periodic reevaluation. Treatment may incorporate several phases with specific objectives at various stages of dentofacial development.

Limited orthodontic treatment

D8010 Limited orthodontic treatment of the primary dentition.

D8020 Limited orthodontic treatment of the transitional dentition.

D8030 Limited orthodontic treatment of the adolescent dentition.

D8040 Limited orthodontic treatment of the adult dentition.

Comprehensive orthodontic treatment

D8070 Comprehensive orthodontic treatment of the transitional dentition. Benefits are DENIED when the supporting documentation does not meet the criteria for coverage.

D8080 Comprehensive orthodontic treatment of the adolescent dentition. Benefits are DENIED when the supporting documentation does not meet the criteria for coverage.

D8090 Comprehensive orthodontic treatment of the adult dentition. Benefits are DENIED when the supporting documentation does not meet the criteria for coverage.

D8091 Comprehensive orthodontic treatment with orthognathic surgery. Benefits are DENIED when the supporting documentation does not meet the criteria for coverage. Fees for limited orthodontic treatment (D8010-D8040) and comprehensive orthodontic treatment (D8070-D8090) when submitted on the same date of service as D8091 are not billable to the patient.

Minor treatment to control harmful habits

D8210 Removable appliance therapy.

D8220 Fixed appliance therapy.

Other orthodontic services

D8660 Pre-orthodontic treatment examination to monitor growth and development. Benefit for patients with orthodontic coverage. Not a benefit for patients with orthodontic treatment history. Benefits are DENIED. Fees for D8660 are not billable to the patient with any other evaluation (D0120-D0180). D8660 is included in the evaluation frequency limits. Fees for D8660 are not billable to the patient when submitted with D8070, D8080, D8090.

D8670 Periodic orthodontic treatment visit. Fees for D8670 are not billable to the patient when done on the same date of service as D8671.

D8671 Periodic orthodontic treatment visit associated with orthognathic surgery. Fees for D8670 are not billable to the patient when done on the same date of service as D8091.

D8680 Orthodontic retention — removal of appliances, construction and placement of retainer(s). A separate fee for orthodontic retention is not billable to the patient within 24 months unless performed by a different dentist and the lifetime orthodontic maximum have not been reached. D8680 submitted after 24 months is DENIED.

D8681 Removable orthodontic retainer adjustment. Fees for removable orthodontic retainer adjustments are not billable to the patient if performed by the same dentist/dental office providing orthodontic treatment. Benefits are DENIED if performed by a different dentist/dental office.

D8695 Removal of fixed orthodontic appliance(s) — other than at conclusion of treatment. Benefits for patient requested removal of fixed orthodontic appliance(s) are DENIED.

D8696 Repair or orthodontic appliance — maxillary. This procedure is generally excluded by group/individual contract. In the absence of a contractual exclusion, benefit as submitted.

D8697 Repair or orthodontic appliance — mandibular. This procedure is generally excluded by group/individual contract. In the absence of a contractual exclusion, benefit as submitted.

D8698 Recement or rebond fixed retainer — maxillary. This procedure is included in the orthodontic case fee. A separate fee is not billable to the patient anytime following placement of the fixed retainer by the same dentist/dental office. In cases where there are excessive or continuous recements and rebonds, individual consideration can always be given. In the case where a different dentist/dental office is recementing/rebonding the fixed retainer, a separate benefit may be given once in a lifetime and benefits for any additional D8698 are DENIED.

D8699 Recement or rebond fixed retainer — mandibular. This procedure is included in the orthodontic case fee. A separate fee is not billable to the patient anytime following placement of the fixed retainer by the same dentist/dental office. In cases where there are excessive or continuous recements and rebonds, individual consideration can always be given. In the case where a different dentist/dental office is recementing/rebonding the fixed retainer, a separate benefit may be given once in a lifetime and benefits for any additional D8699 are DENIED.

