CareFirst
Family of health care plans

Comprehensive Dental Reference Guide

Y0154_H7379-H6067_MA02252_C

PRD1163-1E (1/25)

Introduction

Please use the Comprehensive Dental Reference Guide when preparing your claims and pre-treatment estimates for CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc., (collectively, "CareFirst"), CareFirst BlueCross BlueShield Medicare Advantage, The Dental Network, and the Federal Employee Program®.

- **CDT code descriptions**
- **Utilization review perspectives on clinical presentations appropriate for benefit allowance**
- **CareFirst-required documentation to allow for processing**
- **Identification of codes that require a clinical review by our staff of licensed dentists**

Selecting the most appropriate code to describe treatment rendered and providing required documentation streamlines the claims submission process.

Note: These descriptions and directions are based on standard plan designs. Individual patient plans may vary. Verify benefits and eligibility for each patient before the appointment.

Table of Contents

CareFirst
Family of health care plans

Part 1: Diagnostic

Comprehensive Dental Reference Guide

Please use the Comprehensive Dental Reference Guide when preparing your claims and pre-treatment estimates for CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc., (collectively, "CareFirst"), CareFirst BlueCross BlueShield Medicare Advantage, The Dental Network, and the Federal Employee Program®.

- **CDT code descriptions**
- **Utilization review perspectives on clinical presentations appropriate for benefit allowance**
- **CareFirst-required documentation to allow for processing**
- **Identification of codes that require a clinical review by our staff of licensed dentists**

Selecting the most appropriate code to describe treatment rendered and providing required documentation streamlines the claims submission process.

These descriptions and directions are based on standard plan designs. Individual patient plans may vary. Verify benefits and eligibility for each patient before the appointment.

CareFirst
Family of health care plans

Diagnostic: D0100–D0999

The information provided is based on general clinical policy and can vary for each patient's plan. Verify benefits and eligibility for each patient before the appointment, as there are differences among plans. The following information gives generalized clinical requirements and guidance for each CDT code.

Diagnostic Services			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D0120	Periodic oral evaluation—established patient	Only one exam per provider per day will be covered; the benefit will be exhausted if the patient receives two routine exams at two different dental offices in one day. CareFirst will only pay for two exams per year, which can be any combination of D0120, D0145, D0150, or D0180. (A D0150 can only be paid once in three years per provider.) If a consult (D9310) is billed on the same service date by the same provider, the exam.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	Only one exam per provider per day will be covered; the benefit will be exhausted if the patient receives two routine exams at two different dental offices in one day. CareFirst will only pay for two exams per year, which can be any combination of D0120, D0145, D0150, or D0180. (A D0150 can only be paid once in three years per provider.) If a consult (D9310) is billed on the same service date by the same provider, the exam.	No documentation is required. Approval depends on the plan design's frequency limitation for the individual patient.
D0140	Limited oral evaluation—problem-focused	D0140 can be submitted for telehealth evaluation of a clinical issue along with D9995 (synchronous teledentistry visit) and covered/paid the same as in a dental office with the patient, provided images and discussion occur during that video visit.	No documentation is required. Approval depends on the plan design's frequency limitation for the individual patient.

*Check patient eligibility including age and frequency limitations for each service.

Diagnostic Services			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D0150	Comprehensive oral evaluation—new or established patient	Only one exam per provider per day will be covered; the benefit will be exhausted if the patient receives two routine exams at two different dental offices in one day. CareFirst will only pay for two exams per year, which can be any combination of D0120, D0145, D0150, or D0180. (A D0150 can only be paid once in three years per provider.) If a consult (D9310) is billed on the same service date by the same provider, the exam is considered inclusive of that consult.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D0160	Detailed and extensive oral evaluation—problem-focused, by report	These evaluations are performed to delve into significant and specific clinical issues, such as TMJ problems, sleep-related breathing disorders, exams that include complex medical conditions that may impact dental treatment plans, etc.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D0170	Re-evaluation, limited, problem-focused	This code is used when an extensive problem requires additional follow-up to ensure a successful outcome specific to the original problem-focused evaluation.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D0171	Re-evaluation, post-operative office visit	Post-operative visits are typically considered inclusive to the procedure performed. No additional charges are paid by either the patient or CareFirst.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D0180	Comprehensive periodontal evaluation—new or established patient	Only one exam of any type per provider per day will be covered. The benefit will be exhausted if the patient receives two routine exams at two different dental offices in one day. CareFirst will only pay for two exams per year, which can be any combination of D0120, D0145, D0150, or D0180. (A D0150 can only be paid once in three years per provider.) If a consult (D9310) is billed on the same service date by the same provider, the exam is considered inclusive to that consult.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D0190	Screening of a patient	D0190 is only covered by CareFirst if billed with D9995 as a virtual visit. This benefit is available once per provider per service date.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D0191	Assessment of a patient	Typically not covered.	n/a
D0210	Intraoral—comprehensive series of radiographic images	Most plans allow a benefit once every three years for a complete series (combined with D0330, panoramic X-ray). If seven or more radiographs (bitewings and/or periapicals) are taken on the same service date, the benefit for a full-mouth series will be considered instead of the individual fees for each radiograph. Occlusal radiographs are allowed as a separate benefit. Bitewings or periapicals billed on the same service date as the D0210 are considered inclusive and not chargeable separately.	No documentation is required. Approval depends on the plan design's frequency limitation for the individual patient.

*Check patient eligibility including age and frequency limitations for each service.

Diagnostic Services			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D0220	Intraoral—periapical—first radiographic image	Typically, four periapical X-rays or one bitewing procedure (any number of bitewings) will be paid separately with panoramic X-rays. Benefits for periapicals combined will not exceed that of the full series (see D0120). Be sure to use D0230 for the additional periapical films and not repeat the D0220 for multiple periapicals.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D0230	Intraoral—periapical—each additional radiographic image	Typically, four periapical X-rays or one bitewing procedure (any number of bitewings) will be paid separately with panoramic X-rays. Benefits for periapicals combined will not exceed that of the full series (see D0120). Be sure to use D0220 for the initial periapical film and D0230 for the additional periapicals.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D0240	Intraoral—occlusal radiographic image	Check eligibility and frequency limitations for this service for each patient.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D0250	Extraoral—2D projection radiographic image	Extraoral—2D projection radiographic image is considered a medical procedure. It may be billed under the patient's medical plan. It may or may not be covered.	n/a
D0251	Extraoral—posterior dental radiographic image	Extra-oral posterior dental radiographic image is considered a medical procedure. It may be billed under the patient's medical plan. It may or may not be covered.	n/a
D0270	Bitewing—single radiographic image	Check eligibility and frequency limitations for this service for each patient. Bitewing X-rays D0270, D0272, D0273 or D0274 are typically allowed with D0330 but are considered inclusive to D0210.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D0272	Bitewings—two radiographic images	Check eligibility and frequency limitations for this service for each patient. Bitewing X-rays D0270, D0272, D0273 or D0274 are typically allowed with D0330 but are considered inclusive to D0210.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D0273	Bitewings—three radiographic images	Check eligibility and frequency limitations for this service for each patient. Bitewing X-rays D0270, D0272, D0273 or D0274 are typically allowed with D0330 but are considered inclusive to D0210.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D0274	Bitewings—four radiographic images	Check eligibility and frequency limitations for this service for each patient. Bitewing X-rays D0270, D0272, D0273 or D0274 are typically allowed with D0330 but are considered inclusive to D0210.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D0277	Vertical bitewings—seven or eight radiographic images	Check eligibility and frequency limitations for this service for each patient. Bitewing X-rays D0277 are typically allowed with D0330 but are considered inclusive to D0210.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D0310	Sialography	Sialography is considered a medical procedure. It may be billed under the patient's medical plan. It may or may not be covered.	n/a

*Check patient eligibility including age and frequency limitations for each service.

Diagnostic Services			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D0321	Other temporomandibular joint radiographic images—by report	This is considered a medical procedure. It may be billed under the patient's medical plan. It may or may not be covered.	n/a
D0330	Panoramic radiographic image	Check eligibility and frequency limitations for this service for each patient. Benefit for D0210 or D0330 is typically allowed one time every three years. Four periapicals or one bitewing procedure are allowed with this service.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D0340	2D Cephalometric radiographic image	Check eligibility and frequency limitations for this service for each patient. The benefit is typically allowed once every three years. If taken for a medical diagnostic service instead of dental/ortho, submit to the medical plan for benefits.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D0350	oral/facial photographic images obtained intraorally or extraorally	Check eligibility and frequency limitations for this service for each patient. If covered, the benefit is typically limited to one per service date, not to exceed five photographic images per benefit period.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D0351	3D photographic image	Check eligibility and frequency limitations for this service for each patient. If covered, the benefit is typically limited to one per service date, not to exceed five photographic images per benefit period.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D0364	Cone beam CT capture and interpretation with limited field of view—less than one whole jaw	Typically not covered.	n/a
D0365	Cone beam CT capture and interpretation with field of view of one full dental arch—mandible	Typically not covered.	n/a
D0366	Interpretation with field of view of one full dental arch—maxilla, with or without cranium	Typically not covered.	n/a
D0367	Cone beam CT capture and interpretation with field of view of both jaws with or without cranium	Typically not covered.	n/a
D0368	Cone beam CT capture and interpretation for TMJ series, including two or more exposures	Typically not covered.	n/a
D0369	Maxillofacial MRI capture and interpretation	Typically not covered.	n/a

*Check patient eligibility including age and frequency limitations for each service.

Diagnostic Services			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D0370	Maxillofacial ultrasound capture and interpretation	Typically not covered.	n/a
D0371	Sialoendoscopy capture and interpretation	Typically not covered.	n/a
D0372	Intraoral tomosynthesis—comprehensive series of radiographic images	If covered, the benefit is typically allowed once every three years for a complete series (combined with D0210, comprehensive series of radiographs; D0330, panoramic X-ray). If seven or more intraoral tomosynthesis periapical radiograph procedures (D0374) are submitted with the same service date, the benefit for a full-mouth series of tomographs (D0372) will be considered instead of the individual fees for each tomograph. Any combination of periapical or bitewing intraoral tomographic procedures billed on the same service date as a D0372 is considered inclusive and not chargeable separately.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D0373	Intraoral tomosynthesis—bitewing radiographic image	Check eligibility and frequency limitations for this service for each patient. Bitewing tomographs are typically allowed with D0330 but are considered inclusive to D0210 or D0372.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D0374	Intraoral tomosynthesis—periapical radiographic image	Check eligibility and frequency limitations for this service for each patient. Benefits for four periapical X-rays (D0374) or one bitewing procedure (D0373) will be paid with panoramic X-rays. If seven or more intraoral tomosynthesis periapical radiograph procedures (D0374) are submitted with the same service date, the benefit for a full-mouth series of tomographs (D0372) will be considered instead of the individual fees for each tomograph. Any combination of periapical or bitewing intraoral tomographic procedures billed on the same service date as a D0372 is considered inclusive and not chargeable separately.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D0380	Cone beam CT image capture with limited field of view—less than one whole jaw	Typically not covered.	n/a
D0383	Cone beam CT image capture with field of view of both jaws, with or without cranium	Typically not covered.	n/a
D0384	Cone beam CT image capture for TMJ series, including two or more exposures	Typically not covered.	n/a
D0387	Intraoral tomosynthesis—comprehensive series of radiographic images—image capture only	Typically not covered.	n/a

*Check patient eligibility including age and frequency limitations for each service.

Diagnostic Services			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D0388	Intraoral tomosynthesis—bitewing radiographic image—image capture only	Typically not covered.	n/a
D0389	Intraoral tomosynthesis—periapical radiographic image—image capture only	Typically not covered.	n/a
D0391	Interpretation of diagnostic image by a practitioner not associated with the capture of the image, including report	Typically not covered.	n/a
D0394	Digital subtraction of two or more images or image volumes of the same modality	Typically not covered.	n/a
D0395	Fusion of two or more 3D image volumes from different modalities	Typically not covered.	n/a
D0396	3D printing of a 3D dental surface scan	Benefit available as required, but not on the same date as diagnostic casts.	n/a
D0411	HbA1c in-office point-of-service testing	Typically not covered.	n/a
D0412	Blood glucose level test—in-office using a glucose meter	Typically not covered.	n/a
D0414	Lab processing of microbial specimens to include culture/sensitivity studies, preparation and transmission of the report	This is considered a medical procedure. It may be billed under the patient's medical plan. It may or may not be covered.	n/a
D0145	Collection of microorganisms for culture and sensitivity	Considered for benefit only in cases when moderate to severe infection requires identification of the infective organism to effectively target antimicrobial therapy. This procedure requires a narrative and pathology report for medical necessity review.	Narrative or chart notes that give a clinical rationale for the procedure and a copy of the pathology report.
D0416	Viral culture	Typically not covered.	n/a
D0417	Collection and preparation of saliva samples for laboratory diagnostic testing	Typically not covered.	n/a
D0418	Analysis of saliva sample	Typically not covered.	n/a
D0419	Assessment of salivary flow by measurement	This may be considered a medical procedure and may be billed under the patient's medical plan.	

*Check patient eligibility including age and frequency limitations for each service.

Diagnostic Services			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D0422	Collection and preparation of genetic sample material for laboratory analysis and report	Typically not covered.	n/a
D0423	Genetic test for susceptibility to diseases, specimen analysis	Typically not covered.	n/a
D0425	Caries susceptibility tests	Typically not covered.	n/a
D0431	Adjunctive pre-dx test that aids in the detection of mucosal abnormalities, including premalignant and malignant lesions	Typically not covered.	n/a
D0460	Pulp vitality tests	Pulp tests are considered inclusive if billed on the same service date as the root canal treatment by the treating provider. Typically limited to two tests per year (per tooth).	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D0470	Diagnostic casts	Check eligibility and frequency limitations for this service for each patient. A benefit is available for this service, as required.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D0472	Accession of tissue, gross examination, prep and transmission of a written report	This is considered a medical procedure. It may be billed under the patient's medical plan. It may or may not be covered.	n/a
D0473	Accession of tissue, gross and microscopic examination, prep and transmission of a written report	This is considered a medical procedure. It may be billed under the patient's medical plan. It may or may not be covered.	n/a
D0474	Accession of tissue, gross and microscopic exam, includes assessment of margins, prep and transmission of a report	This is considered a medical procedure. It may be billed under the patient's medical plan. It may or may not be covered.	n/a
D0475	Decalcification procedure	Typically not covered.	n/a
D0476	Special stains for microorganisms	Typically not covered.	n/a
D0477	Special stains, not for microorganisms	Typically not covered.	n/a
D0478	Immunohistochemical stains	Typically not covered.	n/a
D0479	Tissue in-situ hybridization, including interpretation	Typically not covered.	n/a

*Check patient eligibility including age and frequency limitations for each service.

Diagnostic Services			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D0480	Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of a written report	This is considered a medical procedure. It may be billed under the patient's medical plan. It may or may not be covered.	n/a
D0481	Electron microscopy—diagnostic	Typically not covered.	n/a
D0482	Direct immunofluorescence	Typically not covered.	n/a
D0483	Indirect immunofluorescence	Typically not covered.	n/a
D0484	Consultation on slides prepared elsewhere	Typically not covered.	n/a
D0485	Consultation, including preparation of slides from biopsy material supplied by referring source	Typically not covered.	n/a
D0486	Accession of transepithelial cytologic smears, microscopic examination, preparation and transmission of written report	Check eligibility and frequency limitations for this service for each patient.	Pathology report needed for review.
D0502	Other oral pathology procedures, by report	This is considered a medical procedure. It may be billed under the patient's medical plan. It may or may not be covered.	n/a
D0600	Non-ionizing procedure capable to quantify/monitor/record changes in the structure of enamel, dentin and cementum	Typically not covered.	n/a
D0601	Caries risk assessment and documentation, with a finding of low-risk	Check eligibility and frequency limitations for this service for each patient. Typically not covered.	n/a
D0602	Caries risk assessment and documentation, with a finding of moderate risk	Check eligibility and frequency limitations for this service for each patient. Typically not covered.	n/a
D0603	Caries risk assessment and documentation, with a finding of high-risk	Check eligibility and frequency limitations for this service for each patient. Typically not covered.	n/a
D0604	Antigen testing for a public health-related pathogen, including coronavirus	This is considered a medical service. It may be billed under the patient's medical plan. It may or may not be covered.	n/a

*Check patient eligibility including age and frequency limitations for each service.

Diagnostic Services			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D0605	Antibody testing for a public health-related pathogen, including coronavirus	This is considered a medical service. It may be billed under the patient's medical plan. It may or may not be covered.	n/a
D0606	Molecular testing for a public health-related pathogen, including coronavirus	This is considered a medical service. It may be billed under the patient's medical plan. It may or may not be covered.	n/a
D0701	Panoramic radiographic image—image capture only	Considered inclusive to the capture and interpretation procedure.	n/a
D0702	2D cephalometric radiographic image—image capture only	Considered inclusive to the capture and interpretation procedure.	n/a
D0703	2D oral/facial photographic image obtained intra-orally or extra-orally—image capture only	Considered inclusive to the capture and interpretation procedure.	n/a
D0704	3D photographic image—image capture only	Considered inclusive to the capture and interpretation procedure.	n/a
D0705	Extraoral posterior dental radiographic image—image capture only	Considered inclusive to the capture and interpretation procedure.	n/a
D0706	Intraoral—occlusal radiographic image—image capture only	Considered inclusive to the capture and interpretation procedure.	n/a
D0707	Intraoral—periapical radiographic image—image capture only	Considered inclusive to the capture and interpretation procedure.	n/a
D0708	Intraoral—bitewing radiographic image—image capture only	Considered inclusive to the capture and interpretation procedure.	n/a
D0709	Intraoral—complete series of radiographic images—image capture only	Considered inclusive to the capture and interpretation procedure.	n/a
D0801	3D intraoral surface scan—direct	Considered inclusive to the restorative service.	n/a
D0802	3D dental surface scan—indirect	Considered inclusive to the diagnostic service.	n/a

*Check patient eligibility including age and frequency limitations for each service.

Diagnostic Services			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D0803	3D facial surface scan—direct	Check eligibility and frequency limitations for this service for each patient. Benefits are allowed once per service date, with no more than five scanned images per benefit period (similar to photographs).	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D0804	3D facial surface scan—indirect	Typically not covered.	n/a
D0999	Unspecified diagnostic procedure, by report	A narrative describing the procedure and rationale is required. The benefits will not be available if the description aligns with a noncovered service.	Submit a narrative that describes the service and the rationale for performing it.

*Check patient eligibility including age and frequency limitations for each service.

CareFirst
Family of health care plans

Part 2: Preventive

Comprehensive Dental Reference Guide

Please use the Comprehensive Dental Reference Guide when preparing your claims and pre-treatment estimates for CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc., (collectively, "CareFirst"), CareFirst BlueCross BlueShield Medicare Advantage, The Dental Network, and the Federal Employee Program®.

- **CDT code descriptions**
- **Utilization review perspectives on clinical presentations appropriate for benefit allowance**
- **CareFirst-required documentation to allow for processing**
- **Identification of codes that require a clinical review by our staff of licensed dentists**

Selecting the most appropriate code to describe treatment rendered and providing required documentation streamlines the claims submission process.

These descriptions and directions are based on standard plan designs. Individual patient plans may vary. Verify benefits and eligibility for each patient before the appointment.

CareFirst
Family of health care plans

Preventive: D1000–D1999

The information provided is based on general clinical policy and can vary for each patient's plan. Verify benefits and eligibility for each patient before the appointment, as there are differences among plans. The following information gives generalized clinical requirements and guidance for each CDT code.

Preventive			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D1110	Prophylaxis—adult	Benefits are typically allowed (at least) two times per contract year. Benefits for a prophy within one day of perio cleaning procedures (D4341, D4342, D4355 or D4910) are not available as they are considered inclusive of the perio procedures. Benefits for a prophy are not available less than one month after scaling in the presence of gingival inflammation, D4346, is performed.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D1120	Prophylaxis—child	Benefits are typically allowed (at least) two times per contract year. Benefits for a prophy within one day of perio cleaning procedures (D4341, D4342, D4355 or D4910) are not available as they are considered inclusive of the perio procedures. Benefits for a prophy are not available less than one month after scaling in the presence of gingival inflammation, D4346, is performed.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D1206	Topical application of fluoride varnish	Benefits are typically allowed (at least) two times per contract year, which would be any combination of topical application of fluoride varnish (D1206) or topical application of fluoride (D1208). A fluoride benefit is provided for non-Risk members up to the end of the year in which the member turns 19. Effective 8/1/21, the age limit no longer applies to Risk members. Fluoride is available to all patients who have a Risk plan.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.

*Check patient eligibility including age and frequency limitations for each service.

Preventive			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D1208	Topical application of fluoride	Benefits are typically allowed (at least) two times per contract year, which would be any combination of topical application of fluoride varnish (D1206) or topical application of fluoride (D1208). A fluoride benefit is provided for non-Risk members up to the end of the year in which the member turns 19. Effective 8/1/21, the age limit no longer applies to Risk members. Fluoride is available to all patients who have a Risk plan.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D1310	Nutritional counseling for control of dental disease	This service is considered inclusive of other services submitted and is not a covered benefit.	n/a
D1320	Tobacco counseling for the control and prevention of oral disease	This service is considered inclusive of other services submitted and is not a covered benefit.	n/a
D1321	Counseling for the control and prevention of adverse oral, behavioral and systemic health effects associated with high-risk substance use	This service is considered inclusive of other services submitted and is not a covered benefit.	n/a
D1330	Oral hygiene instructions	This service is considered inclusive of other services submitted and is not a covered benefit.	n/a
D1351	Sealant—per tooth	Benefits are typically allowed every three years per permanent molar tooth. A sealant benefit is typically provided up to the end of the year when the member turns 19.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D1352	Preventive resin restoration in a moderate to high caries risk patient—permanent tooth	Typically not covered.	n/a
D1353	Sealant repair, per tooth	This service is considered inclusive of the sealant procedure and is not a covered benefit.	n/a
D1354	Interim caries arresting medicament application—per tooth	This benefit is limited to one application per tooth surface/ lifetime. It is allowed when there is no history of restoration, including Caries preventive medicament application (D1355), on the surface reported on the same service date or before the medicament placement.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D1355	Caries preventive medicament application—per tooth	This benefit is limited to one application per tooth surface/ lifetime. It is allowed when there is no history of restoration, or interim caries arresting medicament application (D1354), on the surface reported on the same service date or before the medicament placement.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.

*Check patient eligibility including age and frequency limitations for each service.

Preventive			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D1510	Space maintainer—fixed—unilateral	Check eligibility (including age limits) and frequency limitations for this service for each patient. Include the tooth number of the lost primary tooth/teeth on the claim form. The benefit is allowed for prematurely lost primary teeth only.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D1516	Space maintainer—fixed—bilateral, maxillary	Check eligibility (including age limits) and frequency limitations for this service for each patient. Include the tooth number of the lost primary tooth/teeth on the claim form. The benefit is allowed for prematurely lost primary teeth only.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D1517	Space maintainer—fixed—bilateral, mandibular	Check eligibility (including age limits) and frequency limitations for this service for each patient. Include the tooth number of the lost primary tooth/teeth on the claim form. The benefit is allowed for prematurely lost primary teeth only.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D1520	Space maintainer—removable—unilateral	Check eligibility (including age limits) and frequency limitations for this service for each patient. Include the tooth number of the lost primary tooth/teeth on the claim form. The benefit is allowed for prematurely lost primary teeth only.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D1526	Space maintainer—removable—bilateral, maxillary	Check eligibility (including age limits) and frequency limitations for this service for each patient. Include the tooth number of the lost primary tooth/teeth on the claim form. The benefit is allowed for prematurely lost primary teeth only.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D1527	Space maintainer—removable—bilateral, mandibular	Check eligibility (including age limits) and frequency limitations for this service for each patient. Include the tooth number of the lost primary tooth/teeth on the claim form. The benefit is allowed for prematurely lost primary teeth only.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D1551	Re-cement or rebond bilateral space maintainer—maxillary	This benefit is typically available one time per 12 months per tooth. It is not available until six months have elapsed from the insertion date. Include the tooth number of the lost primary tooth/teeth on the claim form.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.

*Check patient eligibility including age and frequency limitations for each service.

Preventive			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D1552	Re-cement or rebond bilateral space maintainer—mandibular	This benefit is typically available one time per 12 months per tooth. It is not available until six months have elapsed from the insertion date. Include the tooth number of the lost primary tooth/teeth on the claim form.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D1553	Re-cement or re-bond unilateral space maintainer—per quadrant	This benefit is typically available one time per 12 months per tooth. It is not available until six months have elapsed from the insertion date. Include the tooth number of the lost primary tooth/teeth on the claim form.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D1556	Removal of a fixed unilateral space maintainer—per quadrant	A benefit is only available if the appliance is removed by a dentist other than the dentist who originally placed the appliance. If submitted by the dentist who originally placed the appliance, the service is considered inclusive and is non-billable.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D1557	Removal of fixed bilateral space maintainer—maxillary	A benefit is only available if the appliance is removed by a dentist other than the dentist who originally placed the appliance. If submitted by the dentist who originally placed the appliance, the service is considered inclusive and is non-billable.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D1558	Removal of fixed bilateral space maintainer—mandibular	A benefit is only available if the appliance is removed by a dentist other than the dentist who originally placed the appliance. If submitted by the dentist who originally placed the appliance, the service is considered inclusive and is non-billable.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D1575	Distal shoe space maintainer—fixed—unilateral	Check eligibility (including age limits) and frequency limitations for this service for each patient. Include the tooth number of the lost primary tooth/teeth on the claim form. The benefit is allowed for prematurely lost primary teeth only.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D1701	Pfizer-BioNTech Covid-19 vaccine administration—first dose (SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 1)	Vaccine administration is typically considered a medical procedure. It may be billed under the patient's medical plan. It may or may not be covered.	n/a
D1702	Pfizer-BioNTech Covid-19 vaccine administration—second dose (SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 2)	Vaccine administration is typically considered a medical procedure. It may be billed under the patient's medical plan. It may or may not be covered.	n/a
D1703	Moderna Covid-19 vaccine administration—first dose (SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 1)	Vaccine administration is typically considered a medical procedure. It may be billed under the patient's medical plan. It may or may not be covered.	n/a

*Check patient eligibility including age and frequency limitations for each service.

Preventive			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D1704	Moderna Covid-19 vaccine administration—second dose (SARSCOV2 COVID-19 VAC mRNA 100mcg/0.5mL IM DOSE 2)	Vaccine administration is typically considered a medical procedure. It may be billed under the patient's medical plan. It may or may not be covered.	n/a
D1705	AstraZeneca Covid-19 vaccine administration—first dose (SARSCOV2 COVID-19 VAC rS-ChAdOx1 5x1010 VP/.5mL IM DOSE 1)	Vaccine administration is typically considered a medical procedure. It may be billed under the patient's medical plan. It may or may not be covered.	n/a
D1706	AstraZeneca Covid-19 vaccine administration—second dose (SARSCOV2 COVID-19 VAC rS-ChAdOx1 5x1010 VP/.5mL IM DOSE 2	Vaccine administration is typically considered a medical procedure. It may be billed under the patient's medical plan. It may or may not be covered.	n/a
D1707	Janssen Covid-19 vaccine administration (SARSCOV2 COVID-19 VAC Ad26 5x1010 VP/.5mL IM SINGLE DOSE)—Reject V26Pfizer-BioNTech Covid-19 vaccine administration—first dose (SARSCOV2 COVID-19 VAC mRNA 30mcg/0.3mL IM DOSE 1)	Vaccine administration is typically considered a medical procedure. It may be billed under the patient's medical plan. It may or may not be covered.	n/a
D1781	Vaccine administration—Human Papillomavirus—Dose 1	Vaccine administration is typically considered a medical procedure. It may be billed under the patient's medical plan. It may or may not be covered.	n/a
D1782	Vaccine administration—Human Papillomavirus—Dose 2	Vaccine administration is typically considered a medical procedure. It may be billed under the patient's medical plan. It may or may not be covered.	n/a
D1783	Vaccine administration—human papillomavirus—Dose 3	Vaccine administration is typically considered a medical procedure. It may be billed under the patient's medical plan. It may or may not be covered.	n/a
D1999	Unspecified preventive procedure, by report	D1999 was used during COVID-19 to pay for additional costs related to PPE. Effective 11/1/2020, this code is considered inclusive of other diagnostic or preventive procedures, and benefits are not available.	n/a

*Check patient eligibility including age and frequency limitations for each service.

CareFirst
Family of health care plans

Part 3: Restorative

Comprehensive Dental Reference Guide

Please use the Comprehensive Dental Reference Guide when preparing your claims and pre-treatment estimates for CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc., (collectively, "CareFirst"), CareFirst BlueCross BlueShield Medicare Advantage, The Dental Network, and the Federal Employee Program®.

- **CDT code descriptions**
- **Utilization review perspectives on clinical presentations appropriate for benefit allowance**
- **CareFirst-required documentation to allow for processing**
- **Identification of codes that require a clinical review by our staff of licensed dentists**

Selecting the most appropriate code to describe treatment rendered and providing required documentation streamlines the claims submission process.

These descriptions and directions are based on standard plan designs. Individual patient plans may vary. Verify benefits and eligibility for each patient before the appointment.

CareFirst
Family of health care plans

Restorative: D2000–D2999

The information provided is based on general clinical policy and can vary for each patient's plan. Verify benefits and eligibility for each patient before the appointment, as there are differences among plans. The following information gives generalized clinical requirements and guidance for each CDT code.

Restorative			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D2140	Amalgam—one surface, primary or permanent	Benefits are typically available once per 12 months per surface. If multiple restorations are reported on contiguous surfaces of the same tooth, the surfaces will be combined for an allowable benefit, e.g., if D2140 for #13-O is submitted with D2140 for #13-M, the benefit will be allowed for D2150—#13-MO. However, multiple restorations billed for non-contiguous surfaces will be paid individually. Note: indirect pulp caps (D3120) and considered inclusive to the restoration.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D2150	Amalgam—two surfaces, primary or permanent	Benefits are typically available once per 12 months per surface. If multiple restorations are reported on contiguous surfaces of the same tooth, the surfaces will be combined for an allowable benefit, e.g., if D2150 for #13-MO is submitted with D2150 for #13-DO, the benefit will be allowed for amalgam—three surfaces (D2160)—#13-MOD. Multiple restorations billed for non-contiguous surfaces will be paid individually. Note: Indirect pulp caps (D3120) are considered inclusive to the restoration.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.

*Check patient eligibility including age and frequency limitations for each service.

Restorative			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D2160	Amalgam—three surfaces, primary or permanent	Benefits are typically available once per 12 months per surface. If multiple restorations are reported on contiguous surfaces of the same tooth, the surfaces will be combined for an allowable benefit, e.g., if D2160 for #13-MOD is submitted with D2150 for #13-OL, the benefit will be allowed for D2161—#13-MODL. However, multiple restorations billed for non-contiguous surfaces will be paid individually. Note: indirect pulp caps (D3120) and considered inclusive to the restoration.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D2161	Amalgam—four or more surfaces, primary or permanent	Benefits are typically available once per 12 months per surface. If multiple restorations are reported on contiguous surfaces of the same tooth, the surfaces will be combined for an allowable benefit, e.g., if D2161 for #13-MODB is submitted with D2150 for #13-OL, the benefit will be allowed for D2161—#13-MODBL. However, multiple restorations billed for non-contiguous surfaces will be paid individually. Note: indirect pulp caps (D3120) and considered inclusive to the restoration.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D2330	Resin-based composite—one surface, anterior	Benefits are typically available once per 12 months per surface. If multiple restorations are reported on contiguous surfaces of the same tooth, the surfaces will be combined for an allowable benefit, e.g., if D2330 for #8-F is submitted with D2330 for #8-D, the benefit will be allowed for D2331—#8-DF. However, multiple restorations billed for non-contiguous surfaces will be paid individually. Note: indirect pulp caps (D3120) and considered inclusive to the restoration.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D2331	Resin-based composite—two surfaces, anterior	Benefits are typically available once per 12 months per surface. If multiple restorations are reported on contiguous surfaces of the same tooth, the surfaces will be combined for an allowable benefit, e.g., if D2331 for #8-MF is submitted with D2330 for #8-D, the benefit will be allowed for D2332—#8-MFD. However, multiple restorations billed for non-contiguous surfaces will be paid individually. Note: indirect pulp caps (D3120) and considered inclusive to the restoration.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D2332	Resin-based composite—three surfaces, anterior	Benefits are typically available once per 12 months per surface. If multiple restorations are reported on contiguous surfaces of the same tooth, the surfaces will be combined for an allowable benefit, e.g., if D2332 for #8-MFL is submitted with D2330 for #8-D, the benefit will be allowed for D2335—#8-MFDL. However, multiple restorations billed for non-contiguous surfaces will be paid individually. Note: indirect pulp caps (D3120) and considered inclusive to the restoration.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.

*Check patient eligibility including age and frequency limitations for each service.

