

## **Chapter 505**

### **Dental, Orthodontics, and Oral Health Services**

#### **APPENDIX 505A**

#### **COVERED DENTAL, ORTHODONTIC AND ORAL HEALTH SERVICES**

#### **CHILDREN UP TO AGE 21 YEARS**

**APPENDIX 505A - COVERED DENTAL, ORTHODONTIC AND ORAL HEALTH SERVICES, CHILDREN UP TO AGE 21 YEARS**  
**Children Oral Health Procedures/Codes**  
**PRIOR AUTHORIZATION MUST BE OBTAINED WHEN SERVICE LIMITS ARE EXCEEDED**

<b>CDT Code</b>	<b>Description</b>	<b>Service Limits</b>	<b>Special Instructions</b>
<b>DIAGNOSTIC</b>			
<b>CLINICAL ORAL EVALUATION</b>			
D0120	Periodic oral evaluation - established patient	2 per calendar year	Not billable with D0140, D0145, D0150 or D9310
D0140	Limited oral evaluation - problem focused	EMERGENT	Not billable with D0120, D0145, D0150 or D9310
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	1 per 6 months	Age restriction up to 36 months. Not billable with D0120, D0140, D0150 or D9310
D0150	Comprehensive oral evaluation - new or established patient	1 per calendar year	Not billable with D0120, D0140, D0145, D9310
<b>DIAGNOSTIC IMAGING (INCLUDING INTERPRETATION)</b>			
D0210	Intraoral-complete series of radiographic images	1 per 2 years	Not billable with D0220, D0230, D0240, D0250, D0270, D0272, D0273, D0274
D0220	Intraoral-periapical, first radiographic image	1 per day	Not billable with D0210 and D0240
D0230	Intraoral-periapical, each additional radiographic image	8 per 3 months	Not billable with D0210 and D0240. Must be billed with D0220
D0240	Intraoral - occlusal radiographic image	2 per calendar year	Not billable with D0210 and D0220, D0230
D0250	Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector	4 per 3 years	
D0270	Bitewing - single radiographic image	4 per calendar year	Not billable with D0210, D0272, D0273, D0274
D0272	Bitewings – two radiographic images	1 per calendar year	Not billable with D0210, D0273, D0274
D0273	Bitewings – three radiographic images	1 per calendar year	Not billable with D0210, D0272, D0274
D0274	Bitewings - four radiographic images	1 per calendar year	Not billable with D0210, D0272, D0273
D0290	Posterior - anterior or lateral	2 per calendar year	

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<b>CDT Code</b>	<b>Description</b>	<b>Service Limits</b>	<b>Special Instructions</b>
D0310	Sialography		
D0320	Temporomandibular joint		
D0321	Other temporomandibular joint radiographic images, by report		Requires Prior Authorization with documentation to identify type of radiograph requested.
D0322	Tomographic survey		
D0330	Panoramic radiographic image	1 per 3 years	
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	1 per calendar year	
D0350	Oral/facial photographic images		This code excludes conventional radiographs - For orthodontics only.
<b>TESTS AND EXAMINATIONS</b>			
D0470	Diagnostic casts	2 per calendar year	
D0474	Accession of tissue, gross and Microscopic examination, including assessment of surgical margins for presence of disease, preparation, and transmission of written report.		
<b>ORAL PATHOLOGY LABORATORY</b>			
<b>GENERALLY PERFORMED IN A PATHOLOGY LABORATORY AND DOES NOT INCLUDE THE REMOVAL OF THE TISSUE SAMPLE FROM THE PATIENT.</b>			
D0486	Laboratory accession of transepithelial cytologic sample, microscopic Examination, preparation, and Transmission of written report.		Analysis and written report of findings, of cytological sample of disaggregated transepithelial cells.
<b>PREVENTIVE</b>			

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<b>CDT Code</b>	<b>Description</b>	<b>Service Limits</b>	<b>Special Instructions</b>
<b>DENTAL PROPHYLAXIS</b>			
D1110	Prophylaxis-adult	1 per 6 months	13 to 21 years of age; Not reimbursable with D1120
D1120	Prophylaxis-child	1 per 6 months	up to 13 years of age; Not reimbursable with D1110
<b>TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)</b>			
D1206	Topical application of fluoride varnish	2 per calendar year	Not reimbursable with D1208. Age restriction of 6 months to 21 years; Not reimbursable with D1208
D1208	Topical application of fluoride	2 per calendar year	3 to 21 years of age; Not reimbursable with D1206
<b>OTHER PREVENTIVE SERVICES</b>			
D1320	Tobacco counseling for the control and prevention of oral disease	2 per calendar year	12 to 21 years of age
D1351	Sealant – per tooth	1 sealant per tooth per 3 years	Tooth numbers 1-32 or A-T must be documented on the claim form for payment consideration. Requires dental areas configuration.
D1353	Sealant repair per tooth	1 sealant repair per tooth per 2 years	Tooth numbers 1-32 or A-T must be documented on the claim form for payment consideration. Requires dental areas configuration. Requires Prior Authorization with documentation
D1510	Space maintainer-fixed- unilateral	4 per calendar year	Per quadrant – UR, UL, LL, LR must be included on claim form for payment consideration.
D1515	Space maintainer – fixed - bilateral	2 per calendar year	Upper arch or lower arch must be included on claim form for payment consideration.
D1520	Space maintainer - removable - unilateral	4 per calendar year	See D1510
D1525	Space maintainer - removable - bilateral	2 per calendar year	See D1515
D1550	Re-cementation of space maintainer	1 per calendar year	