D8701 Repair of fixed retainer, includes reattachment — maxillary. This procedure is included in the orthodontic case fee. A separate fee is not billable to the patient within 24 months following placement of the fixed retainer by the same dentist/dental office. In cases where there are excessive or continuous repairs, individual consideration can always be given. D8701 submitted after 24 months of placement is DENIED. In the case where a different dentist/dental office is recementing/rebonding the fixed retainer a separate benefit may be given once per lifetime and benefits for any additional D8701 are DENIED.

D8702 Repair of fixed retainer, includes reattachment — mandibular. This procedure is included in the orthodontic case fee. A separate fee is not billable to the patient within 24 months following placement of the fixed retainer by the same dentist/dental office. In cases where there are excessive or continuous repairs, individual consideration can always be given. D8702 submitted after 24 months of placement is DENIED. In the case where a different dentist/dental office is recementing/rebonding the fixed retainer a separate benefit may be given once per lifetime and benefits for any additional D8702 are DENIED.

D8703 Replacement of lost or broken retainer — maxillary. Benefits subject to orthodontic coverage. Benefits are DENIED within 12 months of completion of orthodontic treatment. After 12 months, benefit once per lifetime.

D8704 Replacement of lost or broken retainer — mandibular. Benefits subject to orthodontic coverage. Benefits are DENIED within 12 months of completion of orthodontic treatment. After 12 months, benefit once per lifetime.

D8999 Unspecified Orthodontic procedure — by report.

ADJUNCTIVE GENERAL SERVICES (D9110-D9949, D9950-D9952, D9970-D9999)

Terms of group contracts vary. Policies in this Handbook that address benefits, limitations and exclusions are "model" policies that have not been tailored to reflect the specific terms of applicable group contracts. This Handbook may not fully or accurately reflect the terms of applicable group contracts and may be inconsistent with such terms. In all cases, the terms of group contracts take precedence over Handbook policies. Please contact the member company listed on the patient's identification card for the specific terms of a group contract.

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

GP Infection control is included in the fee for the dental services provided. Separate fees are not billable to the patient. Infection control is considered a component of all dental procedures performed.

Unclassified treatment

D9110 Palliative treatment of dental pain — per visit. The fee for palliative treatment is not billable to the patient when submitted with all CDT procedures except radiographic images (D0210-D0340) and diagnostic procedure codes (D0120-D0180 and D0460) and is performed by the same dentist/dental office on the same date of service.

D9120 Fixed partial denture sectioning. This procedure is only a benefit if a portion of the fixed prosthesis is to remain intact and serviceable following sectioning and extraction or other treatment. If this code is part of the process or removing and replacing a fixed prosthesis, it is considered integral to the fabrication of the new fixed prosthesis and a separate fee for this code is not billable to the patient. Fees for polishing and recontouring of the retained portion of the prosthesis are not billable to the patient.

D9128 Photobiomodulation therapy — first 15 minute increment, or any portion thereof. Fees for low level laser therapy are not billable to the patient when performed as part of another procedure. When billed as a standalone procedure, low level laser therapy is DENIED.

D9129 **Photobiomodulation therapy — subsequent 15 minute increment, or any portion thereof.** Fees for low level laser therapy are not billable to the patient when performed as part of another procedure. When billed as a standalone procedure, low level laser therapy is DENIED as investigational.

D9130 **Temporomandibular joint dysfunction — non-invasive physical therapies.** Non-invasive TMD physical therapies are DENIED unless covered by group/individual contract. If covered by group/individual contract, benefit once every 12 months.

Anesthesia

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

Providing more than one hour of deep sedation or general anesthesia for routine dental procedures is unusual and additional submissions should only be considered on a by report basis. When documentation of exceptional circumstances is submitted, benefits may be approved, dependent on group/individual contract language.

D9210 **Local anesthesia not in conjunction with operative or surgical procedures.**

D9211 **Regional block anesthesia.**

D9212 **Trigeminal division block anesthesia.**

D9215 **Local anesthesia in conjunction with operative or surgical procedures.** The fee for local anesthesia is not billable to the patient when performed on the same date of service as any other procedure. A separate fee for local anesthesia is not billable to the patient whether stand alone or in conjunction with any other procedure unless covered by the group/individual contract.