Restorative			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D2335	Resin-based composite—four or more surfaces	Benefits are typically available once per 12 months per surface. If multiple restorations are reported on contiguous surfaces of the same tooth, the surfaces will be combined for an allowable benefit, e.g., if D2332 for #8-MFL is submitted with D2330 for #8-D, the benefit will be allowed for D2335—#8-MFDL. However, multiple restorations billed for non-contiguous surfaces will be paid individually. Note: indirect pulp caps (D3120) and considered inclusive to the restoration.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D2390	Resin-based, composite crown—anterior	When this benefit is covered, it is provided once every five years.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D2391	Resin-based, composite, one surface—posterior	Benefits are typically available once per 12 months per surface. If multiple restorations are reported on contiguous surfaces of the same tooth, the surfaces will be combined for an allowable benefit, e.g., if D2391 for #18-M is submitted with D2391 for #18-O, the benefit will be allowed for D2392—#18-MO. However, multiple restorations billed for non-contiguous surfaces will be paid individually. Note: indirect pulp caps (D3120) and considered inclusive to the restoration.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D2392	Resin-based, composite, two surfaces—posterior	Benefits are typically available once per 12 months per surface. If multiple restorations are reported on contiguous surfaces of the same tooth, the surfaces will be combined for an allowable benefit, e.g., if D2392 for #18-MO is submitted with D2392 for #18-DO, the benefit will be allowed for D2393—#18-MOD. However, multiple restorations billed for non-contiguous surfaces will be paid individually. Note: indirect pulp caps (D3120) and considered inclusive to the restoration.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D2393	Resin-based, composite, three surfaces—posterior	Benefits are typically available once per 12 months per surface. If multiple restorations are reported on contiguous surfaces of the same tooth, the surfaces will be combined for an allowable benefit, e.g., if D2393 for #18-MOB is submitted with D2392 for #18-DO, the benefit will be allowed for D2394—#18-MODB. However, multiple restorations billed for non-contiguous surfaces will be paid individually. Note: indirect pulp caps (D3120) and considered inclusive to the restoration.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D2394	Resin-based, composite, four or more surfaces—posterior	Benefits are typically available once per 12 months per surface. If multiple restorations are reported on contiguous surfaces of the same tooth, the surfaces will be combined for an allowable benefit, e.g., if D2394 for #18-MODB is submitted with D2392 for #18-OL, the benefit will be allowed for D2394—#18-MODBL. However, multiple restorations billed for non-contiguous surfaces will be paid individually. Note: indirect pulp caps (D3120) and considered inclusive to the restoration.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.

*Check patient eligibility including age and frequency limitations for each service.

Restorative			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D2410	Gold foil—one surface	Typically not covered.	n/a
D2420	Gold foil—two surfaces	Typically not covered.	n/a
D2430	Gold foil—three surfaces	Typically not covered.	n/a
D2510	Inlay—metallic—one surface	Benefits are typically available once every five years per tooth. Limited to permanent teeth. Any restorative procedure must be required due to extensive caries or trauma. A direct restoration is not feasible. The patient has a documented allergy to direct restorative materials. Free of endodontic signs/symptoms. The tooth must present with a minimum of 50% bone support.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative periapical radiograph, rationale and date of prior placement. For endodontically treated teeth—post-operative periapical radiograph. In addition, an intraoral photo is recommended to demonstrate need.
D2520	Inlay—metallic—two surfaces	Benefits are typically available once every five years per tooth. Limited to permanent teeth. Any restorative procedure must be required due to extensive caries or trauma. A direct restoration is not feasible. The patient has a documented allergy to direct restorative materials. Free of endodontic signs/symptoms. The tooth must present with a minimum of 50% bone support.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative periapical radiograph, rationale and date of prior placement. For endodontically treated teeth—post-operative periapical radiograph. In addition, an intraoral photo is recommended to demonstrate need.
D2530	Inlay—metallic—three surfaces	Benefits are typically available once every five years per tooth. Limited to permanent teeth. Any restorative procedure must be required due to extensive caries or trauma. A direct restoration is not feasible. Free of endodontic signs/symptoms. The tooth must present with a minimum of 50% bone support.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative periapical radiograph, rationale and date of prior placement. For endodontically treated teeth—post-operative periapical radiograph. In addition, an intraoral photo is recommended to demonstrate need.
D2542	Onlay metallic—two surfaces	Benefits are typically available once every five years per tooth. Limited to permanent teeth. Any restorative procedure must be required due to extensive caries or trauma. A direct restoration is not feasible. Free of endodontic signs/symptoms. The tooth must present with a minimum of 50% bone support.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative periapical radiograph, rationale and date of prior placement. For endodontically treated teeth—post-operative periapical radiograph. In addition, an intraoral photo is recommended to demonstrate need.
D2543	Onlay metallic—three surfaces	Benefits are typically available once every five years per tooth. Limited to permanent teeth. Any restorative procedure must be required due to extensive caries or trauma. A direct restoration is not feasible. Free of endodontic signs/symptoms. The tooth must present with a minimum of 50% bone support.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative periapical radiograph, rationale and date of prior placement. For endodontically treated teeth—post-operative periapical radiograph. In addition, an intraoral photo is recommended to demonstrate need.

*Check patient eligibility including age and frequency limitations for each service.

Restorative			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D2544	Onlay metallic—four or more surfaces	Benefits are typically available once every five years per tooth. Limited to permanent teeth. Any restorative procedure must be required due to extensive caries or trauma. A direct restoration is not feasible. The patient has a documented allergy to direct restorative materials. Free of endodontic signs/symptoms. The tooth must present with a minimum of 50% bone support.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative periapical radiograph, rationale and date of prior placement. For endodontically treated teeth—post-operative periapical radiograph. In addition, an intraoral photo is recommended to demonstrate need.
D2610	Inlay—porcelain/ceramic—one surface	Benefits are typically available once every five years per tooth. Limited to permanent teeth. Any restorative procedure must be required due to extensive caries or trauma. A direct restoration is not feasible. The patient has a documented allergy to direct restorative materials. Free of endodontic signs/symptoms. The tooth must present with a minimum of 50% bone support.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative periapical radiograph, rationale and date of prior placement. For endodontically treated teeth—post-operative periapical radiograph. In addition, an intraoral photo is recommended to demonstrate need.
D2620	Inlay—porcelain/ceramic—two surfaces	Benefits are typically available once every five years per tooth. Limited to permanent teeth. Any restorative procedure must be required due to extensive caries or trauma. A direct restoration is not feasible. The patient has a documented allergy to direct restorative materials. Free of endodontic signs/symptoms. The tooth must present with a minimum of 50% bone support.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative periapical radiograph, rationale and date of prior placement. For endodontically treated teeth—post-operative periapical radiograph. In addition, an intraoral photo is recommended to demonstrate need.
D2630	Inlay—porcelain/ceramic—three or more surfaces	Benefits are typically available once every five years per tooth. Limited to permanent teeth. Any restorative procedure must be required due to extensive caries or trauma. A direct restoration is not feasible. The patient has a documented allergy to direct restorative materials. Free of endodontic signs/symptoms. The tooth must present with a minimum of 50% bone support.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative periapical radiograph, rationale and date of prior placement. For endodontically treated teeth—post-operative periapical radiograph. In addition, an intraoral photo is recommended to demonstrate need.
D2642	Onlay—porcelain/ceramic—two surfaces	Benefits are typically available once every five years per tooth. Limited to permanent teeth. Any restorative procedure must be required due to extensive caries or trauma. A direct restoration is not feasible. Free of endodontic signs/symptoms. The tooth must present with a minimum of 50% bone support.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative periapical radiograph, rationale and date of prior placement. For endodontically treated teeth—post-operative periapical radiograph. In addition, an intraoral photo is recommended to demonstrate need.
D2643	Onlay—porcelain/ceramic—three surfaces	Benefits are typically available once every five years per tooth. Limited to permanent teeth. Any restorative procedure must be required due to extensive caries or trauma. A direct restoration is not feasible. Free of endodontic signs/symptoms. The tooth must present with a minimum of 50% bone support.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative periapical radiograph, rationale and date of prior placement. For endodontically treated teeth—post-operative periapical radiograph. In addition, an intraoral photo is recommended to demonstrate need.

*Check patient eligibility including age and frequency limitations for each service.

Restorative			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D2644	Onlay—porcelain/ceramic—four or more surfaces	Benefits are typically available once every five years per tooth. Limited to permanent teeth. Any restorative procedure must be required due to extensive caries or trauma. A direct restoration is not feasible. Free of endodontic signs/symptoms. The tooth must present with a minimum of 50% bone support.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative periapical radiograph, rationale and date of prior placement. For endodontically treated teeth—post-operative periapical radiograph. In addition, an intraoral photo is recommended to demonstrate need.
D2650	Inlay—Resin-based composite—one surface	Benefits are typically available once every five years per tooth. Limited to permanent teeth. Any restorative procedure must be required due to extensive caries or trauma. A direct restoration is not feasible. The patient has a documented allergy to direct restorative materials. Free of endodontic signs/symptoms. The tooth must present with a minimum of 50% bone support.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative periapical radiograph, rationale and date of prior placement. For endodontically treated teeth—post-operative periapical radiograph. In addition, an intraoral photo is recommended to demonstrate need.
D2651	Inlay—Resin-based composite—two surfaces	Benefits are typically available once every five years per tooth. Limited to permanent teeth. Any restorative procedure must be required due to extensive caries or trauma. A direct restoration is not feasible. The patient has a documented allergy to direct restorative materials. Free of endodontic signs/symptoms. The tooth must present with a minimum of 50% bone support.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative periapical radiograph, rationale and date of prior placement. For endodontically treated teeth—post-operative periapical radiograph. In addition, an intraoral photo is recommended to demonstrate need.
D2652	Inlay—Resin-based composite—three or more surfaces	Benefits are typically available once every five years per tooth. Limited to permanent teeth. Any restorative procedure must be required due to extensive caries or trauma. A direct restoration is not feasible. The patient has a documented allergy to direct restorative materials. Free of endodontic signs/symptoms. The tooth must present with a minimum of 50% bone support.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative periapical radiograph, rationale and date of prior placement. For endodontically treated teeth—post-operative periapical radiograph. In addition, an intraoral photo is recommended to demonstrate need.
D2662	Onlay—Resin-based composite—two surfaces	Benefits are typically available once every five years per tooth. Limited to permanent teeth. Any restorative procedure must be required due to extensive caries or trauma. A direct restoration is not feasible. Free of endodontic signs/symptoms. The tooth must present with a minimum of 50% bone support.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative periapical radiograph, rationale and date of prior placement. For endodontically treated teeth—post-operative periapical radiograph. In addition, an intraoral photo is recommended to demonstrate need.
D2663	Onlay—Resin-based composite—three surfaces	Benefits are typically available once every five years per tooth. Limited to permanent teeth. Any restorative procedure must be required due to extensive caries or trauma. A direct restoration is not feasible. Free of endodontic signs/symptoms. The tooth must present with a minimum of 50% bone support.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative periapical radiograph, rationale and date of prior placement. For endodontically treated teeth—post-operative periapical radiograph. In addition, an intraoral photo is recommended to demonstrate need.

*Check patient eligibility including age and frequency limitations for each service.

Restorative			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D2664	Onlay—Resin-based composite—four or more surfaces	Benefits are typically available once every five years per tooth. Limited to permanent teeth. Any restorative procedure must be required due to extensive caries or trauma. A direct restoration is not feasible. Free of endodontic signs/symptoms. The tooth must present with a minimum of 50% bone support.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative periapical radiograph, rationale and date of prior placement. For endodontically treated teeth—post-operative periapical radiograph. In addition, an intraoral photo is recommended to demonstrate need.
D2710	Crown—resin-based composite (indirect)	Benefits are typically available once every five years per tooth. Limited to permanent teeth. Any restorative procedure must be required due to extensive caries or trauma. A direct restoration is not feasible. Free of endodontic signs/symptoms. The tooth must present with a minimum of 50% bone support.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative periapical radiograph, rationale and date of prior placement. For endodontically treated teeth—post-operative periapical radiograph. In addition, an intraoral photo is recommended to demonstrate need.
D2712	Crown—3/4 resin-based composite (indirect)	Benefits are typically available once every five years per tooth. Limited to permanent teeth. Any restorative procedure must be required due to extensive caries or trauma. A direct restoration is not feasible. Free of endodontic signs/symptoms. The tooth must present with a minimum of 50% bone support.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative periapical radiograph, rationale and date of prior placement. For endodontically treated teeth—post-operative periapical radiograph. In addition, an intraoral photo is recommended to demonstrate need.
D2720	Crown—resin with high noble metal	Benefits are typically available once every five years per tooth. Limited to permanent teeth. Any restorative procedure must be required due to extensive caries or trauma. A direct restoration is not feasible. Free of endodontic signs/symptoms. The tooth must present with a minimum of 50% bone support.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative periapical radiograph, rationale and date of prior placement. For endodontically treated teeth—post-operative periapical radiograph. In addition, an intraoral photo is recommended to demonstrate need.
D2721	Crown—resin with predominantly base metal	Benefits are typically available once every five years per tooth. Limited to permanent teeth. Any restorative procedure must be required due to extensive caries or trauma. A direct restoration is not feasible. Free of endodontic signs/symptoms. The tooth must present with a minimum of 50% bone support.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative periapical radiograph, rationale and date of prior placement. For endodontically treated teeth—post-operative periapical radiograph. In addition, an intraoral photo is recommended to demonstrate need.
D2722	Crown—resin with noble metal	Benefits are typically available once every five years per tooth. Limited to permanent teeth. Any restorative procedure must be required due to extensive caries or trauma. A direct restoration is not feasible. Free of endodontic signs/symptoms. The tooth must present with a minimum of 50% bone support.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative periapical radiograph, rationale and date of prior placement. For endodontically treated teeth—post-operative periapical radiograph. In addition, an intraoral photo is recommended to demonstrate need.

*Check patient eligibility including age and frequency limitations for each service.

Restorative			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D2740	Crown—porcelain/ceramic	Benefits are typically available once every five years per tooth. Limited to permanent teeth. Any restorative procedure must be required due to extensive caries or trauma. A direct restoration is not feasible. Free of endodontic signs/symptoms. The tooth must present with a minimum of 50% bone support.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative periapical radiograph, rationale and date of prior placement. For endodontically treated teeth—post-operative periapical radiograph. In addition, an intraoral photo is recommended to demonstrate need.
D2750	Crown—porcelain fused to high noble metal	Benefits are typically available once every five years per tooth. Limited to permanent teeth. Any restorative procedure must be required due to extensive caries or trauma. A direct restoration is not feasible. Free of endodontic signs/symptoms. The tooth must present with a minimum of 50% bone support.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative periapical radiograph, rationale and date of prior placement. For endodontically treated teeth—post-operative periapical radiograph. In addition, an intraoral photo is recommended to demonstrate need.
D2751	Crown—porcelain fused to predominantly base metal	Benefits are typically available once every five years per tooth. Limited to permanent teeth. Any restorative procedure must be required due to extensive caries or trauma. A direct restoration is not feasible. Free of endodontic signs/symptoms. The tooth must present with a minimum of 50% bone support.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative periapical radiograph, rationale and date of prior placement. For endodontically treated teeth—post-operative periapical radiograph. In addition, an intraoral photo is recommended to demonstrate need.
D2752	Crown—porcelain fused to noble metal	Benefits are typically available once every five years per tooth. Limited to permanent teeth. Any restorative procedure must be required due to extensive caries or trauma. A direct restoration is not feasible. Free of endodontic signs/symptoms. The tooth must present with a minimum of 50% bone support.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative periapical radiograph, rationale and date of prior placement. For endodontically treated teeth—post-operative periapical radiograph. In addition, an intraoral photo is recommended to demonstrate need.
D2753	Crown—porcelain fused to titanium and titanium alloys	Benefits are typically available once every five years per tooth. Limited to permanent teeth. Any restorative procedure must be required due to extensive caries or trauma. A direct restoration is not feasible. Free of endodontic signs/symptoms. The tooth must present with a minimum of 50% bone support.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative periapical radiograph, rationale and date of prior placement. For endodontically treated teeth—post-operative periapical radiograph. In addition, an intraoral photo is recommended to demonstrate need.
D2780	Crown—3/4 cast high noble metal	Benefits are typically available once every five years per tooth. Limited to permanent teeth. Any restorative procedure must be required due to extensive caries or trauma. A direct restoration is not feasible. Free of endodontic signs/symptoms. The tooth must present with a minimum of 50% bone support.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative periapical radiograph, rationale and date of prior placement. For endodontically treated teeth—post-operative periapical radiograph. In addition, an intraoral photo is recommended to demonstrate need.

*Check patient eligibility including age and frequency limitations for each service.

Restorative			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D2781	Crown—3/4 cast predominately base metal	Benefits are typically available once every five years per tooth. Limited to permanent teeth. Any restorative procedure must be required due to extensive caries or trauma. A direct restoration is not feasible. Free of endodontic signs/symptoms. The tooth must present with a minimum of 50% bone support.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative periapical radiograph, rationale and date of prior placement. For endodontically treated teeth—post-operative periapical radiograph. In addition, an intraoral photo is recommended to demonstrate need.
D2782	Crown—3/4 cast noble metal	Benefits are typically available once every five years per tooth. Limited to permanent teeth. Any restorative procedure must be required due to extensive caries or trauma. A direct restoration is not feasible. Free of endodontic signs/symptoms. The tooth must present with a minimum of 50% bone support.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative periapical radiograph, rationale and date of prior placement. For endodontically treated teeth—post-operative periapical radiograph. In addition, an intraoral photo is recommended to demonstrate need.
D2783	Crown—3/4 porcelain/ceramic	Benefits are typically available once every five years per tooth. Limited to permanent teeth. Any restorative procedure must be required due to extensive caries or trauma. A direct restoration is not feasible. Free of endodontic signs/symptoms. The tooth must present with a minimum of 50% bone support.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative periapical radiograph, rationale and date of prior placement. For endodontically treated teeth—post-operative periapical radiograph. In addition, an intraoral photo is recommended to demonstrate need.
D2790	Crown—full cast high noble metal	Benefits are typically available once every five years per tooth. Limited to permanent teeth. Any restorative procedure must be required due to extensive caries or trauma. A direct restoration is not feasible. Free of endodontic signs/symptoms. The tooth must present with a minimum of 50% bone support.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative periapical radiograph, rationale and date of prior placement. For endodontically treated teeth—post-operative periapical radiograph. In addition, an intraoral photo is recommended to demonstrate need.
D2791	Crown—full cast predominantly base metal	Benefits are typically available once every five years per tooth. Limited to permanent teeth. Any restorative procedure must be required due to extensive caries or trauma. A direct restoration is not feasible. Free of endodontic signs/symptoms. The tooth must present with a minimum of 50% bone support.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative periapical radiograph, rationale and date of prior placement. For endodontically treated teeth—post-operative periapical radiograph. In addition, an intraoral photo is recommended to demonstrate need.
D2792	Crown—full-cast noble metal	Benefits are typically available once every five years per tooth. Limited to permanent teeth. Any restorative procedure must be required due to extensive caries or trauma. A direct restoration is not feasible. Free of endodontic signs/symptoms. The tooth must present with a minimum of 50% bone support.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative periapical radiograph, rationale and date of prior placement. For endodontically treated teeth—post-operative periapical radiograph. In addition, an intraoral photo is recommended to demonstrate need.

*Check patient eligibility including age and frequency limitations for each service.

Restorative			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D2794	Crown—titanium	Benefits are typically available once every five years per tooth. Limited to permanent teeth. Any restorative procedure must be required due to extensive caries or trauma. A direct restoration is not feasible. Free of endodontic signs/symptoms. The tooth must present with a minimum of 50% bone support.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative periapical radiograph, rationale and date of prior placement. For endodontically treated teeth—post-operative periapical radiograph. In addition, an intraoral photo is recommended to demonstrate need.
D2799	Provisional crown—further treatment or completion of diagnosis necessary before final impression	Benefits for a provisional crown are considered inclusive to the benefits for the permanent crown and will not be billable to CareFirst or to the member.	n/a
D2910	Recement inlay, onlay, or partial coverage restoration	Benefits are typically available once in a 12-month period but not until after the restoration has been in place for six months.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D2915	Recement cast or prefabricated post and core	Benefits are typically available once in a 12-month period but not until after the P&C has been in place for six months.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D2920	Recement crown	Benefits are typically available once in a 12-month period but not until after the P&C has been in place for six months.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D2921	Reattachment of tooth fragment, incisal edge or cusp	Benefits are typically available once in a 12-month period and only for permanent teeth. If additional restorations are reported on contiguous surfaces of the same tooth, they will be combined with the reattachment benefit.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D2928	Prefabricated porcelain/ceramic crown—permanent tooth	Benefits are typically available once every five years per tooth. Limited to permanent teeth. Any restorative procedure must be required due to extensive caries or trauma. A direct restoration is not feasible. Free of endodontic signs/symptoms. The tooth must present with a minimum of 50% bone support.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative periapical radiograph, rationale and date of prior placement. For endodontically treated teeth—post-operative periapical radiograph. In addition, an intraoral photo is recommended to demonstrate need.
D2929	Prefabricated porcelain/ceramic crown—primary tooth	Typically not covered.	n/a
D2930	Prefabricated stainless steel crown—primary tooth	Benefits are typically available once every five years per tooth, with age limitations for the member. Any restorative procedure must be required due to extensive caries or trauma. A direct restoration is not feasible. Free of endodontic signs/symptoms. The tooth must present with a minimum of 50% bone support.	n/a
D2931	Prefabricated stainless steel crown—permanent tooth	Benefits are typically available once every five years per tooth, with age limitations for the member. Any restorative procedure must be required due to extensive caries or trauma. A direct restoration is not feasible. Free of endodontic signs/symptoms. The tooth must present with a minimum of 50% bone support.	n/a

*Check patient eligibility including age and frequency limitations for each service.

Restorative			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D2932	Prefabricated resin crown	Benefits are typically available once every five years per tooth, with age limitations for the member. Any restorative procedure must be required due to extensive caries or trauma. A direct restoration is not feasible. Free of endodontic signs/symptoms. The tooth must present with a minimum of 50% bone support.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative periapical radiograph, rationale and date of prior placement. For endodontically treated teeth—post-operative periapical radiograph. In addition, an intraoral photo is recommended to demonstrate need.
D2933	Prefabricated stainless steel crown with resin window	Benefits are typically available once every five years per tooth, with age limitations for the member. Any restorative procedure must be required due to extensive caries or trauma. A direct restoration is not feasible. Free of endodontic signs/symptoms. The tooth must present with a minimum of 50% bone support.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative periapical radiograph, rationale and date of prior placement. For endodontically treated teeth—post-operative periapical radiograph. In addition, an intraoral photo is recommended to demonstrate need.
D2934	Prefabricated esthetic coated stainless steel crown—primary tooth	Benefits are typically available once every five years per tooth, with age limitations for the member. Any restorative procedure must be required due to extensive caries or trauma. A direct restoration is not feasible. Free of endodontic signs/symptoms. The tooth must present with a minimum of 50% bone support.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative periapical radiograph, rationale and date of prior placement. For endodontically treated teeth—post-operative periapical radiograph. In addition, an intraoral photo is recommended to demonstrate need.
D2940	Placement of interim direct restoration	Benefits are typically available once per tooth per year and only when billed separately; if billed with another restoration, a direct/indirect pulp cap, or endodontic therapy, the protective restoration will be denied as inclusive.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D2949	Restorative foundation for an indirect restoration	This procedure is considered inclusive to all restorations and is not billable to the patient or CareFirst. Undercuts and suboptimal tapered wall shape are relieved with the foundation but it is not critical for retention of the final restoration.	n/a
D2950	Core buildup, including any pins when required	If covered, benefits are typically available once every five years per tooth; it is not payable if submitted with a post and care or with direct restorations, only with indirect restorations. A significant amount of tooth structure is missing, which does not allow for retention of the final restoration.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative periapical radiograph, rationale and date of prior placement. For endodontically treated teeth—post-operative periapical radiograph. In addition, an intraoral photo is recommended to demonstrate need.
D2951	Pin retention—per tooth, in addition to restoration	This benefit is available with direct restorations; up to four pins are allowed per tooth.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D2952	Post and core, in addition to crown, indirectly fabricated	If covered, benefits are typically available once every five years per tooth; it is not payable if submitted with direct restorations or a core buildup on the same tooth.	**Requires clinical review; pre-treatment estimate recommended.** Post-operative periapical radiograph showing the completed root canal.

*Check patient eligibility including age and frequency limitations for each service.

Restorative			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D2953	Each additional indirectly fabricated post—same tooth	If covered, benefits are typically available once every five years per tooth; it is not payable if submitted with direct restorations or a core buildup on the same tooth. It is only payable if submitted with D2952.	**Requires clinical review; pre-treatment estimate recommended.** Post-operative periapical radiograph showing the completed root canal.
D2954	Prefabricated post and core, in addition to crown	If covered, benefits are typically available once every five years per tooth; it is not payable if submitted with direct restorations or a core buildup on the same tooth.	**Requires clinical review; pre-treatment estimate recommended.** Post-operative periapical radiograph showing the completed root canal.
D2955	Post removal	The benefit is available as necessary.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D2956	Removal of an indirect restoration on a natural tooth	This procedures is considered inclusive to the primary restorative service that is performed after the removal of the restoration.	n/a
D2957	Each additional prefabricated post—same tooth	If covered, benefits are typically available once every five years per tooth; it is not payable if submitted with direct restorations or a core buildup on the same tooth. It is only payable if submitted with D2954.	**Requires clinical review; pre-treatment estimate recommended.** Post-operative periapical radiograph showing the completed root canal. (The coding manual doesn't have DDR review for this code)
D2960	Labial veneer (resin laminate)—chairside	This benefit is typically available once every five years per tooth and only if the tooth qualifies for full crown coverage based on clinical necessity.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative periapical radiograph, rationale and date of prior placement. For endodontically treated teeth—post-operative periapical radiograph. In addition, an intraoral photo is recommended to demonstrate need.
D2961	Labial veneer (resin laminate)—laboratory	This benefit is typically available once every five years per tooth and only if the tooth qualifies for full crown coverage based on clinical necessity.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative periapical radiograph, rationale and date of prior placement. For endodontically treated teeth—post-operative periapical radiograph. In addition, an intraoral photo is recommended to demonstrate need.
D2962	Labial veneer (porcelain laminate)—laboratory	This benefit is typically available once every five years per tooth and only if the tooth qualifies for full crown coverage based on clinical necessity.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative periapical radiograph, rationale and date of prior placement. For endodontically treated teeth—post-operative periapical radiograph. In addition, an intraoral photo is recommended to demonstrate need.

*Check patient eligibility including age and frequency limitations for each service.

Restorative			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D2971	Additional procedures to construct new crowns under existing partial denture framework	This benefit is typically available once every five years per tooth and only if the tooth qualifies for full crown coverage based on clinical necessity.	**Requires clinical review if performed on a primary tooth**; Pre-operative periapical radiograph, rationale and date of prior placement. For endodontically treated teeth—post-operative periapical radiograph. In addition, an intraoral photo is recommended to demonstrate need.
D2975	Coping	This benefit is available as required.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D2976	Band stabilization—per tooth	This benefit is considered inclusive to the permanent restoration.	n/a
D2980	Crown repair—necessitated by restorative material failure	The benefit is typically allowed once per tooth every 12 months.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D2981	Inlay repair—necessitated by restorative material failure	Typically not covered.	n/a
D2982	Onlay repair—necessitated by restorative material failure	Typically not covered.	n/a
D2983	Veneer repair—necessitated by restorative material failure	Typically not covered.	n/a
D2989	Excavation of a tooth resulting in the determination of non-restorability	This benefit is typically available once per lifetime per tooth.	**Requires clinical review if performed on a primary tooth;** Pre-operative periapical or bitewing radiograph; an intraoral photo is recommended to demonstrate need.
D2990	Resin infiltration of incipient smooth surface lesions	Typically not covered.	n/a
D2991	Application of hydroxyapatite regeneration medicament—per tooth	Typically not covered.	n/a
D2999	Unspecified restorative procedure, by report	If the service description is a procedure that is not covered, it will be denied with a specific reason. Describe the situation and why an existing code will not accurately represent the treatment performed.	**Requires clinical review with a narrative describing the clinical presentation and specific treatment that is not adequately captured with an existing CDT code.**

*Check patient eligibility including age and frequency limitations for each service.

CareFirst
Family of health care plans

Part 4: Endodontics

Comprehensive Dental Reference Guide

Please use the Comprehensive Dental Reference Guide when preparing your claims and pre-treatment estimates for CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc., (collectively, "CareFirst"), CareFirst BlueCross BlueShield Medicare Advantage, The Dental Network, and the Federal Employee Program®.

- **CDT code descriptions**
- **Utilization review perspectives on clinical presentations appropriate for benefit allowance**
- **CareFirst-required documentation to allow for processing**
- **Identification of codes that require a clinical review by our staff of licensed dentists**

Selecting the most appropriate code to describe treatment rendered and providing required documentation streamlines the claims submission process.

These descriptions and directions are based on standard plan designs. Individual patient plans may vary. Verify benefits and eligibility for each patient before the appointment.

CareFirst
Family of health care plans

Endodontics: D3000–D3999

The information provided is based on general clinical policy and can vary for each patient's plan. Verify benefits and eligibility for each patient before the appointment, as there are differences among plans. The following information gives generalized clinical requirements and guidance for each CDT code.

Endodontics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D3110	Pulp cap—direct (excluding final restoration)	Benefits are typically available once per 12 months per permanent tooth only, except for some ACA pediatric plans. Direct pulp cap will be considered inclusive (not billable) if submitted with a major restoration such as a core buildup or indirect restoration.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D3120	Pulp cap—indirect (excluding final restoration)	Benefits are typically not available, as it is considered inclusive to the permanent or sedative restoration except for some ACA pediatric plans.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D3220	Therapeutic pulpotomy (excluding final restoration)—removal of pulp coronal to dentinocemental junction and medicament	Benefits are typically available on primary teeth only.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D3221	Pulpal debridement, primary and permanent teeth	Benefits are typically available one per tooth per lifetime. If this service is billed along with any other endodontic treatment on the same service date, the debridement will be considered inclusive.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D3222	Partial pulpotomy for apexogenesis—permanent tooth with incomplete root development	Typically not covered.	n/a

*Check patient eligibility including age and frequency limitations for each service.

Endodontics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D3230	Pulpal therapy (resorbable filling)—anterior, primary tooth (excluding final restoration)	Tooth must demonstrate advanced caries or trauma. Root fracture must be absent. Clinical crown must be sufficient to retain a restoration, prefabricated resin or stainless steel crown. Tooth must not be near exfoliation—root resorption may not exceed 50%.	**Requires clinical review.** Pre-operative periapical radiograph and statement of medical necessity.
D3240	Pulpal therapy (resorbable filling)—posterior, primary tooth (excluding final restoration)	Tooth must demonstrate advanced caries or trauma. Root fracture must be absent. Clinical crown must be sufficient to retain a restoration, prefabricated resin or stainless steel crown. Tooth must not be near exfoliation—root resorption may not exceed 50%.	**Requires clinical review.** Pre-operative periapical radiograph and statement of medical necessity.
D3310	Endodontic therapy—anterior tooth (excluding final restoration)	Benefits are typically available once per permanent incisor or canine/cuspid tooth per lifetime (for initial treatment). All canals must be instrumented, cleaned and sealed within 2 mm of the radiographic apex. Tooth must present with endodontic pathology, symptoms. Tooth must be restorable. Tooth must present with at least 50% bone support. Patient must be free of active periodontal disease. Pulp tests and additional radiographs (after initial diagnostic image) are considered inclusive to this procedure.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D3320	Endodontic therapy—premolar tooth (excluding final restoration)	Benefits are typically available once per permanent premolar/bicuspid tooth per lifetime (for initial treatment). All canals must be instrumented, cleaned and sealed within 2 mm of the radiographic apex. Tooth must present with endodontic pathology, symptoms. Tooth must be restorable. Tooth must present with at least 50% bone support. Patient must be free of active periodontal disease. Pulp tests and additional radiographs (after initial diagnostic image) are considered inclusive to this procedure.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D3330	Endodontic therapy—molar tooth (excluding final restoration)	Benefits are typically available once per permanent molar tooth per lifetime (for initial treatment). All canals must be instrumented, cleaned and sealed within 2 mm of the radiographic apex. Tooth must present with endodontic pathology, symptoms. Tooth must be restorable. Tooth must present with at least 50% bone support. Patient must be free of active periodontal disease. Pulp tests and additional radiographs (after initial diagnostic image) are considered inclusive to this procedure.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D3331	Treatment of root canal obstruction—non-surgical access	Benefits are typically available once per permanent tooth per lifetime and if submitted with initial or retreatment endodontic procedures, it will be considered inclusive to the primary endodontic procedure.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.

*Check patient eligibility including age and frequency limitations for each service.