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<b>CDT Code</b>	<b>Description</b>	<b>Service Limits</b>	<b>Special Instructions</b>
<b>RESTORATIVE</b>			
<b>AMALGAM RESTORATIONS (INCLUDING POLISHING)</b>			
D2140	Amalgam - one surface, primary or permanent	5 surfaces per tooth number per 3 years	Tooth numbers 1-32, A-T must be included on the claim form for payment consideration. Tooth preparation, all adhesives (including amalgam bonding agents), liners, bases, & local anesthesia are included the fee & may not be billed separately. Radiographs with documentation must be documented in the medical record for date of service.
D2150	Amalgam - two surfaces, primary or permanent	5 surfaces per tooth number per 3 years	Tooth numbers 1-32, A-T must be included on the claim form for payment consideration. Tooth preparation, all adhesives (including amalgam bonding agents), liners, bases, and local Anesthesia are included the fee and may not be billed separately. Radiographs with documentation must be documented in the Medical record for date of service.
D2160	Amalgam - three surfaces, primary or permanent	5 surfaces per tooth number per 3 years	Tooth numbers 1-32, A-T must be included on the claim form for payment consideration. Tooth preparation, all adhesives (including amalgam bonding agents), liners, bases, and local anesthesia are included the fee and may not be billed separately. Radiographs with documentation must be documented in the medical record for date of service.
D2161	Amalgam - four or more surfaces, primary or permanent	5 surfaces per tooth number per 3 years	Tooth numbers 1-32, A-T must be included on the claim form for payment consideration. Tooth preparation, all adhesives (including amalgam bonding agents), liners, bases, and local anesthesia are included the fee and may not be billed separately. Radiographs with documentation must be documented in the medical record for date of service.

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<b>CDT Code</b>	<b>Description</b>	<b>Service Limits</b>	<b>Special Instructions</b>
<b>RESIN-BASED COMPOSITE RESTORATIONS - DIRECT</b>			
D2330	Resin-based composite - one surface, anterior	5 surfaces per tooth number per 3 years	Tooth numbers 6-11, 22-27, C-H, M-R must be included on the claim form for payment consideration. Fees include bonded composite, light- cured composite, etc., tooth preparation, acid etching, adhesives (included resin bonding agents), liners, bases, curing, glass ionomers and local anesthesia and may not be separately billed. Radiographs with documentation must be documented in the medical record for date of service.
D2331	Resin-based composite - two surfaces, anterior	5 surfaces per tooth number per 3 years	Tooth numbers 6-11, 22-27, C-H, M-R must be included on the claim form for payment consideration. Fees include bonded composite, light- cured composite, etc., tooth preparation, acid etching, adhesives (included resin bonding agents), liners, bases, curing, glass ionomers and local anesthesia and may not be separately billed. Radiographs with documentation must be documented in the medical record for date of service.
D2332	Resin-based composite - three surfaces, anterior	5 surfaces per tooth number per 3 years	Tooth numbers 6-11, 22-27, C-H, M-R must be included on the claim form for payment consideration. Fees include bonded composite, light- cured composite, etc., tooth preparation, acid etching, adhesives (included resin bonding agents), liners, bases, curing, glass ionomers and local anesthesia and may not be separately billed. Radiographs with documentation must be documented in the medical record for date of service.
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)	5 surfaces per tooth number per 3 years	Tooth numbers 6-11, 22-27, C-H, M-R must be included on the claim form for payment consideration. Fees include bonded composite, light- cured

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			composite, etc., tooth preparation, acid etching, adhesives (included resin bonding agents), liners, bases, curing, glass ionomers and local anesthesia and may not be separately billed. Radiographs with documentation must be documented in the medical record for date of service.
D2390	Resin-based composite crown, anterior	1 tooth number per 3 years	Tooth numbers 6-11, 22-27, C-H, M-R must be included on the claim form for payment consideration. Fees include bonded composite, light-cured composite, etc., tooth preparation, acid etching, adhesives (included resin bonding agents), liners, bases, curing, glass ionomers and local anesthesia and may not be separately billed. Radiographs with documentation must be documented in the medical record for date of service.
D2391	Resin-based composite - one surface, posterior	5 surfaces per tooth per 3 years	Tooth numbers 1-5, 12-21, 28-32, A, B, I, J, K, L, S, T, must be included on the claim form for payment consideration. Fees include bonded composite, light-cured composite, etc., tooth preparation, acid etching, adhesives (included resin bonding agents), liners, bases, curing, glass ionomers and local anesthesia and may not be separately billed. Radiographs with documentation must be documented in the medical record for date of service.
D2392	Resin-based composite - two surfaces, posterior	5 surfaces per tooth per 3 years	Tooth numbers 1-5, 12-21, 28-32, A, B, I, J, K, L, S, T, must be included on the claim form for payment consideration. Fees include bonded composite, light-cured composite, etc., tooth preparation, acid etching, adhesives (included resin bonding agents), liners, bases, curing, glass ionomers and local anesthesia and may not be separately billed. Radiographs with documentation must be documented in the medical record for date of service.