D9219 **Evaluation for moderate sedation — deep sedation or general anesthesia.** Benefits for D9219 are limited once per 12 months.

D9222 **Administration of deep sedation/general anesthesia — first 15 minute increment, or any portion thereof.** Benefit in conjunction with oral surgical procedures (D7000-D7999) when covered, or when necessary due to concurrent medical conditions. Otherwise, the benefit for deep sedation/general anesthesia is DENIED unless specifically covered by group/individual contract. Benefits for more than one hour of deep sedation is not billable to the patient unless clinical documentation supports more than an hour was necessary. For example, special health care needs patients may require additional units of anesthesia and more than one hour of

anesthesia may be a benefit according to group/individual contract. The benefit for deep sedation/general anesthesia is DENIED when billed by anyone other than an appropriately licensed and qualified provider.

D9223 **Administration of Deep sedation/general anesthesia — each subsequent 15 minute increment or any portion thereof.** Benefit in conjunction with oral surgical procedures (D7000-D7999) when covered, or when necessary due to concurrent medical conditions. Otherwise, the benefit for deep sedation/general anesthesia is DENIED unless specifically covered by group/individual contract. Benefits for more than one hour of deep sedation is not billable to the patient unless clinical documentation supports more than an hour was necessary. For example, special health care needs patients may require additional units of anesthesia and more than one hour of anesthesia may be a benefit according to group/individual contract. General anesthesia, IV sedation, enteral anesthesia, parenteral anesthesia or nitrous oxide may be a benefit for patients through age six or those with special health care needs. The benefit for deep sedation/general anesthesia is DENIED when billed by anyone other than an appropriately licensed and qualified provider.

D9224 **Administration of general anesthesia with advanced airway — first 15 minute increment or any portion thereof.** Benefit in conjunction with oral surgical procedures (D7000-D7999) when covered, or when necessary due to concurrent medical conditions. Otherwise, the benefit for deep sedation/general anesthesia is DENIED unless specifically covered by group/individual contract. Benefits for more than one hour of deep sedation are not billable to the patient unless clinical documentation supports more than an hour was necessary. For example, special health care needs patients may require additional units of anesthesia and more than one hour of anesthesia may be a benefit according to group/individual contract. Benefits for deep sedation/general anesthesia are DENIED when billed by anyone other than an appropriately licensed and qualified provider.

D9225 **Administration of general anesthesia with advanced airway — each subsequent 15 minute increment or any increment thereof.** Benefit in conjunction with oral surgical procedures (D7000-D7999) when covered, or when necessary, due to concurrent medical conditions. Otherwise, the benefit for deep sedation/general anesthesia is DENIED unless specifically covered by group/individual contract. Benefits for more than one hour of deep sedation are not billable to the patient unless clinical documentation supports more than an hour was necessary. For example, special health care needs patients may require additional units of anesthesia and more than one hour of anesthesia may be a benefit according to group/individual contract. Benefits for deep sedation/general anesthesia are DENIED when billed by anyone other than an appropriately licensed and qualified provider.

D9230 Administration of nitrous oxide. The fee for analgesia is DENIED and the approved amount is collectable from the patient. When covered by group contract inhalation of nitrous oxide/anxiolysis, analgesia is not billable to the patient when submitted more than once on the same date, and/or in conjunction with IV sedation and general anesthesia. Fees for D9230 are not billable to the patient in conjunction with IV sedation (D9239 and D9243) and general anesthesia (D9222, D9223, D9224 and D9225). General anesthesia, IV sedation, enteral anesthesia, parenteral anesthesia or nitrous oxide may be a benefit for patients through age six or those with special health care needs.