Endodontics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D3332	Incomplete endodontic therapy, inoperable, unrestorable or fractured tooth	Benefits are typically available once per permanent tooth per lifetime for an inoperable tooth, calcified canal(s), root fracture, nonrestoreable tooth resulting in incomplete endodontic therapy. If submitted with initial or retreatment endodontic procedures, it will be considered inclusive to the primary endodontic procedure.	**Requires clinical review.** Pre-operative periapical radiograph and statement of medical necessity.
D3333	Internal tooth repair of perforation defects	Benefits are typically available once per permanent tooth per lifetime and if submitted with initial or retreatment endodontic procedures, it will be considered inclusive to the primary endodontic procedure.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D3346	Retreatment of previous root canal therapy—anterior	Benefits are typically available once per previously treated permanent incisor or canine/cuspid tooth per lifetime (for initial treatment). All canals must be instrumented, cleaned and sealed within 2 mm of the radiographic apex. Tooth must present with endodontic pathology, symptoms. Tooth must be restorable. Tooth must present with at least 50% bone support. Patient must be free of active periodontal disease. Pulp tests and additional radiographs (after initial diagnostic image) are considered inclusive to this procedure.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D3347	Retreatment of previous root canal therapy—premolar	Benefits are typically available once per previously treated permanent premolar/bicuspid tooth per lifetime (for initial treatment). All canals must be instrumented, cleaned and sealed within 2 mm of the radiographic apex. Tooth must present with endodontic pathology, symptoms. Tooth must be restorable. Tooth must present with at least 50% bone support. Patient must be free of active periodontal disease. Pulp tests and additional radiographs (after initial diagnostic image) are considered inclusive to this procedure.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D3348	Retreatment of previous root canal therapy—molar	Benefits are typically available once per previously treated permanent molar tooth per lifetime (for initial treatment). All canals must be instrumented, cleaned and sealed within 2 mm of the radiographic apex. Tooth must present with endodontic pathology, symptoms. Tooth must be restorable. Tooth must present with at least 50% bone support. Patient must be free of active periodontal disease. Pulp tests and additional radiographs (after initial diagnostic image) are considered inclusive to this procedure.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D3351	Apexification/recalcification—initial visit (apical closure/calcific repair of perforations, etc.)	Benefits are typically allowed prior to completion of root canal therapy (D3310-D3330, D3346-D3348) with a total of three apexification treatments (any combination of D3351, D3352 and D3353) per lifetime. If this procedure is submitted with a root canal treatment, it will be considered inclusive to the primary treatment.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.

*Check patient eligibility including age and frequency limitations for each service.

Endodontics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D3352	Apexification/recalcification—interim medication replacement	Benefits are typically allowed prior to completion of root canal therapy (D3310-D3330, D3346-D3348) with a total of three apexification treatments (any combination of D3351, D3352 and D3353) per lifetime. If this procedure is submitted with a root canal treatment, it will be considered inclusive to the primary treatment.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D3353	Apexification/recalcification—final visit (includes completed root canal therapy-apical closure/calcific repair)	Benefits are typically allowed prior to completion of root canal therapy (D3310-D3330, D3346-D3348) with a total of three apexification treatments (any combination of D3351, D3352 and D3353) per lifetime. If this procedure is submitted with a root canal treatment, it will be considered inclusive to the primary treatment.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D3355	Pulpal regeneration—initial visit	Benefits are typically allowed once per tooth per lifetime.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D3356	Pulpal regeneration—interim medication replacement	Benefits are typically allowed once per tooth per lifetime.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D3357	Pulpal regeneration—completion of treatment	Benefits are typically allowed once per tooth per lifetime.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D3410	Apicoectomy—anterior	Benefits are typically allowed once per anterior tooth per lifetime and not within 30 days following the primary root canal treatment completion. I&D or other periradicular surgical procedure performed on the same service date is considered inclusive to the apicoectomy. Benefits for general anesthesia/sedation are allowed with this procedure.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D3421	Apicoectomy—premolar (first root)	Benefits are typically allowed once per anterior tooth per lifetime and not within 30 days following the primary root canal treatment completion. I&D or other periradicular surgical procedure performed on the same service date is considered inclusive to the apicoectomy. Benefits for general anesthesia/sedation are allowed with this procedure.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D3425	Apicoectomy—molar (first root)	Benefits are typically allowed once per anterior tooth per lifetime and not within 30 days following the primary root canal treatment completion. I&D or other periradicular surgical procedure performed on the same service date is considered inclusive to the apicoectomy. Benefits for general anesthesia/sedation are allowed with this procedure.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.

*Check patient eligibility including age and frequency limitations for each service.

Endodontics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D3426	Apicoectomy (each additional root)	Benefits are typically allowed once per anterior tooth per lifetime and not within 30 days following the primary root canal treatment completion. I&D or other periradicular surgical procedure performed on the same service date is considered inclusive to the apicoectomy. Benefits for general anesthesia/sedation are allowed with this procedure.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D3428	Bone graft in conjunction with periradicular surgery—per tooth, single site	Benefits are typically allowed once per tooth/single site per lifetime. Surgical defect must be large enough to require graft for adequate healing without significant residual defect. Benefits for general anesthesia/sedation are allowed with this procedure.	**Requires clinical review.** Pre-operative periapical radiograph, rationale. For previously endodontically treated teeth—post-operative periapical radiograph
D3429	Bone graft in conjunction with periradicular surgery—each additional contiguous tooth in the same surgical site	Benefits are typically allowed once per tooth/single site per lifetime. Surgical defect must be large enough to require graft for adequate healing without significant residual defect. Benefits for general anesthesia/sedation are allowed with this procedure.	**Requires clinical review.** Pre-operative periapical radiograph, rationale. For previously endodontically treated teeth—post-operative periapical radiograph
D3430	Retrograde filling—per root	Benefits are allowed in conjunction with an apicoectomy procedure. The maximum number of retrograde fillings allowed align with the type of tooth: anterior—1 root; premolar/bicuspid—2 roots; molar—3 roots.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D3431	Biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery	Benefits are typically allowed once per lifetime in conjunction with periradicular surgery. Biologic materials must result in significant improvement in tissue regeneration and healing. May be considered incidental when used in conjunction with bone grafting and/or guided tissue regeneration (GTR).	**Requires clinical review.** Pre-operative periapical radiograph, history of root canal, rationale. For previously endodontically treated teeth—post-operative periapical radiograph
D3432	Guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery	Benefits are typically allowed once per lifetime in conjunction with periradicular surgery. Use of the resorbable barrier for GTR must result in significant improvement in tissue regeneration and healing. This code is not to be used for resorbable or non-resorbable membranes, allogenic grafting materials or other extra charges. The grafting codes include the material unless otherwise indicated.	**Requires clinical review.** Pre-operative periapical radiograph, history of root canal, rationale. For previously endodontically treated teeth—post-operative periapical radiograph
D3450	Root amputation—per root	Benefits are allowed once per root. The maximum number of root amputations allowed align with the type of tooth: anterior—one root; premolar/bicuspid—two roots; molar—three roots. Benefits for general anesthesia/sedation are allowed with this procedure.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D3460	Endodontic endosseous implant	Benefits will be considered upon clinical review of rationale and treatment plan.	**Requires clinical review.** Pre-operative periapical radiograph, history of root canal, rationale.
D3470	Intentional reimplantation (including necessary splinting)	Typically not covered.	n/a

*Check patient eligibility including age and frequency limitations for each service.

Endodontics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D3471	Surgical repair of root resorption—anterior	Benefits are typically allowed once per anterior tooth root per lifetime. This periradicular surgical procedure performed on the same service date is considered inclusive to the apicoectomy. Benefits for general anesthesia/sedation are allowed with this procedure.	Narrative and periapical radiograph required.
D3472	Surgical repair of root resorption—premolar	Benefits are typically allowed once per premolar/bicuspid tooth root per lifetime. This periradicular surgical procedure performed on the same service date is considered inclusive to the apicoectomy. Benefits for general anesthesia/sedation are allowed with this procedure.	Narrative and periapical radiograph required.
D3473	Surgical repair of root resorption—molar	Benefits are typically allowed once per molar tooth root per lifetime. This periradicular surgical procedure performed on the same service date is considered inclusive to the apicoectomy. Benefits for general anesthesia/sedation are allowed with this procedure.	Narrative and periapical radiograph required.
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption—anterior	Benefits are typically allowed once per anterior tooth root per lifetime. This periradicular surgical procedure performed on the same service date is considered inclusive to the apicoectomy.	Narrative and periapical radiograph required.
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption—premolar	Benefits are typically allowed once per premolar/bicuspid tooth root per lifetime. This periradicular surgical procedure performed on the same service date is considered inclusive to the apicoectomy.	Narrative and periapical radiograph required.
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption—molar	Benefits are typically allowed once per molar tooth root per lifetime. This periradicular surgical procedure performed on the same service date is considered inclusive to the apicoectomy.	Narrative and periapical radiograph required.
D3910	Surgical procedure for isolation of tooth with rubber dam	Benefits are typically available as required.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D3911	Intraorifice barrier	Benefits are typically considered inclusive to the endodontic procedure, either initial or retreatment.	n/a
D3920	Hemisection (including any root removal), not including root canal therapy	If submitted with an extraction of the same tooth number on the same service date, the benefits will not be allowed as the service is considered inclusive to the extraction. Benefits for general anesthesia/sedation are allowed with this procedure.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D3921	Decoronation or submergence of an erupted tooth	Benefits are typically allowed once tooth per lifetime. Benefits for general anesthesia/sedation are allowed with this procedure.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.

*Check patient eligibility including age and frequency limitations for each service.

Endodontics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D3950	Canal preparation and fitting of preformed dowel or post	Benefits are typically available once per tooth per lifetime, unless approved for retreatment. This service may not be reported in conjunction with D2952–D2954 or D2957 by the same practitioner on the same tooth. This service may be reported by an endodontist when performed as ancillary to endodontic therapy but not by the dentist who is preparing the canal for the post and also placing the post and fabricating the core.	**Requires clinical review.** Statement of medical necessity.
D3999	Unspecified endodontic procedure, by report	Benefits are subject to clinical review.	**Requires clinical review.** A narrative and necessary radiographs are required outlining procedure and rationale.

*Check patient eligibility including age and frequency limitations for each service.

CareFirst
Family of health care plans

Part 5: Periodontics

Comprehensive Dental Reference Guide

Please use the Comprehensive Dental Reference Guide when preparing your claims and pre-treatment estimates for CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc., (collectively, "CareFirst"), CareFirst BlueCross BlueShield Medicare Advantage, The Dental Network, and the Federal Employee Program®.

- **CDT code descriptions**
- **Utilization review perspectives on clinical presentations appropriate for benefit allowance**
- **CareFirst-required documentation to allow for processing**
- **Identification of codes that require a clinical review by our staff of licensed dentists**

Selecting the most appropriate code to describe treatment rendered and providing required documentation streamlines the claims submission process.

These descriptions and directions are based on standard plan designs. Individual patient plans may vary. Verify benefits and eligibility for each patient before the appointment.

CareFirst
Family of health care plans

Periodontics: D4000–D4999

The information provided is based on general clinical policy and can vary for each patient's plan. Verify benefits and eligibility for each patient before the appointment, as there are differences among plans. The following information gives generalized clinical requirements and guidance for each CDT code.

Periodontics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D4210	Gingivectomy or gingivoplasty—four or more contiguous teeth or tooth bounded spaces per quadrant	Benefits typically available once every five years unless billed with a restoration on the same service date.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D4211	Gingivectomy or gingivoplasty—one to three contiguous teeth or tooth bounded spaces per quadrant	Benefits typically available once every five years unless billed with a restoration on the same service date.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure—per tooth	Benefits typically available once every five years unless billed with a restoration on the same service date.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D4230	Anatomical crown exposure—four or more contiguous teeth or bounded tooth spaces per quadrant	Benefits typically are available once per tooth per lifetime, but will not receive a benefit if billed with a crown, as the service is considered inclusive on the same service date.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D4231	Anatomical crown exposure—one to three teeth or bounded tooth spaces per quadrant	Benefits typically are available once per tooth per lifetime, but will not receive a benefit if billed with a crown, as the service is considered inclusive on the same service date.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.

*Check patient eligibility including age and frequency limitations for each service.

Periodontics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D4240	Gingival flap procedure, including root planing—four or more contiguous teeth or tooth bounded spaces per quadrant	Benefits are typically available once every five years. Gingival pockets must be moderately deep (5–8 mm) with loss of attachment. Tissue flap must be necessary to access root calculus (modified Kirkland or Widman surgery). May be required to access or determine the presence of a cracked tooth, fractured root or external root resorption. No additional benefit is allowed for the use of a laser. Code may not be used in conjunction with D4210, D4211, D4260 and D4261.	**Requires clinical review; pre-treatment estimate recommended.** Periapical radiograph/ full-mouth series radiographs and periodontal charting, prior history of pre-surgical preparation (e.g., root planing/ scaling).
D4241	Gingival flap procedure, including root planing—one to three contiguous teeth or tooth bounded spaces per quadrant	Benefits are typically available once every five years. Gingival pockets must be moderately deep (5–8 mm) with loss of attachment. Tissue flap must be necessary to access root calculus (modified Kirkland or Widman surgery). May be required to access or determine the presence of a cracked tooth, fractured root or external root resorption. No additional benefit is allowed for the use of a laser. Code may not be used in conjunction with D4210, D4211, D4260 and D4261.	**Requires clinical review; pre-treatment estimate recommended.** Periapical radiograph/ full-mouth series radiographs and periodontal charting, prior history of pre-surgical preparation (e.g., root planing/ scaling).
D4245	Apically positioned flap	Benefits are typically available once every five years. Gingival pockets must be moderately deep (5–8 mm) with loss of attachment. Tissue flap must be necessary to access root calculus (modified Kirkland or Widman surgery). May be required to access or determine the presence of a cracked tooth, fractured root or external root resorption. No additional benefit is allowed for the use of a laser.	**Requires clinical review; pre-treatment estimate recommended.** Full-mouth series or periapical and bitewing (must demonstrate bone levels); Periodontal charting must include measurements of remaining attached gingiva; Rationale including measurements of remaining attached gingiva clearly stated, Intraoral photographs recommended.
D4249	Clinical crown lengthening—hard tissue	Benefits are typically limited to once per tooth per lifetime. When performed in conjunction with osseous surgery, crown lengthening is included as part of the most inclusive procedure. This procedure is carried out to expose sound tooth structure by removal of bone before restorative or prosthodontic procedures. It is not generally provided in the presence of periodontal disease. Sufficient healing time is required prior to final restoration. This procedure is a benefit only when bone is removed and sufficient time is allowed for healing.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.

*Check patient eligibility including age and frequency limitations for each service.

Periodontics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D4260	Osseous surgery (including flap entry and closure)—four or more contiguous teeth or tooth bounded spaces per quadrant	Benefits are typically available once every five years. Should be preceded by scaling and root planing by at least four to six weeks to reduce gingival and osseous inflammation prior to surgery. In cases where pockets are not expected to be resolved with scaling and root planing (SRP) due to their depth (7+ mm) and plaque control is adequate, it may be more therapeutic to go directly to surgery. A detailed narrative should accompany these requests. Post SRP evaluation should be a factor in determining the need for surgical intervention. Includes reshaping the alveolar process to achieve a more physiologic form. Gingivectomies and/or flap surgeries may be considered inclusive to osseous surgery. If root planing is performed along with the osseous surgery, it is considered inclusive to the surgery and will not receive a separate benefit. General anesthesia is covered with this procedure.	**Requires clinical review; pre-treatment estimate recommended.** Periapical radiograph/ full-mouth series radiographs and periodontal charting, prior history of pre-surgical preparation (e.g., root planing/ scaling).
D4261	Osseous surgery (including flap entry and closure)—one to three contiguous teeth or tooth bounded spaces per quadrant	Benefits are typically available once every five years. Should be preceded by scaling and root planing by at least four to six weeks to reduce gingival and osseous inflammation prior to surgery. In cases where pockets are not expected to be resolved with scaling and root planing (SRP) due to their depth (7+ mm) and plaque control is adequate, it may be more therapeutic to go directly to surgery. A detailed narrative should accompany these requests. Post SRP evaluation should be a factor in determining the need for surgical intervention. Includes reshaping the alveolar process to achieve a more physiologic form. Gingivectomies and/or flap surgeries may be considered inclusive to osseous surgery. If root planing is performed along with the osseous surgery, it is considered inclusive to the surgery and will not receive a separate benefit. General anesthesia is covered with this procedure.	**Requires clinical review; pre-treatment estimate recommended.** Periapical radiograph/ full-mouth series radiographs and periodontal charting, prior history of pre-surgical preparation (e.g., root planing/ scaling).
D4263	Bone replacement graft—retained natural tooth—first site in quadrant	Benefits are typically available once every five years. This procedure involves the use of autografts, allografts or non-osseous grafts to stimulate periodontal regeneration when the disease process has resulted in bone deformity. Bone grafts are frequently performed in conjunction with osseous surgery but may be billed as unique procedures. Do not use this code with implants (see codes D6103–D6104). Do not use this code in conjunction with periradicular surgery (see codes D3428). May be considered incidental when used in conjunction with bone grafting and/or GTR.	**Requires clinical review; pre-treatment estimate recommended.** Periapical radiograph/ full-mouth series radiographs and periodontal charting, prior history of pre-surgical preparation (e.g., root planing/ scaling).

*Check patient eligibility including age and frequency limitations for each service.

Periodontics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D4264	Bone replacement graft—retained natural tooth—each additional site in quadrant	Benefits are typically available once every five years. This procedure involves the use of autografts, allografts or non-osseous grafts to stimulate periodontal regeneration when the disease process has resulted in bone deformity. Bone grafts are frequently performed in conjunction with osseous surgery but may be billed as unique procedures. Do not use this code with implants (see codes D6103 – D6104). Do not use this code in conjunction with periradicular surgery (see codes D3428). May be considered incidental when used in conjunction with bone grafting and/or GTR.	**Requires clinical review; pre-treatment estimate recommended.** Periapical radiograph/ full-mouth series radiographs and periodontal charting, prior history of pre-surgical preparation (e.g., root planing/ scaling).
D4265	Biologic materials to aid in soft and osseous tissue regeneration	Benefits are typically available once every five years. These materials may be used alone or with other regenerative materials such as bone and barrier membranes. This procedure does not include surgical entry and closure, debridement, osseous contouring or placement of graft materials and membranes. CareFirst will consider allowing a benefit for this service when traditional regenerative procedures alone are unlikely to provide resolution of the tissue defect. A narrative detailing the necessity of the material is helpful in determining this additional regenerative benefit. Do not use this code in conjunction with periradicular surgery (D3432).	**Requires clinical review; pre-treatment estimate recommended.** Statement of medical necessity for biologic material (specify material name and type), prior history pre-surgical prep.
D4266	Guided tissue regeneration, natural teeth—resorbable barrier—per site	Benefits are typically available once every five years. This procedure may be used as appropriate following surgical exposure and debridement to help close and protect the wound before approximation of the mucoperiosteal flap. GTR is appropriate when the surrounding soft and hard tissue is insufficient to retain the graft material. A narrative detailing the necessity of the membrane material is helpful in determining this additional regenerative benefit. Do not use this code in conjunction with periradicular surgery (D3428).	**Requires clinical review; pre-treatment estimate recommended.** Statement of medical necessity, prior history pre-surgical prep; post-operative periapical radiograph for implant and endodontically treated teeth, if applicable
D4267	Guided tissue regeneration, natural teeth—nonresorbable barrier—per site	Benefits are typically available once very five years. This procedure may be used as appropriate following surgical exposure and debridement to help close and protect the wound before approximation of the mucoperiosteal flap. GTR is appropriate when the surrounding soft and hard tissue is insufficient to retain the graft material. A narrative detailing the necessity of the membrane material is helpful in determining this additional regenerative benefit. Do not use this code in conjunction with periradicular surgery (D3428).	**Requires clinical review; pre-treatment estimate recommended.** Statement of medical necessity, prior history pre-surgical prep; post-operative periapical radiograph for implant and endodontically treated teeth, if applicable
D4268	Surgical revision procedure—per tooth	Benefits are typically available once very five years.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.

*Check patient eligibility including age and frequency limitations for each service.

Periodontics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D4270	Pedicle soft tissue graft procedure	Benefit is typically available once every five years. If a frenectomy is performed on the same service date, it is considered inclusive to the grafting surgery.	**Requires clinical review; pre-treatment estimate recommended.** Full-mouth series or periapical and bitewing (must demonstrate bone levels); Periodontal charting must include measurements of remaining attached gingiva; Rationale including measurements of remaining attached gingiva clearly stated, Intraoral photograph
D4273	Autogenous connective tissue graft procedure—first tooth	Benefit is typically available once every five years. A minimum amount of attached gingival remains, i.e., < 2 mm. Procedure is required for reasons other than cosmetics, i.e., mucogingival defect, root sensitivity treated unsuccessfully by desensitizing techniques or placement of restoration, to increase the band of keratinized/attached gingival, and/or to thicken the gingival housing at a prospective implant site. Procedure includes both recipient bed preparation and obtaining donor tissue, including use of allograft material such as Alloderm. Considered incidental to frenulectomy	**Requires clinical review; pre-treatment estimate recommended.** Full-mouth series or periapical and bitewing (must demonstrate bone levels); Periodontal charting must include measurements of remaining attached gingiva; Rationale including measurements of remaining attached gingiva clearly stated, Intraoral photograph
D4274	Mesial/distal wedge procedure—single tooth (not performed in conjunction with surgical procedure in the same area)	Benefit is typically available once every five years. This procedure is performed in an edentulous area adjacent to a tooth, allowing removal of a tissue wedge to gain access for debridement, permit close flap adaptation, and reduce pocket depths.	**Requires clinical review; pre-treatment estimate recommended.** Full-mouth series or periapical and bitewing (must demonstrate bone levels); Periodontal charting must include measurements of remaining attached gingiva; Rationale including measurements of remaining attached gingiva clearly stated, Intraoral photograph
D4275	Non-autogenuous connective tissue graft—first tooth	Benefit is typically available once every five years. A minimum amount of attached gingival remains, i.e., < 2 mm. Procedure is required for reasons other than cosmetics, i.e., mucogingival defect, root sensitivity treated unsuccessfully by desensitizing techniques or placement of restoration, to increase the band of keratinized/attached gingival, and/or to thicken the gingival housing at a prospective implant site. Considered incidental to frenulectomy (D7960) or frenuloplasty (D7963). No donor site is required. Allograft material is inclusive. No additional charge for the graft material is allowed.	**Requires clinical review; pre-treatment estimate recommended.** Full-mouth series or periapical and bitewing (must demonstrate bone levels); Periodontal charting must include measurements of remaining attached gingiva; Rationale including measurements of remaining attached gingiva clearly stated, Intraoral photograph

*Check patient eligibility including age and frequency limitations for each service.

Periodontics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D4276	Combined connective tissue and double pedicle graft, per tooth	Benefit is typically available once every five years. A minimum amount of attached gingival remains, i.e., < 2 mm. Procedure is required for reasons other than cosmetics, i.e., mucogingival defect, root sensitivity treated unsuccessfully by desensitizing techniques or placement of restoration, to increase the band of keratinized/attached gingival, and/or to thicken the gingival housing at a prospective implant site. Appropriate to correct advanced gingival recession.	**Requires clinical review; pre-treatment estimate recommended.** Full-mouth series or periapical and bitewing (must demonstrate bone levels); Periodontal charting must include measurements of remaining attached gingiva; Rationale including measurements of remaining attached gingiva clearly stated, Intraoral photograph
D4277	Free soft tissue graft procedure—first tooth	Benefit is typically available once every five years. A minimum amount of attached gingiva remains i.e., < 2 mm. Procedure is required for reasons other than cosmetics, i.e., mucogingival defect, root sensitivity treated unsuccessfully by desensitizing techniques or placement of restoration to increase the band of keratinized/attached gingiva, and/or to thicken the gingival housing at a prospective implant site. Procedure includes both recipient bed preparation and obtaining donor tissue, including use of allograft material such as Alloderm. Considered incidental to frenulectomy (D7960) or frenuloplasty (D7963).	**Requires clinical review; pre-treatment estimate recommended.** Full-mouth series or periapical and bitewing (must demonstrate bone levels); Periodontal charting must include measurements of remaining attached gingiva; Rationale including measurements of remaining attached gingiva clearly stated, Intraoral photograph
D4278	Free soft tissue graft procedure—each additional tooth	Benefit is typically available once every five years. A minimum amount of attached gingiva remains i.e., < 2 mm. Procedure is required for reasons other than cosmetics, i.e., mucogingival defect, root sensitivity treated unsuccessfully by desensitizing techniques or placement of restoration to increase the band of keratinized/attached gingiva, and/or to thicken the gingival housing at a prospective implant site. Procedure includes both recipient bed preparation and obtaining donor tissue, including use of allograft material such as Alloderm. Considered incidental to frenulectomy (D7960) or frenuloplasty (D7963).	**Requires clinical review; pre-treatment estimate recommended.** Full-mouth series or periapical and bitewing (must demonstrate bone levels); Periodontal charting must include measurements of remaining attached gingiva; Rationale including measurements of remaining attached gingiva clearly stated, Intraoral photograph
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites)—each additional contiguous tooth, implant or edentulous tooth position in same graft site	Benefit is typically available once every five years. Code D4283 is used in conjunction with D4273 when more than on tooth position in the same graft site is involved. A minimum amount of attached gingiva remains i.e., < 2 mm. Procedure is required for reasons other than cosmetics, i.e., mucogingival defect, root sensitivity treated unsuccessfully by desensitizing techniques or placement of restoration to increase the band of keratinized/attached gingiva, and/or to thicken the gingival housing at a prospective implant site. Procedure includes both recipient bed preparation and obtaining donor tissue, including use of allograft material such as Alloderm. Considered incidental to frenulectomy (D7960) or frenuloplasty (D7963).	**Requires clinical review; pre-treatment estimate recommended.** Full-mouth series or periapical and bitewing (must demonstrate bone levels); Periodontal charting must include measurements of remaining attached gingiva; Rationale including measurements of remaining attached gingiva clearly stated, Intraoral photograph

*Check patient eligibility including age and frequency limitations for each service.

Periodontics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material)—each additional contiguous tooth, implant or edentulous tooth position in same graft site	Benefit is typically available once every five years. Code D4285 is used in conjunction with D4275 when more than one tooth position in the same graft site is involved. Includes donor material and recipient surgical site. A minimum amount of attached gingiva remains i.e., < 2 mm. Procedure is required for reasons other than cosmetics, i.e., mucogingival defect, root sensitivity treated unsuccessfully by desensitizing techniques or placement of restoration to increase the band of keratinized/attached gingiva, and/or to thicken the gingival housing at a prospective implant site.	**Requires clinical review; pre-treatment estimate recommended.** Full-mouth series or periapical and bitewing (must demonstrate bone levels); Periodontal charting must include measurements of remaining attached gingiva; Rationale including measurements of remaining attached gingiva clearly stated, Intraoral photograph
D4286	Removal of non-resorbable barrier	Benefit is typically available once every five years and is allowed with a history of D4267, D6107 or D7957.	Date of placement of original non-resorbable barrier.
D4322	Splint—intra-coronal, natural teeth or prosthetic crowns	Typically, only covered under some DHMO plans and the ACA pediatric plans or possibly under medical benefit if needed post-traumatic accident.	No documentation required for a dental claim; if submitted under the accidental benefit under medical, full case notes and imaging will be required along with the full treatment plan for the patient.
D4323	Splint—extra-coronal, natural teeth or prosthetic crowns	Typically, only covered under some DHMO plans and the ACA pediatric plans or possibly under medical benefit if needed post-traumatic accident.	No documentation required for a dental claim; if submitted under the accidental benefit under medical, full case notes and imaging will be required along with the full treatment plan for the patient.
D4341	Periodontal scaling and root planing—four or more teeth per quadrant	Benefit is typically available once every 24 months per quadrant or partial quadrant based on necessity. This service is considered inclusive to osseous surgery and will not be paid in addition on the same service date. If submitted with a D4910 or D4355, the D4910 or D4355 will be considered inclusive to the D4341/42. Gingival pockets > 4 mm. Radiographic evidence of active horizontal and/or vertical bone loss must be apparent. There must be loss of attachment or apical migration of the attachment. SRP of four quadrants in same appointment must be accompanied by rationale for doing four quadrants in the same visit, anesthesia used, length of appointment and degree of provider (DDS, DMD, RDH). May be repeated every two years, only if medically necessary. May be necessary as a pre-surgical or definitive therapy. Contraindicated as a definitive therapy in cases where the bone loss is so severe that there would be little to no therapeutic effect.	Full-mouth series or periapical and bitewing radiographs (must demonstrate bone levels); periodontal charting

*Check patient eligibility including age and frequency limitations for each service.

Periodontics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D4342	Periodontal scaling and root planing—one to three teeth, per quadrant	Benefit is typically available once every 24 months per quadrant or partial quadrant based on necessity. This service is considered inclusive to osseous surgery and will not be paid in addition on the same service date. If submitted with a D4910 or D4355, the D4910 or D4355 will be considered inclusive to the D4341/42. Gingival pockets > 4 mm. Radiographic evidence of active horizontal and/or vertical bone loss must be apparent. There must be loss of attachment or apical migration of the attachment. SRP of four quadrants in same appointment must be accompanied by rationale for doing four quadrants in the same visit, anesthesia used, length of appointment and degree of provider (DDS, DMD, RDH). May be repeated every two years, only if medically necessary. May be necessary as a pre-surgical or definitive therapy. Contraindicated as a definitive therapy in cases where the bone loss is so severe that there would be little to no therapeutic effect.	Full-mouth series or periapical and bitewing radiographs (must demonstrate bone levels); periodontal charting
D4346	Scaling in presence of generalized moderate or severe gingival inflammation—full-mouth, after oral evaluation	Benefit is typically available once every 24 months with age limitations (typically minimum age of 14). If submitted with a prophy, the prophy will be considered inclusive to the D4346. Must be preceded by an oral evaluation (D0120, D0150, D0180). May be performed on the same day as an oral evaluation. Full-mouth procedure. Patient should be 14 years or older. D4346 is necessary when: Oral exam and periodontal charting indicate the patient presents with: Generalized moderate to severe gingival inflammation involving 10 or more teeth. Moderate to heavy plaque and/or calculus; 2-4 mm pocketing. There maybe pseudopocketing, bleeding points, no vertical or horizontal bone loss, no loss of attachment.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D4355	Full-mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	Benefit is available once every 36 months. If submitted with a prophy, the prophy will be considered inclusive to the D4355. . Must be preceded by an oral evaluation (D0120, D0150, D0180). May be performed on the same day as an oral evaluation. Full-mouth procedure. Patient should be 14 years or older; exceptions made with adequate clinical documentation.	No documentation required unless patient is below minimum age; approval depends on the plan design's frequency limitations for the individual patient.
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	Benefits are available with the EPO plan only and will not be covered if submitted on the same service date as any cleaning procedure.	No documentation required unless patient is below minimum age; approval depends on the plan design's frequency limitations for the individual patient.

*Check patient eligibility including age and frequency limitations for each service.

Periodontics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D4910	Periodontal maintenance	Benefit is available two times per contract year if it is submitted with a service date that is 90 days or more after completion of definitive periodontal therapy (D4240, D4241, D4260, D4261, D4263, D4264, D4341, D4342). History of periodontal treatment must be on file.	Documentation of periodontal history required (D4210, D4211 ,D4240, D4241, D4260, D4261, D4263, D4264, D4266, D4267, D4273, D4341 and D4342) if not on file with CareFirst.
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	Benefits are typically not covered except for ACA plans. The definition of the treating dentist includes dentists and staff in the same dental office. The fee for dressing change performed by a dentist or staff in the same dental office is considered inclusive within 30 days following the surgical procedure.	n/a
D4921	Gingival irrigation—per quadrant	Benefits are considered inclusive to the primary procedure performed; if submitted alone, it is not a covered benefit.	n/a
D4999	Unspecified periodontal procedure, by report	Benefit is dependent on the actual service performed, if not adequately captured with another CDT code.	**Requires clinical review; pre-treatment estimate recommended.** Narrative and necessary radiographs are required outlining procedure and rationale. Use of this code for laser treatment will be denied.

*Check patient eligibility including age and frequency limitations for each service.

CareFirst
Family of health care plans

Part 6: Removable Prosthodontics

Comprehensive Dental Reference Guide

Please use the Comprehensive Dental Reference Guide when preparing your claims and pre-treatment estimates for CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc., (collectively, "CareFirst"), CareFirst BlueCross BlueShield Medicare Advantage, The Dental Network, and the Federal Employee Program®.

- **CDT code descriptions**
- **Utilization review perspectives on clinical presentations appropriate for benefit allowance**
- **CareFirst-required documentation to allow for processing**
- **Identification of codes that require a clinical review by our staff of licensed dentists**

Selecting the most appropriate code to describe treatment rendered and providing required documentation streamlines the claims submission process.