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D2393	Resin-based composite three surfaces, posterior	5 surfaces per tooth per 3 years	Tooth numbers 1-5, 12-21, 28-32, A, B, I, J, K, L, S, T, must be included on the claim form for payment consideration. Fees include bonded composite, light-cured composite, etc., tooth preparation, acid etching, adhesives (included resin bonding agents), liners, bases, curing, glass ionomers and local anesthesia and may not be separately billed. Radiographs with documentation must be documented in the medical record for date of service
D2394	Resin-based composite - four or more surfaces, posterior	5 surfaces per tooth per 3 years	Tooth numbers 1-5, 12-21, 28-32, A, B, I, J, K, L, S, T, must be included on the claim form for payment consideration. Fees include bonded composite, light-cured composite, etc., tooth preparation, acid etching, adhesives (included resin bonding agents), liners, bases, curing, glass ionomers and local anesthesia and may not be separately billed. Radiographs with documentation must be documented in the medical record for date of service
<b>CROWNS – SINGLE RESTORATIONS ONLY</b>			
D2751	Crown- porcelain fused to predominately base metal	1 tooth number per 5 years	Requires Prior Authorization with documentation identifying tooth numbers 1-32 and A, B, I, J, K, L, S & T. Tooth numbers must also be documented on the claim form for payment consideration.
D2791	Crown - full cast predominately base metal	1 tooth number per 5 years	Requires Prior Authorization with documentation identifying tooth numbers 1-32 and A, B, I, J, K, L, S, & T. Tooth numbers must also be documented on the claim form for payment consideration.
<b>OTHER RESTORATIVE SERVICES</b>			
D2920	Recement crown	1 per tooth number per 1 calendar year	Tooth numbers 1-32, A-T must be included on the claim form for payment consideration.



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<b>CDT Code</b>	<b>Description</b>	<b>Service Limits</b>	<b>Special Instructions</b>
D2930	Prefabricated stainless steel crown - primary tooth	1 per tooth number per 1 calendar year	Requires Prior Authorization with radiographs. Tooth number A-T primary teeth must be documented on the claim form for payment consideration. Use only when a regular filling is not applicable. Radiographs with documentation must be documented in the medical record for date of service.
D2931	Prefabricated stainless steel crown - permanent tooth	1 per tooth number per 1 calendar year	Requires Prior Authorization with radiographs. Tooth number 1-32 must be documented on the claim form for payment consideration. Use only when a regular filling is not applicable. Radiographs with documentation must be documented in the medical record for date of service.
D2932	Prefabricated resin crown	1 per tooth number per 1 calendar year	Requires Prior Authorization with radiographs. Tooth numbers 1-32 or A-T must be documented on the claim form for payment consideration. Radiographs with documentation must be documented in the medical record for date of service.
D2933	Prefabricated stainless steel crown with resin window		Requires Prior Authorization with radiographs. Tooth numbers 1-32 must be documented on the claim form for payment consideration. Radiographs with documentation must be documented in the medical record for date of service.
D2940	Protective restoration	2 per calendar year per tooth number	Tooth numbers 1-32, A-T must be documented on claim form for payment consideration. Not Allowed in conjunction with root canal therapy, pulpotomy, pulpectomy or on the same date of services as a restoration.
D2950	Core buildup, including any pins	1 per calendar year per tooth number	Tooth numbers 1-32, A-T must be documented on claim form for payment consideration.

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<b>CDT Code</b>	<b>Description</b>	<b>Service Limits</b>	<b>Special Instructions</b>
D2951	Pin retention- per tooth, in addition to restoration	1 per 3 years per tooth number	Tooth numbers 1-32 must be documented on claim form for payment consideration.
D2952	Post and core in addition to crown -indirectly fabricated	1 per 3 years per tooth number	Tooth numbers 1-32 must be documented on claim form for payment consideration.
D2954	Prefabricated post & core in addition to crown	1 per 3 years per tooth number	Tooth numbers 1-32 or A-T must be documented on claim form for payment consideration.
<b>ENDODONTICS – INCLUDES LOCAL ANESTHESIA</b>			
<b>PULPOTOMY</b>			
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	1 per 3 years per tooth number	Tooth numbers 1-32, A-T must be documented on claim form for payment consideration. Not reimbursable with D3310, D3320, or D3330. To be performed on primary or permanent teeth. This is not to be construed as the first stage of root canal therapy. Not to be used for apexogenesis.
<b>ENDODONTIC THERAPY (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES AND FOLLOW UP CARE)</b>			
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	1 tooth number per lifetime	Tooth numbers 6-11, 22-27 must be documented on the claim form for payment consideration. Not reimbursed with D3220, D3320, or D3330
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	1 tooth number per lifetime	Tooth numbers 4, 5, 12, 13, 20, 21, 28, 29 or C, H, Q, N must be documented on the claim form for payment consideration. Not reimbursed with D3220, D3310, or D3330. To be performed on primary or permanent teeth.
D3330	Endodontic therapy, molar (excluding final restoration)	1 tooth number per lifetime	Tooth numbers 1-3, 14-19, 30-32 and primary teeth # A,B,I,J,K,L,S, and T, if no permanent successor present, must be documented on the claim form for payment consideration. Not reimbursed with D3220, D3310, or D3320