D9239 Administration of moderate sedation intravenous — first 15 minute increment or any portion thereof. Intravenous moderate (conscious) sedation/analgesia is a benefit only when administered; (1) in a dental office with appropriate monitoring by an appropriately licensed and qualified dentist who is acting in compliance with applicable rules and regulations, and (2) in conjunction with oral surgical procedures (D7000-D7999) when covered, or when necessary due to concurrent medical conditions. Otherwise, the benefit for intravenous moderate (conscious) sedation/analgesia is DENIED. Benefits for more than one hour of sedation is not billable to the patient unless clinical documentation (e.g., anesthesia record) supports more than an hour was necessary. The benefit for intravenous moderate (conscious) sedation/analgesia is DENIED when billed by anyone other than an appropriately licensed and qualified dentist. General anesthesia, IV sedation, enteral anesthesia, parenteral anesthesia or nitrous oxide may be a benefit for patients through age six or those with special health care needs.

D9243 Administration of moderate sedation intravenous — each subsequent 15 minute increment or any portion thereof. Intravenous sedation/analgesia is a benefit only when administered by a properly licensed dentist in a dental office in conjunction with specific oral surgery procedures (D7000-D7999) when covered or when necessary due to concurrent medical conditions. Otherwise the fee for intravenous conscious sedation/analgesia is DENIED and the approved amount is collectable from the patient. Anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of a trained personnel and the doctor may safely leave the room to attend to other patients or duties. The fee for intravenous sedation/analgesia is DENIED and the approved amount is collectable from the patient when billed by anyone other than a licensed and qualified dentist. General anesthesia, IV sedation, enteral anesthesia, parenteral anesthesia or nitrous oxide may be a benefit for patients through age six or those with special health care needs.

D9244 **In-office administration of minimal sedation — single drug — enteral.** Benefits D9244 are DENIED, unless the group/individual contract specifies that services are a covered benefit. Fees D9244 are not billable to the patient in conjunction with IV sedation (D9239 and D9243) and general anesthesia (D9222, D9223, D9224, D9225).

D9245 **Administration of moderate sedation — enteral.** Benefits for D9245 are DENIED, unless the group/individual contract specifies that services are a covered benefit. Fees for D9245 are not billable to the patient in conjunction with IV sedation (D9239 and D9243) and general anesthesia (D9222, D9223, D9224 and D9225).

D9246 **Administration of moderate sedation — non-intravenous parenteral — first 15 minute increment, or any portion thereof.** Benefits D9246 are DENIED, unless the group/individual contract specifies that services are a covered benefit. Fees D9246 are not billable to the patient in conjunction with IV sedation (D9239 and D9243) and general anesthesia (D9222, D9223, D9224, and D9225).

D9247 **Administration of moderate sedation — non-intravenous parenteral — each subsequent 15 minute increment, or any portion thereof.** Benefits D9247 are DENIED, unless the group/individual contract specifies that services are a covered benefit. Fees D9247 are not billable to the patient in conjunction with IV sedation (D9239 and D9243) and general anesthesia (D9222, D9223, D9224, and D9225).

Professional consultation

D9310 **Consultation — diagnostic service provided by dentist or physician other than requesting dentist or physician.** A separate fee for a consultation is not billable to the patient when billed in conjunction with an examination/evaluation by the same dentist/dental office. The fee for a consultation in connection with noncovered services is DENIED and the approved amount is collectable from the patient. Consultation (D9310) may be benefited when the service is provided by a dentist whose opinion or advice regarding an evaluation and/or management of a specific problem may be requested by another dentist, physician or appropriate service. The dentist performing the consultation may initiate diagnostic or therapeutic services. When covered, the consultation counts against the contractual evaluation frequency limitations.

D9311 **Consultation with medical health care professional.** Fees for the consultation with a health care professional concerning medical issues is not billable to the patient.

Professional visits

GP The fees for all procedures are DENIED and the approved amount is collectable from the patient.

D9410 **House/extended care facility call.** Benefits for house calls or extended care facility calls are DENIED unless covered by group/individual contract.