These descriptions and directions are based on standard plan designs. Individual patient plans may vary. Verify benefits and eligibility for each patient before the appointment.

CareFirst
Family of health care plans

Removable Prosthodontics: D5000–D5899

The information provided is based on general clinical policy and can vary for each patient's plan. Verify benefits and eligibility for each patient before the appointment, as there are differences among plans. The following information gives generalized clinical requirements and guidance for each CDT code.

Removable Prosthodontics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D5110	Complete denture—maxillary	Benefits are typically available once every five years. Replacement of any fixed or removable prosthesis is limited to five years. All maxillary permanent teeth must be missing.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D5120	Complete denture—mandibular	Benefits are typically available once every five years. Replacement of any fixed or removable prosthesis is limited to five years. All mandibular permanent teeth must be missing.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D5130	Immediate denture—maxillary	Benefits are typically available once every five years. Replacement of any fixed or removable prosthesis is limited to five years. All maxillary permanent teeth must be missing.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D5140	Immediate denture—mandibular	Benefits are typically available once every five years. Replacement of any fixed or removable prosthesis is limited to five years. All mandibular permanent teeth must be missing.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D5211	Maxillary partial denture—resin base including retentive/clasping materials, rests and teeth	Benefits are typically available once every five years. Replacement of any fixed or removable prosthesis is limited to five years. There must be at least one missing tooth (2–15, 18–31). Teeth 1, 16, 17 and 32 are not eligible for replacement.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D5212	Mandibular partial denture—resin base including retentive/clasping materials, rests and teeth	Benefits are typically available once every five years. Replacement of any fixed or removable prosthesis is limited to five years. There must be at least one missing tooth (2–15, 18–31). Teeth 1, 16, 17 and 32 are not eligible for replacement.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.

*Check patient eligibility including age and frequency limitations for each service.

Removable Prosthodontics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D5213	Maxillary partial denture—a cast metal framework with resin denture base including retentive/clasping materials, rests and teeth	Benefits are typically available once every five years. Replacement of any fixed or removable prosthesis is limited to five years. There must be at least one missing tooth (2–15, 18–31). Teeth 1, 16, 17 and 32 are not eligible for replacement.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D5214	Mandibular partial denture—cast metal framework with resin denture base including retentive/clasping materials, rests and teeth)	Benefits are typically available once every five years. Replacement of any fixed or removable prosthesis is limited to five years. There must be at least one missing tooth (2–15, 18–31). Teeth 1, 16, 17 and 32 are not eligible for replacement.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D5221	Immediate maxillary partial denture—resin base including retentive/clasping materials, rests and teeth	Benefits are typically available once every five years. Replacement of any fixed or removable prosthesis is limited to five years. There must be at least one missing tooth (2–15, 18–31). Teeth 1, 16, 17 and 32 are not eligible for replacement.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D5222	Immediate mandibular partial denture—resin base including retentive/clasping materials, rests and teeth	Benefits are typically available once every five years. Replacement of any fixed or removable prosthesis is limited to five years. There must be at least one missing tooth (2–15, 18–31). Teeth 1, 16, 17 and 32 are not eligible for replacement.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D5223	Immediate maxillary partial denture—cast metal framework including retentive/clasping materials, rests and teeth	Benefits are typically available once every five years. Replacement of any fixed or removable prosthesis is limited to five years. There must be at least one missing tooth (2–15, 18–31). Teeth 1, 16, 17 and 32 are not eligible for replacement.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D5224	Immediate mandibular partial denture—cast metal framework including retentive/clasping materials, rests and teeth	Benefits are typically available once every five years. Replacement of any fixed or removable prosthesis is limited to five years. There must be at least one missing tooth (2–15, 18–31). Teeth 1, 16, 17 and 32 are not eligible for replacement.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D5225	Maxillary partial denture—flexible base including retentive/clasping materials, rests and teeth	Benefits are typically available once every five years. Replacement of any fixed or removable prosthesis is limited to five years. There must be at least one missing tooth (2–15, 18–31). Teeth 1, 16, 17 and 32 are not eligible for replacement.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D5226	Mandibular partial denture—flexible base including any clasps, rests and teeth	Benefits are typically available once every five years. Replacement of any fixed or removable prosthesis is limited to five years. There must be at least one missing tooth (2–15, 18–31). Teeth 1, 16, 17 and 32 are not eligible for replacement.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D5227	Immediate maxillary partial denture—flexible base including retentive/clasping materials, rests and teeth	Benefits are typically available once every five years. Replacement of any fixed or removable prosthesis is limited to five years. There must be at least one missing tooth (2–15, 18–31). Teeth 1, 16, 17 and 32 are not eligible for replacement.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D5228	Immediate mandibular partial denture—flexible base including retentive/clasping materials, rests and teeth	Benefits are typically available once every five years. Replacement of any fixed or removable prosthesis is limited to five years. There must be at least one missing tooth (2–15, 18–31). Teeth 1, 16, 17 and 32 are not eligible for replacement.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.

*Check patient eligibility including age and frequency limitations for each service.

Removable Prosthodontics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D5282	Removable unilateral partial denture—one piece cast metal including retentive/clasping materials, rests and teeth—maxillary	Benefits are typically available once every five years. Replacement of any fixed or removable prosthesis is limited to five years. There must be at least one missing tooth (2–15, 18–31). Teeth 1, 16, 17 and 32 are not eligible for replacement.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D5283	Removable unilateral partial denture—one piece cast metal including retentive/clasping materials, rests and teeth—mandibular	Benefits are typically available once every five years. Replacement of any fixed or removable prosthesis is limited to five years. There must be at least one missing tooth (2–15, 18–31). Teeth 1, 16, 17 and 32 are not eligible for replacement.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D5284	Removable unilateral partial denture—one-piece flexible base including retentive/clasping materials, rests and teeth—per quadrant	Benefits are typically available once every five years. Replacement of any fixed or removable prosthesis is limited to five years. There must be at least one missing tooth (2–15, 18–31). Teeth 1, 16, 17 and 32 are not eligible for replacement.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D5286	Removable unilateral partial denture—one piece resin including retentive/clasping materials, rests and teeth—per quadrant	Benefits are typically available once every five years. Replacement of any fixed or removable prosthesis is limited to five years. There must be at least one missing tooth (2–15, 18–31). Teeth 1, 16, 17 and 32 are not eligible for replacement.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D5410	Adjust complete denture—maxillary	Benefits are typically available once per 12 months per arch but not until six months after the initial placement of a conventional complete denture or until three months after the initial placement of an immediate denture.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D5411	Adjust complete denture—mandibular	Benefits are typically available once per 12 months per arch but not until six months after the initial placement of a conventional complete denture or until three months after the initial placement of an immediate denture.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D5421	Adjust partial denture—maxillary	Benefits are typically available once per 12 months per arch but not until six months after the initial placement of a conventional prosthesis or until three months after the initial placement of an immediate prosthesis.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D5422	Adjust partial denture—mandibular	Benefits are typically available once per 12 months per arch but not until six months after the initial placement of a conventional prosthesis or until three months after the initial placement of an immediate prosthesis.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D5511	Repair broken complete denture base—mandibular	Benefits are typically available once per 12 months per arch but not until six months after the initial placement of a conventional complete denture or until three months after the initial placement of an immediate denture.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.

*Check patient eligibility including age and frequency limitations for each service.

Removable Prosthodontics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D5512	Repair broken complete denture base—maxillary	Benefits are typically available once per 12 months per arch but not until six months after the initial placement of a conventional complete denture or until three months after the initial placement of an immediate denture.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D5520	Replace missing or broken teeth—complete denture—per tooth	Benefits are typically available once per 12 months per arch but not until six months after the initial placement of a conventional complete denture or until three months after the initial placement of an immediate denture.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D5611	Repair resin partial denture base—mandibular	Benefits are typically available once per 12 months per arch but not until six months after the initial placement of a conventional prosthesis or until three months after the initial placement of an immediate prosthesis.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D5612	Repair resin partial denture base—maxillary	Benefits are typically available once per 12 months per arch but not until six months after the initial placement of a conventional prosthesis or until three months after the initial placement of an immediate prosthesis.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D5621	Repair cast partial framework—mandibular	Benefits are typically available once per 12 months per arch but not until six months after the initial placement of a conventional prosthesis or until three months after the initial placement of an immediate prosthesis.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D5622	Repair cast partial framework—maxillary	Benefits are typically available once per 12 months per arch but not until six months after the initial placement of a conventional prosthesis or until three months after the initial placement of an immediate prosthesis.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D5630	Repair or replace broken retentive/clasping materials—per tooth	Benefits are typically available once per 12 months per arch but not until six months after the initial placement of a conventional prosthesis or until three months after the initial placement of an immediate prosthesis.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D5640	Replace missing or broken teeth—partial denture—per tooth	Benefits are typically available once per 12 months per arch but not until six months after the initial placement of a conventional prosthesis or until three months after the initial placement of an immediate prosthesis.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D5650	Add tooth to existing partial denture—per tooth	Benefits are typically available once per 12 months per arch but not until six months after the initial placement of a conventional prosthesis or until three months after the initial placement of an immediate prosthesis.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D5660	Add clasp to existing partial denture—per tooth	Benefits are typically available once per 12 months per arch but not until six months after the initial placement of a conventional prosthesis or until three months after the initial placement of an immediate prosthesis.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.

*Check patient eligibility including age and frequency limitations for each service.

Removable Prosthodontics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	Benefits are typically available once per 12 months per arch but not until six months after the initial placement of a conventional prosthesis or until three months after the initial placement of an immediate prosthesis.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D5671	Replace all teeth and acrylic on cast metal framework—mandibular	Benefits are typically available once per 12 months per arch but not until six months after the initial placement of a conventional prosthesis or until three months after the initial placement of an immediate prosthesis.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D5710	Rebase complete denture—maxillary	Benefits are typically available once per 12 months per arch but not until six months after the initial placement of a conventional complete denture or until three months after the initial placement of an immediate denture.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D5711	Rebase complete denture—mandibular	Benefits are typically available once per 12 months per arch but not until six months after the initial placement of a conventional complete denture or until three months after the initial placement of an immediate denture.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D5720	Rebase partial—maxillary denture	Benefits are typically available once per 12 months per arch but not until six months after the initial placement of a conventional prosthesis or until three months after the initial placement of an immediate prosthesis.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D5721	Rebase partial denture—mandibular	Benefits are typically available once per 12 months per arch but not until six months after the initial placement of a conventional prosthesis or until three months after the initial placement of an immediate prosthesis.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D5725	Rebase hybrid prosthesis	Benefits are typically available once per 12 months per arch but not until six months after the initial placement of a conventional prosthesis or until three months after the initial placement of an immediate prosthesis.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D5730	Reline complete maxillary denture—chairside	Benefits are typically available once per 12 months per arch but not until six months after the initial placement of a conventional complete denture or until three months after the initial placement of an immediate denture. For immediate dentures, the first benefit is available after three months since initial placement, and a second reline is is eligible within the first year. Subsequent relines are available every three years after that.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D5731	Reline complete mandibular denture—chairside	Benefits are typically available once per 12 months per arch but not until six months after the initial placement of a conventional complete denture or until three months after the initial placement of an immediate denture. For immediate dentures, the first benefit is available after three months since initial placement, and a second reline is eligible within the first year. Subsequent relines are available every three years after that.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.

*Check patient eligibility including age and frequency limitations for each service.

Removable Prosthodontics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D5740	Reline maxillary partial denture—chairside	Benefits are typically available once per 12 months per arch but not until six months after the initial placement of a conventional complete or partial denture or until three months after the initial placement of an immediate complete or partial denture. For immediate dentures, the first benefit is available after three months since initial placement and a second reline is eligible within the first year. Subsequent relines are available every three years after that.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D5741	Reline mandibular partial denture—chairside	Benefits are typically available once per 12 months per arch but not until six months after the initial placement of a conventional complete or partial denture or until three months after the initial placement of an immediate complete or partial denture. For immediate dentures, the first benefit is available after three months since initial placement and a second reline is eligible within the first year. Subsequent relines are available every three years after that.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D5750	Reline complete maxillary denture—laboratory	Benefits are typically available once per 12 months per arch but not until six months after the initial placement of a conventional complete or partial denture or until three months after the initial placement of an immediate complete or partial denture. For immediate dentures, the first benefit is available after three months since initial placement and a second reline is eligible within the first year. Subsequent relines are available every three years after that.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D5751	Reline complete mandibular denture—laboratory	Benefits are typically available once per 12 months per arch but not until six months after the initial placement of a conventional complete or partial denture or until three months after the initial placement of an immediate complete or partial denture. For immediate dentures, the first benefit is available after three months since initial placement and a second reline is eligible within the first year. Subsequent relines are available every three years after that.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D5760	Reline maxillary partial denture—laboratory	Benefits are typically available once per 12 months per arch but not until six months after the initial placement of a conventional complete or partial denture or until three months after the initial placement of an immediate complete or partial denture. For immediate dentures, the first benefit is available after three months since initial placement and a second reline is eligible within the first year. Subsequent relines are available every three years after that.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.

*Check patient eligibility including age and frequency limitations for each service.

Removable Prosthodontics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D5761	Reline mandibular partial denture—laboratory	Benefits are typically available once per 12 months per arch but not until six months after the initial placement of a conventional complete or partial denture or until three months after the initial placement of an immediate complete or partial denture. For immediate dentures, the first benefit is available after three months since initial placement and a second reline is eligible within the first year. Subsequent relines are available every three years after that.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D5765	Soft liner for complete or partial removable denture—indirect	Benefits are typically available once per 12 months per arch but not until six months after the initial placement of a conventional complete or partial denture or until three months after the initial placement of an immediate complete or partial denture. For immediate dentures, the first benefit is available after three months since initial placement and a second reline is eligible within the first year. Subsequent relines are available every three years after that.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D5810	Interim complete denture—maxillary	Not typically a covered benefit; considered inclusive to the primary prosthetic appliance.	n/a
D5811	Interim complete denture—mandibular	Not typically a covered benefit; considered inclusive to the primary prosthetic appliance.	n/a
D5820	Interim partial denture—maxillary	Not typically a covered benefit; considered inclusive to the primary prosthetic appliance.	n/a
D5821	Interim partial denture—mandibular	Not typically a covered benefit; considered inclusive to the primary prosthetic appliance.	n/a
D5850	Tissue conditioning—maxillary	Benefits are typically available once every 12 months.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D5851	Tissue conditioning—mandibular	Benefits are typically available once every 12 months.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D5862	Precision attachment, by report	Typically not covered.	n/a
D5863	Overdenture—complete maxillary	Benefits are typically available once every five years. Replacement of any fixed or removable prosthesis is limited to five years. Any retained teeth must present with at least 50% bone support. Retained teeth must be permanent teeth at appropriate tooth positions for good retention and stability. Implants and mini-implants may be used to enhance retention and stability.	**Requires clinical review; pre-treatment estimate recommended.** Full-mouth series or panoramic radiographs, post-operative periapical radiograph of the implant if implant-supported, date of prior placement, if applicable.

*Check patient eligibility including age and frequency limitations for each service.

Removable Prosthodontics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D5864	Overdenture—partial maxillary	Benefits are typically available once every five years. Replacement of any fixed or removable prosthesis is limited to five years. Any retained teeth must present with at least 50% bone support. Retained teeth must be permanent teeth at appropriate tooth positions for good retention and stability. Implants and mini-implants may be used to enhance retention and stability.	**Requires clinical review; pre-treatment estimate recommended.** Full-mouth series or panoramic radiographs, post-operative periapical radiograph of the implant if implant-supported, date of prior placement, if applicable.
D5865	Overdenture—complete mandibular	Benefits are typically available once every five years. Replacement of any fixed or removable prosthesis is limited to five years. Any retained teeth must present with at least 50% bone support. Retained teeth must be permanent teeth at appropriate tooth positions for good retention and stability. Implants and mini-implants may be used to enhance retention and stability.	**Requires clinical review; pre-treatment estimate recommended.** Full-mouth series or panoramic radiographs, post-operative periapical radiograph of the implant if implant-supported, date of prior placement, if applicable.
D5866	Overdenture—partial mandibular	Benefits are typically available once every five years. Replacement of any fixed or removable prosthesis is limited to five years. Any retained teeth must present with at least 50% bone support. Retained teeth must be permanent teeth at appropriate tooth positions for good retention and stability. Implants and mini-implants may be used to enhance retention and stability.	**Requires clinical review; pre-treatment estimate recommended.** Full-mouth series or panoramic radiographs, post-operative periapical radiograph of the implant if implant-supported, date of prior placement, if applicable.
D5867	Replacement of replaceable part of semi-precision or precision attachment (male or female component)	Typically not covered.	n/a
D5875	Modification of removable prosthesis following implant surgery	Benefits are typically available once per 12 months per arch but not until six months after the initial placement of a conventional complete denture or until three months after the initial placement of an immediate denture.	No documentation is required. Approval depends on the plan design's frequency limitations for the individual patient.
D5876	Add metal substructure to acrylic full denture—per arch	Typically not covered.	n/a
D5876	Add metal substructure to acrylic full denture—per arch	Typically not covered.	n/a
D5899	Unspecified removable prosthodontic procedure, by report	Benefits may be available, by report.	**Requires clinical review; pre-treatment estimate recommended.** Requires a detailed narrative and necessary radiographs.

*Check patient eligibility including age and frequency limitations for each service.

CareFirst
Family of health care plans

Part 7: Maxillofacial Prosthetics

Comprehensive Dental Reference Guide

Please use the Comprehensive Dental Reference Guide when preparing your claims and pre-treatment estimates for CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc., (collectively, "CareFirst"), CareFirst BlueCross BlueShield Medicare Advantage, The Dental Network, and the Federal Employee Program®.

- **CDT code descriptions**
- **Utilization review perspectives on clinical presentations appropriate for benefit allowance**
- **CareFirst-required documentation to allow for processing**
- **Identification of codes that require a clinical review by our staff of licensed dentists**

Selecting the most appropriate code to describe treatment rendered and providing required documentation streamlines the claims submission process.

These descriptions and directions are based on standard plan designs. Individual patient plans may vary. Verify benefits and eligibility for each patient before the appointment.

CareFirst
Family of health care plans

Maxillofacial Prosthetics: D5900–D5999

The information provided is based on general clinical policy and can vary for each patient's plan. Verify benefits and eligibility for each patient before the appointment, as there are differences among plans. The following information gives generalized clinical requirements and guidance for each CDT code.

Maxillofacial Prosthetics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D5911	Facial moulage—sectional	Typically not covered.	n/a
D5912	Facial moulage—complete	Typically not covered.	n/a
D5913	Nasal prosthesis	Typically not covered.	n/a
D5914	Auricular prosthesis	Typically not covered.	n/a
D5915	Orbital prosthesis	Typically not covered.	n/a
D5916	Ocular prosthesis	Typically not covered.	n/a
D5919	Facial prosthesis	Typically not covered.	n/a
D5922	Nasal septal prosthesis	Typically not covered.	n/a
D5923	Ocular prosthesis—interim	Typically not covered.	n/a
D5924	Cranial prosthesis	Typically not covered.	n/a
D5925	Facial augmentation implant prosthesis	Typically not covered.	n/a
D5926	Nasal prosthesis—replacement	Typically not covered.	n/a
D5927	Auricular prosthesis—replacement	Typically not covered.	n/a
D5928	Orbital prosthesis—replacement	Typically not covered.	n/a
D5929	Facial prosthesis—replacement	Typically not covered.	n/a

*Check patient eligibility including age and frequency limitations for each service.

Maxillofacial Prosthetics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D5931	Obturator prosthesis—surgical	Typically not covered.	n/a
D5932	Obturator prosthesis—definitive	Typically not covered.	n/a
D5933	Obturator prosthesis—modification	Typically not covered.	n/a
D5934	Mandibular resection prosthesis with guide flange	Typically not covered.	n/a
D5935	Mandibular resection prosthesis without guide flange	Typically not covered.	n/a
D5936	Obturator prosthesis—interim	Typically not covered.	n/a
D5937	Trismus appliance (not for TMD treatment)	Typically not covered.	n/a
D5951	Feeding aid	Typically not covered.	n/a
D5952	Speech aid prosthesis—pediatric	Typically not covered.	n/a
D5953	Speech aid prosthesis—adult	Typically not covered.	n/a
D5954	Palatal augmentation prosthesis	Typically not covered.	n/a
D5955	Palatal lift prosthesis—definitive	Typically not covered.	n/a
D5958	Palatal lift prosthesis—interim	Typically not covered.	n/a
D5959	Palatal lift prosthesis—modification	Typically not covered.	n/a
D5960	Speech aid prosthesis—modification	Typically not covered.	n/a
D5982	Surgical stent	Typically not covered.	n/a
D5983	Radiation carrier	Typically not covered.	n/a
D5984	Radiation shield	Typically not covered.	n/a
D5985	Radiation cone locator	Typically not covered.	n/a
D5986	Fluoride gel carrier	Typically not covered.	n/a
D5987	Commissure splint	Typically not covered.	n/a
D5988	Surgical splint	Typically not covered.	n/a
D5991	Vesiculobullous disease medicament carrier	Typically not covered.	n/a
D5992	Adjust maxillofacial prosthetic appliance, by report	Typically not covered.	n/a
D5993	Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral) other than required adjustments, by report	Typically not covered.	n/a

*Check patient eligibility including age and frequency limitations for each service.

Maxillofacial Prosthetics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D5995	Periodontal medicament carrier with peripheral seal—laboratory processed—maxillary	Typically not covered.	If covered on medical plan, required documentation must include periodontal charting, narrative that includes description of medicament, purpose, treatment plan.
D5996	Periodontal medicament carrier with peripheral seal—laboratory processed—mandibular	Typically not covered.	If covered on medical plan, required documentation must include periodontal charting, narrative that includes description of medicament, purpose, treatment plan.
D5999	Unspecified maxillofacial prosthesis, by report	Typically not covered.	n/a

*Check patient eligibility including age and frequency limitations for each service.

CareFirst
Family of health care plans

Part 8: Implant Services

Comprehensive Dental Reference Guide

Please use the Comprehensive Dental Reference Guide when preparing your claims and pre-treatment estimates for CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc., (collectively, "CareFirst"), CareFirst BlueCross BlueShield Medicare Advantage, The Dental Network, and the Federal Employee Program®.

- **CDT code descriptions**
- **Utilization review perspectives on clinical presentations appropriate for benefit allowance**
- **CareFirst-required documentation to allow for processing**
- **Identification of codes that require a clinical review by our staff of licensed dentists**

Selecting the most appropriate code to describe treatment rendered and providing required documentation streamlines the claims submission process.

These descriptions and directions are based on standard plan designs. Individual patient plans may vary. Verify benefits and eligibility for each patient before the appointment.

CareFirst
Family of health care plans

Implant Services: D6000–D6199

The information provided is based on general clinical policy and can vary for each patient's plan. Verify benefits and eligibility for each patient before the appointment, as there are differences among plans. The following information gives generalized clinical requirements and guidance for each CDT code.

Implant Services			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D6010	Surgical placement of implant body—endosteal implant	Benefits are typically available once every five years. General anesthesia and/or intravenous sedation may be covered with this procedure. The implant site will be evaluated before implant placement based on the prognosis for good implant outcome. The alveolar ridge implant placement site must present with good-quality bone of adequate mass and density. Active periodontal disease must be treated and under control before implant placement to avoid possible complications. Limited to the replacement of permanent teeth (2–15, 18–31 only). Replacements of teeth 1, 16, 17 and 32 are not covered unless in functional occlusion and necessary to maintain occlusal support. The implant must have a good crown-to-root ratio. The restorative dentist will evaluate the implant restoration based on the complete osseointegration of the implant body. Benefits will not be approved if the implant body is not fully osseointegrated. The implant must not have more than two implant body threads exposed above the alveolar crest and must not be closer than 1.5 mm to adjacent roots or implants. When there is untreated generalized periodontal disease throughout the remaining dentition, a more conservative treatment modality may be offered as an alternate benefit to restore the edentulous space and replace all missing teeth, e.g., a fixed bridge or a full/partial denture. Implants may be contraindicated in young patients whose growth is expected to continue.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative panoramic or full-mouth series radiographs, pre-periapical radiograph, date of extraction, rationale, periodontal charting and history, list of other missing teeth, rationale for second stage implant surgery, if applicable.

*Check patient eligibility including age and frequency limitations for each service.

Implant Services			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D6011	Surgical access to an implant body (second stage implant surgery)	This is typically not a covered procedure. Supplemental documentation, such as under the DC ACA standalone plan, is required if covered.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative panoramic or full-mouth series radiographs, pre-periapical radiographs demonstrating the full length of the implant body, date of extraction and implant body placement, rationale for second-stage implant surgery.
D6012	Surgical placement of interim implant body for transitional prosthesis: endosteal implant	This is typically considered inclusive to the dental implant body placement procedure and not covered separately.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative panoramic or full-mouth series radiographs, pre-periapical radiographs demonstrating the full length of the implant body, date of extraction and implant body teeth, rationale for second stage implant surgery, if applicable.
D6013	Surgical placement of mini implant	Mini implants are indicated to retain full dentures that would otherwise be unstable. It is not indicated to retain or support fixed partial dentures. It is not indicated to retain or support crowns. Includes the retrofitting of existing prostheses. Does not require surgical flap and osteotomy. Does not require second-stage surgery. Does not require a surgical stent for placement. General anesthesia and/or IV sedation are not covered with this procedure.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative panoramic or full-mouth series radiographs, pre-periapical radiographs demonstrating the full length of the implant body, date of extraction and implant body teeth, rationale for second stage implant surgery, if applicable.

*Check patient eligibility including age and frequency limitations for each service.

Implant Services			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D6040	Surgical placement: eposteal implant	Benefits are typically available once every five years. General anesthesia and/or intravenous sedation may be covered with this procedure. The implant site will be evaluated before implant placement based on the prognosis for good implant outcome. The alveolar ridge implant placement site must present with good-quality bone of adequate mass and density. Active periodontal disease must be treated and under control before implant placement to avoid possible complications. Limited to the replacement of permanent teeth (2–15, 18–31 only). Replacements of teeth 1, 16, 17 and 32 are not covered unless in functional occlusion and necessary to maintain occlusal support. The implant must have a good crown-to-root ratio. The restorative dentist will evaluate the implant restoration based on the complete osseointegration of the implant body. Benefits will not be approved if the implant body is not fully osseointegrated. The implant must not have more than two implant body threads exposed above the alveolar crest and must not be closer than 1.5 mm to adjacent roots or implants. When there is untreated generalized periodontal disease throughout the remaining dentition, a more conservative treatment modality may be offered as an alternate benefit to restore the edentulous space and replace all missing teeth, e.g., a fixed bridge or a full/partial denture. Implants may be contraindicated in young patients whose growth is expected to continue.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative panoramic or full-mouth series radiographs, pre-periapical radiograph, date of extraction, rationale, periodontal charting and history, list of other missing teeth, rationale for second-stage implant surgery, if applicable.

*Check patient eligibility including age and frequency limitations for each service.

Implant Services			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D6050	Surgical placement: transosteal implant	Benefits are typically available once every five years. General anesthesia and/or intravenous sedation may be covered with this procedure. The implant site will be evaluated before implant placement based on the prognosis for good implant outcome. The alveolar ridge implant placement site must present with good-quality bone of adequate mass and density. Active periodontal disease must be treated and under control before implant placement to avoid possible complications. Limited to the replacement of permanent teeth (2–15, 18–31 only). Replacements of teeth 1, 16, 17 and 32 are not covered unless in functional occlusion and necessary to maintain occlusal support. The implant must have a good crown-to-root ratio. The restorative dentist will evaluate the implant restoration based on the complete osseointegration of the implant body. Benefits will not be approved if the implant body is not fully osseointegrated. The implant must not have more than two implant body threads exposed above the alveolar crest and must not be closer than 1.5 mm to adjacent roots or implants. When there is untreated generalized periodontal disease throughout the remaining dentition, a more conservative treatment modality may be offered as an alternate benefit to restore the edentulous space and replace all missing teeth, e.g., a fixed bridge or a full/partial denture. Implants may be contraindicated in young patients whose growth is expected to continue.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative panoramic or full-mouth series radiographs, pre-periapical radiograph, date of extraction, rationale, periodontal charting and history, list of other missing teeth, rationale for second stage implant surgery, if applicable.
D6051	Placement of an interim implant abutment	This procedure is typically not covered as it is considered inclusive to the implant body placement procedure.	n/a
D6055	Connecting bar—implant-supported or abutment-supported	Benefits are typically available once every five years and are allowed only on implants that demonstrate quality osseointegration with fewer than two threads supra osseous. This procedure requires a narrative explaining the treatment plan's rationale and supporting documentation.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative panoramic or full-mouth series radiographs, periapical radiographs showing the entire length of the integrated implant, date of extraction, rationale, periodontal charting and history, list of other missing teeth.
D6056	Prefabricated abutment—includes modification and placement	Benefits are typically available once every five years and are allowed only on implants that demonstrate quality osseointegration with fewer than two threads supra osseous. The abutment is seated separately from the crown.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative panoramic or full-mouth series radiographs, periapical radiographs showing the entire length of the integrated implant, date of extraction, rationale, periodontal charting and history, list of other missing teeth.

*Check patient eligibility including age and frequency limitations for each service.

Implant Services			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D6057	Custom fabricated abutment—includes placement	Benefits are typically available once every five years and are allowed only on implants that demonstrate quality osseointegration with fewer than two threads supra osseous. The abutment is seated separately from the crown.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative panoramic or full-mouth series radiographs, periapical radiographs showing the entire length of the integrated implant, date of extraction, rationale, periodontal charting and history, list of other missing teeth.
D6058	Abutment-supported porcelain/ceramic crown	Benefits are typically available once every five years and are allowed only on implants that demonstrate quality osseointegration with fewer than two threads supra osseous. The abutment is seated separately from the crown. This procedure requires a narrative explaining the treatment plan's rationale and supporting documentation.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative panoramic or full-mouth series radiographs, periapical radiographs showing the entire length of the integrated implant, date of extraction, rationale, periodontal charting and history, list of other missing teeth.
D6059	Abutment-supported porcelain fused to metal crown (high noble metal)	Benefits are typically available once every five years and are allowed only on implants that demonstrate quality osseointegration with fewer than two threads supra osseous. The abutment is seated separately from the crown. This procedure requires a narrative explaining the treatment plan's rationale and supporting documentation.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative panoramic or full-mouth series radiographs, periapical radiographs showing the entire length of the integrated implant, date of extraction, rationale, periodontal charting and history, list of other missing teeth.
D6060	Abutment-supported porcelain fused to metal crown (predominately base metal)	Benefits are typically available once every five years and are allowed only on implants that demonstrate quality osseointegration with fewer than two threads supra osseous. The abutment is seated separately from the crown. This procedure requires a narrative explaining the treatment plan's rationale and supporting documentation.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative panoramic or full-mouth series radiographs, periapical radiographs showing the entire length of the integrated implant, date of extraction, rationale, periodontal charting and history, list of other missing teeth.
D6061	Abutment-supported porcelain fused to metal crown (noble metal)	Benefits are typically available once every five years and are allowed only on implants that demonstrate quality osseointegration with fewer than two threads supra osseous. The abutment is seated separately from the crown. This procedure requires a narrative explaining the treatment plan's rationale and supporting documentation.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative panoramic or full-mouth series radiographs, periapical radiographs showing the entire length of the integrated implant, date of extraction, rationale, periodontal charting and history, list of other missing teeth.
D6062	Abutment-supported cast metal crown (high noble metal)	Benefits are typically available once every five years and are allowed only on implants that demonstrate quality osseointegration with fewer than two threads supra osseous. The abutment is seated separately from the crown. This procedure requires a narrative explaining the treatment plan's rationale and supporting documentation.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative panoramic or full-mouth series radiographs, periapical radiographs showing the entire length of the integrated implant, date of extraction, rationale, periodontal charting and history, list of other missing teeth.

*Check patient eligibility including age and frequency limitations for each service.