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<b>CDT Code</b>	<b>Description</b>	<b>Service Limits</b>	<b>Special Instructions</b>
<b>ENDODONTIC RETREATMENT</b>			
D3346	Retreatment of previous root canal therapy - anterior	1 tooth number per lifetime	Tooth numbers 6-11 and 22-27, must be documented on the claim form for payment consideration includes all diagnostic tests, radiographs, and post-operative treatments and may not be billed separately.
D3347	Retreatment of previous root canal therapy - bicuspid	1 tooth number per lifetime	Tooth numbers 4,5,12,13,20,21,28, and 29 must be documented on the claim form for payment consideration includes all diagnostic tests, radiographs, and post-operative treatments and may not be billed separately.
D3348	Retreatment of previous root canal therapy - molar	1 tooth number per lifetime	Tooth numbers 1-3, 14-19, and 30-32 must be documented on the claim form for payment consideration includes all diagnostic tests, radiographs, and post-operative treatments and may not be billed separately.
<b>APEXIFICATION/RECALCIFICATION AND PULPAL REGENERATION PROCEDURES</b>			
D3351	Apexification/recalcification/pulpal Regeneration - initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)		Tooth numbers 1-32 must be documented on the claim form for payment consideration. Fees include all diagnostic tests, evaluations, radiographs, post-operative treatment and may not be billed separately.
D3352	Apexification/recalcification/pulpal regeneration - interim medication replacement	3 treatment per tooth number per lifetime	Tooth numbers 1-32 must be documented on claim form for payment consideration. Fees include all diagnostic tests, evaluations, radiographs, post-operative treatment and may not be billed separately.
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	1 tooth number per lifetime	Tooth numbers 1-32 must be documented on claim form for payment consideration. Fees include all diagnostic tests, evaluations, radiographs, post-operative treatment and may not be billed separately.
<b>APICTOMY/PERIRADICULAR SERVICES</b>			

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<b>CDT Code</b>	<b>Description</b>	<b>Service Limits</b>	<b>Special Instructions</b>
D3410	Apicoectomy/periradicular surgery - anterior	1 tooth number per lifetime	Requires Prior Authorization with documentation, tooth number(s), and radiographs as appropriate. Tooth numbers 6-11, 22-27 must be documented on the claim form for payment consideration.
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	1 tooth number per lifetime	Requires Prior Authorization with documentation, tooth number(s), and radiographs as appropriate. Tooth numbers 4, 5, 12, 13, 20, 21, 28, 29 must be documented on the claim form for payment consideration.
D3999	Unspecified endodontic procedure, by report		This code should be used only if a more specific CDT code is not available. Requires Prior Authorization with radiographs, documentation, and description of procedure to be performed.
<b>PERIODONTICS</b>			
<b>SURGICAL SERVICES (INCLUDING USUAL POST-OPERATIVE CARE)</b>			
D4210	Gingivectomy or Gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant	1 quadrant per 1 calendar year	Requires Prior Authorization with documentation, identification of the quadrant(s) and radiographs as appropriate. Quadrants are defined as UR, UL, LL, and LR. Not reimbursed with D4211.
D4211	Gingivectomy or Gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant	1 quadrant per 1 calendar year	Requires Prior Authorization with documentation, identification of the quadrant, and radiographs as appropriate. Quadrants are defined as UR, UL, LL, and LR. Not reimbursed with D4210.
D4260	Osseous surgery (including flap entry and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	1 quadrant per 1 calendar year	Requires Prior Authorization with documentation, identification of the quadrant, and radiographs as appropriate. Quadrants are defined as UR, UL, LL, and LR. Not reimbursed with D4210. Must be billed with the number codes.
D4261	Osseous surgery (including flap entry and	1 quadrant per 1	Requires Prior Authorization with documentation,