D9420 Hospital or ambulatory surgical center call. Benefits for hospital or ambulatory call are DENIED unless covered by group/individual contract.

D9430 Office visit for observation — during regularly-scheduled hours — no other services performed. Benefits for office visit for observation are DENIED. Fees for an office visit for observation are not billable to the patient when billed with other procedures.

D9440 Office visit — after regularly-scheduled hours. Benefits for an office visit-after regularly scheduled hours are DENIED.

D9450 Case presentation — subsequent to detailed and extensive treatment planning. The fee for extensive treatment planing is DENIED and the approved amount is collectable from the patient. The fees for routine treatment planning and case presentation are considered inclusive in an evaluation and are not billable to the patient. The fee for extensive treatment planning may be benefited for complex treatment planning cases involving multiple treatment disciplines and multiple providers of care. When covered, the D9450 is subject to the same frequency limitations and processing policies as a comprehensive evaluation (D0150).

Drugs

GP The fees for all procedures are DENIED and the approved amount is collectable from the patient.

D9610 Therapeutic drug injection — by report.

D9612 Therapeutic parenteral drugs — two or more administrations, different medications.

D9613 Infiltration of sustained release therapeutic drug — per quadrant. Benefits for infiltration of sustained release therapeutic drug are DENIED as a specialized procedure unless covered by group/individual contract. When covered: benefit D9613 once per date of service when submitted with extractions (D7220-D7241) and any additional D9613 submitted on the same date of service are not billable to the patient.

D9630 Drugs or medicaments dispensed in the office for home use. Benefits for therapeutic drug injection (D9610) or other drugs and/or medicaments (D9630) are DENIED.

Miscellaneous services

GP All teledentistry claims should include either procedure code D9995 or D9996. This is to identify how the treatment was delivered.

GP Benefits for restorations for altering occlusion, adjusting vertical dimension, replacing tooth structure lost by attrition, erosion, abrasion, abfraction, corrosion, TMD or for periodontal, orthodontic, or other splinting are DENIED, unless covered by group/individual contract.

D9910 **Application of desensitizing medicament.** The fee for application of desensitizing medicaments is DENIED and the approved amount is collectable from the patient.

D9911 **Application of desensitizing resin for cervical and/or root surface — per tooth.** The fee for application of a desensitizing resin is DENIED.

D9912 **Pre-visit patient screening.** The fee for a pre-visit patient screening is not billable to the patient.

D9913 **Administration of neuromodulators.** Benefits for D9913 are DENIED unless covered by group/individual contract.

D9914 **Administration of dermal fillers.** Benefits for D9914 are DENIED unless covered by group/individual contract.

D9920 **Behavior management — by report.** The fee for behavior management is DENIED and the approved amount is collectable from the patient.

D9930 **Treatment of complications (postsurgical) — unusual circumstances.** The fee for dry socket palliation is not billable to the patient within 30 days following the extraction and included in the fee for the extraction by the same dentist/dental office. Benefit treatment of routine complications if done by a different dentist/dental office. Treatment of dry socket benefit may be allowed in recognition of the fact that unusual complications can occasionally occur, but they are only allowed where the provider has furnished a complete documentation of the need for the service.

D9932 **Cleaning and inspection of removable complete denture — maxillary**. Fees for cleaning and inspection of a removable complete denture are not billable to the patient when done with a reline or rebase procedure. In all other instances, benefits for cleaning and inspection of a removable complete denture are DENIED unless covered by group/individual contract. When covered, only a benefit for fully edentulous patients. Benefits are included in prophylaxis frequency. The fee for D9932 is included in D1110 and is not billable to the patient on the same date of service.

D9933 **Cleaning and inspection of removable complete denture — mandibular.** Fees for cleaning and inspection of a removable complete denture are not billable to the patient when done with a reline or rebase procedure. When covered, count towards the contract prophylaxis frequency. In all other instances, benefits for cleaning and inspection of a removable complete denture are DENIED unless covered by group/individual contract. When covered, benefits are included in the prophylaxis frequency. Only a benefit for fully edentulous patients. The fee for D9933 is included in D1110 and is not billable to the patient on the same date of service.