Implant Services			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D6063	Abutment-supported cast metal crown (predominately base metal)	Benefits are typically available once every five years and are allowed only on implants that demonstrate quality osseointegration with fewer than two threads supra osseous. The abutment is seated separately from the crown. This procedure requires a narrative explaining the treatment plan's rationale and supporting documentation.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative panoramic or full-mouth series radiographs, periapical radiographs showing the entire length of the integrated implant, date of extraction, rationale, periodontal charting and history, list of other missing teeth.
D6064	Abutment-supported cast metal crown (noble metal)	Benefits are typically available once every five years and are allowed only on implants that demonstrate quality osseointegration with fewer than two threads supra osseous. The abutment is seated separately from the crown. This procedure requires a narrative explaining the treatment plan's rationale and supporting documentation.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative panoramic or full-mouth series radiographs, periapical radiographs showing the entire length of the integrated implant, date of extraction, rationale, periodontal charting and history, list of other missing teeth.
D6065	Implant-supported porcelain/ ceramic crown	Benefits are typically available once every five years and are allowed only on implants that demonstrate quality osseointegration with fewer than two threads supra osseous. No separate abutment is seated individually before the crown is placed. This procedure requires a narrative explaining the treatment plan's rationale and supporting documentation.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative panoramic or full-mouth series radiographs, periapical radiographs showing the entire length of the integrated implant, date of extraction, rationale, periodontal charting and history, list of other missing teeth.
D6066	Implant-supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	Benefits are typically available once every five years and are allowed only on implants that demonstrate quality osseointegration with fewer than two threads supra osseous. No separate abutment is seated individually before the crown is placed. This procedure requires a narrative explaining the treatment plan's rationale and supporting documentation.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative panoramic or full-mouth series radiographs, periapical radiographs showing the entire length of the integrated implant, date of extraction, rationale, periodontal charting and history, list of other missing teeth.
D6067	Implant-supported metal crown (titanium, titanium alloy, high noble metal)	Benefits are typically available once every five years and are allowed only on implants that demonstrate quality osseointegration with fewer than two threads supra osseous. No separate abutment is seated individually before the crown is placed. This procedure requires a narrative explaining the treatment plan's rationale and supporting documentation.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative panoramic or full-mouth series radiographs, periapical radiographs showing the entire length of the integrated implant, date of extraction, rationale, periodontal charting and history, list of other missing teeth.
D6068	Abutment-supported retainer for porcelain/ceramic FPD	Benefits are typically available once every five years and are allowed only on implants that demonstrate quality osseointegration with fewer than two threads supra osseous. The abutment is seated separately from the retainer crown. This procedure requires a narrative explaining the treatment plan's rationale and supporting documentation.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative panoramic or full-mouth series radiographs, periapical radiographs showing the entire length of the integrated implant, date of extraction, rationale, periodontal charting and history, list of other missing teeth.

*Check patient eligibility including age and frequency limitations for each service.

Implant Services			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D6069	Abutment-supported retainer for porcelain fused to metal FPD (high noble metal)	Benefits are typically available once every five years and are allowed only on implants that demonstrate quality osseointegration with fewer than two threads supra osseous. The abutment is seated separately from the retainer crown. This procedure requires a narrative explaining the treatment plan's rationale and supporting documentation.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative panoramic or full-mouth series radiographs, periapical radiographs showing the entire length of the integrated implant, date of extraction, rationale, periodontal charting and history, list of other missing teeth.
D6070	Abutment-supported retainer for porcelain fused to metal FPD (predominately base metal)	Benefits are typically available once every five years and are allowed only on implants that demonstrate quality osseointegration with fewer than two threads supra osseous. The abutment is seated separately from the retainer crown. This procedure requires a narrative explaining the treatment plan's rationale and supporting documentation.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative panoramic or full-mouth series radiographs, periapical radiographs showing the entire length of the integrated implant, date of extraction, rationale, periodontal charting and history, list of other missing teeth.
D6071	Abutment-supported retainer for porcelain fused to metal FPD (noble metal)	Benefits are typically available once every five years and are allowed only on implants that demonstrate quality osseointegration with fewer than two threads supra osseous. The abutment is seated separately from the retainer crown. This procedure requires a narrative explaining the treatment plan's rationale and supporting documentation.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative panoramic or full-mouth series radiographs, periapical radiographs showing the entire length of the integrated implant, date of extraction, rationale, periodontal charting and history, list of other missing teeth.
D6072	Abutment-supported retainer for cast metal FPD (high noble metal)	Benefits are typically available once every five years and are allowed only on implants that demonstrate quality osseointegration with fewer than two threads supra osseous. The abutment is seated separately from the retainer crown. This procedure requires a narrative explaining the treatment plan's rationale and supporting documentation.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative panoramic or full-mouth series radiographs, periapical radiographs showing the entire length of the integrated implant, date of extraction, rationale, periodontal charting and history, list of other missing teeth.
D6073	Abutment-supported retainer for cast metal FPD (predominately base metal)	Benefits are typically available once every five years and are allowed only on implants that demonstrate quality osseointegration with fewer than two threads supra osseous. The abutment is seated separately from the retainer crown. This procedure requires a narrative explaining the treatment plan's rationale and supporting documentation.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative panoramic or full-mouth series radiographs, periapical radiographs showing the entire length of the integrated implant, date of extraction, rationale, periodontal charting and history, list of other missing teeth.
D6074	Abutment-supported retainer for cast metal FPD (noble metal)	Benefits are typically available once every five years and are allowed only on implants that demonstrate quality osseointegration with fewer than two threads supra osseous. The abutment is seated separately from the retainer crown. This procedure requires a narrative explaining the treatment plan's rationale and supporting documentation.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative panoramic or full-mouth series radiographs, periapical radiographs showing the entire length of the integrated implant, date of extraction, rationale, periodontal charting and history, list of other missing teeth.

*Check patient eligibility including age and frequency limitations for each service.

Implant Services			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D6075	Implant-supported retainer for ceramic FPD	Benefits are typically available once every five years and are allowed only on implants that demonstrate quality osseointegration with fewer than two threads supra osseous. No separate abutment is seated individually before the retainer crown is placed. This procedure requires a narrative explaining the treatment plan's rationale and supporting documentation.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative panoramic or full-mouth series radiographs, periapical radiographs showing the entire length of the integrated implant, date of extraction, rationale, periodontal charting and history, list of other missing teeth.
D6076	Implant-supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	Benefits are typically available once every five years and are allowed only on implants that demonstrate quality osseointegration with fewer than two threads supra osseous. No separate abutment is seated individually before the retainer crown is placed. This procedure requires a narrative explaining the treatment plan's rationale and supporting documentation.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative panoramic or full-mouth series radiographs, periapical radiographs showing the entire length of the integrated implant, date of extraction, rationale, periodontal charting and history, list of other missing teeth.
D6077	Implant-supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	Benefits are typically available once every five years and are allowed only on implants that demonstrate quality osseointegration with fewer than two threads supra osseous. No separate abutment is seated individually before the retainer crown is placed. This procedure requires a narrative explaining the treatment plan's rationale and supporting documentation.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative panoramic or full-mouth series radiographs, periapical radiographs showing the entire length of the integrated implant, date of extraction, rationale, periodontal charting and history, list of other missing teeth.
D6080	Implant maintenance procedures when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments	Benefits are typically available once every 12 months if covered.	n/a
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 are typically available once every 12 months if covered.	n/a
D6082	Implant-supported crown—porcelain fused to predominantly base alloys	Benefits are typically available once every five years and are allowed only on implants that demonstrate quality osseointegration with fewer than two threads supra osseous. No separate abutment is seated individually before the crown is placed. This procedure requires a narrative explaining the treatment plan's rationale and supporting documentation.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative panoramic or full-mouth series radiographs, periapical radiographs showing the entire length of the integrated implant, date of extraction, rationale, periodontal charting and history, list of other missing teeth.

*Check patient eligibility including age and frequency limitations for each service.

Implant Services			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D6083	Implant-supported crown—porcelain fused to noble alloys	Benefits are typically available once every five years and are allowed only on implants that demonstrate quality osseointegration with fewer than two threads supra osseous. No separate abutment is seated individually before the crown is placed. This procedure requires a narrative explaining the treatment plan's rationale and supporting documentation.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative panoramic or full-mouth series radiographs, periapical radiographs showing the entire length of the integrated implant, date of extraction, rationale, periodontal charting and history, list of other missing teeth.
D6084	Implant-supported crown—porcelain fused to titanium and titanium alloys	Benefits are typically available once every five years and are allowed only on implants that demonstrate quality osseointegration with fewer than two threads supra osseous. No separate abutment is seated individually before the crown is placed. This procedure requires a narrative explaining the treatment plan's rationale and supporting documentation.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative panoramic or full-mouth series radiographs, periapical radiographs showing the entire length of the integrated implant, date of extraction, rationale, periodontal charting and history, list of other missing teeth.
D6085	Provisional implant crown	This procedure is typically not covered as it is considered inclusive of the implant restoration procedure.	n/a
D6086	Implant-supported crown—predominantly base alloys	Benefits are typically available once every five years and are allowed only on implants that demonstrate quality osseointegration with fewer than two threads supra osseous. No separate abutment is seated individually before the crown is placed. This procedure requires a narrative explaining the treatment plan's rationale and supporting documentation.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative panoramic or full-mouth series radiographs, periapical radiographs showing the entire length of the integrated implant, date of extraction, rationale, periodontal charting and history, list of other missing teeth.
D6087	Implant-supported crown—noble alloys	Benefits are typically available once every five years and are allowed only on implants that demonstrate quality osseointegration with fewer than two threads supra osseous. No separate abutment is seated individually before the crown is placed. This procedure requires a narrative explaining the treatment plan's rationale and supporting documentation.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative panoramic or full-mouth series radiographs, periapical radiographs showing the entire length of the integrated implant, date of extraction, rationale, periodontal charting and history, list of other missing teeth.
D6088	Implant-supported crown—titanium and titanium alloys	Benefits are typically available once every five years and are allowed only on implants that demonstrate quality osseointegration with fewer than two threads supra osseous. No separate abutment is seated individually before the crown is placed. This procedure requires a narrative explaining the treatment plan's rationale and supporting documentation.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative panoramic or full-mouth series radiographs, periapical radiographs showing the entire length of the integrated implant, date of extraction, rationale, periodontal charting and history, list of other missing teeth.
D6089	Accessing and retorquing loose implant screw—per screw	Benefits are typically not covered.	n/a
D6090	Repair of implant/abutment-supported prosthesis	Benefits are typically available once every five years. Submission of this procedure requires an explanation of the repair needed and what was performed to repair the prosthesis.	**Requires clinical review; pre-treatment estimate recommended.** Periapical radiograph, description of treatment and statement of medical necessity.

*Check patient eligibility including age and frequency limitations for each service.

Implant Services			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D6091	Replacement of semi-precision/ precision attachment (male or female component) of implant/ abutment-supported prosthesis	Typically not covered.	n/a
D6092	Recement implant/abutment supported crown	Benefits are typically available once every 12 months after six months have elapsed since the initial placement. If a bridge or crown is removed and/or repaired on the same service date as the recementation, the recementation is considered inclusive to the removal or repair.	n/a
D6093	Recement implant/abutment supported fixed partial denture	Benefits are typically available once every 12 months after six months have elapsed since the initial placement. If a bridge or crown is removed and/or repaired on the same service date as the recementation, the recementation is considered inclusive to the removal or repair.	n/a
D6094	Abutment-supported crown (titanium)	Benefits are typically available once every five years and are allowed only on implants that demonstrate quality osseointegration with fewer than two threads supra osseous. No separate abutment is seated individually before the crown is placed. This procedure requires a narrative explaining the treatment plan's rationale and supporting documentation.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative panoramic or full-mouth series radiographs, periapical radiographs showing the entire length of the integrated implant, date of extraction, rationale, periodontal charting and history, list of other missing teeth.
D6096	Remove broken implant retaining screw	Typically not covered.	n/a
D6097	Abutment-supported crown—porcelain fused to titanium and titanium alloys	Benefits are typically available once every five years and are allowed only on implants that demonstrate quality osseointegration with fewer than two threads supra osseous. No separate abutment is seated individually before the crown is placed. This procedure requires a narrative explaining the treatment plan's rationale and supporting documentation.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative panoramic or full-mouth series radiographs, periapical radiographs showing the entire length of the integrated implant, date of extraction, rationale, periodontal charting and history, list of other missing teeth.
D6098	Implant-supported retainer—porcelain fused to predominantly base alloys	Benefits are typically available once every five years and are allowed only on implants that demonstrate quality osseointegration with fewer than two threads supra osseous. No separate abutment is seated individually before the retainer crown is placed. This procedure requires a narrative explaining the treatment plan's rationale and supporting documentation.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative panoramic or full-mouth series radiographs, periapical radiographs showing the entire length of the integrated implant, date of extraction, rationale, periodontal charting and history, list of other missing teeth.
D6099	Implant-supported retainer for FPD—porcelain fused to noble alloys	Benefits are typically available once every five years and are allowed only on implants that demonstrate quality osseointegration with fewer than two threads supra osseous. No separate abutment is seated individually before the retainer crown is placed. This procedure requires a narrative explaining the treatment plan's rationale and supporting documentation.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative panoramic or full-mouth series radiographs, periapical radiographs showing the entire length of the integrated implant, date of extraction, rationale, periodontal charting and history, list of other missing teeth.

*Check patient eligibility including age and frequency limitations for each service.

Implant Services			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D6100	Implant removal, by report	Benefits are available if the rationale for removing the implant is clearly documented with narratives and images. Benefits for general anesthesia and sedation are allowed with this service.	**Requires clinical review; pre-treatment estimate recommended.** This procedure requires submitting pre-operative panoramic or full-mouth series and periapical (post-operative) showing implant radiographs, extraction date, rationale, periodontal charting and history and other missing teeth, if applicable.
D6101	Debridement of a peri-implant defect or defects surrounding a single implant and surface cleaning of the exposed implant surfaces, including flap entry and closure	Benefits are typically available once every 12 months. The debridement of the peri-implant defect(s) surrounding a single implant, the surface cleaning of the exposed implant surfaces, and flap entry and closure are included in this procedure code.	**Requires clinical review; pre-treatment estimate recommended.** Periapical radiograph, bitewing radiograph, statement of medical necessity, periodontal charting and history
D6102	Debridement and osseous contouring of a peri-implant defect, including surface cleaning of exposed implant surfaces	Benefits are typically available once every 12 months. The debridement and osseous contouring of the peri-implant defect(s) surrounding a single implant, the surface cleaning of the exposed implant surfaces, and flap entry and closure are included in this procedure code. Benefits for general anesthesia and sedation are allowed with this service.	**Requires clinical review; pre-treatment estimate recommended.** Periapical radiograph, bitewing radiograph, statement of medical necessity, periodontal charting and history
D6103	Bone graft for repair of the peri-implant defect, not including flap entry and closure, when indicated, placement of barrier	Benefits are typically available once every five years. This procedure is necessary when there is an osseous or soft tissue defect at an existing implant site. It may be necessary when surgical intervention is required to access the defect. Does not include flap entry and closure. Does not include barrier membranes or biological materials. Do not use codes D4263, D4264 or D7953. Benefits for general anesthesia and sedation are allowed with this service.	**Requires clinical review; pre-treatment estimate recommended.** Periapical radiograph, bitewing radiograph, statement of medical necessity, periodontal charting and history
D6104	Bone graft at the time of implant placement, not including, when indicated, flap entry and closure, placement of a barrier	Benefits are typically available once every five years. A bone graft may be indicated to repair an osseous defect or improve architecture. Grafting may be indicated when the implant is placed immediately into an extraction socket. Do not use D4263, D4264 or D7953 to report bone grafting with implant placement.	**Requires clinical review; pre-treatment estimate recommended.** Periapical radiograph, bitewing radiograph, statement of medical necessity, periodontal charting and history
D6105	Removal of implant body not requiring bone removal or flap elevation	Benefits are typically available once every five years and only with a history of conventional or mini-implant placement (D6010 or D6013). Removal of osseous tissue is not required to remove the implant body. If the patient was not covered by CareFirst when the original implants were placed, a documented treatment history must be submitted with the claim.	**Requires clinical review; pre-treatment estimate recommended.** Periapical radiograph, bitewing radiograph, statement of medical necessity, periodontal charting and history if not previously covered by CareFirst.

*Check patient eligibility including age and frequency limitations for each service.

Implant Services			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D6106	Guided tissue regeneration—resorbable barrier—per implant	Benefits are typically available once every five years. Use this code if a GTR is placed in an implant site in lieu of D4266, which is used for a site with natural teeth.	**Requires clinical review; pre-treatment estimate recommended.** Statement of medical necessity, prior history pre-surgical prep; post-operative periapical radiograph for implant and endodontically treated teeth, if applicable
D6107	Guided tissue regeneration—non-resorbable barrier—per implant	Benefits are typically available once every five years. Use this code if a GTR is placed in an implant site in lieu of D4267, which is used for a site with natural teeth.	**Requires clinical review; pre-treatment estimate recommended.** Statement of medical necessity, prior history pre-surgical prep; post-operative periapical radiograph for implant and endodontically treated teeth, if applicable
D6110	Implant /abutment-supported removable denture for edentulous arch—maxillary	Benefits are typically available once every five years. This procedure describes a removable maxillary full denture supported by implants or abutments of implants.	**Requires clinical review; pre-treatment estimate recommended.** The procedure requires submitting pre-operative panoramic or full-mouth series and periapical (post-operative) showing implant radiographs, extraction date, rationale, periodontal charting and history and other missing teeth, if applicable.
D6111	Implant /abutment-supported removable denture for edentulous arch—mandibular	Benefits are typically available once every five years. This procedure describes a removable mandibular full denture supported by implants or abutments of implants.	**Requires clinical review; pre-treatment estimate recommended.** The procedure requires submitting pre-operative panoramic or full-mouth series and periapical (post-operative) showing implant radiographs, extraction date, rationale, periodontal charting and history and other missing teeth, if applicable.
D6112	Implant /abutment supported removable denture for partially edentulous arch—maxillary	Benefits are typically available once every five years. This procedure describes a removable maxillary partial denture supported by implants or abutments of implants.	**Requires clinical review; pre-treatment estimate recommended.** The procedure requires submitting pre-operative panoramic or full-mouth series and periapical (post-operative) showing implant radiographs, extraction date, rationale, periodontal charting and history and other missing teeth, if applicable.
D6113	Implant /abutment-supported removable denture for partially edentulous arch—mandibular	Benefits are typically available once every five years. This procedure describes a removable mandibular partial denture supported by implants or abutments of implants.	**Requires clinical review; pre-treatment estimate recommended.** The procedure requires submitting pre-operative panoramic or full-mouth series and periapical (post-operative) showing implant radiographs, extraction date, rationale, periodontal charting and history and other missing teeth, if applicable.

*Check patient eligibility including age and frequency limitations for each service.

Implant Services			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D6114	Implant /abutment-supported fixed denture for edentulous arch—maxillary	Benefits are typically available once every five years. This procedure describes a fixed maxillary hybrid complete denture supported by implants or abutments of implants and can only be removed for cleaning or repair by a dentist.	**Requires clinical review; pre-treatment estimate recommended.** The procedure requires submitting pre-operative panoramic or full-mouth series and periapical (post-operative) showing implant radiographs, extraction date, rationale, periodontal charting and history and other missing teeth, if applicable.
D6115	Implant /abutment-supported fixed denture for edentulous arch—mandibular	Benefits are typically available once every five years. This procedure describes a fixed mandibular hybrid complete denture supported by implants or abutments of implants and can only be removed for cleaning or repair by a dentist.	**Requires clinical review; pre-treatment estimate recommended.** The procedure requires submitting pre-operative panoramic or full-mouth series and periapical (post-operative) showing implant radiographs, extraction date, rationale, periodontal charting and history and other missing teeth, if applicable.
D6116	Implant /abutment-supported fixed denture for partially edentulous arch—maxillary	Benefits are typically available once every five years. This procedure describes a fixed maxillary hybrid partial denture supported by implants or abutments of implants and can only be removed for cleaning or repair by a dentist.	**Requires clinical review; pre-treatment estimate recommended.** The procedure requires submitting pre-operative panoramic or full-mouth series and periapical (post-operative) showing implant radiographs, extraction date, rationale, periodontal charting and history and other missing teeth, if applicable.
D6117	Implant /abutment-supported fixed denture for partially edentulous arch—mandibular	Benefits are typically available once every five years. This procedure describes a fixed mandibular hybrid partial denture supported by implants or abutments of implants and can only be removed for cleaning or repair by a dentist.	**Requires clinical review; pre-treatment estimate recommended.** The procedure requires submitting pre-operative panoramic or full-mouth series and periapical (post-operative) showing implant radiographs, extraction date, rationale, periodontal charting and history and other missing teeth, if applicable.
D6118	Implant/abutment-supported interim fixed denture for edentulous arch—mandibular	Typically not covered.	n/a
D6119	Implant/abutment-supported interim fixed denture for edentulous arch—maxillary	Typically not covered.	n/a

*Check patient eligibility including age and frequency limitations for each service.

Implant Services			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D6120	Implant-supported retainer—porcelain fused to titanium and titanium alloys.	Benefits are typically available once every five years and are allowed only on implants that demonstrate quality osseointegration with fewer than two threads supra osseous. No separate abutment is seated individually before the retainer crown is placed. This procedure requires a narrative explaining the treatment plan's rationale and supporting documentation.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative panoramic or full-mouth series radiographs, periapical radiographs showing the entire length of the integrated implant, date of extraction, rationale, periodontal charting and history, list of other missing teeth.
D6121	Implant-supported retainer for metal fixed partial denture—predominantly base alloys.	Benefits are typically available once every five years and are allowed only on implants that demonstrate quality osseointegration with fewer than two threads supra osseous. No separate abutment is seated individually before the retainer crown is placed. This procedure requires a narrative explaining the treatment plan's rationale and supporting documentation.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative panoramic or full-mouth series radiographs, periapical radiographs showing the entire length of the integrated implant, date of extraction, rationale, periodontal charting and history, list of other missing teeth.
D6122	Implant-supported retainer for metal fixed partial denture—noble alloys	Benefits are typically available once every five years and are allowed only on implants that demonstrate quality osseointegration with fewer than two threads supra osseous. No separate abutment is seated individually before the retainer crown is placed. This procedure requires a narrative explaining the treatment plan's rationale and supporting documentation.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative panoramic or full-mouth series radiographs, periapical radiographs showing the entire length of the integrated implant, date of extraction, rationale, periodontal charting and history, list of other missing teeth.
D6123	Implant-supported retainer for metal fixed partial denture–titanium and titanium alloys.	Benefits are typically available once every five years and are allowed only on implants that demonstrate quality osseointegration with fewer than two threads supra osseous. No separate abutment is seated individually before the retainer crown is placed. This procedure requires a narrative explaining the treatment plan's rationale and supporting documentation.	**Requires clinical review; pre-treatment estimate recommended.** Pre-operative panoramic or full-mouth series radiographs, periapical radiographs showing the entire length of the integrated implant, date of extraction, rationale, periodontal charting and history, list of other missing teeth.
D6180	Implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments	Benefits are typically allowed up to four times per benefit period.	No documentation required; approval depends on the plan design's frequency limitations for the individual patient.
D6190	Radiographic/surgical implant index, by report	Benefits are typically available once every five years. If the index use supports more than one tooth in a quadrant, the benefit will be allowed once per quadrant and not once per tooth.	**Requires clinical review; pre-treatment estimate recommended.** The procedure requires submitting pre-operative panoramic or full-mouth series and periapical (post-operative) showing implant radiographs, extraction date, rationale, periodontal charting and history and other missing teeth, if applicable.
D6191	Semi-precision abutment—placement	Typically not covered.	n/a

*Check patient eligibility including age and frequency limitations for each service.

Implant Services			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D6192	Semi-precision attachment—placement	Typically not covered.	n/a
D6193	Replacement of an implant screw	Benefits are typically available once every five years per tooth.	No documentation required; approval depends on the plan design's frequency limitations for the individual patient.
D6194	Abutment-supported retainer crown for fixed partial denture—(titanium)	Benefits are typically available once every five years and are allowed only on implants that demonstrate quality osseointegration with fewer than two threads supra osseous. No separate abutment is seated individually before the retainer crown is placed. This procedure requires a narrative explaining the treatment plan's rationale and supporting documentation.	**Requires clinical review; pre-treatment estimate recommended.** The procedure requires submitting pre-operative panoramic or full-mouth series and periapical (post-operative) showing implant radiographs, extraction date, rationale, periodontal charting and history and other missing teeth, if applicable.
D6195	Abutment-supported retainer—porcelain fused to titanium and titanium alloys	Benefits are typically available once every five years and are allowed only on implants that demonstrate quality osseointegration with fewer than two threads supra osseous. No separate abutment is seated individually before the retainer crown is placed. This procedure requires a narrative explaining the treatment plan's rationale and supporting documentation.	**Requires clinical review; pre-treatment estimate recommended.** The procedure requires submitting pre-operative panoramic or full-mouth series and periapical (post-operative) showing implant radiographs, extraction date, rationale, periodontal charting and history and other missing teeth, if applicable.
D6197	Replacement of restorative material used to close an access opening of a screw-retained implant-supported prosthesis—per implant	Benefits are typically available once every 12 months and are allowed with a documented history of implant or abutment supported crown placement (D6058-6077, D6082-6084, D6094, D6098-6099, D6120-6123, D6194-6195). If the patient's crown was not covered by CareFirst, then documentation of the crown placement must be submitted with the claim.	Documentation of prior placement with date and periapical radiograph required if prior restoration was not covered by CareFirst.
D6198	Remove interim implant component	Typically not covered.	n/a
D6199	Unspecified implant procedure, by report	Benefits are typically available once every five years. Unspecified implant procedure by report requires a detailed narrative and necessary radiographs.	**Requires clinical review; pre-treatment estimate recommended.** The procedure requires submitting pre-operative panoramic or full-mouth series and periapical (post-operative) showing implant radiographs, extraction date, rationale, periodontal charting and history and other missing teeth, if applicable.

*Check patient eligibility including age and frequency limitations for each service.

CareFirst
Family of health care plans

Part 9: Fixed Prosthodontics

Comprehensive Dental Reference Guide

Please use the Comprehensive Dental Reference Guide when preparing your claims and pre-treatment estimates for CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc., (collectively, "CareFirst"), CareFirst BlueCross BlueShield Medicare Advantage, The Dental Network, and the Federal Employee Program®.

- **CDT code descriptions**
- **Utilization review perspectives on clinical presentations appropriate for benefit allowance**
- **CareFirst-required documentation to allow for processing**
- **Identification of codes that require a clinical review by our staff of licensed dentists**

Selecting the most appropriate code to describe treatment rendered and providing required documentation streamlines the claims submission process.

These descriptions and directions are based on standard plan designs. Individual patient plans may vary. Verify benefits and eligibility for each patient before the appointment.

CareFirst
Family of health care plans

Fixed Prosthodontics: D6200–D6999

The information provided is based on general clinical policy and can vary for each patient's plan. Verify benefits and eligibility for each patient before the appointment, as there are differences among plans. The following information gives generalized clinical requirements and guidance for each CDT code.

Fixed Prosthodontics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D6205	Pontic—indirect resin-based composite	Benefits are typically allowed once every five years. Limited to the replacement of permanent teeth. Must replace a missing permanent tooth (2–5, 18–31 only). Replacements of teeth 1, 16, 17 and 32 are not covered. Pontic space must be 75% of the mesial–distal length of the missing tooth. The associated abutment teeth must demonstrate a good five-year prognosis. If the retainer is denied, the pontic will be denied. Two pontic lengths, maximum. Cantilevers should not involve more than one pontic, and the related abutment must have at least 75% bone support. Non-functional teeth are not considered for benefits.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable.
D6210	Pontic—cast high noble metal	Benefits are typically allowed once every five years. Limited to the replacement of permanent teeth. Must replace a missing permanent tooth (2–5, 18–31 only). Replacements of teeth 1, 16, 17 and 32 are not covered. Pontic space must be 75% of the mesial–distal length of the missing tooth. The associated abutment teeth must demonstrate a good five-year prognosis. If the retainer is denied, the pontic will be denied. Two pontic lengths, maximum. Cantilevers should not involve more than one pontic, and the related abutment must have at least 75% bone support. Non-functional teeth are not considered for benefits.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable.

*Check patient eligibility including age and frequency limitations for each service.

Fixed Prosthodontics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D6211	Pontic—cast predominantly base metal	Benefits are typically allowed once every five years. Limited to the replacement of permanent teeth. Must replace a missing permanent tooth (2–5, 18–31 only). Replacements of teeth 1, 16, 17 and 32 are not covered. Pontic space must be 75% of the mesial–distal length of the missing tooth. The associated abutment teeth must demonstrate a good five-year prognosis. If the retainer is denied, the pontic will be denied. Two pontic lengths, maximum. Cantilevers should not involve more than one pontic, and the related abutment must have at least 75% bone support. Non-functional teeth are not considered for benefits.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable.
D6212	Pontic—cast noble metal	Benefits are typically allowed once every five years. Limited to the replacement of permanent teeth. Must replace a missing permanent tooth (2–5, 18–31 only). Replacements of teeth 1, 16, 17 and 32 are not covered. Pontic space must be 75% of the mesial–distal length of the missing tooth. The associated abutment teeth must demonstrate a good five-year prognosis. If the retainer is denied, the pontic will be denied. Two pontic lengths, maximum. Cantilevers should not involve more than one pontic, and the related abutment must have at least 75% bone support. Non-functional teeth are not considered for benefits.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable.
D6214	Pontic—titanium	Benefits are typically allowed once every five years. Limited to the replacement of permanent teeth. Must replace a missing permanent tooth (2–5, 18–31 only). Replacements of teeth 1, 16, 17 and 32 are not covered. Pontic space must be 75% of the mesial–distal length of the missing tooth. The associated abutment teeth must demonstrate a good five-year prognosis. If the retainer is denied, the pontic will be denied. Two pontic lengths, maximum. Cantilevers should not involve more than one pontic, and the related abutment must have at least 75% bone support. Non-functional teeth are not considered for benefits.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable.
D6240	Pontic—porcelain fused to high noble metal	Benefits are typically allowed once every five years. Limited to the replacement of permanent teeth. Must replace a missing permanent tooth (2–5, 18–31 only). Replacements of teeth 1, 16, 17 and 32 are not covered. Pontic space must be 75% of the mesial–distal length of the missing tooth. The associated abutment teeth must demonstrate a good five-year prognosis. If the retainer is denied, the pontic will be denied. Two pontic lengths, maximum. Cantilevers should not involve more than one pontic, and the related abutment must have at least 75% bone support. Non-functional teeth are not considered for benefits.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable.

*Check patient eligibility including age and frequency limitations for each service.

Fixed Prosthodontics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D6241	Pontic—porcelain fused to predominantly base metal	Benefits are typically allowed once every five years. Limited to the replacement of permanent teeth. Must replace a missing permanent tooth (2–5, 18–31 only). Replacements of teeth 1, 16, 17 and 32 are not covered. Pontic space must be 75% of the mesial–distal length of the missing tooth. The associated abutment teeth must demonstrate a good five-year prognosis. If the retainer is denied, the pontic will be denied. Two pontic lengths, maximum. Cantilevers should not involve more than one pontic, and the related abutment must have at least 75% bone support. Non-functional teeth are not considered for benefits.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable.
D6242	Pontic—porcelain fused to noble metal	Benefits are typically allowed once every five years. Limited to the replacement of permanent teeth. Must replace a missing permanent tooth (2–5, 18–31 only). Replacements of teeth 1, 16, 17 and 32 are not covered. Pontic space must be 75% of the mesial–distal length of the missing tooth. The associated abutment teeth must demonstrate a good five-year prognosis. If the retainer is denied, the pontic will be denied. Two pontic lengths, maximum. Cantilevers should not involve more than one pontic, and the related abutment must have at least 75% bone support. Non-functional teeth are not considered for benefits.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable.
D6243	Pontic—porcelain fused to titanium and titanium alloys	Benefits are typically allowed once every five years. Limited to the replacement of permanent teeth. Must replace a missing permanent tooth (2–5, 18–31 only). Replacements of teeth 1, 16, 17 and 32 are not covered. Pontic space must be 75% of the mesial–distal length of the missing tooth. The associated abutment teeth must demonstrate a good five-year prognosis. If the retainer is denied, the pontic will be denied. Two pontic lengths, maximum. Cantilevers should not involve more than one pontic, and the related abutment must have at least 75% bone support. Non-functional teeth are not considered for benefits.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable.
D6245	Pontic—porcelain/ceramic	Benefits are typically allowed once every five years. Limited to the replacement of permanent teeth. Must replace a missing permanent tooth (2–5, 18–31 only). Replacements of teeth 1, 16, 17 and 32 are not covered. Pontic space must be 75% of the mesial–distal length of the missing tooth. The associated abutment teeth must demonstrate a good five-year prognosis. If the retainer is denied, the pontic will be denied. Two pontic lengths, maximum. Cantilevers should not involve more than one pontic, and the related abutment must have at least 75% bone support. Non-functional teeth are not considered for benefits.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable.

*Check patient eligibility including age and frequency limitations for each service.