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	closure) one to three contiguous teeth or tooth bounded spaces per quadrant	calendar year	identification of the quadrant, and radiographs as appropriate. Quadrants are defined as UR, UL, LL, and LR. Not reimbursed with D4210.
<b>NON-SURGICAL PERIODONTAL SERVICE</b>			
D4341	Periodontal scaling and root planing - four/ or more teeth per quadrant	1 quadrant per 1 calendar year	Requires Prior Authorization. Quadrants are defined as UR, UL, LL, and LR. Not reimbursed with D4342.
D4342	Periodontal scaling and root planing - one – to three teeth, per quadrant	1 quadrant per 1 calendar year	Requires Prior Authorization. Quadrants are defined as UR, UL, LL, and LR. Not reimbursed with D4341.
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis.	1 per 6 months	Requires Prior Authorization. Only covered when there is substantial gingival inflammation (gingivitis in all 4 quadrants).
<b>OTHER PERIODONTAL SERVICE</b>			
D4999	Unspecified periodontal procedure, by report		This code should be used only if a more specific CDT code is not available. Requires Prior Authorization with radiographs, documentation, and description of procedure to be performed.
<b>PROSTHODONTICS (REMOVABLE)</b>			
<b>COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)</b>			
D5110	Complete denture - maxillary	1 per 5 years	Requires Prior Authorization
D5120	Complete denture – mandibular	1 per 5 years	Requires Prior Authorization
D5130	Immediate denture – maxillary	1 per 5 years	Requires Prior Authorization
D5140	Immediate denture – mandibular	1 per 5 years	Requires Prior Authorization
<b>PARTIAL DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)</b>			
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including	1 per 5 years	Requires Prior Authorization Partial and complete dentures may not be re-based or re-lined within a

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	any conventional clasps, rests and teeth)		period of one (1) year after construction.
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	1 per 5 years	Requires Prior Authorization Partials and complete dentures may not be re-based or re-lined within a period of one (1) year after construction.
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	1 per 5 years	Requires Prior Authorization Partials and complete dentures may not be re-based or re-lined within a period of one (1) year after construction.
<b>ADJUSTMENTS TO DENTURES</b>			
D5410	Adjust complete denture – maxillary	3 per calendar year	Adjustments not covered within 3 months of placement
D5411	Adjust complete denture – mandibular	3 per calendar year	Adjustments not covered within 3 months of placement
D5421	Adjust partial denture – maxillary	3 per calendar year	Adjustments not covered within 3 months of placement
D5422	Adjust partial denture – mandibular	3 per calendar year	Adjustments not covered within 3 months of placement
<b>REPAIRS TO COMPLETE DENTURES</b>			
D5510	Repair broken complete denture base	2 per calendar year per arch	Upper arch, Low arch must be documented on the claim form for payment consideration.
D5520	Replace missing or broken teeth - complete denture (each tooth)	2 per calendar year per tooth number	Tooth numbers 1-32 must be documented on the claim form for payment consideration.
<b>REPAIRS TO PARTIAL DENTURES</b>			
D5610	Repair resin denture base	2 per calendar year per arch	Upper arch, Lower arch must be documented on the claim form for payment consideration. Must be billed with the tooth number codes.
D5620	Repair cast framework	2 per calendar year per arch	Upper arch, Lower arch must be documented on the claim form for payment consideration. Must be billed with the tooth number codes.
D5630	Repair or replace broken clasp – per tooth	2 per calendar year	

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D5640	Replace broken teeth – per tooth	2 per calendar year	Tooth number 1-32 must be documented on the claim form for payment consideration.
D5650	Add tooth to existing partial denture	2 per calendar year	Tooth number 1-32 must be documented on the claim form for payment consideration
D5660	Add clasp to existing partial denture – per tooth		
<b>DENTURE REBASED PROCEDURES</b>			
D5710	Rebase complete maxillary denture	1 per 5 years	
D5711	Rebase complete mandibular denture	1 per 5 years	
D5720	Rebase maxillary partial denture	1 per 5 years	
D5721	Rebase mandibular partial denture	1 per 5 years	
<b>DENTURE RELINE PROCEDURES</b>			
D5730	Reline complete maxillary denture (chairside)	1 per 2 years	Not covered within first 6 months of placement unless it is for an immediate denture.
D5731	Reline complete mandibular denture (chairside)	1 per 2 years	Not covered within first 6 months of placement unless it is for an immediate denture.
D5740	Reline maxillary partial denture (chairside)	1 per 2 years	Not covered within first 6 months of placement.
D5741	Reline mandibular partial denture (chairside)	1 per 2 years	Not covered within first 6 months of placement.
D5750	Reline complete maxillary denture (laboratory)	1 per 2 years	Not covered within first 6 months of placement.
D5751	Reline complete mandibular denture (laboratory)	1 per 2 years	Not covered within first 6 months of placement.
D5760	Reline maxillary partial denture (laboratory)	1 per 2 years	Not covered within first 6 months of placement.

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<b>CDT Code</b>	<b>Description</b>	<b>Service Limits</b>	<b>Special Instructions</b>
D5761	Reline mandibular partial denture (laboratory)	1 per 2 years	Not covered within first 6 months of placement.
D5899	Unspecified removable prosthodontics procedure, by report		This code should be used only if a more specific CDT code is not available. Require Prior Authorization with documentation and radiographs as appropriate. Procedure must be documented on the claim form.
<b>MAXILLOFACIAL PROSTHETICS</b>			
D5911	Facial moulage (sectional)		Requires Prior Authorization with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5912	Facial moulage (complete)		Requires Prior Authorization with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5913	Nasal prosthesis		Requires Prior Authorization with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5914	Auricular prosthesis	1 in 5 years	Requires Prior Authorization with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5915	Orbital prosthesis		Requires Prior Authorization with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5916	Ocular prosthesis - Prosthetic eye, plastic, custom Prosthetic eye, other type		Requires Prior Authorization with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5919	Facial prosthesis		Requires Prior Authorization with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist required.