D9934 **Cleaning and inspection of removable partial denture — maxillary.** Fees for cleaning and inspection of a removable partial denture are not billable to the patient when done with a reline or rebase procedure. In all other instances, benefits for cleaning and inspection of a removable partial denture are DENIED.

D9935 Cleaning and inspection of removable partial denture — mandibular. Fees for cleaning and inspection of a removable partial denture are not billable to the patient when done with a reline or rebase procedure. In all other instances, benefits for cleaning and inspection of a removable partial denture are DENIED.

D9936 Cleaning and inspection of an occlusal guard — per appliance. Benefits for cleaning and inspection of an occlusal guard are DENIED unless covered by group/individual contract. If covered, fees for cleaning and inspection of an occlusal guard are not billable to the patient when done with in conjunction with D9942. Benefit once every 12 months.

D9938 Fabrication of a custom removable clear plastic temporary aesthetic appliance. Benefits are DENIED unless covered by group/individual contract.

D9939 Placement of a custom removable clear plastic temporary aesthetic appliance. Benefits are DENIED unless covered by group/individual contract.

D9941 Fabrication of athletic mouthguard. Benefit once every 24 months for patients 18 and younger. For patients over age 18, benefits for D9941 are DENIED.

D9942 Repair or reline of occlusal guard. Occlusal guard and related repair and/or reline is not a covered benefit unless covered by group or individual contract. The fee is DENIED. If covered contractually, the fee for the occlusal guard includes any adjustment or repair required with six months of delivery. Fees for the adjustment or repair of the occlusal guard are not billable to the patient if performed by the same dentist/dental office within six months of initial placement. If covered contractually, the fee for repair of an occlusal guard cannot exceed one-half of the fee for a new appliance and any excess fee is not billable to the patient.

D9943 Occlusal guard adjustment. Benefits for occlusal guard adjustments are DENIED unless covered by group/individual contract. When covered by contract, all adjustments within six months are not billable to the patient. Allow one per year following six months from initial placement.

D9944 Occlusal guard — hard appliance — full arch. Benefits for occlusal guard are DENIED unless covered by group/individual contract. If covered by group contract, allow once every five years.

D9945 Occlusal guard — soft appliance — full arch. Benefits for occlusal guard is DENIED unless covered by group/individual contract. If covered by group contract, allow once every five years.

D9946 Occlusal guard — hard appliance — partial arch. Occlusal guard is not a covered benefit unless it is group/individual contract specified and is DENIED. If covered by group contract, allow once every five years.

D9950 Occlusion analysis — mounted case. Benefits for occlusion analysis are DENIED.

D9951 **Occlusal adjustment — limited.** Benefits for occlusal adjustment — limited are DENIED unless covered by group/individual contract.

D9952 **Occlusal adjustment — complete.** Benefits are DENIED unless covered by group/individual contract.

D9961 **Duplicate/copy patient's records.** Benefits for patient record duplications are DENIED.

D9970 **Enamel microabrasion.** The fees for procedure codes D9940-D9970 are DENIED and the approved amount is collectable from the patient.

D9971 **Odontoplasty — per tooth.** Benefits for D9971 when performed with restorations for altering occlusion, involving vertical dimension, replacing tooth structure lost by attrition, erosion, abrasion (wear) or for periodontal, orthodontic or other splinting are DENIED.

D9972 **External bleaching — per arch — performed in office.** Benefits for bleaching of teeth are DENIED unless covered by group/individual contract.

D9973 **External bleaching — per tooth.** Benefits for bleaching of teeth are DENIED unless covered by group/individual contract. If covered, allow once per 12 months per tooth. Benefits are DENIED within 12 months of D9972.

D9974 **Internal bleaching — per tooth.** Benefits for bleaching of teeth are DENIED unless covered by group/individual contract.