Fixed Prosthodontics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D6250	Pontic—resin with high noble metal	Benefits are typically allowed once every five years. Limited to the replacement of permanent teeth. Must replace a missing permanent tooth (2–5, 18–31 only). Replacements of teeth 1, 16, 17 and 32 are not covered. Pontic space must be 75% of the mesial–distal length of the missing tooth. The associated abutment teeth must demonstrate a good five-year prognosis. If the retainer is denied, the pontic will be denied. Two pontic lengths, maximum. Cantilevers should not involve more than one pontic, and the related abutment must have at least 75% bone support. Non-functional teeth are not considered for benefits.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable.
D6251	Pontic—resin with predominantly base metal	Benefits are typically allowed once every five years. Limited to the replacement of permanent teeth. Must replace a missing permanent tooth (2–5, 18–31 only). Replacements of teeth 1, 16, 17 and 32 are not covered. Pontic space must be 75% of the mesial–distal length of the missing tooth. The associated abutment teeth must demonstrate a good five-year prognosis. If the retainer is denied, the pontic will be denied. Two pontic lengths, maximum. Cantilevers should not involve more than one pontic, and the related abutment must have at least 75% bone support. Non-functional teeth are not considered for benefits.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable.
D6252	Pontic—resin with noble metal	Benefits are typically allowed once every five years. Limited to the replacement of permanent teeth. Must replace a missing permanent tooth (2–5, 18–31 only). Replacements of teeth 1, 16, 17 and 32 are not covered. Pontic space must be 75% of the mesial–distal length of the missing tooth. The associated abutment teeth must demonstrate a good five-year prognosis. If the retainer is denied, the pontic will be denied. Two pontic lengths, maximum. Cantilevers should not involve more than one pontic, and the related abutment must have at least 75% bone support. Non-functional teeth are not considered for benefits.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable.
D6253	Provisional pontic—further treatment or completion of diagnosis necessary before final impression	This procedure is considered inclusive to the permanent prosthesis and cannot be billed to the member.	n/a
D6545	Retainer—cast metal for resin-bonded fixed prosthesis	Benefits are typically allowed once every five years. Limited to the replacement of permanent teeth. Must replace a missing permanent tooth (2–5, 18–31 only). Replacements of teeth 1, 16, 17 and 32 are not covered. Pontic space must be 75% of the mesial–distal length of the missing tooth. The associated abutment teeth must demonstrate a good five-year prognosis. If the retainer is denied, the pontic will be denied. Two pontic lengths, maximum. Cantilevers should not involve more than one pontic, and the related abutment must have at least 75% bone support. Non-functional teeth are not considered for benefits.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable.

*Check patient eligibility including age and frequency limitations for each service.

Fixed Prosthodontics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D6548	Retainer-porcelain/ceramic for resin-bonded fixed prosthesis	Benefits are typically allowed once every five years. Limited to the replacement of permanent teeth. Must replace a missing permanent tooth (2–5, 18–31 only). Replacements of teeth 1, 16, 17 and 32 are not covered. Pontic space must be 75% of the mesial–distal length of the missing tooth. The associated abutment teeth must demonstrate a good five-year prognosis. If the retainer is denied, the pontic will be denied. Two pontic lengths, maximum. Cantilevers should not involve more than one pontic, and the related abutment must have at least 75% bone support. Non-functional teeth are not considered for benefits.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable.
D6549	Resin retainer—for resin-bonded fixed prosthesis	Benefits are typically allowed once every five years. Only one restoration will be considered if an inlay or onlay is billed for the same tooth. Limited to the replacement of permanent teeth. Must replace a missing permanent tooth (2–15, 18–31 only). Replacements of teeth 1, 16, 17 and 32 are not covered. Pontic space must be 75% of the mesial–distal length of the missing tooth. The associated abutment teeth must demonstrate a good five-year prognosis. If the retainer is denied, the pontic will be denied. Two pontic lengths, maximum. Cantilevers should not involve more than one pontic, and the related abutment must have at least 75% bone support. Non-functional teeth are not considered for benefits.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable.
D6600	Retainer inlay—porcelain/ceramic, two surfaces	Benefits are typically allowed once every five years. Only one restoration will be considered if an inlay or onlay is billed for the same tooth. Limited to the replacement of permanent teeth. Must replace a missing permanent tooth (2–15, 18–31 only). Replacements of teeth 1, 16, 17 and 32 are not covered. Pontic space must be 75% of the mesial–distal length of the missing tooth. The associated abutment teeth must demonstrate a good five-year prognosis. If the retainer is denied, the pontic will be denied. Two pontic lengths, maximum. Cantilevers should not involve more than one pontic, and the related abutment must have at least 75% bone support. Non-functional teeth are not considered for benefits.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable.

*Check patient eligibility including age and frequency limitations for each service.

Fixed Prosthodontics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D6601	Retainer inlay—porcelain/ ceramic, three or more surfaces	Benefits are typically allowed once every five years. Only one restoration will be considered if an inlay or onlay is billed for the same tooth. Limited to the replacement of permanent teeth. Must replace a missing permanent tooth (2–15, 18–31 only). Replacements of teeth 1, 16, 17 and 32 are not covered. Pontic space must be 75% of the mesial–distal length of the missing tooth. The associated abutment teeth must demonstrate a good five-year prognosis. If the retainer is denied, the pontic will be denied. Two pontic lengths, maximum. Cantilevers should not involve more than one pontic, and the related abutment must have at least 75% bone support. Non-functional teeth are not considered for benefits.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable.
D6602	Retainer inlay—cast high noble metal, two surfaces	Benefits are typically allowed once every five years. Only one restoration will be considered if an inlay or onlay is billed for the same tooth. Limited to the replacement of permanent teeth. Must replace a missing permanent tooth (2–15, 18–31 only). Replacements of teeth 1, 16, 17 and 32 are not covered. Pontic space must be 75% of the mesial–distal length of the missing tooth. The associated abutment teeth must demonstrate a good five-year prognosis. If the retainer is denied, the pontic will be denied. Two pontic lengths, maximum. Cantilevers should not involve more than one pontic, and the related abutment must have at least 75% bone support. Non-functional teeth are not considered for benefits.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable.
D6603	Retainer inlay—cast high noble metal, three or more surfaces	Benefits are typically allowed once every five years. Only one restoration will be considered if an inlay or onlay is billed for the same tooth. Limited to the replacement of permanent teeth. Must replace a missing permanent tooth (2–15, 18–31 only). Replacements of teeth 1, 16, 17 and 32 are not covered. Pontic space must be 75% of the mesial–distal length of the missing tooth. The associated abutment teeth must demonstrate a good five-year prognosis. If the retainer is denied, the pontic will be denied. Two pontic lengths, maximum. Cantilevers should not involve more than one pontic, and the related abutment must have at least 75% bone support. Non-functional teeth are not considered for benefits.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable.

*Check patient eligibility including age and frequency limitations for each service.

Fixed Prosthodontics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D6604	Retainer inlay—cast predominantly base metal, two surfaces	Benefits are typically allowed once every five years. Only one restoration will be considered if an inlay or onlay is billed for the same tooth. Limited to the replacement of permanent teeth. Must replace a missing permanent tooth (2–15, 18–31 only). Replacements of teeth 1, 16, 17 and 32 are not covered. Pontic space must be 75% of the mesial–distal length of the missing tooth. The associated abutment teeth must demonstrate a good five-year prognosis. If the retainer is denied, the pontic will be denied. Two pontic lengths, maximum. Cantilevers should not involve more than one pontic, and the related abutment must have at least 75% bone support. Non-functional teeth are not considered for benefits.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable.
D6605	Retainer inlay—cast predominantly base metal, three or more surfaces	Benefits are typically allowed once every five years. Only one restoration will be considered if an inlay or onlay is billed for the same tooth. Limited to the replacement of permanent teeth. Must replace a missing permanent tooth (2–15, 18–31 only). Replacements of teeth 1, 16, 17 and 32 are not covered. Pontic space must be 75% of the mesial–distal length of the missing tooth. The associated abutment teeth must demonstrate a good five-year prognosis. If the retainer is denied, the pontic will be denied. Two pontic lengths, maximum. Cantilevers should not involve more than one pontic, and the related abutment must have at least 75% bone support. Non-functional teeth are not considered for benefits.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable.
D6606	Retainer inlay—cast noble metal, two surfaces	Benefits are typically allowed once every five years. Only one restoration will be considered if an inlay or onlay is billed for the same tooth. Limited to the replacement of permanent teeth. Must replace a missing permanent tooth (2–15, 18–1 only). Replacements of teeth 1, 16, 17 and 32 are not covered. Pontic space must be 75% of the mesial–distal length of the missing tooth. The associated abutment teeth must demonstrate a good five-year prognosis. If the retainer is denied, the pontic will be denied. Two pontic lengths, maximum. Cantilevers should not involve more than one pontic, and the related abutment must have at least 75% bone support. Non-functional teeth are not considered for benefits.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable.

*Check patient eligibility including age and frequency limitations for each service.

Fixed Prosthodontics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D6607	Retainer inlay—cast noble metal, three or more surfaces	Benefits are typically allowed once every five years. Only one restoration will be considered if an inlay or onlay is billed for the same tooth. Limited to the replacement of permanent teeth. Must replace a missing permanent tooth (2–15, 18–31 only). Replacements of teeth 1, 16, 17 and 32 are not covered. Pontic space must be 75% of the mesial–distal length of the missing tooth. The associated abutment teeth must demonstrate a good five-year prognosis. If the retainer is denied, the pontic will be denied. Two pontic lengths, maximum. Cantilevers should not involve more than one pontic, and the related abutment must have at least 75% bone support. Non-functional teeth are not considered for benefits.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable.
D6608	Retainer onlay—porcelain/ ceramic, two surfaces	Benefits are typically allowed once every five years. Only one restoration will be considered if an inlay or onlay is billed for the same tooth. Limited to the replacement of permanent teeth. Must replace a missing permanent tooth (2–15, 18–31 only). Replacements of teeth 1, 16, 17 and 32 are not covered. Pontic space must be 75% of the mesial–distal length of the missing tooth. The associated abutment teeth must demonstrate a good five-year prognosis. If the retainer is denied, the pontic will be denied. Two pontic lengths, maximum. Cantilevers should not involve more than one pontic, and the related abutment must have at least 75% bone support. Non-functional teeth are not considered for benefits.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable.
D6609	Retainer onlay—porcelain/ ceramic, three or more surfaces	Benefits are typically allowed once every five years. Only one restoration will be considered if an inlay or onlay is billed for the same tooth. Limited to the replacement of permanent teeth. Must replace a missing permanent tooth (2–15, 18–31 only). Replacements of teeth 1, 16, 17 and 32 are not covered. Pontic space must be 75% of the mesial–distal length of the missing tooth. The associated abutment teeth must demonstrate a good five-year prognosis. If the retainer is denied, the pontic will be denied. Two pontic lengths, maximum. Cantilevers should not involve more than one pontic, and the related abutment must have at least 75% bone support. Non-functional teeth are not considered for benefits.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable.

*Check patient eligibility including age and frequency limitations for each service.

Fixed Prosthodontics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D6610	Retainer onlay—cast high noble metal, two surfaces	Benefits are typically allowed once every five years. Only one restoration will be considered if an inlay or onlay is billed for the same tooth. Limited to the replacement of permanent teeth. Must replace a missing permanent tooth (2–15, 18–31 only). Replacements of teeth 1, 16, 17 and 32 are not covered. Pontic space must be 75% of the mesial–distal length of the missing tooth. The associated abutment teeth must demonstrate a good five-year prognosis. If the retainer is denied, the pontic will be denied. Two pontic lengths, maximum. Cantilevers should not involve more than one pontic, and the related abutment must have at least 75% bone support. Non-functional teeth are not considered for benefits.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable.
D6611	Retainer onlay—cast high noble metal, three or more surfaces	Benefits are typically allowed once every five years. Only one restoration will be considered if an inlay or onlay is billed for the same tooth. Limited to the replacement of permanent teeth. Must replace a missing permanent tooth (2–15, 18–31 only). Replacements of teeth 1, 16, 17 and 32 are not covered. Pontic space must be 75% of the mesial–distal length of the missing tooth. The associated abutment teeth must demonstrate a good five-year prognosis. If the retainer is denied, the pontic will be denied. Two pontic lengths, maximum. Cantilevers should not involve more than one pontic, and the related abutment must have at least 75% bone support. Non-functional teeth are not considered for benefits.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable.
D6612	Retainer onlay—cast predominantly base metal, two surfaces	Benefits are typically allowed once every five years. Only one restoration will be considered if an inlay or onlay is billed for the same tooth. Limited to the replacement of permanent teeth. Must replace a missing permanent tooth (2–15, 18–31 only). Replacements of teeth 1, 16, 17 and 32 are not covered. Pontic space must be 75% of the mesial–distal length of the missing tooth. The associated abutment teeth must demonstrate a good five-year prognosis. If the retainer is denied, the pontic will be denied. Two pontic lengths, maximum. Cantilevers should not involve more than one pontic, and the related abutment must have at least 75% bone support. Non-functional teeth are not considered for benefits.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable.

*Check patient eligibility including age and frequency limitations for each service.

Fixed Prosthodontics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D6613	Retainer onlay—cast predominantly base metal, three or more surfaces	Benefits are typically allowed once every five years. Only one restoration will be considered if an inlay or onlay is billed for the same tooth. Limited to the replacement of permanent teeth. Must replace a missing permanent tooth (2–15, 18–31 only). Replacements of teeth 1, 16, 17 and 32 are not covered. Pontic space must be 75% of the mesial–distal length of the missing tooth. The associated abutment teeth must demonstrate a good five-year prognosis. If the retainer is denied, the pontic will be denied. Two pontic lengths, maximum. Cantilevers should not involve more than one pontic, and the related abutment must have at least 75% bone support. Non-functional teeth are not considered for benefits.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable.
D6614	Retainer onlay—cast noble metal, two surfaces	Benefits are typically allowed once every five years. Only one restoration will be considered if an inlay or onlay is billed for the same tooth. Limited to the replacement of permanent teeth. Must replace a missing permanent tooth (2–15, 18–31 only). Replacements of teeth 1, 16, 17 and 32 are not covered. Pontic space must be 75% of the mesial–distal length of the missing tooth. The associated abutment teeth must demonstrate a good five-year prognosis. If the retainer is denied, the pontic will be denied. Two pontic lengths, maximum. Cantilevers should not involve more than one pontic, and the related abutment must have at least 75% bone support. Non-functional teeth are not considered for benefits.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable.
D6615	Retainer onlay—cast noble metal, three or more surfaces	Benefits are typically allowed once every five years. Only one restoration will be considered if an inlay or onlay is billed for the same tooth. Limited to the replacement of permanent teeth. Must replace a missing permanent tooth (2–15, 18–31 only). Replacements of teeth 1, 16, 17 and 32 are not covered. Pontic space must be 75% of the mesial–distal length of the missing tooth. The associated abutment teeth must demonstrate a good five-year prognosis. If the retainer is denied, the pontic will be denied. Two pontic lengths, maximum. Cantilevers should not involve more than one pontic, and the related abutment must have at least 75% bone support. Non-functional teeth are not considered for benefits.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable.

*Check patient eligibility including age and frequency limitations for each service.

Fixed Prosthodontics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D6624	Retainer inlay—titanium	Benefits are typically allowed once every five years. Only one restoration will be considered if an inlay or onlay is billed for the same tooth. Limited to the replacement of permanent teeth. Must replace a missing permanent tooth (2–15, 18–31 only). Replacements of teeth 1, 16, 17 and 32 are not covered. Pontic space must be 75% of the mesial–distal length of the missing tooth. The associated abutment teeth must demonstrate a good five-year prognosis. If the retainer is denied, the pontic will be denied. Two pontic lengths, maximum. Cantilevers should not involve more than one pontic, and the related abutment must have at least 75% bone support. Non-functional teeth are not considered for benefits.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable.
D6634	Retainer onlay—titanium	Benefits are typically allowed once every five years. Only one restoration will be considered if an inlay or onlay is billed for the same tooth. Limited to the replacement of permanent teeth. Must replace a missing permanent tooth (2–15, 18–31 only). Replacements of teeth 1, 16, 17 and 32 are not covered. Pontic space must be 75% of the mesial–distal length of the missing tooth. The associated abutment teeth must demonstrate a good five-year prognosis. If the retainer is denied, the pontic will be denied. Two pontic lengths, maximum. Cantilevers should not involve more than one pontic, and the related abutment must have at least 75% bone support. Non-functional teeth are not considered for benefits.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable.
D6710	Retainer crown—indirect resin-based composite	Benefits are typically allowed once every five years, Limited to permanent teeth (2–15, 18–31). An endodontically treated tooth must show adequate root canal fill without excessive overfill or periapical pathology. Endodontics must be completed before teeth are prepared, and the bridge is placed. The tooth must present with a minimum of 50% bone support. The patient must be free of active periodontal disease. If pontics are allowed an alternate benefit, the abutment crowns (retainers) will be considered for benefits independently based on their clinical status. Non-functional teeth are not considered for benefits. Abutment teeth should demonstrate zero mobility.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable. Endodontically treated teeth require a periapical that demonstrates adequate fill within 2 mm of the radiographic apex.

*Check patient eligibility including age and frequency limitations for each service.

Fixed Prosthodontics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D6720	Retainer crown—resin with high noble metal	Benefits are typically allowed once every five years. Limited to permanent teeth (2–15, 18–31). An endodontically treated tooth must show adequate root canal fill without excessive overfill or periapical pathology. Endodontics must be completed before teeth are prepared, and the bridge is placed. The tooth must present with a minimum of 50% bone support. The patient must be free of active periodontal disease. If pontics are allowed an alternate benefit, the abutment crowns (retainers) will be considered for benefits independently based on their clinical status. Non-functional teeth are not considered for benefits. Abutment teeth should demonstrate zero mobility.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable. Endodontically treated teeth require a periapical that demonstrates adequate fill within 2 mm of the radiographic apex.
D6721	Retainer crown—resin with predominantly base metal	Benefits are typically allowed once every five years. Limited to permanent teeth (2–15, 18–31). An endodontically treated tooth must show adequate root canal fill without excessive overfill or periapical pathology. Endodontics must be completed before teeth are prepared, and the bridge is placed. The tooth must present with a minimum of 50% bone support. The patient must be free of active periodontal disease. If pontics are allowed an alternate benefit, the abutment crowns (retainers) will be considered for benefits independently based on their clinical status. Non-functional teeth are not considered for benefits. Abutment teeth should demonstrate zero mobility.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable. Endodontically treated teeth require a periapical that demonstrates adequate fill within 2 mm of the radiographic apex.
D6722	Retainer crown—resin with noble metal	Benefits are typically allowed once every five years. Limited to permanent teeth (2–15, 18–31). An endodontically treated tooth must show adequate root canal fill without excessive overfill or periapical pathology. Endodontics must be completed before teeth are prepared, and the bridge is placed. The tooth must present with a minimum of 50% bone support. The patient must be free of active periodontal disease. If pontics are allowed an alternate benefit, the abutment crowns (retainers) will be considered for benefits independently based on their clinical status. Non-functional teeth are not considered for benefits. Abutment teeth should demonstrate zero mobility.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable. Endodontically treated teeth require a periapical that demonstrates adequate fill within 2 mm of the radiographic apex.
D6740	Retainer crown—porcelain/ ceramic	Benefits are typically allowed once every five years. Limited to permanent teeth (2–15, 18–31). An endodontically treated tooth must show adequate root canal fill without excessive overfill or periapical pathology. Endodontics must be completed before teeth are prepared, and the bridge is placed. The tooth must present with a minimum of 50% bone support. The patient must be free of active periodontal disease. If pontics are allowed an alternate benefit, the abutment crowns (retainers) will be considered for benefits independently based on their clinical status. Non-functional teeth are not considered for benefits. Abutment teeth should demonstrate zero mobility.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable. Endodontically treated teeth require a periapical that demonstrates adequate fill within 2 mm of the radiographic apex.

*Check patient eligibility including age and frequency limitations for each service.

Fixed Prosthodontics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D6750	Retainer crown—porcelain fused to high noble metal	Benefits are typically allowed once every five years. Limited to permanent teeth (2–15, 18–31). An endodontically treated tooth must show adequate root canal fill without excessive overfill or periapical pathology. Endodontics must be completed before teeth are prepared, and the bridge is placed. The tooth must present with a minimum of 50% bone support. The patient must be free of active periodontal disease. If pontics are allowed an alternate benefit, the abutment crowns (retainers) will be considered for benefits independently based on their clinical status. Non-functional teeth are not considered for benefits. Abutment teeth should demonstrate zero mobility.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable. Endodontically treated teeth require a periapical that demonstrates adequate fill within 2 mm of the radiographic apex.
D6751	Retainer crown—porcelain fused to predominantly base metal	Benefits are typically allowed once every five years. Limited to permanent teeth (2–15, 18–31). An endodontically treated tooth must show adequate root canal fill without excessive overfill or periapical pathology. Endodontics must be completed before teeth are prepared, and the bridge is placed. The tooth must present with a minimum of 50% bone support. The patient must be free of active periodontal disease. If pontics are allowed an alternate benefit, the abutment crowns (retainers) will be considered for benefits independently based on their clinical status. Non-functional teeth are not considered for benefits. Abutment teeth should demonstrate zero mobility.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable. Endodontically treated teeth require a periapical that demonstrates adequate fill within 2 mm of the radiographic apex.
D6752	Retainer crown—porcelain fused to noble metal	Benefits are typically allowed once every five years. Limited to permanent teeth (2–15, 18–31). An endodontically treated tooth must show adequate root canal fill without excessive overfill or periapical pathology. Endodontics must be completed before teeth are prepared, and the bridge is placed. The tooth must present with a minimum of 50% bone support. The patient must be free of active periodontal disease. If pontics are allowed an alternate benefit, the abutment crowns (retainers) will be considered for benefits independently based on their clinical status. Non-functional teeth are not considered for benefits. Abutment teeth should demonstrate zero mobility.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable. Endodontically treated teeth require a periapical that demonstrates adequate fill within 2 mm of the radiographic apex.
D6753	Retainer crown—porcelain fused to titanium and titanium alloys	Benefits are typically allowed once every five years. Limited to permanent teeth (2–15, 18–31). An endodontically treated tooth must show adequate root canal fill without excessive overfill or periapical pathology. Endodontics must be completed before teeth are prepared, and the bridge is placed. The tooth must present with a minimum of 50% bone support. The patient must be free of active periodontal disease. If pontics are allowed an alternate benefit, the abutment crowns (retainers) will be considered for benefits independently based on their clinical status. Non-functional teeth are not considered for benefits. Abutment teeth should demonstrate zero mobility.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable. Endodontically treated teeth require a periapical that demonstrates adequate fill within 2 mm of the radiographic apex.

*Check patient eligibility including age and frequency limitations for each service.

Fixed Prosthodontics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D6780	Retainer crown—3/4 cast high noble metal	Benefits are typically allowed once every five years. Limited to permanent teeth (2–15, 18–31). An endodontically treated tooth must show adequate root canal fill without excessive overfill or periapical pathology. Endodontics must be completed before teeth are prepared, and the bridge is placed. The tooth must present with a minimum of 50% bone support. The patient must be free of active periodontal disease. If pontics are allowed an alternate benefit, the abutment crowns (retainers) will be considered for benefits independently based on their clinical status. Non-functional teeth are not considered for benefits. Abutment teeth should demonstrate zero mobility.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable. Endodontically treated teeth require a periapical that demonstrates adequate fill within 2 mm of the radiographic apex.
D6781	Retainer crown—3/4 cast predominately based metal	Benefits are typically allowed once every five years. Limited to permanent teeth (2–15, 18–31). An endodontically treated tooth must show adequate root canal fill without excessive overfill or periapical pathology. Endodontics must be completed before teeth are prepared, and the bridge is placed. The tooth must present with a minimum of 50% bone support. The patient must be free of active periodontal disease. If pontics are allowed an alternate benefit, the abutment crowns (retainers) will be considered for benefits independently based on their clinical status. Non-functional teeth are not considered for benefits. Abutment teeth should demonstrate zero mobility.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable. Endodontically treated teeth require a periapical that demonstrates adequate fill within 2 mm of the radiographic apex.
D6782	Retainer crown—3/4 cast noble metal	Benefits are typically allowed once every five years. Limited to permanent teeth (2–15, 18–31). An endodontically treated tooth must show adequate root canal fill without excessive overfill or periapical pathology. Endodontics must be completed before teeth are prepared, and the bridge is placed. The tooth must present with a minimum of 50% bone support. The patient must be free of active periodontal disease. If pontics are allowed an alternate benefit, the abutment crowns (retainers) will be considered for benefits independently based on their clinical status. Non-functional teeth are not considered for benefits. Abutment teeth should demonstrate zero mobility.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable. Endodontically treated teeth require a periapical that demonstrates adequate fill within 2 mm of the radiographic apex.
D6783	Retainer crown—3/4 porcelain/ ceramic	Benefits are typically allowed once every five years. Limited to permanent teeth (2–15, 18–31). An endodontically treated tooth must show adequate root canal fill without excessive overfill or periapical pathology. Endodontics must be completed before teeth are prepared, and the bridge is placed. The tooth must present with a minimum of 50% bone support. The patient must be free of active periodontal disease. If pontics are allowed an alternate benefit, the abutment crowns (retainers) will be considered for benefits independently based on their clinical status. Non-functional teeth are not considered for benefits. Abutment teeth should demonstrate zero mobility.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable. Endodontically treated teeth require a periapical that demonstrates adequate fill within 2 mm of the radiographic apex.

*Check patient eligibility including age and frequency limitations for each service.

Fixed Prosthodontics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D6784	Retainer crown—3/4 titanium and titanium alloys	Benefits are typically allowed once every five years. Limited to permanent teeth (2–15, 18–31). An endodontically treated tooth must show adequate root canal fill without excessive overfill or periapical pathology. Endodontics must be completed before teeth are prepared, and the bridge is placed. The tooth must present with a minimum of 50% bone support. The patient must be free of active periodontal disease. If pontics are allowed an alternate benefit, the abutment crowns (retainers) will be considered for benefits independently based on their clinical status. Non-functional teeth are not considered for benefits. Abutment teeth should demonstrate zero mobility.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable. Endodontically treated teeth require a periapical that demonstrates adequate fill within 2 mm of the radiographic apex.
D6790	Retainer crown—full cast high noble metal	Benefits are typically allowed once every five years. Limited to permanent teeth (2–15, 18–31). An endodontically treated tooth must show adequate root canal fill without excessive overfill or periapical pathology. Endodontics must be completed before teeth are prepared, and the bridge is placed. The tooth must present with a minimum of 50% bone support. The patient must be free of active periodontal disease. If pontics are allowed an alternate benefit, the abutment crowns (retainers) will be considered for benefits independently based on their clinical status. Non-functional teeth are not considered for benefits. Abutment teeth should demonstrate zero mobility.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable. Endodontically treated teeth require a periapical that demonstrates adequate fill within 2 mm of the radiographic apex.
D6791	Retainer crown—full cast predominantly base metal	Benefits are typically allowed once every five years. Limited to permanent teeth (2–15, 18–31). An endodontically treated tooth must show adequate root canal fill without excessive overfill or periapical pathology. Endodontics must be completed before teeth are prepared, and the bridge is placed. The tooth must present with a minimum of 50% bone support. The patient must be free of active periodontal disease. If pontics are allowed an alternate benefit, the abutment crowns (retainers) will be considered for benefits independently based on their clinical status. Non-functional teeth are not considered for benefits. Abutment teeth should demonstrate zero mobility.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable. Endodontically treated teeth require a periapical that demonstrates adequate fill within 2 mm of the radiographic apex.
D6792	Retainer crown—full-cast noble metal	Benefits are typically allowed once every five years. Limited to permanent teeth (2–15, 18–31). An endodontically treated tooth must show adequate root canal fill without excessive overfill or periapical pathology. Endodontics must be completed before teeth are prepared, and the bridge is placed. The tooth must present with a minimum of 50% bone support. The patient must be free of active periodontal disease. If pontics are allowed an alternate benefit, the abutment crowns (retainers) will be considered for benefits independently based on their clinical status. Non-functional teeth are not considered for benefits. Abutment teeth should demonstrate zero mobility.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable. Endodontically treated teeth require a periapical that demonstrates adequate fill within 2 mm of the radiographic apex.

*Check patient eligibility including age and frequency limitations for each service.

Fixed Prosthodontics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D6793	Provisional retainer crown—further treatment or completion of diagnosis necessary before the final impression	This procedure is considered inclusive to the permanent prosthesis and cannot be billed to the member.	n/a
D6794	Retainer crown—titanium	Benefits are typically allowed once every five years. Limited to permanent teeth (2–15, 18–31). An endodontically treated tooth must show adequate root canal fill without excessive overfill or periapical pathology. Endodontics must be completed before teeth are prepared, and the bridge is placed. The tooth must present with a minimum of 50% bone support. The patient must be free of active periodontal disease. If pontics are allowed an alternate benefit, the abutment crowns (retainers) will be considered for benefits independently based on their clinical status. Non-functional teeth are not considered for benefits. Abutment teeth should demonstrate zero mobility.	**Requires clinical review; pre-treatment estimate recommended.** Requires submission of panoramic or full-mouth series radiographs, date of extraction, date of prior placement and other missing teeth, if applicable. Endodontically treated teeth require a periapical that demonstrates adequate fill within 2 mm of the radiographic apex.
D6920	Connector bar	This procedure is typically not covered.	n/a
D6930	Recement fixed partial denture	Benefits are typically available once per 12 months after six months have elapsed since the initial placement. Benefits are unavailable if performed on the same day as repairing or removing the bridge, as it is considered inclusive of the other procedure. As needed, adjusting/balancing the occlusion is part of the recementation procedure.	No documentation is required.
D6940	Stress breaker	This procedure is typically not covered.	n/a
D6950	Precision attachment	This procedure is typically not covered.	n/a
D6980	Fixed partial denture repair necessitated by restorative material failure	This procedure is typically allowed once per tooth every 12 months and is necessitated by a restorative material failure.	No documentation is required.
D6985	Pediatric partial denture, fixed	A fixed prosthetic restoration replaces one or more missing teeth in the primary, transitional or permanent dentition. This restoration attaches to natural teeth, tooth roots, or implants, and it is not removable by the patient. Growth must be considered when using fixed restorations in the developing dentition. Recommendations: Fixed prosthetic restorations to replace one or more missing teeth may be indicated to establish esthetics, maintain arch space or integrity in the developing dentition, prevent or correct harmful habits, or improve function.	**Requires clinical review; pre-treatment estimate recommended.** Requires a statement of medical necessity.
D6999	Unspecified, fixed prosthodontic procedure, by report	An unspecified prosthodontic procedure requires a detailed narrative and necessary radiographs.	**Requires clinical review; pre-treatment estimate recommended.** Requires a statement of medical necessity and necessary radiographs.

*Check patient eligibility including age and frequency limitations for each service.

CareFirst
Family of health care plans

Part 10: Oral & Maxillofacial Surgery

Comprehensive Dental Reference Guide

Please use the Comprehensive Dental Reference Guide when preparing your claims and pre-treatment estimates for CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc., (collectively, "CareFirst"), CareFirst BlueCross BlueShield Medicare Advantage, The Dental Network, and the Federal Employee Program®.

- **CDT code descriptions**
- **Utilization review perspectives on clinical presentations appropriate for benefit allowance**
- **CareFirst-required documentation to allow for processing**
- **Identification of codes that require a clinical review by our staff of licensed dentists**

Selecting the most appropriate code to describe treatment rendered and providing required documentation streamlines the claims submission process.

These descriptions and directions are based on standard plan designs. Individual patient plans may vary. Verify benefits and eligibility for each patient before the appointment.

CareFirst
Family of health care plans

Oral and Maxillofacial Surgery: D7000–D7999

The information provided is based on general clinical policy and can vary for each patient's plan. Verify benefits and eligibility for each patient before the appointment, as there are differences among plans. The following information gives generalized clinical requirements and guidance for each CDT code.

Oral and Maxillofacial Surgery			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D7111	Extraction, coronal remnants—primary tooth	The benefit is typically available once per lifetime per tooth. Extraction of tooth and cyst will have two separate benefits if the cyst is greater than 1.25 cm. Benefits will be denied if there is a history of prior extraction of this tooth. General anesthesia is not covered with this procedure.	No documentation is required.
D7140	Extraction—erupted tooth or exposed root (elevation and/or forceps removal)	The benefit is typically available once per lifetime per tooth. Extraction of tooth and cyst will have two separate benefits if the cyst is greater than 1.25 cm. Benefits will be denied if there is a history of prior extraction of this tooth. General anesthesia is not covered with this procedure. Minor smoothing of the bone is included with this procedure.	No documentation is required.
D7210	Erupted tooth requiring removal of bone or section of tooth, including elevation of mucoperiosteal flap if indicated	The benefit is typically available once per lifetime per tooth. Extraction of tooth and cyst will have two separate benefits if the cyst is greater than 1.25 cm. Benefits will be denied if there is a history of prior extraction of this tooth. General anesthesia is covered with two or more surgical extractions on the same service date. This procedure includes related cutting of the gingiva and bone, removal of the tooth structure, minor smoothing of the socket bone and closure of the surgical site.	No documentation is required.

*Check patient eligibility including age and frequency limitations for each service.