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<b>CDT Code</b>	<b>Description</b>	<b>Service Limits</b>	<b>Special Instructions</b>
D5924	Cranial prosthesis		Requires Prior Authorization with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist required.
D5925	Facial augmentation implant prosthesis		Requires Prior Authorization with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5931	Obturator prosthesis, surgical		Requires Prior Authorization with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5932	Obturator prosthesis, definitive		Requires Prior Authorization with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5933	Obturator prosthesis, modification		Requires Prior Authorization with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5934	Mandibular resection prosthesis with guide flange		Requires Prior Authorization with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5935	Mandibular resection prosthesis without guide flange		Requires Prior Authorization with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5937	Trismus appliance (not for TMD treatment)		Requires Prior Authorization with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5951	Feeding aid		Requires Prior Authorization with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5952	Speech aid prosthesis, pediatric		Requires Prior Authorization with documentation and

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<b>CDT Code</b>	<b>Description</b>	<b>Service Limits</b>	<b>Special Instructions</b>
			radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5954	Palatal augmentation prosthesis		Requires Prior Authorization with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5955	Palatal lift prosthesis, definitive		Requires Prior Authorization with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5982	Surgical stent		Requires Prior Authorization with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5983	Radiation carrier		Requires Prior Authorization with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5984	Radiation shield		Requires Prior Authorization with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5985	Radiation cone locator		Requires Prior Authorization with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5986	Fluoride gel carrier		Requires Prior Authorization with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5987	Commissure splint		Requires Prior Authorization with documentation and radiographs as appropriate. Oral and maxillofacial or prosthodontist certification required.
D5999	Unspecified maxillofacial prosthesis, by report		This code should be used only if a more specific code is not available. Requires Prior Authorization

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<b>CDT Code</b>	<b>Description</b>	<b>Service Limits</b>	<b>Special Instructions</b>
			with Radiographs, documentation and description of procedure to be performed. Oral and maxillofacial or prosthodontist certification required.
<b>PROSTHODONTIC FIXED</b>			
<b>FIXED PARTIAL DENTURE PONTICS – EACH ABUTMENT AND EACH PONTIC CONSTITUTE A UNIT IN A BRIDGE</b>			
D6211	Pontic - cast predominantly base metal	1 per 5 years	Requires Prior Authorization Tooth numbers 1-32 must be documented on the claim form for payment consideration.
D6241	Pontic- porcelain fused to predominantly base metal	1 per 5 years	Requires Prior Authorization Tooth numbers 1-32 must be documented on the claim form for payment consideration.
D6545	Retainer - cast metal for resin bonded fixed prosthesis	1 per 5 years	Requires Prior Authorization Tooth numbers 1-32 must be documented on the claim form for payment consideration.
<b>OTHER FIXED DENTURE SERVICES</b>			
D6930	Recement fixed partial denture	1 per calendar year	
D6999	Unspecified, fixed prosthodontic procedures, by report		This code should be used only if a more specific code is not available. Requires Prior Authorization with radiographs, documentation, and description of procedure to be performed.
<b>ORAL AND MAXILLOFACIAL SURGERY</b>			
<b>EXTRACTION - INCLUDES LOCAL ANESTHESIA AND POST-OPERATIVE CARE. ANY NECESSARY SUTURE INCLUDED IN FEE FOR EXTRACTION.</b>			
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	1 per lifetime per tooth number	Tooth numbers 1-32 or A-T must be documented on the claim form for payment consideration.
D7210	Surgical removal of erupted tooth requiring	1 per lifetime per	Tooth numbers 1-32 or A-T must be documented on

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<b>CDT Code</b>	<b>Description</b>	<b>Service Limits</b>	<b>Special Instructions</b>
	removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	tooth number	the claim form for payment consideration.
D7220	Removal of impacted tooth - soft tissue	1 per lifetime per tooth number	Tooth numbers 1-32 or A-T must be documented on the claim form for payment consideration.
D7230	Removal of impacted tooth - partially bony	1 per lifetime per tooth number	Tooth numbers 1-32 or A-T must be documented on the claim form for payment consideration.
D7240	Removal of impacted tooth - completely bony	1 per lifetime per tooth number	Tooth numbers 1-32 or A-T must be documented on the claim form for payment consideration.
<b>OTHER SURGICAL PROCEDURES</b>			
D7260	Oroantral fistula closure		
D7270	Tooth reimplantation &/or stabilization of accidentally evulsed or displaced tooth (includes splinting and/or stabilization)		Tooth numbers 1-32 and primary teeth # A, B, I, J, K, L, S, and T must also be documented on the claim form for payment consideration.
D7280	Surgical access of an unerupted tooth		Tooth numbers 1-32 must also be documented on the claim form for payment consideration.
D7283	Placement of device to facilitate eruption of impacted tooth		Tooth numbers 1-32 must also be documented on the claim form for payment consideration.
D7285	Biopsy of oral tissue – hard (bone, tooth)		
D7286	Biopsy of oral tissue - soft		
<b>ALVEOLOPLASTY – SURGICAL PREPARATION OF RIDGE</b>			
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	1 quadrant UR, UL, LL, LR per lifetime.	Quadrant UR, UL, LL, LR must also be documented on the claim form for payment consideration. Alveoloplasty is distinct (separate procedure) from extractions. Usually in preparation for a prosthesis or other treatments such as radiation therapy and