D9975 **External bleaching for home application — per arch — includes materials and fabrication of custom tray.** Benefits for bleaching of teeth are DENIED unless covered by group/individual contract.

D9985 **Sales tax.** Sales/service charges are not a benefit of dental plans and are DENIED.

D9986 **Missed appointment.** A missed appointment is not a procedure, therefore the benefit is DENIED.

D9987 **Canceled appointment.** A canceled appointment is not a procedure, therefore the benefit is DENIED.

D9990 **Certified translation or sign language services — per visit.** The fees for translation services are considered inclusive in overall patient management and are not billable to the patient, unless covered by group/individual contract.

D9991 **Dental case management — addressing appointment compliance barriers.** Fees for action taken to schedule and assure compliance with patient appointments are inclusive with office operations and are not billable to the patient.

D9992 **Dental case management — care coordination.** Fees for care coordination are considered inclusive in overall patient management and are not billable to the patient.

D9993 Dental case management — motivational interviewing. Motivational interviewing is not a covered benefit and is DENIED. Fees for motivational interviewing are not billable to the patient when submitted on same date of service as D1310, D1320, D1330.

D9994 Dental case management — patient eduction to improve oral health literacy. Patient education is not a benefit and is DENIED. Fees for patient education to improve oral health literacy are not billable to the patient when submitted on same date of service as D1301, D1310, D1320, D1321 and D1330.

D9995 Teledentistry — synchronous; real-time encounter. The fees for teledentistry — synchronous are considered inclusive in overall patient management and are not billable to the patient.

D9996 Teledentistry — asynchronous; information stored and forwarded to dentist for subsequent review. The fees for teledentistry — asynchronous are considered inclusive in overall patient management and are not billable to the patient.

D9997 Dental case management — patients with special care needs. The fees for patients with special health care needs are considered administrative and used to identify services provided to a particular type of patient and are not billable to the patient.

D9999 Unspecified adjunctive procedure — by report.

SLEEP APNEA SERVICES

GP Benefits for sleep apnea services are DENIED unless covered by group/individual contract.

D9947 Custom sleep apnea appliance fabrication and placement. Benefits are DENIED unless covered by group/individual contract. Subject to coverage under medical plan.

D9948 Adjustment of custom sleep apnea appliance. Benefits are DENIED unless covered by group/individual contract. When a benefit of the group/individual contract, the fees for adjustments custom sleep apnea appliance, if performed within six months of initial placement by the same dentist/dental office, are not billable to the patient. Fees for an adjustment if performed within six months of initial placement by a different dentist/dental office are DENIED.

D9949 Repair of a custom sleep apnea appliance. Benefits are DENIED unless covered by group/individual contract. Fees for repair of custom sleep apnea appliance, if performed within six months of initial placement, by the same dentist/dental office are not billable to the patient. Fees for an adjustment, if performed within six months of initial placement, by a different dentist/dental office are DENIED.

D9953 **Reline custom sleep apnea appliance — indirect.** Benefits DENIED unless covered by group/individual contract. Fees for reline of custom sleep apnea appliance, if performed within six months of initial placement, by the same dentist/dental office are not billable to the patient. Fees for reline, if performed within six months of initial placement, by a different dentist/dental office are DENIED

D9954 **Fabrication and delivery of oral appliance therapy (OAT) morning repositioning device.** Benefits are DENIED unless covered by group/individual contract.

D9955 **Oral appliance therapy (OAT) titration visit.** Benefits are DENIED unless covered by group/individual contract.

D9956 **Administration of a home sleep apnea test (Note: This is not the original diagnosis).** Benefits are DENIED unless covered by group/individual contract.

D9957 **Screening for sleep related breathing disorders.** Benefits are DENIED unless covered by group/individual contract. When covered, benefits are limited to twice per benefit year. Benefits for more than twice per benefit year are DENIED. Does not count towards annual frequency for evaluation.

D9959 **Unspecified sleep apnea services procedure — by report.**

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