Oral and Maxillofacial Surgery			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D7220	Removal of impacted tooth—soft tissue	The benefit is typically available once per lifetime per tooth. Extraction of tooth and cyst will have two separate benefits if the cyst is greater than 1.25 cm. Benefits will be denied if there is a history of prior extraction of this tooth. General anesthesia is covered with this procedure. The occlusal surface of the tooth is covered by soft tissue and requires a mucoperiosteal flap elevation to extract it.	No documentation is required.
D7230	Removal of impacted tooth—partially bony	The benefit is typically available once per lifetime per tooth. Extraction of tooth and cyst will have two separate benefits if the cyst is greater than 1.25 cm. Benefits will be denied if there is a history of prior extraction of this tooth. General anesthesia is covered with this procedure. Part of the crown is covered by bone, requiring a mucoperiosteal flap elevation and bone removal to extract it.	No documentation is required.
D7240	Removal of impacted tooth—completely bony	The benefit is typically available once per lifetime per tooth. Extraction of tooth and cyst will have two separate benefits if the cyst is greater than 1.25 cm. Benefits will be denied if there is a history of prior extraction of this tooth. General anesthesia is covered with this procedure. Most or all of the crown is covered by bone, requiring a mucoperiosteal flap elevation and bone removal to extract it.	No documentation is required.
D7241	Removal of impacted tooth—completely bony, with unusual surgical complications	The benefit is typically available once per lifetime per tooth. Extraction of tooth and cyst will have two separate benefits if the cyst is greater than 1.25 cm. Benefits will be denied if there is a history of prior extraction of this tooth. General anesthesia is covered with this procedure. Most or all of the crown is covered by bone, complicated due to factors such as nerve dissection required, separate closure of the maxillary sinus required or aberrant tooth position/	No documentation is required.
D7250	Removal of residual tooth roots (cutting procedure)	The benefit is typically available once per lifetime per tooth. This procedure includes cutting the soft tissue and bone, removing tooth structure (roots) and closing the surgical site. General anesthesia is covered with this procedure. A benefit for removal of residual roots may be allowed if a coronectomy has been previously paid for the same tooth.	No documentation is required.
D7251	Coronectomy—intentional partial tooth removal	The benefit is typically available once per lifetime per tooth. This procedure is an intentional partial tooth removal performed when a neurovascular complication is likely if the entire impacted tooth is removed. General anesthesia is covered with this procedure.	No documentation is required.

*Check patient eligibility including age and frequency limitations for each service.

Oral and Maxillofacial Surgery			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D7252	Partial extraction for immediate implant placement (Sectioning the root of a tooth vertically, then extracting the palatal portion of the root. The buccal section of the root is retained in order to stabilize the buccal plate prior to immediate implant placement. Also known as the Socket Shield Technique.)	Benefit is typically available once per lifetime per tooth and not allowed with any other extraction code. Only D7250 is allowed if the procedure fails and the remaining root structure needs to be removed.	Requires clinical review; pre-treatment estimate recommended. Statement of medical necessity, periapical radiograph or other appropriate radiographic image.
D7259	Nerve dissection (Involves the separation or isolation of a nerve from surrounding tissues. Performed to gain access to and protect nerves during surgical procedures.)	This procedure is considered inclusive to the primary oral surgical procedure and does not receive separate benefits.	n/a
D7260	Oroantral fistula closure	Oral–antral communication treatment benefits are allowed when the site requires surgical intervention for repair and healing. The procedure includes excision of the fistulous tract between the maxillary sinus and oral cavity, closure by flap advancement and may or may not require a bone graft. A surgical op report to determine the actual extent of surgery and repair. General anesthesia is covered with this procedure.	**Requires clinical review; pre-treatment estimate recommended.** Statement of medical necessity, periapical radiograph or other appropriate radiographic image with operative notes to determine the extent of the surgery and repair needed.
D7261	Primary closure of a sinus perforation	Benefits are available after surgical removal of a tooth, exposure of the sinus requiring repair, or immediate closure of oroantral or oronasal communication in the absence of a fistulous tract. General anesthesia is covered with this procedure.	**Requires clinical review; pre-treatment estimate recommended.** Statement of medical necessity, periapical radiograph or other appropriate radiographic image with operative notes to determine the extent of the surgery and repair needed.
D7270	Tooth reimplantation and/ or stabilization of accidentally avulsed or displaced tooth	This is typically not a covered service under the dental plan, but if allowed (e.g., ACA plans, EPO), it is a benefit once per lifetime per tooth and splinting is included. General anesthesia is covered with this procedure. This service is often related to an accidental injury, covered under medical benefits.	Documentation is not required for the dental benefit, but if submitted to the medical plan, documentation of the accident and all related pre-op and post-op images should be submitted.
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)	The benefit is typically available as needed. General anesthesia is covered with this procedure.	No documentation is required.
D7280	Exposure of an unerupted tooth	The benefit is typically available once per lifetime per tooth. General anesthesia is covered with this procedure. The tooth requires an incision and tissue reflection, bone removal as necessary, to expose the crown of an impacted tooth that is not intended to be extracted.	No documentation is required.

*Check patient eligibility including age and frequency limitations for each service.

Oral and Maxillofacial Surgery			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D7282	Mobilization of an erupted or malpositioned tooth to aid eruption	The benefit is typically available once per lifetime per tooth. General anesthesia is covered with this procedure. The tooth must be ankylosed and not intended to be extracted.	**Requires clinical review; pre-treatment estimate recommended.** Statement of medical necessity, panoramic or other appropriate radiographic image
D7283	Placement of device to facilitate the eruption of impacted tooth	The benefit is typically available once per lifetime per tooth. General anesthesia is covered with this procedure. An attachment is placed on an unerupted tooth after exposure to aid in its eruption. The surgical exposure (D7280) is submitted separately.	No documentation is required.
D7284	Excisional biopsy of minor salivary glands	Benefits are available as needed, and a pathology report must be read by the clinical reviewer. This procedure code is for partial removal of the specimen only. This procedure involves the biopsy of the osseous lesions and is not used for apicoectomy or periradicular surgery submissions. This procedure does not involve an incision.	**Requires clinical review; pre-treatment estimate recommended.** Pathology report, statement of medical necessity and intraoral photograph are recommended in addition.
D7285	Biopsy of oral tissue—hard (bone, tooth)	Benefits are available as needed, and a pathology report must be read by the clinical reviewer. This procedure code is for partial removal of the specimen only. This procedure involves the biopsy of the osseous lesions and is not used for apicoectomy or periradicular surgery submissions. This procedure does not involve an incision.	**Requires clinical review; pre-treatment estimate recommended.** Pathology report, statement of medical necessity and intraoral photograph are recommended in addition.
D7286	Biopsy of oral tissue—soft	Benefits are available as needed, and a pathology report must be read by the clinical reviewer. This procedure code is for partial removal of the specimen only. This procedure involves the biopsy of the soft tissue lesions and is not used for apicoectomy or periradicular surgery submissions. This procedure does not involve an incision.	**Requires clinical review; pre-treatment estimate recommended.** Pathology report, statement of medical necessity and intraoral photograph are recommended in addition.
D7287	Exfoliative cytological sample collection	This procedure collects oral disaggregated transepithelial cells via a rotational brushing of the oral mucosa. It is considered inclusive to the definitive service billed (e.g., an exam that includes an oral cancer examination and pathology report), or if billed alone, the benefit is based on the patient's contract.	Documentation is not required.
D7288	Brush biopsy—transepithelial sample collection	This procedure code is for a sample collection of abnormally appearing mucosal cells or oral mucosal lesions. A biopsy may be required for a definitive diagnosis. This procedure is typically not covered due to the high rate of false positive results. It may be used as a screening technique.	**Requires clinical review; pre-treatment estimate recommended.** Pathology report, statement of medical necessity and intraoral photograph are recommended in addition.
D7290	Surgical repositioning of teeth	This procedure is reviewed by report, and any grafting procedure is considered additional. General anesthesia benefits are allowed with this procedure.	**Requires clinical review; pre-treatment estimate recommended.** Statement of medical necessity; intraoral photograph recommended in addition.
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	Typically not covered.	n/a

*Check patient eligibility including age and frequency limitations for each service.

Oral and Maxillofacial Surgery			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D7292	Placement of temporary anchorage device (screw-retained plate) requiring flap, including device removal	Typically not covered.	n/a
D7293	Placement of temporary anchorage device requiring flap, including device removal	Typically not covered.	n/a
D7294	Placement of temporary anchorage device without flap, including device removal	Typically not covered.	n/a
D7295	Harvest of bone for use in autogenous grafting procedure	This procedure is considered inclusive to the grafting procedure.	Documentation is not required.
D7296	Corticotomy—one to three teeth or tooth spaces, per quadrant	Typically not covered.	n/a
D7297	Corticotomy—four or more teeth or tooth spaces, per quadrant	Typically not covered.	n/a
D7298	Removal of temporary anchorage device (screw-retained plate), requiring flap	Typically not covered.	n/a
D7299	Removal of temporary anchorage device, requiring flap	Typically not covered.	n/a
D7300	Removal of temporary anchorage device without flap	Typically not covered.	n/a
D7310	Alveoloplasty in conjunction with extractions—four or more teeth or tooth spaces, per quadrant	This benefit is typically available if four or more permanent teeth in a quadrant have been extracted and limited to once per quadrant per lifetime. Excess bone is removed from the edentulous areas of the ridge to recontour the bony ridge in preparation for a dental prosthesis (implant retained crown, dentures, RPD, FPD, implant-supported crown or retained FPD, RPD). General anesthesia is a covered benefit with this procedure. The date of extractions must coincide with the date of the alveoloplasty. It is a distinct procedure from the extractions and is usually performed in preparation for a prosthesis or other treatment, such as radiation therapy and transplant surgery. Alveloplasty is reported separately within the same quadrant, in addition to extractions.	No documentation is required.

*Check patient eligibility including age and frequency limitations for each service.

Oral and Maxillofacial Surgery			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D7311	Alveoplasty in conjunction with extractions—one to three teeth or tooth spaces, per quadrant	This benefit is typically available if three or fewer permanent teeth in a quadrant have been extracted and is limited to once per tooth per lifetime. Excess bone is removed from the edentulous areas of the ridge to recontour the bony ridge in preparation for a dental prosthesis (implant retained crown, dentures, RPD, FPD, implant-supported crown or retained FPD, RPD). General anesthesia is a covered benefit with this procedure. The date of extractions must coincide with the date of the alveoloplasty. It is a distinct procedure from the extractions and is usually performed in preparation for a prosthesis or other treatment such as radiation therapy and transplant surgery. Alveloplasty is reported separately within the same quadrant, in addition to extractions.	No documentation is required.
D7320	Alveoloplasty not in conjunction with extractions—four or more teeth or tooth spaces, per quadrant	This benefit is typically available if four or more permanent teeth in a quadrant have been previously extracted and is limited to once per quadrant per lifetime. Excess bone is removed from the edentulous areas of the ridge to recontour the bony ridge in preparation for a dental prosthesis (implant retained crown, dentures, RPD, FPD, implant-supported crown or retained FPD, RPD). General anesthesia is a covered benefit with this procedure. The date of extractions is before the date of the alveoloplasty.	No documentation is required.
D7321	Alveoplasty not in conjunction with extractions—one to three teeth or tooth spaces, per quadrant	This benefit is typically available if three or fewer permanent teeth in a quadrant have been previously extracted and is limited to once per quadrant per lifetime. Excess bone is removed from the edentulous areas of the ridge to recontour the bony ridge in preparation for a dental prosthesis (implant retained crown, dentures, RPD, FPD, implant-supported crown or retained FPD, RPD). General anesthesia is a covered benefit with this procedure. The date of extractions is before the date of the alveoloplasty.	No documentation is required.
D7340	Vestibuloplasty—ridge extension (secondary epithelialization)	This procedure is typically not covered, but it may be covered once per lifetime for ACA plans.	n/a
D7350	Vestibuloplasty—ridge extension, including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied tissue)	This procedure is typically not covered, but it may be covered once per lifetime for ACA plans.	n/a
D7410	Excision of benign lesions up to 1.25 cm	The tissue appearance must be documented and appear abnormal or suspicious on the image provided with the claim. This procedure is performed before pathological examination of abnormal tissue or lesion. It is not to be used with apicoectomy/ periradicular surgery. General anesthesia is a covered benefit with this procedure.	**Requires clinical review; pre-treatment estimate recommended.** Pathology report, statement of medical necessity and intraoral photograph are recommended in addition.

*Check patient eligibility including age and frequency limitations for each service.

Oral and Maxillofacial Surgery			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D7411	Excision of benign lesion greater than 1.25 cm	The tissue appearance must be documented and appear abnormal or suspicious on the image provided with the claim. This procedure is performed before pathological examination of abnormal tissue or lesion. It is not to be used with apicoectomy/ periradicular surgery. General anesthesia is a covered benefit with this procedure. This procedure may be covered by the medical benefit.	**Requires clinical review; pre-treatment estimate recommended.** Pathology report, statement of medical necessity and intraoral photograph are recommended in addition.
D7412	Excision of a benign lesion—complicated	The tissue appearance must be documented and appear abnormal or suspicious on the image provided with the claim. This procedure is performed before pathological examination of abnormal tissue or lesion. It is not to be used with apicoectomy/ periradicular surgery. General anesthesia is a covered benefit with this procedure. This procedure may be covered by the medical benefit.	**Requires clinical review; pre-treatment estimate recommended.** Pathology report, statement of medical necessity and intraoral photograph are recommended in addition.
D7413	Excision of malignant lesion up to 1.25 cm	The tissue appearance must be documented and appear abnormal or suspicious on the image provided with the claim. This procedure is performed before pathological examination of abnormal tissue or lesion. It is not to be used with apicoectomy/ periradicular surgery. General anesthesia is a covered benefit with this procedure.	**Requires clinical review; pre-treatment estimate recommended.** Pathology report, statement of medical necessity and intraoral photograph are recommended in addition.
D7414	Excision of malignant lesion greater than 1.25 cm	The tissue appearance must be documented and appear abnormal or suspicious on the image provided with the claim. This procedure is performed before pathological examination of abnormal tissue or lesion. It is not to be used with apicoectomy/ periradicular surgery. General anesthesia is a covered benefit with this procedure. This procedure may be covered by the medical benefit.	**Requires clinical review; pre-treatment estimate recommended.** Pathology report, statement of medical necessity and intraoral photograph are recommended in addition.
D7415	Excision of a malignant lesion, complicated	The tissue appearance must be documented and appear abnormal or suspicious on the image provided with the claim. This procedure is performed before pathological examination of abnormal tissue or lesion. It is not to be used with apicoectomy/ periradicular surgery. General anesthesia is a covered benefit with this procedure. This procedure may be covered by the medical benefit.	**Requires clinical review; pre-treatment estimate recommended.** Pathology report, statement of medical necessity and intraoral photograph are recommended in addition.
D7440	Excision of malignant tumor—lesion diameter up to 1.25 cm	The tissue appearance must be documented and appear abnormal or suspicious on the image provided with the claim. This procedure is performed before pathological examination of abnormal tissue or lesion. It is not to be used with apicoectomy/ periradicular surgery. General anesthesia is a covered benefit with this procedure. This procedure may be covered by the medical benefit.	**Requires clinical review; pre-treatment estimate recommended.** Pathology report, statement of medical necessity and intraoral photograph are recommended in addition.

*Check patient eligibility including age and frequency limitations for each service.

Oral and Maxillofacial Surgery			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D7441	Excision of malignant tumor—lesion diameter greater than 1.25 cm	The tissue appearance must be documented and appear abnormal or suspicious on the image provided with the claim. This procedure is performed before pathological examination of abnormal tissue or lesion. It is not to be used with apicoectomy/periradicular surgery. General anesthesia is a covered benefit with this procedure. This procedure may be covered by the medical benefit.	**Requires clinical review; pre-treatment estimate recommended.** Pathology report, statement of medical necessity and intraoral photograph are recommended in addition.
D7450	Removal of odontogenic cyst or tumor—lesion diameter up to 1.25 cm	The tissue appearance must be documented and appear abnormal or suspicious on the image provided with the claim. This procedure is performed before pathological examination of abnormal tissue or lesion. It is not to be used with apicoectomy/periradicular surgery. General anesthesia is a covered benefit with this procedure. This procedure may be covered by the medical benefit.	**Requires clinical review; pre-treatment estimate recommended.** Pathology report, statement of medical necessity and intraoral photograph are recommended in addition.
D7451	Removal of odontogenic cyst or tumor—lesion diameter greater than 1.25 cm	The tissue appearance must be documented and appear abnormal or suspicious on the image provided with the claim. This procedure is performed before pathological examination of abnormal tissue or lesion. It is not to be used with apicoectomy/periradicular surgery. General anesthesia is a covered benefit with this procedure. This procedure may be covered by the medical benefit.	**Requires clinical review; pre-treatment estimate recommended.** Pathology report, statement of medical necessity and intraoral photograph are recommended in addition.
D7460	Removal of benign non-odontogenic cyst or tumor—lesion diameter up to 1.25 cm	The tissue appearance must be documented and appear abnormal or suspicious on the image provided with the claim. This procedure is performed before pathological examination of abnormal tissue or lesion. It is not to be used with apicoectomy/periradicular surgery. General anesthesia is a covered benefit with this procedure. This procedure may be covered by the medical benefit.	**Requires clinical review; pre-treatment estimate recommended.** Pathology report, statement of medical necessity and intraoral photograph are recommended in addition.
D7461	Removal of benign non-odontogenic cyst or tumor—lesion diameter greater than 1.25 cm	The tissue appearance must be documented and appear abnormal or suspicious on the image provided with the claim. This procedure is performed before pathological examination of abnormal tissue or lesion. It is not to be used with apicoectomy/periradicular surgery. General anesthesia is a covered benefit with this procedure. This procedure may be covered by the medical benefit.	**Requires clinical review; pre-treatment estimate recommended.** Pathology report, statement of medical necessity and intraoral photograph are recommended in addition.
D7465	Destruction of lesion(s) by physical or chemical method, by report	The tissue appearance must be documented and appear abnormal or suspicious on the image provided with the claim. This procedure is performed before pathological examination of abnormal tissue or lesion. It is not to be used with apicoectomy/periradicular surgery. The tissue ablation can be achieved via cryo, laser or electrosurgery. General anesthesia is a covered benefit with this procedure. This procedure may be covered by the medical benefit.	**Requires clinical review; pre-treatment estimate recommended.** Pathology report, statement of medical necessity and intraoral photograph are recommended in addition.

*Check patient eligibility including age and frequency limitations for each service.

Oral and Maxillofacial Surgery			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D7471	Removal of lateral exostosis—maxilla or mandible	This procedure is covered when placing a removable prosthesis in the arch is impossible due to the extensive bone growth or with a demonstrated compromise to speech, eating, breathing or sleeping. General anesthesia is covered with this procedure.	**Requires clinical review; pre-treatment estimate recommended.** A statement of medical necessity; intraoral photographs or radiographs demonstrate the exostosis's extent.
D7472	Removal of torus palatinus	This procedure is covered when placing a removable prosthesis in the arch is impossible due to the extensive bone growth or with a demonstrated compromise to speech, eating, breathing or sleeping. General anesthesia is covered with this procedure.	**Requires clinical review; pre-treatment estimate recommended.** A statement of medical necessity; intraoral photographs and/or radiographs demonstrate the exostosis's extent.
D7473	Removal of torus mandibularis	This procedure is covered when placing a removable prosthesis in the arch is impossible due to the extensive bone growth or with a demonstrated compromise to speech, eating, breathing or sleeping. General anesthesia is covered with this procedure.	**Requires clinical review; pre-treatment estimate recommended.** A statement of medical necessity; intraoral photographs and/or radiographs demonstrate the exostosis's extent.
D7485	Reduction of osseous tuberosity	This procedure is covered when placing a fixed or removable prosthesis in the arch is impossible due to the extensive bone anatomy. General anesthesia is covered with this procedure.	**Requires clinical review; pre-treatment estimate recommended.** A statement of medical necessity; intraoral photographs and/or radiographs demonstrate the exostosis's extent.
D7490	Radical resection—maxilla or mandible	This procedure is typically not covered and may be covered under the patient's medical plan.	n/a
D7509	Marsupialization of odontogenic cyst	This procedure is typically covered as needed. General anesthesia is covered with this procedure.	No documentation is required.
D7510	Incision and drainage of abscess—intraoral soft tissue	This procedure is typically covered as needed. General anesthesia is covered with this procedure.	No documentation is required.
D7511	Incision and drainage of abscess—intraoral soft tissue—complicated, including drainage of multiple fascial spaces	This procedure is typically covered as needed. General anesthesia is covered with this procedure.	No documentation is required.
D7520	Incision and drainage of abscess—extraoral soft tissue	This procedure is typically covered as needed. General anesthesia is covered with this procedure.	No documentation is required.
D7521	Incision and drainage of abscess—extraoral soft tissue—complicated, including drainage of multiple fascial spaces	This procedure is typically covered as needed. General anesthesia is covered with this procedure.	No documentation is required.
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	This procedure is typically covered once, even if more than one area is reported on the same service date.	No documentation is required.
D7540	Removal of reaction-producing foreign bodies—musculoskeletal system	Benefits for this procedure are typically available as needed.	No documentation is required.

*Check patient eligibility including age and frequency limitations for each service.

Oral and Maxillofacial Surgery			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D7550	Partial ostectomy/ sequestrectomy for removal of non-vital bone	Benefits for this procedure are typically available as needed.	No documentation is required.
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	Benefits for this procedure are typically available as needed.	No documentation is required.
D7610	Maxilla—open reduction (teeth immobilized if present)	Benefits for this procedure are typically not covered under the dental plan.	n/a
D7620	Maxilla—closed reduction (teeth immobilized if present)	Benefits for this procedure are typically not covered under the dental plan.	n/a
D7630	Mandible—open reduction (teeth immobilized if present)	Benefits for this procedure are typically not covered under the dental plan.	n/a
D7640	Mandible—closed reduction (teeth immobilized if present)	Benefits for this procedure are typically not covered under the dental plan.	n/a
D7650	Malar and/or zygomatic arch—open reduction	Benefits for this procedure are typically not covered under the dental plan.	n/a
D7660	Malar and/or zygomatic arch—closed reduction	Benefits for this procedure are typically not covered under the dental plan.	n/a
D7670	Alveolus—closed reduction, may include stabilization of teeth	Benefits for this procedure are typically not covered under the dental plan.	n/a
D7671	Alveolus—open reduction, may include stabilization of teeth	Benefits for this procedure are typically not covered under the dental plan.	n/a
D7680	Facial bones—complicated reduction with fixation and multiple surgical approaches	Benefits for this procedure are typically not covered under the dental plan.	n/a
D7710	Maxilla—open reduction	Benefits for this procedure are typically not covered under the dental plan.	n/a
D7720	Maxilla—closed reduction	Benefits for this procedure are typically not covered under the dental plan.	n/a
D7730	Mandible—open reduction	Benefits for this procedure are typically not covered under the dental plan.	n/a
D7740	Mandible—closed reduction	Benefits for this procedure are typically not covered under the dental plan.	n/a
D7750	Malar and/or zygomatic arch—open reduction	Benefits for this procedure are typically not covered under the dental plan.	n/a
D7760	Malar and/or zygomatic arch—closed reduction	Benefits for this procedure are typically not covered under the dental plan.	n/a
D7770	Alveolus—open reduction stabilization of teeth	Benefits for this procedure are typically not covered under the dental plan.	n/a

*Check patient eligibility including age and frequency limitations for each service.

Oral and Maxillofacial Surgery			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D7771	Alveolus, closed reduction stabilization of teeth	Benefits for this procedure are typically not covered under the dental plan.	n/a
D7780	Facial bones—complicated reduction with fixation and multiple approaches	Benefits for this procedure are typically not covered under the dental plan.	n/a
D7810	Open reduction of dislocation	Benefits for this procedure are typically not covered under the dental plan.	n/a
D7820	Closed reduction of dislocation	Benefits for this procedure are typically not covered under the dental plan.	n/a
D7830	Manipulation under anesthesia	Benefits for this procedure are typically not covered under the dental plan.	n/a
D7840	Condylectomy	Benefits for this procedure are typically not covered under the dental plan.	n/a
D7850	Surgical discectomy, with/ without implant	Benefits for this procedure are typically not covered under the dental plan.	n/a
D7852	Disc repair	Benefits for this procedure are typically not covered under the dental plan.	n/a
D7854	Synovectomy	Benefits for this procedure are typically not covered under the dental plan.	n/a
D7856	Myotomy	Benefits for this procedure are typically not covered under the dental plan.	n/a
D7858	Joint reconstruction	Benefits for this procedure are typically not covered under the dental plan.	n/a
D7860	Arthrotomy	Benefits for this procedure are typically not covered under the dental plan.	n/a
D7865	Arthroplasty	Benefits for this procedure are typically not covered under the dental plan.	n/a
D7870	Arthrocentesis	Benefits for this procedure are typically not covered under the dental plan.	n/a
D7871	Non-arthroscopic lysis and lavage	Benefits for this procedure are typically not covered under the dental plan.	n/a
D7872	Arthroscopy—diagnosis, with or without biopsy	Benefits for this procedure are typically not covered under the dental plan.	n/a
D7873	Arthroscopy—lavage and lysis of adhesions	Benefits for this procedure are typically not covered under the dental plan.	n/a
D7874	Arthroscopy—disc repositioning and stabilization	Benefits for this procedure are typically not covered under the dental plan.	n/a
D7875	Arthroscopy—synovectomy	Benefits for this procedure are typically not covered under the dental plan.	n/a

*Check patient eligibility including age and frequency limitations for each service.

Oral and Maxillofacial Surgery			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D7876	Arthroscopy—discectomy	Benefits for this procedure are typically not covered under the dental plan.	n/a
D7877	Arthroscopy—debridement	Benefits for this procedure are typically not covered under the dental plan.	n/a
D7880	Occlusal orthotic device, by report	Benefits for this procedure are typically not covered under the dental plan.	n/a
D7881	Occlusal orthotic device adjustment	Benefits for this procedure are typically not covered under the dental plan.	n/a
D7899	Unspecified TMD therapy, by report	Benefits for this procedure are typically not covered under the dental plan.	n/a
D7910	Suture of recent small wounds up to 5 cm	Benefits for this procedure are not provided.	n/a
D7911	Complicated suture—up to 5 cm	Benefits for this procedure are not provided.	n/a
D7912	Complicated suture—greater than 5 cm	Benefits for this procedure are not provided.	n/a
D7920	Skin graft (identify defect covered, location and type of graft)	Benefits for this procedure are not provided.	n/a
D7921	Collection and application of autologous blood concentrate product	Benefits for this procedure are typically not covered under the dental plan.	n/a
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	Benefits for this procedure are typically not covered under the dental plan.	n/a
D7939	Indexing for osteotomy using dynamic robotic-assisted or dynamic navigation	Typically not covered.	n/a
D7940	Osteoplasty—for orthognathic deformities	Benefits for this procedure are typically not covered under the dental plan.	n/a
D7941	Osteotomy—mandibular rami	Benefits for this procedure are typically not covered under the dental plan.	n/a
D7943	Osteotomy—mandibular rami with bone graft; includes obtaining the graft	Benefits for this procedure are typically not covered under the dental plan.	n/a
D7944	Osteotomy—segmented or subapical	Benefits for this procedure are typically not covered under the dental plan.	n/a
D7945	Osteotomy—body of mandible	Benefits for this procedure are typically not covered under the dental plan.	n/a

*Check patient eligibility including age and frequency limitations for each service.

Oral and Maxillofacial Surgery			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D7946	Lefort I—maxilla (total)	Benefits for this procedure are typically not covered under the dental plan.	n/a
D7947	Lefort I—maxilla (segmented)	Benefits for this procedure are typically not covered under the dental plan.	n/a
D7948	Lefort II or Lefort III—osteoplasty of facial bones for midface hypoplasia or retrusion—without bone graft	Benefits for this procedure are typically not covered under the dental plan.	n/a
D7949	Lefort II or Lefort III—with bone graft	Benefits for this procedure are typically not covered under the dental plan.	n/a
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla—autogenous or nonautogenous, by report	This procedure is considered necessary and appropriate when: ▪ Performed to repair a significant osseous defect in the maxilla or mandible, which may be caused by disease or injury beyond that of a periodontal defect, commonly referred to as a block graft. ▪ The procedure includes ridge augmentation or reconstruction to increase the height, width and/or volume of the alveolar ridge. ▪ The procedure includes obtaining and placing the graft material (autogenous graft or allograft) and any related follow-up visit. ▪ Placement of a barrier membrane, if used, may be reported separately.	**Requires clinical review; pre-treatment estimate recommended.** Panoramic, full-mouth series and periapical radiographs are acceptable if they show the complete site, statement of medical necessity and rationale.
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	This procedure is considered necessary and appropriate when: ▪ The area must be edentulous. ▪ Must be done for implant site preparation. ▪ It may be appropriate at the time of implant placement when implant stability is not obtained with existing bone. ▪ Short, wide implant body use is contraindicated. ▪ Placed in the absence of sinus pathology. ▪ Implant and implant services are covered services in the plan.	**Requires clinical review; pre-treatment estimate recommended.** Panoramic, full-mouth series and periapical radiographs are acceptable if they show the complete site, statement of medical necessity and rationale.
D7952	Sinus augmentation via a vertical approach	This procedure is considered necessary and appropriate when: ▪ The area must be edentulous. ▪ Must be done for implant site preparation. ▪ It may be appropriate at the time of implant placement when implant stability is not obtained with existing bone. ▪ Short, wide implant body use is contraindicated. ▪ Placed in the absence of sinus pathology. ▪ Implant and implant services are covered services in the plan.	**Requires clinical review; pre-treatment estimate recommended.** Panoramic or full-mouth series radiographs and periapical radiographs are acceptable if they show a complete site, statement of medical necessity and rationale.

*Check patient eligibility including age and frequency limitations for each service.

Oral and Maxillofacial Surgery			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**

D7953	Bone replacement graft for ridge preservation—per site	This procedure is considered necessary and appropriate when:
		▪ Post extraction site presents with compromised bone mass.
		▪ At least one osseous plate is fenestrated or presents with dehiscence or is fractured resulting in a major defect.
		▪ Particular consideration for benefits will be given to:
		  ▪ Maxillary molar and premolar regions that may require grafting to provide adequate space between the sinus and the implant.
		  ▪ Maxillary and mandibular anterior regions that may require bone grafts for compromised (very thin osseous plate) facial bony walls.
			Requires clinical review; pre-treatment estimate recommended. Panoramic or full-mouth series radiographs and periapical radiographs are acceptable if they show a complete site, statement of medical necessity and rationale.

D7955	Repair of maxillofacial soft and/or hard tissue defect	Benefits for this procedure are typically not covered under the dental plan.	n/a
D7956	Guided tissue regeneration, edentulous area—resorbable barrier, per site	This procedure is typically covered once every five years and must be submitted with osseous surgery codes D7950-7955.	**Requires clinical review; pre-treatment estimate recommended.** Statement of medical necessity, prior history, pre-operative periapical or panoramic radiograph.
D7957	Guided tissue regeneration, edentulous area—non-resorbable barrier, per site	This procedure is typically covered once every five years and must be submitted with osseous surgery codes D7950-7955.	**Requires clinical review; pre-treatment estimate recommended.** Statement of medical necessity, prior history, pre-operative periapical or panoramic radiograph.
D7961	Buccal/labial frenectomy (frenulectomy)	This procedure is typically covered once per lifetime per arch. A frenectomy is considered inclusive if a soft tissue graft is performed on the same service date. This procedure is considered necessary and appropriate when: ▪ The child is a young infant and has difficulty "latching" or cannot latch for feeding. ▪ Excessive lingual attachment is impeding speech or swallowing. ▪ High labial attachment prevents the eruption of teeth. ▪ High labial attachment creates a diastema or causes tooth rotation. ▪ Necessary to avoid or proceed with orthodontic treatment.	**Requires clinical review; pre-treatment estimate recommended.** Statement of medical necessity, a referral letter from a physician requesting frenulectomy if a child is younger than three years of age and intraoral photos

*Check patient eligibility including age and frequency limitations for each service.