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<b>CDT Code</b>	<b>Description</b>	<b>Service Limits</b>	<b>Special Instructions</b>
			transplant surgery.
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	1 quadrant UR, UL, LL, LR per lifetime.	Quadrant UR, UL, LL, LR must also be documented on the claim form for payment consideration.
<b>VESTIBULOPLASTY</b>			
D7340	Vestibuloplasty – ridge extension (secondary epithelialization)		Requires Prior Authorization with documentation and radiographs as appropriate.
D7350	Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachments, revision of soft tissue attachment & management of hypertrophied & hyperplastic tissue)		Requires Prior Authorization with documentation and radiographs as appropriate.
D7410	Excision of benign lesion up to 1.25cm		
D7411	Excision of benign lesion greater than 1.25cm		
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm.		
D7441	Excision of malignant tumor - lesion diameter greater than 1.25cm		
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25cm		
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25cm		
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25cm		
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25cm		

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<b>CDT Code</b>	<b>Description</b>	<b>Service Limits</b>	<b>Special Instructions</b>
<b>EXCISION OF BONE TISSUE</b>			
D7471	Removal of lateral exostosis (maxilla or mandible)		UA, LA must be documented on the claim form for payment consideration. Must be billed with the number codes.
D7472	Removal of torus palatinus		
D7473	Removal of torus mandibularis		
D7485	Surgical reduction of osseous tuberosity		
D7490	Radical resection of maxilla or mandible		Requires Prior Authorization with documentation and radiographs as appropriate.
<b>SURGICAL INCISION</b>			
D7510	Incision and drainage of abscess - intraoral soft tissue		
D7520	Incision and drainage of abscess - extraoral soft tissue		
D7530	Removal of foreign body from mucosa, skin or subcutaneous alveolar tissue		
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone		This code should only be used if a more specific code is not available. Requires Prior Authorization with documentation.
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body		
<b>TREATMENT OF FRACTURES - SIMPLE</b>			
D7610	Maxilla - open reduction (teeth immobilized, if present)		
D7620	Maxilla - closed reduction (teeth immobilized,		

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<b>CDT Code</b>	<b>Description</b>	<b>Service Limits</b>	<b>Special Instructions</b>
	if present)		
D7630	Mandible - open reduction (teeth immobilized, if present)		
D7640	Mandible - closed reduction (teeth immobilized, if present)		
D7671	Alveolus - open reduction, may include stabilization of teeth		
D7680	Facial bones – complicated reduction with fixation and multiple surgical approaches		Requires Prior Authorization with documentation and radiographs as appropriate
<b>TREATMENT OF FRACTURES - COMPOUND</b>			
D7710	Maxilla - open reduction		
D7720	Maxilla - closed reduction		
D7730	Mandible - open reduction		
D7740	Mandible - closed reduction		
D7750	Malar and/or zygomatic arch - open reduction		
D7770	Alveolus - open reduction stabilization of teeth		
D7780	Facial bones - complicated reduction with fixation and multiple surgical approaches		Requires Prior Authorization
<b>REDUCTION OF DISLOCATION AND MANAGEMENT OF OTHER TEMPOROMANDIBULAR JOINT DYSFUNCTIONS</b>			
D7810	Open reduction of dislocation		Requires Prior Authorization
D7820	Closed reduction of dislocation		Requires Prior Authorization

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<b>CDT Code</b>	<b>Description</b>	<b>Service Limits</b>	<b>Special Instructions</b>
D7830	Manipulation under anesthesia		Requires Prior Authorization
D7850	Surgical discectomy with/without implant		Requires Prior Authorization. Not reimbursable with D7852
D7852	Disc repair		Requires Prior Authorization. Not reimbursable with D7850
D7858	Joint reconstruction		Requires Prior Authorization
D7865	Arthroplasty		Requires Prior Authorization
D7870	Arthrocentesis		Requires Prior Authorization
D7872	Arthroscopy – diagnosis, with or without biopsy		Requires Prior Authorization
D7873	Arthroscopy – surgical lavage & lysis of adhesions		Requires Prior Authorization
D7874	Arthroscopy - surgical disc repositioning and stabilization		Requires Prior Authorization
D7876	Arthroscopy – surgical discectomy		Requires Prior Authorization
D7877	Arthroscopy – surgical debridement		Requires Prior Authorization
D7880	Occlusal orthotic device, by report		Requires Prior Authorization with documentation and radiographs as appropriate. Covered only for temporomandibular pain dysfunction or associated musculature.
D7910	Suture of recent small wounds up to 5 cm		Excludes closure of surgical incisions
D7911	Complicated suture - up to 5cm	1 unit: not reimbursable with D7912	Excludes closure of surgical incisions
D7912	Complicated suture – greater than 5 cm	1 unit: not	Excludes closure of surgical incisions