Oral and Maxillofacial Surgery			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D7962	Lingual frenectomy (frenulectomy)	This procedure is typically covered once per lifetime per arch. A frenectomy is considered inclusive if a soft tissue graft is performed on the same service date. This procedure is considered necessary and appropriate when: ▪ The child is a young infant and is having difficulty "latching" or cannot latch for feeding. ▪ Excessive lingual attachment is impeding speech or swallowing. ▪ High labial attachment prevents the eruption of teeth. ▪ High labial attachment creates a diastema or causes tooth rotation. ▪ Necessary to avoid or proceed with orthodontic treatment.	**Requires clinical review; pre-treatment estimate recommended.** Statement of medical necessity, a referral letter from a physician requesting frenulectomy if a child is younger than three years of age and intraoral photos
D7963	Frenuloplasty	This procedure is typically covered once per lifetime per arch. A frenectomy is considered inclusive if a soft tissue graft is performed on the same service date. This procedure is considered necessary and appropriate when: ▪ The child is a young infant and is having difficulty "latching" or cannot latch for feeding. ▪ Excessive lingual attachment is impeding speech or swallowing. ▪ High labial attachment prevents the eruption of teeth. ▪ High labial attachment creates a diastema or causes tooth rotation. ▪ Necessary to avoid or proceed with orthodontic treatment.	**Requires clinical review; pre-treatment estimate recommended.** Statement of medical necessity, a referral letter from a physician requesting frenulectomy if a child is younger than three years of age and intraoral photos
D7970	Excision of hyperplastic tissue—per arch	Benefits for this procedure are allowed as needed. General anesthesia is covered with this procedure.	No documentation is required.
D7971	Excision of pericoronal gingiva	Benefits for this procedure are allowed as needed, but if another periodontal or oral surgical procedure (D4210–D4261, D4268–D4278, D7111–D7251, D7280, D7282, D7292–D7294, D7970–D7972) is performed on the same dates of service, no benefits for the excision will be allowed. General anesthesia is covered with this procedure.	No documentation is required.
D7972	Surgical reduction of fibrous tuberosity	Benefits are allowed for this procedure if soft tissue is hypertrophied and interferes with occlusion, the restorative space for a prosthetic restoration or the excess tissue interferes with appropriate denture flange extension.	**Requires clinical review; pre-treatment estimate recommended.** Statement of medical necessity, intraoral photograph (recommended) and panoramic radiograph.
D7979	Non-surgical sialolithotomy	This procedure is typically not covered. A sialolith is removed from the gland or ductal portion without surgical incision into the gland or the gland's duct, for example, via manual manipulation, ductal dilation, or any other non-surgical method.	n/a
D7980	Surgical sialolithotomy	This procedure is typically not covered under the dental plan.	Supporting documentation is required if submitted to the medical plan.

*Check patient eligibility including age and frequency limitations for each service.

Oral and Maxillofacial Surgery			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D7981	Excision of salivary gland, by report	This procedure is typically not covered under the dental plan.	n/a
D7982	Sialodochoplasty	This procedure is typically not covered under the dental plan.	n/a
D7983	Closure of salivary fistula	This procedure is typically not covered under the dental plan.	n/a
D7990	Emergency tracheotomy	This procedure is typically not covered under the dental plan.	n/a
D7991	Coronoidectomy	This procedure is typically not covered under the dental plan.	n/a
D7994	Surgical placement—zygomatic implant	This procedure is typically not covered under the dental plan.	n/a
D7995	Synthetic graft—mandible or facial bones, by report	This procedure is typically not covered under the dental plan.	n/a
D7996	Implant—mandible for augmentation purposes (excluding alveolar ridge), by report	This procedure is typically not covered under the dental plan.	n/a
D7997	Appliance removal not performed by the dentist who placed the appliance, includes removal of arch bar	This procedure is typically not covered under the dental plan.	n/a
D7998	Intraoral placement of a fixation device not in conjunction with a fracture	This procedure is typically not covered under the dental plan.	n/a
D7999	Unspecified oral surgery procedure, by report	This submission requires a detailed description of services not adequately described by an existing oral surgery CDT code.	**Requires clinical review; pre-treatment estimate recommended.** Statement of medical necessity, operative notes, diagnostic images and description of the specific procedure.

*Check patient eligibility including age and frequency limitations for each service.

CareFirst
Family of health care plans

Part 11: Orthodontics

Comprehensive Dental Reference Guide

Please use the Comprehensive Dental Reference Guide when preparing your claims and pre-treatment estimates for CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc., (collectively, "CareFirst"), CareFirst BlueCross BlueShield Medicare Advantage, The Dental Network, and the Federal Employee Program®.

- **CDT code descriptions**
- **Utilization review perspectives on clinical presentations appropriate for benefit allowance**
- **CareFirst-required documentation to allow for processing**
- **Identification of codes that require a clinical review by our staff of licensed dentists**

Selecting the most appropriate code to describe treatment rendered and providing required documentation streamlines the claims submission process.

These descriptions and directions are based on standard plan designs. Individual patient plans may vary. Verify benefits and eligibility for each patient before the appointment.

CareFirst
Family of health care plans

Orthodontics: D8000–D8999

The information provided is based on general clinical policy and can vary for each patient's plan. Verify benefits and eligibility for each patient before the appointment, as there are differences among plans. The following information gives generalized clinical requirements and guidance for each CDT code.

Orthodontics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D8010	Limited orthodontic treatment of the primary dentition	Benefits are subject to the contractual lifetime maximum for orthodontics and are paid as a one-time benefit. This procedure is not covered under ACA pediatric embedded dental contracts. This service includes all required appliances, adjustments and observations. Requests for orthodontic services for members covered under CareFirst Dental Contracts are provided according to the contract. No Dental Director Review is required. Benefits are provided to members who meet the following criteria: Orthodontic coverage is provided in the member's contract. The member is eligible to receive orthodontic benefits. For example, a member's contract may provide coverage for orthodontic services but limited to dependents) and the orthodontic treatment is to reduce or eliminate an existing malocclusion.	n/a

*Check patient eligibility including age and frequency limitations for each service.

Orthodontics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D8020	Limited orthodontic treatment of the transitional dentition	Benefits are subject to the contractual lifetime maximum for orthodontics and are paid as a one-time benefit. This procedure is not covered under ACA pediatric embedded dental contracts. This service includes all required appliances, adjustments and observations. Requests for orthodontic services for members covered under CareFirst Dental Contracts are provided according to the contract. No Dental Director Review is required. Benefits are provided to members who meet the following criteria: Orthodontic coverage is provided in the member's contract. The member is eligible to receive orthodontic benefits. For example, a member's contract may provide coverage for orthodontic services but limited to dependents) and the orthodontic treatment is to reduce or eliminate an existing malocclusion.	n/a
D8030	Limited orthodontic treatment of adolescent dentition	Benefits are subject to the contractual lifetime maximum for orthodontics and are paid as a one-time benefit. This procedure is not covered under ACA pediatric embedded dental contracts. This service includes all required appliances, adjustments and observations. Requests for orthodontic services for members covered under CareFirst Dental Contracts are provided according to the contract. No Dental Director Review is required. Benefits are provided to members who meet the following criteria: Orthodontic coverage is provided in the member's contract. The member is eligible to receive orthodontic benefits. For example, a member's contract may provide coverage for orthodontic services but limited to dependents) and the orthodontic treatment is to reduce or eliminate an existing malocclusion.	n/a
D8040	Limited orthodontic treatment of adult dentition	Benefits are subject to the contractual lifetime maximum for orthodontics and are paid as a one-time benefit. This procedure is not covered under ACA pediatric embedded dental contracts. This service includes all required appliances, adjustments and observations. Requests for orthodontic services for members covered under CareFirst Dental Contracts are provided according to the contract. No Dental Director Review is required. Benefits are provided to members who meet the following criteria: Orthodontic coverage is provided in the member's contract. The member is eligible to receive orthodontic benefits. For example, a member's contract may provide coverage for orthodontic services but limited to dependents) and the orthodontic treatment is to reduce or eliminate an existing malocclusion.	n/a

*Check patient eligibility including age and frequency limitations for each service.

Orthodontics	
Procedure Code	**Description**
D8070, D8080, D8090	Comprehensive orthodontic treatment of transitional dentition

Clinical Criteria and/or Policy and Supporting Documentation Requirements

Benefits are subject to the contractual lifetime maximum for orthodontics and are paid as a one-time benefit.

This service includes all required appliances, adjustments and observations.

Requests for orthodontic services for members covered under CareFirst Dental Contracts are provided according to the contract. Benefits are provided to members who meet the following criteria:

- Orthodontic coverage is provided in the member's contract.
- The member is eligible to receive orthodontic benefits. For example, a member's contract may provide coverage for orthodontic services but limited to dependents.
- The orthodontic treatment is to reduce or eliminate an existing malocclusion.
- One set of retainers is included in comprehensive orthodontics.
- One retainer replacement is allowed per arch per lifetime within 24 months of the date that active treatment ends (debanding, removal of active appliance).
- Rebonding or recementation of any fixed appliance is included during treatment.

Affordable Care Act (ACA) contracts:

Orthodontic benefits for members covered under ACA are limited to comprehensive orthodontic treatment (procedure codes D8070-D8090). All other orthodontic treatment procedure codes are excluded from the contract; therefore, a benefit will not be provided.

A Pre-Treatment Estimate (PTE) must be submitted and approved before any ACA benefits can be allowed and treatment begins. If treatment has started before receipt of an approved PTE, no benefits will be allowed. Benefits for orthodontic services will only be available until the end of the calendar year in which the member turns age 19 if the member:

- Has fully erupted permanent teeth with at least 1/2 to 3/4 of the clinical crown being exposed (unless the tooth is impacted or congenitally missing); and
- Has a severe, dysfunctional, handicapping malocclusion that meets a minimum score of 15 on the Handicapping Labio-Lingual Deviations Index (HLD) or a minimum score of 25 on the Salzmann Evaluation Index (form is dependent upon jurisdiction).
- Points are not awarded for aesthetics; therefore, additional points for aesthetic correction will not be considered part of the determination.

All other contracts (commercial):

The dentist should select the comprehensive ADA Procedure Code that is most appropriate to the patient's current stage of dentofacial development:

- D8070—Comprehensive orthodontic treatment of the transitional dentition
- D8080—Comprehensive orthodontic treatment of the adolescent dentition
- D8090—Comprehensive orthodontic treatment of the adult dentition

Benefits for orthodontic treatment are provided in quarterly or monthly installments, based on the group's specifications, and are determined by the anticipated length of treatment. When submitting the initial claim for orthodontia, include the following information:

- Banding date
- Length of treatment (in months)
- The total charge for the treatment

Dentists will submit one claim for the entire orthodontic course of treatment. An initial payment for comprehensive treatment is made upon banding and consists of the lesser of 25% of the Allowed Benefit or 25% of the member's orthodontia lifetime maximum.

(continued next page)

*Check patient eligibility including age and frequency limitations for each service.

Orthodontics

Clinical Criteria and/or Policy and Supporting Documentation Requirements

(continued from previous page)

Payments of the remaining allowance will be spread throughout the remaining months of treatment. CareFirst will automatically make quarterly or monthly payments based on the existing treatment plan. The benefit will continue to be paid until treatment is completed if the following conditions exist:

- The policy remains active
- The member remains covered under the policy
- The member has not reached the age of ineligibility as defined in the contract
- The member's lifetime maximum has not been exhausted
- The member continues to be under active treatment

CareFirst will provide a monthly benefit based on the patient's current eligibility and the orthodontic lifetime benefit available and is subject to all contractual provisions, exclusions and limitations.

Orthodontic benefits are based on the member's contract. The orthodontic lifetime maximum amount varies by account. To verify a member's eligibility and benefits, call using your Regional provider number or the appropriate Provider Service area.

Members seeking treatment from a Participating orthodontist are responsible for the co-insurance percentage associated with the treatment; the amount of member liability should not exceed the CareFirst Allowed Benefit. Participating providers are encouraged to verify their CareFirst fee schedule to determine the appropriate allowance for the procedure code. The allowance for the comprehensive treatment will be determined when the appliance is placed; any increase in allowances during treatment will not apply to orthodontic cases in progress.

Required documentation to accompany the PTE or claim:

For CareFirst Commercial Dental Contracts: No Dental Director Review is required; the claim form must include:

- Banding date
- Length of treatment (in months)
- The total charge for the treatment

ACA contracts:

Requires clinical review; pre-treatment estimate required. Panoramic and cephalometric radiographs, intraoral photographic series demonstrating occlusion, digital images of study models in centric bite registration and the State-mandated assessment form (HLD or Salzmann Index).

- Current ADA claim form with service code requested and fee
- Images of diagnostic study models, properly trimmed, with individual occlusal views, articulated profile and frontal views, clear enough to measure overjet, overbite, crowding, spacing, etc.
- High-quality facial photographs that equally illustrate the dentition and arch/tooth relationships are acceptable. (Plaster or stone models are no longer accepted.)
- Cephalometric head film with measurements and analysis
- Panoramic or full-series radiographs
- Clinical summary with diagnosis
- Appropriate State-mandated HLD or Salzmann Evaluation assessment form completed and signed by the treating provider
- Treatment plan including anticipated duration of active treatment

*Check patient eligibility including age and frequency limitations for each service.

Orthodontics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy**	**Supporting Documentation Requirements**
D8091	Comprehensive orthodontic treatment with orthognathic surgery (Treatment of craniofacial syndromes or orthopedic discrepancies that require multiple phases of orthodontic treatment including monitoring growth and development between active phases of treatment.)	This procedure is not a covered service on most plans.	n/a
D8210	Removable appliance therapy	Benefits are typically allowed for commercial plans once per appliance per six months and apply to the orthodontic lifetime maximum. This procedure includes all required appliances, adjustments and observations.	No documentation is required.
D8220	Fixed appliance therapy	Benefits are typically allowed for commercial plans once per appliance per six months and apply to the orthodontic lifetime maximum. This procedure includes all required appliances, adjustments and observations.	No documentation is required.
D8660	Pre-orthodontic treatment visit	The benefit may be allowed once per six months for commercial plans, not to exceed 3 pre-orthodontic treatment visits before banding or delivery of the initial appliance. This code describes observational visits to determine when the patient can start orthodontic treatment.	No documentation is required.
D8670	Periodic orthodontic treatment visit (as part of the contract)	This procedure is considered inclusive to the orthodontic treatment rendered and cannot be billed to the member.	n/a
D8671	Periodic orthodontic treatment visit associated with orthognathic surgery	This procedure is not a covered service on most plans.	n/a
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	This procedure is considered inclusive to the orthodontic treatment rendered and cannot be billed to the member.	n/a
D8681	Removable orthodontic retainer adjustment	This procedure is considered inclusive to the orthodontic treatment rendered and cannot be billed to the member.	n/a
D8695	Removal of fixed orthodontic appliances for reasons other than completion of treatment	Typically not covered.	n/a
D8696	Repair of orthodontic appliance—maxillary	This procedure is considered inclusive to the orthodontic treatment rendered and cannot be billed to the member.	n/a
D8697	Repair of orthodontic appliance—mandibular	This procedure is considered inclusive to the orthodontic treatment rendered and cannot be billed to the member.	n/a

*Check patient eligibility including age and frequency limitations for each service.

Orthodontics			
Procedure Code	**Description**	**Clinical Criteria and/or Policy**	**Supporting Documentation Requirements**
D8698	Re-cement or rebond fixed retainer—maxillary	This procedure is considered inclusive to the orthodontic treatment rendered and cannot be billed to the member.	n/a
D8699	Re-cement or rebond fixed retainer—mandibular	This procedure is considered inclusive to the orthodontic treatment rendered and cannot be billed to the member.	n/a
D8701	Repair of the fixed retainer includes reattachment—maxillary	Typically not covered.	n/a
D8702	Repair of the fixed retainer includes reattachment—mandibular	Typically not covered.	n/a
D8703	Replacement of lost or broken retainer—maxillary	Typically not covered.	n/a
D8704	Replacement of lost or broken retainer—mandibular	Typically not covered.	n/a
D8999	Unspecified orthodontic procedure, by report	A detailed narrative that describes the treatment provided, the rationale for the treatment, and any appropriate imaging or treatment notes are needed to review for benefits.	**Requires clinical review; pre-treatment estimate recommended;** A detailed narrative that describes the treatment provided and rationale for the treatment, and any appropriate imaging or treatment notes are needed to review for benefits.

*Check patient eligibility including age and frequency limitations for each service.

CareFirst
Family of health care plans

Part 12: Adjunctive General Services

Comprehensive Dental Reference Guide

Please use the Comprehensive Dental Reference Guide when preparing your claims and pre-treatment estimates for CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc., (collectively, "CareFirst"), CareFirst BlueCross BlueShield Medicare Advantage, The Dental Network, and the Federal Employee Program®.

- **CDT code descriptions**
- **Utilization review perspectives on clinical presentations appropriate for benefit allowance**
- **CareFirst-required documentation to allow for processing**
- **Identification of codes that require a clinical review by our staff of licensed dentists**

Selecting the most appropriate code to describe treatment rendered and providing required documentation streamlines the claims submission process.

These descriptions and directions are based on standard plan designs. Individual patient plans may vary. Verify benefits and eligibility for each patient before the appointment.

CareFirst
Family of health care plans

Adjunctive General: D9000–D9999

The information provided is based on general clinical policy and can vary for each patient's plan. Verify benefits and eligibility for each patient before the appointment, as there are differences among plans. The following information gives generalized clinical requirements and guidance for each CDT code.

Adjunctive General			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D9110	Palliative treatment of dental pain—minor procedure	This service is typically covered once per service date only, but there is no limit to the frequency of this service on different dates. This service is to treat dental pain and is a minor procedure not aligned with any other CDT code. The palliative treatment benefits will not be allowed if definitive services are performed on the same tooth on the same service date. However, this procedure is allowed on the same date as an exam, radiographs and preventive care.	No documentation is required.
D9120	Fixed partial denture sectioning	This procedure is for sectioning of one or more connections between pontics and/or abutments; some portion of the fixed prosthesis must remain intact and serviceable following sectioning; usually, extraction of an abutment tooth is involved, includes recontouring and polishing of the retained potions; teeth must be in functional occlusion; abutment teeth must have adequate bone support.	**Requires clinical review; pre-treatment estimate recommended.** Full-mouth series or panoramic and periapical radiograph; rationale or statement of medical necessity; tooth to be extracted or retained.
D9130	Temporomandibular joint dysfunction—non-invasive physical therapies	Typically not covered.	n/a
D9210	Local anesthesia not in conjunction with operative or surgical procedures	This procedure is considered inclusive to any operative or surgical procedures and cannot be billed separately.	n/a
D9211	Regional block anesthesia	This procedure is considered inclusive to any operative or surgical procedures and cannot be billed separately.	n/a

*Check patient eligibility including age and frequency limitations for each service.

Adjunctive General			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D9212	Trigeminal division block anesthesia	This procedure is considered inclusive to any operative or surgical procedures and cannot be billed separately.	n/a
D9215	Local anesthesia in conjunction with operative or surgical procedures	This procedure is considered inclusive to any operative or surgical procedures and cannot be billed separately.	n/a
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	Benefits for this service are typically allowed up to two per benefit period in addition to the two exams allowed per benefit period, but not on the same service date as the evaluation.	No documentation is required.
D9222	Deep sedation/general anesthesia—first 15 minutes	Deep sedation or general anesthesia is covered along with the following services and is billed in increments of 15 minutes. Endo: 3410, D3421, D3425, D3426, D3450, D3920 Perio: D4260, D4261, D4263, D4264, D4270, D4271, D4273, D4277, D4278 Implant surgery: D6010, D6100, D6103 Oral surgery: D7220, D7230, D7240, D7241, D7250, D7260, D7261, D7280, D7282, D7283, D7290, D7310, D7320, D7311, D7321, D7340, D7350, D7440, D7441, D7450, D7451, D7460, D7461, D746, D7471, D7472, D7473, D7485, D7490, D7510, D7520, D7511, D74=521, D7953, D7970, D7971, D7972 D7210 is covered if there are multiple surgical extractions. It requires a statement of medical necessity along with that claim.	**Requires clinical review; pre-treatment estimate recommended.** For multiple D7210 procedures on the same service date ONLY, submit a narrative with the rationale and description of medical necessity. All other allowed services do not require the submission of additional information.
D9223	Deep sedation/general anesthesia—each subsequent 15-minute increment	Deep sedation or general anesthesia is covered along with the following services and is billed in increments of 15 minutes. Endo: 3410, D3421, D3425, D3426, D3450, D3920 Perio: D4260, D4261, D4263, D4264, D4270, D4271, D4273, D4277, D4278 Implant surgery: D6010, D6100, D6103 Oral surgery: D7220, D7230, D7240, D7241, D7250, D7260, D7261, D7280, D7282, D7283, D7290, D7310, D7320, D7311, D7321, D7340, D7350, D7440, D7441, D7450, D7451, D7460, D7461, D746, D7471, D7472, D7473, D7485, D7490, D7510, D7520, D7511, D74=521, D7953, D7970, D7971, D7972 D7210 is covered if there are multiple surgical extractions. It requires a statement of medical necessity along with that claim.	**Requires clinical review; pre-treatment estimate recommended.** For multiple D7210 procedures on the same service date ONLY, submit a narrative with the rationale and description of medical necessity. All other allowed services do not require the submission of additional information.
D9230	Inhalation of nitrous oxide/ analgesia, anxiolysis	Typically not covered.	n/a

*Check patient eligibility including age and frequency limitations for each service.

Adjunctive General			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D9239	Intravenous moderate (conscious) sedation/analgesia—first 15 minutes	Intravenous moderate (conscious) sedation or analgesia is covered along with the following services and is billed in increments of 15 minutes. Endo: 3410, D3421, D3425, D3426, D3450, D3920 Perio: D4260, D4261, D4263, D4264, D4270, D4271, D4273, D4277, D4278 Implant surgery: D6010, D6100, D6103 Oral surgery: D7220, D7230, D7240, D7241, D7250, D7260, D7261, D7280, D7282, D7283, D7290, D7310, D7320, D7311, D7321, D7340, D7350, D7440, D7441, D7450, D7451, D7460, D7461, D746, D7471, D7472, D7473, D7485, D7490, D7510, D7520, D7511, D74521, D7953, D7970, D7971, D7972 D7210 is covered if there are multiple surgical extractions and requires a statement of medical necessity along with that claim.	**Requires clinical review; pre-treatment estimate recommended.** For multiple D7210 procedures on the same service date ONLY, submit a narrative with the rationale and description of medical necessity. All other allowed services do not require the submission of additional information.
D9243	Intravenous moderate (conscious) sedation/analgesia—each subsequent 15-minute increment	Intravenous moderate (conscious) sedation or analgesia is covered along with the following services and is billed in increments of 15 minutes. Endo: 3410, D3421, D3425, D3426, D3450, D3920 Perio: D4260, D4261, D4263, D4264, D4270, D4271, D4273, D4277, D4278 Implant surgery: D6010, D6100, D6103 Oral surgery: D7220, D7230, D7240, D7241, D7250, D7260, D7261, D7280, D7282, D7283, D7290, D7310, D7320, D7311, D7321, D7340, D7350, D7440, D7441, D7450, D7451, D7460, D7461, D746, D7471, D7472, D7473, D7485, D7490, D7510, D7520, D7511, D74521, D7953, D7970, D7971, D7972 D7210 is covered if there are multiple surgical extractions and requires a statement of medical necessity along with that claim.	**Requires clinical review; pre-treatment estimate recommended.** For multiple D7210 procedures on the same service date ONLY, submit a narrative with the rationale and description of medical necessity. All other allowed services do not require the submission of additional information.
D9248	Non-intravenous conscious sedation	Benefits for this procedure are limited to pediatric dentists without any additional documentation. All other specialists must submit the claim with a statement of medical necessity. This benefit is paid once per service date.	**Requires clinical review; pre-treatment estimate recommended.** For dentists other than pediatric dentists, submit a statement of medical necessity and the medications used.
D9310	Consultation—diagnostic service provided by a dentist or physician other than requesting a dentist or physician	The benefit for consultation is limited to one consultation per dentist per condition. Benefit allowed if billed by a specialist. If being billed by a general dentist, a narrative is required.	**Requires clinical review; pre-treatment estimate recommended.** For general dentists, submit a statement of medical necessity and a description of the condition evaluated.
D9311	Consultation with a medical healthcare professional	This service is considered inclusive to the diagnostic evaluation or exam performed by the dentist who submits the claim.	n/a

*Check patient eligibility including age and frequency limitations for each service.

Adjunctive General			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D9420	Hospital or ambulatory surgical center call	Benefits are available for children up to age 19 when billed by a Pediatric Dentist, for all other providers and with a statement of medical necessity attached.	**Requires clinical review; pre-treatment estimate recommended.** For dentists other than pediatric dentists, submit a statement of medical necessity.
D9430	Office visit for observation (during regularly scheduled hours)—no other services performed	This procedure is considered inclusive to the other services performed for which the follow-up observation was completed.	n/a
D9440	Office visit—after regularly scheduled hours	Typically not covered.	n/a
D9450	Case presentation, detailed and extensive treatment planning	This procedure is considered inclusive to the definitive services performed.	n/a
D9610	Therapeutic parenteral drug, single administration	Typically not covered.	n/a
D9612	Therapeutic parenteral drugs, two or more administrations, different medications	Typically not covered.	n/a
D9613	Infiltration of sustained-release therapeutic drug—single or multiple sites	This procedure is only allowed for long-acting local anesthetics and D7230, D7240 and D7241. Other general anesthesia and conscious sedation procedures can be performed on the same service date (D9222, D9223, D9230, D9239, D9242 and D9248).	No documentation is required.
D9630	Drugs or medicaments dispensed in the office for home use	Typically not covered.	n/a
D9910	Application of desensitizing medicament	Typically not covered.	n/a
D9911	Application of desensitizing resin for cervical and/or root surface, per tooth	This benefit is typically allowed as required but not if billed with a fluoride treatment, other composite restorations or definitive services on the same tooth.	No documentation is required.
D9912	Pre-visit patient screening	This procedure is considered inclusive to the other services performed.	n/a
D9913	Administration of neuromodulators	This procedure is typically not covered under the dental benefit plan.	n/a
D9914	Administration of dermal fillers	This procedure is typically not covered under the dental benefit plan.	n/a
D9920	Behavior management, by report	Benefits for this procedure are available for children over the age of 24 months and under the age of 13. The submission requires a statement of medical necessity. If anesthesia services are performed, then this service will be considered inclusive.	**Requires clinical review; pre-treatment estimate recommended.** Submit a statement of medical necessity detailing the actions that need to be taken to manage the patient.

*Check patient eligibility including age and frequency limitations for each service.

Adjunctive General			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D9930	Treatment of complications (post-surgical)—unusual circumstances, by report	Benefits for this procedure are typically considered inclusive to the surgical procedures performed that day; if this is billed on a separate service date, a narrative describing the complications and treatment plan is required.	**Requires clinical review; pre-treatment estimate recommended.** Submit a statement of medical necessity detailing the issues surrounding the complication and the treatment that was required to manage the case.
D9932	Cleaning and inspection of removable complete denture, maxillary	Benefits are typically limited to two per benefit period. This procedure only applies to patients who are fully edentulous in the mandibular arch.	No documentation is required.
D9933	Cleaning and inspection of removable complete denture, mandibular	Benefits are typically limited to two per benefit period. This procedure only applies to patients who are fully edentulous in the mandibular arch.	No documentation is required.
D9934	Cleaning and inspection of removable partial denture, maxillary	Benefits are typically limited to two per benefit period. This procedure only applies to patients who are partially edentulous in the maxillary arch.	No documentation is required.
D9935	Cleaning and inspection of removable partial denture, mandibular	Benefits are typically limited to two per benefit period; this procedure only applies to patients who are partially edentulous in the mandibular arch.	No documentation is required.
D9938	Fabrication of a custom removable clear plastic temporary aesthetic appliance	Benefits are not typically available as this service is considered inclusive to the primary prosthodontic service.	n/a
D9939	Placement of a custom removable clear plastic temporary aesthetic appliance	This service is not typically covered.	n/a
D9941	Fabrication of athletic mouthguard	Benefits are typically not covered but are dependent upon the patient's contract.	n/a
D9942	Repair and/or reline of an occlusal guard	Benefits are typically not covered but are dependent upon the patient's contract.	n/a
D9943	Occlusal guard adjustment	Benefits are typically not covered but are dependent upon the patient's contract, and if covered, they are not available until six months after the appliance was delivered.	n/a
D9944	Occlusal guard—hard appliance, full arch	Benefits are typically not covered but are dependent upon the patient's contract.	n/a.
D9945	Occlusal guard—soft appliance, full arch	Benefits are typically not covered but are dependent upon the patient's contract.	n/a
D9946	Occlusal guard—hard appliance, partial arch	Benefits are typically not covered but are dependent upon the patient's contract.	n/a.
D9947	Custom sleep apnea appliance fabrication and placement	Custom sleep apnea appliance fabrication and placement is considered a medical service. It may be billed under the patient's medical plan. It may or may not be covered.	n/a

*Check patient eligibility including age and frequency limitations for each service.

Adjunctive General			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D9948	Adjustment of custom sleep apnea appliance	Adjustment of custom sleep apnea appliances is considered a medical service. It may be billed under the patient's medical plan. It may or may not be covered.	**n/a**
D9949	Repair of custom sleep apnea appliance	Repair of custom sleep apnea appliances is considered a medical service. It may be billed under the patient's medical plan. It may or may not be covered.	n/a
D9950	Occlusion analysis—mounted case	Typically not covered.	n/a
D9951	Occlusal adjustment—limited	This benefit is typically limited to once every five years and covered in conjunction with periodontal treatment. It should be billed on a "per visit" basis rather than "per tooth." It will only be paid once, even if billed on the same service date with multiple teeth. If submitted with endodontic or restorative or fixed prosthodontic procedures, it is considered inclusive to the primary treatment.	**Requires clinical review; pre-treatment estimate recommended.** Submit a Full-mouth series or panoramic radiographs, occlusal analysis, perio charting and history, and (for non-ACA policies) a letter of medical necessity.
D9952	Occlusal adjustment—complete	This benefit is typically limited to once every five years and covered in conjunction with periodontal treatment. It should be billed on a "per visit" basis rather than "per tooth." It will only be paid once, even if billed on the same service date with multiple teeth. If submitted with endodontic or restorative or fixed prosthodontic procedures, it is considered inclusive to the primary treatment.	**Requires clinical review; pre-treatment estimate recommended.** Submit a Full-mouth series or panoramic radiographs, occlusal analysis, perio charting and history, and (for non-ACA policies) a letter of medical necessity.
D9953	Reline custom sleep apnea appliance (indirect)	Relining a custom sleep apnea appliance is considered a medical service. It may be billed under the patient's medical plan. It may or may not be covered.	n/a
D9954	Fabrication and delivery of oral appliance therapy (OAT) morning repositioning device	Fabrication and delivery of OAT morning repositioning devices is considered a medical service. It may be billed under the patient's medical plan. It may or may not be covered.	n/a
D9955	Oral appliance therapy (OAT) titration visit	OAT titration visit is considered a medical service. It may be billed under the patient's medical plan. It may or may not be covered.	n/a
D9956	Administration of home sleep apnea test	Administration of a home sleep apnea test is considered a medical service. It may be billed under the patient's medical plan. It may or may not be covered.	n/a
D9957	Screening for sleep-related breathing disorders	Screening for sleep-related breathing disorders is considered a medical service. It may be billed under the patient's medical plan. It may or may not be covered.	n/a
D9959	Unspecified sleep apnea services procedure, by report	Benefits are typically not covered under the dental benefit but may be covered under the medical plan.	n/a
D9961	Duplicate/copy patient records	Typically not covered.	n/a
D9970	Enamel microabrasion	Typically not covered.	n/a

*Check patient eligibility including age and frequency limitations for each service.

Adjunctive General			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D9971	Odontoplasty 1-2 teeth, includes removal of enamel projections	Typically not covered.	n/a
D9972	External bleaching—per arch—performed in the office	Typically not covered.	n/a
D9973	External bleaching-per tooth	Typically not covered.	n/a
D9974	Internal bleaching-per tooth	Typically not covered.	n/a
D9975	External bleaching for home application, per arch, includes materials and fabrication of custom trays.	Typically not covered.	n/a
D9985	Sales Tax	Typically not covered.	n/a
D9986	Missed appointment	Typically not covered.	n/a
D9987	Cancelled appointment	Typically not covered.	n/a
D9990	Certified translation or sign-language services—per visit	Typically not covered.	n/a
D9991	Dental case management-addressing appointment compliance barriers	Typically not covered.	n/a
D9992	Dental case management—care coordination	This procedure is considered inclusive to the examination.	n/a
D9993	Dental case management—motivational interviewing	This procedure is considered inclusive to the examination.	n/a
D9994	Dental case management—patient education to improve oral health literacy	Typically not covered.	n/a
D9995	Teledentistry—synchronous; real-time encounter	This service can be submitted only with a D0140 or D0170 on the same service date to allow for remote, real-time, video or audio examination of a problem-focused issue. There is no additional fee other than that for the examination, but this code allows for tracking the remote teledentistry visit.	n/a
D9996	Teledentistry—asynchronous; information stored and forwarded to a dentist for subsequent review	Examinations with an asynchronous relay of information are not covered benefits.	n/a
D9997	Dental Case Management—Patients with special healthcare needs	Typically not covered.	n/a

*Check patient eligibility including age and frequency limitations for each service.

Adjunctive General			
Procedure Code	**Description**	**Clinical Criteria and/or Policy***	**Supporting Documentation Requirements**
D9999	Unspecified procedure, by report	Treatment that is not accurately described by an existing procedure code can be submitted with D9999, along with the details of the procedure performed.	**Requires clinical review; pre-treatment estimate recommended.** A detailed narrative that describes the treatment provided, the rationale for the treatment, and any appropriate imaging or treatment notes are needed to review for benefits.

*Check patient eligibility including age and frequency limitations for each service.