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<b>CDT Code</b>	<b>Description</b>	<b>Service Limits</b>	<b>Special Instructions</b>
		reimbursable with D7911	
D7920	Skin graft (identify defect covered, location & type of graft)		Requires Prior Authorization
D7941	Osteotomy – mandibular rami		Requires Prior Authorization
D7943	Osteotomy – mandibular rami with bone graft; includes obtaining the graft		Requires Prior Authorization
D7944	Osteotomy - segmented or subapical		Requires Prior Authorization
D7946	LeFort I (maxilla - total)		Requires Prior Authorization
D7947	LeFort I (maxilla - segmented)		Requires Prior Authorization
D7948	LeFort II or LeFort III (osteoplasty of facial bones for mid-face hypoplasia or retrusion) - without bone graft		Requires Prior Authorization
D7949	LeFort II or LeFort III – with bone graft		Requires Prior Authorization
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or facial bones – autogenous or nonautogenous, by report		Requires Prior Authorization
D7955	Repair of maxillofacial soft and/or hard tissue defect		Requires Prior Authorization
D7960	Frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another	2 per site per lifetime	Requires Prior Authorization
D7970	Excision of hyperplastic tissue - per arch		Requires Prior Authorization UALA must be documented on the claim form for payment consideration. Must be billed with the number codes.

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<b>CDT Code</b>	<b>Description</b>	<b>Service Limits</b>	<b>Special Instructions</b>
D7980	Sialolithotomy		Requires Prior Authorization
D7981	Excision of salivary gland, by report		Requires Prior Authorization
D7982	Sialodochoplasty		Requires Prior Authorization
D7991	Coronoidectomy		Requires Prior Authorization
D7999	Unspecified oral surgery procedure, by report		This code should be used only if a more specific code is not available. Requires Prior Authorization with radiographs, documentation, and description of procedure to be performed.
<b>ORTHODONTICS</b>			
D8010	Limited orthodontic treatment of the primary dentition	2 per calendar year	Requires Prior Authorization with documentation, radiographs, and dental molds.
D8020	Limited Orthodontic	2 per calendar year	Requires Prior Authorization with documentation, radiographs, and dental molds.
D8030	Limited orthodontic treatment of the adolescent dentition	2 per calendar year	Requires Prior Authorization with documentation, radiographs, and dental molds.
D8040	Limited orthodontic treatment of the adult dentition	2 per calendar year	Requires Prior Authorization with documentation, radiographs, and dental molds.
D8050	Interceptive orthodontic treatment of the primary dentition	2 per calendar year	Requires Prior Authorization with documentation, radiographs, and dental molds.
D8060	Interceptive orthodontic treatment of the transitional dentition	2 per calendar year	Requires Prior Authorization with documentation, radiographs, and dental molds.
D8070	Comprehensive orthodontic treatment of the transitional dentition	1 per lifetime	Requires Prior Authorization with documentation, radiographs, and dental molds.
D8080	Comprehensive orthodontic treatment of the adolescent dentition	1 per lifetime	Requires Prior Authorization with documentation, radiographs, and dental molds.

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<b>CDT Code</b>	<b>Description</b>	<b>Service Limits</b>	<b>Special Instructions</b>
D8090	Comprehensive orthodontic treatment of the adult dentition	1 per lifetime	Requires Prior Authorization with documentation, radiographs, and dental molds.
D8210	Removable appliance therapy	2 per lifetime	
D8220	Fixed appliance therapy	2 per calendar year	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))		Requires Prior Authorization with documentation, radiographs, and dental molds.
D8692	Replacement of lost or broken retainer	2 per lifetime	
D8693	Rebonding or recementing; and/or repair, as required, of fixed retainers	1 per lifetime	Requires Prior Authorization
D8999	Unspecified orthodontic procedure, by report		This code should be used only if a more specific code is not available. Requires Prior Authorization with radiographs, documentation, and description of procedure to be performed.
<b>ANESTHESIA</b>			
D9223	Deep sedation/general anesthesia – each 15 minute increment	Maximum 4 unit/day	Class 4 anesthesia permit required
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	Maximum 1 unit/day	Not reimbursable with D9223, D9243.
D9243	Intravenous conscious sedation/analgesia – each 15 minute increment	Maximum 4 unit/day	Class 3 or 4 permit required
<b>OTHER SERVICES</b>			
D9310	Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician		Not reimbursable on same day as D1020, D1040, D1045, D0150
D9420	Hospital or ambulatory surgical center call		

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<b>CDT Code</b>	<b>Description</b>	<b>Service Limits</b>	<b>Special Instructions</b>
D9940	Occlusal guard, by report		Requires Prior Authorization
D9951	Occlusal adjustment - limited		Requires Prior Authorization
D9952	Occlusal adjustment - complete		Requires Prior Authorization
D9986	D9986 Missed Appointment		No reimbursement rate- for tracking purposes only
D9987	D9987 Cancelled Appointment		No reimbursement rate- for tracking purposes only
D9999	Unspecified adjunctive procedure, by report		This code should be used only if a more specific code is not available. Requires Prior Authorization with radiographs, documentation, and description of procedure to be performed is required.